DISCHARGE SUMMARY

Name	Master MIRZA MUZZAMMIL BAIG	**UHID**	HNH-00016380
Father/Guardian	Mr MIRZA WAJAHAD BAIG	**Age/Gender**	11 Y 3 M 4 D/ Male
Address	GREEN ESTATE COLONY KANCHANBAGH, Meerpet, Hyderabad, Telangana, INDIA, 500097		
IP No	IP26-00006750	**Admission Date**	05-07-2026
Ref Doctor	SELF		
Discharge Date	07.07.2026.		

Consultant:
Dr. SINDHURA MUNUKUNTLA
MBBS, DCH, DNB PEDIATRICS
66970

DIAGNOSIS	ICD CODE
HYPOCALCEMIC WITH TETANY	

History: Master MIRZA MUZZAMMIL BAIG, 11 Y 3 M 4 D , old boy presented with history of abnormal twitching movements of left hand, dull activity since 1 day prior to admission. For the above complaints he was admitted at Rainbow Children's Hospital - for further management.

Examination: He was afebrile, maintaining saturations at room air and was hemodynamically stable. His heart rate was 112/min, Blood pressure - 116/84 mmHg and Respiratory Rate - 36 /min. Capillary Refill Time was <2 secs.

Name	Master MIRZA MUZZAMMIL BAIG	UHID	HNH-00016380
IP No	IP26-00006750	Admission Date	05-07-2026

Peripheries were warm & pulses well felt. On examination Signs of some dehydration were present, dry lips, oral mucosa, delayed skin turgor, decreased urine output, dull looking, tachycardia, dry oral mucosa, sunken eyes, flushing, throat - congested 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 signs of raised intracranial pressure.

On eliciting, Carpopedal spasm and trousseau sign were positive.

Weight on admission: 39 kilo grams.

Investigations: Enclosed reports.

Ionised calcium was 0.9.
GeneXpert FluA+FluB+RSV were sent, which was negative.

VBG showed pH of 7.34, pCO2 of 44.2 mmHg, pO2 of 30 mmHg, HCO3 of 21.5 mmol/L and BE of -2.6 mmol/L.

Liver function test showed total SBR of 0.4 mg/dl with indirect fraction of 0.3 mg/dl, SGOT -21 U/L, SGPT -17 U/L, ALP - 149 U/L, protein - 7.3 gm/dl, albumin - 4.4 gm/dl, globulin -2.9 gm/dl, A/G ratio of 1.5.
Vitamin D was 12.2 ng/ml. iPTH was 7.10 pg/ml. ECG was done which was normal.

Management: He was admitted in the ward and was started on Intra Venous fluids. Inj Calcium gluconate was given over 1 hour under cardiac monitoring as ionised calcium levels were on the lower side.

Name	Master MIRZA MUZZAMMIL BAIG	**UHID**	HNH-00016380
IP No	IP26-00006750	**Admission Date**	05-07-2026

He was regularly monitored and his hemodynamic status gradually settled. Child maintaining saturations on room air. No further repeat episodes of tetany were noted.
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:

Tablet. Shelcal

Advice:
* Diet as advised.

S.No	MEDICATION	DOSE	TIMINGS	DURATION
1	Tablet SHELCAL 500MG	1 tablet	thrice daily	until follow-up.
2	Tablet Vitamin D(60,000 IU)	1 tablet	weekly once	6 doses (6/7, 13/7, 20/7, 27/7, 3/8, 10/8/26)

Name	Master MIRZA MUZZAMMIL BAIG	**UHID**	HNH-00016380
IP No	IP26-00006750	**Admission Date**	05-07-2026

Plan: To make Tab. Shelcal , twice daily on followup.

Review consultation with Dr. SINDHURA MUNUKUNTLA on Thursday(9/7/26) at Himayatnagar in OPD with prior appointment **(Review consultation will be charged)**.

Regular followup with SELF, Primary Pediatrician.

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

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Name	Master MIRZA MUZZAMMIL BAIG	**UHID**	HNN-00016380
IP No	IP26-00006750	**Admission Date**	05-07-2026

RAINBOW CHILDREN'S MEDICARE LIMITED * HYDERABAD

Registrar/Resident/C.M.O

Dr. SINDHURA MUNUKUNTLA
MBBS, DCH, DNB PEDIATRICS
66970

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ACTIVITY RECORD FOR BILLING

HNH-00016380 IP26-00006750
Master MIRZA MUZZAMMIL BAIG
02-04-2015 11 Y 3 M 3 D (M)
Dr. SINDHURA MUNUKUNTLA

Name: ----------

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

Date of Admission: 5/7/26 Time : ---------- Date of Discharge : ---------- Time: ----------

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
5/7/26	9pm	ER	ward	

Cross Consultation Visit

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

HNH-00016380 IP26-00006750
Master MIRZA MUZZAMMIL BAIG
02-04-2026 11 Y 3 M 3 D (M)
Dr. SINDHURA MUNUKUNTLA

INVESTIGATIONS

Date	Investigations		Sign
5/7/26	VBG	11030	[signature]
	Vitamin D		
	LFT, Para thyroid Hormon	11031	
	TSH, Free T4		
	Cross checked done by Amrutha		
6/7/26	VBG	11096	Sandhya
6/7/26	ECG.	11243	

HNH-00016380 IP26-00006750
Master MIRZA MUZZAMMIL BAIG
02-04-2015 11 Y 3 M 3 D (M)
Dr. SINDHURA MUNUKUNTLA

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnec Time		Signature
5/7/26	Infusion pump	5/7/26 @ 9:40pm	6/7/26 @ 3pm	10992	
				cross checked done by Amrutha	

HNH-00016380 IP26-00006750
Master MIRZA MUZZAMMIL BAIG
02-04-2015 11 Y 3 M 3 D (M)
Dr. SINDHURA MUNUKUNTLA

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
5/7/26	(IV plasm. outside) Dr. Sindhura madam			Accepted.
5/7/26	IV placement	(1)	10989	
		cross	Checked	done by
			Amrutha	
6/7/26	NHA	(1)	11202	Sandhya

ANY OTHER INFORMATION

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

Ref.No. F/IN/PR/10

Rainbow®
Children's
Hospital

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name : HNH-00016380 IP26-00006750
Master MIRZA MUZZAMMIL BAIG
02-04-2015 11 Y 3 M 3 D (M)
Dr. SINDHURA MUNUKUNTLA

Patient ID# :

Consultant :

Final Diagnosis :

Pediatric Multiorgan History & Physical Examinati

Name : _____

Informant _____ Reliability _____

Chief Presenting Complaints & Duration (Chronologically):

c/o abnormal twitching movements of left hand since yesterday Evening
- H/o dull activity since ~~yesterday~~ morning

History of present illness :

- Child presented to ER with c/o r. frequent episodes of abn twitch movement of left hand since yesterd Evening. not a/w loss of consciou / irritability.
- H/o dull activity.
- No h/o vomiting / loose stools / fever / altered sensorium
- No h/o headache.

VBG Low ionized Ca = 0.9.

Pediatric Multiorgan History & Physical Examination

HNH-00016380 IP26-00006750
Master MIRZA MUZZAMMIL BAIG
02-04-2015 11 Y 3 M 3 D (M)
Dr. SINDHURA MUNUKUNTLA

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

Nil

Birth & Neonatal History :

Birth & Socio Economic History :

About Father : Not Signfint

About Mother :

Any additional Information :

Developmental History :

Appropriat

Immunization History :

Up-to date

Anthropometry

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

Weight (kgs) 39 kg. (Centile _____)

On Examination :

Temperature : 98.6. Pulse Rate: 112 Description _____

B.P. 116/ecummHg SPO2 98%. at _____

Resp. rate and type of breathing : _____

Rash _____ Trouen sign (+).

Lymphadenopathy _____ carpopedal spasm (+).

Oedema : _____

Respiratory system :

Inspection (any s/o distress) : _____

Air entry & breath sounds : BL AE (+)

Any addes sounds : NVRS (+)

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

Cardiovasclular System :

Inspection of procordium : _____

Heart Sounds : S1 S2 (+)

Any murmur : No murm

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

Per Abdomen :

Inspection _____

Palpation : ~~BL AE (+)~~ soft

Ausculation : NV' not distended.

Spine: _____ External Genitelia : _____

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

Central Nervous System :

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

Cranial Nerves : WNL

Motor System :

Nutrition :

Tone : WNL Power

Co-ordinator :

Posture :

Involuntary Movements : Carpopedal spasm (+)
Trousseau's sign positive

Reflexes :

DTR **Superficials :**

Plantars

Sensory System : WNL

Bladder / Bowel :

Clinical Summary & Diagnostic :

Hypocalcemia
? Tetany.

Pediatric Multiorgan History & Physical Exa

Preventive aspects of the treatment :

Desired goals of the treatment :

Planned Labs :

ECG Now

Send vitD (25OH) vitD
PTH
TSH, freeT4.
LFT

Tm mng 8AM-VBG

Planned Management :

- IV fluids enough
- Enhance orally.
- I/v Calcium Gluconate under ECG monitg
- Monitor vitals.
- ECG To do

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

Dr. Sindhura Munukuntla
Consultant Pediatrician
Reg. No: 66970

Doctor's Signature Name _____ Date _____ Time _____

HNH-00016380 IP26-00006750
Master MIRZA MUZZAMMIL BAIG
02-04-2015 11 Y 3 M 3 D (M)
Dr. SINDHURA MUNUKUNTLA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/1/26 07:17pm	S/B Dr. Sindhura M	
	- Child deaf [illegible]	
	- carpopedal spasm (+)	
	- HR - 100/min. tachycardia	
	Resp - [illegible]	
	cley [illegible]	
	HYPOCALCEMIC TETANY	
		1st episode
	VBG - icalcium low	
		Adv
		- IV Calcium gluconate 40 mg + 40 mg [illegible] cardiac monitoring
	Rpt VBG [illegible]	
		- IV fluids [illegible]
		Dr. Sindhura Munukuntla Consultant Pediatrician Reg. No: 66970
		[signature] Sindhura M
		[signature] N. 13 Amrutha

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

HNH-00016380 IP26-00006750
Master MIRZA MUZZAMMIL BAIG
02-04-2015 11 Y 3 M 3 D (M)
Dr. SINDHURA MUNUKUNTLA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/7/26. 8 30AM.	c/s/ by, Dr Anuhe	
	hypocalcemic tetany.	
	No further tetany episode.	
	vital stable.	Plan
	S/E BL AE (+)	- Enhance oral
		- T-SHELCAL TID
		- monitor vital
	Af	(VBG) - Now
VBG @ 9am iCa: 1.27		noted by Sr. sandhya 6/7/26 8:30am

HNH-00016380 IP26-00006750
Master MIRZA MUZZAMMIL BAIG
02-04-2015 11 Y 3 M 3 D (M)
Dr. SINDHURA MUNUKUNTLA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/7/26. 10AM	S/B Dr. Sindhura Δ: Hypocalcemic tetany	
	No further episodes after yesterday evening Accepting well orally	Advice ① TSH, free T_4, Vitamin D_3 • Ct Shelcal TDS until flw (change to BD at flw) • Dietary counselling given • Discharge
	o/e Vitally stable	
	s/e wnl	

Dr. Sindhura Munukuntla
Consultant Pediatrician
Reg. No: 66970

noted by sr. sandhya.
6/7/26
10 a.m.

HNH-00016380 IP26-00006750
Master MIRZA MUZZAMMIL BAIG
02-04-2015 11 Y 3 M 3 D (M)
Dr. SINDHURA MUNUKUNTLA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/7/26 2:20PM	C/s/b Dr. Varun / Dr. Sreeghana	
	Δ - Hypocalcemic tetany	
	- No further e/o tetany.	
	- Accepting well orally.	
		Plan
	O/E - vitals stable.	
		- Ct. Shelcal BD.
	S/E - WNL.	- Add Vit D_3 60K IU / week × 6 weeks.
		- D/S SOS.

HNH-00016380 IP26-00006750
Master MIRZA MUZZAMMIL BAIG
02-04-2015 11 Y 3 M 3 D (M)
Dr. SINDHURA MUNUKUNTLA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/7/26 4pm	S/B Dr. Sindhura	
	Δ Hypocalcemic tetany	Plan
	No further episodes of tetany	- Discharge - watch for tetany
	CVS - S1S2 ⊕ RS - B/L AE ⊕	
	P/A - soft Conscious	
		Dr. Sindhura Munukuntla Consultant Pediatrician Reg. No: 66970

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

(P.T.O)

HNH-00016380 IP26-00006750
Master MIRZA MUZZAMMIL BAIG
02-04-2015 11 Y 3 M 3 D (M)
Dr. SINDHURA MUNUKUNTLA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

HNH-00016380 IP26-00006750
Master MIRZA MUZZAMMIL BAIG
02-04-2015 11 Y 3 M 3 D (M)
Dr. SINDHURA MUNUKUNTLA

304

RESULT SHEET

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Date						
Time						
Hb						
PCV						
RBC						
WBC						
N/L						
Platelets						
CRP						
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT	17					
SGOT	21					
T.Bill/Conj	0.4 / 0.1					
T.Protein	7.3					
S.Albumin	4.4					
S.Globulin	2.9					
A/G Ratio	2.9					
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein/Sugar						
Cells						
N/L						

P.T.O.

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

Culture and Sensitivities : .....

.....

.....

.....

Radiology: USG : .....

X-Ray:.....

ECHO: .....

CT: .....

MRI .....

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

HNH-00016350 IP26-00006750
Master MIRZA MUZZAMMIL BAIG
02-04-2015 11 Y 3 M 3 D (M)
Dr. SINDHURA MUNUKUNTLA

/ CLINICAL / 126

SCHOOL AGE (5-12 years)

Children's Observation & Early Warning Scoring Chart

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EARLY WARNING SCORE: CHILDREN'S UNIT

Time:	10 pm	2 AM	6 AM
Doctor / Nurse / Family Concern?			

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

98.2 F | 97.3 F | 98.2 F

Heart Rate (bpm) and Blood Pressure (mmHg) *

Note: BP does not score in early warning scoring

190 180 170 160 150 140 130 120 110 100 90 80 70 60 50

117 (81) 75 | 106 (75) 72

Heart Rate (Number)	96/m	89/m

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

70 60 50 40 30 20 1

Resp Rate (Number)	28/m	25/m
Resp Distress: Mod/ Severe | None / Mild		
Receiving O_2 (l/min)		
O_2 Saturations (%)	100%	98%
Conscious Level: Normal | Altered		
GCS *		
TOTAL SCORE Number of shaded boxes	0	0
Pain Score	0	0
Observer's Initials	[illegible]	[illegible]

ACTIONS

NB: Scores 3 should be recorded overleaf

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

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

Patient Sticker

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BirthRight
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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

MRN-00016380 IP26-00006750
Master MIRZA MUZZAMMIL BAIG
02-04-2015 11 Y 3 M 3 D (M)
Dr. SINDHURA MUNUKUNTLA

Patient Stick

L / 126

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

Rainbow® Children's Hospital
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NING SCORE: CHILDREN'S UNIT

Date : ..6/2/26... Time:	10am	2pm	8pm
Doctor / Nurse / Family Concern?			
Temperature (F)	98.1 F	98.6 F	98.2
Heart Rate (bpm) and Blood Pressure (mmHg) * **Note:** BP does not score in early warning scoring			
Heart Rate (Number)	90bpm	81bpm	
Resp. Rate (bpm) Over 1 Minute) *	20		
Resp Rate (Number)	20b/m	20b/m	
Resp Distress: Mod/ Severe / None / Mild			
Receiving O_2(l/min) O_2Saturations (%)	100 %	100 %	
Conscious Level: Normal / Altered			
GCS *			
TOTAL SCORE Number of shaded boxes	0	0	
Pain Score	0	0	
Observer's Initials	E	A	

ACTIONS NB: Scores 3 should be recorded overleaf	
Score 1	: Continue normal observation by staff nurse
Score 2	: Shift in charge nurse to be informed and continue hourly observations
Score 3	: Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.
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Patient Sticker

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

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Date	Time	Early Warning Score	Date	Time	Name

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A	**ASSESSMENT :** I think the problem is (XXX) and I have ...(e.g. given O2/ analgesia, stopped the infusion), OR I am not sure what the problem is but child (X) is deteriorating, OR I don't know what's wrong but I am really worried.
R	**RECOMMENDATION :** I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

Master MIRZA MUZZAMMIL BAIG
02-04-2015 11 Y 3 M 3 D (M)
Dr. SINDHURA MUNUKUNTLA

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FLUID CHART

Sheet No. : .....

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

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm					NA						
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 :**					
5/7	08:00 pm						L				L	
	09:00 pm											
	10:00 pm	DNS	40ml	40ml						✓		
	11:00 pm	DNS	40ml	40ml			0	NA	NA		0	00
	12:00 am		40ml	40ml	NA							
	01:00 am		40ml	40ml			J				J	
Total Intake :	Taken						**Total Output :**			m - 0	O - 1	
6/7	02:00 am		40ml				L				L	
	03:00 am	DNS	kichidi							✓		
	04:00 am		✓		NA		0	NA			0	A
	05:00 am											
	06:00 am	DNS	H2O							✓		
	07:00 am						J				J	
Total Intake :	Taken									**Total Output :**	m - 0	O - 2

Total 24 hrs. Intake		Total 24 hrs. Output	

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FLUID CHART

Sheet No. : .....

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

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
6/7/26	08:00 am									✓		
	09:00 am	0	Rally + H2O									
	10:00 am									✓	0	
	11:00 am				NM		✓	NM				
	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**	

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NURSING CARE RECORD

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Date: 5/7/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon							
Night	8pm | 8Am	→ Assess the pt condition → monitoring vitals checked and recorded → I/O chart maintain	8pm | 8m	→ Assessed the pt condition → Administration & medication given as per doctor orders	→ Pt is stable	→ Re-Assess the vitals	

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Patient Sticker

NURSING CARE RECORD

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Date: 6/7/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8am – 2pm	→ Assess the patient general Condition → monitor vitals → Administer medications as Per doctor's orders.	8am	→ Assessed the patient general Condition → monitored vitals → Administered medications as Per doctor's orders.	Patient is stable	Rechecked vitals	
Afternoon							
Night							

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NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Sindhura Department: ward Date of Admission: 5/7

SITUATION

Diagnosis: AGE

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

BACKGROUND

Area / Shift Time	5/7 N1	6/7/26 Mrng				
Medical Condition (Any special condition to be noted):	NA	NA				

