

ADMISSION SHEET

Registration Details :



Admission No : IP26-00006753 Admit Date : 06-Jul-2026 Admit Time : 12:29 AM UHID : HNH-00009752

Patient Details :

Patient Name	: Master SHANKUR VIRANSH	Age	: 0 Y 11 M 2 D
Guardian	: Mr VINAY KUMAR	DOB	: 04-08-2025 02:57 PM
Gender	: Male	Religion	:
Occupation	:	Martial Status	:
Address (H)	: FLAT NO 401 PARK VIEW RESIDENCY BAGH AMBERPET Amberpet Hyderabad Telangana INDIA 500013	Phone No	: 9030334332/ 8801013656
		E-mail	: SHIVANI.G211998@GMAIL.COM

Admission Details :

Bed Type : DAY CARE Bed No : ER01 Ward Name : GF -EMERGENCY
Room No : ER01 Admission Type : First Visit

Contact Details :

Name : Mr VINAY KUMAR Relationship : Father
Contact Address : FLAT NO 401 PARK VIEW RESIDENCY BAGH AMBERPET Amberpet Hyderabad Telangana INDIA 500013 Phone No : 9030334332


Signature

Doctor Details :

Doctor Name : Dr. SINDHURA MUNUKUNTLA Specialisation : GENERAL PEDIATRICS
Referral Doctor : Self. Phone No :
Co-Consultant :

Payment Details :

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

PATIENT TRANSFER FORM

Patient Name & UHID No. HNH-00009752 IP26-00006753 Master SHANKUR VIRANSH 04-08-2025 0 Y 11 M 2 D (M) Dr. SINDHURA MUNUKUNTALA 		Date & Time of Admission 5/7/26 @ 12:29 Am.	Date & Time of Transfer Order 5/7/26 @ 1:21 am
		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 251-	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 Bhargava		Name of Person Ordered Transfer Dr. Anusha	
Patient & Clinical Records Received by : Sunanda @ 1.30 am			
Date & Time of Patient Received : 5/7/26			

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

☐ Unavailable Bed

☐ Nurse not Available

☐ Available Bed not ready

ACTIVITY RECORD FOR BILLING

Name: HNH-00009752 IP26-00006753
Master SHANKUR VIRANSH
UHID No: 04-08-2025 0 Y 11 M 2 D (M)
Dr. SINDHURA MUNUKUNTLA
Date of / ne : Date of Discharge : Time: Dept : *pediatric*
Room / Bed No : Ward : Suggested Billable bed type :

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
5/7/26	1:21 Am	ER	ward	<i>(B) / (S)</i>

Cross Consultation Visit

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



INVESTIGATIONS

[illegible]

[illegible]

[illegible]

Ref.No. F/IN/PR/10



Rainbow[®] Children's Hospital

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name : _____

Patient ID# : _____

Consultant : _____

Final Diagnosis : _____

HNH-00009752 IP26-00006753
Master SHANKUR VIRANSH
04-08-2025 0 Y 11 M 2 D (M)
Dr. SINDHURA MUNUKUNTLA



Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Informant _____ Reliability _____

Chief Presenting Complaints & Duration (Chronologically):

~~c/o fever~~ sin. c/o vomitings since evening
multiple episodes
c/o decreased activity & decreased
acceptance of feeds.

History of present illness :

- child presented to ER with c/o multiple episodes of vomitings since morning containing food particles / feeds non bilious non projectile not relieving w/ medication
- c/o decreased activity
- c/o decreased acceptance of feeds.

Pediatric Multiorgan History & Physical Examination

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

nil

Example of words
and of them
and have
and of them
and have

Birth & Neonatal History :

OTD

Birth & Socio Economic History :

About Father : _____

About Mother : _____ *not significant*

Any additional Information : _____

Developmental History :

Appropriate

Immunization History :

Cp to date

Pediatric Multiorgan History & Physical Examination

Anthropometry

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

Weight (kgs) ~ 7 kg (Centile _____)

On Examination :

Temperature : Afebr Pulse Rate: 126 Description _____

B.P. _____ SPO2 98% at _____

Resp. rate and type of breathing : (2) Sign of dehydration

Rash _____ Sunk Eyes

Lymphadenopathy _____ dull look

Oedema : _____ dry lips / oral mucosa

Respiratory system :

Inspection (any s/o distress) : _____

Air entry & breath sounds : B/LAC (+)

Any added sounds : RVBS (+)

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

Cardiovascular System :

Inspection of precordium : _____

Heart Sounds : S1 S2

Any murmur : no

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

Per Abdomen :

Inspection _____

Palpation : Soft not distend

Auscultation : no organomegaly

Spine: _____ External Genitalia : _____

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

Pediatric Multiorgan History & Physical Examination

Central Nervous System :

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

Cranial Nerves : _____

Motor System :

Nutrition : _____

Tone : _____

Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR

Superficials :

Plantars

Sensory System :

Bladder / Bowel : _____

Clinical Summary & Diagnostic :

*Severe Acute Gastritis
w/ Delayed*

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment :

prevent hypovolemia

Desired goals of the treatment :

Planned Labs :

dx
[iVE
- CBP] send
- CRP - collect & keep.
planto send if juice (+)

Planned Management :

- 1g ceftriaxone
iv fluid
- iv fluid DNS @ 21 ml/h
(2/3)
- Assisted feeds aft 2 hours.
- 1g ONDANSETRON
1.5mg iv TID
- 1g ESMOPRazole 7mg
iv OD
- Norm so3.

Please fill up the following details

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

Doctor's Signature Name S. Sridhar Date 2/7/26 Time 1 PM

Date & Time	Progress Notes	Doctor's Order
6/2/20 6PM	S.B. Dr. Sirdane. on	
	Acute gastritis with Dehydration	
	child dull	
	sign of dehydration (+)	
	sunken eyes	
	skin turgor slow	
	<u>Adx</u>	
	- Cefixime 100mg	
	- dehydration oral	
		Dr. Sirdane Dr. Sirdane

Patient Sticker



PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]



DRUG CHART

Date of Admission: 6/7/26 Drug Allergies: NP/1 ☐ 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:																			



REGULAR PRESCRIPTIONS

Weight. Ward.

DRUG : <i>h ONDANSETRON.</i>				Date Time	<i>6/7</i>															
Dose	Route	Frequency	Start Date																	
<i>15mg</i>	<i>iv</i>	<i>TID</i>	<i>6/7</i>	<i>6am</i>	<i>6/7</i>															
Name & Signature of the Doctor Starting the Drugs:																				
<i>AP</i>																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG : <i>h ESMOPRazole</i>				Date Time	<i>6/7</i>															
Dose	Route	Frequency	Start Date																	
<i>2mg</i>	<i>iv</i>	<i>OD</i>	<i>6/7</i>	<i>6am</i>	<i>6/7</i>															
Name & Signature of the Doctor Starting the Drugs:																				
<i>AP</i>																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG :				Date Time																
Dose	Route	Frequency	Start Date																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG :				Date Time																
Dose	Route	Frequency	Start Date																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

(88)

QY11M2D

Dr. SINDHURA MUNUKUNTLA

**STAT / ONCE ONLY DRUGS**[illegible]

Weight. Ward.

[illegible]



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 : 5/7/26 @ 11:30pm

Nurse Name & Signature: Bhargava

Date & Time : 5/7/26 @ 11:35pm

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



wt - 7.6 kg

EMERGENCY ROOM TRIAGE FORM

Patient's Name: Master Shankur Viransh Age: 11 mo Gender: ☒ Male ☐ Female

Date: 05/07/26 Time of Arrival: 10:30 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: 97.7°F PR: 109 bpm BP: 99/71 RR: 24 SpO₂: 99%

Chief Complaints: C/o vomiting since 1 hour 3 episode

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

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

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

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian

Triage Completion Time: 10:32 pm

Communicable Disease Triage Screening

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

- Have you had fever (elevated temperature) in the past 2 weeks? ☐ Yes ☒ No
- Have you had cough or a rash in the past 2 weeks? ☐ Yes ☒ No
- Have you had shortness of breath or difficulty breathing in the past 2 weeks? ☐ Yes ☒ No

PART B. For patients reporting fever and respiratory/rash symptoms: ☐ Not applicable

- Have you travelled outside the INDIA? or had close contact with someone who has recently travelled outside the INDIA, in the past two weeks? ☐ Yes ☒ No
If yes, State Location:
- Are your parents / close contacts at home is/a healthcare worker? {please encircle the choices} (e.g., nurse, physician, ancillary services personnel, allied health services personnel, hospital volunteer, or laboratory worker, others) who has had a recent exposure to an individual with a highly communicable disease or unexplained, severe febrile respiratory or rash disease? ☐ Yes ☒ No

PART C. A positive communicable disease triage screening is considered for any patient who meets one of the two following criteria:

- ☐ Any patient with Fever / Rash / Vesicles / Discharge from Eyes and Cough
- ☐ Any patient with fever and respiratory symptoms who answered "YES" to any of the questions on epidemiologic risk factors in "PART B" of the triage screening above.

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

- ☐ Patients should be immediately isolated in a negative pressure room or a single room (as appropriate) for pending evaluation.
- ☐ The patient should be given a surgical mask immediately, if not already wearing one.
- ☐ Both patient and triage staff should perform hand hygiene.
- ☐ The staff should use PPE (as appropriate).

Name of Triage Nurse: Beabin

Signature of Triage Nurse: [Signature]

Date & Time: 05/07/26 @ 10:32 pm

100

100

1

1

1

1

1

1

1

1



NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 5/7/26 Time of arrival : 10:30pm
Chief Complaints : clo. vomitings since 1 hour 3 episodes
Height : Weight : 7.6kg Head Circumference (<2 years)
Allergies: ☐ Yes ☒ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other:

If yes, identify

Pain Screening: ☐ Yes ☒ No If Yes, Pain Score: Pain Tool Used: ☐ N Pass ☐ FLACC ☐ Wong Baker
☐ Character ☐ Location ☐ Frequency ☐ Duration

RISK FOR FALL:

If patient is < 6 years ☐ Yes ☒ No

If 'Yes' tick below fall risk intervention directly

If Patient is > 6 years

If 'Yes' Assess the below parameters

History of Falling: within past 3 months ☐ Yes ☒ No

Ambulatory Aids:

- Wheelchair ☐ Yes ☒ No
- Uses furniture for support ☐ Yes ☒ No

Gait/Transferring:

- Bedrest / immobile ☐ Yes ☒ No
- Weak ☐ Yes ☒ No
- Impaired ☐ Yes ☒ No

Mental Status: Forgets limitations ☐ Yes ☒ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening: ☒ No Abnormalities Detected

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

Inform consultant for positive criteria

Nutritional Screening: ☒ No Abnormalities Detected

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

Inform consultant for positive criteria

Psychological Screening: ☒ No Significant Findings

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

If Yes Consultant Notified: (Date/Time):

Social History: Lives With family

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

Time of Initial assessment completed by ER Nurse :

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

Time	Nursing Notes
10:36pm	Assess the pt condition monitor the vitals

Samples collected by:

lop

Time:

Time:

lop

Samples sent by :

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1
10:35pm	ondem	po	3 ml		✍

Condition of patient at time of shift - out :	Details of Shift - out
HR: 109b/m BP: CFT: RR: SPO2 at FiO2: 99% GCS: Temperature : 97°F Pain Score: Repeat RBS (if applicable):	Shift - out from ER to: ward Time of Shift - out: 1:21am Handover given to: Sumon (Nurse's Name)

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any):

IV placement done

Name of the Nurse : Bhargava

Signature of the Nurse : 

Date & Time : 5/7/26 @ 10:38pm

211

NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 6/7/26 Time: 10 Am

Weight: 7 kg Centile: 5th

Height: Centile:

Inference: underweight child

RDA: Calories: 98 kcal/kg/d Protein: 1.6 gms/kg/d

Diet Recommendations: High fiber diet = more liquids

Rx-Assessment: Avoid Spicy, chilled & outside foods

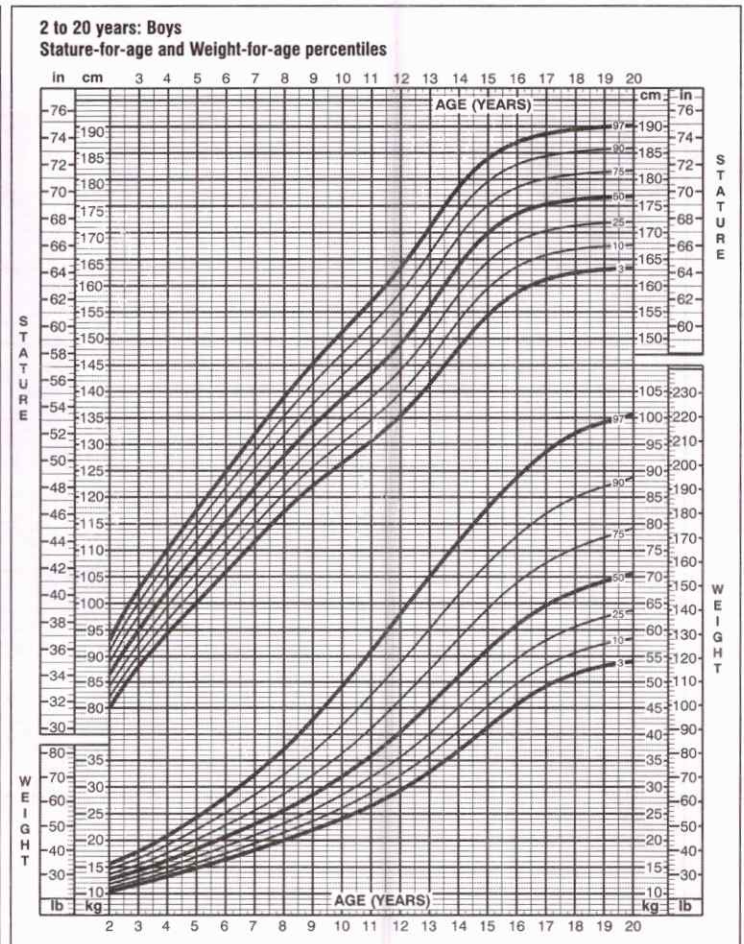
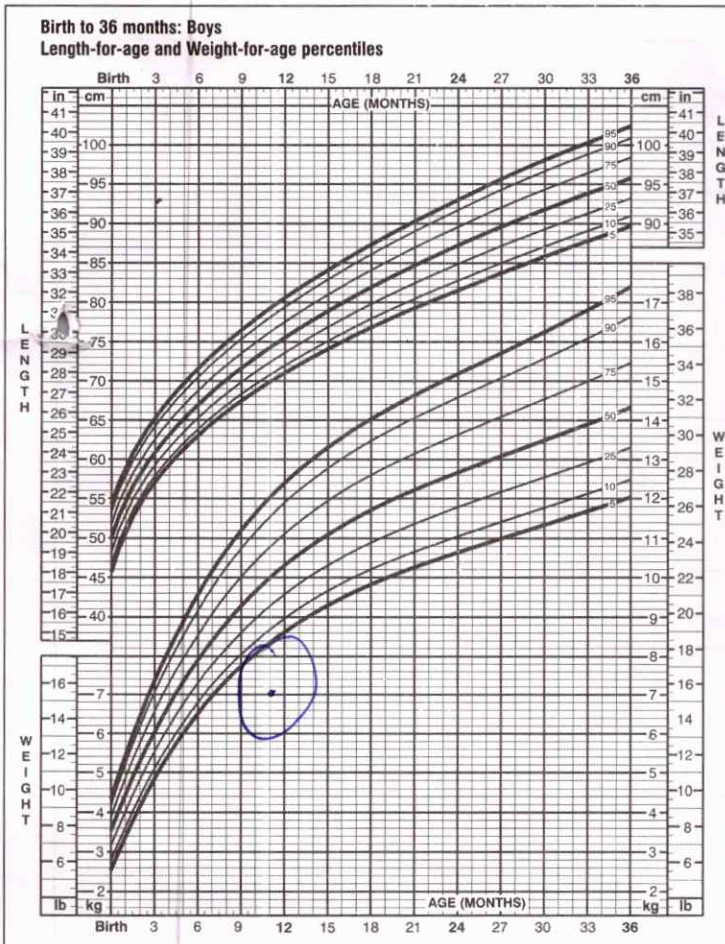
Food Allergies: NO Veg/Non-veg: NON-Veg.

Diagnosis: Severe Acute Gastritis & Dehydration

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: Shivan

GROWTH CHART (BOYS)



Dietician's Name: Sathwik G

Dietician's Signature: [Signature]

[illegible]



246 → 241 → (102)

RESULT SHEET

Date	6/7/26					
Time						
Hb	9.1					
PCV	27.6					
RBC	4.91					
WBC	12.15					
N/L	67.3/27.3					
Platelets	388					
CRP						
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						



Patient Sticker

L / 124

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

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 6/7/25 Time: 2am 5am

Doctor/Nurse/Family Concern?

Temperature
(°F)

104
103
102
101
100
99
98
97
96
95
94

Heart Rate
(bpm)

and

Blood Pressure
(mmHg) *

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

Note:
BP does not score
in early
warning scoring

Heart Rate (Number)

135b/m 125b/m

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

70
60
50
40
30
20
10

Resp Rate (Number)

28b/m 28b/m

Resp Mod/ Severe
Distress None / Mild

Receiving O₂ (l/min)
O₂ Saturations (%)

99% 99%

Conscious Level
Normal
Altered

GCS *

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

ACTIONS

NB: Scores 3 should be
recorded overleaf

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

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)

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 6/7 Time: 10Am 2Am

Doctor/Nurse/Family Concern?

Temperature (°F)

104
103
102
101
100
99
98
97
96
95
94

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

Heart Rate (Number)

125b/m 123b/m

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

70
60
50
40
30
20
10

Resp Rate (Number)

136b/m 136b/m

Resp Mod/ Severe Distress None / Mild

Receiving O₂ (l/min)
O₂ Saturations (%)

100% 99%

Conscious Level Normal Altered

GCS *

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

ACTIONS

NB: Scores 3 should be recorded overleaf

Score 1 : Continue normal observation by staff nurse

Score 2 : Shift in charge nurse to be informed and continue hourly observations

Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.

Score 4 : Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see

Score 5 & 6 : Shift 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.

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

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

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: Time:													
Doctor/Nurse/Family Concern?													
Temperature (°F)	104												
	103												
	102												
	101												
	100												
	99												
	98												
	97												
	96												
	95												
	94												
Heart Rate (bpm) and Blood Pressure (mmHg) *	190												
	180												
	170												
	160												
	150												
	140												
	130												
	120												
	110												
	100												
	90												
Note: BP does not score in early warning scoring	80												
	70												
	60												
	50												
Heart Rate (Number)													
Resp. Rate (bpm) (Over 1 Minute) *	70												
	60												
	50												
	40												
	30												
	20												
	10												
Resp Rate (Number)													
Resp Distress	Mod/ Severe None / Mild												
Receiving O ₂ (l/min) O ₂ Saturations (%)													
Conscious Level	Normal Altered												
GCS *													
TOTAL SCORE													
Number of shaded boxes													
Pain Score													
Observer's Initials													
ACTIONS NB: Scores 3 should be recorded overleaf	Score 1 : Continue normal observation by staff nurse												
	Score 2 : Shift in charge nurse to be informed and continue hourly observations												
	Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.												
	Score 4 : Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see												
	Score 5 & 6 : Shift 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.

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.
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INFANT (<1 year)
Children's Observation &
Early Warning Scoring Chart**EARLY WARNING SCORE: CHILDREN'S UNIT**

Date: Time:

Doctor/Nurse/Family Concern?

Temperature
(°F)104
103
102
101
100
99
98
97
96
95
94Heart Rate
(bpm)

and

Blood Pressure
(mmHg) ***Note:**
BP does not score
in early
warning scoring190
180
170
160
150
140
130
120
110
100
90
80
70
60
50

Heart Rate (Number)

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

Resp Rate (Number)

Resp Mod/ Severe
Distress None / MildReceiving O₂ (l/min)
O₂ Saturations (%)Conscious Normal
Level Altered

GCS *

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

ACTIONSNB: 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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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	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	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 :							
6/1/23	02:00 am	↑		21ml									
	03:00 am	↑	DDF	21ml									
	04:00 am	DMS		21ml									
	05:00 am			21ml									
	06:00 am	↓		21ml									
	07:00 am			21ml									
Total Intake :						Total Output :							
Total 24 hrs. Intake						Total 24 hrs. Output							

FLUID CHART

Sheet No. :

1. All measurements in ml.
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		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
6/7/26		↓ DNC	Mouth	I.V	N.G							1 0 1 M-	
	08:00 am			21 ml									
	09:00 am			21 ml									
	10:00 am			21 ml									
	11:00 am			21 ml									
	12:00 pm			21 ml									
	01:00 pm												
Total Intake :						Total Output : U-							
	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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	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
	Total Intake :						Total Output :					
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						Total Output :						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						Total Output :						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						Total Output :						
Total 24 hrs. Intake												
Total 24 hrs. Output												

Patient Sticker

FLUID CHART

Sheet No. :

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		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
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	12:00 pm												
	01:00 pm												
Total Intake :						Total Output :							
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	03:00 pm												
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Total Intake :						Total Output :							
	08:00 pm												
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	10:00 pm												
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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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	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
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Total Intake :						Total Output :							
Total 24 hrs. Intake						Total 24 hrs. Output							

Patient Sticker

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	06:00 am																								
	07:00 am																								
Total Intake :						Total Output :																			
Total 24 hrs. Intake													Total 24 hrs. Output												

NURSING CARE RECORD

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	2am to 8am	Assess the pt condition to monitor the v/s maintain the I/O Drug as per chart	2am to 8am	Assess the pt condition to monitor the v/s maintain the I/O Drug as per chart	Now baby is stable	Rechecked the v/s	

1-00009/52
 Patient SHANKUR VIRANSH
 08-2025 0 Y 11 M 2 D (M)
 SINDHURA MUNUKUNTALA



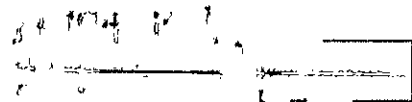
NURSING CARE RECORD

Date: 6/7/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8AM / 2PM	→ Assess the general condition of pt. → Monitor vitals. → Maintain I/O chart. → Administer medication.	8AM / 2PM	→ Assessed the general condition of pt. → Monitored vitals. → Maintained I/O chart. → Administered medication.	Pt is Stable	Re-assess vitals.	Moutush
Afternoon							
Night							



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							

Patient Sticker

NURSING CARE RECORD



Date:

Goals

- ☐ Maintain Airway and Oxygenation
- ☐ Maintain Personal Hygiene
- ☐ Identify Potential Complications
- ☐ Relieve Pain & Discomfort
- ☐ Prevent Infection
- ☐ Any Others. Specify.....
- ☐ Maintain Fluid Balance
- ☐ Meet Elimination Needs
- ☐ Improve Activity Tolerance
- ☐ Ensure Safety
- ☐ Maintain Good Nutritional Status
- ☐ Early Ambulation Reduce Anxiety
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	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon							
Night							

CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0	0									
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									
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	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									
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									
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord pyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5	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 of Ward In Charge :

Signature : Name :

Signature : Name :

Patient Sticker

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

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

CHECKLIST FOR THROMBOPHLEBITIS

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Signature of Ward In Charge :

Signature : Name :

Signature : Name :

CHECKLIST FOR THROMBOPHLEBITIS

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				M	E	N	M	E	N	M	E	N	
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Signature of the Nurse													

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Signature of Shift In Charge :

Signature of Ward In Charge :

Signature : Name :

Signature : Name :

CHECKLIST FOR THROMBOPHLEBITIS

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				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										
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Signature of the Nurse													

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

Signature of Shift In Charge :

Signature of Ward In Charge :

Signature : Name :

Signature : Name :

PAIN ASSESSMENT FORM

Date	Time	(0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
6/7/26	1am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
6/7/26	6Am	0/10	NA	☐ Continuous ☒ Intermittent	☐ Acute ☐ Chronic	☒ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	NA	
6/7/26	10AM	0/10	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:

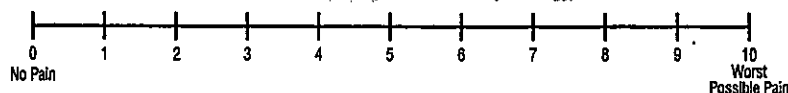
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

Numerical Pain Scale (Obstetric and Gynecology)



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

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

Wong - Baker (Pediatrics) Above 7 Years



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
				☐ 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		
				☐ 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:

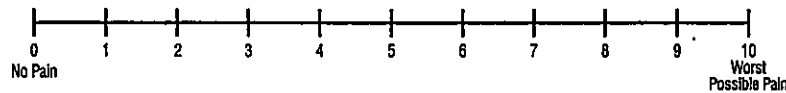
1. Every eight hours for all hospitalized patients.
2. For post-surgical patients, patients with chronic pain, patient with severe pain:
 - a) At least every 2 hours for the first 24 hours
 - b) Then every 4 hours.
 - c) Prior to pain pain-relieving intervention.
 - d) Within 30 – 60 minutes after pain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

PAIN ASSESSMENT TOOLS

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Wong - Baker (Pediatrics) Above 7 Years





Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	5/7/26	6/7/26	Fall Risk Grading		
		Score	M ₁	N ₁			
History of Falling (immediately or w/in 3 months)	Yes	25			Risk Level	Morse Fall Score (MFS)	Action
	No	0	0	0			
Secondary Diagnosis (more than one diagnosis)	Yes	15			Low Risk	0 - 24	Standard Fall Precaution
	No	0	0	0			
Ambulatory Aid	Furniture	30			Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	Crutches, Cane(S), Walker	15					
	None /Bed Rest /Nurse Assist	0	0	0			
IV / Heparin Lock or Saline	Yes	20	20	20	High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	No	0	1				
GAIT / Transferring	Impaired	20					
	Weak (uses touch for balance)	10					
	Normal /On Bed Rest /Immobile	0	0	0			
Mental Status	Forgets limitations	15					
	Oriented to own ability	0	0	0			
Total Morse Fall Scale Score:			20	20			
Signature			(Signature)	(Signature)			

Tick (✓) whichever precaution taken.

Risk Level and Interventions

Low Risk (0 - 24) (Standard Falls Precautions)

- ☐ Ensure patients use their prescribed eye glasses if any, in the hospital
- ☐ Use chairs with arm rests
- ☐ Use safety straps on stretchers and wheelchairs while transporting patients

Moderate Risk (25-50) Apply all low risk intervention and

- ☐ Assist and/or supervise ambulation. Reinforce to always call for assistance
- ☐ Hourly safety check
- ☐ Assess patient after visitors, leave to ensure safety measures in place

High Risk (≥ 51) Apply all low and moderate risk interventions, and.

- ☐ Initiate constant observation by healthcare provider as appropriate to patient's needs

Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time				Fall Risk Grading		
		Score						
History of Falling (Immediately or w/in 3 months)	Yes	25				Risk Level	Morse Fall Score (MFS)	Action
	No	0						
Secondary Diagnosis (more than one diagnosis)	Yes	15				Low Risk	0 - 24	Standard Fall Precaution
	No	0						
Ambulatory Aid	Furniture	30				Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	Crutches, Cane(S), Walker	15						
	None /Bed Rest /Nurse Assist	0						
IV / Heparin Lock or Saline	Yes	20				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	No	0						
GAIT / Transferring	Impaired	20						
	Weak (uses touch for balance)	10						
	Normal /On Bed Rest /Immobile	0						
Mental Status	Forgets limitations	15						
	Oriented to own ability	0						
Total Morse Fall Scale Score:								
Signature								

Tick (✓) whichever precaution taken.

Risk Level and Interventions

Low Risk (0 – 24) (Standard Falls Precautions)

- ☐ Ensure patients use their prescribed eye glasses if any, in the hospital
- ☐ Use chairs with arm rests
- ☐ Use safety straps on stretchers and wheelchairs while transporting patients

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- ☐ Hourly safety check
- ☐ Assess patient after visitors, leave to ensure safety measures in place

High Risk (≥ 51) Apply all low and moderate risk interventions, and.

- ☐ Initiate constant observation by healthcare provider as appropriate to patient's needs

SHIFT HAND OVER FORM

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
	Surgery / Procedure:		Post OP Day:					
BACKGROUND	Date	Shift	5/7/26 N	6/7/26 M				
	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: 98.3°F	98.4°F				
	Res:		22b/m	40b/m				
	SpO ₂ :		99%	99%				
	Pulse:		132b/m	134b/m				
	BP:		—	—				
	LOC:		—	—				
	Fall Risk Score:		"0"	"0"				
Pain Score:		"0"	"0"					
Skin Integrity		Good	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 :		Sugandha Mouthash						
Signature / ID :								
Date:		6/7/26						
Time:		1am						
Taken Over By Name :		Mouthash						
Signature / ID :								
Date:		6/7/26						
Time:		8AM						

Patient Sticker

NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
	Surgery / Procedure:		Post OP Day:					
BACKGROUND	Date							
	Shift							
	Medical Condition (Any special condition to be noted):							
	Diet:							
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Ventilation (RA, NP, NIV, VENTI):							
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Vital Signs:	Temp:						
		Res:						
		SpO ₂ :						
		Pulse:						
		BP:						
		LOC:						
		Fall Risk Score:						
		Pain Score:						
		Skin Integrity						
Recommendations	Safety Needs:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Physiotherapy:							
	Others Specify:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Special Diet:							
	Critical Lab Test / Values:							
	Other Special Orders / Medications:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	PU Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	DVT Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	ADL (Dependent / Non-Dependent):							
Post Operative Procedure Special Orders:								
Handed Over By Name :								
Signature / ID :								
Date:								
Time:								
Taken Over By Name :								
Signature / ID :								
Date:								
Time:								