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DISCHARGE SUMMARY

Name	Master MADIPI AADIVIK	**UHID**	HNH-00015572
Father/Guardian	Mr SRINIVAS	**Age/Gender**	6 Y 9 M 5 D/ Male
Address	2-3-13/1 beside fever hospital, Nallakunta, Hyderabad, Telangana, INDIA, 500044		
IP No	IP26-00006409	**Admission Date**	23-05-2026
Ref Doctor	Self.		
Discharge Date	24.05.2026		

DR. S. TEJASWI REDDY MBBS, MD (Paed) DM Neonatology CONSULTANT PEDIATRICIAN AND INTENSIVIST APMC/FMR/94068	**DR. SPANDANA PASUPULETI** MBBS, MRCPCH CONSULTANT PEDIATRICIAN AND INTENSIVIST Reg No: 30925

DIAGNOSIS	**ICD CODE**
WHEEZE ASSOCIATED WITH LOWER RESPIRATORY TRACT INFECTION WITH RESPIRATORY DISTRESS	

History: Master MADIPI AADIVIK, 6 Y 9 M 5 D old boy presented with history

Name	Master MADIPI AADIVIK	UHID	HNH-00015572
IP No	IP26-00006409	Admission Date	23-05-2026

of cough associated with fast breathing since 1 day, vomitings and decreased oral intake since 1 day, prior to admission. For the above complaints he was admitted at Rainbow Children's Hospital for further management.

Examination: He was afebrile. SpO2 of 91%. Heart rate was 108/min and Respiratory Rate - 44 /min. Peripheries were warm, pulses well felt. Signs of dehydration were present, dry lips, oral mucosa, delayed skin turgor, decreased urine output. Dull looking, tachycardia, dry oral mucosa, sunken eyes were present. On examination tachypnea and subcoastal retarctions present . On auscultation of chest, air entry was bilaterally equal with bilateral wheeze & crepitations were present. Heart sounds were normal and there was no murmur. Abdomen was soft with no organomegaly.

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: 20.1 kgs.

Investigations: Enclosed reports.

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

Initial hemogram showed Hemoglobin of 11.9 gm%, White Blood Cell count of 13960cells/cumm, platelet count of 3.39 lakhs/cumm and C-Reactive Protein of 5.0 mg/l.

Chest X-ray shows:
There are increased perihilar and peribronchial markings bilaterally, in keeping

Name	Master MADIPI AADIVIK	UHID	HNH-00015572
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with lower respiratory tract inflammatory changes - ? Viral in etiology.

VBG showed pH - 7.35, pCO2- 39.4mmhg, pO2 - 35mmhg, HCO3 - 21.7mmol/l , BE: -3.9mmol/l.

Management: He was admitted in WARD and started on oxygen by nasal prongs at 2 L/min and IV fluids. In view of chest signs, he was frequently nebulised with Levolin and Ipravent.

In view of persistent severe wheeze Injection Methylprednisolone and inj MgSO4 stat dose was given .

He was regularly monitored for his hemodynamic status, oxygen saturations and vital parameters. Gradually his oxygen support was tapered & stopped.

As he remained hemodynamically stable, maintaining saturations at room air, tolerated and accepting orally well, hence he is being discharged with the following advice.

Medication during hospital stay:
Injection. Methylprednisolone
Nebulisation Levolin
Nebulisation Ipravent

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

Advice:
* Diet as advised.

Name	Master MADIPI AADIVIK	UHID	HNH-00015572
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S.No	MEDICATION	DOSE	TIMINGS	DURATION
1	NEBULISATION with Levolin (0.31mg)	1 respule	6th hourly	For 3 days
2	Nasoclear nasal drops, 2 drops in each nostril **SOS** for nose block			

Fever Management
* Syrup. Crocin DS (Paracetamol - 5ml/240mg) 6 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. S TEJASWI REDDY **on (26.05.2026) Tuesday** at 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.

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Name	Master MADIPI AADIVIK	**UHID**	HNH-00015572
IP No	IP26-00006409	**Admission Date**	23-05-2026

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**

Dr. Anusha

Registrar/Resident/C.M.O

DR. SPANDANA PASUPULETI
MBBS, MRCPCH
CONSULTANT PEDIATRICIAN AND INTENSIVIST
Reg No: 30925

DR. S. TEJASWI REDDY
MBBS, MD (Paed) DM Neonatology
CONSULTANT PEDIATRICIAN AND INTENSIVIST
APMC/FMR/94068

HNH-00015572 IP26-00006409
Master MADIPI AADIVIK
18-08-2019 6 Y 9 M 5 D (M)
Dr. S TEJASWI REDDY

Levolin - 4H.
Ipravent - 6H.

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NEBULISATION CHART

Date	Time	Drug	Nurse	Parents Signature
	00.00			
	01.00	Ipravent (4)	Sne	[illegible]
23/5/26	02.00			
	03.00	Levolin (5)	Sneha	[illegible]
	04.00			
	05.00			
	06.00			
	07.00	Levolin + Ipravent (6)	Sneha	[illegible] — T-13
	08.00	T-(6)	01760	
	09.00			
	10.00			
	11.00	Levolin - 4790 (1)		
	12.00			
	13.00	Total (14) Nebulization.		
	14.00			
	15.00			
	16.00			
	17.00			
	18.00			
	19.00			
	20.00			
	21.00			
	22.00			
	23.00			

HNH-00015572 IP26-00006409
Master MADIPI AADIVIK
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Dr. S TEJASWI REDDY

Levolin - 3rd hrly
Iprevent - 6th hrly

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NEBULISATION CHART

Date	Time	Drug	Nurse	Parents Signature
	00.00			
23/5/26	01.00	Levolin + Iprevent given in ER (1)		
	02.00			
	03.00	Levolin + O2 (2)	Sneha	
	04.00			
	05.00	Levolin + O2 (3)	Sneha	
	06.00			
	07.00	Iprevent + Levolin (4) + O2	Sneha	
	08.00	T-(4)	01550	
	09.00	Levolin		
	10.00			
	11.00	Levolin (3)	201640	
	12.00			
	13.00	Levolin + Iprevent		
	14.00			
	15.00			
	16.00	Levolin (1)		
	17.00			
	18.00			
	19.00	Iprevent + levolin (2)		
	20.00			
	21.00			
	22.00			
	23.00	Levolin (3)		

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 : IP26-00006409 **Admit Date** : 23-May-2026 **Admit Time** : 02:17 AM **UHID** : HNH-00015572

Patient Details :

Patient Name	: Master MADIPI AADIVIK	**Age**	: 6 Y 9 M 5 D
Guardian	: Mr SRINIVAS	**DOB**	: 18-08-2019
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: 2-3-13/1 beside fever hospital Nallakunta Hyderabad Telangana INDIA 500044	**Phone No**	: 9966352245/ 8897010968
		E-mail	: na@gmail.com

Admission Details :

Bed Type : DAY CARE **Bed No** : ER01 **Ward Name** : GF -EMERGENCY

Room No : ER01 **Admission Type** : First Visit

Contact Details :

Name	: Mr SRINIVAS	**Relationship**	: Father
Contact Address	: 2-3-13/1 beside fever hospital Nallakunta Hyderabad Telangana INDIA 500044	**Phone No**	: 9966352245

Signature

Doctor Details :

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

Payment Details :

		Deposit Amount	: 0.00
Payment Mode	: Cash	**Payor Name**	: NIVA BUPA HEALTH INSURANCE COMPANY LIMITED

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ACTIVITY RECORD FOR BILLING

Name: ---- HNH-00015572 IP26-00006409 ----------
Master MADIPI AADIVIK
UHID No : - 18-08-2019 6 Y 9 M 5 D (M) --------- Consultant : ---------- Dept : ----------
Dr. S TEJASWI REDDY

Date of Adı : ---------- Date of Discharge : ---------- Time: ----------

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
23/5/26	2:50AM	ER	22/	[illegible]

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Sign
23/5/26	CBP, CRP		
	Respiratory panel	8673	Ogen
	VBG	8672	
	X-ray	006249	
		cross checked	done by Sneha

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
23/5	Infusion Pump	3Am	23/5/26 @6pm	01548	Sneha
			Cross checked done by Sneha		
23/5	Oxygen	4:30Am	23/5/26 @4pm	01549	Sneha
			cross checked done.		

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
23/5/26	IV placement	1	1539	[illegible]
24/5/26	NHA	1	1792	Mori
			Nurses checked	

ANY OTHER INFORMATION

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

HNH-00015572 IP26-00006409
Master MADIPI AADIVIK
18-08-2019 5 Y 9 M 5 D (M)
Dr. S TEJASWI REDDY

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NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 24/5/26 Time: 10:10 am

Weight: 20.7 kg Centile: 25th

Height: — Centile: —

Inference: Underweight child

RDA: — Calories: 1450 kcal/d Protein: 25 g/day

Diet Recommendations: High protein diet with liquid

Re-Assesment: No Junk, Oily, Add ilems

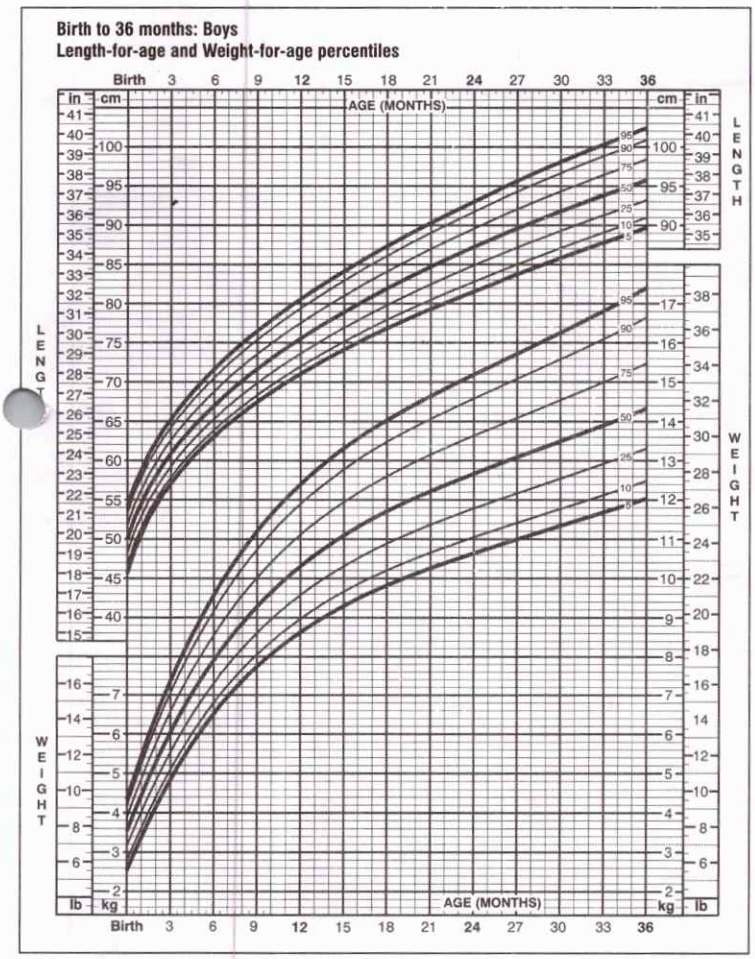
Food Allergies: No PA Veg/Non-veg Non veg

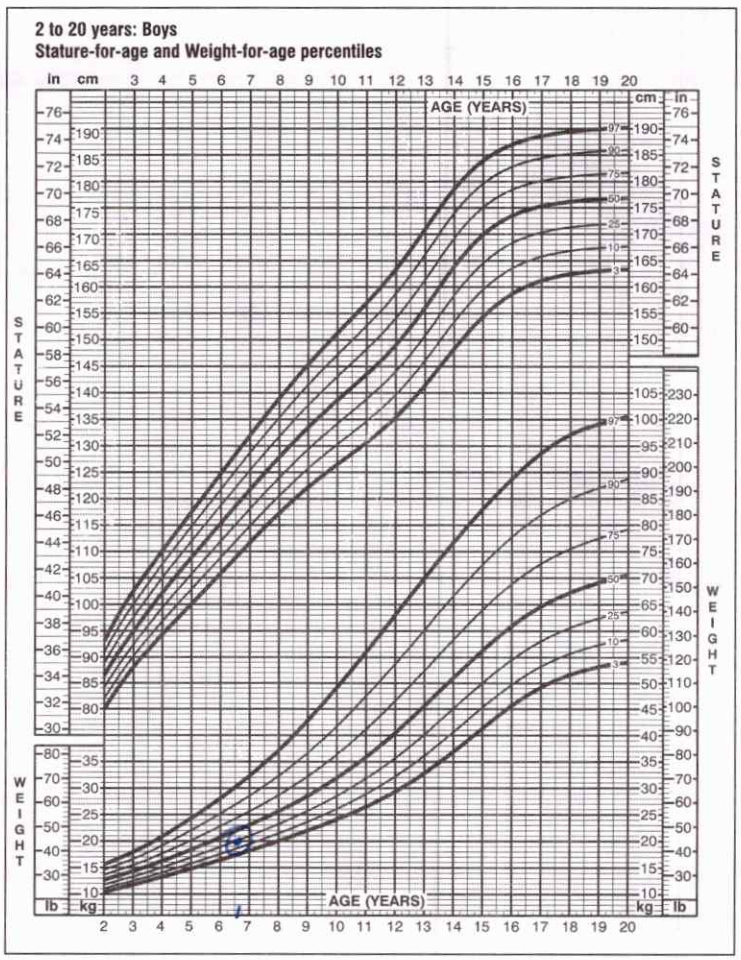
Diagnosis: WAHI CRD

Nutritional Intervention - ☑ Oral ☐ Enteral ☐ Parenteral

Patient's Signature:

GROWTH CHART (BOYS)





Dietician's Name Syeda Sobiya Zaheer Dietician's Signature Sobiya

Docu. No. : RCH /FRM / CLINICAL / 160 (P.T.O.)

Daily Notes:

Ref.No. F/IN/PR/10

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name : _____

Patient ID# : HNH-00015572 IP26-00006409
Master MADIPI AADIVIK
18-08-2019 6 Y 9 M 5 D (M)
Dr. S TEJASWI REDDY

Consultant : _____

Final Diagnosis : _____

Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Informant _____ Reliability _____

Chief Presenting Complaints & Duration (Chronologically):

C/o Cough since Morning
C/o fast breathing since Morning
C/o vomiting since 1 day

History of present illness : C/o decreased oral intake x 1 day

pt was apparently alright before 1 dy then he had Cough, dry Cerementious type

C/o fast breathing since 1 day

C/o vomiting (2episodes / day).
non-projectile non-bilious
Contains feed particles

C/o decreased. oral intake since 1 day

Pediatric Multiorgan History & Physical Examination

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

Nothing significant.

Birth & Neonatal History :

T | 3kg | Cm LSCS

Birth & Socio Economic History :

About Father :

About Mother :

Any additional Information : —

Developmental History :

Developmentally normal.

Immunization History :

Till date according to NIG

Pediatric Multiorgan History & Physical Examination

Anthropometry

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

Weight (kgs) 20.1 kg (Centile _____)

On Examination :

Temperature : 97 °F Pulse Rate: 108 Description _____

B.P. _____ SPO2 91 % at RA.

Resp. rate and type of breathing : 44, SCR (+)

dry oral mucosa
dry lips
sunken eyes
] signs of dehydration present.

Rash (-)

Lymphadenopathy (-)

Oedema : (-),

Respiratory system :

Inspection (any s/o distress) : _____

Air entry & breath sounds : B/L AE (+)

Any addes sounds : B/L wheeze (+) B/L Crepts (+)

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

Cardiovasclular System :

Inspection of procordium : _____

Heart Sounds : S1 S2 heard

Any murmur : NAD

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

Per Abdomen :

Inspection _____

Palpation : soft, nontender.

Ausculation : NO organomegaly

Spine: _____ External Genitelia : _____

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

Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS Score : _____

Cranial Nerves : _____

(N)

Motor System :

Nutrition : _____

Tone : _____ Power _____

Co-ordinator : _____

Posture : _____

(N)

Involuntary Movements : _____

Reflexes :

DTR **Superficials :**

Plantars _____

Sensory System :

(N)

Bladder / Bowel : _____

Clinical Summary & Diagnostic :

WALRI c̄ dehydration c̄ Respiratory distress

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment :

Desired goals of the treatment :

Planned Labs :

CBP, CRP, VBG.
Chest x-ray
Respiratory panel
(5 viruses)
noted by Am

Planned Management :

Neb levalin. 8 2 H.
Neb Ipravent 8 6 H.
IVF DNS 40ml/hr.
Oxygen support 2 L/min.
(SOS)
noted by Am

Please fill up the following details

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

Doctor's Signature Name _____ Date _____ Time _____

HNH-00015572 IP26-00006409
Master MADIPI AADIVIK
18-08-2019 6 Y 9 M 5 D (M)
Dr. S TEJASWI REDDY

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	O/S/G. Dr. Sankanth / Dr. Nagireddy	
23/05/26 7AM	D: WALAL with RO	
	Fast breathing (+) - reduced	
	cough (+)	
	No vomiting	
	O/E: Conscious	
	mild Tachypnea (+)	
	SpO2: 96% @ O2 with NP (2lt/min)	
	S/E: RS:- B/L CAE (+), B/L crepts (+)	
		Advice
		- O2 c NP @ 2lt/min
		- NEB with LEVOLIN 2H
		IPRAVENT 6H
		- Monitor vitals (RR, SpO2)
		Sankanth

HNH-00015572 IP26-00006409
Master MADIPI AADIVIK (M)
18-08-2019 6 Y 9 M 5 D
Dr. S TEJASWI REDDY

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	C/o 16- Dr Tejaswi	
23/05/26 8 am	Afebrile Fast breathing (+)	
	O/E: HR: 110/min SpO2: 99% @ 2 lit/min NP	
	S/E: RS: BCAE, TLC clear (+)	
		Adv - O2 @ 1 lit/min - Levolin 2H Ipratrop 6H - Inj Methylprednisolone 1mg/kg/dose
		Dr Tejaswi MD Pediatrics
	Dr. S. TEJASWI REDDY Registration No: 94068	

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

HNH-00015572 IP26-00006409
Master MADIPI AADIVIK
18-08-2019 6 Y 9 M 5 D (M)
Dr. S TEJASWI REDDY

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
23/5/26 2pm	S/B Dr. Sneyhan Δ WALRI ⊂ RD	Plan
	SpO2 - 97% on O2 by NP @ 0.5 L/min	- cf IV fluid @ 60ml
	CVS - S1 S2 ⊕ RS - BL - AEF ⊕ BK - wheeze ⊕	- Neb ⊂ levolin 3rd h ⊂ Ipravent 6th h
	P/A - soft	- Monitor RR, SpO2
	Conscious	- Trach Adenovirus PCR
	N IB Sent	N IB Sent
23/5/26 4pm	S/B Dr. Spandana Δ WALRI ⊂ RD Stop O2	Plan - Neb ⊂ levolin 3rd h ⊂ Ipravent 6th h
	CVS - S1 S2 ⊕ RS - BL - AEF ⊕ BK - wheeze ⊕	- Monitor RR, SpO2
	P/A - soft	- Trach Adenovirus PCR
	Conscious	- Plan to make level 4th if child is stable

Dr. Spandana Pasupuleti
Consultant Neonatologist and Pediatrician
Reg. No: 30925

D. B Amouk

HNH-00015572 IP26-00006409
Master MADIPI AADIVIK
16-08-2019 6 Y 9 M 5 D (M)
Dr. S TEJASWI REDDY

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
24/05/2026 8 am	S/B Dr. Nameen / Dr. Thani.	
	W ALRI c̄ RD	
	on room air	Plan
	RR - 25/min.	(1) Levolin Q4H ← Q3H
	SpO2 95%	Ipravent Q6H
	asleep, no resp. distress	(2) monitor vitals Q4H
	Chest - B/L crepts > wheeze	(3) w/f resp. distress
		(4) Trace Adenovirus PCR ↓ Not detected
24/5/26. 11 AM	c/s/by Dr Spandan	(Dr Nameen)
	WALRI c̄ RD.	
	- on R/A	
	Tachypnea.	Plan — Q6hly 3% NS Q6hly Levolin
	No Retraction.	— c̄ Levolin NEB
		IPRAVENT
	(RLS) · B/L AE (+). crept (+).	— (T) Adenovirus. (f/u)
		— R/A Tuesday.
		— Monitor vitals
	Dr. Spandana Pasupuleti Consultant Neonatologist and Pediatrician Reg. No: 30925	— c/s today.

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

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Master MADIPI AADIVIK
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RESULT SHEET

Date	23/5/26					
Time						
Hb	11.9					
PCV	33.9					
RBC	4.22					
WBC	13.96					
N/L	67.4/23.0					
Platelets	339					
CRP	5					
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						
23/5 Flu panel - Negative						
Adenovirus - awaited						

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

HNH-00015572 IP26-00006409
Master MADIPI AADIVIK
18-08-2019 6 Y 9 M 5 D (M)
Dr. S TEJASWI REDDY

Patient S

.INICAL / 126

SCHOOL AGE (5-12 years)

Children's Observation & Early Warning Scoring Chart

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 23/5/26 Time:	3	6:30	6
Doctor / Nurse / Family Concern?	Am	Am	Am

Temperature (°F)

104			
103			
102			
101			
100			
99	98.5°F	98.2°F	98.7°F
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	102		99
90			
80	(75)		(66)
70			
60	65		56
50			
Heart Rate (Number)	125bm	113bm	122bm

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

70			
60			
50			
40			
30			
2			
1			
Resp Rate (Number)	25bm	28bm	35bm

Resp Distress	Mod/ Severe		
	None / Mild		
Receiving O_2(l/min)			
O_2Saturations (%)	96%	99%	98%
Conscious Level	Normal	✓	✓
	Altered		
GCS *	-	14/15	14/15
TOTAL SCORE Number of shaded boxes	0	0	0
Pain Score	0		0
Observer's Initials			

ACTIONS

NB: Scores 3 should be recorded overleaf

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

HNH-00015572 IP26-00006409
Master MADIPI AADIVIK
18-08-2019 6 Y 9 M 5 D (M)
Dr. S TEJASWI REDDY

Patient Stic

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

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 23/5/26 Time:	10 AM	2 pm	6 PM	10 PM	2 AM	6 AM
Doctor / Nurse / Family Concern?						
Temperature (°F)	97.6F	98.3F	99.4F	97.8F	98.5F	97.2F
Heart Rate (bpm) and Blood Pressure (mmHg) *						
Heart Rate (Number)	102b/m	100b/m	95b/m	103b/m	113b/m	120b/m
Resp. Rate (bpm) (Over 1 Minute) *						
Resp Rate (Number)	23b/m	20b/m	20b/m	20b/m	20b/m	20b/m
Resp Distress: Mod/ Severe / None / Mild						
Receiving O_2 (l/min) O_2 Saturations (%)	99% on O_2	99%	99%	98%	99%	99%
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	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

Temperature (°F): 104, 103, 102, 101, 100, 99, 98, 97, 96, 95, 94

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

Note: BP does not score in early warning scoring

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

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 24/5/26 ..... Time:	10 AM
Doctor / Nurse / Family Concern?	

Temperature (F)	104, 103, 102, 101, 100, 99, 98, 97, 96, 95, 94	98.4F
Heart Rate (bpm) and Blood Pressure (mmHg) *	190, 180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60, 50	
Note: BP does not score in early warning scoring		
Heart Rate (Number)		180/m
Resp. Rate (bpm) (Per 1 Minute) *	70, 60, 50, 40, 30, 20, 10	
Resp Rate (Number)		20b/m
Resp Distress	Mod/ Severe	
	None / Mild	
Receiving O_2(l/min)		
O_2Saturations (%)		96%
Conscious Level	Normal	
	Altered	
GCS *		15/5
TOTAL SCORE Number of shaded boxes		0
Pain Score		0
Observer's Initials		M

ACTIONS NB: Scores 3 should be recorded overleaf	
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Score 2	: Shift in charge nurse to be informed and continue hourly observations
Score 3	: Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.
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FLUID CHART

Sheet No. : 1

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 :**						
	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			40ml							0	
	04:00 am		Ho	40ml							0	
23/5	05:00 am	DRS	fro	40ml							0	Sre
	06:00 am			40ml							0	
	07:00 am			40ml							0	
Total Intake :						**Total Output :**					U-0 M-0	

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

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FLUID CHART

Sheet No. : 2

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							
23/5	08:00 am	Paracetamol		40ml								
	09:00 am			40ml								
	10:00 am		Jelly	40ml								
	11:00 am		+	40ml								
	12:00 pm		H2O	20ml								
	01:00 pm			20ml								
Total Intake : Taken						Total Output : U - 2 M -						
23/5	02:00 pm	DNS	Chapati	20ml								
	03:00 pm			20ml								
	04:00 pm			20ml								
	05:00 pm			20ml								
	06:00 pm			20ml								
	07:00 pm			20ml								
Total Intake :						Total Output : U - 2 M -						
23/5	08:00 pm	Pals										
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						Total Output : U - M -						
24/5	02:00 am	Pals										
	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. : .....

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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							
24/5/26	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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	01:00 am											
Total Intake :						**Total Output :**						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						**Total Output :**						

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

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NURSING CARE RECORD

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Date: 22/5/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon							
Night	2Am 10 8pm	Assess the pt condition. Monitor vitals & record Maintain I/O chart. Provide the comfortable position. Medication given as per os doctor order.	2Am 10 8pm	Assessed the pt condition. Monitored vitals & recd Maintained I/O chart. Provided the comfortable position. Medication given as per os doctor order.	→ Pt is stable → vitals normal	→ Monitor vitals. → Maintain I/O chart.	

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NURSING CARE RECORD

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Date: 23/5/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8AM to 2pm	→ Assess the pt condition → Monitor the vitals → Maintain I/O chart → Administer medicati-on as per drug chart	8AM to 2pm	→ Assessed pt condition → Monitored vitals → Maintained I/O chart → Administered medicat-ion as per drug chart	Patient is stable	Re-checked vitals	[illegible]
Afternoon	2pm 8pm	- Assess the pt condition - monitor the vital - Maintain I/O Char - Administer medicin as per drug char	2pm 8pm	Assessed the pt condition - Monitored vital - Maintained I/O Char - Administered Medication as per drug chart	pt is stable	Rechecked vitals	[illegible]
Night	8pm 8AM	→ Plan for vital → Plan for I/O chart → ~~main~~ Administer medication as per doctor order	8pm 8AM	→ vital checked & recorded. → Maintain I/O → All medication given as per doctor order	→ Patient is stable	→ Re checked vitals → vitals stable	Smita Br

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NURSING CARE RECORD

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Date: 20/8/26

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
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- ☐ Maintain Skin Integrity
- ☐ Patient & Family Education

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8Am to 2pm	→ Assess the pt condition → monitor vitals → maintain I/O chart → Administer medication → continue Nebulization	8pm to 2pm	→ Assessed the pt condition → Monitored vitals → Maintained I/O chart → continue given Nebulization.	Now pt is stable	Re-check vital	Moni
Afternoon							
Night							

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NURSING CARE RECORD

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Date: .....

Goals

- ☐ Maintain Airway and Oxygenation
- ☐ Maintain Personal Hygiene
- ☐ Identify Potential Complications
- ☐ Relieve Pain & Discomfort
- ☐ Prevent Infection
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	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:				Any Infection: ☐ Yes ☐ No ☑ Not Known If Yes Specify:		
	Surgery / Procedure:				Post OP Day:		
BACKGROUND	Date / Shift	23/5 N1	23/5 M6	23/5/26 E2	23/5 N1	24/5 M6	
	Medical Condition (Any special condition to be noted):	–	–	–	–	–	
	Diet:	Soft	Soft	Soft	Soft	Soft	
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	98.5°F	98.6°F	98.6°F	98.6	
	Res:	28 b/m	25 b/m	28 b/m	29 b/m	29 b/m	
	SpO_2:	98%	99%	99%	99%	97%	
	Pulse:	102 b/m	102 b/m	100 b/m	111 b/m	112 b/m	
	BP:	100/59	100/58	–	–	–	
	LOC:	–	–	–	–	–	
	Fall Risk Score:	–	–	–	–	–	
	Pain Score:	–	–	–	–	–	
	Skin Integrity	–	–	–	Intact	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:	–	–	–	–	–	
	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):	Dependent	–	–	Dependent	dependent	
Post Operative Procedure Special Orders:			–	–	NA	NA	
Handed Over By Name :		Sneha	Anusha	Manisha	sneha	neeru	
Signature / ID :		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	
Date:		23/5	23/5/26	23/5/26	24/5/26	24/5	
Time:		8 Am	8pm	8pm	8Am	2pm	
Taken Over By Name :		Anusha	Manisha	sneha			
Signature / ID :		[illegible]	[illegible]	[illegible]			
Date:		23/5/26	23/5/26	23/5/26			
Time:		8AM	2pm	8pm			

Patient Sticker

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NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:	Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
	Surgery / Procedure:	Post OP Day:					
BACKGROUND	Date / Shift						
	Medical Condition (Any special condition to be noted):						
	Diet:						
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Ventilation (RA, NP, NIV, VENTI):						
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:						
	Res:						
	SpO_2:						
	Pulse:						
	BP:						
	LOC:						
	Fall Risk Score:						
	Pain Score:						
	Skin Integrity						
Recommendations	Safety Needs:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Physiotherapy:						
	Others Specify:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Special Diet:						
	Critical Lab Test / Values:						
	Other Special Orders / Medications:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	PU Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	DVT Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	ADL (Dependent / Non Dependent):						
Post Operative Procedure Special Orders:							
Handed Over By Name :							
Signature / ID :							
Date:							
Time:							
Taken Over By Name :							
Signature / ID :							
Date:							
Time:							

HNH-00015572 IP26-00006409
Master MADIPI AADIVIK
16-08-2019 6 Y 9 M 5 D (M)
Patient Dr. S TEJASWI REDDY

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THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE 23/5	DATE 23/5	DATE 23/5	DATE 24/5	DATE
Age	Less than 3 years old	4					
	3 to less than 7 years old	3	3	3	3	3	
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	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	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	
	Outpatient Area	1	1	1	1	1	
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours/ None	1	1	1	1	1	
Medication Usage	Sedatives (Excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1	1	1	
	Total		9	9	10	10	

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:		Sneha	[illegible]	[illegible]	[illegible]
	Signature:		[illegible]	[illegible]	[illegible]	[illegible]
	Date:		23/5	23/5	24/5	24/5
	Time:		3 AM	8 pm	8 AM	10 AM

HNH-00015572 IP26-00006409
Master MADIPI AADIVIK
16-08-2019 6 Y 9 M 5 D (M)
Dr. S TEJASWI REDDY

BRADEN 'Q' SCALE

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				Date : 23/5	23/5	23/5	23/5
				Time : 8AM	MO	E2	N1
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.	3	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.	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	27	27	28	28
				Evaluator's Name	Sneha	[illegible]	B	[illegible]

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

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

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

HNH-00015572 IP26-00006409
Master MADIPI AADIVIK
18-08-2019 6 Y 9 M 5 D (M)
Dr. S TEJASWI REDDY

BRADEN 'Q' SCALE

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				Date :	24/5			
				Time :	10 Am			
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			
"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			
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			
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			
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			
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			
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			
				TOTAL SCORE	28			
				Evaluator's Name	[illegible]			

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

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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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Master MADIPI AADIVIK
16-08-2019 6 Y 9 M 5 D (M)
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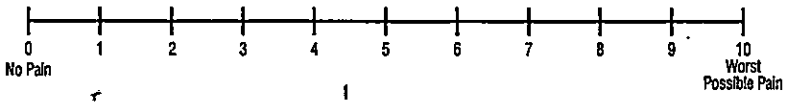
PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
23/5	3Am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	NA	Sneha
23/5	8Am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	NA	Sneha
23/5	2pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	NA	[illegible]
23/5/26	6pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	NA	[illegible]
"	10pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	NA	[illegible]
24/5/26	6AM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	NA	[illegible]
24/5/26	10Am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[illegible]
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

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

PAIN ASSESSMENT TOOLS

Numerical Pain Scale (Obstetric and Gynecology)



Wong - Baker (Pediatrics) Above 7 Years

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

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

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

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CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	22/5 DAY-1			23/5 DAY-2			24/5 DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0			0	0	0	0	0			
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1			NA	NA	NA	NA	NA			
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2			NA	NA	NA	NA	NA			
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3			NA	NA	NA	NA	NA			
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4			NA	NA	NA	NA	NA			
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5			NA	NA	NA	NA	NA			
		Signature of the Nurse				Sneha	Arti	A	Bala	Bala			

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 : Sneha Name : Sneha

Signature of Ward In Charge :
Signature : Balarani Name : Balarani

Docu. No. : RCH /FRM / CLINICAL / 137

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DRUG CHART

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

FOR THE SAFETY OF THE PATIENT

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

DOCTOR
- Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
- Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
- Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
- Discontinue a drug by drawing a line *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 : Syp. Crocin DS				Date/Time
Dose: 6ml	Route: PO	Frequency: SOS	Start Date: 23/5	
Doctor's Signature: [signature]		Valid Period: >100P	Pharm.	
Additional Instructions:				

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:				

Signature

VERIFIED BY : Name

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18-08-2019 6 Y 9 M 5 D (M)
Dr. S TEJASWI REDDY

REGULAR PRESCRIPTIONS Weight. 20.5kg Ward. .....

DRUG : Neb levalin

Dose	Route	Frequency	Start Date
0.3ml	Neb	8 2H	23/5

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date ▸ Time

See the chart

DRUG : Neb ipravent

Dose	Route	Frequency	Start Date
1 respule	Neb	8 6H	23/5

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date ▸ Time

See the chart

DRUG : Inj. METHYL Prednisolone

Dose	Route	Frequency	Start Date
10mg	IV	BD	23/5

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date ▸ Time 23/5/15 23/5

8pm

DRUG : Neb Levolin

Dose	Route	Frequency	Start Date
0.3ml	Neb	3rd h	23/5

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date ▸ Time

See the chart

changed to 4th hrly

Patient Sticker

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Sheet No: .....

REGULAR PRESCRIPTIONS

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

DRUG : Neb c Levolin				Date ➤ Time
Dose	Route	Frequency	Start Dt.	
0.63mg	neb	QuH	24/5	
Name & Signature of the Doctor Starting the Drugs: Nau (Bntameen)				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

See the chart

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

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

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

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																

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

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

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

Docu. No. : RCH /FRM / CLINICAL / 108

(P.T.O.)

HNH-00015572 IP26-00006409

Master MADIPI AADIVIK
18-08-2019 6 Y 9 M 5 D (M)
Dr. S TEJASWI REDDY

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

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
23/5	7:30 Am	Inj. MgSO4	1.5ml in 19ml NS over 40 minutes.	IV		
23/05	8 AM	Inj. METHYLPREDNISOLONE	20mg	IV		

Signature

VERIFIED BY Name

Master MADIPI AADIVIK
18-08-2019 6 Y 9 M 5 D (M)
Dr. S TEJASWI REDDY

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
23/5	3Am	IVF DNS. (2/3M)	IV.	40ml/hr					
23/5	2Pm	DNS	IV	20 ml					

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

HNH-00015572 IP26-00006409
Master MADIPI AADIVIK
18-08-2019 6 Y 9 M 5 D (M)
Dr. S TEJASWI REDDY

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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: ....W....

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. Naipuniya....

Date & Time : ....23/5/26 @ 1:40 Am....

Nurse Name & Signature: ....Jyoti / Jyoti....

Date & Time : ....23/5/26 @ 1:42 Am....

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

HNH-00015572 IP26-00006409
Master MADIPI AADIVIK
18-08-2019 6 Y 9 M 5 D (M)
Dr. S TEJASWI REDDY

Wt - 20 Kg

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EMERGENCY ROOM TRIAGE FORM

Patient's Name : Master M ~~Ad~~ Aadvik Age : 7 Y **Gender:** ☑ Male ☐ Female

Date : 23/5/26 Time of Arrival : 1:20 Am

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: 98.6 F PR: 125 b/m BP: ..... RR: 40 b/m SpO_2: 90%

Chief Complaints: C/O fast breathing, cough since today evening 1 Episode 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 : 1:22 Am

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 : Jyothi

Signature of Triage Nurse : Jyothi

Date & Time : 23/5/26 @ 1:22 Am

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

HNH-00015572 IP26-00006409
Master MADIPI AADIVIK
18-08-2019 6 Y 9 M 5 D (M)
Dr. S TEJASWI REDDY

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 23/5/26 Time of arrival : 1:24 Am

Chief Complaints: C/O fast breathing, cough since 2 days × 1 Episode vomiting RBS: .....

Height : ..... Weight : 20 kg BMI : ..... Head Circumference (<2 years) .....

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

If yes , identify .....

Pain Screening: ☐ Yes ☑ No If Yes, Pain Score: 0 Pain Tool Used: ☐ N Pass ☐ FLACC ☐ Wong Baker

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

RISK FOR FALL:

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

☐ If Patient is > 6 years
Assess the below parameters

History of Falling: within past 3 months ☐ Yes ☑ No

Ambulatory Aids:

- Wheelchair ☐ Yes ☑ No
- Uses furniture for support ☐ Yes ☑ No

Gait/Transferring:

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

Mental Status: Forgets limitations ☐ Yes ☑ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening: ☑ No Abnormalities Detected

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

Inform consultant for positive criteria

.....

.....

Nutritional Screening: ☑ No Abnormalities Detected

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

Inform consultant for positive criteria

Psychological Screening: ☑ No Significant Findings

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

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

Social History: Lives With family

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

Time of Initial assessment completed by ER Nurse : 1:26 Am

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

Time	Nursing Notes
	- Assess the pt condition
	- monitor vitals
	- Nebulization given

Samples collected by: Sjen

Samples sent by :

Time: 2:10 Am

Time:

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1
1:20 Am	levolin 0.63	Neb	0.63 mg	Dr. Naipuna	Sjen
	back to back				
	Ipravent	neb	1 respule		

Condition of patient at time of shift - out :	**Details of Shift - out**
HR: 125 bpm BP: 102/62 CFT:	Shift - out from ER to: 221
RR: 40 bpm SPO$_2$: 93%	Time of Shift - out: 2:30 Am
GCS: 14/15 Temperature : 98.2°F	Handover given to: Sneh
Pain Score:	(Nurse's Name)
Repeat RBS (if applicable):	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any): I.V placement Done

Name of the Nurse : Sjeni

Signature of the Nurse :

Date & Time : 23/5/26 @ 1:97 Am

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PATIENT TRANSFER FORM

Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00015572 IP26-00006409 Master MADIPI AADIVIK 18-08-2019 6 Y 9 M 5 D (M) Dr. S TEJASWI REDDY	23/5/26 @	23/5/26 @ 2:50 PM
	Transfer Ordered by Dr. Naipuniya	Reason for Transfer Admission
From Unit ER	To Unit 221	Information to Attendant Yes ☐ No ☐
Number of Sheets in Clinical File 25	Number of Imaging Films 1	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

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

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Anupam	Dr. Naipuniya

Patient & Clinical Records Received by : @ 23/5/26

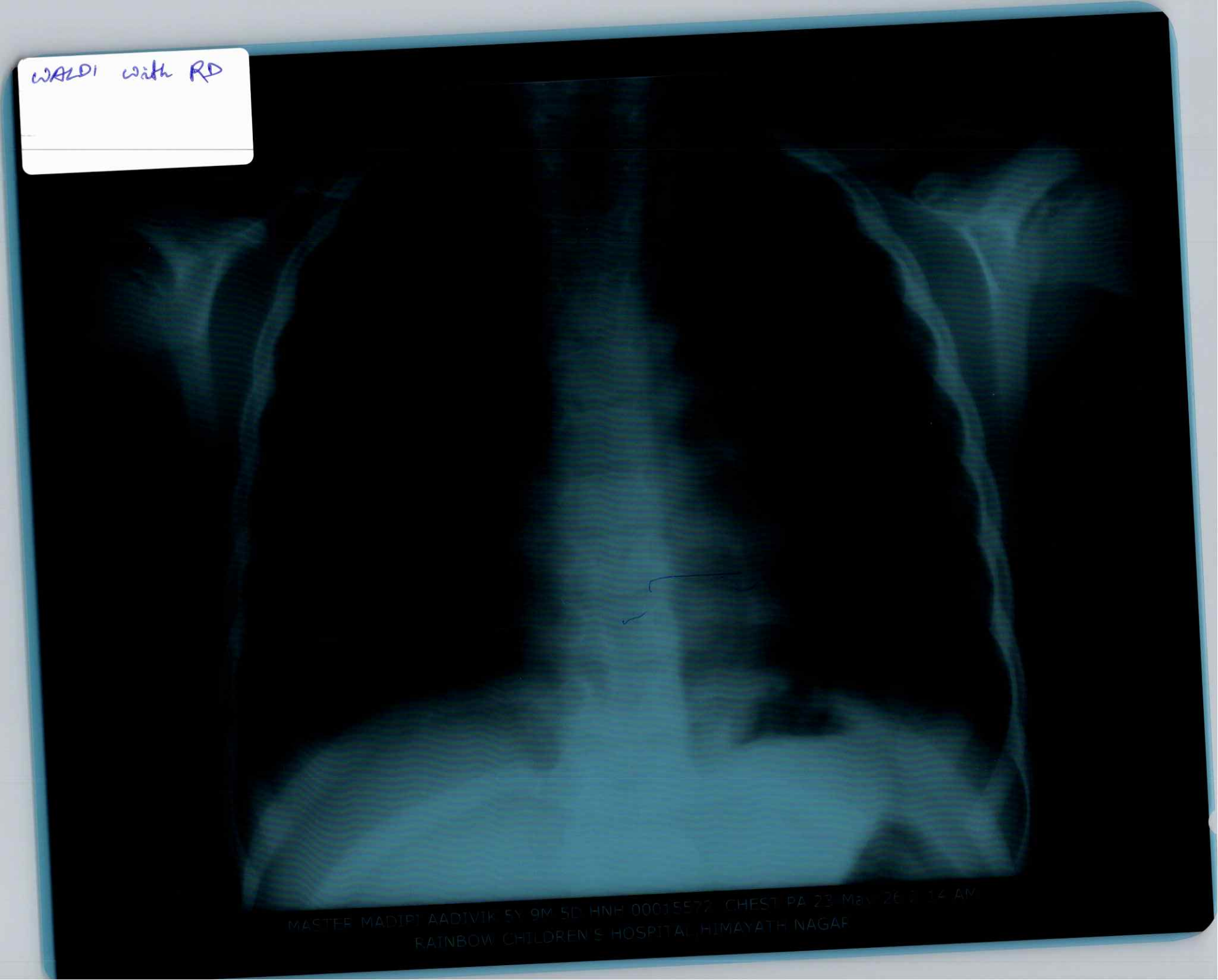
Date & Time of Patient Received : 2 AM

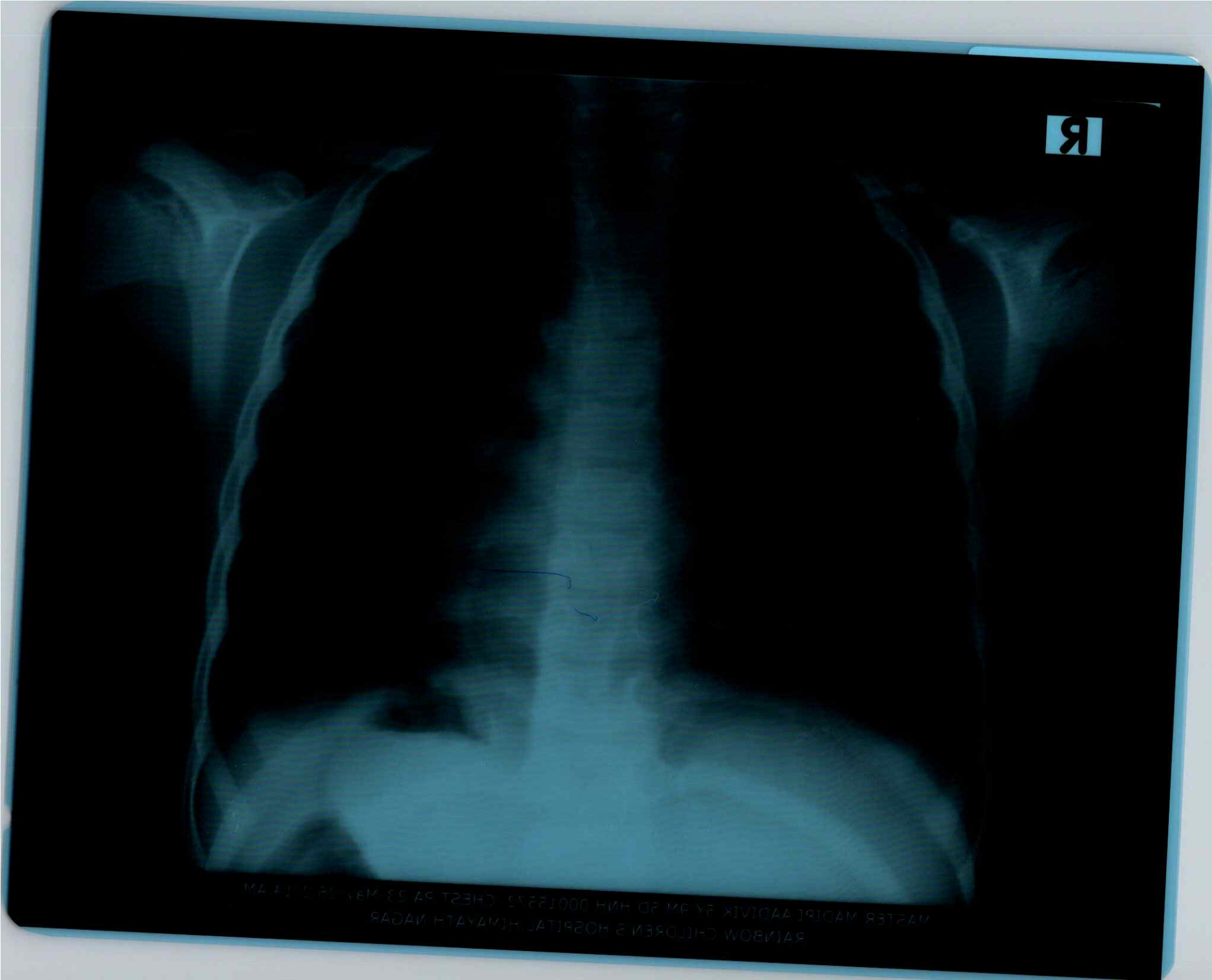
If the transfer order time & Completion time is more than 30 minutes, please tick the reason mentioned below :

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

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

WALDI with RD

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