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:	98.2F	98.4°F					
Res:	20b/m	25b/m					
SpO_2:	96b/m	99%					
Pulse:	89b/m	85b/m					
BP:	109/69	110/70					
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:	NA	NA					
Post Operative Procedure Special Orders:	NA	NA					
Handed Over By Name :	Amruth	Sandhya					
Signature :							
Date:	5/7	6/7/26					
Time:	8AM	2pm					
Taken Over By Name :	Sandhya						
Signature :							
Date:	6/7/26						
Time:	8:c						

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NURSING SHIFT HAND OVER FORM - WARD

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

SITUATION	Diagnosis:				Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:		
BACKGROUND	Area / Shift Time						
	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:							

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THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE 5/2	DATE 6/2	DATE	DATE	DATE
Age	Less than 3 years old	4					
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2					
	Female	1	1	1			
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1					
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own ability	1		1			
	History of Falls or Infant-Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2					
	Outpatient Area	1		1			
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours/ None	1		1			
Medication Usage	Sedatives (Excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1		1			
	Total			5			

Intervention: -Fall Risk: Low Humpty Dumpty Score = 7-11, High Risk Humpty Dumpty Score = 12 or above

	Bed in low position			✓			
	Call device within reach			✓			
	Wheels Locked			✓			
	Room free of clutter			✓			
	Adequate lighting			✓			
	Wheel chair support			✓			
	Other Intervention(s) Specify			✓			
	Nurse's Name:			Sandhya			
	Signature:			[signature]			
	Date:			6/2			
	Time:			2pm			

Docu. No. : RCH /FRM / CLINICAL / 005

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BRADEN 'Q' SCALE

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				Date :	5/7	6/7/26		
				Time :	Night	Morning		
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		
"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		
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		
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		
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		
Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4		
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		
				TOTAL SCORE	28	28		
				Evaluator's Name	[illegible]	[illegible]		

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

Docu. No. : RCH /FRM / CLINICAL / 119

Risk Score	Category	Action	Support Surfaces (**Please Note:** Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice
15-18	At Risk	• Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • Advance to a higher level of risk if other major risk factors are present	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	• Use the Same Protocol as for **"At Risk"** Patients • Position patient at 30 degree lateral incline using foam wedges	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	• Follow the same protocol as for **"Moderate Risk"** Patients • In addition to regular turning schedule • Make small shifts in their position frequently	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	• Use same protocol as for **"High Risk"** Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

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PAIN ASSESSMENT FORM

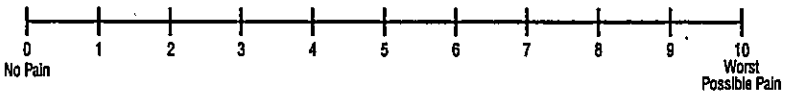
Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
5/7	10pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
5/7	6AM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
6/7/26	10:am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
				☐ 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)



Wong - Baker (Pediatrics) Above 7 Years

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

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

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

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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			NA	NA						
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						
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2			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						
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						
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						
		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 : ..... Name : Amrutha

Signature of Ward In Charge :

Signature : ..... Name : Balaram

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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 cordpyrexia	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 personal ongoing observation of the site should continue for 48 hours post removal to detect post infusion phlebitis.

Signature of Shift In Charge :

Signature : ..... Name : .....

Signature of Ward In Charge :

Signature : ..... Name : .....

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DRUG CHART

Date of Admission: 5/7/26 Drug Allergies: nill ☐ 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 :				Date / Time →
Dose	Route	Frequency	Start Date	
Doctor's Signature		Valid Period	Pharm.	
Additional Instructions:				

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

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

Signa

VERIFIED BY : Name

HNH-00015380 IP26-00006750
Master MIRZA MUZZAMMIL BAIG
02-04-2015 11 Y 3 M 3 D (M)
Dr. SINDHURA MUNUKUNTLA

REGULAR PRESCRIPTIONS

Weight. 39 Ward. .....

DRUG : T. SHELCAL.

Dose	Route	Frequency	Start Date
500mg	PO.	OD	5/7

Name & Signature of the Doctor Starting the Drugs: Af

Additional Instructions: TID

Date / Time	5/7	6/7
10pm	X	
1pm		
10pm		

Daily Doctor's Endorsement by a Sign

DRUG : T. SHELCAL

Dose	Route	Frequency	Start Date
500mg	PO	TID	5/7

Name & Signature of the Doctor Starting the Drugs: Af

Additional Instructions:

Date / Time	5/7	6/7
6AM	X	
1pm	X	
10pm		

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Verified by Dr. Dhakshayani

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02-04-2015 11 Y 3 M 3 D (M)
Dr. SINDHURA MUNUKUNTLA

Weight. 39kgs 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
5/2/26	6.30pm	1/3 Calcium Gluconate	(40ml/+ 40ml/5%D) over 1hour under cardiac monitor (ECG)	IV.		
6/2/26	2:30 PM	Vit. D_3	60,000 IU	PO		

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I.V. FLUIDS CHART

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

		position of I.V. Fluid (mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
5/1/26	9:40 pm	IV fluid DNS.	40ml/h iv	iv 40ml/h.	[signature]	[signature] [signature]			[signature] [signature]

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

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MEDICATION RECONCILIATION FORM

Drug Allergies: ..... Nil ..... ☐ 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 : 5/7/16 @ 6:30 PM

Nurse Name & Signature: [illegible]

Date & Time : 5/7/16 @ 6:30 PM.

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00016380 IP26-00006750 Master MIRZA MUZZAMMIL BAIG 02-04-2016 11 Y 3 M 3 D (M) Dr. SINDHURA MUNUKUNTLA	5/4/26 @ 7:15pm.	5/4/26 @ 9pm
	Transfer Ordered by Dr. Anusha	Reason for Transfer Admission.
From Unit ER	To Unit ward	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File 14	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant Yes ☑ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

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

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Dr. Vijaya	Dr. Anusha

Patient & Clinical Records Received by : Amrutha 5/4/26

Date & Time of Patient Received : @ 9pm

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

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

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Master MIRZA MUZZAMMIL BAIG
02-04-2015 11 Y 3 M 3 D (M)
Dr. SINDHURA MUNUKUNTLA

wt. 39 kgs

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EMERGENCY ROOM TRIAGE FORM

Patient's Name : Master Mirza Muzzammil Age : 11 yrs Gender: ☐ Male ☐ Female

Date : 5/7/26 Time of Arrival : 5:15 pm

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

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

Mode of Arrival : ☑ Ambulatory ☐ Wheelchair ☐ Ambulance

Initial Vital Signs: Temp: 98 f PR: 90 b BP: 111/73 (81) RR: 36 b SpO_2: 99 %

Chief Complaints: c/o abnormal movement

INITIAL PHYSIOLOGICAL CATEGORIZATION

Appearance
☐ Normal
☑ Sick Looking

Circulation / Colour
☑ Normal ☐ Abnormal ☐ Bleeding

Work of Breathing
☑ Normal ☐ Increased
☐ Decreased ☐ Gasping / Apnea

INITIAL PHYSIOLOGICAL STATUS
☑ Stable
☐ Unstable :
- ☐ Not – Life - Threatening
- ☐ Life – Threatening

Triage Classification	CTAS
☐ Level 1 : Resuscitation	☐ Immediate
☐ Level 2 : EMERGENT : Life or limb threatening	☑ < 15 min
☐ Level 3 : URGENT : Significant illness / injury with potential to become life or limb threatening	☐ 30 min
☐ Level 4 : LESS URGENT : Significant illness but not life threatening	☐ 60 min
☐ Level 5 : NON – URGENT : May receive care when convenient	☐ 120 min

NOTE : All immunocompromised children and preterm babies to be considered Level 2.
All Children less than 2 years age with high fever to be considered Level 3.

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian

Triage Completion Time : 5:10 pm

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.

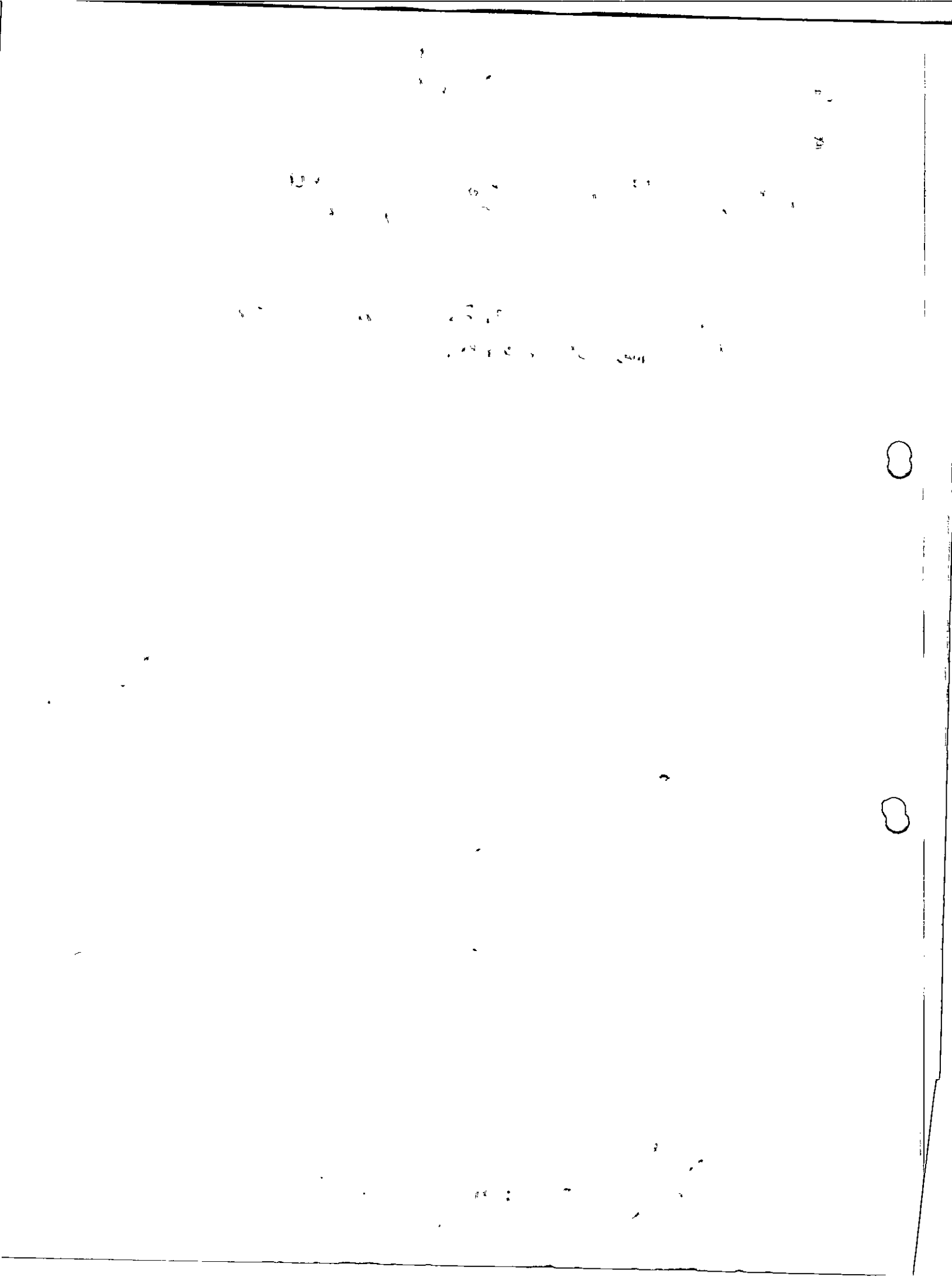
PART D. ACTION / INTERVENTION: (for positive suspected communicable disease triage screening)

- ☐ 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: Kavitha

Signature of Triage Nurse : .....

Date & Time : 5/7/26 @ 5:10 pm



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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 5/7/16 Time of arrival : 5:15 pm

Chief Complaints: c/o abnormal movement

Height : ..... Weight : 34kgs ..... Head Circumference (<2 years) .....

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

If yes , identify .....

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

☐ Character ..N/A.. ☐ Location ..N/A.. ☐ Frequency ..N/A.. ☐ Duration ..N/A..

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: ..N/A.. (Date/Time): ..N/A..

Social History: Lives With ..family..

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

Time of Initial assessment completed by ER Nurse : ..... @ 5:20 pm

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Master MIRZA MUZZAMMIL BAIG
02-04-2015 11 Y 3 M 3 D (M)
Dr. SINDHURA MUNUKUNTLA

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

Time	Nursing Notes
5.10pm	⇒ Assessed the general condition. ⇒ Vitals checked and recorded.

Samples collected by: Vijaya Time: /

Samples sent by : / Time: 8pm

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: 90blm BP: 111/73(85) mmHg CFT:	Shift - out from ER to: ward
RR: 36b SPO2 at FiO2: 99%	Time of Shift - out: 9pm
GCS: ..... Temperature : 98°F	Handover given to: Amrutha
Pain Score:	(Nurse's Name)
Repeat RBS (if applicable):	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

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

IV placement done

Name of the Nurse : Vijaya Signature of the Nurse : .....

Date & Time : 5/7/18 @ 5:20pm

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Dr. SINDHURA MUNUKUNTLA

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NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 6/7/26 Time: 11:10 Am

Weight: 39 kg Centile: >50th

Height: — Centile: —

Inference: well child

RDA: — Calories: 1700 kcal/d Protein: 30 gms/d

Diet Recommendations: soft diet

Re-Assesment: Avoid spicy, chilled & outside foods

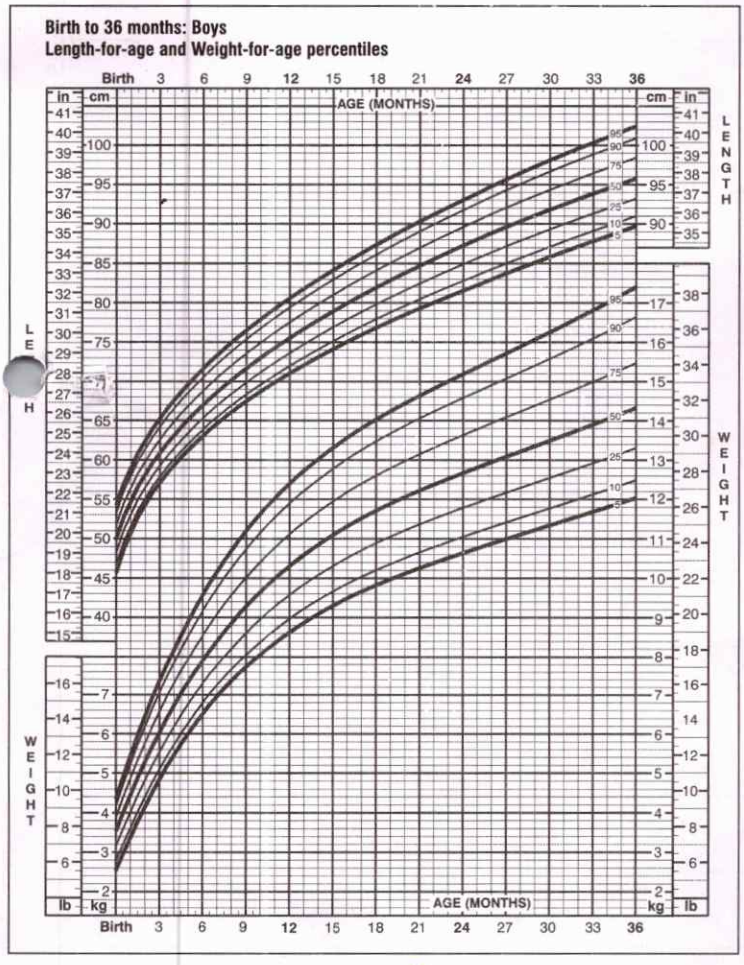
Food Allergies: NO Veg/Non-veg NON-Veg.

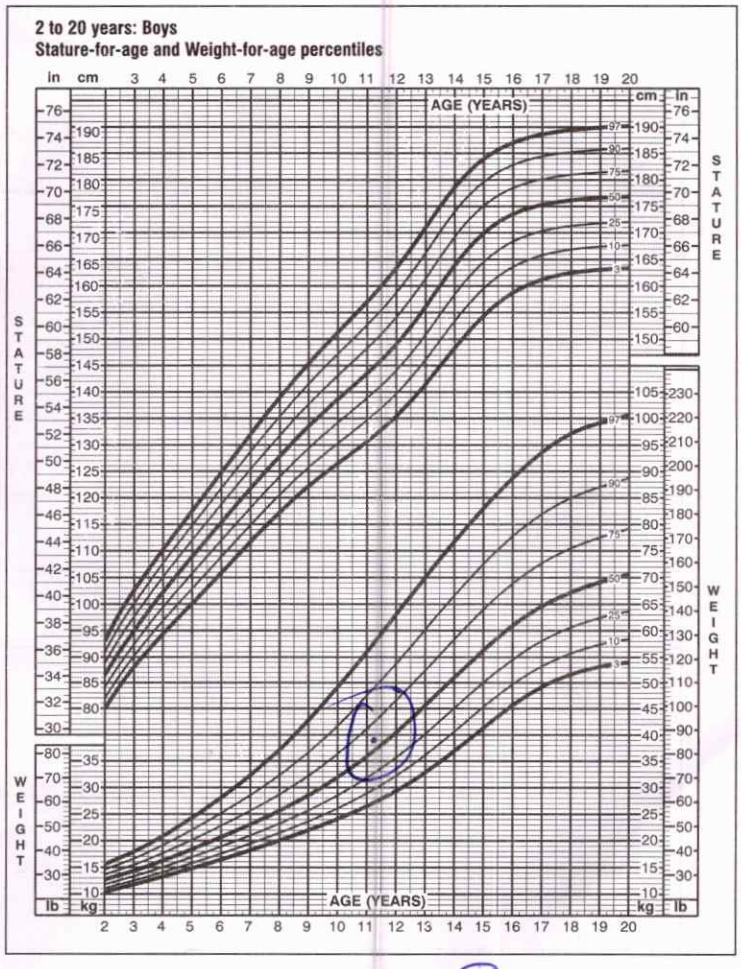
Diagnosis: Hypocalcamic tetany

Nutritional Intervention - ☑ Oral ☐ Enteral ☐ Parenteral

Patient's Signature:

GROWTH CHART (BOYS)





Dietician's Name Sathvika-G Dietician's Signature

Docu. No. : RCH /FRM / CLINICAL / 160 (P.T.O.)

Daily Notes: