DISCHARGE SUMMARY

Name	Baby ZEHRA FATIMA	**UHID**	HNH-00003747
Father/Guardian	Mr MEHDI ALI	**Age/Gender**	5 Y 2 M 28 D/ Female
Address	H.NO: 22-2-511, ALI NAGAR COLONY., Noorkhan Bazar, Hyderabad, Telangana, INDIA, 500024		
IP No	IP26-00006929	**Admission Date**	23-07-2026
Ref Doctor	SELF		
Discharge Date	26.07.2026		

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

DIAGNOSIS	ICD CODE
ADENOVIRAL ILLNESS	

History: Baby ZEHRA FATIMA , 5 Y 2 M 28 D , old girl presented with the history of fever since 5 days, poor oral intake since 3 days, vomitings since 1 day, headache and body pains prior to admission. For the above complaints she was admitted at Rainbow Children's Hospital - for further management.

Name	Baby ZEHRA FATIMA	UHID	HNH-00003747
IP No	IP26-00006929	Admission Date	23-07-2026

Examination: She was febrile(102*F). Her heart rate was 115 /min and Respiratory Rate - 29 /min. Capillary Refill Time was <2 secs. Peripheries were warm & pulses well felt. On examination Signs of some dehydration were present, dry tongue lips, sunken eyes, lethargic were present. On auscultation, air entry was bilaterally equal were present. Heart sounds were normal and there was no murmur. Abdomen was soft with no organomegaly. On neurological examination, she was conscious and alert. Pupils were bilaterally equal and reacting to light. There were no focal neurological or cranial nerve deficits. There were no signs of raised intracranial pressure.

Weight on admission: 20.7 kilo grams.

Investigations: Enclosed reports

GeneXpert FluA+FluB+RSV, SARS-CoV-2 were sent, which was negative. Adenovirus was detected.

Initial hemogram showed Hemoglobin of 12.9 gm%, White Blood Cell count of 6800 cells/cumm, platelet count of 2.37 lakhs/cumm and C-Reactive Protein of 32 mg/l. Complete urine examination was normal. Blood culture and sensitivity shows no growth after 48 hours of incubation.

Management: She was admitted in the ward and started on Intra Venous fluids and Intra Venous antibiotics. She was treated symptomatically with antacids and antipyretics.

In view of fever adenovirus panel was sent which showed adenovirus detected. In view of increase in infective markers IV antibiotics were started. Blood culture and sensitivity sent which showed No growth after 48 hours

Name	Baby ZEHRA FATIMA	**UHID**	HNH-00003747
IP No	IP26-00006929	**Admission Date**	23-07-2026

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

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

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

Medication during hospital stay:
Injection. Esomeprazole
Injection. Ceftriaxone
Syrup. Augmentin
Tablet. Pan

Advice:
* Diet as advised.

Name	Baby ZEHRA FATIMA	**UHID**	HNH-00003747
IP No	IP26-00006929	**Admission Date**	23-07-2026

S.No	MEDICATION	DOSE	TIMINGS	DURATION
1	Syrup. AUGMENTIN DDS (Amoxycillin 200 + Potassium Clavulanate 28.5 mg/5ml)	5 ml	8am-8pm (after food)	till 01/08/2026
2	Tablet. Pantodac (Pantoprazole - 20mg)	One tablet	7am (before breakfast)	For 6 days
3	Syrup. ZINCOVIT	5 ml	10am (after food)	For 1 month
4	Syrup. Mucolite	5ml	twice daily	For 5 days
5	T Bact ointment	apply for local application	thrice daily	For 5 days

Fever Management
* Syrup. Crocin DS (Paracetamol - 5ml/240mg) 6 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.

Review consultation with Dr. ANIKET ANIL PARASHAR on Tuesday(28.07.2026) at Himayatnagar in OPD with prior appointment **(Review consultation will be charged)**.

Food instructions while taking medications:
* **Antibiotics** along with food & milk products prevent their absorption of drugs & supplements. Antibiotics can be given 1 hour before food or 2 hours

Name	Baby ZEHRA FATIMA	UHID	HNH-00003747
IP No	IP26-00006929	Admission Date	23-07-2026

after food based on tolerance of stomach.

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

The content of the patient discharge summary, medication, food & drug interaction, care to be provided at home, nutrition, immunization and safe parenting, when and how to obtain emergency care etc also have been explained by doctor ..... in a language that I can understand and I acknowledge.

Parent/ Attender

In case of emergency contact 9154865030 emergency pediatrician on duty.
To take appointment for OPD consultation at Rainbow **Himayatnagar / Banjara Hills /** Rainbow Clinic **Madhapur / Kukatpally / Vikrampuri / LB Nagar /** dial just one toll free number **18002122.**

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

CHILDREN'S MEDICARE LIMITED HYDERABAD

Registrar/Resident/C.M.O

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

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ACTIVITY RECORD FOR BILLING

HNH-00003747 IP26-00006929
Baby ZEHRA FATIMA
26-04-2021 5 Y 2 M 27 D (F)
Dr. ANIKET ANIL PARASHAR

Name: ---

UHID No : 

---------- Consultant : ---------- Dept : pediatric C

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
23/7/26	7:30p	ER	2nd floor	

Cross Consultation Visit

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

HNH-00003747 IP26-00006929
Baby ZEHRA FATIMA
26-04-2021 5 Y 2 M 27 D (F)
Dr. ANIKET ANIL PARASHAR

INVESTIGATIONS

Date	Investigations		Sign
23/7/26	CBP		
	CRP	2399	
	Blood cls		sunil, MS
23/7/26	Respiratory Panel	2399	
23/7	CUE	2466	A
	Cross	checked by Sneh	Doye

HNH-00003747 IP26-00006929
Baby ZEHRA FATIMA
26-04-2021 5 Y 2 M 27 D (F)
Dr. ANIKET ANIL PARASHAR

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
23/7/26	Infusion Pump	23/7/26 @ 7:57 pm.	11 AM 25/7/26	16367	Sandhya
				Cross checked done by Sneha	

HNH-00003747 IP26-00006929
Baby ZEHRA FATIMA
26-04-2021 5 Y 2 M 27 D (F)
Dr. ANIKET ANIL PARASHAR

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
23/7/26	u. placement	1	16344	
24/7/20 (10 AM)	NNPA	(1)	16506	

Cross Checked done by Sister

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 : _____

Patient ID# : HNH-00003747 IP26-00005929
Baby ZEHRA FATIMA
26-04-2021 5 Y 2 M 27 D (F)
Dr. ANIKET ANIL PARASHAR

Consultant : _____

Final Diagnosis : _____

Pediatric Multiorgan History & Physical Examination

Name : Zaira Fatima Age/Sex 5y

Informant Father Reliability ✓

Chief Presenting Complaints & Duration (Chronologically):

Fever × 5 days
poor oral intake × 3 days
Vomiting × 1 day
Headache and body pains

History of present illness :

Apparently well 5 days back. Illness started with fever × 5 days, high grade documented upto 104°F, not the child partially relieved by oral medication also poor oral intake × 3 days

Vomiting × 1 day, Non projectile, Non bilious mixed with food, not the blood

received oral Antibiotics (Amoxiclav) × 4 days but not relieved,

Headache and body pains. ⊗

Pediatric Multiorgan History & Physical Examination

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

Nil significant

Birth & Neonatal History :

No hx/o NICU stay

Birth & Socio Economic History :

About Father :

About Mother :

Any additional Information :

Developmental History :

Normal for age

Immunization History :

Immunized as per age

Pediatric Multiorgan History & Physical Examination

Anthropometry

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

Weight (kgs) 20.7 kg (Centile _____)

On Examination :

Temperature : 102 F Pulse Rate: 115/min Description _____

B.P. _____ SPO2 99% at RA

Resp. rate and type of breathing : pus points in throat

Normal

Rash _____ / No. Sign of dehydration ⊕

Lymphadenopathy _____ dry tongue, lips

Oedema : _____ Sunken eyes ⊕

lethargic

Respiratory system :

Inspection (any s/o distress) : _____

Air entry & breath sounds : BLAB. Clear

Any addes sounds : _____

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

Cardiovasclular System :

Inspection of procordium : _____

Heart Sounds : S1, S2 ⊕

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 : _____

Cranial Nerves : _____

_____

_____

Motor System :

Nutrition : _____

Tone : _____ Power _____

Co-ordinator : _____ NAD

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR **Superficials :**

Plantars _____

Sensory System :

_____

_____

_____

Bladder / Bowel : _____

Clinical Summary & Diagnostic :

Acute Febrile Illness (AFI)

with dehydration

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment :

prevent complications

Desired goals of the treatment :

Planned Labs :

CBP. CRP.

BCood C/S (paired)

Respiratory panel (5 virus)

CUG

(Extra plain sample)

NB Dyes

Planned Management :

- IV fluids

- IV Antibiotics

(Inj Ceftriaxone)

NB Dyes

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. Aniket ? on whose name the patient is being referred

Doctor's Signature Name _____ Date 23/7/26 Time 06:30 pm

HNH-00003747 IP26-00006929
Baby ZEHRA FATIMA
26-04-2021 5 Y 2 M 27 D (F)
Dr. ANIKET ANIL PARASHAR

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
29/07/26 2PM	c/o c. Dr. Aniket / O. Parmar D: Acute Febrile Illness (AFI) with dehydration	
	Fever ↑ Sore throat Vomiting	
	O/E: Ac-Pale Vitals: Stable Hydration - good	
	I/E: RS: TBLAG ↑	
		Adv - IV fluid - Inj Ceftriaxone - Symptomatic care - Monitor vital and Inform SOS Dr. Aniket

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
24/7 9AM	CMO Dr. Aniket	
	Acute Febrile Illness c Dehydration	
	- Fever - 105°F	Plan
		1) Inj Ceftriaxone
	- oral intake - poor	2) Inj Esomeprazol
		3) Trace Respiratory panel Blood C/S
	Vitals Stable	
	Febrile now	4) Send CUE
	R.S - B/L AE ⊕	5) Monitor Vitals
	P/A - Soft	
		Dr. D. Aniket
		name by Aniket

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

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
24/7/26 9:20 AM	S/B Dr. Aniket	Plan
	Δ AFI c dehydration	
		- cf CEFTRIAXONE
	Fever spikes (+)	
		- Trace Adenovirus PCR
	CVS - S1 S2 (+)	
	RS - BL - AE (+)	- Trace Blood C/S
	P/A - soft	- send CUE now
	conscious	
		- cf IV Fluids @ 30ml/h
		- Monitor vitals
		Dr. D. Aniket
		Dr. ANIKET PARASHAR
		noted by Anitha 9:30 AM

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
24/4/21 2:30 PM	SIB Dr. Sreejhan	Plan
	DAFI Echohydration	
		- IV CEFTRIAXONE
	CVS - S1S2 @	
	RS - BL-AEF @	- Encourage oral
	PLA Jt	- Trace Adenovirus PCR
	Conscious	
		- Trace CVP

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
24/7/26 5:45 pm	Dr. Aniket	
	U/B Dr. Thanu	
	AFI c̄ dehydration	
	- no fever spikes	
	- oral intake : good	Plan
	- no vomitings	1) Inj. ceftriaxone
		2) trace adenovirus, blood c/s.
	- vitals :	WE → (N)
	stable	3) Rest Inj. as per
	- S/E :	Rx chart
	RS: BAE (+)	4) monitor vitals
	clear	5) IVF → ½ main.
	CVS: S_1S_2 (+)	6) next pick → CBP
	no murmur	CRP.
	- did not pass stool.	
		Sign Dr. Aniket
	Dr. ANIKET PARASHAR 568	

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
25/7/26 7 AM	S/B Dr. Archana/ Dr. Thanmi Δ: AFI c dehydration fever spikes (+) < 101.2° @8am yest. 100.5° @6pm vomitings (-) oral intake - fair fresh complaints - none urine - passed. o/e vitally stable S/E P/A: soft, non tender.	Advice - (T) Adenovirus Blood c&s . Ct Ceftriaxone . Ct IVF @ ½ Mtx. . watch for signs of dehydration.

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26-04-2021 5 Y 2 M 28 D (F)
Dr. ANIKET ANIL PARASHAR

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
25/7/26	C/S/B-	Dr. Rahul
12 pm	A- AFIC dehydration / Adenoviral illness	
	fever spikes yest 6pm.	
	oral intake ↓	
	oral cavity ✓	
	Urine ok	Plan
		IV ceftriaxone → Amoxyclav BD
O/E	oral cavity - congestion + pus points +	
	Vitals stable	S/p IVF
		ORS for hydration
S/E	WNL	Tab Adno NB-Monitor @ 1pm
		Dr. D. Aniket
25/7/2026	C/S/B- Dr. Prashanth.	
	A- Adenoviral illness.	
8:15 pm		Plan
	fever spikes +	1) IV ceftriaxone changed to Amoxy clav
	oral intake moderate	2) added PAN 20mg
	O/E oral cavity: Congestion+	3) ↑ hydration
	vitals stable	Pulse
	S/E- WNL	

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26-04-2021 5 Y 2 M 29 D (F)
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
25/7/26 08:30 pm	S/B Dr. Aniket Fever decreased oral intake better vitals stable.	Advice: T-BACT ointment local application twice daily x 5 days Sd/- Dr. Aniket NB- Supriya 25/7/26 @ 8:30pm

Dr. ANIKET PARASHAR Reg.

HNH-00003747 IP26-00006929
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
25/7/26 8 AM	C/c/o Dr. Varun Adenoviral illness. - fever spikes (+)	
	- Oral intake better.	
	O/E - vitals stable.	Plan
		- Ct. oral Amoxy clav.
		- Oral PAM.
		- T. BACT oint. L/A BD x 5 days.
		- Probable D/C today.
		NB Smoke 80

HNH-00003747 IP26-00006929
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26-04-2021 5 Y 2 M 29 D (F)
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
26/4/26 10:00	C/S/B -	Dr. Dhaaz.
	Δ - Adenoviral illness	
	fever spikes ↓	Plan
	oral intake better	1) Tab. Amoxyclav 1/0/1 total 5 days.
		2) Oral PCM
	O/E Vitals stable.	3) T. Bact oint
	S/E O.C - better.	4) Mucolite drops Syrup 5) Neosalen Nasal drops
	RS - clear	Review on Tuesday.

HNH-00003747 IP26-00006929
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26-04-2021 5 Y 2 M 28 D (F)
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210

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RESULT SHEET

Date	28/7					
Time						
Hb	12.9					
PCV	36					
RBC	4.75					
WBC	6800					
N/L	79/14					
Platelets	2.37					
CRP	32					
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

Date						
Time						
CUE - Alb						
CUE - Sugar	Nill					
CUE - Ketones	Trace					
CUE - PUS Cells	3-4					
CUE - RBC Cells	Nil					
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						
~~Respiratory Panel~~ —	(N) negative					
Adenovirus →	Detected					

Culture and Sensitivities : Blood C/S - 24 hrs no growth

Radiology : USG :

X-Ray :

ECHO :

CT :

MRI

Others (ECG, Contrast Studies etc.,) :

HNH-00003747 IP26-00006929
Baby ZEHRA FATIMA
26-04-2021 5 Y 2 M 27 D (F)
Dr. ANIKET ANIL PARASHAR

Patient

LINICAL / 126

SCHOOL AGE (5-12 years)

Children's Observation & Early Warning Scoring Chart

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ARNING SCORE: CHILDREN'S UNIT

Date : 23/7/24 Time: 8PM 10PM 11:30PM 2AM 5AM

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

100

64

Heart Rate (Number) 128b/m

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

70 60 50 40 30 20 10

Resp Rate (Number) 29b/m

Resp Distress	Mod/ Severe / None / Mild
Receiving O_2(l/min) O_2Saturations (%)	99%
Conscious Level	Normal / Altered
GCS *	
TOTAL SCORE Number of shaded boxes	0
Pain Score	0
Observer's Initials	

ACTIONS

NB: Scores 3 should be recorded overleaf

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

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

Patient Sticker

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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)

HNH-00003747 IP26-00006929
Baby ZEHRA FATIMA
26-04-2021 5 Y 2 M 27 D (F)
Dr. ANIKET ANIL PARASHAR

Patient Stick

AL / 126

SCHOOL AGE (5-12 years)

Children's Observation & Early Warning Scoring Chart

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 21/12

Time:	10 Am	2 Pm	6 pm	7:30 pm	10 pm	2 AM	6 AM
Doctor / Nurse / Family Concern?							
Temperature (°F) (scale 94–104)	98.3°F	97.2°F	100.5°F (Crocine given)	98.7°F / 97.8°F		98.3°F	98.0°F
Heart Rate (bpm) and Blood Pressure (mmHg) * (scale 50–190) Note: BP does not score in early warning scoring	99/61 (70)	97/59 (67)	103/62 (73)	96/60 (73)			92/62 (74)
Heart Rate (Number)	119 b/m	120 b/m	126 b/m	84 b/m			80 b/m
Resp. Rate (bpm) (Over 1 Minute) * (scale 10–70)							
Resp Rate (Number)	28 b/m	26 b/m	23 b/m	22 b/m			20 b/m
Resp Distress: Mod/ Severe							
Resp Distress: None / Mild							
Receiving O_2(l/min)							100%
O_2Saturations (%)	100%	98%	99%	100%			
Conscious Level: Normal							
Conscious Level: Altered							
GCS *				15/15			15/15
TOTAL SCORE Number of shaded boxes	0	0	0	1			1
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.

Patient Sticker

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

HNH-00003747 IP26-00006929
Baby ZEHRA FATIMA
26-04-2021 5 Y 2 M 27 D (F)
Dr. ANIKET ANIL PARASHAR

FRM / CLINICAL / 126

SCHOOL AGE (5-12 years)
Children's Observation & Early Warning Scoring Chart

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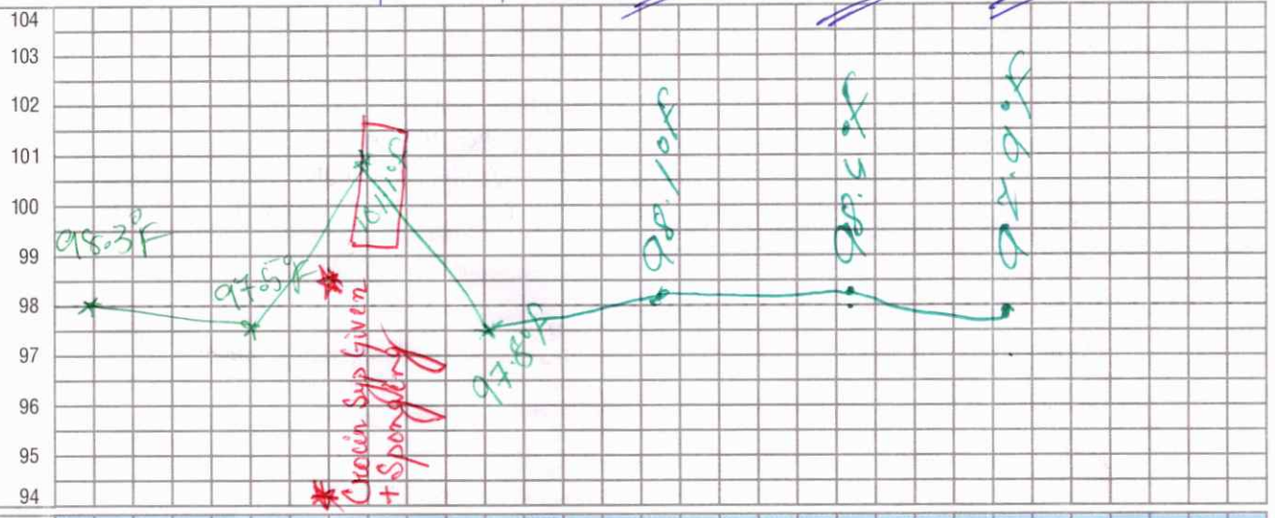
EARLY WARNING SCORE: CHILDREN'S UNIT

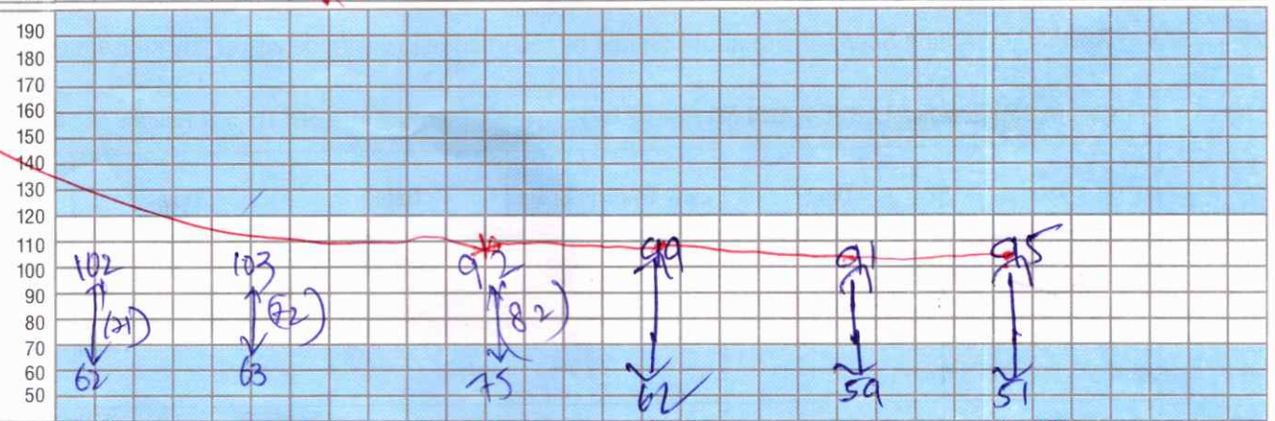
Date: 25/7/26. Time:	10Am	1pm	3 PM	6 PM	10 PM	2 AM	6 AM
Doctor / Nurse / Family Concern?							

Temperature (F)



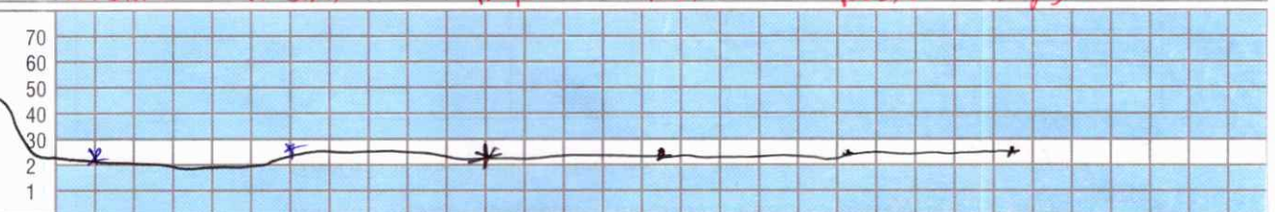
Heart Rate (bpm) and Blood Pressure (mmHg) *

Note: BP does not score in early warning scoring



Heart Rate (Number)	108b/m	112b/m	116b/m	110b/m	108b/m	107b/m

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



Resp Rate (Number)	23b/m	25b/m	25b/m	28b/m	28b/m	28b/m
Resp Distress: Mod/ Severe / None / Mild						
Receiving O_2(l/min) O_2Saturations (%)	99%	100%	97%	98%	98%	98%
Conscious Level: Normal / Altered						
GCS *			15/15	15/15	15/15	15/15
TOTAL SCORE Number of shaded boxes	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0
Observer's Initials	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

ACTIONS NB: Scores 3 should be recorded overleaf	
	Score 1 : Continue normal observation by staff nurse
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Patient Sticker

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

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HNH-00003747 IP26-00006929
Baby ZEHRA FATIMA
26-04-2021 5 Y 2 M 27 D (F)
Dr. ANIKET ANIL PARASHAR

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FLUID CHART

Sheet No. : 1

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

		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 :**						
23/4/26.	08:00 pm			40ml								
	09:00 pm			40ml								
	10:00 pm	DNS		40ml								
	11:00 pm			40ml								
	12:00 am			40ml								
	01:00 am			40ml								
Total Intake :						**Total Output :**						
	02:00 am			40ml								
	03:00 am			40ml								
	04:00 am	DNS		40ml								
	05:00 am			40ml								
	06:00 am			40ml								
	07:00 am			40ml								
Total Intake :						**Total Output :**						

Total 24 hrs. Intake		Total 24 hrs. Output	

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FLUID CHART

Sheet No. : 2

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

		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							
24/7	08:00 am			40ml			L				L	
	09:00 am	DNS	H/y	40ml						✓		
	10:00 am			40ml	— DA —		0	— DA —			0	
	11:00 am	DNS	+	40ml								
	12:00 pm		H2O	40ml			J			✓	J	
	01:00 pm			40ml								
Total Intake : Taken						**Total Output :** M-0					U-2	
24/7	02:00 pm			40ml							0	
	03:00 pm			40ml						—	0	
	04:00 pm	DNS	Kichdi	40ml							0	
	05:00 pm		+	40ml			0				0	
	06:00 pm		H2O	40ml						✓	0	
	07:00 pm			40 ml							0	
Total Intake :						**Total Output :**						
	08:00 pm			20 ml							1	
	09:00 pm			30ml								
	10:00 pm	DNS	Juice	20ml							0	
	11:00 pm			30ml								
	12:00 am			20ml								
	01:00 am			20ml								
Total Intake :						**Total Output :**						
	02:00 am			20ml								
	03:00 am			30ml								
	04:00 am	DNS		30ml							0	
	05:00 am			30ml								
	06:00 am			30ml								
	07:00 am			20ml								
Total Intake :						**Total Output :**						

Total 24 hrs. Intake		Total 24 hrs. Output	

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FLUID CHART

Sheet No. : .....

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

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
25/7/26	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						**Total Output :**						
25/7/26	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						**Total Output :**						
25/7/26	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						**Total Output :**						
26/7/26	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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Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
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	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						**Total Output :**						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						**Total Output :**						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						**Total Output :**						

Total 24 hrs. Intake		Total 24 hrs. Output	

HNH-00003747 IP26-00006929
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NURSING CARE RECORD

Rainbow® Children's Hospital
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Date: 23/7/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon							
Night	8pm 8pm	Assess the baby Monitor V/S administer Medicine Maintain I/O Chart	8pm 8pm	Assessed the baby Monitored V/S administered Medicine Maintained I/O Chart	Administered Medicine	Received the patient good	

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NURSING CARE RECORD

Rainbow® Children's Hospital — It takes a lot to treat the little.
BirthRight BY RAINBOW HOSPITALS — Your Right to a Safe Delivery

Date: 24/7/20

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	8 Am | 2pm	→ Assess the pt condition → monitoring vitals checked and recorded → I/O chart maintained	8 Am | 2pm	→ Assessed the pt condition. → Administration of medication given as per doctor orders	→ Pt is stable	→ RC - Checked vitals	
Afternoon	2Pm to 8pm	Assess the pt condition vital signs maintain I/O chart. Provide the comfortable position. medication given as per as doctor order	2pm to 8pm	Assessed the pt. monitored vitals given maintained I/O chart. provided the comfortable Position. medication given as per as doctor order	→ pt is stable. → vitals normal	→ Monitor vitals → Maintain I/O chart	
Night	8pm to 8	Assess the baby Monitor VS administer Medicine Maintain I/O chart	8pm to 8	Assessed the baby Monitored VS administered Medicine Maintain I/O chart	administered	Reassess the pt	

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NURSING CARE RECORD

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Date: 25/7/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8am to 2pm	→ Assess Pt condition → monitor the vitals → maintain I/O chart → Administer medication as per drug chart → stop IVF	8am to 2pm	→ Assessed Pt condition → monitored vitals → maintained I/O chart → Administered medication as per drug chart → stop IVF	→ Patient is stable → Trace Reports	Re-checked vitals	
Afternoon	2pm to 8pm	→ To assess the pt. condition → To check the vitals & record → To administer the medication as per drug chart → I/O chart maintain	2pm to 8pm	→ To assessed the pt. condition → To checked the vitals & recorded → To administered the medication as per drug chart → I/O chart maintained	→ Patient is stable → Oral antibiotic change	→ Re-checked the vitals ↳ I/O → IV cannula is out	
Night	8pm to 8am	Assess the pt condition. Monitor vitals & record Maintain I/O charts. Provide the comfortable position. Medication give as per as doctor orders.	8pm to 8am	Assessed the pt condition. Monitored vitals & record Maintained I/O charts Provided the comfortable position. Medication given as per as doctors orders.	→ Pt is stable. → Vitals normal	→ Monitor vitals. → Maintain I/O charts	

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NURSING CARE RECORD

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Date: 26/7/26

Goals

- ☐ Maintain Airway and Oxygenation
- ☐ Maintain Personal Hygiene
- ☐ Identify Potential Complications
- ☐ Relieve Pain & Discomfort
- ☐ Prevent Infection
- ☐ Any Others. Specify.....
- ☐ Maintain Fluid Balance
- ☐ Meet Elimination Needs
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- ☐ Patient & Family Education

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

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NURSING SHIFT HAND OVER FORM

SITUATION

Diagnosis: AFI & dehydration

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

Surgery / Procedure:

Post OP Day:

BACKGROUND

Date / Shift	24/7/26 8AM	24/7 M6	24/7 E2	25/7 8AM	25/7 M6	25/7/26 E2
Medical Condition (Any special condition to be noted):	AFI	AFI	—	—	—	AFI
Diet:	—	—	—	—	—	Soft

ASSESSMENT

Allergy:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
Ventilation (RA, NP, NIV, VENTI):	—	—	—	—	—	—
Tubes/Drains/Catheter:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
Vital Signs: Temp:	98.0F	98.2F	98.2°F	98.5°F	98.7F	98.1°F
Res:	27b/m	27b/m	27b/m	26b/m	23b/m	26b/m
SpO_2:	100%	98%	98%	100%	100%	100%
Pulse:	102b/m	103b/m	102b/m	110b/m	103b/m	107b/m
BP:	98/52	101/60	102/62	104/62	100/63	99/63
LOC:	—	—	—	—	—	—
Fall Risk Score:	—	—	—	—	—	—
Pain Score:	—	—	—	—	—	0/10
Skin Integrity	—	—	—	—	—	Good

Recommendations

Safety Needs:	☐ Yes ☑ No	☑ Yes ☐ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☑ Yes ☐ No
Physiotherapy:	—	—	—	—	—	—
Others Specify:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
Special Diet:	—	—	—	—	—	Soft
Critical Lab Test / Values:	—	—	—	—	—	—
Other Special Orders / Medications:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
PU Prophylaxis:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
DVT Prophylaxis:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
ADL (Dependent / Non Dependent):	—	NA	—	—	—	—
Post Operative Procedure Special Orders:	—	Amoxith	—	—	—	—
Handed Over By Name :	Ayesha	[illegible]	Sana	Ajwad	Anusha	Supriya
Signature / ID :	Ayesha	24/7	[illegible]	[illegible]	[illegible]	[illegible]
Date:	24/7	24/7	24/7	25/7	25/7/26	25/7/26
Time:	8AM	2PM	8PM	8AM	2PM	8PM
Taken Over By Name :	Amoxith	[illegible]	[illegible]	Anusha	Supriya	[illegible]
Signature / ID :	[illegible]	24/7	[illegible]	[illegible]	[illegible]	[illegible]
Date:	24/7	[illegible]	24/7	25/7/26	25/7/26	25/7
Time:	8AM	8PM	8PM	8AM	2PM	8PM

HNH-00003747 IP26-00006929
Baby ZEHRA FATIMA
26-04-2021 5 Y 2 M 27 D (F)
Dr. ANIKET ANIL PARASHAR

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NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: AFI ? dehydration.				Any Infection: ☐ Yes ☐ No ☑ Not Known If Yes Specify:		
	Surgery / Procedure:				Post OP Day:		
BACKGROUND	Date / Shift	25/4/26 N1					
	Medical Condition (Any special condition to be noted):	AFI ? dehydration					
	Diet:	Soft					
ASSESSMENT	Allergy:	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Ventilation (RA, NP, NIV, VENTI):						
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:	98.2°F					
	Res:	27b/m					
	SpO_2:	99%					
	Pulse:	103b/m					
	BP:	101/62					
	LOC:	-					
	Fall Risk Score:	-					
	Pain Score:	0					
	Skin Integrity	-					
Recommendations	Safety Needs:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Physiotherapy:	-					
	Others Specify:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Special Diet:	-					
	Critical Lab Test / Values:	-					
	Other Special Orders / Medications:	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	PU Prophylaxis:	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	DVT Prophylaxis:	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	ADL (Dependent / Non Dependent):	-					
Post Operative Procedure Special Orders:		-					
Handed Over By Name :		Sneha					
Signature / ID :		40160)					
Date:		26/4					
Time:		8 Am					
Taken Over By Name :							
Signature / ID :							
Date:							
Time:							

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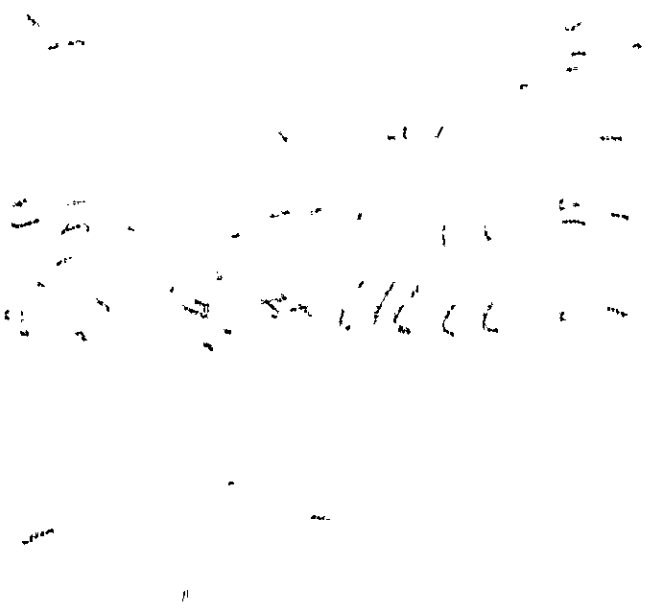
THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE 24/7	DATE 24/7	DATE 25/7	DATE 26/7	DATE
Age	Less than 3 years old	4					
	3 to less than 7 years old	3	3	3	3	3	
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2					
	Female	1	1	1	1	1	
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1	1	1	
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own ability	1					
	History of Falls or Infant-Toddler Placed in Bed	4	4	4	4	4	
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2	2	2	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	1	1	1	1	
	Total		12	12	12	12	

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		X	X	X	X	
	Other Intervention(s) Specify		X	X	X	X	
	Nurse's Name:				Supri		
	Signature:						
	Date:		24/7	24/7	25/7	26/7	
	Time:		8pm	8pm	8pm	8pm	



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BRADEN 'Q' SCALE

					Date : 24/7	24/7	25/7	25/7
					Time : Room	MG	MG	E2
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.	4	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4
				TOTAL SCORE	28	28	28	28
				Evaluator's Name				

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

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

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

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BRADEN 'Q' SCALE

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				Date :	26/7			
				Time :	8PM			
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			
"Activity The degree of physical activity"	**1. Bedfast :** Confined to bed	**2. Chairfast :** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	**3. Walks occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. All patients too young to ambulate; OR walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	3			
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				TOTAL SCORE	27			
				Evaluator's Name	Sng			

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

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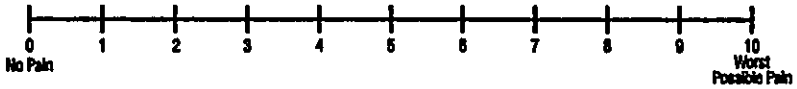
PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
24/7	8am	0	n/a	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	NA	
24/7	2pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
24/7	8pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
24/7	10AM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
25/7	2pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	NA	
25/7	6pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
25/7	10pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
26/7	2am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
26/7	8am	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		

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

25/7/26

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			24/7 DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0			0	0	0	0	0	0	0	
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1			0	NA	NA	NA	NA	NA	NA	
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2			0	NA	NA	NA	NA	NA	NA	IV cannula out
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			0	NA	NA	NA	NA	NA	NA	
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4			0	NA	NA	NA	NA	NA	NA	
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5			0	NA	NA	NA	NA	NA	NA	
		Signature of the Nurse											

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

Signature of Shift In Charge :
Signature : ..... Name : Poonika

Signature of Ward In Charge :
Signature : ..... Name : Baburaj

Patient Sticker

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CHECKLIST FOR THROMBOPHLEBITIS

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 : ..... Name : .....

Signature of Ward In Charge :

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

HNH-00003747 IP26-00006929
Baby ZEHRA FATIMA
26-04-2021 5 Y 2 M 27 D (F)
Dr. ANIKET ANIL PARASHAR

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DRUG CHART

Date of Admission: 23/7/26 Drug Allergies: Nil ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

DOCTOR - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
- Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
- Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
- Discontinue a drug by drawing a line *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 : SYP. CROCIN DS

Dose	Route	Frequency	Start Date
6 ml	PO	SOS/6H	23/07

Doctor's Signature: Sinhalk | Valid Period: | Pharm.: (W)

Additional Instructions: (5ml/240mg)

Date/Time: 24/7 6pm (Sinhalk)

DRUG : SYP. IBUGESIC

Dose	Route	Frequency	Start Date
6 ml	PO	SOS/8H	23/07

Doctor's Signature: Sinhalk | Valid Period: | Pharm.: (W)

Additional Instructions: (5ml/100mg)

Date/Time: 24/7 1pm (W)

DRUG : INJ. ONDANSETRON

Dose	Route	Frequency	Start Date
4mg	IV	SOS/8H	23/07

Doctor's Signature: Sinhalk | Valid Period: | Pharm.: (W)

Additional Instructions:

Date/Time:

Verified by Dr. Dhakshayani

VERIFIED BY : Name ..... Signa

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REGULAR PRESCRIPTIONS Weight. 20.7 kg Ward. .....

Verified by Dr. Dhakshayani

DRUG : INJ. CEFTRIAXONE

Dose	Route	Frequency	Start Date
1gm	IV	12H	23/07

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions: Give over 1 hour

Daily Doctor's Endorsement by a Sign

Date/Time: 23/7 24/7 25/7 — 1000 ✗ ✗ ✗ — STOP

DRUG : INJ. ESOMEPRAZOLE

Dose	Route	Frequency	Start Date
20 mg	IV	OD	23/07

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date/Time: 23/7 24/7 25/7 — STOP

DRUG : SYP. AUGMENTIN DPS

Dose	Route	Frequency	Start Date
5ml	PO	~~OD~~ BD	25/7

Name & Signature of the Doctor Starting the Drugs: Dr. Prashanti

Additional Instructions: Amoxycillin clavulanic acid. (457/5ml)

Daily Doctor's Endorsement by a Sign

Date/Time: 25/7 26/7 — 10ml 1PM ✓ — 10PM

DRUG : Tab. PAN

Dose	Route	Frequency	Start Date
20mg	PO	OD	25/7

Name & Signature of the Doctor Starting the Drugs: Dr. Prashanti

Additional Instructions: once daily, 30 minutes before breakfast

Daily Doctor's Endorsement by a Sign

Date/Time: 25/7 26/7 — 10PM ✓

Baby ZEHRA FATIMA
26-04-2021 5 Y 2 M 29 D (F)
Dr. ANIKET ANIL PARASHAR

Weight 20.7kg Ward. .....

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.	

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
23/07	7PM	INJ. ONDANSETRON	4mg	IV		

Signature .....

VERIFIED BY : Name .....

HNH-00003747 IP26-00006929
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I.V. FLUIDS CHART

Weight. 20.7 kg Ward. .....

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
23/07	6:30pm	IVF - DNS	IV	40 ↓			24/7/26		
24/7/26	6pm	NF - DNS (½ main).	IV	30			29		

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

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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: ..... Shifted to: .....

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

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : .....

Date & Time : .....

Nurse Name & Signature: .....

Date & Time : .....

PATIENT TRANSFER FORM

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HNH-00003747 IP26-00006929 Baby ZEHRA FATIMA 26-04-2021 5 Y 2 M 27 D (F) Dr. ANIKET ANIL PARASHAR	Date & Time of Admission 23/7/26 @ 6:07pm	Date & Time of Transfer Order 23/7/26 7:39
	Transfer Ordered by Dr. Tanu'	Reason for Transfer Admission
From Unit GR	To Unit 2nd, Rl ocv	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File 14	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
	Dr. Tanu'

Patient & Clinical Records Received by : Sr. Sandhya

Date & Time of Patient Received : 23/7/26 @ 7:50 p.m.

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-00003747 IP26-00006929
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Wt 20.7 kg

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EMERGENCY ROOM TRIAGE FORM

Patient's Name: Baby Zaira fatima Age: 5 yrs Gender: ☐ Male ☑ Female

Date: 23/7/26 Time of Arrival: 5:40 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: 102°F PR: 156 b BP: ..... RR: 36 b SpO_2: 99%

Chief Complaints: c/o fever since 4 to 5 days

INITIAL PHYSIOLOGICAL CATEGORIZATION

Appearance
☐ Normal
☑ Sick Looking

Circulation / Colour
☑ Normal ☐ Abnormal ☐ Bleeding

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

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

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

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

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian

Triage Completion Time : 5:45 PM

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 : Kuldeep

Signature of Triage Nurse : .....

Date & Time : 23/7/26 @ 5:45pm

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 23/7/26 Time of arrival : 4:47 PM

Chief Complaints: C/O fever since 5 days RBS: .....

Height : ..... Weight : 20.7 kg BMI : ..... Head Circumference (<2 years) .....

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

If yes , identify .....

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

☐ Character N/A ☐ 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?) N/A

Time of Initial assessment completed by ER Nurse : 5:49 PM

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

Time	Nursing Notes
	- Assess the pt condition
	- monitor vitals
	- IV placement Done
	- Smple collected

Samples collected by: Vijaya Time: 7:20pm

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: 132bl/m BP: 104/70 CFT:	Shift - out from ER to: 2nd floor
RR: 25bl/m SPO_2 : 100%	Time of Shift - out: 7:30pm
GCS: 15/15 Temperature : 98.6F	Handover given to: G. Sandhya (Nurse's Name)
Pain Score: —	
Repeat RBS (if applicable): —	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

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

Name of the Nurse : Jyothi Signature of the Nurse :

Date & Time : 23/7/26 5:52pm

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210

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NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 24/7/24 Time: 9am

Weight: 20.7 kg Centile: 75th

Height: — Centile: —

Inference: Well nourished child.

RDA: — Calories: 1400 KCal/day Protein: 24 gms/day

Diet Recommendations: Balanced diet with liquids

Re-Assesment: NO Junk, Oily, Spicy food

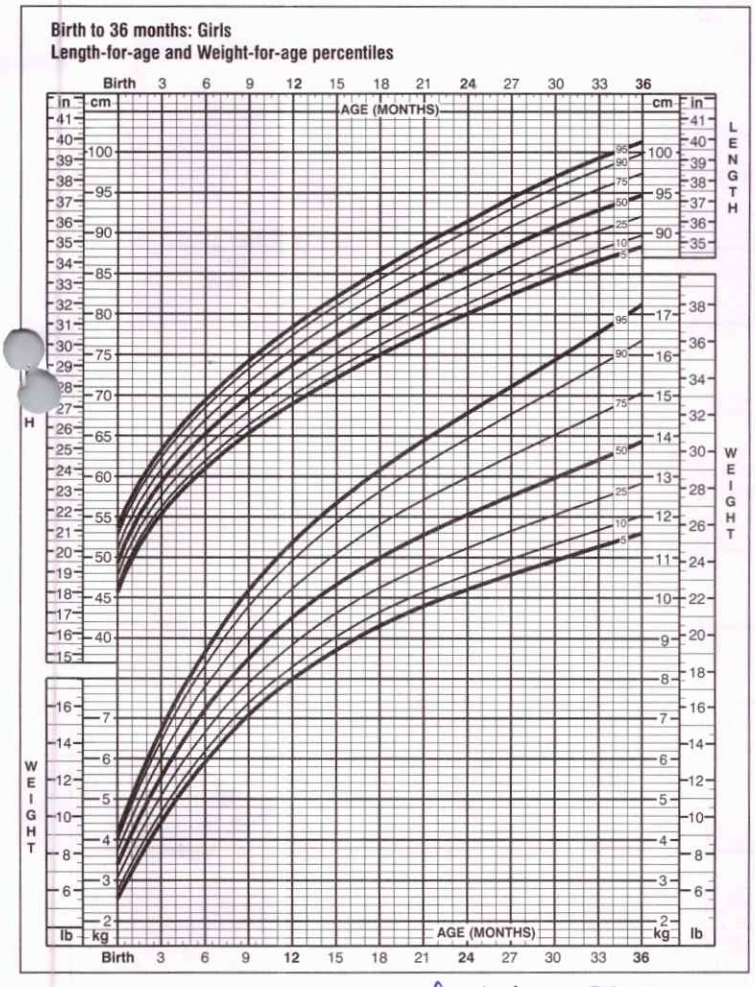
Food Allergies: No Veg/Non-veg Non Veg

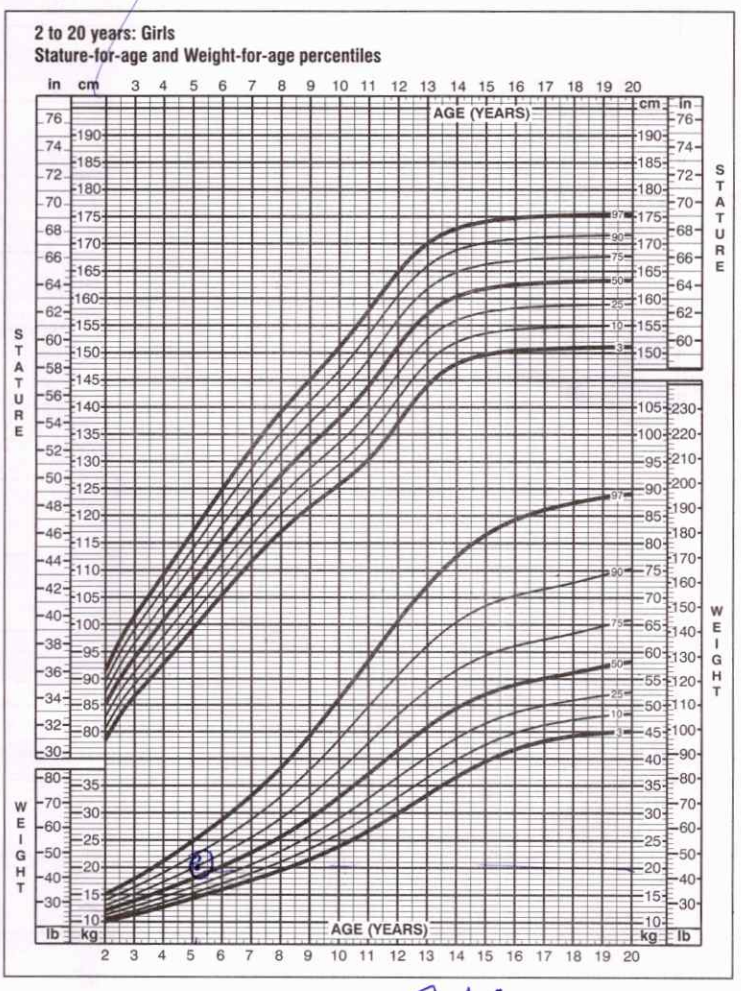
Diagnosis: Afi c dehydration

Nutritional Intervention - ☑ Oral ☐ Enteral ☐ Parenteral

Patient's Signature:

GROWTH CHART (GIRLS)





Dietician's Name Syeda Sobiya Zaheer

Dietician's Signature Sobiya.

Daily Notes: