

DISCHARGE SUMMARY

Name	Master SHANKUR VIRANSH	UHID	HNH-00009752
Father/Guardian	Mr VINAY KUMAR	Age/Gender	0 Y 11 M 2 D/ Male
Address	FLAT NO 401 PARK VIEW RESIDENCY BAGH AMBERPET, Amberpet, Hyderabad, Telangana, INDIA, 500013		
IP No	IP26-00006753	Admission Date	06-07-2026
Ref Doctor	Self.		
Discharge Date	07.07.2026		

Consultant:

Dr. SINDHURA MUNUKUNTLA
MBBS, DCH, DNB PEDIATRICS
66970

DIAGNOSIS	ICD CODE
SEVERE GASTRITIS WITH DEHYDRATION	

History: Master SHANKUR VIRANSH, 0 Y 11 M 2 D , old boy presented with history of multiple episodes of non bilious, non projectile vomiting since 1 day decreased activity and accepting of feeds since 1 day, prior to admission. For the above complaints he was admitted at Rainbow Children's Hospital - Himayathnagar for further management.

Examination: He was afebrile and maintaining saturation at room air. Heart rate - 126/min and Respiratory Rate - 24/min. On examination Signs of some

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dehydration were present, dry lips, oral mucosa, delayed skin turgor, decreased urine output, dull looking, tachycardia, dry oral mucosa, sunken eyes were present. On auscultation of chest, air entry was bilaterally equal with normal heart sounds and no murmur. Abdomen was soft with no organomegaly. On neurological examination, he was conscious, alert. Pupils were bilaterally equal & reacting to light. There were no focal neurological deficits.

Weight on admission: 7 kilo grams.

Investigations: Enclosed reports.

Initial hemogram showed Hemoglobin of 9.1 gm%, White Blood Cell count of 12150 cells/cumm, platelet count of 3.83 lakhs/cumm.

Complete urine examination shows: Pus cells - 3-4, epithelial cells - 2-3.

Management : He was admitted in the ward and was started on Intra Venous fluids . He was treated symptomatically with antacids and antiemetics. In view of vomitings he was administered probiotics and advised gastrodiet.

He was regularly monitored for vomitings frequency and hydration status. His other symptoms settled gradually.

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

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

Name	Master SHANKUR VIRANSH	UHID	HNH-00009752
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Medication during hospital stay:

Injection. Ondansetron

Injection. Esmoprazole

Advice:

* Diet as advised.

S.N o	MEDICATION	DOSE	TIMINGS	DURATION
1	NEXPRO Junior (1 sachet = 10mg)	1 sachet (mix in 10ml water)	8am (30 minutes before food)	2 days
2	Syrup. ONDEM (Ondansetron - 5ml/2mg)	5 ml	7am-7pm (30 minutes before food)	SOS for vomiting

Fever Management

* Syrup. Crocin DS (Paracetamol - 5ml/240mg) 2ml after food as and whenever required, if temperature > 100 °F (maximum 4 times a day at 6 hour intervals).

* Tepid sponging if fever > 101 °F.

Review consultation with Dr. SINDHURA MUNUKUNTALA on Thursday (09.07.2026) at Himayathnagar in OPD with prior appointment **(Review consultation will be charged)**.

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

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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 / Vikramপুরi / 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. SINDHURA MUNUKUNTLA
MBBS, DCH, DNB PEDIATRICS
66970

ADMISSION SHEET

Registration Details :



Admission No : IP26-00006753 Admit Date : 06-Jul-2026 Admit Time : 12:29 AM UHID : HNH-00009752

Patient Details :

Patient Name : Master SHANKUR VIRANSH	Age : 0 Y 11 M 2 D
Guardian : Mr VINAY KUMAR	DOB : 04-08-2025 02:57 PM
Gender : Male	Religion :
Occupation :	Martial Status :
Address (H) : FLAT NO 401 PARK VIEW RESIDENCY BAGH AMBERPET Amberpet Hyderabad Telangana INDIA 500013	Phone No : 9030334332/ 8801013656 E-mail : SHIVANI.G211998@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 VINAY KUMAR **Relationship** : Father
Contact Address : FLAT NO 401 PARK VIEW RESIDENCY BAGH
AMBERPET Amberpet Hyderabad Telangana
INDIA 500013 **Phone No** : 9030334332

Shivani
Signature

Doctor Details :

Doctor Name : Dr. SINDHURA MUNUKUNTLA **Specialisation** : GENERAL PEDIATRICS
Referral Doctor : Self. **Phone No** :
Co-Consultant :

Payment Details :

Payment Mode : DC/CC Card **Deposit Amount** : 10000.00
Payor Name : MEDI ASSIST INSURANCE TPA PVT LTD

PATIENT TRANSFER FORM

Patient Name & UHID No. HNH-00009752 IP26-00006753 Master SHANKUR VIRANSH 04-08-2025 0 Y 11 M 2 D (M) Dr. SINDHURA MUNUKUNTALA 		Date & Time of Admission 5/7/26 @ 12:29 Am.	Date & Time of Transfer Order 5/7/26 @ 1:21 am
		Transfer Ordered by Dr. Anusha	Reason for Transfer Admission
From Unit ER	To Unit ward	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 251-	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☐ If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☐ No ☐			
Name & Signature of Person who is Transferring Bhargavi		Name of Person Ordered Transfer Dr. Anusha	
Patient & Clinical Records Received by : Sunanda @ 1.30 am			
Date & Time of Patient Received : 5/7/26			

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

☐ Unavailable Bed

☐ Nurse not Available

☐ Available Bed not ready

ACTIVITY RECORD FOR BILLING

Name: - HNH-00009752 IP26-00006753
Master SHANKUR VIRANSH
UHID No: 04-08-2025 0 Y 11 M 2 D (M)
Dr. SINDHURA MUNUKUNTLA
Date of /  ne : ----- Date of Discharge : ----- Time: -----
Room / Bed No : ----- Ward : ----- Suggested Billable bed type : -----

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
5/7/26	1:21Am	ER	ward	B) / 

Cross Consultation Visit

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

[illegible]

[illegible][illegible]

Prepared By :

Billing Supervisor

Ref.No. F/IN/PR/10

**Rainbow[®]
Children's
Hospital**

**PEDIATRIC IN-PATIENT
MEDICAL RECORD**

Patient Name : _____

Patient ID# : _____

HNH-00008752 IP26-00006753
Master SHANKUR VIRANSH
04-08-2025 0 Y 11 M 2 D (M)
Dr. SINDHURA MUNUKUNTLA

Consultant : _____

Final Diagnosis : _____

Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Informant _____ Reliability _____

Chief Presenting Complaints & Duration (Chronologically):

~~c/o fever~~ sin. c/o vomitings since evening
multiple episode
c/o decreased activity & decreased
acceptance of feeds.

History of present illness :

- child presented to ER with c/o multiple
episodes of vomitings since morning
containing food particles / feeds non bilious.
non projectile
not relieving w/ medication.

- c/o decreased activity

- c/o decreased acceptance of feeds.

Pediatric Multiorgan History & Physical Examination

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

Birth & Neonatal History :

Birth & Socio Economic History :

About Father :

About Mother :

Any additional Information :

Developmental History :

Immunization History :

Pediatric Multiorgan History & Physical Examination

Anthropometry

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

Weight (kgs) ~ 7 kg (Centile _____)

On Examination :

Temperature : Afebr Pulse Rate: 126 Description _____

B.P. _____ SPO2 98% at _____

Resp. rate and type of breathing : (2) Sign of dehydration (+)

Rash _____ Sunk Eyes

Lymphadenopathy _____ dull look

Oedema : _____ dry lips / oral mucous

Respiratory system :

Inspection (any s/o distress) : _____

Air entry & breath sounds : B/LAC (+)

Any added sounds : RVS (+)

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

Cardiovascular System :

Inspection of precordium : _____

Heart Sounds : S1 S2

Any murmur : no

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

Per Abdomen :

Inspection _____

Palpation : Soft, not distend

Auscultation : no organomegaly

Spine: _____ External Genitalia : 2nd trimester

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

Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS Score : 15/15

Cranial Nerves : _____

Motor System :

Nutrition : _____

Tone : _____

Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR

Superficials :

Plantars _____

Sensory System :

Bladder / Bowel : _____

Clinical Summary & Diagnostic :

*Severe Acute Gastritis
+ Delayed*

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment :

prevent hypovolemia

Desired goals of the treatment :

Planned Labs :

PA
[iVE
- CBP] send
- CRP - collect & keep.
planto send if juve (+).

Planned Management :

- 1/1 ceftriaxone
iv fluid
- iv fluid DNS @ 21 ml/h
(4/3)
- Assisted feeds aft 2 hours.
- 1/1 ONDANSETRON
1.5mg iv tid
- 1/1 ESMOPRAZOLE 7mg
iv od
- Norm so.

Please fill up the following details

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

Doctor's Signature Name

Date

Time

Dr. Sankar Kumar Mumukunda
Consultant Pediatrician
Reg. No. 66370
8/7/26 1 AM

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

Date & Time	Progress Notes	Doctor's Order
6/7/26 10 PM	<u>cl/b Dr. Sindhura</u> <u>Severe acute gastroitis & dehydration</u> fever - 38.5 40.0°C. Activity - Good. <u>NO vomiting.</u> GE - vital stable. GE - WBC. WE	<u>Plan</u> Encourage oral NS fluids to taper if intake improves. Monitor vitals. NB Mouthwash. <u>Dr. Sindhura</u> <u>Dr. Sindhura</u>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/8/26 2pm	S/B Dr. Aschane / Dr. Vasim Δ: Severe Acute Gastritis & dehydration Euthemic Activity - good oral acceptance - improved V passed S ple vitality stable ste wnl	Adv Stop IIV by evening ct rest same NB Mouth 2pm
6/8/26 4:30 PM	S/B Dr. Sindhura Δ Acute Gastritis & dehydration CNS - SCS PI - DIC - AEF PIA - 500 conscious	Plan Encourage orally ct ESMOPRIZOLE ONDANSETRON stop IV fluids Plan discharge - TM N/B of powder

