

DISCHARGE SUMMARY

Name	Baby SEONA THOMAS PONNA	UHID	HNH-00015715
Father/Guardian	Mr P.SUNNY	Age/Gender	5 Y 8 M 4 D/ Female
Address	12-10-587/51/A, Sitaphal Mandi, Hyderabad, Telangana, INDIA, 500061		
IP No	IP26-00006472	Admission Date	31-05-2026
Ref Doctor	DR. GANGADHAR RAO. Y		
Discharge Date	03.06.2026		

Consultant:

Dr. ABHISHEK RAVINDRA JAIN

MBBS, MD(Pediatrics), IAP POST DOCTOR FELLOWSHIP IN PEDIATRIC NEUROLOGY

CONSULTANT PEDIATRIC NEUROLOGIST

TSMC/FMR/02757

DIAGNOSIS	ICD CODE
UNPROVOKED SEIZURES - FEVER TRIGGERED SEIZURES	

History: Baby SEONA THOMAS PONNA, 5 Y 8 M 4 D , old girl presented with the complains of staring looking with unresponsiveness lasting for 10-15 mins , associated with frothing at the mouth and 1 episode of vomiting, aborted after midazolam nasal spray an inj. levipil at the outside hospital around 12:30 pm. She was admitted at Rainbow Children's Hospital - Himayatnagar for further

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management.

Examination: She was afebrile . Her heart rate was 103/min and Respiratory Rate - 30/min. Capillary Refill Time was <2 secs. Peripheries were warm & pulses well felt. On auscultation, air entry was bilaterally equal. Heart sounds were normal and there was no murmur. Abdomen was soft with no organomegaly. On neurological examination, she 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 : 25 kilograms.

Investigations: Enclosed reports.

VBG showed pH of 7.35, pCO₂ of 41.9 mmHg, pO₂ of 49 mmHg, HCO₃ of 21.8 mmol/L and BE of -2.9 mmol/L.

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

Initial hemogram showed Hemoglobin of 13.0 gm%, White Blood Cell count of 6190 cells/cumm, platelet count of 2.02 lakhs/cumm and C-Reactive Protein of 5.0mg/l. Serum Creatinine was 0.5 mg/dl. Serum Calcium was 9.5 mg/dl. Magnesium was 1.8 mg/dl. Liver function test showed total SBR of 0.3mg/dl with indirect fraction of 0.1 mg/dl, SGOT -27 U/L, SGPT - 18U/L, ALP - 136U/L, protein -7.2 gm/dl, albumin - 4.3 gm/dl, globulin -2.9 gm/dl, A/G ratio of 1.4. Complete urine examination shows - Pus cells - 4-6, epithelial cells - 8-10.

Management: She was admitted in the ward and started on Intra Venous fluids, (IV antiseizure medication) and Intra Venous antibiotics. She was treated

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symptomatically with antacids and antipyretics.

EEG done on 31.05.2026 suggestive of liability to develop bilateral temporo-occipital onset seizures.

MRI Brain plane was done on 01.06.2026 suggestive of no acute abnormalities or lateralizing features.

She was regularly monitored for fever spikes, hemodynamic & neurological status. Her fever spikes gradually settled and she had no further seizure episodes during hospital stay.

She remained hemodynamically stable during the hospital stay and is being discharged with the following advice.

Parents were counselled regarding the nature of febrile seizures and measures to reduce fever during future febrile episodes. They were also educated regarding use of intranasal Midazolam spray for termination of future seizure episodes, if any.

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

Medication during hospital

Injection. Levetiracetam

Injection. Ondansetron

Injection. Augmentin

Advice:

* Diet as advised.

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S.No	MEDICATION	DOSE	TIMINGS	DURATION
1	Syrup. Levipil (1ml/100mg)	2.5 ml	8am - 8pm (after food)	To continue till further advice
2	Syrup. AUGMENTIN DDS (Amoxycillin 400 + Potassium Clavulanate 57 mg/5ml)	7.5 ml	8am-8pm (after food)	For 5 days

Febrile Seizure Prophylaxis:

* Syrup. Crocin DS (Paracetamol = 5ml/240mg) 7 ml after food as and whenever required, if temperature > 100 *F (maximum 4 times a day at 6 hour intervals).

* Tepid sponging if fever > 101 *F.

* Tablet. Frisium (Clobazam = 10mg), 1 tablet twice daily for 3 days every time with fever.

* Medistat / Insed / Midacip - nasal spray (Midazolam = 0.5mg/puff), 5 puff intranasal (2 puff in one and 3 puffs in another each nostril) for future seizures.

Review consultation with Dr. ABHISHEK RAVINDRA JAIN on (10.06.2026) Wednesday at Himayatnagar in OPD with prior appointment (**Review consultation will be charged**).

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.

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Follow up immediately in Emergency Room if high grade fever, vomiting, abnormal behavior, altered sensorium or seizure 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 **Himayatnagar / Banjara Hills / Rainbow Clinic Madhapur / Kukatpally / Vikrampuri / LB Nagar** dial just one toll free number **18002122**.

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


Registrar/Resident/C.M.O

Dr. ABHISHEK RAVINDRA JAIN
MBBS, MD(Pediatrics), IAP POST DOCTOR FELLOWSHIP IN PEDIATRIC
NEUROLOGY
CONSULTANT PEDIATRIC NEUROLOGIST
TSMC/FMR/02757



Patient Name : Baby . SEONA THOMAS
PONNA
Age/Gender : 5 Y(s) / Female
Ref.Dr : Dr Abhishek Ravindra Jain
Reference : Self
Reg No : HMN062600011
Reg Date : 01-Jun-2026 11:20
Reported Date : 01-Jun-2026 17:14

MRI BRAIN PLAIN STUDY

PROTOCOL:

DWI, 3D T1, T2,FLAIR,GRE/SWI sequences
Coronal T2 and Sagittal T2 Wt sequences.

FINDINGS:

No cortical, deep grey matter, or white matter lesions.
Myelination is normal for age.
Normal cortical development.
Basal ganglia and thalami are normal.
Midline structures are normally formed.
Sella, pituitary and parasellar regions are normal.
No acute infarct or hemorrhage. No mass effect or herniation.
Ventricles / Extra-axial spaces : Normal.
Brainstem is normal.Cerebellum is normal.
Cranio-vertebral and cervico-medullary junctions are normal.
Flow voids: Intact.
Mild scaphocephalic morphology of the skull.

IMPRESSION:

* No acute abnormalities or lateralising features.

Dr.Sunitha Lingareddy
Consultant Radiologist

Dr.Praveen Jagarlamudi
Consultant Radiologist

Dr.Vikas Reddy P
Consultant Radiologist

Dr.Rajya Lakshmi.D
Consultant Radiologist

Dr.Seshasai Vijaykumar M
Consultant Radiologist

Nihaal Reddy
Dr.Nihaal Reddy K
Consultant Radiologist



ADMISSION SHEET

Registration Details :



Admission No : IP26-00006472

Admit Date : 31-May-2026

Admit Time : 02:33 PM UHID : HNH-00015715

Patient Details :

Patient Name : Baby SEONA THOMAS PONNA

Age : 5 Y 8 M 4 D

Guardian : Mr P.SUNNY

DOB : 27-09-2020

Gender : Female

Religion :

Occupation :

Martial Status :

Address (H) : 12-10-587/51/A Sitaphal Mandi Hyderabad
Telangana INDIA 500061

Phone No : 9381937113

E-mail : ponnasunny@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 P.SUNNY

Relationship : Father

Contact Address : 12-10-587/51/A Sitaphal Mandi Hyderabad
Telangana INDIA 500061

Phone No : 9381937113


Signature

Doctor Details :

Doctor Name : Dr. ABHISHEK RAVINDRA JAIN

Specialisation : PEDIATRIC NEUROLOGY

Referral Doctor : DR. GANGADHAR RAO. Y

Phone No : 9492970916

Co-Consultant :

Payment Details :

Deposit Amount : 30000.00

Payment Mode : DC/CC Card

Payor Name : SELFPAY

HNH-00015715 IP26-0006472
ACTIVE Baby SEONA THOMAS PONNA (F) NG
27-09-2020 6 Y 8 M 4 D
Dr. ABHISHEK RAVINDRA JAIN

Name: -- 

UHID No : ----- IP No : ----- Consultant : ----- Dept : pediatric

Date of Admission : 31/5/26 Time : ----- Date of Discharge : ----- Time : -----

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
<u>31/5/26</u>	<u>3:12pm</u>	<u>ER</u>	<u>2nd floor (209)</u>	<u>Bhargava</u>

Cross Consultation Visit

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



PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
31/5/26	w placement	1	3409	<i>[Signature]</i>
31/5/26	P.A.C	①	3433	<i>[Signature]</i>
1/6/26 10 AM	NHA	①	3499	<i>[Signature]</i>
<p><i>Cross checked done by Supriya 11 PM @ 1/6/26</i></p>				

ANY OTHER INFORMATION

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
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Ref.No. F/IN/PR/10



Rainbow[®] Children's Hospital

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name : HNH-00015715 IP26-00006472

Baby SEONA THOMAS PONNA
27-09-2020 5 Y 8 M 4 D (F)

Patient ID# : Dr. ABHISHEK RAVINDRA JAIN



Consultant : _____

Final Diagnosis : _____

Pediatric Multiorgan History & Physical Examination

Name: Seena Thomas Ponna Age/Sex 5y/ F
Informant mother Reliability _____

Chief Presenting Complaints & Duration (Chronologically):

c/o staring looking with unresponsiveness lasting
for 10-15 minutes
frothing at the mouth noticed.
1 episode of vomiting.

History of present illness :

A 5yr old girl c
c/o staring look with no response to verbal
and tactile stimulation lasting for 10-15 minutes
associated with frothing at mouth.
no h/o jerky movements / tonic posturing
no h/o fever
the limbs are ~~are~~ loss of tone of limbs present

1 episode of vomiting during the episode.

The seizure aborted after Midazolam nasal
spray and inj leucipil at the outside hospital
around 12:30 pm

admitted for further evaluation and treatment

Pediatric Multiorgan History & Physical Examination

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Baby SEONA THOMAS PONNA
27-09-2020 5 Y 8 M 4 D (F)
Dr. ABHISHEK RAVINDRA JAIN



Anthropometry

Head Circum (cms) 54 (Centile _____) Height (cm) : _____ (Centile _____)

Weight (kgs) _____ (Centile _____)

On Examination :

Temperature : 98.4° F Pulse Rate: 103/min Description _____

B.P. _____ SPO2 98% at RA

Resp. rate and type of breathing : 30/min

Rash _____

Lymphadenopathy _____

Oedema : _____

Respiratory system :

Inspection (any s/o distress) : (N)

Air entry & breath sounds : NYSS (+)

Any addes sounds : _____

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

Cardiovascular System :

Inspection of procordium : (N)

Heart Sounds : S2 (+)

Any murmur : _____

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

Per Abdomen :

Inspection (N)

Palpation : Soft

Ausculation : BS (+)

Spine: (N) External Genitelia : _____

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

Pediatric Multiorgan History & Physical Examination

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Dr. ABHISHEK RAVINDRA JAIN



Central Nervous System :

Level of Consciousness : AVPU/GCS Score : Postictal state

Cranial Nerves : no facial deviation
pupils - B/L NSRL (+)

Motor System :

Nutrition : _____

Tone : _____ Power _____

Co-ordinator : _____ (W)

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR

Superficials :

Plantars _____

Sensory System :

Bladder / Bowel : _____

Clinical Summary & Diagnostic :

Unprovoked seizures for evaluation

Pediatric Multiorgan History & Physical Examination

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Baby SEONA THOMAS PONNA
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Dr. ABHISHEK RAVINDRA JAIN



Preventive aspects of the treatment :

prevent complication

Desired goals of the treatment :

Hemodynamic stability

Planned Labs :

CPK, CKMB, URT,
VBC, Sr. Calcium, Magnesium
CRBS
Creatinine
Noted by vijaya

Planned Management :

IVF - 1/2 (M)
Ij LEVIPIL - 25mg/BD
Ij ONDEM - TID
-> MRI Brain - Plain (T/m)
450s control
-> EEG - Today
Noted by vijaya

Please fill up the following details

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

Abhishek
Dr. ABHISHEK RAVINDRA JAIN
Reg. No. 02757

Doctor's Signature Name _____ Date _____ Time _____



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/10/2020 4:30pm	s/s Dr. Nameer / Dr. Pramav. Unprovoked <u>seizures</u> for evaluation	
	no further seizures no fever. activity - oriented. o	Plan ① ct IVF @ 1/2 m ② ct levipil maintenance dose ③ ct ondansetron ④ EEG - today ⑤ MRI Brain plain (1/m) w/ contrast NB Suet @ 9:30. Nau (Dr. Nameer)
1/6/26 11am	c/s/s Dr. Pranav / Dr. Nazneen <u>Unprovoked Seizure</u> Fever ① No Seizures child active Vital stable R-S - BLUE ① PIA - soft CNS - NAD	Plan 1) NPO :: 5AM 2) CT - LEVIPIL 3) MRI Brain - Plain @ 10am 4) Monitor Vitals NB - Mofetil @ 8AM (Dr. Nameer)

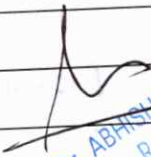


PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
1/6/2026 9:00 AM	c/s/B D. Abhishek S	
	Unprovoked seizures c <u>AEI</u>	
	→ Fever spikes ⊕ → No further episodes of seizure	Ph (1) MRI brain - today - so s contrast
	child asleep	(2) Iij Lorazepam ↓ and by Night
	Vital stable Feverile R-S - B/LAE ⊕ PIA - soft CNS - Alert	(3) Iij Amoxiclav (4) Iij Ondans
	<u>Low</u>	(5) Monitor Vitals
	Hyperpigmented streaks on both lower limbs	(6) If fever ↓ see child stable, can plan DIC - Thu (7) CVS CDE - Now
		TB Sreha C 9:16 AM Dr. ABHISHEK RAVINDRA JAIN Reg No: 02757 Abhishek



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
1/6/20	<u>C/F to Dr. Abhishek</u>	
8:45 pm		
	- low grade fever spike @ 4 pm	
	- oral intake: good	
	- no severe activity ∴ admission	
	<u>O/E</u>	
	- meals: stable.	
		<u>Plan</u>
		1) Rounds aft c sirket sir T/M
		2) take MRI Report
		3) plan to repeat
		cap] of high temp] of high grade fever spikes
		4) based on sirket sir plan discharge
		5) change to oral lempil
	 Dr. ABHISHEK RAVINDRA JAIN Reg. No: 02757	N/B of patient

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16/26 9pm	<u>DOB Dr. Aniket</u>	
	<ul style="list-style-type: none"> - low grade fever spikes (+) - sneezing (+) - no rashes :: admission - no vomit/diarr - oral intake : good. 	
	<u>OLE</u>	
	- vitals : stable	
	- <u>oral cavity</u> :	Plan
	- <u>stE</u> - normal	1) <u>it</u> oral Ceftazidime
		2) <u>trace</u> MRI report.
		3) <u>send</u> Resp. Panel now
		4) if <u>high</u> grade fever spikes send → CRP CRP
		5) <u>stop</u> IVF.
		6) <u>monitor</u> vitals.
		Dr. Aniket Anil Parashar Consultant Pediatrician & Intensivist Reg. No: 8568
		Dr. Aniket
		NB - Supriya
		9:30pm @ 01/06/26



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/6/26 am	<p>elc/B - Dr. Navvi Dr. Akshya</p>	
	<p>APD Unprovoked seizures. Yaw spikes at 10:15 pm (low grade)</p>	<p><u>Advice:</u></p>
	<p>No further seizures.</p>	<p>① Trace respiratory panel</p>
	<p><u>O/e-</u> Vitals stable</p>	<p>④ Trace MRI report</p>
	<p>⑩ CVS H P/A } normal</p>	<p>④ High grade spike CRP; CRP</p>
		<p>④ Coxiase level.</p>
		<p>up NB - Supine 7.29 AM @ 2/6/26</p>

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/6/26 10:30 AM	S/S Dr Aniket & Unprovoked seizure Child stable Better	MRS (N)
	Last spike yesterday night - low grade Snoring + O/S Gc - fair	
	Throat ENT : (N) aphonia T: 99°F. s/s c/w w/w	Ado. Trace adenoids CT. Levipil sup
		Energy orally Hold fluids
		Plan O/S tomorrow
		sup. Augmentin DDC
		Remove IV, hold fluids NB Sicha @ 11 AM
		Dr. Aniket

Dr. Aniket Anil Parashar
 Consultant Pediatrician & Intensivist
 Reg. No: 8568

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/6/26	S/B. Dr. Prabhakar	
2pm	Unprovoked seizure	
	Last spike yesterday 11:30pm	
	100.1°F	
	Spoxig + Mcd intermittent	Adv
	Child stable	
	Oral intake - fair	Trace adenovirus PCR
	o/s G.C. fair	CT Levipil syp
	Vitals stable	Syp Augmentin DDS
	Rx: BAET	Plan Dischng T/m
		NB Mouture 3pm



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/6 7pm	<p><u>AS/D Dr. Abhishek</u></p>	
	<p><u>D^c - Unprovoked seizures</u></p> <p>Last seen - yesterday</p> <p>No further seizures</p>	<p>- <u>Fever Triggered Seizures</u></p> <p>Plan</p> <p>1) Cont - Zepipil</p> <p>2) Ct - Augmentin x 5 days</p>
<p><u>O/E</u></p> <p>Child asleep</p> <p>Vital stable</p>	<p>Afebrile</p> <p>R.S - B/LAE ⊕</p> <p>PLA - Soft</p> <p>CNS - No focal deficits</p>	<p>3) Dic - T/m & f/lp on West today Wednesday</p> <p>4) Monitor Vitals</p>
	<p>DR. ABHISHEK RAVINDRA JAIN Reg. No: 02757</p>	<p>Infor so -</p> <p>Dic on Zepipil</p> <p>SO5 - Mada 2 → 2 puffs each nostril</p> <p>Amoxycilin</p>
		<p>Abhishek</p> <p>NB - Moutushi</p> <p>7:20pm @ 2/06/26</p>

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 Baby SEONA THOMAS PONNA
 27-09-2020 5 Y 8 M 6 D (F)
 Dr. ABHISHEK RAVINDRA JAIN



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/6/2020 8 am	S/B Dr. Nameen / Dr. Nayimya	
	Unprovoked seizure - fever triggered seizure	
	fever spikes - none	Plan
	no further seizure	① ct lempit
	activity good.	② Augmentin x 5 days
	chest clear	③ Discharge today
	P/A soft	④ Monitor vitals
		⑤ R/v on Wednesday
		(Dr. Nameen)
		MD - Supriya
		8:14 AM @ 3/6/20



DRUG CHART

Date of Admission: 31/5/26 Drug Allergies: NP/1 Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

SOS / PRN (As Required Medication)

DRUG : <u>Syp CROCIIN - DS</u>				Date/Time																
Dose	Route	Frequency	Start Date	<u>16</u> <u>WATS</u> <u>(u)</u> <u>10/5</u> <u>(u)</u>																
<u>7 ml</u>	<u>PO</u>	<u>SOS</u>	<u>31/5</u>																	
Doctor's Signature <u>Pharm</u>		Valid Period	Pharm.																	
Additional Instructions:																				

DRUG : <u>Syp IBUGESIC</u>				Date/Time																
Dose	Route	Frequency	Start Date																	
<u>5ml</u>	<u>PO</u>	<u>SOS</u>	<u>17/6/26</u>																	
Doctor's Signature <u>Pharm</u>		Valid Period	Pharm.																	
Additional Instructions: <u>If T > 102°</u>																				

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

Verified by
 Dr. Dhakshayani
 VERIFIED BY : Name

HNH-00015715 IP26-00006472
 Baby SEONA THOMAS PONNA
 27-09-2020 5 Y 8 M 5 D (F)
 Dr. ABHISHEK RAVINDRA JAIN



REGULAR PRESCRIPTIONS

Sheet No:

Weight Ward

DRUG : SYP AUGMENTIN DP				Date Time	2/6/20															
Dose	Route	Frequency	Start Dt.																	
7.5ml	PO	BD	2/6/20	9 AM																
Name & Signature of the Doctor Starting the Drugs:																				
Dr. Prabhakar																				
Additional Instructions:																				
(457mg/5ml)																				
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																				

Signature
Verified by: Name



Weight 25kg Ward

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
3/15	5:30pm	Syp PEDICLORYL	10ml	PO	Pran	SA
2/6	11:05 PM	DULCOLEX SUPP	5mg	PR	Pran	SA

Signature
VERIFIED BY : Name

HNH-00015715 IP26-00006472
 Baby SEONA THOMAS PONNA
 27-09-2020 5 Y 8 M 4 D (F)
 Dr. ABHISHEK RAVINDRA JAIN



RESULT SHEET

211

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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

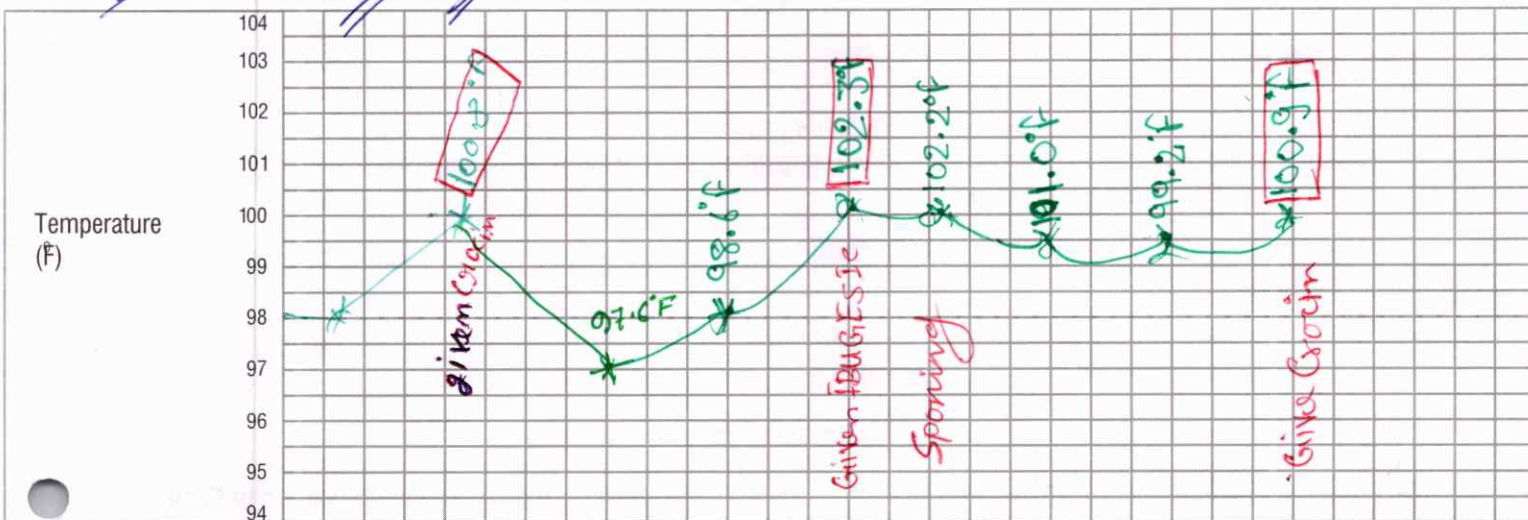
Date	31/5/26				
Time	2pm				
Hb	13.0				
PCV	36.8				
RBC	4.73				
WBC	6.19				
N/L	71.1/17.6				
Platelets	202				
CRP	5				
ESR					
PCT					
RBS					
Na					
K					
Cl	9.5				
Ca/Mg	9.5/				
Phosphate					
Urea					
Creatinine	0.5				
ALP	136				
SGPT	18				
SGOT	27				
T.Bill/Conj	0.3 < 0.2				
T.Protein	7.2				
S.Albumin	4.3				
S.Globulin	2.9				
A/G Ratio	2.9				
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein/Sugar					
Cells					
N/L					

Patient Sticker

L/126

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 3/15	Time: 3:30	5	8	10pm	2Am	3Am	3:45Am	6Am	7:30Am
Doctor / Nurse / Family Concern?	PM	PM	PM						



Heart Rate (bpm)	190	180	170	160	150	140	130	120	110	100	90	80	70	60	50
Blood Pressure (mmHg) *															
Note: BP does not score in early warning scoring															
Heart Rate (Number)	104 bpm			100 bpm						106 bpm					

Resp. Rate (bpm) (Over 1 Minute) *	70	60	50	40	30	20	10
Resp Rate (Number)	25 bpm			26 bpm			26 bpm

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

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

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

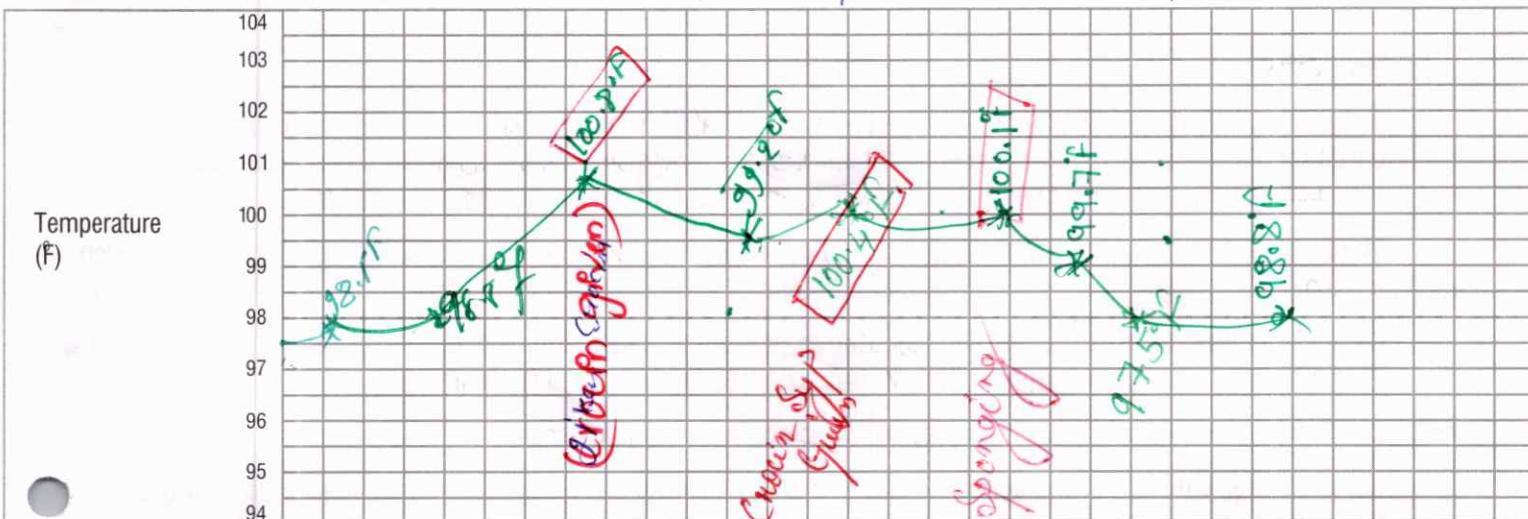
- If at any time additional help is required, call help – regardless of the Early Warning Score!
- Following a Early Warning Score assessment, senior help may be required

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

I	IDENTITY: I am (name), a nurse on ward (X). I am calling about (child X)
S	SITUATION: I am calling because I am concerned that ... (e.g. BP is low/high, pulse is XXX, Temperature is XX, Early Warning Score is XX)
B	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 is there anything I need to do in the meantime? (e.g. stop the fluid/ repeat observation)

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 1/6/26	Time: 10 AM	2 PM	4 PM	6 PM	10:15 PM	11:30 PM	12 AM	2 AM	6 AM
Doctor / Nurse / Family Concern?	Am		PM	PM	PM			ATL	Am



Heart Rate (bpm)	190	180	170	160	150	140	130	120	110	100	90	80	70	60	50
Blood Pressure (mmHg) *															
Note: BP does not score in early warning scoring															
Heart Rate (Number)	95	99	98	100	109	101	101	116	119	95	94	61	63	60	64

Resp. Rate (bpm) (Over 1 Minute) *	70	60	50	40	30	20	10
Resp Rate (Number)	32	31	30	30	29	28	

Resp Distress	Mod/ Severe	None / Mild
Receiving O ₂ (l/min)	100%	100%
O ₂ Saturations (%)	100%	100%
Conscious Level	Normal	Altered
GCS *	15/15	15/15

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

ACTIONS	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: Scores 3 should be recorded overleaf

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

- The paediatric Early Warning Score (i) seeks to identify the abnormal physiological finding seen during serious childhood illnesses and (ii) offers a method to interpret such physiological derangements with clearly defined actions, ensuring that suitably experienced staff are involved with the care of the sickest children.
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Record Details when EARLY WARNING SCORE > 3			Record Time of Review and Plan		
Date	Time	Early Warning Score	Date	Time	Name

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

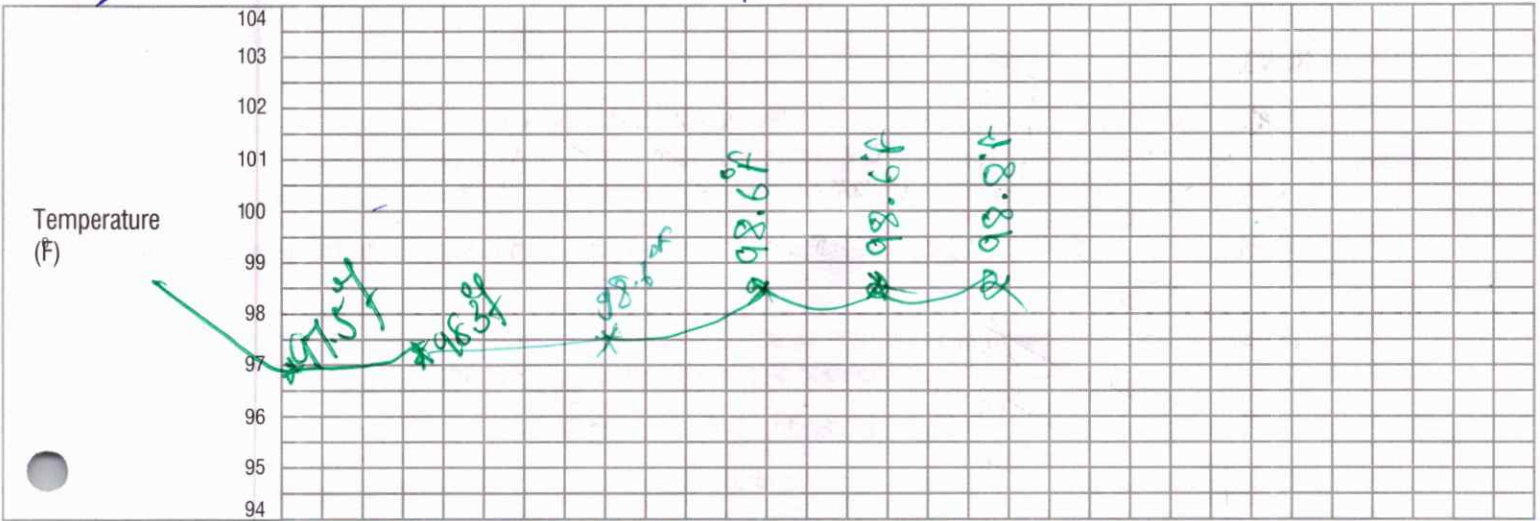
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S	SITUATION: I am calling because I am concerned that ... (e.g. BP is low/high, pulse is XXX, Temperature is XX, Early Warning Score is XX)
B	BACK GROUND: Child (X) was admitted on (XX date) with (e.g. respiratory infection). They have had (X operation/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



WARNING SCORE: CHILDREN'S UNIT

Date: ~~2/6/26~~ 2/6/26 Time: 9pm 6pm 10pm 2pm 6pm
 Doctor / Nurse / Family Concern?



Heart Rate (bpm) and Blood Pressure (mmHg) *	9pm	6pm	10pm	2pm	6pm	
Heart Rate (Number)	130bpm	110bpm	97bpm	102bpm	104bpm	100bpm
Blood Pressure (mmHg) *	110/73 (97)	110/67 (80)	100/67 (78)	92/70 (80)	91/60 (78)	97/61 (71)

Resp Rate (bpm) (Over 1 Minute) *	9pm	6pm	10pm	2pm	6pm	
Resp Rate (Number)	28b/m	28b/m	25b/m	28b/m	28b/m	29b/m

Resp Distress	Mod/ Severe	None / Mild
Receiving O ₂ (l/min)	0	0
O ₂ Saturations (%)	99%	99%
Conscious Level	Normal	Altered
GCS *	15/15	15/15

TOTAL SCORE	9pm	6pm	10pm	2pm	6pm
Number of shaded boxes	0	0	0	0	0
Pain Score	0	0	0	0	0
Observer's Initials	L	L	B	B	B

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

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- Detailed actions are described according to increasing Early Warning Score.
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Date	Time	Early Warning Score	Date	Time	Name

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

HNM-00015715 IP26-00006472
 Baby SEONA THOMAS PONNA
 27-09-2020 5 Y 8 M 5 D (F)
 Dr. ABHISHEK RAVINDRA JAIN



FLUID CHART

Sheet No. : 1

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
Total Intake :						Total Output :							
	02:00 pm												
	03:00 pm												
	04:00 pm	NS		30ml									
	05:00 pm	DNS		30 ml									
	06:00 pm	DNS		30 ml									
	07:00 pm	DNS		30 ml									
Total Intake :						Total Output :							
	08:00 pm			30 ml									
	09:00 pm			30 ml									
	10:00 pm	DNS		30 ml									
	11:00 pm			30 ml									
	12:00 am			30 ml									
	01:00 am			30 ml									
Total Intake :						Total Output :							
	02:00 am			20 ml									
	03:00 am			30 ml									
	04:00 am	DNS		30 ml									
	05:00 am			30 ml									
	06:00 am			30 ml									
	07:00 am			30 ml									
Total Intake :						Total Output :							
Total 24 hrs. Intake						Total 24 hrs. Output							

HNH-00015715 IP26-00006472
 Baby SEONA THOMAS PONNA (F)
 27-09-2020 5 Y 8 M 6 D
 Dr. ABHISHEK RAVINDRA JAIN



FLUID CHART

Sheet No. : 2

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
2/10/20	08:00 am	DNS	200	Bowl									
	09:00 am	DNS	100	30ml									
	10:00 am	DNS	100	30ml	NP								
	11:00 am									✓			
	12:00 pm												
	01:00 pm												
Total Intake :						Total Output :						U-1	M-
01/08/20	02:00 pm												
	03:00 pm												
	04:00 pm	DNS	Bowl		NP								
	05:00 pm	DNS	Bowl		NP								
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :						U-2	M-0
01/08/20	08:00 pm												
	09:00 pm		Curd										
	10:00 pm	IVF	Rice		NP								
	11:00 pm	Stop											
	12:00 am												
	01:00 am												
Total Intake :						Total Output :						U-2	M-x
02/06/20	02:00 am												
	03:00 am												
	04:00 am	IVF											
	05:00 am	Stop	H ₂ O										
	06:00 am												
	07:00 am												
Total Intake :						Total Output :						U-2	M-x

Total 24 hrs. Intake

Total 24 hrs. Output

HNH-00015715 IP26-00006472
 Baby SEONA THOMAS PONNA
 Pal 27-09-2020 5 Y 8 M 5 D (F)
 Dr. ABHISHEK RAVINDRA JAIN



FLUID CHART

Sheet No. : 3

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
2/6/26	08:00 am				/					✓		(Signature)
	09:00 am		Sally		/					✓		
	10:00 am		+ #20		/		o			✓		
	11:00 am	o			/					✓		
	12:00 pm				/					✓		
	01:00 pm				/					✓		
Total Intake : Taken			Total Output :									
2/6/26	02:00 pm				/					✓		(Signature)
	03:00 pm		central rice		/					✓		
	04:00 pm	o			/		o			✓		
	05:00 pm		both		/					✓		
	06:00 pm				/					✓		
	07:00 pm				/					✓		
Total Intake : Taken			Total Output : U-2 M-0									
2/6/26	08:00 pm				/					✓		(Signature)
	09:00 pm		Rice		/					✓		
	10:00 pm	o	egg		/					✓		
	11:00 pm		Milk		/					✓		
	12:00 am				/					✓		
	01:00 am				/					✓		
Total Intake : Taken			Total Output : U-2 M-2									
3/6/26	02:00 am				/					✓		(Signature)
	03:00 am				/					✓		
	04:00 am				/					✓		
	05:00 am	o			/		o			✓		
	06:00 am				/					✓		
	07:00 am				/					✓		
Total Intake :			Total Output : U-0 M-0									

Total 24 hrs. Intake

Total 24 hrs. Output



FLUID CHART

Sheet No. :

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
Total Intake :						Total Output :							
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :							
	08:00 pm												
	09:00 pm												
	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-00015715 IP26-00006472
 Baby SEONA THOMAS PONNA
 27-09-2020 5 Y 8 M 4 D (F)
 Dr. ABHISHEK RAVINDRA JAIN

NURSING CARE RECORD



Date: 3/1/20

- 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				ER			
Afternoon	2pm	Assess the Pt condition Monitor vital signs to maintain I/O chart. Provide the comfortable position.	2pm	Assessed the Pt condition monitored vital signs to maintained I/O chart provided the comfortable position.	Pt is stable.	Monitor vials	[Signature]
	8pm	Medication given as per as doctor order	8pm	medication given as per as doctor order	vitals norm.	Maintain I/O chart	[Signature]
Night	8pm	Assess the Pt condition - monitor vitals - maintain I/O chart - medication given as per doctor order	8pm	Assessed the Pt condition - monitored vitals - maintained I/O chart - medication given as per doctor order	Pt is stable	Re checked vitals	[Signature]

Patient St

HNH-00015715 IP26-00006472
 Baby SEONA THOMAS PONNA
 27-09-2020 5 Y 8 M 4 D (F)
 Dr. ABHISHEK RAVINDRA JAIN



NURSING CARE RECORD



Date: 1/8/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8AM 2PM	Assess the Pt. condition monitor vitals Maintain I/O chart. Plan to do MRI Today.	8PM 2PM	Assessed the Pt. condition monitored vitals maintained I/O chart.	patient is stable now	Re checked vitals	khushbo (K)
Afternoon	4PM 6PM	Assess the baby monitor the vitals administration of pain claritin 20 clut	4PM 6PM	Assessed the baby monitored vitals administration of pain claritin 20 clut	admission of	Rechecked vitals	[Signature]
Night	8PM 9AM	To assess the pt. condition To checked the vitals & record To administer the medication as per drug chart I/O chart maintain IVF stop	8PM 9AM	To assessed the pt. condition To checked vitals & recorded To administered the medication I/O chart maintained IVF stop	patient is stable now Trace MRI report	Re-checked the vitals I/O if high grade fever CBP & CRP	Supriya (S)

HNH-00015715 IP26-00006472
 Baby SEONA THOMAS PONNA
 27-09-2020 5 Y 8 M 5 D (F)
 Dr. ABHISHEK RAVINDRA JAIN

NURSING CARE RECORD



Date: 2/6/26

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8Am	Asses the Pt condition.	8Am	Assessed the Pt condition	PT is stable	Monitor vitals	Sneh
	10	Monitor vitals & record.	10	Monitored vitals & record			
	2Pm	Maintain I/O chart. Provide the comfortable position. Medication give as per as doctor order.	2Pm	Maintained I/O chart. Provided the comfortable position. Medication given as per as doctor order.			
Afternoon	2Pm	Assess the Pt condition	2Pm	Assessed the Pt condition	Patient is stable now	Rechecked vitals	Khusboo
	8Pm	monitor vitals Maintain I/O chart. Provide comfortable position Drug give as per drug chart.	8Pm	monitored vitals Maintained I/O chart Provided comfortable position Drug given as per drug chart.			
Night	8Pm	Assess the Pt condition	8Pm	Assessed the Pt condition	Patient is stable	vitals is Normal	Manish
	8Am	Monitor vitals Maintain I/O chart Medication given as per doctor order	8Am	monitored vitals Maintained I/O chart Medication given as per doctor order			

Patient Sticker

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							



NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: <u>Seizures</u>	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Not Known If Yes Specify:						
	Surgery / Procedure:	Post OP Day:						
BACKGROUND	Date	<u>3/15</u>	<u>3/15/26</u>	<u>3/16/26</u>	<u>1/6/26</u>	<u>1/06/26</u>	<u>2/6/26</u>	
	Shift	<u>EL</u>	<u>Ni</u>	<u>M6</u>	<u>8P</u>	<u>Ni</u>	<u>M6</u>	
	Medical Condition (Any special condition to be noted):	-	-	-	<u>Seizures</u>	-	-	
Diet:	-	-	-	<u>Normal</u>	<u>Soft</u>	-	-	
ASSESSMENT	Allergy:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Ventilation (RA, NP, NIV, VENTI):	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Vital Signs:	Temp:	<u>98.2°F</u>	<u>98.6°F</u>	<u>98.0°F</u>	<u>100.8°F</u>	<u>98.6°F</u>	<u>98.2°F</u>
		Res:	<u>27b/m</u>	<u>28b/m</u>	<u>26b/m</u>	<u>26b/m</u>	<u>26b/m</u>	<u>26b/m</u>
		SpO ₂ :	<u>99%</u>	<u>100%</u>	<u>100%</u>	<u>100</u>	<u>99%</u>	<u>98%</u>
		Pulse:	<u>98</u>	<u>98b/m</u>	<u>98b/m</u>	<u>102b/m</u>	<u>109b/m</u>	<u>112b/m</u>
		BP:	<u>96/52</u>	<u>99/54</u>	<u>93/56</u>	<u>100/62</u>	<u>101/63</u>	<u>99/62</u>
		LOC:	-	-	-	-	-	-
	Fall Risk Score:	-	-	-	-	-	-	
Pain Score:	-	-	-	-	<u>0</u>	<u>0</u>		
Skin Integrity	-	-	-	-	<u>Good</u>	<u>cr</u>		
Recommendations	Safety Needs:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Physiotherapy:	-	-	-	-	-	-	
	Others Specify:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Special Diet:	-	-	-	-	<u>Soft</u>	-	
	Critical Lab Test / Values:	-	-	-	-	-	-	
	Other Special Orders / Medications:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	PU Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
DVT Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
ADL (Dependent / Non Dependent):	-	-	-	-	-	-		
Post Operative Procedure Special Orders:								
Handed Over By Name :								
Signature / ID :								
Date:								
Time:								
Taken Over By Name :								
Signature / ID :								
Date:								
Time:								



NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: <i>Seizures</i>	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify:						
	Surgery / Procedure:	Post OP Day:						
BACKGROUND	Date	<i>2/6/26</i>	<i>2/6/26</i>					
	Shift	<i>E2</i>	<i>NI</i>					
	Medical Condition (Any special condition to be noted):							
	Diet:	<i>Regular</i>	<i>Regular</i>					
ASSESSMENT	Allergy:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Ventilation (RA, NP, NIV, VENTI):	<i>-</i>	<i>-</i>					
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Vital Signs:	Temp:	<i>98.1°F</i>	<i>98.6°F</i>				
		Res:	<i>25b/m</i>	<i>26b/m</i>				
		SpO ₂ :	<i>100.1</i>	<i>100%</i>				
		Pulse:	<i>90b/m</i>	<i>102b/m</i>				
		BP:	<i>92/60</i>	<i>94/66</i>				
		LOC:	<i>-</i>	<i>-</i>				
	Fall Risk Score:	<i>-</i>	<i>-</i>					
Pain Score:	<i>-</i>	<i>"0"</i>						
Skin Integrity	<i>-</i>	<i>Good</i>						
Recommendations	Safety Needs:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Physiotherapy:	<i>-</i>	<i>-</i>					
	Others Specify:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Special Diet:	<i>-</i>	<i>-</i>					
	Critical Lab Test / Values:	<i>-</i>	<i>-</i>					
	Other Special Orders / Medications:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	PU Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
DVT Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
ADL (Dependent / Non Dependent):	<i>yes</i>	<i>-</i>						
Post Operative Procedure Special Orders:		<i>-</i>	<i>-</i>					
Handed Over By Name :		<i>Moulti</i>	<i>Supriya</i>					
Signature / ID :		<i>(Signature)</i>	<i>(Signature)</i>					
Date:		<i>2/6</i>	<i>3/6/26</i>					
Time:		<i>8 PM</i>	<i>8 AM</i>					
Taken Over By Name :		<i>Supriya</i>						
Signature / ID :		<i>(Signature)</i>						
Date:		<i>2/6/26</i>						
Time:		<i>8 PM</i>						

Patic



THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
			3/5	2/6	2/6	2/6	
Age	Less than 3 years old	4					
	3 to less than 7 years old	3	3	3	3	3	
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2					
	Female	1	1	1	1	1	
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.)	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1	1	1	
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own ability	1	1	1	1	1	
	History of Falls or Infant-Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2					
	Outpatient Area	1	1	1	1	1	
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	1	1	1	1	
Medication Usage	Sedatives (Excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
Other Medications / None	1	1	1	1	1		
Total			10	9	9	9	

Intervention:

-Fail Risk: Low Humpty Dumpty Score = 7-11,

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		✓	✓	✓	✓
Call device within reach		✓	✓	✓	✓
Wheels Locked		✓	✓	✓	✓
Room free of clutter		✓	✓	✓	✓
Adequate lighting		✓	✓	✓	✓
Wheel chair support		X	X	X	X
Other Intervention(s) Specify		X	X	X	X
Nurse's Name:		Gurpreet	Sudha	Rohini	
Signature:		[Signature]	[Signature]	[Signature]	
Date:		3/5	2/6	2/6	2/6
Time:		8pm	6pm	8pm	8pm



BRADEN 'Q' SCALE



Date: 3/15/21
 Time: 11:50 AM

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

TOTAL SCORE 27 27 28 28
Evaluator's Name [Signatures]

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

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

BRADEN 'Q' SCALE

Patient ID

					Date:	2/6	2/4/8		
					Time:	6PM	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.		4	4		
"Activity The degree of physical activity"	1. Bedfast: Confined to bed	2. Chairfast: Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.		4	4		
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.		4	4		
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.		4	4		
FRICION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."		4	4		
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.		4	4		
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.		4	4		
					TOTAL SCORE	28	28		
					Evaluator's Name	(K)	10		

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

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

HNM-00015715 IP26-00006472
 Baby SEONA THOMAS PONNA (F)
 27-09-2020 5 Y 8 M 4 D
 Dr. ABHISHEK RAVINDRA JAIN



CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	3/15 DAY-1			1/6/26 DAY-2			2/6 DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0		0	0	0	0	0	0	0	0	
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1		NA	NA	NA	NA	NA	NA	NA	NA	
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2		NA	NA	NA	NA	NA	NA	NA	NA	
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3		NA	NA	NA	NA	NA	NA	NA	NA	
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4		NA	NA	NA	NA	NA	NA	NA	NA	
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord pyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5		NA	NA	NA	NA	NA	NA	NA	NA	
Signature of the Nurse													

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

Signature of Shift In Charge : Sneha
 Signature : Name : Sneha

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



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
3/15	2pm	0	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	NA	Se
3/15	8pm	0	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	NA	Sneb
3/15/26	10pm	0/10	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	NA	NA
1/6/26	6Am	0/10	NA	<input type="checkbox"/> Continuous <input checked="" type="checkbox"/> Intermittent	<input checked="" type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input checked="" type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input checked="" type="checkbox"/> Decreasing	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	NA	Se
1/6/26	10Am	0/10	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	NA	(Se)
1/6	6pm	0	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	NA	Se
1/6/26	10pm	0/10	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	Se
2/6/26	6Am	0/10	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	Se
2/6	10pm	0	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	Se
2/6	2pm	0	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	Se

Re-assessment Frequency:

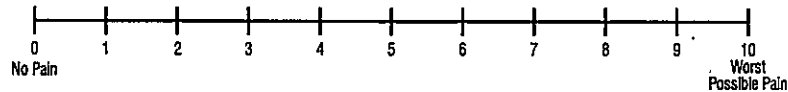
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

Numerical Pain Scale (Obstetric and Gynecology)



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

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

Wong - Baker (Pediatrics) Above 7 Years





PAIN ASSESSMENT FORM

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

Re-assessment Frequency:

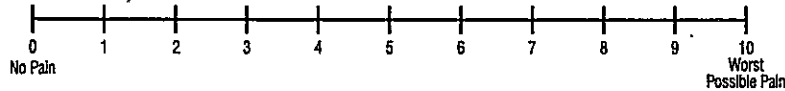
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2. For post-surgical patients, patients with chronic pain, patient with severe pain:
 - a) At least every 2 hours for the first 24 hours
 - b) Then every 4 hours.
 - c) Prior to pain-relieving intervention.
 - d) Within 30 – 60 minutes after pain relief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

PAIN ASSESSMENT TOOLS

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Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

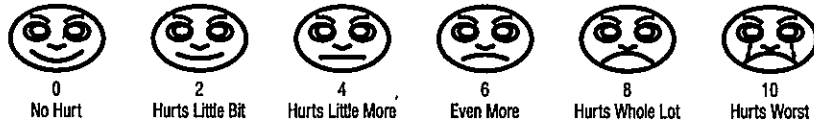
Numerical Pain Scale (Obstetric and Gynecology)



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

Assessment Criteria	Sedation		Normal	Pain / Agitation	
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Vital Signs HR, RR, BP, SaO₂	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO ₂ 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

Wong - Baker (Pediatrics) Above 7 Years



HNH-00015715 IP26-00006472
Baby SEONA THOMAS PONNA
27-09-2020 5 Y 8 M 4 D (F)
Dr. ABHISHEK RAVINDRA JAIN



MEDICATION RECONCILIATION FORM

Drug Allergies: None 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: 2nd floor (209)

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

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: Dr. Pranav

Date & Time: 31/12/26 @ 2pm

Nurse Name & Signature: Bhargava

Date & Time: 31/12/26 @ 2:5pm

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

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

HNH-00015715 IP26-00006472
Baby SEONA THOMAS PONNA
27-09-2020 5Y8M4D (F)
Dr. ABHISHEK RAVINDRA JAIN

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Name: BABY SEONA THOMAS Age: 5y8m Sex: Female UHID.No: HNH-0015715
Date: 31/05/2026 Time: 6:00 PM Proposed Operation: MRI - BRAIN ± CONTRAST
Diagnosis: UNPROVOKED SEIZURES
B.P / CRT: H.R: Weight: 25 kg ASA Physical Status: 1 2 3 4 5

Laboratory Data:

Hgb: <u>13.0</u>	Glucose:	Protein:	HIV:	X-Ray:
PCV: <u>36.8</u>	Urea:	Alb: <u>4.3</u>	HBS Ag:	EKG:
WBC: <u>6190</u>	Creat: <u>0.5</u>	Total Bill: <u>0.3</u>	HCV:	2D Echo:
Plate: <u>2.02</u>	Na:	Dir. Bill: <u>0.2</u>	Blood group:	Stress/Angio:
PT:	K:	LDH:	T3	Other:
PTT:	Ca++:	Alk phos: <u>136</u>	T4	
INR:	Mg++:	Amylase:	TSH	
	Cl-:	SGOT/SGPT:		

Allergies: NKA

Medical History: CS: Baby is staring look with No response to Verbal & tactile
RESP: Also is loss of tone of limbs Diabetes: Stimulation testing for 10-15 mins
CNS: → Associated with Frothing at Mouth & 1 episode of Vomiting
Renal: → No H/o Jaundice or Tonic Clonic Movements
Hepatic / GE: Physical Activity:
Others: Baby: Full Term / CDAB / No NICU stay
Past Anaesthetic History: NIL

Physical Exam: Awake
Airway: MP 1 2 3 4 Mouth Opening: 2.5 Mentohyoid Distance: 2.5 Neck: 2.5 Teeth: No loose teeth
Lungs: Clear
Heart: S1 S2

CNS:
Pregnant: Yes No NA Venous Access Site: Peripher Spine Exam for regional:

Anaesthetic Plan: MAC REGIONAL GA-ETT LMA

Peri-Operative Plan Explained to the Patient: Yes No

CURRENT MEDICATIONS	DOSAGE
<u>Two Levetiracetam</u>	<u>250mg IV BD</u>
<u>Two Ondansetron</u>	<u>4.0mg IV TID</u>

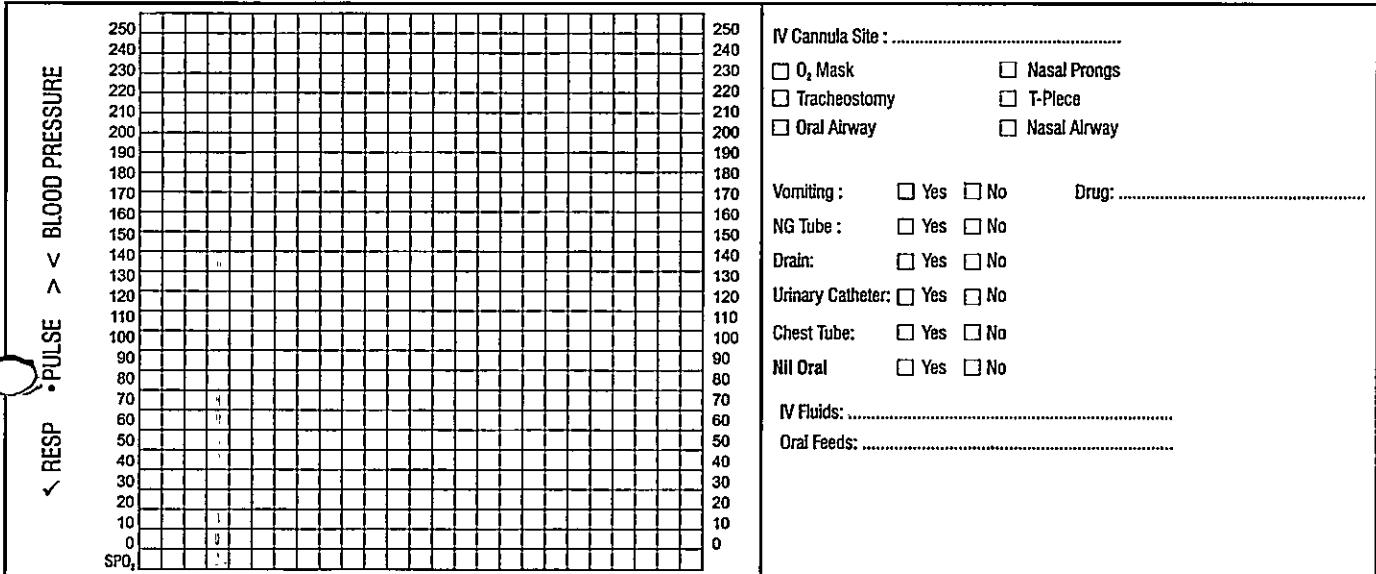
- Pre-Operative Instructions:
- DVT Prophylaxis:
 - NIL ORAL Water / ORS 2 Hours ✓
Others 6 Hours ✓
 - Informed Consent: Standard High Risk
 - Post Operative Pain Management: Discussed with Patient
 - Other Instructions:

Signature: [Signature] Name: Dr. Suresh

Patient Sticker

POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Time Received : Time Discharged :



POST ANAESTHESIA SCORE (Modified Aldrete Score)	IN	MINUTES			OUT	SCORING INTERPRETATION
		30	60	90		
Able to move 4 extremities voluntary or on command = 2 Able to move 2 extremities voluntary or on command = 1 Able to move 0 extremities voluntary or on command = 0						A Minimum Total Score of 8 is Required for Discharge Exceptions to this, are to be explained in the space below by the Discharging Physician:
ACTIVITY						
Able to deep breathe & cough freely = 2 Dyspnea or limited breathing = 1 Apneic = 0						
RESPIRATION						
BP ± 20 of Pre Anaesthetic level = 2 BP ± 20-50 of Pre Anaesthetic level = 1 BP ± 50 of Pre Anaesthetic level = 0						
CIRCULATION						
Fully awake = 2 Arousable on calling = 1 Not responding = 0						
CONSCIOUSNESS						
Pink = 2 Pale, dusky, blotchy, jaundiced, other = 1 Cyanotic = 0						
COLOR						
TOTAL						

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature

Pain Tool Used: N PASS FLACC Wong Baker NPS

Reassessment Frequency:

1. Every eight hours for all hospitalized patients.
2. For post surgical patient, patient with chronic pain, patient with severe pain
 - a. Every 2 hours for first 24 hours
 - b. After 24 hours every 4 hours
 - c. Prior to pain relieving intervention
 - d. With in 30-60 minutes after pain relief intervention

Anaesthesiologist Name :

Anaesthesiologist Signature:

Date & Time:

PACU Nurse Name :

PACU Nurse Signature:

Date & Time:

Transferred to Unit by (PACU):

Date & Time:

CONSENT FORM FOR ANAESTHESIA

HNH-00015715 IP26-00008472
Baby SEONA THOMAS PONNA
27-09-2020 5 Y 8 M 4 D (F)
Dr. ABHISHEK RAVINDRA JAIN



Patient Name : Baby SEONA THOMAS PONNA Age : 5 y 8 m 4 d Gender : Male Female
UHID NO: HNH-0015715 Surgeon Name: Dr. SAMIK
Anaesthesiologist : Dr. SAMIK Operative procedure planned : MRI - BRAIN + CONTRAST

PLEASE READ THIS BEFORE YOU CONSENT FOR ANAESTHESIA

General anaesthesia involves rendering a patient unconscious before an operation. This ensures the patient is not aware of events and does not feel pain during the operation. Drugs given through a vein and / or inhaled from an anaesthesia machine produce it. Regional anaesthesia involves using a local anaesthetic to numb a specific area of the body for surgery: Prolonged pain relief without numbness can be achieved by infusing weak solutions of local anaesthetics and narcotic drugs to particular parts of the body after surgery or injury, using catheters.

Specific High Risk (s) : The doctors have explained to me the details of the high risk involved due to the following medical problems and I have sought necessary clarification on all my doubts.

- Heart disease Hypertension Diabetes mellitus Renal failure
- Hepatic disorders Shock Multiple organ failure Polytrauma / Renal Tubular Acidosis
- Incapacitating Chronic Obstructive Pulmonary Disease Others : SEIZURES

• Doctor to document in medical record also if necessary (Cross-out if not applicable)

DECLARATION BY PATIENT / GUARDIAN / PROXY

I hereby authorize Rainbow Hospital & its authorized doctors to perform upon me / my patient the above mentioned operation / Diagnostic / Therapeutic procedures.

I authorize and give consent for anaesthesia (Regional / General Anesthesia / Monitored Anesthesia Care as considered appropriate by the anaesthesia team.

I acknowledge that the anaesthetists have informed me about the anaesthetic procedure, risk, benefits and alternative treatments and answered my specific queries and concerns about this matter. I have read and understood the information provided in this form I acknowledge that I have discussed with the anaesthetists any significant risk and Complications specific to my individual circumstances, and I have considered them before Consenting for anaesthesia.

I understand that there are some infrequent complications that can occur due to use of anaesthesia, these include pain or some injury at the site of injections, temporary breathing difficulties, asthmatic reactions, headaches.

I authorize the anaesthesia team to perform any additional procedures (for example, Central Venous Pressure line, arterial line, use of nerve blocks for pain relief, changing from regional to general anaesthesia etc), which are considered necessary by them during the course of surgery.

That I authorize and give consent to the team of doctors attending on me to administer blood products during the course of operative period and immediately thereafter in need arises.

I understand that the above mentioned consultant anaesthesiologist or occasionally a colleague deputed by him / her will administer the Anaesthesia.

I have been explained all my queries in the language understood by me.

Patient / Patient Attendant :
Signature : [Signature]
Name : P. Sunny
Relationship with Patient : father
Date & Time : 31/05/2026

Witness :
Signature : [Signature]
Name : Rushi Madhavi
Date & Time : 31/05/2026

Doctor (who is taking the consent) :
Signature : [Signature]

Name : Dr. SAMIK Date & Time : 31/05/2026



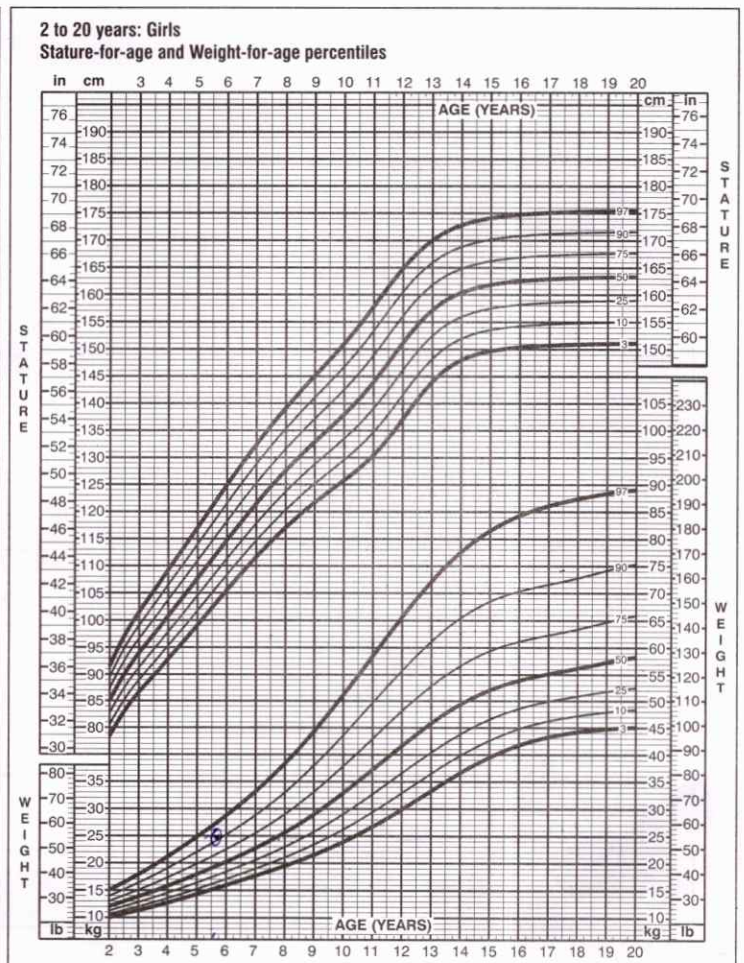
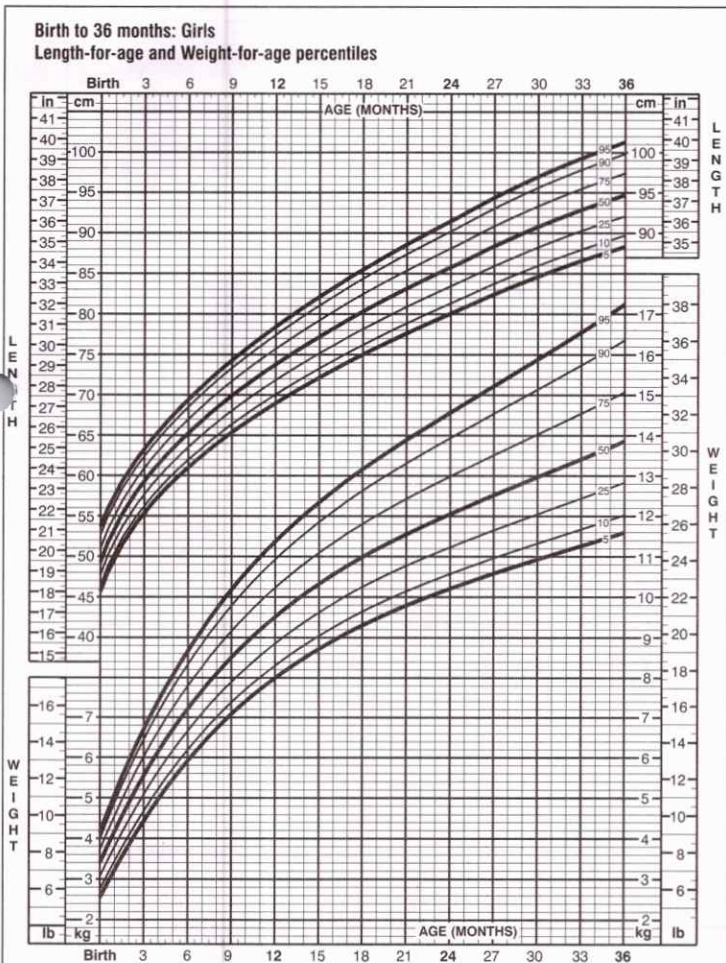
211

NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 1/6/26 Time: 9:40am

Weight: 25 kg Centile: 90th
 Height: - Centile: -
 Inference: Well Nourished child
 RDA: - Calories: 1400 Kcal/day Protein: 24 gms/day
 Diet Recommendations: High Calcium diet with liquids
 Re-Assessment: No Junk foods
 Food Allergies: No Veg/Non-veg Non veg
 Diagnosis: Unprovoked Seizures C AFI
 Nutritional Intervention - Oral Enteral Parenteral
 Patient's Signature: P. Suf

GROWTH CHART (GIRLS)



Dietician's Name: Syeda Sobiya Zaher

Dietician's Signature: Sobiya



wt - 25kg



EMERGENCY ROOM TRIAGE FORM

Patient's Name : baby, seona thomas ponna. Age : 5 yr Gender: Male Female
 Date : 31/5/26 Time of Arrival : 1:30 pm

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

Source of Information : Parents Others (Specify)

Mode of Arrival : Ambulatory Wheelchair Ambulance

Initial Vital Signs: Temp: 98.5F PR: 103b/m BP: RR: 30b/m SpO₂: 97% CO₂

Chief Complaints: cl. seizure activity, vomiting 1 episode

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

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

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

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian

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 : Bhargava

Signature of Triage Nurse : (B)

Date & Time : 31/5/26 @ 1:33pm



NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 31/5/26 Time of arrival : 11:30pm
 Chief Complaints: do. seizure activity vomiting 1 episode
 Height : Weight : 25kg 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

<p>RISK FOR FALL: If patient is < 6 years <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If 'Yes' tick below fall risk intervention directly If Patient is > 6 years If 'Yes' Assess the below parameters History of Falling: within past 3 months <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Ambulatory Aids: • Wheelchair <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No • Uses furniture for support <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Gait/Transferring: • Bedrest / immobile <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No • Weak <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No • Impaired <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Mental Status: Forgets limitations <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>IF YES FOR ANY CATEGORY = RISK FOR FALLING Fall Risk Intervention: <input type="checkbox"/> Escort while ambulating <input checked="" type="checkbox"/> Assist Patient <input checked="" type="checkbox"/> Educate patient and family on fall precautions/prevention</p>	<p>Functional Screening: <input checked="" type="checkbox"/> No Abnormalities Detected <input type="checkbox"/> Mobility Problem <input type="checkbox"/> Walking Problem <input type="checkbox"/> Developmental Delay <input type="checkbox"/> Musculoskeletal Congenital Abnormality</p> <p>Inform consultant for positive criteria</p> <p>Nutritional Screening: <input checked="" type="checkbox"/> No Abnormalities Detected <input type="checkbox"/> Underweight <input type="checkbox"/> Overweight <input type="checkbox"/> Feeding Problem <input type="checkbox"/> Special diet <input type="checkbox"/> Special feeding method</p> <p>Inform consultant for positive criteria</p>
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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 : @@ 11:36pm

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

Time	Nursing Notes
1:37pm	Assess the pt condition monitore the vitals

Samples collected by:

Time:

Samples sent by :

Time:

Ujjaya

2:40pm

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: <i>103b/m</i> BP: CFT: RR: <i>30b/m</i> SPO2 at FiO2: <i>97%</i> GCS: Temperature: <i>98.5°F</i> Pain Score: Repeat RBS (if applicable):	Shift - out from ER to: <i>2nd floor (209)</i> Time of Shift - out: <i>3:12pm</i> Handover given to: <i>Smr</i> (Nurse's Name)

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 : *31/5/2016 1:39pm*

PATIENT TRANSFER FORM

HNH-00015715 IP26-00006472

Baby SEONA THOMAS PONNA
27-09-2020 5 Y 8 M 4 D (F)
Dr. ABHISHEK RAVINDRA JAIN



Date & Time of Admission <i>31/5/26 @ 2:33pm</i>	Date & Time of Transfer Order <i>31/5/26 @ 3:12pm</i>	
Treating Consultant Name	Transfer Ordered by <i>Dr. pranav</i>	Reason for Transfer <i>ADMISSION</i>
From Unit <i>ER</i>	To Unit <i>2nd floor (209)</i>	Information to Attendant Yes <input type="checkbox"/> No <input type="checkbox"/>
Number of Sheets in Clinical File <i>251-</i>	Number of Imaging Films <i>VBH - (1)</i>	Personal belongings including clinical documents. If any handed over to attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.		
2.	<i>VBH-</i>	<i>(1)</i>
3.		
4.		
5.		

Shifting Summary / Notes Written by Doctor : Yes No

Name & Signature of Person who is Transferring <i>Bhargavi</i>	Name of Person Ordered Transfer <i>Dr. pranav</i>
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Patient & Clinical Records Received by : *Sachin 31/5/26 @ 3:12PM*

Date & Time of Patient Received :

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

- Unavailable Bed Nurse not Available Available Bed not ready