DISCHARGE SUMMARY

Name	Master THASVIK PANDURI	**UHID**	HNH-00007273
Father/Guardian	Mr VEERABHADRA PANDURI	**Age/Gender**	1 Y 3 M 6 D/ Male
Address	H.NO: 1-8-701/2/1 PADMA COLONY, Nallakunta, Hyderabad, Telangana, INDIA, 500044		
IP No	IP26-00006417	**Admission Date**	24-05-2026
Ref Doctor	self		
Discharge Date	27.05.2026		

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

DIAGNOSIS	**ICD CODE**
ADENOVIRAL ILLNESS	
E.COLI - URINARY TRACT INFECTION	

History: Master THASVIK PANDURI, 1 Y 3 M 6 D , old boy presented with history of cold and fever since 4 days, loose stools since 2 days, decreased urine output, decreased oral intake prior to admission. For the above complaints he was admitted at Rainbow Children's Hospital - for further management.

Name	Master THASVIK PANDURI	UHID	HNH-00007273
IP No	IP26-00006417	Admission Date	24-05-2026

Examination: He was febrile(103*F). His heart rate was 125/min and Respiratory Rate - 30/min. Capillary Refill Time was <2 secs. Peripheries were warm & pulses well felt. On examination Signs of dehydration were present, dry lips, dull looking, decreased urine output, sunken eyes were present. On auscultation, air entry was bilaterally equal were present. Heart sounds were normal and there was no murmur. Abdomen was soft with no organomegaly. On neurological examination, he was conscious and alert. Pupils were bilaterally equal and reacting to light. There were no focal neurological or cranial nerve deficits. There were no signs of raised intracranial pressure.

Weight on admission: 7.93 kilo grams.

Investigations: Enclosed reports.

VBG showed pH of 7.32, pCO2 of 36.9 mmHg, pO2 of 31 mmHg, HCO3 of 18.3 mmol/L and BE of -6.7 mmol/L.

Adenovirus PCR was detected.

Initial hemogram showed Hemoglobin of 11.6 gm%, White Blood Cell count of 6870 cells/cumm, platelet count of 1.53 lakhs/cumm and C-Reactive Protein of 20.0 mg/l. Complete urine examination was normal.
Blood culture shows : No growth after 24 hrs of incubation

Urine culture shows:
Gross examination : Pale yellow in colour, clear.
Gram stained smear - Shows no polymorphs or organisms.
Colony count: - 10^4cfu/ml
Culture : - E. coli isolated.
Susceptible to –

Gentamicin, Amikacin, Tobramycin, Sulfamethoxazole-Trimethoprim, Trimethoprim and Nitrofurantoin.
Resistant to –
Ampicillin, Amoxycillin-Clavulanic acid, Ampicillin-sulbactam, Cephalexin, Cefuroxime, Cefotaxime, Ceftriaxone, Ceftazidime, Ceftizoxime, Cefoperazone, Cefpodoxime, Cefepime, Cefixime, Cefoxitin, Ticarcillin-Clavulanic Acid, Tazobactam- Piperacillin, Ciprofloxacin, Ofloxacin, Levofloxacin, Moxifloxacin, Norfloxacin, Nalidixic acid, Piperacillin and Aztreonam.
ESBL + Inducible AmpC producer.

Chest X-ray shows:
Rotation noted to left side.
There are increased perihilar and peribronchial markings bilaterally, in keeping with lower respiratory tract inflammatory changes. Retrocardiac atelectatic changes noted.

Management: He was admitted in the ward and was started on Intra Venous fluids and Intra Venous antibiotics. He was treated symptomatically with antacids and antipyretics. In view of loose stools, he was given probiotics and zinc.

Infective workup was done reports suggestive of adenoviral illness and also urine routine showed significant pus cells for which urine culture was sent .

In view of urine culture showed ECOLI growth , susceptable antibiotics were continued .

He was regularly monitored for fever spikes, hemodynamic status. His fever spikes and other symptoms gradually settled. Child maintaining saturations on

Name	Master THASVIK PANDURI	UHID	HNH-00007273
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room air.

He remained hemodynamically stable during the hospital stay. He improved with the above line of management and is being discharged with the following advice.

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

Medication during hospital stay:
Injection. Ceftriaxone
Syrup. Crocin DS
Pro-GG sachet
Z & D drops
Mucolite drops

Advice:
* Diet as advised.

Name	Master THASVIK PANDURI	UHID	HNH-00007273
IP No	IP26-00006417	Admission Date	24-05-2026

S.No	MEDICATION	DOSE	TIMINGS	DURATION
1	Syrup. SEPTRAN DS (Trimethoprim + Sulphmethoxazole-80mg)	2 ml	8am - 8pm (after food)	For 5 days.
2	Mucolite Drops	1 ml	9am-9pm (after food)	For 3 days
3	Pro-GG SACHET	1 SACHET	9am-9pm (after food)	For 3 days
4	Z & D drops (1ml/20mg)	1 ml	9am (after food)	For 10 days
5	Nasoclear nasal drops, 2 drops in each nostril **SOS** for nose block			

Plan:
*** To repeat complete urine examination on followup.**
*** To do MCUG later.**

Fever Management
* Syrup. Crocin DS (Paracetamol - 5ml/240mg) 2.5 ml after food as and whenever required, if temperature > 100 *F (maximum 4 times a day at 6 hour intervals).
* Tepid sponging if fever > 101 *F.

Review consultation with Dr. ANIKET ANIL PARASHAR on Monday (01.06.2026) at Himayatnagar in OPD with prior appointment **(Review consultation will be charged)**.

Name	Master THASVIK PANDURI	UHID	HNH-00007273
IP No	IP26-00006417	Admission Date	24-05-2026

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.
* By consuming your **probiotic** with food you provide a buffering system for the supplement and ensure its safe passage through the digestive tract. Aside from protection, food also provides the friendly bacteria in your probiotic the proper food and nourishment to ensure it survives, grows and multiplies in your gut. It is recommended to take probiotics at the END of a meal. Concurrent administration of antibiotics could kill a large number of the organisms, reducing the efficacy of probiotics. Separate administration of antibiotics from probiotics by **atleast two hours.**

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

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

Parent/ Attender

In case of emergency contact 9154865030 emergency pediatrician on duty.

To take appointment for OPD consultation at Rainbow **Banjara Hills /** Rainbow Clinic **Madhapur / Kukatpally / Vikrampuri / LB Nagar /** dial just one toll

Name	Master THASVIK PANDURI	UHID	HNH-00007273
IP No	IP26-00006417	Admission Date	24-05-2026

free number **18002122.**
You can also take appointments at any time by going **online** to our website **www.rainbowhospitals.in**

Registrar/Resident/C.M.O

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

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 : IP26-00006417 **Admit Date** : 24-May-2026 **Admit Time** : 11:44 AM **UHID** : HNH-00007273

Patient Details :

Patient Name	: Master THASVIK PANDURI	**Age**	: 1 Y 3 M 5 D
Guardian	: Mr VEERABHADRA PANDURI	**DOB**	: 19-02-2025 12:44 PM
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	: Single
Address (H)	: H.NO: 1-8-701/2/1 PADMA COLONY Nallakunta Hyderabad Telangana INDIA 500044	**Phone No**	: 9666460095/ 9010856710
		E-mail	: SWATHI.GP1991@GMAIL.COM

..nission Details :

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

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

Contact Details :

Name	: Mr VEERABHADRA PANDURI	**Relationship**	: Father
Contact Address	: H.NO: 1-8-701/2/1 PADMA COLONY Nallakunta Hyderabad Telangana INDIA 500044	**Phone No**	: 9666460095

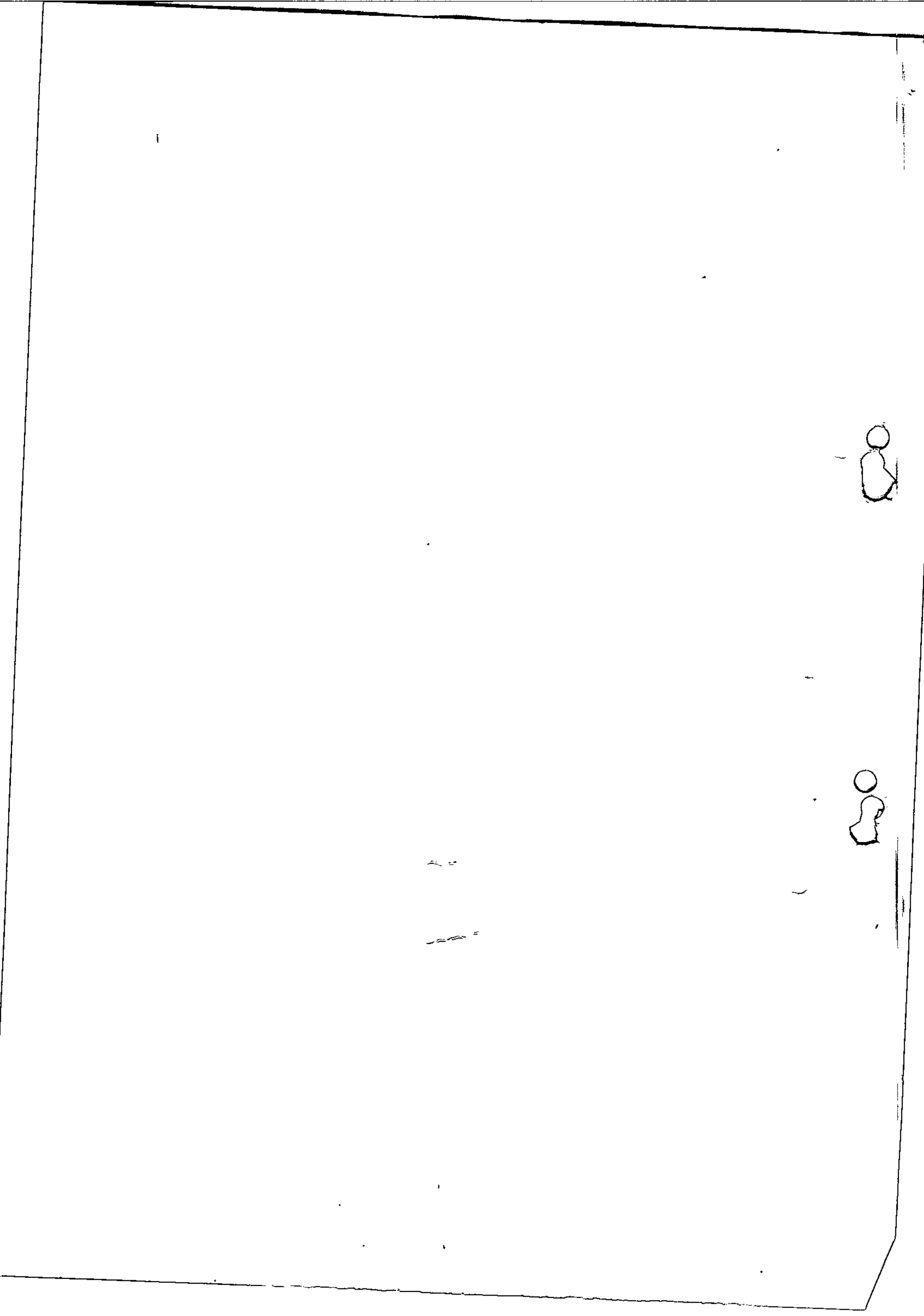
Signature

..or Details :

Doctor Name	: Dr. ANIKET ANIL PARASHAR	**Specialisation**	: GENERAL PEDIATRICS
Referral Doctor	: self	**Phone No**	:
Co-Consultant	:		

Payment Details :

		Deposit Amount	: 10000.00
Payment Mode	: DC/CC Card	**Payor Name**	: MEDI ASSIST INSURANCE TPA PVT LTD



ACTIVI[...]NG

HNH-00007273 IP26-00006417
Master THASVIK PANDURI
19-02-2025 1 Y 3 M 5 D (M)
Dr. ANIKET ANIL PARASHAR

Name: - --

UHID No : -------- ------------ Consultant : ------------------------ Dept : pediatric

Date of Admission : 24/5/26 Time : -------------- Date of Discharge : ---------------- Time: -----------

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
24/5/26	1:30pm	ER	ward	Bhargavi / 8

Cross Consultation Visit

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

HNH-00007273 IP26-00006417
Master THASVIK PANDURI
19-02-2025 1 Y 3 M 5 D (M)
Dr. ANIKET ANIL PARASHAR

INVESTIGATIONS

Date	Investigations	Order No.	Sign
24/5/26	CXR (AP)	6301	
	VBG	8763	[signature]
	CBP, CRP, Adenovirous PCR	8762	
24/5/26	Blood c/s	8774	[signature]
24/5/26	CUE, Urine culture	8776	[signature]
			done
	Cross checked by Sneha		
	Cross checked by Monika @ 12 AM, 26/5/26		

HNH-00007273 IP26-00006417
Master THASVIK PANDURI
19-02-2025 1 Y 3 M 5 D (M)
Dr. ANIKET ANIL PARASHAR

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
24/5/26	Infusion pump	24/5/26 @3pm	26/5/26 @8Am	1870	[illegible]

Cross checked done by Sneha

Cross checked by Mounika @ 12AM, 26/5/26

HNH-00007273 IP26-00006417
Master THASVIK PANDURI
19-02-2025 1 Y 3 M 5 D (M)
Dr. ANIKET ANIL PARASHAR

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
24/5/26.	Iv placement	01	201803	[signature]
24/5/26	NHA	1	1871	[signature]
	cross checked by [illegible] @ 12AM 26/5/26			

Cross checked done DM [illegible]

ANY OTHER INFORMATION

Date :
Time :
Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

Ref.No. F/IN/PR/10

PEDIATRIC IN-PATIENT MEDICAL RECORD

HNH-00007273 IP26-00006417
Master THASVIK PANDURI
19-02-2025 1 Y 3 M 5 D (M)
Dr. ANIKET ANIL PARASHAR

Patient Name : Master Pandusi Thasvik

Patient ID# :

Consultant :

Final Diagnosis :

HNH-00007273 IP26-00006417
Master THASVIK PANDURI
19-02-2025 1 Y 3 M 5 D (M)
Dr. ANIKET ANIL PARASHAR

Pediatric Multiorgan History & Physical Examination

Name : ______________________ Age

Informant ______________________ Reliability ______

Chief Presenting Complaints & Duration (Chronologically):

c/o fever since 4 days.
c/o cold since 4 days.
c/o loose stools since 2 days.
c/o decreased urine output & decreased oral Intake

History of present illness :

- Child presented to ERMD ī c/o fever since 4 days high grade persistant fever spikes. a/w rigors & not a/w rash not relieving c̄ medication.

- c/o cold since 4 day. a/w nasal discharge not a/w fast breathing / retraction.

- c/o loose stools since 2 days multiple Episodes, watery in Consistency. non mucoid / Not blood stained.

- c/o decreased urine output / decreased oral Intake

- c/o decreased activity

Pediatric Multiorgan History & Physical Examination

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

—

Birth & Neonatal History :

—

Birth & Socio Economic History :

About Father :

About Mother : Not Significant

Any additional Information :

Developmental History :

Appropriate

Immunization History :

Upto date

HNH-00007273 IP26-00006417
Master THASVIK PANDURI
19-02-2025 1 Y 3 M 5 D (M)
Dr. ANIKET ANIL PARASHAR

Pediatric Multiorgan History & Physical Examination

Anthropometry

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

Weight (kgs) 7.93 kg (Centile ____________)

On Examination :

Temperature : 103°F Pulse Rate: ____________ Description ____________

B.P. ____________ SPO2 98% at ____________

Resp. rate and type of breathing : ____________

Sunken Eyes

Rash dry lips

Lymphadenopathy dull look

Oedema : decreased o/o

Respiratory system :

Inspection (any s/o distress) : ____________

Air entry & breath sounds : Sidz (+)

Any addes sounds : NVBS (+)

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

Cardiovasclular System :

Inspection of procordium : ____________

Heart Sounds : Sidz (+)

Any murmur : No

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

Per Abdomen :

Inspection ____________

Palpation : Soft Not distended

Ausculation : No organomegaly,

Spine: ____________ External Genitelia : ____________

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

Pediatric Multiorgan History & Physical Examination

HNH-00007273 IP26-00006417
Master THASVIK PANDURI (M)
19-02-2025 1 Y 3 M 5 D
Dr. ANIKET ANIL PARASHAR

Central Nervous System :

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

Cranial Nerves : (N)

Motor System :

Nutrition : (N)

Tone : Power

Co-ordinator :

Posture :

Involuntary Movements :

Reflexes :

DTR **Superficials :**

Plantars (N)

Sensory System :

(N)

Bladder / Bowel :

Clinical Summary & Diagnostic :

AFI c̄ dehydration
? UTI.

Pediatric Multiorgan History & Physical Examination

HNH-00007273 IP26-00006417
Master THASVIK PANDURI (M)
19-02-2025 1 Y 3 M 5 D
Dr. ANIKET ANIL PARASHAR

Preventive aspects of the treatment :

Prevent hypovolemia shock.

Desired goals of the treatment :

Planned Labs :

Send.
- CUE, U/c/s.
- CBP, CRP, B/c/s
- CXR
- VBG.
- Adenoviral PCR
- 1 Extra plain Sample

N.B
Apurba

Planned Management :

- IV fluids. (2/3 M).
- Inj CEFTRIAXONE
- PROG 9 sachet.
- Z&D drops.
- ORS sachet
- CROSIN DS Q6hly.
- IBUGESIC (SOS)
- Monitor vitals

N.B
Apurba

Please fill up the following details

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

Doctor's Signature Name ______ Date ______ Time ______

HNH-00007273 IP26-00006417
Master THASVIK PANDURI
19-02-2025 1 Y 3 M 5 D (M)
Dr. ANIKET ANIL PARASHAR

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	C/O/B - Dr. [illegible] / [illegible]	
24/5/26 3pm		
	Case of acute febrile illness c dehydration	
		Advise:-
	No fever spikes.	(I) Trace Cultures Trace reports
	O/e -	(II) Continue Antibiotics.
	Vitals stable	
	S/e CVS - S1S2 RS - B/L NVBS P/A - soft.	[signature]

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	C/S/B - Dr. Alethya	
25/5/26 9am		
	AFI c̄ dehydration	
	Case of acute febrile illness	Advise:-
		1) Continue Antibiotics
	Fever spikes - No. Oral intake fair.	
	O/E - Vitals stable.	ii) Trace Culture Adenovirus.
		iii) Monitor vitals
	S/E	
	CVS - S1S2	If taking Breakfast 7
	RS - BLAE NVBS	Change to 10ml/h IV fluids.
	P/A - Soft.	[signature]
		NB Sneha 9am

HNH-00007273 IP26-00006417
Master THASVIK PANDURI
19-02-2025 1 Y 3 M 5 D (M)
Dr. ANIKET ANIL PARASHAR

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	c/s/by. Dr Aniketh	
20/5/26 10Am.	AFI c̄ dehydn	
	No fever	
	vital stal	Plan
	S/E NAD	– ct Antibiotics
		– (T) culture
		Adenovirus.
		– Monit vitals.
		– ct 1/2 M IV fluids.
	[signature]	

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
25/5/26 2PM	S/B Dr. Sneghan	
	DAFI ē dehydration	Plan
		~~Trace Adenovirus PCR~~
	CVS - S1 S2 ⊕	
	RS - B/L AE ⊕	~~- IV fluids @ 16ml~~
	P/A - soft	~~- Encourage orally~~
	(Tonsilitis)	
		D.B Amrutha c 2pm
25/5 5:30pm	C/S/B Dr Aniket	
	AFI ē Dehydration	
	UTI (Culture +ve)	
		Plan
	Fever ↓	1) Track { Adeno Virus; Urine c/s
	Oral intake - less	
		2) Inj Ceftriaxone
	Child alert	3) Crocin - SOS
	Vitals stable	4) Taper & Stop IVF
	R-S - B/L AE ⊕	5) Monitor Vitals
	P/A - Soft	6) Encourage orally
		Dr. Aniket

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

noted by Sr. sandhya. 25/5/26 @ 5:30pm

HNH-00007273 IP26-00006417
Master THASVIK PANDURI
19-02-2025 1 Y 3 M 5 D (M)
Dr. ANIKET ANIL PARASHAR

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	C/S/B:	
26/5 8am	C/S/B Dr. Pranav / Dr. Varun	
	Adenoviral illness & Culture +ve UTI	
		Plan
	Fever - ...	1) Trace Urine C/S
	Oral intake - Fair (OBF)	2) Inj Ceftriaxone
		3) Crocin - SOS
	Urine - Passing	4) IVF - Stop
	loose stools - 2 e/o (watery).	5) Encourage orally
	Vitals stable	6) Monitor Vitals
	Afebrile	NB Sneha @ 8Am
	R-S - B/L AE ⊕	
	P/A - Soft	
		Ph
	Blood c/s - 24 hr No growth	

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

(P.T.O)

HNH-00007273 IP26-00006417
Master THASVIK PANDURI
19-02-2025 1 Y 3 M 6 D (M)
Dr. ANIKET ANIL PARASHAR

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	C/s/b Dr. Aniket	
26/5/25 10AM	Admitted illness c̄ further treat	
	- fever abs.	
	- 2 e/o loose stools.	Plan - Treat urine c/s.
	- Oral intake - fair	- Encourage orally.
	R/E - Vitals stable.	- Ct. ceftriaxone.
	S/E - NAD.	- Stop IVF.
		- Prolyte ORS for each c/o stool.
		Dr. Aniket
	Dr. Aniket Anil Parashar Consultant Pediatrician & Intensivist Reg. No: 8568	N.B Amrutha @ 10AM.

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

HNH-00007273 IP26-00006417
Master THASVIK PANDURI
19-02-2025 1 Y 3 M 6 D (M)
Dr. ANIKET ANIL PARASHAR

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
26/5/26 2pm	CMB Dr. Pranav	
	Adenoviral others c cls (+)ve UTI	
	- no fever spikes.	
	- 2 episodes of loose stools.	
	- oral intake - good.	Plan
		1) trace urine cls
	vitals : stable	2) ct. ceftriaxone
	S/E - normal.	3) ct. supportive care
	[signature]	4) monitor vitals.
		N.B Amruth c 2pm.

HNH-00007273 IP26-00006417
Master THASVIK PANDURI
19-02-2025 1 Y 3 M 6 D (M)
Dr. ANIKET ANIL PARASHAR

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
26/5/26 5pm	c/s/b - Dr. Aniket	
	Adenoviral illness	
	c Culture	Advise:
	+ve UTI	
	U/C - +ve for E.coli	
	No fever spikes.	(1) Continue Ceftriaxone
	2 loose stools Episodes	
	Oral intake - good.	(ii) ~~[illegible]~~
	Cough - (+)	
	O/e -	
	Vitals stable	(iii) Mucolite drops 1ml BD.
	S/e	
	CVS - S1S2	(iv) ~~Levolin [illegible] 0.2mg~~
	RS - BLNVBS	
	P/A - Soft	(v) Switch to oral Antibiotic on discharge
		noted by Supriya @ 5pm
		SO: Dr. Aniket P

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

HNH-00007273 IP26-00006417
Master THASVIK PANDURI
19-02-2025 1 Y 3 M 6 D
Dr. ANIKET ANIL PARASHAR (M)

ESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
27/[illegible] 8 Am.	S/B Dr Prabhath / Dr Sucheth. Δ Adenoviral illness c̄ Culture (+) UTI. Urine c/s (−) for E. coli. fever — None. Loose stools — ↓ Oral intake — fair Cough — ↓ O/E Vitals stable S/E CVS S1S2 + CNS C/NL RS BAE+ PA soft. [illegible] C/r/s - Dr. Aniket	Adv 1) Ct. Ceftriaxone. 2) Mucolite 1ml TID. ~~3) Levoli 0.5mg Q8H.~~ 4) Switch to Oral antibiotic on d/c
	Afebrile Loose stools ↓ Hydration - good Hemodynamically stable	Adv Discharge on oral septran x 5 days & follow up after 5th day with CUG on followup Repeat Dr Aniket Anil Parashar Consultant Pediatrician & Intensivist Reg. No. 8568 [signature]

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

HNH-00007273 IP26-00006417
Master THASVIK PANDURI
19-02-2025 1 Y 3 M 6 D (M)
Dr. ANIKET ANIL PARASHAR

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

(P.T.O)

HNH-00007273 IP25-00008417
Master THASVIK PANDURI
19-02-2025 1 Y 3 M 6 D (M)
Dr. ANIKET ANIL PARASHAR

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

HNH-00007273 IP26-00006417
Master THASVIK PANDURI
19-02-2025 1 Y 3 M 7 D (M)
Dr. ANIKET ANIL PARASHAR

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

HNH-00007273 IP26-00006417
Master THASVIK PANDURI
19-02-2025 1 Y 3 M 5 D (M)
Dr. ANIKET ANIL PARASHAR

RESULT SHEET

Date	24/5					
Time						
Hb	11.6					
PCV	32.4					
RBC	4.23					
WBC	6.87					
N/L	28.2/63.7					
Platelets	153					
CRP	20					
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	24/5/26					
Time						
CUE-Alb	Nill					
CUE-Sugar	Nill					
CUE - Ketones	Negative					
CUE-PUS Cells	3-5					
CUE - RBC Cells	Nill					
CUE – Nitrite	Negative					
Epithelial Cells	2-3					
Stool Pus Cell						
OVA/Cyst						
Occult Blood						
Adeno Virus	Detected					

Culture and Sensitivities : Blood culture – 24hrs no growth

Radiology: USG :

X-Ray:

ECHO:

CT:

MRI

Others (ECG, Contrast Studies etc.,) :

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Master THASVIK PANDURI
19-02-2025 1 Y 3 M 5 D (M)
Dr. ANIKET ANIL PARASHAR

FRM / CLINICAL / 124

INFANT (<1 year)
Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 24/5/26

Time:	6pm	10 pm	2 AM	6 AM
Doctor/Nurse/Family Concern?				
Temperature (°F) (scale 94–104)	98.8°F	97.9°F	97.5°F	97.6°F
Heart Rate (bpm) and Blood Pressure (mmHg) * (scale 50–190)		103/63 (73)		92/75 (81)
Heart Rate (Number)	132 b/m	128 b/m		130 bm
Resp. Rate (bpm) (Over 1 Minute) * (scale 10–70)				
Resp Rate (Number)	30 b/m	32 b/m		32 bm
Resp Distress: Mod/ Severe				
Resp Distress: None / Mild				
Receiving O_2 (l/min)				
O_2 Saturations (%)	100%	99%		99%
Conscious Level: Normal				
Conscious Level: Altered				
GCS *				
TOTAL SCORE Number of shaded boxes	0	0		0
Pain Score	0	0		0
Observer's Initials	[illegible]	[illegible]		[illegible]

Note: BP does not score in early warning scoring

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

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)

HNH-00007273 IP26-00006417
Master THASVIK PANDURI
19-02-2025 1 Y 3 M 5 D (M)
Dr. ANIKET ANIL PARASHAR

RCH / FRM / CLINICAL / 124

INFANT (<1 year)
Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 25/5

Time:	10Am	2Pm	6PM	10PM	2Am	6AM
Doctor/Nurse/Family Concern?						
Temperature (°F)	98°F	97.3°F	98.4°F	97.8°F	98.2°F	97.4°F
Heart Rate (bpm) and Blood Pressure (mmHg) *	100/61 (77)	*	100/70	100/74	101/63	96/74
Heart Rate (Number)	121b/m	120b/m	123b/m	120b/m	120b/m	119b/m
Resp. Rate (bpm) (Over 1 Minute) *						
Resp Rate (Number)	28b/m	30b/m	26b/m	28b/m	28b/m	28b/m
Resp Distress: Mod/ Severe / None / Mild						
Receiving O_2 (l/min)						
O_2 Saturations (%)	100%	98%	99	99%	99%	99%
Conscious Level: Normal / Altered						
GCS *						
TOTAL SCORE Number of shaded boxes	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0
Observer's Initials	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

