DISCHARGE SUMMARY

Name	Master SAMARTH HEDA	**UHID**	HNH-00004537
Father/Guardian	Mrs HEMA HEDA	**Age/Gender**	10 Y 8 M 22 D/ Male
Address	4-4-1/D/13 DILSHAD PLAZA HANUMAN TEKDI SULTAN BAZAR, State Bank Of India, Hyderabad, Telangana, INDIA, 500095		
IP No	IP26-00006854	**Admission Date**	15-07-2026
Ref Doctor	DR. SANJAY S		
Discharge Date	17.07.2026		

Consultant:
Dr. SANJAY SRIRAMPUR
MBBD,Md(Pead),DCH
HMC9465

DIAGNOSIS	ICD CODE
INFLUENZA A PNEUMONIA	
SECONDARY BACTERIAL INFECTION	

History: Master SAMARTH HEDA, 10 Y 8 M 22 D , old boy presented with history of fever, cough, cold, generalised body pains since 4 days, vomitings since 3 days prior to admission. For the above complaints he was investigated and treated at nearby hospital. In view of persistence of symptoms, he was referred to Rainbow Children's Hospital - for further management.

Examination: He was (103.5*F)febrile, maintaining saturations at room air.

Name	Master SAMARTH HEDA	UHID	HNH-00004537
IP No	IP26-00006854	Admission Date	15-07-2026

His heart rate was 130/min, Blood pressure - 114/90mmHg and Respiratory Rate - 28/min. Capillary Refill Time was <2 secs. Peripheries were warm & pulses well felt. Mild epigastric, no soft, tenderness present, hepatosplenomegaly. On examination Signs of dehydration were present such as dry lips, dry oral mucosa, decreased skin turgor, dull look and tachycardia, dry oral mucosa, sunken eyes were present. On auscultation, air entry was bilaterally equal. 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: 29.6 kilo grams.

Investigations: Enclosed reports.

GeneXpert SARS-CoV-2+FluA+FluB+RSV were sent, which shows:

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

Complete urine examination was normal. Blood culture was 24 sterile.
Adenovirus PCR - Not detected.
Initial hemogram showed Hemoglobin of 12.7 gm%, White Blood Cell count of 3900 cells/cumm, platelet count of 1.86 lakhs/cumm and C-Reactive Protein of 23.0mg/l. Serum Creatinine was 0.4mg/dl. Blood Urea was 18mg/dl. Liver function test showed total SBR of 0.7 mg/dl with indirect fraction of 0.5 mg/dl, SGOT - 78 U/L, SGPT - 18U/L, ALP - 134U/L, protein - 6.1 gm/dl, albumin - 3.4

Name	Master SAMARTH HEDA	UHID	HNH-00004537
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gm/dl, globulin - 2.7 gm/dl, A/G ratio of 1.2.
Dengue NS1 & IgM were negative.

Chest X-ray shows
Infiltrates / subsegmental atelectatic changes noted in the left lower zone.

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. In view of chest signs, he was nebulised with Levolin . Respiratory panel was sent which was positive for Influenza A and hence started on Oseltamivir.

He was regularly monitored for fever spikes, hemodynamic status, vital parameters, oxygen saturations and any signs of respiratory distress. 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. Pantoprazole
Injection. Ceftriaxone
Injection. Ondansetron
Syrup. Relent plus
Syp. Fluvir
Neb with levolin

Name	Master SAMARTH HEDA	UHID	HNH:00004537
IP No	IP26-00006854	Admission Date	15-07-2026

Syp. Augmentin Duo

Advice:
* Diet as advised.

S.No	MEDICATION	DOSE	TIMINGS	DURATION
1	Syrup. CLAMP-KID FORTE (Amoxycillin 400 + Potassium Clavulanate 57 mg/5ml)	7.5 ml	8am-8pm (after food)	For 5 days
2	Tablet. LANZOL DT (Lansoprazole - 30mg)	1 tablet	7am (before breakfast)	For 5 days
3	Syrup. FLUVIR (OSELTAMIVIR – 5ml/60mg)	5ml	9am-9pm (after food)	For 4 days.
4	Syrup. ONDEM (Ondansetron – 5ml/2mg)	10 ml	7am-7pm (30 minutes before food)	sos for vomiting maximum 3 times a day
5	Syrup. RELENT PLUS (Cetrizine 5mg, Ambroxol 30mg/5ml)	5 ml	8am-8pm (1 hour before food)	For 5 days.
6	NEBULISATION with Levolin (0.63)	1 respule	6th hourly	For 3 days
7	Nasoclear nasal drops, 2 drops in each nostril **SOS** for nose block			

Fever Management
* Syrup. Crocin DS (Paracetamol - 5ml/240mg) 9 ml after food as and whenever

Name	Master SAMARTH HEDA	**UHID**	HNH-00004537
IP No	IP26-00006854	**Admission Date**	15-07-2026

required, if temperature > 100 *F (maximum 4 times a day at 6 hour intervals).
* Tepid sponging if fever > 101 *F.

Review consultation with Dr. SANJAY SRIRAMPUR on Monday (20.07.2026) at his clinic.

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.
* **Anti ulcer drugs** can decrease the absorption of Iron&vit-B12. Anti ulcer drugs can be taken at least 1 hour before food (OR) 2hrs after food. Avoid caffeine that increases stomach acidity.
* **Antiemetics** can be taken before food.
* Food can decrease the absorption of **antihistamines.** Antihistamines can be taken on an empty stomach /before food to increase their effectiveness.

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.

Name	Master SAMARTH HEDA	**UHID**	HNH-00004537
IP No	IP26-00006854	**Admission Date**	15-07-2026

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**

Registrar/Resident/C.M.O

Dr. SANJAY SRIRAMPUR
MBBD,Md(Pead),DCH
HMC9465

HNH-00004537 IP26-00006854
Master SAMARTH HEDA
24-10-2015 10 Y 8 M 23 D (M)
Dr. SANJAY SRIRAMPUR

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DEFICIENCY CHECK LIST OF CASE SHEET

Sl.No.	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission sheet	1			
2	Discharge Summary	1			
3	Nursing Initial assessment	1			
4	Patient Transfer form	1			
5	In-patient Medical record	1			
6	Doctors progress sheets	4			
7	Nursing plan of care and handover sheets	4			
8	Consultation sheet				
9	General consent for treatment	1			
10	Consent for Surgery				
11	Consent for blood transfusion				
12	Consent for chemotherapy				
13	Consent for high risk				
14	Consent for Restraint				
15	LAMA consent				
16	Consent for special procedure / Sedation				
17	Consent for Formula feed				
18	Consent for MTP				
19	Consent for Radiological Investigations				
20	Consent for HIV test				
21	Anaestesia notes (Pre Anaesthesia& post)				
22	Neonatal Admission/Delivery/Physical Exam	1			
23	Medication Reconciliation	1			
24	Emergency Triage record	1			
25	Pre operative check list				
26	Surgical safety checklist				
27	Operation Theatre notes				
28	Nurses clinical Presentation				
29	TPR & BP chart	1			
30	Intake and Out take chart (fluid chart)	1			
31	Drug chart (Regular Prescription)	1			
32	Investigation Values (result sheet)	1			
33	Nebulization chart	1			
34	Nutritional review chart	1			
35	Intensive care unit (ICU Charts)				
36	Consent for Admission in PICU / NICU				
37	The Humpty dumpty scale	1			
38	Braden Q Scale				
39	Bed side check list				
40	PICU bed formula Dilution feeds				
41	Gastro monitoring chart				
42	Rch ED doctors note				
43	BP Monitoring chart				
44	RBS monitoring chart				
	Billing Extra	1			
		6			
	Total No. of Pages	32			

Doc. No. : RCH/ FRM / GENERAL / 126

Signature and Date : 17/7/2020

(P.T.O)

ERROR LOG

LOCATION : OT / Birthing Centre / BirthRight Premium / 3rd Floor (Zone A,B,C) / NICU / PICU / 2nd Floor Ward / Oncology / 1st Floor Wards.

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE

HNH-00004537 IP26-00006854
Master SAMARTH HEDA
24-10-2015 10 Y 8 M 21 D (M)
Dr. SANJAY SRIRAMPUR

levolin 5. 3% NS · 6th hrly

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NEBULISATION CHART

Date	Time	Drug	Nurse	Parents Signature
	00.00			
	01.00			
	02.00			
	03.00			
	04.00			
	05.00			
	06.00			
	07.00			
16/1/26	08.00			
	09.00			
	10.00			
	11.00			
	12.00			
	13.00			
	14.00			
	15.00	levolin + 3% NS (1) 4469		Monika
	16.00			
	17.00			
	18.00			
	19.00			
	20.00			
	21.00			
	22.00	levolin + 3% NS (1)		Monika
	23.00			

HNH-00004537 IP26-00006854
Master SAMARTH HEDA
24-10-2015 10 Y 8 M 21 D (M)
Dr. SANJAY SRIRAMPUR

Levolin + 3% NS 06th hrly

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NEBULISATION CHART

Date	Time	Drug	Nurse	Parents Signature
	00.00			
17/7/26	01.00			
	02.00			
	03.00			
	04.00			
	05.00	3% NS + levolin (2)		
	06.00	IM552		
	07.00		Total-4. Checked by Sis	
	08.00			
	09.00			
	10.00			
	11.00	levolin + 3% NS	M605	
	12.00			
	13.00			
	14.00	Total (4)		
	15.00			
	16.00			
	17.00			
	18.00			
	19.00			
	20.00			
	21.00			
	22.00			
	23.00			

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 : IP26-00006854 **Admit Date** : 15-Jul-2026 **Admit Time** : 07:49 PM **UHID** : HNH-00004537

Patient Details :

Patient Name	: Master SAMARTH HEDA	**Age**	: 10 Y 8 M 21 D
Guardian	: Mrs HEMA HEDA	**DOB**	: 24-10-2015
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: 4-4-1/D/13 DILSHAD PLAZA HANUMAN TEKDI SULTAN BAZAR State Bank Of India Hyderabad Telangana INDIA 500095	**Phone No**	: 9963804440/ 9963104440
		E-mail	: mukeshheda81@gmail.com

Admission Details :

Bed Type : DAY CARE **Bed No** : ER02 **Ward Name** : GF -EMERGENCY

Room No : ER02 **Admission Type** : First Visit

Contact Details :

Name : Mrs HEMA HEDA **Relationship** : Mother

Contact Address : 4-4-1/D/13 DILSHAD PLAZA HANUMAN TEKDI SULTAN BAZAR State Bank Of India Hyderabad Telangana INDIA 500095 **Phone No** : 9963804440

Signature

Doctor Details :

Doctor Name : Dr. SANJAY SRIRAMPUR **Specialisation** : GENERAL PEDIATRICS

Referral Doctor : DR. SANJAY S **Phone No** :

Co-Consultant : Dr. PRITESH NAGAR

Payment Details :

Deposit Amount : 10000.00

Payment Mode : DC/CC Card **Payor Name** : CARE HEALTH INSURANCE LIMITED

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ACTIVITY RECORD FOR BILLING

Name: Samarth.

UHID No : -------- HNH-00004537 IP26-00006854
Master SAMARTH HEDA
24-10-2015 10 Y 8 M 21 D (M)
Dr. SANJAY SRIRAMPUR

-- Consultant : ---------- Dept : ----------

Date of Admissio

--------- Date of Discharge : ---------- Time: ----------

Room / Bed No :

-------- Suggested Billable bed type : ----------

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
15/7/24	8:40 PM	ER	210	

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
15/7/26	CBP, CRP, Blood cls		
	Dengue NS1 + IgM		
	Urea, Creatinine		
	LFT, Respi tang panel	11803	
	VBG	11804	
	CXR	8587	
15/7/26	CUE	1810	

cross check done.

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
15/7/26	Infusion Pump	9:00pm	17/7 8Am	14178	

Cross check done
Mounika

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
15/7/26	IV placement	1	74145	
16/7/26	NHA	1	14330	

ANY OTHER INFORMATION

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

Ref.No. F/IN/PR/10

Rainbow®
Children's
Hospital

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name : HNH-00004537 IP26-00005854
Master SAMARTH HEDA
24-10-2015 10 Y 8 M 21 D (M)
Dr. SANJAY SRIRAMPUR

Patient ID# :

Consultant :

Final Diagnosis :

Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Informant _____ Reliability _____

Chief Presenting Complaints & Duration (Chronologically):

c/o cold x 4days - Generalized Body pain x 4days.
cough x 4days - pain abdomen x 4days -
Fever x 4days.
vomiting x 3days

History of present illness :

Cold - 4days - a/w nose block, no h/o snoring or running nose.

cough - 4days :- wet type, expectoration +, no h/o hurried breathing / noisy breathing.

Fever - low-mod grade, insidious, intermittent
no h/o rash -
no h/o travel / outside food.
no h/o burning micturition.

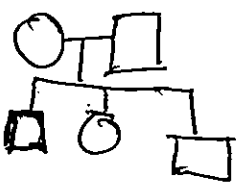
urine output - Good.
Oral intake ↓.

no loose stool

Pain abdomen
↓
Epigastric
↓
non radiating,
non - colicky,
a/w generalized body pains.

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

Birth & Neonatal History : Antenatal – Hypothyroidism
FTL SCS (PrevLSCS), CIAB, Bwt-2.5
NO H/O NNJ,



H/o similar c/o ↑ in the family:

Birth & Socio Economic History :

About Father :

About Mother :

Any additional Information :

Developmental History :
Good Scholastic Performance

Immunization History :
→ Prev vaccine – 2 years ago (not sure)
Influenza – Previously / not this year –

Anthropometry

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

Weight (kgs) 29.6 (Centile _____)

On Examination :

Temperature : ~~99F~~ 103.5°F Pulse Rate: 130/min. Description Dull.

B.P. 114/90 mmHg. SPO2 98% at RA

Resp. rate and type of breathing : 28/min.

Rash Signs of dehydration +

Lymphadenopathy No

Oedema : Sunken eyes +

Respiratory system :

Inspection (any s/o distress) : (N) shape, SR

Air entry & breath sounds : NVBS+

Any addes sounds : ND.

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

Cardiovasclular System :

Inspection of procordium : (N) Shape

Heart Sounds : S1S2+

Any murmur : NO murmur

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

Per Abdomen :

Inspection (N) shape

Palpation : soft, ~~non~~-tenderness +, hepatosplenomegaly

Ausculation : BS+

Spine: N External Genitelia :

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

Central Nervous System :

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

Cranial Nerves : WNL

Motor System :

Nutrition :

Tone : Power

Co-ordinator : WNL

Posture :

Involuntary Movements :

Reflexes :

DTR **Superficials :**

Plantars WNL

Sensory System :

Bladder / Bowel :

Clinical Summary & Diagnostic :

AFI ~~c~~ dehydration ? Viral

Acute Gastroenteritis

Preventive aspects of the treatment :

Desired goals of the treatment :

Planned Labs :

CBC, CRP, Blood C/S
CUE, Dengue < NS1 / IgM
Urea, creatinine, ~~electrolytes~~,
VBG, ~~for~~ 5 virus panel respiratory,
LFT, Chest x-ray ~~done~~

MB Ampam

Planned Management :

IVF - ~~fast~~ maint 2/3rd
Paracetamol
ceftriaxone after blood culture.

MB Amp.

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 _____

HNH-00004537 IP26-00006854
Master SAMARTH HEDA
24-10-2015 10 Y 8 M 21 D (M)
Dr. SANJAY SRIRAMPUR

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16/3/26 1AM	c/s/by Dr Anuch	
	AFI ē dehydration	
	c/o cough & wet cold	
		+ ct IV fluids
	Nasal disch (+)	
		— Ct Inj CEFTRIAXONE
	vital stable	
		- Syp Relent plus 5ml BD
	Chest - clear.	
		- Ct paracetmol
	Af	
		NIB Sputum

Docu. No. : RCH /FRM / CLINICAL / 088 (P.T.O)

HNH-00004537 IP26-00006854
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16/7/16 & AM.	c/s/by Dr Anuche	
	AFI c dehydration.	Inj Mira A illn (+) (verbal)
	Vital stable	Deny – Neg (verbal)
	fever – No	Plan
	Intake] low Activity] low	
	Bp – (N).	Ct iv/fluid Inj CEFTRIAXONE
	S/E (RS) BLAE (+) NVBS (+).	(T) Dengu Rep panel Blc/p
	Af.	ct oth Mx Bp, Uto Monitoring.
		(Ada) FLUVIR.

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

HNH-00004537 IP26-00006854
Master SAMARTH HEDA
24-10-2015 10 Y 8 M 21 D (M)
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16/1/26 9:30 Am	S/B Dr. Pritesh Influenza A illness c̄ dehydration	Adv • Add oral fluid • Ct Ceftriaxone • Ct IVF • (T) labs Dr. Pritesh Nagar Consultant Pediatrician & Intensivist Reg. No: 47184
16/1/26 12:30 PM	C/S/B Dr. Shruti Dsis - Influenza A illness. - fever spikes (+). - Oral intake → poor. - 1 e/o vomiting. O/E - Vitals stable. O/E - R/S - (L) sided wheeze + crepts.	Plan - Start Levolin + Hypertonic neb. Q6H. - Ct. fluid. - Ct. Ceftriaxone. - Trace reports. - chest physiotherapy

HNH-00004537 IP26-00006854
Master SAMARTH HEDA
24-10-2015 10 Y 8 M 21 D (M)
Dr. SANJAY SRIRAMPUR

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16/7/26 2pm	S/B Dr Archana / Dr. Naipunya.	
	Influenza A illness ? dehydration.	
	Afebrile 2 e/o vomitings (+) ↓ passed. SJ	Adv. · Ct Inj CEFTRIAXONE · Ct oral fluvir · Ct rest same as Rx chart · (1) Adenovirus Blood C&S
	ole vitally stable. ste wnl.	S/B o/p

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

HNH-00004537 IP26-00006854
Master SAMARTH HEDA
24-10-2015 10 Y 8 M 21 D (M)
Dr. SANJAY SRIRAMPUR

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	C/i/c O. [illegible] / O. [illegible]	
17/07/26 1AM	Influenza Illness with dehydration	
	Afebrile	
	Vomiting ⊖	
	passing urine/ stools	
	O/E: Ch fair	
	Hydration - good	
	S/E: NAD	Adv
		- Inj Ceftriaxone
		- Cont. oral fluids
		- Cont. same treatment
		[signature]
		noted by sr. sandhya 17/7/26

HNH-00004537 IP26-00006854
Master SAMARTH HEDA
24-10-2015 10 Y 8 M 21 D (M)
Dr. SANJAY SRIRAMPUR

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
17/7 9:30AM	C/S/B Dr. Pritesh Sir	
	Influenza A Illness c Dehydration - (L) LL Pneumonia	
	- Fever - ↓	
	- Cough - Better	Plan
	- No Vomiting	1) Syp Fluvir
	- Oral intake - Fair	2) Neb c Levolin + 3% NaCl } Q6h
	O/E	
	Child Afebrile	3) Inj Ondem to Inj PAN
	R-S - B/L AE (+)	4) Decide on Antibiotic with Dr. Sanjay Sir
	P/A - soft	5) Syp Relent
		6) Oral Amoxyclav
		7) Monitor Vitals.

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

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
17/7/20 10:20AM	S/B Dr. Sanjay Sir	
	D/n Urticaria A/Allergy	
	Afebrile	Plan
	Vitals stable	- Discharge
		- FLUVIR x 5 day
		- AMOXYCLAV - 7 day (total)
		- F/up on Sunday.

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

HNH-00004537 IP26-00006854
Master SAMARTH HEDA
24-10-2016 10 Y 8 M 21 D (M)
Dr. SANJAY SRIRAMPUR

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DRUG CHART

Date of Admission: ..... 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 *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: Tab-PARACETAMOL				Date / Time
Dose: 500 mg	Route: PO	Frequency: SOS	Start Date: 15/7	
Doctor's Signature: Ruchi	Valid Period:	Pharm.:		
Additional Instructions:				

DRUG: ~~ONDEM~~ TAB·ONDEM				Date / Time
Dose: 2mg	Route: PO	Frequency: SOS	Start Date: 15/7	
Doctor's Signature: Ruchi	Valid Period:	Pharm.:		
Additional Instructions:				

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

Signa

VERIFIED BY : Name .....

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Master SAMARTH HEDA
24-10-2015 10 Y 8 M 21 D (M)
Dr. SANJAY SRIRAMPUR

« Blood c/s

REGULAR PRESCRIPTIONS

Weight. 29 kg Ward. .....

DRUG : Inj. CEFTRIAXONE

Dose	Route	Frequency	Start Date
1.5gm	IV	Q12h	15/7

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

Additional Instructions: ≈(100 mg/kg/day)

Daily Doctor's Endorsement by a Sign

Date/Time	15/7	16/7
	10AM X	
	10pm	

DRUG : Inj. PANTOPRAZOLE

Dose	Route	Frequency	Start Date
30mg	IV	Q24h	15/7

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

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date/Time	15/7	16/7	17/7
	10PM		
	6AM		

DRUG : Syp RECENT plus

Dose	Route	Frequency	Start Date
5ml	PO	BD	16/7

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date/Time	16/7	17/7
	1:40 AM	
	12AM	
	12 PM	

DRUG : Nasoclean nasal drop

Dose	Route	Frequency	Start Date
2	B/N	QID	16/7

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date/Time	16/7	17/7
	12AM	
	6AM	
	12PM	
	6PM	

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Sheet No: .....

REGULAR PRESCRIPTIONS

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

DRUG : FLUVIR SYP.

Dose	Route	Frequency	Start Dt.
5ml	PO	BD	16/7

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions: (12mg/1m) (60mg/5ml)

Daily Doctor's Endorsement by a Sign

Date / Time: 16/7 17/7

DRUG : Neb ē LEVOLIN ④ HYPERNEB

Dose	Route	Frequency	Start Dt.
0.63mg 1 resp	Neb	Q6hrly	16/7

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:
0.6mg/1respule - Levolin
④ 1 respule HyperNeb

See the chart

Daily Doctor's Endorsement by a Sign

Date / Time:

DRUG : Inj ONDANSETRON

Dose	Route	Frequency	Start Dt.
4mg	IV		

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time:

DRUG : Inj ONDANSETRON

Dose	Route	Frequency	Start Dt.
4mg	IV	TDS	16/7/26

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time: 16/7 17/7

(P.T.O.)

Patient Sticker

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Sheet No: ....

REGULAR PRESCRIPTIONS

Weight .... Ward ....

DRUG : Syp AMOXYCILLIN + CLAVULANATE				Date / Time
Dose	Route	Frequency	Start Dt.	
7.5ml	PO	BD	17/12	
Name & Signature of the Doctor Starting the Drugs: Praanm				
Additional Instructions: AUGAMP = KID - FORTE (5ml = 400 + 57)				
Daily Doctor's Endorsement by a Sign				

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

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

DRUG :				Date / Time
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 ....

Patient Sticker

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

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

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

Signature .....

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses

VERIFIED BY : Name

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24-10-2015 10 Y 8 M 21 D (M)
Dr. SANJAY SRIRAMPUR

I.V. FLUIDS CHART

Weight. 29 kg Ward. .....

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
15/7/26	8.56pm	IVF (2/3rd DNS maint)	IV	45 ml/hr					

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

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RESULT SHEET

Date	15/7/26					
Time						
Hb	12.7					
PCV	35.4					
RBC	4.60					
WBC	3.90					
N/L	61.8/26.2					
Platelets	186					
CRP	23					
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea	18					
Creatinine	0.4					
ALP	134					
SGPT	18					
SGOT	78					
T.Bill/Conj	0.7/0.5					
T.Protein	6.1					
S.Albumin	3.4					
S.Globulin	2.7					
A/G Ratio	1.2					
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

Date	15/7/26					
Time						
CUE - Alb						
CUE - Sugar	Nil					
CUE - Ketones	Negative					
CUE - PUS Cells	2-4					
CUE - RBC Cells	Nil					
CUE Epithelial Cells →	1 - 2					
Stool Pus Cell						
OVA / Cyst						
Occult Blood						
Dengue NS1 →	Negative					
" IGM →	negative					
Adenovirus →						
SARS-COV2 →						
Influenza A →	Positive					
Influenza B →						
RSV →						

Culture and Sensitivities : Blood C/S →

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

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24-10-2015 10 Y 8 M 21 D (M)
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I/ FRM / CLINICAL / 126

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

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 15/7/26 Time:	10	2	6	PM		
Doctor / Nurse / Family Concern?	PM	AM	AM			

Temperature (F)

104 103 102 101 100 99 98 97 96 95 94

98.6°F 97.1°F 98.3°F 97.1°F

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

Note: BP does not score in early warning scoring

190 180 170 160 150 140 130 120 110 100 90 80 70 60 50

97 (71) 101 (74) 107 100

61 65 70 60

Heart Rate (Number)	94b/m	100b/m	93b/m	101b/m

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

70 60 50 40 30 2 1

Resp Rate (Number)	26b/m	26b/m	28b/m	29b/m
Resp Distress: Mod/ Severe / None / Mild				
Receiving O_2(l/min) O_2Saturations (%)	100%	99%	99%	99%
Conscious Level: Normal / Altered				
GCS *	15/15	15/15	15/15	15/15
TOTAL SCORE Number of shaded boxes	0	0	0	0
Pain Score	0	0	0	0
Observer's Initials				

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.

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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 SAMARTH HEDA
24-10-2015 10 Y 8 M 21 D (M)
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/ CLINICAL / 126

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

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 16/7 Time: 10Am | 2pm | 6pm | 10pm | 2 | 6

Doctor / Nurse / Family Concern? | | | | | Am | Am

Temperature (F) — 104 103 102 101 100 99 98 97 96 95 94

98.3°F | 97.2°F | 97.6°F | 97.1°F | 97.1°F | 98.4°F

Heart Rate (bpm) and Blood Pressure (mmHg) * — 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50

Note: BP does not score in early warning scoring

110 (77) 67 | 111 (80) 69 | 105 (80) 70 | 102 60 | 104 (76) 64 | 110 70

Heart Rate (Number): 109b/m | 110b/m | 98b/m | 113b/m | 106b/m | 106b/m

Resp. Rate (bpm) (Over 1 Minute) * — 70 60 50 40 30 20 10

Resp Rate (Number): 20b/m | 23b/m | 25b/m | 29b/m | 28b/m | 29b/m

Resp Distress	Mod/ Severe / None / Mild					
Receiving O_2(l/min) O_2Saturations (%)		100%	98%	99%	99%	99%	99%
Conscious Level	Normal / Altered					
GCS *					15/15	15/15
TOTAL SCORE Number of shaded boxes		0	0	0	0	0	0
Pain Score		0	0	0	0	0	0
Observer's Initials							

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.

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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.
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- 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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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 :**						
15/4/26	08:00 pm											
	09:00 pm	↑	Khatchi	45ml						✓	0	
	10:00 pm			45ml						✓	0	
	11:00 pm	DNS		45ml							0	
	12:00 am	↓		45ml							0	
	01:00 am			45ml							0	
Total Intake :						**Total Output :** U- M-						
16/4/26	02:00 am	↑		45ml						✓	0	
	03:00 am			45ml							0	
	04:00 am	DNS	H2O	45ml							0	
	05:00 am			45ml							0	
	06:00 am	↓		45ml							0	
	07:00 am									✓	0	
Total Intake :						**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							
16/7	08:00 am			45ml								
	09:00 am			45ml								
	10:00 am	DNS	1 dly	45ml								
	11:00 am		&	45ml								
	12:00 pm		H2O	45ml								
	01:00 pm			45ml								
Total Intake : Taken								Total Output : M-0			U-2	
16/7 //	02:00 pm			45ml								
	03:00 pm			45ml								
	04:00 pm	DNS	Rice	45ml								
	05:00 pm		&	45ml								
	06:00 pm		H2O	45ml								
	07:00 pm			45ml								
Total Intake :								Total Output :				
16/7/26	08:00 pm			45ml								
	09:00 pm			45ml								
	10:00 pm	DNS	Rice	45ml								
	11:00 pm		&	45ml								
	12:00 am		H2O	45ml								
	01:00 am			45ml								
Total Intake : Taken								Total Output :		U-2	M-	
17/7/26	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am	DNS		45ml								
	06:00 am			45ml								
	07:00 am			45ml								
Total Intake : Taken								Total Output :		U-	M-	

Total 24 hrs. Intake		Total 24 hrs. Output	

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NURSING CARE RECORD

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Date: 15/7/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon							
Night	9PM to 8PM	→ To assess the pt. condition → To check the vitals & recorded → To administer the medication as per drug chart → I/O chart maintain	9PM to 8AM	→ To assessed the pt. condition → To checked the vitals & recorded → To administered the medication as per drug chart → I/O chart maintained	→ Patient is stable	→ Re-checked the vitals → I/O	Supriya

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Master SAMARTH HEDA (M)
24-10-2015 10 Y 8 M 21 D
Dr. SANJAY SRIRAMPUR

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NURSING CARE RECORD

Date: 16/7/26

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	8Pm to 2pm	Assess the baby Mouth [illegible] admins Medi Maintain Elo Chart	8Pm to 2Pm	Assesed the baby Mouth [illegible] administered Medi Maintain Elo Ch	Administered Medicine	Reassess [illegible]	[illegible]
Afternoon	2Pm to 8Pm	Assess the baby condition. Monitor vitals record. Maintain I/O chart. Provide the comfortable position. Medication give as per as doctor ord	2Pm to 8Pm	Assessed the Pt condition. Monitored vital signs. Maintained I/O chart. Provided the comfort position. Medication given as per as doctor order.	→ Pt is Stable. → vitals normal.	→ monitor vitals. → maintain I/O chart	[illegible]
Night	8PM to 8am	→ Assess the baby condition → monitor vitals → Administer medications as per doctor's orders	8PM to 8am	→ Assessed the baby condition → monitored vitals → Administered medication as per doctor's orders	Patient is stable	→ Rechecked vitals	[illegible]

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NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: AFI				Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:		
	Surgery / Procedure:				Post OP Day:		
BACKGROUND	Date / Shift	15/7/26 N1	16/7 GS	16/7 E	16/7/26 N8		
	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):	-	-	-	-		
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:	98.4°F	98.3°F	98.2°F	98.3°F		
	Res:	26b/m	20b/m	26b/m	25b/m		
	SpO_2:	100%	100%	99%	99%		
	Pulse:	98b/m	92b/m	72b/m	82b/m		
	BP:	100/61	101/62	104/68	100/70		
	LOC:	-	-	-	-		
	Fall Risk Score:	-	-	-	-		
	Pain Score:	"0"	-	-	-		
	Skin Integrity	Good	-	-	-		
Recommendations	Safety Needs:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Physiotherapy:	-	-	-	-		
	Others Specify:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Special Diet:	Soft	-	-	-		
	Critical Lab Test / Values:	-	-	-	-		
	Other Special Orders / Medications:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	PU Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	DVT Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	ADL (Dependent / Non Dependent):	-	-	-	-		
Post Operative Procedure Special Orders:		-	-	-	-		
Handed Over By Name :		Supriya	[illegible]	[illegible]	Sandhya		
Signature / ID :		[signature]	[signature]	[signature] 2/6/1603	[signature]		
Date:		15/7/26	16/7	16/7	17/7/26		
Time:		8AM	2pm	8pm	8am.		
Taken Over By Name :		[signature]	[signature] 2/6/1603	Sandhya			
Signature / ID :		[signature]	16/7	16/7/26			
Date:		15/7					
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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PAIN ASSESSMENT FORM

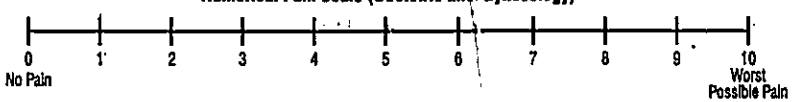
Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
15/7/26	10PM	0/10	NA	☐ Continuous ☑ Intermittent	☑ Acute ☐ Chronic	☐ Sharp ☑ Dull ☐ Aching ☐ Burning	☐ Increasing ☑ Decreasing	☑ Yes ☐ No	NA	[signature]
16/7/26	6AM	0/10	NA	☐ Continuous ☑ Intermittent	☑ Acute ☐ Chronic	☐ Sharp ☑ Dull ☐ Aching ☐ Burning	☐ Increasing ☑ Decreasing	☑ Yes ☐ No	NA	[signature]
16A	2pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	NA	[signature]
16/7/26	10pm	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		
				☐ 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

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CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1 15/7			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0			0	0	0	0				
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			NA	0	NA	NA				
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2			NA	0	NA	NA				
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3			NA	0	NA	NA				
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4			NA	0	NA	NA				
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5			NA	0	NA	NA				
		Signature of the Nurse											

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

Signature of Shift In Charge :

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

Signature of Ward In Charge :

Signature : Balasaraswathi Name : Balasaraswathi

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CHECKLIST FOR THROMBOPHLEBITIS

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

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

Signature of Shift In Charge :

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

Signature of Ward In Charge :

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

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HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE 15/7	DATE 16/7	DATE	DATE	DATE
Age	Less than 3 years old	4					
	3 to less than 7 years old	3					
	7 to less than 13 years old	2	2	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	2	2			
	Outpatient Area	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		—	—			
	Nurse's Name:		Supriya				
	Signature:						
	Date:		15/7	16/7			
	Time:		8AM				

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BRADEN 'Q' SCALE

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				Date : 15/7/26 16/7/26 16/7/26		
				Time : N1 E2 N3		
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	3	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.	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	
				TOTAL SCORE	28	27	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

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EM... TRIAGE FORM

Patient's Name : Samarth heda Age : 10y **Gender:** ☐ Male ☐ Female

Date : 15/7/26 Time of Arrival : 7:15 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: 103.9 PR: 125 BP: 115/73 RR: ..... SpO_2: 98

Chief Complaints: C/O Fever, cold, cough since 8 days. body pain

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 : 7:17 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 : Aarne

Signature of Triage Nurse : A.N.

Date & Time : 15/7/26 @ 7:20 Pm

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INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 15/7/26 Time of arrival : 7:15pm

Chief Complaints: cold, cough, fever, since 2days RBS: .....

Height : ..... Weight : 29kg 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 : 8:40pm

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

Time	Nursing Notes
	Assessed the Patient condition vital checked.

Samples collected by: /

Time:

Samples sent by : /Apmuban

Time: /8:00 pm

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1
8 Jiso pm	pcm ⊗	oral	500mg	⊗	

Condition of patient at time of shift - out :	**Details of Shift - out**
HR: 125 BP: 115/73 CFT: NO	Shift - out from ER to: RIO
RR: 21 SPO_2 : 98	Time of Shift - out: 8:50 pm
GCS: 15/15 Temperature : 100.9	Handover given to: Sujaya (Nurse's Name)
Pain Score: 2	
Repeat RBS (if applicable): NO	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

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

.....

Name of the Nurse : Ampam Signature of the Nurse : A.D

Date & Time : 15/7/26 @ 8:00 pm

HNH-00004537 IP26-00006854
Master SAMARTH HEDA
24-10-2015 10 Y 8 M 21 D (M)
Dr. SANJAY SRIRAMPUR

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MEDICATION RECONCILIATION FORM

Drug Allergies: ..... ☐ Not known any Drug Allergies

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

Shifting From: ..... Shifted to: .....

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

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : .....

Date & Time : .....

Nurse Name & Signature: .....

Date & Time : .....

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
Samarth	15/7/26	15/7/26 @ 8:50pm
HNH-00004537 IP26-00006854 Master SAMARTH HEDA 24-10-2015 10 Y 8 M 21 D (M) Dr. SANJAY SRIRAMPUR	Transfer Ordered by Dr. Prajakta	Reason for Transfer Admission
From Unit ER	To Unit 210	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File 20	Number of Imaging Films X-ray 1	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
Samarth	Dr. Prajakta

Patient & Clinical Records Received by : Supriya

Date & Time of Patient Received : 8:53pm @ 15/7/26

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

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

HNH-00004537 IP26-00006854
Master SAMARTH HEDA
24-10-2015 10 Y 8 M 21 D (M)
Dr. SANJAY SRIRAMPUR

GENERAL CONSENT FOR TREATMENT

Patient Name:	**Master SAMARTH HEDA**	**Age :**	**10 Y 8 M 21 D**
IP No:	**IP26-00006854**	**Sex:**	**Male**
Consultant:	**Dr. SANJAY SRIRAMPUR**	**Ward/Bed No:**	**GF -EMERGENCY/ER02**

The undersigned patient and I or responsible relative or person hereby consent to and authorize Rainbow Hospitals doctors and medical personnel to perform medical examinations, conduct routine investigations and administer medical treatments, outpatient procedures, minor dressings, vaccinations and immunizations during the course of the patient's care, as in patient.

Patient, be deemed advisable or necessary.

I understand that the confidentiality of all medical records shall be protected to the full extent of the Law. The undersigned also consent to the use of health related information/ audiovisuals of the patient for research & training purpose or for insurance coverage and while doing so confidentiality of the patient will be maintained at all times and this will not affect the care of the patient.

In giving my general consent to treatment, I understand that I retain the right to refuse any particular examinations, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by treating doctors. I also understand that the practice of medicine is not an exact science and that no guarantee have been made to me as the results of my evaluation and I or treatment.

I understand that I shall not bring valuables to the Hospitals and that the Hospital will not be responsible for the loss, destruction or theft of my personal belongings. I assume full responsibility for all my personal items and release the Hospital from responsibility and liability for such personal items and valuables.

"I am aware that during the patient care it is inevitable that certain re-useable equipment shall be re-used after sterilization and disinfection. I am informed that the hospital assures maximum level of precaution and care in sterilizing and disinfecting the equipment and monitors the whole process as per evidence based guidelines".

Note:
1 We do not allow use of medication brought from outside by the patient.
2 I have received attendant passes as per my room category. I understand that I have to return it back at the time of final bill clearance. In case of failing the submission, I will pay 200/- Rs.
(Receivers Signature:.....)

3 IP Guide book has been given to me and I have been explained about the Hospitals rules and policies.
4 Financial and billing counseling has been done to me.

Signature of Patient/Relative:

Name: Ronak Hede
Relationship: Brother.
Date: 15/7/26 Time: 8:00 pm.
Witness Name:
Witness Signature:

Patient Address:
4-4-1/D/13 DILSHAD PLAZA HANUMAN TEKDI SULTAN BAZAR State Bank Of India Hyderabad Telangana INDIA 500095

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Master SAMARTH HEDA
24-10-2016 10 Y 8 M 21 D (M)
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BILLING POLICY

- Billing cycle: - With effective from 1st January 2020, Our billing cycle to be start from 12 PM to 12 PM, Settlement post 12 PM, room rent will be charge for half day extra & post 6 pm, it will be charge for full day. Less than 24 hours stay will be considered as one day.
- As per the GOI guidelines, we can collect Rs 1,99,999/- only in cash mode, balance patient can pay through Card tpaIn the event of TPA/ Cashless denial or approval not received due to any reason then hospital tariff will be applicable and any discount or special rates given to TPA's / corporates won't be applicable.
- If the surgery / scans performed in Emergency hours (8pm - 7am), public holiday and on Sunday will be charged TPA processing charges Rs.720 for every TPA route cases.
- All charges vary as per Room category, except Pharmacy and consumables.
- We follows a "No Discounts Policy" kindly cooperate.
- No Duplicate/Second copy of OP OR IP bill is issued.
- ICU/Ward Charges DO NOT INCLUDE - Air Mattress, Monitor, Consultants/ Specialty Doctors Visit, Infusion/syringe pump, Ventilator/C pap, Oxygen, Investigations, Procedures, Consumables, Medicines or any other bedside equipment's/devices etc. (Detailed list can be taken from billing department).

Patient attendant can collect for Interim/provisional bill of the patient from the billing section on daily basis. Interim Bill shall be based on the acknowledged services in HIS. Final Bill of the patient may vary from the Interim bill based on actual update taken on the day of discharge. It is requested that patients/attendants inquire daily about the bill amount from billing section and pay the outstanding as on that day.

Patient bill outstanding should not be increase more than 10,000/-

You are requested to clear your outstanding amount on daily basis before 12 PM.

MODE OF PAYMENT & REFUNDS

- We accept payments by cash (up to Rs 1,99,999/- only), cards, online transfer and Demand Drafts.
- All refund more than Rs.2,000/- will be refund through NEFT in three Bank working days.

Ranak Hedl

Name & signature of Patient/Attendant

(Signature of Admission Desk executive)

NOTE: Self - attested Govt. ID proof is mandatory whosoever is signing the undertaking.

RAINBOW CHILDREN'S MEDICARE PRIVATE LIMITED

Registered Office: Road No.2, Banjara hills, Near Hotel Park Hyatt, Hyderabad - 500 034, T: +91 40 2233 4455.
Corporate Office: 8-2-19/1/A, Daulet Arcade, Karvy Line, Road No.11, Banjara Hills, Hyderabad - 500 034.
Branches : BANJARA HILLS - T: 2233 4455 | VIKRAMPURI - T: 4246 2200 | KONDAPUR - T: 4246 2400 | MADHAPUR - T: 6464 2020 |KUKATPALLY - T: 4246 2300 | L B NAGAR - T: 7111 1333 | MARATHAHALLI, BENGALURU - T: +91 80 7111 2345 | BANNERGHATTA ROAD, BENGALURU - T: +91 80 2551 2345, HIMAYATNAGAR- T:- 40 48873000

CIN: U85110 TG1998 PTC029914 email : info@rainbowhospitals.in **www.rainbowhospitals.in**

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UNDERTAKING OF INSURANCE PATIENT/ CREDIT PATIENT FOR ADVANCE PAYMENT

To

The Management,

Rainbow Children's Hospital, Himayat Nagar,

Hyderabad - 500029.

Sub:- **Undertaking of Insurance Patient for Advance Payment.**

I Mr./Mrs./Ms. Ronak Hedu (Father/ Mother/ Other Brother) of Master/ Baby/ Baby of/ Mrs. / Ms._____ was bought to your hospital on Emergency basis on 18/2/16 at 7:30pm approximate charges deposit details were explained by the front office executive on duty.

As I have cashless insurance so I have to pay 10k as a caution deposit at the time of admission. If there will be any difference amount after getting the approval I'll pay that amount at the time discharge.We explained about care health insurance (medical management)approvel and rejuction process if incase insurance was denied they told will pay the cash .

Thanking You

Signature

Name:- Ronak Hedu

Ph. No.:- 9963804440

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Master SAMARTH HEDA
24-10-2015 10 Y 8 M 21 D (M)
Dr. SANJAY SRIRAMPUR

DECLARATION BY PATIENT OR PATIENT ATTENDANT (TPA / INSURANCE / AROGYA BHADRATA / CORPORATE)

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Date: 25/7/26

I have attended the financial counseling desk / billing desk and understood the approximate expected costs of treatment. I clearly understand and agree that the hospital would bill as per its (hospital's) existing terms and conditions or MOU with my TPA/ Insurance Company/ Corporate /Arogya Bhadrata Scheme.

In case my claim is rejected by my TPA / Insurance Company / Corporate / Arogya Bhadrata Scheme at any point of time, i.e. before admission, during admission, during discharge or post discharge when hospital bill claim is submitted, I promise to settle the claim with the hospital. I understand and agree that there are certain TPA / Insurance Company / Corporate / Arogya Bhadrata Scheme Non - Coverable billing components which have to be paid totally by me like the following.

Registration charges, Insurance Processing fee, Medical Record Charges, MLC Charges, Tax Collected at Source (TCS), Dietician Consultation, F&B charges. Luxury Tax, Pharmacy and Consumables Non Medicals like Gloves, Masks, Draw Sheets, Diapers / Koochees, Intrafix, Q-Syte, Venflon, Sterilium, Splint, Gowns, Stockings, etc, Investigations like HIV, HbsAg, Pre Anesthesia Checkup (PAC), all Genetic Investigations, Double Occupancy, Vaccination Charges etc, instruments like Laparoscope, Thoracoscope, Harmonic, N-Seal, Morcellator, Cobulator, C-Arm, Micro Debrider, Medetronic Drill, Mann Mann Drill, Neuro Microscope, Neuro Endoscope, Endoscope etc, Maternity related like, Anti D, Muhurtham, Welt Baby Charges, Epidural, Entonox, Tubectomy etc. Any other facility used / treatment / investigation done which is not related to the present ailment is not covered.

I promise to clear my medical / non-medical bill dues during admission on daily basis or as and when applicable or whenever called for.

Mandatory Documents to be submitted for cashless process (Corporate Policy)

1. Employee ID Card.
2. Employee Government ID Proof (PAN /Aadhaar Card / Passport / Voter ID).
3. Patient TPA / Insurance Health Card or E-Card.
4. Patient Government ID Proof (PAN /Aadhaar Card / Passport / Voter ID / Birth Certificate)

Mandatory Documents to be submitted for cashless process (Individual Policy)

1. Proposer's ID Proof.
2. Patient TPA / Insurance Health Card or E-Card.
3. Patient Government ID Proof (PAN / Aadhaar Card / Passport / Voter ID / Birth Certificate)

Name of the Patient: Samarth Heda Date & Time of Admission: 25/7/26 7:30 PM

Name of the Parent / Guardian: Ronak Heda Mobile Number: 9963804440

Parent Aadhaar Card Number: .....

Signature & Relation Brother.

HNH-00004537 IP26-00006854
Master SAMARTH HEDA
24-10-2015 10 Y 8 M 21 D (M)
Dr. SANJAY SRIRAMPUR

18/7/20

To,

Medical Director/Medical Superintendent

Hospital Name: RAINBOW CHILDRENS MEDICARE LIMITED

Address: 3-6-234, HIMAYATNAGAR,

City:HYDERABAD

Pincode: 500029

Subject:

Dear Provider,

With reference to above mentioned subject line, hospital is in agreement to amend the existing MOU dated..... with Care Health Insurance and further agrees to service Care Health retail/individual card holders only for surgical procedures and urgent medical emergencies only.

Hospital hereby certifies that they will not admit any Care Health retail/individual card holders for Medical Management cases and shall assume entire liability of same, if done at their hospital.

Hospital Sign/stamp.....

Authorized Signatory Name & Designation.....

CARE CONTACT PERSON & MAIL ID'S

1. **MR ROHIT SINGH** M: +91 7842492985, EMAIL ID: Panjasha.singh@careinsurance.com
2. **MR RISHAV** **M: +91 8465078479, EMAIL ID: rishav.singh@careinsurance.com**

Signature

HNH-00004537 IP26-00006854
Master SAMARTH HEDA
24-10-2015 10 Y 8 M 21 D (M)
Dr. SANJAY SRIRAMPUR

2D

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NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 16/7/26 Time: 8:30 am

Weight: 29.6 kg Centile: 10th

Height: — Centile: 5

Inference: Underweight child

RDA: — Calories: 1650 Kcal/day Protein: 29 gms/day

Diet Recommendations: High fibre Balanced diet with liquid

Re-Assesment: N.D Junk, Oily, spicy food.

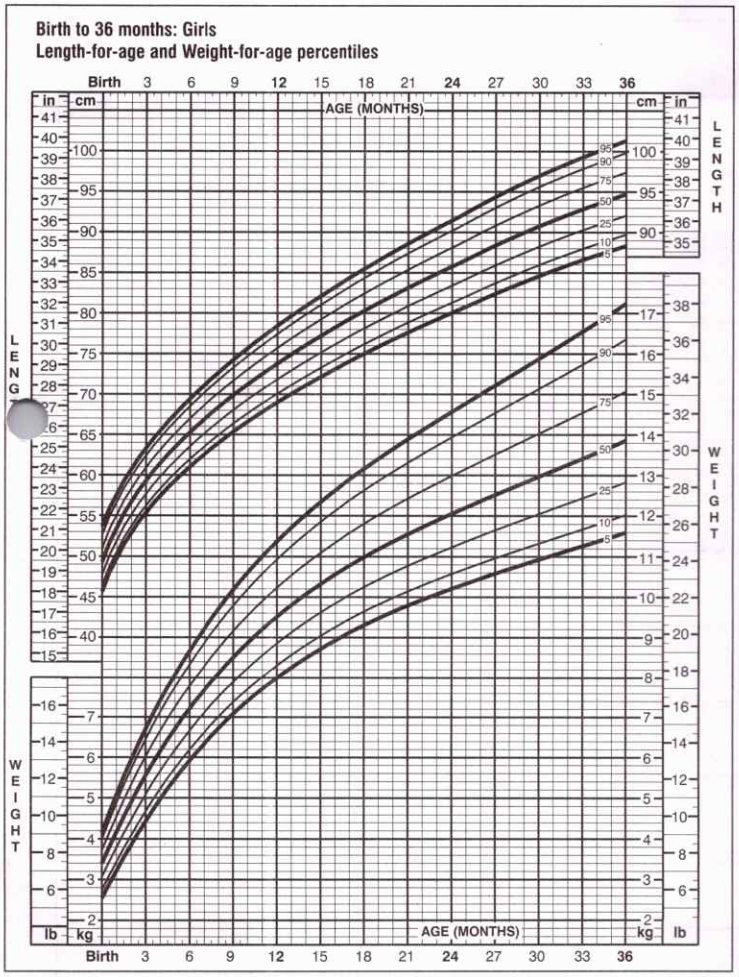
Food Allergies: No Veg/Non-veg Veg

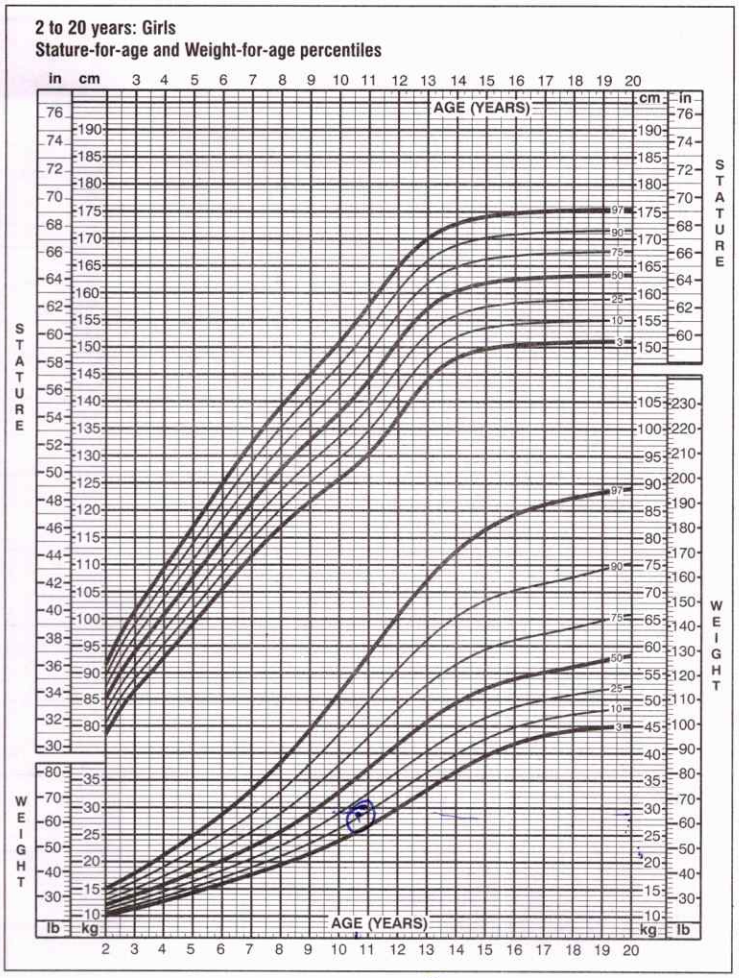
Diagnosis: AFI dehydration

Nutritional Intervention - ☑ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: Monika

GROWTH CHART (GIRLS)





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

Docu. No. : RCH /FRM / CLINICAL / 161

(P.T.O.)

Daily Notes: