DISCHARGE SUMMARY

Name	Master SEVELLI VEERA SAI DEEKSHITH	**UHID**	HNH-00016448
Father/Guardian	Mr S.SRIKANTH RAO	**Age/Gender**	8 Y 8 M 0 D/ Male
Address	HNO:- 12-1-69, NEAR GANESH TEMPLE, Lalapet, Hyderabad, Telangana, INDIA, 500017		
IP No	IP26-00006793	**Admission Date**	09-07-2026
Ref Doctor	Dr. C Abhinav		
Discharge Date	12.07.2026		

Consultant
Dr. SWAPNA PALAKURTHY
MBBS, MS, MCH
CONSULTANT PEDIATRIC SURGEON
69373

Co-Consultant
Dr. ANIKET ANIL PARASHAR
MBBS - MD
TSMC/FMR/08568, dr.aniket.p@rainbowhospitals.in

DIAGNOSIS	ICD CODE
APPENDICULAR PERFORATION	

PROCEDURE: Laparoscopic Appendicectomy done on 09.07.2026.

Name	Master SEVELLI VEERA SAI DEEKSHITH	**UHID**	HNH-00016448
IP No	IP26-00006793	**Admission Date**	09-07-2026

History: Master SEVELLI VEERA SAI DEEKSHITH, 8 Y 8 M 0 D, old boy presented with history of pain abdomen, vomitings since 3 days, decreased acceptance of feeds and decreased activity prior to admission. For the above complaints he was admitted at Rainbow Children's Hospital - for further management.

Outside investigations: USG abdomen shows RIF probe tenderness present and appendix not visualised.

Examination: He was afebrile, maintaining saturations at room air and was hemodynamically stable. His heart rate was 82/min, Blood pressure - 110/86 mmHg and Respiratory Rate - 30/min. Capillary Refill Time was <2 secs. Peripheries were warm & pulses well felt. On examination signs of some dehydration were present in form of, dry lips, oral mucosa, sunken eyes, dull look. On auscultation, air entry was bilaterally equal were present. Heart sounds were normal and there was no murmur. Abdomen was soft with no organomegaly, but tenderness in RIF region.
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: 17 kilo grams.

Investigations: Enclosed reports.

Blood group is B positive.

ABG/VBG showed pH of 7.39, pCO2 of 37.4 mmHg, pO2 of 37 mmHg, HCO3 of 22.4 mmol/L and BE of -2.1 mmol/L.

Name	Master SEVELLI VEERA SAI DEEKSHITH	**UHID**	HNH-00016448
IP No	IP26-00006793	**Admission Date**	09-07-2026

Initial hemogram showed Hemoglobin of 12.8 gm%, White Blood Cell count of 9310 cells/cumm, platelet count of 3.01 lakhs/cumm and C-Reactive Protein of 24 mg/l. Complete urine examination shows 4-6 pus cells, 1-2 epithelial cells. Serum Creatinine was 0.4 mg/dl. Blood group B positive.

Ultrasound abdomen shows

* Acute appendicitis, with visualization of a dilated appendiceal tip (approximately **8 mm**) and surrounding peri appendiceal inflammatory changes.
* The appendix is not visualized in its entirety. Mild focal irregularity / indistinctness of the visualized appendiceal wall and adjacent inflammatory changes raise the possibility of complicated appendicitis.
* Multiple small lymph nodes along the mesentery in the RIF and periumbilical region, in keeping with mesenteric adenopathy.
* Fecal loading in descending and sigmoid colon.

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 Ultrasound abdomen suggesting acute appendicitis, surgical intervention was planned.

Procedure : LAPROSCOPIC APPENDICTOMY DONE ON 09.07.2026

Surgery Notes:

Intra OP Findings:

* Tip of appendix perforated with appendicolith with retrocecal dome adhesion with 10 ml of pus.

Name	Master SEVELLI VEERA SAI DEEKSHITH	UHID	HNH-00016448
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* 1cm of inflamed proximal appendix with inflamed base of appendix.
* Caecum normal.

PROCEDURE:
* Under ASP above said region cleaned and draped.
* Ports (5mm) placed
* Pneumoperitoneum created
* Endoscopy placed
* Appendix dissected
* Appendix excised and sent to HPB
* Suction and irrigation done
* Haemostasis secured
* Post procedure uneventful

Post OP: Post operative period was uneventful. Child was kept NPO for 24 hours. Later initiated on oral clear Liquids, which he tolerated, Gradually soft diet was introduced which child tolerated well. Child remained hemodynamically stable during the hospital stay and operated site remained healthy.

He was regularly monitored for vomitings, abdominal pain, fever spikes, hemodynamic status. His abdominal pain, fever spikes and other symptoms gradually settled.

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.

Name	Master SEVELLI VEERA SAI DEEKSHITH	**UHID**	HNH-00016448
IP No	IP26-00006793	**Admission Date**	09-07-2026

Medication during hospital stay:
Injection. Piptaz
Injection. Ceftriaxone
Injection. Ondansetron
Injection. Pantop
Injection. Paracetamol

Advice:
* Diet as advised.

Name	Master SEVELLI VEERA SAI DEEKSHITH	UHID	HNH-00016448
IP No	IP26-00006793	Admission Date	09-07-2026

S.No	MEDICATION	DOSE	TIMINGS	DURATION
1	Syrup. AUGMENTIN DDS (Amoxycillin 400 + Potassium Clavulanate 57 mg/5ml)	4.5 ml	8am-8pm (after food)	For 7 days
2	Tablet. LANZOL DT (Lansoprazole - 15mg)	1 tablet	7am (before breakfast)	For 7 days
3	Syrup. ONDEM (Ondansetron – 5ml/2mg)	10ml	Max 3 times/day (30 minutes before food)	SOS for vomitings
4	Syrup. Crocin DS (Paracetamol - 5ml/240mg)	5ml	3 times/day (30 minutes after food)	For 3 days. Later SOS for pain
5	Syrup. SMUTH	15 ml	10pm (after food)	To give if not passing stool.
6	Nasoclear nasal drops, 2 drops in each nostril **SOS** for nose block			

Plan: To collect biopsy report on followup.

Fever Management
* Syrup. Crocin DS (Paracetamol - 5ml/240mg) 5 ml after food as and whenever required, if temperature > 100 *F (maximum 4 times a day at 6 hour intervals).
* Tepid sponging if fever > 101 *F.

Name	Master SEVELLI VEERA SAI DEEKSHITH	**UHID**	HNH-00016448
IP No	IP26-00006793	**Admission Date**	09-07-2026

Review consultation with Dr. Swapna on Wednesday (14.07.2026) at Himayatnagar in OPD with prior appointment **(Review consultation will be charged)**.

Regular followup with Dr. C Abhinav, Primary Pediatrician.

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.
* **Laxatives** may deplete/decrease absorption of fat soluble vitamins A,D,E & K. Laxatives can be taken One hour before food or 2 to 4 hours after food & recommended diet to be followed.
* 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.

Name	Master SEVELLI VEERA SAI DEEKSHITH	**UHID**	HNH-00016448
IP No	IP26-00006793	**Admission Date**	09-07-2026

Parent/ Attender

In case of emergency contact 9154865030 emergency pediatrician on duty.

To take appointment for OPD consultation at Rainbow **Banjara Hills /** Rainbow Clinic **Madhapur / Kukatpally / Vikrampuri / LB Nagar /** dial just one toll free number **18002122.**
You can also take appointments at any time by going **online** to our website **www.rainbowhospitals.in**

RAINBOW CHILDREN'S MEDICARE LIMITED HYDERABAD

Registrar/Resident/C.M.O

Dr. ANIKET ANIL PARASHAR
MBBS - MD
TSMC/FMR/08568, dr.aniket.p@rainbowhospitals.in

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ACTIVITY RECORD FOR BILLING

HNH-00016448 IP26-00006793
Name: -------- Master SEVELLI VEERA SAI ----------
10-11-2017 8 Y 8 M 2 D (M)
UHID No : ----- Dr. SWAPNA PALAKURTHY ----- Consultant : ---------- Dept : Pediatric

Date of Admiss[illegible] ---------- Date of Discharge : ---------- Time: ----------

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
9/07/26	1:30PM	ER	ward	
9/7/26	5:48PM	Ward	OT	
9/7/26	8:30PM	OT	MICU	
9/7/26.	10:30pm.	OT	301	

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Sign
9/7/26	CBP		
	CRP	11320	
	KFT	11321	KFT
	Creatinine		
	X-ray	008283	
	LFT	11328	LFT
	ultrasound Abdomen	8234	USG
9/7/26	Blood Grouping.	11346	MRI
9/7/26	Biopsy for histopathology	11371	A
	Cross checked done by Anjuthu.		
10/7/26	10AM RBS (87mg/dl)	11426	
	cross checked done by Supriya 10AM @ 12/7/26		

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
9/7	Infussion pump	9/7/20 @ 2pm	10AM @ 12/7/20	12124.	[illegible]
			Cross checked done		

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
9/7/26	IV placement	1	12066	
9/7/26	PAC	1	12166	
10/7/26	NHA	1	12461	
12/7/26	IV placement	1	2996	

cross checked done by Supriya
10:01AM @ 12/7/26

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 : Masta veera sai Deekshith

Patient ID# : HNH-00016448 IP26-00006793
Master SEVELLI VEERA SAI
10-11-2017 8 Y 8 M 2 D (M)
Dr. SWAPNA PALAKURTHY

Consultant :

Final Diagnosis :

Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Informant _____ Reliability _____

Chief Presenting Complaints & Duration (Chronologically):

c/o pain abdomen since 3 days
c/o vomiting (multiple episode) since 3 days.
c/o decreased acceptance of feed & c/o decreased activity.

History of present illness :

Child presented to ER with c/o pain abdomen since 3 days, diffuse pain, Intermittent progressive in nature.

c/o vomiting - multiple episodes containing food / water. non bilious non projectile. not c/w blood

c/o decreased acceptance of feed

c/o decreased activity.

USG Abd - RIF probe tender (+).
Appendix Non visualized.

Pediatric Multiorgan History & Physical Examination

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

Birth & Neonatal History :

Birth & Socio Economic History :

About Father :

About Mother : Not signific

Any additional Information :

Developmental History :

Appropriate

Immunization History :

Up to date

Pediatric Multiorgan History & Physical Examination

Anthropometry

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

Weight (kgs) 17/12 (Centile _____)

On Examination :

Temperature : Afebrile. Pulse Rate: 82 Description _____

B.P. 110/86 SPO2 99% at _____

Resp. rate and type of breathing : Sign of dehydrate

Sunk Eye

Rash dull look

Lymphadenopathy dry lips.

Oedema : dry oral mucu

Respiratory system :

Inspection (any s/o distress) : _____

Air entry & breath sounds : B/L AE (+)

Any addes sounds : B/L NVBS.

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

Cardiovasclular System :

Inspection of procordium : _____

Heart Sounds : S1 S2 (+)

Any murmur : No. murmur.

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

Per Abdomen :

Inspection _____

Palpation : Soft, tender (+) (↑RIF)

Ausculation : _____

Spine: _____ External Genitelia : _____

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

Pediatric Multiorgan History & Physical Examination

Central Nervous System :

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

Cranial Nerves :

Motor System :

Nutrition :

Tone : (N) Power

Co-ordinator :

Posture :

Involuntary Movements :

Reflexes :

DTR **Superficials :**

Plantars (N)

Sensory System :

(N)

Bladder / Bowel :

Clinical Summary & Diagnostic :

Acute pain abdom
c dehydration

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment :

Desired goals of the treatment :

Planned Labs :

CBP
CRP
VBG
CUE →
Sr Creatinine.
1 Extra plain sample
USG Abd
XR & Erect Abd
I/for Sx opinion (Dr. Swapna)

NIB shifting

Planned Management :

(Last food @ 9AM)
- NPO
- IV fluids (plain + 25% D) @ 50ml/h.
- I/V CEFTRIAXONE
- Monitor vitals

NIB shifting

Please fill up the following details

1. Name of the Referring Doctor : Dr - Abhinav
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 Dr - Aniket on whose name the patient is being referred

Dr. Aniket Anil Parashar
Consultant Pediatrician & Intensivist
Reg. No: 8568

Doctor's Signature Name [signature] Date 9/7/26 Time 4pm

HNH-00016448 IP26-00006793
Master SEVELLI VEERA SAI
10-11-2017 8 Y 8 M 2 D (M)
Dr. SWAPNA PALAKURTHY

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/6/26. 1.30pm.	C/s/by Dr Aniketh. Auth Abdom	
	CBP (N)↑.	
		— NPO
	USG — ? Appendicitis	— (1) USG Abd XRay Abd
		— PAC to do.
		— plan for Appendicectomy / Lap Surgery in Evening (CD Surgn)
		— ct IV fluids.
		— Inj CEFTRIAXONE.
		N/B Inform @ 2pm.
		Dr. Aniket Anil Parashar Consultant Pediatrician & Intensivist Reg. No: 8563

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/7/26 3pm	c/s/by. Dr. Abhinav / Dr. Anik	
	Acute Appendicitis	
	RIF tenderness (+)	
	vital stable	— NBM — iv fluids
		— PAC
		— Plan – Lap Appendicectomy
		— Antibiotics.
		— Plan to send Surgical profile after PAC
		[signature]

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

HNH-00016448 IP26-00006793
Master SEVELLI VEERA SAI (M)
10-11-2017 8 Y 8 M 2 D
Dr. SWAPNA PALAKURTHY

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/7/26 10:30pm	CMB Dr. Tharun	
	post op - lap Appendicectomy	
	- no fever spikes	
	- alert.	
	- no fresh c/o.	Plan
		1) change antibiotic to piptaz
	- O/E	2) NPO for 24 h
	vitals : stable	3) ct. IVF
		4) inj pan
	- ~~dressing~~	5) inj PCM
		6) monitor vitals.
9/7/26 7am	CMB Dr. Tharun	
	P/op Day-1 - lap. appendicectomy.	
	- no fever	
	- no vomitings	Plan
	- Passing urine ✓	1) ct. piptaz
	- mild pain @ surgical site	2) NPO for 14 hours.
	O/E	3) ct. IVF.
	vitals : stable	4) monitor vitals
	S/E - P/A - soft	5) Rest ct. as per
		Rx chart
		NB - Mounika @ 8:15AM
	[signature]	

HNH-00016448 IP26-00006793
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10-11-2017 8 Y 8 M 2 D (M)
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/2/26 10:30AM	S/B Dr. Aniket	
	Δ Post operated	
	Appendicular perforation	
		NPO H/I [illegible]
	Afebrile	
		C IV fluids @ 50 ml/h
	CVS S1S2 ⊕	
	RS-BL-AE ⊕	Monitor Urine output
	P/A soft	
	[illegible]	C IV PCM 6th
		C PIPTAZ
		GRBS monitor 12th
		NB-[illegible] @10:40AM
		[signature] Dr. Aniket P

Dr. Aniket Anil Parashar
Consultant Pediatrician & Intensivist
Reg. No: 8568

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

HNH-00016448 IP26-00006793
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10-11-2017 8 Y 8 M 2 D (M)
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	C/s/B Dr. Naipunya	
10/2 3:00pm	Post op: Appendicular perforation.	
	Afebrile.	Plan
	R/S - B/LAE	- NOP till tomorrow.
	P/A - soft, NT	- Cont IVF
		- Cont & inj PCM Q6H
	Vitals - stable	- Cont PIPTAZ
		- Monitor vitals
		[signature]
	N/B Madhuri @ 3pm.	
10/2/26 6:40pm	c/s/by. Dr Swapn.	
	Abd distn (+).	- NPO today / till Tm
		- DULCOLAX SUPP
		- Ambulate the child.
		- CST.
		[signature]

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

(P.T.O)

HNH-00016448 IP26-00006793
Master SEVELLI VEERA SAI
10-11-2017 8 Y 8 M 2 D (M)
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/7/26 9:45 AM	c/s/by Dr Anush / Dr varun	
	post op - Appendicular perforation.	
	Pass stools (+)	
	Abd distension - No	
	activity - Good.	
	vital stable.	Plan
	S/E	✓ NPO
	P/A - soft. Not distended	✓ ct I.V PCM
		ct Antibiotic.
		ct IV fluid.
		✓ Monitor vital.
	[signature]	NB - Amrutha 8Am @ 11/7/26

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/9/26 9:40 pm	D/w Dr. Swapna.	Adv. Start clear fluids till evening ↓ Reassess Soft diet.
11/9/26 9:45 AM	S/B Dr. Aniket. s/P - Appendicular perforation. No fresh complaints. Activity - good. No fever. No vomitings. No pain per abdomen. o/e vitally stable. s/e P/A - soft	Adv. ✓ Ct piperacillin + tazobactam ✓ Ct rest same ✓ Start clear liquids. D. Aniket P. NB - Supriya 10AM @ 11/9/26

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

(P.T.O)

HNH-00016448 IP26-00006793
Master SEVELLI VEERA SAI (M)
10-11-2017 8 Y 8 M 2 D
Dr. SWAPNA PALAKURTHY

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/7/26 2:45 pm	S/B Dr Sreya	
	Δ Post operated	
	case of Appendicular	perforation
		Plan
	CVS - S1S2 ⊕	
	RS - BL - AE ⊕	- cf PIPTAZ
	P/A soft	- Allow oral soft diet
	Conscious	
		- Monitor vitals
	Afebrile	
	[signature]	
11/7/26 2:50 pm	S/B Dr Abhinav	
	Δ Post-operated	Plan
	case of Appendicular perforation	
		✓ cf PIPTAZ
	Afebrile	
		✓ Allow oral
	CVS - S1S2 ⊕	Soft diet
	RS - BL - AE ⊕	
		✓ Monitor vitals
	P/A soft	
	Conscious.	
		[signature]
	NB Supriya	

HNH-00016448 IP26-00006793
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/7 5pm	C/S/D Dr Swapna	
	Post Appendicular Perforation Repair	P/A
		1) Remove Dressing ↓ Cleaning wound locally T-Bact application ↓ Re Dressing
	Pain - better	
	No Vomitings	
	Child alert	2) Allow soft diet
	Vitals stable	3) If no issues then D/C T/m if stable
	Afebrile	on oral Augmentin x 7 days
	R.S - B/L AE+	Oral PCM x 3 days to late SOS
	P/A - Soft, Non tender	Oral Tab LANZOL
	[signature]	SOS - Syp SMUTH if (15ml (H.S)) not passing stool
		N/B

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

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
12/7/26 9:30 Am	C/S/B - Dr. Archana / Dr. Prashanthi	
	D-S/P- lap Appendicectomy / Repair (Perforated Appendix)	POD - 3+
	Redressing done, Soakage ↓	PLAN
	Soft diet → accepting well	1) Continue Soft diet
	Pain (-)	
	Fever (-)	2) Discharge today if stable ↓
	Vomiting (-)	- On ORAL AUGMENTIN x 7days
	Oral intake → good	- Oral PCM x 3days → then SOS
	O/E	- Oral TAB LANZOL
	Vitals - stable	- Syp. SMUTH 15ml HS, if not passed stool
		3) IVF (2/3) → Stop
	P/E	
	RS - Clear	
	P/A - soft, non tender	
	S/P lap appendicectomy	Dr. Archana

HNH-00016448 IP26-00006793
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
12/7/26 10 AM	S/B Dr-Aniket	
	S/P Appendicular perf repair	
	Accepting well orally Dlo	
		Dr. D. Aniket

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

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DRUG CHART

Date of Admission: 9/07/26 Drug Allergies: N/A ☐ 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 : Inj. BUSCOPAN.

Dose	Route	Frequency	Start Date
0.5ml	iv	SOS	9/7/26

Doctor's Signature: AJ | Valid Period | Pharm.

Additional Instructions:

Date/Time: Ch

DRUG : Inj. PCM.

Dose	Route	Frequency	Start Date
250mg	iv	SOS	9/7

Doctor's Signature: AJ | Valid Period | Pharm.

Additional Instructions: (If Pain)

Date/Time: 9/7 4:30PM

DRUG :

Dose	Route	Frequency	Start Date

Doctor's Signature | Valid Period | Pharm.

Additional Instructions:

Date/Time

Signature

VERIFIED BY : Name

Verified by Dr. Dhakshayani

HNH-00016448 IP26-00006793
Master SEVELLI VEERA SAI
10-11-2017 8 Y 8 M 2 D (M)
Dr. SWAPNA PALAKURTHY

REGULAR PRESCRIPTIONS

Weight. 17 kg Ward. .....

DRUG : Inj CEFTRIAXONE

Dose	Route	Frequency	Start Date
850mg	iv	BD	9/7

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:
850mg in 50cc NS over 1hour

STOP 9/7

Daily Doctor's Endorsement by a Sign

Date/Time	9/7	10/7	11/7	12/7
6AM				
10PM				

Verified by Dr. Dhakshayani

DRUG : Inj ONDAN

Dose	Route	Frequency	Start Date
0.5mg	iv	TID	9/7

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:
(ONDENSETRON)

Date/Time	9/7	10/7	11/7	12/7
6AM	X			
2PM				
10PM				

Daily Doctor's Endorsement by a Sign

Verified by Dr. Dhakshayani

DRUG : Inj PANTOP

Dose	Route	Frequency	Start Date
40mg	iv	OD	9/7

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:
(PANTOPRAZOLE)

Date/Time	9/7	10/7	11/7	12/7
6AM				

Daily Doctor's Endorsement by a Sign

Verified by Dr. Dhakshayani

DRUG : INJ PIPTAZ

Dose	Route	Frequency	Start Date
1.75g	IV	TID	9/7

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:
PIPERACILLIN-TAZOBACTAM

Date/Time	9/7	10/7	11/7	12/7
6AM	X			
2PM				
11:30PM				
10PM				

Daily Doctor's Endorsement by a Sign

Verified by Dr. Dhakshayani

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Your Right to a Safe Delivery

Sheet No: .....

REGULAR PRESCRIPTIONS

Weight 17 kg Ward .....

Verified by Dr. Dhakshayani

DRUG : INJ PCM

Dose	Route	Frequency	Start Dt.
250mg	IV	TID	9/7

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:
(PARACETAMOL)

Daily Doctor's Endorsement by a Sign

Date / Time	9/7	10/7
6AM	X	
2PM	X	
10PM	12 AM	

DRUG : Inj PCM

Dose	Route	Frequency	Start Dt.
250 mg	IV	QID	10/7

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:
PARACETAMOL

Daily Doctor's Endorsement by a Sign

Date / Time	10/7	11/7
12AM		
6AM		
12PM		
6PM		

DRUG : Inj PARACETAMOL

Dose	Route	Frequency	Start Dt.
250mg	IV	6th hly	11/7

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions: 15mg/kg

Daily Doctor's Endorsement by a Sign

Date / Time	11/7	12/7
12AM	✓	
6AM	✓	
12PM	✓	
6PM	Nandu	

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

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

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REGULAR PRESCRIPTIONS

Sheet No: .... Weight .... Ward ....

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

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

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Dr. SWAPNA PALAKURTHY

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

DRUG :	Date ▸ Time		Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.
		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.	

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
9/7/26	7.54	DICLOFENAC SUPP	12 T	PR	Advt.	
9/7/26	7.00	Inj DEXA	2mg	IV	Advt.	
9/7/26	2pm	DOLOCEEX SUPP.	5mg	PR		

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

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I.V. FLUIDS CHART

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

		osition of I.V. Fluid ntion ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
9/7/26	11.30AM	IV fluid (Plasmalyte 400ml + 25% D 100ml) (Full)	iv	50 ml/h					
9/7/26	6.00	RENGER LACTATE	iV	130 ml/hr					
9/7/26	10:30pm	PLASMALYTE -400ml +25% D -100 ml (	IV	50 ml/hr					
10/7/26	12:00 AM	Plasmalyte-400ml +25% D - 100 ml (2/3rd Maint)		30 ml/hr					

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

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MEDICATION RECONCILIATION FORM

Drug Allergies: ..... N/A ..... ☐ 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 (301) .....

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

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : ..... Dr. prashanth .....

Date & Time : ..... 9/07/26 @ 12:04PM .....

Nurse Name & Signature: ..... shirisha .....

Date & Time : ..... 9/07/26 @ 11.30PM .....

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

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301

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RESULT SHEET

Date	9/7/26					
Time						
Hb	12.8					
PCV	36.1					
RBC	5.06					
WBC	9.31					
N/L	83.5/9.5					
Platelets	301					
CRP	24					
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine	0.4					
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

Date	9/7/26					
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones	Present					
CUE - PUS Cells	4 - 6					
CUE - RBC Cells	Nil					
CUE Epithelial Cells -	1 - 2					
Stool Pus Cell						
OVA / Cyst						
Occult Blood						
Blood Group -	B+ve					

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

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H/ 1 / CLINICAL / 126

SCHOOL AGE (5-12 years)

Children's Observation & Early Warning Scoring Chart

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

Date : 9/7/26

Time:	8 PM	9:30 PM	11:30 PM	2Am	6Am
Doctor / Nurse / Family Concern?					
Temperature (F) (scale 94–104)	99.0°F	100.7°F (Inj. paracetamol given)	98.3°F	98.5°F	97.8°F
Heart Rate (bpm) and Blood Pressure (mmHg) * (scale 50–190)	105/68 (78)		106/66 (79)	100/60 (72)	102/63 (71)
Heart Rate (Number)	97 b/m		89 b/m	85 b/m	88 b/m
Resp. Rate (bpm) (Over 1 Minute) * (scale 10–70)					
Resp Rate (Number)	28 b/m		25 b/m	23 b/m	22 b/m
Resp Distress — Mod/ Severe					
Resp Distress — None / Mild					
Receiving O_2 (l/min)					
O_2 Saturations (%)	100%		100%	100%	99%
Conscious Level — Normal					
Conscious Level — Altered					
GCS *					
TOTAL SCORE Number of shaded boxes	0		0	0	0
Pain Score	0		0	0	0
Observer's Initials	[illegible]		[illegible]	[illegible]	[illegible]

Note: BP does not score in early warning scoring

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

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

Patient Sticker

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

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Master SEVELU VEERA SAI
10-11-2017 8 Y 8 M 2 D
Dr. SWAPNA PALAKURTHY (M)

CLINICAL / 126

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

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.Y WARNING SCORE: CHILDREN'S UNIT

Date: 10/7/26

Time:	10	2	6 pm	10pm	2Am	6Am
Doctor / Nurse / Family Concern?	Ono	pro	pm			
Temperature (F) (scale 94–104)	98.6°F	98.6°F	97.0°F	98.3°F	98.2°F	98.3°F
Heart Rate (bpm) and Blood Pressure (mmHg) * (scale 50–190)	103/69 (81)	100/63 (79)	103/70 ([illegible])	106/69 (79)	103/70 (75)
Heart Rate (Number)	86 b/m	92 b/m	98 b/m	98 b/m	97 b/m
Resp. Rate (bpm) (Over 1 Minute) * (scale 10–70)					
Resp Rate (Number)	28 b/m	24 b/m	28 b/m	28 b/m	24 b/m
Resp Distress — Mod/ Severe / None / Mild					
Receiving O_2 (l/min)					
O_2 Saturations (%)	99%	99%	99%	100%	98%
Conscious Level — Normal / Altered					
GCS *					
TOTAL SCORE Number of shaded boxes	0	0	0	0	0
Pain Score	0	0	0	0	0
Observer's Initials	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

Note: BP does not score in early warning scoring

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

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

Patient Sticker

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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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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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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10-11-2017 8 Y 8 M 2 D (M)
Dr. SWAPNA PALAKURTHY

1 / 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 : 11/7/26

Time:	10 AM	2 PM	6pm	10pm	2Am	6Am
Doctor / Nurse / Family Concern?						
Temperature (F) (scale 94–104)	98.1°F	98.9	97.5°F	98.3°F	98.2°F	97.3°F
Heart Rate (bpm) and Blood Pressure (mmHg) * (scale 50–190)	110 / 65 (79)	102 / 69 (76)	95 / 67	101 / 69 (77)	103 / 60 (75)	101 / 69 (77)
Heart Rate (Number)	112 b/m	135 b/m	82 b/m	81 b/m	80 b/m	91 b/m
Resp. Rate (bpm) (Over 1 Minute) * (scale 10–70)						
Resp Rate (Number)	28 b/m	28 b/m	25 b/m	25 b/m	25 b/m	26 b/m
Resp Distress: Mod/ Severe						
Resp Distress: None / Mild						
Receiving O_2 (l/min)						
O_2 Saturations (%)	99%	100%	100%	98%	100%	98%
Conscious Level: Normal						
Conscious Level: 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	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

Note: BP does not score in early warning scoring

ACTIONS		
NB: Scores 3 should be recorded overleaf	Score 1	Continue normal observation by staff nurse
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* NB: If GCS is below 12 or the Oxygen requirement is >3 Lit./min. , then irrespective of rest of the score, the Nurse MUST inform the PICU team.

Patient Sticker

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

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Record Details when EARLY WARNING SCORE > 3			**Record Time of Review and Plan**		
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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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26

SCHOOL AGE (5-12 years)

Children's Observation & Early Warning Scoring Chart

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 12/7 Time: 10

Doctor / Nurse / Family Concern? AM

Temperature (F)

104 103 102 101 100 99 98 97 96 95 94

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

101 / 76 / 65

Heart Rate (Number) 114b/m

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

70 60 50 40 30 20 10

Resp Rate (Number) 28b/m

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

ACTIONS

NB: Scores 3 should be recorded overleaf

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

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

Patient Sticker

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

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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 :**				
9/7/26	02:00 pm	Plasmalyte	NPO	50 ml/hr		NA		NA			0	
	03:00 pm		NPO	50 ml/hr								
	04:00 pm		NPO	50 ml/hr								
	05:00 pm	T 25°C	NPO	50 ml/hr								
	06:00 pm	Dextrose	NPO	50 ml/hr								
	07:00 pm		NPO	50 ml								
Total Intake :								**Total Output :** U -			M -	
9/7/26	08:00 pm	Plasmalyte	NPO	65 ml/hr								
	09:00 pm	T 25°C	NPO	65 ml/hr								
	10:00 pm	Dextrose		65 ml								
	11:00 pm			65 ml		NA		NA			0	
	12:00 am			65 ml								
	01:00 am			65 ml								
Total Intake :								**Total Output :**				
10/7/26	02:00 am	Plasmalyte T 25°C	NPO	65 ml								
	03:00 am			65 ml								
	04:00 am			65 ml								
	05:00 am		NPO	65 ml								
	06:00 am			65 ml								
	07:00 am			65 ml								
Total Intake :								**Total Output :**				

Total 24 hrs. Intake		Total 24 hrs. Output	

Docu. No. : RCH /FRM / CLINICAL / 092

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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							
10/7/26	08:00 am	Plasmalyte + 25% Dextrose	NPO	50							0	
	09:00 am		NPO								0	
	10:00 am		NPO								0	
	11:00 am		NPO			NA			NA		0	
	12:00 pm		NPO								0	
	01:00 pm		NPO								0	
Total Intake : Taken								**Total Output :** U- 1 M- 0				
10/7/26	02:00 pm	Plasmalyte + 25% Dextrose	NPO	50ml								
	03:00 pm		NPO	50ml						70ml		
	04:00 pm		NPO	50ml								
	05:00 pm		NPO	50ml						100ml		
	06:00 pm		NPO	50ml								
	07:00 pm		NPO	50ml								
Total Intake :								**Total Output :**				
10/7/26	08:00 pm	Plasmalyte + Dextrose 25%	NPO	50ml								
	09:00 pm			50ml								
	10:00 pm			50ml								
	11:00 pm			50ml		NA			NA			
	12:00 am			50ml								
	01:00 am			50ml								
Total Intake : Taken								**Total Output :** m- u-				
11/7/26	02:00 am	Plasmalyte + 25% Dextrose		50ml								
	03:00 am			50ml								
	04:00 am			50ml								
	05:00 am			50ml		NA			NA			
	06:00 am			50ml								
	07:00 am			50ml								
Total Intake : Taken								**Total Output :** m- u-				

Total 24 hrs. Intake		Total 24 hrs. Output	

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FLUID CHART

Sheet No. : 3

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							
11/7/26	08:00 am	Plasmalyte + 25% Dextrose	ORS	50ml					NA		0	
	09:00 am			50ml							0	
	10:00 am			50ml							0	
	11:00 am			50ml							0	
	12:00 pm			50ml							0	
	01:00 pm			50ml							0	
Total Intake :						Total Output :						
11/7/26	02:00 pm	Plasmalyte + 25% D	Kichidi, H2O	50ml		NA		NA		✓		Madhu
	03:00 pm			50ml								
	04:00 pm			50ml						✓	0	
	05:00 pm			50ml			0					
	06:00 pm			50ml						✓		
	07:00 pm			50ml								
Total Intake :						Total Output : U-3 M-0						
11/7	08:00 pm	Plasmalyte 25% D	Idly, Kichidi	50ml		NA		NA				
	09:00 pm			50ml								
	10:00 pm			50ml						✓		
	11:00 pm			50ml			0				0	
	12:00 am			50ml								
	01:00 am			50ml								
Total Intake : Taken						Total Output : M-0 U-1						
12/7	02:00 am	Plasmalyte	H2O	50ml		NA		NA				
	03:00 am			50ml						✓		
	04:00 am			50ml							0	
	05:00 am			50ml			0					
	06:00 am			50ml						✓		
	07:00 am			50ml								
Total Intake : Taken						Total Output : M-0 U-2						

Total 24 hrs. Intake		Total 24 hrs. Output	

Docu. No. : RCH /FRM / CLINICAL / 092

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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							
12/7/26	08:00 am		Idly	30ml							0	
	09:00 am			30ml							0	
	10:00 am										0	
	11:00 am	Stop									0	
	12:00 pm										0	
	01:00 pm										0	
Total Intake :						**Total Output :** U-				M-		
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						**Total Output :**						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						**Total Output :**						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						**Total Output :**						

Total 24 hrs. Intake		**Total 24 hrs. Output**	

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NURSING CARE RECORD

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Date: 9/7/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon	2PM / 8PM	→ Assess the general condition of pt. → Monitor vitals → Maintain I/O chart → Administer medication → provide Comfortable position	2PM / 8PM	→ Assessed the general condition of pt → Monitored vitals → Maintained I/O chart → Administered medication	pt is stable	Re-assess vitals.	
Night	8PM to 8AM	→ Assess the pt condition → monitor vitals → maintain I/O chart → Administer medication as per drug chart → provide comfortable position	8PM to 8AM	→ Assessed pt condition → monitored vitals → maintained I/O chart → Administered medication as per drug chart → P.	Patient is stable	Rechecked vitals	

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NURSING CARE RECORD

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Date: 10/7/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8am 2pm	- Assess the pt Condition - Monitor vitals - Maintain I/o Chart - Medication Given as per drug chart	8am 2pm	- Assessed the pt condition - Monitored vitals - Maintained I/o Chart - Medication Given as per drug chart	Pt is stable	Rechecked vitals	
Afternoon	2pm 8pm	-) Assn the pt Condition - monitor vitals I/o chk -) drug as per chk		-) Assed the pt Condi -) monitored vitals -) drugs as per chk	pt is stable	Rechecked vitals	
Night	8pm 8Am	⟹ Assess the pt condition ⟹ monitoring vitals checked and recorded ⟹ I/o chart maintained	8pm 8Am	⟹ Assessed the pt condition ⟹ Administration medication given as per doctor orders ⟹ I/o chart maintained	⟶ Pt is stable	⟶ Re-checked vitals	

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NURSING CARE RECORD

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Date: 11/7/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8am to 2pm	→ To assess the pt condition → To check the vitals & record → To administer the medication as per chart → I/O Chart maintain	8am to 2pm	→ To assessed the pt. condition → To checked the vitals & recorded → To administered the medication as per chart → I/O chart maintained	→ Patient is stable → Contd. IVF	→ Re-checked the vitals → I/O	Supriya
Afternoon	2pm to 8pm	→ Assess the pt condition → TO administerd the medication as. pr chect	8pm to 8pm	→ Assessed the pt condition → TO administerd the medication as pr. chect → I/o chart maintain	pt as a stable.	Re-checked the vitals	Madhu
Night	8pm to 8am	→ Assess the pt condition → monitoring vitals checked and recorded → I/o chart maint.	8pm to 8am	→ Assessed the pt condition → Administerations medication given as per doctor orders	→ ~~Pt is stable~~ pt is stable	→ Re-Checked the vitals	

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10-11-2017 6 YRS (M)
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NURSING CARE RECORD

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Date: .....

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon							
Night							

BRADEN 'Q' SCALE

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					Date : 9/7/26	9/7	10/7	10/7
					Time : 6PM	N	M	E
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	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	4
Moisture Degree to which skin is exposed to moisture	**1. Constantly moist:** Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	**2. Very moist:** Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	**3. Occasionally moist:** Skin is occasionally moist, requiring linen change every 12 hours.	**4. Rarely moist:** Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	4
FRICTION-SHEAR **Friction** Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another	**1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	**2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	**3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	**4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	4
Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4
				TOTAL SCORE	28	24	28	24
				Evaluator's Name				

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

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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BRADEN 'Q' SCALE

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				Date : 11/7/26	11/7	11/7	11/7
				Time : N1	M6	E2	N1
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
FRICTION-SHEAR **Friction** Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another	**1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	**2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	**3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	**4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	4
Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4
				TOTAL SCORE	28	28	28	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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PAIN ASSESSMENT FORM

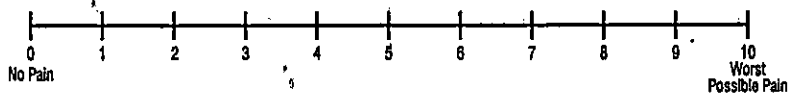
Date	Time	Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
9/7/26	6pm	0/10		☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
9/7/26	2Am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
9/7/26	6Am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
10/7/26	10am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
10/7/26	2pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
10/7/26	3pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
10/7/26	10pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
11/7/26	6Am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
11/7/26	10Am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
11/7/26	2pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	

Re-assessment Frequency:

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

PAIN ASSESSMENT TOOLS

Numerical Pain Scale (Obstetric and Gynecology)



Wong - Baker (Pediatrics) Above 7 Years

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

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

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR RR, BP, SaO_2	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO_2 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO_2 less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

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NURSING SHIFT HAND OVER FORM - WARD

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

SITUATION

Diagnosis: Acute appendicitis

Any Infection: ☐ Yes ☐ No ☐ Not Known
If Yes Specify: ....

Section	Item	9/7/26 E2	9/7/26 N1	10/7/26 M6	10/7/26 E2	10/7/26 N1	11/7/26 E2
BACKGROUND	Medical Condition (Any special condition to be noted):			–	–	–	✓
ASSESSMENT	Allergy: ☐ Yes ☐ No	No ✓	No	No	No	No	No
	Tubes/Drains/Catheter: ☐ Yes ☐ No	No ✓	No	No	No	No	No
	Vital Signs: Temp:	98.4°F	97.3°F	98.6°F	98.1°F	98.3°F	97.4°
	Res:	40b/m	43b/m	28b/m	28b/m	28b/m	28b/m
	SpO₂:	100%	100%	100%	100%	98%	98%
	Pulse:	97	90b/m	98b/m	98b/m	108b/m	109b/m
	BP:	–	–	–		101/60	103/70
	Fall Risk Score:	'0'	–	"0"	'0'	–	✓
	Pain Score:	'0'	–	"0"	'0'	"0"	✓
Recommendations	Safety Needs:	–	yes	Yes	yes	yes	✓
	Physiotherapy: ☐ Yes ☐ No	No ✓	No	No	No	No	No
	Others Specify:	✓	–	–	–	NA	✓
	Special Diet: ☐ Yes ☐ No	No ✓	No	No	No	No	No
	Other Special Orders / Medications:	–	–	–	–	NA	NA
	Post Operative Procedure Special Orders:	–	Anusha	–	–	NA	NA
	Handed Over By Name:	Mounika	Anusha	Mounika	[illegible]	Amrutha	Madhu
	Signature:	[signature]	[signature]	[signature]	[signature]	[signature]	[signature]
	Date:	9/7/26	10/7/26	10/7/26	10/7/26	11/7/26	11/7/26
	Time:	8pm	8Am	2pm	8pm	8Am	8pm
	Taken Over By Name:	Anusha	Mounika	[illegible]	Amrutha	Madhu	Amrutha
	Signature:	[signature]	[signature]	[signature]	[signature]	[signature]	[signature]
	Date:	9/7/26	10/7/26	10/7/26	10/7/26	11/7/26	11/7
	Time:	8pm	8am	2pm	8pm	8pm	8pm

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

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NURSING SHIFT HAND OVER FORM - WARD

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

SITUATION	Diagnosis:						Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:	
BACKGROUND	Area / Shift Time	11/7 W1						
	Medical Condition (Any special condition to be noted):	WA						
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:	98.3F						
	Res:	38b/m						
	SpO_2:	100%						
	Pulse:	126/m						
	BP:	101/60						
	Fall Risk Score:	—						
	Pain Score:	—						
Recommendations	Safety Needs:	—						
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:	—						
	Special Diet:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:	WA						
Post Operative Procedure Special Orders:		WA						
Handed Over By Name :		Amruthe						
Signature :								
Date:		12/7/26						
Time:		3AM						
Taken Over By Name :								
Signature :								
Date:								
Time:								

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OPERATION THEATER NOTES

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Patient's Name : .... Age : .... Gender : ....

UHID.: .... Weight : ....

Surgeon :	Asst. Surgeon :
Anesthetist :	OT Nurse :

Surgical Procedure : Laparoscopic appendicectomy

Indications for Surgery : Appendicular perforation

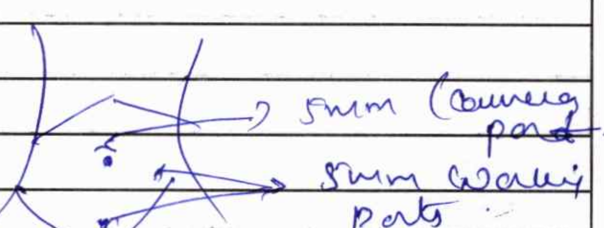
Date :	Start Time :	End Time :

PRE-OPERATIVE PREPARATION :

OPERATION NOTES:

Intra op findings:-
∝ Tip of appendix perforated with appendicolith with retrocecal dense adhesions with 10 ml of pus.
∝ 1 cm of inflamed proximal appendix with inflamed base of appendix. Caecum - (N).

Procedure:- LAP above said region cleaned & draped.
- ports placed
- pneumoperitoneum created
- Appendix dissected
- Endoloops placed
- Appendix excised & sent to HPE.
- Suction & Irrigation done



(P.T.O)

- Haemostasis secure
- post procedure uneventful.

POST - OPERATIVE ORDERS :

Npo till 2 hrs wt : 17 kgs.

IVF → ½ DNS @ 5 ml/hr

Inj. piptaz 1.7 gm/iv/bd

Inj pcm 17 ml/iv/tid

Inj pan 20 mg/iv/od

Monitor vitals/2 hrly hrs.

....

Consultant Surgeon's Name Consultant Surgeon's Signature

Date : .....Time : .....

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Swapna
Asst. Surgeon :
Anaesthetist : Dr. Athidhi
Scrub Nurse : Sr. Sangeetha / Sr. Archana

Pat
UHI
Date .

..... Age : ..... Gender : .....
.... Surgery Name : Lap. appendectomy
: ..... In-time : 5pm Out-time : 8pm

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Before Induction of Anaesthesia ➤➤

SIGN IN Time: 6pm

Patient Has Confirmed
- Identity ☑ Yes ☐ No
- Site ☑ Yes ☐ No
- Procedure ☑ Yes ☐ No
- Consent ☑ Yes ☐ No

Site Marked ☐ Yes ☐ No ☐ NA

Anaesthesia Safety Check Completed ☑ Yes ☐ No

Pulse Oximeter on Patient & Functioning ☑ Yes ☐ No

Does Patient have a:
- Known Allergy? ☐ Yes ☑ No

Difficult Airway / Aspiration Risk?
- Yes, & Equipment / Assistance Available ☐ Yes ☐ No

Risk of > 500ml Blood Loss (7ml/kg In Children)?
- Yes, and Adequate Intravenous Access and Fluids Planned ☐ Yes ☑ No ☐ NA
- Blood Units Reserved ☐ Yes ☐ No ☐ NA

Has Antibiotic Prophylaxis been given within the last 60 minutes? ☑ Yes ☐ No ☐ NA

Signature : Athidhi
Name : Dr. Athidhi

Before Skin Incision ➤➤

TIME OUT Time: 6:54pm

Confirm all team members have introduced themselves by Name and Role ☑ Yes ☐ No

Surgeon, Anaesthesia Professional and Nurse Verbally Confirm
- Correct Patient (Check ID Band) ☑ Yes ☐ No
- Correct Site ☑ Yes ☐ No
- Correct Procedure ☑ Yes ☐ No

Anticipated Critical Events

Surgeon Reviews:
- What are the Critical or Unexpected Steps, Operative Duration, 1hr Anticipated Blood Loss? 50ml ☑ Yes ☐ No ☐ NA

Anaesthesia Team Reviews:
- Are There Any Patient-specific Concerns? ☐ Yes ☑ No ☐ NA

Nursing Team Reviews: Extubation
- Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns? ☑ Yes ☐ No ☐ NA

Is Essential Imaging Displayed? ☑ Yes ☐ No ☐ NA

Signature : Puja @ 6:54PM
Name : Jaya

Before Patient Leaves Operating Room

SIGN OUT Time: 8pm

Nurse Verbally Confirms with the Team:
- The Name of the Procedure Recorded ☑ Yes ☐ No
- That Instrument, Sponge and Needle Counts are Correct (or Not Applicable) ☑ Yes ☐ No ☐ NA
- The Specimen is Labelled (including patient name) ☑ Yes ☐ No ☐ NA
- Whether there are any Equipment Problems to be addressed ☑ Yes ☐ No ☐ NA

To Surgeon, Anaesthetist and Nurse:
- What are the key concerns for recovery and management of this patient? ☑ Yes ☐ No

Signature :
Name :

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00016448 IP26-00006793 Master SEVELLI VEERA SAI 10-11-2017 8Y8M2D Dr. SWAPNA PALAKURTHY (M)	9/1/26 @	9/1/26 @
	Transfer Ordered by Dr. Swapna	Reason for Transfer Observation
From Unit OT	To Unit 301	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File –	Number of Imaging Films –	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☑ If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	Rh	(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
Sis. Puja 9/1/26 @ 10:40pm	Dr. Adithi

Patient & Clinical Records Received by :

Date & Time of Patient Received :

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

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

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PATIENT TRANSFER FORM

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10-11-2017 8 Y 8 M 2 D (M)
Dr. SWAPNA PALAKURTHY

Date & Time of Admission	Date & Time of Transfer Order
9/7/26 @ 12:04 PM	9/7/26 @ 5:30PM

Treating Consultant Name	Transfer Ordered by	Reason for Transfer
Dr. Aniket	Dr. Anush	Surgery

From Unit	To Unit	Information to Attendant
ward (3rd Floor)	OT	Yes ☐ No ☐

Number of Sheets in Clinical File	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant
		Yes ☐ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	IVF- Plasmalyte.	
2.	Inj. Paracetamol	
3.		
4.		
5.		

Shifting Summary / Notes Written by Doctor : Yes ☐ No ☐

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Moutushi	Dr. Anush.

Patient & Clinical Records Received by : Archana

Date & Time of Patient Received : 9/7/26 @ 5:48pm

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

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

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Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

Name: ..... Age: ..... Sex: ..... UHID.No : .....

Date: 9/7/26 Time: 4-23 Proposed Operation: Appendicectomy

Diagnosis: Appendicitis

B.P / CRT: ..... H.R: ..... Weight: 17kg ASA Physical Status: ☐1 ☐2 ☐3 ☐4 ☐5

Laboratory Data:

Hgb: 12.8	Glucose:	Protein:	HIV:	X-Ray: .....
PCV: 36.1	Urea:	Alb:	HBS Ag:	ECG: .....
WBC: 9.31	Creat: 0.4	Total Bill:	HCV:	2D Echo: .....
Plate: 301	Na:	Dir. Bill:	Blood group:	Stress/Anglo: .....
PT:	K:	LDH:	T3	Other: .....
PTT:	Ca++:	Alk phos:	T4	
INR:	Mg++:	Amylase:	TSH	
CRP-24	Cl -:	SGOT/SGPT:		

Allergies: NKDA

Medical History: CVS : —

RESP : — fever (P)

CNS : — Vomiting 2 episodes

Renal : — pain in abdomen

Hepatic / GE : — Physical Activity:

Diabetes : —

Others : —

Past Anaesthetic History: —

Physical Exam:

Airway: MP 1 2 3 4 Mouth Opening: Adeq Mentohyoid Distance: C Neck: C Teeth: 1 missing in upper

Lungs : BEBL

Heart: S1 S2

CNS: NAD

Pregnant: ☐ Yes ☐ No ☐ NA

Venous Access Site : RT: RC Spine Exam for regional :

Anaesthetic Plan: ☐ MAC ☐ REGIONAL ☑ GA-ETT ☐ LMA

Peri-Operative Plan Explained to the Patient: ☑ Yes ☐ No

CURRENT MEDICATIONS	DOSAGE
—	—
—	—
—	—
—	—

Pre-Operative Instructions: FOOD Morning 9 o'clock WATER :- 9 o'clock

1. DVT Prophylaxis :
2. NIL ORAL → Water / ORS 2 Hours; Others 6 Hours
3. Informed Consent: ☑ Standard ☐ High Risk
4. Post Operative Pain Management: ☐ Discussed with Patient
5. Other Instructions:

.....

.....

.....

Signature: ..... Name: Dr Ashok N

Docu. No. : RCH /FRM / CLINICAL / 044

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ANAESTHESIA CHART

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Pre Induction Assessment:

Change in Patient Condition: ☐ Yes ☐ No ✓		Fasting Status: Adequate	
Physical Status:	☐ Patient Identified ✓	☑ Consent Present	☑ Chart Reviewed

H.R:	B.P / CRT:	SpO_2:	R.R:	Last Feed:

Pre-OP Diagnosis: Acute appendicitis Operation: Lap Appendicectomy Date: 9/7/24

Surgeon: Dr Sajjan Anaesthesiologist: Dr Aditi, Dr [illegible] Technician: Arvind

TIME	6				
N_2O / AIR / O_2 LPM	[illegible]				
HALO / ISO / SEVO	MAC 1.0				
Drugs:	INJ PROPOFOL 40MG; INJ FENTANY 40MCG; INJ MIDAZ 0.5MG; INJ ROCURONIUM				
FIO_2 / SaO_2	100 100 100 100 100 100 100 100				
$ETCO_2$	34 35 36 37 34 34 32 34				
ECG	SR SR SR SR SR SR SR				
Temperature	36.6				
Urine Output					
Fluids / Blood	IVF RL 170ml/hr				

Antibiotic: —

Suppository: Diclofen 12.5

Blood Loss: min

NOTES:

B.P: V Systolic, Λ Diastolic, X Mean, • Heart Rate (scale 0–240; values plotted around 100–120 systolic/HR and around 60 diastolic)

Tourniquet on Time / Tourniquet off Time / Throat Pack In / Throat Pack Out

LAB Values: ABG / GRBS / Others

☑ Equipment Checked and Functional ☑ BP ☑ Cuff Site: ...... ☑ Art Site: ...... ☑ EKG Lead ☑ Temp Site Skin ☐ FIO_2 Monitor ☐ Agent Monitor ☑ Pulse Oximeter ☑ Capnograph ☑ Ventilator ☐ Nerve Stimulator **Position:** Supine ☑ Pressure Points Checked **Eye Care:** ☐ Oint ☑ Tape ☐ Padding ☐ Awake	**Temp:** ☑ HME ☐ Fluid Warmer ☐ Cling Film ☐ OH Warmer ☑ Hugger's ☐ Cotton Wool ☐ Other **Times:** Anaes Start: 6. OP Start: 6.30 OP End: 7.50 Leave OR: 8 **Anaesthesia:** ☑ GA ☐ Monitored Anaesthesia Care ☐ Regional **Line (Size & Location)** ☐ CVP: ...... ☐ ART: ...... ☑ IV: L.U.L. - 22G ☐ IV: ...... ☐ IV:	**Induction** ☐ IV ☐ Inhal ☐ Pre O_2 ☐ RSI ☐ Others ☐ Mask ☐ SGA ☐ Airway ☐ Oral ☐ Nasal ETT# 4.5 at 17 cm ☐ Oral ☐ Nasal ☐ Cuff ☐ Tracheostomy ☐ Topical ☐ Drug: Rocuronium ☐ Awake ☐ Direct Vision ☐ Video Laryngoscopy ☐ Stylette / Bougie ☐ Fiberoptic Intubation 3 4 Blade# ...... Attempts: ...... Difficulty Why? S.size tube → unable to pass 4.5 micro cuff tube 4.5 south pole tube ☐ Bilat = BS ☐ Semi-Closed Circle ☐ Closed Circle ☐ Other	**Regional:** Extremity Specify: ...... ☐ Spinal ☐ Epidural ☐ Caudal Others: ...... Position: ...... Site: ...... Needle Size: ...... Depth: ...... Parasthesia ☐ Yes ☐ No Catheter at skin ...... cm Drug Name & Conc: ...... Bolus: ...... Infusion: ...... Block Level: ...... Comments: ...... Transportation to ☑ PACU ☐ ICU ☐ Other Relaxant Reversed ☑ Yes ☐ No ☐ NA Name of the Doctor: Dr. Aditi Signature of the Doctor: [signature]

HNH-00016448 IP26-00006793
Master SEVELU VEERA SAI
10-11-2017 8 Y 8 M 2 D (M)
Dr. SWAPNA PALAKURTHY

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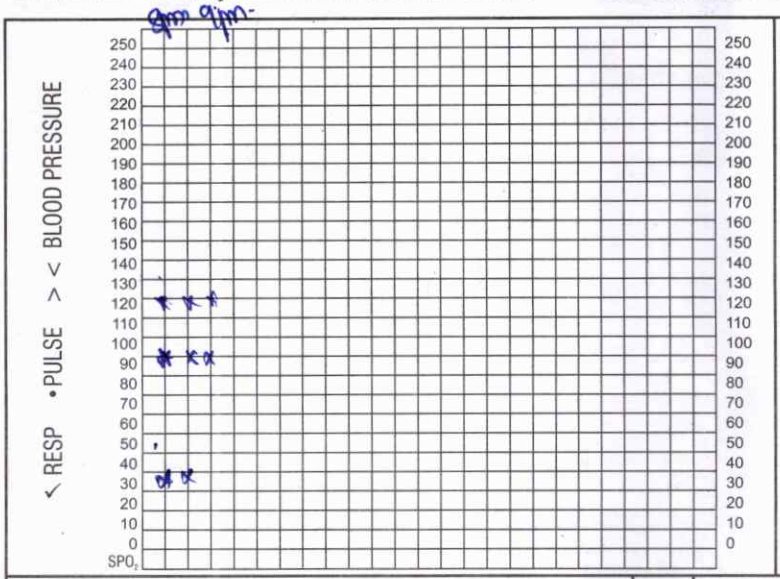
...CARE UNIT RECORD

Received in PACU by : ..... Time Received : ..... Time Discharged : .....



IV Cannula Site : Left Hand

- ☑ O_2 Mask ☐ Nasal Prongs
- ☐ Tracheostomy ☐ T-Piece
- ☐ Oral Airway ☐ Nasal Airway

Vomiting : ☐ Yes ☑ No Drug: .....
NG Tube : ☑ Yes ☐ No
Drain: ☐ Yes ☑ No
Urinary Catheter: ☐ Yes ☑ No
Chest Tube: ☐ Yes ☑ No
Nil Oral ☐ Yes ☐ No

IV Fluids: .....
Oral Feeds: .....

POST ANAESTHESIA SCORE (Modified Aldrete Score)			IN	MINUTES 30	60	90	OUT	SCORING INTERPRETATION
Able to move 4 extremities voluntary or on command Able to move 2 extremities voluntary or on command Able to move 0 extremities voluntary or on command	= 2 = 1 = 0	ACTIVITY		2	2			A Minimum Total Score of 8 is Required for Discharge Exceptions to this, are to be explained in the space below by the Discharging Physician:
Able to deep breathe & cough freely Dyspnea or limited breathing Apneic	= 2 = 1 = 0	RESPIRATION		2	2			
BP ± 20 of Pre Anaesthetic leve BP ± 20-50 of Pre Anaesthetic leve BP ± 50 of Pre Anaesthetic leve	= 2 = 1 = 0	CIRCULATION		1	1			
Fully awake Arousable on calling Not responding	= 2 = 1 = 0	CONSCIOUSNESS		2	2			
Pink Pale, dusky, blotchy, jaundiced, other Cyanotic	= 2 = 1 = 0	COLOR		2	2			
		TOTAL		9	9			

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature

Pain Tool Used: ☐ N PASS ☐ FLACC ☐ Wong Baker ☐ NPS

Anaesthesiologist Name : Mr Achu N
Anaesthesiologist Signature: Achu
Date & Time: 9/7/26

PACU Nurse Name : Sandhya
PACU Nurse Signature:
Date & Time: 9/7/26

Reassessment Frequency:
1. Every eight hours for all hospitalized patients.
2. For post surgical patient, patient with chronic pain, patient with severe pain
   a. Every 2 hours for first 24 hours
   b. After 24 hours every 4 hours
   c. Prior to pain reliving intervention
   d. With in 30-60 minutes after pain relief intervention

Transferred to Unit by (PACU): .....
Date & Time: .....

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Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

Date: ..... Time: ..... Procedure done by .....

CSE /Spinal /Epidural Position : ..... Space :..... Technique (LOR/LOS) .....

Depth: ..... Catheter at Skin: ..... Attempts : .....

Parasthesia : Yes/No if yes details : .....

Solution Composition : .....

Any other issues :

a) .....

b) .....

Time	Infusion Rate (ml/hr)	Bolus (ml)	Level		Maternal		FHR	Comments
			Left	Right	BP	Pulse		

Delivery Details : Time : ..... APGAR: ..... SVD / Instrumental / LSCS (if LSCS Details)

Catheter Removed by and Tip Inspected : .....

Patient Satisfaction : .....

Discharge /Shifting ordered by

Doctor Signature: .....

Doctor Name: .....

Date and Time : .....

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

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Master SEVELU VEERA SAI
10-11-2017 8 Y 8 M 2 D (M)
Dr. SWAPNA PALAKURTHY

Patient Name : . ..... Gender: ☐ Male ☐ Female Age : .....

UHID No : .... Date : .....

Instruction:

This consent form should be signed by Patient (an adult 18 years or older) or by a parent / guardian, if the patient is a minor or lacks the ability to make an informed decision. The purpose of this form is to verify that you have received this information and have given your consent to the surgery or special procedure recommended to you.

I hereby authorize the performance of the following operation (s) or procedure (s) (use no abbreviation / Avoid technical terms)

.....

..... Laparoscopic appendicectomy .....

..... upon .....

(Name of the Patient)

.....

I have been advised of the benefits and reason of the procedure(s) as indicated by the clinical observations and / or diagnostics performed. I recognized that the practice of medicine is as much an art as a science and therefore acknowledge that no guarantees have been or can be made regarding the likelihood of success or outcomes. My questions regarding the condition, the proposed surgery and the outcome have been answered to my satisfaction prior to signing this form by the surgeon.

I have been explained the risks of this surgery /procedure and also about the reasonable alternative and the relevant risks, benefits and side effects related to such alternatives, including the possible results of not receiving care or treatment.

I have been explained that the following complications though rare are possible and will not hold Surgeon, Anesthesiologist or the hospital staff responsible for any untoward event thereof.

..... - peritonitis

..... - Stump appendicitis

..... - pelvic collection .....

My signature on this form indicates that

1. I have read and understood the information provided in this form
2. My doctor had adequately explained to me the operation or procedure along with the complications written above, along with the risks, benefits and other information.
3. I have had a chance to ask my surgeon questions.
4. I have received all the information I desire concerning the operation or procedure and
5. I authorize the consent to the performance of the operation or procedure.

Name of the Doctor who is performing the Surgery / Procedure: .....

Consentee :

Signature : .....

Name : .....

Date & Time : .....

Witness :

Signature : .....

Name : .....

Date & Time : .....

Patient Attendant :

Signature : S. Ashi.

Name : S. Ashwini

Relationship with Patient: mother

Date & Time : 5:48 pm 9/07/26

Doctor (who is taking the consent) :

Signature : .....

Name : Dr Swapna palakurthy

Date & Time : .....

CONSENT FORM FOR

HNH-00016448 IP26-00006793
Master SEVELLI VEERA SAI
10-11-2017 8 Y 8 M 2 D (M)
Dr. SWAPNA PALAKURTHY

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Patient Name : ..... Gender : Male ☐ Female ☐

UHID NO: ..... Surgeon Name: .....

Anaesthesiologist : Dr Arlette ..... Operative procedure planned : Appendicectomy .....

PLEASE READ THIS BEFORE YOU CONSENT FOR ANAESTHESIA

General anaesthesia involves rendering a patient unconscious before an operation. This ensures the patient is not aware of events and does not feel pain during the operation. Drugs given through a vein and / or inhaled from an anaesthesia machine produce it. Regional anaesthesia involves using a local anaesthetic to numb a specific area of the body for surgery: Prolonged pain relief without numbness can be achieved by infusing weak solutions of local anesthetics arid narcotic drugs to particular parts of the body after surgery or injury, using catheters.

Specific High Risk (s) : The doctors have explained to me the details of the high risk involved due to the following medical problems and I have sought necessary clarification on all my doubts.

☐ Heart disease ☐ Hypertension ☐ Diabetes mellitus ☐ Renal failure

☐ Hepatic disorders ☐ Shock ☐ Multiple organ failure ☐ Polytrauma / Renal Tubular Aacidosis

☐ Incapacitating Cronic Obstructive Pulmonary Disease ☐ Others : DEHYDRATION , POST OP O2 requirement

- Doctor to document in medical record also if necessary (Cross-out if not applicable)

DECLARATION BY PATIENT / GUARDIAN / PROXY

I hereby authorize Rainbow Hospital & its authorized doctors to perform upon me / my patient the above mentioned operation / Diagnostic / Therapeutic procedures.

I authorize and give consent for anaesthesia (☐ Regional / ☐ General Anesthesia / ☐ Monitored Anesthesia Care as considered appropriate by the anaesthesia team.

I acknowledge that the anaesthetists have informed me about the anaesthetic procedure, risk, benefits and alternative treatments and answered my specific queries and concerns about this matter. I have read and understood the information provided in this form I acknowledge that I have discussed with the anaesthetists any significant risk and Complications specific to my individual circumstances, and I have considered them before Consenting for anesthesia.

I understand that there are some infrequent complications that can occur due to use of anaesthesia, these include pain or some injury at the site of injections, temporary breathing difficulties, asthmatic reactions, headaches.

I authorize the anaesthesia team to perform any additional procedures (for example, Central Venous Pressure line, arterial line, use of nerve blocks for pain relief, changing from regional to general anaesthesia etc), which are considered necessary by them during the course of surgery.

That I authorize and give consent to the team of doctors attending on me to administer blood products during the course of operative period and immediately thereafter in need arises.

I understand that the above mentioned consultant anesthesiologist or occasionally a colleague deputed by him / her will administer the Anaesthesia.

I have been explained all my queries in the language understood by me.

Patient / Patient Attendant :

Signature : .....

Name : S. SRIKANTH RAO

Relationship with Patient: FATHER.

Date & Time : 9/7/2021 4.26

Witness :

Signature : S. Ashwini

Name : S. Ashwini

Date & Time : 9/7/2021 4.26

Doctor (who is taking the consent) :

Signature : ..... Name : Dr Arlette N Date & Time : 9/7/2021 4.3

Docu. No. : RCH / FRM / CLINICAL / 021

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00016448 IP26-00006793 Master SEVELU VEERA SAI 10-11-2017 8 Y 8 M 2 D (M) Dr. SWAPNA PALAKURTHY	9/07/26 @ 12:04 PM	9/07/26 @ 1:30 PM
	Transfer Ordered by Dr. prashanti	Reason for Transfer Admission
From Unit ER	To Unit ward (301)	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File 15-1-	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☑ If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.		
2.		
3.		
4.		
5.		

Shifting Summary / Notes Written by Doctor : Yes ☐ No ☐

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
shirisha	Dr. prashanti

Patient & Clinical Records Received by : Supr 9/7/26 @ 1:55pm.

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

HNH-00016448 IP26-00006793
Master SEVELU VEERA SAI
10-11-2017 8 Y 8 M 2 D (M)
Dr. SWAPNA PALAKURTHY

Wt – 17.2 kg

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EMERGENCY ROOM TRIAGE FORM

Patient's Name : master veera Sai Deekshith Age : 8 Y Gender: ☐ Male ☐ Female

Date : 9/7/26 Time of Arrival : 11:15 Am

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

Source of Information : ☑ Parents ☐ Others (Specify) .....

Mode of Arrival : ☑ Ambulatory ☐ Wheelchair ☐ Ambulance

Initial Vital Signs: Temp: 97.9F PR: 82b/m BP: 110/86 RR: ..... SpO_2: 97%

Chief Complaints: c/o Abdomen pain & vomiting 7–8 times

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 : 11:26 Am

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 : Jyoti

Signature of Triage Nurse : Jyoti

Date & Time : 9/7/26 @ 11:17 Am

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 9/7/26 Time of arrival : 11:19 AM

Chief Complaints: C/O Abdom pain x vomiting 2-3 times RBS: .....

Height : ..... Weight : 17.1kg 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?) 1

Time of Initial assessment completed by ER Nurse : 11:22 AM

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

Time	Nursing Notes
	- Assess the pt condition
	- monitor vits
	- IV placement done
	- Sample collected

Samples collected by: } sugandhi Time: } 11:50 AM

Samples sent by : } sugandhi Time: } 11:50 AM

Medication given in ER:

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

Condition of patient at time of shift - out :	**Details of Shift - out**
HR: 82 b/m BP: 110/86 mmHg CFT: N/A RR: ~~82 b/m~~ SPO_2 : 98 % GCS: 15 Temperature : 98 F Pain Score: -1 Repeat RBS (if applicable): N/A	Shift - out from ER to: 3rd floor (301) Time of Shift - out: 1:30 pm Handover given to: Anjana (Nurse's Name)

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

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

IV Placement Done

Name of the Nurse : Jyoti Signature of the Nurse : Jyoti

Date & Time : 9/7/26 @ 11:24 Am

H 26-0000212227 H

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NARCOTIC PRESCRIPTION FORM
(PATIENT COPY)

Patient Name: Mst. Sevelli veera Sai deekshith	Age: 8Y	Gender: Female	
UHID No: HNH-0096448	IP No: IP26-00006793	Date: 9/7/26	Time: 09:59 pm
Diagnosis: Appendectomy	ward - OT		

PRESCRIPTION DETAILS (Tick only one of the following)

S.No	Drug Name	Dosage	Remarks
1.	Fentanyl Citrate Inj. 50mcg/Ml	100mcg	1 Amp
2.	Morphine Sulphate Inj. 15mg/Ml	/	/
3.	Remifentanil Hydrochloride Inj. 2MG		
4.	Remifentanil Hydrochloride inj. 1MG		

Doctor Name: Dr. Sk. Ayesha

Doctor Registration No: TSMC/FMR/02705

Signature:

NARCOTIC DISPENSING FORM
APPENDIX 4 – FORM NO. 3E
(Details of the Patient to whom Essential Narcotic Drugs Dispensed)

IP Registration No: IP26-00006793 **Date:** 9/7/26

Aadhaar No. of the Patient (Optional): .....

1.	**Name :** Mst. Sevelli veera Sai deekshith	**Remarks**
2.	Complete postal address (with contact number, if any)	11-100-12-1-69 near ganesh temple Zalapet kyd nelangana 500017
3.	Brief description of the illness	lap Appendectomy
4.	Whether registered with any other registered medical practioner / recognized medical institution (If yes, details of the recorded)	NO
5.	Details of essential Narcotic drug dispensed	Fentanyl

Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any
9/7/26	Fentanyl	1 Amp	S. dhiraj	

Dispensed by (Name & ID No.): Sarma (015442) Signature: Sarma

Received by (Name & ID No.): Saraswathi (021006) Signature:

Time: .....

26-000021222-7

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NARCOTIC PRESCRIPTION FORM
(MEDICAL RECORD)

Patient Name: Mst. Sevelli veera sai deekshith		Age: 8y		Gender: Female	
UHID No: HNH-L006448	IP No: IP26-00006193	Date: 9/7/26		Time: 9:59 pm	
Diagnosis: Appendicectomy		ward - OT			

PRESCRIPTION DETAILS (Tick only one of the following)

S.No	Drug Name	Dosage	Remarks
1.	Fentanyl Citrate Inj. 50mcg/Ml	100mcg	1 Amp
2.	Morphine Sulphate Inj. 15mg/Ml	/	/
3.	Remifentanil Hydrochloride Inj. 2MG	/	/
4.	Remifentanil Hydrochloride inj. 1MG	/	/

Doctor Name: Dr SK. Ayesha

Signature: [signature]

Doctor Registration No: TSMC/FMR/07-705

NARCOTIC DISPENSING FORM
APPENDIX 4 – FORM NO. 3E
(Details of the Patient to whom Essential Narcotic Drugs Dispensed)

IP Registration No: IP26-00006193 **Date:** 9/7/26

Aadhaar No. of the Patient (Optional): ....

1.	**Name :** Mst Sevelli veera sai deekshith	**Remarks**
2.	Complete postal address (with contact number, if any)	H.NO. 12-1-69 near ganesh temple [illegible] hyd telangana 50017
3.	Brief description of the illness	Lap Appendicectomy
4.	Whether registered with any other registered medical practioner / recognized medical institution (If yes, details of the recorded)	NO
5.	Details of essential Narcotic drug dispensed	Fentanyl

Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any
9/7/26	Fentanyl	1 Amp	S.	

Dispensed by (Name & ID No.): Sama (015442) Signature: Sama

Received by (Name & ID No.): [illegible] (021006) Signature: [signature]

Time: ....

NARCOTIC PRESCRIPTION FORM
(MEDICAL RECORD)

Patient Name		Age	Gender
UHID No.	IP No.	Date	Time
Diagnosis			

PRESCRIPTION (Use only one of the following)

S.No	Drug Name	Dosage	Remarks
1.	Fentanyl Citrate Inj. 50mcg/Ml		
2.	Morphine Sulphate Inj. 15mg/Ml		
3.	Pentazocine Hydrochloride Inj. 2Ml/3		
4.	Promethazine Hydrochloride Inj. 1Ml/3		

Doctor Name: Date & Registration No.:

Signature:

NARCOTIC DISPENSING FORM
APPENDIX 4 – FORM NO. 3E
(Details of the Patient to whom Essential Narcotic Drugs Dispensed)

IP Registration No: Date:

Address (local) of the Patient (Optional):

1.	Name	Remarks
2.	Complete postal address (with contact number if any)	
3.	Brief description of the illness	
4.	Whether registered with any other registered medical practitioner; if so, details of the registered medical practitioner	
5.	Details of essential Narcotic drug (s) prescribed	

Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb impression of the patient / Patient's Attender	Remarks, if any

Dispensed by (Name & ID No.): Signature:

Received by (Name & ID No.): Signature:

Time:

Seal of the Dispensing Unit: