DISCHARGE SUMMARY

Name	Master DEVANSH JAIN	**UHID**	HNH-00016459
Father/Guardian	Mr PRATUL JAIN	**Age/Gender**	1 Y 9 M 22 D/ Male
Address	1-8-7/12, PLOT 04 SARVODAYA COLONY CHIKKADPALLY, Chikkadpally, Hyderabad, Telangana, INDIA, 500020		
IP No	IP26-00006796	**Admission Date**	09-07-2026
Ref Doctor	Self.		
Discharge Date	11.07.2026		

Consultant:
Dr. PRITESH NAGAR
MBBS MD
Medical Registration No. 47184

DIAGNOSIS	ICD CODE
COVID ILLNESS	
INFECTIVE COLITIS WITH DEHYDRATION	

History: Master DEVANSH JAIN, 1 Y 9 M 22 D , old boy presented with history of fever, cold since 4 days, vomitings since 3 days, decreased oral intake since 2 days prior to admission. For the above complaints he was admitted at Rainbow Children's Hospital - for further management.

Examination: He was afebrile, maintaining saturations at room air and was hemodynamically stable. His heart rate was 136/min and Respiratory Rate -

Name	Master DEVANSH JAIN	UHID	HNH-00016459
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36/min. Capillary Refill Time was <2 secs. Peripheries were warm & pulses well felt. On examination Signs of some dehydration were present, dry lips, oral mucosa, delayed skin turgor 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, he 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: 15.79 kilo grams.

Investigations: Enclosed reports.

GeneXpert FluA+FluB+RSV were sent, which was

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

Initial hemogram showed Hemoglobin of 11.4 gm%, White Blood Cell count of 7500 cells/cumm, platelet count of 1.96 lakhs/cumm and C-Reactive Protein of 7 mg/l. Complete urine examination shows 3-5 pus cells, 2-3 epithelial cells. Blood culture and sensitivity shows no growth after 24 hours of incubation.

Ultrasound abdomen shows

* Mild submucosal wall thickening involving sigmoid colon - suggestive of mild colitis, likely infective.
* Few non specific lower mesentery nodes.

Name	Master DEVANSH JAIN	**UHID**	HNH-00016459
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Management: He was admitted in the ward and was started on Intra Venous fluids and Intra Venous antibiotics. He was treated symptomatically with antacids and antipyretics.

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

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

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

Medication during hospital stay:
Injection. Esmoprazole
Injection. Ceftriaxone
Pro-GG sachet
Z & D drops

Advice:
* Diet as advised.

Name	Master DEVANSH JAIN	UHID	HNH-00016459
IP No	IP26-00006796	Admission Date	09-07-2026

S.No	MEDICATION	DOSE	TIMINGS	DURATION
1	Syrup. ZIPRAX (Cefixime - 5ml/100mg)	4 ml	8am - 8pm (after food)	For 4 days.
2	PRO GG SACHET	1 SACHET	9am-9pm (after food)	For 3 days
3	Z & D drops (1ml/20mg)	1 ml	9am (after food)	For 12 days
4	Nasoclear nasal drops, 2 drops in each nostril **SOS** for nose block			

PLAN : To decide the duration of antibiotic depending on the final report of blood culture(24 hours : no growth).

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. PRITESH NAGAR on Monday(13.07.2026) 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 after food based on tolerance of stomach.

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Name	Master DEVANSH JAIN	**UHID**	HNH-00016459
IP No	IP26-00006796	**Admission Date**	09-07-2026

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 **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**

RAINBOW CHILDREN'S MEDICARE LIMITED HYDERABAD

Registrar/Resident/C.M.O

Dr. PRITESH NAGAR
MBBS MD
Medical Registration No. 47184

Rainbow Childrens Hospital-Himayatnagar

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

ADMISSION SHEET

Registration Details :

Admission No : IP26-00006796 **Admit Date** : 09-Jul-2026 **Admit Time** : 07:08 PM **UHID** : HNH-00016459

Patient Details :

Patient Name	: Master DEVANSH JAIN	**Age**	: 1 Y 9 M 21 D
Guardian	: Mr PRATUL JAIN	**DOB**	: 18-09-2024 01:00 AM
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: 1-8-7/12, PLOT 04 SARVODAYA COLONY CHIKKADPALLY Chikkadpally Hyderabad Telangana INDIA 500020	**Phone No**	: 8555825578/ 9573522138
		E-mail	: NA@GMAIL.COM

Admission Details :

Bed Type : DAY CARE **Bed No** : ER01 **Ward Name** : GF -EMERGENCY

Room No : ER01 **Admission Type** : First Visit

Contact Details :

Name	: Mr PRATUL JAIN	**Relationship**	: Father
Contact Address	: 1-8-7/12, PLOT 04 SARVODAYA COLONY CHIKKADPALLY Chikkadpally Hyderabad Telangana INDIA 500020	**Phone No**	: 9573522138

Signature

Doctor Details :

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

Payment Details :

Payment Mode	: DC/CC Card	**Deposit Amount**	: 25000.00
		Payor Name	: SELFPAY

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ACTIVITY RECORD FOR BILLING

Name: -------- HNH-00016459 IP26-00006796 ----------
Master DEVANSH JAIN
UHID No : ----- 18-09-2024 1 Y 9 M 21 D (M) ----- Consultant : ---------- Dept : pediatrics
Dr. PRITESH NAGAR
Date of Admis ---------- Date of Discharge : ---------- Time: ----------

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
9/7/26	7:55pm	ER	304	
10/7/26	11:48pm	3rd Flr (301)	219 (2nd Flr)	

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Sign
9/7/26	CBP		
	CRP		
	Blood cly		
	Respiratory panel Sm		
	CUE		
	urine cly	11364	Sunitha.
	cross	checked done by Amrutha	
10/7/26	Ultrasound abdomen	8270	
10/7/26	X-ray Chest	8274	
		cross checked done by Sm	

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
9/7/26	infusion pump	9/7/26 @ 8:38pm	11/7/26 @ 9am	2306	[illegible]
			Cross	Checked	done by
				Amruth	

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
9/7/26	ue placement	1	2219	[illegible]
		cross checked done by Amruth		
10/7/26	NHA	①	2395	[illegible]
		Cross checked done by [illegible]		

ANY OTHER INFORMATION

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

Ref.No. F/IN/PR/10

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PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name :

Patient ID# :

Consultant :

Final Diagnosis :

HNH-00016459 IP26-00006796
Master DEVANSH JAIN
18-09-2024 1 Y 9 M 21 D (M)
Dr. PRITESH NAGAR

1y 9 month

Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Informant _____ Reliability _____

Chief Presenting Complaints & Duration (Chronologically):

C/c 1/ Fever since 4 days
2/ Vomiting since 3 days
3/ Decreased oral intake since 2 days
4/ Cold since 4 days.

History of present illness :

Child was apparently asymptomatic 4 days back after which he had Fever which was initially moderate grade later high grade intermittent Fever spikes were present

Vomiting started 3 days back which was 6-7 episodes/day non-projectile non-bilious (contains food matter

Child has Decreased oral intake since 2 days

Child has running nose since 4 days

Pediatric Multiorgan History & Physical Examination

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

Birth & Neonatal History :

Birth & Socio Economic History :

About Father :

About Mother :

Any additional Information :

Developmental History :

Immunization History :

Pediatric Multiorgan History & Physical Examination

Anthropometry

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

Weight (kgs) 15.79 kg (Centile _____)

On Examination :

Temperature : _____ Pulse Rate: _____ Description _____

B.P. _____ SPO2 96% at RA.

Resp. rate and type of breathing : _____

dry lips

Rash dry oral mucosa

Lymphadenopathy ↓ skin turgor

Oedema : _____

Respiratory system :

Inspection (any s/o distress) : _____

Air entry & breath sounds : BL- AE+

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 PLAJOCE

Palpation : _____

Ausculation : _____

Spine: _____ External Genitelia : _____

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

Central Nervous System :

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

Cranial Nerves : Normal

Motor System :

Nutrition : (N)

Tone : Power

Co-ordinator :

Posture :

Involuntary Movements :

Reflexes :

DTR (N) **Superficials :**

Plantars

Sensory System :

Bladder / Bowel :

Clinical Summary & Diagnostic :

(1) AFI ? dehydration

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment :

IV Antibiotics

Desired goals of the treatment :

Fever subsidence

Planned Labs :

CBP
CRP
CUE
Urine C/S] Catheter sample
Resp. panel (5 viruses)
Blood C/S
Extra plain - 2
w/b [illegible]

Planned Management :

- Inj. CEFTRIAXONE 1.5gm IV OD
- Inj. ESMOPRAZOLE 15mg IV OD
- IV fluids DNS @ 40ml/hr
- Syp. CROCIN - DS 4.5ml SOS/6th L
- Syp. IBUGESIC 4ml SOS/8th L

w/b [illegible]

Please fill up the following details

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

Doctor's Signature Name Dr. Pritesh Nagar Consultant Pediatrician & Intensivist Reg. No: 47184 Date Time

HNH-00016459 IP26-00006796
Master DEVANSH JAIN
18-09-2024 1 Y 9 M 21 D (M)
Dr. PRITESH NAGAR

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/7/26	S/B Dr. Sreejhan	
		PG
1 AM	c/o Loose stools	
	4 episodes	– Drop 2 x D [illegible] OD
	1 episode of	
	blood in	– WHO-ORS 100ml each
	Stool.	loose Stool.
	child Active	– CT CEFTRIAXONE
	playful.	
		– Trace reports
		– w/f dehydration
		[signature]
11/7/26	MUB Dr. Manni	
10am	? dysentery.	
	– fever spikes (+)	Plan:
	– loose stools (–) since morning	1) ct. ceftriaxone
	– oral intake : good	esomeprazole
	– passing urine	2) trace resp panel
	O/E : vitals: stable	urine c/s
	S/E – P/A : soft	Blood c/s
	RS : B/AE (+)	3) monitor vitals
	clear	4) rest ct. as per Rx chart

NB - Moutushi @ 8:15AM.

[signature]

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18-09-2024 1 Y 9 M 21 D (M)
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/7/25 10 am	c/s/b Dr. Pritesh	
	COVID illness c ? dysentery	
	- fever spikes (+) 101 @ 7am	
	- loose stools (+)	
	c blood (+)	
	- cough : ↓	
	- oral intake :	
		Plan
	O/E : active :	1) chest X Ray now
	- vitals : stable	2) USG abd & Pelvis now
	S/E	3) Ct. ceftriaxone
	P/A : soft.	IVF.
	CVS : $S_1 S_2$ (+)	4) Ct. zinc
	no murmur.	ORS
		Pro 44.
		5) trace adeno
		Blood c/s
		urine c/s.
		6) monitor vitals
		7) Rest Ct. as per Rx chart.
	Dr. Pritesh Nagar Consultant Pediatrician & Intensivist Reg. No. 47184	NB Manjusha @ 10:30AM

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

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Master DEVANSH JAIN
18-09-2024 1 Y 9 M 21 D (M)
Dr. PRITESH NAGAR

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/7 2.00pm.	CIS113 Dr. pritesh Covid illness. & dehydration. Infective Colitis. fever (P) loose stools (P). Vitals - stable. P/A - soft NT R/S - BL AE (P).	Plan - Trace USG Abdomen repeat - Cont ceftriaxone - Cont Zinc. ORS PROCG. - (T) Adeno Blood Cls Urine Cls - Cont IVF. Neph.
10/7 3.00pm.	CIS113 Dr. Naipunya Infective Colitis Covid illness & dehydration. fever (P) loose stools (P). P/A - soft NT	Plan (T) Adeno, Blds, u/cls - Cont ceftriaxone.

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Master DEVANSH JAIN
18-09-2024 1 Y 9 M 21 D (M)
Dr. PRITESH NAGAR

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/7/26 9.30pm.	c/s/by Dr. Pritesh	
	Covid illn c dehydn Hyuti colic	
	No fever.	
	vital stab	— Enhance orally.
	No further Blood in stools since morn.	— Tm d/s plan c Cefixime x 5-7 dy. (If No blood in stools & Nausea further) R/w Monday
		— Stop IV fluids If take dinner well.
		— (F) culture. (If +ve — Antibiotic x 14 day)

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

HNH-00016459 IP26-00006796
Master DEVANSH JAIN
18-09-2024 1 Y 9 M 21 D (M)
Dr. PRITESH NAGAR

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
1[illegible]/7/26 7:15 AM	c/s/by Dr Anush Iravan	
	covid illness ē dehydration	
		Infective colitis.
	fever - No	
	stools - No blood.	
	hydration] good.	
	intake] good.	Plan
	vital stable	- Enhance orally
	S/E NAD	- (T) Bld/s ↓,
	P/A soft	plan Ab accordingly.
	Not distended.	
		- ct Antibiotics.
		- plan to d/s after sound.
	[signature]	- Monitor vitals.

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

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Master DEVANSH JAIN
18-09-2024 1 Y 9 M 21 D (M)
Dr. PRITESH NAGAR

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/7/26 9:30 AM	S/b Dr. Aniket.	
	(COVID illness) Infective colitis c dehydration.	
	NO loose stools Euthermic oral acceptance - fair Activity good	Advice Discharge on oral cefixime - Ct symptomatic support.
	O/E vitally stable	
	S/E wnl.	
	Dr. Aniket Anil Parashar Consultant Pediatrician & Intensivist Reg. No: 8568	Dr. D. Aniket

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Master DEVANSH JAIN
18-09-2024 1 Y 9 M 21 D (M)
Dr. PRITESH NAGAR

301 219

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RESULT SHEET

Date	9/7/26					
Time						
Hb	11.4					
PCV	32.4					
RBC	4.53					
WBC	7.50					
N/L	45.6/48.5					
Platelets	196					
CRP	7.0					
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	9/7/26					
Time						
CUE - ~~Alb~~ p.H	6.5					
CUE - Sugar	Nill					
CUE - Ketones	~~Present~~					
CUE - PUS Cells	3-5					
CUE - RBC Cells	Nill					
~~CUE~~ Epithelial cells	2-3					
Nitrite	Neg					
Stool Pus Cell						
OVA / Cyst						
Occult Blood						

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

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HM-00016459 IP26-00006796
Master DEVANSH JAIN
18-09-2024 1 Y 9 M 21 D (M)
Dr. PRITESH NAGAR

RCH/ FRM / CLINICAL / 125

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

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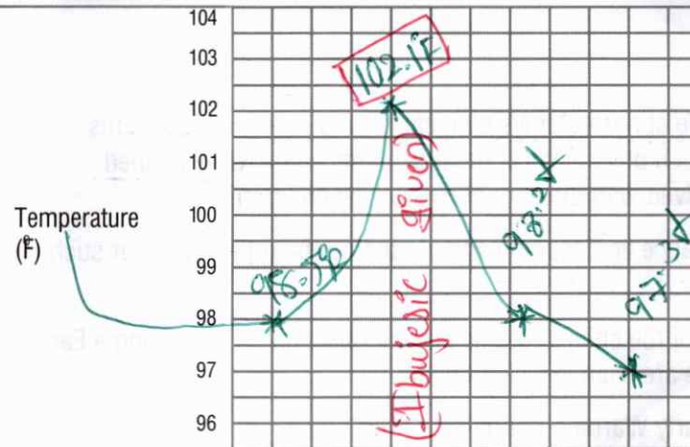
EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 9/7/26 Time: 10PM 1AM 3AM 6AM

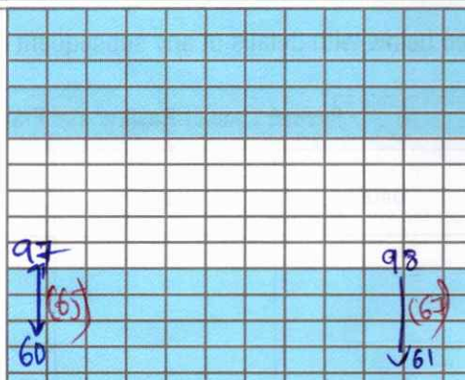
Doctor / Nurse / Family Concern?

Temperature (F)



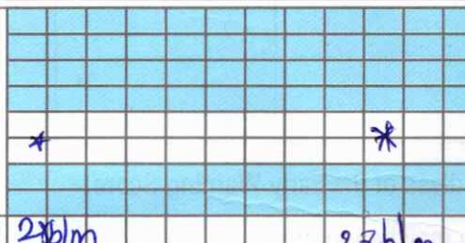
Heart Rate (bpm) and Blood Pressure (mmHg) *

Note: BP does not score in early warning scoring



Heart Rate (Number) 118/m 119/m

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



Resp Rate (Number) 28b/m 28b/m

Resp Distress	Mod/ Severe		
	None / Mild		
Receiving O_2(l/min) O_2Saturations (%)		100%	100%
Conscious Level	Normal		
	Altered		
GCS *			
TOTAL SCORE Number of shaded boxes		0	0
Pain Score		0	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-00016459 IP26-00006796
Master DEVANSH JAIN
18-09-2024 1 Y 9 M 21 D (M)
Dr. PRITESH NAGAR

FRM / CLINICAL / 125

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

Pratiksha Rainbow Children's Hospital
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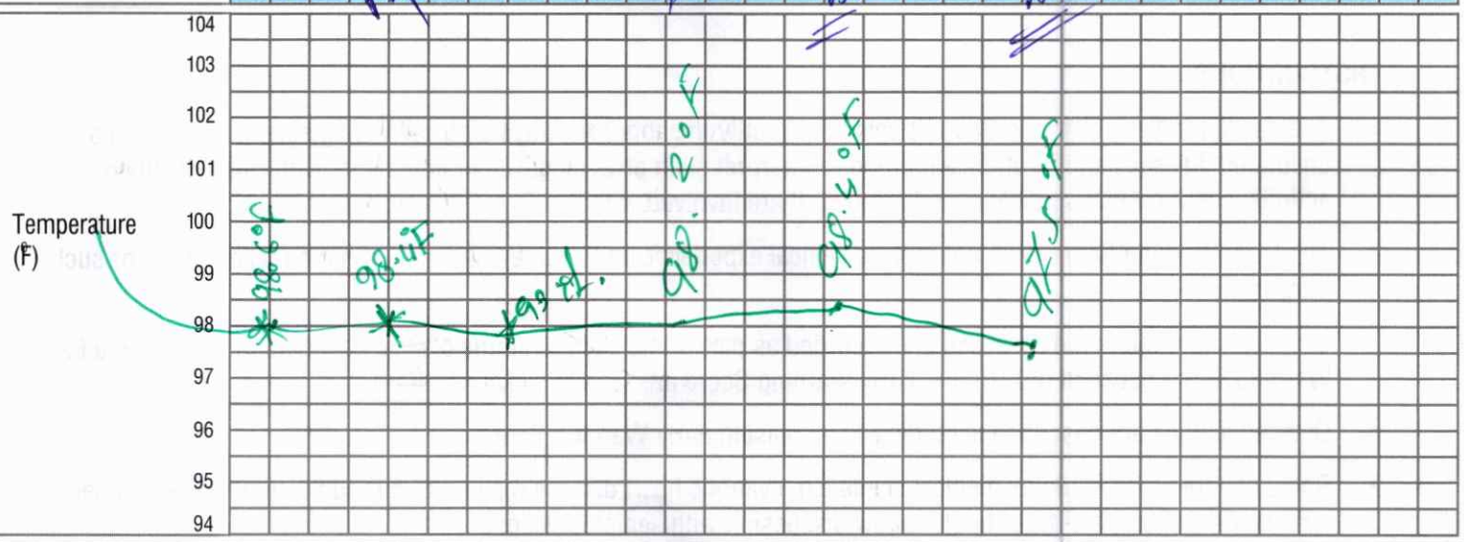
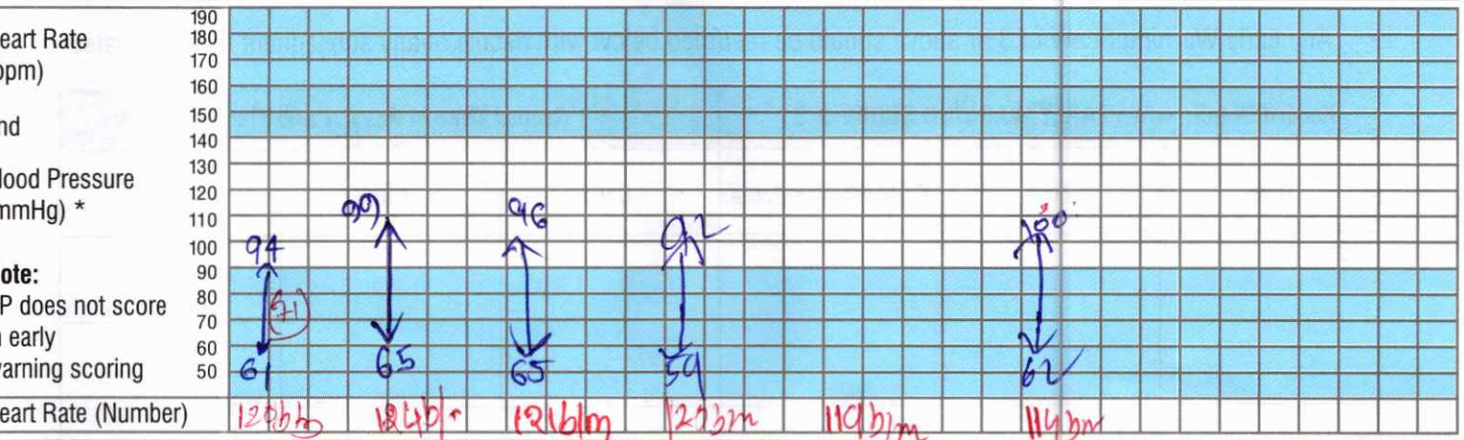
EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 10/9/26 Time: 10 2 6pm 10 2 6

Doctor / Nurse / Family Concern? Amb 2 pm 10 pm 2 Am 6 Am





Heart Rate (Number)	128/m	134/m	128/m	125/m	110/m	114/m

Resp Rate (Number)	28/m	30/m	30/m	30/m	28/m	28/m
Resp Distress: Mod/ Severe / None / Mild						
Receiving O_2(l/min) O_2Saturations (%)	99%	99%	99%	98%	99%	98%
Conscious Level: Normal / Altered						
GCS *				14/15	14/15	14/15
TOTAL SCORE Number of shaded boxes	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0
Observer's Initials	AA					

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)

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Master DEVANSH JAIN
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Dr. PRITESH NAGAR

Pa... FRM / CLINICAL / 125

PRESCHOOL (1-5 years)

Children's Observation & Early Warning Scoring Chart

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : ....1/1/7.... Time:		
~~Doctor / Nurse / Family Concern?~~		
Temperature (F)	104	
	103	
	102	
	101	
	100	
	99	
	98	
	97	
	96	
	95	
	94	
Heart Rate (bpm) and Blood Pressure (mmHg) *	190	
	180	
	170	
	160	
	150	
	140	
	130	
	120	
	110	
	100	
Note: BP does not score in early warning scoring	90	
	80	
	70	
	60	
	50	
Heart Rate (Number)		
Resp. Rate (bpm) (Over 1 Minute) *	70	
	60	
	50	
	40	
	30	
	20	
	10	
Resp Rate (Number)		
Resp Distress	Mod/ Severe	
	None / Mild	
Receiving O_2(l/min)		
O_2Saturations (%)		
Conscious Level	Normal	
	Altered	
GCS *		
TOTAL SCORE Number of shaded boxes		
Pain Score		
Observer's Initials		

ACTIONS NB: Scores 3 should be recorded overleaf	Score 1	: Continue normal observation by staff nurse
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R	**RECOMMENDATION :** I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

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FLUID CHART

Sheet No. : .....

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

		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 :**						
9/7/26	08:00 pm											
	09:00 pm			40ml		✓			✓	✓	1	
	10:00 pm		H2O	40ml			✓					AM
	11:00 pm	ORS		40ml	DR		✓	DR			2	
	12:00 am			40ml			✓				1	
	01:00 am			40ml				✓				
Total Intake :		Taken				**Total Output :**		M -		U - 1		
10/7/26	02:00 am			40ml								
	03:00 am	ORS		40ml		✓	✓		✓	✓	1	
	04:00 am		ORS	40ml								AM
	05:00 am	ORS	+	40ml	DR		0	DR			0	
	06:00 am		H2O	40ml			✓	✓		✓		
	07:00 am			40ml							1	
Total Intake :		Taken				**Total Output :**		M - 0		U - 2		

Total 24 hrs. Intake		Total 24 hrs. Output	

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Sheet No. : .....

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

Date	Time	Intake: Nature of Fluid	Intake: Route – Mouth	Intake: Route – I.V	Intake: Route – N.G	Output: NG	Output: Diarrhoea	Output: Vomit	Output: Drainage	Output: Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
10/7/26	08:00 am		RPO	40ml								
	09:00 am		Milk	40ml								
	10:00 am	ONS	Idli	40ml		NA	✓		NA	✓	0	
	11:00 am	20	Milk	40ml								
	12:00 pm			40ml								
	01:00 pm			40ml			✓			✓		
Total Intake :		Taken				**Total Output :** U – 2 M – 2						
	02:00 pm			40ml								
	03:00 pm		milk	40ml								
	04:00 pm			40ml								
	05:00 pm	DNS	milk	40ml		NA			NA		0	
	06:00 pm			40ml								
	07:00 pm		Chk.	–								
Total Intake :						**Total Output :**						
	08:00 pm			30ml							0	
	09:00 pm			30ml			✓			120ml	0	
	10:00 pm		Milk	30ml							0	
10/7	11:00 pm	DNS		30ml			0				0	Sr
	12:00 am		Milk	30ml			✓				0	
	01:00 am			30ml							0	
Total Intake :						**Total Output :**						
	02:00 am			–							0	
	03:00 am			–							0	
	04:00 am	DNS		–							0	
11/7	05:00 am			–							0	Sr
	06:00 am										0	
	07:00 am										0	
Total Intake :						**Total Output :**						

Total 24 hrs. Intake		Total 24 hrs. Output	

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11/7	08:00 am											
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	10:00 am											
	11:00 am											
	12:00 pm											
12	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											
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	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**	

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		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
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	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**	

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NURSING CARE RECORD

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Date: 9/7/26

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				NA			
Night	8pm to 8AM	→ Assess pt condition → monitor the vitals → Maintain I/o chart → Administer medication as per drug chart → Ct IV fluids	8pm to 8AM	→ Assessed pt condition → monitored vitals → Maintained I/o chart → Administered medication as per drug chart → Ct IV fluids	Patient is Stable	Re-checked vitals	AP

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Patient S

NURSING CARE RECORD

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Date: 10/7/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8AM – 2PM	→ Assess the general condition of pt. → Monitor vitals → Maintain I/O chart. → Administer medication.	8AM – 2PM	→ Assessed the general condition of pt. → Monitored vitals → Maintained I/O chart. → Administered medication.	Pt is stable	Re-assess vitals	[signature]
Afternoon	2pm – 8pm	Assess the baby / Monitor V/s / Ct IV fluids	2pm – 8pm	Assessed baby / Monitored V/s / Ct IV fluids	[illegible]	Reassess pt	[signature]
Night	8pm – 8AM	Assess the pt condition. Monitor vital signs. Maintain I/O chart. Provide the comfortable position. Medication given as per doctor order.	8pm – 8AM	Assessed the pt condition. Monitored vital signs. Maintained I/O chart. Provided the comfortable position. Medication given as per doctor order.	→ Pt is stable. → Vitals mon.	→ Monitor vitals. → Maintain I/O chart	[signature]

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BRADEN 'Q' SCALE

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					Date : 9/7 10/7 10/7	
					Time : N M N	
Mobility	**1. Completely immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	**3. Slightly limited:** Makes frequent through slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.	4 4 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 3	
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	
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	
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	
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.	2 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	
				TOTAL SCORE	24 28 24	
				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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PAIN ASSESSMENT FORM

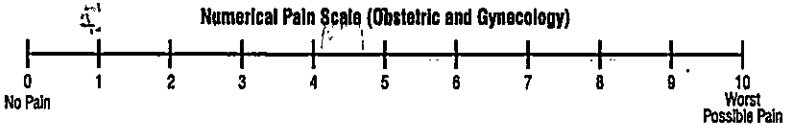
Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
9/7/26	10pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	NA	[signature]
10/7/26	6Am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	NA	[signature]
10/7/26	10AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
10/7	10pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
11/7	2Am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
11/7	8Am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

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

HNH-00016459 IP26-00006796
Master DEVANSH JAIN
18-09-2024 1 Y 9 M 21 D (M)
Dr. PRITESH NAGAR

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NURSING SHIFT HAND OVER FORM - WARD

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

SITUATION	Diagnosis:				Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:		
BACKGROUND	Area / Shift Time	9/7/26 N1	10/7/26 M6	10/7 SN	10/7 N1		
	Medical Condition (Any special condition to be noted):	–	–	–	–		
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:	97.3°F	97.4°F	98.3°F	98.2°F		
	Res:	23b/m	28b/m	22	27b/m		
	SpO_2:	100%	100%	99%	99%		
	Pulse:	115b/m	114b/m	122	124b/m		
	BP:	106/66	106/64	WNL	106/80		
	Fall Risk Score:	–	–	–	–		
	Pain Score:	"0"	0	–	–		
Recommendations	Safety Needs:	Yes	Yes	–	–		
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:	–	–	–	–		
	Special Diet:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:	–	–	–	–		
Post Operative Procedure Special Orders:		–	–	–	–		
Handed Over By Name :		Anusha	Moutushi	SN	SN		
Signature :				SN	SN		
Date:		10/7/26	10/7/26	10/7	10/7		
Time:		8PM	2PM	SN	8PM		
Taken Over By Name :		Moutushi	Moutushi	SN			
Signature :				SN			
Date:		10/7/26	10/7	10/7			
Time:		8AM	2PM	8PM			

Docu. No. : RCH/FRM / CLINICAL / 097

Patient Sticker

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NURSING SHIFT HAND OVER FORM - WARD

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

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

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DRUG CHART

Date of Admission: 9/7/26 Drug Allergies: Nill ☐ 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				Date/Time
Dose: 4.5ml	Route: PO	Frequency: SOS/6th	Start Date: 9/7	
Doctor's Signature:	Valid Period:	Pharm.		
Additional Instructions: if temp >100.4°F				

DRUG: SYP IBUGESIC				Date/Time: 9/7 1:19 AM
Dose: 4ml	Route: PO	Frequency: SOS/8th	Start Date: 9/7	
Doctor's Signature:	Valid Period:	Pharm.		
Additional Instructions: if temp >102.F.				

DRUG: WITO-O RJ				Date/Time
Dose: 200	Route: oral	Frequency: SOS/6h	Start Date: 10/7	
Doctor's Signature:	Valid Period:	Pharm.		
Additional Instructions:				

Verified by Dr. Dhakshayani

Verified by Dr. Dhakshayani

VERIFIED BY : Name ..... Signatu

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REGULAR PRESCRIPTIONS

Weight. 15.7kg Ward. ....

Verified by Dr. Dhakshayani

DRUG : INJ CEFTRIAXONE

Dose	Route	Frequency	Start Date
1.5g	IV	OD	9/7

Name & Signature of the Doctor Starting the Drugs: [signature]

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time	9/7	10/7
	8:30pm	
6pm	[signature]	[signature]

Verified by Dr. Dhakshayani

DRUG : INJ ESOMEPRAZOLE

Dose	Route	Frequency	Start Date
15mg	IV	OD	9/7

Name & Signature of the Doctor Starting the Drugs: [signature]

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time	9/7	10/7	11/7
	9pm		
6AM	[signature]	[signature]	[signature]

Verified by Dr. Dhakshayani

DRUG : Drop. 2XD

Dose	Route	Frequency	Start Date
1 ml	oral	OD	10/7

Name & Signature of the Doctor Starting the Drugs: B-Sm [signature]

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time	9/7	10/7
	1:13pm	
12pm	[signature]	[signature]

Verified by Dr. Dhakshayani

DRUG : PRO GG

Dose	Route	Frequency	Start Date
1sachet	PO	BD	10/7

Name & Signature of the Doctor Starting the Drugs: [signature]

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time	10/7	11/7
10AM	12PM [signature]	[signature]
10PM	[signature]	

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

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

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

Signature .....

VERIFIED BY . Name .....

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses

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I.V. FLUIDS CHART

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

		sition 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
9/7/26	7:30pm	IVF - DNS	IV	40 ml/hr. ↓ 30 ml/hr					

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

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00016459 IP26-00006796 Master DEVANSH JAIN 18-09-2024 1 Y 9 M 21 D (M) Dr. PRITESH NAGAR	9/7/26 @ 7:30 PM	9/7/26 @ 8 PM
	Transfer Ordered by Dr. Dawi	Reason for Transfer Admission.
From Unit ER	To Unit 3rd	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. Dawi

Patient & Clinical Records Received by : Mounteshi

Date & Time of Patient Received : @8:10PM. , 9/7/26

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

☐ Unavailable Bed ☐ Nurse not Available ☐ Available Bed not ready

PATIENT TRANSFER FORM

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Dr. PRITESH NAGAR

Date & Time of Admission	Date & Time of Transfer Order
9/7/26 @ 7:8pm	10/7/26 @ 4:30pm

Treating Consultant Name	Transfer Ordered by	Reason for Transfer
Dr. pritesh	Dr. pranav	OBS

From Unit	To Unit	Information to Attendant
304	Ward - 219	Yes ☑ No ☐

Number of Sheets in Clinical File	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant
30	X-ray - 01	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
Madhuri	Dr. pranav.

Patient & Clinical Records Received by : Ajmal

Date & Time of Patient Received : 10/7/26 @ 4:40pm

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

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MEDICATION RECONCILIATION FORM

Drug Allergies: Nil ☐ Not known any Drug Allergies

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

Shifting From: ER Shifted to: 3OH

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

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Parmar

Date & Time : 9/7/26 @ 7pm

Nurse Name & Signature: Dr. Vijaya IOH

Date & Time : 9/7/26 @ 7:15pm

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

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304

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NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 10/7/26 Time: 11:00am

Weight: 15.79 kg. Centile: 95th

Height: — Centile: —

Inference: Overweight child.

RDA: ..... Calories: 1200Kcal/day Protein: 20g/day

Diet Recommendations: Soft High fiber diet with liquids

Re-Assesment: NO Junk, Spicy food

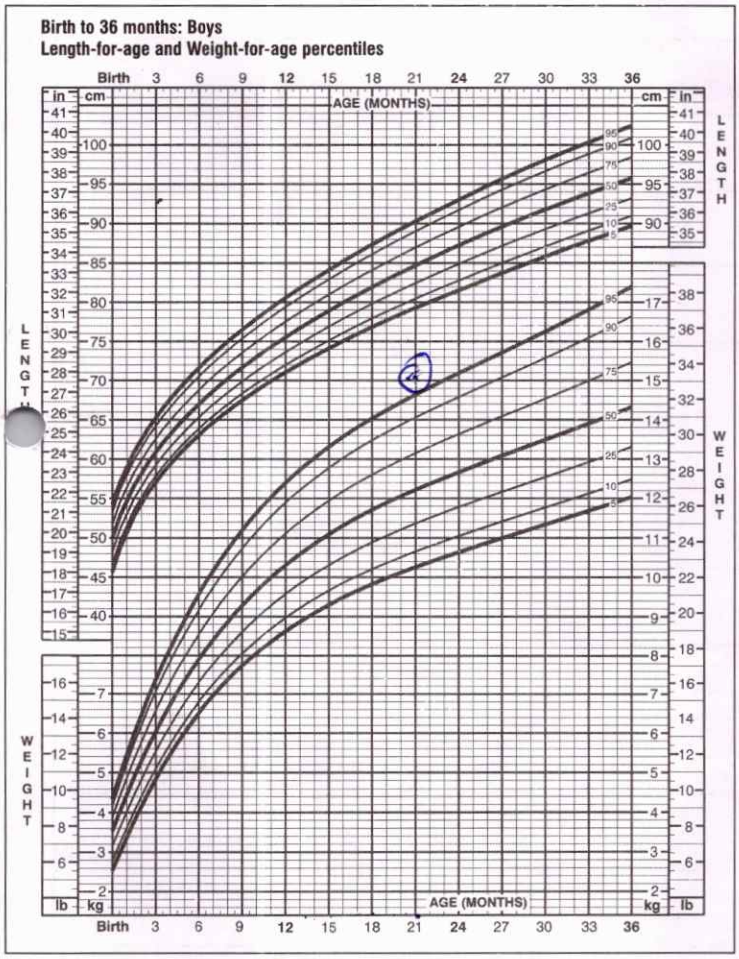
Food Allergies: No Veg/~~Non-veg~~ Veg

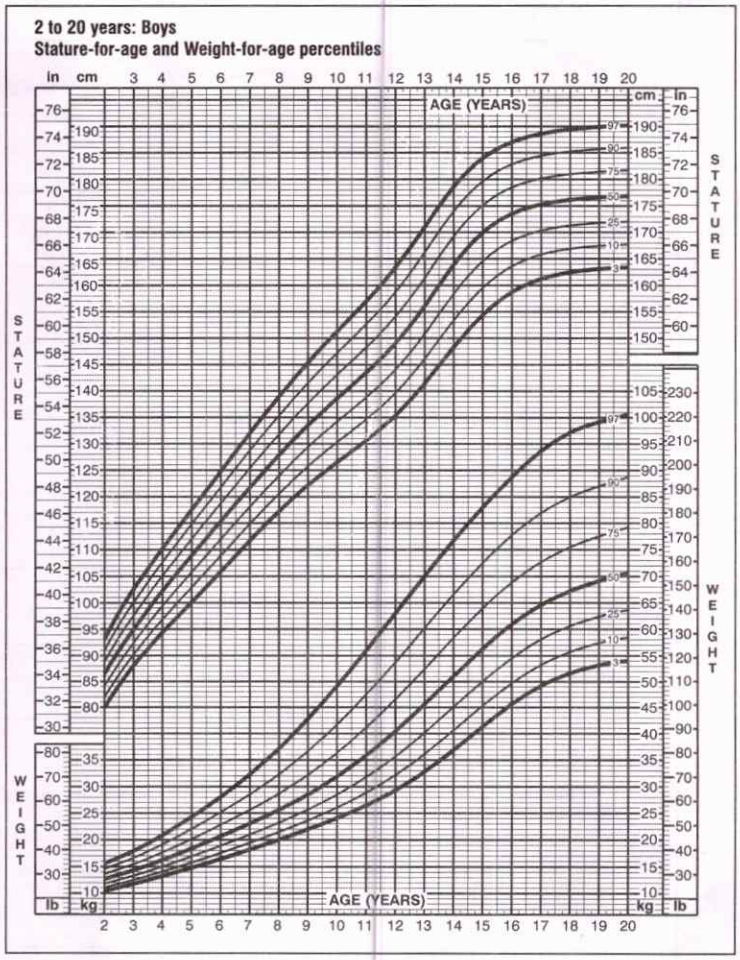
Diagnosis: ? Dysentry

Nutritional Intervention - ☑ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: Soumalaya

GROWTH CHART (BOYS)





Dietician's Name Syeda Sobiya Zaheer Dietician's Signature Sobiya

Daily Notes:

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18-09-2024 1 Y 9 M 21 D (M)
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wt- 11.6kg

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EMERGENCY ROOM TRIAGE FORM

Patient's Name : Devansh Jain Age : 1yrs 9m **Gender:** ☐ Male ☐ Female

Date : 9/7/26 Time of Arrival : 6:50pm

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

Source of Information : ☐ Parents ☐ Others (Specify)

Mode of Arrival : ☐ Ambulatory ☐ Wheelchair ☐ Ambulance

Initial Vital Signs: Temp: 101.4°f PR: 146b BP: RR: 36b SpO_2: 99%

Chief Complaints: c/o fever since 4 days Dull active baby

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 : 6:55 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 : [illegible]

Signature of Triage Nurse : .....

Date & Time : 9/7/26 @ 6:55pm

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 9/7/26 Time of arrival : 6:50 pm

Chief Complaints: c/o fever since 4 days RBS: .....

Height : ..... Weight : 11.6 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 N/A ☐ Frequency N/A ☐ Duration N/A

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: N/A (Date/Time): N/A

Social History: Lives With family

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

Time of Initial assessment completed by ER Nurse : [signature] @ 7 pm

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

Time	Nursing Notes
7pm	=> Assessed The general Condition.
	=> Vitals checked and Recorded.
	=> IV Cannula done.
	=> Sample collected

Samples collected by: K. wilfey Time: 7:15pm

Samples sent by : Time:

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1
9/7/16 7pm	Crocin DS	Oral	8ml	Dr. [illegible]	A.D

Condition of patient at time of shift - out :	Details of Shift - out
HR: 136b BP: .... CFT: <2sec	Shift - out from ER to: 804
RR: 36b SPO$_2$: 99%	Time of Shift - out: 8:00pm
GCS: 15 Temperature : 97°F	Handover given to: (Nurse's Name) Moufushi
Pain Score: 0	
Repeat RBS (if applicable):	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any): IV placement

Name of the Nurse : K. wilfey Signature of the Nurse : [signature]

Date & Time : ....