Rainbow Children's Hospital

DISCHARGE TRACKING SHEET

GUC-00071414 IP18-00036722
Baby PRAHLADH A J
11-05-2024 2 Y 2 M 23 D (M)
Dr. GANESH R

UHID- FLOOR- 6th NAME OF CONSULTANT-

ACTIVITY	INTIME	OUT TIME	NAME & SIGNATURE	REMARKS	<To be filled by Admin>		
Activity Sheet update by Nursing	3/8/26 @11:10Am		02 IN				
Activity Sheet update by Pharmacy							

ACTIVITY RECORD FOR BILLING

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BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Name: GUC-00071414 IP18-00036722
Baby PRAHLADH A J
11-05-2024 2 Y 2 M 22 D (M)
Dr. GANESH R

UHID No: .....

Consultant: ..... Dept: .....

Date of Admission: ..... Time: ..... Date of Discharge: ..... Time: .....

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
02/08/26	4.45pm	CR	606	

CROSS CONSULTATION VISIT

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

INVESTIGATIONS

Date	Investigations	Order No.	Signature
2/08/26	CBC, RP-2 / RBS	26024711	

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
2/8/26	Infusion pump	5pm	2/8/26 10Pm	1736256	[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
02/08/26	IV placement	(1)	1736253	
02/08/26	ECG	(1)	10404	

ANY OTHER INFORMATION:

.....

.....

.....

.....

.....

.....

Date: 3/8/26 Time: @ 11.10AM Prepared By: .....

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

Rainbow Children's Hospital | BirthRight

DISCHARGE TRACKING SHEET

UHID- FLOOR- 6th NAME OF CONSULTANT-

GUC-00071414 IP18-00036722
Baby PRAHLADH A J
11-05-2024 2 Y 2 M 23 D (M)
Dr. GANESH R

ACTIVITY	TIME		NAME & SIGNATURE	REMARKS	<To be filled by Admin>
Discharge Announcement	3/8/26 @11.05Am				
	INTIME	OUT TIME			
Arrangement of File by Nursing	3/8/26 @11.10 Am				
Preparation of Discharge Summary					
Finalization of discharge summary					
Transfer of file from Ward to Billing Dept					
Bill Processing					
Audit Clearance					
Billing Clearance					
Physical Clearance					

Rainbow Children's Hospital

BirthRight by Rainbow

Rainbow Children's Hospital - Guindy

Door No.157 to 160, Anna Salai, Guindy, Guindy ,Chennai ,Tamil Nadu, INDIA ,600015.
TEL NO :044-40122444
WEB : https://rainbowhospitals.in

ADMISSION SHEET

Registration Details :

Admission No : IP18-00036722 **Admit Date** : 02-Aug-2026 **Admit Time** : 04:24 PM **UHID** : GUC-00071414

Patient Details :

Patient Name	: Baby PRAHLADH A J	**Age**	: 2 Y 2 M 22 D
Guardian	: Mr ABHISHEK S	**DOB**	: 11-05-2024
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: NO 121 VELACHERY MAIN ROAD GUINDY CHENNAI Guindy Ind Estate Chennai Tamil Nadu INDIA 600032	**Phone No**	: 8939699954
		E-mail	: NO@GMAIL.COM

Admission Details :

Bed Type : DAY CARE **Bed No** : ER 102 **Ward Name** : 0F-EMERGENCY

Room No : ER 102 **Admission Type** : First Visit

Contact Details :

Name : Mr ABHISHEK S **Relationship** : Father

Contact Address : NO 121 VELACHERY MAIN ROAD GUINDY CHENNAI Guindy Ind Estate Chennai Tamil Nadu INDIA 600032 **Phone No** : / 8939699954

Signature

Doctor Details :

Doctor Name : Dr. GANESH R **Specialisation** : GENERAL PEDIATRICS

Referral Doctor : Dr. Ganesh R **Phone No** :

Co-Consultant :

Payment Details :

Payment Mode : Cash **Deposit Amount** : 0.00

Payor Name : SELFPAY

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GENERAL CONSENT FOR TREATMENT

Patient Name:	**Baby PRAHLADH A J**	**Age :**	**2 Y 2 M 22 D**
IP No:	**IP18-00036722**	**Sex:**	**Male**
Consultant:	**Dr. GANESH R**	**Ward/Bed No:**	**0F-EMERGENCY/ER 102**

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 also 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: Mr. Abhishek
Relationship: Father
Date: 02/08/2026 Time: 04.24 Pm
Witness Name: A. Sivasankari
Witness Signature:

Patient Address:

NO 121 VELACHERY MAIN ROAD
GUINDY CHENNAI Guindy Ind Estate
Chennai Tamil Nadu INDIA 600032

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BILLING POLICY

- Billing Cycle: - Bed charges will be calculated based on 12PM to 12PM checkout. Settlement post 12PM, room rent will be charged for half day extra & post 6PM, it will be charged for full day. Less than 24 hours stay will be considered as one day.
- Room Rent inclusive of Bed, Nursing, Consultation Charges and all other charges, like Diet, Investigations, IP or OP Procedures, Equipment, Cross Consultations, Blood/ Blood Products, Implants, Ward Consumables, Infection Preventive Measure Charges, Pharmacy and Consumables will be charged extra.
- 5% GST Charges applicable on more than INR 5,000/- Bed Charges which was effective from 18.07.2022 as per the GST Council.
- As per the G.O.I. guidelines, we can collect Rs 1,99,999/- only in cash mode, balance patient can pay through Credit Card/ Debit Card/ NEFT / RTGS / Demand Draft and Online Payment.
- In the event of TPA / Cashless denial or approval not received due to any reason then hospital tariff will be applicable and any discount or special rates given to TPA's / Corporate won't 9eapplicable.
- If the Surgery/ Procedures performed in emergency hours (8PM-6AM), Public Holiday and on Sunday will be charged 30% extra.
- Asst. Surgeon and Anesthetist Charges will be charged 30% on the Surgeon Charges.
- Admission will be done according to the ward category chosen by the patient; charges will be applicable as per the ward category. All charges vary as per Room category, except Pharmacy and consumables.
- Patient / Guardian Self Attested Government ID proof is mandatory to submit at the admission.
- TPA/Insurance Processing Fee applicable for all Insurance Cases.
- In our hospital there is "No Discounts Policy". Kindly co-operate.
- No Duplicate/ Second copy of OP or IP bill will be issued.
- In case the patient is shifted from lower category to higher category, all the charges like consultant visits, investigations, operations and procedures etc. from the date of admission will be charged according to the higher category.
- If the patient is shifted to the ICU, the attendant should vacate the room. If the attender occupies the room, it will be charged as per dual occupancy.
- Room eligibility is purely subject to TPA approval. Proportionate difference of the bill amount is applicable in case the patient opts for higher category higher than the TPA approved, which has to paid by the patient and may not be reimbursed by the TPA / Insurance Company at later stage.
- For Non - Medicals, Disposables, Consumables, Infusion Pump, Taxes, Implants, HIV/ HbsAg, Medical Records, Insurance Processing Fee, Double Occupancy and Registration Charges, Etc., credit cannot be extended. These items are not payable to us as per insurance company norms (Depends on the TPA/Insurance Co. T&C).
- It takes time for cash discharge is a minimum 3-4hrs. and in the case of insurance, it will take a minimum 6-7hrs.
- Difference, if any between the final bill amount arid amount permitted / approved by the TPA or total bill amount in case of denial from TPA, has to be paid by the patient.
- Two attendants are permitted with patients in Deluxe, Private Rooms and only one is permitted in the rest of the categories of rooms. No attendant is permitted in ICU's.
- All the refunds more than Rs.5,000/- will be refunded through NEFT within 7 Bank working days.
- Patient attendant can collect for Interim/provisional bill of the patient from the billing section on daily basis. Interim Bill shall be based on the acknowledged services in HIS. Final Bill of the patient may vary from the Interim bill based on actual update taken on the day of discharge. It is requested that patients/attendants enquire daily about the bill amount from billing section and pay the outstanding as on that day. You are requested to clear your outstanding amount on daily basis before 12 PM. **Patient bill outstanding should not be increase more than 10,000/-**

DECLARATION

I have attended the Financial Counselling desk & understood the expected costs & other conditions applicable. In this case, the TPA/Insurance Company rejects the claim for whatsoever reasons at any point of time after discharge. I promise to settle the claim with the hospital as per Hospital Cash Tariff.

Patient Name : Baby prahladh A J	UHID Number : GVC-0007144
Self/Attendant Name :	Relation : Father
Self/ Attendant Signature : Phone Number :	Name & Signature of Financial Counselor A. Sh

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PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: GUC-00071414 IP18-00036722
Baby PRAHLADH A J
11-05-2024 2 Y 2 M 22 D (M)
Dr. GANESH R

UHID ID:

Department: _____

Consultant: _____

GUC-00071414 IP18-00036722
Baby PRAHLADH A J
11-05-2024 2 Y 2 M 22 D (M)
Dr. GANESH R

Pediatric Multiorgan History & Physical Examination

Name: _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

History of present illness :

Brought to the ER c the
Alleged H/o accidental ingestion of Syp. Cetrizine (5mg/5ml)
unknown quantity at home on 21/8/24
around

Child is active, alert, afebrile

GUC-00071414 IP18-00036722
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11-05-2024 2 Y 2 M 22 D (M)
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Past History : (Including details of any previous investigation or treatment)

Admitted for intussusception - 4 months

Birth & Neonatal History:

LSCS | 3.25kg | CIAB | NO NICU stay

Family Chart

Birth & Socio Economic History:

About Father : (N)

About Mother :

Any additional Information :

Developmental History : (N)

Immunization History :

uptodate ↓ IAP Schedule

Anthropometry :

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

Weight (kgs) 13.2kg (Centile _____)

On Examination :

Temperature : 97.0°F Pulse Rate : 106/min B.P. 97/60 (70) SPO2 98% RA

Resp.rate and type of breathing : (N)

Rash (-)

Lymphadenopathy (-)

Oedema : (-)

Allergies (if any): (-)

(P.T.O.)

Patient Sticker

Respiratory System :

Inspection (any s/o distress) : (N)

Air entry & breath sounds : VBS (B)

Any addes sounds : (E)

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

Cardiovascular System :

Inspection of procordium : (N)

Heart Sounds : S1S2 (B)

Any murmur : (E)

Relevant data from outside (Chest X-Ray, ECG, ECHO, etc.,) :

Per Abdomen :

Inspection : (N)

Palpation : SOFT NT

Ausculation : BS (P)

Spine : (N) External Genitelia : (N)

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

Central Nervous System :

Level of Consciousness : AVPU/GCS score : Alert 15/15

Cranial Nerves :

Motor System :

Nutriton : (N)

Tone: Power (N)

Co-ordinator :

Posture :

Involuntary Movements :

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Dr. GANESH R

Refl

DTR

Superficials:

Plantars

Sensory System :

Bladder / Bowel :

Clinical Summary & Diagnostic: Dw: Accidental ingestion of Antihistamine

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

Desired goals of the treatment :

Planned Labs:

CBC
RP-2
ECG

Planned Management

IVF R-S-L DNS 4 cc/hr
Inj PAN 13mg IV R24H

NPO for 1 hr

Oral diet

Signature of the Doctor:

Name of the Doctor: C. DC-FPMK

Date & Time: 2/8/24 @ 3:30PM

Signature of the Consultant:

Name of the Consultant: R. Lakshmi

Date & Time: 03/08/2024

(PTO.)

GUC-00071414 IP18-00036722
Baby PRAHLADH A J
11-05-2024 2 Y 2 M 22 D (M)
Dr. GANESH R

DISCHARGE PLANNING FORM

***NOTE:* * To be completed by a Doctor within (24) hours of admission.**

1. Anticipated Date of Discharge: .....

2. Destination Post Discharge: ☐ Home
   Family Members Notified (Person Contacted)
   ☐ Transfer
   Hospital Facilty Notified (Person Contacted)

3. Discharge Status: ☐ Self Care ☐ Family Home Care ☐ Home Professional Assistance

   ☐ Needs Assistance In: Remarks

☐ Medication	☐ Yes	☐ No	.....
☐ Bathing	☐ Yes	☐ No	.....
☐ Eating	☐ Yes	☐ No	.....
☐ Walking	☐ Yes	☐ No	.....
☐ Dressing	☐ Yes	☐ No	.....
☐ Toileting	☐ Yes	☐ No	.....

4. Nutritional Plan:
   ☐ Dietary Instruction Discussed with the:
   ☐ Patient ☐ Family Member ☐ Others: .....

5. Discharge Planning Discussed with the:
   ☐ Patient ☐ Family Member ☐ Others: .....

6. Patient/Family Educational Plan:
   ☐ Educational Topic/s: .....

   ☐ Patient's Educational Topic/s discussed with the:
   ☐ Patient ☐ Family Member ☐ Others: .....

Doctor Signature: .....

Doctor Name: .....

Date and Time: .....

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/8/26 9AM	S/B Dr. Chandiralega / [illegible]	
	Δ - Accidental antihistamine ingestion CETRIZINE	
	child received	
	Alert, Active	
	no c/o drowsiness, vomiting,	
	Tolerating oral feeds well.	
	Hydration - PPWT, CRT<2secs	
	no new complaints.	
	O/E	Bp - 105/62mmHg
	Afebrile	PR - 120/min
	CVS S1S2 ⊕	
	RS - clear	
	P/A soft	
		Adv
	Ⓝ electrolytes	- monitor vitals
	RFT	- W/F Drowsiness, vomiting, Tachycardia Agitation
	TC - 11,880	
	Plt - 3,23,000	- IV Fluids @ 20ml/hr
	N/L 31/60	- Inform (SOS)
	Hb - 12.4	
	[signature] TAN	Discharge [illegible] [signature]
		B. [illegible] 72140

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

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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Baby PRAHLADH A J
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RESULT SHEET

Date	21/8/24					
Time						
Hb	12.4					
PCV	36					
RBC	4.80					
WBC	11,880					
N/L	31 | 60					
Platelets	323000					
CRP						
ESR						
PCT						
RBS	78					
Na	138					
K	4.2					
Cl	104					
Ca/Mg	1.21					
Phosphate | HCO_3	| 22					
Urea	22					
Creatinine	0.32					
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

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

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

Docu. No. : RCH /FRM / CLINICAL / 162

DOCTOR'S SHIFT CHANGE HANDOVER FORM

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Date: ..... Department: ..... Shift: .....

S.No	Patient Identification	Diagnosis / Procedure	Clinical Findings Problems	Special Concerns / Investigations / Abnormal Results	Recommendations / Follow up needed	Handing Over Doctor	Receiving Over Doctor

Docu. No. : RCH /FRM / CLINICAL / 162

DOCTOR'S SHIFT CHANGE HANDOVER FORM

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BirthRight™ BY RAINBOW HOSPITALS
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Date: ..... Department: ..... Shift: .....

S.No	Patient Identification	Diagnosis / Procedure	Clinical Findings Problems	Special Concerns / Investigations / Abnormal Results	Recommendations / Follow up needed	Handing Over Doctor	Receiving Over Doctor

GUC-00071414 IP18-00036722
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11-05-2024 2 Y 2 M 22 D (M)
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DRUG CHART

Date of Admission: 02/08/26 Drug Allergies: ..... ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

GENERAL - Ensure that all patient details are entered above. ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.

DOCTOR - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
- Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
- Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
- Discontinue a drug by drawing a line *I* through it and a similar line through subsequent recording panels.
- The date and time of stopping the drug along with the doctors name and sign must be mentioned.
- Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.

NURSES - Nurses must follow strictly the FIVE RIGHTS before administration of medication.
1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time
- AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

SOS / PRN (As required Medication)

DRUG :				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:				

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

GUC-00071414 IP18-00036722
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11-05-2024 2 Y 2 M 22 D (M)
Dr. GANESH R

REGULAR PRESCRIPTIONS

Weight. 12.2Kg Ward. 606

DRUG : Inj PAN

Dose	Route	Frequency	Start Date
13mg	IV	Q24H	2/8

Name & Signature of the Doctor Starting the Drugs: C

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date	2/8	3/8
Time	6 4.20pm	AM MM SS

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Patient Sticker

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

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses

Signature .....

VERIFIED BY : Name .....

(P.T.O)

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I.V. FLUIDS CHART

Weight. 13.2kg Ward. 606

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
2/8/24	5pm	0.9% DNS	IV	45ml/hr	[signature]	[signature] 01/08/24	2/8/24 @ 10pm		[signature]
3/8/24		0.9% DNS	IV	20ml/hr	[signature]	[signature]	2/8/24 @10pm		[signature]

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

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MEDICATION RECONCILIATION FORM

Drug Allergies: .... ☑ 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: 606

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 : [signature]

Date & Time : 2/8/26 @ 7:00PM

Nurse Name & Signature: CK. Akshayasri [signature] 01100

Date & Time : 2/08/26 @ 7:20pm

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

GUC-00071414 IP18-00036722
Baby PRAHLADH A J
11-05-2024 2 Y 2 M 22 D (M)
Dr. GANESH R

(1)

No. : RCH/ FRM / CLINICAL / 125

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

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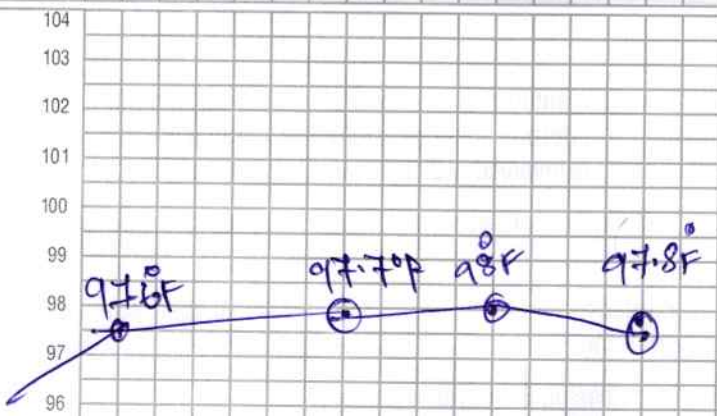
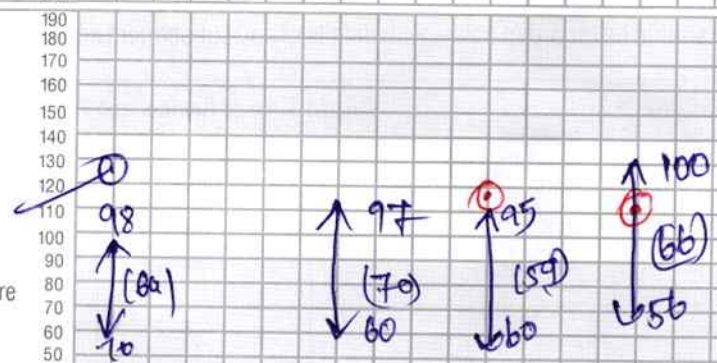
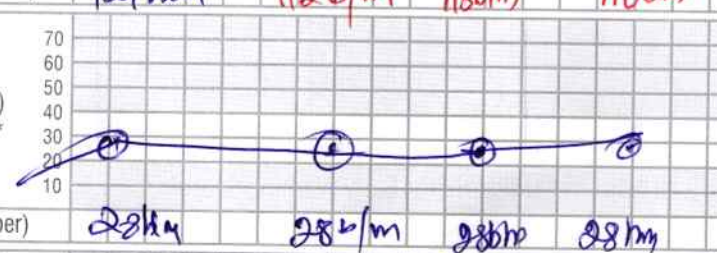
EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 2/8/26. Time:	5pm	8pm	11 AM	4AM
Doctor / Nurse / Family Concern?				





Heart Rate (Number)	129 bpm	112 b/m	118 b/m	110 bpm



Resp Rate (Number)	28 bpm	28 b/m	28 bpm	28 bpm
Resp Distress: Mod/ Severe / None / Mild	✓	✓	✓	✓
Receiving O_2 (l/min)				RA
O_2 Saturations (%)	100%	98 %	100 %	98 %
Conscious Level: Normal / Altered	✓	—	✓	✓
GCS *	15/15	15/15	15/15	15/15
TOTAL SCORE Number of shaded boxes	0	0	0	0
Pain Score	0	0	0	0
Observer's Initials				

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

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

Patient Sticker

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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)

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FLUID CHART

Sheet No. : 1

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.

28/26		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
	02:00 pm											
	03:00 pm											
	04:00 pm	On Admission from ER										
	05:00 pm	N		45ml								
	06:00 pm	P		45ml						✓	0	
	07:00 pm	Milk	100ml	45ml							0	
Total Intake :		100ml		135ml		Total Output :				Time		
	08:00 pm	Milk	100ml	45ml						✓	0	
	09:00 pm			45ml								
	10:00 pm	Milk	100ml	45ml						✓	0	
	11:00 pm			Stop								
	12:00 am									✓	0	
	01:00 am											
Total Intake :		200ml + 135				Total Output :				3 Time		
	02:00 am											
	03:00 am										0	
	04:00 am									✓		
	05:00 am										0	
	06:00 am											
	07:00 am	Milk	100ml							✓	0	
Total Intake :		100ml				Total Output :				2 Time		

Total 24 hrs. Intake	630ml	Total 24 hrs. Output	6 Time

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(1)

NURSES NOTES

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☑ No Known Drug Allergies
☐ Drug Allergies ....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		On admission from ER	
2/8/26	4.45pm	child details hand over taken from ER staff child admitted complaints of Accidental ingestion of syp. Cetrizine in home child while receiving active and oriented playing GCS 15/15 child in NPO till further order	Jey OTHER
	5pm	IVF 0.9-1, hrs 46ml/hr. vitals checked and recorded	Jey OTHER
	6:30pm	Maintained I/O chart for the child.	
	7:00pm	Child details having no complaints of vomiting. Inform to Dr. Deepak sir & told to starts oral intake	nyth 60744
	7:30pm	Child details are handing over given to Night duty staff	nyth 60744
		Night duty staff	
2/8/26	7-30pm	child details hand over taken form evening duty staff. child consious & active.	Sen OTHER
	8pm	child vitals checked & recorded temp is normal. CP ++ PP ++ CRT <3s child had diner no vomiting no outher complaints.	
	10pm	child vitals checked & record	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Patient Sticker

NURSES NOTES

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☑ No Known Drug Allergies
☐ Drug Allergies .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		→ child w iv(+) iv line observed & heavy. child IVF DNS 45 ml/hr on flow →	Staff Nurse
03/8/26	12 AM	→ child vital signs checked and record. vitals are stable PP CP CRT N N <2sec	
		no vomiting sensation, sleeping well. otherwise no complaints	Duty doctor
	8 AM	→ child intake and output chart maintained & record.	Duty doctor
	4 AM	→ child vital signs checked and record. vitals are stable PP CP CRT N N <2sec	Duty nurse
	6 AM	→ child due medication given as per order chart, intake and output chart maintained and record.	Duty nurse
	7:30 AM	→ child detail hand over given to morning duty RN Morning Duty	Duty doctor
3/8/26	7:30 AM	child details handovers taken from night duty child IV line healthy (+)	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

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Patient's GUC-00071414 IP18-00036722
Baby PRAHLADH A J
MRD NO: 11-05-2024 2 Y 2 M 22 D (M)
Dr. GANESH R
Age :........ ex: ☐ M ☐ F
Consultant :..

PHLEBITIS ASSESSMENT

CANNULA 1

Date : 02/08/26 Time: @ 4:30pm
Location : (Lt) metacarpal
Size : 24G
Cannula inserted by : c/H. Akshayami

Date	Time	Phlebitis	Infiltration	Nursing Intervention	Sign
2/8	4:30pm	☐Yes ☑No	☐Yes ☑No	Observe	[illegible]
	5pm	☐Yes ☑No	☐Yes ☑No	observe	[illegible]
	7pm	☐Yes ☑No	☐Yes ☑No	observe	[illegible]
	9pm	☐Yes ☑No	☐Yes ☑No	observe	[illegible]
	11pm	☐Yes ☑No	☐Yes ☑No	observe	[illegible]
	3Am	☐Yes ☑No	☐Yes ☑No	observ	[illegible]
	7Am	☐Yes ☑No	☐Yes ☑No	obser	[illegible]
	11Am	☐Yes ☑No	☐Yes ☑No	obser	[illegible]
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		

Cannula removed : ☐Yes ☐No, if yes date and time :
RX any initiated : ☐Yes ☐No ☐NA If Yes specify-
Phlebitis score:

CANNULA 2

Date : Time:
Location :
Size :
Cannula inserted by :

Date	Time	Phlebitis	Infiltration	Nursing Intervention	Sign
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		

Cannula removed : ☐Yes ☐No, if yes date and time :
RX any initiated : ☐Yes ☐No ☐NA If Yes specify-
Phlebitis score:

NOTE :
- ❋ To be assessed within 30 minutes of insertion.
- ❋ Every 2 hours if on fluid infusion.
- ❋ Every 4 hours if only on IV medication.

V.I.P. SCORE (VISUAL INFUSION PHLEBITIS SCORE)........ Next page

PHLEBITIS ASSESSMENT AND MANAGEMENT RECORD

CANNULA 3

Date : Time:

Location :

Size :

Cannula inserted by :

Date	Time	Phlebitis	Infiltration	Nursing Intervention	Sign
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		

Cannula removed : ☐Yes ☐No, if yes date and time :
RX any initiated : ☐Yes ☐No ☐NA If Yes specify-
Phlebitis score:

CANNULA 4

Date : Time:

Location :

Size :

Cannula inserted by :

Date	Time	Phlebitis	Infiltration	Nursing Intervention	Sign
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
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		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		

Cannula removed : ☐Yes ☐No, if yes date and time :
RX any initiated : ☐Yes ☐No ☐NA If Yes specify-
Phlebitis score:

NOTE :
- To be assessed within 30 minutes of insertion.
- Every 2 hours if on fluid infusion.
- Every 4 hours if only on IV medication.

V.I.P. SCORE (VISUAL INFUSION PHLEBITIS SCORE)

0	1	2	3	4	5
IV site appears healthy	ONE of the following is evident: ❋ Slight pain near I.V. site or slight redness near I.V site	TWO of the following is evident: ❋ Pain near I.V. Site ❋ Erythema ❋ Induration	ALL of the following is evident: ❋ Pain along path of cannula ❋ Erythema ❋ Induration	ALL of the following is evident and extensive: ❋ Pain along path of cannula ❋ Erythema ❋ Induration ❋ Palpable venous cord	ALL of the following is evident and extensive: ❋ Pain along path of cannula ❋ Erythema ❋ Induration ❋ Palpable venous cord ❋ Pyrexia
OBSERVE CANNULA	OBSERVE CANNULA	RESITE / REMOVE CANNULA	RESITE / REMOVE CANNULA CONSIDER TREATMENT	RESITE / REMOVE CANNULA CONSIDER TREATMENT	INITIATE TRETMENT RESITE / REMOVE CANNULA

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Nursing General Admission Assessment Form For Pediatrics

Diagnosis: Accidental ingestion of Antihistamine

Arrival Time: 4:50PM Mode of Arrival: Walking Admitting From: ☑ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction NIL

Body Weight: 13.2 Kg

Height: ..... cm

Past Medical History: Obtained From ☐ Patient ☑ Family Member ☐ Medical Record ☐ Other (specify) .....

Past Medical History	Past Surgical History	Previous Hospital Admission
NIL	NIL	NIL

Family History: NIL

Has the child or close family member had recent contact with a communicable disease? ☐ Yes ☑ No

If yes please list, ...

Was the child's birth normal? ☑ Yes ☐ No If No, please describe problems: .....

Are the child's immunization up to date? ☑ Yes ☐ No

Current Medication: ☐ None ☐ Yes, If Yes, fill reconciliation form

Observations: Weight: 13.2 Length: — Head Circumference (< 2 years): .....

Temp.: 97.6F HR: 129bl/m RR: 23bl/m BP: 97/70(64)

Pain Score: 0/10 Specify Site: ..... (Follow Pain Assessment Sheet & Document)

Fall Risk Assessment: ☑ Yes ☐ No Score: 11 (Document in the Humpty Dumpty Sheet)

Risk of Pressure Sore (Braden Q Score 23) (Document in the Braden Q Assessment Sheet)

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

Character of Pain ..... Location ..... Frequency ..... Duration .....

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 ☐ Special Feeding Method

☐ Feeding Problem ☐ Special diet ☐ No Abnormality Detected

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?) ....

All Information Obtained From ☐ Patient ☑ Mother ☐ Father ☐ Other Family Member

Orientation has been given regarding the following aspects:

Call Bell in Reach : ☑ Yes ☐ No

Waste Disposal Explained: ☑ Yes ☐ No

Infusion Pump : ☑ Yes ☐ No

Hand hygiene Explained: ☑ Yes ☐ No ☐ Others

Patient Rights & Responsibilities: ☑ Yes ☐ No

Information given to Mother

Nurse's Name: Jacintha. B Date: 2/8/26 Time: 5pm Signature [signature]

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INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Part - I.

Patient's / Learner Language: Tamil Patient / Learner Literacy: ☐ Read ☐ Write ☐ Speak Willingness to Learn: Yes No Healthcare Literacy: Yes ☐ No ☐

Identified Education Needs:

1. Diagnosis
2. Treatment and Care
3. Plan
4. Pain Management
5. Informed Consent
6. Medication / Therapy (safety, effects/ side effect, interactions)
7. Discharge Medication
8. Infection Control Measures
9. Diagnostic Test / Procedures
10. Nutrition / Diet
10. Fall Risk Education
11. Safe use of Medical Equipment / Implantable Devices Safety
12. Patient's / Family Rights
13. Risk / Safety

Part - II

Date	Time	Need identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
2/8/20	5pm	Yes	Explained about NPO status and IV fluids.	M/other	Yes	oral	Nil	Yes	Good	Jeyalina

Part - III: CODES

Who was taught: PT: Patient F: Father M: Mother S: Spouse Sn: Son D: Daughter C: Caregiver O: Other (Specify) .....

Learning Barriers:

1. No Learning Barriers
2. Physical Impairment
3. Emotional Barriers
4. Language Barrier
5. Educational Level
6. Desire / Motivate to Learn
7. Impaired Thought Process/Cognitive limitations
8. Responsibilities at Home
9. Cultural Differences
10. Financial Difficulties
11. Beliefs and Values
12. Impaired Vision/ or Hearing
13. Cultural/Religion Practice
14. Others (Specify .....

Teaching Tools Used: A: Audio D: Demonstration V: Video O: Oral P: Printed

Mechanism/s to overcome barrier/s:

1. None
2. Obtain translator
3. Reassurance & Support
4. Teach Family / Others
5. Respect values & beliefs
6. Respect Cultural / Religion Preference
7. Other, Specify .....

Understanding: 1. Verbalizes Understanding 2. Demonstrates Understanding 3. Needs Review

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EMERGENCY ROOM TRIAGE FORM

wt - 13.2kg

Patient's Name : Prahlad. Age : 2Y3M Gender: ☑ Male ☐ Female

Date : 2/8/26. Time of Arrival : 3.25PM

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: 96.5°F PR: 106 BP: 97/60(70) RR: 26 SpO_2: 98

Chief Complaints: Accidental ingestion of Syp. Cetrizine @ 2.40PM @ 1

INITIAL PHYSIOLOGICAL CATEGORIZATION

Appearance: ☑ Normal ☐ Sick Looking

Circulation / Colour: ☑ Normal ☐ Abnormal ☐ Bleeding

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

INITIAL PHYSIOLOGICAL STATUS

☑ Stable

☐ Unstable :
- ☐ Not – Life - Threatening
- ☐ Life – Threatening

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

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

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian

Triage Completion Time : 2min

Communicable Disease Triage Screening

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

1. Have you had fever (elevated temperature) in the past 2 weeks ☐ Yes ☑ No
2. Have you had cough or a rash in the past 2 weeks ☐ Yes ☑ No
3. Have you had shortness of breath or difficulty breathing in the past 2 weeks ☐ Yes ☑ No

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

1. Have you travelled outside the INDIA? or had close contact with someone who has recently travelled outside the INDIA, in the past two weeks? ☐ Yes ☑ No

   If yes, State Location: .....
2. Are your parents / close contacts at home is/a healthcare worker? {please encircle the choices} (e.g., nurse, physician, ancillary services personnel, allied health services personnel, hospital volunteer, or laboratory worker, others) who has had a recent exposure to an individual with a highly communicable disease or unexplained, severe febrile respiratory or rash disease? ☐ Yes ☑ No

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

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

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

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

Name of Triage Nurse : Iman

Signature of Triage Nurse : 17894

Date & Time : 2/8/26 @ 3.30PM

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

GUC-00071414 IP18-00036722
Baby PRAHLADH A J
11-05-2024 2 Y 2 M 22 D (M)
Dr. GANESH R

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 02/08/26 Time of arrival : 3.25pm cetirizine @ 2.40pm

Chief Complaints: H/O. Accidental Ingestion of CYP. RBS: .....

Height : ..... Weight : 13.21kg BMI : ..... Head Circumference (<2 years) .....

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

If yes , identify ..... NIL .....

Pain Screening: ☐ Yes ☑ No If Yes, Pain Score: 0/10 Pain Tool Used: ☐ N Pass ☐ FLACC ☐ Wong Baker

☐ Character ..... ☐ Location ..... ☐ Frequency ..... ☐ Duration .....

RISK FOR FALL:

☑ If patient is < 6 years
tick below fall risk intervention directly

☐ If Patient is > 6 years
Assess the below parameters

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

Ambulatory Aids:

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

Gait/Transferring:

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

Mental Status: Forgets limitations ☐ Yes ☑ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening: ☑ No Abnormalities Detected

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

Inform consultant for positive criteria

NIL

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: NIL (Date/Time): .....

Social History: Lives With Parents

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

Time of Initial assessment completed by ER Nurse : 10mins

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

Time	Nursing Notes
02/08 4.15pm	The pt came for ER c̄ c/o. Accidental ingestion
	of Syp. Cetrizine @2.10pm. Vitals mn Chesu
	h Recorded. C/b/b Dr. Deepak inform to
	Dr. Ganesh. To Advice the Admission. Iv line
	secu. blood sample sent to Lab
	pt shift to ward. ECG - done

Samples collected by: Iman Time: 4:30pm

Samples sent by : Time:

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: 106 mins BP: 94/60 CFT: < 3 sec	Shift - out from ER to: 606
RR: 26 b/m SPO$_2$: 98 %	Time of Shift - out: 4.50pm
GCS: 15/15 Temperature : 97 F	Handover given to: (Nurse's Name) S/N Jeritha
Pain Score: 0/10	
Repeat RBS (if applicable): –	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any): - Iv placement done. (L) metacarpal venflon - 24g.

Name of the Nurse : C.N. Akshaya Signature of the Nurse : C.N. [signature]

Date & Time : 2/08/26 @ 4.20pm

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PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : ..... Date : .....

Type of Admission: ☐ OPD ☐ ER ☐ Referral (if referral, Doctor's Name: .....

Start Time of Assessment: ..... Weight: .....

Allergic History: .....

Chief Complaints: .....

.....

.....

.....

.....

.....

.....

.....

Pediatric Assessment Triangle

A Appearance - TICLS .....

B Breathing
- ☐ ↑ WOB
- ☐ ↓ WOB
- ☐ Normal
- ☐ Gasping / Apnea

C Circulation
- ☐ Normal
- ☐ Abnormal
  - Pallor ☐
  - Cyanosis ☐
  - Mottling ☐
  - Bleeding ☐

Initial Physiological Status: ☐ Stable ☐ Unstable
- Life Threatening ☐
- Non Life Threatening ☐

Any urgent interventions needed: ☐ Yes ☐ No
If Yes .....
.....

Significant Past History: .....

Medication History: .....

Relevant Investigations: .....

.....

.....

Primary Assessment

Airway
- ☐ Open
- ☐ Maintainable
- ☐ Not Maintainable

Any urgent interventions needed: ☐ Yes ☐ No
If Yes .....
.....

Breathing

Rate: ..... SpO_2 on FiO_2 .....

Rhythm: .....

Retractions: ☐ Suprasternal ☐ ICR ☐ SCR ☐ Sternal ☐ Supraclavicular ☐ Nasal Flaring

Respiratory Noises: ☐ Stridor ☐ Wheezing ☐ Grunting

Air Entry: .....

Palpation Findings (If necessary).....

Any urgent interventions needed: ☐ Yes ☐ No
If Yes .....
.....
.....
.....
.....

Circulation

HR: .....

CFT — Central ..... / Peripheral .....

Any urgent interventions needed: ☐ Yes ☐ No

If Yes .....

BP: ..... mmHg

Pulse Volume: Central ..... / Peripheral .....

If in Shock: Compensated ..... / Hypotensive .....

Muffled Heart Sound: ☐ Yes ☐ No

Engorged Neck Veins: ☐ Yes ☐ No

Murmurs: ☐ Yes ☐ No

Liver Span: .....

ECG: .....

Any Signs of Heart Failure: ☐ Yes ☐ No

.....

.....

.....

.....

Disability

GCS: ..... AVPU: .....

Pupils: Responsive ☐ Non-Responsive ☐

Size — Right ..... / Left .....

Active Seizures: ☐ Yes ☐ No Sugars: .....

Signs of Neurological compromise .....

.....

Any urgent interventions needed: ☐ Yes ☐ No

If Yes .....

.....

.....

.....

.....

Exposure

Temp.: .....

Any Rash: ☐ Yes ☐ No,

If yes describe the rash .....

Active bleed .....

Lacerations ☐ Abrasions ☐ bruises ☐

Describe: .....

Any urgent interventions needed: ☐ Yes ☐ No

If Yes .....

.....

.....

.....

Final Physiological Status: ☐ Respiratory Distress ☐ Respiratory Failure ☐ Respiratory Arrest

☐ Shock - Compensated ☐ Hypotensive ☐

☐ Cardiopulmonary Arrest ☐ Hemodynamically Stable

Secondary Assessment: Head to toe examination with positive findings: .....

.....

.....

Labs Planned: .....

.....

.....

.....

.....

.....

.....

Treatment Planned: .....

.....

.....

.....

.....

.....

.....

Need for Oxygen: ☐ Yes ☐ No if yes Low Flow ☐ High Flow ☐ PPV ☐

Final Diagnosis with possible Differential Diagnosis (If necessary): .....

Assessment done by

Name of the Doctor: .....

Signature: .....

Date & Time: .....

Sr. Doctor on Duty (If necessary)

Name of the Sr. Doctor: .....

Signature: .....

Date & Time: .....

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RBS CHART

Date	Time	RBS (mg/dl)	IVF %	Signature
02/8/26	4:35pm	79mg/dl	—	

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PATIENT TRANSFER FORM

GUC-00071414 IP18-00036722
Baby PRAHLADH A J (M)
11-05-2024 2 Y 2 M 22 D
Dr. GANESH R

	Date & Time of Admission	Date & Time of Transfer Order
	02/08/26 @ 4.24 pm	2/08/26 @ 4.50pm.
Treating Consultant Name	**Transfer Ordered by**	**Reason for Transfer**
Dr. Ganesh	Dr. Deepak	Further management
From Unit	**To Unit**	**Information to Attendant**
CR	606.	Yes ☑ No ☐
Number of Sheets in Clinical File	**Number of Imaging Films**	**Personal belongings including clinical documents. If any handed over to attendant**
9	—	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
CHC. Aishwarya [signature] CHC.	

Patient & Clinical Records Received by : Jayintha 014913 [signature]

Date & Time of Patient Received : 2/8/26 @ 4.50pm

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

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

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