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Rainbow® Children's Hospital
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Your Right to a Safe Delivery

DISCHARGE SUMMARY

Name	Master BESTHA SAURYANSH VYAS	**UHID**	HNH-00014137
Father/Guardian	Mr B V NISHANTH VYAS	**Age/Gender**	1 Y 0 M 9 D/ Male
Address	vasavi hospital ladikapool, Nallakunta, Hyderabad, Telangana, INDIA, 500044		
IP No	IP26-00006453	**Admission Date**	29-05-2026
Ref Doctor	Self.		
Discharge Date	30.05.2026		

Consultant:
Dr. SINDHURA MUNUKUNTLA
MBBS, DCH, DNB PEDIATRICS
66970

DIAGNOSIS	ICD CODE
SEVERE ACUTE GASTRITIS WITH DEHYDRATION	

History: Master BESTHA SAURYANSH VYAS, 1 Y 0 M 9 D , old boy presented with history of greenish vomiting, dull activity since 1 day prior to admission. For the above complaints he was admitted at Rainbow Children's Hospital - Himayatnagar for further management.

Examination: He was afebrile, hemodynamically stable and maintaining saturation at room air. Heart rate - 148/min, blood pressure - 98/47 (57)mmHg and Respiratory Rate - 26/min. On examination Signs of dehydration were

Name	Master BESTHA SAURYANSH VYAS	**UHID**	HNH-00014137
IP No	IP26-00006453	**Admission Date**	29-05-2026

present, dry lips, reduced skin turgor were present. On auscultation of chest, air entry was bilaterally equal with normal heart sounds and no murmur . Abdomen was soft with no organomegaly. On neurological examination, he was conscious, alert. Pupils were bilaterally equal & reacting to light. There were no focal neurological deficits.

Weight on admission: 8.7 kilo grams.

Investigations: Enclosed reports.

ABG/VBG showed pH of 7.39, pCO2 of 31 mmHg, pO2 of 64 mmHg, HCO3 of 19.5 mmol/L and BE of -6.0 mmol/L.

Initial hemogram showed Hemoglobin of 11.2 gm%, White Blood Cell count of 21090 cells/cumm, platelet count of 4.82 lakhs/cumm. Complete urine examination shows 4-6 pus cells, 1-2 epithelial cells.

Management : He was admitted in the ward and given IV NS bolus in view of dehydration and started on Intra Venous fluids . He was treated symptomatically with antacids and antiemetics .

He was regularly monitored for vomiting frequency and hydration status. His vomitings and other symptoms settled gradually.

He remained hemodynamically stable during the hospital stay. He improved with the above line of management and is being discharged with the following advice.

At the time of discharge : He is active, afebrile and hemodynamically stable.

Name	Master BESTHA SAURYANSH VYAS	**UHID**	HNH-00014137
IP No	IP26-00006453	**Admission Date**	29-05-2026

Medication during hospital stay:
Injection. Esmoprazole
Injection. Ondensetron

Advice:
* Diet as advised.

S.No	MEDICATION	DOSE	TIMINGS	DURATION
1	NEXPRO SACHETS	1 SACHET	10am (after food)	For 3 days
2	Syrup. ONDEM (Ondansetron – 5ml/2mg)	4 ml	TID (30 minutes before food)	TODAY F/B SOS

Fever Management
* Syrup. Crocin DS (Paracetamol - 5ml/240mg) 2.5 ml after food as and whenever required, if temperature > 100 *F (maximum 4 times a day at 6 hour intervals).
* Tepid sponging if fever > 101 *F.

Review consultation with Dr. SINDHURA MUNUKUNTLA on Tuesday (02.06.2026) at Himayatnagar in OPD with prior appointment **(Review consultation will be charged)**.

Food instructions while taking medications:

Name	Master BESTHA SAURYANSH VYAS	**UHID**	HNH-00014137
IP No	IP26-00006453	**Admission Date**	29-05-2026

* **Antibiotics** along with food & milk products prevent their absorption of drugs & supplements. Antibiotics can be given 1 hour before food or 2 hours after food based on tolerance of stomach.

Follow up immediately in Emergency Room if high grade fever, vomiting, breathlessness or refusal to feed occurs.

The content of the patient discharge summary, medication, food & drug interaction, care to be provided at home, nutrition, immunization and safe parenting, when and how to obtain emergency care etc also have been explained by doctor ..... in a language that I can understand and I acknowledge.

Parent/ Attender

In case of emergency contact 9154865030 emergency pediatrician on duty.

To take appointment for OPD consultation at Rainbow **Himayatnagar** / **Banjara Hills** / Rainbow Clinic **Madhapur** / **Kukatpally** / **Vikrampuri** / **LB Nagar** dial just one toll free number **18002122.**

You can also take appointments at any time by going **online** to our website **www.rainbowhospitals.in**

Registrar/Resident/C.M.O

Dr. SINDHURA MUNUKUNTLA
MBBS, DCH, DNB PEDIATRICS
66970

Rainbow Childrens Hospital-Himayatnagar

Rainbow Children's Hospital, Door no. 3-6-267, opp. Cafe niloufer, Old MLA quarters road AP State Housing Board Himayatnagar ,Hyderabad ,Telangana, INDIA ,500029.
TEL NO :040-48873000
WEB : https://rainbowhospitals.in

ADMISSION SHEET

Registration Details :

Admission No : IP26-00006453 **Admit Date** : 29-May-2026 **Admit Time** : 05:18 PM **UHID** : HNH-00014137

Patient Details :

Patient Name	: Master BESTHA SAURYANSH VYAS	**Age**	: 1 Y 0 M 8 D
Guardian	: Mr B V NISHANTH VYAS	**DOB**	: 21-05-2025 01:00 AM
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: vasavi hospital ladikapool Nallakunta Hyderabad Telangana INDIA 500044	**Phone No**	: 6281877769/ 8328513588
		E-mail	: nishanthvyas123@gmail.com

Admission Details :

Bed Type : DAY CARE **Bed No** : ER02 **Ward Name** : GF -EMERGENCY

Room No : ER02 **Admission Type** : First Visit

Contact Details :