Note: BP does not score in early warning scoring

Temperature scale: 94–104; Heart Rate/BP scale: 50–190; Resp. Rate scale: 10–70

ACTIONS

NB: Scores 3 should be recorded overleaf

Score	Action
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 incharge and PICU /NICU fellow or PICU/NICU 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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

- The paediatric Early Warning Score i) seeks to identify the abnormal physiological finding seen during serious childhood illnesses and ii) offers a method to interpret such physiological derangements with clearly defined actions, ensuring that suitably experienced staff are involved with the care of the sickest children.
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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)

HNH-00007273 IP26-00006417
Master THASVIK PANDURI
19-02-2025 1 Y 3 M 5 D (M)
Dr. ANIKET ANIL PARASHAR

Patient S

CLINICAL / 124

INFANT (<1 year)
Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 26/5

Time:	10Am	2pm	6pm	10pm	2AM	6AM
Doctor/Nurse/Family Concern?						
Temperature (ºF)	98.6°F	98.9°F	98.5°F	97.6°F	97.5°F	96.9°F
Blood Pressure (mmHg) *	98/71 (77)	94/70 (78)	97/75	99/72 (79)	98/72	96/65
Heart Rate (Number)	118b/m	120b/m	119b/m	123b/m	124b/m	119b/m
Resp Rate (Number)	40b/m	40/m	41b/m	41b/m	42b/m	41b/m
Resp Distress Mod/ Severe / None / Mild						
Receiving O_2(l/min)						
O_2Saturations (%)	100%	100%	99%	99%	99%	99%
Conscious Level Normal / Altered						
GCS *						
TOTAL SCORE Number of shaded boxes	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0
Observer's Initials	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

Temperature scale: 104, 103, 102, 101, 100, 99, 98, 97, 96, 95, 94

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

Note: BP does not score in early warning scoring

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

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

Patient Sticker

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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: Nature of Fluid	Intake: Route – Mouth	Intake: Route – I.V	Intake: Route – N.G	Output: NG	Output: Diarrhoea	Output: Vomit	Output: Drainage	Output: Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
24/5/26	02:00 pm	DNS	Milk	24 ml		NA			NA		0	[illegible]
	03:00 pm			24 ml						✓		
	04:00 pm			24 ml								
	05:00 pm			24 ml								
	06:00 pm			24 ml						✓		
	07:00 pm			24 ml								
Total Intake :						Total Output :				U-2	M	
24/5/26	08:00 pm	DNS	khichdi + H2O	24 ml		NA			NA		0	[illegible]
	09:00 pm			24 ml								
	10:00 pm			24 ml						✓		
	11:00 pm			24 ml								
	12:00 am			24 ml								
	01:00 am											
Total Intake :						Total Output :				U-1	M-0	
25/5/26	02:00 am	DNS		24 ml		NA			NA		0	[illegible]
	03:00 am			24 ml								
	04:00 am			24 ml						✓		
	05:00 am			24 ml								
	06:00 am			24 ml								
	07:00 am						✓					
Total Intake :						Total Output :				U-1	M1	

Total 24 hrs. Intake		Total 24 hrs. Output	

FLUID CHART

Sheet No. : 2

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

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							
25/5											0	
	08:00 am			16 ml							0	
	09:00 am		milk	16 ml				NA		✓	0	
	10:00 am	DNS		16 ml			✓				0	
	11:00 am		+	16 ml	ND						0	
	12:00 pm		daily	16 ml						✓	0	
	01:00 pm			16 ml							0	
Total Intake : Taken						Total Output : M-1					U-2	
25/5/26	02:00 pm			16 ml								
	03:00 pm			16 ml								
	04:00 pm		milk	16 ml						✓	0	
	05:00 pm	DNS	+	16 ml								
	06:00 pm		milk	16 ml	NA			NA		✓		
	07:00 pm			16 ml								
Total Intake : Taken						Total Output : U-2					M-0	
25/5	08:00 pm			16 ml							0	
	09:00 pm		milk	16 ml						✓	0	
	10:00 pm		+	16 ml							0	
	11:00 pm	DNS	H2O	16 ml		NA	0	NA			0	
	12:00 am			16 ml						✓	0	
	01:00 am			16 ml							0	
Total Intake :						Total Output :						
26/5	02:00 am			16 ml							0	
	03:00 am			16 ml							0	
	04:00 am	DNS	milk	16 ml							0	
	05:00 am			16 ml		NA		NA		✓	0	
	06:00 am		milk	16 ml							0	
	07:00 am			16 ml							0	
Total Intake :						Total Output :						

Total 24 hrs. Intake	

Total 24 hrs. Output	

HNH-00007273 IP26-00006417
Master THASVIK PANDURI
19-02-2025 1 Y 3 M 5 D (M)
Dr. ANIKET ANIL PARASHAR

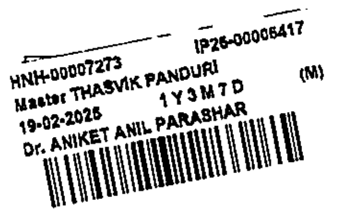
FLUID CHART

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							
26/5/26	08:00 am		Idli									
	09:00 am		Soup				✓		NA	✓	0	
	10:00 am	IVF Stop			NA							
	11:00 am											
	12:00 pm									✓		
	01:00 pm											
Total Intake : Taken						Total Output : V-2 M-1						
26/5/26	02:00 pm											
	03:00 pm		milk							✓		
	04:00 pm	IVF stop	+								0	
	05:00 pm		H2O.		NA			NA		✓		
	06:00 pm											
	07:00 pm									✓		
Total Intake :						Total Output :						
26/5/26	08:00 pm											
	09:00 pm		milk									
	10:00 pm									✓		
	11:00 pm		milk		NA			NA			0	
	12:00 am											
	01:00 am											
Total Intake :						Total Output :						
27/5/26	02:00 am											
	03:00 am		milk									
	04:00 am									✓		
	05:00 am		milk		NA			NA			0	
	06:00 am											
	07:00 am											
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						
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	

HNH-00007273 IP26-00006417
Master THASVIK PANDURI (M)
19-02-2025 1 Y 3 M 5 D
Dr. ANIKET ANIL PARASHAR

NURSING CARE RECORD

Date: 24/5/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning				NA			
Afternoon	2pm – 8pm	- Assess the pt condition. - Monitor vitals - Maintain I/O Chart - Administer Medication as per doctor orders	2pm – 8pm	- Assessed the pt condition - Monitored vitals - Maintained I/O chart - Administer Medicatio as per doctor orders	Pt is stable	Re-Checke vitals	[signature]
Night	8pm to 8am	- Assess the pt condition - Monitor the v/s - Maintain the I/O - Drug as per chart	8pm to 8am	- Assess the pt condition - Monitor the v/s - Maintain the I/O - Drug as per chart	- pt is stable	- Rechecked the v/s	[signature]

HNH-00007273 IP26-00006417
Master THASVIK PANDURI
19-02-2025 1 Y 3 M 5 D (M)
Dr. ANIKET ANIL PARASHAR

Patient Sticker

NURSING CARE RECORD

Date: 25/5/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8Am – 2pm	→ Assess the pt condition → monitoring vitals checked and recorded → I/O chart maintain	8Am – 2pm	→ Assessed the pt condition → Administration medication given as per doctor orders	→ pt is stable	→ Re-checked vitals	[signature]
Afternoon	2PM – 8pm	→ Assess the patient condition → monitor vitals → IV fluids DNS 16ml/h to cont → Administer medication as per doctor's orders.	2P.M. – 8PM	→ Assessed the patient condition → monitored vitals → Administered medications as per doctor's orders.	Patient is stable	Rechecked vitals	[signature]
Night	8Pm to 8Am	Assess the pt condition. Monitor vitals & record. Maintain I/O chart. Provide the comfortable position. Medication give as per as doctor order.	8Pm to 8Am	Assessed the pt condition. Monitored vitals & record. Maintained I/O chart. Provided the comfortable position. Medication given as per as doctor order	→ pt is stable. → vitals normal.	→ monitor vitals. → maintain I/O chart	Sneha [signature]

HNH-00007273 IP26-00006417
Master THASVIK PANDURI
19-02-2025 1 Y 3 M 6 D (M)
Dr. ANIKET ANIL PARASHAR

NURSING CARE RECORD

Date: 26/5/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8Am – 2pm	- Assess the pt condition - monitor vitals - maintain I/O chart - Administer medication as per drug chart	8pm – 2pm	- Assessed the pt condition - Monitored vitals - maintained I/O chart - Administered medication as per drug chart	pt is stable	Re-checked vitals	[signature]
Afternoon	2pm – 8pm	- Assess the pt condition - Monitor vitals & I/O chart - drug as per chart - provide comfortable position		→ Assessed the pt condition - Monitored vitals & I/O chart - drugs as per chart → provided comfortable position	pt is stable	Rechecked vitals	[signature]
Night	8pm – 8Am	→ Assess the pt condition → monitor the vitals → maintain I/O chart → drugs give as per drug chart.	8pm – 8Am	→ Assessed the pt condition. → monitored the vitals. → Maintained I/O chart. → drugs give as per drug chart.	→ pt is stable now	→ Reassessed the vitals	[signature]

HNH-00007273 IP26-00006417
Master THASVIK PANDURI (M)
1 Y 3 M 7 D
19-02-2025
Dr. ANIKET ANIL PARASHAR

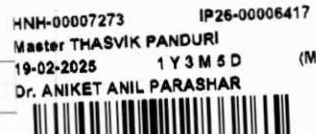
NURSING CARE RECORD

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							



HNH-00007273 IP26-00006417
Master THASVIK PANDURI
19-02-2025 1 Y 3 M 5 D (M)
Dr. ANIKET ANIL PARASHAR

NURSING SHIFT HAND OVER FORM

SITUATION

Diagnosis:	Any Infection: ☐ Yes ☐ No ☑ Not Known If Yes Specify: ....
Surgery / Procedure:	Post OP Day:

	Date / Shift	24/5/26 E2	24/5/26 N1	25/5/26 M6	25/5/26 Evng	25/5 N1	26/5/26 M6
BACKGROUND	Medical Condition (Any special condition to be noted):	–	–	–	–	–	–
	Diet:	Soft	Soft	–	–	–	–
ASSESSMENT	Allergy:	No	No	No	No	No	No
	Ventilation (RA, NP, NIV, VENTI):	–	–	–	–	–	–
	Tubes/Drains/Catheter:	No	No	No	No	No	No
	Vital Signs: Temp:	98.6°F	98.3°F	98.2°F	98.3°F	98.2°F	98.6°F
	Res:	28 b/m	28 b/m	28 b/m	28 b/m	30 b/m	30 b/m
	SpO_2:	100%	100%	98%	99%	98%	99%
	Pulse:	109 b/m	112 b/m	117 b/m	114 b/m	114 b/m	116 b/m
	BP:	–	–	101/60	–	107/62	98/64
	LOC:	–	–	–	–	–	–
	Fall Risk Score:	–	–	–	–	–	–
	Pain Score:	"0"	"0"	"0"	"0"	–	"0"
	Skin Integrity	Good	Good	Good	–	–	Good
Recommendations	Safety Needs:	Yes	Yes	Yes	Yes	Yes	Yes
	Physiotherapy:	–	–	–	–	–	–
	Others Specify:	No	No	No	No	No	No
	Special Diet:	–	–	–	–	–	–
	Critical Lab Test / Values:	–	–	–	–	–	–
	Other Special Orders / Medications:	No	No	No	No	No	No
	PU Prophylaxis:	No	No	No	No	No	No
	DVT Prophylaxis:	No	No	No	No	No	No
	ADL (Dependent / Non Dependent):	–	–	NA	NA	–	–
	Post Operative Procedure Special Orders:	–	–	NA	NA	–	–
	Handed Over By Name :	Manisha	Sneha	Amrutha	Sandhya	Sneha	Manisha
	Signature / ID :	[signature]	[signature]	[signature]	[signature]	[signature] (0/6031)	[signature]
	Date:	24/5/26	25/5/26	25/5/26	25/5/26	26/5	26/5/26
	Time:	8pm	8am	2pm	8pm	8Am	2pm
	Taken Over By Name :	Sneha	Amrutha	Sandhya	Sneha	Manisha	Subiya
	Signature / ID :	[signature]	[signature]	[signature]	[signature] (0/6031)	[signature]	[signature]
	Date:	24/5/26	25/5	25/5/26	25/5	26/5/26	26/5/26
	Time:	8pm	8Am	2pm	8Pm	8pm	2pm

HNH-00007273 IP26-00006417
Master THASVIK PANDURI
19-02-2025 1 Y 3 M 6 D (M)
Dr. ANIKET ANIL PARASHAR

NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:	Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify: ....
	Surgery / Procedure:	Post OP Day:

Section	Date / Shift	26/5/26 E2	26/5/26 N				
BACKGROUND	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:	98.4°F	98.1°F				
	Res:	30b/m	30b/m				
	SpO_2:	99%	99%				
	Pulse:	132b/m	130b/m				
	BP:	—	—				
	LOC:	—	—				
	Fall Risk Score:	—	—				
	Pain Score:	—	—				
	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:	—	—				
	Critical Lab Test / Values:	—	—				
	Other Special Orders / Medications:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	PU Prophylaxis:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	DVT Prophylaxis:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	ADL (Dependent / Non Dependent):		—				
Post Operative Procedure Special Orders:			—				
Handed Over By Name :		Supriya	mahi				
Signature / ID :		[signature]	[signature]				
Date:		26/5/26	27/5/26				
Time:		8PM	8AM				
Taken Over By Name :		mahi					
Signature / ID :		[signature]					
Date:		26/5/26					
Time:		8PM					

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

HNH-00007273 IP26-00006417
Master THASVIK PANDURI
19-02-2025 1 Y 3 M 5 D (M)
Dr. ANIKET ANIL PARASHAR

CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	24/5 DAY-1			25/5 DAY-2			26/5 DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0	,	0	0	0	0	0	0	0	0	
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1		NA	NA	NA	NA	NA	NA	NA	NA	
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2		NA	NA	NA	NA	NA	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		NA	NA	NA	NA	NA	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		NA	NA	NA	NA	NA	NA	NA	NA	
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5		NA	NA	NA	NA	NA	NA	NA	NA	
			Signature of the Nurse		[signature]	[signature]	[signature]	[signature]	[signature]	[signature]	[signature]	[signature]	

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

Signature of Shift In Charge :

Signature : Manisha Name : Manisha

Signature of Ward In Charge :

Signature : Balarani Name : Balarani

Docu. No. : RCH /FRM / CLINICAL / 137

HNH-00007273 IP26-00006417
Master THASVIK PANDURI
19-02-2025 1 Y 3 M 5 D (M)
Dr. ANIKET ANIL PARASHAR

PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
24/5/26	6pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
24/5	10pm	0/0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
24/5	2am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
25/5	8am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
25/5	10Am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
25/5	2pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
25/5/26	4pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
25/5	10Pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
26/5	2Am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
26/5	8Am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]

Re-assessment Frequency:

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

PAIN ASSESSMENT TOOLS

Numerical Pain Scale (Obstetric and Gynecology)

0 1 2 3 4 5 6 7 8 9 10

0 No Pain — 10 Worst Possible Pain

Wong - Baker (Pediatrics) Above 7 Years

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

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

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

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

PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
26/5/26	10Am	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
26/5/26	3pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
27/5/26	6Am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

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

PAIN ASSESSMENT TOOLS

Numerical Pain Scale (Obstetric and Gynecology)

0 No Pain — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10 Worst Possible Pain

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

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

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

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

HNH-00007273 IP26-00006417
Master THASVIK PANDURI
19-02-2025 1 Y 3 M 5 D (M)
Dr. ANIKET ANIL PARASHAR

DRUG CHART

Date of Admission: 24/5/26 Drug Allergies: Nil ☑ 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: Walyte ORS.				Date ▸ Time ▾
Dose	Route	Frequency	Start Date	
	PO	adlib	24/5	
Doctor's Signature	Valid Period	Pharm.		
[signature]				
Additional Instructions: 1 sachet in 200ml water				

DRUG: IBUGESIC SYP				Date ▸ Time ▾
Dose	Route	Frequency	Start Date	
2.5ml	PO	SOS	24/5	
Doctor's Signature	Valid Period	Pharm.		
[signature]				
Additional Instructions: (100mg/5ml)				

DRUG: Syp CROCIN - DS				Date ▸ Time ▾
Dose	Route	Frequency	Start Date	
2.5ml	PO	SOS	25/5	
Doctor's Signature	Valid Period	Pharm.		
[signature]				
Additional Instructions:				

VERIFIED BY : Name .... Signature

HNH-00007273 IP26-00006417
Master THASVIK PANDURI
19-02-2025 1 Y 3 M 5 D (M)
Dr. ANIKET ANIL PARASHAR

REGULAR PRESCRIPTIONS

Weight: 7.9 kgs. Ward: ....

DRUG: Inj CEFTRIAXONE.

Dose	Route	Frequency	Start Date
800mg	iv	OD	24/5

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

Additional Instructions: in 20ml NS over 1 hour.

Daily Doctor's Endorsement by a Sign

Dates: 24/5, 25/5, 26/5 — Time: 6pm (5pm)

DRUG: CROSIN DS Syp

Dose	Route	Frequency	Start Date
2.5ml	PO	Q6 hly	24/5

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

Additional Instructions: (240mg/5ml)

Daily Doctor's Endorsement by a Sign

Dates: 24/5, 25/5 — Times: 12AM, 6AM, 12pm (2pm), 6pm (4pm)

change to SOS 25/5 [signature]

DRUG: PROG-G Sachet

Dose	Route	Frequency	Start Date
1 Sachet	PO	BD	24/5

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

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Dates: 24/5, 25/5, 26/5, 27/5 — Times: 6AM, 6pm (2pm)

DRUG: Z & D drops.

Dose	Route	Frequency	Start Date
1ml	po	OD	24/5

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

Additional Instructions: (20mg/1ml)

Daily Doctor's Endorsement by a Sign

Dates: 24/5, 25/5, 26/5 — Time: 3pm

HNH-00007273 IP26-00006417
Master THASVIK PANDURI
19-02-2025 1 Y 3 M 7 D (M)
Dr. ANIKET ANIL PARASHAR

Sheet No: ....

REGULAR PRESCRIPTIONS

Weight .... Ward ....

DRUG : MUCAITE DROPS				Date/Time	26/5	27/5
Dose	Route	Frequency	Start Dt.			
1 ml	PO	BD	26/5	8AM	X	
Name & Signature of the Doctor Starting the Drugs:						
Additional Instructions:				8pm		
Daily Doctor's Endorsement by a Sign						

DRUG : LEVOLIN NEB				Date/Time	26/5
Dose	Route	Frequency	Start Dt.		
0.31mg	Neb	Q8H	26/5		
Name & Signature of the Doctor Starting the Drugs:					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					

See the chart.

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

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

Docu. No. : RCH /FRM / CLINICAL / 108

(P.T.O.)

Patient Sticker

Sheet No: ....

REGULAR PRESCRIPTIONS

Weight .... Ward ....

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

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

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

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

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

19-02-2025 1 Y 3 M 5 D (M)
Dr. ANIKET ANIL PARASHAR

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.	

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
2/3	8:30PM	ONDANSETRON	IV [illegible]mg	IV	[illegible]	[illegible]

Signature ....

VERIFIED BY : Name ....

Master THASVIK PANDURI
HNH-00007273 IP26-0000641 7

I.V. FLUIDS CHART

Weight. 7.9 kg. Ward. ....

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
24/5/	12pm	N fluids DNS.	iv	24ml/h ↓	[signature]	[signature] [signature]	[signature] 25/5		[signature] [signature]
25/5	8Am	DNS (1/2 NS)	IV	16ml/h		[signature] [signature]		26/5	[signature] [signature]

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

HNH-00007273 IP26-00006417
Master THASVIK PANDURI
19-02-2025 1 Y 3 M 5 D (M)
Dr. ANIKET ANIL PARASHAR

wt - 7.93kg

EMERGENCY ROOM TRIAGE FORM

Patient's Name : master. pandure. Thasvik Age : 1yr 3 month **Gender:** ☑ Male ☐ Female

Date : 24/5/26 Time of Arrival : 11:30pm

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

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

Mode of Arrival : ☑ Ambulatory ☐ Wheelchair ☐ Ambulance

Initial Vital Signs: Temp: 103°F PR: 125b/m BP: .... RR: .... SpO_2: 97%

Chief Complaints: c/o. fever since 4days

INITIAL PHYSIOLOGICAL CATEGORIZATION	**INITIAL PHYSIOLOGICAL STATUS**
Appearance: ☑ Normal ☐ Sick Looking Circulation / Colour: ☑ Normal ☐ Abnormal ☐ Bleeding Work of Breathing: ☑ Normal ☐ Increased ☐ Decreased ☐ Gasping / Apnea	☑ 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 : ....

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 : Bhargavi

Signature of Triage Nurse : (B)

Date & Time : 24/5/26@ 11:32 pm

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

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 24/5/26 Time of arrival : 11:34 Am

Chief Complaints: c/o fever since 4 days RBS: ...

Height : ... Weight : 7.93kg 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 : ...

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

Time	Nursing Notes
11:36Am	Assess the pt condition
	monitore the vitals

Samples collected by: Apueshy   Time:

Samples sent by :   Time: 12:1Am

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: 125b/m BP: .... CFT:	Shift - out from ER to: ward.
RR: 24b/m SPO_2 : 97%.	Time of Shift - out: 1:30pm
GCS:........ Temperature : 103°F	Handover given to: .... (Nurse's Name)
Pain Score:	
Repeat RBS (if applicable):	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

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

IV placement Done

Name of the Nurse : Bhargavi   Signature of the Nurse : B.

Date & Time : 24/1/26 @ 11:38 Am.

PATIENT TRANSFER FORM

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	Date & Time of Admission	Date & Time of Transfer Order
	24/5/26 @ 11:44 Am	24/5/26 @ 1:30pm
Treating Consultant Name	Transfer Ordered by	Reason for Transfer
	Dr. Anusha	ADmission
From Unit	To Unit	Information to Attendant
ER	ward	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 ?
25/-		

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
Bhargavi	Dr. Anusha.

Patient & Clinical Records Received by : Madhu

Date & Time of Patient Received : @24/5/26 1:30pm

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

Docu. No. : RCH /FRM / CLINICAL / 102

[illegible]

[illegible] [illegible]

[illegible]

[illegible]

MEDICATION RECONCILIATION FORM

Drug Allergies: Nill ☑ Not known any Drug Allergies

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

Shifting From: ER Shifted to: ward

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1						☐ 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. Anusha

Date & Time : 24/5/26 @ 11:50Am

Nurse Name & Signature: Bhargavi

Date & Time : 24/5/26 @ 11:55Am.

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2/4

NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 24/5/26 Time: 3:00 pm

Weight: 7.93 Kg Centile: 5th

Height: — Centile: —

Inference: Underweight child

RDA: — Calories: 1200 Kcal/day Protein: 20 gms/day

Diet Recommendations: Gastro diet Can have:- ORS (WHO), sagowater, Coconut Water, Rice based foods

Re-Assesment: Avoid:- Oats, Ragi, Egg, Milk, Citrus, Sugar

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

Diagnosis: AFI c̄ dehydration ?UTI

Nutritional Intervention - ☑ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: G. Swathi

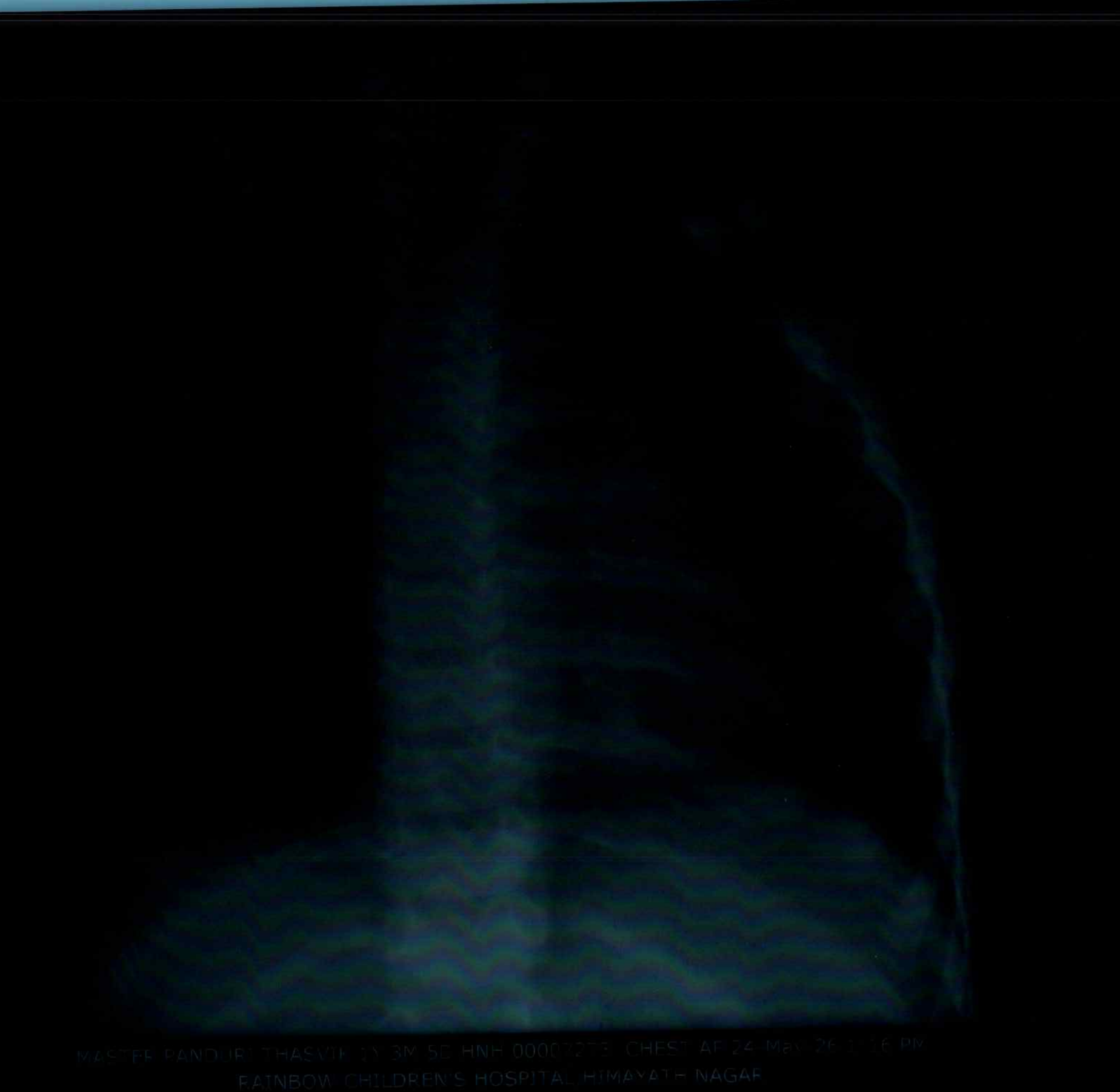
GROWTH CHART (BOYS)

Birth to 36 months: Boys
Length-for-age and Weight-for-age percentiles

2 to 20 years: Boys
Stature-for-age and Weight-for-age percentiles

Dietician's Name: Syeda Sobiya Zaheer Dietician's Signature: Sobiya

Daily Notes:


RAINBOW CHILDREN'S HOSPITAL HIMAYATH NAGAR