301
O.C

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

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Your Right to a Safe Delivery

DISCHARGE SUMMARY

Name	Baby Of N SASI PRIYA	**UHID**	HNH-00016442
Father/Guardian	Mr N SESHA SAI PRASAD	**Age/Gender**	0 Y 0 M 9 D/ Male
Address	MEGHANA ALLURI HOMES, APHB Colony Moulali, Hyderabad, Telangana, INDIA, 500040		
IP No	IP26-00006878	**Admission Date**	18-07-2026
Ref Doctor	Self.		
Discharge Date	19.07.2026		

Consultant:
Dr. S TEJASWI REDDY
MBBS, MD Pediatrics, DM Neonatology
APMC/FMR/94068

DIAGNOSIS	ICD CODE
UNCONJUGATED NEONATAL HYPERBILIRUBINEMIA	

History: Baby Of N SASI PRIYA is a 0 Y 0 M 9 D old baby boy presented with history of yellowish discolouration of skin and eyes since 2 days prior to admission. For the above complaints, he was investigated on OPD basis (Transcutaneous bilirubin was 17.2 mg/dl). In view of hyperbilirubinemia, he was admitted to Rainbow Children's Hospital, Himayatnagar for further management.

Name	Baby Of N SASI PRIYA	UHID	HNH-00016442
IP No	IP26-00006878	Admission Date	18-07-2026

Birth history: Baby Of N SASI PRIYA is a moderate preterm (33 weeks + 4 days) / AGA / baby boy of birth weight 2.40 kgs, born to G4P1L1A2 mother delivered by emergency LSCS (Indication: Prodromal Preterm labour) on 09.07.2026 at 07:12 . Baby cried immediately after birth. Apgar scores and resuscitation details were 7/10 at 1 min, 9/10 at 5 min. Baby developed respiratory distress after birth for which baby was shifted to NICU - for further management.

Mother's blood group is A positive. Baby's blood group is AB positive.

Examination: He was euthermic, euvolemic & maintaining saturations at room air. Heart Rate- 125/min, Blood pressure was 86/65mmHg and Respiratory Rate - 40/min. Icterus was present. Chest was clear with normal heart sounds. Abdomen was soft without organomegaly. Cry, tone, activity and newborn reflexes were normal. There were no obvious external congenital anomalies.

Weight at admission : 2140 grams.
Weight at discharge : 2140 grams.

Investigations: Enclosed reports.

Management: Baby was admitted in ward. His Transcutaneous bilirubin was 17.2 mg/dl at admission done on OP basis. He was started on double surface phototherapy. Baby was continued on demand breast feeds + measured feeds. Phototherapy was administered for 24hrs. Serum bilirubin on 10 day of life was 11.1 mg/dl with indirect fraction of 10.8 mg/dl which does not come under phototherapy range, hence phototherapy was stopped.

He remained hemodynamically stable and is being discharged with the

Name	Baby Of N SASI PRIYA	UHID	HNH-00016442
IP No	IP26-00006878	Admission Date	18-07-2026

following advice.

At the time of discharge : Baby was active, afebrile, hemodynamically stable, maintaining temperature, accepting & tolerating feeds well.

Advice:
Warmth care.
Exclusive breast feeding.
Continue direct breast feeds + measured feeds as advised.
Burping after each feed.
Monitor urine output.
Immunization to be given as per schedule.
Vitamin D3 Drops (1ml/800IU) 0.5ml once daily till further advice.
Nasoclear Nasal drops 2 drops in each nostril SOS for nose block.

Review consultation with Dr. S TEJASWI REDDY on Tuesday (21.07.2026) in OPD at Himayatnagar with prior appointment **(Review consultation will be charged).**

Review back to Hospital:
If baby is not feeding continuously for > 6 hours, If breathing fast, Fever or poor activity or lethargy, Bluish discolouration of lips, Increase in jaundice, Abnormal movements 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.

Name	Baby Of N SASI PRIYA	**UHID**	HNH-00016442
IP No	IP26-00006878	**Admission Date**	18-07-2026

Parent/ Attender

In case of emergency contact 9154865030 emergency pediatrician on duty.

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

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

Registrar/Resident/C.M.O

Rainbow Children's Medicare Ltd. Himayathnagar 500029 Hyderabad

Dr. S TEJASWI REDDY
MBBS, MD Pediatrics, DM Neonatology
APMC/FMR/94068

HNH-00016442 IP26-00006878
Baby Of N SASI PRIYA
09-07-2026 0 Y 0 M 9 D (M)
Dr. S TEJASWI REDDY

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DEFICIENCY CHECK LIST OF CASE SHEET

Sl.No.	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission sheet	1			
2	Discharge Summary	1			
3	Nursing Initial assessment	1			
4	Patient Transfer form	1			
5	In-patient Medical record	1			
6	Doctors progress sheets	2			
7	Nursing plan of care and handover sheets	2			
8	Consultation sheet				
9	General consent for treatment	1			
10	Consent for Surgery				
11	Consent for blood transfusion				
12	Consent for chemotherapy				
13	Consent for high risk				
14	Consent for Restraint				
15	LAMA consent				
16	Consent for special procedure / Sedation				
17	Consent for Formula feed				
18	Consent for MTP				
19	Consent for Radiological Investigations				
20	Consent for HIV test				
21	Anaestesia notes (Pre Anaesthesia& post)				
22	Neonatal Admission/Delivery/Physical Exam				
23	Medication Reconciliation	1			
24	Emergency Triage record	1			
25	Pre operative check list				
26	Surgical safety checklist				
27	Operation Theatre notes				
28	Nurses clinical Presentation				
29	TPR & BP chart	1			
30	Intake and Out take chart (fluid chart)	1			
31	Drug chart (Regular Prescription)	1			
32	Investigation Values (result sheet)	1			
33	Nebulization chart				
34	Nutritional review chart				
35	Intensive care unit (ICU Charts)				
36	Consent for Admission in PICU / NICU				
37	The Humpty dumpty scale				
38	Braden Q Scale	1			
39	Bed side check list				
40	PICU bed formula Dilution feeds				
41	Gastro monitoring chart				
42	Rch ED doctors note				
43	BP Monitoring chart				
44	RBS monitoring chart				
	Billing	1			
	Extras	6			
	Total No. of Pages	25			

Doc. No. : RCH/ FRM / GENERAL / 126

Signature and Date : 19/4/26

(P.T.O)

ERROR LOG

LOCATION : OT / Birthing Centre / BirthRight Premium / 3rd Floor (Zone A,B,C) / NICU / PICU / 2nd Floor Ward / Oncology / 1st Floor Wards.

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE

Rainbow Children's Hospital

BirthRight Rainbow

Rainbow Childrens Hospital-Himayatnagar

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

ADMISSION SHEET

Registration Details :

Admission No : IP26-00006878 **Admit Date** : 18-Jul-2026 **Admit Time** : 12:54 PM **UHID** : HNH-00016442

Patient Details :

Patient Name	: Baby Of N SASI PRIYA	**Age**	: 0 Y 0 M 9 D
Guardian	: Mr N SESHA SAI PRASAD	**DOB**	: 09-07-2026 07:12 AM
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: MEGHANA ALLURI HOMES APHB Colony Moulali Hyderabad Telangana INDIA 500040	**Phone No**	: 8019733546/ 9121338489
		E-mail	: SASIANNADATHA@GMAIL.COM

Admission Details :

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

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

Contact Details :

Name : Mr N SESHA SAI PRASAD **Relationship** : Father

Contact Address : MEGHANA ALLURI HOMES APHB Colony Moulali Hyderabad Telangana INDIA 500040 **Phone No** : 8019733546

Signature

Doctor Details :

Doctor Name : Dr. S TEJASWI REDDY **Specialisation** : GENERAL PEDIATRICS

Referral Doctor : Self. **Phone No** :

Co-Consultant :

Payment Details :

Deposit Amount : 25000.00

Payment Mode : DC/CC Card **Payor Name** : SELFPAY

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ACTIVIT[illegible] FOR BILLING

HNH-00016442 IP26-00006878
Baby Of N SASI PRIYA
09-07-2026 0 Y 0 M 9 D (M)
Dr. S TEJASWI REDDY

Name: ---

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

Date of Admission : 18/7/26 Time : 12:54 pm Date of Discharge : ---------- Time: ----------

Room / Bed No : 301 Ward : 3rd floor Suggested Billable bed type : ----------

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
18/7/26	1:15 pm	ER	3rd floor/301	

Cross Consultation Visit

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

HNH-00016442 IP26-00006878
Baby Of N SASI PRIYA
09-07-2026 0 Y 0 M 9 D (M)
Dr. S TEJASWI REDDY

INVESTIGATIONS

Date	Investigations	Order No.	Sign
18/7/26	TcB — Forehead — 17.2 mg/dl	OP Basic	[signature]
	Chest — 16.1 mg/dl	Done	
19/7/26	SBR	2070	[signature]
		Cross checked done by	
		Amrutha 19/7/26	

HNH-00016442 IP26-00006878
Baby Of N SASI PRIYA
09-07-2026 0 Y 0 M 9 D (M)
Dr. S TEJASWI REDDY

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
18/7	DSPT	18/7/26 @ 1:40pm.	19/7/26 @ 10 AM	4947	[signature]

Cross checked done by Amruthee

HNH-00016442 IP26-00006878
Baby Of N SASI PRIYA
09-07-2026 0 Y 0 M 9 D (M)
Dr. S TEJASWI REDDY

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature

ANY OTHER INFORMATION

18/7/26 Home feed allowed

Syeda Sabiya Zaheer
Dietician.

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

Ref.No. F/IN/PR/10

Rainbow®
Children's
Hospital

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name : HNH-00015442 IP26-00005378
Baby Of N SASI PRIYA
09-07-2026 0 Y 0 M 9 D (M)
Dr. S TEJASWI REDDY

Patient ID# :

Consultant :

Final Diagnosis :

Pediatric Multiorgan ... & Physical Examination

HNH-00016442 IP26-00006878
Baby Of N SASI PRIYA
09-07-2026 0 Y 0 M 9 D (M)
Dr. S TEJASWI REDDY

Name : _____ Age/Sex _____

Informant _____ Reliability _____

Chief Presenting Complaints & Duration (Chronologically):

do yellowish discolouration of eye and skin

History of present illness :

DOL - 9 / Mod. PT (37+4d) / RDS / CBCS

T.wt: 2.4 kg / NNJ

do yellowish discolouration of eye and skin (all over body)

TCB: Chest (17.2 mg/dl)
Forehead (16.1 mg/dl).

T.wt: 2.14 kg

Pediatric Multiorgan History & Physical Examination

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

Birth & Neonatal History :

Mod IT (33w + 4d) / ROI / LBW / 2.4kg / NNJ

Birth & Socio Economic History :

About Father :

About Mother :

Any additional Information :

Developmental History :

Immunization History :

Birth vaccination received

Pediatric Multiorgan History & Physical Examination

HNH-00016442 IP26-00006878
Baby Of N SASI PRIYA
09-07-2026 0 Y 0 M 9 D (M)
Dr. S TEJASWI REDDY

Anthropometry

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

Weight (kgs) 2.14 kg (Centile _____)

On Examination :

Temperature : Euthermic Pulse Rate: 140/min Description _____

B.P. _____ SPO2 98% @ RA at _____

Resp. rate and type of breathing : _____

Normal

Rash _____

Lymphadenopathy _____ Icterus (+)

Oedema : _____

Respiratory system :

Inspection (any s/o distress) : _____

Air entry & breath sounds : BAEC (+), clear

Any addes sounds : _____

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

Cardiovasclular System :

Inspection of procordium : _____

Heart Sounds : $S_1 S_2$ (+)

Any murmur : _____

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

Per Abdomen :

Inspection _____

Palpation : soft

Ausculation : _____

Spine: _____ External Genitelia : _____

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

Central Nervous System :

Level of Consciousness : AVPU/GCS Score : Alert

Cranial Nerves :

Motor System :

Nutrition :

Tone : Power (NAD)

Co-ordinator : AR @ level

Posture :

Involuntary Movements :

Reflexes :

DTR **Superficials :**

Plantars

Sensory System :

Bladder / Bowel :

Clinical Summary & Diagnostic :

Neonatal Hyperbilirubinemia for phototherapy

Preventive aspects of the treatment :

Desired goals of the treatment :

Planned Labs :

Planned Management :

Double surface phototherapy (DSPT)

- Repeat STBR @ 6AM T/M

Notified by

Please fill up the following details

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

Dr. S. TEJASWI REDDY
Registration No. [illegible]

Doctor's Signature Name _____ Date 18/7 Time _____

HNH-00016442 IP26-00006878
Baby Of N SASI PRIYA
09-07-2026 0 Y 0 M 9 D (M)
Dr. S TEJASWI REDDY

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
18/7 2:30pm	C/S/B Dr. Pranav / Dr. Sushant	
	NNHB	
		Plan
	Baby ↓ DSPT (SBR - 17.2)	1) DSPT c̄ eyes & genitals covered
		2) SBR → T/m - 6AM
	Baby Euthermic	3) DBF / 16 burping Q2H + spoon feed
	C/T/A } Good	4) Monitor vitals
	Feeding Well	
		Noted by [illegible] Pranav 18/7/26 @ 8:20pm

HNH-00016442 IP26-00006878
Baby Of N SASI PRIYA
09-07-2026 0 Y 0 M 9 D (M)
Dr. S TEJASWI REDDY

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
18/7	C/s by Dr Tejaswi	
10 pm	Baby euthermic	Rx
	vitals stable	→ Trimo mng 6am SBR.
		— Continue DSPT
		Dr S TEJASWI REDDY Registration No: 94068
	S/B Dr. Sreeja	
19/7/26 7:50 AM	D NNJ	P(x)
	Euthermic	— Trace SBR
	CVS - S1 S2 ⊕	— C/F DSPT
	RS - B/L - AEE ⊕	
		— DBF + EFF
	P/A - soft	Burp well
	CT A good	
	Today - 2.14 kg	
	Same weight	
		LB-S

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

HNH-00016442 IP26-00006878
Baby Of N SASI PRIYA
09-07-2026 0 Y 0 M 9 D (M)
Dr. S TEJASWI REDDY

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/7/2026	c/s by Dr Tejan	
4.40am	Baby bleached	
	taking feed well	Rp
		→ plan (D)
		→ Review on Tuesday morning
		Dr. Tejan
		Dr. S. TEJASWI REDDY Regn. No. 94888

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

HNH-00016442 IP26-00006878
Baby Of N SASI PRIYA
09-07-2026 0 Y 0 M 9 D (M)
Dr. S TEJASWI REDDY

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MEDICATION RECONCILIATION FORM

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

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

Shifting From: ..... ER ..... Shifted to: .....

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, Susanth. .....

Date & Time : ..... 18/7/26 @ 12:50pm. .....

Nurse Name & Signature: ..... Atma / .....

Date & Time : ..... 18/7/26 @ 1:15Pm .....

HNH-00016442 IP26-00006878
Baby Of N SASI PRIYA
09-07-2026 0 Y 0 M 9 D (M)
Dr. S TEJASWI REDDY

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DRUG CHART

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

FOR THE SAFETY OF THE PATIENT

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

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

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

NURSES - Nurses must follow strictly the FIVE RIGHTS before administration of medication.
1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time

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

SOS / PRN (As Required Medication)

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

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

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

Signature .....

VERIFIED BY : Name .....

HNH-00016442 IP26-00006878
Baby Of N SASI PRIYA
08-07-2026 0 Y 0 M 9 D (M)
Dr. S TEJASWI REDDY

REGULAR PRESCRIPTIONS

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

DRUG : SYP. CALCIMAX-P

Dose	Route	Frequency	Start Date
2.5ml	PO	12H	18/07

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time: 18/7 — 10am ✗ — 10pm ✓

DRUG : DEKSEL KIDS DROPS NANO

Dose	Route	Frequency	Start Date
0.5ml	PO	OD	18/07

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions: (400IU/0.5ml)

Daily Doctor's Endorsement by a Sign

Date / Time: 18/7 — 10pm ✓

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time:

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time:

HNH-00016442 IP26-00006878
Baby Of N SASI PRIYA
09-07-2026 0 Y 0 M 9 D (M)
Dr. S TEJASWI REDDY

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

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses

Signature .....

VERIFIED BY : Name .....

HNH-00016442 IP26-00005878
Baby Of N SASI PRIYA
09-07-2026 0 Y 0 M 9 D (M)
Dr. S TEJASWI REDDY

I.V. FLUIDS CHART

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

		Composition of I.V. Fluid (... mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign

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

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RESULT SHEET

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

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

HNH-00016442 IP26-00006878
Baby Of N SASI PRIYA
09-07-2026 0 Y 0 M 9 D (M)
Dr. S TEJASWI REDDY

.: RCH / FRM / CLINICAL / 124

INFANT (<1 year)
Children's Observation & Early Warning Scoring Chart

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ARLY WARNING SCORE: CHILDREN'S UNIT

Date: ..../.../.... Time:	18/7/26 1:30 PM	6pm	10 PM	2 AM	6 AM
Doctor/Nurse/Family Concern?					

Temperature (°F)

104 103 102 101 100 99 98 97 96 95 94

98.6°F 98.4°F 97.1°F 98.2°F 97.3°F

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

Note: BP does not score in early warning scoring

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

Heart Rate (Number)	142 b/m	138 b/m	140 b/m	143 b/m	144 b/m

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

70 60 50 40 30 20 10

Resp Rate (Number)	42 b/m	48 b/m	40 b/m	42 b/m	48 b/m
Resp Distress: Mod/ Severe / None / Mild					
Receiving O_2 (l/min) O_2 Saturations (%)	99%	100%	99%	100%	99%
Conscious Level: Normal / Altered					
GCS *					
TOTAL SCORE Number of shaded boxes	0	0	0	0	0
Pain Score	0	0	0	0	0
Observer's Initials					

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

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

Patient Sticker

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

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Baby Of N SASI PRIYA
09-07-2026 0 Y 0 M 9 D (M)
Dr. S TEJASWI REDDY

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FLUID CHART

Sheet No. : .....

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

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
18/4/26	08:00 am											
	09:00 am		DBF									
	10:00 am		EBM								0	
	11:00 am				NA		✓	NA		✓		
	12:00 pm											
	01:00 pm											
Total Intake :						**Total Output :**				V-	M-	
18/4	02:00 pm		DBF									
	03:00 pm		EBM							✓		
	04:00 pm	0										
	05:00 pm		EBM		NA		✓	NA				
	06:00 pm		+ DBF							✓		
	07:00 pm											
Total Intake :						**Total Output :**						
18/4	08:00 pm		DBF									
	09:00 pm		EBM									
	10:00 pm	0								✓	0	
	11:00 pm		EBM		NA		✓	NA				
	12:00 am		DBF							✓		
	01:00 am											
Total Intake :						**Total Output :**						
19/4	02:00 am		EBM									
	03:00 am		DBF									
	04:00 am	0					✓				0	
	05:00 am		EBM		NA			NA				
	06:00 am		DBF				✓			✓		
	07:00 am											
Total Intake :						**Total Output :**						

Total 24 hrs. Intake		Total 24 hrs. Output	

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FLUID CHART

Sheet No. : .....

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

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

Total 24 hrs. Intake		Total 24 hrs. Output	

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NURSING CARE RECORD

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Date: 18/7/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8AM to 2pm	→Assess the Baby condition →monitor the vitals. →Maintain I/o chart. →DBF+EBM 2nd hourly give	8Am to 2pm.	→Assessed the baby condition. →monitored the vitals. →maintained i/o chart. →DBF+EBM 2nd hourly given.	→Baby is stable now.	→Reassessed the vitals	
Afternoon	2pm to 8pm	⇒Assessed the pt condition ⇒monitored vitals every 2nd ⇒maintained I/O chart ⇒DBF + ff 2nd hrly	2pm to 8pm	⇒Assess the pt condition ⇒Monitor vitals every 2nd ⇒Maintain I/O chart ⇒DBF + ff 2nd hrly	⇒Baby is stable	⇒Rechecked vitals	
Night	8pm to 8am	- Assess the patient Condition - Monitored the V/S - Maintain the I/O - DBF + ff 2nd hourly	8pm to 8am	- Assess the patient condition - monitored the V/S - Maintain the I/O - DBF + EBM 2nd hourly	- Now baby is stable	- Rechecked the V/S	

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Patien

NURSING CARE RECORD

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Date: .....

Goals

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

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

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BRADEN 'Q' SCALE

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					Date : 18/7	19/7	18/8	
					Time : Pm	AM	N	
Mobility	**1. Completely immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	**3. Slightly limited:** Makes frequent through slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.	3	3	4	
"Activity The degree of physical activity"	**1. Bedfast :** Confined to bed	**2. Chairfast :** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	**3. Walks occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. All patients too young to ambulate; OR walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	3	3	4	
Sensory Perception	**1. Completely limited:** Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	**2. Very limited:** responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	**3. Slightly limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	**4. No impairment:** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	3	3	4	
Moisture Degree to which skin is exposed to moisture	**1. Constantly moist:** Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	**2. Very moist:** Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	**3. Occasionally moist:** Skin is occasionally moist, requiring linen change every 12 hours.	**4. Rarely moist:** Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	2	2	4	
FRICTION-SHEAR **Friction** Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another	**1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	**2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	**3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	**4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	
Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4	2	4	
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	3	3	4	
				TOTAL SCORE	19	17	28	
				Evaluator's Name				

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

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

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

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Baby Of N SASI PRIYA
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SING SHIFT HAND OVER FORM

SITUATION	Diagnosis: NNJ.				Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:		
	Surgery / Procedure:				Post OP Day:		
BACKGROUND	Date / Shift	18/7 M6.	18/7 E2	8/7 N1			
	Medical Condition (Any special condition to be noted):	—	—	—			
	Diet:	DBF+EBM	DBF+BF	EBM+DBF			
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:	97.1°F	98.2°F	98.3°F			
	Res:	40b/m	38b/m	42b/m			
	SpO_2:	100%	100%	100%			
	Pulse:	140b/m	138b/m	138b/m			
	BP:	—	—	—			
	LOC:	—	—	—			
	Fall Risk Score:	—	—	—			
	Pain Score:	1/1	—	—			
	Skin Integrity	Good	—	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:	DBF+EBM	—	DBF+EBM			
	Critical Lab Test / Values:	—		—			
	Other Special Orders / Medications:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	PU Prophylaxis:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	DVT Prophylaxis:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	ADL (Dependent / Non Dependent):	Dependent	—	—			
Post Operative Procedure Special Orders:		—	—	—			
Handed Over By Name :		Yashi	Swathi	Sirisha			
Signature / ID :							
Date:		18/7/26	18/7/26	18/7/26			
Time:		2pm	8pm	8am			
Taken Over By Name :		Swathi	Sirisha				
Signature / ID :							
Date:		18/7/26	18/7/26				
Time:		8pm	8pm				

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NURSING SHIFT HAND OVER FORM

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

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wt - 2.14kg

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EMERGENCY ROOM TRIAGE FORM

Patient's Name : BABY N Sasi Priya Age : 9 D **Gender:** ☑ Male ☐ Female

Date : 18/7/26 Time of Arrival : 12:30pm

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: 98.3°F PR: 125b/m BP: 86/71(63) RR: 40b/m SpO_2: 98%

Chief Complaints: c/o yellowish discolouration on skin

INITIAL PHYSIOLOGICAL CATEGORIZATION

Appearance
☑ Normal
☐ Sick Looking

Circulation / Colour
☑ Normal ☐ Abnormal ☐ Bleeding

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

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

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

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

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian

Triage Completion Time : 12:32pm

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 : Atonu

Signature of Triage Nurse : .....

Date & Time : 18/7/26 @ 12:32pm.

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 18/7/26 Time of arrival : 12:34pm

Chief Complaints: ..... RBS: N/A

Height : — Weight : 2.14kg BMI : ..... Head Circumference (<2 years) .....

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

If yes , identify —

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

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

RISK FOR FALL:

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

☐ If Patient is > 6 years
Assess the below parameters

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

Ambulatory Aids:

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

Gait/Transferring:

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

Mental Status: Forgets limitations ☐ Yes ☑ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening: ☑ No Abnormalities Detected

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

Inform consultant for positive criteria

.....

.....

Nutritional Screening: ☑ No Abnormalities Detected

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

Inform consultant for positive criteria

Psychological Screening: ☐ No Significant Findings

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

If Yes Consultant Notified: N/A (Date/Time): N/A

Social History: Lives With family.

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

Time of Initial assessment completed by ER Nurse : 12:34 Pm /

HNH-00016442 IP26-00006878
Baby Of N SASI PRIYA
09-07-2026 0 Y 0 M 9 D (M)
Dr. S TEJASWI REDDY

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

Time	Nursing Notes
12:36 pm	~~Admission~~ Assessed the Patient condition.
	monitore vitals Done.

Samples collected by: / N/A Time:

Samples sent by : / N/A Time:

Medication given in ER:

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

Condition of patient at time of shift - out :	**Details of Shift - out**
HR: 127 b/m BP: 83/71 (62) CFT: —	Shift - out from ER to: 3rd floor 1301
RR: 41 b/m SPO_2 : 98%	Time of Shift - out: 1:15 pm.
GCS: 15/15 Temperature : 98.6°F	Handover given to: ..... (Nurse's Name)
Pain Score: No	
Repeat RBS (if applicable): N/A	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any): N/A

Name of the Nurse : Atara Signature of the Nurse :

Date & Time : 18/7/26 @

PATIENT TRANSFER FORM

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Patient Name & UHID No	Date & Time of Admission	Date & Time of Transfer Order
HNH-00016442 IP26-00006878 Baby Of N SASI PRIYA 09-07-2026 0 Y 0 M 9 D (M) Dr. S TEJASWI REDDY	18/7/26 @ 12:54pm	18/7/26 @ 1:15pm
	Transfer Ordered by Dr, Sasikant	Reason for Transfer Abruption.
From Unit ER	To Unit 302/20 / 301	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File 20	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
Aroma /	Dr, Sasanth.

Patient & Clinical Records Received by : Maheshwari

Date & Time of Patient Received : 18/7/26 1:29 pm

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