Dr. Sindhura Munukuntala
 Consultant Pediatrician
 Reg. No. 66970

Pharmacist
 Dr. Sindhura Munukuntala



246 → 241 → (102)

RESULT SHEET

Date	6/7/26					
Time						
Hb	9.1					
PCV	27.6					
RBC	4.91					
WBC	12.15					
N/L	67.3/27.3					
Platelets	388					
CRP						
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

Date	6/2/26					
Time	5:06 AM					
CUE - Alb						
CUE - Sugar	Nil					
CUE - Ketones	Negative					
CUE - PUS Cells	3-4					
CUE - RBC Cells	Nil					
CUE epithelial cells	2-3					
Stool Pus Cell						
OVA / Cyst						
Occult Blood						

Culture and Sensitivities :

.....

.....

.....

Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI :

 Others (ECG, Contrast Studies etc.,) :

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

Patient Sticker

L/124

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 6/7/25 Time: 2 am 8 am

Doctor/Nurse/Family Concern?

Temperature
(°F)

104
103
102
101
100
99
98
97
96
95
94

Heart Rate
(bpm)

and

Blood Pressure
(mmHg) *

Note:

BP does not score
in early
warning scoring

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

Heart Rate (Number)

135b/m 125b/m

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

70
60
50
40
30
20
10

Resp Rate (Number)

28b/m 28b/m

Resp Mod/ Severe
Distress None / Mild

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

99% 99%

Conscious Normal
Level Altered

GCS *

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

ACTIONS

NB: Scores 3 should be
recorded overleaf

Score 1 : Continue normal observation by staff nurse

Score 2 : Shift in charge nurse to be informed and continue hourly observations

Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.

Score 4 : Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see

Score 5 & 6 : Shift incharge and PICU /NICU fellow or PICU/NICU consultant to be informed

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

- If at any time additional help is required, call help – regardless of the Early Warning Score!
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The SBAR communication tool (situation, background, assessment, recommendations) is a helpful mnemonic that can be used to describe a child's clinical condition to a colleague.

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

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

24

Patient Sticker

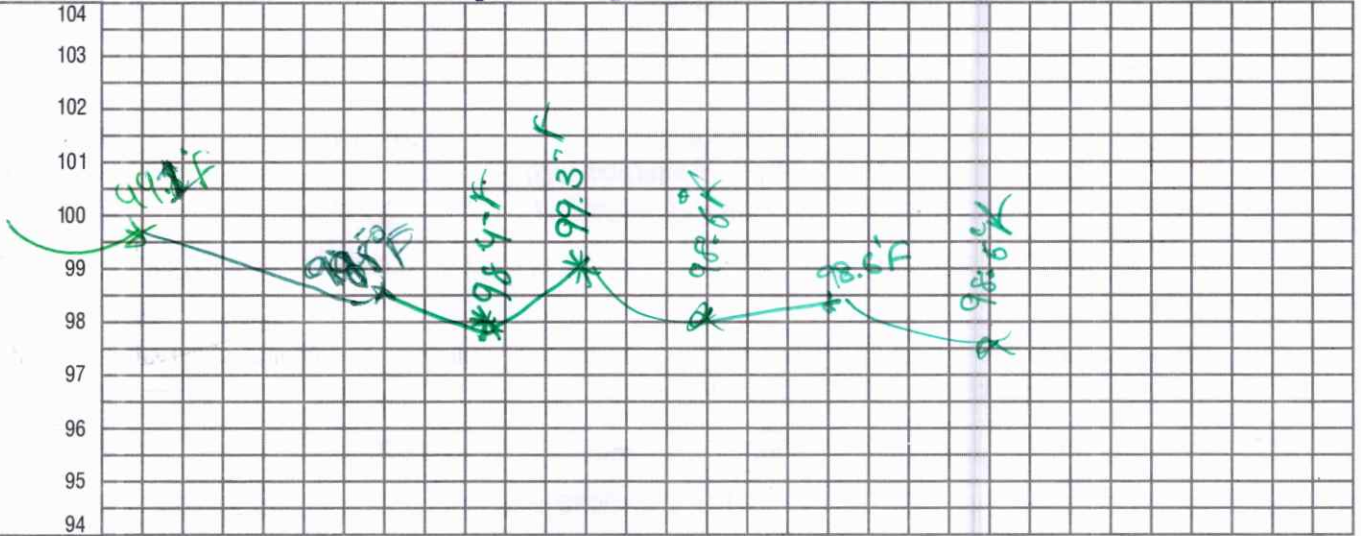
EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 6/7 Time: 10Am 2pm 4pm 5:30pm 10pm 2am 6am

Doctor/Nurse/Family Concern?

Temperature
(°F)

104
103
102
101
100
99
98
97
96
95
94



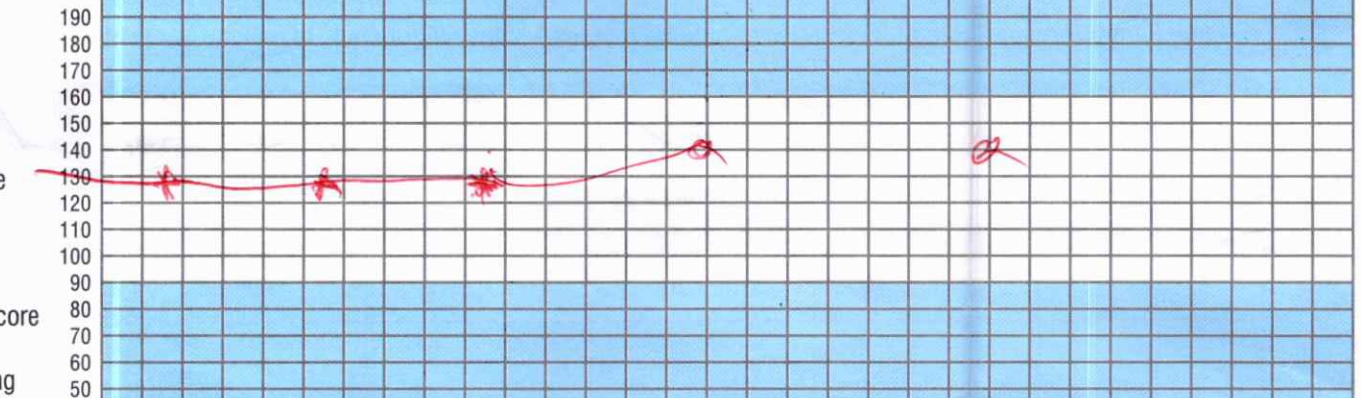
Heart Rate
(bpm)

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

and

Blood Pressure
(mmHg) *

Note:
BP does not score
in early
warning scoring

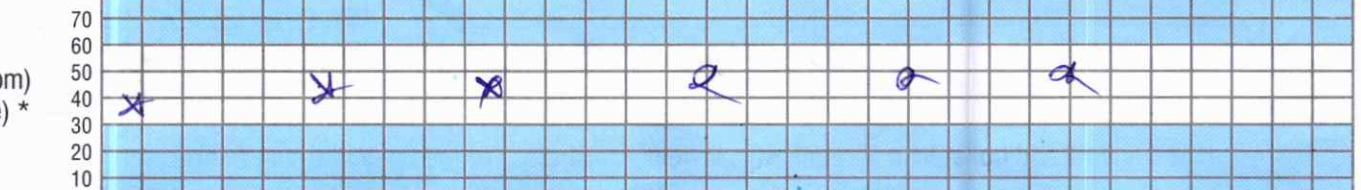


Heart Rate (Number)

125b/m 123b/m 126b/m 124b/m 122b/m 126b/m

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

70
60
50
40
30
20
10



Resp Rate (Number)

136b/m 136b/m 30b/m 30b/m 32b/m 39b/m

Resp Mod/ Severe
Distress None / Mild

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

100% 99% 99% 99% 99% 94%

Conscious Level
Normal Altered

GCS *

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

0 0 0 0 0 0
0 0 0 0 0 0
0 0 0 0 0 0

ACTIONS

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 7/7/26	Time: 11:26
Doctor/Nurse/Family Concern?	
Temperature (°F)	104 103 102 101 100 99 98 97 96 95 94
Heart Rate (bpm)	190 180 170 160 150 140 130 120 110 100 90 80 70 60 50
and Blood Pressure (mmHg) *	
Note: BP does not score in early warning scoring	
Heart Rate (Number)	
Resp. Rate (bpm) (Over 1 Minute) *	70 60 50 40 30 20 10
Resp Rate (Number)	
Resp Distress	Mod/ Severe None / Mild
Receiving O ₂ (l/min)	
O ₂ Saturations (%)	
Conscious Level	Normal Altered
GCS *	
TOTAL SCORE	
Number of shaded boxes	
Pain Score	
Observer's Initials	
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 incharge and PICU /NICU fellow or PICU/NICU consultant to be informed
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FLUID CHART

Sheet No. :

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

Date	Time	Nature of Fluid	Intake			Output					IV Site 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 :							
6 Apr	02:00 am	↑		21ml									
	03:00 am	↑	DBF	21ml									
	04:00 am	DNS		21ml									
	05:00 am	↓		21ml									
	06:00 am			21ml									
	07:00 am			21ml									
	Total Intake :						Total Output :						
Total 24 hrs. Intake						Total 24 hrs. Output							

FLUID CHART

Sheet No. :

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

		Intake			Output					IV Site	Sign.	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	Thrombo- phlebitis Score	Nurse
6/7/26			Mouth	I.V	N.G							
	08:00 am			21 ml								
	09:00 am			21 ml								
	10:00 am	BNC	Milk	21 ml								
	11:00 am		21 ml									
	12:00 pm		21 ml									
01:00 pm												
Total Intake :					Total Output : U-2					M-		
6/8/26	02:00 pm			15 ml								
	03:00 pm			15 ml								
	04:00 pm			15 ml								
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :					Total Output : U-					M-		
6/9/26	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :					Total Output : U-					M-		
7/2/26	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :					Total Output : U-2					M-1		
Total Intake :					Total Output : U-2					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.

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G								
11/7	08:00 am										0	S	
	09:00 am										0		
	10:00 am										0		
	11:00 am										0		
	12:00 pm										0		
	01:00 pm										0		
Total Intake :						Total Output :						6	
	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							

Patient Sticker

FLUID CHART

Sheet No. :

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

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

NURSING CARE RECORD

Date: 5/7/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon							
Night	2am to 8am	Assess the pt condition Monitor the v/s Maintain the I/O Drug as per chart	2am to 8am	Assess the pt condition Monitor the v/s Maintain the I/O Drug as per chart	Now baby is stable	Rechecked the v/s	

000009/04 11:40-11:50/03
 ster SHANKUR VIRANSH
 08-2025 0 Y 11 M 2 D (M)
 SINDHURA MUNUKUNTALA



NURSING CARE RECORD

Date: 6/7/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8AM / 2PM	→ Assess the general condition of pt. → Monitor vitals. → Maintain I/O chart. → Administer medication.	8AM / 2PM	→ Assessed the general condition of pt. → Monitored vitals. → Maintained I/O chart. → Administered medication.	Pt is Stable	Re-assess vitals.	Moutush
Afternoon	2PM / 5PM	Assess the baby about the vitals administer the maintain the w	2PM / 5PM	Assess the baby about the vitals administer the maintain the w	administer medication	Reassess w	San D
Night	8PM / 8PM	Assessed the pt condition - Monitor vitals - maintain I/O chart - medication given as per drug chart	8PM / 8PM	Assessed the pt condition - monitored vitals - maintain I/O chart - medication given as per drug chart	Pt is Stable	Rechecked vitals	

NURSING CARE RECORD

Date:

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8am 2pm	→ Assess the Patient General condition. → check the vital → Maintain I/p chart → Administer the medication as Per doctor order	8am 2pm	→ Assessed the Patient General condition. → checked the vital → Maintain I/p chart → Administer the medication as Per doctor order	→ checked the vital & recorded	pt is stable	Suf Saisxi
Afternoon							
Night							

Patient Sticker

NURSING CARE RECORD



Date:

Goals

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

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



CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	6/7/20 DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0	0	0	0							
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	0	0							
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	NA	0	0							
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	0	0							
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	0	0							
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5	NA	0	0							
Signature of the Nurse				<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>							

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

Signature of Shift In Charge :

Signature : *[Signature]* Name : *[Signature]*

Signature of Ward In Charge :

Signature : Name :

Patient Sticker

CHECKLIST FOR THROMBOPHLEBITIS

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0										
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										
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2										
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										
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										
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5										
Signature of the Nurse													

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

Signature of Shift In Charge :

Signature of Ward In Charge :

Signature : Name :

Signature : Name :



PAIN ASSESSMENT FORM

Date	Time	(W/D)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
6/7/26	1am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Ⓟ
6/7/26	6Am	0/10	NA	☐ Continuous ☒ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	NA	Ⓟ
6/7/26	10AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	Ⓟ
6/7/26	12pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	Ⓟ
6/7/26	10pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Ⓟ
6/7/26	6Am	0	NA	☐ Continuous ☒ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	NA	Ⓟ
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

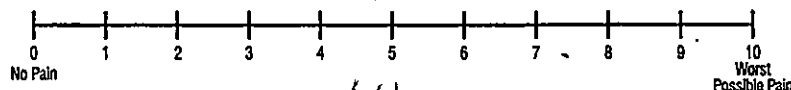
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

Numerical Pain Scale (Obstetric and Gynecology)



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

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

Wong - Baker (Pediatrics) Above 7 Years



0

No Hurt

2

Hurts Little Bit

4

Hurts Little More

6

Even More

8

Hurts Whole Lot

10

Hurts Worst

Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	5/7/26	6/7/26	Fall Risk Grading		
		Score	N ₁	N ₁			
History of Falling (immediately or w/in 3 months)	Yes	25			Risk Level	Morse Fall Score (MFS)	Action
	No	0	0	0			
Secondary Diagnosis (more than one diagnosis)	Yes	15			Low Risk	0 - 24	Standard Fall Precaution
	No	0	0	0			
Ambulatory Aid	Furniture	30			Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	Crutches, Cane(S), Walker	15					
	None /Bed Rest /Nurse Assist	0	0	0			
IV / Heparin Lock or Saline	Yes	20	20	20	High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	No	0	0	0			
GAIT / Transferring	Impaired	20			High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Weak (uses touch for balance)	10					
	Normal /On Bed Rest /Immobile	0	0	0			
Mental Status	Forgets limitations	15			High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Oriented to own ability	0	0	0			
Total Morse Fall Scale Score:			20	20			
Signature			(Signature)	(Signature)			

Tick (✓) whichever precaution taken.

Risk Level and Interventions

Low Risk (0 - 24) (Standard Falls Precautions)

- ☐ Ensure patients use their prescribed eye glasses if any, in the hospital
- ☐ Use chairs with arm rests
- ☐ Use safety straps on stretchers and wheelchairs while transporting patients

Moderate Risk (25-50) Apply all low risk intervention and

- ☐ Assist and/or supervise ambulation. Reinforce to always call for assistance
- ☐ Hourly safety check
- ☐ Assess patient after visitors, leave to ensure safety measures in place

High Risk (≥ 51) Apply all low and moderate risk interventions, and.

- ☐ Initiate constant observation by healthcare provider as appropriate to patient's needs

4



SHIFT HAND OVER FORM

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:			
	Surgery / Procedure:		Post OP Day:			
BACKGROUND	Date	Shift	5/7/26 N1	6/7/26 M6	6/7/26 N1	6/7/26 M1
	Medical Condition (Any special condition to be noted):		—	—	—	—
	Diet:		—	—	—	—
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Ventilation (RA, NP, NIV, VENTI):	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:	Temp:	98.3°F	98.4°F	98.0°F	98.6°F
	Res:	22b/m	40b/m	42b/m	40b/m	
	SpO ₂ :	99%	99%	100	100%	
	Pulse:	132b/m	134b/m	124b/m	132b/m	
	BP:	—	—	—	—	
	LOC:	—	—	—	—	
	Fall Risk Score:	"0"	"0"	—	—	
Pain Score:	"0"	"0"	—	—		
Recommendations	Safety Needs:	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☒ No	☒ Yes ☐ No	☐ Yes ☒ No
	Physiotherapy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Others Specify:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Special Diet:	—	—	—	—	
	Critical Lab Test / Values:	—	—	—	—	
	Other Special Orders / Medications:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	PU Prophylaxis:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	DVT Prophylaxis:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	ADL (Dependent / Non Dependent):	—	—	—	—	
	Post Operative Procedure Special Orders:	—	—	—	—	
Handed Over By Name :		Suganda Mouthash		Simamda		
Signature / ID :		[Signature]		[Signature]		
Date:		6/7/26		7/7/26		
Time:		1pm		8am		
Taken Over By Name :		Mouthash		Simamda		
Signature / ID :		[Signature]		[Signature]		
Date:		6/7/26		6/7/26		
Time:		8AM		8pm		

Patient Sticker

NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:				
	Surgery / Procedure:		Post OP Day:				
BACKGROUND	Date	Shift					
	Medical Condition (Any special condition to be noted):						
	Diet:						
ASSESSMENT	Allergy:		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Ventilation (RA, NP, NIV, VENTI):						
	Tubes/Drains/Catheter:		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs:	Temp:					
		Res:					
		SpO ₂ :					
		Pulse:					
		BP:					
		LOC:					
		Fall Risk Score:					
Pain Score:							
Skin Integrity							
Recommendations	Safety Needs:		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Physiotherapy:						
	Others Specify:		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Special Diet:						
	Critical Lab Test / Values:						
	Other Special Orders / Medications:		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	PU Prophylaxis:		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	DVT Prophylaxis:		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
ADL (Dependent / Non-Dependent):							
Post Operative Procedure Special Orders:							
Handed Over By Name :							
Signature / ID :							
Date:							
Time:							
Taken Over By Name :							
Signature / ID :							
Date:							
Time:							



DRUG CHART

Date of Admission: 6/7/26 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 :				Date Time															
Dose	Route	Frequency	Start Date																
Doctor's Signature		Valid Period	Pharm.																
Additional Instructions:																			

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

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



REGULAR PRESCRIPTIONS

Weight 71kg Ward.

Dr. Dhakshayani
 Verified by
 Dr. Dhakshayani

DRUG : <u>1/ ONDANSETRON.</u>				Date Time	<u>6/7</u>	<u>2/2</u>
Dose <u>15mg</u>	Route <u>iv</u>	Frequency <u>TID</u>	Start Date <u>6/7</u>	Name & Signature of the Doctor Starting the Drugs: <u>Al</u>		
Additional Instructions:				<u>2pm</u> <u>10pm</u> <u>6</u>		
Daily Doctor's Endorsement by a Sign						
DRUG : <u>1/ ESOMOPRAZOLE</u>				Date Time	<u>6/7</u>	<u>2/2</u>
Dose <u>40mg</u>	Route <u>iv</u>	Frequency <u>OD</u>	Start Date <u>6/7</u>	Name & Signature of the Doctor Starting the Drugs: <u>Al</u>		
Additional Instructions:				<u>6am</u> <u>2pm</u> <u>6</u>		
Daily Doctor's Endorsement by a Sign						
DRUG :				Date Time		
Dose	Route	Frequency	Start Date	Name & Signature of the Doctor Starting the Drugs:		
Additional Instructions:						
Daily Doctor's Endorsement by a Sign						
DRUG :				Date Time		
Dose	Route	Frequency	Start Date	Name & Signature of the Doctor Starting the Drugs:		
Additional Instructions:						
Daily Doctor's Endorsement by a Sign						

Weight: Ward:



Date Time									
		Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.	

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses

Weight. 57kg Ward.

[illegible]



MEDICATION RECONCILIATION FORM

Drug Allergies: Nil ☐ Not known any Drug Allergies

Medication Reconciliation will be done at the time of admission and also whenever there is change in the treating team or shifting from one unit to another unit.

(Example: at the time of admission shifting from ICU to Ward, or Ward to ICUs)

Shifting From: ER Shifted to: ward

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

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: Dr. Anusha

Date & Time: 5/7/26 @ 11:30pm

Nurse Name & Signature: Bhargava

Date & Time: 5/7/26 @ 11:35pm

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



wt - 7.6 kg

EMERGENCY ROOM TRIAGE FORM

Patient's Name: Master Shankur Viranish Age: 11 mo

Gender: ☒ Male ☐ Female

Date: 05/07/26 Time of Arrival: 10:30 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: 97.7°F PR: 109 bpm BP: RR: SpO₂: 99%

Chief Complaints: C/O vomiting since 1 hour 3 episodes

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

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

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

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian: [Signature]
Triage Completion Time: 10:32 PM

Communicable Disease Triage Screening

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

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

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

- Have you travelled outside the INDIA? or had close contact with someone who has recently travelled outside the INDIA, in the past two weeks? ☐ Yes ☒ No
If yes, State Location:
- Are your parents / close contacts at home is/a healthcare worker? {please encircle the choices} (e.g., nurse, physician, ancillary services personnel, allied health services personnel, hospital volunteer, or laboratory worker, others) who has had a recent exposure to an individual with a highly communicable disease or unexplained, severe febrile respiratory or rash disease? ☐ Yes ☒ No

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

- ☐ Any patient with Fever / Rash / Vesicles / Discharge from Eyes and Cough
- ☐ Any patient with fever and respiratory symptoms who answered "YES" to any of the questions on epidemiologic risk factors in "PART B" of the triage screening above.

PART D. ACTION / INTERVENTION: (for positive suspected communicable disease triage screening)

- ☐ Patients should be immediately isolated in a negative pressure room or a single room (as appropriate) for pending evaluation.
- ☐ The patient should be given a surgical mask immediately, if not already wearing one.
- ☐ Both patient and triage staff should perform hand hygiene.
- ☐ The staff should use PPE (as appropriate).

Name of Triage Nurse: Beabin

Signature of Triage Nurse: [Signature]

Date & Time: 05/07/26 @ 10:32 PM

1
2
3



NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 5/7/26 Time of arrival : 10:34pm
Chief Complaints : Clo. vomitings since 1 hour 3 episodes
Height : Weight : 7.6kg Head Circumference (<2 years)
Allergies: ☐ Yes ☒ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other:

If yes, identify

Pain Screening: ☐ Yes ☒ No If Yes, Pain Score: Pain Tool Used: ☐ N Pass ☐ FLACC ☐ Wong Baker
☐ Character ☐ Location ☐ Frequency ☐ Duration

RISK FOR FALL:

If patient is < 6 years ☐ Yes ☒ 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 ☐ Yes ☒ No

Ambulatory Aids:

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

Gait/Transferring:

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

Mental Status: Forgets limitations ☐ Yes ☒ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening: ☒ No Abnormalities Detected

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

Inform consultant for positive criteria

Nutritional Screening: ☒ No Abnormalities Detected

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

Inform consultant for positive criteria

Psychological Screening: ☒ No Significant Findings

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

If Yes Consultant Notified: (Date/Time):

Social History: Lives With family

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

Time of Initial assessment completed by ER Nurse :

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

Time	Nursing Notes
10:36pm	Assess the pt condition monitore the vitals

Samples collected by:

Time:

Samples sent by :

Time:

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1
10:35pm	ondem	po	3 ml		✗

Condition of patient at time of shift - out :	Details of Shift - out
HR: 109b/m BP: CFT: RR: SPO2 at FiO2: 99% GCS: Temperature : 97°F Pain Score: Repeat RBS (if applicable):	Shift - out from ER to: ward Time of Shift - out: 1:21am Handover given to: Sumin (Nurse's Name)

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any):

IV placement done

Name of the Nurse : Bhargava

Signature of the Nurse : 

Date & Time : 5/12/2023 @ 10:38pm

211

NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 6/7/26 Time: 10 AM

Weight: 7 kg Centile: 5th

Height: Centile:

Inference: underweight child

RDA: Calories: 98 kcal/kg/d Protein: 1.6 gms/kg/d

Diet Recommendations: High fiber diet & more liquids

Re-Assessment: Avoid Spicy, chilled & outside foods

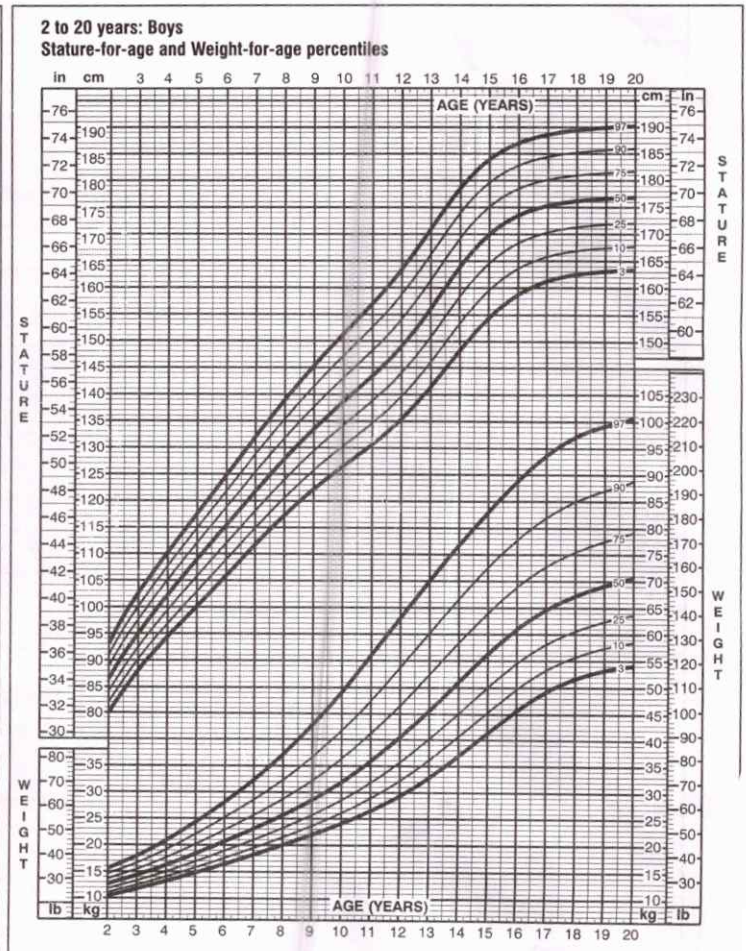
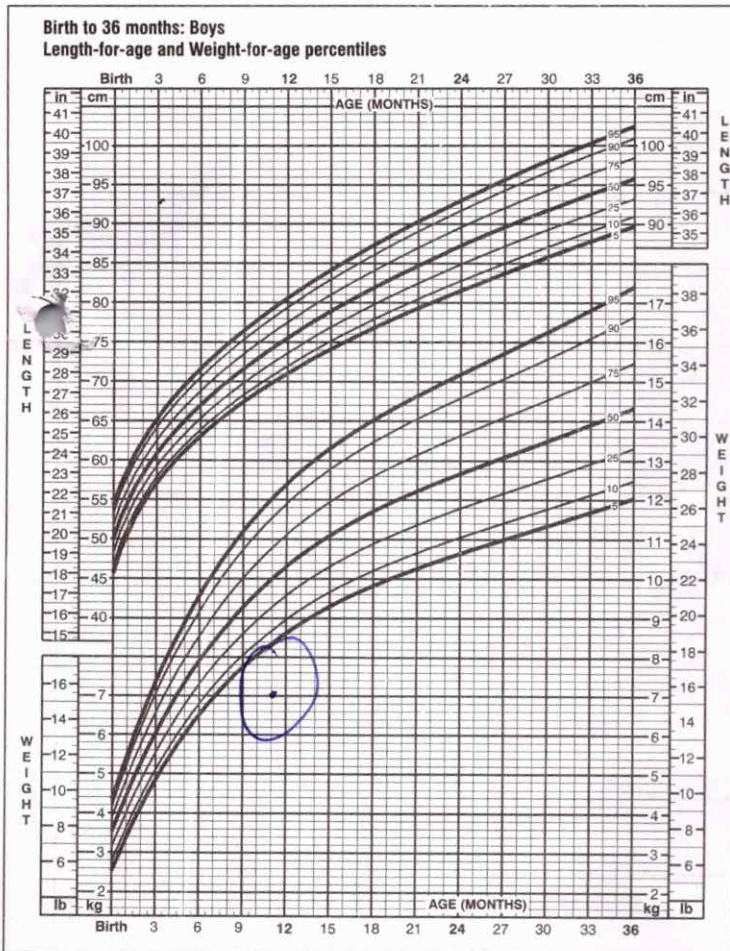
Food Allergies: NO Veg/Non-veg: NON-Veg.

Diagnosis: Severe Acute Gastritis & Dehydration

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: Shivan

GROWTH CHART (BOYS)



Dietician's Name: Sathwika G

Dietician's Signature: S

This image shows a single sheet of white paper with horizontal blue or grey ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.