DISCHARGE SUMMARY

Name	Master T. SAMARTH SINGH	**UHID**	HNH-00004224
Father/Guardian	Mr T. ABHISHEK SINGH	**Age/Gender**	3 Y 10 M 4 D/ Male
Address	h. no. 1-1-287/7/2/c bapunagar,, Chikkadapalli Market, Hyderabad, Telangana, INDIA, 500020		
IP No	IP26-00006682	**Admission Date**	29-06-2026
Ref Doctor	Self.		
Discharge Date	01.07.2026		

Consultant:
Dr. DILNAAZ FAROOQUI
MBBS DNB
56763

DIAGNOSIS	ICD CODE
ENTERIC FEVER WITH CYSTITIS WITH DEHYDRATION	K52.9

History: Master T. SAMARTH SINGH, 3 Y 10 M 4 D , old boy presented with history of fever since 5 days, loose stools (multiple episodes/day) since 4 days associated with non bilious, non projectile vomiting since 2 days, poor oral intake, prior to admission . For the above complaints he was admitted at Rainbow Children's Hospital - Himayatnagar for further management.

Examination: He was (100.3*F) febrile, maintaining saturation at room air. Heart rate - 116/min and Respiratory Rate - 26/min . On examination Signs of

Name	Master T. SAMARTH SINGH	UHID	HNH-00004224
IP No	IP26-00006682	Admission Date	29-06-2026

dehydration were present, dry lips, oral mucosa, delayed skin turgor, dull looking, sunken eyes were present. On auscultation of chest, air entry was bilaterally equal with normal heart sounds and no murmur. Abdomen was soft with hepato-splenomegaly. On neurological examination, he was conscious, alert. Pupils were bilaterally equal & reacting to light. There were no focal neurological deficits.

Weight on admission: 13.18 kilo grams.

Investigations: Enclosed reports.

Initial hemogram showed Hemoglobin of 9.4 gm%, White Blood Cell count of 5050 cells/cumm, platelet count of 1.19 lakhs/cumm and C-Reactive Protein of 86 mg/l. Serum electrolytes showed sodium of 127 mmol/L, potassium of 4.4 mmol/L & Chloride of 99 mmol/L. Liver function test showed total SBR of 0.7 mg/dl with indirect fraction of 0.4 mg/dl, SGOT - 181 U/L, SGPT - 148 U/L, ALP - 165 U/L, protein - 5.8 gm/dl, albumin - 2.7 gm/dl, globulin - 3.1 gm/dl, A/G ratio of 0.8. Urine culture and sensitivity shows no growth after 24 hours of incubation.

Widal shows
SALMONELLA TYPHI O - AGGLUTINATION SEEN IN TITRE 1 : 240
SALMONELLA TYPHI H - AGGLUTINATION NOT SEEN
SALMONELLA PARATYPHI AH - AGGLUTINATION SEEN IN TITRE 1 : 250
SALMONELLA PARATYPHI BH - AGGLUTINATION NOT SEEN

Dengue NS1 and IgM was non reactive.

Complete stool examination.

Name	Master T. SAMARTH SINGH	**UHID**	HNH-00004224
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COLOUR	GREENISH			
CONSISTENCY	SEMI FORMED			
pH	7.0	5 - 8.5		-
MUCUS	PRESENT	ABSENT		-
BLOOD	ABSENT			
UNDIGESTED FOOD	ABSENT	ABSENT		-
HELMINTHES	NIL	NIL		-
PUS CELLS	8 - 10			
RED BLOOD CELLS (Stool)	1 - 2	NIL	HPF	L
STARCH GRANULES	ABSENT	ABSENT		-
YEAST CELLS	PRESENT ++	NIL		-
FAT GLOBULES	ABSENT	ABSENT		-
PROTOZOA	NIL	NIL		

Ultrasound abdomen and pelvis shows

* Mild gall bladder wall thickening.
* Mild splenomegaly.
* Internal echoes in urinary bladder - Suggested CUE correlation to rule out cystitis.
* Fluid filled colon as described. No evidence of sonographic features of colitis at present.
* Multiple small lymph-nodes along the mesentery in the RIF and periumbilical

Name	Master T. SAMARTH SINGH	UHID	HNH-00004224
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region - in keeping with mesenteric adenopathy.
* Mild free fluid in the peritoneal cavity.

Management : He was admitted in the ward and was started on Intra Venous fluids and Intra Venous antibiotics . He was treated symptomatically with antacids and antipyretics . In view of loose stools, he was administered probiotics and advised gastrodiet.

In view fever since 5 days with GI symptoms , necessary investigations sent , reports suggestive of Enteric fever for which Inj ceftriaxone continued and also added Azithromycin .

He was regularly monitored for loose stool frequency and hydration status. His loose stools 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.

Medication during hospital stay:
Injection. Esmoprazole
Injection. Ceftriaxone
Injection. Ondansetron
Syp. Zinconia.
Redotril sachet
Syrup. Azithromycin

Name	Master T. SAMARTH SINGH	**UHID**	HNH-00004224
IP No	IP26-00006682	**Admission Date**	29-06-2026

Advice:
* Diet as advised.

S.No	MEDICATION	DOSE	TIMINGS	DURATION
1	Injection. Ceftriaxone	650mg -dilute in 100ml NS , give over 1hour	8am - 8pm (after food)	Till blood culture report
2	Syrup. AZITHRAL (5ml=200 mg)	7 ml	8am (after food)	For 5 days
3	Darolac sachet	1 sachet, dilute in 5ml water	twice daily	For 1 day
4	Tablet. LANZOL JR (Lansoprazole - 15mg)	1 tablet	7am (before breakfast)	For 5 days
5	Syrup. ZINCONIA	5 ml	10am (after food)	For 10 days
6	Nasoclear nasal drops, 2 drops in each nostril **SOS** for nose block			

Plan: To blood culture report on followup

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

Name	Master T. SAMARTH SINGH	UHID	HNH-00004224
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* Tepid sponging if fever > 101 *F.

Review consultation with Dr. DILNAAZ FAROOQUI on Friday (03.07.2026) at Himayatnagar in OPD with prior appointment **(Review consultation will be charged)**.

Food instructions while taking medications:
* **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.

If any Intra Venous antibiotics - will be given in Emergency Room between 7am - 8am for morning dose, between 2pm-3pm for afternoon dose and between 8pm-9pm for evening dose (Outside medication shall not be allowed within the hospital as per the hospital protocol).

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

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Name	Master T. SAMARTH SINGH	**UHID**	HNH-00004224
IP No	IP26-00006682	**Admission Date**	29-06-2026

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**

CHILDREN'S MEDICARE LIMITED HYDERABAD

Registrar/Resident/C.M.O

Dr. DILNAAZ FAROOQUI
MBBS DNB
56763

PATIENT TRANSFER FORM

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HNH-00004224 IP26-00006682 Master T. SAMARTH SINGH 25-08-2022 3 Y 10 M 4 D (M) Dr. DILNAAZ FAROOQUI	Date & Time of Admission 25/06/26 @ 11:42 Am	Date & Time of Transfer Order 29/06/26 @
	Transfer Ordered by Dr, SAMIR	Reason for Transfer Admition
From Unit ER	To Unit 302	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File 18	Number of Imaging Films —	Personal belongings including clinical documents. If any handed over to attendant 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
Afsana	Dr. Samir

Patient & Clinical Records Received by :
Sr. Sandhya

Date & Time of Patient Received 29/6/26 @ 1:20 pm

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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ACTIVITY RECORD FOR BILLING

HNH-00004224 IP26-00006682
Master T. SAMARTH SINGH
25-08-2022 3 Y 10 M 4 D (M)
Dr. DILNAAZ FAROOQUI

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

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

Date of Admission : 27/06/26 Time : 11:42 Date of Discharge : ---------- Time: ----------

Room / Bed No : 304/Pm Ward : 302 Suggested Billable bed type : ----------

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
27/06/26	12:28pm	ER	302	

Cross Consultation Visit

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

HNH-00004224 IP26-00006682
Master T. SAMARTH SINGH
25-08-2022 3 Y 10 M 4 D (M)
Dr. DILNAAZ FAROOQUI

INVESTIGATIONS

Date	Investigations	Order No.	Sign
29/6/26	CBP CRP Dengue NS1 IgM widal, Blood c/s	0583 ✓	[signature]
	VBG.	0584 ✓	
29/6/26	USG Abdomen c̄ pelvis	7735 ✓	sandhya
29/6/26	stool Routine.	10598 ✓	sandhya
29/6/26	Urine c/s	10611 ✓	[signature]
29/6/26	CUE	10612 ✓	[signature]
29/6/26	Electrolyte, LFT	10614 ✓	[signature]
		cross checked done by maheshwari	
30/6/26	~~CBG~~ VBG	10615	[signature]
	Cross checked by [signature] 1/7/26 @ 10:36 Am		

HNH-00004224 IP26-00006682
Master T. SAMARTH SINGH
25-08-2022 3 Y 10 M 4 D (M)
Dr. DILNAAZ FAROOQUI

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
29/6/26	Infusion Pump	29/6/26 @ 1:pm	1/7/26. @ 8Am	9227	sandhya.
				crosscheckeddone by maheshwari	
		are checked	R 1/7/26 ew		

HNH-00004224 IP26-00006682
Master T. SAMARTH SINGH
25-08-2022 3 Y 10 M 4 D (M)
Dr. DILNAAZ FAROOQUI

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
29/6/26	IV placement.	1	9173	[illegible]
29/6/26	NHA	1	209311	[illegible]

cross checked done by maheshwari

crs chd by [illegible]
1/7/26 [illegible]

ANY OTHER INFORMATION

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

Ref.No. F/IN/PR/10

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Hospital

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name : _____ HNH-00004224 IP26-00005582
Master T. SAMARTH SINGH
25-08-2022 3 Y 10 M 4 D (M)
Dr. DILNAAZ FAROOQUI

Patient ID# : _____

Consultant : _____

Final Diagnosis : _____

HNH-00004224 IP26-00006682
Master T. SAMARTH SINGH
25-08-2022 3 Y 10 M 4 D (M)
Dr. DILNAAZ FAROOQUI

History & Physical Examination

Name : [illegible] Age/Sex 3y/male

Informant Reliability

Chief Presenting Complaints & Duration (Chronologically):

Fever x 5 days
Loosestools x 4 days
Intermittent Vomiting x 2 days
poor oral intake

History of present illness :

Fever x 5 days, high grade, documented upto 104F not alw chills and rigors, partially relieved on oral medication

Loosestools x 4 days, watery consistency, not alw blood or mucous / blood, increased purge upto 8 in 1 day a/w Intermittent Vomiting and poor oral intake

Pediatric Multiorgan History & Physical Examination

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

Birth & Neonatal History :

Normal

Birth & Socio Economic History :

About Father :

About Mother :

Any additional Information :

Developmental History :

Normal for age

Immunization History :

As per age

Anthropometry

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

Weight (kgs) 13kg (Centile _____)

On Examination :

Temperature : 100.3F Pulse Rate: 116/min Description _____

B.P. _____ SPO2 94% at RA

Resp. rate and type of breathing : _____

Rash No

Lymphadenopathy

Oedema :

Signs of dehydration ⊕
Sunken eyes ⊕
dry tongue, lips
dull activity

Respiratory system :

Inspection (any s/o distress) : _____

Air entry & breath sounds : BAE ⊕. clear

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 Non tender

Ausculation : _____

Spine: _____ External Genitelia : _____

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

Central Nervous System :

Level of Consciousness : AVPU/GCS Score : _____

Cranial Nerves : _____

_____

_____

Motor System :

Nutrition : _____

Tone : _____ Power _____

Co-ordinator : _____ NAD

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR **Superficials :**

Plantars _____

Sensory System :

_____

_____

_____

Bladder / Bowel : _____

Clinical Summary & Diagnostic :

Acute Gastroenteritis with dehydration

_____

_____

_____

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment :

prevent complications

Desired goals of the treatment :

Planned Labs :

CBP, CRP, VBG
- Dengue NS1 IgM
- Widal test
- TSWood culture
- Urine culture, CUE
- Stool Routine
- USG Abdomen

Noted by @ Atomic

Planned Management :

- IV fluids
- IV Antibiotics
- Supportive care

IV fluids 6cc/kg (NS 10ml/kg)

Monitor vitals and Inform SRs

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 _____ on whose name the patient is being referred

Dr. Dilnaaz Farooqui
Consultant Pediatrician
Reg. No: 27476

Doctor's Signature Name Dr Dilnaaz Date 29/6/26 Time 10 am

HNH-00004224 IP26-00006682
Master T. SAMARTH SINGH
25-08-2022 3 Y 10 M 4 D (M)
Dr. DILNAAZ FAROOQUI

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
29/6 3:00pm	C/S/B Dr. Naipunya	
	AGE c dehydration.	
	loose stools (+)	Plan
	Vomiting (+).	- Cont. Inj. ceftriaxone
	oral intake - poor.	- Cont Syp. Zinconia
	R/S - B/L AE (+)	PAROLAC sachet
	P/A - soft, NT	REDOTIL sachet
		- Encourage orally
		- Monitor vitals
		Dr [illegible]
29/6/26 5 PM	C/S/B Dr. Aniket	
	AGE c dehydration	
	loose stools (+)	Plan
	Oral intake - poor	- Ct. Ceftriaxone.
	O/E - vitals stable	- Encourage orally
	S/E - P/A - SOA, NT,	- Trace CUE, urine C/S,
	hepatomegaly (+)	blood C/S.
		- Trace Dengue serology.
		- Trace USG, ATP report.
		- Send LFT in same sample.
		S/ electrolytes [illegible] - Dr. Aniket

Dr. Aniket Anil Parashar
Consultant Pediatrician & Intensivist
Reg. No: 8568

Noted by Swetha @ 5pm 29/6/26

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

(P.T.O)

HNH-00004224 IP26-00006682
Master T. SAMARTH SINGH
25-08-2022 3 Y 10 M 4 D (M)
Dr. DILNAAZ FAROOQUI

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
29/6/26	C/o/B Dr. Shami	
9:15 pm	I/do Dr. Ankit	
	? ENTERIC FEVER	
	- S/E - Na: 127	
	- Albumin - low	
	- LFT - AST, ALT ↑	
		Plan
		1) CBG - T/M capillary
		2) CBP, CRP, S/E, LFT - next sample
		3) Trace Reports
		4) Rest of the as per Rx chart.
		NB Maheswari
		10pm @ 29/6/26

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

HNH-00004224 IP26-00006682
Master T. SAMARTH SINGH
25-08-2022 3 Y 10 M 5 D (M)
Dr. DILNAAZ FAROOQUI

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...OGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
30/8/26	C/S/B - Dr. Prashanti / Dr. Thanvi	
8Am	A - ? Enteric Fever	
	Fever Spikes (+)	
	loose stools (+)	Plan
	vomiting (-)	
	oral intake improved	1) CBP, CRP, S/E, LFT — next prick.
	O/E	
	vitals stable	2) Trace reports.
		3) Rest ct asper Ro chart
	S/E	
	P/A - Soft	
	CVS - S1S2+	Prati
	RS - clear	
	CNS - WNL	

HNH-00004224 IP26-00006682
Master T. SAMARTH SINGH
25-08-2022 3 Y 10 M 5 D (M)
Dr. DILNAAZ FAROOQUI

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
30/6/26 10 am	S/B Dr Dilnaaz Fever spikes – High grade (+) 1 loose stool No vomiting Oral intake – satisfactory Urine output – Adequate O/E Afebrile Sleeping comfortably No signs of dehydration P/A – Soft, no tenderness	Adv – Continue Inj CEFTRIAXONE – Add AZITHROMYCIN Enteric fever dose) – ½ main IVF – Continue probiotics Dr. Dilnaaz Farooqui Consultant Pediatrician Reg. No: 27476 Dilnaaz

HNH-00004224 IP26-00006682
Master T. SAMARTH SINGH
25-08-2022 3 Y 10 M 5 D (M)
Dr. DILNAAZ FAROOQUI

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
30/6 3:15pm	c/s/B Dr. Pram	
	Δ' - Enteric Fever c cystitis	
	Fever - Better	Plan
	oral intake - less	1) Inj Ceftriaxone
	Loose stool - Better	2) Syp Azee
		3) Inj order Esomeprazole
	child alert	4) IVF - 1/2 (N)
	Vitals stable	5) Darolac Zincovit
	R.S - B/L AE ⊕	
	P/A - soft	6) Monitor vitals
		Pram
30/6 4:50pm	c/s/B Dr. Dilnaaz	
	Δ' - Enteric Fever	Plan
	Fever ⊕	1) C/t - Ceftriaxone Azee
	Loose stool - Semi solid	2) C/t - Rest supportive care
	child dull	3) Inj D/C - on IV Abx
	Vitals stable	4) Monitor vitals
	R.S - B/L AE ⊕	5) IVF - 1/2 (m)
	P/A - Soft	6) Trace blood c/s.
		Dr. Dilnaaz Farooqui Consultant Pediatrician Reg. No: 27476
		Dilnaaz

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

noted by Sr. Sandhya 30/6/25 @ 3:30

HNH-00004224 IP26-00006682
Master T. SAMARTH SINGH
25-08-2022 3 Y 10 M 5 D (M)
Dr. DILNAAZ FAROOQUI

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	c/s/o Dr. Varun / Dr. Sushanth.	
1/7/26 7AM.	D- Enteric fever.	
	- fever - 2nd at 3:30AM (101.3°F).	
	- loose stools - None.	
	- Activity - Good.	
	O/E - vitals stable.	Plan - Ct. ceftriaxone Azee.
	O/E - WNL.	- Ct. other medications as per Rx chart. - Trace blood c/c. Noted by Divya 1/7/26

HNH-00004224 IP26-00006682
Master T. SAMARTH SINGH
25-08-2022 3 Y 10 M 5 D (M)
Dr. DILNAAZ FAROOQUI

Rainbow® Children's Hospital
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RESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
1/7/26 10 am	S/B Dr Dilnaaz	
	Fever spikes ⊕ but spacing out No further loose stools No vomiting Hydration – improved O/E Afebrile Active Vitals – stable P/A – Soft, mild distension Other S/E – NAD	
		Rx – Discharge today Discharge Adv
		1) Inj. CEFTRIAXONE Till blood culture report BD 2) Syp AZITHRAL (5ml = 200mg) 7ml x 5 days more (Total of 7 days)
		3) DAROLAC Sachet BD x 1 more day
		4) Syp ZINCONIA (Started prior to admission) (Total of 2 w
	5) TAB LANZOL JR (15mg) o – x 5 days Dr. Dilnaaz Farooqui Consultant Pediatrician Reg. No: 27476 Dilnaaz	

HNH-00004224 IP26-00006682
Master T. SAMARTH SINGH
25-08-2022 3 Y 10 M 5 D (M)
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

HNH-00004224 IP26-00006682
Master T. SAMARTH SINGH
25-08-2022 3 Y 10 M 4 D (M)
Dr. DILNAAZ FAROOQUI

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HNH-00004224 IP26-00006682
Master T. SAMARTH SINGH
25-08-2022 3 Y 10 M 4 D (M)
Dr. DILNAAZ FAROOQUI

RESULT SHEET

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Date	29/6					
Time	12:30pm					
Hb	9.4					
PCV	25.5					
RBC	3.1					
WBC	5,050					
N/L	76/20					
Platelets	1.19 lakh					
CRP	86					
ESR						
PCT						
RBS						
Na	127					
K	4.4					
Cl	99					
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT	148					
SGOT	181					
T.Bill/Conj	0.7/0.3					
T.Protein	5.8					
S.Albumin	2.7					
S.Globulin	3.1					
A/G Ratio	0.8					
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein/Sugar						
Cells						
N/L						

Date	29/6/26					
Time						
CUE-Alb						
CUE-Sugar	Nil					
CUE - Ketones	Present					
CUE-PUS Cells	3-5					
CUE - RBC Cells	Nil					
CUE Epithelial cells	- 6-8					
Stool Pus Cell	8-10					
OVA/Cyst						
Occult Blood RBC stool	- 1-2					
Dengue NS1 & IgM	- Negative					
WIDAL	- 1:250 Positive					

Culture and Sensitivities : .....

.....

.....

.....

Radiology: USG : .....

X-Ray:.....

ECHO: .....

CT: .....

MRI .....

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

HNH-00004224 IP26-00006682
Master T. SAMARTH SINGH
25-08-2022 3 Y 10 M 4 D (M)
Dr. DILNAAZ FAROOQUI

Patient Sticker

Doc. No. : RCH/ ...

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

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 29/6/26. Time: 2pm | 6 pm | 8pm. | 2Am. | 5:10Am. | 7Am.

Doctor / Nurse / Family Concern?

Temperature (F)

104 103 102 101 100 99 98 97 96 95 94

98.3°F | 98.6°F | 102°F Syp. Ibugesic given | 97.8°F | 102.1°F Syp. Ibugesic given | 98.8°F

Heart Rate (bpm) and Blood Pressure (mmHg) *

190 180 170 160 150 140 130 120 110 100 90 80 70 60 50

99/70 | 99/72 | 98/64 | 110/(65)/65

Note: BP does not score in early warning scoring

Heart Rate (Number): 150b/m | 132b/m | 128b/m | 106b/m.

Resp. Rate (bpm) (Over 1 Minute) *

70 60 50 40 30 20 10

Resp Rate (Number): 25b/m | 26b/m | 30b/m | 30b/m

Resp Distress	Mod/ Severe / None / Mild			
Receiving O_2 (l/min) O_2 Saturations (%)	99%	99%	99%	98%
Conscious Level	Normal / Altered			
GCS *				
TOTAL SCORE Number of shaded boxes	0	0	0	0
Pain Score	0	0	0	0
Observer's Initials		SM		

ACTIONS

Scores 3 should be ...rleaf

Score 1	:	Continue normal observation by staff nurse
Score 2	:	Shift in charge nurse to be informed and continue hourly observations
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.

* 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)

HNH-00004224 IP26-00006682
Master T. SAMARTH SINGH
25-08-2022 3 Y 10 M 4 D (M)
Dr. DILNAAZ FAROOQUI

Patient

CLINICAL / 125

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

Pratiksha Rainbow Children's Hospital — It takes a lot to treat the little.
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EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 30/6

Time:	10 am	2 pm	4 pm	5:30 pm	7 pm	10 pm	2 am	3:38 am	5 am	6 am
Doctor / Nurse / Family Concern?										
Temperature (F)	99.8F	99.8F	100.2F (crocin given)	99.8F?	98.3F	98.5F?	98.1F	101.3F (syp- ibuprofen given)	98.5F	97.?F
Heart Rate (Number)	115 b/m	120 b/m		105 b/m?	102 b/m?	109 b/m	110 b/m			101 b/m
Resp Rate (Number)	28 b/m	32 b/m	22 b/m	29 b/m		28 b/m	26 b/m			28 b/m
Receiving O_2 (l/min) / O_2 Saturations (%)	100%	99%	99%	99%		100%	99%			100%
TOTAL SCORE (Number of shaded boxes)	0	0	0	0		0	0			0
Pain Score	0	0	0	0		0	0			0
Observer's Initials	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]			[illegible]

Temperature scale: 104, 103, 102, 101, 100, 99, 98, 97, 96, 95, 94

Heart Rate (bpm) and Blood Pressure (mmHg) *: 190, 180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60, 50

Note: BP does not score in early warning scoring

Resp. Rate (bpm) (Over 1 Minute) *: 70, 60, 50, 40, 30, 20, 10

Resp Distress: Mod/ Severe; None / Mild

Conscious Level: Normal; Altered

GCS *

ACTIONS

NB: Scores 3 should be recorded overleaf

Score 1	: Continue normal observation by staff nurse
Score 2	: Shift in charge nurse to be informed and continue hourly observations
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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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)

Patient

HNH-00004224 IP26-00006682
Master T. SAMARTH SINGH
25-08-2022 3 Y 10 M 4 D (M)
Dr. DILNAAZ FAROOQUI

Rainbow® Children's Hospital
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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			ADMISSION								
	12:00 pm											
	01:00 pm											
Total Intake :						**Total Output :**						
29/6	02:00 pm			30ml			✓				0	
	03:00 pm	↑		30ml								
	04:00 pm	DNS	MM	30ml			✓			✓		
	05:00 pm			30ml			✓	NA				
	06:00 pm	↓	+ HD	30ml			✓			✓	↓	
	07:00 pm			30ml				↓			0	
Total Intake : Tallies						**Total Output :** U - 2					M - 4	
29/6/26	08:00 pm	↑		30ml							0	
	09:00 pm			30ml							0	
	10:00 pm			30ml							0	
	11:00 pm	DNS		30ml				NA		✓	0	
	12:00 am	↓		30ml							0	
	01:00 am										0	
Total Intake :						**Total Output :** U -					M -	
30/6/26	02:00 am			30ml							0	
	03:00 am	↑		30ml			✓			✓	0	
	04:00 am			30ml							0	
	05:00 am	DNS		30ml				NB			0	
	06:00 am			30ml						✓	0	
	07:00 am	↓		30ml	NB						0	
Total Intake :						**Total Output :** U -					M -	

Total 24 hrs. Intake		Total 24 hrs. Output	

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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							
30/6	08:00 am		2	25ml			✓					
	09:00 am			25ml								
	10:00 am	DNS		25ml						✓		
	11:00 am			25ml		NA	✓	NA				
	12:00 pm			25ml								
	01:00 pm			25ml								
Total Intake : Taken										**Total Output :** U-1		
30/6/26	02:00 pm			25ml								
	03:00 pm			25ml			✓			✓		
	04:00 pm	DNS		25ml			✓				0	
	05:00 pm			25ml			✓			✓		
	06:00 pm			25ml		NA	✓	NA				
	07:00 pm			25ml								
Total Intake : Taken										**Total Output :** U-2	M-4	
30/6/26	08:00 pm			25ml								
	09:00 pm		Daily	25ml								
	10:00 pm	DNS	Tablet	25ml		NA		NA		✓	0	
	11:00 pm			25ml								
	12:00 am			25ml			✓			✓		
	01:00 am			25ml								
Total Intake :										**Total Output :** U —	M —	
1/7/26	02:00 am			25ml								
	03:00 am			25ml								
	04:00 am	DNS		25ml						✓		
	05:00 am			25ml		NA		NA			0	
	06:00 am			25ml						✓		
	07:00 am			25ml								
Total Intake :										**Total Output :**		

Total 24 hrs. Intake		Total 24 hrs. Output	

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Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
1/7/26	08:00 am		•	25 ml								
	09:00 am			25 ml								
	10:00 am	NS		25 ml							0	
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :										**Total Output :**		
1/7/26	02:00 pm											
	03:00 pm											
	04:00 pm										0	
	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	

Patient Sticker

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FLUID CHART

Sheet No. : .....

1. All measurements in ml.
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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

Date: 29/6/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon	2pm to 8pm	→ Assess the pt condition → monitor vitals & record → maintain I/O chart → Administer medication as per drug chart	2pm to 8pm	→ Checked the pt condition → monitored vital & recorded → Maintained I/O chart → Administered medication as per drug chart	→ Pt is stable	→ Re checked vitals	
Night	8pm to 8AM	→ To assess the pt. condition → To check the vitals & record → To administer the medication as per drug chart → I/O chart maintain	8pm to 8AM	→ To assessed the pt. condition → To checked the vitals as per drug chart → I/O chart maintain → To administered the medication	→ Patient is stable.	→ Re-checked the vitals I & I/O	

HNH-00004224 IP26-00006682
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25-08-2022 3 Y 10 M 5 D (M)
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NURSING CARE RECORD

Rainbow® Children's Hospital
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BirthRight™ BY RAINBOW HOSPITALS
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Date: 30/8

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8am to 2pm	→ Assess the pt condition → monitor vitals & record → maintain I&O chart → Administer medication as per drug chart	8am to 2pm	→ Assessed the pt condition → monitored vitals & recorded → maintained I&O chart → Administered medication on as pt drug chart	→ Pt is stable	→ Rechecked vitals	
Afternoon	2pm 8pm	→ Assess the patient general Condition → Monitored vitals → Administered medications as Per doctor's orders.	2pm 8pm	→ Assessed the patient general Condition → Monitored vitals → Administered medications as Per doctor's orders.	Patient is stable	Rechecked vitals	
Night	8pm 8am	→ Assess the Pt condition → monitor vitals → maintained I&O chart → Administer medication as per drug chart	8pm 8am	→ Assessed the Pt condition → monitored vitals recorded → maintained I&O chart → medication as Per drug chart	→ Pt is stable	→ rechecked vitals	

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PAIN ASSESSMENT FORM

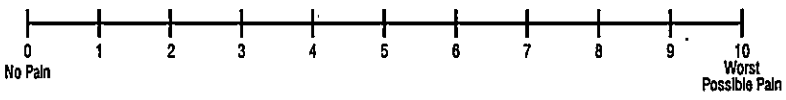
Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
29/6/26	2 pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
29/6/26	10PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
30/6/26	6AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
30/6/26	10AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
30/6/26	3 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
30/6/26	9PM	0/10	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		

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 - Bakér (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

HNH-00004224 IP26-00006682
Master T. SAMARTH SINGH
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BRADEN 'Q' SCALE

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

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Your Right to a Safe Delivery

					Date : 29/6/26	29/6	30/6	30/6/26
					Time : 2:PM	10PM	6AM	9PM
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	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.	4	4	4	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	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	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	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	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	4	4
					TOTAL SCORE	28	28	28	28
					Evaluator's Name				

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

Patient Sticker

HNH-00004224 IP26-00006682
Master T. SAMARTH SINGH
25-08-2022 3 Y 10 M 4 D (M)
Dr. DILNAAZ FAROOQUI

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NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: ..... Department: ..... Date of Admission: .....

SITUATION

Diagnosis: Enteric Fever

Any Infection: ☐ Yes ☐ No ☐ Not Known
If Yes Specify: .....

BACKGROUND

Area / Shift Time	29/6/26 morng	29/6 Eve	29/6/26 N1	30/6 M6	30/6/26 N1	
Medical Condition (Any special condition to be noted):	-	-	-	-	-	

ASSESSMENT

Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Vital Signs: Temp:	98.3°f	98.4°f	98.1°f	98.4°f	98.4°f	
Res:	25 b/m	26 b/m	30 b/m	30 b/m	30 b/m	
SpO_2:	99%	99%	99%	99%	98%	
Pulse:	115 b/m	112 b/m	116 b/m	117 b/m	107 b/m	
BP:	99/70	100/70	101/69	100/70	100/60	
Fall Risk Score:	-	-	-	-	-	
Pain Score:	-	-	0	6	0	

Recommendations

Safety Needs:	Yes	Yes	Yes	Yes	Yes	
Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Others Specify:	-	-	-	-	-	
Special Diet:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Other Special Orders / Medications:	-	-	-	-	-	
Post Operative Procedure Special Orders:	-	-	-	-	-	
Handed Over By Name :	Sandhya	Preetha	Maheshwari	Preetha	Divya	
Signature :						
Date:	29/6/26	29/6/26	30/6/26	30/6/26	30/6/26	
Time:	2pm	8pm	8AM	2pm	8am	
Taken Over By Name :	Preetha	Maheshwari	Preetha			
Signature :						
Date:	29/6/26	29/6/26	30/6/26			
Time:	2pm	8pm	8AM			

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NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: ..... Department: ..... Date of Admission: .....

SITUATION	Diagnosis:	Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
BACKGROUND	Area / Shift Time						
	Medical Condition (Any special condition to be noted):						
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:						
	Res:						
	SpO_2:						
	Pulse:						
	BP:						
	Fall Risk Score:						
	Pain Score:						
Recommendations	Safety Needs:						
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:						
	Special Diet:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:						
Post Operative Procedure Special Orders:							
Handed Over By Name :							
Signature :							
Date:							
Time:							
Taken Over By Name :							
Signature :							
Date:							
Time:							

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DRUG CHART

Date of Admission: 29/6/26 Drug Allergies: .... ☐ 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 **/** 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.

13 kg

SOS / PRN (As Required Medication)

DRUG: SYP. CROCIN DS				Date/Time		
Dose	Route	Frequency	Start Date		29/6	30/6
4 ml	PO	SOS/6H	26/06			4:33 pm
Doctor's Signature	Valid Period	Pharm.				
Sinhal						
Additional Instructions: (5 ml / 240 mg)						

DRUG: SYP. IBUGESIC				Date/Time			
Dose	Route	Frequency	Start Date		29/6 6pm	30/6 5/10	1/7/26
4 ml	PO	SOS/8H	26/06				
Doctor's Signature	Valid Period	Pharm.					
Sinhal							
Additional Instructions: (5 ml / 100 mg)							

DRUG: INJ. ONDANSETRON				Date/Time	
Dose	Route	Frequency	Start Date		See regular medication
2.5 mg	IV	8H	26/06		
Doctor's Signature	Valid Period	Pharm.			
Sinhal					
Additional Instructions:					

Verified by Dr. Dhakshayani

Verified by Dr. Dhakshayani

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

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Dr. DILNAAZ FAROOQUI

REGULAR PRESCRIPTIONS

Weight. 13 kg Ward. ....

DRUG : INJ. CEFTRIAXONE				Date ▸ / Time ▾	29/6	30/6	1/7/2?
Dose	Route	Frequency	Start Date				
650mg	IV	12H	29/06				
Name & Signature of the Doctor Starting the Drugs: Sushant				6am			
Additional Instructions: Give over 1-2 hours				6pm	3PM		
Daily Doctor's Endorsement by a Sign							

DRUG : INJ. ESOMEPRAZOLE				Date ▸ / Time ▾	29/6	30/6	1/7/26
Dose	Route	Frequency	Start Date				
10mg	IV	OD	29/06		2PM		
Name & Signature of the Doctor Starting the Drugs: Sushant				6am			
Additional Instructions:							
Daily Doctor's Endorsement by a Sign							

DRUG : DAROLAC SACHET				Date ▸ / Time ▾	29/6	30/6	1/7/26
Dose	Route	Frequency	Start Date				
1 sachet	PO	12H	29/06				
Name & Signature of the Doctor Starting the Drugs: Sushant				6am			
Additional Instructions:				6pm	3PM		
Daily Doctor's Endorsement by a Sign							

DRUG : SYP. ZINCONIA				Date ▸ / Time ▾	29/6	30/6
Dose	Route	Frequency	Start Date			
5ml	PO	OD	29/06			
Name & Signature of the Doctor Starting the Drugs: Sushant				2pm		
Additional Instructions:						
Daily Doctor's Endorsement by a Sign						

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Sheet No: .....

REGULAR PRESCRIPTIONS

Weight 13/kg Ward .....

DRUG : ZEDOTIC SACHET (10mg)

Dose	Route	Frequency	Start Dt.
1 Sachet	PO	8H	29/06

Name & Signature of the Doctor Starting the Drugs: Sankalp

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date/Time: 29/6 30/6 1/7/22

6am X

2pm

10pm

DRUG : INJ. ONDANSETRON

Dose	Route	Frequency	Start Dt.
2.5mg	IV	8H	29/06

Name & Signature of the Doctor Starting the Drugs: Sankalp

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date/Time: 29/6 30/6 1/7/22

6am X

2pm

10pm

DRUG : Syp AZITHROMYCIN

Dose	Route	Frequency	Start Dt.
3.5ml	oral	BD	30/6

Name & Signature of the Doctor Starting the Drugs: B. Sneha

Additional Instructions: AZITHROMYCIN 15ml/200mg.

Daily Doctor's Endorsement by a Sign

Date/Time: 30/6

11AM

11PM

DRUG : Syp AZITHROMYCIN

Dose	Route	Frequency	Start Dt.
7ml	PO	O.D	30/6

Name & Signature of the Doctor Starting the Drugs: Pravin

Additional Instructions: 5ml = 200mg

Daily Doctor's Endorsement by a Sign

Date/Time:

11AM

Verified by Dr. Dhakshayani

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

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REGULAR PRESCRIPTIONS

Sheet No: .... Weight .... Ward ....

DRUG :				Date/Time
Dose	Route	Frequency	Start Dt.	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

DRUG :				Date/Time
Dose	Route	Frequency	Start Dt.	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

DRUG :				Date/Time
Dose	Route	Frequency	Start Dt.	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

DRUG :				Date/Time
Dose	Route	Frequency	Start Dt.	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

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

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Dr. DILNAAZ FAROOQUI

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

	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.	

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
24/06	11:20pm	IVF - NS	130ml over 1hour	IV	Sushant	Sugheina Afoun

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Master T. SAMARTH SINGH
25-08-2022 3 Y 10 M 4 D (M)
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I.V. FLUIDS CHART

Weight. 13kg ..... 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
29/06	2:30pm	IVF - DNS (2/3rd)	IV	30					
30/6	11AM	DNS	IV	25					

Signature .....

VERIFIED BY : Name .....

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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: 3rd floor 302

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*

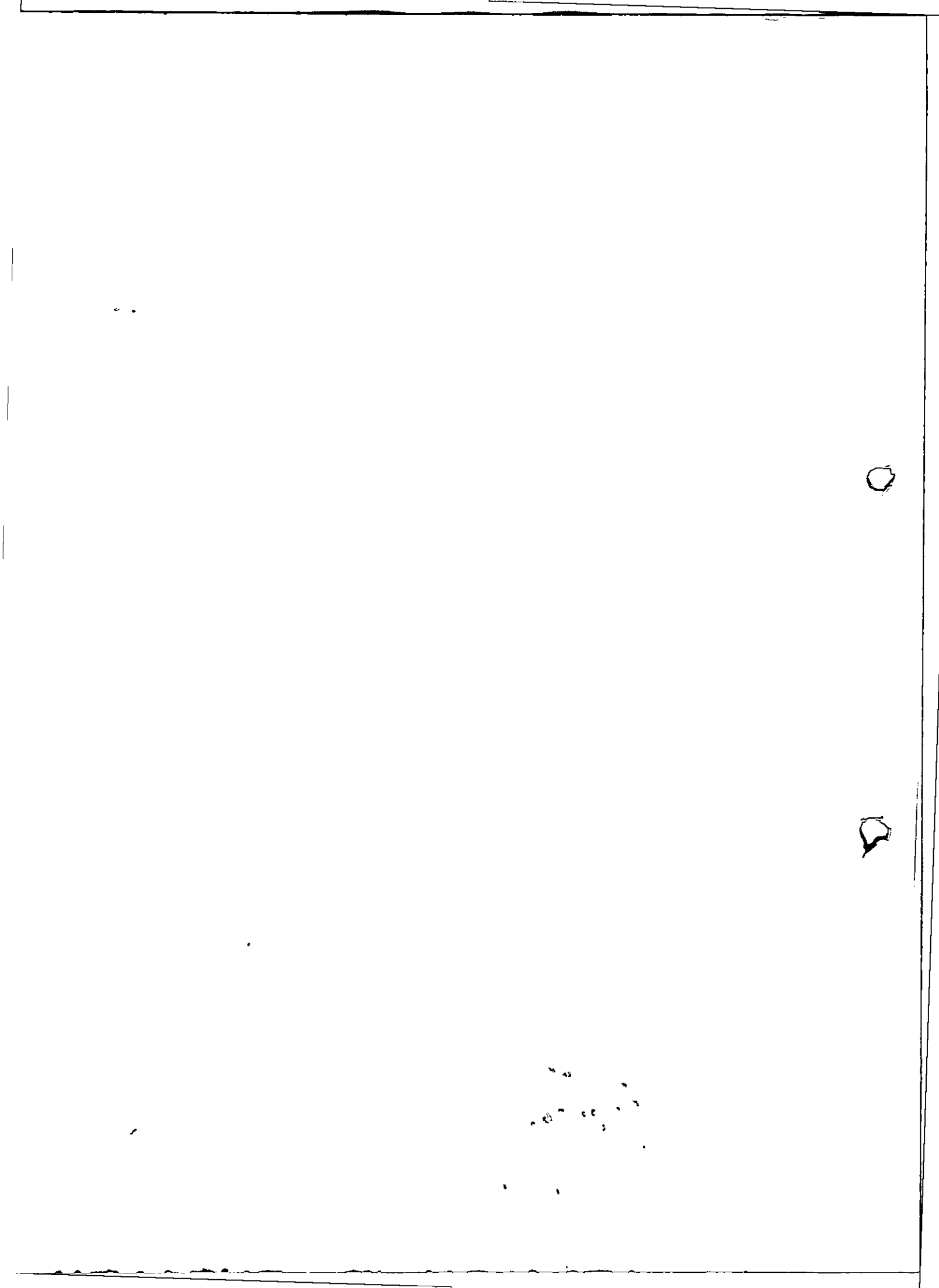
MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Sambhu

Date & Time : 29/06/26.

Nurse Name & Signature: Hanan /

Date & Time : 29/06/26 @ 12:28 PM



Patient Sticker

3 Y 10 M

302

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NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 30/6/26 Time: 11 Am

Weight: 13.1 kg Centile: 40th

Height: 101 cms Centile: 50th

Inference: underweight child

RDA: Calories: 1300 kcal/d Protein: 22 gms/d

Diet Recommendations: Gastro Diet

Re-Assesment:

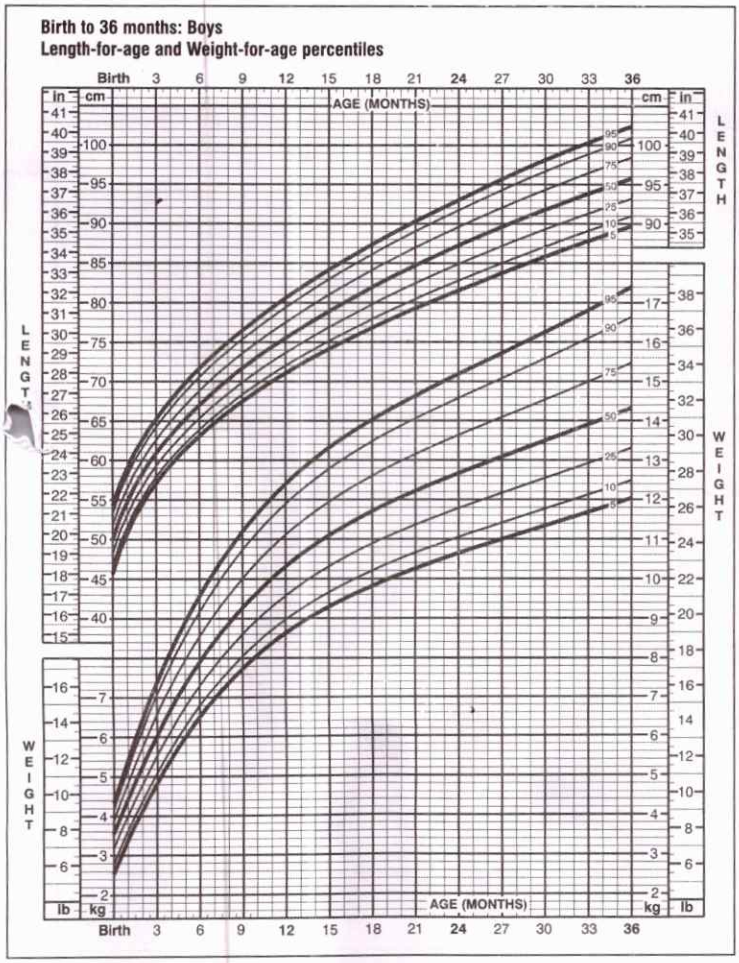
Food Allergies: NO Veg/Non-veg Veg

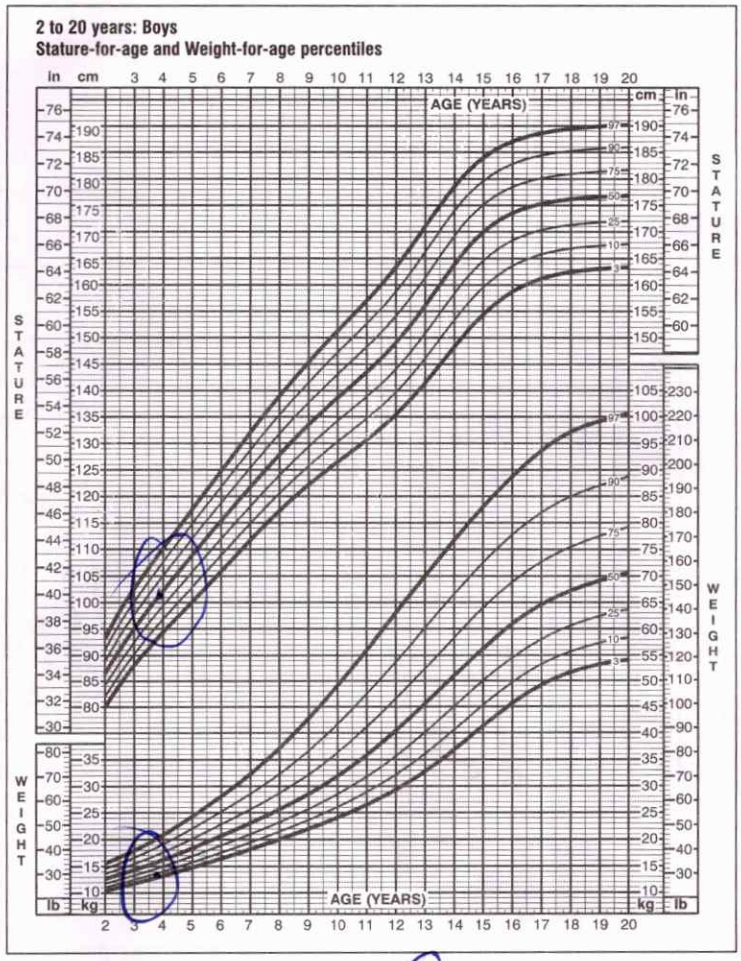
Diagnosis: AGE

Nutritional Intervention - ☑ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: ASH

GROWTH CHART (BOYS)





Dietician's Name Sathwika-G Dietician's Signature

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

(P.T.O.)

Daily Notes:

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Master T. SAMARTH SINGH
25-08-2022 3 Y 10 M 4 D (M)
Dr. DILNAAZ FAROOQUI

wt – 13.018 kg

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EMERGENCY ROOM TRIAGE FORM

Patient's Name : T. Samarth singh Age : 2 year **Gender:** ☑ Male ☐ Female

Date : 29/6/26 Time of Arrival : 11:20 a.m

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: 100.3°F PR: 115 b/m BP: ..... RR: 26 b/m SpO_2: 98%

Chief Complaints: c/o fever, vomiting, loose motion x 7 days.

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 : 11:22 a.m

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 : Rachit

Signature of Triage Nurse : .....

Date & Time : 29/6/26 @ 11:22 a.m

HNH-00004224 IP26-00006682
Master T. SAMARTH SINGH
25-08-2022 3 Y 10 M 4 D (M)
Dr. DILNAAZ FAROOQUI

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

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Your Right to a Safe Delivery

NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 29/6/26 Time of arrival : 11:20 AM

Chief Complaints: C/O Fever since 5 days, vomiting, motions. RBS: .....

Height : ..... Weight : 13.18 kg BMI : ..... Head Circumference (<2 years) .....

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

If yes , identify .....

Pain Screening: ☐ Yes ☑ No If Yes, Pain Score: 0 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): 29/06/26 @ 11:22 AM

Social History: Lives With Family

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

Time of Initial assessment completed by ER Nurse : 11:22 AM

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

Time	Nursing Notes
	→ Assessed the pt condition
	→ checked the pt vitals
	→ Medication given to the pt

Samples collected by: Sugeerdha @ 29/06/26 Time: 11:50 Am.

Samples sent by : Time:

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1

Condition of patient at time of shift - out :	**Details of Shift - out**
HR: 111 bpm BP: CFT:	Shift - out from ER to: 3rd floor / 302
RR: SPO$_2$: 98 %	Time of Shift - out: 12:28 pm
GCS: Temperature : 99.8 F	Handover given to: Sr. Sandhya
Pain Score: 0	(Nurse's Name)
Repeat RBS (if applicable):	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

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

Name of the Nurse : Bradin Signature of the Nurse :

Date & Time : 29/6/26 @ 11:22 Am