

210
D.C

DISCHARGE SUMMARY

Name	Baby K. SAI TRISHIKA	UHID	HNH-00002673
Father/Guardian	Mr K. SRAVAN KUMAR	Age/Gender	4 Y 3 M 27 D/ Female
Address	FLAT NO. 406, LEGEND VENKATESHA, Narayanguda, Hyderabad, Telangana, INDIA, 500029		
IP No	IP26-00006474	Admission Date	01-06-2026
Ref Doctor	Self.		
Discharge Date	04.06.2026		

Consultant:

Dr. SINDHURA MUNUKUNTLA
MBBS, DCH, DNB PEDIATRICS
66970

DIAGNOSIS	ICD CODE
IMMUNE THROMBOCYTOPENIC PURPURA (ITP)	

History: Baby K. SAI TRISHIKA, 4 Y 3 M 27 D old girl presented with history of complaining of lesions (multiple ecchymotic spots) of both legs and hands since 3 months, prior to admission. For the above complaints she was admitted at Rainbow Children's Hospital for further management.

Examination: She was afebrile, maintaining saturations / SpO2 of 98% at

Name	Baby K. SAI TRISHIKA	UHID	HNH-00002673
IP No	IP26-00006474	Admission Date	01-06-2026

room air. Heart rate was 123/min and Respiratory Rate - 24/min. Peripheries were warm, pulses well felt. On auscultation of chest, air entry was bilaterally equal. Heart sounds were normal and there was no murmur. Abdomen was soft with no organomegaly. Multiple ecchymotic patches present over both legs and arm and forearm size 1 x 1 cm.

On neurological examination, child was conscious and irritable. Pupils were bilaterally equal and reacting to light. There were no focal neurological deficits, no meningeal signs and no signs of raised intracranial pressure.

Weight on admission: 14.5 kgs.

Investigations: Enclosed reports.

Initial hemogram showed Hemoglobin of 11.0 gm%, White Blood Cell count of 10550 cells/cumm, platelet count of 0.79 cumm

Uric acid was 3.7 mg/dl. LDH - 322 U/L

Liver function test showed total SBR of 0.2 mg/dl with indirect fraction of 0.1 mg/dl, SGOT - 34 U/L, SGPT - 14 U/L, ALP -175 U/L, protein -8.2 gm/dl, albumin - 4.9 gm/dl, globulin - 3.3 gm/dl, A/G ratio of 1.4.

Management: She was admitted in ward and started on IV fluids and supportive care. Bone marrow aspiration and biopsy was done in aseptic precautions.

She was regularly monitored for his hemodynamic status, oxygen saturations and vital parameters and was also monitored for any new skin lesions or any progression of old skin lesions and also for bleeding manifestations. After the bone marrow reports clarified as ITP, child was given a dose of nj.methylprednisolone as the treatment for ITP. As she remained

Name	Baby K. SAI TRISHIKA	UHID	HNH-00002673
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hemodynamically stable and no fresh lesions, maintaining saturations at room air, accepting orally well, she is being discharged on oral steroid.

Medication during hospital stay:

Injection. Esomeprazole

Inj.Methyl prednisolone 450mg iv stat(30mg/kg)

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

Advice:

* Diet as advised.

S.N	MEDICATION	DOSE	TIMINGS	DURATION
1	SYP.OMNACORTIL FORTE(15mg/5mg)	2.5ml	9am-9pm (after food)	For 5 days
2	TAB.JUNIOR LANOZOLE	15mg	8am (before breakfast)	For 5 days

Fever Management

* Syrup. Crocin DS (Paracetamol - 5ml/240mg) 4.5 ml after food as and whenever required, if temperature > 100 *F (maximum 4 times a day at 6 hour intervals).

* Tepid sponging if fever > 101 *F.

Review consultation with Dr. SINDHURA MUNUKUNTLA on **08/6/2026** at

Name	Baby K. SAI TRISHIKA	UHID	HNH-00002673
IP No	IP26-00006474	Admission Date	01-06-2026

Himayatnagar in OPD with prior appointment (**Review consultation will be charged**).

Follow up immediately in Emergency Room in case of any emergency like high grade fever, vomiting, breathlessness, refusal to feed occurs or any abnormal movements.

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

Parent/ Attender

In case of emergency contact 9154865030 emergency pediatrician on duty.

To take appointment for OPD consultation at Rainbow **Himayatnagar / 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. SINDHURA MUNUKUNTLA
MBBS, DCH, DNB PEDIATRICS
66970

ADMISSION SHEET

Registration Details :



Admission No : IP26-00006474 Admit Date : 01-Jun-2026 Admit Time : 09:57 PM UHID : HNH-00002673

Patient Details :

Patient Name : Baby K. SAI TRISHIKA Age : 4 Y 3 M 26 D
Guardian : Mr K. SRAVAN KUMAR DOB : 06-02-2022
Gender : Female Religion :
Occupation : Martial Status :
Address (H) : FLAT NO. 406, LEGEND VENKATESHA Phone No : 9701482117/ 9701502937
Narayanguda Hyderabad Telangana INDIA E-mail : monikachevula6@gmail.com
500029

Admission Details :

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

Contact Details :

Name : Mr K. SRAVAN KUMAR Relationship : Father
Contact Address : FLAT NO. 406, LEGEND VENKATESHA Phone No : 9701482117
Narayanguda Hyderabad Telangana INDIA
500029


Signature

Doctor Details :

Doctor Name : Dr. SINDHURA MUNUKUNTLA Specialisation : GENERAL PEDIATRICS
Referral Doctor : Self. Phone No :
Co-Consultant :

Payment Details :

Payment Mode : DC/CC Card Deposit Amount : 10000.00
Payor Name : STAR HEALTH AND ALLIED
INSURANCE CO LTD

ACTIVITY RECORD FOR BILLING

HNH-00002673 IP26-00006474

Baby K. SAI TRISHIKA



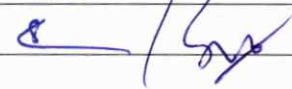
Name: ----- 06-02-2022 4 Y 3 M 26 D (F) -----
Dr. SINDHURA MUNUKUNTLA

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


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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
9/06/26	10 PM	ER	ward	
2/06/26	9-AM	2nd floor 310	PLW	
2/6/26	12 PM	PLW	2nd floor 210	

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1.	Dr. Anurag (Hematology)	2/6/26	3682	
2.	<p><i>cross checked done by Anurag</i> <i>1:30 PM @ 4/6/26</i></p>			
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Ref.No. F/IN/PR/10



**Rainbow[®]
Children's
Hospital**

**PEDIATRIC IN-PATIENT
MEDICAL RECORD**

Patient Name : HNH-00002573 IP26-00006474
Baby K. SAI TRISHIKA

Patient ID# :

06-02-2022 4 Y 3 M 28 D (F)
Dr. SINDHURA MUNUKUNTLA

Consultant :

Final Diagnosis :

Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Informant _____ Reliability _____

Chief Presenting Complaints & Duration (Chronologically):

CB lesions on both legs & hands since 2 months
on & off.

History of present illness :

CB lesions on both legs & hands
multiple darkish spots ; @

No CB trauma

No CB insect-bites

No CB swelling of joints

Pediatric Multiorgan History & Physical Examination

HNH-00002673 IP26-00006474

Baby K. SAI TRISHIKA

06-02-2022 4 Y 3 M 26 D (F)

Dr. SINDHURA MUNUKUNTLA

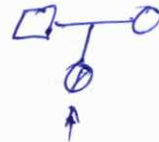


Past History : (Including details of any previous investigation or treatment)

Not significant

Birth & Neonatal History :

Normal.



Birth & Socio Economic History :

About Father :

About Mother :

Any additional Information :

Developmental History :

Normal

Immunization History :

Immunised till date

Pediatric Multiorgan History & Physical Examination

Anthropometry

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

Weight (kgs) 24.5 kg (Centile _____)

On Examination :

Temperature : 98.0°F Pulse Rate: 123 bpm Description _____

B.P. _____ SPO2 96% at _____

Resp. rate and type of breathing : _____

Rash _____ Multiple Erythematous patches

Lymphadenopathy _____ over both legs & arm; clear.

Oedema : _____ size 1x1cm.

Respiratory system :

Inspection (any s/o distress) : _____

Air entry & breath sounds : _____ g Bk NURS

Any added sounds : _____

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

Cardiovascular System :

Inspection of precordium : _____

Heart Sounds : _____ g S1S2 ⊕

Any murmur : _____

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

Per Abdomen :

Inspection _____

Palpation : _____ soft; non-tender

Auscultation : _____ No hepatosplenomegaly.

Spine: _____ External Genitalia : _____

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

Pediatric Multiorgan History & Physical Examination

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Baby K. SAI TRISHIKA
06-02-2022 4 Y 3 M 26 D (F)
Dr. SINDHURA MUNUKUNTLA



Central Nervous System :

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

Cranial Nerves : _____

Motor System :

Nutrition : _____

Tone : _____ Power _____

Co-ordinator : (N)

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR (N) Superficials : _____

Plantars _____

Sensory System :

Normal.

Bladder / Bowel : _____

Clinical Summary & Diagnostic :

Immune thrombocytopenic purpura

Pediatric Multiorgan History & Physical Examination

HNH-00002673

IP26-00006474

Baby K. SAI TRISHIKA

06-02-2022

4 Y 3 M 26 D

(F)

Dr. BINDHURA MUNUKUNTLA



Preventive aspects of the treatment :

Desired goals of the treatment :

Planned Labs :

Planned Management :

LDH
Uric acid
LFT
+ 2 Extra plates.

(1) To slide. → from 6am

(2) Bone marrow
Examination

NPO from tomorrow
morning 6am

(3) Incc. (if required).

Noted By Beethi

Noted By Beethi

Please fill up the following details

1. Name of the Referring Doctor : _____

2. Name of the Referring Hospital : _____
(Including the name of City)

3. Contact number of the Referring Doctor : _____
(Preferring Mobile #)

4. Name of the doctor in Rainbow Team _____ on
whose name the patient is being referred

Doctor's Signature Name _____ Date 2/6/26 Time 10 AM

Dr. Bindhura Munukunta
Consultant Pediatrician
Reg. No: 66970

Dr. Bindhura on

[Handwritten signature]



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/6/26 7am	e/b/b - Dr. Manvi Dr. Akshaya	
	Case of ? ITP. Advice!	
	No jaw	① NO from 6am
	No fresh bleeding manifested	④ Bone marrow aspiration + biopsy at 9am
Ole-	Edyoses & bruises on arms & legs.	④ Monitor for bleeding manifestations.
	Vital stable	
⑩	DIA - Polt.	
		NB - Supriya
		7:28 AM @ 2/6/26



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/6/26	<u>Procedural Notes:-</u>	
9am	<p>Under all aseptic precautions, bone marrow aspiration & bone marrow biopsy was done at right posterior iliac spine only after Exsurg the need for procedure & risk of sedation after the consent from the parent/guardian. Procedure was unsuccessful. Samples were taken & sent to lab.</p>	
	<u>Vitals before Procedure</u>	<u>Vitals after Procedure</u>
	HR - 108 bpm	HR - 107 bpm
	RR - 24 cpm	RR - 28 cpm
	CFT - 22 sec	CFT - 22 sec
	SpO ₂ - 98% at room air	SpO ₂ - 97%
		NiBP - 91/60 (73)
	Procedure done by:- Dr. Prithvi Dr. Alekhya.	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/6/20 10:00 AM	<p>S/B Dr Sindhura</p> <p>Case of ITP.</p> <p>No fever.</p> <p>No fresh.</p>	
	<p>of child in leg</p> <p>HR - 95/min</p> <p>RR 32/min</p> <p>SpO₂ 98%</p> <p>BP 97/60 (73)</p> <p>P/A - No cyanosis</p>	<p><u>Adv</u></p> <p>1) Dr. Anurag, Haematologist upon</p> <p>2) Shift steroid after BM report</p> <p>3) Shift out after conc down</p>
	<p>Dr. Sindhura Munukuntla Consultant Pediatrician Reg. No: 66970</p>	<p><i>[Signature]</i></p>

HNH-00002673 IP26-00006474
 Baby K. SAI TRISHIKA
 05-02-2022 4 Y 3 M 26 D (F)
 Dr. SINDHURA MUNUKUNTLA



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/6/22	<u>Caregiver notes</u>	
10 AM	<p>Lesions appearing & disappearing according to father.</p> <p>— Normality</p>	
		<p>Bleeding diathesis</p>
		<p>PH count → 15k. TLC → Hb →] Normal.</p>
		<p>Problem in bone marrow.</p>
	<p>LFT, Uric acid, S-LDH → Normal.</p>	
	<p>Liver function is normal.</p>	
	<p>Bleeding → Coagulation factors (N).</p>	
	<p>↓ not clotting</p>	
	<p>↓ ecchymotic patches.</p>	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	<ul style="list-style-type: none"> - Bone pains not there - No pyrexia. 	
	<ul style="list-style-type: none"> - Treatment → IV Steroids. 	
	<ul style="list-style-type: none"> - Bone marrow aspiration done. 	<p>Bx</p>
	<ul style="list-style-type: none"> - Nature & course of illness explained. 	
	<ul style="list-style-type: none"> - Avoid contact sports as of now. (Kabaddi) 	
	<ul style="list-style-type: none"> - The Bone marrow aspirate & Bx report 	
	<ul style="list-style-type: none"> - Presumptive report → Will start treatment. 	
	<ul style="list-style-type: none"> - Will shift out once conscious, awake and taking liquids. 	
	<ul style="list-style-type: none"> - NO Aspirin, only Ibuprofen, only PCM. 	
	<ul style="list-style-type: none"> - No use of blood transfusion 	

HNM-00002673 IP26-00006474

Baby K. SAI TRISHIKA
08-02-2022 4 Y 3 M 27 D (F)

Dr. SINDHURA MUNUKUNTLA



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/6/26	- Own Antibodies are acting against body	
	- No role of food (trigger)	
	- Check MCV, RDW, P/S.	
	- Hb & WBC are normal.	
	Geny	
	Kunz.	

Dr. Sindhura Munukuntla
Consultant Pediatrician
Reg. No: 66970

~~of unwell
antrum~~



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/6/2026	- C/S/B - Dr. Prashanth.	
2pm		Plan:
	Child shifted to ward	1) F/up Bone marrow
	Sedation weaned off	aspiration & biopsy
	Child awake	reports & p/s.
	oral sips given	2) F/up P.H.O consultation
	i.e/o vomiting post	
	solids.	3) To consider steroids
	c/o pain	post P.H.O op.
	v/e vitals stable	
	Edymoses & Bruises	4) Pij. Esomeprazole 15mg
	over arms & legs.	15mg IV qd Dr. Prashanth.
	SE	
	CVS - awake, coherent	
	CVS AS HA	
	whL	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/6 6pm	<p><u>CLSI/D</u> Dr. Sindhura</p> <p><u>I.T.P</u></p>	
	<p>skin lesion ⊕</p>	<p>Plz</p> <p>1) Trace BMA & BM biopsy } Report</p>
	<p>child alert</p> <p>Vitals stable</p> <p>Pupils ⊕ / Biceps ⊕</p> <p>Echymotic patch</p>	<p>2) Hemat - consultation & decide on steroid</p> <p>3) Jj exam</p> <p>4) Monitor Vitals</p> <p>Inform SOS</p>
	<p>RIS - B/L O/E ⊕</p> <p>PIA - soft</p>	<p>5) stop IV fluid</p> <p>6) No NSAIDs</p> <p>7) SOS - Crocin</p>
	<p>CBP - TM</p>	<p>NB - Montushi @ 6:40PM</p>
		<p>M. Indira</p> <p>Dr. Sindhura</p>
	<p>Dr. Sindhura Munukuntla Consultant Pediatrician Reg. No: 66970</p>	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/6	C/S/B Dr. Naipunya / Dr. Nazneem	
7:00 AM	Acute. ITP	Plan
	Ecchymosis & bruises (+) Fresh lesion. - none Vitals - stable.	- (+) BMA & BM biopsy reports.
	No fever -	Cont by: esuprozole.
	R/S - BIL ACP PIA - soft, NT.	Encourage orally
		Monitor vitals @ Nil
		NS Sujanya 8:13 AM @ 3/6/26



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/6/22 10am	O/S/B - Deplindhuse	
	Case of ITP	<u>Advice:</u>
	No new skin lesions No bleeding manifestations	① Trace Blm aspiration & biopsy report
	O/e - Vitals stable	④ Oj Emopazole ⑤ Monitor vitals NB Mantoux @ 10AM
	⑥ O/A - P/I Cvsly non as	Mundline amwam
	Dr. Sindhura Munukuntla Consultant Pediatrician Reg. No: 66970	

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/6/22	S/A Dr. Alekya	Play
2:40 PM	D? JTP	
	No fresh skin lesions	- Trace B/M Aspiration & Biopsy repeat
	No bleeding manifestation	- cf ESMOPRAZOLE
	CVI - J, S, ⊕	- Monitor vitals
	M-BL-ALP	- Encourage oral
	PIA - 300	
	continued	n/b apnea



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	<p>US/Re. Thrombi</p>	
4/6	<p>Re - Repeat</p>	
7:30 AM	<p>I TP</p>	
	<p>- no fever complaints</p>	
	<p>- no active bleeding</p>	
	<p><u>o LE</u></p>	<p>Plan</p>
	<p>- vitals = stable</p>	<p>1) have BM report</p>
	<p>- vit - normal</p>	<p>2) it. esomeprazole</p>
	<p>es : BRT (+)</p>	<p>3) monitor vitals</p>
	<p>dx</p>	<p>4) d/s. today.</p>
	<p>ur = S/B (+)</p>	
	<p>no mucus.</p>	
		<p>Plan</p>
		<p>N/B Supra</p>
		<p>8 AM 4/6/24</p>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
4/6/26	<u>clerk-Dr. Sindhura</u>	
1pm		
	? ITP	<u>Advise:-</u>
	No fresh lesion No fresh bleeding menorrhagia	(1) Trace fcl bone marrow sept
	Vitals stable	(2) Continue Empirazole
	(see) PlA - S/I C/S - S/Sz NS - B/C NBS	(3) Monitor vitals
		(4) Discharge after sept
		N/B of parent
	Dr. Sindhura Munukuntla Consultant Pediatrician Reg. No: 66970	<u>Sindhura</u> Sindhura-17



CROSS CONSULTATION FORM

Doctor Name: DR. SINDHURA Date: 2/6/26. Time: 10:30AM

Diagnosis: ? ITP.

Hospital: RCH, HIMAYATNAGAR.

- Type of Referral :
- Emergency
 - Urgent
 - Non Urgent

Referred for : Opinion Co-Management Transfer of care

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

Signature:

Findings and Recommendations : cd/w Dr. ANURAG

Adv:

- Wait for bone marrow aspirate & Biopsy report (Preliminary).

- Review SOS.

WZ

Consultant :

Name: DR. ANURAG Signature: [Signature] Date & Time: 2/6/26 10:30AM



DRUG CHART

Date of Admission: 1/6/26 Drug Allergies: N/A Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

- GENERAL** - Ensure that all patient details are entered above. ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.
- DOCTOR** - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
 - Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
 - Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
 - Discontinue a drug by drawing a line **I** through it and a similar line through subsequent recording panels.
 - The date and time of stopping the drug along with the doctors name and sign must be mentioned.
 - Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.
- NURSES** - Nurses must follow strictly the FIVE RIGHTS before administration of medication.
 1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time
 - AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

SOS / PRN (As Required Medication)

DRUG : <u>PARACETAMOL (240/5)</u>				Date Time
Dose <u>225=4x5 mg/ml</u>	Route <u>PO</u>	Frequency <u>SOS</u>	Start Date <u>2/6/26</u>	
Doctor's Signature <u>[Signature]</u>		Valid Period	Pharm. <u>[Signature]</u>	
Additional Instructions: <u>SOS, if pain</u>				
DRUG :				Date Time
Dose	Route	Frequency	Start Date	
Doctor's Signature		Valid Period	Pharm.	
Additional Instructions:				
DRUG :				Date Time
Dose	Route	Frequency	Start Date	
Doctor's Signature		Valid Period	Pharm.	
Additional Instructions:				

Verified by Dr. Dhakshayani
 Signature: [Signature]
 VERIFIED BY : Name

REGULAR PRESCRIPTIONS

Weight. 14.5kg Ward.



Verified by Dr. Dhakshayani

DRUG :				Date Time																	
Dose	Route	Frequency	Start Date																		
Name & Signature of the Doctor Starting the Drugs:																					
Additional Instructions:																					
Daily Doctor's Endorsement by a Sign																					
DRUG :				Date Time																	
Dose	Route	Frequency	Start Date																		
15mg	iv	OD	16/2/2022	16/2/22	3/2/22																
Name & Signature of the Doctor Starting the Drugs:																					
Additional Instructions:																					
Daily Doctor's Endorsement by a Sign																					
DRUG :				Date Time																	
Dose	Route	Frequency	Start Date																		
Name & Signature of the Doctor Starting the Drugs:																					
Additional Instructions:																					
Daily Doctor's Endorsement by a Sign																					
DRUG :				Date Time																	
Dose	Route	Frequency	Start Date																		
Name & Signature of the Doctor Starting the Drugs:																					
Additional Instructions:																					
Daily Doctor's Endorsement by a Sign																					

Weight. 14.5 kg Ward.

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
2/6/26	9 AM	Inj. Ketamine	10mg	IV	[Signature]	[Signature]
2/6/26	9:05 AM	Inj. Ketamine	10mg	IV	[Signature]	[Signature]
2/6/26	10 AM	Inj. Ketamine	10mg	IV	[Signature]	[Signature]
2/6/26	12 PM	Inj. PARACETAMOL	225mg (22.5 ml)	IV	[Signature]	[Signature]
2/6/26	12 PM	Inj. DNDANSETRON	2mg	IV	[Signature]	[Signature]

Signature
Name
Verified by

Dr. Dhakshayani



210

RESULT SHEET



MCC-75.1

Date	1/6/26	3/6/26			
Time					
Hb	11.1	11			
PCV	31.4	31.3			
RBC RDW	11	4.14			
WBC	7K	10.55			
N/L	42.6/48.6	45.1/47			
Platelets	55K	79			
CRP					
ESR					
PCT					
RBS					
Na					
K					
Cl					
Ca/Mg					
Phosphate					
Urea					
Creatinine					
ALP	175				
SGPT	14				
SGOT	34				
T.Bill/Conj	0.2/0.1				
T.Protein	8.2				
S.Albumin	4.9				
S.Globulin	3.3				
A/G Ratio	3.3				
Uric Acid	3.7				
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR	15/1.1				
APTT	37				
CSF Protein/Sugar					
Cells					
N/L					

Date	1/6/26					
Time						
CUE-Alb						
CUE-Sugar						
CUE - Ketones						
CUE-PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA/Cyst						
Occult Blood						
LDH →	322					

Culture and Sensitivities :

.....

.....

.....

Radiology: USG :

 X-Ray:.....

 ECHO:

 CT:

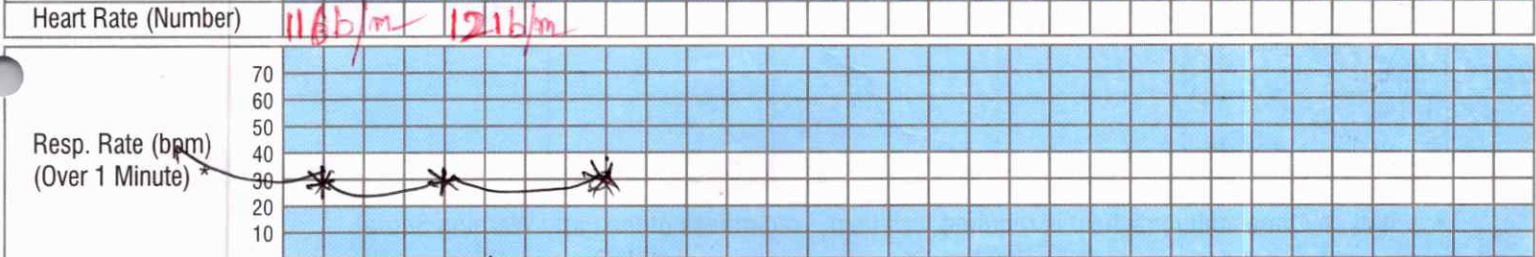
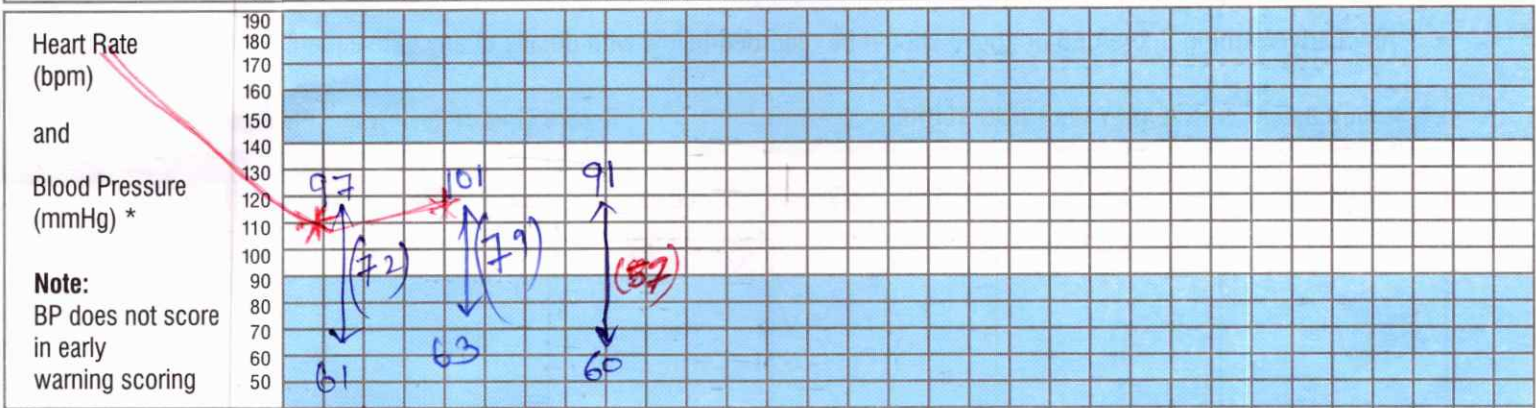
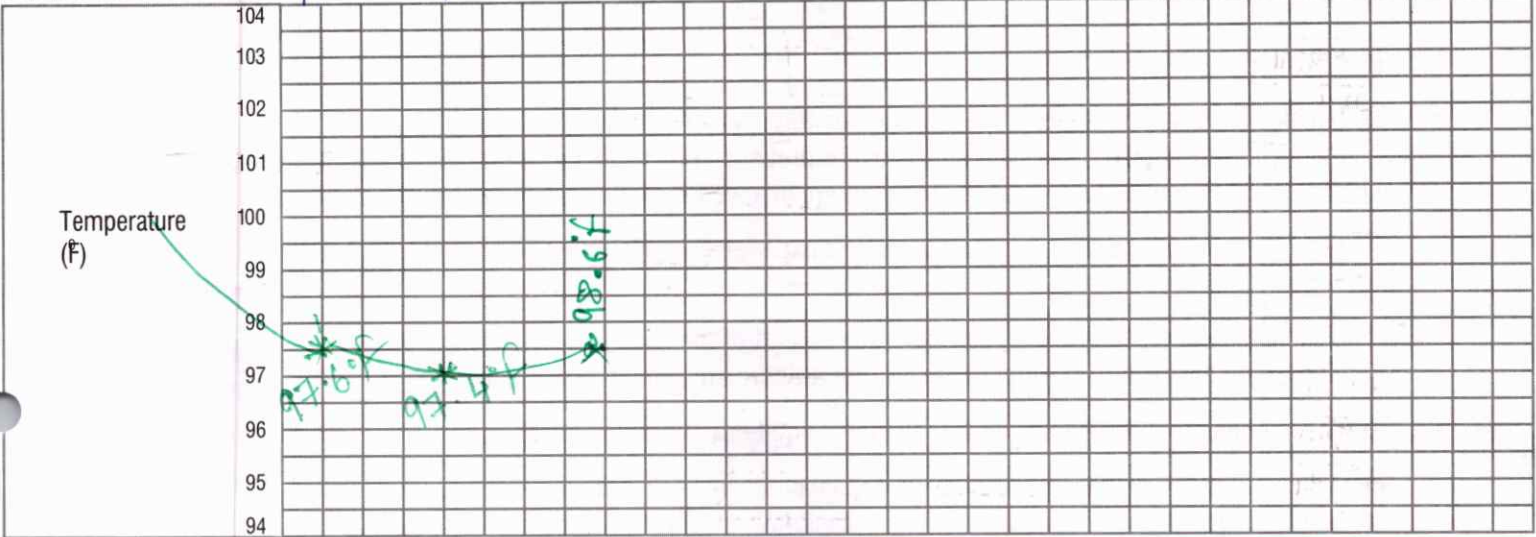
 MRI

 Others (ECG, Contrast Studies etc.):

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 1/6/26 Time: 11:30 2 6

Doctor / Nurse / Family Concern? PM AM AM



Heart Rate (Number)	<u>116b/m</u>	<u>121b/m</u>	<u>91b/m</u>
Resp Rate (Number)	<u>28b/m</u>	<u>29b/m</u>	<u>28b/m</u>
Resp Mod/ Severe Distress			
Receiving O ₂ (l/min)			
O ₂ Saturations (%)	<u>100%</u>	<u>100%</u>	<u>100%</u>
Conscious Level			
GCS *	<u>15/5</u>	<u>15/15</u>	<u>15/5</u>

TOTAL SCORE			
Number of shaded boxes	<u>0</u>	<u>0</u>	<u>0</u>
Pain Score	<u>0</u>	<u>0</u>	<u>0</u>
Observer's Initials	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>

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.

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

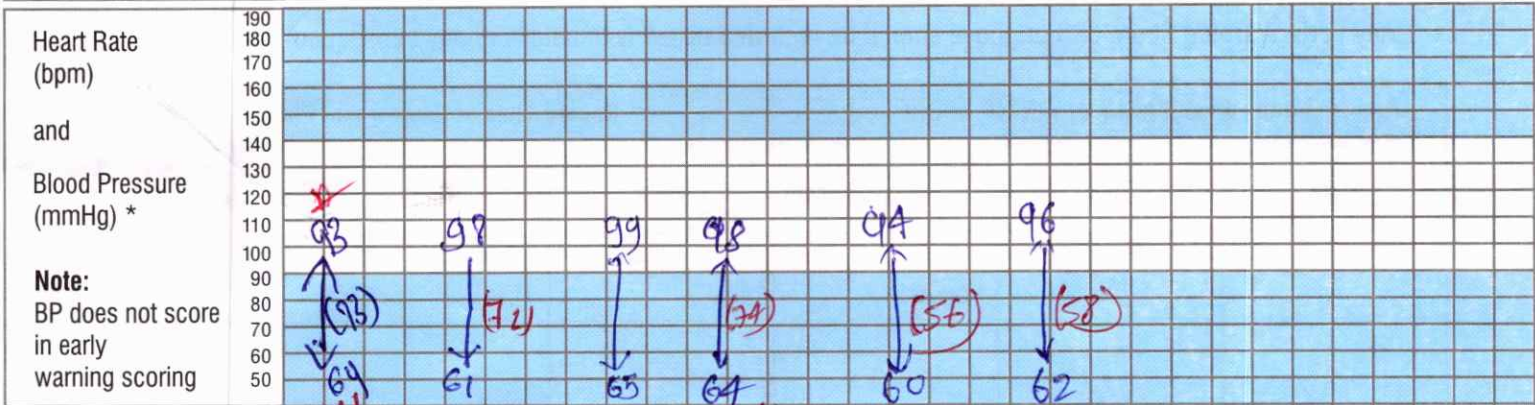
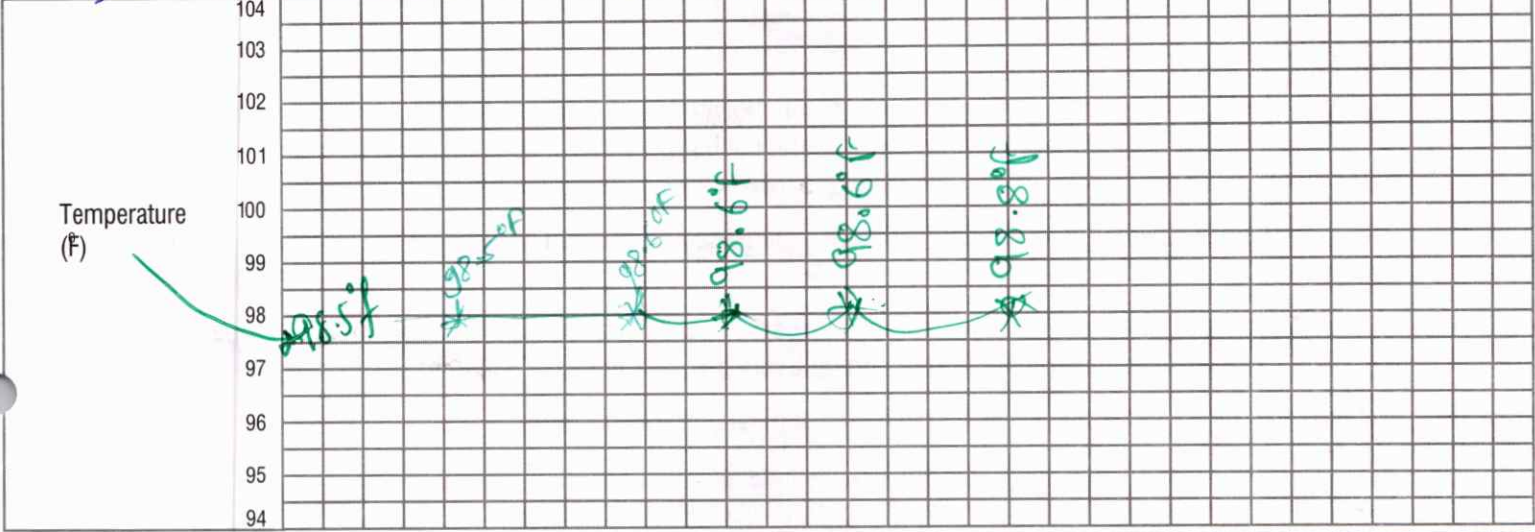
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S	SITUATION : I am calling because I am concerned that ... (e.g. BP is low/high, pulse is XXX, Temperature is XX, Early Warning Score is XX)
B	BACK GROUND : Child (X) was admitted on (XX date) with (e.g. respiratory infection). They have had (X operation/ 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)
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R	RECOMMENDATION : I need you to ... come to see the child in the next (XX mins) AND Is there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 2/16/26 Time: 10 AM 9 6 10 2 6

Doctor / Nurse / Family Concern? PM PM PM PM PM PM



Resp Distress	Mod/ Severe	
	None / Mild	
Receiving O ₂ (l/min)		
O ₂ Saturations (%)		99% 99% 100% 100% 100% 100%
Conscious Level	Normal / Altered	
GCS *		

TOTAL SCORE	
Number of shaded boxes	0 0 0 0 0 0
Pain Score	0 0 0 0 0 0
Observer's Initials	L K J R B B

ACTIONS NB: Scores 3 should be recorded overleaf	Score 1 : Continue normal observation by staff nurse
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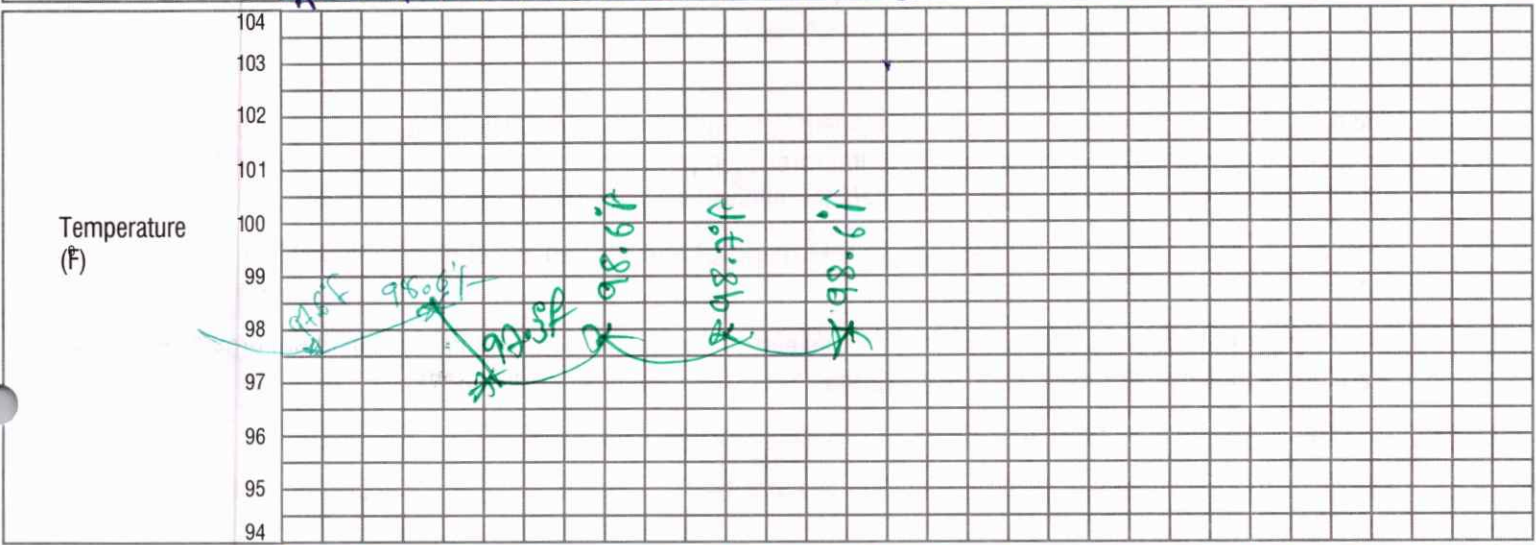
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R	RECOMMENDATION : I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

WARNING SCORE: CHILDREN'S UNIT

Date: 3/6/22	Time: 10 AM	2 PM	10 PM	2 AM	6 AM
Doctor / Nurse / Family Concern?					



Heart Rate (bpm)	190	180	170	160	150	140	130	120	110	100	90	80	70	60	50
Blood Pressure (mmHg) *	98	80	96	94	96	92	92	92	92	92	92	92	92	92	92
Note: BP does not score in early warning scoring	75	75	75	75	75	75	75	75	75	75	75	75	75	75	75
Heart Rate (Number)	118bpm	120bpm	120bpm	116bpm	118bpm	118bpm	118bpm	118bpm	118bpm	118bpm	118bpm	118bpm	118bpm	118bpm	118bpm

Resp. Rate (bpm) (Over 1 Minute) *	70	60	50	40	30	20	10
Resp Rate (Number)	32bpm	20bpm	20bpm	28bpm	24bpm	28bpm	28bpm

Resp Mod/ Severe Distress	None / Mild
Receiving O ₂ (l/min)	
O ₂ Saturations (%)	100% 100% 100% 100% 100% 100%
Conscious Level	Normal / Altered
GCS *	

TOTAL SCORE	1	0	0	0	0
Number of shaded boxes	1	0	0	0	0
Pain Score	0	0	0	0	0
Observer's Initials	CS	CS	CS	CS	CS

ACTIONS	Score 1	: Continue normal observation by staff nurse
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A	ASSESSMENT: I think the problem is (XXX) and I have ... (e.g. given O2/ analgesia, stopped the infusion), OR I am not sure what the problem is but child (X) is deteriorating, OR I don't know what's wrong but I am really worried.
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R	RECOMMENDATION : I need you to ... come to see the child in the next (XX mins) AND is there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

HNH-00002673 IP26-00006474
 Baby K. SAI TRISHIKA
 08-02-2022 4 Y 3 M 26 D (F)
 Dr. SINDHURA MUNUKUNTLA



FLUID CHART

Sheet No. :

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	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												
1/06/26	10:00 pm	DNS	Dasha	32ml								0	
	11:00 pm	↓	H ₂ O	32ml	NA							0	
	12:00 am			32ml								0	
	01:00 am			32ml								0	
Total Intake :						Total Output : U-1 M-1							
	02:00 am	↑		32ml								0	
	03:00 am			32ml								0	
2/06/26	04:00 am	DNS		32ml								0	
	05:00 am	↓		32ml								0	
	06:00 am		N	32ml								0	
	07:00 am		B M	32ml								0	
Total Intake :						Total Output : U-2 M-0							
Total 24 hrs. Intake						Total 24 hrs. Output							



FLUID CHART

Sheet No. :

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

		Intake				Output					IV Site Thrombophlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G								
2/6	08:00 am		NPO	32ml						✓	0	Sru	
	09:00 am		NPO	32ml							0		
	10:00 am	DNS	NPO	32ml							0		
	11:00 am		NPO	32ml						✓	0		
	12:00 pm		NPO	32ml				✓			0		
	01:00 pm		Orly								0		
Total Intake :						Total Output :						U- 0	M- 0
2/6/26	02:00 pm			32ml							0	Kd	
	03:00 pm		H ₂ O	32 ml						✓	0		
	04:00 pm		+ Cyroma	32 ml							0		
	05:00 pm	DNS		32 ml				✓			0		
	06:00 pm			32 ml						✓	0		
	07:00 pm			32 ml							0		
Total Intake :						Total Output :						M- 1	U- 2
2/6/26	08:00 pm										0	B	
	09:00 pm										0		
	10:00 pm	Stop IV								✓	0		
	11:00 pm										0		
	12:00 am										0		
	01:00 am										0		
Total Intake :						Total Output :						U- 1	M- 0
3/6/26	02:00 am										0	B	
	03:00 am									✓	0		
	04:00 am										0		
	05:00 am									✓	0		
	06:00 am									✓	0		
	07:00 am									✓	0		
Total Intake :						Total Output :						U- 2	M- 0

Total 24 hrs. Intake

Total 24 hrs. Output

HNH-00002673 IP26-00006474
 Baby K. SAJ TRISHIKA (F)
 08-02-2022 4 Y 3 M 27 D
 Dr. SINDHURA MUNUKUNTLA



FLUID CHART

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			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
2/5/26	08:00 am												
	09:00 am	0	Jelly	SOP									
	10:00 am	0	+ H2O	SOP									
	11:00 am												
	12:00 pm												
	01:00 pm												
Total Intake : Taken						Total Output : U → M →							
3/6/26	02:00 pm												
	03:00 pm												
	04:00 pm		200	SOP									
	05:00 pm												
	06:00 pm												
	07:00 pm												
Total Intake : Taken						Total Output :							
4/6/26	08:00 pm												
	09:00 pm												
	10:00 pm	0	Chapati										
	11:00 pm												
	12:00 am												
	01:00 am												
Total Intake : Taken						Total Output : U = 1 M = 0							
5/6/26	02:00 am												
	03:00 am												
	04:00 am	0											
	05:00 am												
	06:00 am												
	07:00 am												
Total Intake :						Total Output : U = 2 M = 0							
Total 24 hrs. Intake						Total 24 hrs. Output							

Patient Sticker



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					IV Site Thrombophlebitis Score	Sign. Nurse	
Date	Time	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												
	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

BRADEN 'Q' SCALE

					Date :	1/06/22	2/6	2/6	2/6
					Time :	Ni	M6	E2	Ni
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	4	4
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.		3	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
FRICION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."		4	4	4	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 of 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	27	27	28	28
					Evaluator's Name				

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

Risk Score	Category	Action	Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice)
15-18	At Risk	<ul style="list-style-type: none"> • Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • Advance to a higher level of risk if other major risk factors are present 	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	<ul style="list-style-type: none"> • Use the Same Protocol as for "At-Risk" Patients • Position patient at 30 degree lateral incline using foam wedges 	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	<ul style="list-style-type: none"> • Follow the same protocol as for "Moderate Risk" Patients • In addition to regular turning schedule • Make small shifts in their position frequently 	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	<ul style="list-style-type: none"> • Use same protocol as for "High Risk" Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors. 	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

HNH-00002673 IP26-00006474
 Baby K. SAI TRISHIKA
 08-02-2022 4 Y 3 M 27 D (F)
 Dr. SINDHURA MUNUKUNTLA



BRADEN 'Q' SCALE



					Date :	3/6/26	3/6/26	3/6/26	
					Time :	Mc	N8	Nf	
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.		4	4	4	
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.		4	4	4	
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.		4	4	4	
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.		4	4	4	
FRICION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."		4	4	4	
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Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.		4	4	4	
					TOTAL SCORE	28	28	28	
					Evaluator's Name	28	28	28	

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

Risk Score	Category	Action	Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice)
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13-14	Moderate Risk	<ul style="list-style-type: none"> • Use the Same Protocol as for “At Risk” Patients • Position patient at 30 degree lateral incline using foam wedges 	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	<ul style="list-style-type: none"> • Follow the same protocol as for “Moderate Risk” Patients • In addition to regular turning schedule • Make small shifts in their position frequently 	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	<ul style="list-style-type: none"> • Use same protocol as for “High Risk” Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors. 	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1 1/6/26			DAY-2 2/6/26			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0			0	0	0	0	0	0	0	
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1			NA	NA	NA	NA	NA	0	0	
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2			NA	NA	NA	NA	NA	0	0	
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3			NA	NA	NA	NA	NA	0	0	
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4			NA	NA	NA	NA	NA	0	0	
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	NA	NA	NA	NA	0	0	
Signature of the Nurse						<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	

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]*
 Signature : *[Signature]* Name : *[Signature]*

Signature of Ward In Charge :
 Signature : *[Signature]* Name : *[Signature]*

17-18 (A) " " (A) "

18-19 (A) " " (A) "

19-20 (A) " " (A) "

20-21 (A) " " (A) "

21-22 (A) " " (A) "

22-23 (A) " " (A) "

23-24 (A) " " (A) "

24-25 (A) " " (A) "



Handwritten notes and scribbles in the bottom right corner.



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
1/6/26	11PM	0/10	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	NA	D
2/6/26	6AM	0/10	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	NA	D
2/6	10Am	0	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	NA	Ena
2/6	2PM	0	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	NA	Ena
2/6	6PM	0	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	NA	(D)
2/6/26	10PM	0/10	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	NA	D
3/6/26	6AM	0/10	NA	<input type="checkbox"/> Continuous <input checked="" type="checkbox"/> Intermittent	<input checked="" type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input checked="" type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input checked="" type="checkbox"/> Decreasing	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	NA	D
3/6/26	10AM	0/10	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	NA	(D)
3/6	9PM	0	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	NA	Ena
3/6/26	10PM	0	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	D

Re-assessment Frequency:

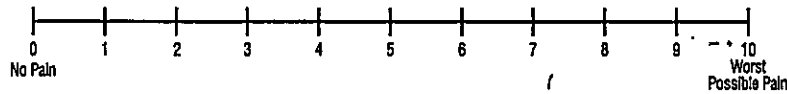
1. Every eight hours for all hospitalized patients.
2. For post-surgical patients, patients with chronic pain, patient with severe pain:
 - a) At least every 2 hours for the first 24 hours
 - b) Then every 4 hours.
 - c) Prior to pain relieving intervention.
 - d) Within 30 - 60 minutes after pain relief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

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

Numerical Pain Scale (Obstetric and Gynecology)



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

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression Intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR, RR, BP, SaO₂	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO ₂ 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

Wong - Baker (Pediatrics) Above 7 Years



PAIN ASSESSMENT FORM

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

Re-assessment Frequency:

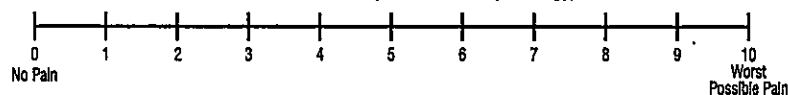
1. Every eight hours for all hospitalized patients.
2. For post-surgical patients, patients with chronic pain, patient with severe pain:
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 - c) Prior to pain pain-relieving intervention.
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Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
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Vital Signs HR, RR, BP, SaO₂	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO ₂ 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

Wong - Baker (Pediatrics) Above 7 Years



HN-00002873 IP26-00006474

Baby K. SAI TRISHIKA
08-12-2022 4 Y 3 M 26 D (F)
D: SINDHURA MUNUKUNTLA



NURSING CARE RECORD



Date: 1/06/25

- 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						
11pm	<ul style="list-style-type: none"> → To assess the pt. condition → To check the vitals & record → To administer the medication as per drug chart 	11pm	<ul style="list-style-type: none"> → To assessed the pt. condition → To checked the vitals & recorded → To administered the medication as per chart → I/O maintained 	<ul style="list-style-type: none"> → Patient is stable now → NBSM start at 6AM 	<ul style="list-style-type: none"> → Re-checked the vitals → I/O → T/M bone marrow examination at 9AM 	Supriya

02673
 AI TRISHIKA
 2022 4 Y 3 M 26 D (F)
 SINDHURA MUNUKUNTLA


NURSING CARE RECORD



Date: 2/6/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8AM	Assess the pt condition Monitor vitals & record. Maintain I/O chart. Provide the comfortable position. Medication given as per os doctor order.	8AM	Assessed the pt condition monitored vitals & record. Maintained I/O chart. Provided the comfortable position. Medication given as per os doctor order.	Pt is stable vitals normal.	Monitor vital. Maintain I/O chart.	Sichy M
	2PM	Bone marrow plan today	2PM	Bone marrow done			
Afternoon	2PM	Assess the pt condition monitor vitals Maintain I/O chart. Provide comfortable position	2PM	Assessed the pt condition Monitored vitals Maintained I/O chart. Provided comfortable position	patient is stable Now	Rechecked vitals	Kheishba K
	8PM	Drug given as per drug chart.	8PM	Drug given as per drug chart.			
Night	8PM	Assess the pt condition - monitor vitals - monitor I/O chart - medication given as per drug chart.	8PM	Assessed the pt condition - monitored vitals - monitor I/O chart - medication given as	pt is stable	vitals is normal	
	8PM		8PM				

HNH-0002673 IP26-00006474
 Baby K. SAI TRISHIKA
 08-02-2022 4 Y 3 M 28 D (F)
 Dr. SINDHURA MUNUKUNTLA



NURSING CARE RECORD



Date: 1/06/26

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	11pm	<ul style="list-style-type: none"> → To assess the pt. condition → To check the vitals & record → To administer the medication as per drug chart 8AM → I/O chart maintain 	11pm	<ul style="list-style-type: none"> → To assessed the pt. condition → To checked the vitals & recorded → To administered the medication as per chart 8AM → I/O maintained chart 	<ul style="list-style-type: none"> → Patient is stable now → NBM start at 6AM 	<ul style="list-style-type: none"> → Re-checked the vitals → I/O → T/M bone marrow examination at 9AM 	<p style="text-align: center;">Supriya</p>

102873
 JAI TRISHIKA IP26-00006474
 2022 4 Y 3 M 26 D (F)
 SINDHURA MUNUKUNTLA



NURSING CARE RECORD

Date: 2/6/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8Am	Assess the pt condition Monitor vitals & record. to maintain I/O chart. Provide the comfortable position.	8Am	Assessed the pt condition monitored vitals & record. to maintain I/O chart. Provided the comfortable position.	Pt is stable vitals normal	Monitor vitals. maintain I/O chart.	Sreejy M
	2Pm	medication give as per as doctor order. Bone marrow plan today	2Pm	medication give as per as doctor order. Bone marrow done			
Afternoon	2Pm	Assess the pt condition monitor vitals Maintain I/O chart. Provide comfortable position	2Pm	Assessed the pt condition monitored vitals Maintained I/O chart. Provided comfortable position	patient is stable now	Rechecked vitals	Krushboo K
	8Pm	Drug give as per drug chart.	8Pm	Drug given as per drug chart.			
Night	8Pm	Assess the pt condition monitor vitals Monitor I/O chart medication given	8Pm	Assessed the pt condition monitored vitals Monitor I/O chart medication given	Pt is stable	vitals is normal	Mamisha M
	8Am	as per drug chart	8Am	as			

NURSING CARE RECORD

Date: 08/6/26

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8AM	→ Assess the general condition of pt. → Monitor vitals → Maintain NPO chart → Administer medication.	8AM	→ Assessed the general condition of pt. → Monitor vitals. → Maintained NPO chart. → Administered medication	Re-assess Pt is stable	→ Re-assess vitals. → Re-assess NPO report.	Megha [Signature]
Afternoon	2PM	Assess the baby Administer vitals Administer NPO Administer med	2PM	Assess the baby Administer vitals Administer NPO Administer med	Administer vitals	Re-assess vitals	[Signature]
Night	8PM	→ Assess the patient general condition → monitor vitals → maintain NPO → Administer medications as per doctor's orders	8PM	→ Assessed the patient general condition → monitored vitals → Administer medications as per doctor's orders	Patient is stable	Rechecked vitals	[Signature]

Patient Sticker

NURSING CARE RECORD



Date:

- 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							



NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: <i>Immune Thrombocytopenic</i>	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Not Known If Yes Specify:						
	Surgery / Procedure:	Post OP Day:						
BACKGROUND	Date	<i>01/06/26</i>	<i>2/6/26</i>	<i>2/6/26</i>	<i>2/6/26</i>	<i>3/6/26</i>	<i>3/6/26</i>	
	Shift	<i>Ni</i>	<i>Mb</i>	<i>Ea</i>	<i>Ni</i>	<i>M/G</i>	<i>3/1</i>	
	Medical Condition (Any special condition to be noted):	-	-	-	-	-	-	
ASSESSMENT	Diet:	<i>NBM</i>	-	-	<i>Regular</i>	-	-	
	Allergy:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Ventilation (RA, NP, NIV, VENTI):	-	-	-	-	-	-	
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Vital Signs:	Temp:	<i>98.1°F</i>	<i>98.2°F</i>	<i>98.5°F</i>	<i>98.6°F</i>	<i>98.4°F</i>	<i>98.0°F</i>
		Res:	<i>29b/m</i>	<i>29b/m</i>	<i>29b/m</i>	<i>28b/m</i>	<i>28b/m</i>	<i>26</i>
		SpO ₂ :	<i>99%</i>	<i>99%</i>	<i>99+</i>	<i>100%</i>	<i>100%</i>	<i>100</i>
		Pulse:	<i>116b/m</i>	<i>117b/m</i>	<i>100b/m</i>	<i>118b/m</i>	<i>100b/m</i>	-
		BP:	<i>92/63</i>	<i>92/62</i>	<i>98/65</i>	<i>94/63</i>	<i>95/62</i>	-
		LOC:	-	-	-	-	-	-
Fall Risk Score:	-	-	-	-	-	-		
Pain Score:	<i>"0"</i>	<i>0</i>	<i>0</i>	<i>"0"</i>	<i>"0"</i>	-		
Skin Integrity:	<i>Good</i>	<i>Good</i>	<i>Good</i>	<i>Good</i>	<i>Good</i>	-		
Recommendations	Safety Needs:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Physiotherapy:	-	-	-	-	-	-	
	Others Specify:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Special Diet:	<i>NBM</i>	-	-	-	-	-	
	Critical Lab Test / Values:	-	-	-	-	-	-	
	Other Special Orders / Medications:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	PU Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
DVT Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
ADL (Dependent / Non Dependent):	-	-	-	-	-	-		
Post Operative Procedure Special Orders:	<i>Bone Mass - ow extreme 9AM</i>	-	-	-	-	-		
Handed Over By Name :	<i>Supriya</i>	<i>Sneha</i>	<i>Moultu</i>	<i>Supriya</i>	<i>Moultu</i>	<i>Paul</i>		
Signature / ID :	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>		
Date:	<i>2/6/26</i>	<i>2/6/26</i>	<i>2/6/26</i>	<i>3/6/26</i>	<i>3/6/26</i>	<i>3/6/26</i>		
Time:	<i>8AM</i>	<i>2PM</i>	<i>8PM</i>	<i>8AM</i>	<i>2PM</i>	<i>8PM</i>		
Taken Over By Name :	<i>Sneha</i>	<i>Moultu</i>	<i>Supriya</i>	<i>Moultu</i>	<i>Paul</i>	<i>Paul</i>		
Signature / ID :	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>		
Date:	<i>2/6</i>	<i>2/6/26</i>	<i>2/6/26</i>	<i>3/6/26</i>	<i>3/6</i>	<i>3/6</i>		
Time:	<i>8PM</i>	<i>2PM</i>	<i>8PM</i>	<i>8AM</i>	<i>2PM</i>	<i>8PM</i>		

Patient Sticker



NURSING SHIFT HAND OVER FORM

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

HNH-00002673 IP26-00006474
 Baby K. SAI TRISHIKA
 08-02-2022 4 Y 3 M 28 D (F)
 Dr. SINDHURA MUNUKUNTLA



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: ward

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

* C - Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Alankhya

Date & Time : 01/06/26 @ 10 PM

Nurse Name & Signature: Prabin

Date & Time : 01/06/26 @ 10 PM

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

HNH-00002673 IP26-00006474
Baby K. SAI TRISHIKA
06-02-2022 4 Y 3 M 27 D (F)
Dr. SINDHURA MUNUKUNTLA



CONSENT FOR SPECIAL PROCEDURES

Patient Name : Baby Sai Trishika Gender: Male Female
UHID No : Department : Pediatrics Date : 2/6/26

I S/D/W/O

Here by give consent for procedure of :

For my patient, Named :

The doctors have clearly explained to me that the procedure has following possible complications:
.....
.....

The doctor have explained to me about the alternatives, risks and benefits for this procedure that :
.....
.....

I have understood the matter mentioned above in language known to me and give consent for the procedure.

Name of the Doctor performing the procedure:

Patient Attendant :
Signature : [Signature]
Name : K. Shravan Kumar
Relationship with Patient: Father
Date & Time : 2/6/26; 9am

Witness :
Signature :
Name :
Date & Time :

Doctor (who is taking the consent) :
Signature : [Signature]
Name : Dr. Sindhu
Date & Time : 2/6/26; 9am

201
 2/10

NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 2/6/26 Time: 9:40am

Weight: 14.5 kg Centile: 50th

Height: 101 cm Centile: 50th

Inference: Well nourished child

RDA: - Calories: 1350 kcal/day Protein: 23 gms/day

Diet Recommendations: Normal soft high protein diet

Re-Assesment: Avoid spicy, chilled & outside foods

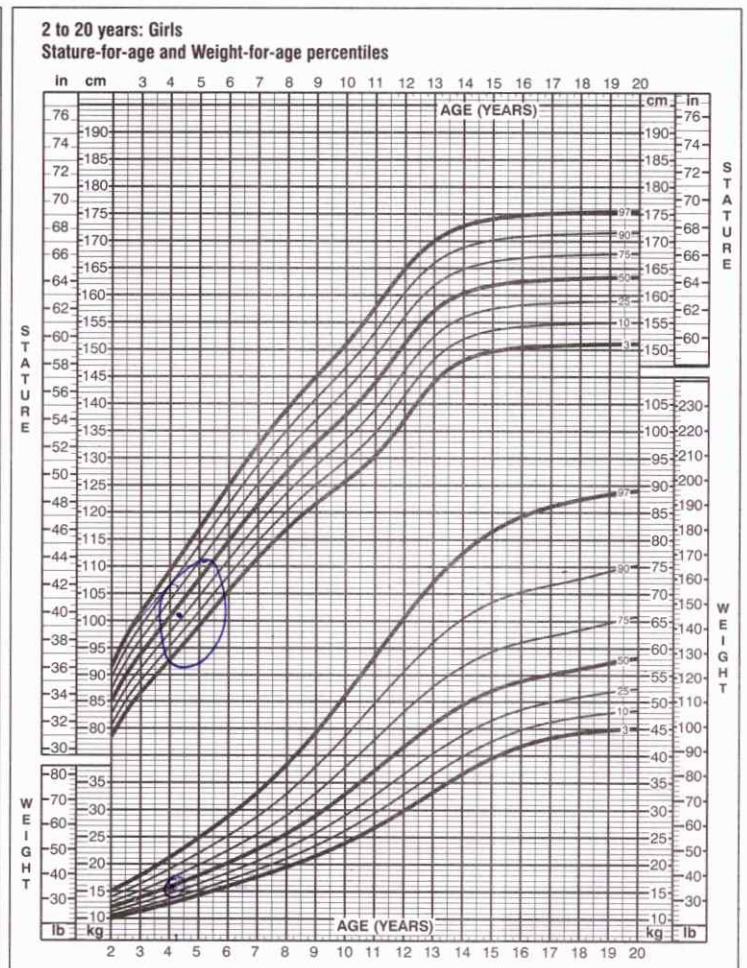
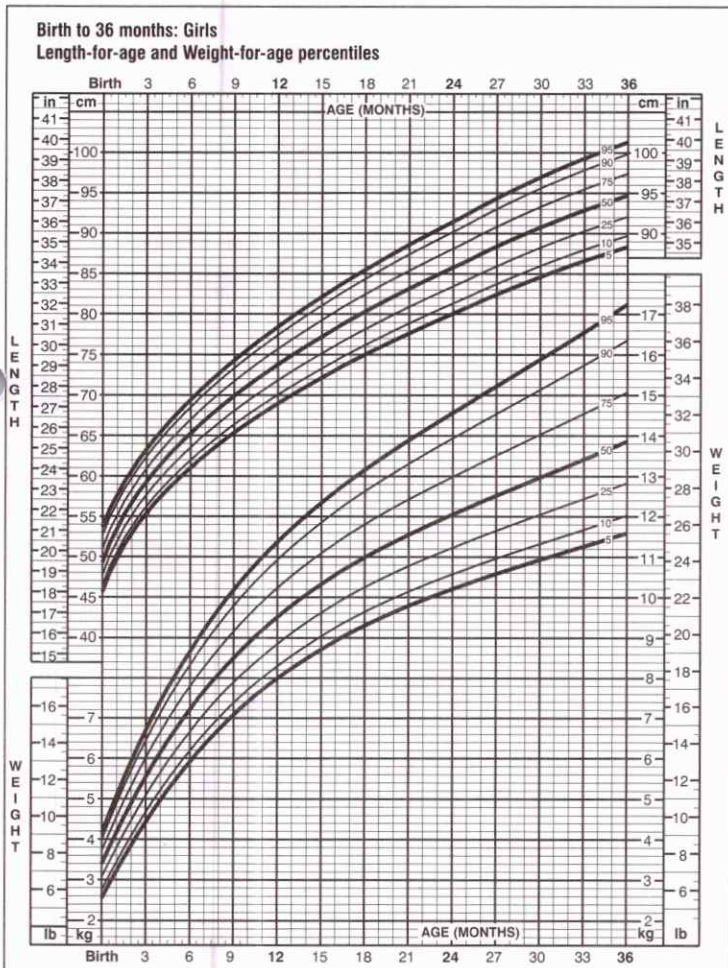
Food Allergies: NO Veg/Non-veg: ~~meat~~ - veg

Diagnosis: ITP

Nutritional Intervention - Oral Enteral Parenteral

Patient's Signature: *Sindhura*

GROWTH CHART (GIRLS)



Dietician's Name: Syeda Sobiya Zahoor

Dietician's Signature: Sobiya



wt - 14.5 kg



EMERGENCY ROOM TRIAGE FORM

Patient's Name : K. Sai Trishika Age : 4 years Gender: Male Female

Date : 01/06/26 Time of Arrival : 9:50 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: 98°F PR: 125b/m BP: RR: SpO₂: 98%

Chief Complaints: c/o lesions on both legs and hand noticed since 2 wks

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

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

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

* CTAS - Canadian Triage and Acuity Scale

Sankar
 Signature of Parent / Guardian

Triage Completion Time : 9:55 PM

Communicable Disease Triage Screening

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

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

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

- Have you travelled outside the INDIA? or had close contact with someone who has recently travelled outside the INDIA, in the past two weeks? Yes No
 If yes, State Location:
- Are your parents / close contacts at home is/a healthcare worker? {please encircle the choices} (e.g., nurse, physician, ancillary services personnel, allied health services personnel, hospital volunteer, or laboratory worker, others) who has had a recent exposure to an individual with a highly communicable disease or unexplained, severe febrile respiratory or rash disease? Yes No

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

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

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

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

Name of Triage Nurse : Prabir

Signature of Triage Nurse : [Signature]

Date & Time : 01/06/26 @ 9:55 PM



NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 01/06/26 Time of arrival : 9:50pm

Chief Complaints: c/o lesion both hand and legs, swelling of face

Height : Weight : Head Circumference (<2 years)

Allergies: Yes No Medications Blood Transfusion Food Other:

If yes, identify

Pain Screening: Yes No If Yes, Pain Score: 6/10 Pain Tool Used: N Pass FLACC Wong Baker

Character Location Frequency Duration

RISK FOR FALL:

If patient is < 6 years Yes No

If 'Yes' tick below fall risk intervention directly

If Patient is > 6 years

If 'Yes' 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 : 9:55pm

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

Time	Nursing Notes
	→ Assessed the pt condition
	→ checked the pt vitals
	→ IV placement done

Samples collected by: /

Time: /

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: 125 bpm BP: CFT: 2.5 cm	Shift - out from ER to: Wood
RR: SPO2 at FiO2: 98%	Time of Shift - out: 10:30 PM
GCS: 15/15 Temperature: 98°F	Handover given to: Sudaiya
Pain Score: 10	(Nurse's Name)
Repeat RBS (if applicable):	

Tick as applicable: MLC LAMA BROUGHT DEAD


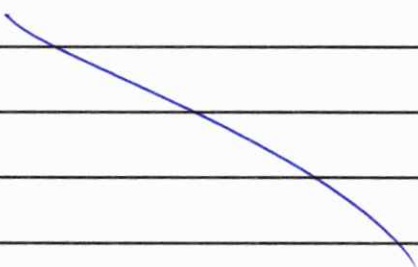
Procedures done with details (if any):

Name of the Nurse: Babir Signature of the Nurse: /

Date & Time: 01/06/26 @ 9:55 PM

PATIENT TRANSFER FORM




HNH-00002673 IP26-00006474 Baby K. SAI TRISHIKA 06-02-2022 4 Y 3 M 26 D (F) Dr. SINDHURA MUNUKUNTALA 		Date & Time of Admission 1/6/20	Date & Time of Transfer Order 2/6/20 @ 11:55 AM
Treating Consultant Name Dr. Sindhura	Transfer Ordered by Dr. Sindhura	Reason for Transfer Stable	
From Unit Pw	To Unit 2nd Floor	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File 38	Number of Imaging Films -	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring Sujata 2/6/20		Name of Person Ordered Transfer Dr. Susanth	
Patient & Clinical Records Received by : Sujata @ 2/6/20 @ 11:55 AM			
Date & Time of Patient Received :			

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

- Unavailable Bed
 Nurse not Available
 Available Bed not ready

PATIENT TRANSFER FORM

Patient Name & UHID No. HNH-00002673 IP26-00006474 Baby K. SAI TRISHIKA 06-02-2022 4 Y 3 M 26 D (F) Dr. SINDHURA MUNUKUNTLA 		Date & Time of Admission 1/6/26 @ 9:57 Am	Date & Time of Transfer Order 2/6/26 @ 9 Am
		Transfer Ordered by Dr. Tanvi	Reason for Transfer Bone marrow
From Unit 210	To Unit PICU	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File 20	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes <input type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring Dr. Sreeraj		Name of Person Ordered Transfer Dr. Tanvi	
Patient & Clinical Records Received by : Sujata 2/6/26 @ 9:10 Am			
Date & Time of Patient Received :			

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

- Unavailable Bed
 Nurse not Available
 Available Bed not ready

PATIENT TRANSFER FORM

HNH-00002673 IP26-00006474
Baby K. SAI TRISHIKA
06-02-2022 4 Y 3 M 26 D (F)
Dr. SINDHURA MUNUKUNTLA


Date & Time of Admission <i>01/06/26 @</i>	Date & Time of Transfer Order <i>01/06/26 @ 10:39pm</i>	
Treating Consultant Name <i>Dr. Sindhura</i>	Transfer Ordered by <i>Dr. Alekhya</i>	Reason for Transfer <i>Admission</i>
From Unit <i>ER</i>	To Unit <i>ward</i>	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Number of Sheets in Clinical File <i>(20)</i>	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If yes, what ?

Medications / Consumables / Surgicals / Hand over

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

Shifting Summary / Notes Written by Doctor : Yes No

Name & Signature of Person who is Transferring <i>Prabin</i>	Name of Person Ordered Transfer <i>Dr. Alekhya</i>
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Patient & Clinical Records Received by :
Supriya

Date & Time of Patient Received :
01/06/26 @ 10:39pm

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