Name : Mr B V NISHANTH VYAS **Relationship** : Father

Contact Address : vasavi hospital ladikapool Nallakunta Hyderabad Telangana INDIA 500044 **Phone No** : 6281877769

Nishanth

Signature

Doctor Details :

Doctor Name : Dr. SINDHURA MUNUKUNTLA **Specialisation** : GENERAL PEDIATRICS

Referral Doctor : Self. **Phone No** :

Co-Consultant :

Payment Details :

Payment Mode : DC/CC Card **Deposit Amount** : 10000.00

Payor Name : ICICI ICICI LOMBARD GENERAL INSURANCE

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HNH-00014137 IP26-00006453
ACTIV Master BESTHA SAURYANSH VYAS **ING**
21-05-2025 1 Y 0 M 8 D (M)
Dr. SINDHURA MUNUKUNTLA

Name: ----------

UHID No : ---------- IP No : ---------- Consultant : ---------- Dept : ----------

Date of Admission : ---------- Time : ---------- Date of Discharge : ---------- Time: ----------

Room / Bed No : ---------- Ward : ---------- Suggested Billable bed type : ----------

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
29/5/26	6pm	ER	2nd floor (208)	Bhargavi.

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

HNH-00014137 IP26-00006453
Master BESTHA SAURYANSH VYAS
21-05-2025 1 Y 0 M 8 D (M)
Dr. SINDHURA MUNUKUNTLA

INVESTIGATIONS

Date	Investigations	Order No.	Sign
29/5/26	CBP	9007	
	UBT	9006	
29/5/26	CUE	9021	
	Cross by Rs 11:41 AM 30/5/26		

HNH-00014137 IP26-00006453
Master BESTHA SAURYANSH VYAS
21-05-2025 1 Y 0 M 8 D (M)
Dr. SINDHURA MUNUKUNTLA

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
29/5/26	Infusion pump	6pm	11 Am 30/5/26	9945	[signature]
	Cross check by fair			11:41Am 30/5/26	

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Master BESTHA SAURYANSH VYAS
21-05-2025 1 Y 0 M 8 D (M)
Dr. SINDHURA MUNUKUNTLA

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
29/5/26	IV Placement	(1)	2936	
30/5/26	NHA	(1)	3113	

Cross checked by
11:41 AM 30/5/26

ANY OTHER INFORMATION

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

Ref.No. F/IN/PR/10

Rainbow® Children's Hospital

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name : HNH-00014137 IP26-00006453
Master BESTHA SAURYANSH VYAS
21-05-2025 1 Y 0 M 8 D (M)
Dr. SINDHURA MUNUKUNTLA

Patient ID# :

Consultant :

Final Diagnosis :

HNH-00014137 IP26-00006453
Master BESTHA SAURYANSH VYAS
21-05-2025 1 Y 0 M 8 D (M)
Dr. SINDHURA MUNUKUNTLA

Pediatric Multiorgan History & Physical Examination

Name : _____ Age/S

Informant _____ Reliability _____

Chief Presenting Complaints & Duration (Chronologically):

c/o Vomitings :- 1 day
Greenish Vomiting
c/o Dull activity :- 1 day
c/o No Urine :- 12 pm

History of present illness :

child brought with c/o Vomitings :- 1 day
Multiple episodes of Vomiting
greenish bilious Vomiting - 3 episodes

c/o Dull activity :- 1 day

c/o Reduced Urine :- 12pm

No loose stools
No fever

Severe Dehydration (+)

Past History : (Including details of any previous investigation or treatment)

Birth & Neonatal History :

Birth & Socio Economic History :

About Father :

About Mother :

Any additional Information :

Developmental History :

Immunization History :

Upto date

Pediatric Multiorgan History & Physical Examination

Anthropometry

Head Circum (cms)_____(Centile _____) Height (cm) : _____ (Centile _____)

Weight (kgs) 8.7 Kg (Centile _____)

On Examination :

Temperature : 99° F Pulse Rate: 148/min Description _____

B.P. 78/47 (57) mmHg SPO2 99 at _____

Resp. rate and type of breathing : 26 /min

Rash Signs of Dehydration ⊕ - Sunken eyes

Lymphadenopathy Dry lips & oral cavity

Oedema : Reduced skin turgor

Respiratory system :

Inspection (any s/o distress) : _____

Air entry & breath sounds : B/L AE ⊕

Any addes sounds : _____

Relevant data from outside (Chest X-Ray, ABG, etc.,) _____

Cardiovasclular System :

Inspection of procordium : _____

Heart Sounds : $S_1 S_2$ ⊕

Any murmur : _____

Relevant date from outside (Chest X-Ray, ECG, ECHO, Etc.,) _____

Per Abdomen :

Inspection _____

Palpation : Soft

Ausculation : _____

Spine: _____ External Genitelia : _____

Relevant data from outside (CT, USG etc.,) _____

Central Nervous System :

Level of Consciousness : AVPU/GCS Score : Drowsy & Lethargic

Cranial Nerves :

Motor System :

Nutrition :

Tone : Power

Co-ordinator :

Posture :

Involuntary Movements :

Reflexes :

DTR **Superficials :**

Plantars

Sensory System :

Bladder / Bowel :

Clinical Summary & Diagnostic :

Acute Gastritis c Severe Dehydration
c Bilious Vomiting

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Master BESTHA SAURYANSH VYAS
21-05-2025 1 Y 0 M 8 D (M)
Dr. SINDHURA MUNUKUNTLA

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment :

Desired goals of the treatment :

Planned Labs :

VBG
CBP
CUE (Due)
+ 1 plan
Noted by Jyothi

Planned Management :

NPO till further order.
IVF - 10ml/kg - IV one 1 hour
IVF - .
Inj Ondem
Inj Esomeprazole
Noted by Jyothi

Please fill up the following details

1. Name of the Referring Doctor :
2. Name of the Referring Hospital : (Including the name of City)
3. Contact number of the Referring Doctor : (Preferring Mobile #)
4. Name of the doctor in Rainbow Team Dr. Sindhura on whose name the patient is being referred

