

DISCHARGE SUMMARY

Name	Baby SIYONA LINGAM	UHID	HNH-00008009
Father/Guardian	Mr L KRISHNASAI PRASAD	Age/Gender	1 Y 2 M 21 D/ Female
Address	5-2-63/2/A PREMAVATHI PET, Rajendra Nagar, Hyderabad, Telangana, INDIA, 500030		
IP No	IP26-00006842	Admission Date	14-07-2026
Ref Doctor	Self.		
Discharge Date	15.07.2026		

Consultant:

Dr. ANIKET ANIL PARASHAR

MBBS - MD

TSMC/FMR/08568, dr.aniket.p@rainbowhospitals.in

DIAGNOSIS	ICD CODE
ACUTE FEBRILE ILLNESS	
SIMPLE FEBRILE SEIZURE (1ST EPISODE)	

History: Baby SIYONA LINGAM, 1 Y 2 M 21 D , old girl presented with the history of fever since 1 day, 1 episode of seizure in the form of uprolling of eyeballs / generalised tonic clonic movements of lasting followed by post ictal drowsiness on the day of admission. For the above complaints, she was admitted at Rainbow Children's Hospital - Himayatnagar for further

Name	Baby SIYONA LINGAM	UHID	HNH-00008009
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management.

Examination: She was afebrile. Her heart rate was 168/min and Respiratory Rate - 36/min. Capillary Refill Time was <2 secs. Peripheries were warm & pulses well felt. On auscultation, air entry was bilaterally equal. Heart sounds were normal and there was no murmur. Abdomen was soft with no organomegaly. On neurological examination, she 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 : 7.4 kilograms.

Investigations: Enclosed reports.

VBG showed pH of 7.32, pCO₂ of 42.9 mmHg, pO₂ of 48 mmHg, HCO₃ of 21.2 mmol/L and BE of -4.0 mmol/L.

Initial hemogram showed Hemoglobin of 12 gm%, White Blood Cell count of 11820 cells/cumm, platelet count of 3.96 lakhs/cumm and C-Reactive Protein of 5 mg/l. Serum Calcium was 10.1 mg/dl. Magnesium was 2.1 mg/dl.

Management: She was admitted in the ward and started on Intra Venous fluids. She was treated symptomatically with antacids and antipyretics. She was started on febrile seizure prophylaxis with Frisium.

She was regularly monitored for fever spikes, hemodynamic & neurological status. Her fever spikes gradually settled and she had no further seizure episodes during hospital stay.

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She remained hemodynamically stable during the hospital stay and is being discharged with the following advice.

Parents were counselled regarding the nature of febrile seizures and measures to reduce fever during future febrile episodes. They were also educated regarding use of intranasal Midazolam spray for termination of future seizure episodes, if any.

At the time of discharge: She is active, afebrile and hemodynamically stable.

Medication during hospital stay:

Injection. Levetiracetam

Syrup. Clobazam

Advice:

* Diet as advised.

S.N o	MEDICATION	DOSE	TIMINGS	DURATION
1	Syrup. Clobium (Clobazam - 1ml/2.5mg)	1 ml	twice daily	For 1 day.
2	Nasoclear nasal drops, 2 drops in each nostril SOS for nose block			

Febrile Seizure Prophylaxis:

* Syrup. Crocin DS (Paracetamol = 1ml/100mg) 1ml after food as and whenever required, if temperature > 100 °F (maximum 4 times a day at 6 hour

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intervals).

* Tepid sponging if fever > 101 *F.

* Syrup. Clobium (Clobazam - 1ml/2.5mg) 1 ml twice daily for 3 days every time with fever.

* Medistat / Insed / Midacip - nasal spray (Midazolam = 1.25mg/puff), 1puff intranasal (into nostril) for future seizures..

Review consultation with Dr. ANIKET ANIL PARASHAR on Friday(17.07.2026) at Himayatnagar in OPD with prior appointment (**Review consultation will be charged**).

Food instructions while taking medications:

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

Follow up immediately in Emergency Room if high grade fever, vomiting, abnormal behavior, altered sensorium or seizure occurs.

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

Parent/ Attender

In case of emergency contact 9154865030 emergency pediatrician on duty.

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IP No	IP26-00006842	Admission Date	14-07-2026

To take appointment for OPD consultation at Rainbow **Himayatnagar / Banjara Hills / Rainbow Clinic Madhapur / Kukatpally / Vikramपुरi / LB Nagar** dial just one toll free number **18002122**.

You can also take appointments at any time by going **online** to our website **www.rainbowhospitals.in**

Dr. Archana
Registrar/Resident/C.M.O

Dr. ANIKET ANIL PARASHAR

MBBS - MD

TSMC/FMR/08568, dr.aniket.p@rainbowhospitals.in



CROSS CONSULTATION FORM

Doctor Name : Abhishek Date : 14/7/26 Time : 2pm

Diagnosis : Simple febrile seizure

Hospital : RCH - Hiran

Type of Referral :

☐ Emergency

☐ Urgent

☒ Non Urgent

Referred for : ☒ Opinion ☐ Co-Management ☐ Transfer of care

Reason for Referral : If for concurrent care specify the particular need, especially in the absence of a second diagnosis:

Signature: _____

Findings and Recommendations :

- do you : 1 day
- do YTCs type of seizure - 1st episode yesterday

? simple febrile seizures

up-rally of eyeballs
} 2 min

associated fever

walks with support

Development - Normal.

No family history of seizures

Plan

- 1) STOP lempile
- 2) 1st. clonazepam
- 3) will review in the evening

Consultant :

Name : Dr. Abhishek Signature : Dr. Abhishek Parashar Date & Time : 14/7/26 2pm

Q

P

ACTIVITY RECORD FOR BILLING

Name: ----- HNH-00008009 IP26-00006842
Baby SIYONA LINGAM
23-04-2025 1 Y 2 M 21 D (F)
 UHID No : -- Dr. ANIKET ANIL PARASHAR ----- 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
14/7/26	2:35 Am	ER	317	A.D. / [Signature]

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1.	Dr. Abhishek	14/7/26	213730	[Signature]
2.				
3.	cross checked done by. Supriya			
4.				
5.				
6.				
7.				
8.				
9.				
10.				

INVESTIGATIONS

Date	Investigations	Order No.	Sign
14/7/26	UBP, CRP, Blood U/s Calcium, Magnesium VBG	11680 11679	
14/7/26	CUE	11733	
<i>Crosschecked done by Supriya</i>			

[illegible]

Cron checked done
by Supriya

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
14/7/26	IV Placement	①	213594	
14/7/26	N+HA	①	3731	

Cross checked done
by Supriya

ANY OTHER INFORMATION

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor



PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name : HNH-00008009 IP26-00006842
Baby SIYONA LINGAM
23-04-2025 1 Y 2 M 21 D (F)
Dr. ANIKET ANIL PARASHAR

Patient ID# : 

Consultant : _____

Final Diagnosis : Simple Febrile seizures

Pediatric Multiorgan History & Physical Examination

Name: Siyona Age/Sex F / 194m
Informant mother Reliability Good

Chief Presenting Complaints & Duration (Chronologically):

c/o Fever x 1 day
c/o Abnormal movements - 1 episode - today

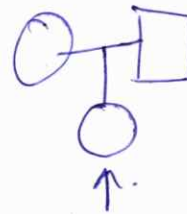
History of present illness:

insidious
Fever - Moderate grade
1 spike
not a/w rash
no h/o travel / outside food consumption
Urine ✓
oral intake ↓

Seizure 1 episode a/w stiffening of b/lk
GITCs type
- upper limb / lower limb, oprolling of eyes &
frothing
- no h/o passage of ~~urine~~ urine / stool.
- Subsided on its own

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

FT Embscs (cord ^{rocks}), Bwt-2.26,
NWJ on P4 for P_T p24 hrs.



No
F/H/O
Seizure

About Father :

About Mother :

Any additional Information :

- walks i support
- Wams Bye Bye

Immunization History :

immunised up to JULY (JULY) optional
1 year

Pediatric Multiorgan History & Physical Examination

Anthropometry

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

Weight (kgs) 7.4 kg (Centile _____)

On Examination :

Temperature : 98 F Pulse Rate: 168/min Description: regular

B.P. _____ SPO2 98% at _____

Resp. rate and type of breathing : 36/min, rhythmic

Rash NO

Lymphadenopathy NO

Oedema : NO

Respiratory system :

Inspection (any s/o distress) : normal chest shape

Air entry & breath sounds : NOBst BIAE

Any addes sounds : NO

Relevant data from outside (Chest X-Ray, ABG, etc.,) None

Cardiovascular System :

Inspection of procordium : (N) shape

Heart Sounds : S1S2+

Any murmur : NO

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

Per Abdomen :

Inspection (N) shape

Palpation : (N) tender

Ausculation : (N)

Spine: (N) External Genitalia : _____

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 : _____

B/L
Pupil RTL

Motor System :

Nutrition : _____

Tone : _____

Power _____

Co-ordinator : _____

WNL

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR

Superficials :

Plantars _____

Sensory System :

WNL

Bladder / Bowel : _____

Clinical Summary & Diagnostic :

Simple Febrile seizure

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment :

Desired goals of the treatment :

Planned Labs :

Planned Management :

cBC, CRP, COE, Blood c/s
Serum Calcium, VBG
magnesium

- INT. LEVERA 70mg IV Q 12h
- ~~PO~~ TAB. CLOBAZAM
- Paracetamol
- IVF

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. Shikha on
whose name the patient is being referred

Doctor's Signature Name Dr. Anil Parashar Date 12/7/26 Time _____

Dr. Anil Parashar
Consultant & Intensivist
568

Date & Time	Progress Notes	Doctor's Order
14/7/26	C/HB-Dr. Poarav Dr. Prashanti	
8:49 Am.	1- <u>Simple Febrile Seizure</u>	
	Fever - No Seizure - No further signs	<u>Plan</u>
O/E		1) Z-Leripid 2) Temp Cloths - 2-Song
HR - 130/min		3) Temp Lids
RR - 26/min		4) Monitor Vitals
SPO ₂ - 97%		Neuro opinion
child alert		<u>Plan</u>
R-S-B/LAB ⊕		
PIA - soft		



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
14/8/25	C/S/B - Dr. Aniket	
10:00 AM	Simple febrile seizure	
	no c/o fever	Plan
	no further seizure	- Not sure if fever
	irritable	
O/E		- Neurology opinion
vitals stable		- collect COE
S/E		
CNS - WNL		Dr. D. Aniket

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

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

Date & Time	Progress Notes	Doctor's Order
14/1/26 - 5:30pm	S/B <u>Dr. Aniket</u> Simple febrile seizure No fever spikes No further episodes of seizures c/o Rashes over face ⊕ Oral acceptance - fair. pt vitally stable pt well	<u>Advice</u> - send C/E - ct rest same
		<u>Dr. Aniket</u>

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
14/7/16 6:20 PM	S/B Dr. Abhishek Δ Simple febrile seizure No further seizures - et CLOBAZAM [up-rolling of eyeballs stiffening of upper limbs loss of consciousness 2 mins ↓ Post-ictal period of vomiting No family history	N/B Sreenidhi @ 6:30 PM
15/7/2016 7:30 AM	S/B Dr. Sreeghar / Dr. Alameen Simple Febrile Seizures No fever spikes. no further seizures oral intake - fair chest - clear P/A - soft COE (N)	Plan ① et clobazam ② w/t further fever spikes ③ Monitor vitals ④ Plan d/c N/B Supriya @ 7:30 AM (Dr. Alameen)

Date & Time	Progress Notes	Doctor's Order
15/7/26 10 AM	S/B Dr. Aniket Δ: simple febrile seizures + dehydration	15/7/26 10 AM
	fever spikes ⊖ seizures ⊖ oral acceptance good.	Adv • Discharge on midazolam spray • Lt clobazam • ⊕ blood c/s • Dietary counselling ↓ Give Diet chart.
	pt vitally stable slt wnl.	Dr. Aniket N.B. Maheshwari 15/7/26.
		Dr. Aniket Anil Parashar Consultant Pediatrician & Intensivist Pho. No. 8555

HNH-00008009 IP26-00006842

Baby SIYONA LINGAM

23-04-2025 1 Y 2 M 21 D (F)

Dr. ANIKET ANIL PARASHAR



DRUG CHART

Date of Admission: 14/7/26 Drug Allergies: ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

- GENERAL** - Ensure that all patient details are entered above. ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.
- DOCTOR** - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
- Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
 - Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
 - Discontinue a drug by drawing a line **I** through it and a similar line through subsequent recording panels.
 - The date and time of stopping the drug along with the doctors name and sign must be mentioned.
 - Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.
- NURSES** - Nurses must follow strictly the FIVE RIGHTS before administration of medication.
- 1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time
- AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

SOS / PRN (As Required Medication)

DRUG : <u>PARACETAMOL drops</u>				Date Time															
Dose <u>1 ml</u>	Route <u>PO</u>	Frequency <u>SOS</u>	Start Date <u>14/7</u>																
Doctor's Signature <u>[Signature]</u>		Valid Period	Pharm. <u>[Signature]</u>																
Additional Instructions: <u>(100mg/ml)</u>																			

DRUG : <u>MIDACIP Nasal spray</u>				Date Time															
Dose <u>0.7 mg</u>	Route <u>Nasal</u>	Frequency <u>SOS</u>	Start Date <u>14/7</u>																
Doctor's Signature <u>[Signature]</u>		Valid Period	Pharm. <u>[Signature]</u>																
Additional Instructions:																			

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

Verified by

Verified by

VERIFIED BY : Name



REGULAR PRESCRIPTIONS

Weight. 7.4kg Ward.

Verified by
Dr. Dhakshayani

Verified by
Dr. Dhakshayani

Verified by
Dr. Dhakshayani

DRUG : <u>Inj. LEVETACETAM</u>				Date Time	<u>14/7</u>															
Dose	Route	Frequency	Start Date																	
<u>70mg</u>	<u>IV</u>	<u>Q12h</u>	<u>14/7</u>	<u>6AM</u>	<u>4pm</u>															
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Parashanti</u>																				
Additional Instructions:				<u>6pm</u>																
Daily Doctor's Endorsement by a Sign				<u>6</u>																
DRUG : <u>TAB. CLOBAZAM</u>				Date Time	<u>14/7</u>															
Dose	Route	Frequency	Start Date																	
<u>2.5mg</u>	<u>PO</u>	<u>BD</u>	<u>14/7</u>	<u>6AM</u>	<u>4pm</u>															
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Parashanti</u>																				
Additional Instructions: <u>1 tab = 5mg</u> <u>(1 1/2 tabs)</u>				<u>6pm</u>																
Daily Doctor's Endorsement by a Sign				<u>6</u>																
DRUG : <u>Syr. CLOBAZAM</u>				Date Time	<u>14/7</u>															
Dose	Route	Frequency	Start Date																	
<u>1ml</u>	<u>PO</u>	<u>BD</u>	<u>14/7</u>	<u>6AM</u>	<u>4pm</u>															
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Parashanti</u>																				
Additional Instructions: <u>(2.5mg/ml)</u>				<u>6pm</u>																
Daily Doctor's Endorsement by a Sign				<u>6</u>																
DRUG :				Date Time																
Dose	Route	Frequency	Start Date																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

HNH-00005009 IP26-00006842
 Baby SIYONA LINGAM 1 Y 2 M 21 D
 23-04-2025 Dr. ANKET ANIL PARASHAR (F)



Weight. Ward.

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses

Signature

VERIFIED BY : Nani

Dr. ANIKET ANIL PARASHAR



Weight. Ward.

[illegible]

Signature: _____

VERIFIED BY : Name :

HNH-00008009 IP26-00006842
Baby SIYONA LINGAM
23-04-2026 1 Y 2 M 21 D (F)
Dr. ANIKET ANIL PARASHAR



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

BirthRight[™]
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

MEDICATION RECONCILIATION FORM

Drug Allergies: No

☐ 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: 317

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. Prasanti

Date & Time : 14/7/26 @ 2:5 AM

Nurse Name & Signature: Amritha

Date & Time : 14/7/26 @ 2:00 AM

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

HNH-00008009 IP26-00006842
 Baby SIYONA LINGAM
 23-04-2025 1 Y 2 M 21 D (F)
 Dr. ANIKET ANIL PARASHAR

317

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

BirthRight[™]
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

RESULT SHEET

Date	14/7/26				
Time					
Hb	12.0				
PCV	33.6				
RBC	4.50				
WBC	11.82				
N/L	59.9/34.4				
Platelets	396				
CRP	5.0				
ESR					
PCT					
RBS					
Na					
K					
Cl	10.1				
Ca/Mg	2.7/10.1	10.1/2.1			
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	14/7/26					
Time						
CUE - Alb						
CUE - Sugar	NIL					
CUE - Ketones	Negative					
CUE - PUS Cells	2-3					
CUE - RBC Cells	NIL					
CUE - Epithelial	1-2					
Nitrite	Negative					
Stool Pus Cell						
OVA / Cyst						
Occult Blood						

Culture and Sensitivities : Blood c/s :-

Radiology : USG :

X-Ray :

ECHO :

CT :

MRI :

Others (ECG, Contrast Studies etc.,) :

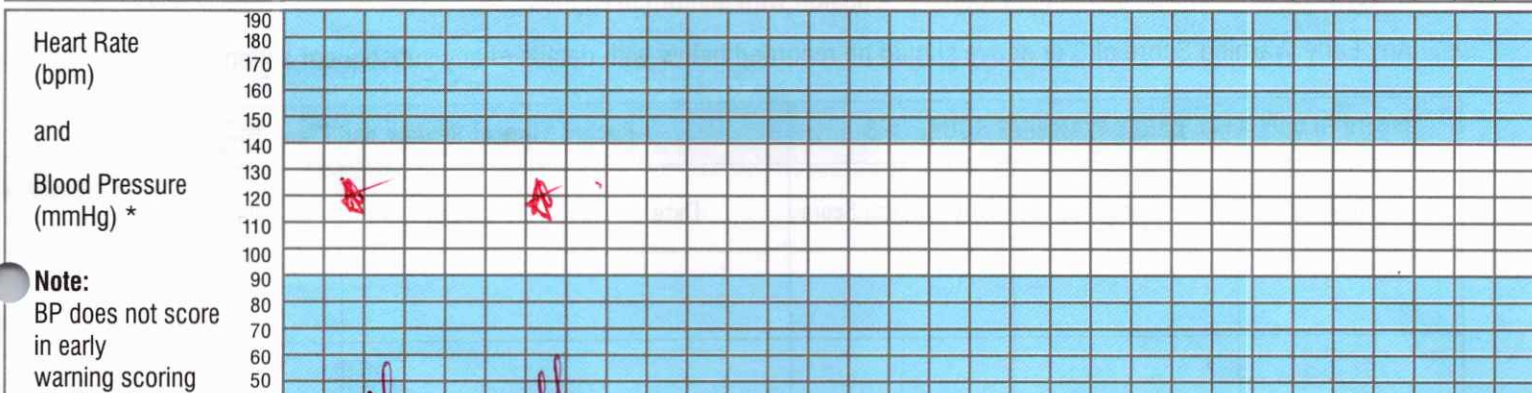
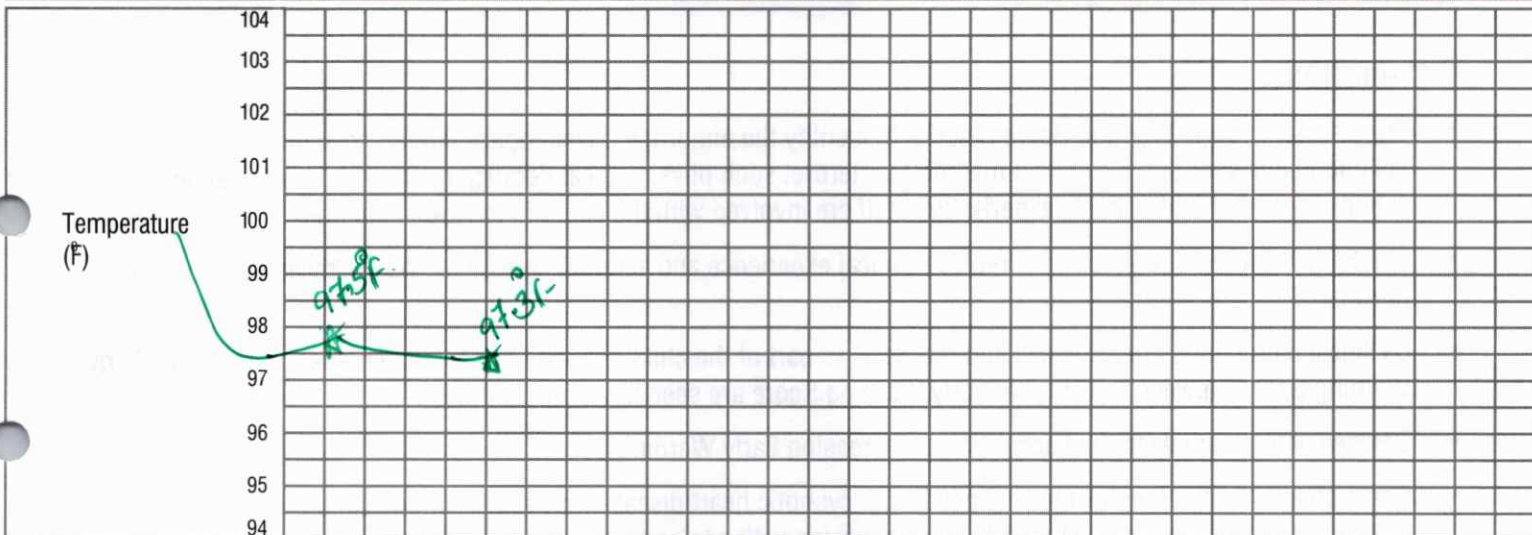


PRESCHOOL (1-5 years)
**Children's Observation &
Early Warning Scoring Chart**

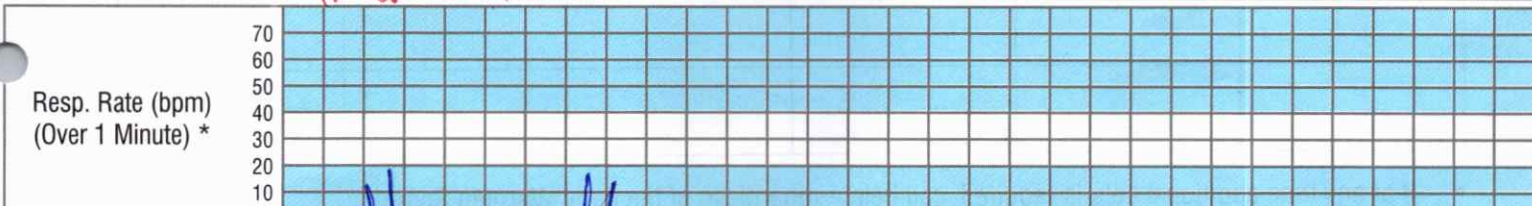
EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 14/7/20 Time: 4PM 6PM

Doctor / Nurse / Family Concern?



Heart Rate (Number)



Resp Rate (Number)

Resp Mod/ Severe Distress None / Mild

Receiving O₂(l/min)
O₂Saturations (%)

Conscious Level Normal / Altered

GCS *

TOTAL SCORE
Number of shaded boxes
Pain Score
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.

CHILDREN’S OBSERVATION
and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 14/4	Time: 10 AM	2 PM	5 PM	10 PM	2 AM	6 AM
Doctor / Nurse / Family Concern?						
Temperature (F)	98.2	98.0	98.3	98.2	98.2	97.5
Heart Rate (bpm)	128	128	129	130	128	130
Blood Pressure (mmHg) *	120/80	120/80	120/80	120/80	120/80	120/80
Resp. Rate (bpm) (Over 1 Minute) *	32	32	32	31	30	31
Resp Rate (Number)	32	32	32	31	30	31
Resp Mod/ Severe Distress	None	None	None	None	None	None
Receiving O ₂ (l/min)	100%	100%	100%	100%	100%	100%
O ₂ Saturations (%)	100	100	100	100	100	100
Conscious Level	Normal	Normal	Normal	Normal	Normal	Normal
GCS *	15	15	15	15	15	15
TOTAL SCORE	0	0	0	0	0	0
Number of shaded boxes	0	0	0	0	0	0
Pain Score	1	1	1	1	1	1
Observer's Initials	AN	AN	AN	AN	AN	AN

ACTIONS

NB: Scores 3 should be recorded overleaf

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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Patient S

CLINICAL / 125

Pratiksha TM
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HNH-00008009

IP25-0000542

P.

Baby SIYONA LINGAM

23-04-2025

Dr. ANIKET ANIL PARASHAR

1 Y 2 M 21 D

(F)



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					IV Site Thrombo- phlebitis Score	Sign. Nurse		
Date	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine				
			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 :								
14/7/20	02:00 am	DMS	milk	20ml	NA								
	03:00 am												20ml
	04:00 am												20ml
	05:00 am												20ml
	06:00 am												20ml
	07:00 am												20ml
Total Intake :					Total Output :								
Total 24 hrs. Intake		Total 24 hrs. Output											

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					IV Site	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		Thrombo-phlebitis Score
			Mouth	I.V	N.G							
14/7/26	08:00 am			20ml		/			/		0	
	09:00 am			20ml		/	✓		/		0	
	10:00 am	DNS	Milk	20ml		/			NA		0	Ⓢ
	11:00 am			20ml		/			/		0	
	12:00 pm			20ml		/	✓		/		0	
	01:00 pm			20ml		/			/		0	
Total Intake : 100ml					Total Output : 0 - 0 - 0							
14/7/26	02:00 pm			20ml		/			/		0	
	03:00 pm			20ml		/			/		0	
	04:00 pm	DNS		—		/			/	✓	0	Ⓢ
	05:00 pm			—		NA			NA	✓	0	
	06:00 pm			—		/			/	✓	0	
	07:00 pm			—		/			/	✓	0	
Total Intake :					Total Output : 0 - 2ml - 0							
14/7/26	08:00 pm					/			/		0	
	09:00 pm					/			/		0	
	10:00 pm	DNS		15ml		/			/	✓	0	
	11:00 pm			15ml		/			/		0	
	12:00 am			15ml		/			/		0	
	01:00 am			15ml		/			/		0	
Total Intake :					Total Output :							
14/7/26	02:00 am			15ml		/			/		0	
	03:00 am			15ml		/			/	✓	0	
	04:00 am	DNS		15ml		/			/		0	
	05:00 am			15ml		/			/		0	
	06:00 am			15ml		/			/	✓	0	
	07:00 am			15ml		/			/	✓	0	
Total Intake :					Total Output :							
Total 24 hrs. Intake					Total 24 hrs. Output							

HNH-00008009 IP26-00006842

Baby SIYONA LINGAM
23-04-2025 1 Y 2 M 21 D (F)

Dr. ANIKET ANIL PARASHAR



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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					IV Site Thrombo- phlebitis Score	Sign. Nurse			
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine					
			Mouth	I.V	N.G										
15/4/25	08:00 am					NA		NA		✓		(M)			
	09:00 am														
	10:00 am	o	zdy												
	11:00 am		ntk												
	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

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					IV Site Thrombo- phlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			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



NURSING CARE RECORD

Date: 13/7/25

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	3AM	Assess the pt. condition - Monitor vitals & records - Maintain I/O chart - Give Medication as prescribed by doctor	3AM	Assessed the pt condition - Monitored vitals & records - Maintained I/O chart - Given medication as prescribed by doctor	Baby is Stable now	Re-checked vitals	

HNH-00008009 IP26-00006842
 Baby SIYONA LINGAM
 23-04-2025 1 Y 2 M 21 D (F)
 Dr. ANIKET ANIL PARASHAR



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NURSING CARE RECORD

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Date: 17/5/24

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 to 2pm	→ Assess the pt condition → monitor vital & record → Maintain I/O chart → Administer medication as per drug chart	8am to 2pm	→ Assessed the pt condition → monitor vital & record → Maintained I/O chart → Administered medication as per drug chart	⇒ Pt is stable	⇒ Rechecked vital	
Afternoon	2pm to 8pm	- Assess the pt condition - Monitor the v/s - Maintain the I/O - Drug as per chart	2pm to 8pm	- Assess the pt condition - Monitor the v/s - Maintain the I/O - Drug as per chart	- Now pt is stable	- Rechecked the v/s	
Night	8pm to 8am	→ Assess the pt condition - Monitor vital & I/O → drug as per chart → provide comfortable position		→ Assessed the pt condition - Monitored vital & I/O chart → drug as per chart → provided comfortable position	pt is stable	Rechecked vital	

HNH-00008009
 Baby SIYONA LINGAM
 23-04-2025 1 Y 2 M 21 D (F)
 Dr. ANIKET ANIL PARASHAR

IP26-00006842

NURSING CARE RECORD

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Date: 15/2/25

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8Am	→ Assess the pt condition. → Monitor the vitals. → Maintain I/O chart. → drugs give as per drug chart.	8Am	→ Assesed the pt condition. → Monitored the pt vitals. → Maintained I/O chart. → drugs given as per drug chart.	→ pt is stable Now.	→ Reassessed the vitals.	(Signature)
Afternoon	2pm		2pm				
Night							

Patient Sticker

NURSING CARE RECORD



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							

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☒ No ☐ Not Known				
	<i>Acute Simple febrile Seizures</i>		If Yes Specify:				
BACKGROUND	Area	Shift Time	13/7 N1	14/7 M6	14/7 E2	14/7 N1	15/7 M6
	Medical Condition (Any special condition to be noted):		-	-	-	-	-
ASSESSMENT	Allergy:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Tubes/Drains/Catheter:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:	Temp:	97.8°F	98.5°F	98.3°F	98.4°F	98.1°F
	Res:	28b/m	28b/m	28b/m	29b/m	28b/m	
	SpO ₂ :	100%	100%	99%	99%	100%	
	Pulse:	138b/m	146b/m	142b/m	140b/m	125b/m	
	BP:	-	-	-	-	-	
	Fall Risk Score:	-	-	-	-	-	
Recommendations	Pain Score:	-	-	-	-	-	
	Safety Needs:	-	-	Yes	Yes	Yes	
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:	-	-	-	-	-	
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
Other Special Orders / Medications:		-	-	-	-	-	
Post Operative Procedure Special Orders:		-	-	-	-	-	
Handed Over By Name :		Priyanka	Surekha	Suranda	Chitra	Mahi	
Signature :		<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	
Date:		14/7/26	14/7/26	14/7/26	15/7/26	15/7/26	
Time:		8AM	8AM	8PM	8AM		
Taken Over By Name :		Surekha	Suranda	Agny	Mahi		
Signature :		<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>		
Date:		14/7/26	14/7/26	14/7/26	15/7/26		
Time:		8AM	2PM	8PM	8AM		

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							
	Medical Condition (Any special condition to be noted):							
ASSESSMENT	Allergy:	☐ 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	
	Vital Signs:	Temp:						
		Res:						
		SpO ₂ :						
		Pulse:						
		BP:						
		Fall Risk Score:						
	Pain Score:							
	Recommendations	Safety Needs:						
Physiotherapy		☐ 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	
Other Special Orders / Medications:								
Post Operative Procedure Special Orders:								
Handed Over By Name :								
Signature :								
Date:								
Time:								
Taken Over By Name :								
Signature :								
Date:								
Time:								



BRADEN 'Q' SCALE

					Date :	13/7	14/7	14/7	14/7
					Time :	10	10	10	10
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	7
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.		4	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	27
					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

HNH-00008009
Baby SIYONA LINGAM
23-04-2025 1 Y 2 M 21 D
Dr. ANIKET ANIL PARASHAR (F)

BRADEN 'Q' SCALE

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					Date : 15/2			
					Time : mo			
Mobility	Very 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.	3			
"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.	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			
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.	4			
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4			
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	3			
					TOTAL SCORE	95		
					Evaluator's Name	(Signature)		

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
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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

CHECKLIST FOR THROMBOPHLEBITIS

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

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

Signature of Shift In Charge :

Signature : [Signature] Name : [Name]

Signature of Ward In Charge :

Signature : [Signature] Name : [Name]

Patient Sticker

CHECKLIST FOR THROMBOPHLEBITIS

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

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

Signature of Shift In Charge :

Signature of Ward In Charge :

Signature : Name :

Signature : Name :

PAIN ASSESSMENT FORM

Date	Time	Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
14/7/26	6 AM	0/10	NA	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☒ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	NA	P
14/7/26	10 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	SW
14/7/26	2 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	CA
14/7/26	10 PM	0/10	NA	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☒ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	NA	P
15/7/26	2 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	CA
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

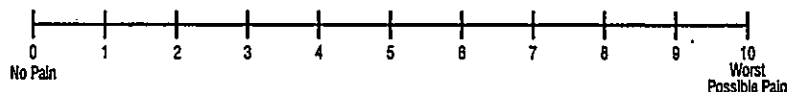
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

Numerical Pain Scale (Obstetric and Gynecology)



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

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

Wong - Baker (Pediatrics) Above 7 Years



0
No Hurt

2
Hurts Little Bit

4
Hurts Little More

6
Even More

8
Hurts Whole Lot

10
Hurts Worst

PATIENT TRANSFER FORM

Patient Name & UHID No. HNH-00008009 IP26-00006842 Baby SIYONA LINGAM 23-04-2025 1 Y 2 M 21 D (F) Dr. ANIKET ANIL PARASHAR 		Date & Time of Admission 14/7/26 @ 2:8 Am	Date & Time of Transfer Order 14/7/26 @ 3:0 Am
		Transfer Ordered by Dr. Prasant	Reason for Transfer Admission
From Unit ER	To Unit 317	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 01	Number of Imaging Films 1	Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring Anupam		Name of Person Ordered Transfer Dr. Prasant	
Patient & Clinical Records Received by : Siyanka			
Date & Time of Patient Received : 14/7/26 @ 3:30 Am			

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-00008009 IP26-00006842

Baby SIYONA LINGAM
23-04-2025 1 Y 2 M 22 D (F)
Dr. ANIKET ANIL PARASHAR



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NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 14/7/26 Time: 11:25 AM

Weight: 7.4 kg Centile: 5th

Height: Centile:

Inference: underweight child

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

Diet Recommendations: Normal soft diet

Re-Assessment: Avoid spicy, chilled & outside foods

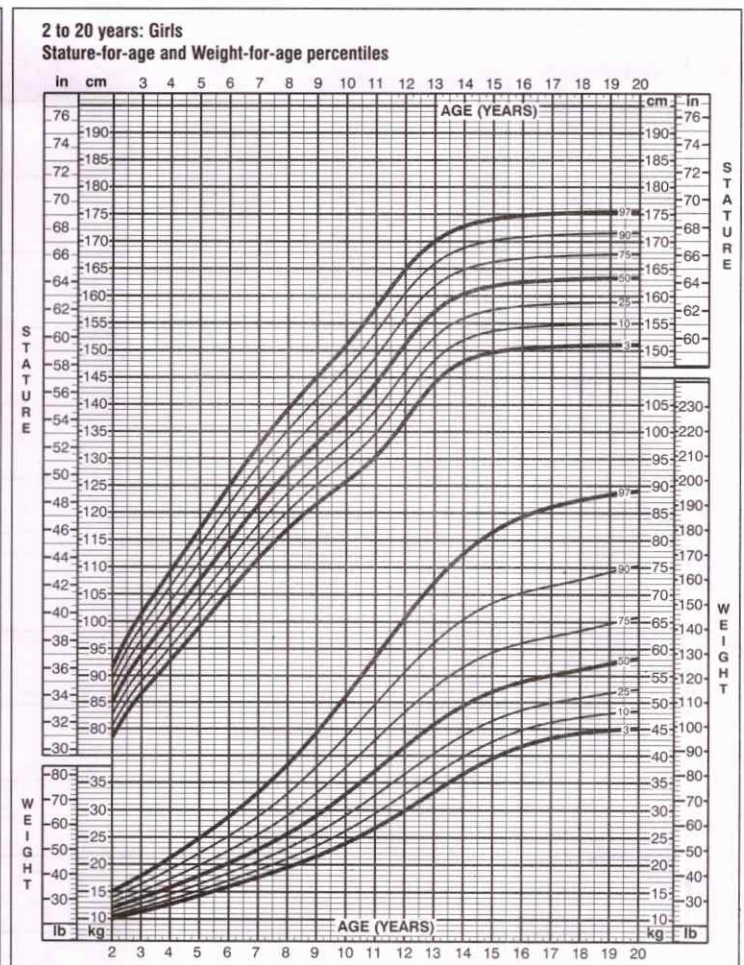
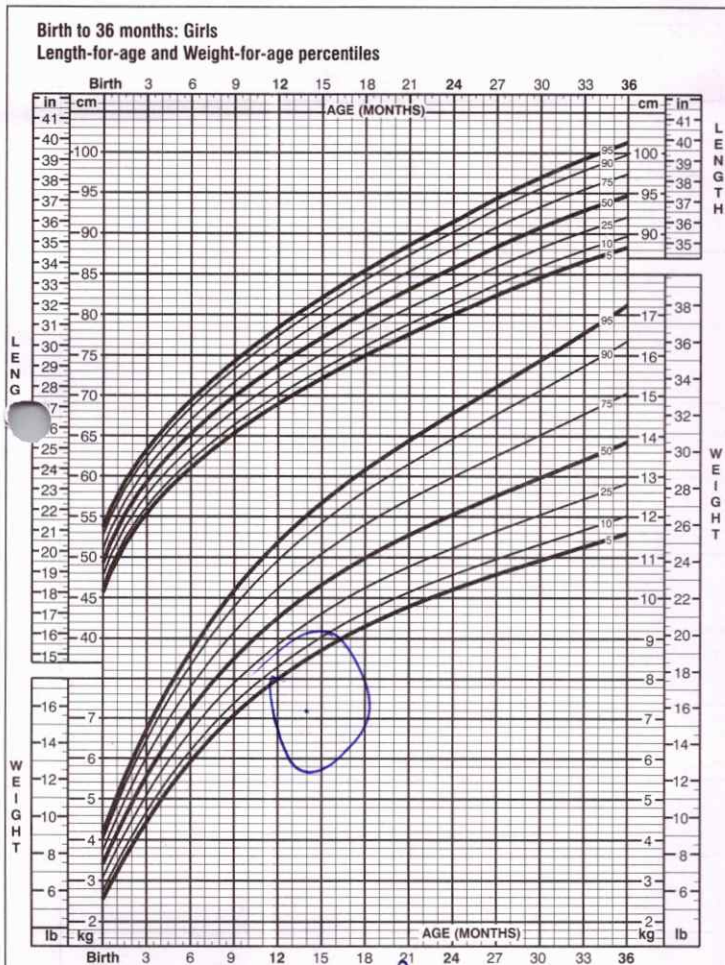
Food Allergies: NO Veg/Non-veg: Non-veg.

Diagnosis: Simple febrile seizures

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: [Signature]

GROWTH CHART (GIRLS)



Dietician's Name: Sathwika-G Dietician's Signature: [Signature]

[illegible]



Urocin Drop Given by 12Am

wt-74kg

EMERGENCY ROOM TRIAGE FORM

Patient's Name : SiYona Lingam Age : 1y 4m Gender: ☐ Male ☒ Female

Date : 14/7/26 Time of Arrival : 1:50AM

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: 99 PR: 127 BP: RR: SpO₂: 97

Chief Complaints: clonic seizure activity by 12:15 Am

INITIAL PHYSIOLOGICAL CATEGORIZATION		INITIAL PHYSIOLOGICAL STATUS
Appearance ☒ Normal ☐ Sick Looking	Work of Breathing ☒ Normal ☐ Increased ☐ Decreased ☐ Gasping / Apnea	☒ Stable ☐ Unstable : ☐ Not - Life - Threatening ☐ Life -Threatening
Circulation / Colour ☒ Normal ☐ Abnormal ☐ Bleeding		

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: [Signature]
 Triage Completion Time : 1:52AM

Communicable Disease Triage Screening

PART A. The following questions should be asked to all patients at the initial screening:

- Have you had fever (elevated temperature) in the past 2 weeks ☐ Yes ☒ No
- Have you had cough or a rash in the past 2 weeks ☐ Yes ☒ No
- 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

- 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:
- 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 : Amulya

Signature of Triage Nurse : [Signature]

Date & Time : 14/7/26 @ 1:55AM

HNH-00008009
Baby SIYONA LINGAM
23-04-2026 1 Y 2 M 21 D
Dr. ANIKET ANIL PARASHAR (F)

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 14/8/26 Time of arrival : 1:58 AM
Chief Complaints : Seizure Activity b/w 12 PM
Height : Weight : 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 ☐ Yes ☒ No

If 'Yes' tick below fall risk intervention directly

If Patient is > 6 years

If 'Yes' 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 : 1:58 AM

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

Time	Nursing Notes
	Assessed the patient condition
	vital checked.

Samples collected by:

Samples sent by :

Time:

Time:

Medication given in ER:

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

Condition of patient at time of shift - out :	Details of Shift - out
HR: 127 BP: CFT: -	Shift - out from ER to: 317
RR: 26 SPO2 at FiO2: 98	Time of Shift - out: 3:20 PM
GCS: 15/15 Temperature :	Handover given to: Priyanka
Pain Score: 2	(Nurse's Name)
Repeat RBS (if applicable): NO	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any):

Name of the Nurse : Anurupa

Signature of the Nurse : Anurupa

Date & Time : 14/11/2020 @ 2:20 PM