

ACTIVITY RECORD FOR BILLING

VIH-00206684 IP-00060610

Master ADIYAN AHMED

08-02-2014 12 Y 5 M 0 D (M)

Name: ----- Dr. AKHEEL SYED RIZWAN

UHID No: -----

Consultant: ----- Dept: ped. Pediatrician

Date of Admission: 8/7/26 Time: ----- Date of Discharge: ----- Time: -----

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
8/7/26	5am	ER	PICU	<u>[Signature]</u>

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1.	Dr. Mohd Abdul Chaudhary	8/7/26	3098860	<u>[Signature]</u>
2.	Dr. Sukvinder Bindra	8/7/26	3099099	<u>[Signature]</u>
3.	Dr. Hemaja	09/7/26	3100669	<u>[Signature]</u>
4.	<u>Class checked by Team</u>			<u>09/7/26 at 11:30</u>
5.				
6.				
7.				
8.				
9.				
10.				

INVESTIGATIONS			
Date	Investigations	Order No.	Sign
8/7/26	Covid RAT Negative.	26022740	(14)
	VBG RBS -100 mg/dl		
	CBP, CRP, Blood c/s	26022739	(14)
	Electrolytes Urea		
	Creatinine LFT		
	PT/APTT, HIV test		
8/7/26	CE spot protein (negative)	26022790	✓
8/7/26	Ultrasound Abdomen	26010923	✓
8/7/26	Aso titers	26022849	✓
8/7/26	ESR, CPK	26022781	✓
	Clen checked by Bhuvi 09/7/26 at 11:30p		
11/7	CBP, LFT, PT/INR	26028134	✓
	Clen checked by Bhuvi		

INVESTIGATIONS			
Date	Investigations	Order No.	Sign
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	VBG RBS -100 mg/dl		
	CBP, CRP, Blood c/s	26022739	(14)
	Electrolytes Urea		
	Creatinine LFT		
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8/7/26	CE spot protein (negative)	26022790	✓
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	Clen checked by Bhuvi 09/7/26 at 11:30p		
11/7	CBP, LFT, PT/INR	26028134	✓
	Clen checked by Bhuvi		

MEDICAL EQUIPMENT (WARD & ICU)

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
8/7/26	IV placement	3098719	1	
	(CLO) checked by Reed 09/11/26 at 11:30			

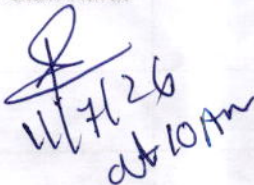
ANY OTHER INFORMATION

Covid Trat - Negative

Date :

Time :

Prepared By :

Staff Nurse  11/7/26 at 10 AM	Shift / Ward	Billing Assistant	Billing Supervisor
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IP-00060610

Patient Name : 08-02-2014 12 Y 5 M 2 D (M)

Dr. AKHEEL SYED RIZWAN

Sl.No	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission Sheet	1	-	-	
2	Discharge Summary				
3	Nursing Initial assessment form	1	-	-	
4	Patient Transfer Forms	2	-	-	
5	In-patient Medical Record	3	-	-	
6	Doctors Progress Sheets	8	-	-	
7	Nurses Progress notes	6	-	-	
8	Consultation Sheets	9	-	-	
9	General Consent for Treatment	1	-	-	
10	Consent for Surgery				
	Consent for Blood Transfusion				
12	Consent for Chemotherapy				
13	Consent for High Risk				
14	Consent for Restraint				
15	DAMA Consent				
16	Consent for Special Procedure				
17	Consent for Radiological Investigations				
18	Consent for HIV Test	1	-	-	
19	Anaesthesia consent form				
20	Anaesthesia notes(Pre Anaesthesia & Post)				
21	Pre Operative checklist				
22	Surgical safety Checklist				
23	Operation Theatre notes				
24	Nurses Clinical Presentation				
25	TPR & BP chart	3	-	-	
26	Intake and Output chart (fluid Chart)	2	-	-	
	Drug Chart (Regular prescription)	4	-	-	
28	Daily Investigation sheet				
29	Investigation Values (Result Sheet)	1	-	-	
30	Nebulization Chart				
31	Diabetic chart				
32	Nutritional Review chart	1	-	-	
33	MLC form (in case of MLC)				
34	Patient Education Form				
	Admission in PICU	1	-	-	
	Others	23	-	-	
	Total No. of Pages	59			

Signature and Date : *Vaidyanathan*
11/7/26

ERROR LOG

LOCATION: - NICU / PICU / HDU / OT / GENERAL WARD

ICD CODE :-

OBSERVATION: -

DATE :

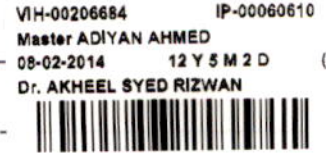
MRD EXECUTIVE



NEBULISATION CHART

Date	Time	Drug	Nurse	Parents Signature
8/7/26	00:00	2PM → Zytec gel, liquid paraffin	Thana 8/7/26 8PM	
	01:00	4PM → liquid paraffin		
	02:00	6PM → Zytec gel + liquid paraffin		
	03:00	8PM → liquid paraffin		
	04:00	10PM → Zytec gel + liquid paraffin	Sr. Dewira 9/7/26 @ 8AM	
9/7/26	05:00	12AM → liquid paraffin		
	06:00	2AM → Zytec gel		
	07:00	4AM → liquid paraffin		
	08:00	6AM → Zytec gel + liquid paraffin	Remy 9/7/26 2PM	
	09:00	8AM → liquid paraffin		
9/7/26	10:00	10:45 - liquid paraffin		
	11:00	12:15 PM - Liquid Paraffin		
	12:00	2:15 PM - Liquid Paraffin	Nik Khattha 9/7/26 @ 8PM	
	13:00	4PM - Liquid paraffin 12 Zytec gel		
	14:00	6PM - liquid paraffin,		
	15:00	8PM - liquid paraffin, Zytec		
	16:00	12AM 3AM - Liquid paraffin	Gor	
	17:00	12AM - Zytec gel		
	18:00	7AM - Liquid paraffin + Zytec gel	Gor	
	19:00			
10/9.	20:00	11AM - Liquid paraffin + Zytec gel	Ashwaq	
	21:00	12PM - Zytec gel		
	22:00	3PM - Liquid paraffin		
	23:00	3PM - Zytec gel		
		7PM - Liquid paraffin		
		1PM - Zytec gel		

Patient Name : **Master ADIYAN AHMED**
08-02-2014 12 Y 5 M 2 D (M)
Dr. AKHEEL SYED RIZWAN
Registration No.: -



NEBULISATION CHART

Date	Time	Drug	Nurse	Parents Signature
10/7/26	00.00	11pm - Liquid parafin + xylte gel.	Gap	
11/7/26	1.00			
	2.00	3Am - Liquid parafin + xylte gel.	Gap	
	3.00		Refused	
	4.00	8.00Am - Liquid parafin + xylte gel.	Gap	
	5.00			
	6.00			
	7.00			
	8.00			
	9.00			
	10.00			
	11.00			
	12.00			
	13.00			
	14.00			
	15.00			
	16.00			
	17.00			
	18.00			
	19.00			
	20.00			
	21.00			
	22.00			
	23.00			

ADMISSION SHEET



Registration Details :

Admission No : IP-00060610

Admit Date : 08-Jul-2026

Admit Time : 03:43 AM UHID : VIH-00206684

Patient Details :

Patient Name : Master ADIYAN AHMED

Age : 12 Y 5 M 0 D

Guardian : Mr ASHFAQE AHMED

DOB : 08-02-2014

Gender : Male

Religion :

Occupation :

Marital Status :

Address (H) : 9-20-1081,MUJAHID NAGAR,NIZAMABAD
Nizamabad Hyderabad Telangana INDIA
503001

Phone No : 9347457486

E-mail : NA@GMAIL.COM

Admission Details :

Bed Type : SHARED WARD

Bed No : ER 101

Ward Name : N 0 GF-EMERGENCY

Room No : ER 101

Admission Type : First Visit

Contact Details :

Name : Mr ASHFAQE AHMED

Relationship : Father

Contact Address : 9-20-1081,MUJAHID NAGAR,NIZAMABAD
Nizamabad Hyderabad Telangana INDIA 503001

Phone No : 9347457486

Signature

Doctor Details :

Doctor Name : Dr. AKHEEL SYED RIZWAN

Specialisation : GENERAL PEDIATRICS

Referral Doctor : DR ARCHANA CHITIMILLA

Phone No :

Co-Consultant :

Payment Details :

Deposit Amount : 40000.00

Payment Mode : Cash

Payor Name : SELFPAY

Patient Name : Mast. ADIYAN AHMED UHID : VIH-00206684 IPD : IP-00060610 Gender : Male Age : 12 Y 5 M 0 D

VIH-00206684 IP-00060610
Master ADIYAN AHMED
08-02-2014 12 Y 5 M 0 D (M)
Dr. AKHEEL SYED RIZWAN



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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 8/7/26 Time of arrival : 2:45AM
Chief Complaints: Fevers, leg pains, Rash all over the body RBS: 100 mg/dl
Height : 137cm Weight : 26.9kg BMI : — Head Circumference (<2 years) : —
Allergies: ☐ Yes ☒ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other: —
If yes, identify : —
Pain Screening: ☒ Yes ☐ No If Yes, Pain Score: 4 Pain Tool Used: ☐ N Pass ☐ FLACC ☒ Wong Baker
☐ Character: Aching ☐ Location: legs ☐ Frequency: Intermittent ☐ Duration: —

RISK FOR FALL:

- ☐ If patient is < 6 years
tick below fall risk intervention directly
☒ If Patient is > 6 years
Assess the below parameters
- History of Falling: within past 3 months ☐ Yes ☒ No
- Ambulatory Aids:
- Wheelchair ☐ Yes ☒ No
 - Uses furniture for support ☐ Yes ☒ No
- Gait/Transferring:
- Bedrest / immobile ☐ Yes ☒ No
 - Weak ☐ Yes ☒ No
 - Impaired ☐ Yes ☒ No
- Mental Status: Forgets limitations ☐ Yes ☒ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening: ☒ No Abnormalities Detected

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

Inform consultant for positive criteria

Nutritional Screening: ☒ No Abnormalities Detected

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

Inform consultant for positive criteria

Psychological Screening: ☒ No Significant Findings

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

If Yes Consultant Notified: (Date/Time):

Social History: Lives With Parents

Siblings in household ☒ Yes ☐ No (if yes How Many?) 2

Time of Initial assessment completed by ER Nurse : 2:48AM

Patient Name : Mast. ADIYAN AHMED UHID : VIH-00206684 IPD : IP-00060610 Gender : Male Age : 12 Y 5 M 0 D

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

Time	Nursing Notes
2:40 AM	Pt came to ER.
2:45 AM	Pt vitals checked and recoddy done.
2:50 AM	Dr. SARNA seen the pt advice Admission. Pt admission Process Done.
4:10 AM	IV placement done and Blood sample
4:20 AM	collected and send to the
4:26 AM	VBC, CovidRAT - Negative RBS my lab. Patient shifted to the PICU

Samples collected by: Dr. Iqbal
Samples sent by: Dr. Samuel

Time: 4:20 AM

Medication given in ER:

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

Condition of patient at time of shift - out	Details of Shift - out
HR: <u>97b/m</u> BP: <u>117/78</u> CFT: <u>23sec</u> RR: <u>20b/m</u> SPO ₂ : <u>100%</u> GCS: <u>15/15</u> Temperature: <u>98.4°F</u> Pain Score: <u>0/1</u> Repeat RBS (if applicable): <u>—</u>	Shift - out from ER to: <u>PICU</u> Time of Shift - out: <u>8/7/26 @ 5AM</u> Handover given to: <u>Dr. Bishu</u> (Nurse's Name) <u>Dr. Sanjay</u>

