Rainbow Childrens Hospital-Himayatnagar

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

ADMISSION SHEET

Registration Details :

Admission No : IP26-00006441 **Admit Date** : 28-May-2026 **Admit Time** : 10:21 AM **UHID** : VIH-00203019

Patient Details :

Patient Name	: Master DARSH SONI	**Age**	: 1 Y
Guardian	: Mr PRITESH SONI	**DOB**	: 28-06-2024 10:47 AM
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: malakpet Malakpet Colony Hyderabad Telangana INDIA 500036	**Phone No**	: 9700809591/
		E-mail	: na@gmail.com

Admission Details :

Bed Type : DAY CARE **Bed No** : ER01 **Ward Name** : GF -EMERGENCY

Room No : ER01 **Admission Type** : First Visit

Contact Details :

Name : Mr PRITESH SONI **Relationship** : Father

Contact Address : malakpet Malakpet Colony Hyderabad Telangana INDIA 500036 **Phone No** : 9700809591

Signature

Doctor Details :

Doctor Name : Dr. SWAPNA PALAKURTHY **Specialisation** : PEDIATRIC SURGERY

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

Co-Consultant :

Payment Details :

Deposit Amount : 10000.00

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

VIH-00203019 IP26-00006441
Master DARSH
18-06-2024 1 Y (M)
Dr. SWAPNA PALAKURTHY

Wt + 10.2kg

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EMERGENCY ROOM TRIAGE FORM

Patient's Name : Darsh Age : 17 **Gender:** ☐ Male ☐ Female

Date : 28/5/26 Time of Arrival : 10:2 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: 98.1 PR: 141 BP: ..... RR: ..... SpO_2: 100%

Chief Complaints: c/o Fall in home in night injured Right side forehead.

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 : 10:4Am

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 : Anupam

Signature of Triage Nurse : A.P

Date & Time : 28/5/26 @ 10:5Am.

Docu. No. : RCH /FRM / CLINICAL / 085

VIH-00203019 IP26-00006441
Master DARSH
28-06-2024 1 Y (M)
Dr. SWAPNA PALAKURTHY

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 28/5/26 Time of arrival : 10:2 Am

Chief Complaints: c/o fall in home might injuri Right side forehea. RBS: ......

Height : ...... Weight : 10.2 Kg BMI : ...... Head Circumference (<2 years) ......

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

If yes , identify ......

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

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

RISK FOR FALL:

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

☐ If Patient is > 6 years
Assess the below parameters

History of Falling: within past 3 months	☐ Yes	☑ No
Ambulatory Aids:		
• Wheelchair	☐ Yes	☑ No
• Uses furniture for support	☐ Yes	☑ No
Gait/Transferring:		
• Bedrest / immobile	☐ Yes	☑ No
• Weak	☐ Yes	☑ No
• Impaired	☐ Yes	☑ No
Mental Status: Forgets limitations	☐ Yes	☑ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening: ☑ No Abnormalities Detected

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

Inform consultant for positive criteria

......

......

Nutritional Screening: ☑ No Abnormalities Detected

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

Inform consultant for positive criteria

Psychological Screening: ☑ No Significant Findings

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

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

Social History: Lives With family.

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

Time of Initial assessment completed by ER Nurse : 10.18 Am

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

Time	Nursing Notes
	Assessed the patient condition vital checked.

Samples collected by:

Samples sent by : Sufanda.

Time:

Time: 11:00am

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: 131 BP: 110/60 CFT:	Shift - out from ER to: 3/6
RR: 31 SPO_2: 100 %	Time of Shift - out: 11:00 AM
GCS: — Temperature : 98	Handover given to: ..... (Nurse's Name)
Pain Score: 0	
Repeat RBS (if applicable):	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

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

.....

Name of the Nurse : Anupam Signature of the Nurse : A.P

Date & Time : 28/5/26 @ 10:5 Am

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
VIH-00203019 IP26-00006441 Master DARSH 28-06-2024 1 Y (M) Dr. SWAPNA PALAKURTHY	28/5/26 @10:3	28/5/26
	Transfer Ordered by Dr: Pranav	Reason for Transfer Admission
From Unit ER	To Unit 316	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.		
2.		
3.		
4.		
5.		

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Anupam	Dr. Pranav

Patient & Clinical Records Received by : Sapna

Date & Time of Patient Received : 11:50 AM @ 28/5/26

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

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

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ACTIVITY RECORD FOR BILLING

Name: ----- VIH-00203019 IP26-00006441 ----------
Master DARSH
28-06-2024 1 Y (M)
UHID No : - Dr. SWAPNA PALAKURTHY --------- Consultant : ---------- Dept : ----------

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
28/5/26	11.00 Am	ER	316	AD

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
28/5/26	CBP	89935	

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
28/5/15	Infsion pum	12:49 pm.		202592	[signature]

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
28/·	Iv canula.		2569	
28/5/26 11:38 AM	N+I A	(1)	202591	

ANY OTHER INFORMATION

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

Ref.No. F/IN/PR/10

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Hospital

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name : _____

Patient ID# : VIH-00203019 IP26-00006441
Master DARSH
28-06-2024 1 Y (M)
Dr. SWAPNA PALAKURTHY

Consultant : _____

Final Diagnosis : _____

Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Informant _____ Reliability _____

Chief Presenting Complaints & Duration (Chronologically):

c/o Fall at home in the night & injury over Ⓡ side forehead.

History of present illness :

child brought with c/o fall at home yesterday night @ 12 AM & injury over Ⓡ side forehead

↓

Post fall child was taken to local hospital

↓

Where CT head was done

↓

No evidence of IC bleed

Ⓡ side Forehead injury - 3 x 1 x 0.5 cm laceration

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 :

Any additional Information :

Developmental History :

Immunization History :

Upto 1yr ago

Not received 18m booster

Pediatric Multiorgan History & Physical Examination

Anthropometry

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

Weight (kgs) 10.2 kg (Centile _____)

On Examination :

Temperature : 98°F Pulse Rate: 138/m Description _____

B.P. _____ SPO2 99% at _____

Resp. rate and type of breathing : _____

_____

Rash (R) side laceration over forehead - 3x1x0.5cm

Lymphadenopathy _____

Oedema : _____

Respiratory system :

Inspection (any s/o distress) : _____

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

Any addes sounds : _____

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

_____

_____

Cardiovasclular System :

Inspection of procordium : _____

Heart Sounds : S1 S2 (+)

Any murmur : _____

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

_____

_____

Per Abdomen :

Inspection _____

Palpation : Soft

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 : Power

Co-ordinator :

Posture :

Involuntary Movements :

Reflexes :

DTR **Superficials :**

Plantars

Sensory System :

Bladder / Bowel :

Clinical Summary & Diagnostic :

® Side forehead laceration, eye

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment :

Desired goals of the treatment :

H. I) Stability

Planned Labs :

CBP C Cannula

Planned Management :

PAC

NPO :→ 6:30Am (Solid) Till 11:45Am (Liq)

IV Fluids

Inj Augmentin

Pruning Suturing ↓ GA

Please fill up the following details

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

Doctor's Signature Name _____ Date 28/5/24 Time _____

VIH-00203019 IP26-00006441
Master DARSH
28-06-2024 1 Y (M)
Dr. SWAPNA PALAKURTHY

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

VIH-00203019 IP26-00006441
Master DARSH
28-06-2024 1 Y (M)
Dr. SWAPNA PALAKURTHY

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

VH-00203019
Master DARSH
28-06-2024 1 Y
Dr. SWAPNA PALAKURTHY (M)
IP26-00006441

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DRUG CHART

Date of Admission: .... Drug Allergies: .... ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

DOCTOR - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
- Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
- Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
- Discontinue a drug by drawing a line / 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 :				Date ➤ / Time ▼
Dose	Route	Frequency	Start Date	
Doctor's Signature		Valid Period	Pharm.	
Additional Instructions:				

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

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

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

[illegible] [illegible]
Master DARSH
28-06-2024 1 Y (M)
Dr. SWAPNA PALAKURTHY

REGULAR PRESCRIPTIONS Weight. 14 kg Ward. ....

DRUG : Inj AMOXICILLIN + CLAVULANATE

Dose	Route	Frequency	Start Date
300mg	IV	TID	28/5

Name & Signature of the Doctor Starting the Drugs: [signature]

Additional Instructions: 30mg/kg

Date ▸ / Time ▾	28/5
6AM	
	12:30 pm [signature]
2pm	
10pm	

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Date ▸ Time ▾

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Date ▸ Time ▾

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Date ▸ Time ▾

Daily Doctor's Endorsement by a Sign

Patient Sticker

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

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

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

Signature .....

VERIFIED BY : Name .....

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses

VIH-00203019 IP26-00006441
Master DARSH
28-06-2024 1 Y (M)
Dr. SWAPNA PALAKURTHY

I.V. FLUIDS CHART

Weight. ...10.2kg... Ward. .....

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
28/5	11 AM	IVF - DNS (2/3rd (M))	IV	27 ml/hr					

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

VIH-00203019 IP26-00006441
Master DARSH
28-06-2024 1 Y (M)
Dr. SWAPNA PALAKURTHY

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MEDICATION RECONCILIATION FORM

Drug Allergies: ..... N D ..... ☐ 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: ..... OT .....

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. Pnam .....

Date & Time : ..... 28/5/26 @ 10:30 AM .....

Nurse Name & Signature: ..... Anupam .....

Date & Time : ..... 28/5/26 @ 10:30 Am .....

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Master DARSH
28-06-2024 1 Y (M)
Dr. SWAPNA PALAKURTHY

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NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 28/5/26 Time: 12pm

Weight: 10.2 kg Centile: 25th

Height: - Centile: -

Inference: underweight child

RDA: - Calories: 1200 kcal/d Protein: 20 gms/d

Diet Recommendations: Soft high protain Diet

Re-Assesment: Avoid spicy, Chilled & Outside foods

Food Allergies: NO Veg/Non-veg Veg

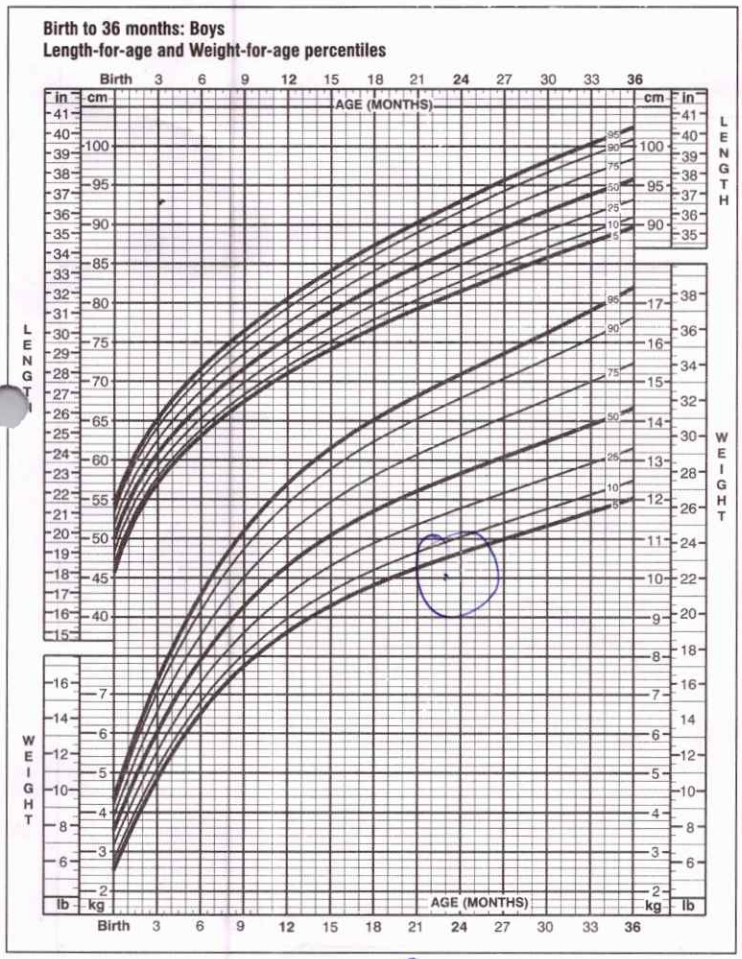
Diagnosis: Right side forehead injury

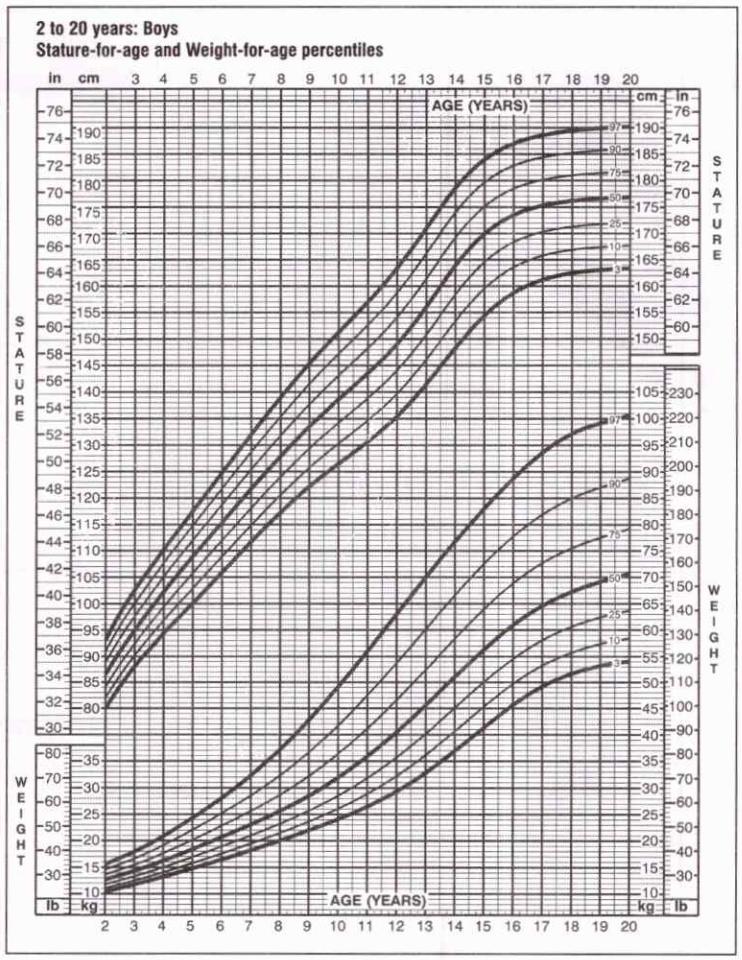
Nutritional Intervention - ☑ Oral ☐ Enteral ☐ Parenteral

Patient's Signature:

P.T.O

GROWTH CHART (BOYS)





Dietician's Name Sathwika Dietician's Signature

Daily Notes:

28/5/26
12:5pm Child is on Npo till further advice

Sathvika.G
Dietitian

VIH-00203019 IP26-00006441
Master DARSH
28-06-2024 1 Y (M)
Dr. SWAPNA PALAKURTHY

3/6

RESULT SHEET

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

Date						
Time						
CUE-Alb						
CUE-Sugar						
CUE - Ketones						
CUE-PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA/Cyst						
Occult Blood						

Culture and Sensitivities : .....

.....

.....

.....

Radiology: USG : .....

X-Ray:.....

ECHO: .....

CT: .....

MRI .....

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

VIH-00203019 IP26-00006441
Master DARSH
28-06-2024 1 Y (M)
Dr. SWAPNA PALAKURTHY

RM / CLINICAL / 125

PRESCHOOL (1-5 years)
Children's Observation & Early Warning Scoring Chart

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

Date : 28/5/26 Time: 1

Doctor / Nurse / Family Concern? PM

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

Heart Rate (bpm) and Blood Pressure (mmHg) *
190 180 170 160 150 140 130 120 110 100 90 80 70 60 50
90
69

Note: BP does not score in early warning scoring

Heart Rate (Number) 126b/m

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

Resp Rate (Number) 32b/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	SN

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

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

BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

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)

VIH-00203019 IP26-00006441
Master DARSH
28-06-2024 1 Y (M)
Dr. SWAPNA PALAKURTHY

CLINICAL / 125

PRESCHOOL (1-5 years)

Children's Observation & Early Warning Scoring Chart

Pratiksha Rainbow Children's Hospital
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Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : ..... Time:																															
Doctor / Nurse / Family Concern?																															
Temperature (F)	104																														
	103																														
	102																														
	101																														
	100																														
	99																														
	98																														
	97																														
	96																														
	95																														
	94																														
Heart Rate (bpm) and Blood Pressure (mmHg) *	190																														
	180																														
	170																														
	160																														
	150																														
	140																														
	130																														
	120																														
	110																														
	100																														
Note: BP does not score in early warning scoring	90																														
	80																														
	70																														
	60																														
	50																														
Heart Rate (Number)																															
Resp. Rate (bpm) (Over 1 Minute) *	70																														
	60																														
	50																														
	40																														
	30																														
	20																														
	10																														
Resp Rate (Number)																															
Resp Distress: Mod/ Severe																															
Resp Distress: None / Mild																															
Receiving O_2(l/min)																															
O_2Saturations (%)																															
Conscious Level: Normal																															
Conscious Level: Altered																															
GCS *																															
TOTAL SCORE Number of shaded boxes																															
Pain Score																															
Observer's Initials																															

ACTIONS NB: Scores 3 should be recorded overleaf	
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	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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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)

Patient Sticker

VIH-00203019 IP26-00006441
Master DARSH
28-06-2024 1 Y (M)
Dr. SWAPNA PALAKURTHY

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

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.

Date	Time	Intake				Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
		Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
28/5/26	08:00 am										0	
	09:00 am										0	
	10:00 am										0	
	11:00 am			27ml							0	
	12:00 pm	DNS	N BM	27ml							0	
	01:00 pm			27ml							0	
Total Intake :						**Total Output :**						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						**Total Output :**						
	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	

Rainbow® Children's Hospital
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Your Right to a Safe Delivery

FLUID CHART

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			Mouth	I.V	N.G							
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	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						**Total Output :**						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						**Total Output :**						
	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	

Patient Sticker

VIH-00203019 IP26-00006441
Master DARSH 1 Y (M)
25-06-2024
Dr. SWAPNA PALAKURTHY

Rainbow® Children's Hospital
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Your Right to a Safe Delivery

FLUID CHART

Sheet No. : .....

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

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						**Total Output :**						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						**Total Output :**						
	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	

Patient Sticker

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Your Right to a Safe Delivery

FLUID CHART

Sheet No. : .....

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		Intake				Output						
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	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**	

VIH-00203019 IP26-00006441
Master DARSH
28-06-2024 1 Y (M)
Dr. SWAPNA PALAKURTHY

NURSING CARE RECORD

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Your Right to a Safe Delivery

Date: 28/5/24

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 the vitals →Maintain the IO chart →Administer medication as per drug chart	8am to 2pm	→Assessed pt condition →Monitored vitals →Maintained IO chart →Administered medication as per drug chart	Patient is stable	→Re-checked the vitals	Supriya
Afternoon							
Night							

Patient Sticker

NURSING CARE RECORD

Rainbow® Children's Hospital
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BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Date: .....

Goals

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

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

VIH-00203019 IP26-00006441
Master DARSH
28-06-2024 1 Y (M)
Dr. SWAPNA PALAKURTHY

BRADEN 'Q' SCALE

Rainbow® Children's Hospital
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BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

					Date : 28/5/26			
					Time : 1926			
Mobility	**1. Completely immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	**3. Slightly limited:** Makes frequent through slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.	4			
"Activity The degree of physical activity"	**1. Bedfast :** Confined to bed	**2. Chairfast :** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	**3. Walks occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. All patients too young to ambulate; OR walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4			
Sensory Perception	**1. Completely limited:** Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	**2. Very limited:** responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	**3. Slightly limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	**4. No impairment:** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4			
Moisture Degree to which skin is exposed to moisture	**1. Constantly moist:** Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	**2. Very moist:** Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	**3. Occasionally moist:** Skin is occasionally moist, requiring linen change every 12 hours.	**4. Rarely moist:** Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4			
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."	3			
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			
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.	3			
				TOTAL SCORE	26			
				Evaluator's Name	D			

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

VIH-00203019 IP26-00006441
Master DARSH
28-06-2024 1 Y (M)
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Your Right to a Safe Delivery

NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:					Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:	
	Surgery / Procedure:					Post OP Day:	
BACKGROUND	Date / Shift	28/5/26 M6					
	Medical Condition (Any special condition to be noted):	-					
	Diet:	NBM					
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Ventilation (RA, NP, NIV, VENTI):	-					
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:	97.1°F					
	Res:	32 b/m					
	SpO_2:	99%					
	Pulse:	128 b/m					
	BP:	90/62					
	LOC:	-					
	Fall Risk Score:	-					
	Pain Score:	"0"					
	Skin Integrity	Good					
Recommendations	Safety Needs:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Physiotherapy:	-					
	Others Specify:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Special Diet:	NBM					
	Critical Lab Test / Values:	-					
	Other Special Orders / Medications:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	PU Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	DVT Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	ADL (Dependent / Non Dependent):	-					
Post Operative Procedure Special Orders:		-					
Handed Over By Name :		Supreeja					
Signature / ID :							
Date:		28/5/26					
Time:		2pm					
Taken Over By Name :							
Signature / ID :							
Date:							
Time:							

VIH-00203019 IP26-00006441
Master DARSH
28-06-2024 1 Y (M)
Dr. SWAPNA PALAKURTHY

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