

**DISCHARGE SUMMARY**

<b>Name</b>	Master PAMULA SREE SAHISHNU	<b>UHID</b>	BAH-00379383
<b>Father/Guardian</b>	Mr P.SREE RAM	<b>Age/Gender</b>	8 Y 11 M 25 D/ Male
<b>Address</b>	H.NO:-2-2-1075/28, Amberpet, Hyderabad, Telangana, INDIA, 500013		
<b>IP No</b>	IP26-00006432	<b>Admission Date</b>	26-05-2026
<b>Ref Doctor</b>	Self		
<b>Discharge Date</b>	28.05.2026		

**Consultant:**

**Dr. ANIKET ANIL PARASHAR**

MBBS - MD

TSMC/FMR/08568, dr.aniket.p@rainbowhospitals.in

<b>DIAGNOSIS</b>	<b>ICD CODE</b>
ADENOVIRAL ILLNESS	

**History:** Master PAMULA SREE SAHISHNU, 8 Y 11 M 25 D , old boy presented with history of fever associated with cough since 4 days, decreased oral intake since 3 days, prior to admission. For the above complaints he was admitted at Rainbow Children's Hospital - for further management.

**Examination:** He was febrile with temperature 101.6 F, maintaining saturations at room air. His heart rate was 116/min, Blood pressure - 100/62mmHg and Respiratory Rate - 24/min. Capillary Refill Time was <2 secs. Peripheries were warm & pulses well felt. On examination Signs of some dehydration were present, dry lips, oral mucosa, decreased urine output, sunken eyes were present. On auscultation, air entry was bilaterally equal bilateral conducted sounds were present. Heart sounds were normal and there was no murmur. Abdomen was soft with no organomegaly. On neurological examination, he was conscious and alert. Pupils were bilaterally equal and reacting to light. There were no focal neurological or cranial nerve deficits. There were no signs of raised intracranial pressure.

Weight on admission: 32 kilo grams.

**Investigations:** Enclosed reports.

Name	Master PAMULA SREE SAHISHNU	UHID	BAH-00379383
IP No	IP26-00006432	Admission Date	26-05-2026

Initial hemogram showed Hemoglobin of 12.1 gm%, White Blood Cell count of 7970 cells/cumm, platelet count of 1.90 lakhs/cumm and C-Reactive Protein of 61 mg/l. Blood culture and sensitivity shows no growth after 24 hours of incubation. Ferritin 45.7 ng/ml.

Mycoplasma IgM was non reactive.  
Adenovirus PCR was detected.

**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 chest signs, he was frequently nebulised with Levolin.

He was regularly monitored for fever spikes, hemodynamic status. His fever spikes and other symptoms gradually settled. Child maintaining saturations on room air.

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. Ceftriaxone  
Injection. Esmoprazole  
Nebulisation Levolin  
Nebulisation 3% Nacl  
Syrup. Azithromycin  
Syp. Reswas Jr  
Vomikind Fast strip

**Advice:**

\* Diet as advised.

<b>Name</b>	Master PAMULA SREE SAHISHNU	<b>UHID</b>	BAH-00379383
<b>IP No</b>	IP26-00006432	<b>Admission Date</b>	26-05-2026

S.No	MEDICATION	DOSE	TIMINGS	DURATION
1	Syp. AUGMENTIN DDS (400mg Amoxicillin+ 57mg Clavulanic acid/5ml)	7.5 ml	8am-8pm (after food)	For 5 days
2	Syrup. Reswas Jr	5 ml	8am-8pm (after food)	For 3 days
3	Vomikid fast strip	1 strip	SOS nausea, vomiting	
4	Nasoclear nasal drops, 2 drops in each nostril <b>SOS</b> for nose block			

**Plan: To collect final blood culture report on followup.**

### Fever Management

- \* Syrup. P-500 (Paracetamol - 5ml/500mg) 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. ANIKET ANIL PARASHAR on monday (1/6/26) 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.

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.

<b>Name</b>	Master PAMULA SREE SAHISHNU	<b>UHID</b>	BAH-00379383
<b>IP No</b>	IP26-00006432	<b>Admission Date</b>	26-05-2026

Parent/ Attender

In case of emergency contact 9154865030 emergency pediatrician on duty.

To take appointment for OPD consultation at Rainbow **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](http://www.rainbowhospitals.in)**



**Registrar/Resident/C.M.O**

**Dr. ANIKET ANIL PARASHAR**

MBBS - MD

TSMC/FMR/08568, dr.aniket.p@rainbowhospitals.in

ADMISSION SHEET



Registration Details :

Admission No : IP26-00006432      Admit Date : 26-May-2026      Admit Time : 06:58 PM      UHID : BAH-00379383

Patient Details :

Patient Name : Master PAMULA SREE SAHISHNU      Age : 8 Y 11 M 24 D  
Guardian : Mr P.SREE RAM      DOB : 02-06-2017  
Gender : Male      Religion :  
Occupation :      Martial Status : Single  
Address (H) : H.NO:-2-2-1075/28 Amberpet Hyderabad      Phone No : 9160043200/ 9985078696  
Telangana INDIA 500013      E-mail : vutukuri.tejaswini@gmail.com

Admission Details :

Bed Type : DAY CARE      Bed No : ER01      Ward Name : GF -EMERGENCY  
Room No : ER01      Admission Type : First Visit

Contact Details :

Name : Mr P.SREE RAM      Relationship : Father  
Contact Address : H.NO:-2-2-1075/28 Amberpet Hyderabad      Phone No : 9160043200  
Telangana INDIA 500013

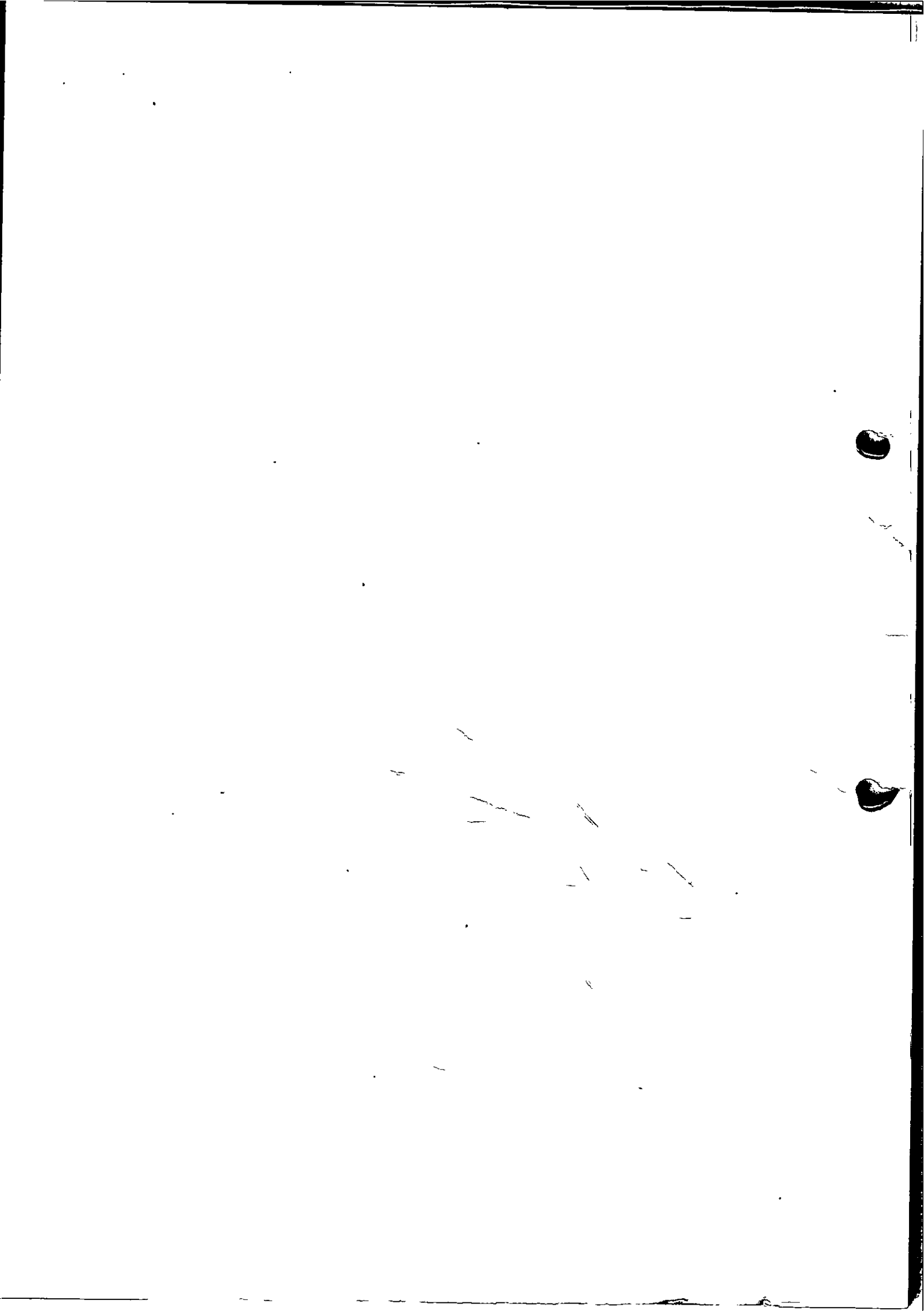
  
Signature

Doctor Details :

