218
FC

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

DISCHARGE SUMMARY

Name	Master UG BHARGAV AKHIL	**UHID**	BAH-00310898
Father/Guardian	Mr U G RAMANJANEYULU	**Age/Gender**	11 Y 2 M 7 D/ Male
Address	1-2-606/145,BANDI MAISAMMA NAGAR,INDIRA PARK, Gandhi Nagar, Hyderabad, Telangana, INDIA, 500380		
IP No	IP26-00006855	**Admission Date**	15-07-2026
Ref Doctor	SELF		
Discharge Date	18.07.2026		

Consultant:
Dr. ANIKET ANIL PARASHAR
MBBS - MD
TSMC/FMR/08568, dr.aniket.p@rainbowhospitals.in

DIAGNOSIS	ICD CODE
SEVERE ACUTE ABDOMINAL PAIN	
ACUTE GASTRITIS WITH DEHYDRATION	

History: Master UG BHARGAV AKHIL, 11 Y 2 M 7 D , old boy presented with history of multiple episodes of vomitings and pain abdomen since 3 days, abdominal distension since 1 day prior to admission. For the above complaints he was admitted at Rainbow Children's Hospital - for further management.

Outside investigations: Done on 14.07.2026: CBP showed Hemoglobin - gm%, White blood cells - cell/cmm, Platelets - lakh/cmm, C-Reactive Protein - 12.9 mg/L, Erythrocyte Sedimentation Rate - 29 mm/1st hr.

Name	Master UG BHARGAV AKHIL	UHID	BAH-00310898
IP No	IP26-00006855	Admission Date	15-07-2026

Examination: He was afebrile, maintaining saturations at room air and was hemodynamically stable. His heart rate was 98 /min, Blood pressure - 107/77 mmHg and Respiratory Rate - 24 /min. Capillary Refill Time was <2 secs. Peripheries were warm & pulses well felt. On examination signs of dehydration were present in form of dry lips & oral mucosa, delayed skin turgor, decreased urine output, dull looking, tachycardia, sunken eyes, flushing, throat congested. On auscultation, air entry was bilaterally equal with bilateral wheeze & occasional crepitations were present. Heart sounds were normal and there was no murmur. Abdomen was soft with no organomegaly with tenderness in RIF region.
On neurological examination, he was conscious and alert. Pupils were bilaterally equal and reacting to light. There were no focal neurological or cranial nerve deficits. There were no signs of raised intracranial pressure.

Weight on admission: 46.8 kilo grams.

Investigations: Enclosed reports.

VBG showed pH of 7.37, pCO2 of 44.5 mmHg, pO2 of 41 mmHg, HCO3 of 24.4 mmol/L and BE of 0.4 mmol/L.

Initial hemogram showed Hemoglobin of 12.4 gm%, White Blood Cell count of 4850 cells/cumm, platelet count of 2.59 lakhs/cumm and C-Reactive Protein of 8.0 mg/l. Serum Creatinine was 0.6 mg/dl.

Ultrasound abdomen showed
* Severe probe tenderness noted in the RIF. Appendix could not be visualised due to bowel gas and thick abdominal wall. However no obvious collection in the RIF at present.

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CECT Abdomen was normal.

Management: He was admitted in the ward, kept NPO and was started on Intra Venous fluids and Intra Venous antibiotics.
He was treated symptomatically with antacids and antipyretics.

In view of pain abdomen and RIF tenderness, Dr. Jyothi (Paediatric Surgeon) consultation was done who advised for CT scan and conservative mangement. After CECT abdomen was normal, and abdominal pain persisted, plan for Meckel scan later on follow up.

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

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

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

Medication during hospital stay:
Injection. Pantop
Injection. Ondem
Injection. Ceftriaxone
Syrup. Smuth
Tablet. Paracetamol

Name	Master UG BHARGAV AKHIL	UHID	BAH-00310898
IP No	IP26-00006855	Admission Date	15-07-2026

Mu out powder
Syrup. Sucralfate

Advice:
* Diet as advised.

S.No	MEDICATION	DOSE	TIMINGS	DURATION
1	Tablet. Cefixime (200mg)	1 tablet	8am - 8pm (after food)	For 4 days.
2	Tab. Pantoprazole (40mg)	1 tablet	7am (before breakfast)	For 4 days
3	Syrup. Smuth	15 ml	10 pm	For 5 days.
4	Muout powder	4 scoops in 200 ml of water	10pm (after food)	For 15 days
5	Syrup. Sucralfate	6ml	thrice daily	For 3 days

Plan: To do Meckel scan later if symptoms reoccur.

Fever Management
* Tablet. Paracetamol - 500mg, 1 tablet after food as and whenever required, if temperature > 100 *F (maximum 4 times a day at 6 hour intervals).
* Tepid sponging if fever > 101 *F.

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Review consultation with Dr. ANIKET ANIL PARASHAR on Monday(20.07.2026) at Himayatnagar in OPD with prior appointment **(Review consultation will be charged)**.

Food instructions while taking medications:

* **Antibiotics** along with food & milk products prevent their absorption of drugs & supplements. Antibiotics can be given 1 hour before food or 2 hours after food based on tolerance of stomach.
* **Anti ulcer drugs** can decrease the absorption of Iron&vit-B12. Anti ulcer drugs can be taken at least 1 hour before food (OR) 2hrs after food. Avoid caffeine that increases stomach acidity.
* **Laxatives** may deplete/decrease absorption of fat soluble vitamins A,D,E & K. Laxatives can be taken One hour before food or 2 to 4 hours after food & recommended diet to be followed.

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

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

Parent/ Attender

In case of emergency contact 9154865030 emergency pediatrician on duty.

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To take appointment for OPD consultation at Rainbow **Banjara Hills /** Rainbow Clinic **Madhapur / Kukatpally / Vikrampuri / LB Nagar /** dial just one toll free number **18002122.**
You can also take appointments at any time by going **online** to our website **www.rainbowhospitals.in**

Registrar/Resident/C.M.O

Dr. ANIKET ANIL PARASHAR
MBBS - MD
TSMC/FMR/08568, dr.aniket.p@rainbowhospitals.in

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 : IP26-00006855 **Admit Date** : 15-Jul-2026 **Admit Time** : 08:01 PM **UHID** : BAH-00310898

Patient Details :

Patient Name	: Master UG BHARGAV AKHIL	**Age**	: 11 Y 2 M 6 D
Guardian	: Mr U G RAMANJANEYULU	**DOB**	: 09-05-2015
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: 1-2-606/145,BANDI MAISAMMA NAGAR, INDIRA PARK Gandhi Nagar Hyderabad Telangana INDIA 500380	**Phone No**	: 9948880546
		E-mail	: INFO@RAIN.IN

Admission Details :

Bed Type : DAY CARE **Bed No** : ER03 **Ward Name** : GF -EMERGENCY

Room No : ER03 **Admission Type** : First Visit

Contact Details :

Name : Mr U G RAMANJANEYULU **Relationship** : S/O

Contact Address : 1-2-606/145,BANDI MAISAMMA NAGAR,INDIRA PARK Gandhi Nagar Hyderabad Telangana INDIA 500380 **Phone No** : 9948880546

Signature

Doctor Details :

Doctor Name : Dr. ANIKET ANIL PARASHAR **Specialisation** : GENERAL PEDIATRICS

Referral Doctor : SELF **Phone No** :

Co-Consultant :

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash **Payor Name** : SBI General Insurance Company Ltd

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Master UG BHARGAV AKHIL
09-05-2015 11 Y 2 M 6 D (M)
Dr. ANIKET ANIL PARASHAR

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ACTIVITY RECORD FOR BILLING

Name: Master Bhargav.

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

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

Room / Bed No : 218 Ward : Ward Boy. Suggested Billable bed type : ----------

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
15/7/26	8:45pm.	ER	218.	

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1.	Dr. Jyothi	16/7/26	14365	
2.	Dr' Jyothi	17/7/26	14634	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Cross check done

IP26-00006855
Master UG BHARGAV AKHIL
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Dr. ANIKET ANIL PARASHAR

INVESTIGATIONS

Date	Investigations	Order No.	Sign
15/7/16.	CRP		
	CRP	11806.	
	Sr. creatinine		
	HBG	11805	
16/7	USG abdomen	8597.	
16/7	CT whole Abd Contrast	8614	

Cross checked done by Sneha

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MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
15/7/26	Infusion Pump	9:30pm	17/7/26 11:30	4165	
			Cross	Checked done	

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PROCEEDURE

Date	Proceedure		Order No.	Signature
16/7/26	IV placement	1	14158	
16/7/26	NHA	1	4266	
				cross checked done by Sr
16/7/26	IV placement	1	14506	sandhya

ANY OTHER INFORMATION

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

Ref.No. F/IN/PR/10

Rainbow® Children's Hospital

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name : Bhargbav Akhil

Patient ID# : BAH-00310898 IP26-00006855
Master UG BHARGAV AKHIL
09-05-2015 11 Y 2 M 6 D (M)

Consultant : Dr. ANIKET ANIL PARASHAR

Final Diagnosis :

Pediatric Multiorgan History & Physical Examination

Name : Bhargav Age/Sex

Informant Reliability

Chief Presenting Complaints & Duration (Chronologically):

c/o multiple vomiting since 3 days
c/o pain abdomen since 3 days.
c/o abdominal distension since yesterday.

History of present illness :

- Child presented with c/o multiple vomiting since 3 days, containing food particle. Non bilious non projectile., not blood stain.

- c/o pain abdomen since 3 days, squeezing type localising @ Right iliac fossa.

- c/o abdominal distension since yesterday.

Outside (14/7).

TC = 13.5

N/L = 75/20

CUE - (N)

ESR = 29

CRP = 12.9

USG RT IF - Probe tender (+).

Pediatric Multiorgan History & Physical Examination

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

Birth & Neonatal History :

Birth & Socio Economic History :

About Father :

About Mother : Not significant

Any additional Information :

Developmental History :

Appropriate

Immunization History :

Up to date

Anthropometry

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

Weight (kgs) 46.8 kg (Centile _____)

On Examination :

Temperature : Afebrile. Pulse Rate: 98 Description _____

B.P. 107/77 (87) MAP. SPO2 100%. at _____

Resp. rate and type of breathing : _____

Sign of dehydration (+).

Rash _____

Lymphadenopathy _____

Oedema : _____

Respiratory system :

Inspection (any s/o distress) : _____

Air entry & breath sounds : Bl AE (+)

Any addes sounds : NVBS (+)

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

Cardiovasclular System :

Inspection of procordium : _____

Heart Sounds : S1 S2 (+)

Any murmur : No

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

Per Abdomen :

Inspection _____

Palpation : Abd. distended (+)

Ausculation : Tenderness present (+) RIF.

Spine: _____ External Genitelia : _____

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

Central Nervous System :

Level of Consciousness : AVPU/GCS Score : 15/15

Cranial Nerves :

Motor System :

Nutrition : N

Tone : Power

Co-ordinator :

Posture :

Involuntary Movements :

Reflexes :

DTR N **Superficials :**

Plantars

Sensory System :

N

Bladder / Bowel :

Clinical Summary & Diagnostic :

Acute pain abdomen . c dehydrat

(R/o Acute Appendicitis)

of the treatment :

Acute hypovolemia

Desired goals of the treatment :

Planned Labs :

CBC, CRP, VBG, Creatinine

[Surgical profile → take & w/H] 13/6/T

[XRay Abdomen] if vitals (N) wait → plan.
CT Abd & contrast

Planned Management :

inj. CEFTRIAXONE
IVF
Inj. Pan
inj. ONDEm
inj. Paracetamol
Keep NBM
Paed Surgeon (Dr. Jyothi) Opinion (Informed)
Ag Monitor Hourly (@ umbilicus level) - 8 cm

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. Aniket P on whose name the patient is being referred

Doctor's Signature Name _____ Date 15/07/26 Time _____

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Master UG BHARGAV AKHIL
09-05-2015 11 Y 2 M 6 D (M)
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16/2/26, 8.15 pm.	c/s/by. Dr. Anuche	
	Acute pain abdom.	
		Plan
	Pain abdon (+)	- N/PO
	P/A distended abdem ↓	- CT Abd & contrast (plan)
	RIF - tenderness (+).	- Inj CEFTRIAXONE in fluids.
	vital stable	- Inj PANTOP
	AG - 79 cm.	- Inj ONDEM
		- I/o chest, BP
		- Paed Surgn (Dr Jyothi)
		- AG Monitor Outs. (Inform if >2cm change)
	Af	

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
16/7/26 10 AM	S/B Dr. Aniket	
	Acute pain abdomen ↓ evaluation	
	USG abdomen (verbal report) → WNL	Adv
	Afebrile	• CT scan abdomen now (with oral + IV contrast)
	Tenderness in Rt iliac fossa ++	• Paediatric surgery (Dr. Jyoti) reference following that
	O/E vitally stable	• Ct NPO
		• Ct IVF
		• PAC
		NB Sneha e 10 AM
	Dr. ANIKET PARASHAR Reg. No: 06568	Dr. Aniket

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

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Master UG BHARGAV AKHIL
09-05-2015 11 Y 2 M 6 D (M)
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16/5/26 2pm	S/B. Dr. Archana Acute pain abdomen ↓ evaluation. CT abdomen report - awl Afebrile NPO. U/O - maintained USG is s/o fecal impaction (+) o/e vitally stable. s/e P/A : soft, tenderness in RIF (+)	Adv. ~~Enema~~ (Proctoclysis 100ml) P/R stat. Break NPO after enema (evacuation of bowels) · Ct RL F. · Ct Ceftriaxone. · Ct rest same. NB Sedia c 2 Pk

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16/7/26 ·	S/B Dr. Aniket	
6pm	Δ: Acute Gastritis c̄ dehydration.	
	oral acceptance - fair	Adv -
	Afebrile	◦ Continue Smuth syrup
	Pain per abdomen ⊕	◦ Add mu-out powder
		◦ oral cyclopam (SOS)
	o/e	◦ ~~Inj~~ oral PCM every Q8 hourly
	vitally stable.	· Ct IVF (½) mtx.
		· Pediatric surgery reference (y/m)
		· Start soft diet.
		NB Snehe [signature]
	Dr. ANIKET PARASHAR Reg. No. [illegible]	
		[signature] Dr. Aniket P

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Master UG BHARGAV AKHIL
09-05-2015 11 Y 2 M 6 D (M)
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	C/O/S: Dr. Subash / O. Thanvi	
17/07/26 7 AM		
	Acute Gastritis with dehydration	
	pain abdomen ↓	
	Afebrile	
	No fresh concerns	
	O/E: vitals stable	
	Hydration - good	
		Adv
	S/E: NAD	✓ Cont. Murut powder
		✓ Cont. Smuth Syrup
		- Paed surgeon reference
		- Rest continue same
		Subash
		NB - Supriya 7:36 AM @ 17/7/26

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

(P.T.O)

BAH-00310898 IP26-00006855
Master UG BHARGAV AKHIL
09-05-2015 11 Y 2 M 8 D (M)
Dr. ANIKET ANIL PARASHAR

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
18/7 7:00AM	c/s/13 POD. Naipuya	POD-Archana
	Acute Gastritis	C dehydration
	No pain abdomen	Plan
	oral intake fair	- Discharge today
	vitals - Stable	- Encourage orally
		- Cont Ceftriaxone
		Advf.
		noted by Sr. Sandhya 18/7/26.
18/7 9:40AM	c/o/w Dr. Aniket.	Plan 1) D/c Today P/V/P monthly 2) Syp Combiflam Paracet Tab Cefixime

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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CROSS CONSULTATION FORM

Doctor Name: Dr- ANIKET Date: Time:

Diagnosis:

Hospital:

Referred for: ☐ Opinion ☐ Co-Management ☐ Transfer of care

Type of Referral :
☐ Emergency
☐ Urgent
☐ Non Urgent

Reason for Referral : If for concurrent care specify the particular need, especially in the absence of a second diagnosis:

Signature:

Findings and Recommendations : S/B Dr Jyoti

- Many thanks for ref.
- Case capsule noted.

1dyr Mlle, Pain in abd
P/A- Tenderness, rebound (+), No rigidity.

Adv
- CBC & RFT & LFT reports
- NPO

Consultant :
Name : Dr Jyoti Bala Signature : Date & Time : 16/7/26 11:30 AM

S/B Dr Jyothi

12/7/26
11:30 AM

C/o pain
post head.

Plan

CECT-report
↓
WNL

- Add Sucralfate
×7 days
- Plan for
MEEKEC's scan after
today if pain persists.

Bottles
Dr Sylvia

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DRUG CHART

Date of Admission: 15/7/26 Drug Allergies: Nil ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

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

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

SOS / PRN (As Required Medication)

DRUG : Tab PARACETAMOL.				Date / Time
Dose	Route	Frequency	Start Date	
500mg	iv	SOS	15/7/26	
Doctor's Signature	Valid Period	Pharm.		
Af				
Additional Instructions: (4 pain)				

DRUG : Tab DICYCLOMINE				Date / Time
Dose	Route	Frequency	Start Date	
1 Tab	PO	SOS	16/7/26	
Doctor's Signature	Valid Period	Pharm.		
Af	-			
Additional Instructions: (20 mg)				

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

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

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Dr. ANIKET ANIL PARASHAR

REGULAR PRESCRIPTIONS

Weight. 46 kg Ward. .....

DRUG : Inj PANTOP

Dose	Route	Frequency	Start Date
40mg	iv	OD	15/7

Name & Signature of the Doctor Starting the Drugs: AP

Additional Instructions: (PANTOPRAZOLE)

Daily Doctor's Endorsement by a Sign

Date/Time	15/7	16/7	17/7	18/7
	10:30			
6AM				

DRUG : Inj ONDEM

Dose	Route	Frequency	Start Date
4mg	iv	TID	15/7

Name & Signature of the Doctor Starting the Drugs: AP

Additional Instructions: (ONDANSETRON)

Date/Time	15/7	16/7	17/7	18/7
6AM	x			
2pM	x	6pM		
10pm				

DRUG : Inj CEFTRIAXONE.

Dose	Route	Frequency	Start Date
2g	iv	BD	15/7/24

Name & Signature of the Doctor Starting the Drugs: AP

Additional Instructions: 2g in 50cc NS over 1 hour.

Date/Time	15/7	16/7	17/7	18/7
10am	x			
10pm		10:30		

Daily Doctor's Endorsement by a Sign

DRUG : Syp SMUTH

Dose	Route	Frequency	Start Date
15ml	PO	H/S	16/7

Name & Signature of the Doctor Starting the Drugs: AP

Additional Instructions:

Date/Time	16/7	17/7
10pm		

Daily Doctor's Endorsement by a Sign

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REGULAR PRESCRIPTIONS

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

DRUG : Tab. PARACETAMOL

Dose	Route	Frequency	Start Dt.
1 tab	PO	TDS	16/7/26

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:
(500 mg)

Daily Doctor's Endorsement by a Sign

Date / Time	16/7	17/7	18/7
6am	X		
2pm	X		
10pm			

DRUG : MV-OUT powder

Dose	Route	Frequency	Start Dt.
4 scoops	PO	H/S	16/7/26

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:
4 scoops in 200 ml water

Daily Doctor's Endorsement by a Sign

Date / Time	16/7	17/7
10pm		

DRUG : SYP. SUCRALFATE

Dose	Route	Frequency	Start Dt.
6ml	oral	TID	17/7

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time	17/7	18/7
6AM	X	
2pm		
10pm		

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

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

Patient Sticker

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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														

Signature

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														

BAH-00310898 IP26-00006855
Master UG BHARGAV AKHIL
09-05-2015 11 Y 2 M 6 D (M)
Dr. ANIKET ANIL PARASHAR

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

DRUG :	Date➤ Time		Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.
		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
16/7/26	2pm	PROCTOCLYSIS ENEMA.	(100ml) stat	P/R	Sd	

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

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Master UG BHARGAV AKHIL
09-05-2015 11 Y 2 M 6 D (M)
Dr. ANIKET ANIL PARASHAR

I.V. FLUIDS CHART

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

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
15/7/26	5pm.	IV fluids ~~DNS~~ 400ml (full) plasmolyte + 25% D 100ml	iv	60 ml/hr	AJ.	✓			✓
						✓			✓
16/7/26	6pm		↓	30 ml/hr	AJ.	✓			
						✓			

Signature .....

VERIFIED BY : Name .....

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Dr. ANIKET ANIL PARASHAR

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RESULT SHEET

Date	5/7/26					
Time						
Hb	12.4					
PCV	35.3					
RBC	4.92					
WBC	4.85					
N/L	43.5/44					
Platelets	259					
CRP	8					
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine	0.6					
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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09-05-2015 11 Y 2 M 6 D (M)
Dr. ANIKET ANIL PARASHAR

IICAL / 126

SCHOOL AGE (5-12 years)
Children's Observation & Early Warning Scoring Chart

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 13/9/26 Time:	10	2	6
Doctor / Nurse / Family Concern?	PM	AM	AM

Temperature (F)

104 103 102 101 100 99 98 97 96 95 94

97.3°F 97.1°F 98.4°F

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

Note: BP does not score in early warning scoring

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

107 (77) 63 103 (76) 64 100 60

Heart Rate (Number)	113b/m	110b/m	112b/m

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

70 60 50 40 30 2 1

Resp Rate (Number)	26 b/m	26b/m	25b/m
Resp Distress: Mod/ Severe / None / Mild			
Receiving O_2(l/min) O_2Saturations (%)	100 %	99%	99%
Conscious Level: Normal / Altered			
GCS *	15/15	15/15	15/15
TOTAL SCORE Number of shaded boxes	0	0	0
Pain Score	0	0	0
Observer's Initials	SA	SA	SA

ACTIONS

NB: Scores 3 should be recorded overleaf

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

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

Patient Sticker

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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)

AH-00310898 IP26-00006855
Master UG BHARGAV AKHIL
09-05-2015 11 Y 2 M 6 D (M)
Dr. ANIKET ANIL PARASHAR

Patient / CLINICAL / 126

SCHOOL AGE (5-12 years)

Children's Observation & Early Warning Scoring Chart

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 16/7

Time:	10am	2pm	6pm	10pm	2 AM	6 AM
Doctor / Nurse / Family Concern?						
Temperature (F)	98.2°F	97.2°F	97.7F	97.3°F	97.6°F	97.1°F
Heart Rate (bpm) and Blood Pressure (mmHg) *	101/62 (82)	100/62 (82)	100/65 (68)	105/70	109/67 (75)	102/63 (79)
Heart Rate (Number)	102b/m	108	100b/m	105b/m	109b/m	102b/m
Resp. Rate (bpm) (Over 1 Minute) *					*	*
Resp Rate (Number)	24	24	22b/m	25b/m	26b/m	24b/m
Resp Distress (Mod/ Severe / None / Mild)						
Receiving O_2(l/min) / O_2Saturations (%)	100%	99%	99%.	99%	100%	99%
Conscious Level (Normal / Altered)						
GCS *	15/15	15/15		15/15	15/15	15/15
TOTAL SCORE Number of shaded boxes	1	1	1	0	0	0
Pain Score	0	0	0	0	0	0
Observer's Initials	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

Note: BP does not score in early warning scoring

Temperature scale: 104, 103, 102, 101, 100, 99, 98, 97, 96, 95, 94
Heart rate / BP scale: 190, 180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60, 50
Resp. rate scale: 70, 60, 50, 40, 30, 20, 10

ACTIONS

NB: Scores 3 should be recorded overleaf

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

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

Patient Sticker

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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)

BAH-00310898 IP26-00006855
Master UG BHARGAV AKHIL
09-05-2015 11 Y 2 M 6 D (M)
Dr ANIKET ANIL PARASHAR

Patien

/ CLINICAL / 126

SCHOOL AGE (5-12 years)

Children's Observation & Early Warning Scoring Chart

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 17/7 Time: 10AM 2PM 6 PM 9PM 6AM

Doctor / Nurse / Family Concern?

Temperature (F)

104 103 102 101 100 99 98 97 96 95 94

98.3F 98.7F 99.1F 97.4F 98.5F 97.4F

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

Note: BP does not score in early warning scoring

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

99 95 101 102 109 99

60 61 63 70 60 62

Heart Rate (Number) 108/m 98/m 98/m 99/m 105/m 103/m

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

70 60 50 40 30 2 1

Resp Rate (Number) 22/m 28/m 28/m 29/m 23/m 25/m

Resp Distress	Mod/ Severe / None / Mild

Receiving O_2(l/min)
O_2Saturations (%) 100% 100% 99% 99% 99% 99%

Conscious Level	Normal / Altered

GCS * 15 15 15 15

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

ACTIONS NB: Scores 3 should be recorded overleaf	
	Score 1 : Continue normal observation by staff nurse
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* 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.

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

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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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Master UG BHARGAV AKHIL
09-05-2015 11 Y 2 M 6 D (M)
Dr. ANIKET ANIL PARASHAR

RCH/ FRM / CLINICAL / 126

SCHOOL AGE (5-12 years)

Children's Observation & Early Warning Scoring Chart

Rainbow® Children's Hospital
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ARLY WARNING SCORE: CHILDREN'S UNIT

Date : ..... Time:																																	
Doctor / Nurse / Family Concern?																																	
Temperature (F)	104																																
	103																																
	102																																
	101																																
	100																																
	99																																
	98																																
	97																																
	96																																
	95																																
	94																																
Heart Rate (bpm) and Blood Pressure (mmHg) * **Note:** BP does not score in early warning scoring	190																																
	180																																
	170																																
	160																																
	150																																
	140																																
	130																																
	120																																
	110																																
	100																																
	90																																
	80																																
	70																																
	60																																
	50																																
Heart Rate (Number)																																	
Resp. Rate (bpm) (Over 1 Minute) *	70																																
	60																																
	50																																
	40																																
	30																																
	2																																
	1																																
Resp Rate (Number)																																	
Resp Distress: Mod/ Severe / None / Mild																																	
Receiving O_2(l/min) O_2Saturations (%)																																	
Conscious Level: Normal / Altered																																	
GCS *																																	
TOTAL SCORE Number of shaded boxes																																	
Pain Score																																	
Observer's Initials																																	

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Patient Sticker

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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)

BAH-00310898 IP26-00006855
Master UG BHARGAV AKHIL
09-05-2015 11 Y 2 M 6 D (M)
Dr. ANIKET ANIL PARASHAR

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FLUID CHART

Sheet No. : .....

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

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						**Total Output :**						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						**Total Output :**						
15/7/26	08:00 pm			~~60ml~~							0	
	09:00 pm			60ml							0	
	10:00 pm	Plasmalyte +25% Dex.	N	60ml						✓	0	
	11:00 pm		B	60ml							0	
	12:00 am			60ml							0	
	01:00 am		M	60ml							0	
Total Intake :						**Total Output :** U-					M-	
16/7/26	02:00 am	Plasmalyte +25% Dextrose		60ml							0	
	03:00 am		N	60ml							0	
	04:00 am		B	60ml						✓	0	
	05:00 am			60ml							0	
	06:00 am		M	60ml							0	
	07:00 am			60ml							0	
Total Intake :						**Total Output :** U-					M-	

Total 24 hrs. Intake		Total 24 hrs. Output	

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FLUID CHART

Sheet No. : .....

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

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
16/7	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
16/7	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						Total Output :						
16/7/26	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake : Taken						Total Output : Urine 2 ml						
17/7/26	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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FLUID CHART

Sheet No. : .....

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

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
16/7	08:00 am		Idli + H2O		NA		✓	NA		✓	0	
	09:00 am											
	10:00 am											
	11:00 pm											
	12:00 pm											
	01:00 pm											
Total Intake : Taken						Total Output :						
17/7	02:00 pm		Khichdi + H2O		NA			NA		✓	0	
	03:00 pm										0	
	04:00 pm										0	
	05:00 pm										0	
	06:00 pm									✓	0	
	07:00 pm										0	
Total Intake : Taken						Total Output : U-2 M-0						
17/7/16	08:00 pm		Rice + H2O		NA			NA		✓	0	
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am									✓		
	01:00 am											
Total Intake : Taken						Total Output : U-2 M-						
18/7/16	02:00 am				NA			NA		✓	0	
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am									✓		
	07:00 am											
Total Intake : Taken						Total Output : U-2 M-						

Total 24 hrs. Intake		Total 24 hrs. Output	

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

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

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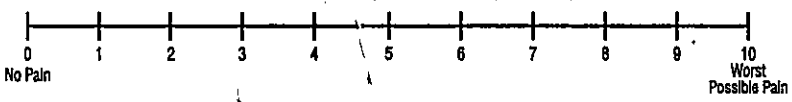
PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
15/7/26	10pm	0/10	Abdomen	☐ Continuous ☑ Intermittent	☑ Acute ☐ Chronic	☐ Sharp ☑ Dull ☐ Aching ☐ Burning	☐ Increasing ☑ Decreasing	☑ Yes ☐ No	NA	
16/7/26	6AM	0/10	Abdomen	☐ Continuous ☑ Intermittent	☑ Acute ☐ Chronic	☐ Sharp ☑ Dull ☐ Aching ☐ Burning	☐ Increasing ☑ Decreasing	☑ Yes ☐ No	NA	
16/7	2pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	NA	
16/7	8pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
16/7/26	10pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
17/7/26	2pm	0/10	NA	☐ Continuous ☑ Intermittent	☑ Acute ☐ Chronic	☑ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☑ Decreasing	☑ Yes ☐ No	NA	
17/7	8pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
17/7/26	10pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
				☐ 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 drawn 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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CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1 15/7			DAY-2 16/7			DAY-3 17/7			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0			0	0	0	0	0	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	0	NA	NA	NA	NA	NA	Cannula Changed 16/7/23 @ 11:30pm
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2			NA	0	NA	NA	NA	NA	NA	
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3			NA	0	NA	NA	NA	NA	NA	
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4			NA	0	NA	NA	NA	NA	NA	
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5			NA	0	NA	NA	NA	NA	NA	
		Signature of the Nurse											

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

Signature of Shift In Charge :
Signature : ..... Name : .....

Signature of Ward In Charge :
Signature : Balamani Name : Balamani

Patient Sticker

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CHECKLIST FOR THROMBOPHLEBITIS

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

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

Signature of Shift In Charge :

Signature : ..... Name : .....

Signature of Ward In Charge :

Signature : ..... Name : .....

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BRADEN 'Q' SCALE

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					Date : 15/7	15/7	16/7/16	17/7/16
					Time : N1	E2	N8	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	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	3	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	4	4
Moisture Degree to which skin is exposed to moisture	**1. Constantly moist:** Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	**2. Very moist:** Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	**3. Occasionally moist:** Skin is occasionally moist, requiring linen change every 12 hours.	**4. Rarely moist:** Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	4
FRICTION-SHEAR **Friction** Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another	**1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	**2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	**3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	**4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	4
Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4
				TOTAL SCORE	28	24	27	28
				Evaluator's Name				

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

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

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BRADEN 'Q' SCALE

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				Date : 18/7	19/7		
				Time : 5PM	NB		
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	3	
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	
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Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	
				TOTAL SCORE	23	23	
				Evaluator's Name			

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

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
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...UMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE 15/7	DATE 16/7	DATE 17/7	DATE	DATE
Age	Less than 3 years old	4					
	3 to less than 7 years old	3					
	7 to less than 13 years old	2	2	2	2		
	13 years old and above	1					
Gender	Male	2	2	2	2		
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1	1		
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own ability	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	2	2	2		
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours/ None	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	1		
	Total		7	7	7		

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

	Bed in low position		✓	✓	✓	
	Call device within reach		✓	✓	✓	
	Wheels Locked		✓	✓	✓	
	Room free of clutter		✓	✓	✓	
	Adequate lighting		✓	✓	✓	
	Wheel chair support		—	X	X	
	Other Intervention(s) Specify		—	X	X	
	Nurse's Name:		[signature]	[signature]	[signature]	
	Signature:		[signature]	[signature]	[signature]	
	Date:		15/7	16/7	17/7	
	Time:		8AM	2P	8P	

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Master UG BHARGAV AKHIL
09-05-2015 11 Y 2 M 6 D (M)
Dr. ANIKET ANIL PARASHAR

NURSING CARE RECORD

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Date: 15/7/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon							
Night	9PM to 8AM	→ To assess the pt. condition → To check the vitals & record → To administer the medication as per drug chart → I/O chart maintain	9PM to 8AM	→ To assessed the pt. condition → To checked the vitals & recorded → To administered the medication as per drug chart → I/O chart maintained	→ Patient is stable → AG 4th hourly → Paed. Surg. opinion	→ Re-checked the vitals → I/O → NBM	Supriya

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Patient

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NURSING CARE RECORD

Date: 16/1/26

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	8Am to 2Pm	Assess the Patient. Monitor the 4th daily. Monitor v/s. Ct IV fluids. Maintain I/O chart	8Am to 2Pm	Assessed the pt. The 4th daily. v/s checked. Ct IV fluids. Maintain I/O chart	Ct IV fluid	Reassessed the v/s	[signature]
Afternoon	2Pm to 8Pm	Assess the Pt condition. Monitor vitals in ren. Maintain I/O chart. Provide the comfortable position. Medication given as per as doctor order.	2Pm to 8Pm	Assessed the Pt condition. Monitored vitals. 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	[signature]
Night	8PM to 8am	→ Assess the patient general condition. → monitor vitals → maintain IV fluids → Administer medications as per doctor's orders	8PM to 8am	→ Assessed the patient general condition → monitored vitals → administered medications as per doctor's orders.	Patient is stable	Rechecked vitals	[signature]

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NURSING CARE RECORD

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Date: 17/7

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8AM 2pm	- Assess the pt. condition - Monitor vitals & records - Maintain I/o chart - Give medication as prescribed by doctor	8AM 2pm	- Assessed the pt. condition - Monitored vitals & records - Maintained I/o chart - Given medication as prescribed by doctor	Patient is stable now	Re-checked vitals	
Afternoon	2pm to 8pm	Assess the pt. Condition monitor vitals & record maintain I/o charting. Provide the comfortable position. medication given Per as doctor orders.	2pm to 8pm	Assessed the pt. condition monitored vitals & recorded maintained I/o charting Provided the Comfortable position. medication given as per as doctor orders	→ pt is stable. → vitals normal	→ Observation given → maintain I/o Chart.	
Night	8pm to 8am	→ Assess the patient general Condition → monitor vitals → Administer medications as Per doctor's orders.	8pm to 8am	→ Assessed the patient general Condition → monitored vitals → administered medications as per doctor's orders.	Patient is stable.	Rechecked vitals	

Patient Sticker

NURSING CARE RECORD

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Date: .....

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon							
Night							

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NURSING SHIFT HAND OVER FORM

SITUATION

Diagnosis: Acute Pain Abdomen

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

Surgery / Procedure:

Post OP Day:

	Date / Shift	15/7/26 N1	16/7	17/7 N1			
BACKGROUND	Medical Condition (Any special condition to be noted):	–	–	–			
	Diet:	NBM	–	–			
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:	98.8°f	98.3f	98.4f			
	Res:	26b/m	22	25b/m			
	SpO_2:	100%	99%	99%			
	Pulse:	112b/m	106	115b/m			
	BP:	106/69	102/72	105/76			
	LOC:	–	–	–			
	Fall Risk Score:	–	–	–			
	Pain Score:	"0"	–	–			
	Skin Integrity	Good	–	–			
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:	NBM	–	–			
	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 :		Supriya	Afzal	Sandhya			
Signature / ID :							
Date:		16/7/26	16/7	18/7/26			
Time:		8Am.	2P	8Am			
Taken Over By Name :							
Signature / ID :							
Date:		16/7	16/7				
Time:		8	2pm				

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NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: Acute Pain Abdomen.			Any Infection: ☐ Yes ☐ No ☑ Not Known If Yes Specify:			
	Surgery / Procedure:			Post OP Day:			
BACKGROUND	Date / Shift	16/7 E	16/7/26 N	17/7 E			
	Medical Condition (Any special condition to be noted):	Acute pain	–	–			
	Diet:	Liquid	–	–			
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Ventilation (RA, NP, NIV, VENTI):	–	–	–			
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:	98.2°F	98.2°F	98.2°F			
	Res:	22 b/m	25 b/m	26 b/m			
	SpO_2:	99%	99%	99%			
	Pulse:	98	82 b/m	98			
	BP:	102/62	105/70	102/62			
	LOC:	–	–				
	Fall Risk Score:	–	–	–			
	Pain Score:	–	–	–			
	Skin Integrity	–	–	–			
Recommendations	Safety Needs:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Physiotherapy:	–	–	–			
	Others Specify:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Special Diet:	–	–	–			
	Critical Lab Test / Values:	–	–	–			
	Other Special Orders / Medications:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	PU Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	DVT Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	ADL (Dependent / Non Dependent):		–	–			
Post Operative Procedure Special Orders:		–	–	–			
Handed Over By Name :		Sanchaya	Sanchaya	Sanchaya			
Signature / ID :		16037		16037			
Date:		16/7	17/7/26	17/7			
Time:		8PM	8am	8am			
Taken Over By Name :		Sanchaya	Sanchaya				
Signature / ID :			16037				
Date:		16/7/26	17/7				
Time:		8am	8PM				

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wt 46.8kg

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EMERGENCY ROOM TRIAGE FORM

Patient's Name : Mast Bhargav Age : 12y. **Gender:** ☑ Male ☐ Female

Date : 15/7/26. Time of Arrival : 7:25pm.

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: 97.6°F PR: 086/m BP: 107/76 mm RR: 26/mt SpO_2: 100

Chief Complaints: C/o Pain Abdominal since 3 days vomiting.

INITIAL PHYSIOLOGICAL CATEGORIZATION

Appearance
☑ Normal
☐ Sick Looking

Circulation / Colour
☑ Normal ☐ Abnormal ☐ Bleeding

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

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

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

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

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian

Triage Completion Time : 7:22pm.

Communicable Disease Triage Screening

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

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

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

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

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

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

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

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

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

Name of Triage Nurse : Afsana

Signature of Triage Nurse : .....

Date & Time : 15/7/26 @ 7:27pm

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 15/7/26 Time of arrival : 2:20pm

Chief Complaints: c/o Pain Abdominal since 3 days RBS: .....

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: ..... Pain Tool Used: ☐ N Pass ☑ FLACC ☐ Wong Baker

☐ Character N/A ☐ Location N/A ☐ Frequency N/A ☐ Duration N/A

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: N/A (Date/Time): N/A

Social History: Lives With Parents

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

Time of Initial assessment completed by ER Nurse : 2:31 pm

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

Time	Nursing N
	Assessed the Patient Condition.
	monitor vitals Done.

Samples collected by: / Anushka Time: / 8:40 Pm

Samples sent by : / Time:

Medication given in ER:

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

Condition of patient at time of shift - out :	**Details of Shift - out**
HR: 98 BP: 107/65 CFT: WNL	Shift - out from ER to: 2 Male 2 Female
RR: 21 SPO_2 : 99%	Time of Shift - out: 8:45 Pm
GCS: 15/15 Temperature : 98.2	Handover given to: Supriya (Nurse's Name)
Pain Score: 2	
Repeat RBS (if applicable): WNL	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

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

.....

Name of the Nurse : Aruna Signature of the Nurse : .....

Date & Time : 15/7/26 8

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MEDICATION RECONCILIATION FORM

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

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

Shifting From: ..... ER ..... Shifted to: ..... 2nd. Floor .....

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. Prasanth. .....

Date & Time : ..... 15/7/26 @ 9PM .....

Nurse Name & Signature: ..... Aruna / .....

Date & Time : ..... 15/7/26 @ 9PM .....

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

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
Mast Bhargav.	15/7/26 @ 8.01pm	15/7/26
Treating Consultant Name	**Transfer Ordered by**	**Reason for Transfer**
	Dr, Prasanth	Ademetion
From Unit	**To Unit**	**Information to Attendant**
ER	2nd Floor	Yes ☑ No ☐
Number of Sheets in Clinical File	**Number of Imaging Films**	**Personal belongings including clinical documents. If any handed over to attendant**
20	—	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
Aruna	Dr, Prasanth

Patient & Clinical Records Received by : Supriya

Date & Time of Patient Received : 9:30pm @ 15/7/26

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

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

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NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 16/7/26 Time: 8:45am

Weight: 46.8 Kg Centile: 75th

Height: — Centile: —

Inference: Well nourished child

RDA: — Calories: 1700 Kcal/day Protein: 30 gms/day

Diet Recommendations: Baby on NPO

Re-Assesment: No Junk, Oily, Spicy food.

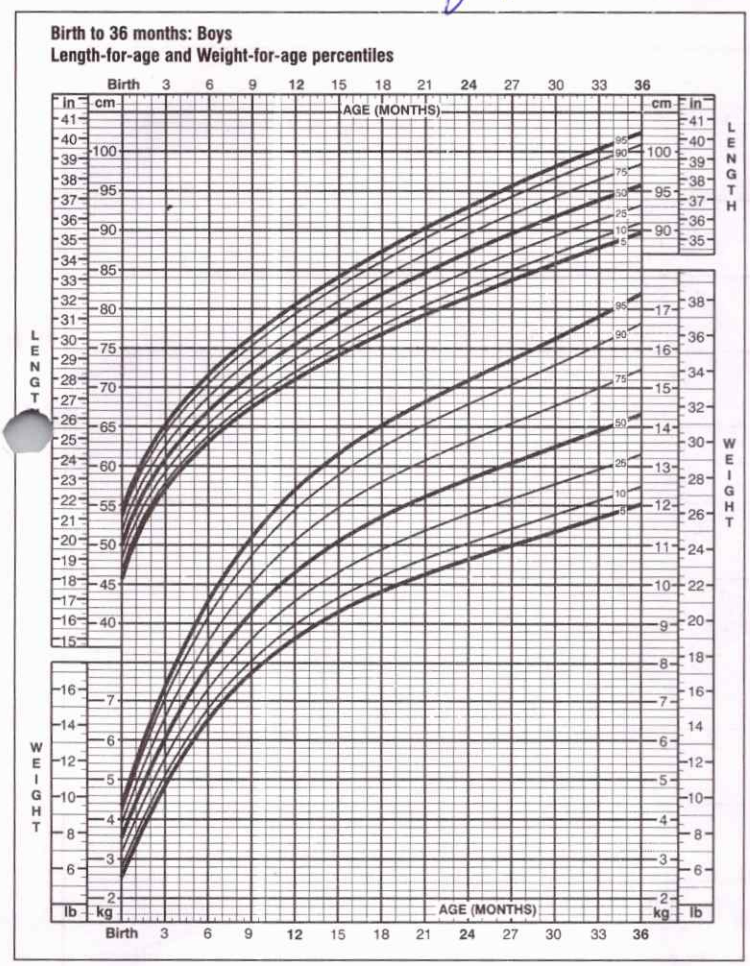
Food Allergies: No Veg/Non-veg Non Veg

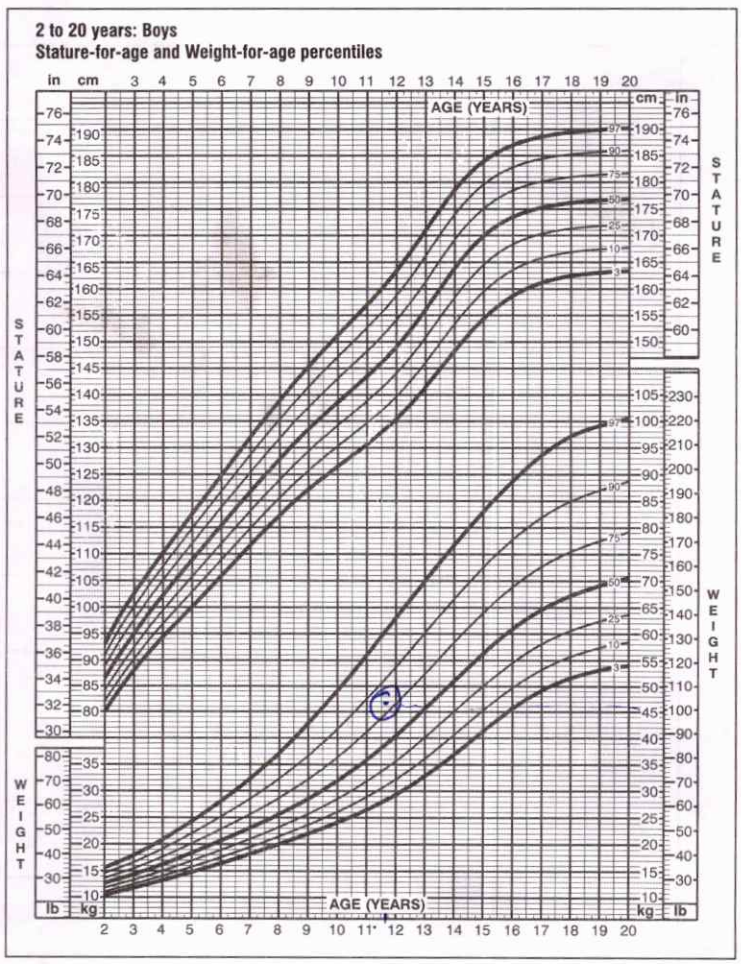
Diagnosis: Acute Pain Abdomen.

Nutritional Intervention - ☐ Oral ☐ Enteral ☐ Parenteral

Patient's Signature:

GROWTH CHART (BOYS)





Dietician's Name Syeda Sabiya Zaheer

Dietician's Signature Sabiya

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

(P.T.O.)

Daily Notes:

17/7/26 child is stable, oral intake poor
1pm encourage orally liquids as advised

Sathvika.S