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any):

IV placement done

Name of the Nurse: Dr. Sanjay Samuel

Signature of the Nurse: Dr. Sanjay Samuel

Date & Time: 8/7/26 @ 5AM

Patient Name : Mast. ADIYAN AHMED UHID : VIH-00206684 IPD : IP-00060610 Gender : Male Age : 12 Y 5

M O D

VIH-00206684 IP-00060610
Master ADIYAN AHMED
08-02-2014 12 Y 5 M O D (M)
Dr. AKHEEL SYED RIZWAN



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EMERGENCY ROOM TRIAGE FORM

Patient's Name : Adiyan Ahmed Age : 13y Gender : ☒ Male ☐ Female

Date : 8/7/26 Time of Arrival : 2:40AM

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: 98.2°F PR: 112b/m BP: 119/70(90) RR: 21b/m SpO₂: 99%

Chief Complaints: Fever x 1 week, leg pains x 1 week, Rash all over the body x 1 week

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 : 2:44AM

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 : Samuel

Date & Time : 8/7/26 @ 2:44AM

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

Signature of Triage Nurse : Sam

PATIENT TRANSFER FORM

Patient Name & UHID No. VIH-00206684 IP-00060610 Master ADIYAN AHMED 08-02-2014 12 Y 5 M 1 D (M) Dr. AKHEEL SYED RIZWAN 		Date & Time of Admission 8/7/26 at 3:43AM	Date & Time of Transfer Order 9/7/26 at 11:40pm
		Transfer Ordered by Dr. Akheel	Reason for Transfer stable
From Unit PICU	To Unit 102	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 50 pages	Number of Imaging Films N/A	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.	Zyteegel	1	
2.	Syr. Sucralfate	1	
3.	Liquid paritaz	1	
4.	TAB. Consofunov	10	
5.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring S. Devika		Name of Person Ordered Transfer Dr. Akheel	
Patient & Clinical Records Received by : Subham			
Date & Time of Patient Received : 10/7/26 @ 11:40pm			

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

→ Cloxider mouthwash →

Kenacort gel - 1

T. Bactantment - 1

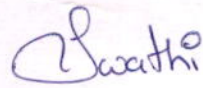
Syp. Sulfat - 1

Tab Shetcal 500mg - 10

Cetaphil + monate cream - 1

Betadine mouthwash - 1

PATIENT TRANSFER FORM

Patient Name & UHID No. VIH-00206684 IP-00060610 Master ADIYAN AHMED 08-02-2014 12 Y 5 M 0 D (M) Dr. AKHEEL SYED RIZWAN 		Date & Time of Admission 8/7/26 @ 8:	Date & Time of Transfer Order 8/7/26 @ 5a
		Transfer Ordered by Dr. Krishna Rao	Reason for Transfer for Admission
From Unit ER	To Unit PICU	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 2	Number of Imaging Films 2 BGR - 1 (1)	Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☐ No ☐			
Name & Signature of Person who is Transferring 		Name of Person Ordered Transfer Dr. Krishna Rao	
Patient & Clinical Records Received by : S. Densha			
Date & Time of Patient Received : 8/7/26 5am			

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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PEDIATRIC IN-PATIENT MEDICAL RECORD

VIH-00206684 IP-00060610
Master ADIYAN AHMED (M)
08-02-2014 12 Y 5 M 0 D
Dr. AKHEEL SYED RIZWAN


Patient Name: _____

UHID ID: _____

Department: _____

Consultant: _____



Pediatric Multiorgan History & Physical Examination

Name : Shabran Abhayan Age/Sex 12y/M
Information given by : Mother / Father Relationship Good

Chief Presenting Complaints & Duration (Chronologically)

1/0 Fever x 10 days.
vomiting / Abd. pain.
Rash.

History of present illness :

A 12yrs old Male child came to

1/0 Fever x 10 days. Max temp -
vomiting 2
Abd. pain 3 days.

↓
Local hospital 2 days symptomatically.

↓
On Day 7, severe leg pain (hip to foot) 2 myalgia
for which some meds (2 PCM + Tramadol hydrochloride)

↓
⇒ Rashes started on ~~same~~ day after tab.
non-palpable non-blanchable on 1/0

Initially on VL → gradually progressive → LL → face
" erythematous → violet line. abdom.

↓
⇒ yellowish discoloration (+). (not noticed by parents)

↓
No persistence of symp, admitted on

Manorome hospital. → Rx c doxy, pphz, Amikacin

⇒ Blood color stool (+).

⇒ ↓ oral intake, ↓ urine output



Pediatric Multiorgan History & Physical Examination

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

<u>3/9/20:</u>	<u>6/7/20:</u>	<u>LEI</u>
Hb - 12.4.	Hb - 13	SR - 4.4
WBC - 5000 (85/10).	WBC - 5000 (64/24)	OT/PT - 123
PLT - 1.80L	PLT - 2.5L	ALP - 300
USG - Abd: ? cystic.	Dejne - neg.	S. Cr - 0.6
	PT, aPTT - 36.2	INR - 1.12
	14.4.	

1.0
3.4
15

Birth & Neonatal History:

Birth & Socio Economic History:

About Father : _____
 About Mother : _____
 Any additional Information : _____

Developmental History :

Immunization History :



Pediatric Multiorgan History & Physical Examination

Anthropometry :

Head Circum (cms) _____ (Centile _____) Height (cms): _____ (Centile _____)
Weight (kgs) 26.9 kg (Centile _____)

On Examination :

Temperature : 98.2 F Pulse Rate : 112/m B.P. 119/74 (90) SPO2 99%
Resp. rate and type of breathing : 21/mt

Rash (+) Erythematous to violet line all over U/L, abdomen.
Lymphadenopathy _____

Oedema : _____
Allergies (if any): _____

Respiratory System :

Inspection (any s/o distress) : (N)
Air entry & breath sounds : BDE (+)
Any addles sounds : _____
Relevant data from outside (Chest X-Ray, ABG, etc.,) _____

Cardiovascular System :

Inspection of precordium : (N)
Heart Sounds : S1 2F
Any murmur : _____
Relevant data from outside (Chest X-Ray, ECG, ECHO, etc.,) : _____

Per Abdomen :

Inspection (N)
Palpation : soft
Auscultation : B (+)
Spine : _____ External Genitalia : _____
Relevant data from outside (CT, USG etc.,) _____

Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score :

Alert

Cranial Nerves :

Motor System:

Nutriton :

Tone:

Power

Co-ordinator :

Posture :

Involuntary Movements :

Reflexes :

DTR

Superficials:

Plantars

Sensory System :

Bladder / Bowel :

Clinical Summary & Diagnostic:

? SJS / ? Pickett's / ? meningococcal
(? NSAID induced)



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

To prevent complications

Desired goals of the treatment:

To treat the underlying cause

Planned Labs:

CBP, CRP, B/C/S, VBG
 2/4 B-uric, S. creatinine
 RBS, PT APTT INR
 LFT, USA - Abd - ✓

• extraplain ✓

• CVG upls ✓

• stool for occult blood ✓

Planned Management

- IVF 1/2 (M).

- 1w. PIPRAZ

- 1w. Esmoprazole.

- Antipyretics (PRN).

- SpO chest.

- T-MARK long BA.

noted by Samuel
 8/1/16 @ 4:30 AM

Signature of the Doctor: _____

Signature of the Consultant: _____

of the Doctor: Dr. Sharique

Name of the Consultant: _____

Date & Time: 08/07/26.

Date & Time: _____

not signed

[illegible]

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8 AM	cl/b PICU fellow.	
08/07.	Dis :- fever & Rash. ? Vasculitis ? Dry rash ? Bickettrial fever. ? STS	? Infectious mononucleosis
	cl/c No fever & Admission	
	Accepting food.	
	Arm :- Patent, Maintaining on RA.	
	Breath :- SpO ₂ : 100% on RA.	
	No distress	
	Circulation :- Peripheries warm & palp. pulses	
	HR 105 bpm	
	CRP < 3 sec.	
	Disability :- E4 V5 M6	
	pupils B/L reactive to light	
	Exposure :- Atelectasis	

noted by
Devilay 8/7/24
888

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
		<u>plan</u>
		- <u>Derma - opinion</u>
SGOT 84		- <u>Hold Piptaz & Afarax tab.</u>
SGPT 238		
T.BI 3.6		- <u>OMfs - opinion</u>
		- <u>Gastro</u>
		- <u>Nephro</u> } <u>opinion</u>
10:30 AM	clsb dr. Vishnu Sir	
	? fixed dry lips	
		- <u>Moisturize / Vaseline max.</u>
		- <u>Hospital clothing</u>
		- <u>Dermat opinion</u>
		- <u>Spot UPCA / CUT</u>
		- <u>Stool for occult blood</u>
		- <u>USG Abd.</u>
		- <u>CPK</u>

Noted by
 Remya
 8/7/24
 12:30 AM



Date & Time	Progress Notes	Doctor's Order
		— Vaseline / Lig. paraffin for lip
		— Oral care Zylce gel.
10/20/20 11:20 AM	<u>counseling notes</u> C. Vishnubabu History reviewed This can be due to drug reaction (or) infection. This should be managed conservatively if it is a drug reaction. There may be chance of skin peeling also. He needs to be followed up observed for 2-3 days for complications. He needs multidisciplinary approach with dermatology. <u>to follow</u>	Noted by Renuka 8/11/20 H

(3)

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
08/07 11:40 AM	C/D/w Dr. Himaja Reddy (Deema)	
	? SJS	
	? FDE	plan
		Inj Methylprednisolone 1mg/kg/day
		- stat dose -
		- Will review tomorrow
		see if pt. req. biopsy
08/07 11:54	C/D/w Dr. Sukinder (please see again) ONE surgeon	
	? SJS	plan
		- TO start Inj methylprednisolone @ 1mg/kg/day
		- kenalog gel 4-5 times a day.
		- NO red ASO time
		- T. Bact ointment
		Noted by Renuka/8/7/20

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



4

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/7/2026 8:30 AM	C/SIB prev fellow	
	A ¹⁵ - SJS vs PDE [? to Mmado]	
	on Room Air	
	maintaining saturation.	Plan
	Hemodynamically stable	
	no skin lesions / swelling	" To decide on cyclospore
	Ord mucosa (2)	continued may
	UPC8 → 0.05 (2) Lip pearly (2)	3) do continue
	ERM 10	and case
	Genital involvement	skin case
	CPK → 20 (+)	4) No collect too like
	continue do study Q	report
	Getentried p	
	Body pain of	
	Get up pain	

- ① LRF - Apply once over the body.
- ② Cetaphil Restoderm lotion.
- ③ Betadine mouth washer.
- ④ Teff gel (for oral application)
- ⑤ i.v methyl Prednisolone
- ⑥ cap. Shalcal HD 0.5mg/kg body weight x 3 days
- ⑦ stop

DERMATOLOGY

A: 7.555

Date & Time

PROGRESS NOTES AND DOCTOR'S ORDER

Rainbow Children's Hospital

BirthRight BY RAINBOW HOSPITALS

VIH-00206684
 Master ADIYAN AHMED
 08-02-2014
 12Y5M0D
 DR. AKHEEL SYED RIZWAN
 (M)
 IP-00060610

[illegible]

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/8/2022 11:30pm	Shift out notes	
	$\Delta = 803$ vs FDE	
	A 12 year, 5 month old boy presented with fever since 10 days, rash since 5 days and vomiting, pain abdomen since 3 days.	
	On Day 4, patient had leg pain / myalgia for which OTC medications taken (ULTRACET). Rash started becoming after taking the drug - an itchy rash, initially on upper limbs, gradually progressed to involve face abdomen.	
	Initially it was erythematous. Later changed to dark brown, coloured lesions.	
	In view of persistent symptoms, patient was taken to other hospital (Manorama) treated with Doxy, pspks2 and amikacin.	
	Patient had blood in stools, decreased oral intake and decreased urine output - hence admitted in PICU.	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	In PICU, patient was started on IV fluids.	
	Relevant investigations sent: Hb = 12g/dl platelets = 4.1 lakhs, crp of 4mg/dl, urea of 6.4, creatinine of 0.5, SGPT of 238 and SGOT of 84; ESR of 18; VPCR 0.05, CUE normal, CPK 20.	
	Omphs and Dermatology opinioners taken, started on IV methylprednisolone, emollient, kenalog-steroid ointment, oral care was given.	
	USG abd was normal.	
	<u>Plan</u>	
	- oral diet	
	- IV methylprednisolone @ 0.5mg/kg/day OD x 2 days and then stop.	
	- cetaphil lotion	
	- T-Sheal 500mg OD x 10 days.	
	- liquid paraffin apply every 4 hours on entire face and body	
	- Betadine mouth washes three times a day.	



Date & Time	Progress Notes	Doctor's Order
	- Kenacort-gel - oral (mucosa & skin) 4-5 times a day - monate f cream - To blend with cetaphil lotion - Two times a day ↓ Apply on affected areas	Noted by S. Desai 11/30/11



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/2/26 8am	S/B Dr. Kundama nam SFS vs FDE (? To tramadol) off Bleed active Eutermec Vitals stable crs } rfs } rin }	
10/2/26 8am		plan 1) TO send stool for occult blood t/m
10/2/26 8am		Hold Add Atarax antiepileptic to cephalosporin
10/2/26 8am		3) CRP / CFT t/m
10/2/26 8am		Hold Plan to add 1st Atarax
		Noted by Manisha 10/2/26 @2pm

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/7/26 9 AM	CL/B Residual <u>SSS</u> No fresh complex healing lesion O/E entire WS SIS (C) B-BLAD (C) PR SSK	<u>Plan</u> Doxycycline Plan Plan + Atarax Codan Cetaphil lozin Zyke gel TRALF Kenacort gel Succralyke T. Sheldal Betadine moles Dr She
11/7/26 10:45 AM	CL/B Residual <u>SSS</u>	Plan Flip after 1 week LF 7 after 1 week Medication as per doc Noted by Vaishnavi 11/7/26 11 AM



NURSE HAND OFF COMMUNICATION - ICU

SITUATION & BACKGROUND	DOA: 8/7/26	Diagnosis: SJS, meningitis	Surgery / Procedures: —	
	Allergies: N/A	Post OP Day: —		
	Date: 8/7/26			
	Area			
	Shift Time			
	Diet: Soft diet		Plcu Night Soft diet	
INVASIVE LINES	Ventilation (RA, NP, NIV, VENTI)	RA	RA	
	1. IV cannulation	#22G	#26 cannula	
	2.			
	3.			
	4.			
ASSESSMENT	Infusions / Transfusions	—	WE DNS 35ml/hr	
	PU Prophylaxis	—	—	
	DVT Prophylaxis	—	—	
	Vitals	BP	119/79 (ao)	119/76 (84)
		PR	112b/m	120b/m
		RR	20b/m	20b/m
		SpO ₂	98%	98%
		Temp	98.2°F	98.2°F
	Pain Score	0	0	
	LOC (Alert, Conscious, Confusion, Unconscious)	conscious	conscious	
	Skin Integrity (Intact / Bedsore / Any other condition)	Intact	Intact other condition	
	Restraints If any	Physical	—	—
		Chemical	—	—
	Fall Risk (Vulnerable Y/N) if yes score		14	
(Ambulation, walking, moving with assistance, bed ridden)	Ambulation	walking		
ADL (Dependent / Non-Dependent)	dependent	dependent		
Critical Lab Test / Values (if any)	—	—		

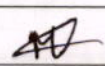
Note: RA (Room Air, NP Nasal Prongs, NIV Non-Invasive Ventilation, VENTI Ventilator)

RECOMMENDATIONS	Date:	8/7/26		
	Area			PICU
	Shift Time			Night
	Ordered / Planned	CEP, CRP, B/CIS, VBG, S/E, RAS, PT/APTT-IN, LFT, USG Abdomen		
	Due	CEP, UICIS stat for count blood		CUG, urine c/s
	Reports Pending	-		All reports
	Referrals (If any)	ATV		N/A
	Remarks (Special Interventions like, Drainage tube flushing etc.)	-		-
Handed Over By Name :		Dr. Sankar Samal		S. Datta
Signature :		Lam		LA
Date:		8/7/26		8/7
Time:		5 AM		8 AM
Taken Over By Name :		S. Datta		Ramley
Signature :		LA		By
Date:		8/7		8/7/26
Time:		8 AM		8 AM

NUISSE HAND OFF COMMUNICATION - ICU

SITUATION & BACKGROUND	DOA: 8/7/26	Diagnosis: SSS,	Surgery / Procedures: —	
	Allergies: Tab-ultraacet	Post OP Day: —		
	Date: 8/7/26			
	Area	plw	PICU	
	Shift Time	mmg	2PM-8PM	
	Diet:	soft diet	S-diet	
INVASIVE LINES	Ventilation (RA, NP, NIV, VENTI)	R/A	P/A	
	1.	1v cannula	2v cannula	
	2.	—	—	
	3.	—	—	
	4.	—	—	
ASSESSMENT	Infusions / Transfusions	DNS 35ml/w	DNS @ 35ml/hr	
	PU Prophylaxis	—	Nil	
	DVT Prophylaxis	—	Nil	
	Vitals	BP	104/70(81)mmHg	116/75(86)mmHg
		PR	101b/m	98b/m
		RR	28b/m	18b/m
		SpO ₂	98%	99%
		Temp	98.6°F	98.6°F
	Pain Score	02	0	
	LOC (Alert, Conscious, Confusion, Unconscious)	Alert	Alert	
	Skin Integrity (Intact / Bedsore / Any other condition)	Intact	Intact	
	Restraints If any	Physical	—	
		Chemical	—	
	Fall Risk (Vulnerable Y/N) if yes score	—	10	
	(Ambulation, walking, moving with assistance, bed ridden)	walking	walking	
ADL (Dependent / Non-Dependent)	Dependent	Dependent		
Critical Lab Test / Values (If any)	—	—		

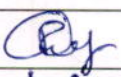
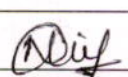
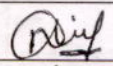
Note: RA (Room Air, NP Nasal Prongs, NIV Non-Invasive Ventilation, VENTI Ventilator)

RECOMMENDATIONS	Date:	8/7/26		
	Area	Plw / mny	Plu 2PM-8PM	Plu 8pm-8Am
	Shift Time			
	Ordered / Planned	C.S.T.	→ gastro nephro oncology C/N	→ derm g review
	Due	Nil	Nil	stool cl x11 occult blood
	Reports Pending	Nil	Blood culture	Nil
	Referrals (If any)	Nil	Nil	Nil
Remarks (Special Interventions like, Drainage tube flushing etc.)	Nil	Nil	Nil	
Handed Over By Name :		Renuka	Thann	Devi
Signature :				
Date:		8/7/26	8/7/26	9/7
Time:		2pm.	@8PM	8Am
Taken Over By Name :		Thann	Sr Devika	Renuka
Signature :				
Date:		8/7/26	9/7	9/7/26
Time:		@2PM	8Am	@8Am

NURSE HAND OFF COMMUNICATION - ICU

SITUATION & BACKGROUND	DOA: 8/7/26	Diagnosis: STS.	Surgery / Procedures:	
	Allergies: -	Post OP Day:		
	Date: 09/7/26			
	Area	PLW 8am-2pm	PLW 2pm-8pm	
	Shift Time	PLW 8pm-2pm	PLW 2pm-8pm	
INVASIVE LINES	Diet: orally allowed	soft diet	soft diet	
	Ventilation (RA, NP, NIV, VENTI)	R/A	RA	
	1. Iv-cannula	iv cannula	iv cannula	
	2. -	-	-	
ASSESSMENT	3. -	-	-	
	4. -	-	-	
	Infusions / Transfusions	-	-	
	PU Prophylaxis	-	-	
	DVT Prophylaxis	-	-	
	Vitals	BP 108/63 (88) mmHg	103/73 (81)	107/76 (84)
		PR 82 b/m	102 b/m	107 b/m
		RR 28 b/m	21 b/m	21 b/m
		SpO ₂ 99%	100%	100%
		Temp 98.6°F	98.6°F	98.6°F
	Pain Score	0	0	0
	LOC (Alert, Conscious, Confusion, Unconscious)	Alert	Alert	Alert
	Skin Integrity (Intact / Bedsores / Any other condition)	Intact	Intact	Intact
	Restraints If any	Physical	-	-
		Chemical	-	-
Fall Risk (Vulnerable Y/N) if yes score	10	10	10	
(Ambulation, walking, moving with assistance, bed ridden)	walking	walking	walking	
ADL (Dependent / Non-Dependent)	dependent	dependent	dependent	
Critical Lab Test / Values (If any)	-	-	-	

Note: RA (Room Air, NP Nasal Prongs, NIV Non-Invasive Ventilation, VENTI Ventilator)

RECOMMENDATIONS	Date:			
	Area		PICU 2pm-8pm	PICU 8pm-8am
	Shift Time			
	Ordered / Planned	- demo series.	Nil	plan to shift to room
	Due	stool occult Blood.	stool culture	stool culture due
	Reports Pending	Nil	Nil	Nil
	Referrals (If any)	Nil	Nil	Nil
Remarks (Special Interventions like, Drainage tube flushing etc.)	Nil	Nil	Nil	
Handed Over By Name :		Renuka	Nikhitha	SrDevika
Signature :				
Date:		9/7/26	9/7/26	10/7/26
Time:		2pm.	8pm	8am
Taken Over By Name :		Nikhitha	Devika	
Signature :				
Date:		9/7/26	9/7	
Time:		2pm	8pm	



NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: <u>SJS vs RDE</u>		Any Infection: ☒ Yes ☐ No ☐ Not Known If Yes Specify:				
	Surgery / Procedure: <u>—</u>		Post OP Day: <u>—</u>				
BACKGROUND	Date	Shift	10/7/26 N	10/7/26 M	10/7/26 E	10/7/26 Night	11/7/26 M
	Medical Condition (Any special condition to be noted):		<u>Nil</u>	<u>Nil</u>	<u>Nil</u>	<u>Nil</u>	<u>Nil</u>
	Diet:		<u>N. Diet</u>	<u>N. diet</u>	<u>N. diet</u>	<u>N. diet</u>	<u>N. diet</u>
ASSESSMENT	Allergy:		☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No
	Ventilation (RA, NP, NIV, VENTI):		<u>R.A</u>	<u>RA</u>	<u>RA</u>	<u>RA</u>	<u>RA</u>
	Tubes/Drains/Catheter:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:		Temp: <u>98.6°F</u>	<u>98.6°F</u>	<u>98.4°F</u>	<u>97.6°F</u>	<u>98.1°F</u>
	Res:		<u>28bpm</u>	<u>29bpm</u>	<u>20bpm</u>	<u>24bpm</u>	<u>20bpm</u>
	SpO ₂ :		<u>100%</u>	<u>99%</u>	<u>100%</u>	<u>100%</u>	<u>99%</u>
	Pulse:		<u>94bpm</u>	<u>100bpm</u>	<u>98bpm</u>	<u>93bpm</u>	<u>94bpm</u>
	BP:		<u>106/66(80)</u>	<u>99/78(63)</u>	<u>107/70(81)</u>	<u>112/66(80)</u>	<u>105/69(80)</u>
	LOC:		<u>conscious</u>	<u>conscious</u>	<u>conscious</u>	<u>conscious</u>	<u>conscious</u>
	Fall Risk Score:		<u>11</u>	<u>11</u>	<u>11</u>	<u>11</u>	<u>11</u>
Pain Score:		<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	
Skin Integrity		<u>Intact</u>	<u>Intact</u>	<u>Intact</u>	<u>Intact</u>	<u>Intact</u>	
Recommendations	Safety Needs:		☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No
	Physiotherapy:		<u>Nil</u>	<u>Nil</u>	<u>Nil</u>	<u>Nil</u>	<u>Nil</u>
	Others Specify:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Special Diet:		<u>Nil</u>	<u>Nil</u>	<u>Nil</u>	<u>N. diet</u>	<u>N. diet</u>
	Critical Lab Test / Values:		<u>Nil</u>	<u>Nil</u>	<u>Nil</u>	<u>Nil</u>	<u>Nil</u>
	Other Special Orders / Medications:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	PU Prophylaxis:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	DVT Prophylaxis:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
ADL (Dependent / Non Dependent):		<u>Dependent</u>	<u>Dependent</u>	<u>Dependent</u>	<u>dependent</u>	<u>dependent</u>	
Post Operative Procedure Special Orders:		<u>Nil</u>	<u>Nil</u>	<u>Nil</u>	<u>Nil</u>	<u>Nil</u>	
Handed Over By Name :		<u>Subham</u>	<u>manisha</u>	<u>Aniltha</u>	<u>Subham</u>	<u>Vaishnavi</u>	
Signature / ID :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>10/7/26</u>	<u>10/7/26</u>	<u>10/7</u>	<u>11/7/26</u>	<u>11/7/26</u>	
Time:		<u>8am</u>	<u>@ 2pm</u>	<u>@ 8pm</u>	<u>@ 8AM</u>	<u>@ 11AM</u>	
Taken Over By Name :		<u>manisha</u>	<u>Aniltha</u>	<u>Subham</u>	<u>Vaishnavi</u>	<u>Rife Sand</u>	
Signature / ID :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>10/7/26</u>	<u>10/7/26</u>	<u>10/7</u>	<u>11/7/26</u>	<u>11/7/26</u>	
Time:		<u>@ 8AM</u>	<u>@ 2pm</u>	<u>@ 8pm</u>	<u>@ 8AM</u>	<u>@ 11AM</u>	

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
	Ventilation (RA, NP, NIV, VENTI):						
	Tubes/Drains/Catheter:		☐ 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	
	Physiotherapy:						
	Others Specify:	☐ 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	
	PU Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	DVT Prophylaxis:	☐ 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:							

NURSING CARE RECORD

Date: 8/7/26

Goals

- ☐ Maintain Airway and Oxygenation
☐ Maintain Personal Hygiene
☐ Identify Potential Complications
☐ Relieve Pain & Discomfort
☐ Prevent Infection
☐ Any Others. Specify: nil
- ☒ 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		Assess the general condition of the child Provide IV fluids		Assessed the general condition of the child To maintain fluid balance	child is stable To prevent dehydration	child is hemodynamically stable	Renee 8/7/26 2 PM
Afternoon	2 PM ↓ 8 PM	→ Assessment → vital signs → maintain fluid balance	2 PM ↓ 8 PM	→ Assess the child condition → vitals are checked & recorded → maintained fluid balance	→ child is alert → vitals are normal → DNS @ 35 mL/hr	→ Now child is stable	Thany 8/7/26 @ 8 PM
Night	8 PM 8 AM	Assessment vitals monitoring Airway		Assessed child condition vitals monitored Airway is patent	child condition is stable Airway is clear	child is hemodynamically stable	8/7/26 @ 8 AM

NURSING CARE RECORD

Date: 9/7/26

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: <u>N.I.</u> | | | | |

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8Am	- Assessment		- Assessed the general condition	- Maintaining I/O	- hemodynamically stable	Zeenab 9/7/26 @2pm
		- vitals		- monitored vitals & Recorded.	chart.		
	2pm	- Medications.					
Afternoon	2pm	assess the patient condition	2pm	assessed the patient condition	to I/O chart	* maintain intake and output chart	Niketha 9/7/26 @8pm
		monitor vital's check & record		monitored vital's checked & Recorded	maintain 6th hrly		
Night	8pm	- Assessment		Assessed child general condition	child condition is stable	child is hemodynamically stable	Afia 10/8/26
		vitals monitoring		- vitals monitored			



NURSING CARE RECORD

Date: 10/7/26

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: <u>Nil</u> | | | | | |

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	9am	→ maintain Good Nutritional Status → Ensure safety	9:30 Am	- oral intake is Good - side rail kept up	- provided N.diet - prevent from fall risk	- patient is stable - NO fresh complaints	Manisha 10/7/26 @2pm
	3pm	→ prevent infection		→ Educated about Hand hygiene	→ To prevent infection	→ patient is Stable	Anitha 10/7 @8pm
Night	5pm	→ Ensure safety		→ To side rails kept up	→ To prevent fall risk		
	9pm	maintain good nutritional status	9pm	→ oral intake is good	→ To Provided by soft diet	→ patient is Stable	Subha 11/7 @8Am

NURSING CARE RECORD

Date: 11/12/26

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	9 AM	Maintain Fluid Balance - Ensure Safety		Discharge Notes Doctor came for rounds Patient is stable and advised for Discharge			Vaighanai 11/12/26 @11am
Afternoon							
Night							



THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
			8/7	8/7	8/7	8/7	8/7
Age	Less than 3 years old	4					
	3 to less than 7 years old	3					
	7 to less than 13 years old	2	2	2	2	2	2
	13 years old and above	1					
Gender	Male	2	2	2	2	2	2
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1	1	1	1
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own ability	1	1	1	1	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					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3			3	3	3
	Within 48 hours	2					
	More than 48 hours / None	1	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	1	1	1	1
Total		8	8	8	10	10	10

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	✓	X	✓	X	X	X
Wheels Locked	✓	✓	✓	✓	✓	✓
Room free of clutter	✓	✓	✓	✓	✓	✓
Adequate lighting	X	✓	✓	✓	✓	✓
Wheel chair cup	X	✓	✓	X	X	X
Other Intervention(s) Specify	X	X	✓	✓	X	X
Nurse's Name:	DWJ	Renay	Thorn	Decker	Renay	Renay
Signature:	Sh	Renay	Thorn	Decker	Renay	Renay
Date:	8/7/14	8/7	8/7	8/7	9/7	9/7
Time:	4:30 AM	5AM	2PM	8PM	4AM	12PM



THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
			9/7	9/7	10/7/26		10/7
Age	Less than 3 years old	4					
	3 to less than 7 years old	3					
	7 to less than 13 years old	2	2	2	2	2	2
	13 years old and above	1					
Gender	Male	2	2	2	2	2	2
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1	1	1	1
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own ability	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	2	2	2	2	2
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours/ None	1	1	1	1	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	1	1	1	1
Total			9	9	9	9	9

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		✓	X	✓	✓	✓
Wheels Locked		✓	✓	✓	✓	✓
Room free of clutter		✓	✓	✓	✓	✓
Adequate lighting		✓	✓	✓	✓	✓
Wheel chair support		✓	X	X	X	X
Other Intervention(s) Specify		✓	X	✓	✓	✓
Nurse's Name:		Renu	Manisha	Shilpa	Suh	
Signature:		Renu	Manisha	Shilpa	Suh	
Date:		9/7	10/7	10/7	10/7	4/7
Time:		4 PM	12 PM	9 AM	7 PM	3 AM



THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	11/7				
	3 to less than 7 years old	3					
	7 to less than 13 years old	2	2				
	13 years old and above	1					
Gender	Male	2	2				
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1				
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own ability	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	2				
	Outpatient Area	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			11				

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 safe		✓					
Other Intervention(s) Specify		✓					
Nurse's Name:		Haich					
Signature:							
Date:		11/7					
Time:		9AM					

BRADEN 'Q' SCALE

					Date :	8/12	8/15	8/17	8/17
					Time :	4:00 PM	5 AM	2 PM	8 PM
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4	4	4	
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4	4	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	4	4	
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	4	
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	1	1	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 of meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	4	
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4	
TOTAL SCORE					25	25	28	28	
Evaluator's Name					AK	AK	AK	AK	

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

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

BRADEN 'Q' SCALE

					Date :	9/7	9/7	9/7	10/7
					Time :	4AM	12pm	7pm	12AM
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.		4	4	4	4
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.		4	4	4	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	4	4
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.		4	4	4	4
FRICION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."		4	4	4	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 of meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.		4	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.		4	4	4	4
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23					TOTAL SCORE	28	28	28	28
Docu. No. : RCH /FRM / CLINICAL / 119					Evaluator's Name	Dr	Ram	Ry	ls

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



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
8/7/26	4:00 AM	0	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	—	Sajid
8/7	5 AM	0	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	—	hs
8/7	2 pm	02	skin burning	☒ Continuous ☐ Intermittent	☒ Acute ☐ Chronic	☒ Sharp ☐ Dull ☐ Aching ☐ Burning	☒ Increasing ☐ Decreasing	☒ Yes ☐ No	T. Butoint	Ref
8/7/26	8 pm	0	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	—	Thur
9/7	4 AM	0	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	—	hs
9/7	12 pm	0	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	—	Penk
9/7	8 pm	0	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	—	Niklu
10/7	12 AM	0	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	—	hs
10/7/26	9 AM	0	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	manisha
10/7	7 pm	0	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	Amey

Re-assessment Frequency:

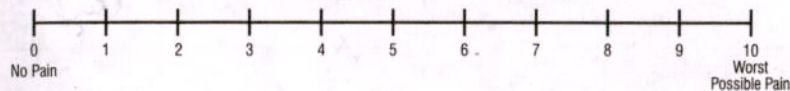
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

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, 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

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
10/2/26	10PM	0	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	Subhan
11/2/26	9AM	0	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	—	Varishul
				☐ 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:

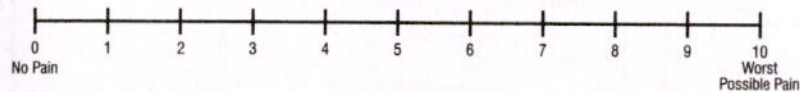
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

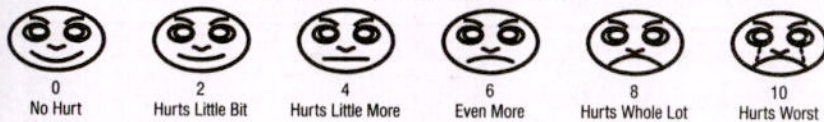
Numerical Pain Scale (Obstetric and Gynecology)



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





CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0			0	0	0	0	0	0	0	
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1			-	-	-	-	-	-	-	
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						Su	Raj	R	to	re	R	to	

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 : Kiran Name : Kiran

Signature of Ward In Charge :

Signature : Suj Name : Sujata



CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	10/9/26 DAY-1			11/9 DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0	0	0	0	0						
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1	-	-	-	-						
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	-	-	-	-						
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3	-	-	-	-						
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4	-	-	-	-						
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord pyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5	-	-	-	-						
Signature of the Nurse				MS	AK	sub	MS						

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 : priyanka Name : priyanka

Signature of Ward In Charge :

Signature : Eliz Name : Elizabeth

GENERAL CONSENT FOR TREATMENT

Patient Name:	Master ADIYAN AHMED	Age :	12 Y 5 M 0 D
IP No:	IP-00060610	Sex:	Male
Consultant:	Dr. AKHEEL SYED RIZWAN	Ward/Bed No:	N 0 GF-EMERGENCY/ER 101

The undersigned patient and I or responsible relative or person hereby consent to and authorize Rainbow Hospitals doctors and medical personnel to perform medical examinations, conduct routine investigations and administer medical treatments, outpatient procedures, minor dressings, vaccinations and immunizations during the course of the patient's care, as in patient.

Patient, be deemed advisable or necessary.

I understand that the confidentiality of all medical records shall be protected to the full extent of the Law. The undersigned consent to the use of health related information/ audiovisuals of the patient for research & training purpose or for insurance coverage and while doing so confidentiality of the patient will be maintained at all times and this will not affect the care of the patient.

In giving my general consent to treatment, I understand that I retain the right to refuse any particular examinations, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by treating doctors. I also understand that the practice of medicine is not an exact science and that no guarantee have been made to me as the results of my evaluation and I or treatment.

I understand that I shall not bring valuables to the Hospitals and that the Hospital will not be responsible for the loss, destruction or theft of my personal belongings. I assume full responsibility for all my personal items and release the Hospital from responsibility and liability for such personal items and valuables.

"I am aware that during the patient care it is inevitable that certain re-useable equipment shall be re-used after sterilization and disinfection. I am informed that the hospital assures maximum level of precaution and care in sterilizing and disinfecting the equipment and monitors the whole process as per evidence based guidelines".

Note:

1 We do not allow use of medication brought from outside by the patient.

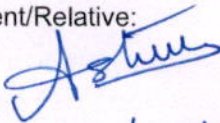
2 I have received attendant passes as per my room category. I understand that I have to return it back at the time of final bill clearance. In case of failing the submission, I will pay 200/- Rs.

(Receivers Signature:.....)

3 IP Guide book has been given to me and I have been explained about the Hospitals rules and policies.

4 Financial and billing counseling has been done to me.

Signature of Patient/Relative:



Name: Ashirac Ahmed

Relationship: Father

Date: 08-07-2026

Time:

Witness Name: 

Witness Signature: 

Patient Address:

9-20-1081,MUJAHID NAGAR,
NIZAMABAD Nizamabad Hyderabad
Telangana INDIA 503001



CONSENT FORM FOR HIV

Patient Name : most. Adiyon Ahmed Age : 17.4
 Gender : M ☒ F ☐ - IP No : 60610 Marital Status : —
 Ward / Bed No. : PIU IP/OP No. : 60610 Date : 8/7/26

I have to say that I have been counseled about the test and the reason for undergoing the test has been clearly explained to me. I have also been explained about the implications of the test result-positive, negative or indeterminate All the details pertaining to HIV, its transmission, testing procedure Its limitations and interpretation of the results have been explained to me in language that I can understand.

I, hereby give my willful consent for the HIV test to be conducted on me in order to ascertain my HIV sero status. The status of my HIV test will be confidential

Patient Attendant :

Signature : Ashfaq
 Name : Ashfaq Ahmed
 Relationship with Patient : Father
 Date & Time : 8/7/26 @ 4:30 AM

Parent (when patient is minor) :

Signature :
 Name :
 Relation :
 Date & Time :

OR (Next to kin in case of unconscious patient) :

Signature : Name :
 Relation : Date & Time :

I, certify that the Consent form for the HIV test has been signed in my presence and patient has been given pre-test counseling and post-test counseling is ensured by me and my team.

Doctor :

Signature : [Signature]
 Name : Dr. Shoune
 Date & Time : 8/7/26 @ 4:30 AM

హెచ్.ఐ.వీ పరీక్ష అంగీకార పత్రం

రోగి పేరు వయస్సు లింగం పు ☐ స్త్రీ ☐

వివాహస్థితి వార్డు / బెడ్ నెంబర్.....

హెచ్.ఐ.వి టెస్ట్ గురించి నాకు అవగాహన కల్పించటమైనదనియు మరియు పరీక్ష చేయించుకోవలసిన కారణము నాకు స్పష్టముగా వివరించటమైనది అప నేను చెప్పుచున్నాను. ఈ టెస్ట్ ఫలితం యొక్క పర్యవసానాలకు పాజిటివ్, నెగిటివ్ లేక నిర్ధారణ విధానము, దాని పరిమితులు మరియు ఫలితాల వివరణకు నాకు అర్థమయ్యే భాషలో వివరించారు.

నా హెచ్.ఐ.వి. రోగిస్థితి అంచనా వేయటానికి నాపై జరుపబడే టెస్టుకు నేను ఇష్టపూర్వకంగా తెలుపుతున్నాను. నా హెచ్.ఐ.వి. పరీక్ష ఫలితం రహస్యంగా వుంచాలి.

రోగి	సాక్షి
సంతకము:	సంతకము:
పేరు:	పేరు:
బంధము:	బంధము:
తేదీ మరియు సంతకము:	తేదీ మరియు సమయము:
(రోగి అవస్థారక స్థితిలో వున్నచో అతని దగ్గరి రక్త బంధువు)	
పేరు:.....	సంతకము:
సంబంధము :	తేదీ మరియు సంతకము:

హెచ్.ఐ.వి. టెస్ట్ అంగీకార పత్రంపై నా సమక్షంలో సంతకం చేయబడిన దనియు, టెస్టుకు ముందు ఇవ్వవలసిన సలహా ఇవ్వబడిన దనియు మరియు టెస్ట్ తర్వాత ఇవ్వవలసిన అవగాహన ఖచ్చితంగా ఇవ్వగలమని నేను నా బృందం ధృవీకరిస్తున్నాము.

డాక్టర్

సంతకము

పేరు

తేదీ మరియు సమయము

**CONSENT FOR ADMISSION
IN PEDIATRIC INTENSIVE CARE UNIT**

Name: Master Adiyun Ahmed Age: 124 Gender: Male ☒ Female ☐
UHID.No : 206684 Date: 8/7/26
I, Ashfaqur Ahmed S/o, D/o, W/o, M.A Majeed, hereby
declare that our patient Master/Baby Adiyun Ahmed who is related to me as child
is getting admitted in the Pediatric Intensive Care Unit of Rainbow Children's Hospital on 8/7/26

The doctors have explained to me in a language understood by me that my child has following health related issues :

The doctors have clearly explained to me that my patient Master / Baby Adiyun Ahmed during his / her stay in the Pediatric Intensive Care Unit may undergo various medical and surgical procedures like airway management, mechanical ventilation, Central Line Insertion, Peripherally Inserted Central Catheter Line and arterial line placements, chest drain, or peritoneal drain insertion etc.

I have been told by the doctors that while performing such procedures I will be informed and a separate consent for this p Health shall be taken. However, in case of any life threatening emergency if the time is not available for taking informed consent it is implied that I give consent for various invasive procedure to save the life of my child. I understand that a sick child in Pediatric Intensive Care Unit has life threatening medical conditions.

I understand that when a child is sick in the Pediatric Intensive Care Unit with multiple medical and surgical procedures performed upon him/her, there are inherent risks due to these high risk procedures, and high risk medications, in the form of infections, bleeding, air leaks, skin and other tissue damage etc.

I give my consent to the team of doctors to go ahead and admit the child Master / Baby : Adiyun Ahmed in the Pediatric Intensive Care Unit fully understanding the associated risk, benefits and alternatives involved from various procedures, high risk medications and infections in the Pediatric Intensive Care Unit and treat him/her with all necessary means.

The doctors have explained to me in the language best understood to me.

Patient Attendant :

Signature: Ashfaqur Ahmed
Name: Ashfaqur Ahmed
Relationship with Patient: Father
Date & Time: 8/7/26 @ 4:30 AM

Witness :

Signature: _____
Name: _____
Date & Time: _____

Doctor (who is taking the consent) :

Signature: Dr. Sharina
Name: Dr. Sharina
Date & Time: 8/7/26 @ 4:30 AM

**పిల్లల ఇంటెన్సివ్ కేర్ యూనిట్ లో
అడ్మిషన్ కొరకు సమ్మతి**

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

రోగి పేరు వయస్సు లింగం ☐ పు ☐ స్త్రీ

యు.హెచ్.డి.

నేను s/o. d/o. w/o.

..... అనే బాలుడు / బాలిక యొక్క చికిత్స మేరకు రెయిన్ బో చిల్డ్రన్స్ పిల్లల అనుపత్తి లోని పిల్లల ఇంటెన్సివ్ కేర్ యూనిట్
తేదీ నాడు పూర్తి సమ్మతితో చేర్చితిని.

మా బాలుడి / బాలిక లో ఈ కింద తెలిపిన ఆరోగ్య సమస్యల గురించి విద్య నిపుణుడు నాకు అర్థమగు భాషలో వివరించితిరి.

రెయిన్ బో చిల్డ్రన్స్ హాస్పిటల్ లోని పీడియాట్రిక్ ఇంటెన్సివ్ కేర్ విభాగం లో చేరింది జడ్డకు ఆరోగ్య సంబంధిత సమస్యలు ఉన్నాయని వైద్యులు నాకు అర్థమయ్యే భాషలో వివరించారు. రోగి పీడియాట్రిక్ ఇంటెన్సివ్ కేర్ విభాగం లో ఉన్న సమయంలో అతను వివిధ వైద్య మరియు శస్త్ర చికిత్సలకు లోనవుతారని వైద్యులు నాకు స్పష్టంగా వివరించారు. ఎయిర్ వే మేనేజ్ మెంట్, మెకానికల్ వెంటిలేషన్, బొడ్డు ధమని కాథెటర్, బొడ్డు సిర మరియు ధమనుల కాథెటర్ వంటి . పెరిఫెరల్ ఇన్ఫర్జన్ చేయబడిన సెంట్రల్ కాథెటర్ లైన్ మరియు ఆర్థో లైన్ ప్లేస్ మెంట్స్, ఛాతీ డ్రైన్ లేదా పెరిటోనియల్ డ్రైన్ ఇన్ఫర్జన్ మొదలైనవి.

..... పంటి ప్రక్రియలు చేస్తున్నప్పుడు నాకు సమాచారం ఇవ్వబడుతుందని మరియు దీనికి ప్రత్యేక సమ్మతి ఉంటుందని వైద్యులు నాకు ఏదేమైనప్పటికీ, ఏదైనా ప్రాణాంతక అత్యవసర పరిస్థితుల్లో సమాచారం తీసుకోవడానికి సమయం లేకపోతే నా జడ్డ ప్రాణాన్ని కాపాడేందుకు ఇతర వైద్య ప్రక్రియలకు నేను సమ్మతి ఇస్తున్నాను.

పీడియాట్రిక్ ఇంటెన్సివ్ కేర్ విభాగం లో అనారోగ్యంతో ఉన్న పిల్లవాడికి ప్రాణాంతకమైన వైద్య పరిస్థితులు ఉన్నాయని అర్థం చేసుకోవడమైనది.

ఒక జడ్డ అనారోగ్యంతో పీడియాట్రిక్ ఇంటెన్సివ్ కేర్ విభాగం లో ఉన్నప్పుడు అతని/ఆమెపై నిర్వహించబడు అనేక వైద్య మరియు శస్త్రచికిత్సా విధానాలతో ఈ అధిక ప్రమాదకరమైన విధానాల వల్ల సంభవించు నష్టాలు మరియు అధిక ప్రమాదకరమైన మందుల రూపంలో అంటువ్యాధులు, రక్తప్రావం, శ్వాసపరమైన, చర్మం మరియు ఇతర కణజాల నష్టం మొదలైనవి కలిగవచ్చు డాక్టర్లు నాకు బాగా అర్థమయ్యే భాషలో వివరించారు.

మా బాలుడు / బాలిక ను ఇంటెన్సివ్ కేర్ యూనిట్ (పి.ఐ.సి.యు)లో చేర్చుకొని అవసరమయ్యే వైద్యం చేయుటకు నేను వైద్య బృందానికి నా సమ్మతి ధృవపరుస్తున్నాను.

సహాయకుడు(అటెండెంట్)

సంతకము

పేరు

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము

పేరు

Docu. No. : RCH / FRM / CLINICAL / 013

సాక్షి

సంతకము

పేరు

తేదీ మరియు సమయము



CONSULTATION FORM

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Doctor Name : Dr. Sukhinder Binda
Date : 8/7/26 Hour : 7pm

Hospital :

Type of Referral : ☐ Emergency (within one hr.)

Referred for : ☐ Opinion ☐ Co-Management

☐ Urgent (within 6 hrs.) ☐ Non Urgent (within 24 hrs.)

☐ Transfer of care

Date : Time : By :

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

Signature: _____

M.D. _____

Report of Findings and Recommendations :

It has reported with multiple petechiae and
rash. vomiting and abd. pain x 3 dx
H/o fever x 10 days
Day - 4 severe leg pain myalgia
Pt was given Tab. Ultracet and resches
Started the same day.
O/E - Mucocutaneous rash, crusting of the
lip.
- Pain in the lips
- No intraoral rash / ulceration.
Tx Plan continue the same medication
Review tomorrow...

Consultant :

Name : Dr. Sukhinder Binda Signature : _____ Date & Time : 8/7/26 @ 7pm

NOTE : If more space is required use another consultation sheet as continuation



TEENAGE (12 + years) Children's Observation & Early Warning Scoring Chart

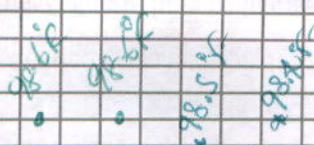
EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 9/7/26 Time: 12 2 5 7

Doctor / Nurse / Family Concern? Am Am Am Am

Temperature
(°F)

104
103
102
101
100
99
98
97
96
95
94



Heart Rate
(bpm)

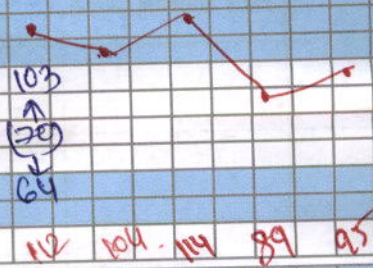
and

Blood Pressure
(mmHg) *

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

Note:

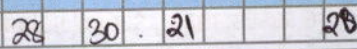
BP does not score
in early
warning scoring



Heart Rate (Number)

Resp. Rate (bpm)
(Over 1 Minute)

70
60
50
40
30
20
10



Resp Rate (Number)

Resp Mod/ Severe
Distress None / Mild

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

Conscious Normal
Level Altered

GCS *

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

N	N	N	N	N
98	99	102	97	98
N	N	N	N	N
15	15	15	15	15
0	0	0	0	0
0	0	0	0	0
SK	SK	SK	SK	SK

Noted by Rizwan

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.

OBSERVATION EARLY WARNING SCORING TOOL

The Early Warning Score (i) seeks to identify the abnormal physiological finding seen during serious illness and (ii) offers a method to interpret such physiological derangements with clearly defined criteria. It is a tool 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 decisions.

Children are assessed and recorded as part of the child's routine clinical observation, providing an Early Warning Score between 0-6 (Higher Early Warning Scores are seen in sicker children).

Children are described according to increasing Early Warning Score.

Children with complex medical needs e.g. cyanotic heart disease may require modification to their trigger plan - this should follow discussion with senior colleagues.

An Early Warning Score of 3 or above should be recorded below with details of any subsequent action initiated.

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

If additional help is required, call help – regardless of the Early Warning Score!

For an Early Warning Score assessment, senior help may be required.

The Early Warning Scoring tool (situation, background, assessment, recommendations) is a helpful mnemonic that can be used to communicate a child's clinical condition to a colleague.

I am (name), a nurse on ward (X). I am calling about (child X)

V: 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)

OUND: Child (X) was admitted on (XX date) with (e.g. respiratory infection). They have had (X operation/ investigation). Child (X)'s condition has changed in the last (XX mins). Their last set of observations (X). The child's normal condition is ... (e.g. alert/ drowsy/ confused, pain free)

MENT: 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.

COMMENDATION: I need you to ... come to see the child in the next (XX mins) AND is there anything I need to do in the meantime? (e.g. stop the fluid/ repeat observation)

VIH-00206684

PICU

ULTRA SOUND ABDOMEN REQUEST FORM

PATIENT NAME :

VIH-00206684 IP-00060610
Master ADIYAN AHMED
08-02-2014 12 Y 5 M 0 D (M)
Dr. AKHEEL SYED RIZWAN

DATE:

08/07/2026
Time 11:35 AM

12.6 cm

LIVER : Normal in size and echotexture. No intra hepatic biliary duct dilatation. Portal vein is normal. No focal lesions.

GALL BLADDER : Distended well and appears normal. No evidence of calculi or wall thickening. Common bile duct appears normal.

9.7 cm

SPLEEN : Normal in size and echotexture.

PANCREAS : Normal in size and echotexture. MPD not dilated. No calcification noted.

KIDNEYS : Right kidney : 82 mm. Normal in size and echotexture and shows smooth contour. No hydronephrosis or calculi.

Left kidney : 85 mm. Normal in size and echotexture and shows smooth contour. No hydronephrosis or calculi.

URINARY BLADDER : Distended well and appears normal.
No ascites / Lymphadenopathy. No evidence bowel wall thickening / edema.

IMPRESSION : ~~No obvious sonological abnormality in abdomen.~~

Rest unremarkable

Suggested clinical correlation.

Mild splenomegaly
- No focal lesions.

DR MOHD ABDUL KHALID MD, DNB.

DR V. MAHIDHAR (MD)

DR VAISHNAVI REDDY B (MD)

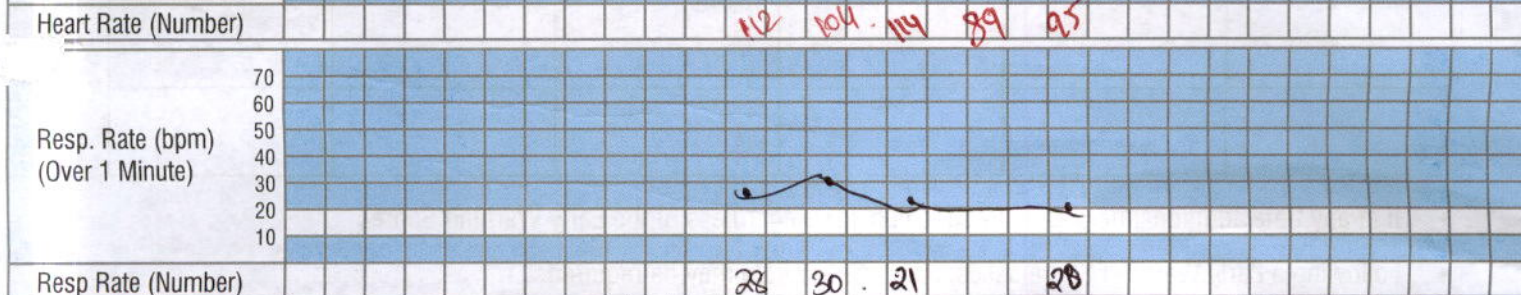
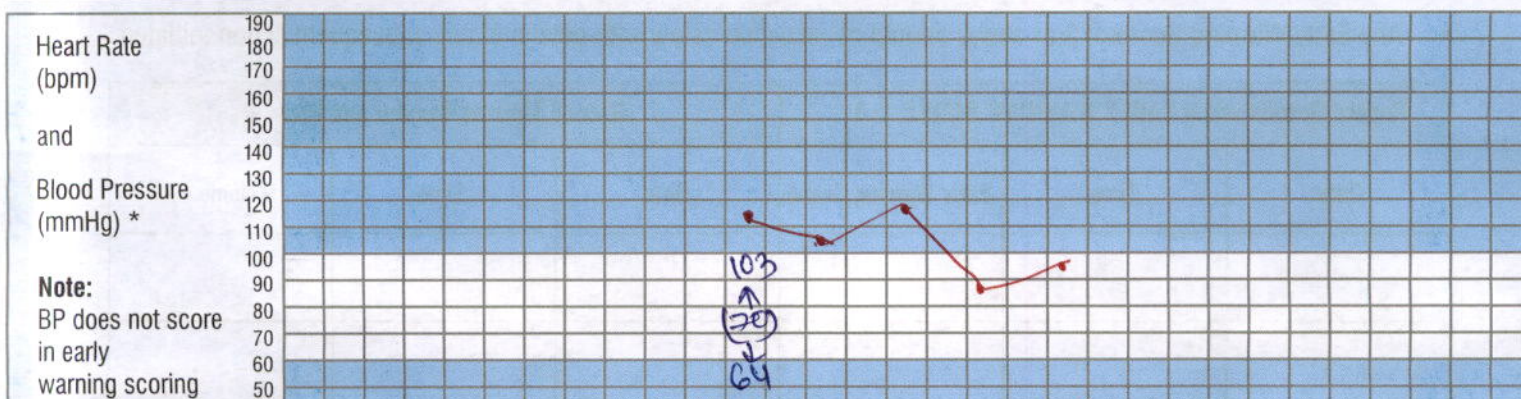
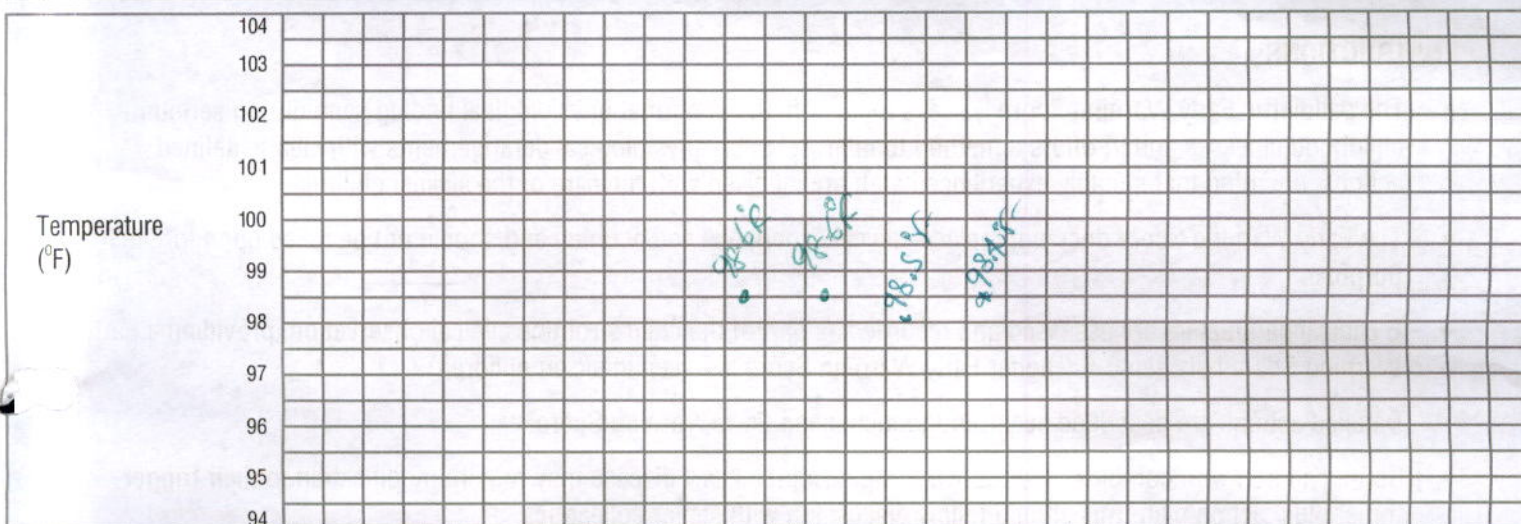
(Consultant Radiologist)

TEENAGE (12 + years)

Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 9/1/26 Time: 12 2 5 7
Doctor / Nurse / Family Concern? Am Am Am Am



Resp Distress	Mod/ Severe	None / Mild							
			N	N	N	N	N	N	N
Receiving O ₂ (l/min)									
O ₂ Saturations (%)			98	99	100	97	98		
Conscious Level	Normal	Altered	N	N	N	N	N		
GCS *			15	15	15	15	15		

TOTAL SCORE									
Number of shaded boxes	0	0	0	0	0				
Pain Score	0	0	0	0	0				
Observer's Initials	S	S	SK	SK	SK				

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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)

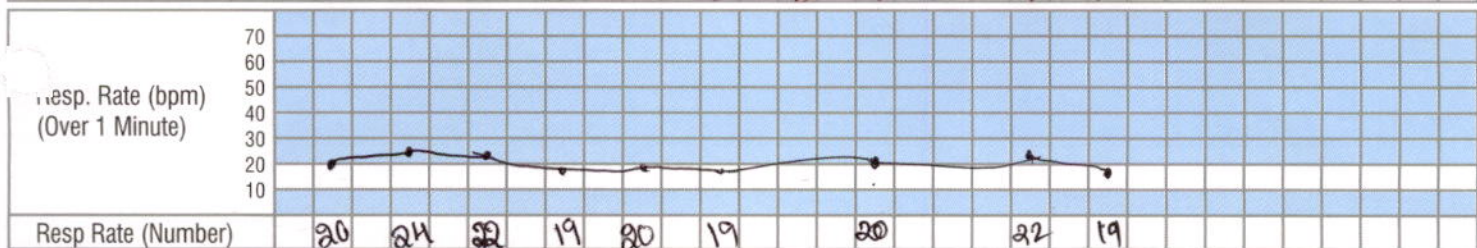
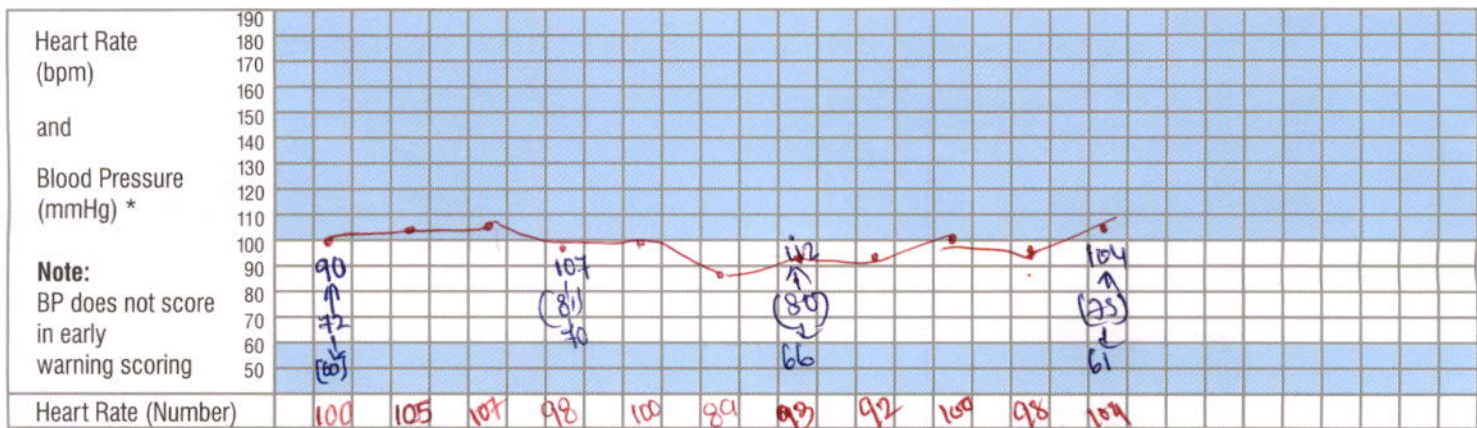
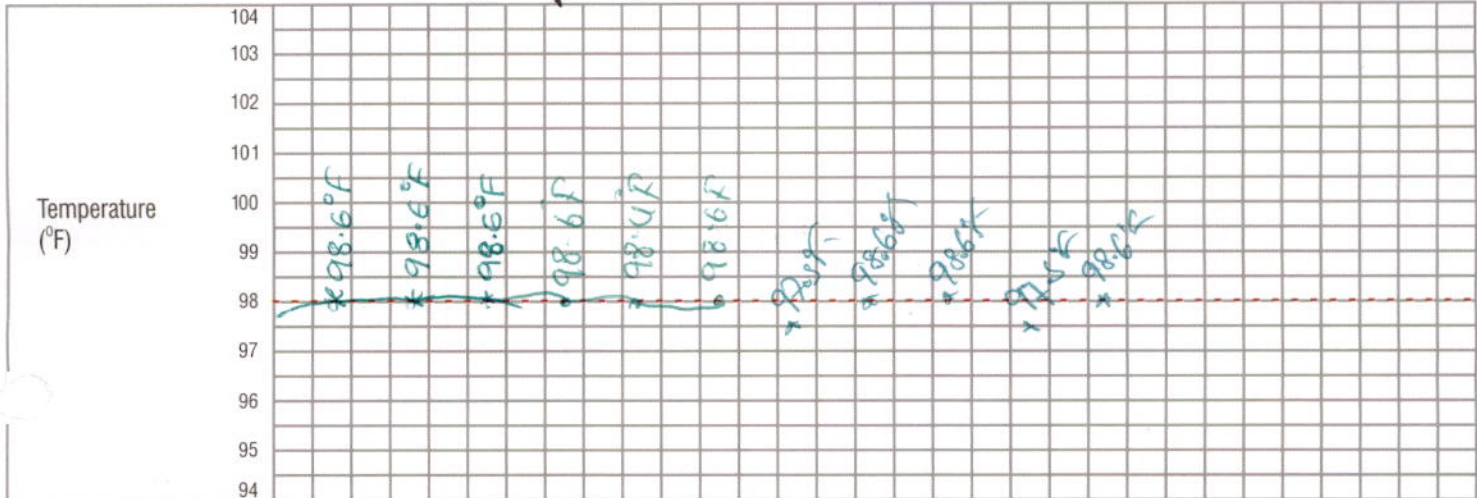


TEENAGE (12 + years)

Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 10/7/26 Time: 9 11 1 3 5 7 10 1 3 5 7
Doctor / Nurse / Family Concern? AM AM PM PM PM PM AM AM AM AM AM



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	0	0	0	0	0	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0	0	0	0	0	0
Observer's Initials	M	M	M	A	A	A	SK	SK	SK	SK	SK

ACTIONS	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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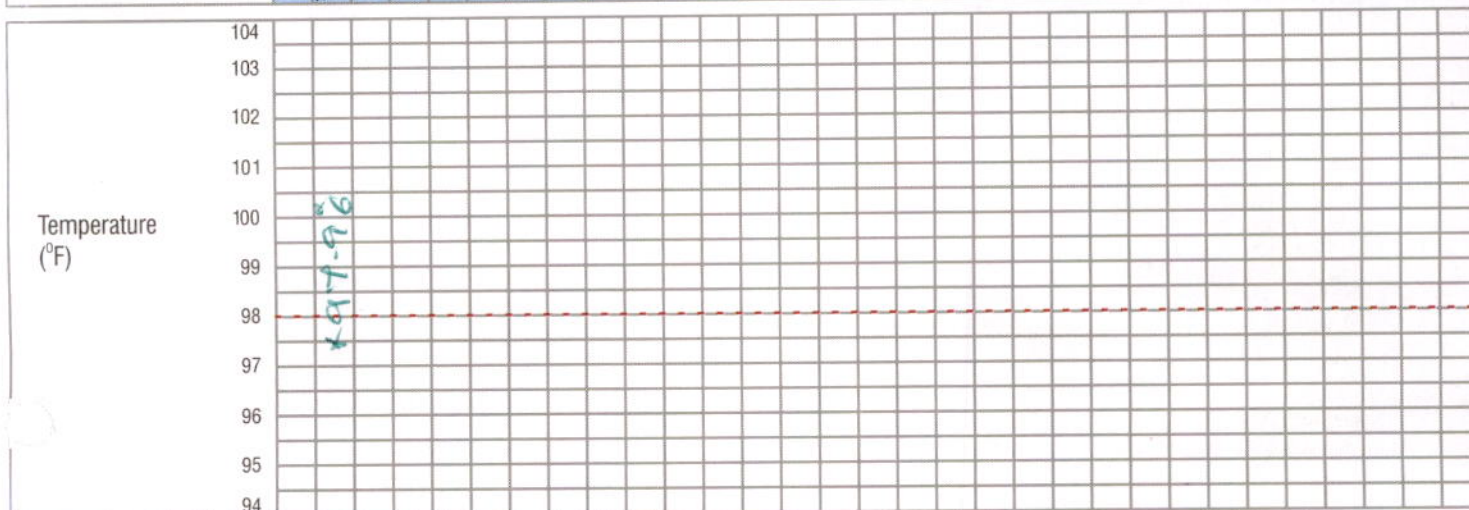


TEENAGE (12 + years) Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 11/5/2016 Time: 9

Doctor / Nurse / Family Concern? AM



Heart Rate (bpm)

and

Blood Pressure (mmHg) *

Note:
BP does not score in early warning scoring

Heart Rate (Number)

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

105
102

Resp. Rate (bpm)
(Over 1 Minute)

70
60
50
40
30
20
10

Resp Rate (Number)

19

Resp Distress Mod/ Severe
None / Mild

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

29

Conscious Level Normal
Altered

2

GCS *

15

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

0

0

✓

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.

Noted by Vasekhna
11/5/2016 AM

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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R	RECOMMENDATION: I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)



FLUID CHART

Sheet No. :

9/7/26

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

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
	Total Intake :					Total Output :						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :					Total Output :							
9/7	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am	water								✓	0	
	01:00 am											
Total Intake :					Total Output :							
10/7/26	02:00 am	Idly water										
	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					24mls		



FLUID CHART

Sheet No. :

10/7/26

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

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse				
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine						
			Mouth	I.V	N.G											
10/7/26	08:00 am		Idly + water									1	manisha 10/7/26 @			
	09:00 am										✓					
	10:00 am															
	11:00 am															
	12:00 pm									✓						
	01:00 pm															
Total Intake :						Total Output :										
10/7	02:00 pm		Rice water									1	Anitha			
	03:00 pm										✓					
	04:00 pm															
	05:00 pm															
	06:00 pm									✓						
	07:00 pm															
Total Intake :						Total Output :										
	08:00 pm		Rice water									1	Subha			
	09:00 pm															
	10:00 pm									✓						
	11:00 pm															
	12:00 am			Idly water						✓						
	01:00 am															
Total Intake :						Total Output :										
11/2	02:00 am											1	11/02 @ 8am			
	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		7 times	



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		
11/4/20	08:00 am		3 dte									Vaishnav 11/4/20 Callam
	09:00 am		4.50									
	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



MEDICATION RECONCILIATION FORM

Drug Allergies: N/A ☒ 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: PICU

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. Sharone

Date & Time: 8/7/26 @ 3:44AM

Nurse Name & Signature: Swathi

Date & Time: 8/7/26 @ 3:44AM

MEDICATION RECONCILIATION FORM

Drug Allergies: N/A ☐ 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: ICU Shifted to: 102

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	IV METHYLPREDNISOLONE	13mg	IV	OD	12pm/9/7	☒ C ☐ DC
2	Succalfate	4ml	oral	8th HOURLY	4pm/9/7	☒ C ☐ DC
3	Tab. SHELICAL 500mg	500mg	ORAL	ONCE A DAY		☒ C ☐ DC
4	CETAPHIL + MOMATE F CREAM		L/A ON AFFECTED PARTS	TWO TIMES A DAY		☒ C ☐ DC
5	KENACORT GEL		LIPS & BULLAL MUCOSA	4-5 TIMES A DAY		☒ C ☐ DC
6	LIQUID PARAFFIN		ALL OVER BODY	EVERY 4th HOURLY		☒ C ☐ DC
7	BETADINE MOUTH WASHES			3 TIMES A DAY		☒ C ☐ DC
8	T. BACT OINTMENT		ON AFFECTED PARTS	6th HOURLY		☒ C ☐ DC
9	ZYTEE GEL		ORAL	4th HOURLY		☒ C ☐ DC
10						☐ C ☐ DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: Dr. Amulya Anly

Date & Time: 9/7/16 at 11:30pm

Nurse Name & Signature: Sr. Devika

Date & Time: 9/7/16 at 11:30pm



DRUG CHART

Date of Admission: 8.17.12 Drug Allergies: Nil ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

- GENERAL** - Ensure that all patient details are entered above. ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.
- DOCTOR** - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
- Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
- Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
- Discontinue a drug by drawing a line **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 26 Ward PICU

Naagif Sue 8/7/26

Naagif Sue 8/7/26

Naagif Sue 8/7/26

Verified
Dr. Rishika
Clinical Pharmacologist

DRUG : <u>IND. PIPERACILLIN</u>				Date Time
Dose <u>2.2g</u>	Route <u>IV</u>	Frequency <u>THICE DAILY</u>	Start Date <u>8/7/26</u>	
Name & Signature of the Doctor Starting the Drugs: <u>(Signature)</u>				<u>Hold</u> <u>Dr. Munir</u> <u>8/7/26</u>
Additional Instructions: <u>(AFTER TEST DONE)</u> <u>100mg/kg/dose</u>				
Daily Doctor's Endorsement by a Sign				

DRUG : <u>IND. ESOMEPRAZOLE</u>				Date Time
Dose <u>20mg</u>	Route <u>IV</u>	Frequency <u>ONCE DAILY</u>	Start Date <u>8/7/26</u>	
Name & Signature of the Doctor Starting the Drugs: <u>(Signature)</u>				<u>Stop</u> <u>Dr. J. K.</u> <u>09/07</u>
Additional Instructions: <u>5mg/kg/dose</u>				
Daily Doctor's Endorsement by a Sign				

DRUG : <u>T. ADARAX</u>				Date Time
Dose <u>10mg</u>	Route <u>P/O</u>	Frequency <u>TWICE DAILY</u>	Start Date <u>8/7/26</u>	
Name & Signature of the Doctor Starting the Drugs: <u>(Signature)</u>				<u>Hold</u> <u>Dr. Munir</u> <u>8/7/26</u>
Additional Instructions: <u>1 TAB = 10mg</u> <u>(or 5mg/kg/dose)</u>				
Daily Doctor's Endorsement by a Sign				

DRUG : <u>ZYTEE GEL</u>				Date Time
Dose <u>LA</u>	Route <u>LA</u>	Frequency <u>4PM</u>	Start Date <u>8/07/2</u>	
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Anurag Anurag</u>				<u>12 AM DENIED</u> <u>4 AM DENIED</u> <u>8 AM DENIED</u> <u>12 PM DENIED</u> <u>4 PM DENIED</u> <u>8 PM DENIED</u>
Additional Instructions: <u>oral mucus</u>				
Daily Doctor's Endorsement by a Sign				

Sheet No:

REGULAR PRESCRIPTIONS

Weight 24kg Ward PLCU

DRUG : LIQUID PARAFFIN				Date	Time															
Dose	Route	Frequency	Start Dt.																	
	LA	Q2HOURLY	8/7/26																	
Name & Signature of the Doctor Starting the Drugs:				See the chart																
Additional Instructions:				whole body																
Daily Doctor's Endorsement by a Sign																				
DRUG : T-BALT OINTMENT				Date	Time	8/7	9/7	10/7	11/7											
Dose	Route	Frequency	Start Dt.																	
	LA	Q2HOURLY	8/7/26																	
Name & Signature of the Doctor Starting the Drugs:				See the chart																
Additional Instructions:				whole body																
Daily Doctor's Endorsement by a Sign																				
DRUG : KENACORT GEL				Date	Time	8/7	9/7	10/7	11/7											
Dose	Route	Frequency	Start Dt.																	
	LA	Q2HOURLY	8/7/26																	
Name & Signature of the Doctor Starting the Drugs:				See the chart																
Additional Instructions:				Oral mucosa & Lips.																
Daily Doctor's Endorsement by a Sign																				
DRUG : CORTICOSTEROID MOUTH WASH				Date	Time	8/7	9/7	10/7	11/7											
Dose	Route	Frequency	Start Dt.																	
	YA	12 HOURS	8/7/26																	
Name & Signature of the Doctor Starting the Drugs:				STOP																
Additional Instructions:				10/7/26																
Daily Doctor's Endorsement by a Sign																				



Sheet No:

REGULAR PRESCRIPTIONS

Weight 26.795 Ward Plcu

DRUG: <u>200mg METHYL PREDNISOLONE</u>				Date Time												
Dose <u>200mg</u>	Route <u>IV</u>	Frequency <u>ONCE DAILY</u>	Start Dt. <u>9/07</u>													
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Akheel Syed Rizwan</u>																
Additional Instructions: <u>1mg/kg/day</u>																
Daily Doctor's Endorsement by a Sign																
DRUG: <u>Canzol Junior</u>				Date Time												
Dose <u>30mg</u>	Route <u>Oral</u>	Frequency <u>200mg</u>	Start Dt. <u>09/07</u>													
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Akheel Syed Rizwan</u>																
Additional Instructions: <u>1mg/kg/day</u>																
Daily Doctor's Endorsement by a Sign																
DRUG: <u>Succralfate</u>				Date Time												
Dose <u>1g</u>	Route <u>Oral</u>	Frequency <u>8thly</u>	Start Dt. <u>09/07</u>													
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Akheel Syed Rizwan</u>																
Additional Instructions: <u>80mg/kg/day</u>																
Daily Doctor's Endorsement by a Sign																
DRUG: <u>ENT METHYLPREDNI SOLON</u>				Date Time												
Dose <u>13mg</u>	Route <u>IV</u>	Frequency <u>ONCE DAILY</u>	Start Dt. <u>9/7</u>													
Name & Signature of the Doctor Starting the Drugs: <u>Ankur</u>																
Additional Instructions: <u>0.5mg/kg/day</u>																
Daily Doctor's Endorsement by a Sign																

Patient Name :

I.P. No.

Sheet No.

Wards

Weight (kg)

2

PIU

26 kg

REGULAR PRESCRIPTIONS

DRUG : T-SHELLAC				Date	10/7/14														
Dose	Route	Frequency	Start Dt.	Time	10/7/14														
500mg	ORAL	ONCE DAILY	9/7																
Name & Signature of the Doctor starting the Drugs:				b Bay Gor am															
Additional Instructions:																			
Daily Doctor's Endorsement by a Sign.																			

DRUG : CETAPHIL + MOMATE F CREAM				Date	10/7/14														
Dose	Route	Frequency	Start Dt.	Time	10/7/14														
ON AFFECTED AREAS		TWICE DAILY	9/7																
Name & Signature of the Doctor starting the Drugs:				b Bay Gor am															
Additional Instructions:				b pm															
Daily Doctor's Endorsement by a Sign.																			

DRUG : BETADINE MOUTH WASHES				Date	10/7/14														
Dose	Route	Frequency	Start Dt.	Time	10/7/14														
ORAL		8th HOURLY	10/7																
Name & Signature of the Doctor starting the Drugs:				b Bay Gor am															
Additional Instructions:				2 pm 10 Bay pm															
Daily Doctor's Endorsement by a Sign.																			

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

As per doctor's order
Prescribed 10/7/2014 at 10
As per doctor's order
Prescribed 10/7/14 at 10
As per doctor's order
Prescribed 10/7/14 at 10

Patient Name		I.P. No.	Sheet No.	Wards PICU	Weight (kg) 26 kg
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REGULAR PRESCRIPTIONS

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

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

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

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

Date Time	Nurse Sig.	Nurse Sig.	Nurse Sig.	Nurse Sig.
DRUG : LIQUID PARAFFIN	Dose	Dose	Dose	Dose
	Dr. Sign.	Dr. Sign.	Dr. Sign.	Dr. Sign.
Route 2nd HOURLY LA	Dose	Dose	Dose	Dose
Start Date 8/7/21	Dr. Sign.	Dr. Sign.	Dr. Sign.	Dr. Sign.
Name & Signature of the Doctor Dr. AMULYA Anshu	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.

Date Time	Nurse Sig.	Nurse Sig.	Nurse Sig.	Nurse Sig.
VARIABLE DOSE	Dose	Dose	Dose	Dose
	Dr. Sign.	Dr. Sign.	Dr. Sign.	Dr. Sign.
Route	Dose	Dose	Dose	Dose
Start Date	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
8/07/21	4:20 am	IND. PHENIRAMINE MALATE (AVIL)	13ma	IM	[Signature]	Me Sam
08/07	12pm	Methylprednisol.	26mg	IV	[Signature]	Renuka MHA
8/7	11pm	IND. PHENIRAMINE MALATE	13mg	IV	[Signature]	Rashika Bindu

Nurse
Sign

g	bat
	birds



Thorn
yacht



RESULT SHEET

Date	8/7/26	8/7/26	11/7			
Time	9: Am	1: pm	6:43 AM			
Hb	12.0		12.3			
PCV	32.9		33.6			
RBC	4.16		4.18			
WBC	6.09		8.25			
N/L	52.1/33.6		51.0/34.1			
Platelets	411		6.56			
CRP	4.0					
ESR		18				
PCT						
RBS	100					
Na	137					
K	4.9					
Cl	94					
Ca/Mg						
Phosphate						
Urea	6.4					
Creatinine	0.5					
ALP	330		320			
SGPT	238		343			
SGOT	84		152			
T.Bill/Conj	3.6/2.9		2.2/1.3			
T.Protein	6.9		7.5			
S.Albumin	3.8		4.1			
S.Globulin	3.1		3.4			
A/G Ratio	1.2		1.2			
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR	12.3/0.87		14.0/1.0			
APTT	28.5		28.0			
CSF Protein / Sugar						
Cells						
N/L						

Date	8/7/26					
Time	12:29 PM					
CUE - Alb	Trace					
CUE - Sugar	neg					
CUE - Ketones	negative					
CUE - PUS Cells	3-4					
CUE - RBC Cells	none					
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						
Covid Rapid	N-ve					
HIV Card	Non React					
	-ive					
CPK	20					

Culture and Sensitivities : 08/7/26 at 12:29 PM

Spot Protein : 2.4

Spot Creatinine : 47.8

Ratio : 0.05

Radiology : USG :

X-Ray :

ECHO :

CT :

MRI :

Others (ECG, Contrast Studies etc.) :