Doctor Name : Dr. ANIKET ANIL PARASHAR      Specialisation : GENERAL PEDIATRICS  
Referral Doctor : Self      Phone No :  
Co-Consultant :

Payment Details :

Payment Mode : DC/CC Card      Deposit Amount : 10000.00  
Payor Name : MEDI ASSIST INSURANCE TPA PVT LTD



BAH-00379383 IP26-00006432  
 Master PAMULA SREE SAHISHNU  
 02-06-2017 8 Y 11 M 24 D (M)  
 Dr. ANIKET ANIL PARASHAR

*Levelin 6th hour*

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

**BirthRight**  
 BY RAINBOW HOSPITALS  
 Your Right to a Safe Delivery



# NEBULISATION CHART

Date	Time	Drug	Nurse	Parents Signature
	00.00			
	01.00			
	02.00			
	03.00			
	04.00	Levelin <sup>(2)</sup>	<del>SA</del>	Sushy
	05.00			
	06.00			
	07.00			
	08.00			
	09.00			
	10.00	Levelin <sup>(2)</sup>	SA	
	11.00			
	12.00			
	13.00			
	14.00			
	15.00			
	16.00			
	17.00			
	18.00			
	19.00			
	20.00			
	21.00			
	22.00			
	23.00			

*Parental check = OK  
 Cross checked done by upinder.*

BAH-00379383 IP26-00006432  
 Master PAMULA SREE SAHISHNU  
 02-06-2017 8 Y 11 M 24 D (M)  
 Dr. ANIKET ANIL PARASHAR

*Levulin - 6<sup>th</sup> Hz*

# NEBULISATION CHART

Date	Time	Drug	Nurse	Parents Signature
	00.00			
	01.00			
	02.00			
<i>27/5/26</i>	03.00			
	04.00	<i>Levulin</i> (2)	(S)	<i>Daddy</i>
	05.00	<del>2308</del> (2)		
	06.00			
	07.00			
	08.00			
	09.00			
	10.00	<i>Levulin</i> (1) (3)	<del>M</del>	<i>Mammy</i>
	11.00			
	12.00	(2) - <i>Levulin</i>		
	13.00			
	14.00			
	15.00	<i>Levulin</i> (2) (4)	(S)	<i>Mammy</i>
	16.00			
	17.00			
	18.00			
	19.00			
	20.00		(S)	
	21.00		(S)	<i>Daddy</i>
	22.00	<i>Levulin</i>	(S)	
	23.00			

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8

8

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BAH-00379383 IP26-00006432  
 Master PAMULA SREE SAHISHNU  
 02-06-2017 8 Y 11 M 24 D (M)  
 Dr. ANIKET ANIL PARASHAR



*Levolin  
 GAH/HK*



## NEBULISATION CHART

Date	Time	Drug	Nurse	Parents Signature
	00.00			
	01.00			
	02.00			
	03.00			
	04.00			
	05.00			
	06.00			
	07.00			
	08.00			
	09.00			
	10.00			
	11.00			
	12.00			
	13.00			
	14.00			
	15.00			
	16.00			
	17.00			
	18.00			
	19.00			
	20.00			
	21.00			
<i>26/5/2017</i>	22.00	Levolin	<i>(1)</i> <i>(1)</i>	<i>(Signature)</i>
	23.00			

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8


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### ACTIVITY RECORD FOR BILLING

Name: **BAH-00379383 IP26-00006432**  
**Master PAMULA SREE SAHISHNU**  
**02-06-2017 8 Y 11 M 24 D (M)**  
**Dr. ANIKET ANIL PARASHAR**


UHID No : 

Date of Admission : \_\_\_\_\_ Date of Discharge : \_\_\_\_\_ Time: \_\_\_\_\_

Room / Bed No : \_\_\_\_\_ Ward : \_\_\_\_\_ Suggested Billable bed type : \_\_\_\_\_

Consultant : \_\_\_\_\_ Dept : \_\_\_\_\_

### WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
26/5/26	7:45pm	ER	210	

### Cross Consultation Visit

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





**PROCEEDURE**

Date	Proceedure	Quantity	Order No.	Signature
25/5/26	Tr amula	1	202253	<del>AM</del>
<p><i>cross checked by Manishu@IAM 26/7/26</i></p>				
27/5/26	NHA	1	2426	Sm
<p><i>cross checked du by...</i></p>				

**ANY OTHER INFORMATION**

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Date :

Time :

Prepared By :

<p>Staff Nurse</p> <p><i>Amul</i></p>	<p>Shift / Ward</p> <p><i>2nd floor</i></p>	<p>Billing Assistant</p>	<p>Billing Supervisor</p>
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Ref.No. F/IN/PR/10



**Rainbow<sup>®</sup>  
Children's  
Hospital**

**PEDIATRIC IN-PATIENT  
MEDICAL RECORD**

Patient Name :

BAH-00379383 IP26-00006432

Master PAMULA SREE SAHISHNU

02-06-2017 8 Y 11 M 24 D (M)

Dr. ANIKET ANL PARASHAR

Patient ID# :



Consultant :

Final Diagnosis :

Pediatric Multiorgan History & Physical Examination

Name : \_\_\_\_\_ Age/Sex \_\_\_\_\_

Informant \_\_\_\_\_ Reliability \_\_\_\_\_

Chief Presenting Complaints & Duration (Chronologically):

Ch fever since 4 days  
Ch cough since 4 days  
Ch decreased oral intake x 3 days

History of present illness :

pt was apparently alright 4 days before then had fever. on soft type moderate. - high degree

Ch cough since 4 days, dry cough.

Ch decreased oral intake since 3 days

**Pediatric Multiorgan History & Physical Examination**

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

Nothing Significant

Birth & Neonatal History :

NAD

Birth & Socio Economic History :

About Father :

About Mother :

Any additional Information :

Developmental History :

Developmentally normal

Immunization History :

upto date acc to NIS.

Pediatric Multiorgan History & Physical Examination

Anthropometry

Head Circum (cms) \_\_\_\_\_ (Centile \_\_\_\_\_) Height (cm) : \_\_\_\_\_ (Centile \_\_\_\_\_)

Weight (kgs) 32 kg (Centile \_\_\_\_\_)

**On Examination :**

Temperature : 101.6°F Pulse Rate: \_\_\_\_\_ Description \_\_\_\_\_

B.P. \_\_\_\_\_ SPO2 96% at RA

Resp. rate and type of breathing : \_\_\_\_\_

Rash  \_\_\_\_\_

Lymphadenopathy  \_\_\_\_\_

Oedema :  \_\_\_\_\_

dry oral Mucosa  
dry lips  
Sunken eye

**Respiratory system :**

Inspection (any s/o distress) : \_\_\_\_\_

Air entry & breath sounds : BIL ACP

Any addes sounds : BIL. NVBS B/L. Crackled Sound

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

**Cardiovascular System :**

Inspection of precordium : \_\_\_\_\_

Heart Sounds : S1S2 heard

Any murmur : No Murmur

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

**Per Abdomen :**

Inspection \_\_\_\_\_

Palpation : Soft, nontender

Ausculation : No organomegaly

Spine: \_\_\_\_\_ External Genitalia : \_\_\_\_\_

Relevant data from outside (CT, USG etc.,) \_\_\_\_\_

**Pediatric Multiorgan History & Physical Examination**

**Central Nervous System :**

Level of Consciousness : AVPU/GCS Score : \_\_\_\_\_

Cranial Nerves : \_\_\_\_\_

**Motor System :**

Nutrition : \_\_\_\_\_

Tone : \_\_\_\_\_ Power \_\_\_\_\_

Co-ordinator : \_\_\_\_\_

Posture : \_\_\_\_\_

Involuntary Movements : \_\_\_\_\_

**Reflexes :**

**DTR**

**Superficials :**

Plantars \_\_\_\_\_

**Sensory System :**

Bladder / Bowel : \_\_\_\_\_

**Clinical Summary & Diagnostic :**

AFE & dehydration  
? LRTI

**Pediatric Multiorgan History & Physical Examination**

Preventive aspects of the treatment :

Desired goals of the treatment :

**Planned Labs :**

**Planned Management :**

CBP, CRP.  
Blood C/S  
Adenovirus PCR  
Chest X ray  
Mycoplasma IgM.

IVF Plasmyte. Hom/w.  
Zy-ceftriaxone 1.5 gm. BD  
Syp. Azithromycin 8ml OD  
Syp. P-500 4.5ml Q6H  
Syp. ibuprofen 7.5ml SOS  
Syp. Resveratrol 5ml. BD  
neb levofloxacin 0.63mg  
Q6H.