Doctor's Signature Name [signature] Date 29/5/24 Time 6:30 pm

HNH-00014137 IP26-00006453
Master BESTHA SAURYANSH VYAS
21-05-2025 1 Y 0 M 8 D (M)
Dr. SINDHURA MUNUKUNTLA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	C/S/B - Dr. Sindhura	
29/08/26 6PM	Acute Gastritis with dehydration	
	Vomiting x 1 day	
	poor oral intake	
	O/E: GC - fair	
	vitals - stable	
	Signs of dehydration (+)	
	S/E: PA soft Nontender	
		Adv
		- IVF plasmalyte (full m) for 4 hours → reassess
		- If any bilious vomiting ↓ X-ray Abdomen erect USG abdomen
		- Inj Ondansetron SOS
		- Inj Esomeprazole OD
		-

Dr. Sindhura Munukuntla
Consultant Pediatrician
Reg. No. 66970

[signature]

Docu. No. : RCH /FRM / CLINICAL / 088

HNH-00014137 IP26-00006453
Master BESTHA SAURYANSH VYAS
21-05-2025 1 Y 0 M 8 D (M)
Dr. SINDHURA MUNUKUNTLA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
30/5/26 7AM	c/o/b Dr. Verma / Dr. Siddharth.	
	Dx - Acute gastritis c dehydration.	
	- Afebrile.	
	- Loose stools - None	
	- Vomiting - No c/o.	Plan
	- Oral intake - fair.	- If any bilious vomiting ↓
	G/E - vitals stable.	- X ray ERECT abdomen.
	S/E - NAD.	- Ct. Esomeprazole, ondansetron.

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Master BESTHA SAURYANSH VYAS
21-05-2025 1 Y 0 M 9 D (M)
Dr. SINDHURA MUNUKUNTLA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
30/5/26	C/S/B - Dr Sindhura	
11 am	Acute gastritis c dehydration	Advise:
	Afebrile	(i) Any further
	No loose stools. no vomitings.	bilious vomitings ↓ Xray Abdomen erect
	Oral intake - fair.	(ii) Continue Esomeprazole & Ondem.
	O/E - Vitals stable.	(iii) Monitor vitals.
	R/S P/A - S/L	(iv) Can be discharged today. Review on Tuesday Continue Ondem for today.
		Dr. Sindhura Munukuntla Consultant Pediatrician Reg. No: 66970 [signature]

(P.T.O)

Docu. No. : RCH /FRM / CLINICAL / 088

HNH-00014137 IP26-00006453
Master BESTHA SAURYANSH VYAS
21-05-2025 1 Y 0 M 9 D (M)
Dr. SINDHURA MUNUKUNTLA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

HNH-00014137 IP26-00006453
Master BESTHA SAURYANSH VYAS
21-05-2026 1 Y 0 M 8 D (M)
Dr. SINDHURA MUNUKUNTLA

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DRUG CHART

Date of Admission: 29/5/26 Drug Allergies: NIL ☑ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

GENERAL - Ensure that all patient details are entered above. ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.

DOCTOR - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).

- Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
- Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
- Discontinue a drug by drawing a line *I* through it and a similar line through subsequent recording panels.
- The date and time of stopping the drug along with the doctors name and sign must be mentioned.
- Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.

NURSES - Nurses must follow strictly the FIVE RIGHTS before administration of medication.

1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time

- AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

SOS / PRN (As Required Medication)

DRUG :				Date / Time
Dose	Route	Frequency	Start Date	
Doctor's Signature		Valid Period	Pharm.	
Additional Instructions:				

DRUG :				Date / Time
Dose	Route	Frequency	Start Date	
Doctor's Signature		Valid Period	Pharm.	
Additional Instructions:				

DRUG :				Date / Time
Dose	Route	Frequency	Start Date	
Doctor's Signature		Valid Period	Pharm.	
Additional Instructions:				

Sig... VERIFIED BY : Name ...

HNH-00014137 IP26-00006453
Master BESTHA SAURYANSH VYAS
21-05-2025 1 Y 0 M 8 D (M)
Dr. SINDHURA MUNUKUNTLA

REGULAR PRESCRIPTIONS

Weight. 8.7 kg Ward. .....

DRUG : Inj ESOMEPRAZOLE

Dose	Route	Frequency	Start Date
10 mg	IV	OD	29/5

Name & Signature of the Doctor Starting the Drugs: Pharm

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time																
29/5																
	5:40															
6pm	ER															

DRUG : Inj ONDANSETRON

Dose	Route	Frequency	Start Date
1.5mg	IV	TID	29/5

Name & Signature of the Doctor Starting the Drugs: Pharm

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time																
29/5																
6Am	X															
	5:40															
2pm	ER															
10Pm																

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time																

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time																

21-05-2025 1 Y 0 M 8 D (M)
Dr. SINDHURA MUNUKUNTLA

Weight. ..... Ward. .....

VARIABLE DOSE	Date▸ Time		Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.
DRUG :		Dose		Dose		Dose		Dose	
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Route / Start Date		Dose		Dose		Dose		Dose	
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Name & Signature of the Doctor		Dose		Dose		Dose		Dose	
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Additional Instructions:		Dose		Dose		Dose		Dose	
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	

VARIABLE DOSE	Date▸ Time		Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.
DRUG :		Dose		Dose		Dose		Dose	
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Route / Start Date		Dose		Dose		Dose		Dose	
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Name & Signature of the Doctor		Dose		Dose		Dose		Dose	
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Additional Instructions:		Dose		Dose		Dose		Dose	
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
29/5	5:30pm	NS BOLUS	100 ml	IV over 1 hr	T	Jyothi

Signature .....

VERIFIED BY : Name .....

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Master BESTHA SAURYANSH VYAS
21-05-2025 1 Y 0 M 8 D (M)
Dr. SINDHURA MUNUKUNTLA

HNH-00014137 IP26-00006453
Master BESTHA SAURYANSH VYAS

I.V. FLUIDS CHART

Weight. ..... Ward. .....

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
29/05	6pm	IVF. PLASMALYTE	IV	35					
	11pm			↓			11 Am 30/5/26		

VERIFIED BY : Name ..... Signature .....

HNH-00014137 IP26-00006453
Master BESTHA SAURYANSH VYAS
21-05-2025 1 Y 0 M 8 D (M)
Dr. SINDHURA MUNUKUNTLA

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MEDICATION RECONCILIATION FORM

Drug Allergies: ..... Nill ☐ Not known any Drug Allergies

Medication Reconciliation will be done at the time of admission and also whenever there is change in the treating team or shifting from one unit to another unit.
(Example: at the time of admission shifting from ICU to Ward, or Ward to ICUs)

Shifting From: ..... ER Shifted to: ..... 2nd floor (208)

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1						☐ C ☐ DC
2						☐ C ☐ DC
3						☐ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : ..... Dr. pranav

Date & Time : ..... 29/5/26 @ 5:30pm

Nurse Name & Signature: ..... Bhargavi

Date & Time : ..... 29/5/26 @ 5:35pm

HNH-00014137 IP26-00006453
Master BESTHA SAURYANSH VYAS
21-05-2025 1 Y 0 M 8 D (M)
Dr. SINDHURA MUNUKUNTLA

213

RESULT SHEET

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Date	29/5/26					
Time						
Hb	11.2					
PCV	31.3					
RBC	4.25					
WBC	21.09					
N/L	51.1/44.0					
Platelets	482					
CRP						
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein/Sugar						
Cells						
N/L						

P.T.O.

Date	29/5/26					
Time						
CUE-Alb						
CUE-Sugar						
CUE - Ketones	Negative					
CUE-PUS Cells	4-6					
CUE - RBC Cells	Nil					
CUE						
Epithelial cells	1-5					
Stool Pus Cell						
OVA/Cyst						
Occult Blood						

Culture and Sensitivities : .....

.....

.....

.....

Radiology: USG : .....

X-Ray:.....

ECHO: .....

CT: .....

MRI .....

Others (ECG, Contrast Studies etc.,) : .....

HNH-00014137 IP26-00006453
Master BESTHA SAURYANSH VYAS
21-05-2025 1 Y 0 M 8 D (M)
Dr. SINDHURA MUNUKUNTLA

Patient S

CLINICAL / 125

PRESCHOOL (1-5 years)
Children's Observation & Early Warning Scoring Chart

Rainbow® Children's Hospital — It takes a lot to treat the little.

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 29/5 Time:

Parameter	6 PM	9 PM	11 pm	2 AM	6 AM
Doctor / Nurse / Family Concern?					
Temperature (F) (scale 94–104)	98°F	97.4°F	98.4°F?	98.1°F?	97.4°F
Heart Rate (bpm) and Blood Pressure (mmHg) * (scale 50–190)	78/36 mmHg (sleeping)	80/45	100/71 (87)		
Heart Rate (Number)	116 bpm	124 b/m	130 b/m	120 b/m	126 b/m
Resp. Rate (bpm) (Over 1 Minute) * (scale 10–70)					
Resp Rate (Number)	30 bpm	30 b/m	36 b/m?	30 b/m	30 b/m
Resp Distress — Mod/ Severe					
Resp Distress — None / Mild					
Receiving O_2 (l/min)					
O_2 Saturations (%)	98%	99%	99%	99%	100%
Conscious Level — Normal					
Conscious Level — Altered					
GCS *					
TOTAL SCORE Number of shaded boxes	0	0	0	0	0
Pain Score	0	0	0	0	0
Observer's Initials	(initials)	(initials)	(initials)	(initials)	(initials)

Note: BP does not score in early warning scoring

ACTIONS		
	Score 1	: Continue normal observation by staff nurse
	Score 2	: Shift in charge nurse to be informed and continue hourly observations
NB: Scores 3 should be recorded overleaf	Score 3	: Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.
	Score 4	: Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see
	Score 5 & 6	: Shift in charge AND PICU fellow or PICU consultant to be informed.

* NB: If GCS is below 12 or the Oxygen requirement is >3 Lit./min. , then irrespective of rest of the score, the Nurse MUST inform the PICU team.

Patient Sticker

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

- The paediatric Early Warning Score i) seeks to identify the abnormal physiological finding seen during serious childhood illnesses and ii) offers a method to interpret such physiological derangements with clearly defined actions, ensuring that suitably experienced staff are involved with the care of the sickest children.
- The Early Warning Score does not replace clinical experience and acumen and should not be relied upon for such purpose.
- 6 clinical parameters are assessed and recorded as part of the child's routine clinical observation, providing a Early Warning Score between 0-6 (Higher Early Warning Score are seen in sicker children)
- Detailed actions are described according to increasing Early Warning Score.
- Some children with complex medical needs e.g. cyanotic heart disease may require modification to their trigger thresholds/ action plan- this should follow discussion with senior colleagues.
- Any Early Warning Score of 3 or above should be recorded below with details of any subsequent action initiated

Record Details when EARLY WARNING SCORE >3			**Record Time of Review and Plan**		
Date	Time	Early Warning Score	Date	Time	Name

- If at any time additional help is required, call help – regardless of the Early Warning Score!
- Following a Early Warning Score assessment, senior help may be required

The SBAR communication tool (situation, background, assessment, recommendations) is a helpful mnemonic that can be used to describe a child's clinical condition to a colleague.

I	**IDENTITY:** I am (name), a nurse on ward (X). I am calling about (child X)
S	**SITUATION :** I am calling because I am concerned that ... (e.g. BP is low/high, pulse is XXX, Temperature is XX, Early Warning Score is XX)
B	**BACK GROUND :** Child (X) was admitted on (XX date) with (e.g. respiratory infection). They have had (X operation/ procedure/ investigation). Child (X)'s condition has changed in the last (XX mins). Their last set of observations were (XXX). The child's normal condition is ... (e.g. alert/ drowsy/ confused, pain free)
A	**ASSESSMENT :** I think the problem is (XXX) and I have ...(e.g. given O2/ analgesia, stopped the infusion), OR I am not sure what the problem is but child (X) is deteriorating, OR I don't know what's wrong but I am really worried.
R	**RECOMMENDATION :** I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

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Patient Stick

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FLUID CHART

Sheet No. : ....

1. All measurements in ml.
2. Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.

Date	Time	Intake				Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
		Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am					E 12						
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
29/5	02:00 pm	plasmalyte	milk			NA			NA			Sm
	03:00 pm										0	
	04:00 pm										0	
	05:00 pm			35 ml							0	
	06:00 pm			35 ml							0	
	07:00 pm			35 ml							0	
Total Intake :						Total Output : U-0 M-0						
29/5/26	08:00 pm	plasmalyte	diluted + Hm	35 ml		NA		NA			0	[signature]
	09:00 pm			35 ml						✓		
	10:00 pm			35 ml			✓					
	11:00 pm			35 ml						✓		
	12:00 am			35 ml								
	01:00 am			35 ml								
Total Intake :						Total Output : U-2 M-1						
30/5/26	02:00 am	plasmalyte		35 ml		NA		NA			0	[signature]
	03:00 am			35 ml			✓					
	04:00 am			35 ml						✓		
	05:00 am			35 ml								
	06:00 am			35 ml								
	07:00 am			35 ml								
Total Intake :						Total Output : U-1 M-1						

Total 24 hrs. Intake		Total 24 hrs. Output	

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FLUID CHART

Sheet No. : .....

1. All measurements in ml.
2. Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						**Total Output :**						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						**Total Output :**						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						**Total Output :**						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						**Total Output :**						

Total 24 hrs. Intake		**Total 24 hrs. Output**	

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NURSING CARE RECORD

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Date: 29/5/25

Goals

- ☐ Maintain Airway and Oxygenation
- ☐ Relieve Pain & Discomfort
- ☐ Maintain Fluid Balance
- ☐ Improve Activity Tolerance
- ☐ Maintain Good Nutritional Status
- ☐ Maintain Skin Integrity
- ☐ Maintain Personal Hygiene
- ☐ Prevent Infection
- ☐ Meet Elimination Needs
- ☐ Ensure Safety
- ☐ Early Ambulation Reduce Anxiety
- ☐ Patient & Family Education
- ☐ Identify Potential Complications
- ☐ Any Others. Specify.....

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning				EP			
Afternoon	2pm 8pm	Assess the Pt condition. monitor vitals & cond. Maintain I/O chart. Provide the comfortable posing. medication given Per as doctor ord.	2pm 8pm	Assessed the Pt condition. monitored vitals & cond. Maintained I/O chart. Provided the comfortable posing. medication given as per as doctor ord.	→ Pt is stable. → vitals monit.	→ monitor vitals. → Maintain I/O Chart.	Sneh
Night	8PM / 8AM	→ Assess the General Condition of pt. → Monitor vitals → Maintain I/O chart. → Administer medication	8PM / 8AM	→ Assessed the General Condition of pt. → Monitored vitals → Maintained I/O chart. → Administered medicin.	→ Pt is Stable.	→ Re-assess vitals. → Maintain I/O Chart	Maanvi

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NURSING CARE RECORD

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Date: 30/05/25

Goals

- ☐ Maintain Airway and Oxygenation
- ☐ Relieve Pain & Discomfort
- ☐ Maintain Fluid Balance
- ☐ Improve Activity Tolerance
- ☐ Maintain Good Nutritional Status
- ☐ Maintain Skin Integrity
- ☐ Maintain Personal Hygiene
- ☐ Prevent Infection
- ☐ Meet Elimination Needs
- ☐ Ensure Safety
- ☐ Early Ambulation Reduce Anxiety
- ☐ Patient & Family Education
- ☐ Identify Potential Complications
- ☐ Any Others. Specify.......................................

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	800	Assess the baby mouth ulcer administer oral [illegible] ordered [illegible]	805	Assessed the baby found ulcer administered oral [illegible]	[illegible]	Reassess the pt	[illegible]
Afternoon							
Night							

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NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:			Any Infection: ☐ Yes ☐ No ☑ Not Known If Yes Specify:			
	Surgery / Procedure:			Post OP Day:			
BACKGROUND	Date / Shift	29/5 EL	29/5/26 N	30/5 2m			
	Medical Condition (Any special condition to be noted):	—	—	—			
	Diet:						
ASSESSMENT	Allergy:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Ventilation (RA, NP, NIV, VENTI):	—	—	—			
	Tubes/Drains/Catheter:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:	98.2 F	98.4°F	98.6			
	Res:	30 b/m	30 b/m	33 b/m			
	SpO_2:	99%	99%	100%			
	Pulse:	112	116 b/m	104			
	BP:	102/62	108/65	99/62			
	LOC:	—		—			
	Fall Risk Score:	—	—	—			
	Pain Score:	—	—	—			
	Skin Integrity	—	—	—			
Recommendations	Safety Needs:	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Physiotherapy:	—	—	—			
	Others Specify:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Special Diet:	—	—	—			
	Critical Lab Test / Values:	—	—	—			
	Other Special Orders / Medications:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	PU Prophylaxis:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	DVT Prophylaxis:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	ADL (Dependent / Non Dependent):	—	—	—			
Post Operative Procedure Special Orders:		—	—	—			
Handed Over By Name :		Sneha	Moutushi	[illegible]			
Signature / ID :		5010603	[illegible]	[illegible]			
Date:		29/5	30/5/26	30/5			
Time:		8 PM	8 AM	2 PM			
Taken Over By Name :		Moutushi	[illegible]				
Signature / ID :		[illegible]	[illegible]				
Date:		29/5/26	30/5				
Time:		8 PM	8 AM				

Docu. No. : RCH /FRM / CLINICAL / 097

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NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:				Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:		
	Surgery / Procedure:				Post OP Day:		
BACKGROUND	Date / Shift						
	Medical Condition (Any special condition to be noted):						
	Diet:						
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Ventilation (RA, NP, NIV, VENTI):						
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:						
	Res:						
	SpO_2:						
	Pulse:						
	BP:						
	LOC:						
	Fall Risk Score:						
	Pain Score:						
	Skin Integrity						
Recommendations	Safety Needs:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Physiotherapy:						
	Others Specify:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Special Diet:						
	Critical Lab Test / Values:						
	Other Special Orders / Medications:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	PU Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	DVT Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	ADL (Dependent / Non Dependent):						
Post Operative Procedure Special Orders:							
Handed Over By Name :							
Signature / ID :							
Date:							
Time:							
Taken Over By Name :							
Signature / ID :							
Date:							
Time:							

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THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE 29/5	DATE 30/5	DATE	DATE	DATE
Age	Less than 3 years old	4	4	4			
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	2	2			
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1			
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own ability	1	1	1			
	History of Falls or Infant-Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2					
	Outpatient Area	1	1	1			
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours/ None	1	1	1			
Medication Usage	Sedatives (Excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1			
	Total		11	11			

Intervention: -Fall Risk: Low Humpty Dumpty Score = 7-11, High Risk Humpty Dumpty Score = 12 or above

	Bed in low position		✓	✓			
	Call device within reach		✓	✓			
	Wheels Locked		✓	✓			
	Room free of clutter		✓	✓			
	Adequate lighting		✓	✓			
	Wheel chair support		✗	✗			
	Other Intervention(s) Specify		✗	✗			
	Nurse's Name:		[illegible]	[illegible]			
	Signature:		[illegible]	[illegible]			
	Date:		29/5	30/5			
	Time:		8pm	8AM			

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BRADEN 'Q' SCALE

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					Date : 29/5	29/5		
					Time : 8Hr	10PM		
Mobility	**1. Completely immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	**3. Slightly limited:** Makes frequent through slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.	4	4		
"Activity The degree of physical activity"	**1. Bedfast :** Confined to bed	**2. Chairfast :** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	**3. Walks occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. All patients too young to ambulate; OR walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	3	4		
Sensory Perception	**1. Completely limited:** Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	**2. Very limited:** responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	**3. Slightly limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	**4. No impairment:** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4		
Moisture Degree to which skin is exposed to moisture	**1. Constantly moist:** Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	**2. Very moist:** Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	**3. Occasionally moist:** Skin is occasionally moist, requiring linen change every 12 hours.	**4. Rarely moist:** Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4		
FRICTION-SHEAR **Friction** Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another	**1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	**2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	**3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	**4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4		
Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4		
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4		
				TOTAL SCORE	23	28		
				Evaluator's Name		VM		

Severe Risk : less than 9 | High Risk : 10-12 | Moderate Risk : 13-14 | Mild Risk : 15-18 | Not at Risk: 19-23

Risk Score	Category	Action	**Support Surfaces** **(Please Note:** Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice
15-18	At Risk	• Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • Advance to a higher level of risk if other major risk factors are present	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	• Use the Same Protocol as for **"At Risk"** Patients • Position patient at 30 degree lateral incline using foam wedges	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	• Follow the same protocol as for **"Moderate Risk"** Patients • In addition to regular turning schedule • Make small shifts in their position frequently	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	• Use same protocol as for **"High Risk"** Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

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CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1 29/5			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0		0	0							
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1		NA	NA							
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2		NA	NA							
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3		NA	NA							
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4		NA	NA							
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5		NA	NA							
		Signature of the Nurse			Sneh	M							

NOTE : Phlebitis greater than grade 2 should be reported to physicians and other appropriate health care personal ongoing observation of the site should continue for 48 hours post removal to detect post infusion phlebitis.

Signature of Shift In Charge :
Signature : Sneh Name : Sneha

Signature of Ward In Charge :
Signature : Balaram Name : Balaram

Docu. No. : RCH /FRM / CLINICAL / 137

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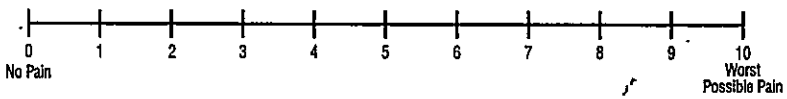
PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
29/5	8pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Sn
29/5	10pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:
1. Every eight hours for all hospitalized patients.
2. For post-surgical patients, patients with chronic pain, patient with severe pain:
   a) At least every 2 hours for the first 24 hours
   b) Then every 4 hours.
   c) Prior to pain pain-relieving intervention.
   d) Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

Numerical Pain Scale (Obstetric and Gynecology)



Wong - Baker (Pediatrics) Above 7 Years

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
	0	1	2
Face	No Particular expression or smile	Occasional Grimace or Frown, withdraw, Disoriented	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs brawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, right, or Jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams of sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

Neonatal Pain, Agitation and Sedation Scale (upto 1 Month)

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR RR, BP, SaO_2	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO_2 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO_2 less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

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Master BESTHA SAURYANSH VYAS
21-05-2025 1 Y 0 M 8 D (M)
Dr. SINDHURA MUNUKUNTLA

Wt - 8.78 kg

GRBS - 99 PP

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EMERGENCY ROOM TRIAGE FORM

Patient's Name : Master B. Sauryansh Vyas Age : 1 Y **Gender:** ☑ Male ☐ Female

Date : 29/5/26 Time of Arrival : 5:10 PM

Allergies: ☑ No ☐ Yes ☐ Food ☐ Medications ☐ Blood Transfusion ☐ Other (Specify): ..... ☐ Not known

Source of Information : ☑ Parents ☐ Others (Specify) .....

Mode of Arrival : ☑ Ambulatory ☐ Wheelchair ☐ Ambulance

Initial Vital Signs: Temp: 97°F PR: 148/m BP: 78/46 mmHg RR: ..... SpO_2: 99%

Chief Complaints: C/O multiple episode vomiting

INITIAL PHYSIOLOGICAL CATEGORIZATION

Appearance
☑ Normal
☐ Sick Looking

Circulation / Colour
☑ Normal ☐ Abnormal ☐ Bleeding

Work of Breathing
☑ Normal ☐ Increased
☐ Decreased ☐ Gasping / Apnea

INITIAL PHYSIOLOGICAL STATUS
☑ Stable
☐ Unstable :
- ☐ Not – Life - Threatening
- ☐ Life – Threatening

Triage Classification	CTAS
☐ Level 1 : Resuscitation	☐ Immediate
☐ Level 2 : EMERGENT : Life or limb threatening	☐ < 15 min
☐ Level 3 : URGENT : Significant illness / injury with potential to become life or limb threatening	☐ 30 min
☐ Level 4 : LESS URGENT : Significant illness but not life threatening	☑ 60 min
☐ Level 5 : NON – URGENT : May receive care when convenient	☐ 120 min

NOTE : All immunocompromised children and preterm babies to be considered Level 2.
All Children less than 2 years age with high fever to be considered Level 3.

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian

Triage Completion Time : .....

Communicable Disease Triage Screening

PART A. The following questions should be asked to all patients at the initial screening:

1. Have you had fever (elevated temperature) in the past 2 weeks ☐ Yes ☑ No
2. Have you had cough or a rash in the past 2 weeks ☐ Yes ☑ No
3. Have you had shortness of breath or difficulty breathing in the past 2 weeks ☐ Yes ☑ No

PART B. For patients reporting fever and respiratory/rash symptoms: ☐ **Not applicable**

1. Have you travelled outside the INDIA? or had close contact with someone who has recently travelled outside the INDIA, in the past two weeks? ☐ Yes ☑ No
   If yes, State Location: .....
2. Are your parents / close contacts at home is/a healthcare worker? {please encircle the choices} (e.g., nurse, physician, ancillary services personnel, allied health services personnel, hospital volunteer, or laboratory worker, others) who has had a recent exposure to an individual with a highly communicable disease or unexplained, severe febrile respiratory or rash disease? ☐ Yes ☑ No

PART C. A positive communicable disease triage screening is considered for any patient who meets one of the two following criteria:

- ☐ Any patient with Fever / Rash / Vesicles / Discharge from Eyes and Cough
- ☐ Any patient with fever and respiratory symptoms who answered "YES" to any of the questions on epidemiologic risk factors in "PART B" of the triage screening above.

PART D. ACTION / INTERVENTION: (for positive suspected communicable disease triage screening)

- ☐ Patients should be immediately isolated in a negative pressure room or a single room (as appropriate) for pending evaluation.
- ☐ The patient should be given a surgical mask immediately, if not already wearing one.
- ☐ Both patient and triage staff should perform hand hygiene.
- ☐ The staff should use PPE (as appropriate).

Name of Triage Nurse : Jyothi

Signature of Triage Nurse : .....

Date & Time : 29/5/26 @ 5:12 PM

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 29/5/26 Time of arrival : 5:14PM

Chief Complaints: C.I.O multiple Episode. RBS: .....

Height : ..... Weight : 8.78kg BMI : ..... Head Circumference (<2 years) .....

Allergies: ☐ Yes ☑ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other: .....

If yes , identify .....

Pain Screening: ☐ Yes ☑ No If Yes, Pain Score: ..... Pain Tool Used: ☐ N Pass ☐ FLACC ☐ Wong Baker

☐ Character ..... ☐ Location ..... ☐ Frequency ..... ☐ Duration .....

RISK FOR FALL:

☐ If patient is < 6 years
tick below fall risk intervention directly

☐ If Patient is > 6 years
Assess the below parameters

History of Falling: within past 3 months ☐ Yes ☑ No

Ambulatory Aids:

- Wheelchair ☐ Yes ☑ No
- Uses furniture for support ☐ Yes ☑ No

Gait/Transferring:

- Bedrest / immobile ☐ Yes ☑ No
- Weak ☐ Yes ☑ No
- Impaired ☐ Yes ☑ No

Mental Status: Forgets limitations ☐ Yes ☑ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

☐ Escort while ambulating
☑ Assist Patient
☑ Educate patient and family on fall precautions/prevention

Functional Screening: ☑ No Abnormalities Detected

☐ Mobility Problem
☐ Walking Problem
☐ Developmental Delay
☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

.....

.....

Nutritional Screening: ☑ No Abnormalities Detected

☐ Underweight
☐ Overweight
☐ Feeding Problem
☐ Special diet
☐ Special feeding method

Inform consultant for positive criteria

Psychological Screening: ☑ No Significant Findings

Unusual concerns about patient's Psychological Status: ☐ Yes ☑ No

If Yes Consultant Notified: ..... (Date/Time): .....

Social History: Lives With family

Siblings in household ☐ Yes ☐ No (if yes How Many?) .....

Time of Initial assessment completed by ER Nurse : .....

Nursing Notes (Including Labs / Medications / Other Care):

Time	Nursing Notes
5:16pm	Assess the pt condition monitore the vitals

Samples collected by: Jyothi   Time:

Samples sent by : Jyothi   Time: 5:30pm

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1
5:40 pm	Fesmopanasol	IV	10mg		A.D
	ondem	IV	1.5 mg		A.D

Condition of patient at time of shift - out :	**Details of Shift - out**
HR: 148b/m BP: .... CFT:	Shift - out from ER to: 2nd floor (208)
RR: .... SPO_2: 99%	Time of Shift - out: 6pm
GCS: .... Temperature : 97°F	Handover given to: (signature) (Nurse's Name)
Pain Score:	
Repeat RBS (if applicable): 99 mg/dl	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any): IV placement Done

Name of the Nurse : Jyothi   Signature of the Nurse : (signature)

Date & Time : 29/5/26 @ 5:30pm

PATIENT TRANSFER FORM

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Dr. SINDHURA MUNUKUNTLA

	Date & Time of Admission	Date & Time of Transfer Order
	29/5/26 @ 5:18pm	29/5/26 @ 6pm
Treating Consultant Name	**Transfer Ordered by**	**Reason for Transfer**
	Dr. pranav	Admission
From Unit	**To Unit**	**Information to Attendant**
ER	2nd floor (208)	Yes ☑ No ☐
Number of Sheets in Clinical File	**Number of Imaging Films**	**Personal belongings including clinical documents. If any handed over to attendant**
15		Yes ☑ No ☐
		If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.		
2.		
3.		
4.		
5.		

Shifting Summary / Notes Written by Doctor : Yes ☐ No ☐

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Bhargavi	Dr. pranav.

Patient & Clinical Records Received by : Sneha

Date & Time of Patient Received : 29/5/26 @ 6pm

If the transfer order time & Completion time is more than 30 minutes, please tick the reason mentioned below :

☐ Unavailable Bed ☐ Nurse not Available ☐ Available Bed not ready

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NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 30/5/26 Time: 9:50 am

Weight: 8.7 kg Centile: 5th

Height: — Centile: —

Inference: Underweight child.

RDA: — Calories: 1200 Kcal/day Protein: 20 gms/day

Diet Recommendations: Soft and bland diet with liquids

Re-Assesment: Avoid oily, spicy food.

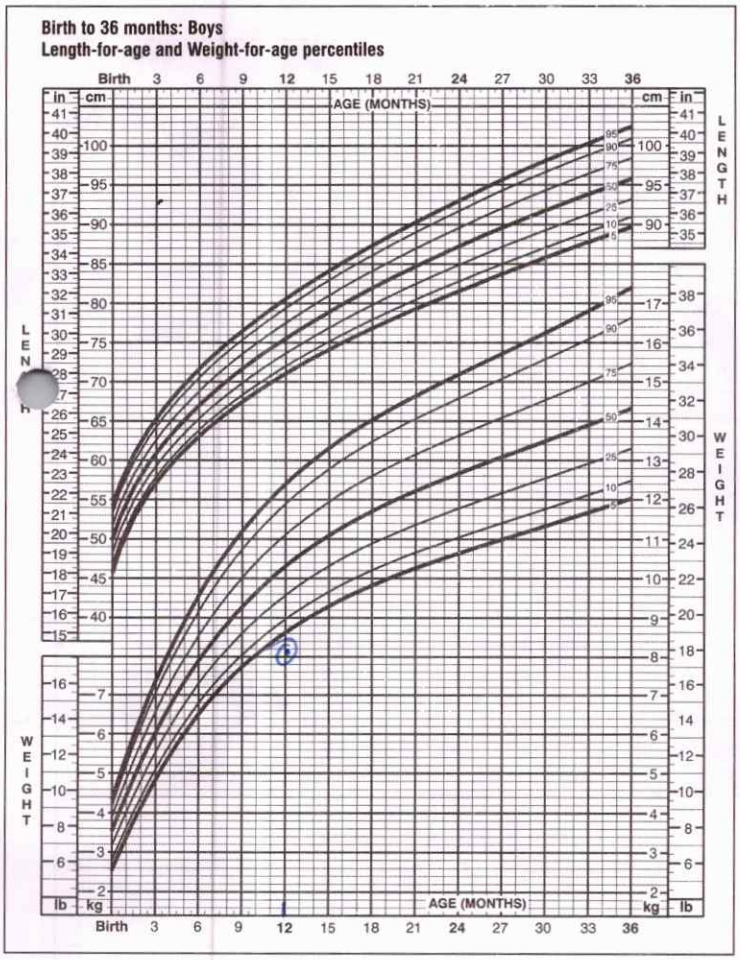
Food Allergies: N.K.F.A Veg/Non-veg Non veg

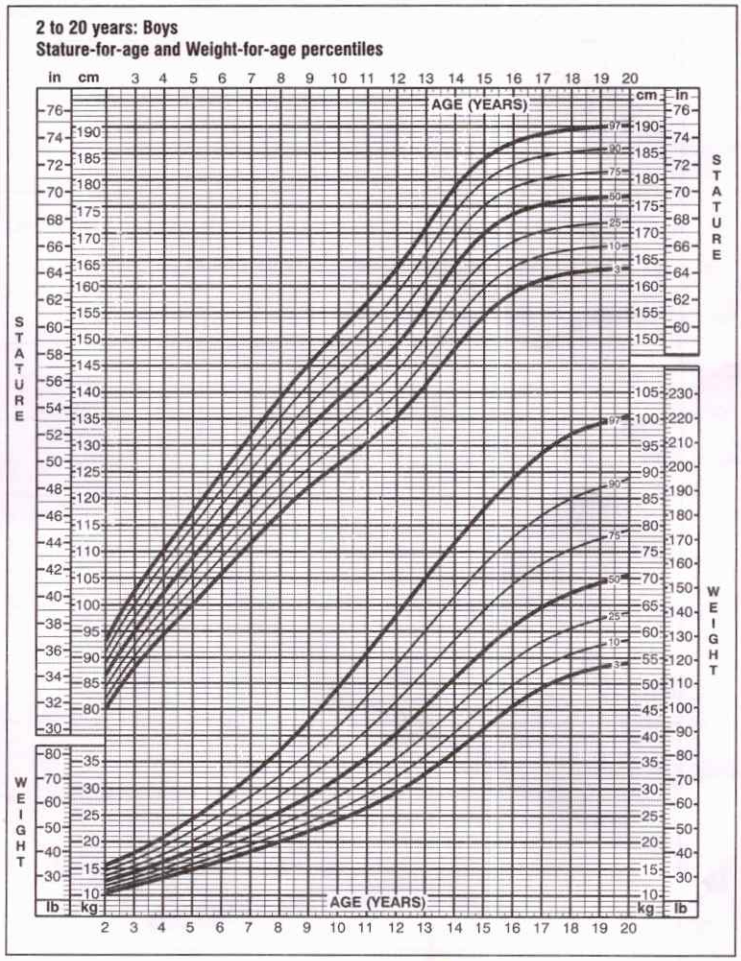
Diagnosis: Acute gastritis & dehydration

Nutritional Intervention - ☑ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: Soumya

GROWTH CHART (BOYS)





Dietician's Name Syeda Sabiya Zaheer Dietician's Signature Sabiya

Docu. No. : RCH /FRM / CLINICAL / 160

(P.T.O.)

Daily Notes: