DISCHARGE SUMMARY

Name	Baby Of DIVYA KOYALKAR	**UHID**	HNH-00006395
Father/Guardian	Mrs SAINATH GOWLIKAR	**Age/Gender**	1 Y 3 M 19 D/ Male
Address	16-2-146/28/1, Malakpet Colony, Hyderabad, Telangana, INDIA, 500036		
IP No	IP26-00006327	**Admission Date**	12-05-2026
Ref Doctor	Self.		
Discharge Date	14.05.2026		

Dr. PRITESH NAGAR **MBBS, MD** CONSULTANT PEDIATRICIAN & PEDIATRIC INTENSIVIST Reg No. 47184	**Dr. ANIKET ANIL PARASHAR** MBBS- MD CONSULTANT PEDIATRICIAN TSMC/FMR/08568

DIAGNOSIS	**ICD CODE**
INFLUENZA A ILLNESS WITH COMPLEX FEBRILE SEIZURES	

History: Baby Of DIVYA KOYALKAR, 1 Y 3 M 19 D old boy presented with history of fever since 1 day, 1 episode of uprolling of eyes, jerky tonic-clonic

Name	Baby Of DIVYA KOYALKAR	UHID	HNH-00006395
IP No	IP26-00006327	Admission Date	12-05-2026

movements of right upper limbs, frothing from mouth lasting for 1-2 mins, post ictal drowsiness present at home and 1 episode of convulsion in ER, in form of staring look lasting for 5-10 sec, post midazolam spray seizure aborted and later he was admitted at Rainbow Children's Hospital for further management.

Examination: He was febrile (101.6), maintaining saturations at room air & hemodynamically stable. Heart rate was 178/min and Respiratory Rate - 32 /min. Peripheries were warm, pulses well felt. On auscultation of chest, air entry was bilaterally equal. Heart sounds were normal and there was no murmur. Abdomen was soft with no organomegaly.

On neurological examination, child was drowsy & irritable. Pupils were bilaterally equal and reacting to light. There were no focal neurological deficits, no meningeal signs and no signs of raised intracranial pressure.

Weight on admission: 9.5 kgs.

Investigations: Enclosed reports.

VBG showed pH - 7.30, pCO2- 39.5 mmhg, pO2 - 35 mmhg, HCO3 - 18.4 mmol/l, BE: -7.2 mmol/l.

Adenovirus PCR test was sent, which was negative.

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

SARS-CoV-2	NEGATIVE
Influenza A	**POSITIVE**
Influenza B	NEGATIVE
Respiratory Syncytial Virus (RSV)	NEGATIVE

Name	Baby Of DIVYA KOYALKAR	**UHID**	HNH-00006395
IP No	IP26-00006327	**Admission Date**	12-05-2026

Date	**On 12.05.2026**
TEST	**Result**
CBP: Hemoglobin	12.1 g/dl
While blood cell	10970 cell/cmm
Platelets	2.42 lakh/cmm
CRP	17 mg/L
Magnesium	2.1 mg/dl
Calcium	9.8 mg/dl
BLOOD CULTURE	No growth after 24 hours of incubation

Management: He was admitted in PICU in view of complex febrile seizure and was started on IV fluids and IV antibiotics after sending blood culture.

In view of fever, nasopharyngeal swab for 5 virus respiratory panel was sent, which showed Influenza A virus positive. Child was started on Oseltamivir for the same.

Name	Baby Of DIVYA KOYALKAR	UHID	HNH-00006395
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Paediatric neurologist Dr. Abhishek jain opinion was taken who advised to give levetiracetam loading dose.

He was regularly monitored for his hemodynamic status, oxygen saturations and vital parameters. As he remained hemodynamically stable, maintaining saturations at room air, accepting orally well, he was shifted to ward for further management.

During ward stay he was regularly monitored for his neurological status, hemodynamic status, oxygen saturations and vital parameters.
There were further seizures were noted during hospital stay.

As he remained hemodynamically stable, accepting orally well, hence he is being discharged with the following advice.

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

Medication during hospital stay:
Tablet. Frisium
Injection. Amoxiclav
Syrup. Crocin DS
Syrup. Fluvir

Advice:
* Diet as advised.

Name	Baby Of DIVYA KOYALKAR	**UHID**	HNH-00006395
IP No	IP26-00006327	**Admission Date**	12-05-2026

S.No	MEDICATION	DOSE	TIMINGS	DURATION
1	Syrup. AUGMENTIN DUO (Amoxycillin 400 + Potassium Clavulanate 57 mg/5ml)	2.5ml	8am-8pm (after food)	For 3 days
2	Syrup. FLUVIR (OSELTAMIVIR – 5ml/60mg)	2.5 ml	9am-9pm (after food)	For 3 days.
3	Tab. FRISIUM(Clobazam-5mg)	1/2 tablet	6am-6pm	for today evening dose.
4	Nasoclear nasal drops, 2 drops in each nostril **SOS** for nose block			

Plan: To collect final blood culture report on followup.

Febrile Seizure Prophylaxis:
* Syrup. Crocin DS (Paracetamol = 5ml/240mg) 3 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 = 5mg), 1/2 tablet twice daily for 3 days every time with fever.
* Midacip- nasal spray (Midazolam = 1.25 mg/puff), 1 puff in right nostril) for future seizures.

Review consultation with Dr. ANIKET ANIL PARASHAR **on Saturday(16.05.2026)** at Himayatnagar in OPD with prior appointment

Name	Baby Of DIVYA KOYALKAR	**UHID**	HNH-00006395
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(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.
* **Anticonvulsants** along with food decreases absorption of nutrient vitamin D, K B6, B12, folate, calcium stores. Anticonvulsants can be taken at least one hour before food & recommended diet to be followed.

Follow up immediately in Emergency Room in case of any emergency like high grade fever, vomiting, breatlessness, refusal to feed occurs or any abnormal movements.

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

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Name	Baby Of DIVYA KOYALKAR	UHID	HNH-00006395
IP No	IP26-00006327	Admission Date	12-05-2026

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Registrar/Resident/C.M.O

Dr. ANIKET ANIL PARASHAR
MBBS - MD
TSMC/FMR/08568, dr.aniket.p@rainbowhospitals.in

HNH-00006395 IP26-00006327
Baby Of DIVYA KOYALKAR
24-01-2025 1 Y 3 M 18 D (M)
Dr. ANIKET ANIL PARASHAR

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DEFICIENCY CHECK LIST OF CASE SHEET

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

Signature and Date : 14/05/2026

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

(P.T.O)

Rainbow Children's Hospital

BirthRight by Rainbow

Rainbow Childrens Hospital-Himayatnagar

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

ADMISSION SHEET

Registration Details :

Admission No : IP26-00006327 **Admit Date** : 12-May-2026 **Admit Time** : 09:08 AM **UHID** : HNH-00006395

Patient Details :

Patient Name	: Baby Of DIVYA KOYALKAR	**Age**	: 1 Y 3 M 18 D
Guardian	: Mrs SAINATH GOWLIKAR	**DOB**	: 24-01-2025 05:28 AM
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: 16-2-146/28/1 Malakpet Colony Hyderabad Telangana INDIA 500036	**Phone No**	: 9866800629
		E-mail	: na@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 : Mrs SAINATH GOWLIKAR **Relationship** : Father

Contact Address : 16-2-146/28/1 Malakpet Colony Hyderabad Telangana INDIA 500036 **Phone No** : 9866800629 / 9394991894

Signature

Doctor Details :

Doctor Name : Dr. ANIKET ANIL PARASHAR **Specialisation** : GENERAL PEDIATRICS

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

Co-Consultant :

Payment Details :

Payment Mode : DC/CC Card **Deposit Amount** : 10000.00

Payor Name : BAJAJ ALLIANZ GENERAL INSURANCE CO LTD.

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ACTIVITY RECORD FOR BILLING

HNH-00006395 IP26-00006327
Name: - Baby Of DIVYA KOYALKAR
24-01-2025 1 Y 3 M 18 D (M)
Dr. ANIKET ANIL PARASHAR

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

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
12/5/26	9:55Am	ER	PICU	AD
13/5/26	10.43am	PICU	210	Sujatha / Abusk.

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1.	Dr. Abhishek	12/5/26	9272	
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

INVESTIGATIONS

Date	Investigations	Order No.	Sign
12/5/26	CBP, LRP, calcium magnicium	8042	
	VBG	8043	
	Respanitory Pannel	8042	A.D
12/5/26	Blood cls	8055	
		Cross checked done by	
		Anjuthe c 2Am	

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
12/5/26	Invasive Monitor				
10:30 am	Infusion Pump	10.30 am	13/5/26	9264	
			Cross	checked	done

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
12/5/26	IV canula	1	99291	A.D
12/5/26	NHA	1	9268	&
		Cross	checked	done by
			Amrutha	

ANY OTHER INFORMATION

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

Ref.No. F/IN/PR/10

Rainbow® Children's Hospital

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name : HNH-00005395 IP26-00006327
Baby Of DIVYA KOYALKAR
24-01-2025 1 Y 3 M 18 D (M)
Dr. ANIKET ANIL PARASHAR

Patient ID# :

Consultant :

Final Diagnosis :

Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Informant _____ Reliability _____

Chief Presenting Complaints & Duration (Chronologically):

C/o fever since 1 day
C/o seizure like activity x 1 day
~~upon~~ ET

History of present illness :

Pt was apparently alright 1 day before then had fever, on & off type, mod - high degree.

C/o 1 episode of upwelling of eyes to L for movements of Rt upper limbs noting from mouth lasted for 1-2 minutes.

Postictal drowsiness (+)

1 episode of Convulsion in ER, in form of Stony load lasting for 5-10 sec post midazolam spray, seizure aborted

C/o irritability post seizure.

Pediatric Multiorgan History & Physical Examination

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

Nothing significant.

Birth & Neonatal History :

NAD.

Birth & Socio Economic History :

About Father :

About Mother : —

Any additional Information :

Developmental History :

Developmentally normal.

Immunization History :

Immunized till 15M of age.

Pediatric Multiorgan History & Physical Examination

Anthropometry

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

Weight (kgs) 9.5 kg. (Centile _____)

On Examination :

Temperature : _____ Pulse Rate: _____ Description _____

B.P. _____ SPO2 _____ at _____

Resp. rate and type of breathing : _____

Rash (-)

Lymphadenopathy (-)

Oedema : (-)

Respiratory system :

Inspection (any s/o distress) : _____

Air entry & breath sounds : B/L NVBS.

Any addes sounds : _____

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

Cardiovasclular System :

Inspection of procordium : _____

Heart Sounds : $S_1 S_2$ heard

Any murmur : _____

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

Per Abdomen :

Inspection _____

Palpation : Soft non tender.

Ausculation : _____

Spine: _____ External Genitelia : _____

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

Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS Score : 13/15, Drowsiness (+)

Cranial Nerves : (N)

Motor System :

Nutrition :

Tone : Power

Co-ordinator :

Posture : (N)

Involuntary Movements :

Reflexes : (P)

DTR **Superficials :**

Plantars

Sensory System : Normal

Bladder / Bowel :

Clinical Summary & Diagnostic :

~~Sepsis~~ Complex febrile Seizure (1st episode)

Preventive aspects of the treatment :

Desired goals of the treatment :

Planned Labs :

- CBP, CRP, VBG
- Blood C/S. ~~with~~ L/H
  CUE
- Sr. Calcium. levels
- Sr. Magnesium levels
- Respiratory panel (5 Virus)

1 Extra plain Sample

Planned Management :

- IVF DNS. 2/3 M
- Tab. Frisium 5mg BD. X 3 days.
- Inj. Amoxiclav.

Please fill up the following details

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

Doctor's Signature Name _____ Date 12/6/26 Time _____

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

HNH-00006395 IP26-00006327
Baby Of DIVYA KOYALKAR
24-01-2026 1 Y 3 M 18 D (M)
Dr. ANIKET ANIL PARASHAR

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	10:05am 12/02/26 Counselled. (Fits) — Likely related to fever Reason Vaccine / Any other reason 2 times → observation 24–48h If again repeat ↓ NO Fever ↓ → No problem Yes Fever ↑	Fever ✗ Yesterday afternoon Vaccinated yesterday evening Fever ↑↑ 6:30am → Seizure Fits — Yashoda (Here) = ⁉ Right Focal Febrile myoclonus → Further evaluation SOS Scan CSF analysis

Dr. Ashish Nagar
Consultant Pediatrician & Intensivist
Reg. No: 47184

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

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
12/5/26 10:15 Am	S/B Dr. Pritesh/Aniket	
	Δ Complex febrile seizure	
	HR - 176/min	Plan
	SpO2 - 96% on RA	
		- Inj. LEVETIRACETAM
	BP - 98/66 (75)	400mg IV stat Loading dose 40mg/kg/dose
	CVS - S1, S2 ⊕	
	RS - B/L - AE ⊕	
		- T. FRISIUM
	CNS:- drowsy	Syr [illegible] BD
	Temp:- 104°F	- Crocin 6th hrly
	Right focal seizures ↓ 2 episodes	- w/f seizures
		- Paed Neurologist opinion
		- Trace Resp. panel

Dr. Nitesh Nagar
Consultant Pediatrician & Intensivist
Reg. No: 47184

Noted by Vaishnavi

HNH-00006395 IP26-00006327
Baby Of DIVYA KOYALKAR
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
12/5/26 2 30pm.	c/s/by Dr Anusha	
	Complex febrile Seizure	
		No furth fever.
	HR = 145/min SpO2 = 97% RA RR = 37/min. BP = 87/58 (66) mmHg	– 4 taking orally well → Next feed ↓ taper IV 20ml/h (1/2 M)
		Plan
	R/s B/L AE (+) NVBS. No added sounds.	– w/f activity / GCS / furth seizure.
		– Temp Monitoring
	CNS child active → taken DBF/FF	– ct LEVITERACITAM Maintainance done (to decide after Evening Rounds)
		– ct FRISIUM. CROSIN DS Q6thly.
	4 flu Neg Send Dengue NS1 ←	– (T) Resp panel Bl c/s.
(sign)		– Monitor Temp, vitals

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

(P.T.O)

HNH-00006395 IP26-00006327
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
12/5/26	S/B Dr. Pritesh	
4:40pm	Δ Complex febrile seizures.	Plan
	No further seizures	C/t AMOXYCLAV
	Fever spikes (+)	
No RD		C/t CROCIN 6th hly
U/O ✓	CVS - S1S2 (+)	
SpO2 ok	PA - BS - AE (+)	- w/f seizure
	P/A - soft	- Monitor vitals
	tonsillitis	
Feeding ✓		
Resting HR 140 when fever ↓		

Dr. Pritesh Nagar
Consultant Pediatrician & Intensivist
Reg. No: 47184

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
12/5/26 4:45PM	Counselled	
	Report – Flu +ve	Blood Reports ok
	Contact – High Fever → Fits	
	No fits till now	
	Flu Rx – Syrup start Fluids Fits Med	48h Effect Fever expected
	T/M → fits x Fever ok Comfortable	→ If all ok Shift Room.
		Fever Related fits – 5-6yr Age Risk
		Fever Precautions – PCM, Clobazam

Dr. Pritesh Nagar
Consultant Pediatrician & Intensivist
Reg. No: 47184

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/05/2026 10:15pm	S/B Dr. Sindhuna	
	Influenza A illness	
	Complex febrile seizures	
	- Fever spikes (+)	Plan
	- Oral intake - fair	(1) Ct same as per chart.
	Chest clear	
	P/A - soft	
	HR - 150/min	
		Sindhuna BHAVANA M
		Noted by [illegible]

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

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
13/5/26 7:30am	c/s/B Dr. Tharun	
	Influenza A illness c complex febrile seizures.	
	- fever spikes (+)	
	[last spike at 5am 100.6]	
	- oral intake : fair.	
	- No further seizures.	
	O/E	
	HR : 132bpm	
	RR : 36cpm	Plan
	SpO_2 : 100%.	1) ct - amoxiclav
	RS : BAE (+)	ferrous
	clear	ferrium
	CVS : S_1S_2 (+)	2) trace adenovirus
		Blood c/s.
		3) STOP IVF
	[signature]	4) monitor vitals.

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
12/5/26 9:30 AM	S/B Dr. Pritesh / Dr. Aniket Δ Complex febrile seizures Influenza A Illness. Plan	
	Fever spikes ⊕ No further seizures.	- IT AMOXYCLAV
		- CT CLOBAZAM
	HR - 124/min SpO2 - 98% on RA	- Stop IV fluids
		- CT CROCIN 6th hly
	CVS - S1 S2 ⊕ RS - BL - AE ⊕	- Shift to ward.
	Sleeping.	N/B ✓

Dr. Pritesh Nagar
Consultant Pediatrician & Intensivist
Reg. No: 47184

HNH-00006395 IP26-00006327
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Dr. ANIKET ANIL PARASHAR

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9:30am 13/05/26	Counselled	
	Stable No fits	Feeding better Fluids stop
	Shift Room	Fever better
		(>48hrs) → Response ✓
		NIB Sug Hr

Dr. Pritesh Nagar
Consultant Pediatrician & Intensivist
Reg. No: 47184

HNH-00006395 IP26-00006327
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
13/5/26, 4:30PM	S/B Dr. Sreejhan	Plan
	Δ Complex Febrile Seizures	
	Influenza A	- Cf AMOXYCLAV
		- cf FLUVIR
	CVS - S1S2 ⊕	
	RS - BL-AE ⊕	- Encourage orally
	P/A - Soft	
	Cons/Conv	
	13-5y	
13/5/26 6 30pm.	c/s/by. Dr Aniketh Sir	
	Complex febrile Seizure.	
	Influenza A.	
	Child active	
	No further [illegible]	Plan
	vital stable	- ct Antibiot
		flouir
	S/E B/L AE (+)	
	NVBS (+)	- Enhance orally
		- Monit vitals
	Dr. Aniket Anil Parasher Consultant Paediatrician & Intensivist Reg. No: 8568	Dr. R. Aniket P

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/5/26 TAM.	c/s/hy. Ds Anuch / Ds Varun	
	Complex febrile Seizure. Influenza A illness.	
	- Child Active - fever absent. Activity - Good. Intake - Good.	
	- vital stable	Plan - ct Amoxyclav. - Fluvir Syp
	SLG R/S B/L AE (+) NVBS (+)	- Enhance orally.
		- Monitor vitals. - D/S today.

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
14/1/16 10 Am	S/B Dr Aniketh	Plan
	Δ Influenza A illness	
	c̄ complex febrile seizure	
		- Amoxyclav - 3 day
	Afebrile	
	No further seizure	- Discharge
	CVS - S1 S2 ⊕	- F/up on Saturday
	RS - B/L AE ⊕	
		- FLUVIR - 3 day
	P/A - soft	
	Conscious	for Dr Aniketh
		(Dr Sagar)

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

HNH-00006395 IP26-00006327
Baby Of DIVYA KOYALKAR
24-01-2025 1 Y 3 M 18 D (M)
Dr. ANIKET ANIL PARASHAR

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CROSS CONSULTATION FORM

Doctor Name : Dr. Abhishek Date : 12/5/26 Time : 10:30 Am

Diagnosis : Complex Febrile Seizure

Hospital : RCH-HMNR

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

Type of Referral :
☐ Emergency
☐ Urgent
☐ Non Urgent

8

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

Signature:

Findings and Recommendations :

C/o 1) Fever since yesterday
4-2 Episodes of focal seizure
↓
(Rt) side upper limb
& frothing from mouth
lasting for 1-2 minutes
Post-ictal drowsiness (+)
↓
treated in outside hospital
↓
1 more episode in ER
Staring look lasting for 10 seconds
Irritability post seizure

8

Rx
- Inj. LEVETIRACETAM 400mg IV loading dose
- Plan EEG later.

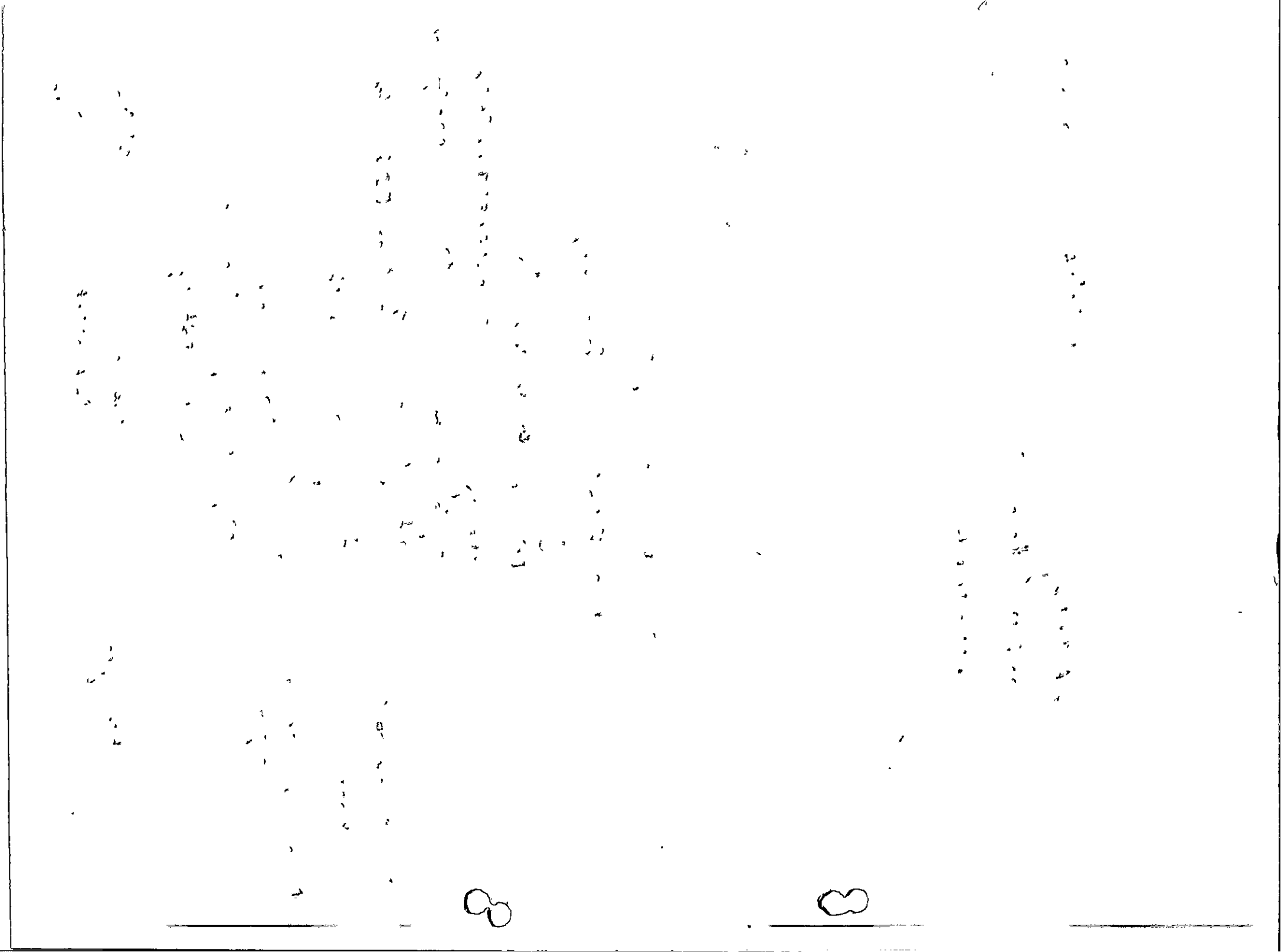
Developmentally normal.

Δ Complex Febrile Seizure

Consultant :

Name : B. Sneghan Signature : [signature] Date & Time : 12/5/26

Dr. Abhishek 10:30 Am



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MEDICATION RECONCILIATION FORM

Drug Allergies: ..... ☐ Not known any Drug Allergies

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

Shifting From: ER Shifted to: PICU

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. Navpurya

Date & Time : 9:30 Am

Nurse Name & Signature: Anupam

Date & Time : 9:30 Am.

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

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DRUG CHART

Date of Admission: 12/5/26 Drug Allergies: .... ☐ ~~Not known~~ any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

DOCTOR - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
- Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
- Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
- Discontinue a drug by drawing a line / 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: Syp. Crocin DS				Date / Time
Dose	Route	Frequency	Start Date	
3ml	PO	>100°F	12/5	
Doctor's Signature		Valid Period	Pharm.	
[signature]			[signature]	
Additional Instructions:				

DRUG: Syp. ibugesic.				Date / Time
Dose	Route	Frequency	Start Date	12/5
2.5ml	PO	>102°F	12/5	10:30am [signature]
Doctor's Signature		Valid Period	Pharm.	6pm [signature]
[signature]			[signature]	
Additional Instructions:				1:[illegible] pm [signature]

DRUG: MIDACIP Spray				Date / Time
Dose	Route	Frequency	Start Date	
	nasal.	SOS	14/5	
Doctor's Signature		Valid Period	Pharm.	
[signature]			[signature]	
Additional Instructions: 1.25g/ puff — 1 puff (Rt) nostril.				

Verified by Dr. Dhakshayani

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REGULAR PRESCRIPTIONS

Weight. 9.5 kg. Ward. ....

DRUG : T. Frisium				Date / Time	12/5	13/5	14/5
Dose	Route	Frequency	Start Date				
5mg	PO	BD	12/5	8AM	Home		
Name & Signature of the Doctor Starting the Drugs:							
Additional Instructions: → ½ tablet				8pm			
Daily Doctor's Endorsement by a Sign							

DRUG : Inj. Amoxiclav.				Date / Time
Dose	Route	Frequency	Start Date	
200mg	IV	TID	12/5	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

DRUG : Inj. AMOXICLAV				Date / Time	12/5	13/5	14/5
Dose	Route	Frequency	Start Date				
300mg	IV	TID	12/5	7AM	11AM		
Name & Signature of the Doctor Starting the Drugs: B. Singh				3pm	4pm		
Additional Instructions:				11pm			
Daily Doctor's Endorsement by a Sign							

DRUG : Syp. CROCIN-D				Date / Time	12/5	13/5		Stop
Dose	Route	Frequency	Start Date					
3ml	oral	6th	12/5	6pm				
Name & Signature of the Doctor Starting the Drugs: B. Singh				12pm				13/5
Additional Instructions: Paracetamol (Suspension)				6pm				
				12AM				
Daily Doctor's Endorsement by a Sign								

Verified by Dhakshayani

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REGULAR PRESCRIPTIONS

Sheet No: .... Weight 9.5kg Ward ....

DRUG : Syp. FLUVIR				Date / Time	12/5	13/5	14/5
Dose	Route	Frequency	Start Dt.				
2.5ml	oral	BD	12/5	7am	X		[signature]
Name & Signature of the Doctor Starting the Drugs: B. Sreeylay							
Additional Instructions: OSELTAMIVIR (5ml/60mg)				7pm	[signature]	[signature]	
Daily Doctor's Endorsement by a Sign					[signature]	[signature]	

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

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

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

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

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Sheet No: ....

REGULAR PRESCRIPTIONS

Weight .... Ward ....

DRUG :

Date ➤ / Time ▼

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Date ➤ / Time ▼

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Date ➤ / Time ▼

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Date ➤ / Time ▼

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

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

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

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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
12/5	9:30 AM	Midazolam Spray	3 Puffs.	Nasal		
12/5	10:30 AM	LEVETIRACETAM	400mg over 30 mins	IV		

Page: 3/4 (P.T.O)

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I.V. FLUIDS CHART

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

Date	Time	Composition of I.V. Fluid (mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
12/1/5	10 PM	IVF DNS (2/3 M)	IV	25ml/hr			12/1/26		
12/1/5	9 PM	IVF DNS (2)	IV	20ml			13/1/5		

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

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RESULT SHEET

Date	12/5/26					
Time	9:45					
Hb	12.1					
PCV	33.7					
RBC	4.96					
WBC	10.97					
N/L	76.0/20.4					
Platelets	242					
CRP	17					
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg	9.8/2.1					
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						

(P.T.O)

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						
influenza A	positive.					
~~Adenovirus~~ —	Not	detected.				

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

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IBH / FRM / CLINICAL / 125

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

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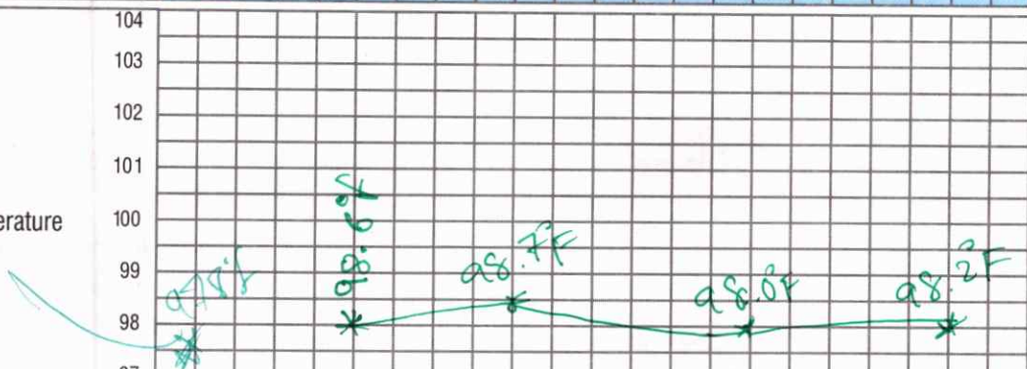
LY WARNING SCORE: CHILDREN'S UNIT

Date : 13/5/26 Time: 9pm 6pm 10pm 2Am 6Am

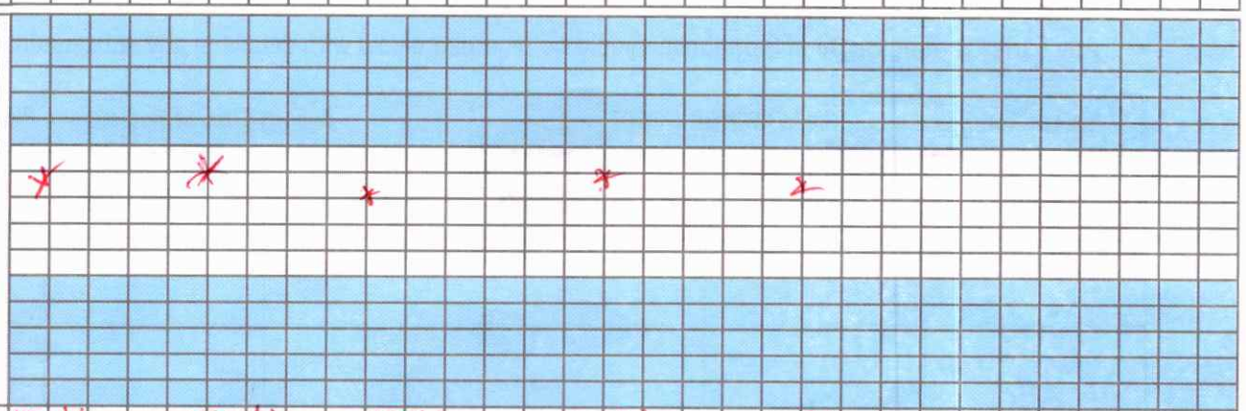
Doctor / Nurse / Family Concern?

Temperature (F)



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

Note: BP does not score in early warning scoring



Heart Rate (Number)	130b/m	132b/m	130b/m	128b/m	125b/m

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

Resp Rate (Number)	31b/m	34b/m	33b/m	32b/m	35b/m
Resp Distress: Mod/ Severe / None / Mild					
Receiving O_2 (l/min) O_2 Saturations (%)	99%	100	100%	99%	100%
Conscious Level: Normal / Altered					
GCS *					
TOTAL SCORE Number of shaded boxes	0	0	0	0	0
Pain Score	0	0	0	0	0
Observer's Initials	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

ACTIONS

NB: Scores 3 should be recorded overleaf

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

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

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

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FLUID CHART

Sheet No. : .....

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

Date	Time	Intake: Nature of Fluid	Intake: Route – Mouth	Intake: Route – I.V	Intake: Route – N.G	Output: NG	Output: Diarrhoea	Output: Vomit	Output: Drainage	Output: Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
13/5/26	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm		milk.									
	01:00 pm											
Total Intake :						**Total Output :**						
13/5/26	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						**Total Output :** U- 2 M-						
13/5/26	08:00 pm											
	09:00 pm											
	10:00 pm		KGClot + Milk									
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						**Total Output :** U- 2 M- 1						
14/5/26	02:00 am											
	03:00 am											
	04:00 am		Milk									
	05:00 am		H2O									
	06:00 am											
	07:00 am											
Total Intake : Talah						**Total Output :** U- 2 M-						

Total 24 hrs. Intake		Total 24 hrs. Output	

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FLUID CHART

Sheet No. : .....

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

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

Total 24 hrs. Intake		**Total 24 hrs. Output**	

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NURSING CARE RECORD

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Date: 13/5/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8Am 2pm	→ Assess the baby condition. → stop IV fluids. → continue Crocine 6th hourly. → maintain I/o chart.	8Am 2pm	→ Assessed the baby condition. → stoped IV fluids. → continued crocine 6th hourly. → maintained I/o chart.	Baby is stable now	→ Reassessed the vitals	
Afternoon	2pm ↓ 8pm	⇒ Assess the baby condition ⇒ Monitor vitals & record ⇒ Continue crocin ⇒ Maintain I/o Chart	8pm to 8pm	⇒ Assessed the baby condition ⇒ monitored vitals & recorded ⇒ continue crocin ⇒ Maintained I/o chart	Baby is stable	Rechecked vital	
Night	8pm to 8Am	→ Assess the baby condition → Monitor the vitals → Maintain I/o chart → Administer medication as per drug chart	8pm to 8Am	→ Assessed baby condition → monitored vitals → Maintained I/o chart → Administered medication as per drug chart	Baby is stable	re-checked vitals	

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NURSING CARE RECORD

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Date: .....

Goals

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

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

HNH-00006395 IP26-00006327
Baby Of DIVYA KOYALKAR
24-01-2025 1 Y 3 M 18 D (M)
Dr. ANIKET ANIL PARASHAR

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NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. [illegible] Department: PICU Date of Admission: 12/5/26

SITUATION

Diagnosis: Febrile Seizure

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

BACKGROUND

Area / Shift Time	12/5/26 M6	12/5/26 E2	12/5/26 N1	13/5 M6	13/5 E2	13/5 N1
Medical Condition (Any special condition to be noted):	Seizure	seizures	seizures	seizures.	seizures	seizures

ASSESSMENT

Allergy:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
Tubes/Drains/Catheter:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
Vital Signs: Temp:	104.5 f	103.5°F		98.6°F	98.6°F	98.7°F
Res:	56 bpm	42.3°F	39.6/m	34 b/m	38 b/m	35 b/m
SpO_2:	100%	98%	99.1°F	100%	100%	100%
Pulse:	166 b/m	172 b/m	169 b/m	140 b/m	140 b/m	100/65
BP:	100/60	.	—	—	—	—
Fall Risk Score:	—	—	—	—	—	—
Pain Score:	—	—	—	—	—	—

Recommendations

Safety Needs:	Yes	Yes	Yes	Yes.	Yes	Yes
Physiotherapy	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
Others Specify:	—	—	—	—	—	—
Special Diet:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
Other Special Orders / Medications:	NA	NA	NA	—	—	—
Post Operative Procedure Special Orders:	NA	NA	NA	—	—	—
Handed Over By Name :	Vinitha	Sunitha	Renuga	mahi	Swetha	Anusha
Signature :						
Date:	12/5/26	12/5/26	13/5/26	13/5/26	13/5/26	14/5/26
Time:	2pm	8pm	8 PM	2pm	8pm	8AM
Taken Over By Name :	Sunitha	Renuga	mahi	Swetha	Anusha	
Signature :						
Date:	12/5/26	12/5/26	13/5/26	13/5/26	13/5/26	
Time:	2pm	8 pm	2 PM	2 PM	8pm	

Patient Sticker

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NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: ..... Department: ..... Date of Admission: .....

SITUATION	Diagnosis:				Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:		
BACKGROUND	Area / Shift Time						
	Medical Condition (Any special condition to be noted):						
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:						
	Res:						
	SpO_2:						
	Pulse:						
	BP:						
	Fall Risk Score:						
	Pain Score:						
Recommendations	Safety Needs:						
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:						
	Special Diet:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:						
Post Operative Procedure Special Orders:							
Handed Over By Name :							
Signature :							
Date:							
Time:							
Taken Over By Name :							
Signature :							
Date:							
Time:							

HNH-00006395 IP26-00006327
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BRADEN 'Q' SCALE

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					Date :	12/5	12/5	13/5	12/5
					Time :	M6	M4	M6	[illegible]
Mobility	**1. Completely immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	**3. Slightly limited:** Makes frequent through slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.		4	4	4	4
"Activity The degree of physical activity"	**1. Bedfast :** Confined to bed	**2. Chairfast :** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	**3. Walks occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. All patients too young to ambulate; OR walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.		4	4	4	4
Sensory Perception	**1. Completely limited:** Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	**2. Very limited:** responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	**3. Slightly limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	**4. No Impairment:** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.		4	4	4	4
Moisture Degree to which skin is exposed to moisture	**1. Constantly moist:** Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	**2. Very moist:** Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	**3. Occasionally moist:** Skin is occasionally moist, requiring linen change every 12 hours.	**4. Rarely moist:** Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.		4	4	4	4
FRICTION-SHEAR **Friction** Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another	**1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	**2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	**3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	**4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."		4	4	4	4
Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.		3	3	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.		3	3	3	3
					TOTAL SCORE	23	26	23	24
					Evaluator's Name	[illegible]	[illegible]	[illegible]	[illegible]

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

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

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

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24-01-2025 1 Y 3 M 18 D (M)
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Patient ID

BRADEN 'Q' SCALE

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				Date :	13/5/26			
				Time :	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			
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				TOTAL SCORE	24			
				Evaluator's Name	[illegible]			

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
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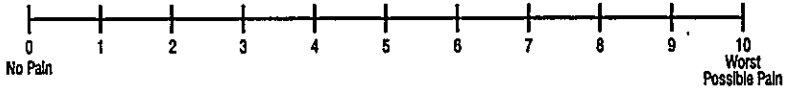
PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
12/5/26	8PM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	NA	
12/5	10PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
13/5	4AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
13/5	10AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
5/5	12pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
13/5	2pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
13/5	8pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
14/5	6AM	0/10	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		

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

PAIN ASSESSMENT TOOLS

Numerical Pain Scale (Obstetric and Gynecology)



Wong - Baker (Pediatrics) Above 7 Years

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

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

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR RR, BP, SaO_2	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO_2 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO_2 less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

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CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	12/5 DAY-1			13/5 DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0		0	0	0	0	0				
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				
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				
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				
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				
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5		NA	NA	NA	NA	NA				
		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 : ..... Name : Suvitha

Signature of Ward In Charge :

Signature : ..... Name : Sujatha

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

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THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE 12/25	DATE 13/25	DATE 01/25	DATE 02	DATE
Age	Less than 3 years old	4	✓	✓	✓		
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	✓	✓	✓		
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	✓	✓	✓		
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own ability	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					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2	✓	✓	✓		
	More than 48 hours/ None	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	✓				
	Total			13	17		

Intervention: -Fall 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		✓	—	✓		
	Other Intervention(s) Specify		✓	—	—		
	Nurse's Name:			Nancy	[illegible]		
	Signature:			[illegible]	[illegible]		
	Date:			13/5	16/5		
	Time:			8pm	2pm		

Docu. No. : RCH /FRM / CLINICAL / 005

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NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 12/5/26 Time: 11:30 am

Weight: 9.5 kg Centile: 3rd

Height: — Centile: —

Inference: Underweight child

RDA: — Calories: 1200 Kcal/day Protein: 20 gms/day

Diet Recommendations: NPO

Re-Assesment: No dairy, spicy food.

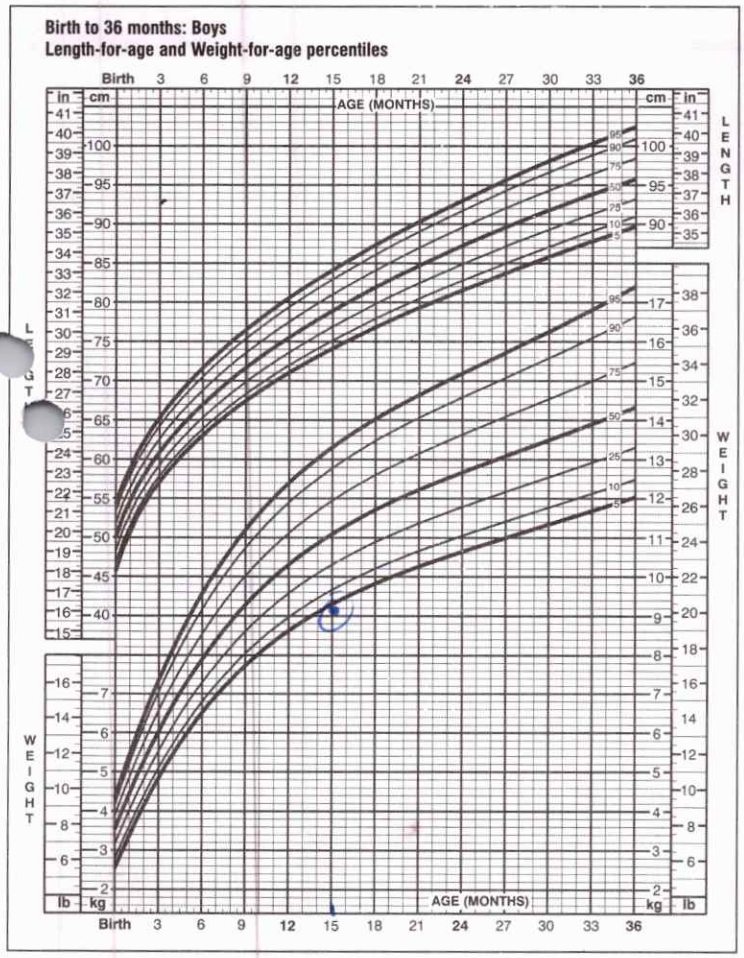
Food Allergies: NO FA Veg/Non-veg Non Veg

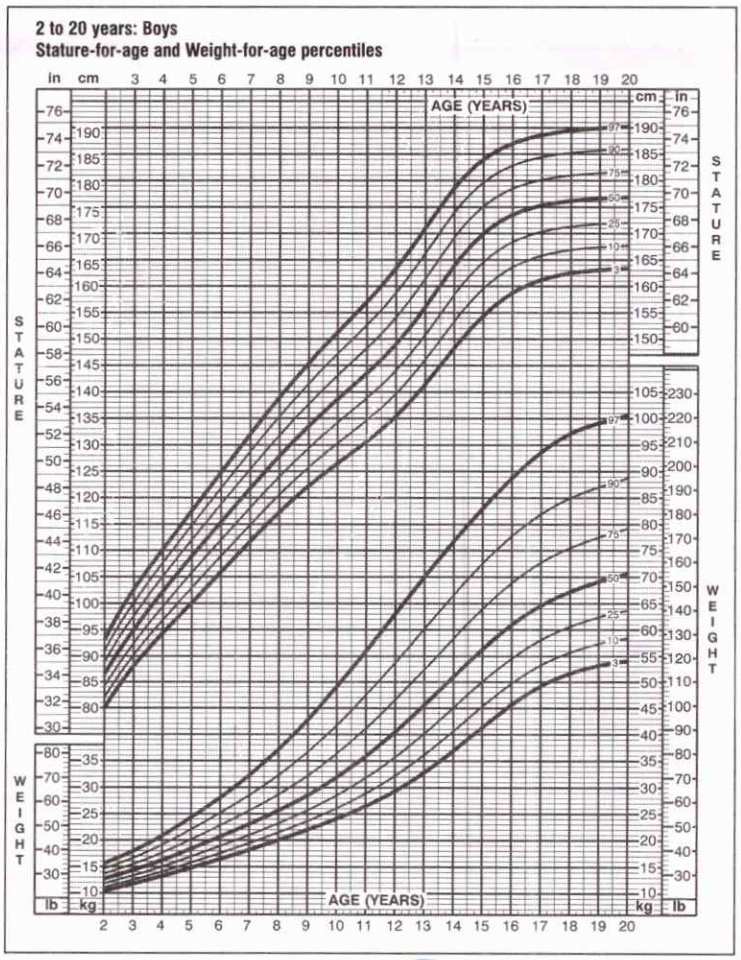
Diagnosis: Complex Febrile Seizures

Nutritional Intervention - ☐ Oral ☐ Enteral ☐ Parenteral NPO

Patient's Signature:

GROWTH CHART (BOYS)





Dietician's Name Syeda Sabiya Zaheer Dietician's Signature Sabiya

Daily Notes:

CONSENT FOR ADMISSION IN PEDIATRIC INTENSIVE CARE UNIT

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Name: B/o Divya Kayalkan Age: 1.5 month Gender: Male ☑ Female ☐

UHID.No : HNH 0000 6395 Date: 12/5/26

I ..... S/o, D/o, W/o, ... hereby declare that our patient Master/Baby ..... B/o Divya ..... who is related to me as ..... Son ..... is getting admitted in the Pediatric Intensive Care Unit of Rainbow Children's Hospital on ..... 12/5/26 .....

The doctors have explained to me in a language understood by me that my child has following health related issues :

..... Complex Febrile seizures .....

.....

.....

The doctors have clearly explained to me that my patient Master / Baby ..... B/o Divya ..... during his / her stay in the Pediatric Intensive Care Unit may undergo various medical and surgical procedures like airway management, mechanical ventilation, Central Line Insertion, Peripherally Inserted Central Catheter Line and arterial line placements, chest drain, or peritoneal drain insertion etc.

I have been told by the doctors that while performing such procedures I will be informed and a separate consent for this procedure shall be taken. However, in case of any life threatening emergency if the time is not available for taking informed consent it is implied that I give consent for various invasive procedure to save the life of my child.

I understand that a sick child in Pediatric Intensive Care Unit has life threatening medical conditions.

I understand that when a child is sick in the Pediatric Intensive Care Unit with multiple medical and surgical procedures performed upon him/her, there are inherent risks due to these high risk procedures, and high risk medications, in the form of infections, bleeding, air leaks, skin and other tissue damage etc.

I give my consent to the team of doctors to go ahead and admit the child Master / Baby : B/o Divya ..... in the Pediatric Intensive Care Unit fully understanding the associated risk, benefits and alternatives involved from various procedures, high risk medications and infections in the Pediatric Intensive Care Unit and treat him/her with all necessary means.

The doctors have explained to me in the language best understood to me.

Patient Attendant :

Signature: .....

Name: .....

Relationship with Patient: .....

Date & Time: .....

Witness :

Signature: .....

Name: .....

Date & Time: .....

Doctor (who is taking the consent) :

Signature: .....

Name: Bisanjay

Date & Time: 12/5/26 11Am

PATIENT TRANSFER FORM

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HNH-00006395 IP26-00006327
Baby Of DIVYA KOYALKAR
24-01-2025 1 Y 3 M 18 D (M)
Dr. ANIKET ANIL PARASHAR

	Date & Time of Admission	Date & Time of Transfer Order
	12/5/26 @ 9:18 am.	13/5/26 @ 10:45 am
Treating Consultant Name	**Transfer Ordered by**	**Reason for Transfer**
Dr. Aniket Anil	Dr: Pritesh Nagar	Stable
From Unit	**To Unit**	**Information to Attendant**
PICU		Yes ☑ No ☐
Number of Sheets in Clinical File	**Number of Imaging Films**	**Personal belongings including clinical documents. If any handed over to attendant**
33	No	Yes ☑ No ☐
		If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	Inj-Aug Mem (IV)	1
2.	NS	1
3.		
4.		
5.		

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Sujata	DR. Pritesh.

Patient & Clinical Records Received by : Anuradha

Date & Time of Patient Received : 13/05/26 @ 10:45 am

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

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00006395 IP26-00006327 Baby Of DIVYA KOYALKAR 24-01-2026 1 Y 3 M 18 D (M) Dr. ANIKET ANIL PARASHAR	12/5/26	12/5/26
	Transfer Ordered by Dr. Navpurnya.	Reason for Transfer Admission
From Unit ER	To Unit PICU	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File 21	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant Yes ☑ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

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

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Anupam	Dr. Navpurnya.

Patient & Clinical Records Received by :

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

HNH-00006395 IP26-00006327
Baby Of DIVYA KOYALKAR
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wt 9.5 kgs

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EMERGENCY ROOM TRIAGE FORM

Patient's Name : Mayur . Vinil .... Age : 15 M ..... **Gender:** ☑ Male ☐ Female

Date : .... Time of Arrival : 8:40 Am

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: 101.6 PR: 179 BP: .... RR: .... SpO_2: 99%

Chief Complaints: c/o fever 1 episode today 1 day, fever since.

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

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

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

Signature of Parent / Guardian

* CTAS - Canadian Triage and Acuity Scale

Triage Completion Time : 8:42 Am

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 : Anupam

Signature of Triage Nurse : A.D

Date & Time : 12/5/26 @ 8:45 Am

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

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 12/5/26 Time of arrival : 8:40Am

Chief Complaints: No seizure today 1 episode high fever RBS: .....

Height : ..... Weight : 9.5kg BMI : ..... Head Circumference (<2 years) .....

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

If yes , identify .....

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

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

RISK FOR FALL:

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

☐ If Patient is > 6 years
Assess the below parameters

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

Ambulatory Aids:

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

Gait/Transferring:

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

Mental Status: Forgets limitations ☐ Yes ☑ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening: ☑ No Abnormalities Detected

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

Inform consultant for positive criteria

.....

.....

Nutritional Screening: ☑ No Abnormalities Detected

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

Inform consultant for positive criteria

Psychological Screening: ☑ No Significant Findings

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

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

Social History: Lives With family .....

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

Time of Initial assessment completed by ER Nurse : 8:45Am

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

Time	Nursing Notes
	Assessed The patient condition
	vital checked

Samples collected by: Time:

Samples sent by : Time:

Medication given in ER:

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

Condition of patient at time of shift - out :	**Details of Shift - out**
HR: ..... BP: ..... CFT:	Shift - out from ER to: .....
RR: ..... SPO_2 :	Time of Shift - out: .....
GCS:..... Temperature :	Handover given to: ..... (Nurse's Name)
Pain Score:	
Repeat RBS (if applicable):	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

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

.....

Name of the Nurse : Anupam Signature of the Nurse : AP

Date & Time : 12/5/26 @ 8:45 Am

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

GENERAL CONSENT FOR TREATMENT

Patient Name:	**Baby Of DIVYA KOYALKAR**	**Age :**	**1 Y 3 M 18 D**
IP No:	**IP26-00006327**	**Sex:**	**Male**
Consultant:	**Dr. ANIKET ANIL PARASHAR**	**Ward/Bed No:**	**GF -EMERGENCY/ER01**

The undersigned patient and I or responsible relative or person hereby consent to and authorize Rainbow Hospitals doctors and medical personnel to perform medical examinations, conduct routine investigations and administer medical treatments, outpatient procedures, minor dressings, vaccinations and immunizations during the course of the patient's care, as in patient.

Patient, be deemed advisable or necessary.

I understand that the confidentiality of all medical records shall be protected to the full extent of the Law. The undersigned al[illegible]consent to the use of health related information/ audiovisuals of the patient for research & training purpose or for insurance coverage and while doing so confidentiality of the patient will be maintained at all times and this will not affect the ca[illegible]of the patient.

In giving my general consent to treatment, I understand that I retain the right to refuse any particular examinations, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by treating doctors. I also understand that the practice of medicine is not an exact science and that no guarantee have been made to me as the results of my evaluation and I or treatment.

I understand that I shall not bring valuables to the Hospitals and that the Hospital will not be responsible for the loss, destruction or theft of my personal belongings. I assume full responsibility for all my personal items and release the Hospital from responsibility and liability for such personal items and valuables.

"I am aware that during the patient care it is inevitable that certain re-useable equipment shall be re-used after sterilization and disinfection. I am informed that the hospital assures maximum level of precaution and care in sterilizing and disinfecting the equipment and monitors the whole process as per evidence based guidelines".

Note:
1 We do not allow use of medication brought from outside by the patient.
2 [illegible]ave received attendant passes as per my room category. I understand that I have to return it back at the time of final bill cle[illegible]nce. In case of failing the submission, I will pay 200/- Rs.
(Re[illegible]ivers Signature:.....)

3 IP Guide book has been given to me and I have been explained about the Hospitals rules and policies.
4 Financial and billing counseling has been done to me.

Signature of Patient/Relative:

Name: Sainath

Relationship: Father

Date:

Time:

Patient Address:
16-2-146/28/1 Malakpet Colony
Hyderabad Telangana INDIA 500036

Witness Name:

Witness Signature:

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Dr. ANIKET ANIL PARASHAR

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LLING POLICY

- Billing cycle: - With effective from 1st January 2020, Our billing cycle to be start from 12 PM to 12 PM, Settlement post 12 PM, room rent will be charge for half day extra & post 6 pm, it will be charge for full day. Less than 24 hours stay will be considered as one day.
- As per the GOI guidelines, we can collect Rs 1,99,999/- only in cash mode, balance patient can pay through Card tpaln the event of TPA/ Cashless denial or approval not received due to any reason then hospital tariff will be applicable and any discount or special rates given to TPA's / corporates won't be applicable.
- If the surgery / scans performed in Emergency hours (8pm - 7am), public holiday and on Sunday will be charged TPA processing charges Rs.720 for every TPA route cases.
- All charges vary as per Room category, except Pharmacy and consumables.
- We follows a "No Discounts Policy" kindly cooperate.
- No Duplicate/Second copy of OP OR IP bill is issued.
- ICU/Ward Charges DO NOT INCLUDE - Air Mattress, Monitor, Consultants/ Specialty Doctors Visit, Infusion/syringe pump, Ventilator/C pap, Oxygen, Investigations, Procedures, Consumables, Medicines or any other bedside equipment's/devices etc. (Detailed list can be taken from billing department).

Patient attendant can collect for Interim/provisional bill of the patient from the billing section on daily basis. Interim Bill shall be based on the acknowledged services in HIS. Final Bill of the patient may vary from the Interim bill based on actual update taken on the day of discharge. It is requested that patients/attendants inquire daily about the bill amount from billing section and pay the outstanding as on that day.

Patient bill outstanding should not be increase more than 10,000/-

You are requested to clear your outstanding amount on daily basis before 12 PM.

MODE OF PAYMENT & REFUNDS

- We accept payments by cash (up to Rs 1,99,999/- only), cards, online transfer and Demand Drafts.
- All refund more than Rs.2,000/- will be refund through NEFT in three Bank working days.

Sainath Jamb

Name & signature of Patient/Attendant

(Signature of Admission Desk executive)

NOTE: Self - attested Govt. ID proof is mandatory whosoever is signing the undertaking.

RAINBOW CHILDREN'S MEDICARE PRIVATE LIMITED

Registered Office: Road No.2, Banjara hills, Near Hotel Park Hyatt, Hyderabad - 500 034, T: +91 40 2233 4455.
Corporate Office: 8-2-19/1/A, Daulet Arcade, Karvy Line, Road No.11, Banjara Hills, Hyderabad - 500 034.
Branches : BANJARA HILLS - T: 2233 4455 | VIKRAMPURI - T: 4246 2200 | KONDAPUR - T: 4246 2400 | MADHAPUR - T: 6464 2020 |KUKATPALLY - T: 4246 2300 | L B NAGAR - T: 7111 1333 | MARATHAHALLI, BENGALURU - T: +91 80 7111 2345 | BANNERGHATTA ROAD, BENGALURU - T: +91 80 2551 2345, HIMAYATNAGAR- T:- 40 48873000

CIN: U85110 TG1998 PTC029914 email : info@rainbowhospitals.in www.rainbowhospitals.in

HNH-00006395 IP26-00006327
Baby Of DIVYA KOYALKAR
24-01-2025 1 Y 3 M 18 D (M)
Dr. ANIKET ANIL PARASHAR

DECLARATION BY ENDANT
(TPA / INSURANC ORPORATE)

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Date: .....

I have attended the financial counseling desk / billing desk and understood the approximate expected costs of treatment. I clearly understand and agree that the hospital would bill as per its (hospital's) existing terms and conditions or MOU with my TPA/ Insurance Company/ Corporate /Arogya Bhadrata Scheme.

In case my claim is rejected by my TPA / Insurance Company / Corporate / Arogya Bhadrata Scheme at any point of time, i.e. before admission, during admission, during discharge or post discharge when hospital bill claim is submitted, I promise to settle the claim with the hospital. I understand and agree that there are certain TPA / Insurance Company / Corporate / Arogya Bhadrata Scheme Non - Coverable billing components which have to be paid totally by me like the following.

Registration charges, Insurance Processing fee, Medical Record Charges, MLC Charges, Tax Collected at Source (TCS), Dietician Consultation, F&B charges, Luxury Tax, Pharmacy and Consumables Non Medicals like Gloves, Masks, Draw Sheets, Diapers / Koochees, Intrafix, Q-Syte, Venflon, Sterilium, Splint, Gowns, Stockings, etc, Investigations like HIV, HbsAg, Pre Anesthesia Checkup (PAC), all Genetic Investigations, Double Occupancy, Vaccination Charges etc, instruments like Laparoscope, Thoracoscope, Harmonic, N-Seal, Morcellator, Cobulator, C-Arm, Micro Debrider, Medetronic Drill, Mann Mann Drill, Neuro Microscope, Neuro Endoscope, Endoscope etc, Maternity related like, Anti D, Muhurtham, Welt Baby Charges, Epidural, Entonox, Tubectomy etc. Any other facility used / treatment / investigation done which is not related to the present ailment is not covered.

I promise to clear my medical / non-medical bill dues during admission on daily basis or as and when applicable or whenever called for.

Mandatory Documents to be submitted for cashless process (Corporate Policy)

1. Employee ID Card.
2. Employee Government ID Proof (PAN /Aadhaar Card / Passport / Voter ID).
3. Patient TPA / Insurance Health Card or E-Card.
4. Patient Government ID Proof (PAN /Aadhaar Card / Passport / Voter ID / Birth Certificate)

Mandatory Documents to be submitted for cashless process (Individual Policy)

1. Proposer's ID Proof.
2. Patient TPA / Insurance Health Card or E-Card.
3. Patient Government ID Proof (PAN / Aadhaar Card / Passport / Voter ID / Birth Certificate)

Name of the Patient: ~~Sainath~~. Vidit. Date & Time of Admission: .....

Name of the Parent / Guardian: Sainath. Mobile Number: 9866800129.

Parent Aadhaar Card Number: .....

Father.

Signature & Relation

Docu. No. : RCHBH /FRM / GENERAL / 476