**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

Doctor's Signature Name \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
26/05/26 9:00 PM	<p>DOB - Dr. Sankar / Dr. Prabhat</p> <p>Fever ⊕            Weight ⊕            poor oral intake            vomiting (1 episode)            O/E: G.C. fair            Hemodynamically stable</p>	
	<p>S/E - PSLT BUCAC ⊕, conducted</p>	<p>Sound ⊕</p>
	<p>CVC - S. Sa ⊕            PA: soft non-tender            CNO &amp; NAD</p>	<p><u>Ach</u></p>
		<ul style="list-style-type: none"> <li>- IV fluids</li> <li>- IV Ceftriaxone</li> <li>- Syp Acetaminophen</li> <li>- Supportive care</li> <li>- Monitor vitals and</li> </ul> <p>Inform S/S</p> <ul style="list-style-type: none"> <li>- Trace blood reports</li> </ul> <p>Sincerely,</p>
		<p><del>NB - Mouthwash            @ 10 PM.</del></p>

**PROGRESS NOTES AND DOCTOR'S ORDER**

Date & Time	Progress Notes	Doctor's Order
27/05/20	S/O Dr. Prabhakar	
8 Am	<p>△ ARI - Dehydration ? LRTI.</p> <p>Fever spiked (+)</p> <p>High grade</p> <p>10pm 101.5°F</p> <p>12 AM 102.7°F</p> <p>1:30 AM 100.3°F</p> <p>Cough (+), Productive</p> <p>Oral intake - fair.</p>	
	<p><u>o/s</u> vitals</p> <p>stable,</p> <p>Child dull</p>	<p><u>Adv</u></p> <p>① CT. Ceftriaxone</p> <p>② Trace Adenovirus</p> <p>Mycoplasma IgM</p>
	<p>DL: BAC +</p> <p>B/c Conducted sounds.</p>	<p>③ w/ fever spikes</p>
	<p><u>Dr</u></p>	



**PROGRESS NOTES AND DOCTOR'S ORDER**

Date & Time	Progress Notes	Doctor's Order
27/5 9:30 AM	<p><u>CRIB D. Aniket</u></p> <p><u>D<sup>o</sup> - HFI - Dehydration</u>  <u>? LRTI</u></p>	
	<p>- Fever spikes ⊕ (High grade)          - Cough ⊕ - Productive          - Oral intake - less - (Nausea)</p>	<p><u>PLU</u></p> <ol style="list-style-type: none"> <li>1) Inj Ceftriaxone</li> <li>2) Syrup Azee</li> <li>3) Oral C Levofloxacin</li> <li>4) Syrup Resorcinol - J4</li> <li>5) Tablet Adenomin              ↓ Mycophenolate Mofetil</li> <li>6) Monitor Vitals</li> <li>7) Send <u>Ferritin</u> in <sup>yellow</sup> sample <del>serum</del></li> <li>8) Add Esomeprazole              Vomiting just stop</li> </ol>
	<p>Vital stable          P-V - Good          R-S - B/LHE ⊕          Conducted sounds ⊕          PLA - Soft</p>	<p>9) Inj SOS</p>
		<p>n/B          of mouth</p> <p>Dr. Aniket Anil Parashar          Consultant Pediatrician &amp; Intensivist          Reg. No: 8568</p> <p><i>[Signature]</i>          D. Aniket</p>

## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	C/S/B. Dr. Naipunya	
22/5		
2:30 PM	AFB & dehydration : LRTI.	
		Plan
	Fever spike (P) - 100°F	
	Cough (P).	
	oral intake - fair.	- Cont Ceftriaxone
	vitals - stable	- Trace ← Adenovirus
		Mycoplasma IgM
	R/S - BIL AE (P)	- Trace Sr-ferritin
	B/L Condensed Solds	- Monitor vitals
		N/B popyanka
		ay



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
27/5/26 7pm	<p>US/BS Dr. Aniket  <u>Adenomaal others</u></p>	
	<p>- low grade fever spikes (+)</p>	
	<p>- cough (+)</p>	
	<p>- oral intake : good</p>	
	<p><u>o/c</u></p>	
	<p>- vitals : stable</p>	<p>Plan</p>
	<p>- vitals - BPE (+)          conducted</p>	<p>1) STOP Azee</p>
	<p>ventil (+)</p>	<p>2) vit. Ref as per Rx          chart</p>
		<p>3) monitor vitals</p>
		<p>4) plan discharge T/M → if no          high grade spikes</p>
		<p>5) STOP IVE</p>
		<p>Noted by Salsiya @ 7pm          27/5/26</p>

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

*Aniket P*



## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
28/5/16 7:15 AM	SIB Dr. Sneethan D Adenoviral Illness Plan	
	Fever spikes ⊕	✓ CE CEFTRIAXONE
	CVS S <sub>1</sub> S <sub>2</sub> ⊕	✓ Encourage oral
	R <sub>1</sub> -B <sub>1</sub> -A <sub>1</sub> C <sub>1</sub> ⊕	NB-Mouthwash ⊕
	PIA-506	
	Conclies	
		✓ 15/7
28/5/26 10 AM	SIB Dr. Aniket D Adenoviral Illness Plan	
	Low grade Fever spikes ⊕	✓ Discharge
	CVS S <sub>1</sub> S <sub>2</sub> ⊕	✓ AMOXICILLAV-3d
	R <sub>1</sub> -B <sub>1</sub> -A <sub>1</sub> C <sub>1</sub> ⊕	✓ Flup alba
	PIA-506	✓ 2 day
	Conclies	✓
		✓ VOMIKIND Strip-3d
		✓ REJWASIN-3 day
		✓
		✓
		✓ Dr. Aniket

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



# DRUG CHART

Date of Admission: 26/5/26 Drug Allergies: N/A  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 : <u>SyP. P-500</u>				Date	<u>26/5</u>
				Time	<u>27/5</u>
Dose	Route	Frequency	Start Date		
<u>4.5ml</u>	<u>PO</u>	<u>SOS</u>	<u>@ 6H</u>		
Doctor's Signature		Valid Period	Pharm.		
<u>[Signature]</u>		<u>&gt; 100F</u>			
Additional Instructions:					

DRUG : <u>SyP. ibugesic</u>				Date	<u>26/5</u>
				Time	<u>12:00 PM</u>
Dose	Route	Frequency	Start Date		
<u>7.5ml</u>	<u>PO</u>	<u>SOS</u>			
Doctor's Signature		Valid Period	Pharm.		
<u>[Signature]</u>		<u>&gt; 102F</u>			
Additional Instructions:					

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

VERIFIED BY : Name



REGULAR PRESCRIPTIONS

Weight. 32 kg Ward. ....

<b>DRUG :</b> <u>inj. Ceftriaxone</u>					Date Time	<u>26/5</u>	<u>27/5</u>	<u>28/5</u>												
Dose	Route	Frequency	Start Date																	
<u>1.5gm</u>	<u>IV</u>	<u>BD</u>	<u>26/5</u>		<u>10am</u>	<u>X</u>	<u>27/5</u>	<u>10am</u>	<u>X</u>	<u>28/5</u>	<u>10am</u>	<u>X</u>								
Name & Signature of the Doctor Starting the Drugs: <u>Deep</u>																				
Additional Instructions:					<u>10pm 9PM</u>															
<b>Daily Doctor's Endorsement by a Sign</b>																				
<b>DRUG :</b> <u>Syr. Azithromycin</u>					Date Time	<u>26/5</u>														
Dose	Route	Frequency	Start Date																	
<u>8ml</u>	<u>PO</u>	<u>OD</u>	<u>26/5</u>																	
Name & Signature of the Doctor Starting the Drugs: <u>Deep</u>					<u>STOP 27/5</u>															
Additional Instructions:																				
<b>Daily Doctor's Endorsement by a Sign</b>																				
<b>DRUG :</b> <u>Syr. ibuprofen</u>					Date Time															
Dose	Route	Frequency	Start Date																	
<u>7.5ml</u>	<u>PO</u>																			
Name & Signature of the Doctor Starting the Drugs: <u>Deep</u>																				
Additional Instructions:																				
<b>Daily Doctor's Endorsement by a Sign</b>																				
<b>DRUG :</b> <u>Syr. Reswas Jr</u>					Date Time	<u>26/5</u>	<u>27/5</u>	<u>28/5</u>												
Dose	Route	Frequency	Start Date																	
<u>5ml</u>	<u>PO</u>	<u>BD</u>	<u>26/5</u>		<u>10am</u>	<u>X</u>	<u>27/5</u>	<u>10am</u>	<u>X</u>	<u>28/5</u>	<u>10am</u>	<u>X</u>								
Name & Signature of the Doctor Starting the Drugs: <u>Deep</u>																				
Additional Instructions:					<u>10pm 9PM</u>															
<b>Daily Doctor's Endorsement by a Sign</b>																				



Sheet No: .....

**REGULAR PRESCRIPTIONS**

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

<b>DRUG :</b> Neb E levolin				Date Time																		
Dose	Route	Frequency	Start Dt.																			
0.3ml Neb		Q6H	26/5																			
Name & Signature of the Doctor Starting the Drugs:																						
Additional Instructions:																						
<b>Daily Doctor's Endorsement by a Sign</b>																						
<b>DRUG :</b> Syp. P-500				Date Time																		
Dose	Route	Frequency	Start Dt.																			
4.5ml	PO	Q6H	26/5																			
Name & Signature of the Doctor Starting the Drugs:																						
Additional Instructions:																						
<b>Daily Doctor's Endorsement by a Sign</b>																						
<b>DRUG :</b> Inj ESOMEPRAZOLE				Date Time																		
Dose	Route	Frequency	Start Dt.																			
30mg	IV	OD	27/5																			
Name & Signature of the Doctor Starting the Drugs:																						
Additional Instructions:																						
<b>Daily Doctor's Endorsement by a Sign</b>																						
<b>DRUG :</b> Inj ONDANSETRON				Date Time																		
Dose	Route	Frequency	Start Dt.																			
4mg	IV	TID	27/5																			
Name & Signature of the Doctor Starting the Drugs:																						
Additional Instructions:																						
<b>Daily Doctor's Endorsement by a Sign</b>																						

Signature  
Name







BAH-00379383 IP26-00006432  
 Master PAMULA SREE SAHISHNU  
 32-06-2017 8 Y 11 M 24 D (M)  
 Dr. ANIKET ANIL PARASHAR



210

# RESULT SHEET

Rainbow<sup>®</sup>  
 Children's  
 Hospital  
 It takes a lot to treat the little.

BirthRight<sup>™</sup>  
 BY RAINBOW HOSPITALS  
 Your Right to a Safe Delivery

Date	26/5/26				
Time					
Hb	12.1				
PCV	33.8				
RBC	4.43				
WBC	7.97				
N/L	72.7/17				
Platelets	190				
CRP	6.1				
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					

Docu. No. : RCH/FRM/CLINICAL/0138

Feminin-45.7

P.T.O.

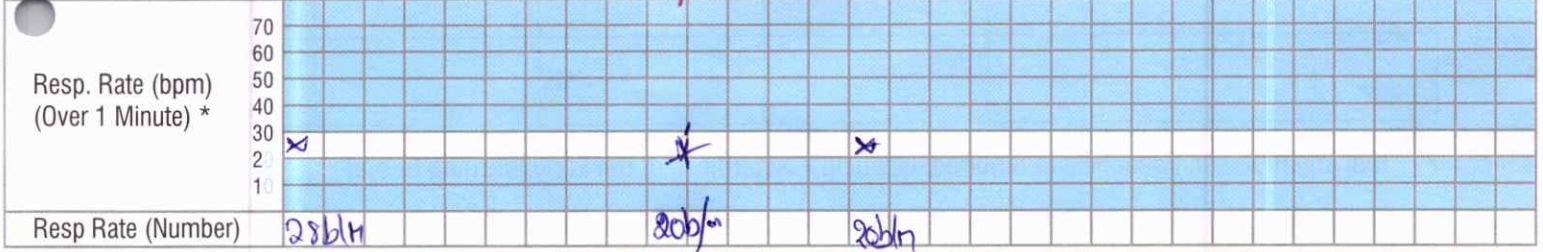
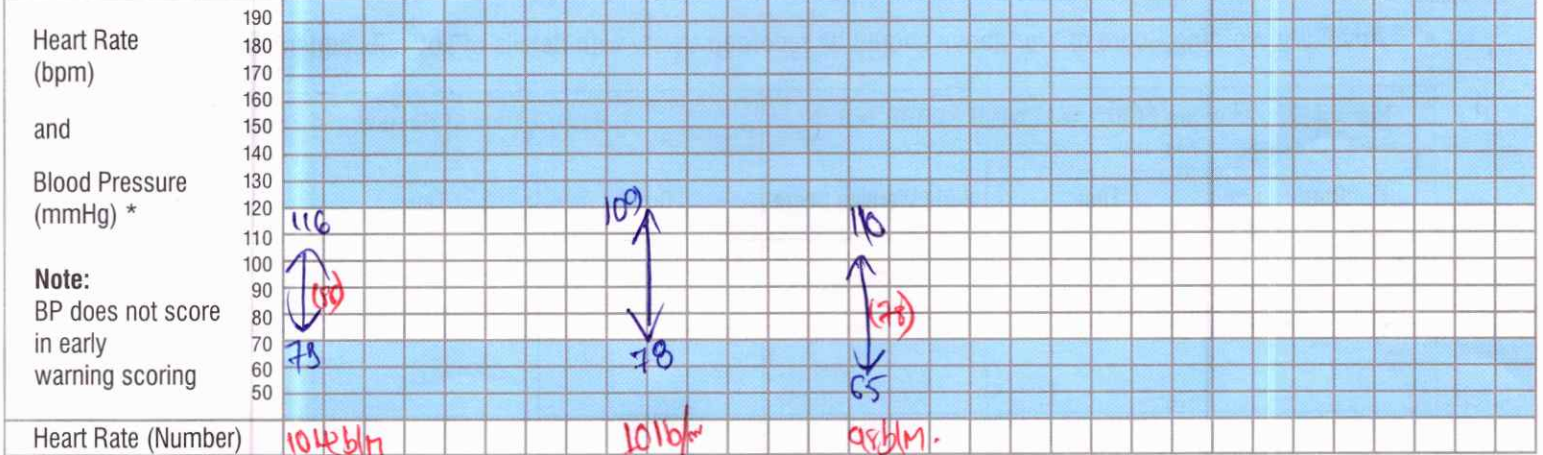
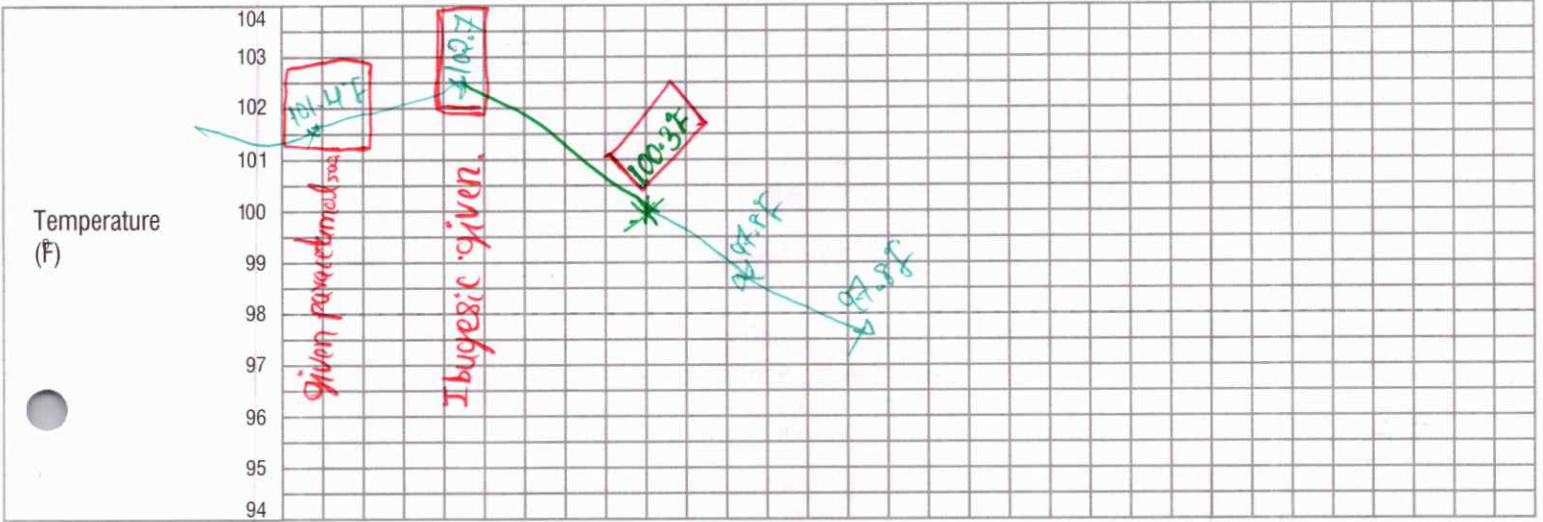




EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 26/5/2017 Time: 10:5 PM, 12:10 AM, 1:30 AM, 5 AM, 6 AM

Doctor / Nurse / Family Concern?



Resp Distress	Mod/ Severe None / Mild	
Receiving O <sub>2</sub> (l/min)		
O <sub>2</sub> Saturations (%)	98%	99%
Conscious Level	Normal Altered	
GCS *		

<b>TOTAL SCORE</b>	
Number of shaded boxes	0
Pain Score	0
Observer's Initials	M

<b>ACTIONS</b>	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.

## 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

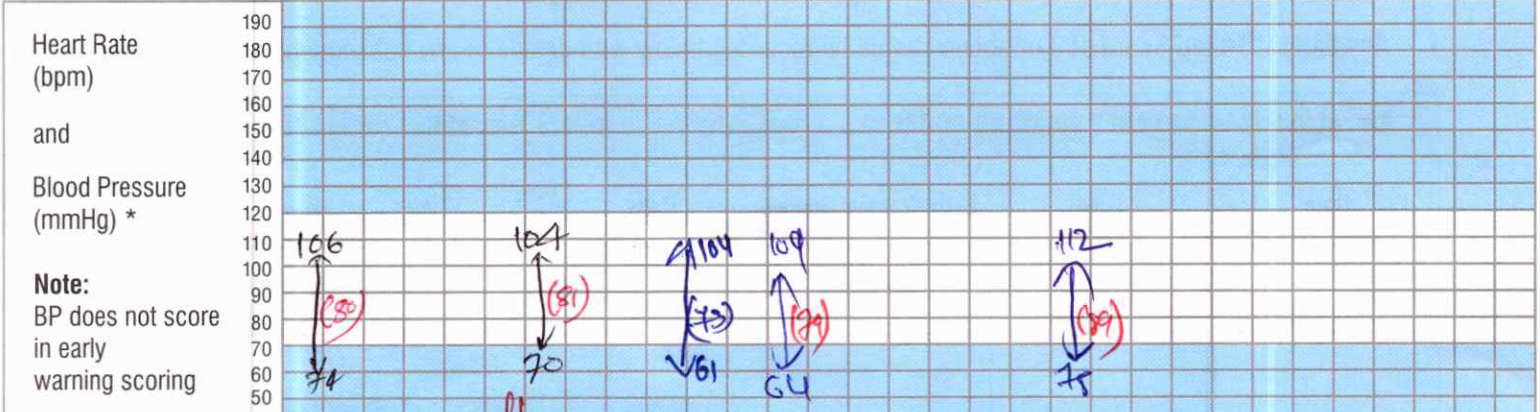
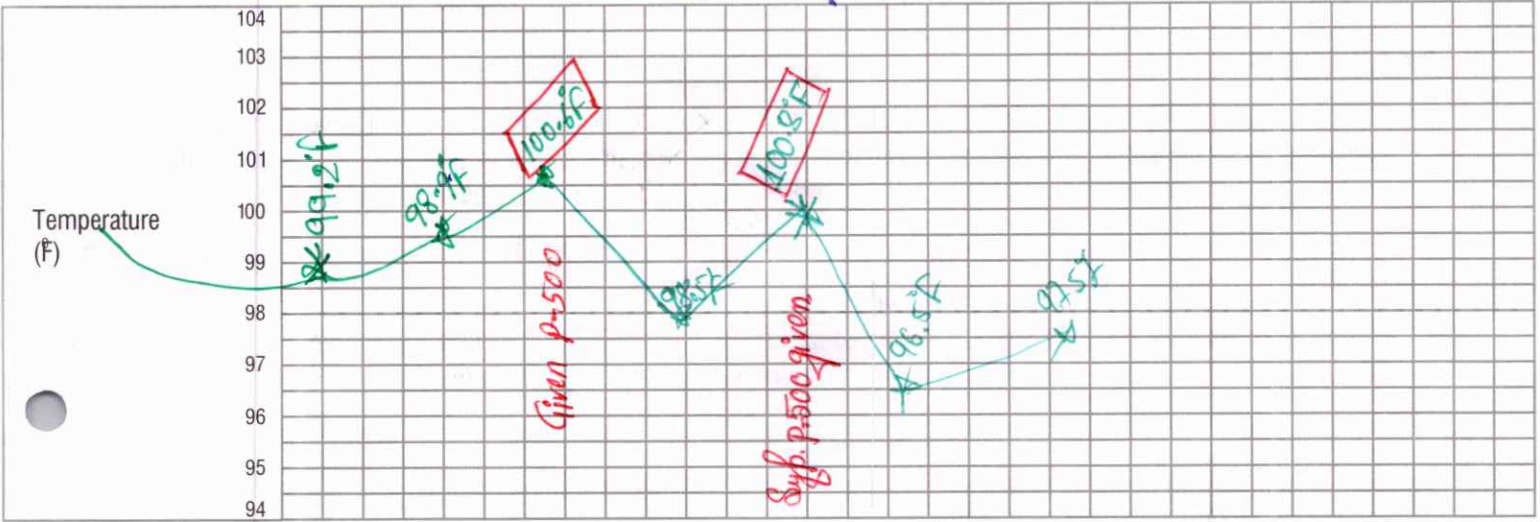
The SBAR communication tool (situation, background, assessment, recommendations) is a helpful mnemonic that can be used to describe a child's clinical condition to a colleague.

<b>I</b>	<b>IDENTITY:</b> I am (name), a nurse on ward (X). I am calling about (child X)
<b>S</b>	<b>SITUATION:</b> 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>B</b>	<b>BACK GROUND:</b> 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)
<b>A</b>	<b>ASSESSMENT:</b> 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.
<b>R</b>	<b>RECOMMENDATION:</b> I need you to ... come to see the child in the next (XX mins) AND Is there anything I need to do in the meantime? (e.g. stop the fluid/ repeat observation)



EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 24/5/20 Time: 10 AM 1 PM 2 PM 6 PM 9 PM 12 AM 6 AM  
 Doctor / Nurse / Family Concern?



Heart Rate (Number) 103b/m 115b/m 110b/m 98b/m 96b/m

Resp. Rate (bpm) (Over 1 Minute) \*  
 20b/m 20b/m 20b/m 25b/m 23b/m

Resp Mod/ Severe Distress None / Mild

Receiving O<sub>2</sub> (l/min) O<sub>2</sub> Saturations (%) 100% 99% 100% 100% 99%

Conscious Level Normal / Altered  
 GCS \* 1

TOTAL SCORE  
 Number of shaded boxes 0 0 0 0 0  
 Pain Score 0 0 0 0 0  
 Observer's Initials B N B M B

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

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<b>S</b>	<b>SITUATION:</b> 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>B</b>	<b>BACK GROUND:</b> 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)
<b>A</b>	<b>ASSESSMENT:</b> 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.
<b>R</b>	<b>RECOMMENDATION:</b> I need you to ... come to see the child in the next (XX mins) AND is there anything I need to do in the meantime? (e.g. stop the fluid/ repeat observation)



# 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	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
			Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
<b>Total Intake :</b>						<b>Total Output :</b>						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
<b>Total Intake :</b>						<b>Total Output :</b>						
	08:00 pm			uoml								
	09:00 pm	plasmalt		uoml								
	10:00 pm	glt R:CP		uoml								
	11:00 pm	+ H <sub>2</sub> O		uoml								
	12:00 am			uoml								
	01:00 am			uoml								
	26/5/16											
<b>Total Intake :</b>						<b>Total Output :</b>						
	02:00 am			uoml								
	03:00 am	plasmalt		uoml								
	04:00 am			uoml								
	05:00 am	H <sub>2</sub> O		uoml								
	06:00 am			uoml								
	07:00 am			uoml								
	27/5/16											
<b>Total Intake :</b>						<b>Total Output :</b>						
<b>Total 24 hrs. Intake</b>						<b>Total 24 hrs. Output</b>						

# FLUID CHART

Sheet No. : .....

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
27/5/26	08:00 am	↓	↓	30ml	↘	↘	↘	↘	✓	1		
	09:00 am		30ml	✓								
	10:00 am	30ml	✓									
	11:00 am	30ml	✓									
	12:00 pm	30ml	✓									
	01:00 pm	30ml	✓									
<b>Total Intake :</b>						<b>Total Output :</b> U-3 M-						
28/5	02:00 pm	↓		30ml	↘	↘	↘	↘		0		
	03:00 pm		30ml	✓								
	04:00 pm		30ml	✓								
	05:00 pm		30ml	✓								
	06:00 pm		30ml	✓								
	07:00 pm		30ml	✓								
<b>Total Intake :</b> taken						<b>Total Output :</b> U-2 M-1						
28/5	08:00 pm	↓			↘	↘	↘	↘		0		
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
<b>Total Intake :</b>						<b>Total Output :</b>						
28/5	02:00 am	↓			↘	↘	↘	↘		0		
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
<b>Total Intake :</b>						<b>Total Output :</b>						
<b>Total 24 hrs. Intake</b>						<b>Total 24 hrs. Output</b>						

BAH-00379383 IP26-00006432  
 Master PAMULA SREE SAHISHNU  
 02-06-2017 8 Y 11 M 24 D (M)  
 Dr. ANIKET ANIL PARASHAR



# NURSING CARE RECORD



Date: 20/8/26

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							
Afternoon				ER			
Night	8 PM	<ul style="list-style-type: none"> <li>→ Assess the pt condition.</li> <li>→ monitor the vitals.</li> <li>→ maintain I/O chart.</li> <li>→ plan nebulizations. 5th hourly, levolin 0.63 mg.</li> </ul>	8 PM	<ul style="list-style-type: none"> <li>→ assessed the pt condition.</li> <li>→ monitored the vitals.</li> <li>→ maintained I/O chart</li> <li>→ planed nebulizations. 5th hourly levolin 0.63mg.</li> </ul>	→ pt is stable now	→ Re assessed the liver spics.	

BAH-00379383 IP26-00006432  
 Master PAMULA SREE SAHISHNU  
 02-06-2017 8 Y 11 M 24 D (M)

Pati Dr. ANIKET ANIL PARASHAR



# NURSING CARE RECORD



Date: 27/5/26

- 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	8Am	<ul style="list-style-type: none"> <li>- Assess the Pt condition</li> <li>- monitor vitals</li> <li>- Maintain I/O chart</li> <li>- Administer Medication as per drug chart</li> </ul>	8Am	<ul style="list-style-type: none"> <li>- Assess the Pt condition</li> <li>- monitor vitals</li> <li>- Maintained I/O chart</li> <li>- Administered Medication as per drug chart</li> </ul>	Pt is stable	Rechecked	[Signature]
	2pm		2pm				
Afternoon	2Pm	<ul style="list-style-type: none"> <li>Assess the Pt condition.</li> <li>Monitor, vitals &amp; record</li> <li>to maintain I/O chart.</li> <li>Provide the comfortable position.</li> <li>Medication give as per as doctor order.</li> </ul>	2pm	<ul style="list-style-type: none"> <li>Assessed the Pt condition.</li> <li>Monitored vitals</li> <li>Maintained I/O chart.</li> <li>Provided the comfortable position.</li> <li>Medication given as per as doctor order.</li> </ul>	<ul style="list-style-type: none"> <li>→ Pt is stable.</li> <li>→ vitals norms.</li> </ul>	<ul style="list-style-type: none"> <li>→ monitor vials.</li> <li>→ maintain I/O charts.</li> </ul>	Sneh [Signature]
	8Pm		8pm				
Night	8pm	<ul style="list-style-type: none"> <li>→ Assess the pt condition.</li> <li>→ monitor the vitals.</li> <li>→ provide comfortable position.</li> <li>→ drugs give as per drug chart.</li> </ul>	8pm	<ul style="list-style-type: none"> <li>→ Assessed the pt condition.</li> <li>→ monitored the vitals.</li> <li>→ provided comfortable position.</li> <li>→ drugs given as per drug chart.</li> </ul>	→ pt is stable now	→ Reassessed the vitals	[Signature]

BAH-00370383 IP26-00006432  
 Master PAMULA SREE SAHISHNU  
 02-06-2017 8 Y 11 M 24 D (M)  
 Dr. ANIKET AML PARASHAR



# NURSING CARE RECORD

Date: 28/5/26

**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	8am   2pm	- Assess the Pt condition - Monitor vitals - Maintain I/O Chart - Medication Given as per doctor order	8am   2pm	- Assessed the Pt condition - Monitored vitals - Maintained I/O Chart - Medication Given as per doctor order	Pt is Stable	Re-Assessment Vitals	
Afternoon							
Night							

Patient Sticker

# NURSING CARE RECORD



Date: .....

**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
<b>Morning</b>							
<b>Afternoon</b>							
<b>Night</b>							

BAH-00379383 IP26-00006432  
 Master PAMULA SREE SAMISHNU (M)  
 02-06-2017 8 Y 11 M 24 D  
 Dr. ANIKET ANIL PARASHAR



## NURSING SHIFT HAND OVER FORM

<b>SITUATION</b>	Diagnosis: <u>AFIC CRTI</u>	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Not Known If Yes Specify: .....				
	Surgery / Procedure:	Post OP Day:				
<b>BACKGROUND</b>	Date	Shift	<u>26/5/26</u>	<u>27/5/26</u> Mc	<u>27/5/26</u> FL CRTI	<u>28/5/26</u> Mc
	Medical Condition (Any special condition to be noted):		-	-	-	-
	Diet:		-	-	-	-
<b>ASSESSMENT</b>	Allergy:		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	Ventilation (RA, NP, NIV, VENTI):		-	-	-	-
	Tubes/Drains/Catheter:		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	Vital Signs:		Temp: <u>98.1° F</u>	<u>98.6° F</u>	<u>98.2° F</u>	<u>98.1° F</u>
			Res: <u>25 b/m</u>	<u>26 b/m</u>	<u>24 b/m</u>	<u>25 b/m</u>
			SpO <sub>2</sub> : <u>98%</u>	<u>99%</u>	<u>98%</u>	<u>99%</u>
			Pulse: <u>105</u>	<u>104 b/m</u>	<u>98 b/m</u>	<u>98 b/m</u>
			BP: <u>-</u>	<u>-</u>	<u>110/65</u>	<u>99/65</u>
			LOC: <u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>
	Fall Risk Score:		-	-	-	-
Pain Score:		<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	
Skin Integrity		<u>Good</u>	<u>Good</u>	<u>Good</u>	<u>Good</u>	
<b>Recommendations</b>	Safety Needs:		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	Physiotherapy:		-	-	-	-
	Others Specify:		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	Special Diet:		-	-	-	-
	Critical Lab Test / Values:		-	-	-	-
	Other Special Orders / Medications:		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	PU Prophylaxis:		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
DVT Prophylaxis:		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
ADL (Dependent / Non Dependent):		-	-	-	-	
Post Operative Procedure Special Orders: <u>-</u>						
Handed Over By Name :		<u>Mahi</u>	<u>Manisha</u>	<u>Sneha</u>	<u>mahi</u>	<u>Manisha</u>
Signature / ID :		<u>(Signature)</u>	<u>(Signature)</u>	<u>(Signature)</u>	<u>(Signature)</u>	<u>(Signature)</u>
Date:		<u>27/5/26</u>	<u>27/5/26</u>	<u>27/5/26</u>	<u>27/5/26</u>	<u>28/5/26</u>
Time:		<u>8 AM</u>	<u>2 PM</u>	<u>8 PM</u>	<u>8 AM</u>	<u>2 PM</u>
Taken Over By Name :		<u>Manisha</u>	<u>Sneha</u>	<u>mahi</u>	<u>Manisha</u>	
Signature / ID :		<u>(Signature)</u>	<u>(Signature)</u>	<u>(Signature)</u>	<u>(Signature)</u>	
Date:		<u>27/5/26</u>	<u>27/5/26</u>	<u>27/5/26</u>	<u>28/5/26</u>	
Time:		<u>8 PM</u>	<u>2 PM</u>	<u>8 PM</u>	<u>8 AM</u>	

Patient Sticker



## NURSING SHIFT HAND OVER FORM

<b>SITUATION</b>	Diagnosis:	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify: .....					
	Surgery / Procedure:	Post OP Day:					
<b>BACKGROUND</b>	Date						
	Shift						
	Medical Condition (Any special condition to be noted):						
	Diet:						
<b>ASSESSMENT</b>	Allergy:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Ventilation (RA, NP, NIV, VENTI):						
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Vital Signs:	Temp:					
		Res:					
		SpO <sub>2</sub> :					
		Pulse:					
		BP:					
		LOC:					
		Fall Risk Score:					
	Pain Score:						
	Skin Integrity						
<b>Recommendations</b>	Safety Needs:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Physiotherapy:						
	Others Specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Special Diet:						
	Critical Lab Test / Values:						
	Other Special Orders / Medications:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	PU Prophylaxis:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	DVT Prophylaxis:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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:							



## PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
27/5/20	6AM	0/10	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	
27/5/20	10AM	0/10	NA	<input type="checkbox"/> Continuous <input checked="" type="checkbox"/> Intermittent	<input checked="" type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input checked="" type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input checked="" type="checkbox"/> Decreasing	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	NA	
27/5/20	2PM	0/10	NA	<input type="checkbox"/> Continuous <input checked="" type="checkbox"/> Intermittent	<input checked="" type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input checked="" type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input checked="" type="checkbox"/> Decreasing	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	NA	
27/5	8PM	0	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	
28/5	6AM	0/10	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	
28/5/20	10AM	0/10	NA	<input type="checkbox"/> Continuous <input checked="" type="checkbox"/> Intermittent	<input checked="" type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input checked="" type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input checked="" type="checkbox"/> Decreasing	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	NA	
28/5/20	2PM	0/10	NA	<input type="checkbox"/> Continuous <input checked="" type="checkbox"/> Intermittent	<input checked="" type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input checked="" type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input checked="" type="checkbox"/> Decreasing	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	NA	
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		

**Re-assessment Frequency:**

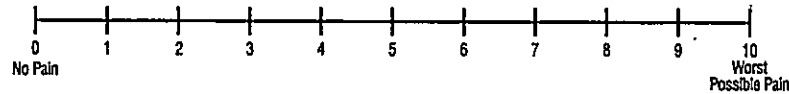
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
  - At least every 2 hours for the first 24 hours
  - Then every 4 hours.
  - Prior to pain pain-relieving intervention.
  - Within 30 – 60 minutes after pain relief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

# PAIN ASSESSMENT TOOLS

## 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 drawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, rigid, 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

## Numerical Pain Scale (Obstetric and Gynecology)



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

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
<b>Crying Irritability</b>	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
<b>Behavior State</b>	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)
<b>Facial Expression</b>	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
<b>Extremities Tone</b>	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
<b>Vital Signs HR, RR, BP, SaO<sub>2</sub></b>	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 <sub>2</sub> 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO <sub>2</sub> less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

## Wong - Baker (Pediatrics) Above 7 Years



BAH-00379383  
 Master PAMULA SREE SAMISHNU  
 02-06-2017 8 Y 11 M 24 D (M)  
 Dr. ANIKET ANIL PARASHAR

# BRADEN 'Q' SCALE

					Date:	02/5/20	02/5/20	02/5/20	02/5/20
					Time:	4	Mc	12	10
Mobility	<b>1. Completely immobile:</b> Does not make even slight changes in body or extremity position without assistance.	<b>2. Very limited:</b> Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	<b>3. Slightly limited:</b> Makes frequent through slight changes in body or extremity position independently.	<b>4. No limitations:</b> Makes major and frequent changes in position without assistance.		4	4	4	4
"Activity The degree of physical activity"	<b>1. Bedfast:</b> Confined to bed	<b>2. Chairfast:</b> Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	<b>3. Walks occasionally:</b> Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	<b>4. All patients too young to ambulate; OR walks frequently:</b> Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.		4	4	3	4
Sensory Perception	<b>1. Completely limited:</b> 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.	<b>2. Very limited:</b> 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.	<b>3. Slightly limited:</b> 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.	<b>4. No impairment:</b> 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	<b>1. Constantly moist:</b> Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	<b>2. Very moist:</b> Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	<b>3. Occasionally moist:</b> Skin is occasionally moist, requiring linen change every 12 hours.	<b>4. Rarely moist:</b> Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.		4	4	4	4
<b>FRICITION-SHEAR</b> <b>Friction</b> Occurs when Skin moves against support surfaces <b>Shear</b> Occurs when skin and adjacent bony surface slide across one another	<b>1. Significant problem:</b> Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	<b>2. Problem:</b> 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.	<b>3. Potential problem:</b> 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.	<b>4. No apparent problem:</b> 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	<b>1. Very Poor:</b> 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.	<b>2. Inadequate:</b> 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.	<b>3. Adequate:</b> 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.	<b>4. Excellent:</b> 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	<b>1. Extremely compromised:</b> Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	<b>2. Compromised:</b> Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	<b>3. Adequate:</b> Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	<b>4. Excellent:</b> Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.		3	4	4	4
<b>TOTAL SCORE</b>						27	28	27	28
<b>Evaluator's Name</b>						AG	10	AG	AG

