

DISCHARGE SUMMARY

Name	Master AVISH BASHETTY	UHID	HNH-00012706
Father/Guardian	Mr RAGHUVEER	Age/Gender	9 Y 0 M 10 D/ Male
Address	H.NO: 3-4-835/2, Barkatpura, Hyderabad, Telangana, INDIA, 500027		
IP No	IP26-00006479	Admission Date	02-06-2026
Ref Doctor	SELF		
Discharge Date	04.06.2026		

Consultant:

Dr. SINDHURA MUNUKUNTLA
MBBS, DCH, DNB PEDIATRICS
66970

DIAGNOSIS	ICD CODE
ACUTE GASTRITIS WITH DEHYDRATION	
LEFT RENAL CALCULI + VUJ CALULUS	

History: Master AVISH BASHETTY, 9 Y 0 M 10 D , old boy presented with history of pain abdomen since 2 days, vomitings (multiple episodes) since morning, dull activity and decreased urine output, decreased oral intake, prior to admission. For the above complaints he was admitted at Rainbow Children's Hospital - Himayathnagar for further management.

Name	Master AVISH BASHETTY	UHID	HNH-00012706
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Examination: He was afebrile, hemodynamically stable and maintaining saturation at room air. Heart rate - 78/min, blood pressure - 104/60 mmHg and Respiratory Rate - 34/min. On examination Signs of some dehydration were present, dry lips, oral mucosa, decreased urine output were present. On auscultation of chest, air entry was bilaterally equal with normal heart sounds and no murmur. Abdomen was soft with no organomegaly. On neurological examination, he was conscious, alert. Pupils were bilaterally equal & reacting to light. There were no focal neurological deficits.

Weight on admission: 28 kilo grams.

Investigations: Enclosed reports.

VBG showed pH of 7.36, pCO₂ of 36.1 mmHg, pO₂ of 50 mmHg, HCO₃ of 20.6 mmol/L and BE of -4.8 mmol/L.

Initial hemogram showed Hemoglobin of 11.1 gm%, White Blood Cell count of 9650 cells/cumm, platelet count of 3.38 lakhs/cumm and C-Reactive Protein of 5.0 mg/l. Serum electrolytes showed sodium of 133 mmol/L, potassium of 4.5 mmol/L & Chloride of 103 mmol/L. Serum Creatinine was 0.5 mg/dl. Blood Urea was 25 mg/dl. Serum Calcium was 9.6 mg/dl. Magnesium was __ mg/dl. Phosphorus was 5.6

Spot calcium / creatinine ratio

SPOT CALCIUM	10.2			
SPOT CREATININE	30.3	24 - 392	mg/dl	-
RATIO	0.33			

Name	Master AVISH BASHETTY	UHID	HNH-00012706
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Ultrasound abdomen shows:

- * Mild left sided hydronephrosis.
- * Tiny echogenic focus at the mid pole of left kidney, likely small calculus.
- * Focal urinary bladder wall thickening at the left VUJ with an associated left VUJ calculus.
- For clinical correlation and CT KUB if clinically indicated.

Ultrasound abdomen shows:

- * Left renal calculus with mild hydronephrosis.
- * Focal urinary bladder wall thickening at the left VUJ with an associated left VUJ calculus.
- For clinical correlation and CT KUB if clinically indicated.

Management : He was admitted in the ward and was started on Intra Venous fluids and antibiotics. In view of usg suggestive of renal calculi and pain abdomen , he was administered alpha 1 adrenergic receptor blocker for renal stones to relax the smooth muscle of the ureter for easy passage and stool softeners for constipation. USGs were regularly monitored for the size of the renal stone. Pediatric Nephrologist consultation was taken for renal and bladder stones and has advised for few blood and urine investigations and probable cause of stones and also explained about amount of proper timings of water intake. Child's pain abdomen has come down and 24 hour urinary investigations were sent and reports are awaited.

He was regularly monitored for urine colour, urine output and hydration status.

Child is being discharged as overall investigations were normal and clinical

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improvement was present but the size of stones in kidney and VUJ is more or less same and hence in case of any further pain or high coloured urine and any presence of warning signs explained, advised to rush to ER immediately and there might also be requirement of surgical intervention in future if medical treatment does not resolve the issue.

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

Medication during hospital stay:

Injection. Esmoprazole

Injection. Ceftriaxone

Injection. Ondansetron

Tab. Tamsulosin

Syp. Ceitralka

Syp. Muout powder

Advice:

* Diet as advised.

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S.No	MEDICATION	DOSE	TIMINGS	DURATION
1	Syrup. TAXIM O (Cefixime - 5ml/200mg)	3.5 ml	8am - 8pm (after food)	For 2 days.
2	Tablet. LANZOL DT (Lansoprazole - 30mg)	1 tablet	7am (before breakfast)	For 7 days
3	TAB. TAMSULOSIN (0.2MG)	2 TABLETS	9PM(AFTER FOOD)	For 4 weeks
4	SYP.POTRATE MB-6	5ML IN 1/4TH GLASS OF WATER	9AM- 9PM(AFTER FOOD)	FOR 6 WEEKS

Fever Management

- * Syrup. Crocin DS (Paracetamol - 5ml/240mg) 5 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. SINDHURA MUNUKUNTALA on Saturday (06/06/2026) at Himayatnagar in OPD with prior appointment (**Review consultation will be charged**).

FOLLOW UP WITH DR.SHRUTHI PEDIATRIC NEPHROLOGIST AT OPD OF BANJARAHILLS OR SECUNDRABAD BRANCH ON MONDAY 8/6/26 FROM 9AM.

Food instructions while taking medications:

- * **Antibiotics** along with food & milk products prevent their absorption of drugs & supplements. Antibiotics can be given 1 hour before food or 2 hours after food based on tolerance of stomach.

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* **Anti ulcer drugs** can decrease the absorption of Iron&vit-B12. Anti ulcer drugs can be taken at least 1 hour before food (OR) 2hrs after food. Avoid caffeine that increases stomach acidity.

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**


Registrar/Resident/C.M.O

Dr. SINDHURA MUNUKUNTLA
MBBS, DCH, DNB PEDIATRICS
66970

ADMISSION SHEET

Registration Details :



Admission No : IP26-00006479 Admit Date : 02-Jun-2026 Admit Time : 02:34 PM UHID : HNH-00012706

Patient Details :

Patient Name : Master AVISH BASHETTY Age : 9 Y 0 M 9 D
Guardian : Mr RAGHUVVEER DOB : 24-05-2017
Gender : Male Religion :
Occupation : Martial Status :
Address (H) : H.NO: 3-4-835/2 Barkatpura Hyderabad Phone No : 9849938889/ 9849904040
Telangana INDIA 500027 E-mail : no@gmail.com

Admission Details :

Bed Type : DAY CARE Bed No : ER01 Ward Name : GF -EMERGENCY
Room No : ER01 Admission Type : First Visit

Contact Details :

Name : Mr RAGHUVVEER Relationship : Father
Contact Address : H.NO: 3-4-835/2 Barkatpura Hyderabad Phone No : 9849938889
Telangana INDIA 500027


Signature

Doctor Details :

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

Payment Details :

Payment Mode : DC/CC Card Deposit Amount : 10000.00
Payor Name : FAMILY HEALTH PLAN INSURANCE TPA LTD

ACTIVITY RECORD FOR BILLING

HNH-00012706 IP26-00006479

Name: - Master AVISH BASHETTY 24-05-2017 9 Y O M 9 D (M) -----

UHID No:  ----- Consultant: ----- Dept: *pediatric*

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
<i>2/06/26</i>	<i>3:17PM</i>	<i>ER</i>	<i>ward</i>	<i>[Signature]</i>

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1.	<i>Dr. Swapna Palakuthy</i>	<i>2/06/26</i>	<i>3773</i>	<i>[Signature]</i>
2.	<i>Dr. Shanthi Batta</i>	<i>3/06/26</i>	<i>3843</i>	<i>[Signature]</i>
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				



INVESTIGATIONS

Date	Investigations	Order No.	Sign
2/6/26	CRP ✓		
	CRP ✓		
	ser. creatinine ✓		
	ser. electrolytes ✓		
	ser. Calcium ✓	9219	
	Phosphorous ✓		
	uric Acid ✓		
	VBC ✓	9218	
2/6/26	urine C/S ✓		
	Spot Calcium / creatinine Ratio ✓	9220	
3/6/26	ultrasound KUB ✓	6657	
3/6/26	X-RAY Abdomen (Erect) ✓	6666	
3/6/26	Spot Urine for uric acid ✓	9266	
4/6/26	Ser. Magnesium, Bicarbonate ✓	9290	
	Vit. D3, PTH ✓		
	VBC ✓	9291	
4/6/26	CVE ✓	9292	
<i>Cross checked done by Supriya</i>			
4/6/26	USG KUB ✓	6202	
4/6/26	24 hrs (urine phosphate, oxalate, uric acid, citrate, creatinine, calcium) Urine ✓	9305	

Ref.No. F/IN/PR/10



Rainbow[®] Children's Hospital

PEDIATRIC IN-PATIENT MEDICAL RECORD

HNH-00012706 IP26-00006479
Master AVISH BASHETTY
24-05-2017 9 Y 0 M 9 D (M)
Dr. SINDHURA MUNUKUNTLA



Patient Name : Master Avish Bashetty.

Patient ID# : _____

Consultant : _____

Final Diagnosis : _____

Pediatric Multiorgan History & Physical Examination



Name : _____

Informant _____ Reliability _____

Chief Presenting Complaints & Duration (Chronologically):

c/o pain abdomen since 2 days,
c/o vomiting (multiple episodes) since morning
c/o dull activity & decreased urine output
c/o decreased oral intake.

History of present illness :

- Child presented to OPD with c/o
pain abdomen since 2 days, Intercostal,
suprapubic region.
also decreased urine output.

- c/o vomits since morning multiple. Episodes
Non bilious, non projectile
contain food particles.

- c/o decreased oral intake & decreased
activity.

- c/o decreased urine output.

Pediatric Multiorgan History & Physical Examination

HNH-00012706 IP26-00006479
Master AVISH BASHETTY
24-05-2017 9 Y 0 M 9 D (M)
Dr. SINDHURA MUNUKUNTLA



Anthropometry

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

Weight (kgs) 28 kg. (Centile _____)

On Examination :

Temperature : Afebrile Pulse Rate: 78/min Description _____

B.P. 104/68 (80) mm/Hg SPO2 98% at _____

Resp. rate and type of breathing : _____

- Sign of dehydration (+)

Rash _____

decreased urine output.

Lymphadenopathy _____

Oedema : _____

Respiratory system :

Inspection (any s/o distress) : _____

Air entry & breath sounds : ~~ST~~ B/L AC (+)

Any addles sounds : AKBS (+)

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

Cardiovascular System :

Inspection of procordium : _____

Heart Sounds : S1,2 (+)

Any murmur : no murmur.

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

Per Abdomen :

Inspection _____

Palpation : Soft, Non tender, no organomegaly.

Auscultation : suprapubic tenderness (+)

Spine: _____ External Genitalia : _____

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

Pediatric Multiorgan History & Physical Examination

HNH-00012706 IP26-00006479
Master AVISH BASHETTY
24-05-2017 9 Y O M 9 D (M)
Dr. SINDHURA MUNUKUNTLA



Central Nervous System :

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

Cranial Nerves : _____

Motor System :

Nutrition : _____

Tone : _____ Power _____

Co-ordinator : (N)

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR

Superficials :

Plantars (N)

Sensory System :

(N)

Bladder / Bowel : _____

Clinical Summary & Diagnostic :

Sever Acute Gastritis & dehydration
& ? ~~diarrhea~~

Dr. Sindhura Munukuntla
Consultant Pediatrician
Reg. No. 36470

Pediatric Multiorgan History & Physical Examination

HNH-00012706 IP26-00006479
Master AVISH BASHETTY
24-05-2017 9 Y 0 M 9 D (M)
Dr. SINDHURA MUNUKUNTALA



Preventive aspects of the treatment :

prevent hypovolemic shock.

Desired goals of the treatment :

Planned Labs :

CBP CRP, VBS.
Ss UA, Cs, Urine acid
pou-

spot urin Ca:Cr ratio
serul u/dp, Sr Electrolyt
Extra Sample.

(T) CUE.
CSG abd - done.

NIB shivering

Planned Management :

IV fluid full M.
Tamsulosin TAB orom
1/2 BD

4 PANITOP
4 ONDANSETRON
Monitor vital.

Nephrology opinion. (after
COE, RFT, S/E Rept)

Paed Sx opinion.

NIB shivering

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. Sindhu - M on _____
whose name the patient is being referred

Doctor's Signature Name

[Signature]
Dr. Sindhura Munukuntla
Consultant Pediatrician
Reg. No: 66970

Date 6/5/20 Time 2:30 pm

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/6/26 2:30pm	<p>diffy as Anucha / as Sindhur. Severe acute Gastritis & dehydration. ? Renal Calculi.</p>	
	<p>vomit (+) (+) u/o pain abdomen (+) signs of dehydration (+)</p>	
	<p>Bp = 104/68 (80) mmHg. HR = SpO₂ = 100%.</p>	<p>→ iv fluids (full Maint) @ 68 ml/h → LI PANTOP 30mg iv OD LI ONDONSERON 4mg iv TID</p>
		<p>- TAB TAMSOLOAN 0.4g 1 tablet after paed surge BD. Opinion.</p>
	<p>- DUCLOUX 10mg PR Suppository stat.</p>	<p>- Paed Surgery Opinion - Nephrologist Opinion.</p>
		<p>- (+) CUE - Send VBG / CBP / CRP Sx Cx urea, Ca, PO₄, uric acid Sx Electrolytes. send u/cp.</p>
		<p>spot urine Ca Cx ratio. - 1 Extra Sample.</p>
		<p>HB Shrinig</p>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/6/16 9:50 AM	S/B Dr. Sindhura Δ Acute Gastritis	Pla
	WS - S ₁₀ 10 R ₇ - B ₁₄ - A ₁₀ 10	- CE CEFTRIAXONE - Start IV fluids Full maintenance
	PIA - soft tenderness in suprapubic area conscious	- Paed surgeon opinion - Paed. Nephrologic opinion tomorrow
		- LE TAMBULOSIN
		- Trace reports
		A/R S. Sindhura Munukuntla Dr. Sindhura M.

Dr. Sindhura Munukuntla
Consultant Pediatrician
Reg. No: 66970

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
26/6/26	SIB Dr. Sindhura	
6:30 PM	D Acute gastritis	
	E dehydration	Plan
	C ? Renal calculi	✓ CE CEFTRIAZONE
	WS - SCS @	
	PI - BU - AFO	✓ Tnen
	PIA - soh	Spot urine calcium
	Lactinap	Urative ratio
	Pain ↓	✓ Urine <C
	Passing urine	✓ USA
		✓ CE IV Fluids
		Full maintenance
		✓ CE CITRALKA
		TAMSULOSIN
		DROXIN-DS
		on Ibuprofen
		for pain
		Encourage orally
		✓ Paed Nephrologist
		opinion tomorrow

Dr. Sindhura Munukuntla
 Consultant Pediatrician
 Reg. No: 66970

Sindhura Munukuntla
 SINDHURA-M

NB Mouth
 6:30 PM



GROSS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/6	CLS/IB 100 - Naipunya / Dr. Nazmeem	
7:00 AM	Acute Gastritis & dehydration Renal calculi.	
	No fever.	Plan
	Pain - ↓↓.	→ Cont IVF.
	Vitals - stable.	→ Cont Syp - CITRALKA
	R/S NAD	T - GAMSULOSIN
	PIA	→ Encourg orally.
		→ Cont Syp - ceftioxiel.
		①
		N.B - Supriya
		Sant @ 3/6/20



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
03/04/26 10am	c/s/r - Dr. Sindhura	
	Case of Acute gastritis c dehydration c left renal calculi Pain reduced.	<u>Advised:</u> (i) USG Abdomen ^{REP.} Today
	ole - vitals stable.	(ii) Nephrologist opinion today
	O/A - soft easy pass ps	(iii) Encourage daily
	Dr. Sindhura Munukuntla Consultant Pediatrician Reg. No. 66970	

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/6/20 11:20am	<p><u>ED/W - Dr Shruithi</u></p>	
	<p>Case of acute gastritis & dehydration & left renal calculi</p>	
	<p>ole -</p>	<p>Repeat COE tomorrow evening</p>
	<p>Pain reduced.</p>	<p>Advise! Strict No chesting.</p>
	<p>Vitals stable</p>	<p>USG Abdomen to repeat now.</p>
	<p><u>NO</u></p>	<p>Send VBU; Serum bicarbonate PTH; 25-OH Vit D₃ P₂₄; ALP</p>
	<p>ESR - 25 AL - 1300 U/L</p>	
	<p>PIA - 10/L</p>	<p>Send spot urine (Calcium to creat ratio) & spot urine (uric acid)</p>
		<p>No X-ray Abdomen sent</p>
		<p>24 hour urine to collect for Calcium; creat; Citrate; Uric acid Oxalate & Phos</p>
		<p>NB. Mouthwash @ 2:30pm</p>

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/6/26 20u	<u>elst/B- Dr. Alekhye</u>	
	Case of Acute gastritis rt-renal calculi & bladder calculi	<u>Advised:</u>
	Pain reduced. Daily taking better ok Vitals stable	① Collect 24h urine from now to send investigations
	② CVS - S/S AB - BLU WORS DIA - soft	② Strict 2L monitoring ③ send spt urine uric acid.
		④ Plan for VBG low bicarbonate 20 OH vit E D3 Pot ⁺ & Mg ⁺⁺ ⑤ CVS to repeat tomorrow morning. as per



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/6/20 6pm	<p><u>CS/B Dr. Sindhura</u></p> <p>Acute Gastritis ± Left Renal Calculi with ⊕ VUJ Bladder Calculi</p>	<p>Plm</p> <p>1) 24 hour urine for Calcium Creatinine Uric Acid Oxalate Phosphate</p>
	Pain - Belly	<p>2) VBG HCO₃⁻ (Bicarbonate) PTM 25-OH-Vit D3 & Magnesium</p> <p>T/m 6 AM</p>
	oral intake - both	
	Passing Urine - Adequately	
	<p>Vitals stable Afebrile R-S - B/LAE ⊕ P/A - Soft</p>	<p>3) CUE - T/m 8 AM</p> <p>4) Inj Ceftriaxone Syrup Citralpha Tab Tambulone</p>
		5) VSG Aldora - T/m (9 AM)
		6) MVOUT powder
		<p>N/B powder</p> <p>Minelline ANTHURON</p>

Dr. Sindhura Munukuntla
 Consultant Pediatrician
 Reg. No: 66970

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
4/6	cls/B Di. Prasad / Di. Tharri	
7:30 AM		
	D ^s - Acute Gastritis & Dehydration	
	① Renal calculi +	
	② VUS Calculus	
		Ph
	Pain - Better	1) VBS - Done
	No Fever	Sem Bicarbonate
	No Vomiting	PTN
	Passing Urine	Vit D ₃ - 25(OH)
		S Magnesium
	child alert	2) CUE - Test
	Vitals stable	
	R-S-B/LAET	3) Ij Ceftriaxone
	PIA - Soft	Tab Tamoxifen
		Syp Citralin
		MUOUT
		4) USC Abdom ^{KUB} aft 9 AM
		5) Monitor Vitals
		N/B Suppiger.
		Pann

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 Master AVISH BASHETTY
 24-05-2017 9 Y 0 M 9 D (M)
 Dr. SINDHURA MUNUKUNTLA



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RESULT SHEET

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

BirthRight[™]
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Date	2/6/26				
Time					
Hb	11.1				
PCV	31.1				
RBC	3.95				
WBC	9.65				
N/L	85.4/100				
Platelets	338				
CRP	5.0				
ESR					
PCT					
RBS					
Na	133				
K	4.5				
Cl	103				
Ca/Mg	9.6/				
Phosphate	5.6				
Urea	25				
Creatinine	0.5				
ALP					
SGPT					
SGOT					
T.Bill/Conj					
T.Protein					
S.Albumin					
S.Globulin					
A/G Ratio					
Uric Acid	3.8				
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein/Sugar					
Cells					
N/L					

Docu. No. : RCH/FRM/CLINICAL/0138

phosphorus → 5.6

856

Date	2/6/26	3/6/26				
Time		1:58pm				
CUE-Alb						
CUE-Sugar						
CUE - Ketones						
CUE-PUS Cells						
CUE - RBC Cells						
CUE						
Spot Calcium	→ 10.2					
Spot Creatinine	→ 30.3					
Ratio	→ 0.33					
Stool Pus Cell						
OVA/Cyst						
Occult Blood						
Spot urine for Uric acid	→	10.5				

Culture and Sensitivities :

.....

.....

.....

Radiology: USG :

X-Ray:.....

ECHO:

CT:

MRI

Others (ECG, Contrast Studies etc.):

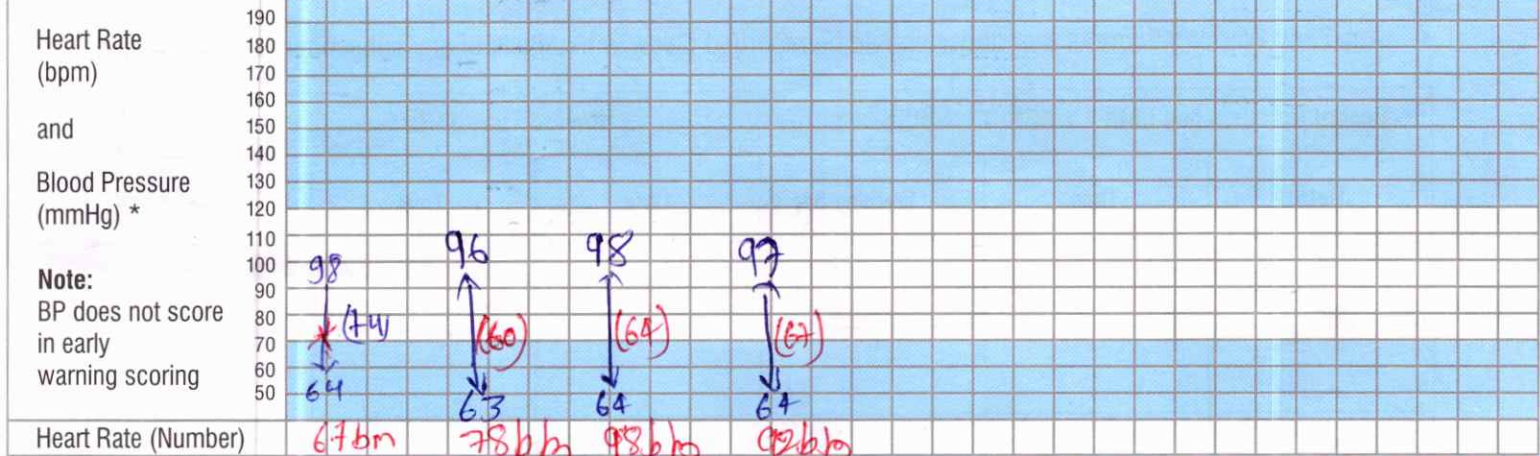
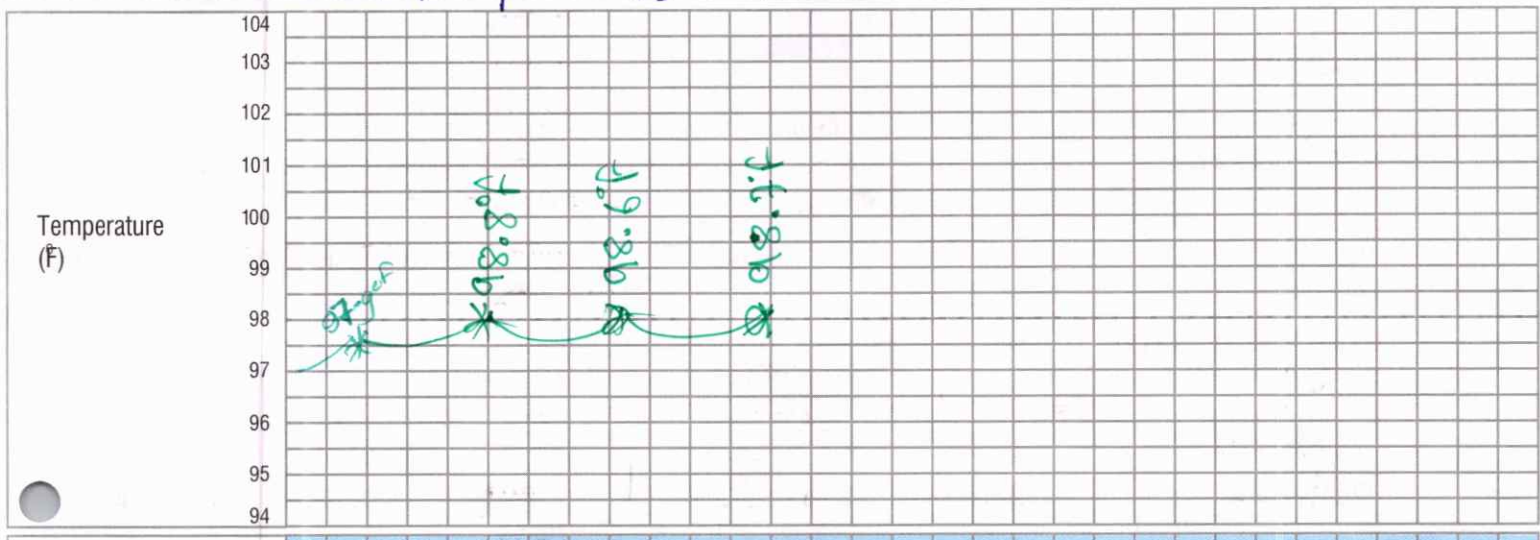


SCHOOL AGE (5-12 years)
Children's Observation & Early Warning Scoring Chart



EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 21.6.2017 Time: 4:40 PM 10 PM 2 AM 6 AM
 Doctor / Nurse / Family Concern? PM PM AM AM



Resp Distress: None / Mild
 Receiving O₂ (l/min): 100%, 100%, 100%, 100%
 O₂ Saturations (%):
 Conscious Level: Normal / Altered
 GCS *: 14/15, 15/15, 15/15, 15/15

TOTAL SCORE
 Number of shaded boxes: 0, 0, 0, 0
 Pain Score: 0, 0, 0, 0
 Observer's Initials: (K), (B), (B), (G)

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.

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

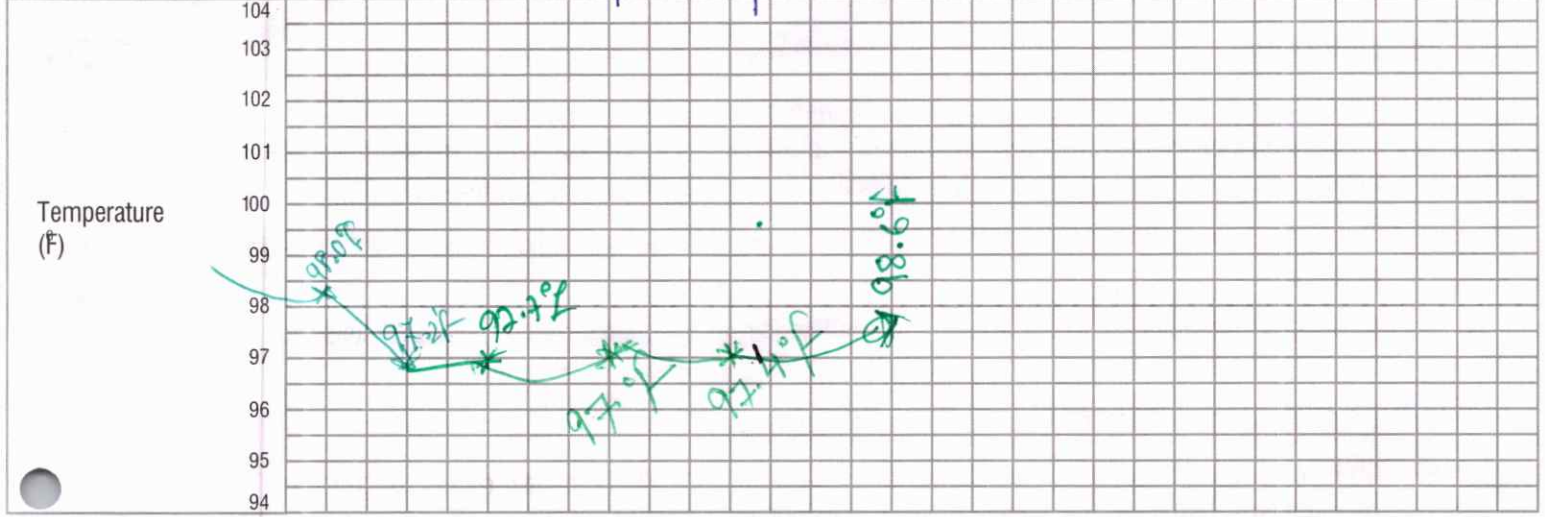
The SBAR communication tool (situation, background, assessment, recommendations) is a helpful mnemonic that can be used to describe a child's clinical condition to a colleague.

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)



EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 3/6/26	Time: 10 AM	2 PM	10 PM	2 AM	6 AM
Doctor / Nurse / Family Concern?	AM	PM	PM	AM	AM



Heart Rate (bpm)	190	180	170	160	150	140	130	120	110	100	90	80	70	60	50
Blood Pressure (mmHg) *	98	96	96	94	100	83	55	63	65	66	63	57			
Note: BP does not score in early warning scoring															
Heart Rate (Number)	70b/m	87b/m	71b/m	71b/m	91b/m	96b/m									

Resp. Rate (bpm)	70	60	50	40	30	20	10
Resp Rate (Number)	28b/m	20b/m	20b/m	28b/m	28b/m	29b/m	

Resp Distress	Mod/ Severe	None / Mild
Receiving O ₂ (l/min)		
O ₂ Saturations (%)	100%	99%
Conscious Level	Normal	Altered
GCS *	15/15	15/15

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

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

FLUID CHART

Sheet No. : 1

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
2/16/26	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
	Total Intake :						Total Output :					
2/16/26	02:00 pm											
	03:00 pm		68ml									
	04:00 pm	Plasmalyte	68ml									
	05:00 pm		68ml									
	06:00 pm		68ml									
	07:00 pm		68ml									
Total Intake : Taken						Total Output : U-2 M-1						
2/16/26	08:00 pm		68ml									
	09:00 pm	Plasmalyte Rice + H2O	68ml									
	10:00 pm		68ml									
	11:00 pm		68ml									
	12:00 am		68ml									
	01:00 am		68ml									
Total Intake : Taken						Total Output : U-2 M-0						
3/16/26	02:00 am		68ml									
	03:00 am		68ml									
	04:00 am	Plasmalyte H2O	68ml									
	05:00 am		68ml									
	06:00 am		68ml									
	07:00 am		68ml									
Total Intake :						Total Output : U-3 M-0						

Total 24 hrs. Intake

Total 24 hrs. Output



FLUID CHART

Sheet No. : 2

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
3/6/26	08:00 am			68ml						✓		
	09:00 am	Pharmalyte	Tidy +H ₂ O	68ml	NA	NA	NA	NA	NA	✓		
	10:00 am			68ml						✓		
	11:00 am			68ml						✓		
	12:00 pm			68ml						✓		
	01:00 pm			68ml						✓		
Total Intake :				Total Output : U- M-								
3/6/26	02:00 pm			68ml								
	03:00 pm	Pharmalyte		68ml	NA	NA	NA	NA	NA	240ml		
	04:00 pm		68ml	✓								
	05:00 pm		68ml	✓								
	06:00 pm		68ml	✓								
	07:00 pm		68ml	✓								
Total Intake :			Total Output : U- M-									
3/6/26	08:00 pm			68ml								
	09:00 pm	Pharmalyte	Pice +H ₂ O	68ml	NA	NA	NA	NA	NA	✓		
	10:00 pm			68ml						✓		
	11:00 pm			68ml						✓		
	12:00 am			68ml						✓		
	01:00 am			68ml						✓		
Total Intake :				Total Output : U-2 M-								
4/6/26	02:00 am			68ml								
	03:00 am	Pharmalyte		68ml	NA	NA	NA	NA	NA	✓		
	04:00 am		68ml	✓								
	05:00 am		68ml	✓								
	06:00 am		68ml	✓								
	07:00 am		68ml	✓								
Total Intake :			Total Output : U-1 M-									

Total 24 hrs. Intake

Total 24 hrs. Output

HNH-00012706 IP26-00006479
 Master AVISH BASHETTY
 24-05-2017 9 Y 0 M 9 D (M)
 Dr. SINDHURA MUNUKUNTALA



FLUID CHART

Sheet No. :

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

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

24 hrs c/s Sample

Total 24 hrs. Intake

Total 24 hrs. Output

FLUID CHART

Sheet No. :

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

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



NURSING CARE RECORD

Date: 9/10/20

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning				FR			
Afternoon	9PM	Assess the Pt. condition monitor vitals Maintain I/O chart. Drug give as per drug chart.	2PM	Assessed the Pt. condition monitored vitals Maintained I/O chart Drug given as per drug chart	Baby is stable now	Vitals is normal	Khushboo (Signature)
Night	8PM	- Assess the Pt condition - monitor vitals - maintain I/O chart - medication given as per doctor order	8PM	- Assessed the Pt condition - monitored vitals - maintained I/O chart - medication given as per doctor order	Pt is stable	vitals is normal	(Signature)
	8AM		8AM				

00012706 IP26-00006479
 Doctor AVISH BASHETTY
 24-05-2017 9 Y 0 M 9 D (M)
 Dr. SINDHURA MUNUKUNTLA



NURSING CARE RECORD

Date: 3/6/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8AM 2PM	→ Assess the general condition of pt. → Monitor vitals. → Maintain I/O chart. → Administer medication.	8AM 2PM	→ Assessed the general condition of pt. → Monitor vitals. → Maintained I/O chart. → Administered medication.	→ Pt is stable. → Given urine for uric acid.	Re-assess vitals.	Montush
Afternoon	2pm to 8pm	→ Assess the pt condition → monitor the vitals → Maintain I/O chart → Administer medication as per drug chart	2pm to 8pm	→ Assessed pt condition → monitored vitals → Maintained I/O chart → Administered medication as per drug chart	Patient is stable.	Re-checked vitals	Anubha
Night	8pm to 8AM	→ To assess the pt. condition → To check the vitals & record → To administer the medication as per drug chart → I/O chart monitor → Contd. IVF	8pm to 8AM	→ To assessed the pt. condition → To checked the vitals & recorded → To administer the medication as per drug chart → I/O chart monitoring → Contd IVF	→ Patient is stable now → USG abdomen T/M 9AM	→ re-checked the vitals → I/O → T/M 6AM CUE, VBG, Si. Bicarbonate, PTH, vit D3, Si. magnesium	Supriya



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
2/6/26	6PM	0/10	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	NA	(Signature)
2/6/26	10pm	0/10	NA	<input type="checkbox"/> Continuous <input checked="" type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	NA	(Signature)
3/6/26	6AM	0/10	NA	<input type="checkbox"/> Continuous <input checked="" type="checkbox"/> Intermittent	<input checked="" type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input checked="" type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input checked="" type="checkbox"/> Decreasing	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	NA	(Signature)
3/6/26	10AM	0/10	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	NA	(Signature)
3/6/26	2pm	0/10	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	NA	(Signature)
3/6	8pm	0	(Signature)	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	(Signature)	(Signature)
3/6/26	10pm	0/10	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	(Signature)
4/6/26	6AM	0/10	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	(Signature)
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		

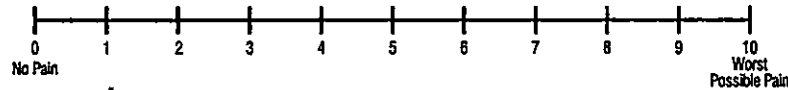
Re-assessment Frequency:
 1. Every eight hours for all hospitalized patients.
 2. For post-surgical patients, patients with chronic pain, patient with severe pain:
 a) At least every 2 hours for the first 24 hours b) Then every 4 hours.
 c) Prior to pain-relieving intervention. d) Within 30 – 60 minutes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

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

Numerical Pain Scale (Obstetric and Gynecology)



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

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

Wong - Baker (Pediatrics) Above 7 Years



0 No Hurt 2 Hurts Little Bit 4 Hurts Little More 6 Even More 8 Hurts Whole Lot 10 Hurts Worst



CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1 2/6/21			DAY-2 3/6			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0		0	0	0	0					
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				
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				
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				
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				
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord pyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5		0	NA	NA	NA	NA				
Signature of the Nurse					<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>				

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

Signature of Shift In Charge :

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

Signature of Ward In Charge :

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

BRADEN 'Q' SCALE

					Date :	2/6/20	2/6/20	2/6/20	3/6/20
					Time :	9	11	16	2
Mobility	Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.		3	3	4	4
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.		3	3	4	4
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.		4	4	4	4
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.		4	4	4	4
FRICION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."		4	4	4	4
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings 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 meat and dairy products. Occasionally eats between meals. Does not require supplementation.		3	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						25	28	28	24
Evaluator's Name						(Signature)	(Signature)	(Signature)	(Signature)

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

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



BRADEN 'Q' SCALE

					Date : 5/6/23			
					Time : Ni			
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.	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: Unresponsive 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			
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			
FRICION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4			
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 meat and dairy products. Occasionally eats between meals. Does not require supplementation.	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			
TOTAL SCORE					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

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

HNH-00012706
 Master AVISH BASHETTY
 24-05-2017 9 Y 0 M 9 D (M)
 Dr. SINDHURA MUNUKUNTLA



NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: AGE C Dehydration	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Not Known If Yes Specify:					
	Surgery / Procedure:	Post OP Day:					
BACKGROUND	Date	2/6/26	2/6/26	3/6/26	3/6/26	3/6/26	
	Shift	E2	N1	MG	E2	N1	
	Medical Condition (Any special condition to be noted):						
	Diet:	Soft	Soft	Soft	Soft	Soft	
ASSESSMENT	Allergy:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Ventilation (RA, NP, NIV, VENTI):						
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Vital Signs:	Temp:	97.5°F	98.6°F	98.1°F	98.3°F	98.1°F
		Res:	23b/m	28b/m	20b/m	32b/m	28b/m
		SpO ₂ :	100%	100%	100%	100%	100%
		Pulse:	67b/m	104b/m	84b/m	80b/m	102b/m
		BP:	98/54	99/63	99/65	98/65	101/64
		LOC:					
		Fall Risk Score:					
	Pain Score:	0	0	0		0	
	Skin Integrity	Good	Good	Good	Good	Good	
RECOMMENDATIONS	Safety Needs:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Physiotherapy:						
	Others Specify:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Special Diet:					Soft	
	Critical Lab Test / Values:						
	Other Special Orders / Medications:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	PU Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
DVT Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	ADL (Dependent / Non Dependent):	Yes					
	Post Operative Procedure Special Orders:					CVE, VtA, PTH, S. Moq, S. Bicalan	
	Handed Over By Name :	Maitulika	Supriya	Maitulika	Anusha	Supriya	
	Signature / ID :	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	
	Date:	2/6/26	3/6/26	3/6/26	3/6/26	4/6/26	
	Time:	8 PM	8 AM	2 PM	8 PM	8 PM	
	Taken Over By Name :	Supriya	Maitulika	[Signature]	Supriya	[Signature]	
	Signature / ID :	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	
	Date:	2/6/26	3/6/26	4/6	3/6/26	4/6	
	Time:	8 pm	8 AM	2 pm	8 pm	8 pm	

Patient Sticker



NURSING SHIFT HAND OVER FORM

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



CROSS CONSULTATION FORM

Doctor Name: Dr. Swapna Date: 2/5/26 Time: 8:20 PM

Diagnosis: 1 renal Calculi

Hospital: RGH, HMR

Type of Referral :

Emergency

Urgent

Non Urgent

Referred for: Opinion Co-Management Transfer of care

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

Signature: _____

Findings and Recommendations :

No pain Abdomen

USG KUB- s/o Calculi @ VUJ
3-3mm

mid pole-3mm

P/A-soft
non-tender

Plan

- If IV fluids

Full maintenance

- CE TAMBULOSIN

- CE UTRAKA
(synup)

- Repeat USG KUB
ETM

Consultant :

Name: Dr. Swapna Signature: Date & Time: 2/5/26 8:20 PM

HNH-00012708 IP26-00006479
Master AVISH BASHETTY
24-05-2017 9 Y O M 9 D (M)
Dr. SINDHURA MUNUKUNTLA



CROSS CONSULTATION FORM

Doctor Name : Date : Time :

Diagnosis :

Hospital :

Type of Referral :

Emergency

Urgent

Non Urgent

Referred for : Opinion Co-Management Transfer of care

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

Signature: _____

Findings and Recommendations :

Consultant :

Name : Signature : Date & Time :



REGULAR PRESCRIPTIONS

Weight. 28kg Ward.

Verified by
Dr. Dhakshayani

Verified by
Dr. Dhakshayani

Verified by
Dr. Dhakshayani

DRUG : <u>9j. ESMOPRAZOLE</u>				Date Time	<u>2/6</u>	<u>3/6</u>	<u>4/6</u>													
Dose	Route	Frequency	Start Date																	
<u>30mg</u>	<u>IV</u>	<u>OD</u>	<u>2/6</u>																	
Name & Signature of the Doctor Starting the Drugs: <u>B. Sreythar M</u>				<u>6pm 3pm</u> <u>2/6</u> <u>3/6</u> <u>4/6</u> 																
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign				<u>[Signature]</u>																
DRUG : <u>9j. ONDANSETRON</u>				Date Time	<u>2/6</u>	<u>3/6</u>	<u>4/6</u>													
Dose	Route	Frequency	Start Date																	
<u>4mg</u>	<u>IV</u>	<u>TID</u>	<u>2/6</u>																	
Name & Signature of the Doctor Starting the Drugs: <u>B. Sreythar M</u>				<u>6pm 3pm</u> <u>2/6</u> <u>3/6</u> <u>4/6</u> 																
Additional Instructions:				<u>10pm</u> 																
Daily Doctor's Endorsement by a Sign				<u>[Signature]</u>																
DRUG : <u>Tab. TAMBULOJIN</u>				Date Time	<u>2/6</u>	<u>3/6</u>														
Dose	Route	Frequency	Start Date																	
<u>0.4mg</u>	<u>oral</u>	<u>BD</u>	<u>2/6</u>																	
Name & Signature of the Doctor Starting the Drugs: <u>B. Sreythar M</u>				<u>6AM X</u> <u>2/6</u> <u>3/6</u> <u>Revised</u> 																
Additional Instructions:				<u>6pm</u> 																
Daily Doctor's Endorsement by a Sign				<u>[Signature]</u>																
DRUG : <u>9j. CEFTRIAXONE</u>				Date Time	<u>2/6</u>	<u>3/6</u>	<u>4/6</u>													
Dose	Route	Frequency	Start Date																	
<u>1.4gm</u>	<u>IV</u>	<u>BD</u>	<u>2/6</u>																	
Name & Signature of the Doctor Starting the Drugs: <u>B. Sreythar M</u>				<u>6pm</u> <u>2/6</u> <u>3/6</u> <u>4/6</u> 																
Additional Instructions:				<u>6pm</u> 																
Daily Doctor's Endorsement by a Sign				<u>[Signature]</u>																



Date Time	Nurse Sig.	Nurse Sig.	Nurse Sig.	Nurse Sig.
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DRUG :	Dose	Dose	Dose	Dose
	Dr. Sign.	Dr. Sign.	Dr. Sign.	Dr. Sign.
Route	Start Date	Dose	Dose	Dose
		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
		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
2/6/26	3:30 pm	Tab. BISACODYL (DULCOLAX)	10 mg	P/R STAT	[Signature]	[Initials]
3/6						

Signature
VERIFIED BY : Name

HNH-00012706 IP26-00006479
 Master AVISH BASHETTY
 24-05-2017 9 Y O M 9 D (M)
 Dr. SINDHURA MUNUKUNTLA



MEDICATION RECONCILIATION FORM

Drug Allergies: N/A 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: ICU Shifted to: ward

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

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Anurag

Date & Time : 2/06/26 @ 2:34 PM

Nurse Name & Signature: Shivani

Date & Time : 2/06/26 @ 3:18 PM

208

NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 2/6/26 Time: 4 pm

Weight: 28 Kgs Centile: 50th

Height: 131 cms Centile: 25th

Inference: Well nourished child

RDA: - Calories: 1600 kcal/day Protein: 28 gms/day

Diet Recommendations: Normal soft diet with more liquids

Re-Assessment: Avoid spicy curries & outside foods.

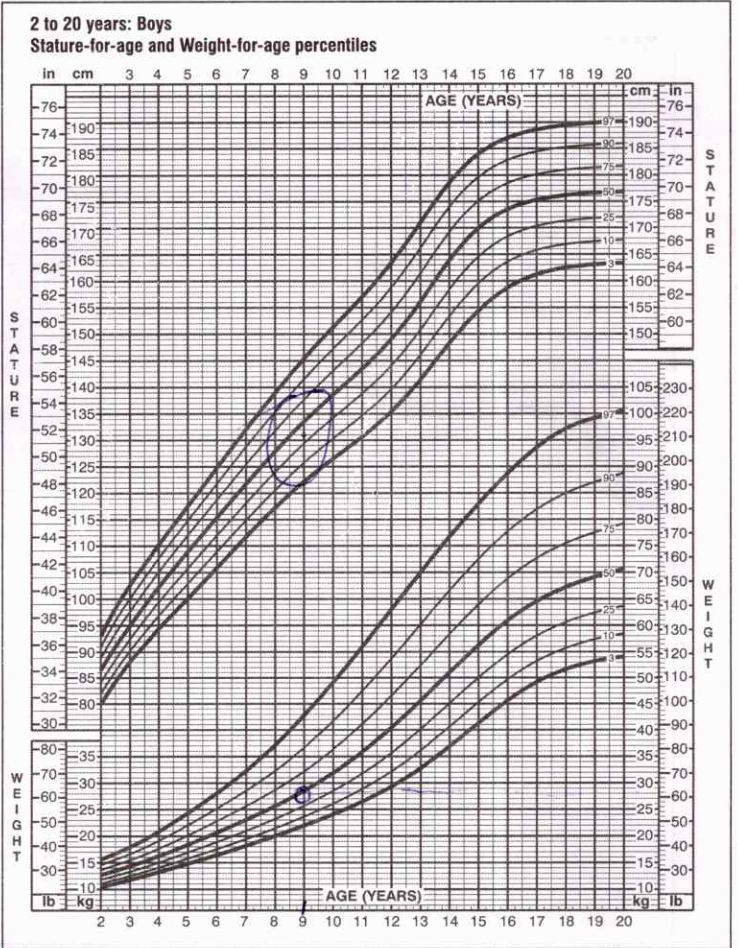
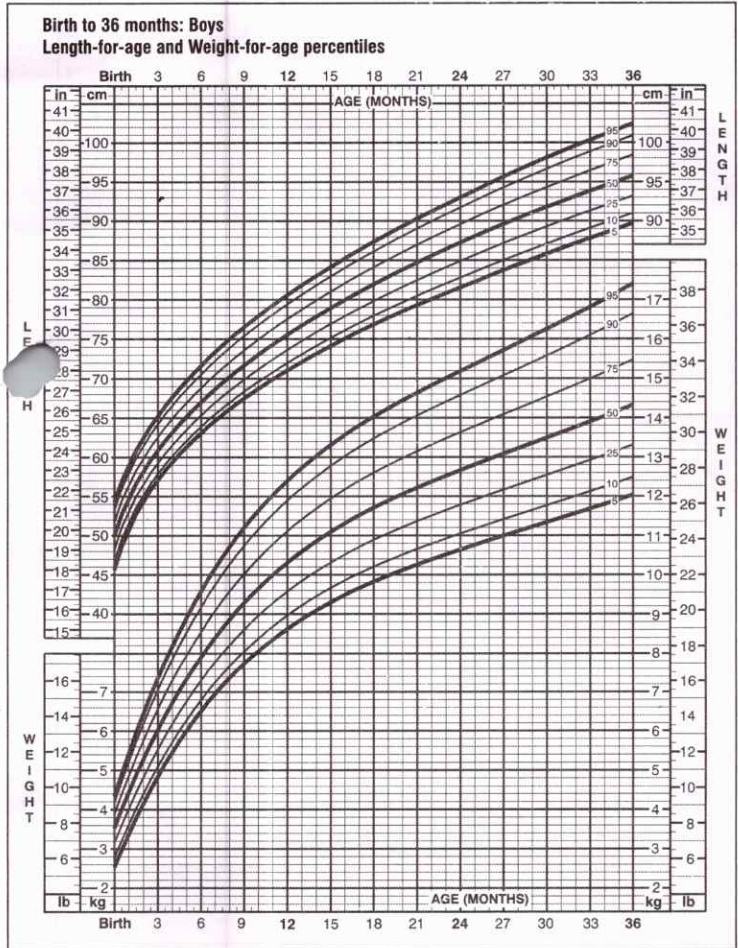
Food Allergies: NO Veg/Non-veg: Veg

Diagnosis: Severe Acute gastritis & dehydration ? Renal Calculi

Nutritional Intervention - Oral Enteral Parenteral

Patient's Signature: [Signature]

GROWTH CHART (BOYS)



Dietician's Name: Syeda Sabiya Zahoor

Dietician's Signature: [Signature]

wt - 28.01 kg



EMERGENCY ROOM TRIAGE FORM

Patient's Name : Avish Bashetty Age : 9 years Gender: Male Female

Date : 2/06/26 Time of Arrival : 2:17 PM

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

Source of Information: Parents Others (Specify)

Mode of Arrival: Ambulatory Wheelchair Ambulance

Initial Vital Signs: Temp: 97.0 F PR: 79b/m BP: 104/65/100 mmHg RR: 28b/m SpO₂: 98%

Chief Complaints: no vomit abdomen pain since morning 3 episodes today

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

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

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

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian
 Triage Completion Time : 2:26 PM

Communicable Disease Triage Screening

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

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

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

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

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

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

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

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

Name of Triage Nurse : S. Sindhura

Signature of Triage Nurse : [Signature]

Date & Time : 2/06/26 @ 2:19 PM

NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date: 2/06/26 Time of arrival: 2:21 PM 3 episode
 Chief Complaints: cto: abdominal pain since morning vomiting since
 Height: Weight: 28.01 Kgs Head Circumference (<2 years)

Allergies: Yes No Medications Blood Transfusion Food Other:

If yes, identify

Pain Screening: Yes No If Yes, Pain Score: -1 Pain Tool Used: N Pass FLACC Wong Baker

Character acute Location g. stomach Frequency Duration

RISK FOR FALL:

If patient is < 6 years Yes No

If 'Yes' tick below fall risk intervention directly

If Patient is > 6 years

If 'Yes' Assess the below parameters

History of Falling: within past 3 months Yes No

Ambulatory Aids:

- Wheelchair Yes No
- Uses furniture for support Yes No

Gait/Transferring:

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

Mental Status: Forgets limitations Yes No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening: No Abnormalities Detected

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

Inform consultant for positive criteria

Nutritional Screening: No Abnormalities Detected

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

Inform consultant for positive criteria

Psychological Screening: No Significant Findings

Unusual concerns about patient's Psychological Status: Yes No

If Yes Consultant Notified: (Date/Time):

Social History: Lives With family

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

Time of Initial assessment completed by ER Nurse : @ 2:23 PM

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

Time	Nursing Notes
2:25 PM	assess the patient condition. monitor the vital signs

Samples collected by:

Time:

Samples sent by:

visaya

Time:

2:50 PM

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1
<i>[A large diagonal line is drawn across the entire table body.]</i>					

Condition of patient at time of shift - out :	Details of Shift - out
HR: <i>78/111</i> BP: <i>104/68/80</i> CFT: <i>N/A</i> RR: <i>28/111</i> SPO2 at FiO2: <i>98%</i> GCS: <i>15/1</i> Temperature: <i>98.6</i> Pain Score: <i>-1</i> Repeat RBS (if applicable): <i>N/A</i>	Shift - out from ER to: <i>2nd floor (208)</i> Time of Shift - out: <i>3:17 PM</i> Handover given to: <i>M. [Signature]</i> (Nurse's Name)

Tick as applicable: MLC LAMA BROUGHT DEAD

Procedures done with details (if any):


IX placement done

Name of the Nurse: *Shirley*

Signature of the Nurse: *[Signature]*

Date & Time: *2/06/26 @ 2:27 PM*

PATIENT TRANSFER FORM

Patient Name & UHID No. HNN-00012706 IP26-00006479 Master AVISH BASHETTY 24-05-2017 9 Y 0 M 9 D (M) Dr. SINDHURA MUNUKUNTLA 		Date & Time of Admission 2/06/26 @ 2:34 PM	Date & Time of Transfer Order 2/06/26 @ 3:18 PM
		Transfer Ordered by Dr. Anusha	Reason for Transfer Admission
From Unit ER	To Unit ward	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File 15-1-	Number of Imaging Films _____	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring S. Srinivasan		Name of Person Ordered Transfer Dr. Anusha	
Patient & Clinical Records Received by : Meehan			
Date & Time of Patient Received : @ 3:20 PM, 2/06/26			

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

- Unavailable Bed Nurse not Available Available Bed not ready

Handwritten text at the top of the page, possibly bleed-through from the reverse side. The text is mirrored and difficult to decipher but appears to contain several lines of writing.

MASTER ALISH BASHIRI 9Y 10D W GNR 00012706 ERCT ABDOMEN 03 JUN 26 12 12 PM
RAINBOW CHILDREN'S HOSPITAL HIMAYATH NAGAR

AGE