219.

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DISCHARGE SUMMARY

Name	Master VALATHATI JOSHITH	**UHID**	CUV-00088690
Father/Guardian	Mr NAVEEN KUMAR V	**Age/Gender**	6 Y 6 M 26 D/ Male
Address	Kamakoti Nagar, Vijayawada, Andhra Pradesh, INDIA, 520012		
IP No	IP26-00006909	**Admission Date**	21-07-2026
Ref Doctor	Self.		
Discharge Date	23.07.2026		

Consultant:
Dr. SPANDANA PASUPULETI
MBBS, MRCPCH
30925

DIAGNOSIS	ICD CODE
ACUTE GASTROENTERITIS WITH DEHYDRATION	

History: Master VALATHATI JOSHITH, 6 Y 6 M 26 D , old boy presented with history of fever since 5 days, loose stools (2 episodes/day), vomiting since 1 day and poor oral intake prior to admission. For the above complaints he was admitted at Rainbow Children's Hospital - Himayatnagar for further management.

Examination: He was febrile(100.5*F). Heart rate - 132/min and Respiratory Rate - 25/min. On examination Signs of dehydration were present such as dry lips, decreased skin turgor, sunken eyes 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: 21.5 kilo grams.

Investigations: Enclosed reports.

Initial hemogram showed Hemoglobin of 13.1 gm%, White Blood Cell count of 10700 cells/cumm, platelet count of 3.31 lakhs/cumm and C-Reactive Protein of 12.0 mg/l.

Name	Master VALATHATI JOSHITH	UHID	CUV-00088690
IP No	IP26-00006909	Admission Date	21-07-2026

Blood culture shows: No growth after 24 hrs of incubation .
Complete urine examination was normal.

Management : He was admitted in the ward , relevant investigations were sent and was started on Intra Venous fluids and Intra Venous antibiotics. He was treated symptomatically with antacids and antipyretics. In view of loose stools, he was administered probiotics and advised gastrodiet.

He was regularly monitored for loose stool frequency and hydration status. His loose stools and other symptoms settled gradually.

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. Esomeprazole
Injection. Ceftriaxone
Pro-GG sachet
Syrup. Crocin DS
Redotil sachet
Syrup. Zinconia

Advice:
* Diet as advised.

Name	Master VALATHATI JOSHITH	**UHID**	CUV-00088690
IP No	IP26-00006909	**Admission Date**	21-07-2026

S.No	DOSE	DOSE	TIMINGS	DURATION
1	Syp. Zinc (5ml/20mg)	5ml	once daily (afterfood)	For 12 days.
2	PRO GG	1 sachet mix in10ml water	8am - 8pm (afterfood)	For 3 days.
3	Syp. ONDEM (5ml/2mg)	10 ml		SOS maxium 3 times a day

Plan: To collect blood c/s repot on followup

Fever Management
* Syrup. Crocin DS (Paracetamol - 5ml/240mg) 7 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. SPANDANA PASUPULETI on **(Saturday) 25.07.26** at Himayatnagar in OPD with prior appointment **(Review consultation will be charged)**.

Food instructions while taking medications:
* **Antiemetics** can be taken before food.
* By consuming your **probiotic** with food you provide a buffering system for the supplement and ensure its safe passage through the digestive tract. Aside from protection, food also provides the friendly bacteria in your probiotic the proper food and nourishment to ensure it survives, grows and multiplies in your gut. It is recommended to take probiotics at the END of a meal. Concurrent administration of antibiotics could kill a large number of the organisms, reducing the efficacy of probiotics. Separate administration of antibiotics from probiotics by **atleast two hours.**

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

Name	Master VALATHATI JOSHITH	**UHID**	CUV-00088690
IP No	IP26-00006909	**Admission Date**	21-07-2026

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. SPANDANA PASUPULETI
MBBS, MRCPCH
30925

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 : IP26-00006909 **Admit Date** : 21-Jul-2026 **Admit Time** : 08:39 PM **UHID** : CUV-00088690

Patient Details :

Patient Name	: Master VALATHATI JOSHITH	**Age**	: 6 Y 6 M 25 D
Guardian	: Mr NAVEEN KUMAR V	**DOB**	: 26-12-2019
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: ~ Kamakoti Nagar Vijayawada Andhra Pradesh INDIA 520012	**Phone No**	: 8297679597/ 8297679597
		E-mail	: na123@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 NAVEEN KUMAR V **Relationship** : Father

Contact Address : ~ Kamakoti Nagar Vijayawada Andhra Pradesh INDIA 520012 **Phone No** : 8297679597

Signature

Doctor Details :

Doctor Name : Dr. SPANDANA PASUPULETI **Specialisation** : GENERAL PEDIATRICS

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

Co-Consultant :

Payment Details :

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

Payor Name : HERITAGE HEALTH INSURANCE TPA PVT LTD

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CUV-00088590 IP26-00006909
Master VALATHATI JOSHITH
26-12-2019 6 Y 6 M 25 D (M)
Dr. SPANDANA PASUPULETI

ACTIVITY IG

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

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

Date of Admission : 21/7/26 Time : ---------- Date of Discharge : ---------- Time: ----------

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
21/7/26	9.50pm	ER	ward	Bhargavi.

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
21/7/26	CBP, CRP, Blood c/s	12230	
	VBG	12229	
29/7/26	LUE	2242	
		Cross checked done	

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
21/7	Infusion pump	21/7/26 @ 10:00pm	22/7/26 @ [illegible]	15803	[illegible]

Cross checked done by Sujita on 23/7/2…

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
21/7/26	IV placement	01	5792	
			Cross checked done	
22/7/26	NJHA	①	5991	

ANY OTHER INFORMATION

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

Ref.No. F/IN/PR/10

Rainbow®
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Hospital

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name : CUV-00088690 IP26-00006909
Master VALATHATI JOSHITH
25-12-2019 6 Y 6 M 25 D (M)
Dr. SPANDANA PASUPULETI

Patient ID# :

Consultant :

Final Diagnosis : ACUTE GASTROENTERITIS WITH DEHYDRATION

Pediatric Multiorgan History & Physical Examination

Name : JOSHITH Age/Sex 6yr 6m. male

Informant Mother Reliability Good

Chief Presenting Complaints & Duration (Chronologically):

fever on & off x 5 days.
loose stools } today morning.
vomiting
Poor oral intake

History of present illness :

- Child presented with complaints of fever on & off since 5 days, high grade associated with chills & rigor, relieved temporarily on medication & recurring again. last
- Child had fever on Thursday & friday, treated symptomatically & was afebrile on Saturday & Sunday.
- H/o consumption of chicken curry prepared at home on Sunday.
- H/o 1 episode of vomiting today morning.
- H/o 2 episodes of loose stools since today, loose, watery, yellowish, non mucoid, not blood stained, foul smelling.
- H/o bad food intake.

Pediatric Multiorgan History & Physical Examination

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

Nil premorbid

Birth & Neonatal History :

Term / AGA / Male.

Birth & Socio Economic History :

About Father :

About Mother :

Any additional Information :

Developmental History :

Developmentally (N).

Immunization History :

As per NIS.

Pediatric Multiorgan History & Physical Examination

Anthropometry

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

Weight (kgs) 21.5 kgs. (Centile _____)

On Examination :

Temperature : 100.5°F. Pulse Rate: _____ Description _____

B.P. _____ SPO2 100% at RA.

Resp. rate and type of breathing : _____

Rash Absent – Sunken eyes.

Lymphadenopathy – Dry lips.

Oedema : – Skin turgor > 2sec.

Respiratory system :

Inspection (any s/o distress) : BAE (+), NVBS.

Air entry & breath sounds : _____

Any addes sounds : _____

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

Cardiovasclular System :

Inspection of procordium : S1, S2 (+), No murmur.

Heart Sounds : _____

Any murmur : _____

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

and periumbilical

Per Abdomen :

Inspection SNT, epigastric tenderness,

Palpation : BS (+).

Ausculation : _____

Spine: _____ External Genitelia : _____

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

Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS Score : _____

Cranial Nerves : _____

_____

_____

Motor System :

Nutrition : _____

Tone : _____ Power 5/5

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR **Superficials :**

Plantars _____

Sensory System :

_____

_____

_____

Bladder / Bowel : _____

Clinical Summary & Diagnostic :

ACUTE GASTROENTERITIS WITH DEHYDRATION

_____

_____

_____

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment :

Desired goals of the treatment :

Planned Labs :

CBP, CRP
VBG, Blood C/S, CUE.
Keep 1 extra pkin.

NB Prabir

Planned Management :

- IVF 2/3rd maint.
- Inj. Ceftriaxone.
- Inj. Esoz / ONDANSETRON /
- Pro 4 4 sachets.

NB Prabir

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

Dr. Sp[illegible] Pasupul[illegible]
Consultant Neonatologist and Pediatrician
Reg. No: 30925

Doctor's Signature Name Date Time

-00088690 IP26-00006909
[Mas]ter VALATHATI JOSHITH
[..]-2019 6 Y 6 M 25 D (M)
[S]PANDANA PASUPULETI

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/07/2026 8am	S/B Dr Nameer/Dr. Anusha	
	AGE c̄ dehydration	
	fever spikes (+)	Plan
	hemodynamically stable	(1) ct ceftriaxone
	oral intake fair	(2) ct IV fluids
	chest clear	(3) Sucromage orally
	P/A soft	(4) Trace CUE; Blood c/s
	3 episodes of loose stools since admission	(5) Monitor vitals
		(Dr Nameer)
22/7/26 9:30am	d/s/b Dr. Yasin	
	Acute GE c̄ dehydration	
	- fever spikes (+)	
	- loose stools (+)	Plan
	↳ 1-2 episodes	1) ct. ceftriaxone
	watery, no blood.	2) ORS - round the clock
	- oral intake : fair.	3) ct IVF.
		4) trace blood c/s
	O/E	5) start Redotil
	vitals - stable	6) Rest ct. as per Rx
		chart
	S/E	
	P/A - soft.	
	RS : BAE (+).	

V-00088690 IP26-00006909
ster VALATHATI JOSHITH
12-2019 6 Y 6 M 25 D (M)
SPANDANA PASUPULETI

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/1/26 3:00pm	C/S/B Dr. Spandana AGE ~ dehydration	
		Plan →
		- Cont Ceftriaxone.
		- Cont PRO GG Salute
22/1/26 3pm	S/B Dr-Archana/Dr-Naipunya Δ: AGE ~ dehydration	
	Last spike @ 6 AM cough (+) No vomitings Pain per abdomen (-) loose motions → consistency improved, greenish, 2 episodes	Adv - . Add Relent plus . Ct ceftriaxone . Ct rest as per Rx chart . Stop IVF by evening (after the current fluid bag empties)
	o/e - vitally stable S/E P/A - soft, nt.	

Dr. Spandana Pasupuleti
Consultant Neonatologist and Pediatrician
Reg. No: 30825

JV-00088690 IP26-00006909
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-12-2019 6 Y 6 M 25 D (M)
. SPANDANA PASUPULETI

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
23/7/22. 7:40 AM	S/B Dr. Sneghan	Plan
	Δ AGE ē dehydration	
		- CF CEFTRIAXONE
	↓ loose stools	
	CVS - S1S2 (+)	- CF ZINC
	RS - BLL - ACF (+)	Pro-GC
	P/A - Soft	- CF REDOTRIL
	Conscious.	
		- Encourage orally
23/7/22	S/B Dr. Tejaswi	
		Plan
	Δ AGE ē dehydration	
		- Discharge
	CVS - S1S2 (+)	
	RS - BLL - ACF (+)	- Tab ZINC - 14 days later
		Pro GC - x 3 days
	P/A - Soft	Dr. S. TEJASWI REDDY Registration No: 94068
	Conscious.	
	↓ loose stools.	Dr Tejaswi

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

IV-00088690 IP26-00006909
ister VALATHATI JOSHITH
·12-2019 6 Y 6 M 25 D (M)
SPANDANA PASUPULETI

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

CUV-00088690 IP26-00006909
Master VALATHATI JOSHITH
26-12-2019 6 Y 6 M 25 D (M)
Dr. SPANDANA PASUPULETI

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DRUG CHART

Date of Admission: 21/07/2024 Drug Allergies: .... ☑ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

DOCTOR
- Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
- Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
- Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
- Discontinue a drug by drawing a line / through it and a similar line through subsequent recording panels.
- The date and time of stopping the drug along with the doctors name and sign must be mentioned.
- Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.

NURSES
- Nurses must follow strictly the FIVE RIGHTS before administration of medication.
  1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time
- AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

21.58 kgs

SOS / PRN (As Required Medication)

DRUG: Syp. CROCIN DS				Date ▸ / Time ▾	21/7
Dose	Route	Frequency	Start Date		8.30 (signed)
7 ml	PO	SOS	21/7		
Doctor's Signature	Valid Period	Pharm.			
(signed)		(signed)			
Additional Instructions: (5ml/240mg) if Temp >100°F					

DRUG: Syp. IBUGESIC				Date ▸ / Time ▾	21/7
Dose	Route	Frequency	Start Date		10.30 (signed)
6 ml	PO	SOS	21/7		
Doctor's Signature	Valid Period	Pharm.			
(signed)		(signed)			
Additional Instructions: (5ml/100mg) if Temp >102°F					

Verified by Dr. Dhakshayani

Verified by Dr. Dhakshayani

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

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

CUV-00088590 IP26-00006909
Master VALATHATI JOSHITH
26-12-2019 6 Y 6 M 25 D (M)
Dr. SPANDANA PASUPULETI

REGULAR PRESCRIPTIONS

Weight. 21.55kg Ward. .....

DRUG : Inj CEFTRIAXONE

Dose	Route	Frequency	Start Date
1gm	IV	BD	21/7

Name & Signature of the Doctor Starting the Drugs: (Dr Nameen)

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time: 21/7 22H

10AM X

10pm

DRUG : Inj ESOMEPRAZOLE

Dose	Route	Frequency	Start Date
20mg	IV	OD	21/7

Name & Signature of the Doctor Starting the Drugs: (Dr Nameen)

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time: 21/7 22H 23P

6AM 10pm

DRUG : Inj ONDANSETRON

Dose	Route	Frequency	Start Date
4mg	IV	BD	21/7

Name & Signature of the Doctor Starting the Drugs: (Dr Nameen)

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time: 21/7 22H

10AM X

10pm

DRUG : ROCG SACHETS

Dose	Route	Frequency	Start Date
1sachet	PO	BD	21/7

Name & Signature of the Doctor Starting the Drugs: (Dr Nameen)

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time: 21H 22H

10AM X

10pm

CUV-00088690 IP26-00006909
Master VALATHATI JOSHITH
26-12-2019 6 Y 6 M 25 D (M)
Dr. SPANDANA PASUPULETI

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Sheet No: .....

REGULAR PRESCRIPTIONS

Weight 21.58kg Ward .....

DRUG : SYP CROWN-DS

Dose	Route	Frequency	Start Dt.
7ml	PO	B.6thh	22/7

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time: 22/7 8AM 2PM 6PM 10PM

DRUG : REDOTIL SACHET

Dose	Route	Frequency	Start Dt.
1 sachet	PO	TID	22/7

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:
(1 sachet = 10mg)

Daily Doctor's Endorsement by a Sign

Date / Time: 22/7 6AM 2PM 10PM

DRUG : SYP ZINCONIA

Dose	Route	Frequency	Start Dt.
5ml	PO	OD	22/7

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time: 22/7 10AM

DRUG : SYP. MEDIRYL DS

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time:

Verified by Dr. Dhakshayani

Verified by Dr. Dhakshayani Signature

Verified by Dr. Dhakshayani Name

VERIFIED BY

IV-00088690 IP26-00006909
Master VALATHATI JOSHITH
-12-2019 6 Y 6 M 25 D (M)
. SPANDANA PASUPULETI

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Sheet No: ....

REGULAR PRESCRIPTIONS

Weight .... Ward ....

				Date / Time
DRUG : Syp RELENT PLUS				22/7
Dose	Route	Frequency	Start Dt.	
5ml	PO	BD	22/7	
Name & Signature of the Doctor Starting the Drugs:				10am X
				7pm
Additional Instructions:				10pm
Daily Doctor's Endorsement by a Sign				

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

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

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

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

CUV-00088690 IP26-00005909
Master VALATHATI JOSHITH
25-12-2019 6 Y 6 M 25 D (M)
Dr. SPANDANA PASUPULETI

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 : Nam

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses

CUV-00088590 IP26-00006909
Master VALATHATI JOSHITH
26-12-2019 6 Y 6 M 25 D (M)
Dr. SPANDANA PASUPULETI

I.V. FLUIDS CHART

Weight. 21.58 kg Ward. .....

Date	Time	Composition of I.V. Fluid (Mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
21/7	10pm	DNS (2/3rd mantance)	IV	40 ml/hr	Nau		22/7	1	
22/7	9:30am	IVF - DNS. (1/3rd main)	IV	30 ml/hr	M		22/7		

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

V-00088690 IP26-00006909
ster VALATHATI JOSHITH
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SPANDANA PASUPULETI

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RESULT SHEET

Date	21/7/26					
Time						
Hb	13.1					
PCV	37.6					
RBC	5.19					
WBC	10.70					
N/L						
Platelets	331					
CRP	12.0					
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						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
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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SPANDANA PASUPULETI

Patient Stick

L / 126

SCHOOL AGE (5-12 years)

Children's Observation & Early Warning Scoring Chart

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

BirthRight BY RAINBOW HOSPITALS — Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 21/7 Time:	10:30pm	11:30pm	3:30AM	6Am	7:30am
Doctor / Nurse / Family Concern?					
Temperature (F) (104–94)	101.4 f	98.2 f	99.2 f	100° f	99.2 f
	Ibugesic given			Crocin given	
Heart Rate (bpm) and Blood Pressure (mmHg) * (190–50)	130			130; BP 102/68	
Note: BP does not score in early warning scoring					
Heart Rate (Number)	130 b/min			128 b/min	
Resp. Rate (bpm) (Over 1 Minute) * (70–10)	25			26	
Resp Rate (Number)	25 b/min			26 b/min	
Resp Distress: Mod/ Severe					
Resp Distress: None / Mild					
Receiving O_2(l/min)					
O_2Saturations (%)	99%			100%	
Conscious Level: Normal					
Conscious Level: Altered					
GCS *	15/15			15/15	
TOTAL SCORE Number of shaded boxes	0			0	
Pain Score	0			0	
Observer's Initials	Sr			Sr	

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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SCHOOL AGE (5-12 years)

Children's Observation & Early Warning Scoring Chart

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 22/7

Time:	10AM	2pm	6 pm	10pm	2am	6am
Doctor / Nurse / Family Concern?						
Temperature (F) (104–94)	97.8F	97.3F	97.6F	98.0F	98.2F	97.3F
Heart Rate (bpm) and Blood Pressure (mmHg) * (190–50)	88/64 (73)			100/62 (76)		98/72 (82)
Heart Rate (Number)	101b/m	110b/m	102b/m			98b/m
Resp. Rate (bpm) (Over 1 Minute) * (70–10)						
Resp Rate (Number)	28b/m	30b/m	20b/m			22b/m
Resp Distress — Mod/ Severe						
Resp Distress — None / Mild						
Receiving O_2(l/min)						
O_2Saturations (%)	100%	100%	99%			100%
Conscious Level — Normal						
Conscious Level — Altered						
GCS *	–					15/15
TOTAL SCORE Number of shaded boxes	0	0	0			1
Pain Score	0	0	0			0
Observer's Initials	[illegible]	[illegible]	[illegible]			[illegible]

Note: BP does not score in early warning scoring

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
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	Score 4	: Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see
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B	**BACK GROUND :** Child (X) was admitted on (XX date) with (e.g. respiratory infection). They have had (X operation/ procedure/ investigation). Child (X)'s condition has changed in the last (XX mins). Their last set of observations were (XXX). The child's normal condition is ... (e.g. alert/ drowsy/ confused, pain free)
A	**ASSESSMENT :** I think the problem is (XXX) and I have ...(e.g. given O2/ analgesia, stopped the infusion), OR I am not sure what the problem is but child (X) is deteriorating, OR I don't know what's wrong but I am really worried.
R	**RECOMMENDATION :** I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

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FLUID CHART

Sheet No. : .....

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

		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 :**						
21/7	08:00 pm											
	09:00 pm											
	10:00 pm			40ml							0	
	11:00 pm	DNS		40ml							0	
	12:00 am		H2O	40ml							0	
	01:00 am			40ml							0	
Total Intake : Ralen						**Total Output :** U-0 M-0						
22/7	02:00 am			40ml							0	
	03:00 am			40ml							0	
	04:00 am			40ml							0	
	05:00 am	DNS		40ml							0	
	06:00 am		H2O	40ml							0	
	07:00 am			40ml							0	
Total Intake : Ralen						**Total Output :** U- M-						

Total 24 hrs. Intake		Total 24 hrs. Output	

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FLUID CHART

Sheet No. : 2

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

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
22/7	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
22/7	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: 21/4

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							
Afternoon							
Night	10pm to 8am	→ Assess the pt condition → Monitor vitals & record → maintain I&O chart → Administer medications as per drug chart	10pm to 8am	→ Assessed the pt condition → monitored vitals & recorded → Maintained I&O chart → Administered medications as per drug chart	→ Pt is stable	→ Rechecked vitals	SN

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Patient S

NURSING CARE RECORD

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Date: 22/7/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8Am to 2pm	Assess the Pt condition. Monitor vitalsigns. maintain I/O chart. Provide the comfortable position. medication given per as doctors	8Am to 2pm	Assessed the Pt condi. monitored vitalsigns maintained I/O chart provided the comfortable position. Medication give. as per doctor	Pt is stable. vitals normal	monitor vital. maintain I/O chart	Sneha [signature]
Afternoon	2pm to 8pm	→ Assess the pt condition → monitoring vitals checked and accorded → I/O chart maintain.	2pm to 8Am	→ Assessed the pt condition → Administrations medication given as per doctor order's	→ Pt is stable	→ Re-checked vitals	[signature]
Night	8pm to 8am	Assess the baby Monitor v/s administer medicine Maintain I/O chart	8pm to 8am	Assessed the baby Monitored v/s administer the Maintain I/O chart	administer [illegible]	Reassess the pt	[signature]

Docu. No: RCH /FRM / CLINICAL / 148

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NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: AGE & Dehydration				Any Infection: ☐ Yes ☐ No ☑ Not Known If Yes Specify:		
	Surgery / Procedure: —				Post OP Day:		
BACKGROUND	Date / Shift	21/7 N1	22/7 M6	22/7 E2	23/7		
	Medical Condition (Any special condition to be noted):	—	—	—	—		
	Diet:	Soft	—	—	—		
ASSESSMENT	Allergy:	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No
	Ventilation (RA, NP, NIV, VENTI):	RA	—	—	—		
	Tubes/Drains/Catheter:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:	101.4°F	98.2°F	98.3°F	98.0°F		
	Res:	28b/m	28b/m	28b/m	20b/m		
	SpO_2:	100%	99%	98%	100%		
	Pulse:	128b/m	127b/m	121b/m	112b/m		
	BP:	—	—	—	—		
	LOC:	—	—	—	—		
	Fall Risk Score:	—	—	—	—		
	Pain Score:	—	—	—	—		
	Skin Integrity	—	—	—	—		
Recommendations	Safety Needs:	☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Physiotherapy:	—	—	—	—		
	Others Specify:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No
	Special Diet:	—	—	NA	—		
	Critical Lab Test / Values:	—	—	NA	—		
	Other Special Orders / Medications:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No
	PU Prophylaxis:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No
	DVT Prophylaxis:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No
	ADL (Dependent / Non Dependent):	—	—	NA	—		
Post Operative Procedure Special Orders:		—	—	NA	—		
Handed Over By Name :		Jyothi	Sri	Amrutha	Jyothi		
Signature / ID :							
Date:		22/7/26	22/7	22/7	23/7		
Time:		8AM	2pm	8pm	8AM		
Taken Over By Name :		Sri	Amrutha				
Signature / ID :							
Date:		22/7	22/7	22/7			
Time:		8pm	2pm	8pm			

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NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:				Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:		
	Surgery / Procedure:				Post OP Day:		
BACKGROUND	Date / Shift						
	Medical Condition (Any special condition to be noted):						
	Diet:						
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Ventilation (RA, NP, NIV, VENTI):						
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:						
	Res:						
	SpO_2:						
	Pulse:						
	BP:						
	LOC:						
	Fall Risk Score:						
	Pain Score:						
	Skin Integrity						
Recommendations	Safety Needs:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Physiotherapy:						
	Others Specify:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Special Diet:						
	Critical Lab Test / Values:						
	Other Special Orders / Medications:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	PU Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	DVT Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	ADL (Dependent / Non-Dependent):						
Post Operative Procedure Special Orders:							
Handed Over By Name :							
Signature / ID :							
Date:							
Time:							
Taken Over By Name :							
Signature / ID :							
Date:							
Time:							

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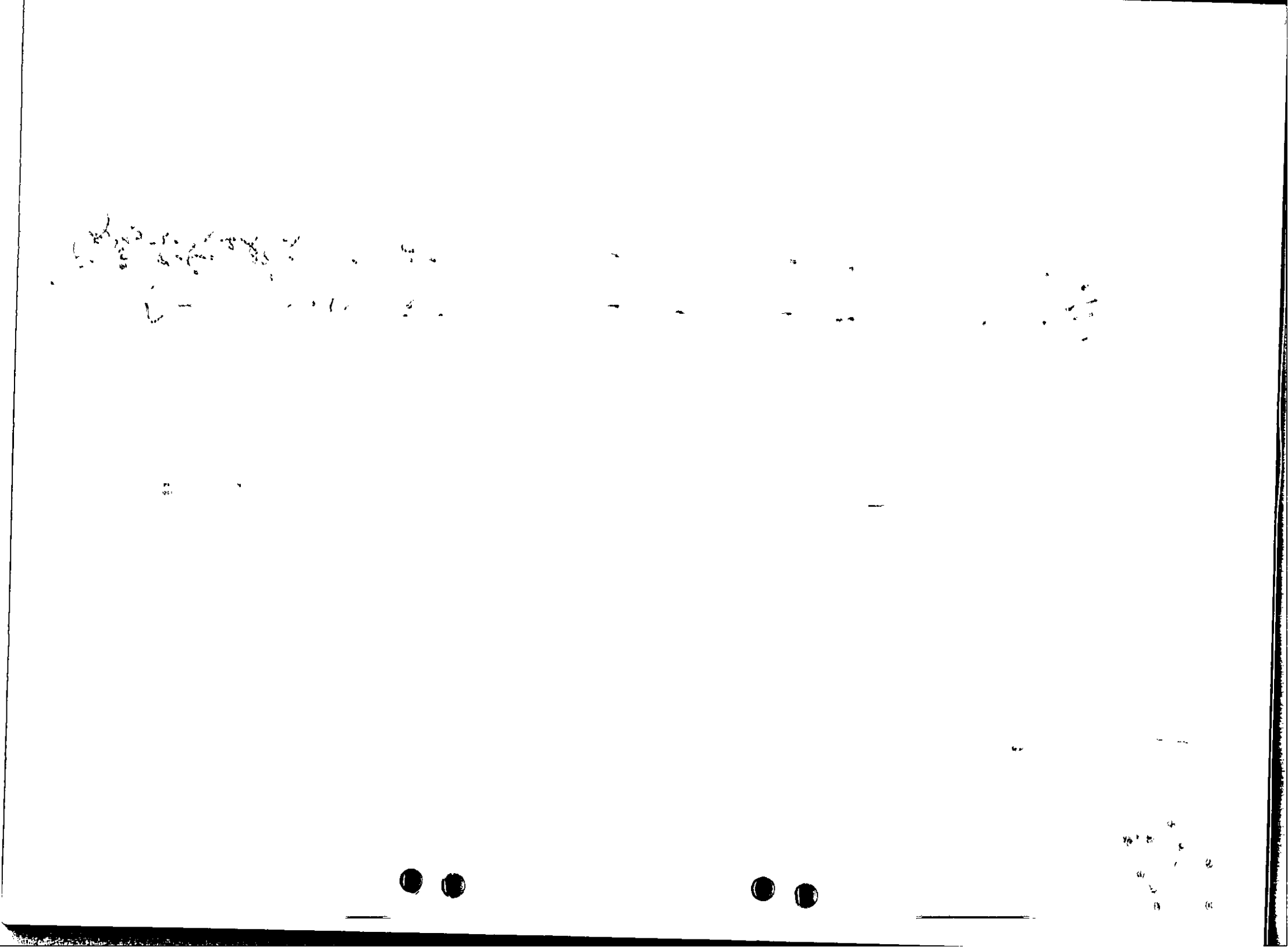
TY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE 24/7	DATE 25/7	DATE	DATE	DATE
Age	Less than 3 years old	4					
	3 to less than 7 years old	3	3	3			
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	2	2			
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1			
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own ability	1	1	1			
	History of Falls or Infant-Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2					
	Outpatient Area	1	1	1			
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours/ None	1	1	1			
Medication Usage	Sedatives (Excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1			
	Total		10	10			

Intervention: -Fall Risk: Low Humpty Dumpty Score = 7-11, High Risk Humpty Dumpty Score = 12 or above

	Bed in low position		✓	✓		
	Call device within reach		✓	✓		
	Wheels Locked		✓	✓		
	Room free of clutter		✓	✓		
	Adequate lighting		✓	✓		
	Wheel chair support		—	—		
	Other Intervention(s) Specify		X	X		
	Nurse's Name:					
	Signature:					
	Date:		24/7	25/7		
	Time:					

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



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CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1 21/7/22			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0			0	0	0	0				
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	0				
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2			0	NA	NA	0				
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	0				
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	0				
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5			0	NA	NA	0				
		Signature of the Nurse				[signature]	[signature]	[signature]	[signature]				

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 : [illegible]

Signature of Ward In Charge :

Signature : [signature] Name : Balavani

Patient Sticker

-00006690 IP26-00006909
ter VALATHATI JOSHITH
2-2019 6 Y 6 M 25 D (M)
SPANDANA PASUPULETI

CKLIST FOR THROMBOPHLEBITIS

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

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

Signature of Shift In Charge :

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

Signature of Ward In Charge :

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

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2-2019 6 Y 6 M 25 D (M)
SPANDANA PASUPULETI

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PAIN ASSESSMENT FORM

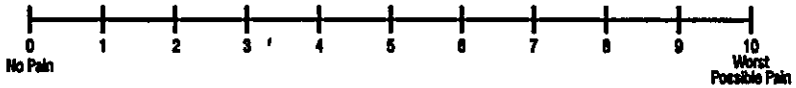
Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
21/7	10pm	10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
22/7	10Am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	NA	[signature]
22/7	2pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	NA	[signature]
22/7	12pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	NA	[signature]
23/7	[illegible]	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		
				☐ 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 drawn 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

BRADEN 'Q' SCALE

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					Date : 2/4	2/4	24/7	23/8
					Time : N	M6	E.	6P
Mobility	**1. Completely immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	**3. Slightly limited:** Makes frequent through slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.	4	4	4	4
"Activity The degree of physical activity"	**1. Bedfast :** Confined to bed	**2. Chairfast :** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	**3. Walks occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. All patients too young to ambulate; OR walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	3	3	4
Sensory Perception	**1. Completely limited:** Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	**2. Very limited:** responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	**3. Slightly limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	**4. No impairment:** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	4
Moisture Degree to which skin is exposed to moisture	**1. Constantly moist:** Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	**2. Very moist:** Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	**3. Occasionally moist:** Skin is occasionally moist, requiring linen change every 12 hours.	**4. Rarely moist:** Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	4
FRICTION-SHEAR **Friction** Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another	**1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	**2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	**3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	**4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	4
Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4
				TOTAL SCORE	28	24	23	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	• 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

CUV-00088690 IP26-00006909
Master VALATHATI JOSHITH
25-12-2019 6 Y 6 M 25 D (M)
Dr. SPANDANA PASUPULETI

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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: .....

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. Varun .....

Date & Time : ..... 21/7/26 @ 8:20 pm .....

Nurse Name & Signature: ..... Bhargai .....

Date & Time : ..... 21/7/26 @ 8:25 pm .....

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

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PATIENT TRANSFER FORM

CUV-00088590 IP26-00006909
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26-12-2019 6 Y 6 M 25 D (M)
Dr. SPANDANA PASUPULETI

Date & Time of Admission	Date & Time of Transfer Order
21/7/26 @ 9:50pm	21/7/26 @ 9:50pm

Treating Consultant Name	Transfer Ordered by	Reason for Transfer
	Dr. Varun	Admission

From Unit	To Unit	Information to Attendant
ER	Ward	Yes ☑ No ☐

Number of Sheets in Clinical File	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant
25/-		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
Bhargavi	Dr. Varun

Patient & Clinical Records Received by : Swetha 21/7/26 @ 9:50pm

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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wt - 21.58 kg

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EMERGENCY ROOM TRIAGE FORM

Patient's Name : master. Joshith Age : 6 yr Gender: ☐ Male ☐ Female

Date : 21/7/26 @ Time of Arrival : 8:10 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: 101°F PR: 132 b/m BP: ..... RR: ..... SpO_2: 98%

Chief Complaints: c/o fever since 5 days.

INITIAL PHYSIOLOGICAL CATEGORIZATION

Appearance
☐ Normal
☐ Sick Looking

Circulation / Colour
☐ Normal ☐ Abnormal ☐ Bleeding

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

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

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

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

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian

Triage Completion Time : 8:18 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 : Bhargavi

Signature of Triage Nurse : B

Date & Time : 21/7/26 @ 8:12 pm

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 21/7/26 Time of arrival : 8:14pm.

Chief Complaints: c/o fever since 5 days RBS: .....

Height : ..... Weight : 21.58 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: ..... 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 : .....

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

Time	Nursing Notes
8.15pm	Assess the pt Condition monitore the vitals

Samples collected by: Prabin Time: 8:50 PM

Samples sent by : Time:

Medication given in ER:

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

Condition of patient at time of shift - out :	**Details of Shift - out**
HR: 132 b/m BP: ..... CFT: 2sec	Shift - out from ER to: ward
RR: ..... SPO_2 : 98%	Time of Shift - out: 9:45 PM
GCS: 15/15 Temperature : A	Handover given to: Sweta
Pain Score: 0	(Nurse's Name)
Repeat RBS (if applicable):	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

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

.....

Name of the Nurse : Bhangare Signature of the Nurse : B

Date & Time : 21/7/26 @ 8:17pm

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NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 22/7/26 Time: 8:30 am

Weight: 21.5 kg Centile: <25th

Height: – Centile: –

Inference: Underweight child.

RDA: – Calories: 1450 Kcal/day Protein: 25 gms/day

Diet Recommendations: Gastro diet (can have :- ORS(WHO), Sago Water, Coconut Water, Rice based foods

Re-Assesment: Avoid :- Ragi, Milk, Egg, Citrus, Sugar, Wheat

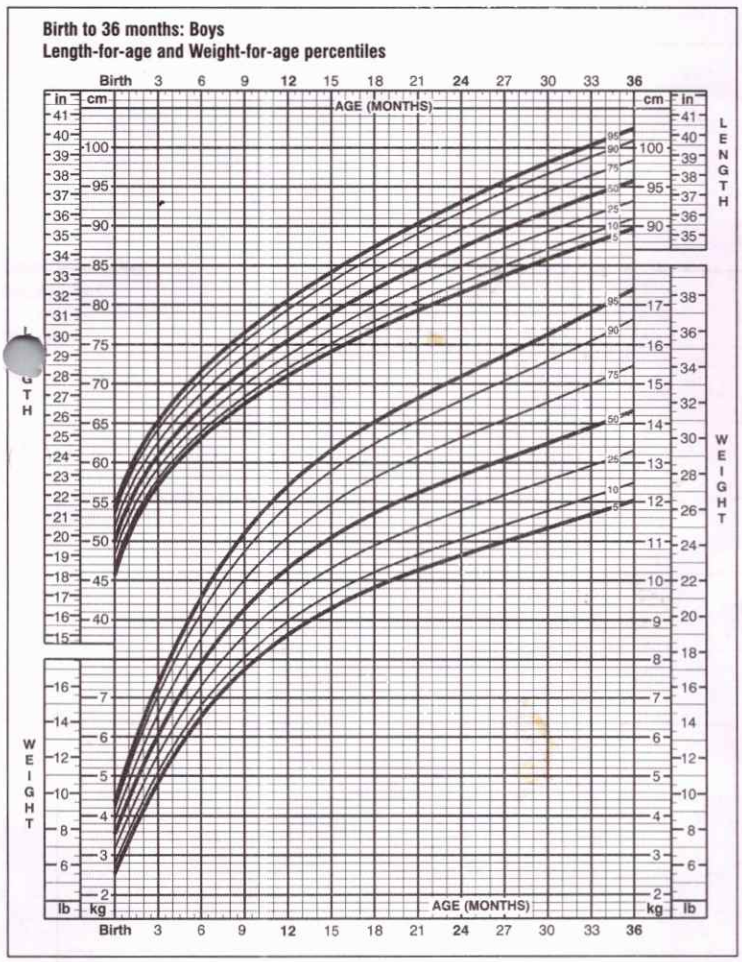
Food Allergies: NO Veg/Non-veg Non-Veg

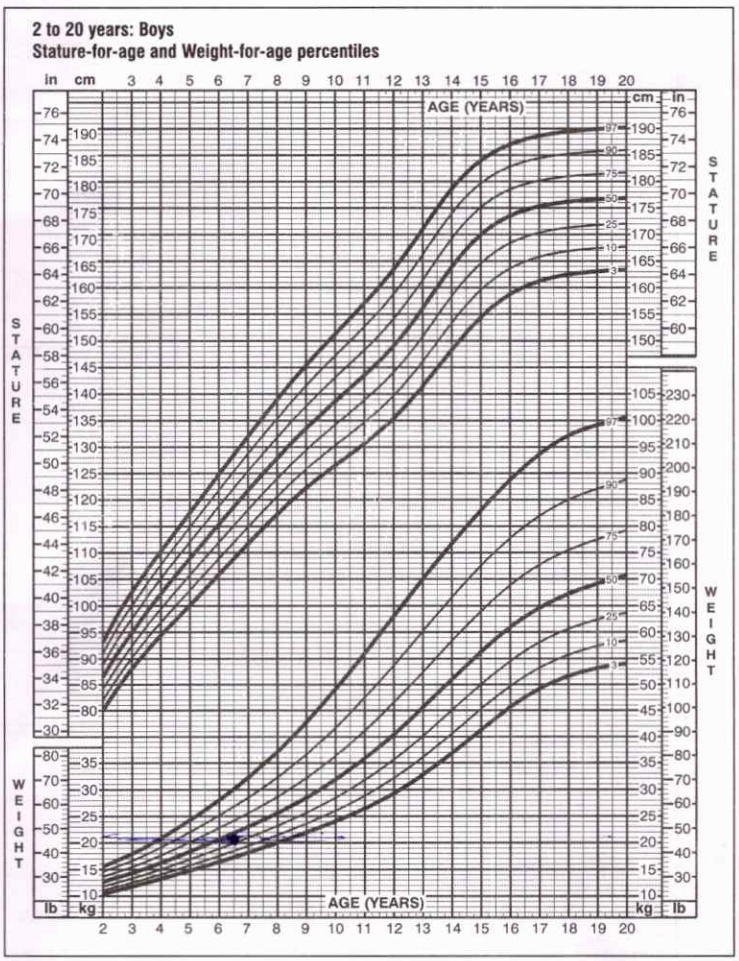
Diagnosis: Acute GE ~ dehydration

Nutritional Intervention - ☑ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: G Lila

GROWTH CHART (BOYS)





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

Daily Notes: