

DISCHARGE SUMMARY

Name	Master DEVANSH TAWARE	UHID	BAH-00569547
Father/Guardian	Mr SAMEER	Age/Gender	2 Y 10 M 11 D/ Male
Address	H.NO- 2-2-1075/15, BAGH., Amberpet, Hyderabad, INDIA, 500013		
IP No	IP26-00006818	Admission Date	12-07-2026
Ref Doctor	DR. PREM KUMAR RAMPALLY		
Discharge Date	17.07.2026		

Consultant:

Dr. SINDHURA MUNUKUNTLA
MBBS, DCH, DNB PEDIATRICS
66970

DIAGNOSIS	ICD CODE
ACUTE FEBRILE ILLNESS WITH DEHYDARATION	
EBV INFECTION	
ORAL CANDIDIASIS	

History: Master DEVANSH TAWARE, 2 Y 10 M 11 D , old boy presented with history of fever associated with cold since 2 days, headache, abdominal pain and poor oral intake since 2 days, prior to admission. For the above complaints he was admitted at Rainbow Children's Hospital - for further management.

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Examination: He was (100°F) febrile, maintaining saturations at room air. His heart rate was 156/min and Respiratory Rate - 28/min. Capillary Refill Time was <2 secs. Peripheries were warm & pulses well felt. On examination signs of dehydration were present in form of dry chapped lips, dry oral mucosa, sunken eyes, irritability. On auscultation, air entry was bilaterally equal. Heart sounds were normal and there was no murmur. Abdomen was soft with no organomegaly. On neurological examination, he was conscious and alert. Pupils were bilaterally equal and reacting to light. There were no focal neurological or cranial nerve deficits. There were no signs of raised intracranial pressure. Throat examination showed bilateral enlarged and congested tonsils.

Weight on admission: 13.9 kilo grams.

Investigations: Enclosed reports.

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

Adenovirus PCR was not detected.

Dengue NS1 and IGM were not detected.

Blood culture shows : No growth after 48 hrs of incubation

Complete urine examination shows:

Epithelial cells : ketone bodies present, epithelial cells -2-3, pus cells - 2-3, RBCS - 3-4.

VBG showed pH of 7.44, pCO₂ of 28.1 mmHg, pO₂ of 31 mmHg, HCO₃ of 19.2 mmol/L and BE of -5.0 mmol/L.

Initial hemogram showed Haemoglobin of 10.4 gm%, White Blood Cell count of 26260 cells/cumm, platelet count of 2.57 lakhs/cumm and C-Reactive Protein

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of 28 mg/l.

Albert Stained Smear - Does not show any structures morphologically resembling *Corynebacteria diphtheriae*.

EBV ANTIBODIES TETRA PANEL:

EBNA IGM - NON REACTIVE

EBNA IGG - NON REACTIVE

EBV VCA IGM - REACTIVE.

EBV VCA IGG - REACTIVE.

Mycoplasma IGM - Non reactive

Throat swab for culture & sensitivity sent, report awaited.

Blood culture was sterile.

Complete urine examination was normal.

Dengue NS1 & IgM were negative.

X-Ray Nasopharynx shows:

Lobulated soft tissue along posterior nasopharyngeal wall causing severe narrowing of nasopharyngeal air way - Likely enlarged adenoid.

Ultrasound Neck shows:

Both lobes of thyroid are normal in size, shape and echogenicity.

Isthmus is normal in size and echogenicity.

No focal or diffuse mass lesions.

Great vessels of neck appears normal

Bilateral parotid and submandibular glands appear normal.

Few prominent lymphnodes noted bilaterally in the neck, largest measuring 2.3 x 1.1 cm on the right and 2.2 x 0.8 cm in the left level II region with increased

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hilar vascularity. No obvious necrosis/ abscess at present. Findings in with keeping with cervical lymphadenitis - likely reactive.

- For clinical correlation.

Ultrasound abdomen shows:

* Mildly coarse splenic echotexture, likely reflecting reactive changes in the setting of EBV infection.

* Multiple small lymph-nodes along the mesentery in the RIF and periumbilical region - in keeping with mesenteric adenopathy.

- For clinical correlation.

Management: He was admitted in the ward and was started on Intra Venous fluids and Intra Venous antibiotics. He was treated symptomatically with antipyretics. In view of pain abdomen, he was administered antacids and advised gastrodiet.

During ward stay, child had persistent high grade fever spikes and as first line investigations were negative, mycoplasma IgM and EBV tetrapanel was sent, which showed EBV VCA IgM and IgM were positive.

Child developed follicular tonsillitis, which progressed to membranous tonsils, hence repeat throat swab for culture was sent, report awaited and Inj. Clindamycin was started for antitoxin cover. Throat swab verbal report was suggestive of oral candidiasis.

Child also had persistent snoring and mouth breathing, for which X-Ray nasopharynx was done, which showed enlarged adenoids for which management was started.

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In view of above findings, Dr. Chandana (ENT surgeon) consultation was taken who advised to continue conservative management.

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

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

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

Medication during hospital stay:

Injection. Esmoprazole

Injection. Ceftriaxone

Syp. Xyzal

Syp. Duphalac

Syp. Crocin DS

Metatop nasal spray

Advice:

* Diet as advised.

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S.N o	MEDICATION	DOSE	TIMINGS	DURATION
1	Tablet. LANZOL DT (Lansoprazole - 15mg)	1 tablet	7am (before breakfast)	For 5 days
2	Syrup. Xyzal	2.5ml	10pm (after food)	For 5 days
3	Metatop Nasal Spray	1 spray each nostril	10am-10pm (after food)	For 15 days
4	Nasoclear Mist Nasal Spray	1 spray	6th hourly	For 5 days.
5	Candid Mouth Paint	Local Application	8am-8pm	For 5 days
6	Nasivion-P Nasal Drops	1 drop each nostril	9am -9pm	For 5 days
7	Nasoclear nasal drops, 2 drops in each nostril SOS for nose block			

Plan: To collect final throat swab culture report on followup.

Fever Management

* Syrup. Crocin DS (Paracetamol - 5ml/240mg) 4 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 Monday (20.07.2026)

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

Food instructions while taking medications:

* **Anti ulcer drugs** can decrease the absorption of Iron&vit-B12. Anti ulcer drugs can be taken at least 1 hour before food (OR) 2hrs after food. Avoid caffeine that increases stomach acidity.

* Food can decrease the absorption of **antihistamines**. Antihistamines can be taken on an empty stomach /before food to increase their effectiveness.

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

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

Parent/ Attender

In case of emergency contact 9154865030 emergency pediatrician on duty.

To take appointment for OPD consultation at Rainbow **Banjara Hills** / Rainbow Clinic **Madhapur** / **Kukatpally** / **Vikrampuri** / **LB Nagar** / dial just one toll free number **18002122**.

You can also take appointments at any time by going **online** to our website **www.rainbowhospitals.in**

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Prem
Registrar/Resident/C.M.O



Dr. SINDHURA MUNUKUNTLA
MBBS, DCH, DNB PEDIATRICS
66970

ADMISSION SHEET



Registration Details :

Admission No : IP26-00006818 **Admit Date** : 12-Jul-2026 **Admit Time** : 09:28 AM **UHID** : BAH-00569547

Patient Details :

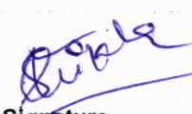
Patient Name	: Master DEVANSH TAWARE	Age	: 2 Y 10 M 10 D
Guardian	: Mr SAMEER	DOB	: 02-09-2023
Gender	: Male	Religion	:
Occupation	:	Martial Status	:
Address (H)	: H.NO- 2-2-1075/15, BAGH. Amberpet Hyderabad INDIA 500013	Phone No	: 6309861793/ 8019893553
		E-mail	: dharmishikhajaiswal@gmail.com

Admission Details :

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

Contact Details :

Name	: Mr SAMEER	Relationship	: Father
Contact Address	: H.NO- 2-2-1075/15, BAGH. Amberpet Hyderabad INDIA 500013	Phone No	: 8019893553

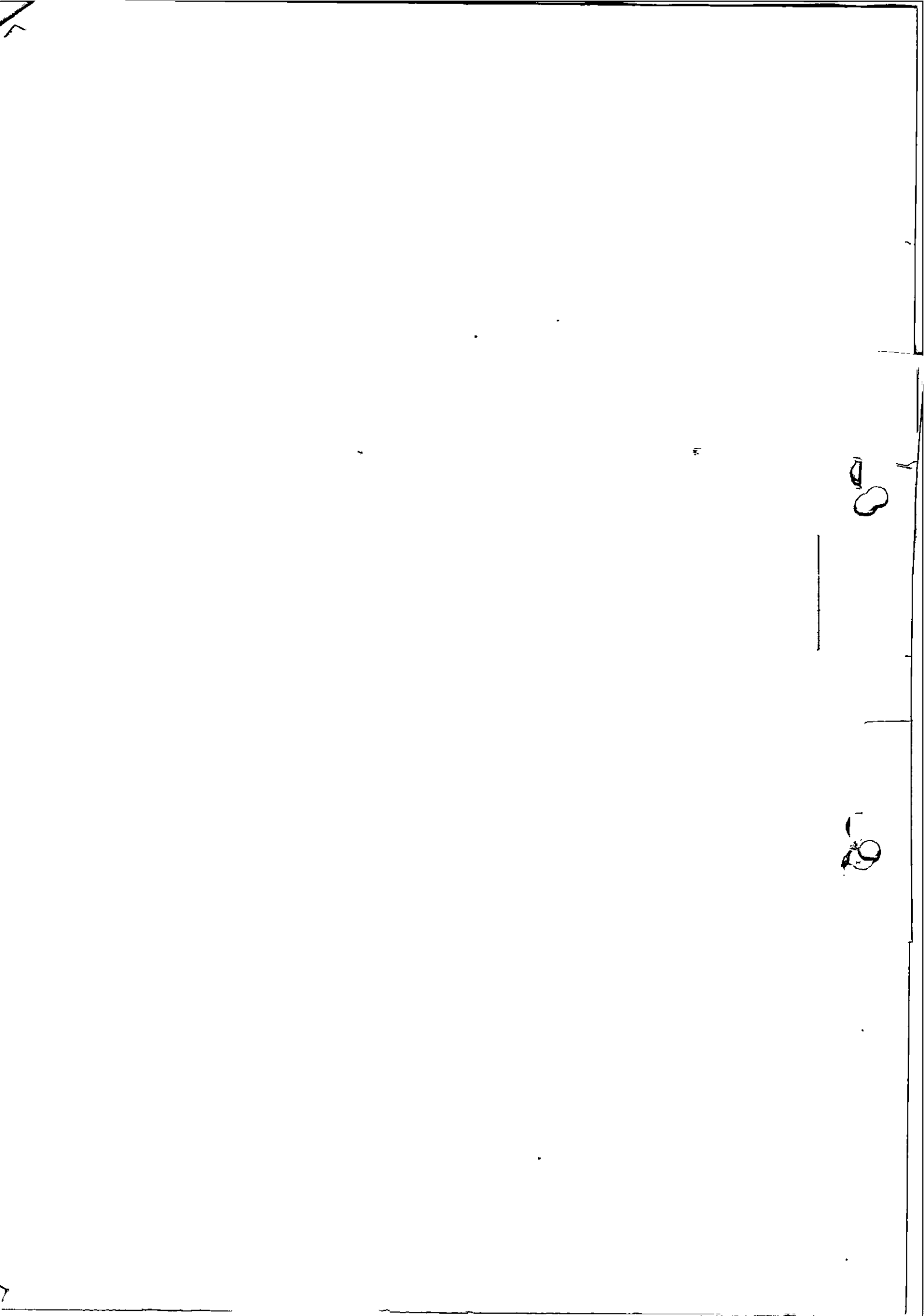

Signature

Doctor Details :

Doctor Name	: Dr. SINDHURA MUNUKUNTLA	Specialisation	: GENERAL PEDIATRICS
Referral Doctor	: DR. PREM KUMAR RAMPALLY	Phone No	:
Co-Consultant	:		

Payment Details :

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



ACTIVITY RECORD FOR BILLING

Name: ----- BAH-00569547 IP26-00006818 -----
Master: DEVANSH TAWARE
02-09-2023 2 Y 10 M 10 D (M)
UHID No: - Dr. SINDHURA MUNUKUNTLA ----- Consultant: ----- Dept: -----
Date of Adr ----- Date of Discharge: ----- Time: -----
Room / Bed No: ----- Ward: ----- Suggested Billable bed type: -----



WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
12/7/26	10:25 AM	ER	Ward	[Signature]

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1.	Dr. Alkeshandara	14/2/26	13721	[Signature]
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Cross checked by [Signature]

INVESTIGATIONS

Date	Investigations	Order No.	Sign
12/7/26	CBP, CRP	11547	JST
	VBW	11548	
	Respiratory panel		
12/7/26	X-ray Nasopharynx	8408	Q
12/7/26	Dengue NS1 + IgM	1557	Q
12/7/26	COE	11572	ST
12/7/26	Blood c/s	11570	Q
Cross checked done by Amornak			
13/7/26	Albert stain	11633	Baj
	Throat swab. Streptococcal group A & C	11633	Baj
13/7/26	CBP, CRP, LFT, Mycoplasma. IgM Adenovirus PCR, EBV-DNA IgM	11675	ST
13/7/26	EBV-Tetra panel	11676	ST
cross checked by Younshin @ SAM, 14/7/26			
14/7/26	Albert stain	1722	Q
	Throat swab streptococcal group A c/s	8508	ST
14/7/26	USG neck		cross checked done

MEDICAL EQUIPMENT (WARD & ICU)

[illegible]

[illegible]

ANY OTHER INFORMATION

Date : _____ Time : _____ Prepared By : _____

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

ACTIVITY RECORD FOR BILLING

Name : _____

BAH-00569547 IP26-00006618

UHID No. : _____

Master DEVANSH TAWARE

02-09-2023 2 Y 10 M 12 D (M)

Dr. BINDHURA MUNUKUNTLA

Consultant: _____ Dept : _____

Date of Admission: _____



Date of Discharge: _____ Time: _____

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse

Cross Consultation Visit

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

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature

ANY OTHER INFORMATION

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.....

.....

.....

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

BAH-00569547 IP26-00006818
Master DEVANSH TAWARE 2 Y 10 M 14 D (M)
02-09-2023 Dr. BINDHURA MUNUKUNTIA

3-1. NS 6th hourly

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

NEBULISATION CHART

Date	Time	Drug	Nurse	Parents Signature
17/7/20	00.00			
	01.00	3-1. NS ①	AS	SS
	02.00			
	03.00			
	04.00	2-1. NS ②		
	05.00			
	06.00			
	07.00	3-1. NS ②	AS	SS
	08.00			
	09.00			
	10.00			
	11.00			
	12.00			
17/7/20	13.00	3-1. NS		
	14.00			
	15.00			
	16.00			
	17.00			
	18.00			
	19.00			
	20.00			
	21.00			
	22.00			
	23.00			

5% NS-6th hourly

NEBULISATION CHART

Date	Time	Drug	Nurse	Parents Signature
	00.00	5% NS (1)	Shubh	Shubh
	01.00			
	02.00			
	03.00			
	04.00			
	05.00			
	06.00	3% NS (2)	Shubh	Shubh
	07.00	4/7/1		
	08.00			
	09.00			
	10.00			
	11.00			
	12.00	3% NS (1)	Shubh	Shubh
	13.00			
	14.00			
	15.00			
	16.00			
	17.00			
	18.00	3% NS (2)	Shubh	Shubh
	19.00	14/4/4		
	20.00			
	21.00			
	22.00			
	23.00			

47





3% NS -
6th Hourly

NEBULISATION CHART

Date	Time	Drug	Nurse	Parents Signature
15/7/23	00.00	3% NS (1)	(Signature)	(Signature)
	01.00			
	02.00			
	03.00			
	04.00			
	05.00			
	06.00	3% NS (2)	(Signature)	(Signature)
	07.00			
	08.00			
	09.00			
	10.00			
	11.00			
	12.00	3% NS (1) 2/4044	(Signature)	(Signature)
	13.00			
	14.00			
	15.00			
	16.00			
	17.00			
	18.00	3% NS (1) 14/48	(Signature)	(Signature)
	19.00			
	20.00			
	21.00			
	22.00			
	23.00			



BAH-00569547

IP26-00006818

Master DEVANSH TAWARE

02-09-2023

2 Y 10 M 11 D

(M)

Dr. SINDHURA MUNUKUNTLA



3% NS - 6th hourly

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It takes a lot to treat the little.

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Your Right to a Safe Delivery

NEBULISATION CHART

Date	Time	Drug	Nurse	Parents Signature
14/7/2023	00.00			
	01.00			
	02.00			
	03.00			
	04.00	3% NS		
	05.00			
	06.00			
	07.00			
	08.00			
	09.00			
	10.00	3% NS		
	11.00			
	12.00			
	13.00			
	14.00			
	15.00			
	16.00			
	17.00	3% NS		
	18.00			
	19.00			
	20.00			
	21.00			
	22.00			
	23.00			

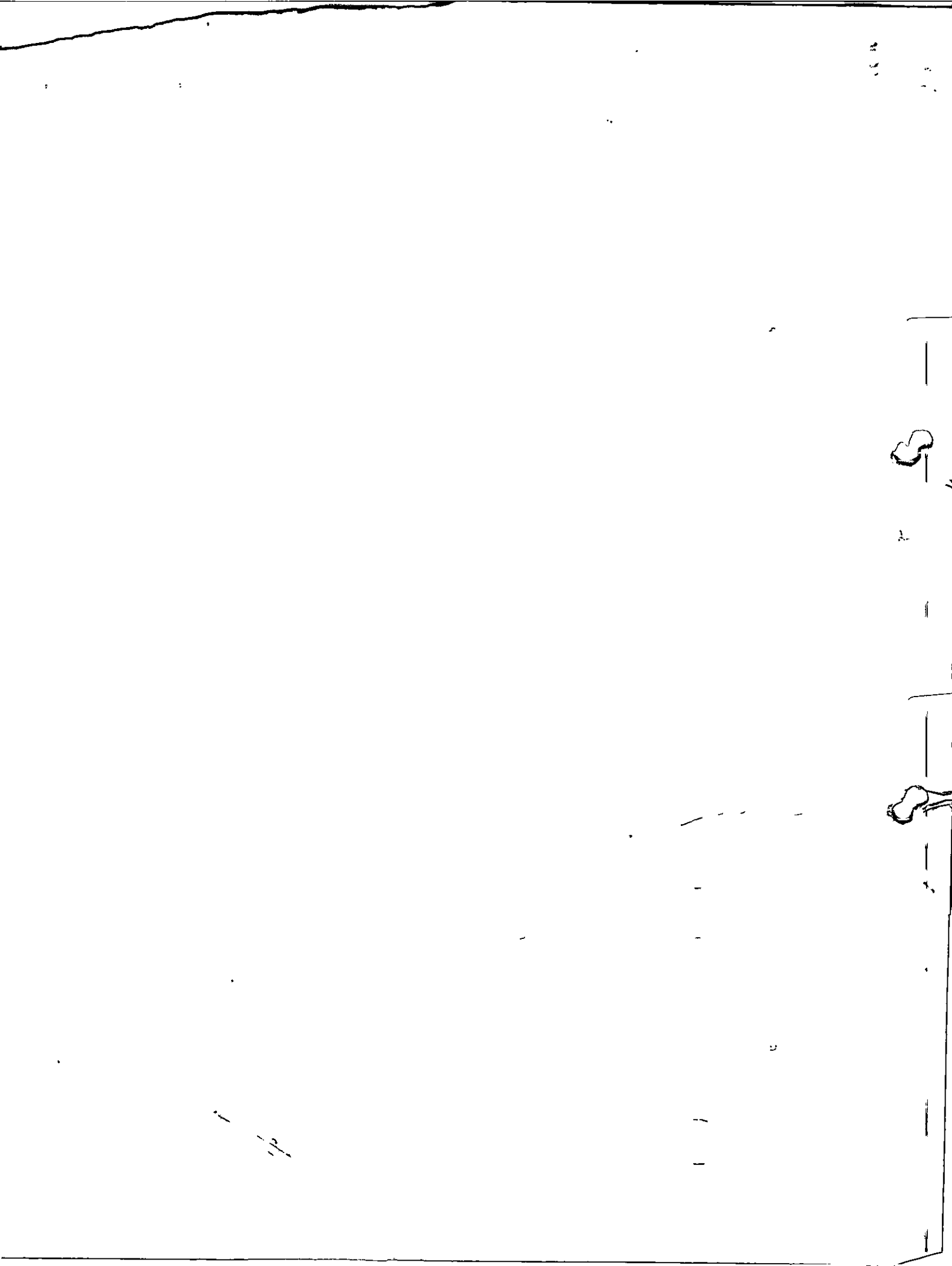




3% NS 6th
hourly

NEBULISATION CHART

Date	Time	Drug	Nurse	Parents Signature
	00.00			
	01.00			
	02.00			
	03.00			
	04.00			
	05.00			
	06.00			
	07.00			
	08.00			
	09.00			
	10.00			
	11.00			
	12.00			
	13.00			
	14.00			
	15.00			
	16.00	3% NS (U) 13455	ISA	[Signature]
	17.00			
	18.00			
	19.00			
	20.00			
	21.00			
	22.00	3% NS - (A)	[Signature]	[Signature]
	23.00			



Ref.No. F/IN/PR/10



PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name :

Devansh

Patient ID# :

BAH-00569547 IP26-00006818
Master DEVANSH TAWARE
02-09-2023 2 Y 10 M 10 D (M)
Dr. SINDHURA MUNUKUNTLA

Consultant :



Final Diagnosis :

Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Informant _____ Reliability _____

Chief Presenting Complaints & Duration (Chronologically):

cb fever x 2 days cb ↓^{sed} oral acceptance x 1 day.
cb cold x 2 days
cb headache ?
cb stomach } x 2 days

History of present illness :

pt was apparently asymptomatic 2 days ago
when he developed fever, high-grade, c chills,
reduced with medication, continuous spikes, c headache

cb cold x 2 days, not ass with breathlessness
cb stomach pain since 2 days, ass with reduced
oral acceptance

c

Pediatric Multiorgan History & Physical Examination

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

Birth & Neonatal History :

Born @ Yashoda Krishna
FT/CAB 2.8 kgs/ MCH

Birth & Socio Economic History :

About Father :

About Mother :

Any additional Information :

Developmental History :

Immunization History :

upto date

Pediatric Multiorgan History & Physical Examination

Anthropometry

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

Weight (kgs) _____ (Centile _____)

On Examination :

Temperature : 100°F Pulse Rate: 156 bpm Description _____

B.P. _____ SPO2 98% at _____

Resp. rate and type of breathing : 28/min

Rash _____

Lymphadenopathy _____

Oedema : _____

dry chapped lips ⊕
sunken eyes ⊕
irritability ⊕

Respiratory system :

Inspection (any s/o distress) : _____

Air entry & breath sounds : _____

Any added sounds : _____

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

AEBE, BL clear

Cardiovascular System :

Inspection of precordium : _____

Heart Sounds : _____

Any murmur : _____

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

S1S2 ⊕ No.

Per Abdomen :

Inspection _____

Palpation : _____

Auscultation : _____

Spine: _____ External Genitalia : _____

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

Soft, nt

Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS Score : _____

Cranial Nerves : _____

Motor System :

Nutrition : _____

Tone : _____ Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR

Superficials :

Plantars _____

Sensory System :

Bladder / Bowel : _____

Clinical Summary & Diagnostic :

AFI & Dehydration

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment :

Desired goals of the treatment :

Planned Labs :

CBP , VBG

CRP , Blood c/s

↓
send if needed

- keep sample for tongue
- SVirus Respiratory panel

NB Prabir

Planned Management :

IVF DNS @ 33ml/hr

NaSo clear

(decide) CRP
(IV Abs)

noted By Prabir

Please fill up the following details

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

Doctor's Signature Name

Date

12/2/26

Time

11:50 AM

Dr. Sindhu m
Consultant Pediatrician
Reg. No. 66970

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
12/1/26 11 AM	8/B Dr. Sindhura fever spikes (+) oral acceptance ↓ Throat - mild congestion, No tonsillar hypertrophy / folicles vitality stable gle w al	Adv Make oral paracetamol 6th hourly (SOS) Ibuprofen 7.5ml • Diphalarac syrup 10ml • Esmoprazole • [Dulcolax suppository (1/2) to day if not passing stool • (C) Dengue NS, / 8gm xray nasopharynx CUE <i>[Signature]</i> Dr. Sindhura Munukuntla Consultant Pediatrician Reg. No: 66979

Date & Time	Progress Notes	Doctor's Order
12/7/26 4pm	<u>ulr3 re. mahm</u> <u>AFIC dehydration</u>	
	- fever spikes (+) 100 if 4pm - cough (+) - mild - oral intake : <u>poor</u> - not passed stool yet. <u>O/E</u> intake : stable <u>st</u> : RS : RPE (+) clear ms : LRS, (+) R/A : soft <u>mm</u>.	<u>Plan</u> 1) it - ceftriaxone 2) leave CRP WE dengue NS, IgM Resp. panel blood cl. 3) Revt it. as per Rx chart 4) monitor intake <u>NB Sumanda @ 4.30pm</u>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
13/7/23 10 AM	C/S/b Dr. Sindhu re	
	Δ- APH & dehydration. / Day 4 of fever	
	few spikes - persistent.	
	- Oral intake - poor.	Plm -
	- Pain abdomen ↓	Oct. ceftriaxone
	GE - vitals stable.	- Gt. Metatop N/S.
	ECS - B/L ⊕.	- x-ray
		- Esnap x-ray.
	SE - R/S - BAFA.	- Trace Dmgue serology
	Temp. pert - eve.	- Trace adenovirus.
		- Force throat swab for
		- Trace blood cl. C/S.
		- Monitor vitals
		- Send throat swab for Albert stain
		- Next line changes
		→ CRP, CRP, ESR, ferritin
		panels.
		- Reserve sample for
		Microbes & Mycoplasma

Tonsils - point point follicles & pseudo membrane over tonsils.

PTO

Dr. SINDHURA MUNDKUNT

BAH-00569547

Master DEVANSH TAWARE

02-09-2023 2 Y 10 M 10 D (M)

Dr. SINDHURA MUNUKUNTLA



Date & Time	Progress Notes	Doctor's Order
		- Hata change Crair DS to Q4H. @ 10mg/kg/dose
		- Theopopen Q8H.
		- Tepid sponging SOS.
	N/B ✓	Sleeping at 11 AM @ 13 hrs

Date & Time	Progress Notes	Doctor's Order
13/1/26	C/S/b Dr. Varma	
3PM	Δ -ARI & dehydration.	
	- fever spikes - persistent.	
	- oral intake - poor	
	8/E - vitals stable.	Plan
	8/E - WNL.	- Cont. CEFTRIAXONE.
		- Ct. Metatop xygal Esomeprazole.
		- Toner administration.
		- Tracheal swab for C/S / Albert stain.
		- Next line change - CBP, CRP, EBV tetra panel.
		- Reserve sample for Mucos & Mycoplasma.



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	C/S by Dr. Sindhura	
13/7		
6:00pm	AFE & dehydration snoring (+) fever spike - persistent	Plan
	Vitals - stable	- Cont Ceftriaxone
	R/S - B/L ACP B/L NVBS	- Trace Adenovirus
	Oral intake - poor	if negative Add linezolid chills
	PIA - soft, NT	Change Canula Repeat CBP, CRP, LFT
	U/O/p - Adequate	EBV (Tetrapack) [Scrub types Sym Measles Sym] Preset extra NaCl
		- Trace Throat Swab for Streptococci group's, C/S
		- Trace Albert stain - Monitor Vitals
		- Cont Neb & 3Y-NS
		- ENT opinion tomorrow
		- Cont paracetamol 86H ibuprofen 86H
		at my sign

Dr. Sindhura Munukuntla
 Consultant Pediatrician
 Reg. No: 66970

Sindhura
 Munukuntla

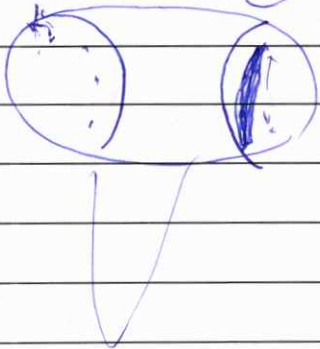


PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
14/7 8:30 AM	C/S/B D. Prasad / Dr. Prashanthi A* - Acute Febrile Illness Fever Spikes (P) Oral intake - less Vitals stable O/E child asleep afebrile R-S - B/LAC (P) PIA - Self-	 Dehydration - D4 Pls 1) Temp Albert Stat Throat Swab C/S EBV / Mycoplasma / Aden 2) Sig Ceftriaxone Sig Chloramphenicol 3) Monitor Vitals 4) Symp Xyzal Molaxolol 5) Symp Ibuprofen - Q8H Symp OTC - Q4H 6) Neb $\pm$ 3% NaCl Nasomax - P Nasomist Nasal Spray 7) Monitor Vitals 8) ENT Opinion NB. Mouthwash @ 8:40 AM



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
14/7 10:00	C/S/O Dr. Sindhura	
	Acute Febrile Illness & Dehydrated ? Evolving Cervical Abscess	
	Plan	
	Forward spike ⊕ Better	1) VSG - Neck
	Oral intake - less	2) ENT Operation today
	Vitals Stable	3) Stop IVF
		4) Z ₁ Ceftriaxone - D3
		Z ₂ Chloramphenicol - D1
	OK - Child Alert	5) Cont Supportive care
	Afebrile	6) Trace Labs - Culture
	R/S - D/LAEB ⊕	EBV / Mycoplasma
	P/A - Soft	7) (R/V) ENT to check for any membrane scraping
	Throat - Membrane over ⊕ tonsil (eroded from follicles)	8) Crocin - 6 th hly Ibuprofen - 500
		

Dr. Sindhura Munukuntla
Consultant Pediatrician
Reg. No: 66970

[Signature]
SINDHURA-M

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
14/7/26	ULB de. manini	
2pm	AFI c dehydration	
	c encasing cervical abscess	
	- fine rashes (+)	
	- oral intake : poor	
	- throat pain (+)	
	o/e	Plan
	vitals : stable	✓ 1. ceftriaxone
	stc →	iv. clindamycin
	RA : not	✓ 2. USG neck now
	oral cavity :	✓ 3. send membrane
	which membrane	swab for
	one the	ds of albert stain
	sonic (+)	✓ 4. leave EBY
		mycoplasma
		throat swab ds of
		albert stain
		✓ 5. Rpt ct. as per
		Rx chart
		✓ 6. monitor vitals .
		HB Suvanda @
		2.30pm

Date & Time	Progress Notes	Doctor's Order
14/7/20 5.30PM	e/s/b Mr. Sindhuva Mx c dehydration. fever spikes (+) Oral intake - poor. S/E - vitals stable. S/E - WNL.	N 1) IVP stop 2) Hyr wacin @ 611 3) Hyr Kypus (ms) 4) Contin IV antibiotics 5) Trace urine. NB: Mentally @ 9PM. Dr. Sindhuva Munukuntla Consultant Pediatrician Reg. No: 66970

Date & Time	Progress Notes	Doctor's Order
15/7/26 9:30 AM	S/B D2. <u>Sindhuva</u> Δ: AFI = dehydration Evolving cervical abscess	
	fever spikes (+) febrile oral intake - fair Irritable (+) de HR - 120 bpm de CNS - conscious CIS - G2 (+) RS - AEBE PIA - soft	<u>Advice</u> • Ct Int CEFTRIAXONE & CLINDAMYCIN • Ct Ibuprofen (SOS) • Make oral PCM (SOS) • (1) Throat Swab C&S, Blood C&S, A/Best stain EBV • (2) CBP, CRP with cannulation Dr. Sindhu Munukunla Consultant Pediatrician Reg. No: 66970
		M. Sindhu Munukunla



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
15/07/20	S/B Dr. Archana	Dr. Sushanth
2 PM	Δ: Viral illness (EBV positive) = dehydration + Evolving cervical abscess.	
	No fever spikes x 1 day. oral acceptance - fair Irritability ↓.	Adv Ct Intj CEFTRIAXONE Intj METRONIDAZOLE
06	vitality stable	Ct CANDID mouth paint (4A) over tonsils
06	WNL	Ct rest same
06	bl Tonsillar enlargement ⊕ congestion ⊕	TPR LDO c - Inform sos
		TPR LDO c - Inform sos

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
15/9/26. 6pm	c/i/b Dr. Sindhu M. EBV illness - dehydration - 2 Secondary Bacterial Infection - No fever since mng. (P/A) Spleen - palpable +ip vital stable. S/E B/L AC (+) AIVBS (+)	✓ Tm mng usg (abd) ✓ ct Antibiotics ✓ PCM (sos) ✓ ct Candida mouth paint ✓ I/O ✓ (T) culture.
	NB Sunanda @ 6pm Dr. Sindhura Munukuntla Consultant Pediatrician Reg. No: 66970	Wine Dr. Sindhu M.

BAH-00569547

IP26-00006818

Master DEVANSH TAWARE

02-09-2023

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(M)

Dr. SINDHURA MUNUKUNTLA

Rainbow[®]
Children's
Hospital

It takes a lot to treat the little.



BirthRight™

BY RAINBOW HOSPITALS

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CONGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
1/7/26	c/s/by Dr. Anuhe	
10AM.	EBV illness	e delydet
	Cervical CN (+).	
	Ab to jaw	
	Child active	<u>Plan</u>
	<u>vital</u> stable	— cl 17 CEFTRIAXONE METROGYL
	<u>S/C</u>	— csg Abd today.
	NAD	— (1) cultu.
		— Monit vital
	<u>Al</u> num.	

Date & Time	Progress Notes	Doctor's Order
16/2/26	8/B Dr. Sindhu M EBV illness Res for culture child also Went to school	Adm trace treatment Continue with antibiotics
16/2/26 2 PM	Dr. Sindhu M. Munukuntla Consultant Pediatrician Reg. No: 66970 8/B Dr. Varun / Dr. Nairam Δ- EBV illness & dehydration. Plan - Abx - nil. - Active, playful. - FE - vitals stable. - FE - WNL.	Dr. Sindhu M. Munukuntla - Ct. Capriciousness & Munchausen's. - Isc a US of report



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	ultra thin Dr. Thamm Dr. - subcut	
	<u>EBV illness & fungal growth</u>	
	- few spores: - no germ cells - pairing none	
	<u>O/E</u>	<u>Plan</u>
	- molar stable	1) it ceftriaxone metronidazole
	- <u>slit</u> :	2) if if control out → change to amoxicillin
	MR: S.S. (+)	
	RS: RRE (+)	
	more.	3) Rest Rest it. as per chart
		4) monitor vitals
		N.B Supriya @ 8AM

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
17/7/26 10 AM	S/B Dr. Sindhu DEBU 1 st Rection C dehydration Pla Atelbula Vibrio Shabla - Discharge CNS - S, S, S - Amoxycillin M-11-11-11-11 METRONIDAZOLE - - 7/1 up on Monday	
		M Sindhu Dr. Sindhu



CROSS CONSULTATION FORM

Doctor Name : Dr. Chandana Date : 14/7/26 Time : 1pm.

Diagnosis : Acute Membranous Tonsillitis

Hospital :

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 :

- 7E
- febrile
 - runny nose
 - B/L ID nodes ⊕
tender
 - Gr 3 tonsils
white membrane
⊕ tonsil
Scrapings sent
for c/s
no bleed on
scraping.
B/L TM intact

h/o fever / throat pain /
runny nose. } 3-4 days

↓ feeding 2 days
drooling / taking orally
↑ past day

prev. h/o Influenza - 2025
h/o rec colds / fevers / throat
inf.

Bloods noted / X ray - NP
adenoids ⊕

Consultant :

Name : Dr. Chandana Signature : [Signature] Date & Time : 14/7/26.

Ash

- Trace throat swabs
- CST / Nasomist Q24.
- σ u sos.
- encourage oral feeds.



DRUG CHART

Date of Admission: 12/7/26 Drug Allergies: ☒ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

- GENERAL** - Ensure that all patient details are entered above. ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.
- DOCTOR** - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
- Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
 - Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
 - Discontinue a drug by drawing a line **I** through it and a similar line through subsequent recording panels.
 - The date and time of stopping the drug along with the doctors name and sign must be mentioned.
 - 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>SYP PARACETAMOL</u>				Date Time
Dose <u>4ml</u>	Route <u>PO</u>	Frequency <u>SOS</u>	Start Date <u>12/7</u>	
Doctor's Signature <u>[Signature]</u>		Valid Period	Pharm. <u>[Signature]</u>	
Additional Instructions: <u>290mg/5ml</u>				

DRUG : <u>SYP IBUGESIC</u>				Date Time
Dose <u>3.5ml</u>	Route <u>PO</u>	Frequency <u>SOS</u>	Start Date <u>12/7</u>	<u>12:19 PM</u>
Doctor's Signature <u>[Signature]</u>		Valid Period	Pharm. <u>[Signature]</u>	<u>3PM</u>
Additional Instructions: <u>100/5</u>				

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

Verified by
Dr. Dhakshayani

VERIFIED BY : Name



REGULAR PRESCRIPTIONS

Weight. 13.9 Ward.

DRUG : <u>SYP PARACETAMOL</u>				Date Time																
Dose	Route	Frequency	Start Date																	
4.5ml	PO	6 th hourly	12/9/26	3AM	X															
Name & Signature of the Doctor Starting the Drugs:				9AM	✓															
Additional Instructions:				9PM	✓															
240 mg/5ml				9PM	✓															
Daily Doctor's Endorsement by a Sign																				
DRUG : <u>SYP DUPHALAC</u>				Date Time																
Dose	Route	Frequency	Start Date																	
7.5ml	PO	BD	12/9/26	1:40	✓															
Name & Signature of the Doctor Starting the Drugs:				1:40	✓															
Additional Instructions:				11PM	✓															
LACTULOSE																				
Daily Doctor's Endorsement by a Sign																				
DRUG : <u>LANZOL JR</u>				Date Time																
Dose	Route	Frequency	Start Date																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
1 tab in 5ml water (15mg)																				
Daily Doctor's Endorsement by a Sign																				
DRUG : <u>INJ ESMOPRAZOLE</u>				Date Time																
Dose	Route	Frequency	Start Date																	
15mg	IV	OD	12/9/26	1:40	✓															
Name & Signature of the Doctor Starting the Drugs:				1:40	✓															
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

Verified by
Dr. Dhakshayani

Verified by
Dr. Dhakshayani



REGULAR PRESCRIPTIONS

Sheet No:

Weight ^{13.91g} Ward

DRUG : INJ LEFTRIAZONE				Date Time	12/7	13/7														
Dose	Route	Frequency	Start Dt.																	
700mg	IV	BD	12/7	CANCY																
Name & Signature of the Doctor Starting the Drugs:				13/7																
Additional Instructions:				6pm 4pm 13/7																
Daily Doctor's Endorsement by a Sign																				
DRUG : SYM XYRAL				Date Time	12/7	13/7	14/7	15/7	16/7											
Dose	Route	Frequency	Start Dt.																	
2.5ml	PO	ITS	12/7	10pm																
Name & Signature of the Doctor Starting the Drugs:				13/7																
Additional Instructions:				13/7																
Daily Doctor's Endorsement by a Sign																				
DRUG : METAP nasal spray				Date Time	12/7	13/7	14/7	15/7	16/7											
Dose	Route	Frequency	Start Dt.																	
1 spray	EN	BD	12/7	10pm																
Name & Signature of the Doctor Starting the Drugs:				13/7																
Additional Instructions:				13/7																
Daily Doctor's Endorsement by a Sign																				
DRUG : SYPIBUQESIC				Date Time	12/7	13/7	14/7	15/7	16/7											
Dose	Route	Frequency	Start Dt.																	
Eme	PO	Q 8th	12/7	4pm 12pm 8pm 13/7																
Name & Signature of the Doctor Starting the Drugs:				13/7																
Additional Instructions:				13/7																
Daily Doctor's Endorsement by a Sign																				

Verified by
Dr. Dhakshayani

Verified by
Dr. Dhakshayani

Verified by
Dr. Dhakshayani

Verified by
Dr. Dhakshayani

Sheet No:

REGULAR PRESCRIPTIONS

Weight 13.9kg Ward

DRUG: <u>SYN PARACETAMOL</u>				Date Time																
Dose	Route	Frequency	Start Dt.																	
<u>45ml</u>	<u>PO</u>	<u>Q 8H</u>	<u>12/7</u>																	
Name & Signature of the Doctor Starting the Drugs:				<u>12 AM</u>																
Additional Instructions: <u>alternate 15mg/kg</u> <u>of paracetamol</u> <u>every 4th hr</u>				<u>8 AM</u>																
Daily Doctor's Endorsement by a Sign				<u>4 PM</u>																
DRUG: <u>SYN - CROCEIN DS</u>				Date Time																
Dose	Route	Frequency	Start Dt.																	
<u>3ml</u>	<u>oral</u>	<u>Q 4H</u>	<u>13/7</u>																	
Name & Signature of the Doctor Starting the Drugs:				<u>3 AM</u>																
Additional Instructions: <u>PARACETAMOL</u> <u>(5ml = 240mg)</u>				<u>7 AM</u>																
Daily Doctor's Endorsement by a Sign				<u>11 AM</u>																
DRUG: <u>NXSONIST NXAL</u>				Date Time																
Dose	Route	Frequency	Start Dt.																	
<u>PRAY</u>	<u>NS</u>	<u>Q 6H</u>	<u>13/7</u>																	
Name & Signature of the Doctor Starting the Drugs:				<u>2 AM</u>																
Additional Instructions:				<u>6 PM</u>																
Daily Doctor's Endorsement by a Sign				<u>10 PM</u>																
DRUG: <u>NXIVION P</u>				Date Time																
Dose	Route	Frequency	Start Dt.																	
<u>10 to 15</u>	<u>NS</u>	<u>Q 8H</u>	<u>13/7</u>																	
Name & Signature of the Doctor Starting the Drugs:				<u>2 AM</u>																
Additional Instructions:				<u>10 PM</u>																
Daily Doctor's Endorsement by a Sign																				



Sheet No:

REGULAR PRESCRIPTIONS

Weight **13.9kg** Ward

DRUG : Neb. 2% NS				Date Time																
Dose	Route	Frequency	Start Dt.																	
1 respule	Neb.	Q6H	13/7																	
Name & Signature of the Doctor Starting the Drugs:				See the chart																
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG : Tab CLINDAMACIN				Date Time	13/7	14/7	15/7													
Dose	Route	Frequency	Start Dt.																	
140mg	IV	TID	13/7		6AM	X	X	X												
Name & Signature of the Doctor Starting the Drugs:				Pran																
Additional Instructions:				10mg/kg																
Daily Doctor's Endorsement by a Sign				Stop																
DRUG : Tab CEFTRIAXONE				Date Time	14/7	15/7	16/7	17/7												
Dose	Route	Frequency	Start Dt.																	
1.4g	IV	once daily	13/7																	
Name & Signature of the Doctor Starting the Drugs:				Pran																
Additional Instructions:				IV oral 2 hours																
Daily Doctor's Endorsement by a Sign				6																
DRUG : Syb CROCIN-DS				Date Time	14/7	15/7														
Dose	Route	Frequency	Start Dt.																	
4ml	PO	6thly	14/7		6AM	X	X	X												
Name & Signature of the Doctor Starting the Drugs:				Pran																
Additional Instructions:				Stop																
Daily Doctor's Endorsement by a Sign																				

Verified by
Dr. Dhakshayani



306

RESULT SHEET

Date	12/7/26	14/7/26	15/7/26			
Time	9.40am	4AM				
Hb	10.4	9.9	9.9			
PCV	29.9	28.7	28.5			
RBC	4.72	4.55	4.53			
WBC	26.26	23.73	13.98			
N/L	31.3/59.5	34.9/59.1	26/64			
Platelets	257	251	294			
CRP	28	67	39			
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT		60				
SGOT		51				
T.Bill/Conj	0.3/0.2	0.3/0.2				
T.Protein	6.0	6.0				
S.Albumin	3.0	3.8				
S.Globulin	3.	3.1				
A/G Ratio		1.2				
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

Date	12/7/26				
Time					
CUE - Alb					
CUE - Sugar	NIL				
CUE - Ketones	present ⁺⁺				
CUE - PUS Cells	2-3				
CUE - RBC Cells	3-4				
CUE - Epithelial	2-3				
Nitrite	Negative				
pH -	6.0				
Stool Pus Cell					
OVA / Cyst					
Occult Blood					
Influenza A -					
B -					
RSV -					
SARS V -					
Adeno -					
Mycoplasma Igm -	Negative				
Dengue NS1 -	Not detected				
Igm -	Non-Reactive				

Culture and Sensitivities : Blood c/s :- 24th no growth

48th hrs no growth

Adeno

Radiology : USG :

X-Ray :

ECHO :

CT :

MRI :

Others (ECG, Contrast Studies etc.):

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 12/7/23	Time: 12:20 PM	1:50 PM	3:40 PM	7 PM	8 PM	10:40 PM	11:30 PM	1:20 AM	2:40 AM	3:20 AM	5 AM	7 AM
Doctor / Nurse / Family Concern?												
Temperature (F)	101.3°F	100.5°F	100.3°F	100.0°F	102.6°F	100.4°F	103.3°F	101°F	100.5°F	101.4°F	101.4°F	101.4°F
Heart Rate (bpm)	136b/m	118b/m	118b/m	122b/m								
Blood Pressure (mmHg) *												
Resp. Rate (bpm) (Over 1 Minute) *	28b/m	22b/m	20b/m	22b/m								
Resp Mod/ Severe Distress												
Receiving O ₂ (l/min)												
O ₂ Saturations (%)	99%	99%	100%	100%								
Conscious Level	15/15	15/15	-	-								
GCS *	15/15	15/15	-	-								
TOTAL SCORE	0	0	0	0								
Number of shaded boxes	0	0	0	0								
Pain Score	0	0	0	0								
Observer's Initials	SP	NA	NA	NA								

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.

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

BAH-00569547 IP26-00006818
Master DEVANSH TAWARE
02-09-2023 2 Y 10 M 10 D (M)
Dr. SINDHURA MUNUKUNTLA



o. : RCH/ FRM / CLINICAL / 125

PRESCHOOL (1-5 years) Children's Observation & Early Warning Scoring Chart

Pratiksha
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Hospital
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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 13/7/26	Time: 8 AM	9	10	11:30	1:30	3	3:30	4:40	6 PM	7:30	8	10	12:30	1:15 AM	2
Doctor / Nurse / Family Concern?		AM	AM	AM	PM	PM	PM	PM	PM	PM	PM	PM	AM	AM	AM

Temperature (F)	104	103	102	101	100	99	98	97	96	95	94
	102.6F	101.6F	102.1F	99.1F	97.4F	98.2F	99.6F	100.9F	102.4F	100.5F	97.6F
Heart Rate (bpm)	190	180	170	160	150	140	130	120	110	100	90
	136b/m	121b/m									
Blood Pressure (mmHg) *	130	120	110	100	90	80	70	60	50		
	126b/m	123b/m									
Resp. Rate (bpm) (Over 1 Minute)	70	60	50	40	30	20	10				
	30b/m	30b/m									
Resp Rate (Number)	30b/m	30b/m									
Resp Mod/ Severe Distress											
Receiving O ₂ (l/min)											
O ₂ Saturations (%)	98%	98%									
Conscious Level											
GCS *	15/15	15/15									
TOTAL SCORE											
Number of shaded boxes	0	0									
Pain Score	0	0									
Observer's Initials	AS	AS									

ACTIONS

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I	IDENTITY: I am (name), a nurse on ward (X). I am calling about (child X)
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B	BACK GROUND : Child (X) was admitted on (XX date) with (e.g. respiratory infection). They have had (X operation/ procedure/ investigation). Child (X)'s condition has changed in the last (XX mins). Their last set of observations were (XXX). The child's normal condition is ... (e.g. alert/ drowsy/ confused, pain free)
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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)

BAH-00569547

IP26-00006818

Master DEVANSH TAWARE

02-09-2023

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o. : RCH/ FRM / CLINICAL / 125

Dr. SINDHURA MUNUKUNTALA

PRESCHOOL (1-5 years)

Children's Observation & Early Warning Scoring Chart

Pratiksha
Rainbow
Children's
Hospital

It takes a lot to treat the little.

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date	14/9/23	Time	4 AM	6 AM	7:30 AM
Doctor / Nurse / Family Concern?	AM	AM	AM		
Temperature (°F)	96.6°F	97.6°F	100.6°F		
Heart Rate (bpm)					
and					
Blood Pressure (mmHg) *					
Note: BP does not score in early warning scoring					
Heart Rate (Number)	128/1				
Resp. Rate (bpm) (Over 1 Minute) *	30/1				
Resp Rate (Number)	30/1				
Resp Mod/ Severe Distress None / Mild					
Receiving O ₂ (l/min) O ₂ Saturations (%)	100%				
Conscious Level Normal Altered					
GCS *	15/5				
TOTAL SCORE					
Number of shaded boxes	0				
Pain Score	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.

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!
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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 15/7/23	Time:	9 AM	10 AM	11 AM	1:30 PM	3:30 PM	5:30 PM	6:30 PM	8:30 PM	10:30 PM	12:30 AM
Doctor / Nurse / Family Concern?											
Temperature (°F)	104										
	103										
	102										
	101										
	100										
	99										
	98										
	97										
	96										
	95										
94											
100.3°F, 100.2°F, 99.5°F, 101.5°F, 98.2°F, 97.6°F, 97.1°F, 97.6°F, 98.1°F, 99.0°F Ibuprofen given											
Heart Rate (bpm)	190										
and	180										
Blood Pressure (mmHg) *	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)		123b/m			121b/m		128b/m		125b/m		
Resp. Rate (bpm) (Over 1 Minute) *	70										
	60										
	50										
	40										
	30										
	20										
	10										
Resp Rate (Number)		28b/m			28b/m		25b/m		28b/m		
Resp Distress	Mod/ Severe										
	None / Mild										
Receiving O ₂ (l/min)											
O ₂ Saturations (%)		100%			100%		100%		100%		
Conscious Level	Normal										
	Altered										
GCS *		15/15			15/15		15/15		15/15		
TOTAL SCORE											
Number of shaded boxes		0			0		0		0		
Pain Score		0			2		0		0		
Observer's Initials		SN			W		A		SN		

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
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- Score 5 & 6 : Shift in charge AND PICU fellow or PICU consultant to be informed.

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INSTRUCTIONS:

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CH/ FRM / CLINICAL / 125

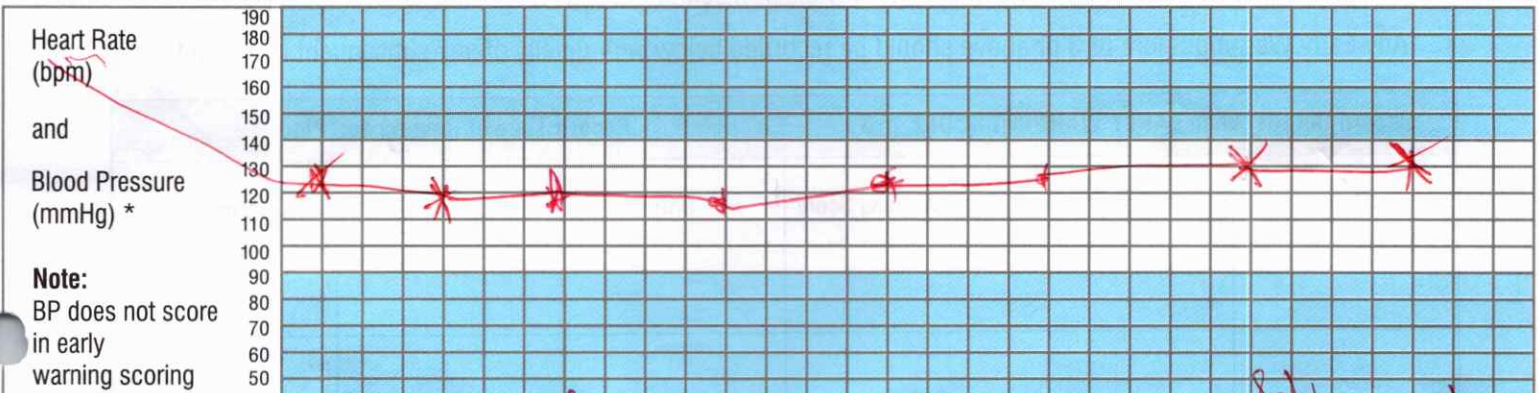
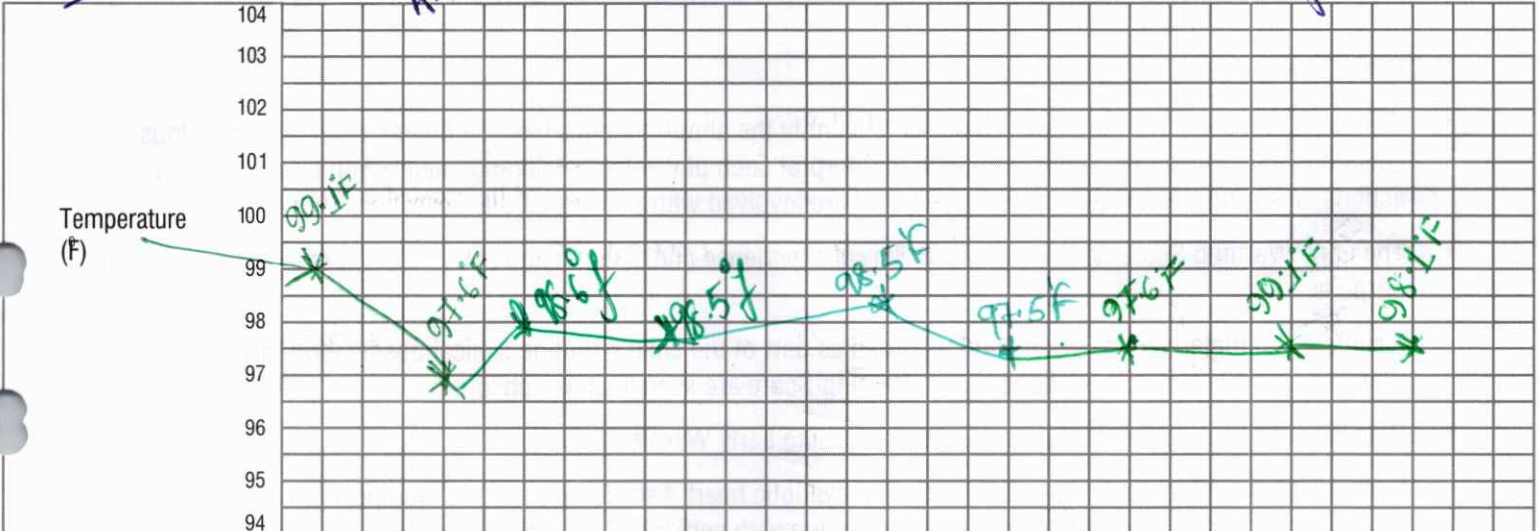
PRESCHOOL (1-5 years)
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Early Warning Scoring Chart**

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It takes a lot to treat the little.

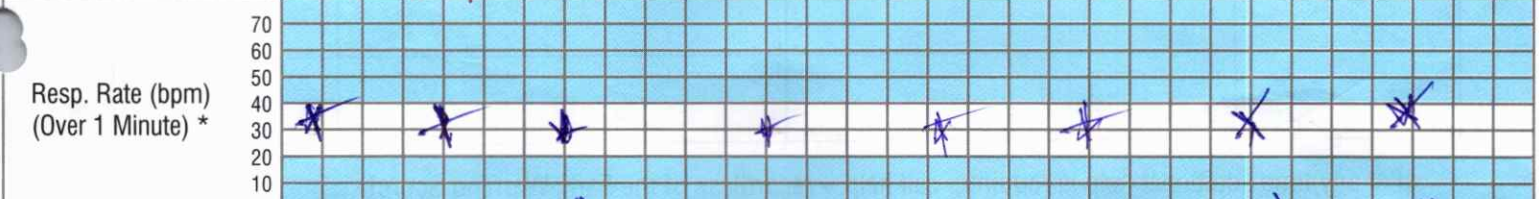
BirthRight™
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Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 15/09/23 Time: 2 AM 6 AM 9:30 AM 12:00 PM 2 PM 6 PM 9 PM 12 PM 12 AM
Doctor / Nurse / Family Concern? AM AM PM PM PM PM PM PM AM



Heart Rate (Number) 126 121 126 126 128 129 126 126



Resp Rate (Number) 36 36 35 36 35 36 40 40

Resp Mod/ Severe Distress None / Mild

Receiving O₂ (l/min) O₂ Saturations (%) 100% 100% 100% 99% 99% 100% 100% 100%

Conscious Level Normal / Altered

GCS *

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

ACTIONS
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PRESCHOOL (1-5 years)
Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 16/9/23	Time: 6 AM	6 AM	10 AM	2 PM	6 PM	10 PM	2 AM	6 AM
Doctor / Nurse / Family Concern?								
Temperature (F)	98.6 F	97.5 F	98.5 F	98.5 F	98.5 F	97.5 F	98.2 F	98.7 F
Heart Rate (bpm)	122 bpm	126 bpm	125 bpm	125 bpm	128 bpm	128 bpm	128 bpm	123 bpm
Blood Pressure (mmHg) *	120/70	120/70	120/70	120/70	120/70	120/70	120/70	120/70
Resp. Rate (bpm) (Over 1 Minute) *	30 bpm	30 bpm	30 bpm	30 bpm	29 bpm	20 bpm	21 bpm	20 bpm
Receiving O ₂ (l/min)	100%	100%	100%	100%	100%	99%	99%	99%
O ₂ Saturations (%)	100%	100%	100%	100%	100%	99%	99%	99%
Conscious Level	Normal	Normal	Normal	Normal	Normal	Normal	Normal	Normal
GCS *	15	15	15	15	15	15	15	15
TOTAL SCORE	0	0	0	0	0	0	0	0
Number of shaded boxes	0	0	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0	0	0
Observer's Initials	SD	SD	SD	SD	SD	SD	SD	SD

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BAH-00589547 IP26-00006818

Master DEVANSH TAWARE

02-09-2023

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(M)

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FLUID CHART

Sheet No. :

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
12/7/26	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm	DNS		33ml								
	01:00 pm	DNS		33ml								
Total Intake :						Total Output :						
12/7/26	02:00 pm			33ml								
	03:00 pm			33ml								
	04:00 pm			33ml								
	05:00 pm	DNS		33ml								
	06:00 pm			33ml								
	07:00 pm			33ml								
Total Intake :						Total Output :						
12/7/26	08:00 pm			33ml								
	09:00 pm			33ml								
	10:00 pm			33ml								
	11:00 pm	DNS		33ml								
	12:00 am			33ml								
	01:00 am			33ml								
Total Intake : Taken						Total Output : m-						
13/7/26	02:00 am			33ml								
	03:00 am			33ml								
	04:00 am			33ml								
	05:00 am	DNS		33ml								
	06:00 am			33ml								
	07:00 am			33ml								
Total Intake : Taken						Total Output : m- u-						

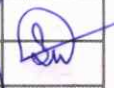
Total 24 hrs. Intake

Total 24 hrs. Output

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Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
13/7/26	08:00 am	↑		-			✓				0		
	09:00 am			-							0		
	10:00 am	DNS	Soup	33ml						0			
	11:00 am			33ml						0			
	12:00 pm	↓		33ml		✓			✓	0			
	01:00 pm			33ml						0			
Total Intake :						Total Output : U-						M-	
13/7/28	02:00 pm	↑		33ml			✓				0		
	03:00 pm			33ml					✓	0			
	04:00 pm			33ml						0			
	05:00 pm	DNS		-	NA			NA		0			
	06:00 pm	↓		-	NA					0			
	07:00 pm			33ml						0			
Total Intake :						Total Output : U-						M-	
13/7/26	08:00 pm			33ml							0		
	09:00 pm			33ml							0		
	10:00 pm	DNS		33ml					✓	0			
	11:00 pm			33ml						0			
	12:00 am			33ml		✓				0			
	01:00 am			33ml					✓	0			
Total Intake :						Total Output : U-						M-	
14/7/26	02:00 am			33ml							0		
	03:00 am			33ml							0		
	04:00 am	DNS		33ml						0			
	05:00 am			33ml						0			
	06:00 am			33ml						0			
	07:00 am			33ml						0			
Total Intake :						Total Output : U-						M-	

Total 24 hrs. Intake

Total 24 hrs. Output

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			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
14/7/26	08:00 am	↓		33 ml									
	09:00 am			33 ml									
	10:00 am	↓	Soup + H ₂ O	38 ml									
	11:00 am	↓		25 ml									
	12:00 pm	↓		25 ml									
	01:00 pm	↓		25 ml									
Total Intake : Taken						Total Output : U - m -							
14/7/26	02:00 pm	↑		15 ml									
	03:00 pm												
	04:00 pm	stop											
	05:00 pm												
	06:00 pm												
	07:00 pm	↓											
Total Intake :						Total Output :							
15/7/26	08:00 pm	↑											
	09:00 pm												
	10:00 pm	stop	Artificial H ₂ O										
	11:00 pm	↓											
	12:00 am												
	01:00 am	↓	Soup										
Total Intake :						Total Output : U - 1 M -							
15/7/26	02:00 am	↑	Milk										
	03:00 am												
	04:00 am	stop											
	05:00 am												
	06:00 am												
	07:00 am	↓											
Total Intake :						Total Output : U - 2 M - 1							

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.

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
15/7	08:00 am	1					1		1			
	09:00 am	0	Soup				0	NA		✓		
	10:00 am	1	Bro.				1	NA		✓	0000	
	11:00 am	1					1	NA		✓	0000	
	12:00 pm	1					1	NA		✓	0000	
	01:00 pm	1					1	NA		✓	0000	
Total Intake : 600ml						Total Output : 0-3-						
15/7	02:00 pm	1					1					
	03:00 pm	1	Milk				1			✓		
	04:00 pm	0	Soup				0	NA			0	
	05:00 pm	1					1	NA		✓	1	
	06:00 pm	1					1	NA		✓	1	
	07:00 pm	1					1	NA		✓	1	
Total Intake :						Total Output :						
15/7/26	08:00 pm	1					1					
	09:00 pm	1					1					
	10:00 pm	0	Rice				0	NA		✓	0	
	11:00 pm	1	Coconut				1	NA			1	
	12:00 am	1	Curry				1	NA			1	
	01:00 am	1					1	NA			1	
Total Intake :						Total Output : 0-1-						
16/7/26	02:00 am	1					1					
	03:00 am	1					1					
	04:00 am	0					0	NA		✓	0	
	05:00 am	1					1	NA		✓	1	
	06:00 am	1					1	NA			1	
	07:00 am	1					1	NA			1	
Total Intake :						Total Output : 0-1-						

Total 24 hrs. Intake

Total 24 hrs. Output

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			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
16/7/26	08:00 am	1											
	09:00 am	1											
	10:00 am	0	Soup										
	11:00 am	1											
	12:00 pm	1											
	01:00 pm												
Total Intake : Taken						Total Output : 0-2 m-0							
16/7/26	02:00 pm	1											
	03:00 pm	1	Milk										
	04:00 pm	0	H2O										
	05:00 pm	1											
	06:00 pm	1											
	07:00 pm	1											
Total Intake :						Total Output : 0-2 m-1							
16/7/26	08:00 pm	1											
	09:00 pm	1											
	10:00 pm	0	Sally										
	11:00 pm	1											
	12:00 am	1											
	01:00 am												
Total Intake : taken						Total Output : 0- m-							
17/7/26	02:00 am	1											
	03:00 am	1											
	04:00 am	0	H2O										
	05:00 am	1											
	06:00 am	1											
	07:00 am	1											
Total Intake : taken						Total Output : 0 m-							

Total 24 hrs. Intake

Total 24 hrs. Output

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 Thrombo- phlebitis 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												

BAH-00569547 IP26-00006818
Master DEVANSH TAWARE
02-09-2023 2 Y 10 M 10 D (M)
Dr. SINDHURA MUNUKUNTLA



NURSING CARE RECORD

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Date: 12/7/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	12pm	To assess the pt. condition To check the vitals To record	12pm	To assessed the pt. condition To checked the vitals To recorded	Pt. is Stable	Rechecked the vitals I/O	Spruj
	2pm	To adm the medication as per chart. To I/O chart maintain	2pm	To adm the medication as per chart To I/O chart maintain	CVE pending		
Afternoon	2pm	Assess pt condition Monitor the vitals Maintain I/O chart Administer medication as per drug chart	2pm	To Assess pt condition monitored vitals maintained I/O chart Administered medication as per drug chart	Patient is stable	Re-checked vitals	Ajay
	8pm		8pm				
Night	8pm	Assess the pt condition monitor vitals maintained I/O chart Administer medication	8pm	Assess the pt condition monitored vitals maintained I/O chart Administered medication	Pt is Stable	Re-check the vitals	Nase
	8am		8am				

BAH-00569547 IP26-00006818
Master DEVANSH TAWARE
02-09-2023 2 Y 10 M 10 D (M)
Dr. SINDHURA MUNUKUNTLA



NURSING CARE RECORD

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Date: 13/7/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8AM	→ To assess the pt. condition	8AM	→ To assessed the pt. condition	Patient is stable	→ re-checked the vitals → I/O	Supriya
	10	→ To check the vitals & records	10	→ To checked the vitals & recorded			
	2PM	→ To administer the medication as per drug chart	2PM	→ To administered the medication as per drug chart	→ Throat swab for C/S to be done		
Afternoon		→ I/O chart maintain	2PM	→ I/O chart maintained			
	2PM	- To assess the pt condition	2PM	- To assess the pt condition	- Now patient is stable	- Rechecked the vitals	S
	10	- Monitor the v/s & maintain the I/O	10	- Monitor the v/s & Record			
	8PM	- Drug as per chart	8PM	- maintain the I/O			
Night		→ Assess the general condition of pt.	8PM	→ Assess the general condition of pt.	Pt is stable.	Re-assess vitals.	Mounish
		→ Monitor vitals		→ Monitor vitals			
		→ Maintain I/O chart		→ Maintained I/O chart			
	8AM	→ Administer medication	8AM	→ Administered medication			



NURSING CARE RECORD

Date: 14/9/21

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8 AM to 2 PM	→ Assess the pt condition → monitor vital & record → Maintain I/O chart → Administer medication as per drug chart	8 AM to 2 PM	→ Assessed the pt condition → Monitored vital & recorded → Maintained I/O chart → Administered medication as per drug chart	→ pt is stable	→ pt vitals checked & recorded	
Afternoon	2 PM to 8 PM	- Assess the patient condition - monitor the v/s - maintain the I/O - Drug as per chart	2 PM to 8 PM	- Assess the patient condition - monitor the v/s - maintain the I/O - Drug as per chart	- Now baby is stable	- Rechecked the v/s	
Night	8 PM to 8 AM	→ Assess the general condition of pt. → Monitor vitals → Maintain I/O chart. → Administer medication. → provide comfortable position	8 PM to 8 AM	→ Assessed the general condition of pt. → Monitored vitals → Maintained I/O chart. → Administered medication. → provided comfortable position	→ baby is stable	→ Re-assess vitals.	

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Master DEVANSH TAWARE
02-09-2023 2 Y 10 M 12 D (M)
Dr. SINDHURA MUNUKUNTLA



NURSING CARE RECORD

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Children's
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BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Date: 15/7/23

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8 AM to 2 PM	→ Assess the pt condition → monitor vital & record → Maintain I/O chart → Administer medication as per drug chart	8 AM to 2 PM	→ checked the pt condition → Monitor vitals & recorded → Maintained I/O chart → Administered Medication as per drug chart	→ pt is stable	→ Rechecked vital	SD
Afternoon	2 PM to 8 PM	- Assess the patient condition - Monitor the v/s - Maintain the I/O - Drug as per chart	2 PM to 8 PM	- Assess the patient condition - Monitor the v/s - Maintain the I/O - Drug as per chart	- Now pt is stable	- Rechecked the v/s	KS
Night	8 PM / 8 AM	→ Assess the general condition of pt. → Monitor vitals → Maintain I/O chart. → Administer medication → provide comfortable position.	8 PM / 8 AM	→ assessed the general condition of pt. → Monitored vitals. → Maintained I/O chart. → Administered medication → provided comfortable position.	→ Now baby is stable.	Re-assess vitals.	Maital

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Master DEVANSH TAWARE

02-09-2023

IP26-00006818

2 Y 10 M 12 D

Dr. SINDHURA MUNUKUNTALA

(M)



NURSING CARE RECORD

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Date: 16/11/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8 AM to 2 PM	→ Assess the pt condition → Monitor vitals & record → Maintain I/O chart → Administer medication as per drug chart	8 AM to 2 PM	→ Assessed the pt condition → Monitored vitals & recorded → Maintained I/O chart → Administered medication as per drug chart	→ pt is stable	→ Rechecked vitals	
	2 PM to 8 PM	- Assess the patient condition - monitor the v/s - maintain the I/O - Drug as per chart	2 PM to 8 PM	- Assess the patient condition - monitor the v/s - maintain the I/O - Drug as per chart	- Now patient is stable	- Rechecked the v/s	
Night	8 PM to 8 AM	→ Assess the pt condition → Monitor vitals & I/O chart → drug as per chart → provided comfortable position		→ Assessed the pt condition → Monitored vitals & I/O chart → druged as per chart → provided comfortable position	→ pt is stable	Rechecked vitals	

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 Master DEVANSH TAWARE
 02-09-2023 2 Y 10 M 12 D (M)
 Dr. SINDHURA MUNUKUNTLA



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							

BRADEN 'Q' SCALE

					Date :	12/2	12/7	12/2/2	13/7
					Time :	N6	E2	N1	M6
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.		4	4	4	4
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.		4	4	9	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 meat and dairy products. Occasionally eats between meals. Does not require supplementation.		4	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.		4	4	4	4
					TOTAL SCORE	28	28	28	28
					Evaluator's Name	A	A	A	A

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	• 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

BAH-00569547 IP26-00006818
Master DEVANSH TAWARE
02-09-2023 2 Y 10 M 10 D (M)
Dr. SINDHURA MUNUKUNTLA



BRADEN 'Q' SCALE

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Your Right to a Safe Delivery

					Date :	13/7	14/7	14/7	15/7
					Time :	5:2	4:16	N1	1:16
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	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	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
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Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.		4	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.		4	4	4	4
TOTAL SCORE						28	28	28	28
Evaluator's Name						Ch	Ch	Ch	Ch

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
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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

BAH-00569547

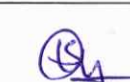
IP26-00006818

Master DEVANSH TAWARE

02-09-2023 2 Y 10 M 10 D (M)

Dr. SINDHURA MUNUKUNTALA

PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
12/7	1pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
12/7	6pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	
12/7	8pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
13/7	8AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
13/7/26	10AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
13/7/26	2PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
13/7/26	10PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
13/7/26	2AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
14/7/26	10AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
14/7/26	2pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	

Re-assessment Frequency:

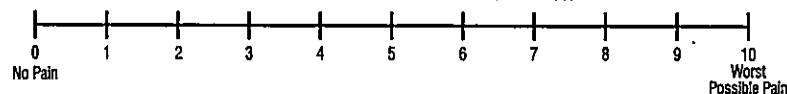
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

Numerical Pain Scale (Obstetric and Gynecology)



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

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry inconsolable.
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR, RR, BP, 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

Wong - Baker (Pediatrics) Above 7 Years



PAIN ASSESSMENT FORM

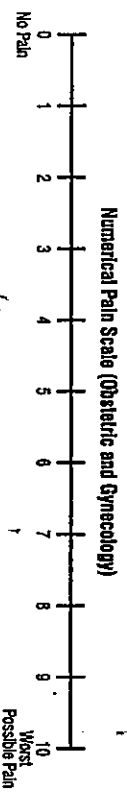
Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
14/7/26	10PM	0/10	0/10	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
15/7/26	2AM	0/10	0/10	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
15/7/26	10AM	NA	2nd hand	☒ Continuous ☐ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	NA	
15/7/26	2PM	NA	0/10	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
15/7/26	10PM	NA	0/10	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
15/7/26	2AM	NA	0/10	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
16/7/26	10AM	NA	0/10	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
16/7/26	2PM	NA	0/10	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
16/7/26	10PM	NA	0/10	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☒ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	NA	
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

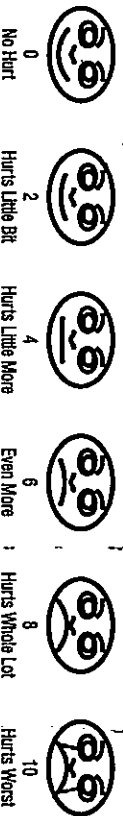
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)



Wong - Baker (Pediatrics) Above 7 Years



CATEGORY	SCORING			
	0	1	2	3
Face	No Particular expression or smile	Occasional Grimace or Frown, withdrawn, Disoriented	Frequent to constant frown, quivering chin, clenched jaw	
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs drawn up	
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, rigid, or jerking	
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams or sobs, frequent complaints	
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort	

Neonatal Pain, Agitation and Sedation Scale (up to 1 Month)

Assessment Criteria	Sedation		Normal		Pain / Agitation	
	-2	-1	0	1	2	3
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	Arouses minimally to stimuli	Appropriate for gestational age	Restless, squirming or Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)	
Facial Expression	Mouth is lax	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual	
Extremities Tone	No grasp reflex	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay	Continual clenched toes, fists, or finger splay	
Vital Signs HR, RR, BP, SaO ₂	No variability with stimuli	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	

CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	12/7 DAY-1			13/7 DAY-2			14/7/26 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	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	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	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	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	NA	NA	NA		
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord pyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5	NA	NA	NA	NA	NA	NA	NA	NA		
Signature of the Nurse													

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

Signature of Shift In Charge :

Signature : TO Name : Amrutha

Signature of Ward In Charge :

Signature : TS Name : Balaramani

BAH-00569547
Master DEVANSH TAWARE
02-09-2023 2 Y 10 M 12 D (M)
Dr. SINDHURA MUNUKUNTLA



CHECKLIST FOR THROMBOPHLEBITIS

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

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

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

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

Signature of Shift In Charge :

Signature : _____ Name : _____

Signature of Ward In Charge :

Signature : _____ Name : _____

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
	AFI & dehydration							
BACKGROUND	Area	Shift Time	12/7/26 M6	12/7 E2	12/7 N1	13/7/26 M6	13/7/26 E2	13/7/26 N1
	Medical Condition (Any special condition to be noted):		-	-	-	-	-	-
ASSESSMENT	Allergy:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Tubes/Drains/Catheter:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:	Temp:	98.1°F	98.3°F	98	99.6°F	98.2°F	98.4°F
	Res:	28b/m	25b/m	25b/m	30b/m	32b/m	32b/m	
	SpO ₂ :	100%	100%	100%	99%	99%	99%	
	Pulse:	126b/m	123b/m	123b/m	121b/m	120b/m	121b/m	
	BP:	-	-	-	-	-	-	
	Fall Risk Score:	-	-	-	-	-	-	
Pain Score:	0	0	0	0	0	0		
Recommendations	Safety Needs:		Yes	Yes	Yes	Yes	Yes	Yes
	Physiotherapy		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Others Specify:		-	-	-	-	-	-
	Special Diet:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Other Special Orders / Medications:		-	-	-	-	-	-
Post Operative Procedure Special Orders:			-	-	-	-	-	-
Handed Over By Name :			Supriya	Anusha	Madi	Supriya	Suranda	Montush
Signature :			[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date:			12/7/26	12/7/26	13/7/26	13/7/26	13/7/26	14/7/26
Time:			2pm	8pm	8AM	2pm	8pm	8AM
Taken Over By Name :			Anusha	Madi	Supriya	Suranda	Montush	[Signature]
Signature :			[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date:			12/7/26	12/7/26	13/7/26	13/7/26	13/7/26	14/7/26
Time:			2pm	8pm	8AM	2pm	8pm	8AM



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

SITUATION	Diagnosis: <i>AEI to Dehydration</i>		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
	Area	Shift Time	<i>14/7</i> <i>M₁</i>	<i>14/7/26</i> <i>E₂</i>	<i>14/7/26</i> <i>N₁</i>	<i>15/7</i> <i>M₁</i>	<i>15/7</i> <i>E₂</i>	<i>15/7/26</i> <i>N₁</i>
BACKGROUND	Medical Condition (Any special condition to be noted):		<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>
ASSESSMENT	Allergy:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Tubes/Drains/Catheter:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:		Temp: <i>100.3°F</i>	<i>98.4°F</i>	<i>98.4°F</i>	<i>98.5°F</i>	<i>98.3°F</i>	<i>98.4°F</i>
	Res:		<i>28b/m</i>	<i>28b/m</i>	<i>32b/m</i>	<i>30b/m</i>	<i>32b/m</i>	<i>30b/m</i>
	SpO ₂ :		<i>100%</i>	<i>100%</i>	<i>100%</i>	<i>100%</i>	<i>99%</i>	<i>99%</i>
	Pulse:		<i>126b/m</i>	<i>120b/m</i>	<i>124b/m</i>	<i>123b/m</i>	<i>124b/m</i>	<i>126b/m</i>
	BP:		<i>116/70</i>	<i>106/72</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>
	Fall Risk Score:		<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>5</i>
Recommendations	Safety Needs:		<i>yes</i>	<i>yes</i>	<i>yes</i>	<i>yes</i>	<i>yes</i>	<i>yes</i>
	Physiotherapy		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Others Specify:		<i>ENT op in</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>
	Special Diet:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Other Special Orders / Medications:		<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>
Post Operative Procedure Special Orders:			<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	
Handed Over By Name :			<i>Shweta</i>	<i>Suranda</i>	<i>Mouthashi</i>	<i>Shweta</i>	<i>Suranda</i>	<i>Mouthashi</i>
Signature :			<i>(Signature)</i>	<i>(Signature)</i>	<i>(Signature)</i>	<i>(Signature)</i>	<i>(Signature)</i>	
Date:			<i>14/7/26</i>	<i>14/7/26</i>	<i>14/7/26</i>	<i>15/7</i>	<i>15/7/26</i>	<i>16/7/26</i>
Time:			<i>2pm</i>	<i>8pm</i>	<i>8AM</i>	<i>2pm</i>	<i>8pm</i>	<i>8AM</i>
Taken Over By Name :			<i>Suranda</i>	<i>Mouthashi</i>	<i>Shweta</i>	<i>Suranda</i>	<i>Mouthashi</i>	<i>Shweta</i>
Signature :			<i>(Signature)</i>	<i>(Signature)</i>	<i>(Signature)</i>	<i>(Signature)</i>	<i>(Signature)</i>	
Date:			<i>14/7/26</i>	<i>14/7/26</i>	<i>15/7/26</i>	<i>15/7/26</i>	<i>16/7/26</i>	
Time:			<i>2pm</i>	<i>8pm</i>	<i>8AM</i>	<i>2pm</i>	<i>8pm</i>	



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

SITUATION	Diagnosis: <i>AFI & Dehydration</i>		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:			
BACKGROUND	Area	<i>16/7/26</i> <i>Ms</i>	<i>16/7/26</i> <i>Es</i>	<i>16/7/26</i> <i>PI</i>		
	Shift Time					
	Medical Condition (Any special condition to be noted):	<i>-</i>	<i>-</i>	<i>-</i>		
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs:	Temp: <i>98.4 F</i>	Temp: <i>98.4 F</i>	Temp: <i>98.4 F</i>		
	Res:	<i>32b/m</i>	<i>32b/m</i>	<i>31b/m</i>		
	SpO ₂ :	<i>100%</i>	<i>100%</i>	<i>100%</i>		
	Pulse:	<i>97b/m</i>	<i>97b/m</i>	<i>98b/m</i>		
	BP:	<i>-</i>	<i>-</i>	<i>-</i>		
	Fall Risk Score:	<i>0</i>	<i>0</i>	<i>0</i>		
Recommendations	Pain Score:	<i>0</i>	<i>Good</i>	<i>Good</i>		
	Safety Needs:		<i>Yes</i>	<i>yes</i>		
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:	<i>-</i>	<i>-</i>	<i>-</i>		
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:	<i>-</i>	<i>-</i>	<i>-</i>		
	Post Operative Procedure Special Orders:	<i>-</i>	<i>-</i>	<i>-</i>		
	Handed Over By Name :	<i>Sunanda</i>	<i>Sunanda</i>	<i>Sunanda</i>		
	Signature :	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>		
	Date:	<i>16/7/26</i>	<i>16/7/26</i>	<i>16/7/26</i>		
	Time:	<i>2PM</i>	<i>8PM</i>	<i>8AM</i>		
	Taken Over By Name :	<i>Sunanda</i>	<i>Sunanda</i>	<i>Sunanda</i>		
	Signature :	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>		
	Date:	<i>16/7/26</i>	<i>16/7/26</i>	<i>16/7/26</i>		
	Time:	<i>2PM</i>	<i>8PM</i>	<i>8AM</i>		

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:			
BACKGROUND	Area Shift Time					
ASSESSMENT	Medical Condition (Any special condition to be noted):					
ASSESSMENT	Allergy:		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
ASSESSMENT	Tubes/Drains/Catheter:		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
ASSESSMENT	Vital Signs:					
ASSESSMENT	Temp:					
ASSESSMENT	Res:					
ASSESSMENT	SpO ₂ :					
ASSESSMENT	Pulse:					
ASSESSMENT	BP:					
ASSESSMENT	Fall Risk Score:					
ASSESSMENT	Pain Score:					
Recommendations	Safety Needs:					
Recommendations	Physiotherapy		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Recommendations	Others Specify:					
Recommendations	Special Diet:		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Recommendations	Other Special Orders / Medications:					
Post Operative Procedure Special Orders:						
Handed Over By Name :						
Signature :						
Date:						
Time:						
Taken Over By Name :						
Signature :						
Date:						
Time:						



NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 13/7/26 Time: 12pm

Weight: 14 kg Centile: 50th

Height: Centile: -

Inference: well child

RDA: - Calories: 1250 kcal/d Protein: 21 gms/d

Diet Recommendations: soft diet & more liquid

Re-Assessment: Avoid spicy, chilled & outside foods

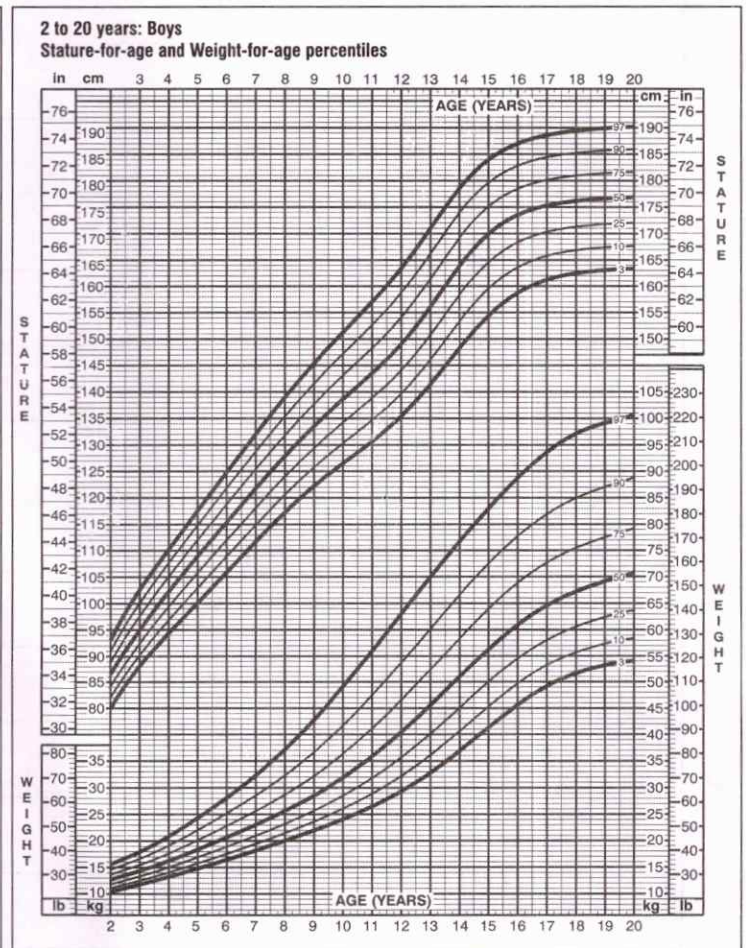
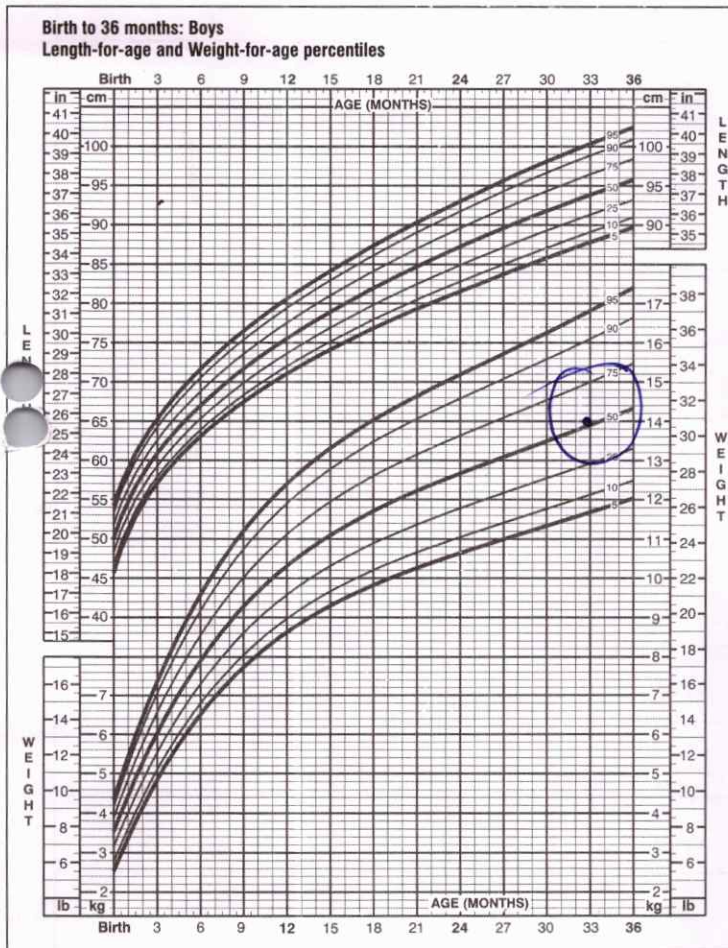
Food Allergies: NO Veg/Non-veg: NON-veg.

Diagnosis: AFI & dehydration

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: Sathwika

GROWTH CHART (BOYS)



Dietician's Name: Sathwika G. Dietician's Signature: S2

Wt- 13.9 kg



EMERGENCY ROOM TRIAGE FORM

Patient's Name : Devansh Age : 28 10 months Gender : ☒ Male ☐ Female

Date : 12/7/26 Time of Arrival : 8:50 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: 100°F PR: 156b/m BP: RR: SpO₂: 97.1

Chief Complaints: c/o fever since 2 days

INITIAL PHYSIOLOGICAL CATEGORIZATION		INITIAL PHYSIOLOGICAL STATUS
Appearance	Work of Breathing	☒ Stable
☐ Normal	☒ Normal	☐ Unstable :
☒ Sick Looking	☐ Increased	☐ Not - Life - Threatening
☐ Normal	☐ Decreased	☐ Life - Threatening
☐ Abnormal	☐ Gasping / Apnea	
☐ Bleeding		

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 : 8:52 AM

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 : 12/6/26 @ 8:52 AM

1. 2. 3. 4. 5. 6. 7. 8. 9. 10.

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12. 13. 14. 15. 16. 17. 18. 19. 20.

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27. 28. 29. 30.

NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 12/7/26 Time of arrival : 8:52 AM

Chief Complaints : C.I.O. fever since 2 days RBS:

Height : Weight : 13.9 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?) N/A

Time of Initial assessment completed by ER Nurse : 8:54 AM

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

Time	Nursing Notes
8:56 AM	- Assess the pt condition
	- monitor vitals
	- IV placement done
	- Sample collected

Samples collected by: 3

Time: 3

Samples sent by :

Time: 3

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1
9/15/20	Procin	PO	4 ml		+

Condition of patient at time of shift - out :	Details of Shift - out
HR: 156 b/m BP: CFT: 25cc RR: SPO ₂ : 99% GCS: 15/15 Temperature: 101°F Pain Score: 0- Repeat RBS (if applicable):	Shift - out from ER to: word Time of Shift - out: 10:20 AM Handover given to: Supriya (Nurse's Name)

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any):

IV placement done

Name of the Nurse : Syan

Signature of the Nurse : [Signature]

Date & Time : 12/7/26 @ 9 AM



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						☐ 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. prasanti

Date & Time : 12/7/26 @ 9:10 AM

Nurse Name & Signature : Jyoti / Jyoti

Date & Time : 12/7/26 @ 9:12 AM

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

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PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00569547 IP26-00006818 Master DEVANSH TAWARE 02-09-2023 2 Y 10 M 10 D (M) Dr. SINDHURA MUNUKUNTALA 		Date & Time of Admission 12/7/26 @	Date & Time of Transfer Order 12/7/26 @ 10:20 AM
		Transfer Ordered by Dr. prasanti	Reason for Transfer Admission
From Unit ER	To Unit Ward	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 25	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☐ If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☐ No ☐			
Name & Signature of Person who is Transferring sis ojan / 12/7/26		Name of Person Ordered Transfer Dr. prasanti	
Patient & Clinical Records Received by : Supriya			
Date & Time of Patient Received : 10:20 AM @ 12/7/26			

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

☐ Unavailable Bed

☐ Nurse not Available

☐ Available Bed not ready

