HNH-00009615 IP26-00006427
Baby Of K POOJA
28-07-2025 0 Y 9 M 28 D (F)
Dr. S TEJASWI REDDY

DEFICIENCY CHECK LIST OF CASE SHEET

Sl.No.	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission sheet	1			
2.	Discharge Summary	1			
3	Nursing Initial assessment	1			
4	Patient Transfer form	1			
5	In-patient Medical record	1			
6	Doctors progress sheets	4			
7	Nursing plan of care and handover sheets	5			
8	Consultation sheet				
9	General consent for treatment	1			
10	Consent for Surgery				
11	Consent for blood transfusion				
12	Consent for chemotherapy				
13	Consent for high risk				
14	Consent for Restraint				
15	LAMA consent				
16	Consent for special procedure / Sedation				
17	Consent for Formula feed				
18	Consent for MTP				
19	Consent for Radiological Investigations				
20	Consent for HIV test				
21	Anaestesia notes (Pre Anaesthesia& post)				
22	Neonatal Admission/Delivery/Physical Exam	1			
23	Medication Reconciliation	1			
24	Emergency Triage record	1			
25	Pre operative check list				
26	Surgical safety checklist				
27	Operation Theatre notes				
28	Nurses clinical Presentation				
29	TPR & BP chart	1			
30	Intake and Out take chart (fluid chart)	1			
31	Drug chart (Regular Prescription)	1			
32	Investigation Values (result sheet)	1			
33	Nebulization chart	2			
34	Nutritional review chart	1			
35	Intensive care unit (ICU Charts)				
36	Consent for Admission in PICU / NICU				
37	The Humpty dumpty scale	1			
38	Braden Q Scale				
39	Bed side check list				
40	PICU bed formula Dilution feeds				
41	Gastro monitoring chart				
42	Rch ED doctors note				
43	BP Monitoring chart				
44	RBS monitoring chart				
	Billing	1			
	Extras	6			
	Total No. of Pages	35			

Doc. No. : RCH/ FRM / GENERAL / 126

Signature and Date : [signature] 26/05/2026

(P.T.O)

LEAVE AGAINST MEDICAL ADVISE SUMMARY

Name	Baby Of K POOJA	**UHID**	HNH-00009615
Father/Guardian	Mr K DEVENDAR	**Age/Gender**	0 Y 9 M 27 D/ Female
Address	FLAT NO 303, SOMWAY TOWERS, Narayanguda, Hyderabad, Telangana, INDIA, 500029		
IP No	IP26-00006427	**Admission Date**	25-05-2026
Ref Doctor	Self.		
LAMA Date	26.05.2026		

Consultant:
Dr. S TEJASWI REDDY
MBBS, MD Pediatrics, DM Neonatology
APMC/FMR/94068

DIAGNOSIS	ICD CODE
? NEPHRITIC SYNDROME (NEEDS URGENT EVALUATION AND TREATMENT)	
URINARY TRACT INFECTION / CYSTITIS	

History: Baby Of K POOJA , 0 Y 9 M 27 D , old girl presented with the history of on and off cold since 2 months, fever since1 day, she was admitted at Rainbow Children's Hospital - for further management.

Name	Baby Of K POOJA	UHID	HNH-00009615
IP No	IP26-00006427	Admission Date	25-05-2026

Examination: She was afebrile, maintaining saturations at room air and was hemodynamically stable. Her heart rate was 110/min and Respiratory Rate - 30/min. Capillary Refill Time was <2 secs. Peripheries were warm & pulses well felt. On auscultation, air entry was decreased and crepitations were present. Heart sounds were normal and there was no murmur. Abdomen was soft with no organomegaly. On neurological examination, she 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: 6.68 kilo grams.

Investigations: Enclosed reports

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

Initial hemogram showed Hemoglobin of 10.9 gm%, White Blood Cell count of 13770 cells/cumm, platelet count of 4.74 lakhs/cumm and C-Reactive Protein of 30.mg/l.

Complete urine examination was :

Name	Baby Of K POOJA	UHID	HNH-00009615
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COLOUR	PALE YELLOW			
APPEARANCE	SLIGHTLY TURBID			
pH	6.5	5 - 8.5		-
SPECIFIC GRAVITY	1.015	1.005 - 1.030		-
SEDIMENT	PRESENT	NIL		-
PROTEIN	PRESENT +++			
GLUCOSE	NIL			
KETONE BODIES	NEGATIVE	NEGATIVE		-
BILE SALTS	ABSENT			
BILE PIGMENTS	ABSENT			
UROBILINOGEN	0.4	0.2 - 8	mg/dl	-
NITRITE	NEGATIVE			
BLOOD	NON - HEMOLYZED +++			
LEUCOCYTES	PRESENT(++)	NEGATIVE		-
PUS CELLS	15 - 20	0 - 5	HPF	L
EPITHELIAL CELLS	10 - 12	0 - 5	HPF	L
RBCS.	20 - 25	0 - 2	HPF	L
CRYSTALS	ABSENT			
CASTS	Granular Casts Present +			
BACTERIA	ABSENT			

Name	Baby Of K POOJA	UHID	HNH-00009615
IP No	IP26-00006427	Admission Date	25-05-2026

Ultrasound abdomen shows:
* Mildly diffusely enlarged bilateral kidneys with increased echotexture and relatively reduced corticomedullary differentiation as described, findings most likely in keeping with acute bilateral renal parenchymal disease / nephritic involvement.
* Internal echoes in urinary bladder.
- For clinico-biochemical correlation.

Management: She was admitted in the ward and saturations were not maintained on room air on day 1 of admission and hence started on oxygen by nasal prongs by at 2L/min. In view of suspected infection with raised inflammatory markers baby was started on iv antibiotics. baby was monitored for urine output and was on lower side and baby had BP readings on higher side throughout the stay around 95th centile on day 1 of admission and 90th centile on day 2 of admission. Urine routine done showed 3 plus proteinuria, and 15 to 20 pus cells and 20 to 25 RBCs, granular casts present and hence usg abdomen was done showed enlarged bilateral kidneys with increased echotexture and reduced cortico medullary differentiation suggestive of acute bilateral renal parenchymal disease and nephritic involvement and internal echoes in urinary bladder . Parents were counselled about the nature of disease and further investigations and management was planned and co consulation and co mangement with pediatric nephrologist and plan to monitor BP and plan to start anti hypertensives if required. But however, parents were not willing for further treatment and taking the baby against medical advise. Parents were clearly counselled about the need for hospitalisation and advised to go to another hospital and also explained about **NEED FOR EVALUATION AND TREATMENT UNDER PEDIATRIC NEPHROLOGIST.**

Parents were counselled about the nature, severity of illness and possible

Name	Baby Of K POOJA	UHID	HNH-00009615
IP No	IP26-00006427	Admission Date	25-05-2026

prognosis of the childs condition. They were also counselled about the need for further hospital stay. How ever parents were unwilling for further management on persona grounds and requested the child to be discharged. Hence chid is being **LEFT AGAINST MEDICAL ADVICE.**

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

Medication during hospital stay:
Injection. Amoxiclav

Advice:
* Diet as advised.
* SYP MOXCLAV DS(228.5mg/ml) 3.5ml 1-0-1.

Registrar/Resident/C.M.O

Dr. S TEJASWI REDDY
MBBS, MD Pediatrics, DM Neonatology
APMC/FMR/94068

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ACTIVITY RECORD FOR BILLING

HNH-00009615 IP26-00006427
Baby Of K POOJA
28-07-2025 0 Y 9 M 27 D (F)
Dr. S TEJASWI REDDY

Name: ------ --

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

Date of Adm ------------- Date of Discharge : ---------------- Time: ----------

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
25/5/26	8:25pm	ER	220	[signature]

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Sign
25/5/26	CBP, CRP	8825	[illegible]
	~~[illegible]~~ RSV (S) virus	8838	
	VBG	8824	
	Cross checked done by Sneha		
26/5	CUE	8844	[illegible]
26/5	Ultrasound ABd & Pelvis.	6359	[illegible]
26/5	X-ray chest	6345	

HNH-00009615 IP26-00006427
Baby Of K POOJA
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3% NS - 6H
Levolin - 8H

O2 0.5.

NEBULISATION CHART

Date	Time	Drug	Nurse	Parents Signature
	00.00			
	01.00			
26/5/26	02.00			
	03.00			
	04.00	3% NS ②	Sneha	[signature]
	05.00			
	06.00	Levolin ③	Sneha	[signature]
	07.00	7 ③	[202148]	[signature]
	08.00			
	09.00			
	10.00	~~3% NS~~	[initials]	not given.
	11.00			
	12.00	~~Levolin~~		
	13.00			
	14.00	~~Levolin~~	[initials]	
	15.00			
	16.00	~~3% NS~~		
	17.00			
	18.00			
	19.00			
	20.00			
	21.00			
	22.00			
	23.00			

HNH-00009615 IP26-00006427
Baby Of K POOJA
28-07-2025 0 Y 9 M 27 D (F)
Dr. S TEJASWI REDDY

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			
25/5/26	19.00			
	20.00			
	21.00			
	22.00	3% NS + Levolin ①	Sneha	[illegible]
	23.00			

Doc. No. : RCH / FRM / CLINICAL / 170

Rainbow Children's Hospital BirthRight by Rainbow

Rainbow Childrens Hospital-Himayatnagar

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

ADMISSION SHEET

Registration Details :

Admission No : IP26-00006427 **Admit Date** : 25-May-2026 **Admit Time** : 02:39 PM **UHID** : HNH-00009615

Patient Details :

Patient Name	: Baby Of K POOJA	**Age**	: 0 Y 9 M 27 D
Guardian	: Mr K DEVENDAR	**DOB**	: 28-07-2025 10:27 AM
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: FLAT NO 303, SOMWAY TOWERS Narayanguda Hyderabad Telangana INDIA 500029	**Phone No**	: 9014440315/ 9441051674
		E-mail	: POOJADEVKHETHAVATH@GMAIL.CO

A[illegible]ission Details :

Bed Type	: DAY CARE	**Bed No**	: ER02	**Ward Name**	: GF -EMERGENCY
Room No	: ER02	**Admission Type**	: First Visit		

Contact Details :

Name	: Mr K DEVENDAR	**Relationship**	: Father
Contact Address	: FLAT NO 303, SOMWAY TOWERS Narayanguda Hyderabad Telangana INDIA 500029	**Phone No**	: 9014440315

Signature

[illegible]or Details :

Doctor Name	: Dr. S TEJASWI REDDY	**Specialisation**	: GENERAL PEDIATRICS
Referral Doctor	: Self.	**Phone No**	:
Co-Consultant	:		

Payment Details :

Payment Mode	: DC/CC Card	**Deposit Amount**	: 10000.00
		Payor Name	: SELFPAY

CONSENT FOR LEFT AGAINST MEDICAL ADVICE
(Taking Ambulance for Transport)

Patient Name : B/O K. pooja Age : 9m 22d Gender : ☐ Male ☐ Female

UHID NO : HNH-0000916 Department : Paediatrics Date : 26/5/26

I Pooja S/D/W/O .... here by give declare that my daughter is diagnosed of ? Nephritic syndrome & requires further Evaluation, Confirmation, monitoring of urine output, BP, further investigations, Consultation & Co-management c Paediatric Nephrologist

The doctor has explained me nature of illness and need of hospitalisation treatment, Investigations care. After extensive discussion with the family members about the risk and alternatives I have decided not to continue treatment in this hospital and I want to take my daughter to another health care facility. The hospital staff have advised and helped me in arranging an ambulance with appropriate medical care facilities and a healthcare worker for safe transportation of my daughter

I wish to take my daughter in the private ambulance to another health care facility fully understanding that such transportation can be consiquences for my daughter due to his / her sickness. I do not have any complaints against the doctors and hospital staff.

Patient Attendant :

Signature : pooja

Name : K. pooja

Relationship with Patient: daughter

Date & Time : 26-05-2026

Witness :

Signature : [signature]

Name : V. Ruthvik

Date & Time : 26/5 5:00pm

Doctor :

Signature : [signature]

Name : Dr. Tejasvi Reddy

Date & Time : 26/5/26; 3:50pm

Doc. No. : RCH / FRM / CLINICAL / 017

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
25/5	Infusion pump	8pm	26/5/26 6am	202114	Sneha
25/5	Oxygen	8pm	26/5/26 6AM	202114	Sneha
			Cross	checked	done by Sneha

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
25/5/26	I v canula	1	202091	[signature]
26/5/26	NHA	1	2228	

ANY OTHER INFORMATION

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
		[signature]	

Ref.No. F/IN/PR/10

Rainbow® Children's Hospital

PEDIATRIC IN-PATIENT MEDICAL RECORD

HNH-00009615 IP26-00006427
Baby Of K POOJA
28-07-2025 0 Y 9 M 27 D (F)
Dr. S TEJASWI REDDY

Patient Name :

Patient ID# :

Consultant :

Final Diagnosis :

Pediatric Multiorgan History & Physical Examination

Name : ______________________ Age/Sex ______

Informant ______________________ Reliability ______

Chief Presenting Complaints & Duration (Chronologically):

C/o fever since 1 day
C/o cough since 2 days
C/o vomiting since 2 days.

History of present illness : C/o decreased urine output

patient was apparently alright 2 days before then she had cough dry type associated with post tussive vomiting

C/o fever since 1 day, on & off type mod - high degree fever.
C/o decreased urine output since 1 day

Pediatric Multiorgan History & Physical Examination

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

Nothing significant.

Birth & Neonatal History :

Birth & Socio Economic History :

About Father :

About Mother :

Any additional Information :

Developmental History :

Developmentally normal.

Immunization History :

upto date till 9m.

Pediatric Multiorgan History & Physical Examination

Anthropometry

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

Weight (kgs) 6.68kg (Centile ________)

On Examination :

Temperature : 100°F. Pulse Rate: 108. Description ________

B.P. ________ SPO2 85% on Room at R.A.

Resp. rate and type of breathing : 32/min 93-95% on 0.5Lt Oxygen

dry lips & oral mucosa] dehydrat

Rash ⊖ Sunken eyes] dehydrat

Lymphadenopathy ⊖ Delayed skin turgor]

Oedema : ⊖

Respiratory system :

Inspection (any s/o distress) : Mild Tachypnea (32/min)

Air entry & breath sounds : Reduced air entry bilaterally

Any addes sounds : fine basal crepts ⊕

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

Cardiovasclular System :

Inspection of procordium : ________

Heart Sounds : $S_1 S_2$ ⊕

Any murmur : ________

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

Per Abdomen :

Inspection ________

Palpation : Soft

Ausculation : ________

Spine: ________ External Genitelia : ________

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

Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS Score : Irritable

Cranial Nerves : N

Motor System :

Nutrition :

Tone : Power

Co-ordinator : N

Posture :

Involuntary Movements :

Reflexes :

DTR

Superficials :

Plantars

Sensory System :

N

Bladder / Bowel :

Clinical Summary & Diagnostic :

AFI c̄ Dehydration
? Pneumonia c̄ Hypoxia

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment :

Desired goals of the treatment :

Planned Labs :

CBP
CRP
VBG ✗
CUE

Chest XRay
5 Virus Respiratory Panel
~~noted by [illegible]~~

Planned Management :

Low flow Oxygen
- IV Fluids @ full (M)
- Inj Amoxyclav
- Neb c̄ 3% NaCl - 6th hrly
  Neb c̄ Levolin - 8th hrly

SOS ↓ Nasal
Crocin
~~noted by [illegible]~~

Please fill up the following details

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

Doctor's Signature Name Date 25/1/26 Time

Dr. S. TEJASWI REDDY
Registration No: 94068

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
25/5/26 2:30pm	UHB Dr. Tejaswini	
	AFI c̄ severe dehydration.	
	- c/o fever -: 1day	
	- c/o cough -: 2days	a/w part dusine vomiting
	- 1 c/o -: morning	
	O/E	- signs of dehydration (+)
		- dry lips
	- HR : 120 bpm	- sunken eyes
	- RR : 36 cpm	- dull activity.
	- SpO_2 : 100%.	
	- RS : BAE (+) clear	
	- P/A : soft.	
		Plan
		1) send CBP, CRP, VBG, WE.
		2) IV - NS bolus 100ml over 30min
		3) Inj amoxiclav
		4) ct. fuel maint over fluids till evening
		5) Reassess in the evening
		6) monitor vitals

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Baby Of K POOJA
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Dr. S TEJASWI REDDY

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
25/5	C/S/B Dr Naipunya	
7:30 pm		
	AFI c Severe Dehydration	
	? LRTI	
		Plan
	→ Not maintaining Saturation	1) Start low flow Oxygen
	- Did not pass Urine.	2) IVF - Full (M)
		3) Inj Amoxyclav
	O/E	
	Child dull	4) Monitor Vitals
	Afebrile.	
	SpO_2 - 85% on RA	
	R.S - B/L AE Reduced (L>R)	
	Basal crepts (+)	(signature)
	P/A - Soft.	

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

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
25/5 6pm	C/s/B - Dr Pranav / Dr. Prabhath	
	AFI ē Severe Dehydration ? Pneumonia	
		Plan - Full admission
	→ Not maintaining off oxyg Sats Room Air → 75-85%	1) To Cont. Low flow Oxygen
		2) IVF - full ⓜ
	- No RD	
	- Yet to pass Urine	3) Chest X-ray - Now
	Vitals	4) Inj Amoxyclav
	HR - 116/min SpO$_2$ - 98% on 1L O$_2$	
	RR - 32/min	5) Monitor Vitals
	R.S - B/L AE reduced fine basal crepts	6) Cont Low flow Oxygen @ 1L
	P/A - Soft	
		Pranav

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Dr. S TEJASWI REDDY

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
25/5	C/S/B Dr. Spandana	
7pm		
	AFI c̄ Severe Dehydration	
	c̄ Pneumonia c̄ RD	Pk
		1) Admit - HDU
	- On Oxygen - 1 lit c̄ NP	Ct - Low flow O2 c̄ Nasal Prong.
	- Minimal RD	2) Send for Viral Respiratory panel
	- Did not pass	
	Child Dull	3) Neb c̄ 3% NaCl
	Poor Oral intake	
		4) IVF - Full (M)
	Vitals	
	HR - 106/min	5) Monitor Vitals
	RR - 32/min	
	SpO_2 - 97% on 1 lit O_2	6) Inform SOS
	Dehydration (+)	
	R-S - Reduced AE bilaterally	
	Fine Crepts (+)	Pranav
	P/A - Soft	

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
25/5 10:30pm	c/s/b Dr Prasan	
	AFI c Severe Dehydration c Pneumonia	CRP - 30
		Plan
	On Low flow O_2 c N.P @ 1 lit/m	1) Ct - Low flow O_2
		2) Trace Respiratory panel
	Child irritable	
	Vitals : HR - 122/min	3) Ct - Nebs
	SpO_2 - 96% on 1Lt O_2	
		4) IVF @ 2/3rd (M)
	R-S - B/L AE (+) (reduced) fine crepts (+)	5) Monitor Vitals
	P/A - Soft	6) Infuse SOS
	? Urine status not known Passed stool Twice	7) Send CUE
		Prm

Docu. No. : RCH /FRM / CLINICAL / 088 (P.T.O)

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
26/5 7AM	c/s/B Dr. Pranav / Dr. Varun	
	AFI c̄ Severe Dehydration	
	Pneumonia c̄ RD	
		Plan
	On Low flow O_2 – 1 L/t	1) Low flow O_2 – Trial off O_2
	RD – Mild	To taper
	Fever – 101.7°F @ 2AM	
	Loose stools ⊕ (Small Volume)	2) Neb c̄ 3% NaCl – 6th hly
	Oral intake on DBF	Levolin – 8th hly
	Vitals : HR – 110/min	3) IVF – 1/2 (M).
	RR – 30/min SpO2 – 97%	
		4) Monitor Vitals
	Child alert	
	R-S – B/L AE, air entry better	5) Trace 5 Virus panel
	occ crepts ⊕	
	P/A – Soft	6) Encourage orally
		7) Add Pro GG
		NB Srichee 8m
	Flu – negative (Verbal)	Pranav

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

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0 Y 9 M 27 D
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(F)

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GRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
26/5/26 10 35AM.	c/s/by. Dr Anuha. / Dr Tejaswi mam	
	?UTI c	
	? AGN.	
	c̄ Pneu E RD	
	fever spike (+)	
		– Urine dipstick now.
	Protein 3+	– ~~Nephrologist Opinion~~
	pus cell (+).	
	RBC (+).	→ Send u/c/s
	Cast cell (+).	
	Bp = 99th Centile.	→ USG Abdomen & Pelvis today.
		plan – ASO titres
		– RFT: (urea, creatinine)
		– ~~[illegible]~~.
	s/E	
	B/L AE (+).	– strict (I/O) Monitoring
	(Pls) NVBS (+)	(Bp) Q2hly → Everyhourly.
		– N/t SpO2
		– If SpO2 < 94% ⇒ O2 1lit/h
		– If Bp > 110 SBP – Inform
		[signature] noted by @ 10:40AM – Amruth

Dr. S. TEJASWI REDDY
Registration No. [illegible]

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/5/25 3 PM	S/B Dr. Spandana	
	Δ) Acute glomerulonephritis	
	①Dipstick - (3+) ; CUE - 3+	
	feeding adequately ⊕.	Advise:-
	Intermittent high BP readings.	①
	O/e -	Oral co-amoxyclav
	Vitals stable	
	(Rx)	② Input/output monitoring.
	Cr - 8.52	
	[illegible] - [illegible]	
	[illegible]	③ BP monitoring
		④ [illegible]
		④ LAMA.

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

HNH-00009615 IP26-00006427
Baby Of K POOJA
28-07-2025 0 Y 9 M 27 D (F)
Dr. S TEJASWI REDDY

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DRUG CHART

Date of Admission: .... Drug Allergies: .... ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

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

NURSES - Nurses must follow strictly the FIVE RIGHTS before administration of medication.
1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time
- AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

SOS / PRN (As Required Medication)

DRUG : Drop. CROCIN			
Dose	Route	Frequency	Start Date
1ml	Oral	SOS/6th	25/5
Doctor's Signature	Valid Period	Pharm.	
[signature]			
Additional Instructions: Paracetamol (1ml/100mg)			

Date ▸	25/5	26/5
Time ▾	2PM	10 AM
	[signature]	[signature]

DRUG : Inj. ONDENSETRON			
Dose	Route	Frequency	Start Date
1mg	IV.	SOS	25/5
Doctor's Signature	Valid Period	Pharm.	
[signature]			
Additional Instructions:			

Date ▸	25/5
Time ▾	3pm
	[signature]

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

Date ▸
Time ▾

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

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REGULAR PRESCRIPTIONS

Weight. 6.68 kg Ward. ....

DRUG : Inj. AMOXYCLAV				Date/Time
Dose	Route	Frequency	Start Date	
200g	IV	TID		
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

DRUG : Inj. AMOXYCLAV				Date/Time	25/5	26/5
Dose	Route	Frequency	Start Date	6AM	✓	[signature]
300g	IV	BD	25/5			
Name & Signature of the Doctor Starting the Drugs: B. Sangharsh				6pm	6pm [signature]	
Additional Instructions: dilute in 10ml and give over 1 hour.						
Daily Doctor's Endorsement by a Sign						

DRUG : NEB c 3% NaCl				Date/Time
Dose	Route	Frequency	Start Date	
1 respule	NEB	6th hly	25/5	
Name & Signature of the Doctor Starting the Drugs: Pranav				see the chart
Additional Instructions: Hypal Neb ★				
Daily Doctor's Endorsement by a Sign				

DRUG : NEB c LEVOLIN				Date/Time
Dose	Route	Frequency	Start Date	
0.31mg	NEB	8th hly	25/5	
Name & Signature of the Doctor Starting the Drugs: Pranav				see the chart
Additional Instructions: 0.31mg				
Daily Doctor's Endorsement by a Sign				

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Sheet No: ....

REGULAR PRESCRIPTIONS

Weight .... Ward ....

DRUG: PRO-SG Drops				Date/Time	26/5
Dose	Route	Frequency	Start Dt.	8Am	[signature]
15 drops	PO	BD	26/5		
Name & Signature of the Doctor Starting the Drugs: Pranam					
Additional Instructions:				8Pm	
Daily Doctor's Endorsement by a Sign					

DRUG: CROSIN drops				Date/Time	26/5
Dose	Route	Frequency	Start Dt.		
1ml	PO	Q6hrly	26/5	12AM	X
Name & Signature of the Doctor Starting the Drugs: [signature]				6AM	X
Additional Instructions:				12pm	10AM [signature]
				6pm	
Daily Doctor's Endorsement by a Sign					

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

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

VERIFIED BY - Name Signature

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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															

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

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
25/5	2:15 PM	NS bolus.	100ml over 30 minutes	IV	[signature]	[signature]

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

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I.V. FLUIDS CHART

Weight. 6.6 kg Ward. ....

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
25/5	2:30 PM	DNS	IV	30 ml/hr	[signature]	[signature] / [signature]	25/5	[signature]	[signature] / [signature]
25/5	10:30 pm	DNS	IV	20 ml/h	[signature]	[signature] / [signature]	26/5	[signature]	[signature] / [signature]
26/5	8am	DNS (1/2 M)	IV	13 ml/h	[signature]	[signature] / [signature]	26/5	[signature]	[signature] / [signature]

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

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RESULT SHEET

Date	25/5/26					
Time						
Hb	10.9					
PCV	31.1					
RBC	4.64					
WBC	13.77					
N/L	72.1/21.7					
Platelets	474					
CRP	30					
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						

Date						
Time						
CUE-Alb						
CUE-Sugar						
CUE - Ketones						
CUE-PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA/Cyst						
Occult Blood						

Culture and Sensitivities : ....

....

....

....

Radiology: USG : ....

X-Ray:..

ECHO: ....

CT: ....

MRI ....

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

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Dr. S TEJASWI REDDY

H / FRM / CLINICAL / 124

INFANT (<1 year)

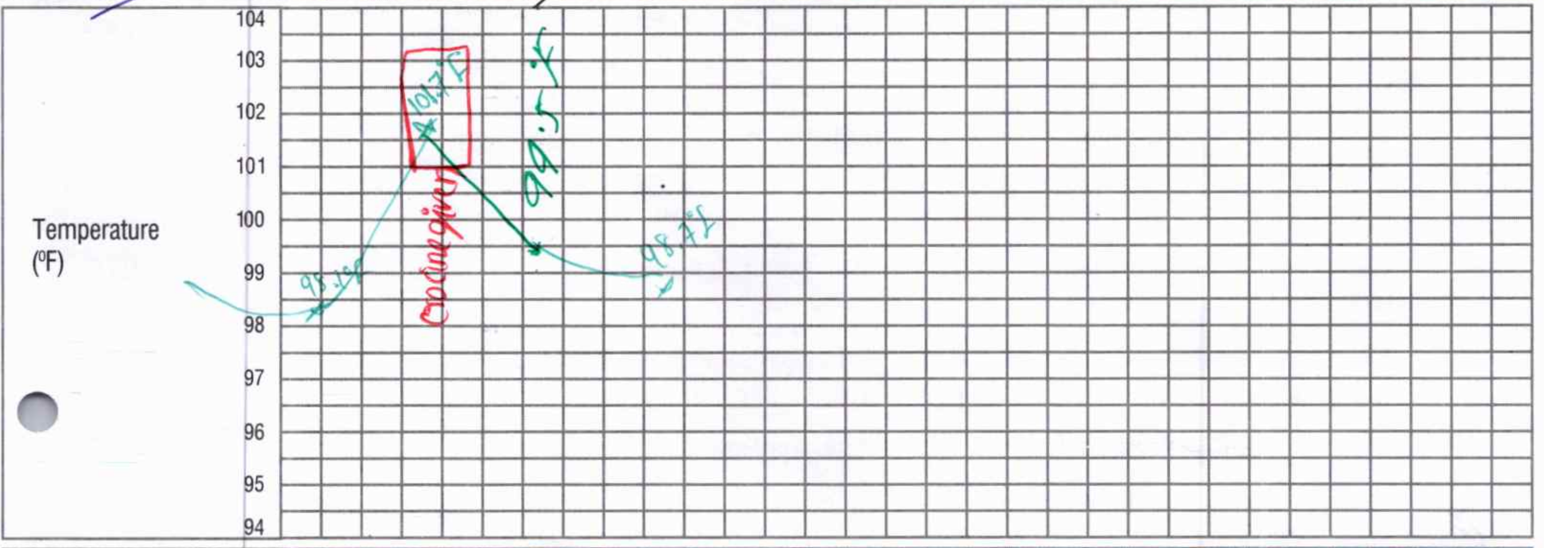
Children's Observation & Early Warning Scoring Chart

[E]LY WARNING SCORE: CHILDREN'S UNIT

Date: 25/5 Time: 10PM. 2Am. 3 Am 6Am.

Doctor/Nurse/Family Concern?

Temperature (°F)



	10PM	2Am	3Am	6Am
Temperature (°F)	98.3°F	101.7°F	99.5°F	98.7°F
Heart Rate (bpm) and Blood Pressure (mmHg) *	113 / 87 (97)	110 / 80		110 / 72 (87)
Heart Rate (Number)	118 b/m.	100 b/m		128 b/m
Resp. Rate (bpm) (Over 1 Minute) *	x	x		x
Resp Rate (Number)	38 b/m.	31 b/m		31 b/m
Resp Distress (Mod/ Severe; None / Mild)				
Receiving O_2 (l/min)	c O_2	c O_2		c O_2
O_2 Saturations (%)	100 %	99 %		100 %
Conscious Level (Normal; Altered)				
GCS *				
TOTAL SCORE Number of shaded boxes	0	0		0
Pain Score	0	0		0
Observer's Initials	[illegible]	[illegible]		[illegible]

Note: BP does not score in early warning scoring

Handwritten on chart (red): antipyretic given

ACTIONS	
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: Scores 3 should be recorded overleaf

* 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.

O_2 0.5 liter.

Patient Sticker

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

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0 Y 9 M 27 D
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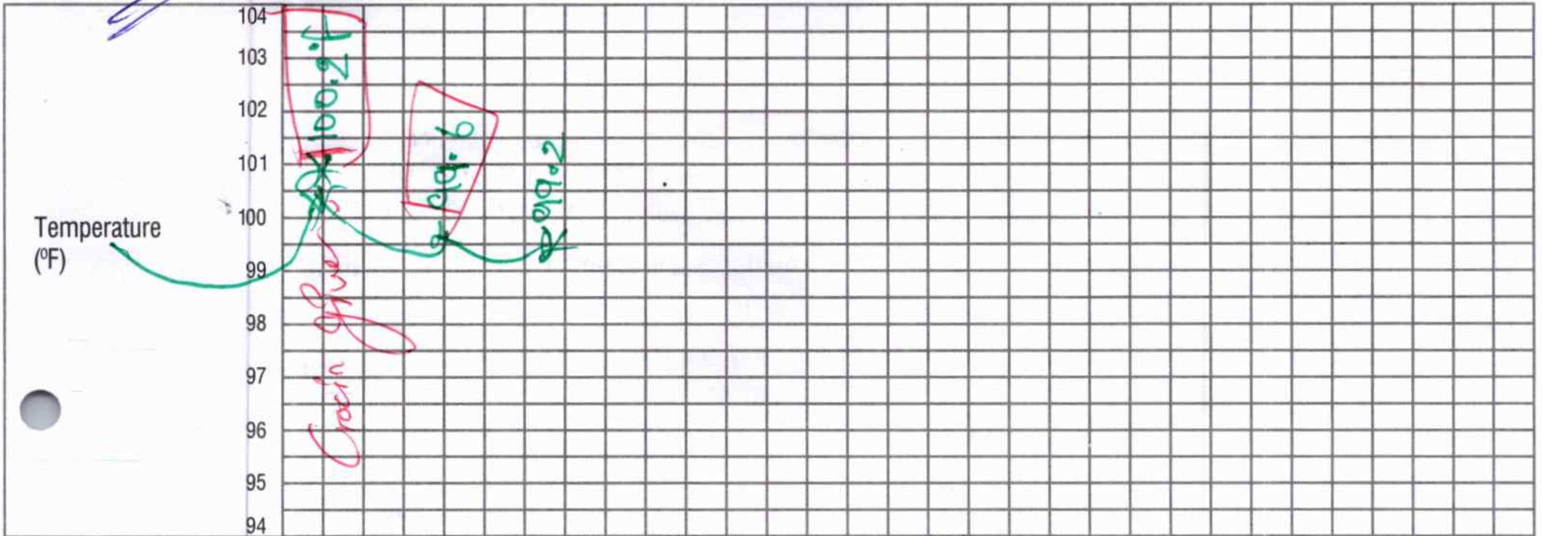
(F)

CH / FRM / CLINICAL / 124

INFANT (<1 year)
Children's Observation & Early Warning Scoring Chart

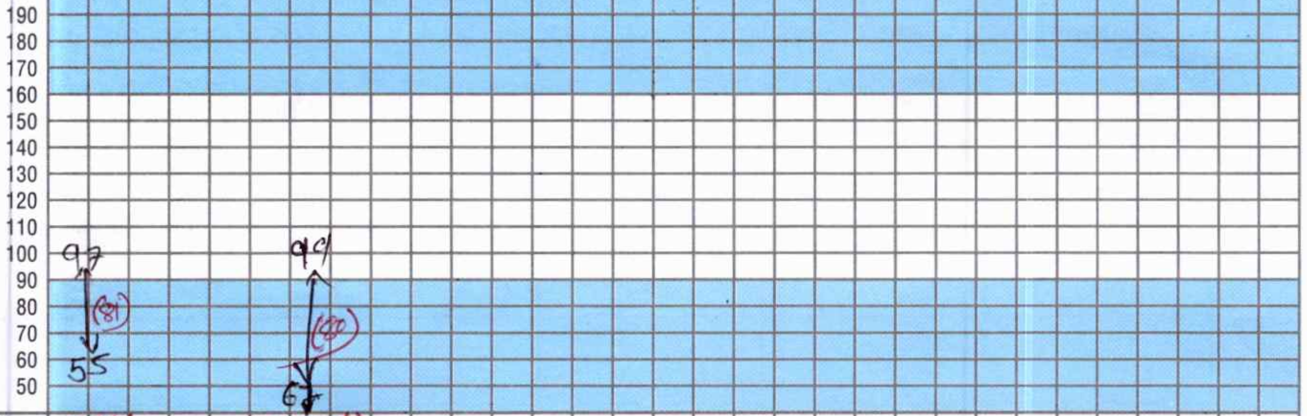
EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 26/8/5 Time:	10Am	11Am	9pm
Doctor/Nurse/Family Concern?			



Temperature (⁰F)
104 103 102 101 100 99 98 97 96 95 94

100.2°F (Crocin given), 99.6, 99.2



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

Note: BP does not score in early warning scoring

BP: 97/55 (81); 99/67 (80)

	10Am	11Am	9pm
Heart Rate (Number)	124 b/m		127 b/m
Resp Rate (Number)	34 b/m		36 b/m
Resp Distress – Mod/ Severe			
Resp Distress – None / Mild			
Receiving O_2 (l/min)			
O_2 Saturations (%)	100%		100%
Conscious Level – Normal			
Conscious Level – Altered			
GCS *			
TOTAL SCORE Number of shaded boxes	0		0
Pain Score	0		0
Observer's Initials	B		B

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

ACTIONS	
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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NB: Scores 3 should be recorded overleaf

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Patient Sticker

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Record Details when EARLY WARNING SCORE > 3			Record Time of Review and Plan		
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B	**BACK GROUND :** Child (X) was admitted on (XX date) with (e.g. respiratory infection). They have had (X operation/ procedure/ investigation). Child (X)'s condition has changed in the last (XX mins). Their last set of observations were (XXX). The child's normal condition is ... (e.g. alert/ drowsy/ confused, pain free)
A	**ASSESSMENT :** I think the problem is (XXX) and I have ...(e.g. given O2/ analgesia, stopped the infusion), OR I am not sure what the problem is but child (X) is deteriorating, OR I don't know what's wrong but I am really worried.
R	**RECOMMENDATION :** I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

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Baby Of K POOJA
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Dr. S TEJASWI REDDY

FLUID CHART

Sheet No. : ....

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

Date	Time	Intake				Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
		Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
	02:00 pm				ER							
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						Total Output :						
	08:00 pm			30ml								
	09:00 pm			30ml							0	
	10:00 pm		milk	20ml							0	
25/5	11:00 pm	DNS		20ml	NA		✓	NA		✓	0	Sn
	12:00 am			20ml			✓			✓	0	
	01:00 am			20ml							0	
Total Intake :						Total Output :				U -	M -	
	02:00 am			20ml							0	
	03:00 am			20ml							0	
	04:00 am		milk	20ml							0	
26/5	05:00 am	DNS		20ml	NA			NA			0	Sn
	06:00 am						✓			✓	0	
	07:00 am										0	
Total Intake :						Total Output :				U -	M -	

Total 24 hrs. Intake		Total 24 hrs. Output	U - M -

Docu. No. : RCH /FRM / CLINICAL / 092

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FLUID CHART

Sheet No. : ....

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

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
26/5			Mouth	I.V	N.G							
	08:00 am	DNS	milk	13 ml		NA		NA	NA		0	
	09:00 am			13 ml								[illegible]
	10:00 am			13 ml							0	
	11:00 am			13 ml			✓			20 ml		
	12:00 pm			13 ml								
	01:00 pm			13 ml			✓					
Total Intake :						Total Output :				U - 1 M - 2		
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						Total Output :						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						Total Output :						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						Total Output :						

Total 24 hrs. Intake		Total 24 hrs. Output	

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NURSING CARE RECORD

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Date: 25/5/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning		E.R.					
Afternoon							
Night	8pm to 8Am	Assess the pt condition. Monitor vitals spo2. Maintain I/O chart. Provide the comfortable position. Medication given per os doctor order.	8pm to 8Am	Assessed the pt cond. Monitored vitals spo2. Maintained I/O chart. Provided the comfortable position. Medication given as per as doctor order.	Pt is stable. Vitals normal.	Monitor vitals. Maintain I/O chart.	Sneha

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NURSING CARE RECORD

Date: 26/5/26

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	8 Am – 2 pm	- Assess the pt condition - Monitor vitals - Manitain I/O Chart - Administer Medications as per drug chart	8 Am – 2 pm	- Assessed the pt condition - Monitor vitals - Manitain I/O Chart - Administer Medication as per drug chart	Pt is Stable	Re Checked vitals	[signature]
Afternoon							
Night							

HNH-00009615 IP26-00006427
Baby Of K POOJA
28-07-2025 0 Y 9 M 27 D (F)
Dr. S TEJASWI REDDY

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NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:	Any Infection: ☐ Yes ☐ No ☑ Not Known If Yes Specify: ....
	Surgery / Procedure:	Post OP Day:

	Date / Shift	25/5 N	26/5/26 M				
BACKGROUND	Medical Condition (Any special condition to be noted):	–	–				
	Diet:	–	–				
ASSESSMENT	Allergy:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Ventilation (RA, NP, NIV, VENTI):	–	–				
	Tubes/Drains/Catheter:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:	98.4F	98.6F				
	Res:	38b/m	37bm				
	SpO_2:	99%	99%				
	Pulse:	142	140bm				
	BP:	–	–				
	LOC:	–	–				
	Fall Risk Score:	–	–				
	Pain Score:	–	–				
	Skin Integrity	–	–				
Recommendations	Safety Needs:	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Physiotherapy:	–	–				
	Others Specify:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Special Diet:	–	–				
	Critical Lab Test / Values:	–	–				
	Other Special Orders / Medications:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	PU Prophylaxis:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	DVT Prophylaxis:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	ADL (Dependent / Non Dependent):	–	–				
	Post Operative Procedure Special Orders:	–	–				
	Handed Over By Name :	Sneha	Manisha				
	Signature / ID :	[illegible] (6037)	[signature]				
	Date:	26/5	26/5/26				
	Time:	9Am	2pm				
	Taken Over By Name :	Manisha					
	Signature / ID :	[signature]					
	Date:	26/5/26					
	Time:	8Am					

Patient Sticker

NURSING SHIFT HAND OVER FORM

SITUATION		
	Diagnosis:	Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify: ....
	Surgery / Procedure:	Post OP Day:

Section	Item						
BACKGROUND	Date / Shift						
	Medical Condition (Any special condition to be noted):						
	Diet:						
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Ventilation (RA, NP, NIV, VENTI):						
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:						
	Res:						
	SpO_2:						
	Pulse:						
	BP:						
	LOC:						
	Fall Risk Score:						
	Pain Score:						
	Skin Integrity						
Recommendations	Safety Needs:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Physiotherapy:						
	Others Specify:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Special Diet:						
	Critical Lab Test / Values:						
	Other Special Orders / Medications:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	PU Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	DVT Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	ADL (Dependent / Non Dependent):						
	Post Operative Procedure Special Orders:						
	Handed Over By Name :						
	Signature / ID :						
	Date:						
	Time:						
	Taken Over By Name :						
	Signature / ID :						
	Date:						
	Time:						

-00009615 IP26-00006427
Baby Of K POOJA 0 Y 9 M 27 D (F)
25-07-2025
Dr. S TEJASWI REDDY

THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE 25/5	DATE 26/5	DATE	DATE	DATE
Age	Less than 3 years old	4	4	4			
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2					
	Female	1	1	1			
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1			
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own ability	1	1	1			
	History of Falls or Infant-Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2					
	Outpatient Area	1	1	1			
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours/ None	1	1	1			
Medication Usage	Sedatives (Excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1			
	Total		10	10			

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

Intervention						
Bed in low position		✓	✓			
Call device within reach		✓	✓			
Wheels Locked		✓	✓			
Room free of clutter		✓	✓			
Adequate lighting		✓	✓			
Wheel chair support		✗	✗			
Other Intervention(s) Specify		✗	✗			
Nurse's Name:		[illegible]	Manisha			
Signature:		[illegible]	[illegible]			
Date:		25/5	26/5			
Time:		8 PM	2 PM			

Docu. No. : RCH /FRM / CLINICAL / 005

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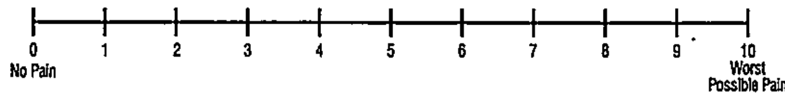
PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
25/5	10Pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
26/5	2Am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
26/5	8Am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
26/5	10Am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

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

PAIN ASSESSMENT TOOLS

Numerical Pain Scale (Obstetric and Gynecology)



Wong - Baker (Pediatrics) Above 7 Years

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

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

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

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Baby Of K POOJA
28-07-2025 0 Y 9 M 27 D (F)
Dr. S TEJASWI REDDY

BRADEN 'Q' SCALE

					Date :	25/5	26/5		
					Time :	8 Pm	M6		
Mobility	**1. Completely immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	**3. Slightly limited:** Makes frequent through slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.		4	4		
"Activity The degree of physical activity"	**1. Bedfast :** Confined to bed	**2. Chairfast :** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	**3. Walks occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. All patients too young to ambulate; OR walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.		3	4		
Sensory Perception	**1. Completely limited:** Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	**2. Very limited:** responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	**3. Slightly limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	**4. No impairment:** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.		4	4		
Moisture Degree to which skin is exposed to moisture	**1. Constantly moist:** Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	**2. Very moist:** Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	**3. Occasionally moist:** Skin is occasionally moist, requiring linen change every 12 hours.	**4. Rarely moist:** Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.		4	4		
FRICTION-SHEAR **Friction** Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another	**1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	**2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	**3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	**4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."		4	4		
Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.		4	4		
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.		4	4		
				TOTAL SCORE		27	28		
				Evaluator's Name		[illegible signature]	[illegible signature]		

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

Docu. No. : RCH /FRM / CLINICAL / 119

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

HNH-00009615 IP26-00006427
Baby Of K POOJA
28-07-2025 0 Y 9 M 27 D (F)
Dr. S TEJASWI REDDY

MEDICATION RECONCILIATION FORM

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

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

Shifting From: ....ER........ Shifted to: ....ER........

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

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : ....Dr. maipunya.....

Date & Time : ....25/5/26 @ 2:30PM....

Nurse Name & Signature: ....Amrfam....

Date & Time : ....25/5/26 @ 2:25PM....

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

PATIENT TRANSFER FORM

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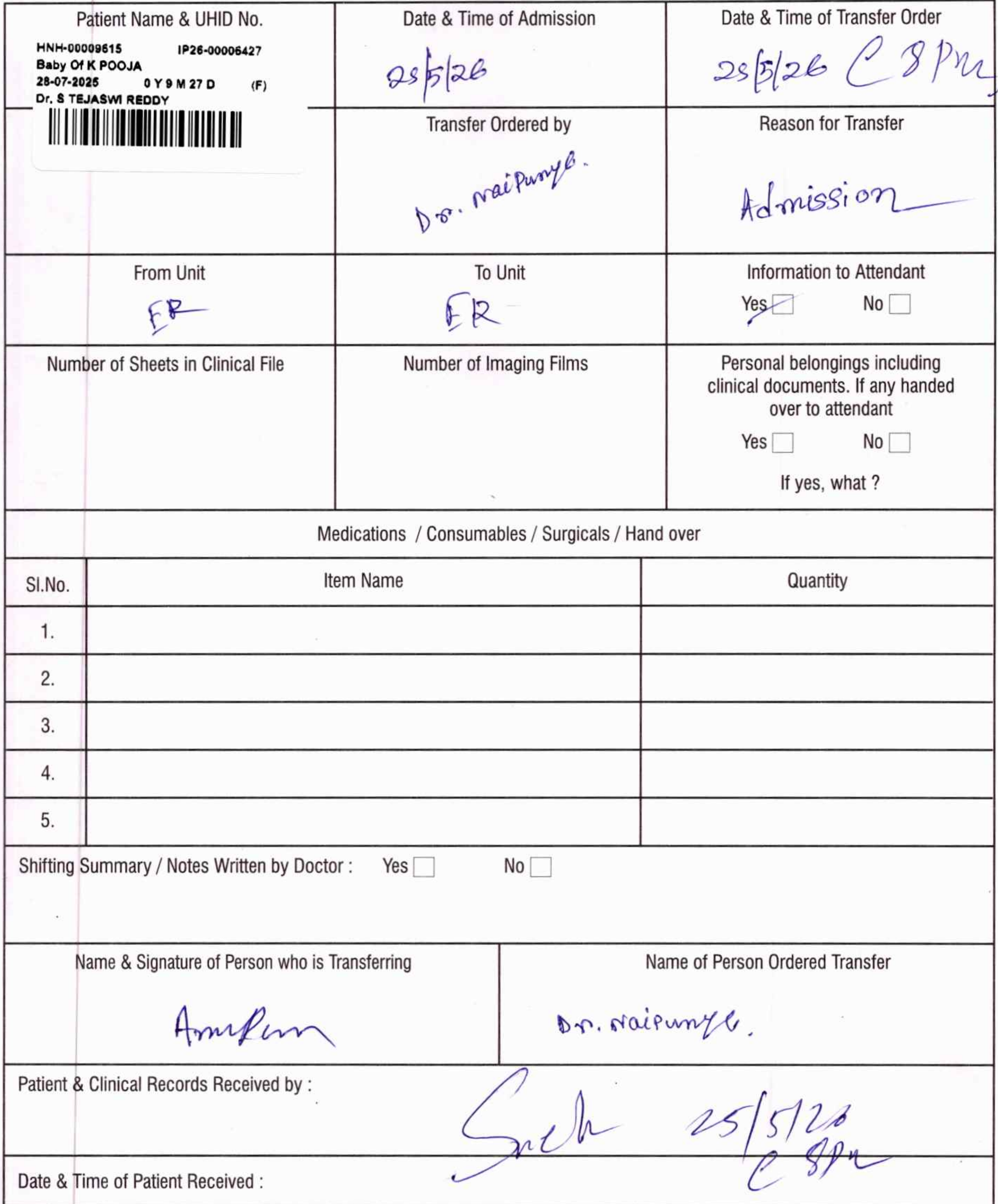

Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00009615 IP26-00006427 Baby Of K POOJA 28-07-2025 0 Y 9 M 27 D (F) Dr. S TEJASWI REDDY	25/5/26	25/5/26 @ 8 PM
	Transfer Ordered by	Reason for Transfer
	Dr. Naipunya.	Admission
From Unit	To Unit	Information to Attendant
ER	ER	Yes ☑ No ☐
Number of Sheets in Clinical File	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

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

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
[illegible]	Dr. Naipunya.

Patient & Clinical Records Received by : [illegible] 25/5/26

Date & Time of Patient Received : @ 8pm

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

Docu. No. : RCH /FRM / CLINICAL / 102

HNH-00009615 IP26-00006427
Baby Of K POOJA
28-07-2025 0 Y 9 M 27 D (F)
Dr. S TEJASWI REDDY

wt. 6.68 kgs

EMERGENCY ROOM TRIAGE FORM

Patient's Name : B/O K pooja Age : 9 months **Gender:** ☐ Male ☑ Female

Date : 25/05/26 Time of Arrival : 2:05 PM

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

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

Mode of Arrival : ☑ Ambulatory ☐ Wheelchair ☐ Ambulance

Initial Vital Signs: Temp: 97 F PR: 117b/m BP: .... RR: SpO2: 98%

Chief Complaints: c/o fever since yesterday cough on/off 2 months

INITIAL PHYSIOLOGICAL CATEGORIZATION

Appearance
☑ Normal
☐ Sick Looking

Circulation / Colour
☑ Normal ☐ Abnormal ☐ Bleeding

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

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

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

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

Signature of Parent / Guardian

* CTAS - Canadian Triage and Acuity Scale

Triage Completion Time : ....

Communicable Disease Triage Screening

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

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

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

1. Have you travelled outside the INDIA? or had close contact with someone who has recently travelled outside the INDIA, in the past two weeks? ☐ Yes ☑ No

   If yes, State Location: ....

2. Are your parents / close contacts at home is/a healthcare worker? {please encircle the choices} (e.g., nurse, physician, ancillary services personnel, allied health services personnel, hospital volunteer, or laboratory worker, others) who has had a recent exposure to an individual with a highly communicable disease or unexplained, severe febrile respiratory or rash disease? ☐ Yes ☑ No

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

☐ Any patient with Fever / Rash / Vesicles / Discharge from E and Cough

☐ Any patient with fever and respiratory symptoms who ans "YES" to any of the questions on epidemiologic risk fact "PART B" of the triage screening above.

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

☐ Patients should be immediately isolated in a negati room or a single room (as appropriate) for pendin

☐ The patient should be given a surgical mask imm already wearing one.

☐ Both patient and triage staff should perform ha

☐ The staff should use PPE (as appropriate).

Name of Triage Nurse : Shirisha Signature of Triage Nurse : S

Date & Time : 25/05/26 @ 2:07 AM

Docu. No. : RCH /FRM / CLINICAL / 085

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 25/05/26 Time of arrival : 2:09pm

Chief Complaints: c/o fever since yesterday cough on/off 2 months RBS: ....

Height : .... Weight : 6.68kg BMI : .... Head Circumference (<2 years) ....

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

If yes , identify ....

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

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

RISK FOR FALL:

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

☐ If Patient is > 6 years
Assess the below parameters

History of Falling: within past 3 months	☐ Yes	☒ No
Ambulatory Aids:		
• Wheelchair	☐ Yes	☒ No
• Uses furniture for support	☐ Yes	☒ No
Gait/Transferring:		
• Bedrest / immobile	☐ Yes	☒ No
• Weak	☐ Yes	☒ No
• Impaired	☐ Yes	☒ No
Mental Status: Forgets limitations	☐ Yes	☒ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening: ☒ No Abnormalities Detected

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

Inform consultant for positive criteria

....

....

Nutritional Screening: ☒ No Abnormalities Detected

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

Inform consultant for positive criteria

Psychological Screening: ☐ No Significant Findings

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

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

Social History: Lives With family

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

Time of Initial assessment completed by ER Nurse : @2:12pm

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

Time	Nursing Notes
2:14 pm	Asses the patient condition monitor the vital sign

Samples collected by: / Time: /

Samples sent by : Aparna Time: 2:30pm

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: 131 BP: .... CFT:	Shift - out from ER to: 220
RR: .... SPO_2 : 100	Time of Shift - out: 8:20 pm
GCS: .... Temperature : 98	Handover given to: .... (Nurse's Name)
Pain Score:	
Repeat RBS (if applicable):	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any): ....

....

Name of the Nurse : Shirisha Signature of the Nurse : [signature]

Date & Time : 25/05/26 @ 2:16pm

HNH-00009615 IP26-00006427
Baby Of K POOJA
28-07-2025 0 Y 9 M 27 D (F)
Dr. S TEJASWI REDDY

220

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

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Your Right to a Safe Delivery

NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 26/5/26 Time: 9:55am

Weight: 6.68Kg Centile: 5th

Height: — Centile: —

Inference: Underweight child

RDA: — Calories: 0.98 Kcal/Kg/day Protein: 1.6 gms/Kg/day

Diet Recommendations: Semisolid foods with liquids

Re-Assesment: No spicy, Oily, Cold items food

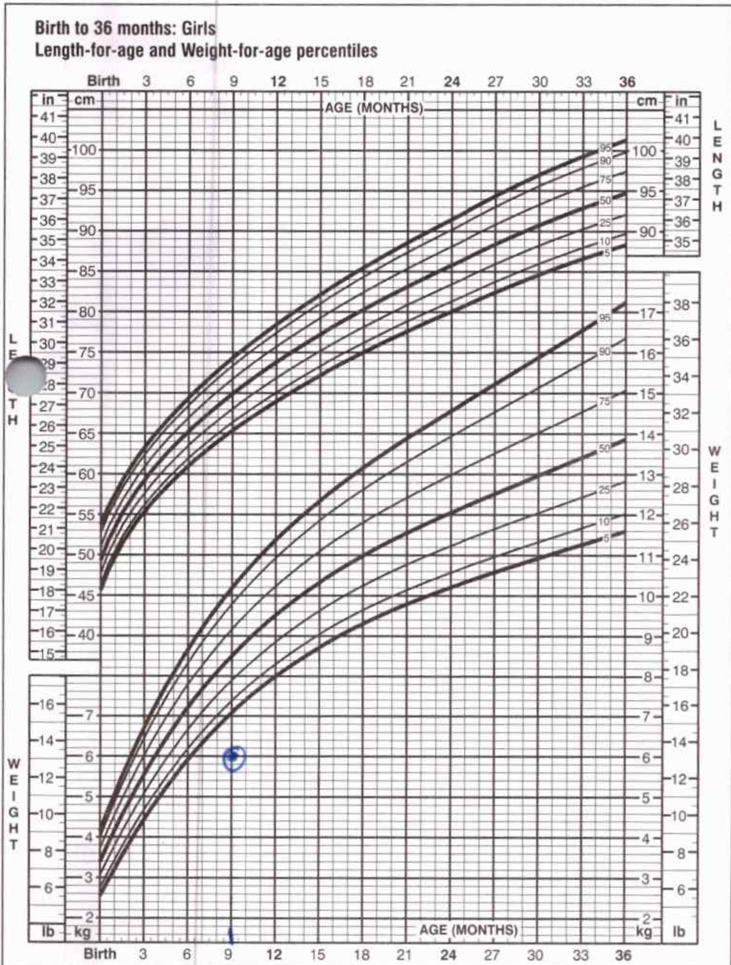
Food Allergies: NO FA Veg/~~Non-veg~~: Veg

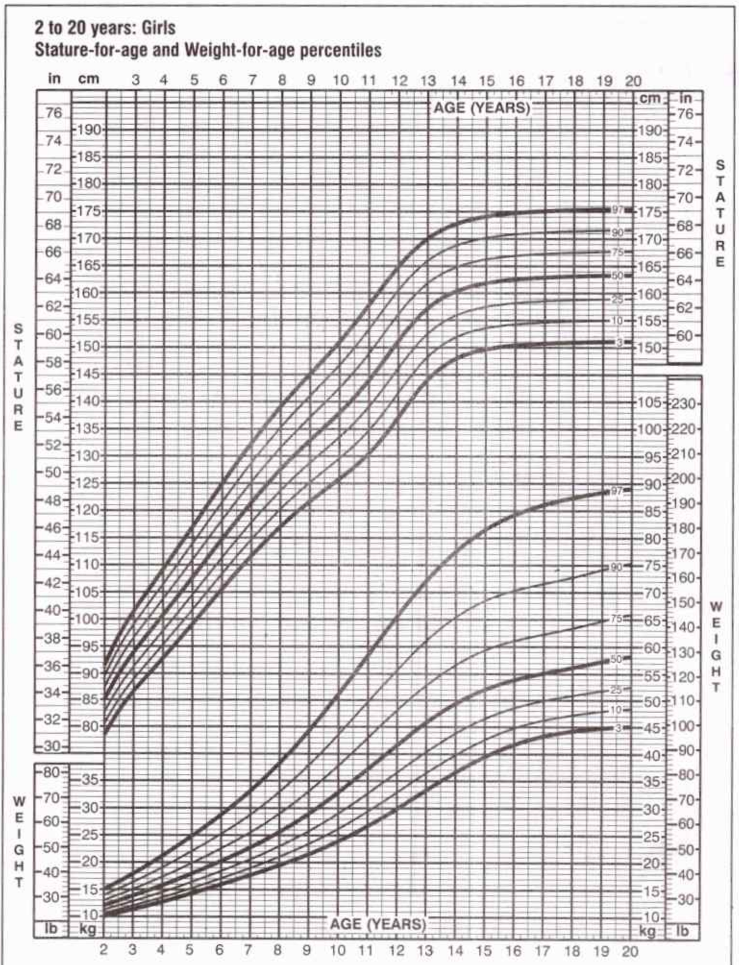
Diagnosis: AF I c̄ severe dehydⁿ pneumonia c̄ RD

Nutritional Intervention - ☑ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: [signature]

GROWTH CHART (GIRLS)





Dietician's Name: Syeda Sobiya Zaheer

Dietician's Signature: Sobiya