315

DISCHARGE SUMMARY

Name	Master J REVANTH	**UHID**	HNH-00015608
Father/Guardian	Mr J THIRUMALESH	**Age/Gender**	14 Y 10 M 19 D/ Male
Address	13-4-56/26/1/1/, Jiaguda, Hyderabad, Telangana, INDIA, 500006		
IP No	IP26-00006426	**Admission Date**	25-05-2026
Ref Doctor	Dr Vinay Kumar Manthati		
Discharge Date	30.05.2026		

Consultant:
Dr. VINAY KUMAR MANTHATI
MBBS DNB (Pediatrics)
Reg No:91733

DIAGNOSIS	**ICD CODE**
AMEOBIC LIVER ABSCESS	

History: Master J REVANTH, 14 Y 10 M 19 D , old boy presented with history of fever associated with decreased oral intake since 2 weeks, body pains since 1 week, dull activity since 2 weeks, prior to admission. For the above complaints he was admitted at Rainbow Children's Hospital - for further management.

Examination: He was afebrile, maintaining saturation at room air. His heart rate was 96/min, Blood pressure - 120/80 mmHg and Respiratory Rate -

Name	Master J REVANTH	**UHID**	HNH-00015608
IP No	IP26-00006426	**Admission Date**	25-05-2026

20/min. Capillary Refill Time was <2 secs. Peripheries were warm & pulses well felt. On examination Signs of some dehydration were present, dry lips, oral mucosa, delayed skin turgor, decreased urine output, dull looking were present. per abdominal examination tenderness over right lumbar region was felt and no organomegaly. On auscultation, air entry was bilaterally equal Heart sounds were normal and there was no murmur. On neurological examination, he was conscious and alert. Pupils were bilaterally equal and reacting to light. There were no focal neurological or cranial nerve deficits. There were no signs of raised intracranial pressure.

Weight on admission: 78 kilo grams.

Investigations: Enclosed reports.

Date	**On 25.05.2026**	**On 27.05.2026**	**On 29.05.2026**
TEST	**Result**	**Result**	**Result**
CBP: Hemoglobin	13.3g/dl	12.7 g/dl	12.6 g/dl
While blood cell	12110cell/cmm	11760 cell/cmm	10270 cell/cmm
Platelets	5.72lakh/cmm	5.55 lakh/cmm	2.56 lakh/cmm
CRP	249mg/L	151 mg/L	-

Name	Master J REVANTH	UHID	HNH-00015608
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Serum.CREATININE	0.9mg/dl	-	0.9 mg/dl
Urea			26 mg/dl
Serum.FERRITIN	718 ng/ml	-	-
Sodium	-	-	137 mmol/L
Potassium	-	-	5.4 mmol/L
Chloride	-	-	101 mmol/L
ESR	15 mm/hour	-	-
PROCALCITONIN	0.284 ng/ml	-	-
LFT: SBR	0.7mg/dl	-	0.4 mg/dl
DIRECT FRACTION	0.3 mg/dl	-	0.2 mg/dl
SGOT	31 U/L	-	20 U/L
SGPT	30 U/L	-	22 U/L
ALP	173 U/L	--	138 U/L

Name	Master J REVANTH	UHID	HNH-00015608
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PROTEIN	9.3 g/dl	-	8.4 g/dl
ALBUMIN	4.3 g/dl	-	3.8
GLOBULIN	5 g/dl	-	4.59
A/G Ratio	0.8		0.8
BLOOD CULTURE	24 hours no incubation	-	-

Complete urine examination was normal.
Urine culture showed no growth after 24 hrs.
SCRUB TYPHUS IGM ANTIBODY - non reactive
BRUCELLA SEROLOGY - non reactive
Entamoeba Histolytica Antibodies - 11.24 (borderline positive)

Chest X-ray was normal.

Ultrasound abdomen done on 25.05.2026:
* Multiple hypoechoic focal hepatic lesions as described, with a larger partially liquified lesion / evolving abscess in the right lobe. In the given clinical setting are highly suggestive of multifocal hepatic abscesses.
* Mild hepatomegaly.
- For clinical correlation.

Ultrasound abdomen done on 27.05.2026:
* F/c/o focal hepatic abscesses, showing partially liquified lesions / evolving abscesses in the right lobe of liver as described.

Name	Master J REVANTH	**UHID**	HNH-00015608
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* Mild hepatomegaly.
* Confluent B lines in the right lung lower zone anterior lateral aspect - suggestive of subpleural septal congestion.
- 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 antacids and antipyretics.

In view of USG abdomen showing liver abscess, Dr. Swapna paediatric surgeon consultation was done. Advised Injection Piptaz, Injection Metronidazole in view of suspected liver abscess. Serial ultrasounds showed decrease in the volume of the abscess in liver which did not require pig tail catheter incision and drainage.
Advised to continue IV antibiotics and metronidazole, repeat USG after 3 days.

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

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

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

Medication during hospital stay:
Injection. Piptaz
Injection. Ceftriaxone
Injection. Pantop

Name	Master J REVANTH	UHID	HNH-00015608
IP No	IP26-00006426	Admission Date	25-05-2026

Injection. Metronidazole
Tab. Metrogyl

Advice:
* Diet as advised.

S.No	MEDICATION	DOSE	TIMINGS	DURATION
1	Injection. Piptaz	4.5gm	8am - 12pm - 8pm (after food)	For 12 days.
2	Tablet. Pan (Pantoprazole - 40mg)	1 tablet	7am (before breakfast)	For 12 days
3	Tab. METROGYL (Metronidazole - 400mg)	1 tablet	Thrice daily (after food)	For 12 days

Plan: To collect blood and urine culture reports on follow up.
To do USG abdomen on follow up ON THURSDAY 4/6/26.

Fever Management
* Tablet. Paracetamol (Paracetamol - 1 tab/650mg) 1 tablet after food as and whenever required, if temperature > 100 *F (maximum 4 times a day at 6 hour intervals).
* Tepid sponging if fever > 101 *F.

Review consultation with Dr. VINAY KUMAR M on Monday (01.06.2026) at his clinic.
Review consultation with pediatric surgeon on Thursday on 4/6/26..

Name	Master J REVANTH	UHID	HNH-00015608
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Food instructions while taking medications:
* **Antibiotics** along with food & milk products prevent their absorption of drugs & supplements. Antibiotics can be given 1 hour before food or 2 hours after food based on tolerance of stomach.
* **Anti ulcer drugs** can decrease the absorption of Iron&vit-B12. Anti ulcer drugs can be taken at least 1 hour before food (OR) 2hrs after food. Avoid caffeine that increases stomach acidity.

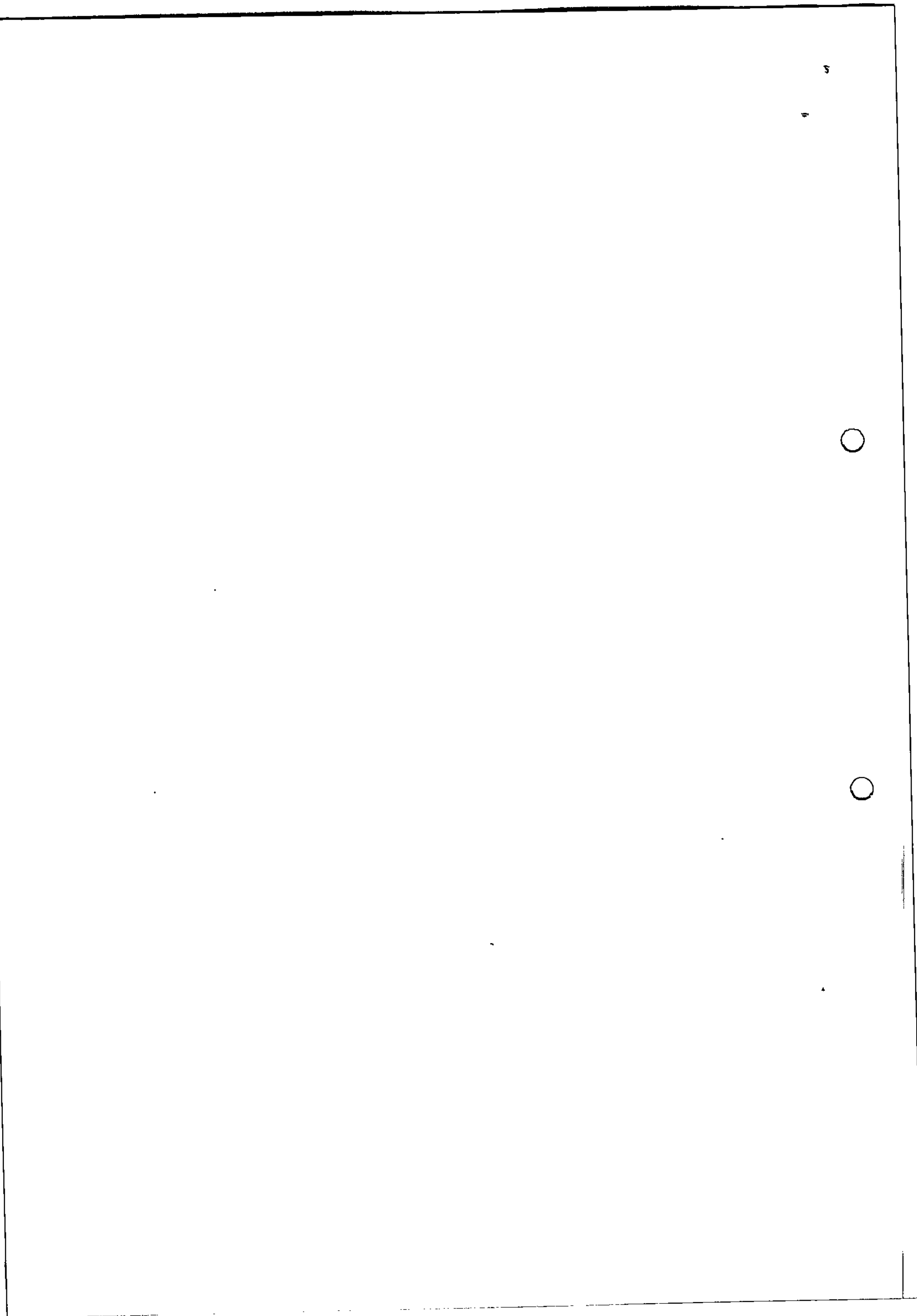
Follow up immediately in Emergency Room if high grade fever, vomiting, breathlessness or refusal to feed occurs.

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**



Name	Master J REVANTH	UHID	HNH-00015608
IP No	IP26-00006426	Admission Date	25-05-2026

Registrar/Resident/C.M.O

Dr. VINAY KUMAR MANTHATI
MBBS DNB (Pediatrics)
Reg No:91733

HNH-00015608 IP26-00006426
Master J REVANTH
07-07-2011 14 Y 10 M 20 D (M)
Dr. VINAY KUMAR M

CROSS CONSULTATION FORM

Doctor Name : D. MUKTA Date : 2/5 Time :

Diagnosis : Liver Abscess

Hospital : RCH – HNH

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

Type of Referral :
☐ Emergency
☐ Urgent
☐ Non Urgent

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

LIVER ABSCESS

Signature:

Findings and Recommendations :

S/b Dr Mukta
14yr / Male / pain abdo
fever on/off x 15 days.
Evaluation s/o seg 5/6 liver abscess
~ 50cc (partially liquefied)
.. two small subcap. < 5cc abscess.

P/A soft

Adv
– Ct. IV Antibiotics
– R/V USG after 5 days Ct rest
– No drainable abscess at present

Consultant :

Name : 10.50AM Signature : [signature] Date & Time :

12-35pm
30/5/26

S/B Dr Mulla

No fever - in last 24 hrs.
Stable

USG - [illegible]ed in size.

Plan :- R/V USG on Thursday
Can be discharged on [illegible]

[signature]

HNH-00015608 IP26-00006426
Master J REVANTH
07-07-2011 14 Y 10 M 18 D (M)
Dr. VINAY KUMAR M

CROSS CONSULTATION FORM

Doctor Name: Dr. Swapna Date: 25/5/26 Time: 5:10 PM

Diagnosis: Liver Abscess

Hospital: RCH-HMNR

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

Type of Referral :
☐ Emergency
☐ Urgent
☐ Non Urgent

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

Signature:

Findings and Recommendations :

Fever - 2 weeks,
C/o Liver Abscess
3 sites.
Taken IV Monocef (Ceftriaxone) outside
Plan
- Inj. PIPTAZ 4.5gm IV TID
- Inj. METRONIDAZOLE 500mg IV TID
- Repeat USG Abdomen after 48h

Consultant :

Name: Dr Swapna Signature: [signature] Date & Time:

Doc. No. : RCH / FRM / CLINICAL / 049

Rainbow Children's Hospital

Rainbow Childrens Hospital-Himayatnagar

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

ADMISSION SHEET

Registration Details :

Admission No : IP26-00006426 **Admit Date** : 25-May-2026 **Admit Time** : 11:42 AM **UHID** : HNH-00015608

Patient Details :

Patient Name	: Master J REVANTH	**Age**	: 14 Y 10 M 18 D
Guardian	: Mr J THIRUMALESH	**DOB**	: 07-07-2011
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: 13-4-56/26/1/1/ Jiaguda Hyderabad Telangana INDIA 500006	**Phone No**	: 9398033296/ 7013119898
		E-mail	: no@gmail.com

Admission Details :

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

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

Contact Details :

Name	: Mr J THIRUMALESH	**Relationship**	: Father
Contact Address	: 13-4-56/26/1/1/ Jiaguda Hyderabad Telangana INDIA 500006	**Phone No**	: 9398033296

J. Sa

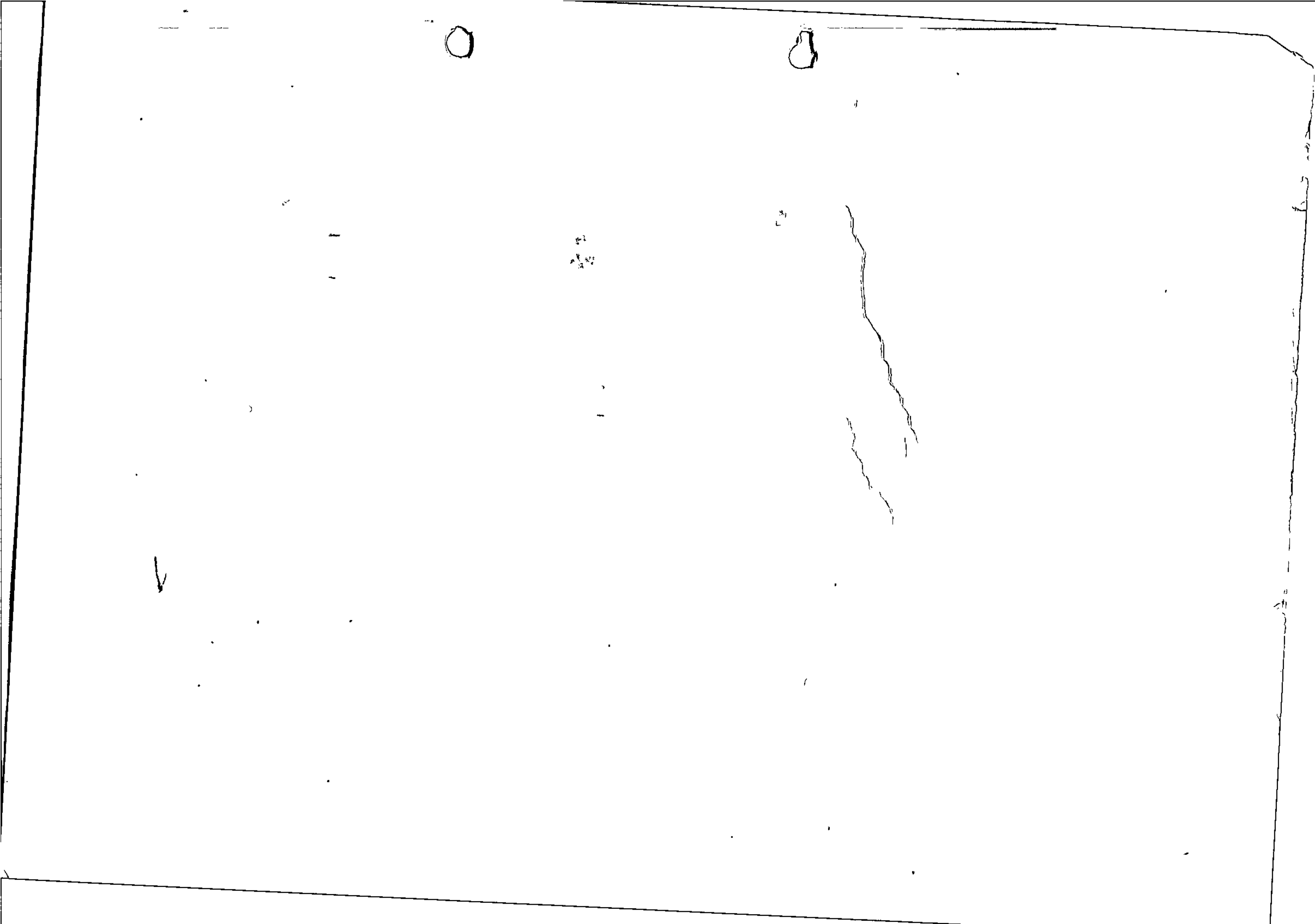
Signature

Doctor Details :

Doctor Name	: Dr. VINAY KUMAR M	**Specialisation**	: GENERAL PEDIATRICS
Referral Doctor	: Dr Vinay Kumar Manthati	**Phone No**	: 9533799099
Co-Consultant	: Dr. ANIKET ANIL PARASHAR		

Payment Details :

		Deposit Amount	: 10000.00
Payment Mode	: Cash	**Payor Name**	: SELFPAY



ACTIVITY RECORD FOR BILLING

Name: HNH-00015608 IP26-00006426
Master J REVANTH
07-07-2011 14 Y 10 M 18 D (M)
Dr. VINAY KUMAR M

UHID N -------------- Consultant : ------------------------ Dept : pediatric

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
25/05/26	2pm	ER	ward	[signature]

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1.	Dr. Swapna Chakravarthy	25/5/26	202073	[signature]
2.	Dr. Muka Subhash	27/5/26	2348	[signature]
3.	Dr. Mukta Subhash	30/5/26	3142	[signature]
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Docu. No. : RCH / FRM / GENERAL / 145

HNH-00015608 IP26-00006426
Master J REVANTH
07-07-2011 14 Y 10 M 18 D (M)
Dr. VINAY KUMAR M

INVESTIGATIONS

Date	Investigations	Order No.	Sign
20/5/26	Ultrasound, chest xray	6320.	Sugandha.
	CBP, CRP, ESR blood culture, creatinine LFT, [illegible]. scrub typhus IgM, brucella serology	8810	
	urine culture and sensi	08819	[signature]
	-HIV/HBsAg. CUE.	08819	
25/5/26	Entamoeba Histolytica Antibody (IgM)	8828	[signature]
25/5/26	PCT	8830	[signature]
	cross checked done by Neha		
27/5/26	Ultra Sound Abdomen.	6383	[signature]
27/5/26	CBP, CRP	8907	[signature]
	cross checked done by Neha		
29/5/26	LFT, Electrolytes, Urea Creatine, CBP, CRP Blood culture.	8984	[signature]
	Cross checked done		
30/5/26	Ultra Sound Abdomen	6498	[signature]

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Master J REVANTH
07-07-2011 14 Y 10 M 18 D (M)
Dr. VINAY KUMAR M

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
25/5/26	Infusion pump	25/5/26 @ 3pM.	10 Am @ 26/5/26	2065 ✓	[signature]
		cross checked done			

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Master J REVANTH
07-07-2011 14 Y 10 M 18 D (M)
Dr. VINAY KUMAR M

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
25/5/26.	IV placement	01 ✓	2018.	Sugandha
25/5/26	NHA	1 ✓	2090	[signature]
	cross checked done by Neha			
2?/5/26	IV placement ✓	1	2430	[signature]
29/5/26	IV placement	1	2952	[signature]

ANY OTHER INFORMATION

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

HNH-00015608 IP26-00006426

Ref.No. F/IN/PR/10

PEDIATRIC IN-PATIENT MEDICAL RECORD

HNH-00015608 IP26-00006426
Master J REVANTH
07-07-2011 14 Y 10 M 18 D (M)
Dr. VINAY KUMAR M

Patient Name :

Patient ID# :

Consultant :

Final Diagnosis :

Master J REVANTH
07-07-2011 14 Y 10 M 18 D (M)
Dr. VINAY KUMAR M

Pediatric Multiorgan History & Physical Examination

Name : ______________________ Age/Sex ______

Informant ______________________ Reliability ______

Chief Presenting Complaints & Duration (Chronologically):

C/o fever since 2 weeks
C/o body pain since 1 week
C/o decreased oral intake x 2 weeks
C/o dull activity x 2 weeks

History of present illness :

Pt was apparently alright 2 weeks before. then had fever, on & off type, moderate - high degree fever. not associated with chills / rigors.

C/o body pains since 1 week, more over shoulder region.

C/o decreased oral intake since 2 weeks, dull activity since 2 weeks.

Recieved IV antibiotics outside but no improvement.

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Master J REVANTH
07-07-2011
Dr. VINAY KUMAR M
IP26-00006426
14 Y 10 M 18 D
(M)

Pediatric Multiorgan History & Physical Examination

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

Nothing significant.

Birth & Neonatal History :

NAD

Birth & Socio Economic History :

About Father :

About Mother :

Any additional Information : —

Developmental History :

Developmentally normal.

Immunization History :

Immunized uptodate. till 3 yrs acc to NIS.

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Master J REVANTH
07-07-2011 14 Y 10 M 18 D (M)
Dr. VINAY KUMAR M

Pediatric Multiorgan History & Physical Examination

Anthropometry

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

Weight (kgs) 78kg (Centile ________)

On Examination :

Temperature : 100°F Pulse Rate: 96. Description ________

B.P. 120/80mmg SPO2 98% at RA.

Resp. rate and type of breathing : 20.

dry oral mucosa
dry lips
sunken eyes

Rash (−)

Lymphadenopathy (−)

Oedema : (−)

Respiratory system :

Inspection (any s/o distress) : ________

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

Any addes sounds : B/L NVBS(+)

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

Cardiovasclular System :

Inspection of procordium : ________

Heart Sounds : $S_1 S_2$ heard.

Any murmur : No murmur.

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

Per Abdomen :

Inspection ________

Palpation : soft, tender.(+) over (Rt) lumbar region.

Ausculation : NO organomegaly

Spine: ________ External Genitelia : ________

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

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Master J REVANTH
07-07-2011 14 Y 10 M 18 D (M)
Dr. VINAY KUMAR M

Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS Score : ______

Cranial Nerves : ______ (N)

Motor System :

Nutrition : ______

Tone : ______ Power ______

Co-ordinator : ______ (N)

Posture : ______

Involuntary Movements : ______

Reflexes :

DTR **Superficials :**

Plantars ______

Sensory System :

(N)

Bladder / Bowel : ______

Clinical Summary & Diagnostic :

Pyrexia of unknown origin c̄
dehydration

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment :

Desired goals of the treatment :

Planned Labs :

CBP, CRP, ESR.
Blood C/S (Paired C/S) two bottles.
CUE, Urine C/S.
CXR, USG Abdomen & pelvis
Sr. Creatinine
Scrub typhus IgM
Brucella IgM.
Sr. Ferritin, LFT
1 extra plain.

Planned Management :

Inj. Ceftriaxone 2gm BD
Inj. Doxycycline 100mg BD
T. Dolo 650 SOS
Inj. pantop 40mg.

Please fill up the following details

1. Name of the Referring Doctor : Dr. Vinay Kumar
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. Ankit P on whose name the patient is being referred

Doctor's Signature Name [signature] Date 28/5/26 Time

HNH-00015608 IP26-00006426
Master J REVANTH
07-07-2011 14 Y 10 M 18 D (M)
Dr. VINAY KUMAR M

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	C/S/B Dr. Naipriya	
25/5 2:00pm	PUO c̄ dehydration	
	fever (+)	Plan
	oral intake - poor.	
	Vitals - stable.	- Cont ceftriaxone Doxycycline.
	R/S - B/L AE (+)	- Cont. IVF DNS.
	P/A - soft, non-tender	- Trace reports
		- Monitor vitals
		NB. Mounika @ 2PM.
25/5/26 3pm	Case d/w Dr. Aniketh	- Send Entamoeba IgG
	USG Abdomen	- Stop Doxycycline
	s/o Liver Abscess	
		- Start Metronidazole
		- Continue CEFTRIAXONE
		- c/f IV fluids
	25/5/26	- Paed surgeon opinion
		NB. Mounika @ 6PM

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

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Master J REVANTH
07-07-2011 14 Y 10 M 18 D (M)
Dr. VINAY KUMAR M

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
25/5/26 5:30pm	S/B Dr. Vinay	
	Δ Liver Abscess	
		Plan
	Fever spikes ⊕	
	CVS - S1S2 ⊕	Send PROCALCITONIN same sample
	BS - B/L - AE ⊕	Trace reports
	P/A - soft	c/t PIPTAZ, METRONIDAZOLE
	USG Abdomen → S/o Liver Abscess	c/t IV fluids @80ml/hr
		NB - Mounika @6PM
		[signature]

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Master J REVANTH
07-07-2011 14 Y 10 M 18 D (M)
Dr. VINAY KUMAR M

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
26/5 7Am	C/S/B Dr. Pranav / Dr. Valun	
	D - LIVER ABSCESS	
		Plan
	- Fever Spikes ⊕ (101.6°F)	1) Inj PIPTAZ
	- Abdominal pain - ✓sc	Inj METRONIDAZOLE
	child alert	Inj PANTOP
	Vitals stable	2) IVF @ 80ml/hr
		To stop after [illegible]
	R-S - B/LAE⊕	3) USG abdomen after 2 days (T/m)
	P/A soft	
		4) Encourage orally
	Oral intake - fair	
		NB Sunanda
		Pranav

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Master J REVANTH
07-07-2011 14 Y 10 M 18 D (M)
Dr. VINAY KUMAR M

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
26/5/26 10 am	CMB re - Amicit	
	Liver abscess	
	- fever spikes (+)	
	- oral intake - fair	
	- no pain abdomen / vomitings	Plan
		1) Inj. piptaz, metronidazole
	O/E	
	- vitals stable	2) USG abdomen → 2T/M
	S/E :	3) trace reports
	P/A - soft	4) IVF - STOP
	RS : BAE (+) clear.	5) monitor vitals.
		6) high protein diet.
		7) if change of IV → send CBP, CRP.
		Dr. Anil [illegible]
		NB - Supriya 10:35AM @ 26/5/26

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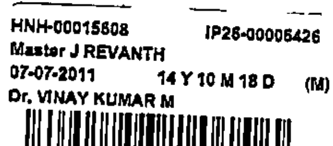
Master J REVANTH
07-07-2011 14 Y 10 M 18 D (M)
Dr. VINAY KUMAR M

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
26/5/26	c/s/hy · ...	
3pm.	liver abscess.	
	No fever spike since mng.	
	oral Intake / good activity	
		PL
	vitals stable.	
		Cт PIPTAZ
	S/E	METRONIDAZOLE
	P/A soft	
	No tender.	– Tm USG abdomen.
		– (T) Hepatitis.
		– high protein diet.
		– Next pvick CBP, CRP.
	[signature]	

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



HNH-00015608 IP26-00006426
Master J REVANTH
07-07-2011 14 Y 10 M 18 D (M)
Dr. VINAY KUMAR M

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
26/5/26 5.30PM	S/B Dr. Aniketh	· Plan
	Δ Liver Abscess	
		– C/ PIPTAZ
	Fever spike (+)	METRONIDAZOLE
	↳ 100.9° F	
		– Encourage orally
	CVS – S1S2 (+)	
	RS – BLL – AE (+)	– Next prick CBP, CRP
	P/A – Soft	– Monitor vitals
	Conscious	
		– USG Abdomen
		↳ Tomorrow evening.
		[signature] – Dr. Aniketh
		– Trace Blood C/S
26/5/26 5.35PM	S/B Dr. Vinay	
	Δ Liver Abscess	Plan
		– C/ PIPTAZ
	Fever spikes (+)	METRONIDAZOLE
	CVS – S1 S2 (+)	– Encourage orally
Next prick	RS – BLL – AE (+)	
		– Next prick CBP, CRP
	P/A Soft	
	Conscious	✓ USG Abdomen
		↳ Tommorrow evening

[signature] [signature]

noted by Sr. Sandhya (RT.O) 26/5/26 6:15

HNH-00015608 IP26-00006426
Master J REVANTH
07-07-2011 14 Y 10 M 18 D (M)
Dr. VINAY KUMAR M

PROGRESS NOTES AND DOCTOR'S ORDER

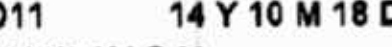
Date & Time	Progress Notes	Doctor's Order
	S/B. Dr Prabhath / Dr Prashanth.	
22/05/26 8AM		
	△ Liver abscess.	
	fever spikes (+) low grade	
		Adv
	fresh c/o	
		– Ct Piptaz
	O/E GC fair.	Metronidazole
	Vitals	
	stable.	– Encourage oral
	C/E CVS $S_1 S_2$ +	– Next pri
	CNS WNL	
	RS BAE+	– USG
	PA soft.	

HNH-00015608 IP26-00006426
Master J REVANTH
07-07-2011 14 Y 10 M 18 D (M)
Dr. VINAY KUMAR M

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
/5/26	C/s/by Dr Aniketh	
	Δ liver abscess	
		-Next prick → CBP, CRP
		- USG Abd →
		Pediatic Surgery Opinion
		...ele Cannula
		...ure orally
		...tibiotic
		Dr. Aniketh P

Docu. No. : RCH /FRM / CLINICAL / 0...



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Master J REVANTH
07-07-2011 14 Y 10 M 18 D (M)
Dr. VINAY KUMAR M

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/05/26 8AM	S/B. Dr Prabhath / Dr Sushanth.	
	△ Liver abscess.	
	fever spikes ⊕ low grade	
	fresh c/o	Adv
		– Ct Peptaz
	O/E GC fair.	Metronidazole
	Vitals stable.	– Encourage orally
	S/E CVS $S_1 S_2$ +	– Next prick CBP
	CNS WNL	CRP.
	RS BAE +	– USG abdomen evening.
	PA soft.	
		Srikanth
		NB Neha

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07-07-2011 14 Y 10 M 18 D (M)
Dr. VINAY KUMAR M

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
27/5/26 10 AM	c/s/by Dr Aniketh	
	Δ liver abscess	
	- No new sympt	
	- oral Intake - Moderate	
	- fever spike	- Next prick → CBP, CRP
	vital - stable	- USG Abd → ↓
		Pediatric Surgery Opinion
	s/e P/A Soft Not distended	- check Cannula
		- Enhance orally
		- ct Antibiotics
		Dr Aniketh P
		[illegible] 10 AM

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Master J REVANTH
07-07-2011 14 Y 10 M 20 D (M)
Dr. VINAY KUMAR M

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
27/5/26	C/S/B Dr. Varun / Dr. Pranav	
2PM	D - Liver abscess.	
	- Last fever at 3:30 AM (10[illegible].5°F).	
	- Oral intake - fair.	
	- No fresh complaints.	
	O/E - Vitals stable.	Plan
	O/E - P/A - Soft, no abdominal distension.	- Ct. antibiotics. - Next prick CBP, CRP. - Encourage orally. - Rpt. USG after 5 days.
		NB- Supriya 2:17pm @ 27/5/26

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Master J REVANTH
07-07-2011 14 Y 10 M 20 D (M)
Dr. VINAY KUMAR M

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
27/5/26	c/s/b Dr. Vinay	
4PM	- Afebrile.	
	- oral intake - fair.	
	- O/E - vitals stable.	
	S/E - WNL.	Plan -
		✓ Ct. same.
		✓ Rpt. USG after 5 days -
		✓ ? PICC line - for Abx.
		✓ Encourage [illegible] orally.
		✓ Watch for fever spikes.
		[signature]
		NB Sunanda @ 4pm

GRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
28/5/26 8am	c/o/b re-drainm	
	liver abscess	
	low grade spike	
	- at 5am	
	- no vomitings	
	- pain abdomen ↓	
	vitals : stable	
	HE - (N)	Plan
		1) ct. antibiotics
		2) Repeat USG after
		4 days
	[signature]	3) plan PICC line
		4) monitor vitals
		5) Rest ct. as per
		Rx chart
		HB [signature]

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Master J REVANTH
07-07-2011 14 Y 10 M 22 D (M)
Dr. VINAY KUMAR M

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
28/8/26 10AM	c/s/b Dr. Aniket	
	Dx: liver abscess	
	- last fever @ 5am (low grade).	
	- CRP ↓	Plan - Make
	- No pain abdomen	metronidazole od
	P/E - vitals stable.	- Cont. IV piptaz.
		- Make pantop oral.
	S/E - LOAL.	- Repeat USG after 4 days.
		- Monitor vitals.
		- follow up blood c/s & urine c/s.
		- Rpt. CBP, CRP, blood c/s on next prick.
		Take 5cc blood.
		[signature] Dr. Aniket
		NB - Supriya 11AM @ 28/8/26

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Master J REVANTH
07-07-2011 14 Y 10 M 22 D (M)
Dr. VINAY KUMAR M

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
28/5 3pm	c/S/B Dr. Pran	
	D - Amoebic Liver Abscess	
	Last fever @ 5am	Plan
		1) CBP, CRP, Blood c/s (Sent) — Next Prick
	Abdominal pain better	2) Tab. Pan
	Vitals stable	3) Tab Metronidazole
		4) Inj PIPTAZ
	R-S-B/L AE ⊕	5) Repeat USG abdomen after 4 days.
	P/A - Soft	
		6) Monitor vitals.
		Pran
		NB - Supriya

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
28/5/26 5pm	s/b Dr Vinay Kumar	
	△ Amoebic Liver abscess.	
	Last fever spike 5Am today	
	Abdomen pain better	Adv
	o/e Gc- fair Vital stable	1) CT. Inj Metronidazole piptaz
		2) CT. Tab Pcm
	Pu B AE +	
	PA soft	3) USG abdomen after 4 days
		4) ~~Toke~~ Send CBP CRP Blood c/s (2 samples) 5ML. LFT, RFT. — Next prick 6am T/m
		5) Probable D/c tomorrow if afebrile.
		[signature] Noted by Divya @ 28/5/26 5PM

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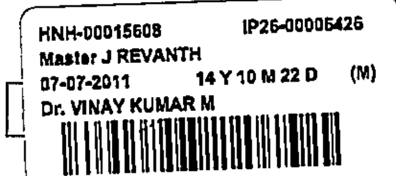
Dr. VINAY KUMAR M

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	C/S/R3 Dr. Naipuja / Dr. Alekya	
~~28/5~~ 29/5	Amoebic liver Abscess	
7:00 AM	Fever spike – 99.9°F (7:00pm)	Plan
	Vitals – stable	– Cont Piptaz
	R/S – B/L AE ⊕.	Metronidazole
	P/A – soft, nontender	
	No organomegaly	– CBP
	R/S – B/L AE ⊕.	CRP
		Blood C/S (2 sample)
		LFT, RFT
		} ~~next~~ ~~prick~~ sent 6am tomorrow.
	C/S/R	– Trace reports.
		[signature]
		HB [signature]

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


HNH-00015608 IP26-00006426
Master J REVANTH
07-07-2011 14 Y 10 M 22 D (M)
Dr. VINAY KUMAR M

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
29/5/26 11AM	S/B Dr Anikethh	
	D. Liver Abscess	
		Plan
	Afebrile	
	Vitals stable	– Discharge → Plan – T/M
		– C/F IV. PIPTAZ
	CRT – Sus (+)	– METRONIDAZOLE
	P/ Blc – Acce (B)	
		– F/up c Dr. Swapna
	P/A – soft	+ Dr. Vinay after 3 days
	Non tender	
		– USG Abdomen
		~~after 3 days~~
		Tomorrow morning
		Dr. Aniketh

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

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Master J REVANTH
07-07-2011 14 Y 10 M 22 D (M)
Dr. VINAY KUMAR M

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
29/5/26 2:55 PM	S/B Dr. Sneytha	
		Plan
	Δ Liver Abscess	
		- C/F PIPTAZ
	Afebrile	METRONIDAZOLE
	Vitals stable	
		- USG Abdomen - Tomorrow
	CVS - S1, S2 ⊕	
	RS - B/L - AE ⊕	
		- Encourage orally
	P/A - Soft	
	Conscious.	
		S/B - Sneytha
29/5 8 pm	O/S/B Dr. Aniket	
	Δ - Entamoeba Liver Abscess	
		Plan
	Fever - ↓	1) Inj PIPTAZ
		2) Inj METROGYL
	Child alert	3) T/m - USG Abdomen
	Vitals stable	4) Monitor Vitals
		Inform SOS
	R-S - B/L AE ⊕	
	P/A - Soft, Non Tender	
		Dr. D. Aniket
		NB Sunanda

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

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Master J REVANTH
07-07-2011 14 Y 10 M 22 D (M)
Dr. VINAY KUMAR M

RESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	c/s/b Dr. Varun / Dr. Sushanth	
30/5/26 7AM.		
	Dx - Amoebic liver abscess	
	- fever - +	
	- oral intake - good.	
		Plan - USG today
	- No fresh c/o.	- probable D/C
		today
	O/E - vitals stable.	
	P/E - 20N.	- ct. IV piptaz,
		oral metrogyl, ipan
		N/B Sathya @7Am

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Master J REVANTH
07-07-2011 14 Y 10 M 22 D (M)
Dr. VINAY KUMAR M

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
30/5/26 10 AM	F/s/b Dr. Aniket	
	A/s/o Amoebic liver abscess:	
	- Afebrile since 48 hrs.	
	- Ord intake good.	
	- No fresh c/o.	Plan
	O/E - vitals stable.	- USG today
		- Ct. IV Antibiotics post discharge.
	S/E - WNL.	- D/s today.
		- Review with pediatric surgery before Discharge.
		f/u: Dr. Aniket P
		N/B Supriya @ 10 Am

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Master J REVANTH
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Dr. VINAY KUMAR M

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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

HNH-00015608 IP26-00006426
Master J REVANTH
07-07-2011 14 Y 10 M 18 D (M)
Dr. VINAY KUMAR M

DRUG CHART

Date of Admission: 25/5/26 Drug Allergies: Nil ☑ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

DOCTOR - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).

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

NURSES - Nurses must follow strictly the FIVE RIGHTS before administration of medication.

1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time

- AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

SOS / PRN (As Required Medication)

DRUG : Tab PARACETAMOL			
Dose	Route	Frequency	Start Date
650mg	Po	SOS	25/5
Doctor's Signature		Valid Period	Pharm.
Pranav			
Additional Instructions:			

Date / Time	25/5/26	26/5	27/5	27/5	28/5
Time	6pm	5:30 pm	3:30 AM	5:30 pm	5:40 AM
Sign	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

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

Date / Time

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

Date / Time

VERIFIED BY : Name .... Signature

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Master J REVANTH
07-07-2011 14 Y 10 M 18 D (M)
Dr. VINAY KUMAR M

REGULAR PRESCRIPTIONS

Weight. 76 Kg Ward. ....

DRUG : Inj. CEFTRIXONE

Dose	Route	Frequency	Start Date
2GM	IV	BD	25/5

Name & Signature of the Doctor Starting the Drugs: [signature]

Additional Instructions:

Date/Time: 26/5 — 10AM, 2:30PM, 10PM

STOP 25/5

Daily Doctor's Endorsement by a Sign

DRUG : Inj. DOXYCYCLINE

Dose	Route	Frequency	Start Date
100mg	IV	BD	25/5

Name & Signature of the Doctor Starting the Drugs: [signature]

Additional Instructions:

STOP 25/5

Daily Doctor's Endorsement by a Sign

DRUG : Inj. PANTOP

Dose	Route	Frequency	Start Date
40mg	IV	OD	25/5

Name & Signature of the Doctor Starting the Drugs: [signature]

Additional Instructions:

Date/Time: 26/5, 26/5, 27/5, 28/5 — 6AM, 3PM

CHANGE 28/5/26 @ 10:30AM

Daily Doctor's Endorsement by a Sign

DRUG : Inj. METRONIDAZOLE

Dose	Route	Frequency	Start Date
500mg	IV	TID	25/5

Name & Signature of the Doctor Starting the Drugs: [signature]

Additional Instructions:

Date/Time: 26/5, 26/5, 27/5, 28/5 — 6AM, 2PM, 3:30PM, 10PM

CHANGE 28/5/26 @ 10:30 AM.

Daily Doctor's Endorsement by a Sign

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Master J REVANTH
07-07-2011 14 Y 10 M 18 D (M)
Dr. VINAY KUMAR M

Sheet No: .... **REGULAR PRESCRIPTIONS** Weight .... Ward ....

DRUG: Inj. PIPTAZ				Date/Time	25/5	26/5	27/5	28/5	29/5	30/5
Dose	Route	Frequency	Start Dt. 25/5							
4.5gm	IV	TID	25/5	7am						
Name & Signature of the Doctor Starting the Drugs: B. Sreeghu				2pm						
Additional Instructions: 4gm PIPERACILLIN 500mg TAZOBACTUM				10PM						
Daily Doctor's Endorsement by a Sign										

DRUG: Tab. PAN				Date/Time	29/5	30/5
Dose	Route	Frequency	Start Dt.			
40mg	PO	OD	29/5	6AM		
Name & Signature of the Doctor Starting the Drugs:						
Additional Instructions:						
Daily Doctor's Endorsement by a Sign						

DRUG: Tab. METROGYL				Date/Time	28/5	29/5	30/5
Dose	Route	Frequency	Start Dt.				
400mg	PO	TID	28/5	6AM			
Name & Signature of the Doctor Starting the Drugs:				2pm			
Additional Instructions:				10pm			
Daily Doctor's Endorsement by a Sign							

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

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

Patient Sticker

Sheet No: ....

REGULAR PRESCRIPTIONS

Weight .... Ward ....

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

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

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

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

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

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

(P.T.O.)

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Master J REVANTH
07-07-2011 14 Y 10 M 18 D (M)
Dr. VINAY KUMAR M

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

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

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses

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Master J REVANTH
07-07-2011 14 Y 10 M 18 D (M)
Dr. VINAY KUMAR M

I.V. FLUIDS CHART

Weight. 78 kg Ward. ....

		osition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
25/5		IVF DNS	IV	80ml/hr	[signature]	[signature] [signature]	26/5/24	[signature]	[signature] [signature]

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

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Master J REVANTH
07-07-2011 14 Y 10 M 18 D (M)
Dr. VINAY KUMAR M

RESULT SHEET

Date	25/5/26	27/5/26	29/5/26			
Time						
Hb	13.3	12.7	12.6			
PCV	38.9	37.1	37.1			
RBC	4.58	4.38	4.37			
WBC	12.11	11.76	10.27			
N/L	70.3/22.7	75.4/17.8	69.6/23.0			
Platelets	572	555	256			
CRP	249	151				
ESR	15					
PCT	0.284					
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine	0.9					
ALP	173					
SGPT	30					
SGOT	31					
T.Bill/Conj	0.7/0.4					
T.Protein	9.3					
S.Albumin	4.3					
S.Globulin	5.0					
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein/Sugar						
Cells						
N/L						

Docu. No. : RCH/FRM/CLINICAL/0138

Ferritin
→ 798

P.T.O.

Date	25/5/26					
Time						
CUE-Alb	Trace					
CUE-Sugar						
CUE - Ketones	Negative					
CUE-PUS Cells	3-5					
CUE - RBC Cells	NIL					
CUE						
Leucocyte - Negative						
Stool Pus Cell						
OVA/Cyst						
Occult Blood						
Scrub Typhus IgM —		Non-Reactive				
Brucella Serology —		Non-Reactive				
Entamoeba Hystolytica Antibody IgG —						

Culture and Sensitivities : Blood c/s :- 24hrs No Growth

Urine c/s :- 24hrs No Growth

Radiology: USG :

X-Ray:

ECHO:

CT:

MRI

Others (ECG, Contrast Studies etc.,) :

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07-07-2011 14 Y 10 M 18 D (M)
Dr. VINAY KUMAR M

Patient

CLINICAL / 127

TEENAGE (12 + years)

Children's Observation & Early Warning Scoring Chart

[E]ARNING SCORE: CHILDREN'S UNIT

Date : 25/5/26 Time: 4pm 6pm 7pm 10 pm 12 am 2 am 8 am

Doctor / Nurse / Family Concern?

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

Recorded: 4pm 98.7°F; 6pm 99.0°F; 7pm 101.8°F (Tab. calpol given); 10pm 100.3 (sponging); 12am 98.5°F; 2am 98.0°F; 8am 99.6

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

Note: BP does not score in early warning scoring

Time	4pm	6pm	10 pm	2 am	8 am
BP	120/67 (82)	118/66 (81)	121/78	112/68	104/62
Heart Rate (Number)	100 b/m	102 b/m	100 b/m	98 b/m	103 b/m
Resp Rate (Number)	20 b/m	21 b/m	22 b/m	22 b/m	20 b/m
O_2 Saturations (%)	100%	100%	98%	99%	99%
Total Score (Number of shaded boxes)	0	0	0	0	0
Pain Score	0	0	0	0	0
Observer's Initials	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

Resp. Rate (bpm) (over 1 Minute): 70, 60, 50, 40, 30, 20, 10

Resp Distress: Mod/ Severe; None / Mild

Receiving O_2 (l/min)

Conscious Level: Normal; Altered

GCS *

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

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

Patient Sticker

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

HNH-00015608 IP26-00006426
Master J REVANTH
07-07-2011 14 Y 10 M 18 D (M)
Dr. VINAY KUMAR M

IBH/ FRM / CLINICAL / 127

TEENAGE (12 + years)
Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 26/5/26

Time:	10 AM	2 PM	5:30 pm	7 PM	10 PM	12 AM	1:30 AM	3:30 PM	4:30 AM	7 AM
Doctor / Nurse / Family Concern?										
Temperature (°F) (scale 94–104)	98.9°F	98.3°F	100.9°F (Tab. dolo given)	98.3°F	99.2°F	98.8°F	98.5°F	100.5°F (Tab dolo)	98.6°F	98.2°F
Heart Rate (bpm) and Blood Pressure (mmHg) * (scale 50–190)	120/79 (93)	120/71 (86)	105/70	120/80	115/60		112/69			115/64 (82)
Heart Rate (Number)	91 b/m	87 b/m	85 b/m	103 b/m	98 b/m		95 b/m			98 b/m
Resp. Rate (bpm) Over 1 Minute (scale 10–70)	20	18								
Resp Rate (Number)	26 b/m	26 b/m	30 b/m	25 b/m	25 b/m		28 b/m			28 b/m
Resp Distress: Mod/ Severe / None / Mild										
Receiving O_2 (l/min) / O_2 Saturations (%)	99%	99%	99%	99%	100%		99%			99
Conscious Level: Normal / Altered										
GCS *	15/15	15/15	15/15	15/15	14/15		14/15			14/15
TOTAL SCORE Number of shaded boxes	0	0	0	0	0		0			0
Pain Score	0	0	0		0		0			
Observer's Initials										

Note: BP does not score in early warning scoring

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

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

Patient Sticker

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

I	**IDENTITY:** I am (name), a nurse on ward (X). I am calling about (child X)
S	**SITUATION :** I am calling because I am concerned that ... (e.g. BP is low/high, pulse is XXX, Temperature is XX, Early Warning Score is XX)
B	**BACK GROUND :** Child (X) was admitted on (XX date) with (e.g. respiratory infection). They have had (X operation/ procedure/ investigation). Child (X)'s condition has changed in the last (XX mins). Their last set of observations were (XXX). The child's normal condition is ... (e.g. alert/ drowsy/ confused, pain free)
A	**ASSESSMENT :** I think the problem is (XXX) and I have ...(e.g. given 02/ analgesia, stopped the infusion), OR I am not sure what the problem is but child (X) is deteriorating, OR I don't know what's wrong but I am really worried.
R	**RECOMMENDATION :** I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

HNH-00015608 IP26-00006426
Master J REVANTH
07-07-2011 14 Y 10 M 18 D (M)
Dr. VINAY KUMAR M

Patient Sticker

27

TEENAGE (12 + years) Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 27/5/26 Time:	10 Am	2 PM	5 PM	7 PM	10 PM	2 Am	5:40 Am	6:50 Am
Doctor / Nurse / Family Concern?								
Temperature (°F)	98.7 F	98.2 F	100.9 F (T. Dolo)	98.5 F	98.2 F	98.1 F	100.6 F (Tab Dolo)	98.3 F
Heart Rate (bpm) and Blood Pressure (mmHg) *	121/66 (83)	115/63 (78)		120/80	116/76	110/72	116/76	
Heart Rate (Number)	97 b/m	86 b/m		96 b/m	95 b/m	99 b/m	90 b/m	
Resp. Rate (bpm) over 1 Minute)								
Resp Rate (Number)	18 b/m	20 b/m		20 b/m	20 b/m	20 b/m	20 b/m	
Resp Distress: Mod/ Severe								
Resp Distress: None / Mild								
Receiving O_2 (l/min)								
O_2 Saturations (%)	99%	99%		99%	100%	99%	99%	
Conscious Level: Normal								
Conscious Level: Altered								
GCS *								
TOTAL SCORE Number of shaded boxes	0	0		0	0	0	0	
Pain Score	0	0		0	0	0	0	
Observer's Initials	[illegible]	[illegible]		[illegible]	[illegible]	[illegible]	[illegible]	

Note: BP does not score in early warning scoring

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

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

Patient Sticker

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

I	**IDENTITY:** I am (name), a nurse on ward (X). I am calling about (child X)
S	**SITUATION :** I am calling because I am concerned that ... (e.g. BP is low/high, pulse is XXX, Temperature is XX, Early Warning Score is XX)
B	**BACK GROUND :** Child (X) was admitted on (XX date) with (e.g. respiratory infection). They have had (X operation/ procedure/ investigation). Child (X)'s condition has changed in the last (XX mins). Their last set of observations were (XXX). The child's normal condition is ... (e.g. alert/ drowsy/ confused, pain free)
A	**ASSESSMENT :** I think the problem is (XXX) and I have ...(e.g. given 02/ analgesia, stopped the infusion), OR I am not sure what the problem is but child (X) is deteriorating, OR I don't know what's wrong but I am really worried.
R	**RECOMMENDATION :** I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

HNH-00015608 IP26-00006426
Master J REVANTH
07-07-2011 14 Y 10 M 20 D (M)
Dr. VINAY KUMAR M

Patient Sticker

7

TEENAGE (12 + years) Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 28/5/26 Time:	10AM	2PM	6 PM	7 PM	10 PM	9 AM	6AM
Doctor / Nurse / Family Concern?							
Temperature (°F) (scale 94–104)	97.0°F	98.5°F	99°F	99.9°F (T. Dolo given)	97.2°	98.2°	98.6°F
Heart Rate (bpm) and Blood Pressure (mmHg) * (scale 50–190) Note: BP does not score in early warning scoring	123/68	115/70	113/75 (88)	110/72 (83)	116/64 (80)	100/70	
Heart Rate (Number)	72b/m	68b/m	90b/m	92b/m	93b/m	85b/m	
Resp. Rate (bpm) Over 1 Minute (scale 10–70)	*	*	*	*	*		
Resp Rate (Number)	20b/m	18b/m	20b/m	20b/m	20b/m	20b/m	
Resp Distress: Mod/ Severe							
Resp Distress: None / Mild							
Receiving O_2(l/min)							
O_2Saturations (%)	99%.	99%.	100%	100%,	100%	100%	
Conscious Level: Normal							
Conscious Level: Altered							
GCS *							
TOTAL SCORE Number of shaded boxes	0	0	0	0	0	0	
Pain Score	0	0	0	0	0	0	
Observer's Initials	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	

ACTIONS

NB: Scores 3 should be recorded overleaf

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

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

Patient Sticker

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.
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- 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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I	**IDENTITY:** I am (name), a nurse on ward (X). I am calling about (child X)
S	**SITUATION :** I am calling because I am concerned that ... (e.g. BP is low/high, pulse is XXX, Temperature is XX, Early Warning Score is XX)
B	**BACK GROUND :** Child (X) was admitted on (XX date) with (e.g. respiratory infection). They have had (X operation/ procedure/ investigation). Child (X)'s condition has changed in the last (XX mins). Their last set of observations were (XXX). The child's normal condition is ... (e.g. alert/ drowsy/ confused, pain free)
A	**ASSESSMENT :** I think the problem is (XXX) and I have ...(e.g. given O2/ analgesia, stopped the infusion), OR I am not sure what the problem is but child (X) is deteriorating, OR I don't know what's wrong but I am really worried.
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HNH-00015608 IP26-00006426
Master J REVANTH
07-07-2011 14 Y 10 M 22 D (M)
Dr. VINAY KUMAR M

Patient Sticker

127

TEENAGE (12 + years) Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date 29/5/26 Time:	10Am	2 pm	6 pm	10 pm	2 Am	6 Am
Doctor / Nurse / Family Concern?						
Temperature (°F)	98.5°F	97.3°F	97.2°F	98°F	97.8°F	98.6°F
Heart Rate (bpm) and Blood Pressure (mmHg) *	113/76 (88)	109/78 (82)	104/62	115/72 (84)	109/49 (88)	117/69
Heart Rate (Number)	90b/m	89b/m	92b/m	83bm	92bm	100b/m
Resp. Rate (bpm) over 1 Minute						
Resp Rate (Number)	18b/m	20b/m	20b/m	20bm	20b	20
Resp Distress (Mod/ Severe; None / Mild)						
Receiving O_2(l/min) / O_2Saturations (%)	99%	99%	98%	99%	99%	99%
Conscious Level (Normal; Altered)						
GCS *						
TOTAL SCORE Number of shaded boxes	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0
Observer's Initials	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

Note: BP does not score in early warning scoring

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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Patient Sticker

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.
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HNH-00015608 IP26-00006426
Master J REVANTH
07-07-2011 14 Y 10 M 18 D (M)
Dr. VINAY KUMAR M

Sheet No. : ....

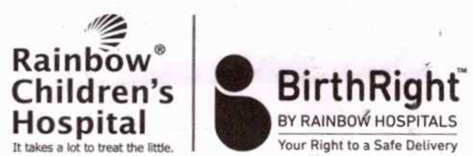
FLUID CHART

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

Date	Time	Intake: Nature of Fluid	Route: Mouth	Route: I.V	Route: N.G	Output: NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
25/5/26	08:00 am										0	
	09:00 am											
	10:00 am											[signature]
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						**Total Output :**						
25/5/26	02:00 pm	DNS	Rice + curd + dal			NA	0	NA		✓	0	[signature]
	03:00 pm			80ml								
	04:00 pm			80ml								
	05:00 pm			80ml								
	06:00 pm			80ml								
	07:00 pm			80ml								
Total Intake :						**Total Output :** U - 1					M -	
25/5/26	08:00 pm	DNS	Rice khichdi	80ml		NA	0	NA		✓	0	[signature]
	09:00 pm			80ml								
	10:00 pm			80ml						✓		
	11:00 pm			80ml								
	12:00 am			80ml								
	01:00 am			80ml								
Total Intake :						**Total Output :** U - 2					M - 0	
26/5/26	02:00 am	DNS	H_2O	80ml		NA		NA			0	[signature]
	03:00 am			80ml								
	04:00 am			80ml								
	05:00 am			80ml								
	06:00 am			80ml								
	07:00 am			80ml								
Total Intake :						**Total Output :** U -					M -	

Total 24 hrs. Intake		Total 24 hrs. Output	

HNH-00015608 IP26-00006426
Master J REVANTH
07-07-2011 14 Y 10 M 18 D (M)
Dr. VINAY KUMAR M



FLUID CHART

Sheet No. : ....

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

Date	Time	Intake: Nature of Fluid	Route: Mouth	Route: I.V	Route: N.G	Output: NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
26/5/26	08:00 am	DNS	Idly	80ml							0	
	09:00 am			80ml						✓	0	
	10:00 am	Stop									0	
	11:00 am	IVF			NA					✓	0	[illegible]
	12:00 pm										0	
	01:00 pm									✓	0	
Total Intake :						**Total Output :** U- 3					M- 0	
26/5/26	02:00 pm											
	03:00 pm									✓		
	04:00 pm		chapati + rice				0				0	
	05:00 pm									✓		
	06:00 pm			NA				NA				
	07:00 pm									✓		
Total Intake :						**Total Output :** U-3					M-0	
26/5	08:00 pm											
	09:00 pm		kichery									
	10:00 pm	0	+	NA						✓	0	[illegible]
	11:00 pm		H2O				0	NA				
	12:00 am									✓		
	01:00 am											
Total Intake :						**Total Output :**				Mo	U-2	
27/5	02:00 am											
	03:00 am											
	04:00 am	0	H2O				0				0	[illegible]
	05:00 am			NA				NA		✓		
	06:00 am		+									
	07:00 am		H2O									
Total Intake :						**Total Output :**						

Total 24 hrs. Intake		Total 24 hrs. Output	

Patient Sticker: HNH-00015608 Master J REVANTH IP26-00006426 07-07-2011 14 Y 10 M 18 D (M) Dr. VINAY KUMAR M

[FLU]ID CHART

Sheet No. : ....

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

Date	Time	Intake				Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
		Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
27/5/26	08:00 am	0	Idly & H2O					NA			0	[signature]
	09:00 am											
	10:00 am				NA							
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake : Taken						**Total Output :**						
27/5/26	02:00 pm	0	Rice dal + H2O	NA				NA		✓	0	[signature]
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm									✓		
	07:00 pm											
Total Intake :						**Total Output :** U – 2. M –						
27/5/26	08:00 pm	0	Rice + H2O	NA			0	NA		✓	0	[signature]
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						**Total Output :** M – 0 U – 1						
28/5/26	02:00 am	0	H2O + H2O	NA			0	NA		✓	0	[signature]
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						**Total Output :** M – 0 U – 1						

Total 24 hrs. Intake			Total 24 hrs. Output	

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

HNH-00015608 IP26-00006426
Master J REVANTH
07-07-2011 14 Y 10 M 20 D (M)
Dr. VINAY KUMAR M

FLUID CHART

Sheet No. : ....

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

Date	Time	Intake: Nature of Fluid	Intake: Route – Mouth	Intake: Route – I.V	Intake: Route – N.G	Output: NG	Output: Diarrhoea	Output: Vomit	Output: Drainage	Output: Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
28/5/26	08:00 am											
	09:00 am									✓		
	10:00 am	0	Idly		NA			NA			0	Aus
	11:00 am		+									
	12:00 pm		H2O							✓		
	01:00 pm											
Total Intake : Taken						Total Output : U-2 M–						
28/5/26	02:00 pm											
	03:00 pm									✓		
	04:00 pm				NA			NA				
	05:00 pm	0									0	
	06:00 pm									✓		
	07:00 pm											
Total Intake :						Total Output : U – M–						
28/5/26	08:00 pm											
	09:00 pm		Rice									
	10:00 pm	0			NA							
	11:00 pm		+					NA		✓	0	
	12:00 am		H2O									
	01:00 am											
Total Intake :						Total Output :						
29/5/26	02:00 am											
	03:00 am		H2O									
	04:00 am				NA							
	05:00 am	0	+					NA			0	
	06:00 am		H2O									
	07:00 am											
Total Intake :						Total Output :						

Total 24 hrs. Intake		Total 24 hrs. Output	

HNH-00015608 IP26-00006426
Master J REVANTH
07-07-2011 14 Y 10 M 22 D (M)
Dr. VINAY KUMAR M

FLUID CHART

Sheet No. : ....

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

Date	Time	Intake: Nature of Fluid	Route: Mouth	Route: I.V	Route: N.G	Output: NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
29/5/26	08:00 am						✓					
	09:00 am	0	idly							✓		
	10:00 am				NA						0	[illegible]
	11:00 am		[illegible]					NA				
	12:00 pm		Rice									
	01:00 pm											
Total Intake :									**Total Output :**	V — M —		
29/5/26	02:00 pm											
	03:00 pm		Rice							✓		
	04:00 pm		+ H_2O		NA			NA			0	[illegible]
	05:00 pm	0										
	06:00 pm									✓		
	07:00 pm											
Total Intake : taken									**Total Output :**	V — M —		
29/5/26	08:00 pm											
	09:00 pm											
	10:00 pm		Rice				0			✓	0	[illegible]
	11:00 pm	0			NA			NA				
	12:00 am		H_2O							✓		
	01:00 am											
Total Intake :									**Total Output :**	V-2	M-0	
30/5/26	02:00 am											
	03:00 am									✓		
	04:00 am	0					0					[illegible]
	05:00 am		H_2O		NA			NA			0	
	06:00 am									✓		
	07:00 am											
Total Intake :									**Total Output :**	V-2	M—	

Total 24 hrs. Intake		Total 24 hrs. Output	

HNH-00015608 IP26-00006426
Master J REVANTH
07-07-2011 14 Y 10 M 22 D (M)
Dr. VINAY KUMAR M

FLUID CHART

Sheet No. : ....

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

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

HNH-00015608 IP26-00006426
Master J REVANTH
07-07-2011 14 Y 10 M 18 D (M)
Dr. VINAY KUMAR M

PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
12/5/26	2PM	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
25/5	10pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
26/5	2am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
26/5	6am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
26/5/26	10AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
26/5/26	4:pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
26/5/26	10PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
27/5/26	10Am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
27/5/26	2pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
27/5/26	10pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]

Re-assessment Frequency:

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

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

Numerical Pain Scale (Obstetric and Gynecology)

0 No Pain — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10 Worst Possible Pain

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

0	2	4	6	8	10
No Hurt	Hurts Little Bit	Hurts Little More	Even More	Hurts Whole Lot	Hurts Worst

HNH-00015608
Master J REVANTH IP26-00006426
07-07-2011 14 Y 10 M 20 D (M)
Dr. VINAY KUMAR M

PAIN ASSESSMENT FORM

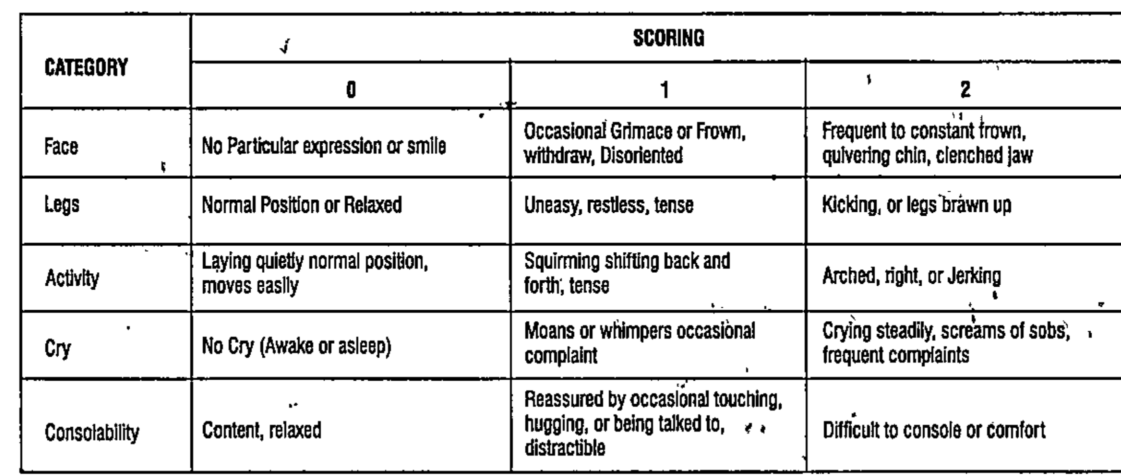
Date	Time	e (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
28/5/26	10Am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
28/5/26	4Pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
28/5/26	10Pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
29/5/26	4Pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
29/5/26	10pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

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

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)



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

Numerical Pain Scale (Obstetric and Gynecology)

0 No Pain — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10 Worst Possible Pain

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

Assessment Criteria	Sedation -2	Sedation -1	Normal 0	Pain / Agitation 1	Pain / Agitation 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

0
No Hurt

2
Hurts Little Bit

4
Hurts Little More

6
Even More

8
Hurts Whole Lot

10
Hurts Worst

HNH-00015608 IP26-00006426
Master J REVANTH
07-07-2011 14 Y 10 M 18 D (M)
Dr. VINAY KUMAR M

CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1 25/5			DAY-2 26/5/25			DAY-3 27/5			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	
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	0	0	0	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	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	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	NA	
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5	NA	NA	NA	NA	NA	NA	NA	NA	NA	
		Signature of the Nurse		[signature]	[signature]	[signature]	[signature]	[signature]	[signature]	[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 : ....

CHECKLIST FOR THROMBOPHLEBITIS

28/5/26

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	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				
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				
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				
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				
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5	NA	NA	NA	NA	NA	NA				
			Signature of the Nurse	[signature]	[signature]	[signature]	[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.

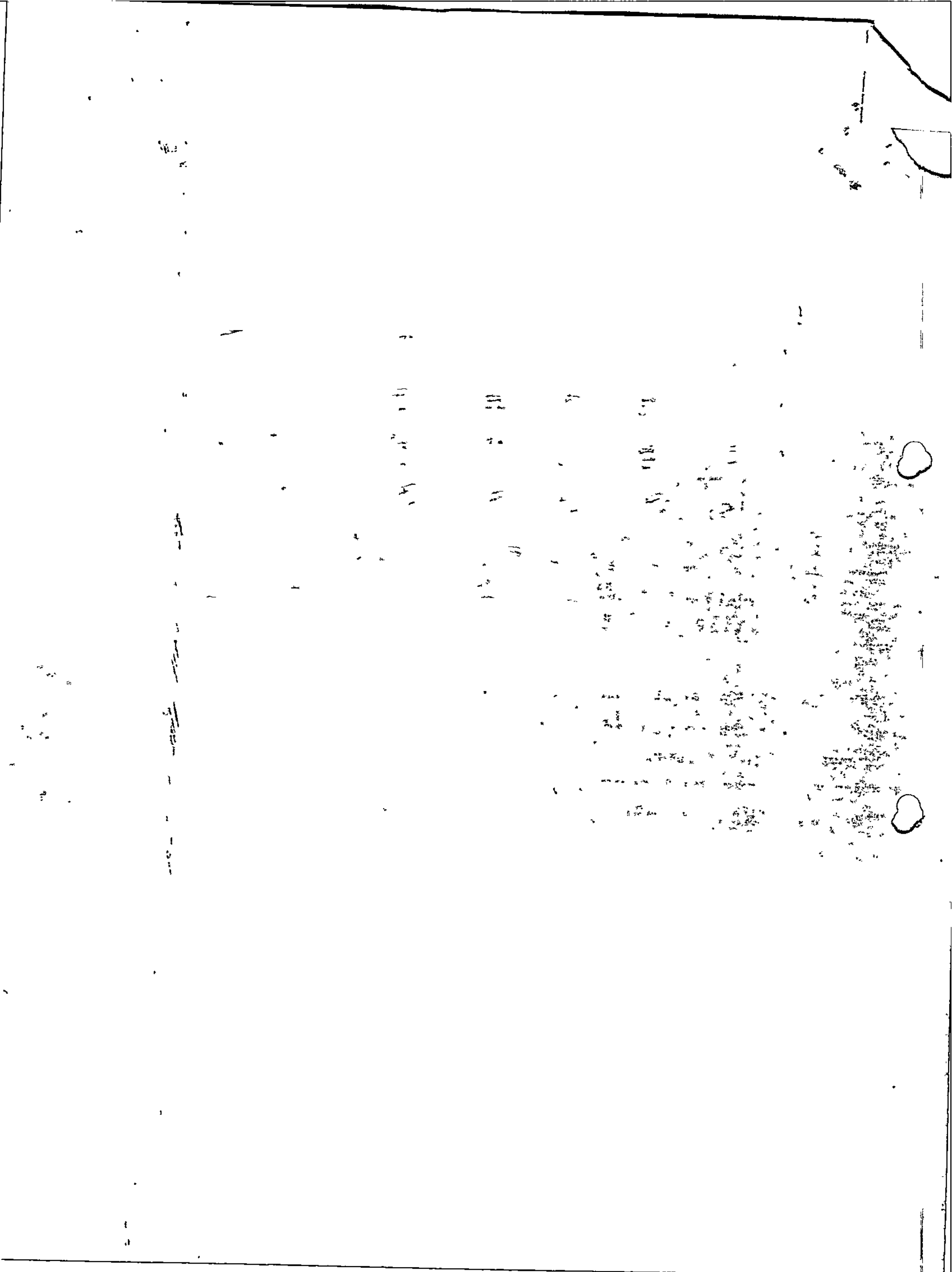
Signature of Shift In Charge :

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

Signature of Ward In Charge :

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

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



HNH-00015608 IP26-00006426
Master J REVANTH
07-07-2011 14 Y 10 M 18 D (M)
Dr. VINAY KUMAR M

NURSING CARE RECORD

Date: 25/5/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8AM to 2PM	- Assess the pt condition - Monitor the vitals - Maintain I/O charts - Medication given as per drugs charts	8AM to 2PM	- Assess the pt condition - Monitor the vitals - Maintain I/O charts - Medication given as per drugs charts	- Patient is Haue stable	- Monitor the vitals	[signature]
Afternoon	2PM to 8PM	→ Assess the general condition of pt. → Monitor vitals → Maintain I/O chart. → Administer medication	2PM to 8PM	→ Assessed the general condition of pt. → Monitored vitals → Maintained I/O chart → Administered medication	Pt is stable.	Re-assess vitals.	Mounika [signature]
Night	8pm to 8am	- Assess the pt condition - Monitor the v/s - Maintain the I/O - Drug as per chart	8pm to 8am	- Assess the pt condition - Monitor the v/s - Maintain the I/O - Drug as per chart	- Now pt is stable	- Rechecked the v/s	[signature]

HNH-00015608 IP26-00006426
Master J REVANTH
07-07-2011 14 Y 10 M 18 D (M)
Dr. VINAY KUMAR M

Patient Sticker

NURSING CARE RECORD

Date: 26/5/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8am to 2pm	→ To assess the pt. condition → To check the vitals & record → To administer the medication as per drug chart → I/O chart maintain	8AM to 2pm	→ To assessed the pt. condition → To checked the vitals & recorded → To administered the medication as per drug chart. → I/O chart maintained → If cannula out CBP, CRP	→ Patient is stable now → Trace pending Reports	→ Re-checked the vitals → I/O → IVF Stop → T/M repeat USG abdomen	Supriya
Afternoon	2PM to 8PM	→ Assess the patient general condition → monitor vitals → no IV fluids → Administer medications as per doctor's orders	2PM to 8PM	→ Assessed the patient general condition → monitored vitals → Administered medications as per doctor's orders	Patient is stable	Rechecked vitals. → Tomorrow evening USG Abdomen to do	[signature]
Night	8PM to 8AM	- Assess the pt condition - Monitor the vitals - maintain I/O charts - No I/V fluids - cannula present - medication given as per drugs charts	8PM to 8AM	- Assess the pt condition - Monitor the vitals - maintain I/O charts - cannula present - Next prick CBP, CRP - medication given as per drugs charts	- Patient is Have stable	- Monitor the vitals - Plan USG Abdomen evening	[signature]

HNH-00015608 IP26-00006426
Master J REVANTH
07-07-2011 14 Y 10 M 18 D (M)
Dr. VINAY KUMAR M

NURSING CARE RECORD

Date: 27/5/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8AM to 2PM	→ Assess the pt condition → Monitor the vitals → Maintain I/O chart → Administer the medication as per drug chart	8AM to 2PM	→ Assessed pt condition → Monitored vitals → Maintained I/O chart → Administered medication as per drug chart	Patient is stable	Re-checked vitals	[signature]
Afternoon	2pm to 8pm	– Assess the pt condition – Monitor the v/s – Maintain the I/O – Drug as per chart	2pm to 8pm	– Assess the pt condition – Monitor the v/s – Maintain the I/O – Drug as per chart	– Now baby is stable	– Rechecked the v/s	[signature]
Night	8Pm to 8Am	– Assess the Pt condition – Monitor the vitals – maintain I/O charts – medication given as per drugs charts	8Pm to 8Am	– Assess the Pt condition – Monitor the vitals – maintain I/O charts – medication given as per drugs charts	– Pt is Now stable	– monitor the vitals	[signature]

Patient Sticker

HNH-00015608 IP26-00006426
Master J REVANTH
07-07-2011 14 Y 10 M 20 D (M)
Dr. VINAY KUMAR M

NURSING CARE RECORD

Date: 28/5/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8AM to 2PM	→ Assess the pt condition → monitor the vitals → maintain I/O chart → Administer medication as per drug chart	8AM to 2PM	→ Assessed the pt condition → monitored vitals → maintained I/O chart → Administer medication as per chart	Patient is stable	Re-checked vitals	[illegible]
Afternoon	2PM to 8PM	→ Assess the pt condition → monitor vitals → maintain I/O chart → administer medication as per drug chart → cannula present	2PM to 8PM	→ Assessed the pt condition → monitored vitals & recorded → maintained I/O chart → medication as per drug chart → IV cannula presented → IV fluid stop	→ Pt is stable	→ rechecked vitals	[illegible]
Night	8PM to 8AM	- Asses the pt condition - Monitor the vitals - maintain I/O charts - Medication given as per drugs charts - I/V fluids stop	8PM to 8A	- Assess the baby condition - Monitor the vitals - Maintain I/O charts - Medication given as per drugs charts - I/V fluids stop	- Pt is More stable	- Re-Assessment done	[illegible]

HNH-00015608 IP26-00006426
Master J REVANTH
07-07-2011 14 Y 10 M 22 D (M)
Dr. VINAY KUMAR M

NURSING CARE RECORD

Date: 29/5/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8AM to 2PM	→ Assess pt condition → monitor the vitals → Maintain I/O chart → Administer medication as per drug chart	8AM to 2pm	→ Assessed pt condition → monitored vitals → Maintained I/O chart → Administered medication as per chart	Patient is stable	Re-checked vitals	Ajay
Afternoon				DAY			
Night	8pm to 8AM	→ Assess the condition → maintain vitals → Administer medication on as per drug chart	8pm to 8AM	→ Assess the pt condition → Monitored vitals → Maintained I/O chart	pt is a stable	Re-checked vitals	[illegible]

HNH-00015608 IP26-00006426
Master J REVANTH 14 Y 10 M 22 D (M)
07-07-2011
Dr. VINAY KUMAR M

NURSING CARE RECORD

Date: ....

Goals

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

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

HNH-00015608 IP26-00006426
Master J REVANTH
07-07-2011 14 Y 10 M 18 D (M)
Dr. VINAY KUMAR M

NURSING SHIFT HAND OVER FORM

SITUATION

Diagnosis: Liver Abscess

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

Surgery / Procedure:

Post OP Day:

Section	Date / Shift	25/5/26 M6	25/5/26 E2	25/5/26 N1	26/5/26 M6	26/5/26 M6	26/5/26 N1
BACKGROUND	Medical Condition (Any special condition to be noted):	—	—	—	—	—	—
	Diet:	—	—	—	Soft	Soft	—
ASSESSMENT	Allergy:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
	Ventilation (RA, NP, NIV, VENTI):	—	—	—	—	—	—
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
	Vital Signs: Temp:	98.5F	98.4°F	98.3°F	98.1°F	98.3°F	98.6F
	Res:	25 b/m	26 b/m	27 b/m	28 b/m	30 b/m	30 b/m
	SpO_2:	99%	100%	99%	99%	99%	100%
	Pulse:	120 b/m	120 b/m	115 b/m	116 b/m	114 b/m	145 b/m
	BP:	100/61	100/57	100/62	110/70	|	100/60
	LOC:	—	—	—	—	—	—
	Fall Risk Score:	—	—	—	—	—	—
	Pain Score:	—	—	"0"	"0"	"0"	0
	Skin Integrity	0	0	Good	Good	Good	0
Recommendations	Safety Needs:	☐ Yes ☐ No	☐ Yes ☑ No	☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☑ No
	Physiotherapy:	—	—	—	—	—	—
	Others Specify:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
	Special Diet:	—	—	—	Soft	Soft	Soft
	Critical Lab Test / Values:	—	—	—	—	—	—
	Other Special Orders / Medications:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
	PU Prophylaxis:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
	DVT Prophylaxis:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
	ADL (Dependent / Non Dependent):	Yes	Non Depen	NA	—	—	—
	Post Operative Procedure Special Orders:	—	—	—	—	—	—
	Handed Over By Name :	Neha	Mounika	Sunanda	Supriya	Sandhya	Neha
	Signature / ID :	[signature]	[signature]	[signature]	[signature]	[signature]	[signature]
	Date:	25/5/26	25/5/26	26/5/26	26/5/26	26/5/26	27/5/26
	Time:	2PM	8PM	8am	2pm	8pm	8Am
	Taken Over By Name :	Mounika	Sunanda	Supriya	Sandhya	Neha	Anusha
	Signature / ID :	[signature]	[signature]	[signature]	[signature]	[signature]	[signature]
	Date:	25/5/26	25/5/26	26/5/26	26/5/26	26/5/26	27/5/26
	Time:	2PM	8pm	8AM	2pm	8pm	8Am

HNH-00015608 IP26-00006426
Master J REVANTH
07-07-2011 14 Y 10 M 20 D (M)
Dr. VINAY KUMAR M

NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:			Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:			
	Surgery / Procedure:			Post OP Day:			
BACKGROUND	Date / Shift	27/5 M6	27/5 E2	27/5/26 H1	28/5 M6	28/5/26 E2	28/5/26 M1
	Medical Condition (Any special condition to be noted):	–	–	–	–	–	–
	Diet:	–	–	–	–	–	–
ASSESSMENT	Allergy:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
	Ventilation (RA, NP, NIV, VENTI):	–	–	–	–	–	–
	Tubes/Drains/Catheter:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
	Vital Signs: Temp:	98.7F	98.7'F	98'5F	98.3F	97.2'F	98'8F
	Res:	20b/m	20b/m	20b/m	22b/m	20b/M	20b/m
	SpO2:	99%	99%	98%	99%	99%	99%
	Pulse:	97 b/m	98b/m	90b/m	87 b/m	92b/M	85b/m
	BP:	121/66	120/72	115/70	100/80	110/71	100/60
	LOC:	–	–	–	–	–	–
	Fall Risk Score:	–	–	–	–	–	–
	Pain Score:	–	"0"	–	–	–	–
	Skin Integrity	–	Good	–	–	–	–
Recommendations	Safety Needs:	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
	Physiotherapy:	–	–	–	–	–	–
	Others Specify:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
	Special Diet:	–	–	–	–	–	–
	Critical Lab Test / Values:	–	–	–	–	–	–
	Other Special Orders / Medications:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
	PU Prophylaxis:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
	DVT Prophylaxis:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
	ADL (Dependent / Non Dependent):	–	–	–	–	–	–
Post Operative Procedure Special Orders:		–	–	–	–	–	–
Handed Over By Name :		Anusha	Sunanda	Neha	Anusha	Divya	Neha
Signature / ID :		[signature]	[signature]	[signature]	[signature]	[signature]	[signature]
Date:		27/5/26	27/5/26	27/5/26	28/5/26	28/5/26	29/5/26
Time:		2pm	8pm	8Am	2pm	8PM	8Am
Taken Over By Name :		Sunanda	Neha	Anusha	Divya	Neha	Anusha
Signature / ID :		[signature]	[signature]	[signature]	[signature]	[signature]	[signature]
Date:		27/5/26	27/5/26	28/5/26	28/5/26	28/5/26	29/5/26
Time:		2pm	8pm	8AM	2pm	8pm	8AM

HNH-00015608 IP26-00006426
Master J REVANTH
07-07-2011 14 Y 10 M 22 D (M)
Dr. VINAY KUMAR M

NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:	Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
	Surgery / Procedure:	Post OP Day:					
BACKGROUND	Date / Shift	29/5 M6	29/5/26 E2	30/5/26 N1			
	Medical Condition (Any special condition to be noted):	—	—	—			
	Diet:		—	—			
ASSESSMENT	Allergy:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Ventilation (RA, NP, NIV, VENTI):	—	—	—			
	Tubes/Drains/Catheter:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:	98.3°F	97.5°F	98.5			
	Res:	23	20b/m	20b/m			
	SpO_2:	99%	99%	99%			
	Pulse:	90b/m	90b/m	90b/m			
	BP:	113/86	104/62	105/63			
	LOC:	—	—	—			
	Fall Risk Score:	—	—	—			
	Pain Score:	—	—	—			
	Skin Integrity	—	—	—			
Recommendations	Safety Needs:	☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Physiotherapy:	—	—	—			
	Others Specify:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Special Diet:	—	—	—			
	Critical Lab Test / Values:	—	—	—			
	Other Special Orders / Medications:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	PU Prophylaxis:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	DVT Prophylaxis:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	ADL (Dependent / Non Dependent):	—	—	—			
Post Operative Procedure Special Orders:		—	—	✓			
Handed Over By Name :		Anusha	Divya	Madhu			
Signature / ID :		[signature]	[signature]	[signature]			
Date:		29/5/26	29/5/26	30/5/26			
Time:		2PM	8PM	8AM			
Taken Over By Name :		Divya	Madhu				
Signature / ID :		[signature]	[signature]				
Date:		29/5/26	29/5/26				
Time:		2PM					

Docu. No. : RCH /FRM / CLINICAL / 097

HNH-00015608 IP26-00006426
Master J REVANTH
07-07-2011 14 Y 10 M 22 D (M)
Dr. VINAY KUMAR M

NURSING SHIFT HAND OVER FORM

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

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

HNH-00015608 IP26-00006426
Master J REVANTH
07-07-2011 14 Y 10 M 18 D (M)
Dr. VINAY KUMAR M

MEDICATION RECONCILIATION FORM

Drug Allergies: ............N.A.. ☑ 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

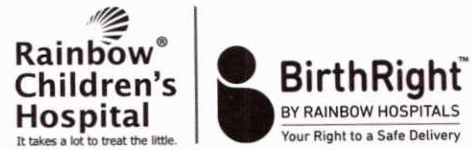
Doctor Name & Signature : ....Dr. Nairunya........................

Date & Time : ....25/05/26 @..........................

Nurse Name & Signature: ....Shirisha..........................

Date & Time : ....25/05/26 @..........................

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



PATIENT TRANSFER FORM

Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00015608 IP26-00006426 Master J REVANTH 07-07-2011 14 Y 10 M 18 D (M) Dr. VINAY KUMAR M	25/05/26@11:42Am.	25/05/26 @2pm
	Transfer Ordered by Dr. Naipunya	**Reason for Transfer** Admission
From Unit ER	**To Unit** ward	**Information to Attendant** Yes ☑ No ☐
Number of Sheets in Clinical File 15-/-	**Number of Imaging Films**	**Personal belongings including clinical documents. If any handed over to attendant** Yes ☐ No ☑ If yes, what ?

Medications / Consumables / Surgicals / Hand over

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

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Shirisha	Dr. Naipunya.

Patient & Clinical Records Received by : Mounika.

Date & Time of Patient Received : @ 2:15PM, 25/5/26

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

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

HNH-00015608 IP26-00006426
Master J REVANTH
07-07-2011 14 Y 10 M 18 D (M)
Dr. VINAY KUMAR M

wt - 76 kgs

EMERGENCY ROOM TRIAGE FORM

Patient's Name : Revanth Age : 15yr **Gender:** ☑ Male ☐ Female

Date : 25/05/26 Time of Arrival : 11:25AM

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

Source of Information : ☑ Parents ☐ Others (Specify)

Mode of Arrival : ☑ Ambulatory ☐ Wheelchair ☐ Ambulance

Initial Vital Signs: Temp: 98°F PR: 92b/m BP: 129/82(96) mmHg RR: 20b/m SpO_2: 98%

Chief Complaints: c/o fever since 2weeks body pain since 1week

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

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

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

Signature of Parent / Guardian

* CTAS - Canadian Triage and Acuity Scale

Triage Completion Time : ....

Communicable Disease Triage Screening

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

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

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

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

   If yes, State Location: ....

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

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

☐ Any patient with Fever / Rash / Vesicles / Discharge from 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 : Bhargavi

Signature of Triage Nurse : B

Date & Time : 25/5/26 @ 11:27Am

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

HNH-00015608 IP26-00006426
Master J REVANTH
07-07-2011 14 Y 10 M 18 D (M)
Dr. VINAY KUMAR M

NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 20/5/26 Time of arrival : 11:29Am

Chief Complaints: c/o fever since 2 weeks body pain since 1 weeks RBS: ....

Height : .... Weight : 76 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: .... Pain Tool Used: ☐ N Pass ☐ FLACC ☐ Wong Baker

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

RISK FOR FALL:

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

☐ If Patient is > 6 years
Assess the below parameters

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

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

☐ Escort while ambulating

☑ Assist Patient

☑ Educate patient and family on fall precautions/prevention

Functional Screening: ☑ No Abnormalities Detected

☐ Mobility Problem

☐ Walking Problem

☐ Developmental Delay

☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

....

....

Nutritional Screening: ☑ No Abnormalities Detected

☐ Underweight

☐ Overweight

☐ Feeding Problem

☐ Special diet

☐ Special feeding method

Inform consultant for positive criteria

Psychological Screening: ☑ No Significant Findings

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

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

Social History: Lives With family

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

Time of Initial assessment completed by ER Nurse : B @ 11:30Am

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

Time	Nursing Notes
11:33Am	Assess the pt condition monitore the vitals

Samples collected by: Surender Time:

Samples sent by : Time: 12:15 PM

Medication given in ER:

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

Condition of patient at time of shift - out :	**Details of Shift - out**
HR: 92b/m BP: 129/82(96)mmHg CFT:	Shift - out from ER to: ward
RR: 20b/m SPO$_2$: 98%	Time of Shift - out: 2pm
GCS:........ Temperature : 98°F	Handover given to: .... (Nurse's Name)
Pain Score:	
Repeat RBS (if applicable):	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

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

Name of the Nurse : Bhargavi Signature of the Nurse : B

Date & Time : 25/5/26 @ 11:35Am

Liver Abscess

R

MASTER J REVANTH 14Y 10M 18D M HNH 00015608 CHEST PA 25-May-26 4:02 PM
RAINBOW CHILDREN S HOSPITAL,HIMAYATH NAGAR