

DISCHARGE SUMMARY

Name	Master MOHAMMED TAIMUR	UHID	HNH-00015534
Father/Guardian	Mr MOHAMMED SAIF	Age/Gender	1 Y 4 M 11 D/ Male
Address	16-9-307/32/1 4TH FLOOR, KHAN MANZIL, Malakpet, Hyderabad, Telangana, INDIA, 500036		
IP No	IP26-00006395	Admission Date	21-05-2026
Ref Doctor	Self.		
Discharge Date	23.05.2026		

Consultant:

Dr. SINDHURA MUNUKUNTLA
MBBS, DCH, DNB PEDIATRICS
66970

DIAGNOSIS	ICD CODE
WHEEZE ASSOCIATED LOWER RESPIRATORY INFECTION WITH RESPIRATORY DISTRESS	

History: Master MOHAMMED TAIMUR, 1 Y 4 M 11 D , old boy presented with history of cough since 2 days, fever and cold since 1 day, fast breathing since morning, prior to admission. For the above complaints he was admitted at Rainbow Children's Hospital - for further management.

Examination: He was afebrile, maintaining saturations at room air. His heart rate was 156/min and Respiratory Rate - 42/min. Capillary Refill Time was <2

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IP No	IP26-00006395	Admission Date	21-05-2026

secs. Peripheries were warm & pulses well felt. Respiratory distress present in the form of tachypnea, subcostal and intercostal retractions. On auscultation, air entry was bilaterally equal with mild wheeze were present. Heart sounds were normal and there was no murmur. Abdomen was soft with no organomegaly. On neurological examination, he was conscious and alert. Pupils were bilaterally equal and reacting to light. There were no focal neurological or cranial nerve deficits. There were no signs of raised intracranial pressure.

Weight on admission: 8.3 kilo grams.

Investigations: Enclosed reports.

GeneXpert FluA+FluB+RSV, SARS-CoV-2 were sent, which was negative. Adenovirus PCR was not detected.

VBG showed pH of 7.38, pCO₂ of 33.9 mmHg, pO₂ of 48 mmHg, HCO₃ of 20.4 mmol/L and BE of -5.2 mmol/L.

Initial hemogram showed Hemoglobin of 10.9 gm%, White Blood Cell count of 18030 cells/cumm, platelet count of 3.12 lakhs/cumm and C-Reactive Protein of 22.7 mg/l.

Chest X-ray shows:

There are mildly increased perihilar and peribronchial markings bilaterally, in keeping with lower respiratory tract inflammatory changes - ? Viral in etiology.

Management: He was admitted in the ward and was started on oxygen by nasal prongs by at 2L/min, intra Venous fluids and intra Venous antibiotics. He was treated symptomatically with antacids and antipyretics. In view of chest signs, he was frequently nebulised with Levolin and Ipravent. In view of

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IP No	IP26-00006395	Admission Date	21-05-2026

persistent wheezing, Injection.Methyl prednisolone and magnesium sulphate was given.

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's saturations levels improved gradually and oxygen support tapered and stopped. Child maintaining saturations on room air.

X-ray nasopharynx was done which was suggestive of adenoid hypertrophy and hence intranasal mometasone spray was started.

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. Augmentin
Nebulisation Levolin
Nebulisation Budecort
Metatop nasal spray
Nasoclear saline drops

Advice:

* Diet as advised.

Name	Master MOHAMMED TAIMUR	UHID	HNH-00015534
IP No	IP26-00006395	Admission Date	21-05-2026

S.No	MEDICATION	DOSE	TIMINGS	DURATION
1	Syrup. AUGMENTIN DUO (Amoxicillin 200 + Potassium Clavulanate 28.5 mg/5ml)	4.5 ml	8am-8pm (after food)	For 5 days
2	Metatop nasal spray (1 puff-50mcg mometasone)	1 puff	10 pm (after food)	For 1 month
3	Drop.Mucolite (1ml/7.5mg)	1 ml	orally thrice daily(7am-3pm-10pm)	For 3 days.
4	Syrup. XYZAL(levocetirizine 5ml/2.5mg)	2.5 ml	10 pm (BED TIME)	For 3 days.
5	NEBULISATION with Levolin (0.31mg)	1 respule	6th hourly	For 2 days
6	MDI with huff puff kit Budecort (1 puff-100mcg)	1 puff	12 th hourly	For 1 month
7	Nasoclear nasal drops, 2 drops in each nostril SOS for nose block			

Fever Management

* Syrup. Crocin DS (Paracetamol - 5ml/240mg) 2.5 ml after food as and whenever required, if temperature > 100 *F (maximum 4 times a day at 6 hour intervals).

* Tepid sponging if fever > 101 *F.

Name	Master MOHAMMED TAIMUR	UHID	HNH-00015534
IP No	IP26-00006395	Admission Date	21-05-2026

Review consultation with Dr. SINDHURA MUNUKUNTLA on Monday (25.05.2026) at Himayatnagar in OPD with prior appointment (**Review consultation will be charged**).

Food instructions while taking medications:

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

Follow up immediately in Emergency Room if high grade fever, vomiting, breathlessness or refusal to feed occurs.

The content of the patient discharge summary, medication, food & drug interaction, care to be provided at home, nutrition, immunization and safe parenting, when and how to obtain emergency care etc also have been explained by doctor in a language that I can understand and I acknowledge.


Parent/ Attender

In case of emergency contact 9154865030 emergency pediatrician on duty.

To take appointment for OPD consultation at Rainbow **Banjara Hills** / Rainbow Clinic **Madhapur / Kukatpally / Vikramपुरi / 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**

Name	Master MOHAMMED TAIMUR	UHID	HNH-00015534
IP No	IP26-00006395	Admission Date	21-05-2026



Registrar/Resident/C.M.O

Dr. SINDHURA MUNUKUNTLA
MBBS, DCH, DNB PEDIATRICS
66970

ADMISSION SHEET

Registration Details :



Admission No : IP26-00006395 Admit Date : 21-May-2026 Admit Time : 10:24 AM UHID : HNH-00015534

Patient Details :

Patient Name : Master MOHAMMED TAIMUR Age : 1 Y 4 M 11 D
Guardian : Mr MOHAMMED SAIF DOB : 10-01-2025 01:00 AM
Gender : Male Religion :
Occupation : Martial Status :
Address (H) : 16-9-307/32/1 4TH FLOOR, KHAN MANZIL Phone No : 8296206974/ 9538222027
Malakpet Hyderabad Telangana INDIA 500036 E-mail :
AMJADBEINGHUMAN124@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 MOHAMMED SAIF Relationship : Father
Contact Address : 16-9-307/32/1 4TH FLOOR, KHAN MANZIL Phone No : 8296206974
Malakpet Hyderabad Telangana INDIA 500036


Signature

Doctor Details :

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

Payment Details :

Deposit Amount : 5000.00
Payment Mode : DC/CC Card Payor Name : NAVI GENERAL INSURANCE LIMITED



ACTIV HNH-00015534 IP26-00006395
Master MOHAMMED TAIMUR
10-01-2025 1 Y 4 M 11 D (M)
Dr. SINDHURA MUNUKUNTLA

ING

Name: _____



UHID No : _____ IP No : _____ Consultant : _____ Dept : *pediatric*

Date of Admission : *21/5/26* Time : _____ Date of Discharge : _____ Time: _____

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
<i>21/5/26</i>	<i>11:15 AM</i>	<i>ER</i>	<i>Ward</i>	<i>[Signature]</i>

Cross Consultation Visit

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

Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Informant _____ Reliability _____

Chief Presenting Complaints & Duration (Chronologically):

- cough : 2 days.
- fever : 1 day
- cough : 1 day
- ~~xxx~~
- do part breathing : morning.

History of present illness :

child was apparently normal 2 days ago,
it developed cough - dry cough,
no diurnal variation.

- do fever - : 1 day - undocumented.
- do cold : 1 day.

(also blocked nose,
heavy breathing)

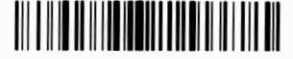
- do part breathing : morning

- no do localities/pain abdomen/

- Paused urine adequately.

Pediatric Multiorgan History & Physical Examination

HNH-00015534 IP26-00006395
Master MOHAMMED TAIMUR
10-01-2025 1 Y 4 M 11 D (M)
Dr. SINDHURA MUNUKUNTLA

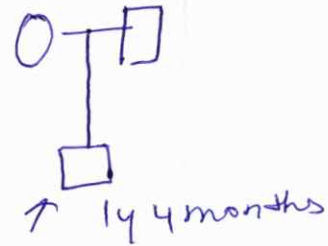


Past History : (Including details of any previous investigation or treatment)

Blank lined area for Past History notes.

Birth & Neonatal History :

late preterm / 1.8 kg / NIW 1 CAB
i/v/o oligo i/v/o LBW
Jae 3 days



Birth & Socio Economic History :

About Father : - no h/o asthma.

About Mother :

Any additional Information :

Developmental History :

- Rest up to date

- delay in speech development

Immunization History :

missed 6, 10 weeks vaccination ?
↳ received at 14 mo age
again.

HNH-00015534 IP26-00006395
Master MOHAMMED TAIMUR
10-01-2025 1 Y 4 M 11 D (M)
Dr. SINDHURA MUNUKUNTLA

History & Physical Examination

Anthropometry



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

Weight (kgs) 8.3 kg (Centile _____)

On Examination :

Temperature : 98.1 F Pulse Rate: 156 bpm Description _____

B.P. _____ SPO2 93% eka at _____

Resp. rate and type of breathing : - RR: 42 rpm
- SK (+)

Rash - mild ICR (+)

Lymphadenopathy _____

Oedema : _____

Respiratory system :

Inspection (any s/o distress) : - BAE (+)
- mild wheeze (+)

Air entry & breath sounds : _____

Any added sounds : _____

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

Cardiovascular System :

Inspection of precordium : S1 S2 (+)
no murmur

Heart Sounds : _____

Any murmur : _____

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

Per Abdomen :

Inspection - soft

Palpation : _____

Auscultation : _____

Spine: _____ External Genitalia : _____

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

Pediatric Multiorgan History & Physical Examination

HNH-00015534 IP26-00006395
Master MOHAMMED TAIMUR
10-01-2025 1 Y 4 M 11 D (M)
Dr. SINDHURA MUNUKUNTLA



Central Nervous System :

Level of Consciousness : AVPU/GCS Score : _____

Cranial Nerves : _____

Motor System :

Nutrition : _____

Tone : _____ Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

→ (N)

Reflexes :

DTR

Superficials :

Plantars _____

Sensory System :

Bladder / Bowel : _____

Clinical Summary & Diagnostic :

LRTI

? WARTI ERD.

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment :

Desired goals of the treatment :

Planned Labs :

Planned Management :

- VBG
- CBp
- CKP
- Chest X Ray
- Respiratory panel
- Blood clts [urgent & withheld]

- 1) O₂ c NP ezulmin
- 2) inj amoxiclar (after reports)
- 3) neb c lenalin q.3H.
- 4) neb c iperment q.6th h
- 5) Supportive care
- 6) sos methylpred.

Noted By Prabir

Noted By 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

Doctor's Signature Name Dr. Indira Date 21/4/2016 Time 2pm

HNH-00015534 IP26-00006395
 Master MOHAMMED TAIMUR
 10-01-2025 1 Y 4 M 11 D (M)
 Dr. SINDHURA MUNUKUNTLA



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<p>21/5 9:00pm</p>	<p>CLSB Do. Sindhura Dr. Nanjuna WALRI CRD</p>	
	<p>on NPO₂ 2L/min</p>	
	<p>Vitals - Stable.</p>	<p style="text-align: center;"><u>Plan</u></p>
	<p>R/S - BL ACP BL whee.</p>	<p>- Cont O₂ 2L/min</p>
		<p>- Cont Neb' levolin 3H Neb' Ipratropium 6H</p>
		<p>- Cont. Amoxiclav.</p>
		<p>- (T) CRP. Rest panel. Bkts.</p>
	<p>NIB Swethi</p>	<p>of medicine amount</p>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
21/5	<u>CRIB In Scindhu</u>	
6 pm	<u>Wheezing associated CRIB I & RD</u>	
	RD (+) :- Both	
	No fever	Plr
	On low flow - O ₂	(-1) Temp Adesovirus
	Accepted DRF	2) Neb C Lincis - R ₂ → 200µg
		Ipratium - 0.6
		5) NaCl
	Vital	3) Sig Amoxiclav
	HR - 114/min	4) night - 1 Lt O ₂
	SpO ₂ - 98%	Taper to stop - T ₁₂
	RR - 38/min	5) X-ray Nasopharynx - RD
	OK	T ₁₂ 9 AM
	Child asleep	6) Monitor vitals
	Afebrile	7) IVF - 1/2 (M)
	CRS - S ₁ , S ₂ (1)	Taper & stop, if oral intake betts
	R-S - B/NPE (1)	N
	Wheezing (1)	
	PIA - soft	
		Sindhura MUNUKUNTLA (M)



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
27/5/26	C/S/b or. Sindhura Venur / or. Anushe	
8 AM	Δ - LMCRI E RD.	
	- Afebrile.	off O ₂ = 100%.
	- Respiratory distress - ↓↓.	
	- Oral intake - Good.	
	- Activity - Good.	Plan
	S/E - HR - 110/min.	- Continue meds.
	RR - 26/min.	- Stop O ₂ .
	SpO ₂ - 95% @ NA.	- Stop IVF.
	S/E - R/S - BAC ⊕,	x-ray lateral
	B/L O ₂ wheeze ⊕	neck to chest @ 9 am
	CNS } CNS } PIA }	=
	NAD.	

HNH-00015534 IP26-00006395
 Master MOHAMMED TAIMUR (M)
 10-01-2025 1 Y 4 M 11 D
 Dr. SINDHURA MUNUKUNTLA



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/5 9:30am	<u>CB/B Dr. SINDHURA</u>	
	<u>Wheeze associated LRTI & Respiratory Distress</u>	
	RD - Betta	Plan 1) Proj Amoxyclo
	off oxygen @ 8am	2) Neb @ Levoflo - 0.4ml Ipratent - for 24 hrs - Stop 3% NaCl - 0.6ml - Stop
	Vitals: RR - 120/min SpO ₂ - 96% RR - 70/min	Add Budecort - 3) off O ₂ SOS - low flow
	R.S - B/LAE ⊕ Wheeze betta PIA - soft	4) Monitor vitals w/ distres
		5) Erasing tapelastic to 0.2
		6) Stop IV Fluid
		7) X ray Nasopharynx - No
	N/B priyanka	Handwritten signature

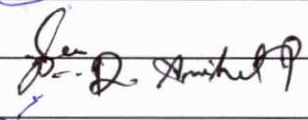
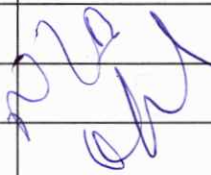
PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/5/25 3pm	<p><u>MR. DE. THAMMI</u> <u>WALATI</u> c RD</p>	
	<p>- SpO₂ = 80%</p>	
	<p>- no fever</p>	
	<p>- no tachypnea</p>	
	<p>- oral intake: good.</p>	
	<p><u>OLE</u> <u>meals</u> HR: 120 bpm RR: 34 bpm SpO₂: 98%</p>	<p><u>Plan</u></p>
	<p><u>RS</u>: RPE ⊕ SLE dyspnea wheeze ⊕</p>	<p>1) ut. inj amoxiclav 2) ut. neb c levofloxacin 4th c budesonid.</p>
	<p><u>US</u>: S1 S2 ⊕ no murmur</p>	<p>3) Sor O₂ support 4) monitor vitals.</p>
	<p><u>Jr.</u></p>	<p>N/B <u>Jr.</u></p>

HNH-00015534 IP26-00006395
 Master MOHAMMED TAIMUR
 10-01-2025 1 Y 4 M 12 D (M)
 Dr. SINDHURA MUNUKUNTLA



..... LESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/5/24 5:20 PM	S/B Dr. Anitha	
	D WALKER & PD	Pla
	WS - S4 S10 Ps - B11 - A10 B11 - w huge PLA - 506	CF Ncb & level in wk 23/11/24 E Budacool 1204
	Conscious	Monitor RR, SpO2
	SpO2 > 94% on RA	CF AMOXICILLIN
		METATOP nasal Spray I pull BD
		 



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/05/25 7 AM	<p>OLG: Dr. Sankar / Dr. Neeraj</p> <p>Δ: WALRI with RB</p>	
	<p>- sent baculifer & Afchub</p>	
	<p>OLG: AL-Jua</p> <p>Homodynamically stable</p> <p>SpO₂: 98% @ RA.</p>	
	<p>STG: NSI- TBAG@, TBCCheer@</p>	
		<p>Akka</p> <ul style="list-style-type: none"> - IV fluids (2/3 m) - NETS & LEVOCIN 9H TBudewant 12H - Inj Amoxiclav - Mombor vitals (RR, SpO₂) <p>Sankar</p>

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/23/26	5/8 Dr Lindh...	
10:44	△ Waken's ...	
	Cough ⊕	
	activity - fair	
	Child appropriate	
	Oral intake fair	Adv
	of ...	→ Discharge
		- P.U. on Monday
	Rx: BACT	→ Budesonide inhaler
	= ...	- 2 puffs BID
		→ Neb, 2 Levoflo
		Q4H
		→ Metatop nasal
		spray 1 puff BID
	→ Xyzal 2.5ml HS.	
	→ Mucolite down 1ml TID.	
	→ Augmentin total 7 tabs.	
		Handwritten signature
		Handwritten signature

MNH-00015534 IP26-00006395
 Master MOHAMMED TAIMUR
 10-01-2025 1 Y 4 M 11 D (M)
 Dr. SINDHURA MUNUKUNTLA



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 : SYP UROGIN-DS				Date Time															
Dose	Route	Frequency	Start Date																
2.5ml	PO	sos qid	2/15																
Doctor's Signature		Valid Period	Pharm.																
Additional Instructions:		(5ml = 240mg)																	
DRUG :				Date Time															
Dose	Route	Frequency	Start Date																
Doctor's Signature		Valid Period	Pharm.																
Additional Instructions:																			
DRUG :				Date Time															
Dose	Route	Frequency	Start Date																
Doctor's Signature		Valid Period	Pharm.																
Additional Instructions:																			

VERIFIED BY : Name Signature

Sheet No:

REGULAR PRESCRIPTIONS

Weight Ward

DRUG : Amoxiclav				Date/Time	22/5	25/5																
Dose	Route	Frequency	Start Dt.																			
180mg	IV	TID	21/5																			
Name & Signature of the Doctor Starting the Drugs: Aref																						
Additional Instructions:																						
Daily Doctor's Endorsement by a Sign																						

DRUG : NEB C LEVELIN				Date/Time																			
Dose	Route	Frequency	Start Dt.																				
0.3mg	NEB	4 th hly	21/5																				
Name & Signature of the Doctor Starting the Drugs: Pran				See the chart																			
Additional Instructions:																							
Daily Doctor's Endorsement by a Sign																							

DRUG : NEB C BUDECORT				Date/Time																			
Dose	Route	Frequency	Start Dt.																				
0.5mg	NEB	BD	22/5																				
Name & Signature of the Doctor Starting the Drugs: Pran				see the chart																			
Additional Instructions:																							
Daily Doctor's Endorsement by a Sign																							

DRUG : METASP nasal spray				Date/Time	22/5	25/5																	
Dose	Route	Frequency	Start Dt.																				
1 pull	nasal	BD	22/5																				
Name & Signature of the Doctor Starting the Drugs: B. Sanyal																							
Additional Instructions: 1 pull - Sanyal Mometasone																							
Daily Doctor's Endorsement by a Sign																							

VERIFIED BY : Name Signature

HNH-00015534 IP26-00006395
 Master MOHAMMED TAIMUR
 10-01-2025 1 Y 4 M 11 D (M)
 Dr. SINDHURA MUNUKUNTLA



Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward

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																			
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.	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.	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.	

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
2/5/26	9:45am	neb c lenalin	(0.3mg)	neb	<i>[Signature]</i>	<i>[Signature]</i>
		↓ 20min				
		neb c iproment	(250mcg)	neb	<i>[Signature]</i>	<i>[Signature]</i>

