Rainbow Children's Hospital

BirthRight by Rainbow

Rainbow Childrens Hospital-Himayatnagar

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

ADMISSION SHEET

Registration Details :

Admission No : IP26-00006687 **Admit Date** : 29-Jun-2026 **Admit Time** : 10:20 PM **UHID** : HNH-00016261

Patient Details :

Patient Name	: Baby MARYAM ZARA	**Age**	: 3 Y 3 M 22 D
Guardian	: Mr IMRAN SAZID MOHAMMAD	**DOB**	: 07-03-2023
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: plot no - 92 mmq prime hills colony , mm pahadi Attapur Hyderabad Telangana INDIA 500048	**Phone No**	: 9966737031/ 7093860104
		E-mail	: imransazid@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 IMRAN SAZID MOHAMMAD **Relationship** : Father

Contact Address : plot no - 92 mmq prime hills colony , mm pahadi Attapur Hyderabad Telangana INDIA 500048 **Phone No** : 9966737031

Signature

Doctor Details :

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

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

Co-Consultant :

Payment Details :

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

Payor Name : ADITYA BIRLA HEALTH INSURANCE CO. LTD

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ACTIVITY RECORD FOR BILLING

HNH-00016261 IP26-0000665 /
Baby MARYAM ZARA
07-03-2023 3 Y 3 M 22 D (F)
Dr. ANIKET ANIL PARASHAR

Name: ---- ----------

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

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
29/6/26	11:19pm	ER	2nd floor (219)	Sindhya

Cross Consultation Visit

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

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Dr. ANIKET ANIL PARASHAR

INVESTIGATIONS

Date	Investigations	Order No.	Sign
29/6/26	CBP		
	CRP		
	widal	10632	
	LFT		
	Blood clg	10633	
29/6	CUE	10636	
29/6	X-ray Chest	7773	
	Forms Checked N/B		
30/6/26	USG abdomen	7774	Sneha

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MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time		
29/6/26	Infusion Pump	11pm		209411	

cross checked by [illegible]

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PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
29/6/26	W placement	1	9351	
30/6/26	NHA	1	9470	

Cross checked done by Sneha

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

HNH-00016261 IP26-00006687
Baby MARYAM ZARA
07-03-2023 3 Y 3 M 22 D (F)
Dr. ANIKET ANIL PARASHAR

Patient Name : _____

Patient ID# : mariyam

Consultant : Dr. Aniket

Final Diagnosis : PYREXIA OF UNKNOWN ORIGIN

Pediatric Multiorgan History & Physical Examination

Name : mariyam Age/Sex 3y 3m

Informant Parents Reliability Good

Chief Presenting Complaints & Duration (Chronologically):

c/o - Fever x 20 days
- loose stools - on & off for 10 days, reduced now

History of present illness :

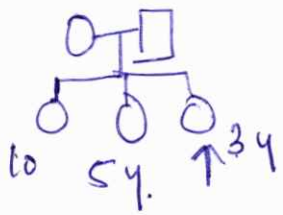
A 3year old child presented with complaints of fever for 20 days, mod-high grade, insidious onset, intermittent, subsided on taking medication, but re-assed, no h/o rash, no h/o Pain abdomen, no h/o burning micturition, no h/o vomiting, no h/o cough/cold.
took Azithromycin, cefixme, Antimalarials & stopped outside CRP-47
c/o loose stool after starting Ab's, subsided after 10days, demisolid, yellowish 3-4 episodes/day
no h/o water change.
(N) Bowel & Bladder now
Rev - (N)
Growth - (N) Jacc to parents

Pediatric Multiorgan History & Physical Examination

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

Birth & Neonatal History :

Hypothyroidism, FT1SCS (PrevLSCS)
Bwt- 3.5kg, CIAB, NONICU admission
nonNS



Birth & Socio Economic History :

About Father :

About Mother :

Any additional Information :

Developmental History :

uptodate
can scribble

Immunization History :

immunised upto 18months-
BCG.

Pediatric Multiorgan History & Physical Examination

Anthropometry

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

Weight (kgs) 12.66kg (Centile _____)

On Examination :

Temperature : 98F Pulse Rate: 108 Description Regular

B.P. 100/60 SPO2 98% at Room air

Resp. rate and type of breathing : 23/mn rhythmic

Signs of dehydration

Rash NO

Lymphadenopathy NO Oral cavity dry

Oedema : NO Oral cavity - (N)

Respiratory system :

Inspection (any s/o distress) :

Air entry & breath sounds : NVBS+, BL CAE+, No added sounds

Any addes sounds :

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

Cardiovasclular System :

Inspection of procordium :

Heart Sounds : S1S2+, No murmurs

Any murmur :

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

Per Abdomen :

Inspection (N) Shape, umbilicus Prolapsed

Palpation : Soft, Non-tender, liver → Just palpable
spleen → tip (+)

Ausculation :

Spine: N External Genitelia :

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

Pediatric Multiorgan History & Physical Examination

Central Nervous System :

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

Cranial Nerves : WNL

Motor System :

Nutrition :

Tone : Power

Co-ordinator : WNL

Posture :

Involuntary Movements :

Reflexes :

DTR **Superficials :**

Plantars

Sensory System : WNL

Bladder / Bowel : Regular

Clinical Summary & Diagnostic :

Pyrexia of unknown origin.

Preventive aspects of the treatment :

Desired goals of the treatment :

Planned Labs :

Paired Blood culture
CRP, CBP, WIDAL, LFT
CUE, XRAY chest, } due
~~Urine~~ USG Abdomen
Extra Sample (Scrub | Brucella Serology)
MLB shifting

Planned Management :

IVF NS (D5 1/2 NS)
Ceftriaxone
Antipyretics
MLB shifting

Please fill up the following details

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

Doctor's Signature Name _____ Date _____ Time _____

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07-03-2023 3 Y 3 M 22 D (F)
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
30/6/23 7am	UHB Dr. Shamin PUO.	
	- fever spike @ 2am (100.4) F	
		Plan ~~H~~ Trail CRP LFT Widal Blood cs. ~~2)~~ It. ceftriaxone ~~3)~~ It. IVF ~~4)~~ Rest it. as per Rx chart. ~~Noted by~~ Navnika

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
30/6 9AM	c/S/B Dr Aniket Pyrexia of Unknown Origin (PUO) Fever :- 20 day ↳ Night - 100.6°F child asleep vitals stable Afebrile now R-S - B/L AE⊕ P/A - Soft	Plan 1) Inj Ceftriaxone 2) Trm blood c/s 3) To do USG Abdo 4) Encourage orally 5) stop IVF 6) If repeat fever spikes, to send 5 Viral panel NB Sneh @10AM Sr Dr. Aniket P

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

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

HNH-00016261 IP26-00005687
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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DRUG CHART

Date of Admission: 29/6/26 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: 4ml	Route: Po	Frequency: SOS	Start Date: 29/6	30/6 12 noon
Doctor's Signature: Ruth	Valid Period	Pharm.		11 Am
Additional Instructions: (240 mg / 5 ml)				2 PM

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

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

VERIFIED BY : Name ..... Signa

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Dr. ANIKET ANIL PARASHAR

REGULAR PRESCRIPTIONS

Weight. 12.6 Ward. .....

DRUG : Inj. CEFTRIAXONE

Dose	Route	Frequency	Start Date
500 mg	IV	BD 12h	Ruth

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

Additional Instructions: 100mg/kg/day

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG : Inj. CEFTRIAXONE

Dose	Route	Frequency	Start Date
1.2g	IV	Q24h	29/6

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

Additional Instructions: 100mg/kg/day

Daily Doctor's Endorsement by a Sign

Date / Time 29/6

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

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Dr. ANIKET ANIL PARASHAR

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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Baby MARYAM ZARA
07-03-2023 3 Y 3 M 22 D (F)
Dr. ANIKET ANIL PARASHAR

I.V. FLUIDS CHART

Weight. 12·6 Ward. .....

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
29/6/26	10:45 AM	IVF PLASMALYTE	25 ml/hr	IV	Ruth		30/6		

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

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MEDICATION RECONCILIATION FORM

Drug Allergies: ..... Nill ..... ☐ 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: ..... 2nd Floor (209) .....

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. Prayhanthi .....

Date & Time : 29/6/26 @ 10:15pm .....

Nurse Name & Signature: Vijaya (RN) .....

Date & Time : 29/6/26 @ 10:20pm .....

PATIENT TRANSFER FORM

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Patient Name & UHID No	Date & Time of Admission	Date & Time of Transfer Order
HNH-00016261 IP26-00006687 Baby MARYAM ZARA 07-03-2023 3 Y 3 M 22 D (F) Dr. ANIKET ANIL PARASHAR	29/6/26 @ 10:20 PM	29/6/26 @ 11:19 PM
	Transfer Ordered by Dr. prashanth	Reason for Transfer Admission.
From Unit ER	To Unit 2nd floor (209)	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File (1W)	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
[signature]	Dr. prashanth

Patient & Clinical Records Received by : Monika 11:30PM 29/6/26

Date & Time of Patient Received :

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

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

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NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 20/6/26 Time: 9:30 Am

Weight: 12.6 kg Centile: 10th

Height: — Centile: —

Inference: underweight child

RDA: — Calories: 1300 kcal/d Protein: 22 gms/d

Diet Recommendations: soft diet with more liquids

Re-Assesment: Avoid spicy, chilled & outside foods.

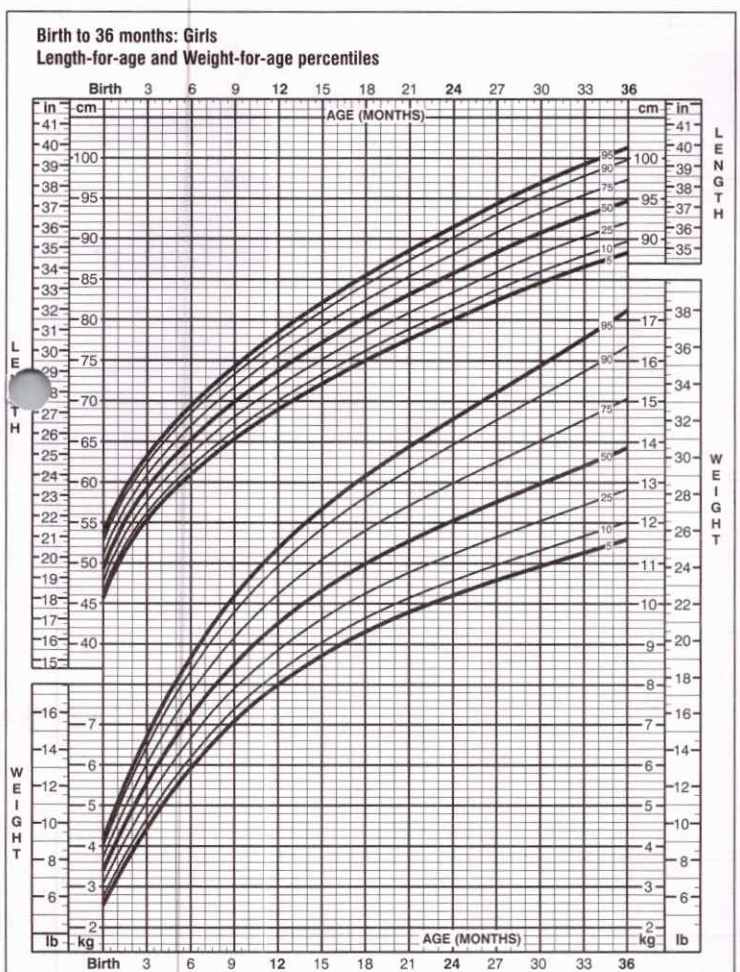
Food Allergies: NO Veg/Non-veg NON-veg

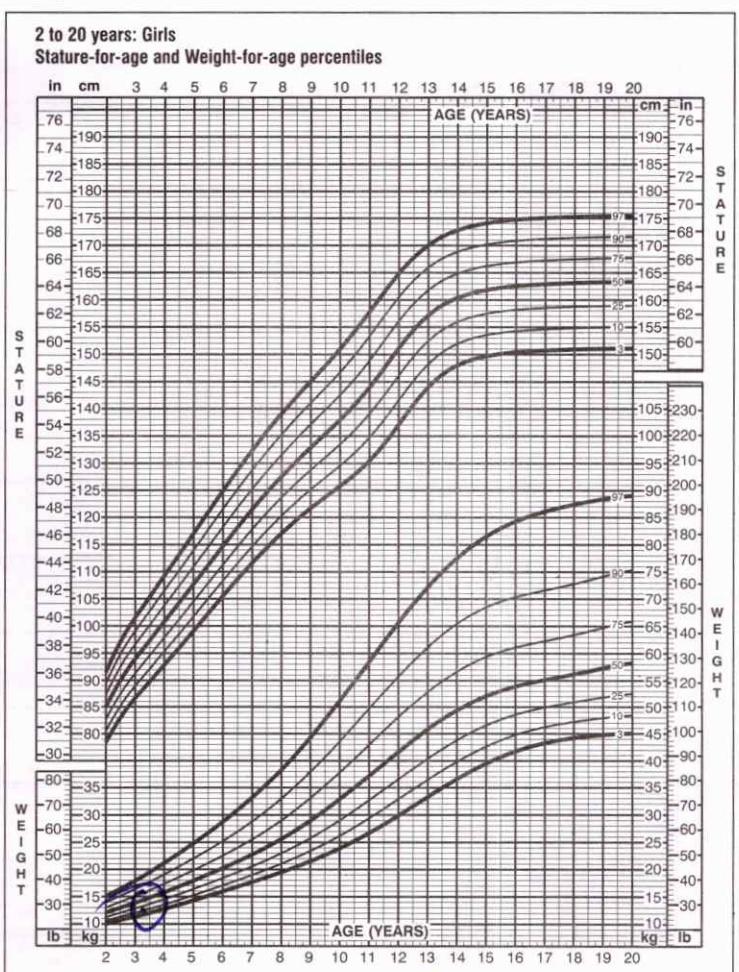
Diagnosis: PVO

Nutritional Intervention - ☑ Oral ☐ Enteral ☐ Parenteral

Patient's Signature:

GROWTH CHART (GIRLS)





Dietician's Name sathwika.G Dietician's Signature

Daily Notes:

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Dr. ANIKET ANIL PARASHAR

wt - 12.66 kgs

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EMERGENCY ROOM TRIAGE FORM

Patient's Name : maryam zara Age : 3 years **Gender:** ☐ Male ☑ Female

Date : 29/06/26 Time of Arrival : 9:33PM

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: 97.6 F PR: 105b/M BP: 93/61 (72) mmHg RR: 28 b/M SpO_2: 98%

Chief Complaints: c/o fever since 15 days

INITIAL PHYSIOLOGICAL CATEGORIZATION

Appearance
☐ Normal
☑ Sick Looking

Circulation / Colour
☑ Normal ☐ Abnormal ☐ Bleeding

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

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

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

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

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian

Triage Completion Time : .....

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 : Shivani

Signature of Triage Nurse : .....

Date & Time : 29/06/26 @ 9:35PM

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 29/06/26 Time of arrival : 9:38PM

Chief Complaints: c/o fever since 15 days RBS: .....

Height : ..... Weight : 12.66kg BMI : ..... Head Circumference (<2 years) .....

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

If yes , identify .....

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

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

RISK FOR FALL:

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

☐ If Patient is > 6 years
Assess the below parameters

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

Ambulatory Aids:

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

Gait/Transferring:

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

Mental Status: Forgets limitations ☐ Yes ☐ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening: ☐ No Abnormalities Detected

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

Inform consultant for positive criteria

.....

.....

Nutritional Screening: ☐ No Abnormalities Detected

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

Inform consultant for positive criteria

Psychological Screening: ☐ No Significant Findings

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

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

Social History: Lives With family

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

Time of Initial assessment completed by ER Nurse : @ 9:40PM

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

Time	Nursing Notes
9:42 PM	Assess the patient condition monitor the vital sign

Samples collected by: /

Samples sent by : / Vijaya

Time: /

Time: / 11:10 PM

Medication given in ER:

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

Condition of patient at time of shift - out :	**Details of Shift - out**
HR: 105 b/m BP: 93/61 (72) mmHg CFT: N/A	Shift - out from ER to: 2nd floor (20 q)
RR: 28 b/m SPO_2 : 98%	Time of Shift - out: 11:19 PM
GCS: 15/15 Temperature : 98°F	Handover given to: Monika
Pain Score: 01	(Nurse's Name)
Repeat RBS (if applicable): N/A	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

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

Name of the Nurse : Shivaraj Signature of the Nurse : Sd

Date & Time : 29/06/26 @ 9:44 PM