

DISCHARGE SUMMARY

Name	Master PATLOLLA CHANDRANSH REDDY	UHID	HNH-00002278
Father/Guardian	Mr P VINOD REDDY	Age/Gender	2 Y 9 M 12 D/ Male
Address	H NO 1-9-34/6/1 RAM NAGAR, Ram Nagar, Hyderabad, Telangana, INDIA, 500020		
IP No	IP26-00006380	Admission Date	19-05-2026
Ref Doctor	Self.		
Discharge Date	21.05.2026		

Consultant:
Dr. PRITESH NAGAR
MBBS MD
Medical Registration No. 47184

DIAGNOSIS	ICD CODE
SIMPLE FEBRILE SEIZURES (FIRST EPISODE)	
ADENOVIRUS ILLNESS	

History: Master PATLOLLA CHANDRANSH REDDY , 2 Y 9 M 12 D , old boy presented with the history of fever since 2 days, 1 episode of seizure in the form of uprolling of eyeballs , generalised tonic clonic movements of lasting for 4-5 minutes prior to admission. For the above complaints, he was admitted at Rainbow Children's Hospital - Himayatnagar for further management.

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Examination: He was febrile (103.5 *C). His heart rate was 129/min and Respiratory Rate -30/min. Capillary Refill Time was <2 secs. Peripheries were warm & pulses well felt. On auscultation, air entry was bilaterally equal. 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. B/L conjunctival redness present.

Weight on admission : 12.9 kilograms.

Investigations: Enclosed reports.

VBG showed pH of 7.37, pCO2 of 35.9 mmHg, pO2 of 38 mmHg, HCO3 of 20.3 mmol/L and BE of -5.1 mmol/L.

Initial hemogram showed Hemoglobin of 10.2 gm%, White Blood Cell count of 16120cells/cumm, platelet count of 2.53 lakhs/cumm and C-Reactive Protein of 52 mg/l. Serum Calcium was 8.8 mg/dl. Magnesium was 1.8 mg/dl.

Complete urine examination shows: Pus cells - 6-8, epithelial cells - 3-5, nitrate - negative.

Blood culture and sensitivity shows no growth after 24 hours of incubation.

Adenovirus PCR was detected.

GeneXpert FluA+FluB+RSV, SARS-CoV-2 were sent, which was negative.

Management: He was admitted in the ward and started on Intra Venous fluids and Intra Venous antibiotics i/v/o elevated CRP and stopped after 24H as blood c/s was negative. He was treated symptomatically with antacids and antipyretics. He was started on febrile seizure prophylaxis with clobazam.

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He was regularly monitored for fever spikes, hemodynamic & neurological status. His fever spikes gradually settled and there were no further seizure episodes during hospital stay.

He remained hemodynamically stable and is being discharged with the following advice.

Parents were counselled regarding the nature of febrile seizures and measures to reduce fever during future febrile episodes. They were also educated regarding use of intranasal Midazolam spray for termination of future seizure episodes, if any.

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

Advice:

* Diet as advised.

S.No	MEDICATION	DOSE	TIMINGS	DURATION
1	Moxifloxacin eye drops	2 drops	thrice a day	For 5 days.
2	Nasoclear nasal drops, 2 drops in each nostril SOS for nose block			

Febrile Seizure Prophylaxis:

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

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intervals).

* Tepid sponging if fever > 101 *F.

* Syrup. Clobium (Clobazam - 1ml/2.5mg) 1 ml twice daily for 3 days every time with fever.

* Medistat - nasal spray (Midazolam = 1.25mg/puff), 1 puff intranasal (into each nostril). To be given only in case of active convulsions.

Review consultation with Dr. PRITESH NAGAR on Saturday(23.05.2026) at 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, abnormal behavior, altered sensorium or seizure occurs.

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



Parent/ Attender

In case of emergency contact 9154865030 emergency pediatrician on duty.

To take appointment for OPD consultation at Rainbow **Himayatnagar** /

Name	Master PATLOLLA CHANDRANSH REDDY	UHID	HNH-00002278
IP No	IP26-00006380	Admission Date	19-05-2026

Banjara Hills / Rainbow Clinic Madhapur / Kukatpally / Vikramপুরi / 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

Dr. PRITESH NAGAR
MBBS MD
Medical Registration No. 47184


Registrar/Resident/C.M.O



ADMISSION SHEET

Registration Details :



Admission No : IP26-00006380 Admit Date : 19-May-2026 Admit Time : 02:18 PM UHID : HNH-00002278

Patient Details :

Patient Name	: Master PATLOLLA CHANDRANSH REDDY	Age	: 2 Y 9 M 12 D
Guardian	: Mr P VINOD REDDY	DOB	: 07-08-2023
Gender	: Male	Religion	:
Occupation	:	Martial Status	:
Address (H)	: H NO 1-9-34/6/1 RAM NAGAR Ram Nagar Hyderabad Telangana INDIA 500020	Phone No	: 9963293534/ 9959423505
		E-mail	: pat.vinodreddy@gmail.com

Admission Details :

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

Contact Details :

Name	: Mr P VINOD REDDY	Relationship	: Father
Contact Address	: H NO 1-9-34/6/1 RAM NAGAR Ram Nagar Hyderabad Telangana INDIA 500020	Phone No	: 9963293534



Signature

Doctor Details :

Doctor Name	: Dr. PRITESH NAGAR	Specialisation	: PEDIATRIC INTENSIVE CARE
Referral Doctor	: Self.	Phone No	:
Co-Consultant	:		


Payment Details :

Payment Mode	: DC/CC Card	Deposit Amount	: 10000.00
		Payor Name	: ICICI ICICI LOMBARD GENERAL INSURANCE



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PATIENT TRANSFER FORM

HNH-00002278 IP26-00006380 Master PATLOLLA CHANDRANSH 07-08-2023 2 Y 9 M 12 D (M) Dr. PRITESH NAGAR 		Date & Time of Admission <i>19/5/26 @ 2:18 PM</i>	Date & Time of Transfer Order <i>19/5/26 @ 3:20 PM</i>
Treating Consultant Name <i>Dr. Pritesh</i>		Transfer Ordered by <i>Dr. Sreegham</i>	Reason for Transfer <i>Admission</i>
From Unit <i>ER</i>	To Unit <i>ward</i>	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File <i>20</i>	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input checked="" 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 type="checkbox"/>			
Name & Signature of Person who is Transferring <i>Prabin</i>		Name of Person Ordered Transfer <i>Dr. Sreegham</i>	
Patient & Clinical Records Received by : <i>Madhyan Q</i> <i>19/5/26 @ 3:30 PM</i>			
Date & Time of Patient Received :			

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

HNH-00002278 IP26-00006380

Master PATLOLLA CHANDRANSH
07-08-2023 2 Y 9 M 12 D (M)

IG

Name: --- Dr. PRITESH NAQAR -----



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

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
19/5/26	3:26 pm	IP	ward	[Signature]

Cross Consultation Visit

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

Ref.No. F/IN/PR/10



Rainbow[®] Children's Hospital

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name :

Chandranth / 2.5 months

Patient ID# :

HNH-00002278 IP26-00006380
Master PATLOLLA CHANDRANSH
07-08-2023 2 Y 9 M 12 D (M)
Dr. PRITESH NAGAR

Consultant :



Final Diagnosis :

Pediatric Multorgan History & Physical Examination

Name : _____ Age/Sex _____

Informant _____ Reliability _____

Chief Presenting Complaints & Duration (Chronologically):

- 1) Fever since 2 days
- 2) Abnormal movements today
- 3) Cold since 2 days

History of present illness:

Child was apparently asymptomatic 2 days back after which he had fever which was high grade intermittent responding to oral paracetamol.

Cold started 2 days back which comprises of runny nose

Child had one episode of abnormal movements comprising of up-rolling of eye-balls and stiffness of all 4 limbs ~~and~~ lasting for 4-5 minutes.

No post-ictal drowsiness
↓

Child was brought to ER for further management

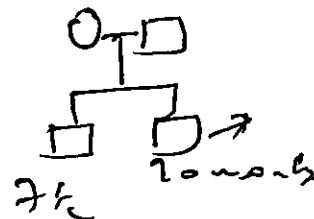


Past History : (Including details of any previous investigation or treatment)

Blank lined area for Past History.

Birth & Neonatal History :

Term / 3.5 kg CTAB / NVD.



Birth & Socio Economic History :

About Father : _____

About Mother : _____

Any additional information : _____

Developmental History :

Normal

Immunization History :

NTJ scheduled - up-to-date

Pediatric Multiorgan History & Physical Examination

Anthropometry

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

Weight (kgs) 12.9 kg (Centile _____)

On Examination :

Temperature : 103.5°F Pulse Rate: _____ Description _____

B.P. _____ SPO2 97% at RA

Resp. rate and type of breathing : Redness of both eyes (P)

Rash _____

Lymphadenopathy _____

Oedema : _____

Respiratory system :

Inspection (any s/o distress) : _____

Air entry & breath sounds : BU-ACE (P)

Any addes sounds : _____

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

Cardiovasclular System :

Inspection of procordium : _____

Heart Sounds : S4 S2 (P)

Any murmur : _____

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

Per Abdomen :

Inspection _____

Palpation : PIA-J26

Ausculation : _____

Spine: _____ External Genitalia: _____

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

Pediatric Multiorgan History & Physical Examination

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Master PATLOLLA CHANDRANSH
07-08-2023 2 Y 9 M 12 D (M)
Dr. PRITESH NAGAR



Central Nervous System :

Level of Consciousness : AVPU/GCS Score : _____

Cranial Nerves : _____

15/15

Motor System :

Nutrition : _____

Tone : _____ Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes : _____

DTR _____

Superficials : _____

Plantars _____

Sensory System : _____

Bladder / Bowel : _____

Clinical Summary & Diagnostic :

D Acute Febrile Illness

E Simple Febrile Seizure (1st episode)

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment :

Desired goals of the treatment :

Fever Subsidence

Seizure Subsidence

Planned Labs :

CBP

CRP

Blood C_s - Holo

(VE (DVE))

Resp. panel / CSU / Urinary

S. Co ++

S. Mg ++

VBA.

a RBS - 111 mg/dl

Noted By Babbar

Planned Management :

- Symp. (ROXIN-D)

(50/240mg) 3-5u 6hr

- Symp. (BUGGIC (50/100mg))

3-5u 10/18hr

⊙ - T. (CLOBAZAM)

- MIDAZOLAM nasal

Spray 2 puffs each nostril

(2 puffs / 1.25mg)

AB Babbar

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 _____

Dr. Pritesh Nagar
Consultant Pediatrician & Intensivist
Reg. No: 47184



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/5/26	S/B Dr. Sneyhan	
4:30 pm	<p>Δ Acute febrile illness</p> <p>Simple febrile seizure (1st episode)</p>	
		Plg
	CVS - S ₁ S ₂ ⊕	
	M - BL - ACF ⊕	CF IVF 2/3 rd maintenance
	PLA - soft	CF CLOBAZAM
	conscious	
	oriented	w/ P seizures
		CF CROCIN Syrup 6 th k
		- Trace reports.
19/5/26	S/B Dr. Pritesh N	
5 pm	<p>Δ Simple febrile seizure (2nd episode)</p>	Plg
	CF syrup	CF IV fluids
	CVS - S ₁ S ₂ ⊕	
	M - BL - ACF ⊕	CF CLOBAZAM
	PLA - soft	w/ P seizures
	conscious	
		Trace reports CRP
		Pop. panel
		noted by Madhvi @ 5 pm

Dr. Pritesh Nagari
 Consultant Pediatrician & In.
 Reg. No: 47184



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/8 8M	c/s/B <u>Dr. Pranav / Dr. Alakhyia</u>	
	Acute febrile illness c <u>1st Episode febrile seizure</u>	
	<ul style="list-style-type: none"> - Fever - 101-9°F c/s - (R) eye redness. - Noisy breathing - non black Oral intake - fair 	<p style="text-align: center;">Ph</p> <ul style="list-style-type: none"> ✓ 1) Inj AMOXYCLAV ✓ 2) syp CLOSAZOL ✓ 3) Tranq Adena <p style="text-align: right;">Blood c/s</p>
	<p>child asleep Vitaly stable R-S - B/L AB ⊕ conducted saw P/A - soft</p>	<ul style="list-style-type: none"> ✓ 4) Monitor vitals ✓ 5) Add Naso cann
	⊕ Phisasin ⊕	<p style="text-align: right;">PP</p> <p>NB <u>Sunanda</u></p>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<u>20/5</u>	<u>26/5 Dr. Pritesh</u>	
	Acute febrile illness	
	<u>1st Episode Febrile Seizure</u>	Plu
	Fever ⊕	1) IVF - ↓ to 200/6
	Red eye	2) Rx Amoxicillin
	child alert	3) Trace Adrenine
	Vital stable	4) CT - Fracture
		5) Monitor Vital
		NB - Supervise
		9:36 AM (20/5/26)

Dr. Pritesh Nagar
 Consultant Pediatrician & Intensivist
 Reg. No. 47184

Dr. Pritesh Nagar
 Consultant Pediatrician & Intensivist
 Reg. No. 47184



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/5	<u>CLSIB Dr pritesh</u>	
5:00 PM	APR ± dehydration 1 st episode of febrile seizure	
	Rt eye redness ⊕ No fever	Plans
	NO further seizures	- ⊕ Adenovirus
	Vitals - Stable	- Gent Amoxicillin
	RIS - BIL A ⊕	- Gent fluconazole
	PLA - soft, NT	- monitor vitals
		- Moxifloxacin eye drops
		- Stop IVP
		MS
		MS Mehra

Dr. Pritesh Nagari
 Consultant Pediatrician & Intensivist
 Reg. No. 47184



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/5/26	SIB Dr. Pritesh	
8:30 PM	DAFI - dehydration Admission	Plg
	- C/O sneezing	- Stop AMOXYCLAV
	Adenovirus - positive PCR	- Monitor vitals
	Vitals stable	- Plan - discharge
	CVS - S, S, @ R - B, L, A, K, @	TIM
20/5/26	SIB Dr. Sneekha	
8:10 AM	DAFI - dehydration Adenoviral Illness	Plg
	Simple febrile Rx given	Dr. Pritesh Nagar Consultant Pediatrician & Intensivist Reg. No: 47184
	Afebrile	✓ Maxicil 5 days
	Vitals stable	✓ Discharge
		✓ Stop on Sunday
	- Dr. Pritesh Nagar Consultant Pediatrician & Intensivist Reg. No: 47184	NB - Supriya 8:20 AM @ 21/5/26

HNH-00002278 IP26-00006380
Master PATLOLLA CHANDRANSH
07-08-2023 2 Y 9 M 12 D (M)
Dr. PRITESH NAGAR

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RESULT SHEET

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

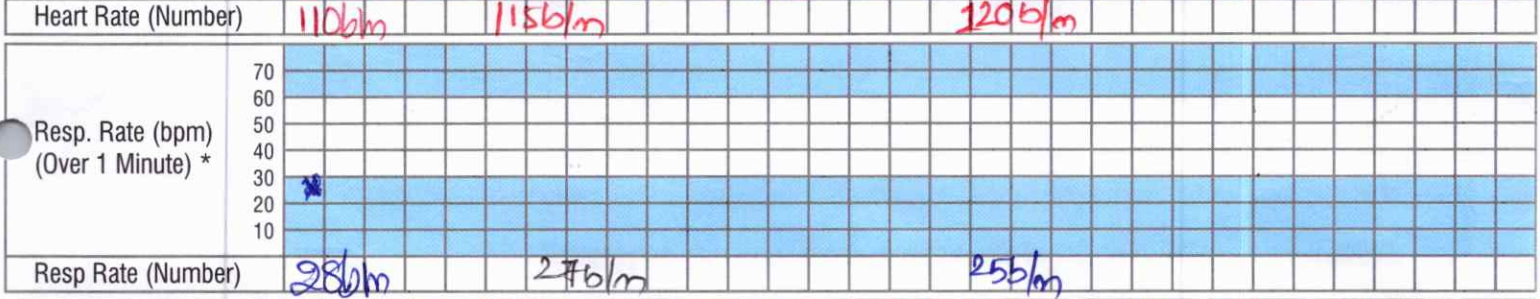
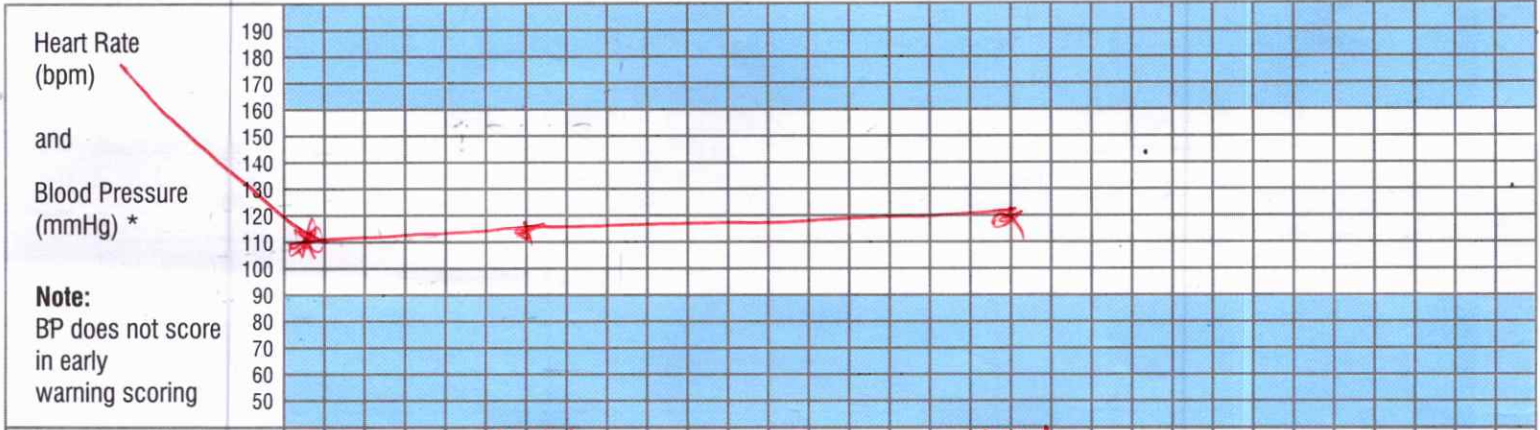
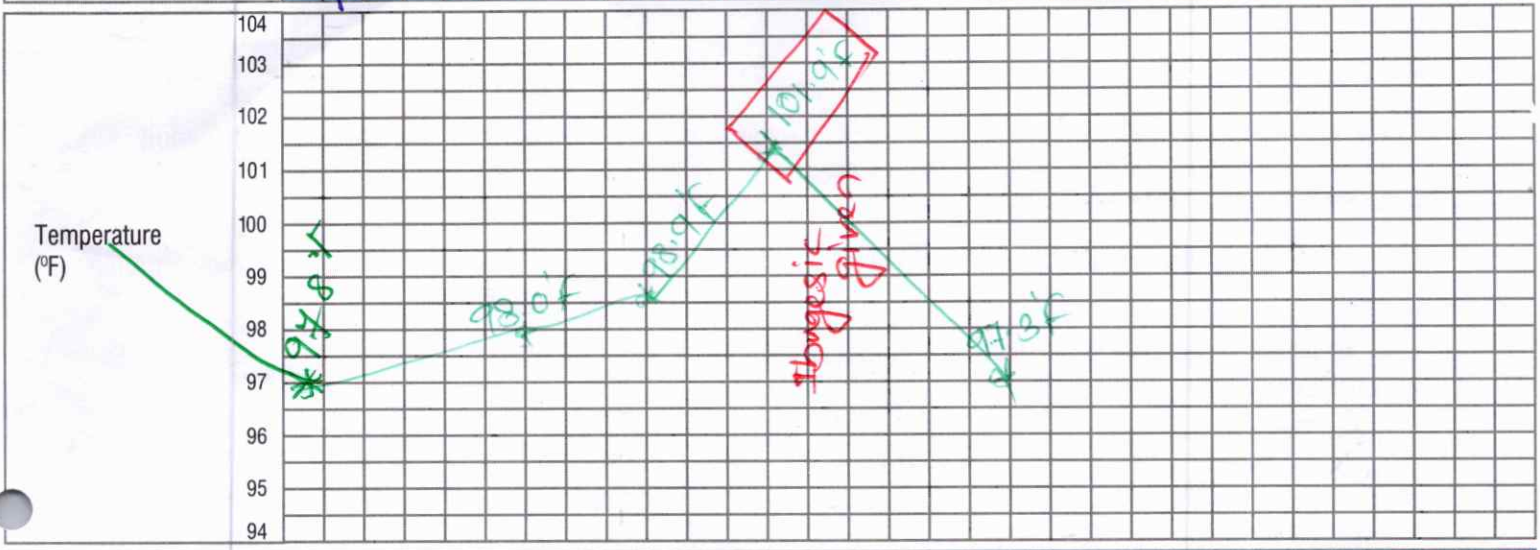
BirthRight[™]
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Date	19/5/26					
Time						
Hb	10.2					
PCV	28.6					
RBC	4.37					
WBC	16.12					
N/L	71.0/21.0					
Platelets	253					
CRP	52					
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg	8.8/1.8					
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						



EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 19/05/23 Time: 3:50 PM 10 PM 2 AM 4:30 AM 6 AM
 Doctor/Nurse/Family Concern?



Resp Mod/ Severe Distress None / Mild
 Receiving O₂ (l/min) O₂ Saturations (%)
 Conscious Level Normal / Altered
 GCS *

TOTAL SCORE
 Number of shaded boxes
 Pain Score
 Observer's Initials

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 incharge and PICU /NICU fellow or PICU/NICU 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.

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 is there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

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 07-08-2023 2 Y 9 M 12 D (M)
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Patient S



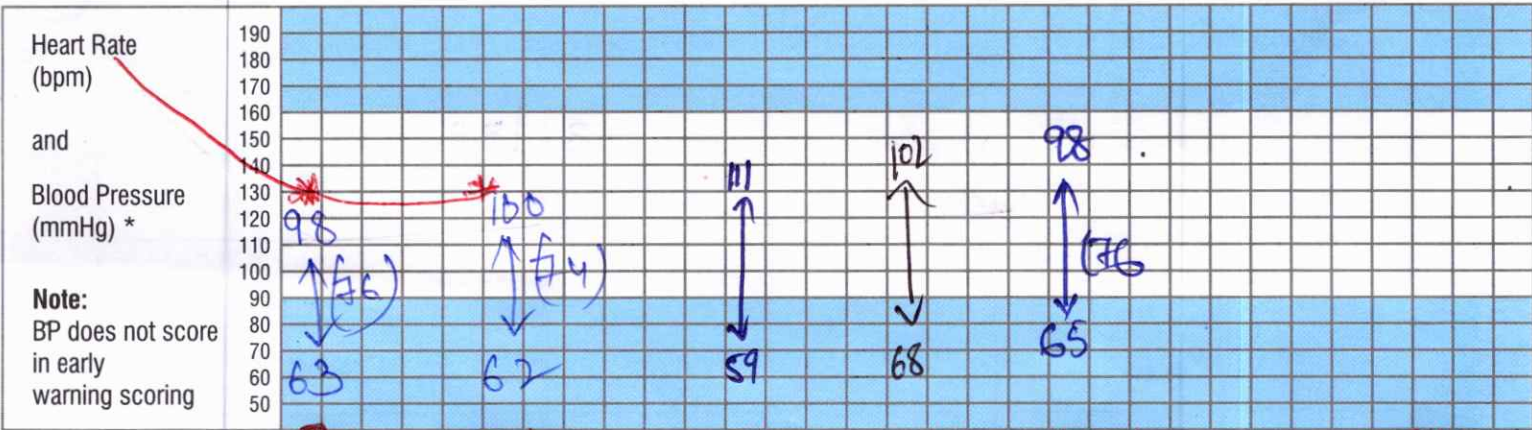
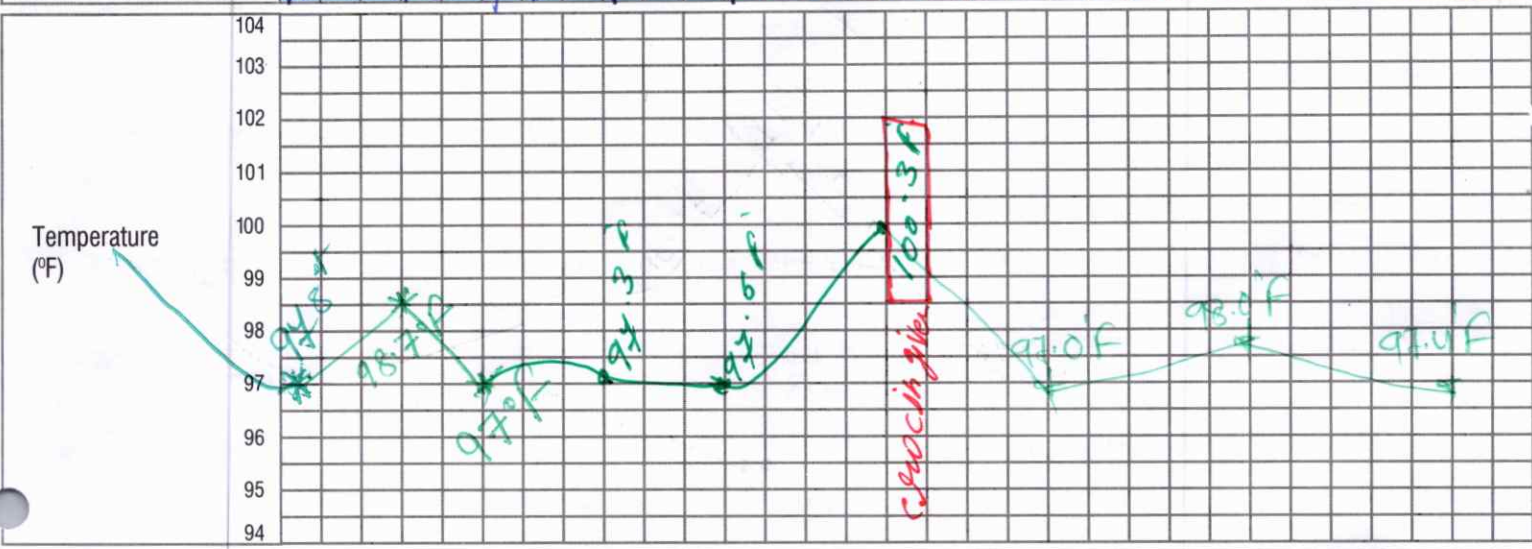
LINICAL / 124

(1-5 year)
INFANT (~~1-5 year~~)
 Children's Observation &
 Early Warning Scoring Chart



EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 20/5/23	Time: 10	11:50	2	4	5	7:30 PM	10 PM	2 am	6 am
Doctor/Nurse/Family Concern?	AD	AM	PM	PM	PM				



Heart Rate (Number)	130b/m	127b/m	124b/m	121b/m	130b/m	131b/m
Resp. Rate (bpm) (Over 1 Minute) *		*	e	e		
Resp Rate (Number)	28b/m	28b/m	30b/m	30b/m	32b/m	32b/m

Resp Mod/ Severe Distress None / Mild						
Receiving O ₂ (l/min) O ₂ Saturations (%)	100%	100%	99%	100%	100%	99%
Conscious Level Normal / Altered						
GCS *		15/15	14/15	14/5		
TOTAL SCORE	0	0	0	0	0	0
Number of shaded boxes	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0
Observer's Initials	PN	PN	PN	PN	PN	PN

ACTIONS	Score 1 : Continue normal observation by staff nurse
	Score 2 : Shift in charge nurse to be informed and continue hourly observations
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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 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	Intake				Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
		Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G								
19/5/20	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
	Total Intake :					Total Output :							
19/5/20	02:00 pm	PlasmaLyte											
	03:00 pm			35ml									
	04:00 pm			35ml						✓			
	05:00 pm			35ml									
	06:00 pm			35ml						✓			
	07:00 pm			35ml									
Total Intake :					Total Output :								
19/5/20	08:00 pm	PlasmaLyte Krichel H ₂ O		35ml									
	09:00 pm			35ml									
	10:00 pm			35ml						✓			
	11:00 pm			35ml									
	12:00 am			35ml									
	01:00 am			35ml									
Total Intake :					Total Output :								
20/5/20	02:00 am	PlasmaLyte H ₂ O		35ml									
	03:00 am			35ml									
	04:00 am			35ml						✓			
	05:00 am			35ml									
	06:00 am			35ml									
	07:00 am			35ml									
Total Intake :					Total Output :								
Total 24 hrs. Intake													
Total 24 hrs. Output													

HNH-00002278 IP26-00006380
 Master PATLOLLA CHANDRANSH
 07-08-2023 2 Y 9 M 12 D (M)
 Dr. PRITESH NAGAR



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 Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
20/5/26		PlasmaLyte	Mouth	I.V	N.G								
	08:00 am		Idly	35ml									
	09:00 am		+ H ₂ O	20ml						✓			
	10:00 am			20ml									
	11:00 am			20ml									
	12:00 pm			20ml			NA			✓			
01:00 pm			20ml										
Total Intake :						Total Output :							
20/5/26	02:00 pm	PlasmaLyte	cupna	90ml							0		
	03:00 pm		+ H ₂ O	20ml					✓		0		
	04:00 pm			90ml			NA				0		
	05:00 pm			20ml							0		
	06:00 pm			Stop						✓		0	
	07:00 pm											0	
Total Intake :						Total Output : M-1 U-2							
20/5/28	08:00 pm	Michol H ₂ O											
	09:00 pm												
	10:00 pm									✓			
	11:00 pm												
	12:00 am												
	01:00 am												
Total Intake :						Total Output : U- M-							
21/5/28	02:00 am	Michol H ₂ O											
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
Total Intake :						Total Output : U- M-							

Total 24 hrs. Intake

Total 24 hrs. Output

HNH-00002278 IP26-00006380
 Master PATLOLLA CHANDRANSH
 07-08-2023 2 Y 9 M 12 D (M)
 Dr. PRITESH NAGAR



NURSING CARE RECORD



Date: 19/5/23

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							
Night	8pm to 8am	— Assess the pt condition — Monitor the v/s — Maintain the I/O — Drug as per chart	8pm to 8am	— Assess the pt condition — Monitor the v/s — Maintain the I/O — Drug as per chart	— Now baby is stable	— Rechecked the v/s	(Signature)



NURSING CARE RECORD

Date: 20/5/26

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 to 2pm	→ Assess the pt condition → check the vitals → maintain I/O chart → To adm. the medication as per drug chart	8AM to 2pm	⇒ Assess the pt condition. ⇒ check the vitals ⇒ maintain I/O chart → To administered the medication as per drug chart	check the vitals	pt is a stable → Trace Blood C/S & Respiratory panel	Madhvi
Afternoon	2PM to 8PM	- Assess the pt condition - Monitor the vitals - maintain I/O charts - C/T I/O fluids @ 20ml/h - Medication given as per drug chart	2PM to 8PM	- Assess the pt condition - Monitor the vitals - maintain I/O charts - C/T I/O fluids 20ml/h - Medication given as per drug chart - Trace Blood C/S	pt is now stable	Re-Assessment done	Meha
Night	8pm to 8am	- Assess the pt condition - monitor the v/s - maintain the I/O - Drug as per chart	8pm to 8am	- Assess the pt condition - monitor the v/s - maintain the I/O - Drug as per chart	- Now baby is stable	- Rechecked the v/s	Py



BRADEN 'Q' SCALE

					Date :	19/8	20/8	21/8	
					Time :	10pm	2PM	10pm	
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.		4	4	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	
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	
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	
FRICION-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	
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 meat and dairy products. Occasionally eats between meals. Does not require supplementation.		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	
					TOTAL SCORE	28	28	28	
					Evaluator's Name	(Signature)	(Signature)	(Signature)	

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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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



CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1 19/5 2023				DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N		
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0			0	0	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					
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2			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					
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					
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					
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 of Ward In Charge :

Signature : Name :

Signature : Name :



NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: AFI		Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify:				
	Surgery / Procedure:		Post OP Day:				
BACKGROUND	Date		21	20/5/23	20/5/23	20/5/23	
	Shift		MC	ER	MC	MC	
	Medical Condition (Any special condition to be noted):		-	-	-	-	
ASSESSMENT	Diet:		-	-	-	-	
	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:		98.1 F	98.3 F	98.6 F	98.5 F
		Res:		29 b/m	29 b/m	28 b/m	25 b/m
		SpO ₂ :		99%	99%	100%	100%
		Pulse:		132 b/m	132 b/m	135 b/m	142 b/m
		BP:		-	-	-	-
		LOC:		-	-	-	-
		Fall Risk Score:		0	0	0	0
	Pain Score:		0	0	0	0	
	Skin Integrity		Good	Good	Good	Good	
	Recommendations	Safety Needs:		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input 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):		-	-	Yes	-		
Post Operative Procedure Special Orders:		-	Yes	-	-		
Handed Over By Name :		Syanda	Madhu	Meha	Syanda		
Signature / ID :		<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>		
Date:		19/5	20/5/23	20/5/23	21/5/23		
Time:		11pm	2pm	8pm	8am		
Taken Over By Name :		Madhu	Meha	Syanda			
Signature / ID :		<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>			
Date:		20/05	20/5/23	20/5/23			
Time:		8Am	2pm	8pm			

Patient Sticker



NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify:					
	Surgery / Procedure:	Post OP Day:					
BACKGROUND	Date	/	/				
	Shift						
	Medical Condition (Any special condition to be noted):						
	Diet:						
ASSESSMENT	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 ₂ :					
		Pulse:					
		BP:					
		LOC:					
		Fall Risk Score:					
	Pain Score:						
	Skin Integrity						
Recommendations	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
19/5/26	10pm	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	(Signature)
20/5/26	2am	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	(Signature)
20/5/26	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	(Signature)
20/5/26	10AM	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	Madly
20/5/26	2PM	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	(Signature)
20/5/26	10pm	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	(Signature)
				<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		
				<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:

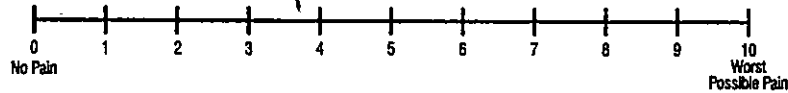
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

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 or 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
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, SaO₂	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

Wong - Baker (Pediatrics) Above 7 Years





DRUG CHART

Date of Admission: 19/8/26 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 **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.
- NURSES** - 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 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: Syp. IBUGESTIC				Date Time																	
Dose	Route	Frequency	Start Date																		
3.5ml	oral	3-5/6h	19/5	19/5 am																	
Doctor's Signature		Valid Period	Pharm.																		
Dr																					
Additional Instructions:																					
IBUPROFEN (Sul/000)																					

DRUG: M IDAZO (AM nasal)				Date Time																	
Dose	Route	Frequency	Start Date																		
1 puff nasal	nasal	SOS	19/5																		
Doctor's Signature		Valid Period	Pharm.																		
Dr																					
Additional Instructions:																					
1 puff / each nostril 1.25mg																					

DRUG: Syp. Crocin DS				Date Time																	
Dose	Route	Frequency	Start Date																		
4ml	PO	SOS	19/5																		
Doctor's Signature		Valid Period	Pharm.																		
Dr		> 100F																			
Additional Instructions:																					

Verified by: Name
 Dr. Dhakshayani

REGULAR PRESCRIPTIONS

Weight. 12.9 kg Ward.



Verified by
Dr. Dhakshayani

DRUG : <u>Syp. CROCIN-DJ</u>				Date Time	<u>19/5/2015</u>
Dose	Route	Frequency	Start Date		
<u>4ml</u>	<u>Oral</u>	<u>6thh</u>	<u>19/5</u>	<u>12AM</u>	<u>X</u>
Name & Signature of the Doctor Starting the Drugs:					
<u>B. Sreeghan</u>				<u>6AM</u>	<u>X</u>
Additional Instructions:				<u>9AM</u>	<u>X</u>
<u>Paracetamol</u>				<u>12PM</u>	<u>X</u>
<u>(5ml/240mg)</u>				<u>6PM</u>	<u>X</u>
Daily Doctor's Endorsement by a Sign				<u>BY</u>	

DRUG : <u>T. FRISIUM</u>				Date Time	
Dose	Route	Frequency	Start Date		
<u>5mg</u>	<u>Oral</u>	<u>BD</u>	<u>19/5</u>		
Name & Signature of the Doctor Starting the Drugs:					
<u>B. Sreeghan</u>					
Additional Instructions:					
<u>1/2 tablet</u>					
Daily Doctor's Endorsement by a Sign					

DRUG : <u>SYP. CLOBAZAM</u>				Date Time	<u>19/5/2015</u>
Dose	Route	Frequency	Start Date		
<u>1ml</u>	<u>PO</u>	<u>Q12H</u>	<u>19/5</u>	<u>6AM</u>	<u>X</u>
Name & Signature of the Doctor Starting the Drugs:					
<u>[Signature]</u>					
Additional Instructions:				<u>6PM</u>	<u>X</u>
<u>(2.5mg/1ml)</u>					
Daily Doctor's Endorsement by a Sign				<u>BY</u>	

DRUG : <u>Inj CEFTRIAXONE</u>				Date Time	
Dose	Route	Frequency	Start Date		
<u>650mg</u>	<u>IV</u>	<u>BD</u>	<u>19/5</u>		
Name & Signature of the Doctor Starting the Drugs:					
<u>[Signature]</u>					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					

Verified by
Dr. Dhakshayani

HNH-00002278 IP26-00006380
 Master PATLOLLA CHANDRANSH
 07-08-2023 2 Y 9 M 12 D (M)
 Dr. PRITESH NAGAR



Verified by
Dr. Dhakshayani

Sheet No:

REGULAR PRESCRIPTIONS

Weight 29kg Ward

DRUG : <u>Amoxicillin + Clavulanate</u>				Date Time					
Dose	Route	Frequency	Start Dt.						
<u>450mg</u>	<u>IV</u>	<u>TID</u>	<u>19/5</u>	<u>6AM</u>	<u>9AM</u>	<u>12PM</u>			
Name & Signature of the Doctor Starting the Drugs:									
<u>Pram</u>				<u>2PM</u>	<u>5PM</u>				
Additional Instructions:									
<u>100mg/kg/day</u>				<u>10PM</u>	<u>5PM</u>				
Daily Doctor's Endorsement by a Sign				<u>6</u>	<u>✓</u>				

~~STOP
R
20/5~~

DRUG : <u>NASOCLEAR NASAL drops</u>				Date Time					
Dose	Route	Frequency	Start Dt.						
<u>2°</u>	<u>PN</u>	<u>4th hly</u>	<u>20/5</u>	<u>2AM</u>	<u>9AM</u>	<u>12PM</u>			
Name & Signature of the Doctor Starting the Drugs:									
<u>Pram</u>				<u>6AM</u>	<u>9AM</u>	<u>10AM</u>			
Additional Instructions:				<u>2PM</u>	<u>10PM</u>				
Daily Doctor's Endorsement by a Sign				<u>6</u>	<u>✓</u>				

DRUG : <u>Moxifloxacin eye drops</u>				Date Time					
Dose	Route	Frequency	Start Dt.						
<u>2/2</u>	<u>eye</u>	<u>BID</u>	<u>20/5</u>	<u>12AM</u>	<u>6AM</u>	<u>12PM</u>			
Name & Signature of the Doctor Starting the Drugs:									
<u>Prashant</u>				<u>6AM</u>	<u>12PM</u>				
Additional Instructions:				<u>6PM</u>					
Daily Doctor's Endorsement by a Sign				<u>6</u>	<u>✓</u>				

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

Verified by
Signature
Name

Patient Sticker



Sheet No: **REGULAR PRESCRIPTIONS** 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																			

Signature
VERIFIED BY : Name



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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses

Signature

VERIFIED BY

wf - 12.90 kg



EMERGENCY ROOM TRIAGE FORM

Patient's Name: Chancheris Paddy Age: 2 year Gender: Male Female

Date: 19/5/2026 Time of Arrival: 1:40 PM

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

Source of Information: Parents Others (Specify)

Mode of Arrival: Ambulatory Wheelchair Ambulance

Initial Vital Signs: Temp: 100.3 F PR: 135/1m BP: RR: SpO₂: 99%

Chief Complaints: c/c fever since 2 days and seizure 1st episode today

INITIAL PHYSIOLOGICAL CATEGORIZATION		INITIAL PHYSIOLOGICAL STATUS	
Appearance	Work of Breathing	<input checked="" type="checkbox"/> Stable	
<input type="checkbox"/> Normal	<input checked="" type="checkbox"/> Normal <input type="checkbox"/> Increased	<input type="checkbox"/> Unstable:	
<input checked="" type="checkbox"/> Sick Looking	<input type="checkbox"/> Decreased <input type="checkbox"/> Gasping / Apnea	<input type="checkbox"/> Not - Life - Threatening	
Circulation / Colour		<input type="checkbox"/> Life - Threatening	
<input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Bleeding			

Triage Classification	CTAS
<input type="checkbox"/> Level 1: Resuscitation	<input type="checkbox"/> Immediate
<input type="checkbox"/> Level 2: EMERGENT: Life or limb threatening	<input type="checkbox"/> < 15 min
<input type="checkbox"/> Level 3: URGENT: Significant illness / injury with potential to become life or limb threatening	<input type="checkbox"/> 30 min
<input type="checkbox"/> Level 4: LESS URGENT: Significant illness but not life threatening	<input checked="" type="checkbox"/> 60 min
<input type="checkbox"/> Level 5: NON - URGENT: May receive care when convenient	<input type="checkbox"/> 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: 1:45 PM

Communicable Disease Triage Screening

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

- Have you had fever (elevated temperature) in the past 2 weeks? Yes No
- Have you had cough or a rash in the past 2 weeks? Yes No
- 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

- 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: _____
- 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: Brabin

Signature of Triage Nurse: _____

Date & Time: 19/5/26

HNH-00002278 IP26-00006380
Master PATLOLLA CHANDRANSH
07-08-2023 2 Y 9 M 12 D (M)
Dr. PRITESH NAGAR



INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 19/5/26 Time of arrival : 1:40 PM

Chief Complaints : C/O Fever since 2 days and seizures 1st episode today morning RBS: 111 mg/dl

Height : Weight : BMI : Head Circumference (<2 years)

Allergies: Yes No Medications Blood Transfusion Food Other:

If yes, identify

Pain Screening: Yes No If Yes, Pain Score: 10/10 Pain Tool Used: N Pass FLACC Wong Baker

Character Location Frequency Duration

RISK FOR FALL:

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

If Patient is > 6 years

Assess the below parameters

History of Falling: within past 3 months Yes No

Ambulatory Aids:

- Wheelchair Yes No
- Uses furniture for support Yes No

Gait/Transferring:

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

Mental Status: Forgets limitations Yes No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening: No Abnormalities Detected

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

Inform consultant for positive criteria

Nutritional Screening: No Abnormalities Detected

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

Inform consultant for positive criteria

Psychological Screening: No Significant Findings

Unusual concerns about patient's Psychological Status: Yes No

If Yes Consultant Notified: (Date/Time):

Social History: Lives With Family

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

Time of Initial assessment completed by ER Nurse : 1:45 PM

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

Time	Nursing Notes
	→ Assessed the pt. condition
	→ checked the pt vitals
	→ intervention done
	→ medication given

Samples collected by: / Time: /
 Samples sent by: / Time: /

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1
1:45 PM 12/15/26	Zpogesic	PO	3.5ml		/
3:10 PM 12/15/26	clonazepam	PO	1ml (205mg)		/

Condition of patient at time of shift - out :	Details of Shift - out
HR: 145b/m BP: CFT: 25°C	Shift - out from ER to: 3:20 PM
RR: SPO ₂ : 98%	Time of Shift - out: 3:25 PM
GCS: 15/15 Temperature: 100.8°F	Handover given to: (Nurse's Name)
Pain Score: 10/1	
Repeat RBS (if applicable): 111 mg/dl	

Tick as applicable: MLC LAMA BROUGHT DEAD

Procedures done with details (if any):

Name of the Nurse: Brebin Signature of the Nurse: /

Date & Time: 12/15/26 @ 1:45 PM

HNH-00002278 IP26-00006380
 Master PATLOLLA CHANDRANSH
 07-08-2023 2 Y 9 M 12 D (M)
 Dr. PRITESH NAGAR



MEDICATION RECONCILIATION FORM

Drug Allergies: NA 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: ward

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						<input type="checkbox"/> C <input type="checkbox"/> DC
2						<input type="checkbox"/> C <input type="checkbox"/> DC
3						<input type="checkbox"/> C <input type="checkbox"/> DC
4						<input type="checkbox"/> C <input type="checkbox"/> DC
5						<input type="checkbox"/> C <input type="checkbox"/> DC
6						<input type="checkbox"/> C <input type="checkbox"/> DC
7						<input type="checkbox"/> C <input type="checkbox"/> DC
8						<input type="checkbox"/> C <input type="checkbox"/> DC
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. Sreephan

Date & Time: 19/5/26 @ 2:10 PM

Nurse Name & Signature: Prabin

Date & Time: 19/5/26 @ 2:10 PM

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

77 111

111

111

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111



111

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303

NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 19/5/26 Time: 3:45 AM

Weight: 12.9 Kg Centile: 25th

Height: Centile: -

Inference: Underweight child.

RDA: - Calories: 1250 Kcal/day Protein: 21gms/day

Diet Recommendations: Soft diet with plenty of fluids with calcium diet

Re-Assessment: No oily, spicy food

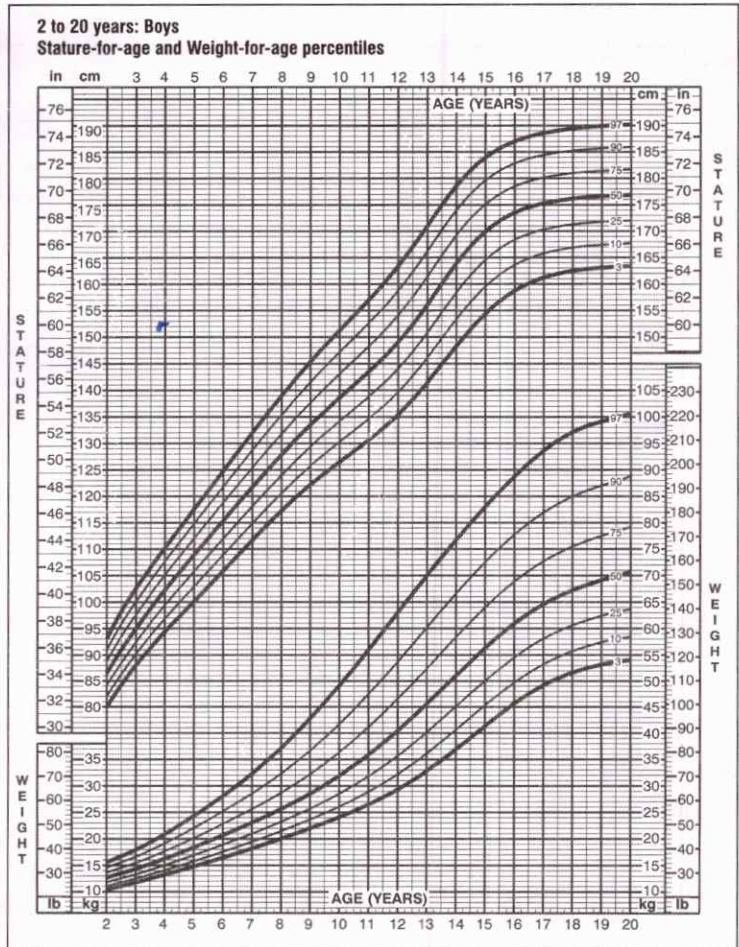
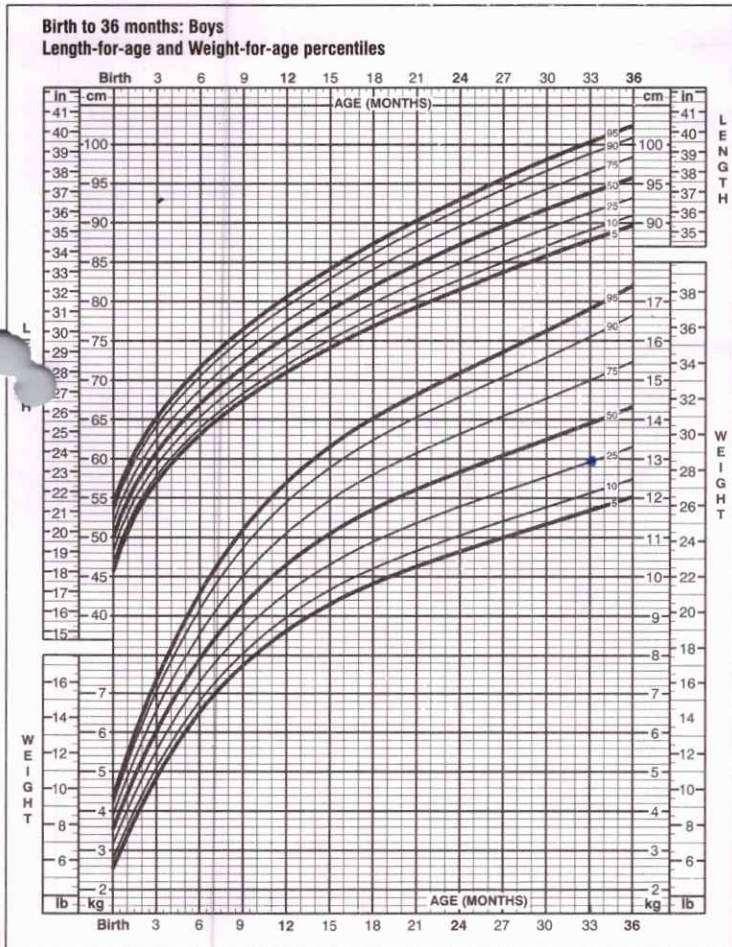
Food Allergies: No f A Veg/Non-veg: Ovo Veg

Diagnosis: AFI ± Simple febrile seizures

Nutritional Intervention - Oral Enteral Parenteral

Patient's Signature: Bhavani

GROWTH CHART (BOYS)



Dietician's Name: Syeda Sobiya Zaher

Dietician's Signature: Sobiya