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	<b>Support Surfaces</b> (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	<ul style="list-style-type: none"> <li>• Regular Turning Schedule</li> <li>• Enable as much activity as possible</li> <li>• Protect the heels</li> <li>• Use pressure redistribution surfaces</li> <li>• Manage moisture, friction and shear</li> <li>• Advance to a higher level of risk if other major risk factors are present</li> </ul>	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	<ul style="list-style-type: none"> <li>• Use the Same Protocol as for "At Risk" Patients</li> <li>• Position patient at 30 degree lateral incline using foam wedges</li> </ul>	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	<ul style="list-style-type: none"> <li>• Follow the same protocol as for "Moderate Risk" Patients</li> <li>• In addition to regular turning schedule</li> <li>• Make small shifts in their position frequently</li> </ul>	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	<ul style="list-style-type: none"> <li>• Use same protocol as for "High Risk" Patients</li> <li>• Add a pressure redistribution surface for patients with severe pain or with additional risk factors.</li> </ul>	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

# BRADEN 'Q' SCALE

					Date :	25/12/20			
					Time :	16			
Mobility	<b>1. Completely immobile:</b> Does not make even slight changes in body or extremity position without assistance.	<b>2. Very limited:</b> Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	<b>3. Slightly limited:</b> Makes frequent through slight changes in body or extremity position independently.	<b>4. No limitations:</b> Makes major and frequent changes in position without assistance.		4			
*Activity The degree of physical activity*	<b>1. Bedfast :</b> Confined to bed	<b>2. Chairfast :</b> Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.*	<b>3. Walks occasionally:</b> Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	<b>4. All patients too young to ambulate; OR walks frequently:</b> Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.		4			
Sensory Perception	<b>1. Completely limited:</b> 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.	<b>2. Very limited:</b> 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.	<b>3. Slightly limited:</b> 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.	<b>4. No impairment:</b> Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.		4			
Moisture Degree to which skin is exposed to moisture	<b>1. Constantly moist:</b> Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	<b>2. Very moist:</b> Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	<b>3. Occasionally moist:</b> Skin is occasionally moist, requiring linen change every 12 hours.	<b>4. Rarely moist:</b> Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.		4			
<b>FRICION-SHEAR</b> Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	<b>1. Significant problem:</b> Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	<b>2. Problem:</b> 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.	<b>3. Potential problem:</b> 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.	<b>4. No apparent problem:</b> 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			
Nutritional Usual food intake pattern	<b>1. Very Poor:</b> 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.	<b>2. Inadequate:</b> 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.	<b>3. Adequate:</b> 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.	<b>4. Excellent:</b> 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 meat and dairy products. Occasionally eats between meals. Does not require supplementation.		4			
Tissue Perfusion & Oxygenation	<b>1. Extremely compromised:</b> Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	<b>2. Compromised:</b> Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	<b>3. Adequate:</b> Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	<b>4. Excellent:</b> Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.		4			
					<b>TOTAL SCORE</b>	28			
					<b>Evaluator's Name</b>	15			

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	<b>Support Surfaces</b> (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	<ul style="list-style-type: none"> <li>• Regular Turning Schedule</li> <li>• Enable as much activity as possible</li> <li>• Protect the heels</li> <li>• Use pressure redistribution surfaces</li> <li>• Manage moisture, friction and shear</li> <li>• Advance to a higher level of risk if other major risk factors are present</li> </ul>	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	<ul style="list-style-type: none"> <li>• Use the Same Protocol as for <b>"At Risk"</b> Patients</li> <li>• Position patient at 30 degree lateral incline using foam wedges</li> </ul>	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	<ul style="list-style-type: none"> <li>• Follow the same protocol as for <b>"Moderate Risk"</b> Patients</li> <li>• In addition to regular turning schedule</li> <li>• Make small shifts in their position frequently</li> </ul>	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	<ul style="list-style-type: none"> <li>• Use same protocol as for <b>"High Risk"</b> Patients</li> <li>• Add a pressure redistribution surface for patients with severe pain or with additional risk factors.</li> </ul>	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay



## CHECKLIST FOR THROMBOPHLEBITIS

28/5/26

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	26/5 DAY-1			DAY-2			28 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	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	NA	NA	NA			
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2			NA	NA	NA	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	NA	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	NA	NA	NA			
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord pyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5			NA	NA	NA	NA	NA			
Signature of the Nurse													

**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.


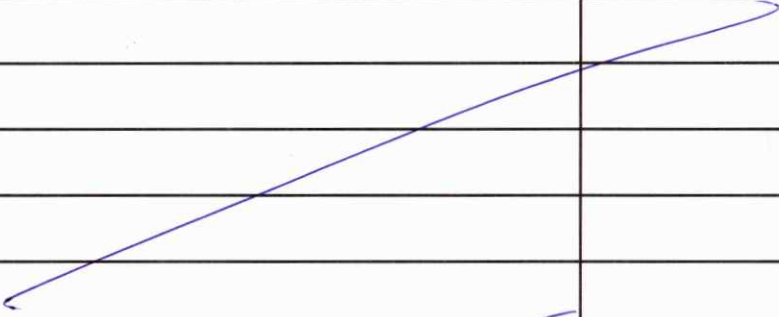
Signature of Shift In Charge :

Signature : Name :

Signature of Ward In Charge :

Signature : Name :

# PATIENT TRANSFER FORM

Patient Name & UHID No.  BAH-00379383 IP26-00006432 Master PAMULA SREE SAHISHNU 02-06-2017 8 Y 11 M 24 D (M) Dr. ANIKET ANIL PARASHAR 		Date & Time of Admission  26/5/26 @ 6:58pm	Date & Time of Transfer Order  26/5/26 8:58pm
		Transfer Ordered by  Dr. Aniket Parashar	Reason for Transfer  Admission
From Unit  ER	To Unit  210	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File  — 10 —	Number of Imaging Films  X-ray - ①	Personal belongings including clinical documents. If any handed over to attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> 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 <input type="checkbox"/> No <input checked="" type="checkbox"/>			
Name & Signature of Person who is Transferring  Aniket Parashar		Name of Person Ordered Transfer  Dr. Aniket Parashar	
Patient & Clinical Records Received by :  Moutish			
Date & Time of Patient Received :  9PM 26/5/26			

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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BAH-00379383 IP26-00006432  
 Master PAMULA SREE SAHISHNU  
 02-06-2017 8 Y 11 M 24 D (M)  
 Dr. ANIKET ANIL PARASHAR



## MEDICATION RECONCILIATION FORM

Drug Allergies: ..... N/A .....  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: ..... ICU ..... Shifted to: ..... W/O .....

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
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4						<input type="checkbox"/> C <input type="checkbox"/> DC
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9						<input type="checkbox"/> C <input type="checkbox"/> DC
10						<input type="checkbox"/> C <input type="checkbox"/> DC

\* C - Continue, DC - Discontinue

### MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : ..... Dr. Rajiv Singh .....

Date & Time : ..... 26/5/26 @ 7:28 PM .....

Nurse Name & Signature: ..... Amfom .....

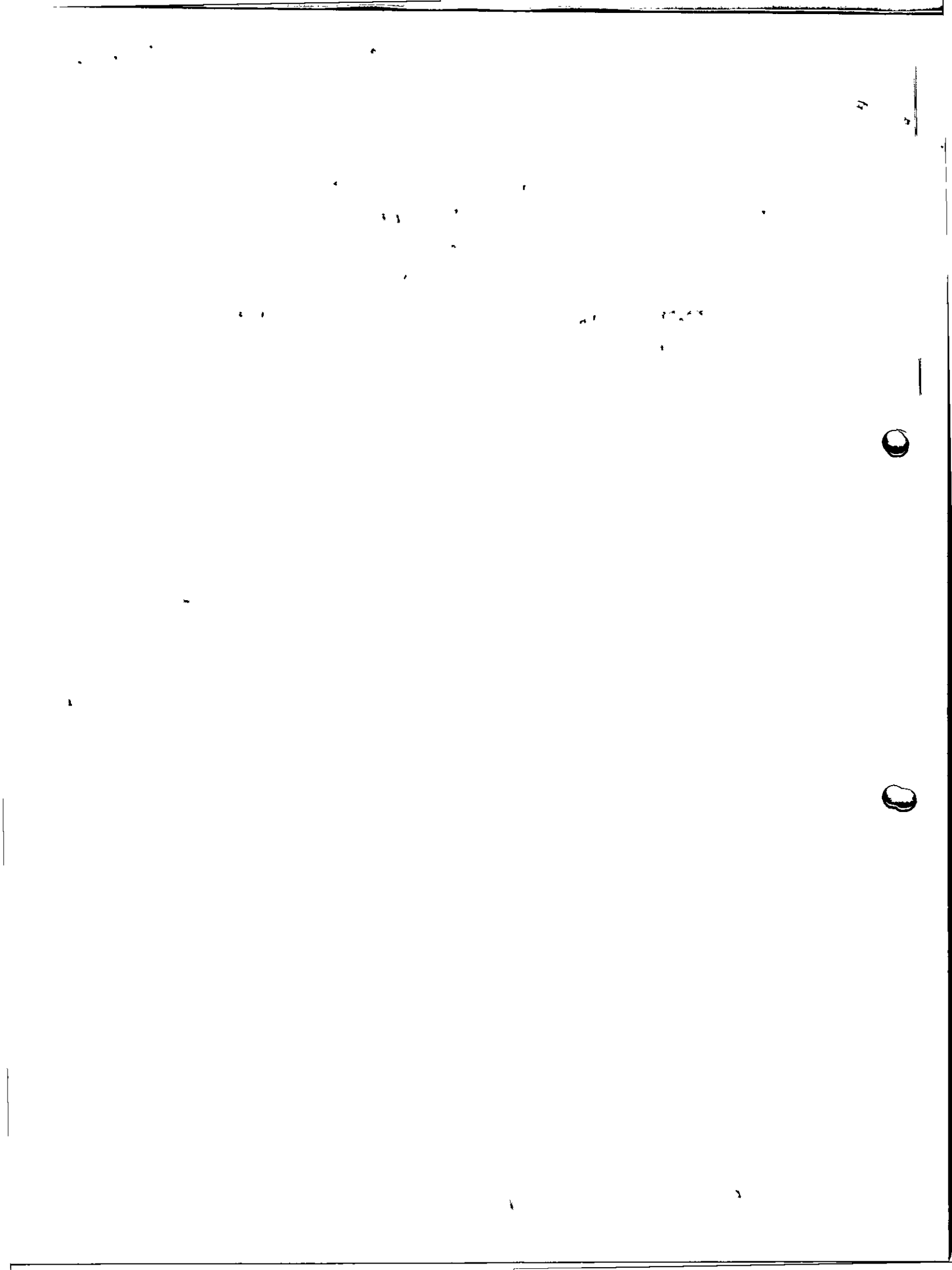
Date & Time : ..... 26/5/26 @ 7:00 PM .....

Docu. No. : RCH / FRM / GENERAL / 090



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## NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 26/5/26 Time of arrival : 6:34 PM

Chief Complaints : C/O fever since 4 days RBS: —

Height : ..... Weight : 32.6 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 N/A  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?) N/A

Time of Initial assessment completed by ER Nurse : 6:34 PM

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

Time	Nursing Notes
6:38 pm	- Assess the pt condition
	- monitor vitals
	- IV placement done
	- Sample collected

Samples collected by: } Apurba  
 Samples sent by :

Time: }  
 Time: } 7:20 pm

**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: 116 BP: 100/62 CFT: N/A	Shift - out from ER to: 210
RR: 24/min SPO <sub>2</sub> : 100	Time of Shift - out: 7:40 pm
GCS: 15/15 Temperature: 98.2	Handover given to: _____
Pain Score: 0	(Nurse's Name)
Repeat RBS (if applicable): NA	

Tick as applicable:  MLC  LAMA  BROUGHT DEAD

Procedures done with details (if any):

IV placement done

Name of the Nurse: Jyoti Signature of the Nurse: Jyoti

Date & Time: 26/5/26 @



210

# NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 27/5/26 Time: 10:15am

Weight: 32kg Centile: 75<sup>th</sup>

Height: \_\_\_\_\_ Centile: \_\_\_\_\_

Inference: Wellnourished child

RDA: \_\_\_\_\_ Calories: 1500Kcal/day Protein: 26gms/day

Diet Recommendations: Normal Balanced diet with liquids

Re-Assessment: No Junk food, oily food.

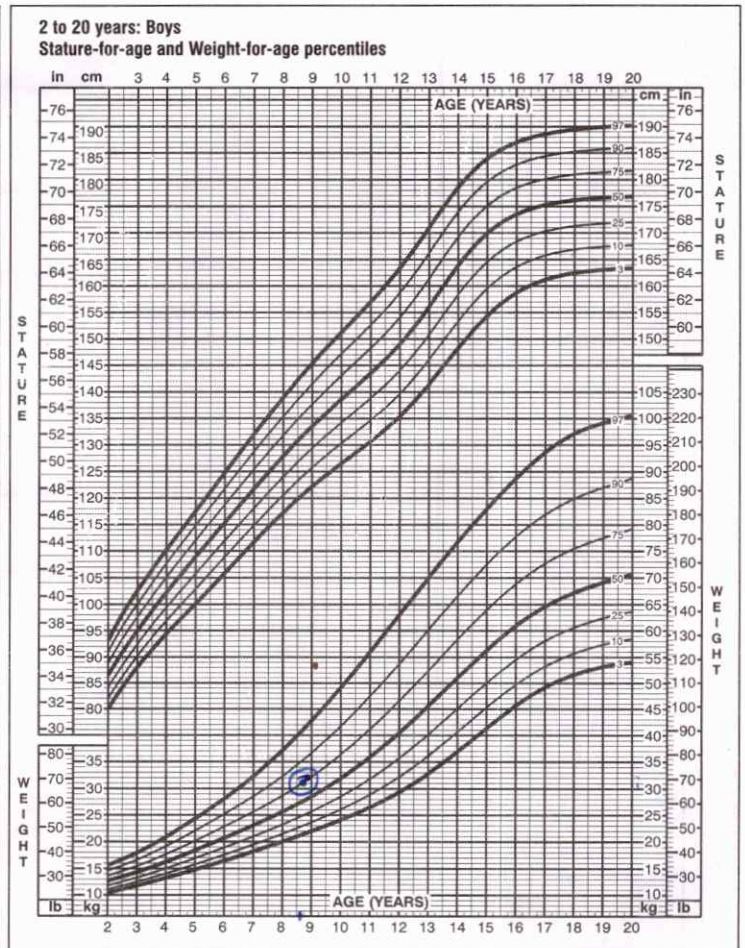
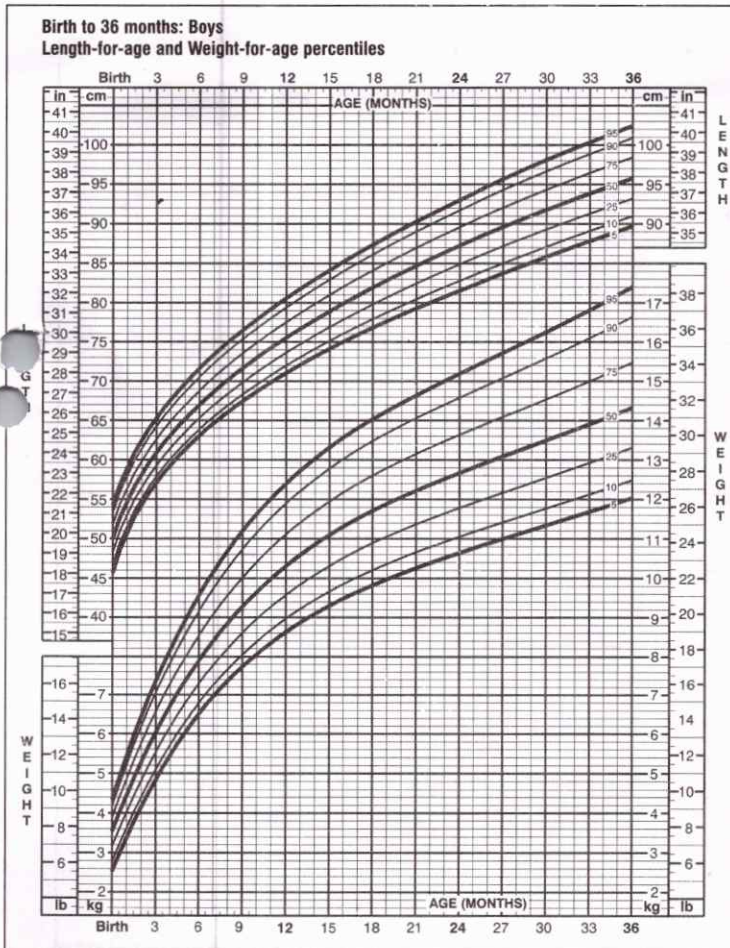
Food Allergies: No P.A Veg/Non-veg veg

Diagnosis: AFIC dehydration ?LRTI

Nutritional Intervention -  Oral  Enteral  Parenteral

Patient's Signature: *[Signature]*

## GROWTH CHART (BOYS)



Dietician's Name: Syeda Sobiya Zahoor

Dietician's Signature: Sobiya