Signature

VERIFIED Name

HNH-00015534 IP26-00006395
 Master MOHAMMED TAIMUR
 10-01-2025 1 Y 4 M 11 D (M)
 Dr. SINDHURA MUNUKUNTLA



MEDICATION RECONCILIATION FORM

Drug Allergies: NA 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: Ward

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

* C - Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: Dr. Tanvi

Date & Time: 21/5/26 @ 10:20 AM

Nurse Name & Signature: Babi

Date & Time: 21/5/26 @ 10:20 AM

5

0

HNH-00015534 IP26-00006395
 Master MOHAMMED TAIMUR
 10-01-2025 1 Y 4 M 11 D (M)
 Dr. BINDHURA MUNUKUNTLA

216



RESULT SHEET

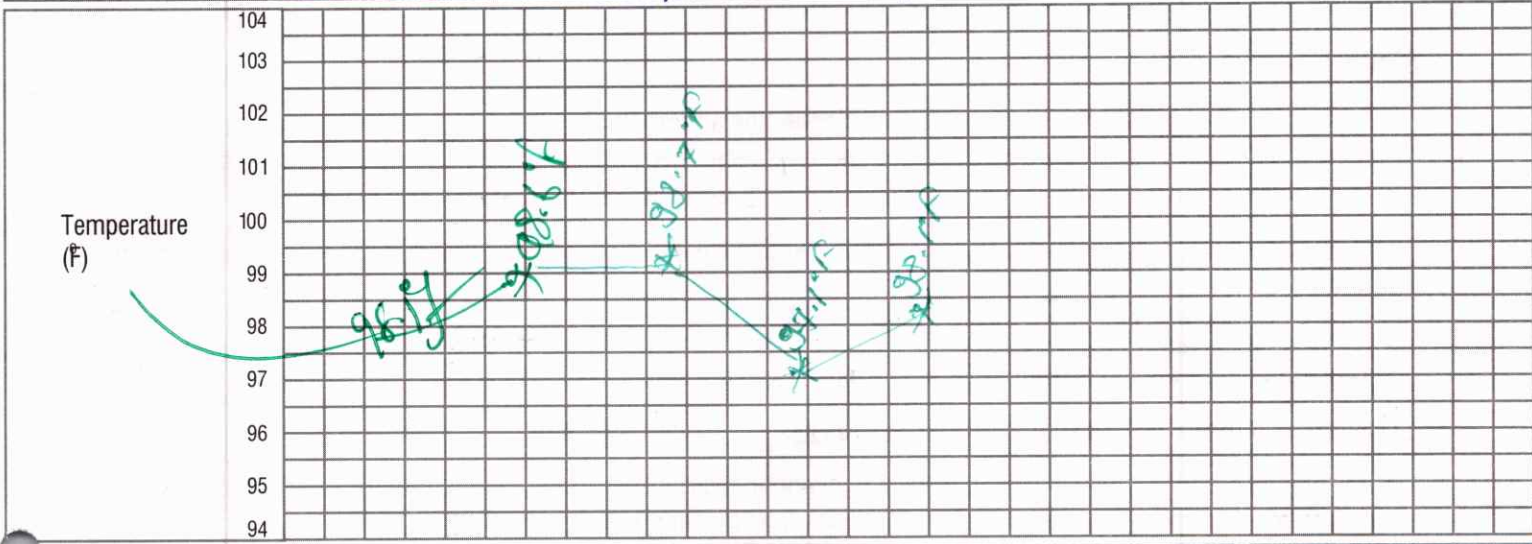


Date	21/5/20				
Time					
Hb	10.9				
PCV	30.5				
RBC	4.76				
WBC	8.03				
N/L	55/40				
Platelets	312				
CRP	22.7				
ESR					
PCT					
RBS					
Na					
K					
Cl					
Ca/Mg					
Phosphate					
Urea					
Creatinine					
ALP					
SGPT					
SGOT					
T.Bill/Conj					
T.Protein					
S.Albumin					
S.Globulin					
A/G Ratio					
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein/Sugar					
Cells					
N/L					



EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 21/5 Time: 11:00 AM - 6:00 PM 10 2 6 10
 Doctor / Nurse / Family Concern? PM AM AM AM



Heart Rate (bpm) and Blood Pressure (mmHg) *				
Note: BP does not score in early warning scoring				
Heart Rate (Number)		128 bpm	136 bpm	134 bpm

Resp. Rate (bpm) (Over 1 Minute) *				
Resp Rate (Number)	36 bpm	37 bpm	35 bpm	35 bpm

Resp Distress	Mod/ Severe	None / Mild		
Receiving O ₂ (l/min)			O ₂ 1 liter	
O ₂ Saturations (%)	100	100%	100%	97%
Conscious Level	Normal	Altered		
GCS *				

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

ACTIONS

NB: Scores 3 should be recorded overleaf

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

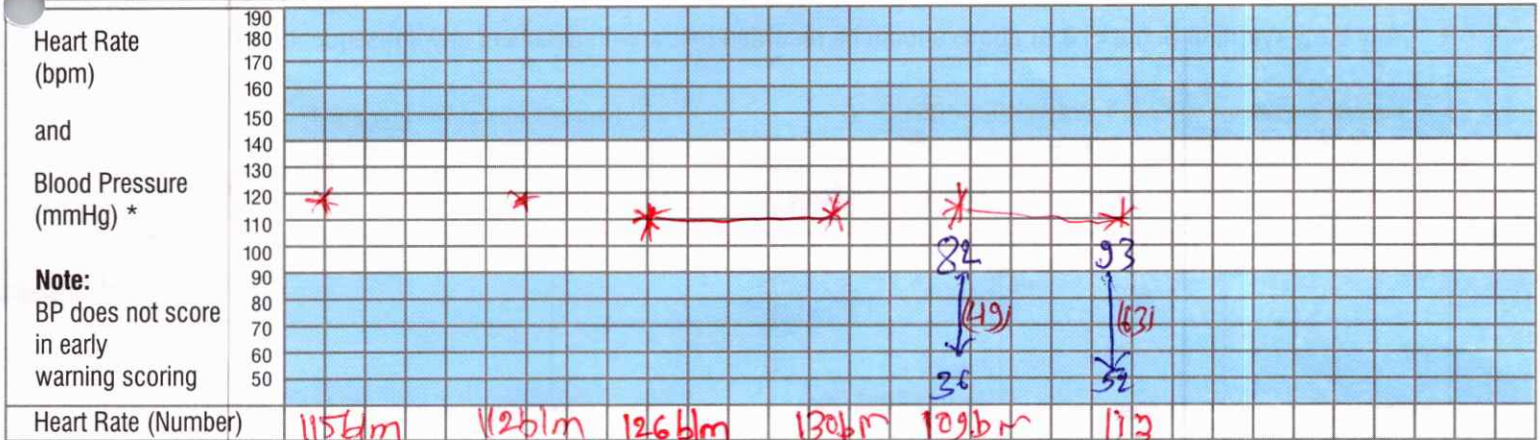
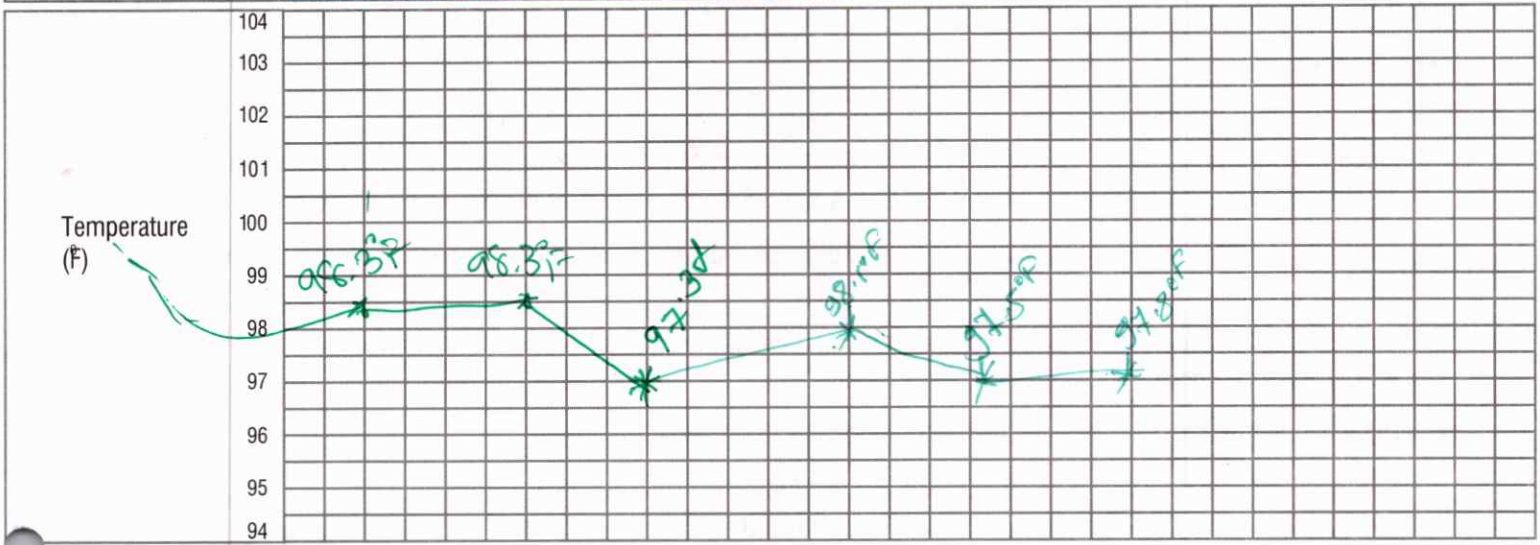
The SBAR communication tool (situation, background, assessment, recommendations) is a helpful mnemonic that can be used to describe a child's clinical condition to a colleague.

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



EARLY WARNING SCORE: CHILDREN'S UNIT

Date: <u>22/5/26</u>	Time: <u>10 AM</u>	<u>2 PM</u>	<u>6 PM</u>	<u>10 PM</u>	<u>2 AM</u>	<u>6 AM</u>
Doctor / Nurse / Family Concern?						



Heart Rate (Number)	115b/m	121b/m	126b/m	130b/m	109b/m	113
Resp. Rate (bpm) (Over 1 Minute) *	28	25	26	27	28	29
Resp Rate (Number)	28b/m	25b/m	26b/m	27b/m	28b/m	29b/m

Resp Mod/ Severe Distress None / Mild						
Receiving O ₂ (l/min) O ₂ Saturations (%)	99%	100%	98%	98%	98%	97%
Conscious Level Normal / Altered						
GCS *						

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

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

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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 is there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

HNH-00015534 IP26-00006395
 Master MOHAMMED TAIMUR
 10-01-2025 1 Y 4 M 11 D (M)
 Dr. SINDHURA MUNUKUNTLA



FLUID CHART

2 2 litres

Sheet No. :

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
21/5	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm	Plasma	20ml										
	01:00 pm	Ure	20ml										
Total Intake :						Total Output :							
21/5/26	02:00 pm	Plasma	20ml										
	03:00 pm	Plasma	20ml										
	04:00 pm	Plasma	20ml										
	05:00 pm	Plasma	20ml										
	06:00 pm	Plasma	20ml										
	07:00 pm	Plasma	20ml										
Total Intake :						Total Output :						U-2	M-
21/5/26	08:00 pm	Plasma	20ml										
	09:00 pm	Plasma	20ml										
	10:00 pm	Plasma	20ml										
	11:00 pm	Plasma	20ml										
	12:00 am	Plasma	20ml										
	01:00 am	Plasma	20ml										
Total Intake :						Total Output :						U-1	M-0
21/5/26	02:00 am	Plasma	20ml										
	03:00 am	Plasma	20ml										
	04:00 am	Plasma	20ml										
	05:00 am	Plasma	20ml										
	06:00 am	Plasma	20ml										
	07:00 am	Plasma	20ml										
Total Intake :						Total Output :						U-2	M-1

Total 24 hrs. Intake

Total 24 hrs. Output

HNH-00015534 IP26-00006395
 Master MOHAMMED TAIMUR
 10-01-2025 1 Y 4 M 11 D (M)
 Dr. SINDHURA MUNUKUNTLA



FLUID CHART

Sheet No. : 9

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

Date	Time	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
		Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
22/5			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am	2vf										
	11:00 am	stop	SOAP + Milk									
	12:00 pm											
Total Intake : Taken					Total Output : U-2 M-1							
22/5	02:00 pm									0		
	03:00 pm									0		
	04:00 pm	stop	M20							0		
	05:00 pm									0		
	06:00 pm									0		
	07:00 pm									0		
Total Intake : Taken					Total Output : M-3 U-4							
22/5	08:00 pm									0		
	09:00 pm									0		
	10:00 pm	stop	curd							0		
	11:00 pm									0		
	12:00 am		RICE							0		
	01:00 am									0		
Total Intake :					Total Output : U-1 M-1							
23/5	02:00 am									0		
	03:00 am									0		
	04:00 am	stop	curd							0		
	05:00 am									0		
	06:00 am		curd							0		
	07:00 am									0		
Total Intake :					Total Output : U-1 M-							
Total 24 hrs. Intake					Total 24 hrs. Output							

NURSING CARE RECORD

Date: 21/5

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	8 AM	<ul style="list-style-type: none"> → Assess the pt condition → monitor vitals & record → Maintain I/O chart → Administer medication as per doctor order 	9 AM	<ul style="list-style-type: none"> → Assessed the pt condition → monitored vitals & recorded → Administered medication as per doctor order 	⇒ Baby is fine	⇒ Rechecked vitals	<i>[Signature]</i>
Afternoon	2 PM	<ul style="list-style-type: none"> - Assess the pt condition - Monitor vitals - Maintain I/O Chart - Administer Medication as per doctor order 	3 PM	<ul style="list-style-type: none"> - Assessed the pt condition - Monitored vitals - Maintained I/O Chart - Administered Medication as per doctor order 	pt is stable	Rechecked vitals	<i>[Signature]</i>
Night	8 PM	<ul style="list-style-type: none"> Assess the pt condition monitor vitals maintain I/O chart. Administer medication as per doctor order 	8 PM	<ul style="list-style-type: none"> Assessed the pt condition monitored vitals Maintained I/O chart Administered medication as per doctor order 	patient is stable now	Rechecked vitals	<i>[Signature]</i>

NURSING CARE RECORD

Date: 22/5/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8AM	Assess the pt. condition - monitor vitals & record - maintain I/O chart - Give medication as prescribed by doctor	8AM	Assessed the pt. condition - monitored vitals & record - maintained I/O chart - Given medication as prescribed by doctor.	patient is stable now	Re-checked vitals	[Signature]
Afternoon	2pm	→ Assess the pt condition → monitoring vitals checked and recorded → I/O chart maintain	2pm	→ Assessed the pt condition → Administration & medication given as per doctor orders	→ pt is stable	→ Re-checked vitals	[Signature]
Night	8pm	Assess the pt condition monitor vitals & record maintain I/O chart provide the comfortable position.	8pm	Assessed the pt condition monitored vitals & record maintained I/O chart Provided the comfortable position.	pt is stable	monitor vitals	[Signature]
	8AM	medication give as per as doctor order.	8AM	medication given as per as doctor order	vitals normal	maintain I/O chart.	[Signature]



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	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	0	0	NA	NA					
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	0	0	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	0	0	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	0	0	0	NA	NA					
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord pyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5	0	0	0	NA	NA					
Signature of the Nurse				[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 of Ward In Charge :

Signature : [Signature] Name : Moukesh

Signature : [Signature] Name : Balar

HNH-00015534

IP26-00006395

Master MOHAMMED TAIMUR
10-01-2025 1 Y 4 M 11 D (M)
Dr. SINDHURA MUNUKUNTLA



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
21/5	9pm	0	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	NA	
21/5/26	8pm	0/10	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	
21/5/26	10PM	0/10	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	
22/5/26	10AM	0/10	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	NA	
22/5/26	2pm	0/10	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	NA	
22/5	5pm	0/10	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	
22/5	8pm	0/10	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	
22/5	10pm	0	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	
23/5	2AM	0	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	
23/5	8AM	0	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	

Re-assessment Frequency:

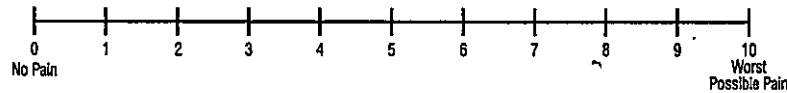
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

Numerical Pain Scale (Obstetric and Gynecology)



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

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

Wong - Baker (Pediatrics) Above 7 Years



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

HNH-00015534
 Master MOHAMMED TAIMUR
 10-01-2025
 Dr. SINDHURA MUNUKUNTLA (M)
 1 Y 4 M 11 D
 IP26-00006395

BRADEN 'Q' SCALE



Date : 21/12/2025
 Time : 10:30 AM

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	4	4	4
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	4
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	4
FRICITION-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

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

TOTAL SCORE	28	28	28	28
Evaluator's Name	[Signature]	[Signature]	[Signature]	[Signature]

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

HNH-00015534 IP26-00006395
 Maester MOHAMMED TAIMUR
 10-01-2025 1 Y 4 M 11 D (M)
 Dr. SINDHURA MUNUKUNTLA

BRADEN 'Q' SCALE



Date : 22/5
 Time : 8:2

Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4			
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4			
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: 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			
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4			
FRICION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4			
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4			
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4			
TOTAL SCORE					20			
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)
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13-14	Moderate Risk	<ul style="list-style-type: none"> • Use the Same Protocol as for “At Risk” Patients • Position patient at 30 degree lateral incline using foam wedges 	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
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Less than 9	Severe Risk	<ul style="list-style-type: none"> • Use same protocol as for “High Risk” Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors. 	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

SHIFT HAND OVER FORM

SITUATION	Diagnosis: WALVE RD	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Not Known If Yes Specify:						
	Surgery / Procedure:	Post OP Day:						
BACKGROUND	Date	21/5	21/5/26	21/5/26	22/5	22/5/26	22/5/26	
	Shift	M ₃	E ₂	N ₁	M ₆	E ₂	N ₁	
	Medical Condition (Any special condition to be noted):	-	-	-	-	-	-	
	Diet:	-	-	-	-	-	-	
ASSESSMENT	Allergy:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Ventilation (RA, NP, NIV, VENTI):	-	-	-	-	-	-	
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Vital Signs:	Temp:	98.1 F	98.6 F	98.1 F	97.8 F	98.2 F	98.2 F
		Res:	-	32b/m	32b/m	30b/m	30b/m	32b/m
		SpO ₂ :	99%	99%	99%	100%	98%	98%
		Pulse:	88b/m	130b/m	136b/m	140b/m	131b/m	129b/m
		BP:	-	-	-	-	-	-
		LOC:	-	-	-	-	-	-
	Fall Risk Score:	-	-	-	-	-	-	
Pain Score:	-	0	-	-	-	-		
Skin Integrity	-	Good	-	-	-	-		
Recommendations	Safety Needs:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Physiotherapy:	-	-	-	-	-	-	
	Others Specify:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Special Diet:	-	-	-	-	-	-	
	Critical Lab Test / Values:	-	-	-	-	-	-	
	Other Special Orders / Medications:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	PU Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
DVT Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
ADL (Dependent / Non Dependent):	-	-	-	-	NO	-		
Post Operative Procedure Special Orders:		-	-	-	-	NA	-	
Handed Over By Name :		<i>[Signature]</i>	Manisha	Suhra	Priyanka	Amrutha	<i>[Signature]</i>	
Signature / ID :		<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	
Date:		21/5/26	21/5/26	22/5/26	22/5/26	22/5	23/5	
Time:		2 PM	8 PM	8 AM	2 PM	8 PM	8 AM	
Taken Over By Name :		<i>[Signature]</i>	Suhra	Priyanka	Amrutha	<i>[Signature]</i>	<i>[Signature]</i>	
Signature / ID :		<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	
Date:		21/5	21/5/26	22/5/26	22/5/26	22/5	22/5	
Time:		8 AM	8 PM	8 AM	2 PM	8 PM	8 PM	

Patient Sticker



NURSING SHIFT HAND OVER FORM

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



*Levolin - 4H
 Budecont - 12H*

NEBULISATION CHART

Date	Time	Drug	Nurse	Parents Signature
	00.00			
<i>23/5/26</i>	01.00			
	02.00			
	03.00	<i>Levolin</i>	<i>Sneha Rukshan</i>	
	04.00			
	05.00			
	06.00			
	07.00	<i>Levolin</i>	<i>Sneha Rukshan</i>	
	08.00		<i>Lot 535</i>	<i>-15</i>
	09.00			<i>Cross checked done by Sneha.</i>
	10.00			
	11.00	<i>Levolin + Budecont.</i>		
	12.00			
	13.00			
	14.00			
	15.00			
	16.00			
	17.00			
	18.00			
	19.00			
	20.00			
	21.00			
	22.00			
	23.00			



Levulin - 4 H
 Ipratent - 6 H
 3% NS - 6



NEBULISATION CHART

Date	Time	Drug	Nurse	Parents Signature
22/5/26	00.00	Levulin + 3% NS (7)	Sneha	[Signature]
	01.00			
	02.00			
	03.00	Levulin + Ipratent (9)	Sin	[Signature]
	04.00			
	05.00			
	06.00	3% NS + Levulin (9)	Sin	[Signature]
	07.00			
	08.00			
	09.00	Levulin + Ipratent		
10.00	Levulin			
11.00	Budecont (1)			
12.00	3% NS			Ruksar
13.00				
14.00	Levulin			
15.00	levulin (2)			Ruksar
16.00				
17.00				
18.00				
19.00	levulin (3)			Ruksar
20.00				
21.00				
22.00				
23.00	Budecont + Levulin (1)	Sneha	Ruksar	

20/287

1470



Levolin - 3Hrly
 Ipratent - 6Hrly
 3% NS - 6Hrly

NEBULISATION CHART

Date	Time	Drug	Nurse	Parents Signature
	00.00			
	01.00			
	02.00			
	03.00			
	04.00			
	05.00			
	06.00			
	07.00			
	08.00			
	09.00	Ipratent		
	10.00			
	11.00			
21/5/26	12.00	Levolin	Sh	Levolin
	13.00	3% NS.	Sh	Sh
	14.00			
	15.00	Levolin + Ipratent	Sh	Ruksar
	16.00			
	17.00			
	18.00	Levolin + 3% NS	Sh	Ruksar
	19.00			
	20.00			
	21.00	Levolin + Ipratent	Sh	Sh
	22.00			
	23.00			



Handwritten scribbles or marks.

Handwritten text, possibly "1944" and "1945".

Handwritten scribbles or marks.

Handwritten scribbles or marks.



Handwritten scribbles or marks at the bottom center of the page.

PATIENT TRANSFER FORM

HNH-00015534 IP26-00006395

Master MOHAMMED TAIMUR
10-01-2025 1 Y 4 M 11 D (M)
Dr. SINDHURA MUNUKUNTLA



Date & Time of Admission <i>21/5/26 @ 10:24</i>		Date & Time of Transfer Order <i>21/5/26 @ 10:00 AM</i>
Treating Consultant Name <i>Dr.</i>	Transfer Ordered by <i>Dr. Tanvi</i>	Reason for Transfer <i>Admission</i>
From Unit <i>ER</i>	To Unit <i>Ward</i>	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Number of Sheets in Clinical File <i>26</i>	Number of Imaging Films <i>1</i>	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If yes, what ?
Medications / Consumables / Surgicals / Hand over		
Sl.No.	Item Name	Quantity
1.		
2.		
3.		
4.		
5.		
Shifting Summary / Notes Written by Doctor : Yes <input type="checkbox"/> No <input type="checkbox"/>		
Name & Signature of Person who is Transferring <i>Beakhi</i>		Name of Person Ordered Transfer <i>Dr. Tanvi</i>
Patient & Clinical Records Received by : <i>Sweetha @ 21/5/26</i>		
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

wt - 8.3 kg



EMERGENCY TRIAGE FORM

Patient's Name : MD. Ahamad Age : 1y 4m Gender: Male Female
 Date : 21/05/26 Time of Arrival : 9:30pm
 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: 98.1F PR: 160 BP: using RR: 56 SpO₂: 98%
 Chief Complaints: C/O fast breathing since morning

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

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

NOTE: All immunocompromised children and preterm babies to be considered Level 2.
 All Children less than 2 years age with high fever to be considered Level 3.
 * CTAS - Canadian Triage and Acuity Scale
 Signature of Parent / Guardian _____
 Triage Completion Time : 9:33pm

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

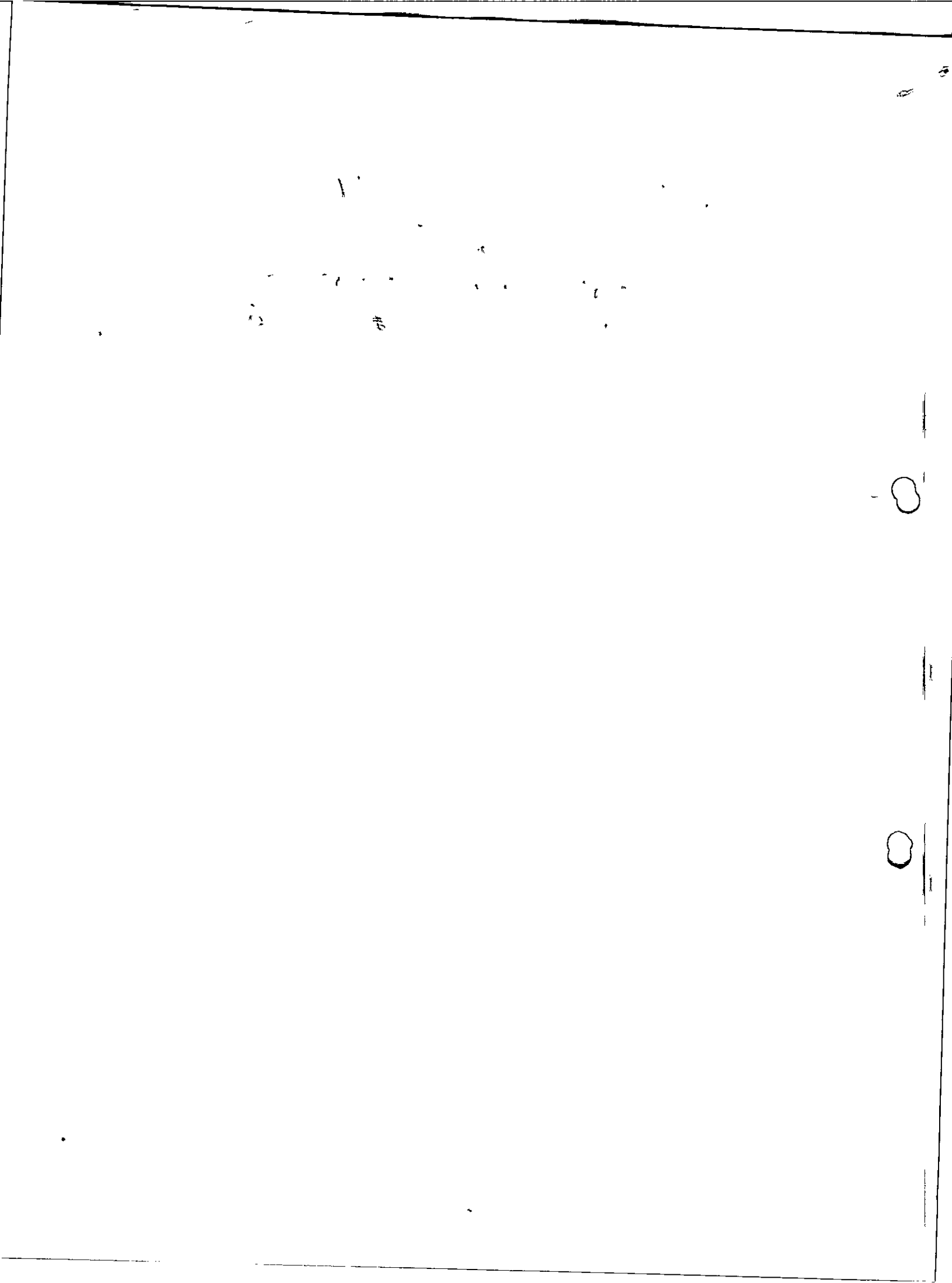
PART C. A positive communicable disease triage screening is considered for any patient who meets one of the two following criteria:

- 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 : Apurba Signature of Triage Nurse : _____
 Date & Time : 21/5/26 @ 9:33pm
 Docu. No. : RCH / FRM / CLINICAL / 085



NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 2/19/26 Time of arrival : 9:30 AM
 Chief Complaints : c/o Fast Breathing since morning RBS:

Height : Weight : BMI : Head Circumference (<2 years)

Allergies: Yes No Medications Blood Transfusion Food Other:

If yes, identify

Pain Screening: Yes No If Yes, Pain Score: 0 Pain Tool Used: N Pass FLACC Wong Baker

Character Location Frequency Duration

RISK FOR FALL:

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

If Patient is > 6 years
 Assess the below parameters

History of Falling: within past 3 months Yes No

Ambulatory Aids:

- Wheelchair Yes No
- Uses furniture for support Yes No

Gait/Transferring:

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

Mental Status: Forgets limitations Yes No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening: No Abnormalities Detected

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

Inform consultant for positive criteria

.....

.....

Nutritional Screening: No Abnormalities Detected

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

Inform consultant for positive criteria

Psychological Screening: No Significant Findings

Unusual concerns about patient's Psychological Status: Yes No

If Yes Consultant Notified: (Date/Time):

Social History: Lives With Family

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

Time of Initial assessment completed by ER Nurse : 9:33 AM

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

Time	Nursing Notes
	→ Assess the pt condition
	→ checked the pt vital
	→ IV placement done
	→ medication given to the pt

Samples collected by: /

Time: /

Samples sent by: /

Time: /

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1
9:33pm	levolin	Neb.	.31 mg		<i>[Signature]</i>
9:38pm	proavent	Neb.	500meg		<i>[Signature]</i>

Condition of patient at time of shift - out :	Details of Shift - out
HR: 166 b/m BP: CFT: 2500	Shift - out from ER to: N-7AR
RR: SPO ₂ : 96%	Time of Shift - out: 11 AM
GCS: 15/15 Temperature: 98.4F	Handover given to: <i>[Signature]</i>
Pain Score: 0/1	(Nurse's Name)
Repeat RBS (if applicable):	

Tick as applicable: MLC LAMA BROUGHT DEAD

Procedures done with details (if any):

Name of the Nurse: *[Signature]* Signature of the Nurse: *[Signature]*

Date & Time: 2/15/26 @ 9:33pm

HNH-00015534 IP26-00006395
 Master MOHAMMED TAJMUR 1 Y 4 M 11 D (M)
 10-01-2025
 Dr. SINDHURA MUNUKUNTLA

216



NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 21/5/26 Time: 1:00 pm

Weight: 8.3 Kg Centile: 5th

Height: Centile:

Inference: Underweight child

RDA: Calories: 1200 Kcal/day Protein: 20 gm/day

Diet Recommendations: Semi solid foods with fluids

Re-Assessment: No cold items, spicy, oily foods

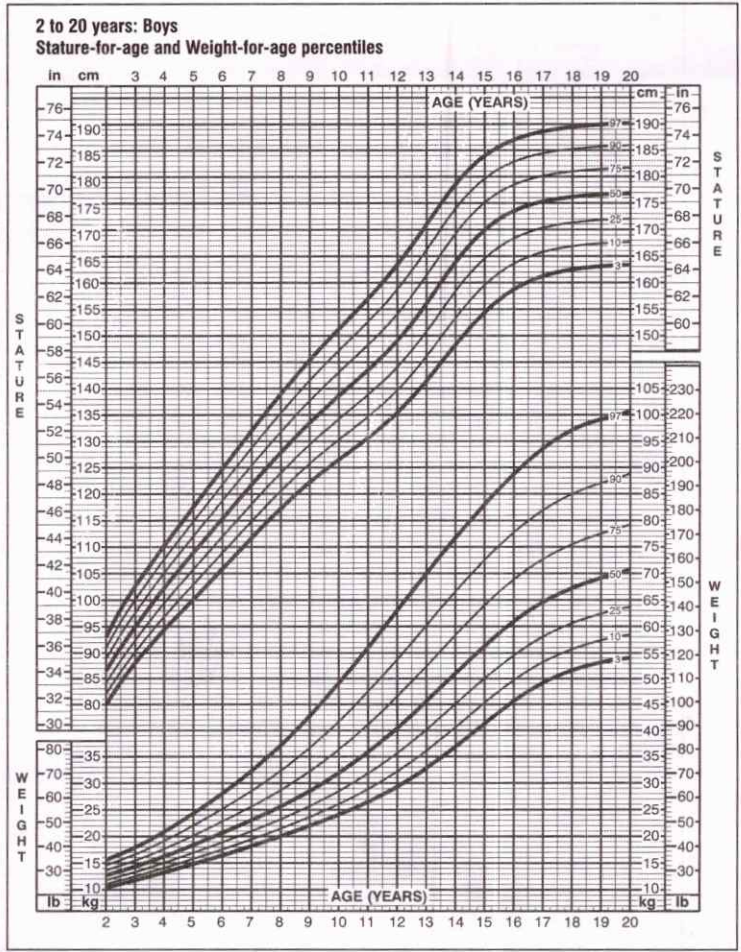
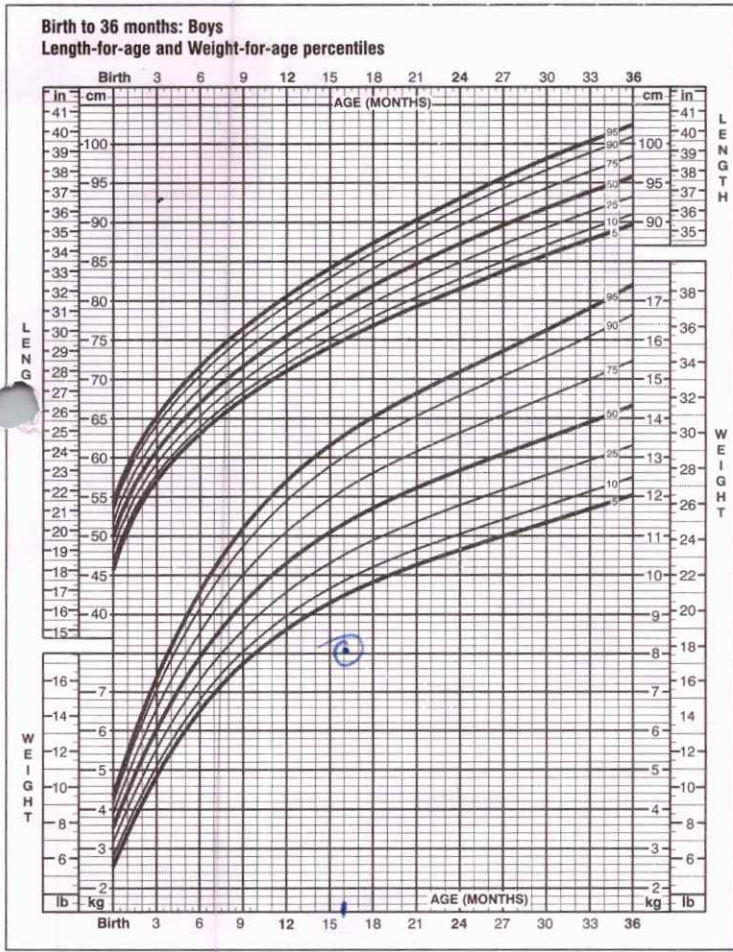
Food Allergies: No FA Veg/Non-veg Non veg

Diagnosis: LRTI ? W/LRTI CRD

Nutritional Intervention - Oral Enteral Parenteral

Patient's Signature: *[Signature]*

GROWTH CHART (BOYS)



Dietician's Name: Sada Sobiya Zaher

Dietician's Signature: *[Signature]*

WALLET 2
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MASTER MOHAMMED RAJIB R 25 JAN 2020 11:41 AM CHEST AP 10 MAR 2025 11:20 AM
RAINBOW CHILDREN'S HOSPITAL HIMAYATHI MAGAR

