GUC-00094060 IP18-00036530
Baby J.A RYAN MATHEW
14-05-2025 1 Y 1 M 6 D (M)
Dr. S. KEERTHIVASAN

Rainbow Children's Hospital

DISCHARGE TRACKING SHEET

UHID- FLOOR- NAME OF CONSULTANT-

ACTIVITY	INTIME	OUT TIME	NAME & SIGNATURE	REMARKS	<To be filled by Admin>		
Activity Sheet update by Nursing		01:45	20/7/26 10.40am			✓	
Activity Sheet update by Pharmacy		12:00					

ACTIVITY RECORD FOR BILLING

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Name: .....

GUC-00094060 IP18-00036530
Baby J.A RYAN MATHEW
14-06-2025 1 Y 1 M 5 D (M)
Dr. S. KEERTHIVASAN

.....

UHID No: .....

ultant: ..... Dept: .....

Date of Admission: .....

of Discharge: ..... Time: .....

Room / Bed No: .....

Ward: .....

Suggested Billable bed type: .....

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
19/6/25	7:20PM	ER	511	

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

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
20/7/26	X-ray abdomen supine	(1)	009751	S. Karfa

ANY OTHER INFORMATION:

.....

.....

.....

.....

.....

.....

Date: 20/7/26 Time: 10.40Am Prepared By: .....

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
01/2/26			

Rainbow Children's Hospital | BirthRight

GUC:-00094060 IP18-00036530
Baby J.A RYAN MATHEW
14-08-2025 1 Y 1 M 6 D (M)
Dr. S. KEERTHIVASAN

DISCHARGE TRACKING SHEET

UHID- FLOOR- NAME OF CONSULTANT-

ACTIVITY	TIME		NAME & SIGNATURE	REMARKS	<To be filled by Admin>
Discharge Announcement					
	INTIME	OUT TIME			
Arrangement of File by Nursing					
Preparation of Discharge Summary		Plw 01/1/26	20/1/26 CR 10.40am		
Finalization of discharge summary					
Transfer of file from Ward to Billing Dept					
Bill Processing					
Audit Clearance					
Billing Clearance					
Physical Clearance					

Rainbow Children's Hospital

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 : IP18-00036530 **Admit Date** : 19-Jul-2026 **Admit Time** : 06:47 PM **UHID** : GUC-00094060

Patient Details :

Patient Name	: Baby J.A RYAN MATHEW	Age	: 1 Y 1 M 5 D
Guardian	: Mr AROCKIA RUBAN	DOB	: 14-06-2025 01:00 AM
Gender	: Male	Religion	:
Occupation	:	Martial Status	:
Address (H)	: 4/18, SOUTH ST, SILAKKUVARPATTI, DINDIGUL Siukuvarpatti Madurai Tamil Nadu INDIA 624215	Phone No	: 8489200376/ 9488764073
		E-mail	: NO@GMAIL.COM

Admission Details :

Bed Type : DAY CARE **Bed No** : ER 101 **Ward Name** : 0F-EMERGENCY

Room No : ER 101 **Admission Type** : First Visit

Contact Details :

Name	: Mr AROCKIA RUBAN	Relationship	: Father
Contact Address	: 4/18, SOUTH ST, SILAKKUVARPATTI, DINDIGUL Siukuvarpatti Madurai Tamil Nadu INDIA 624215	Phone No	: / 8489200376

Signature

Doctor Details :

Doctor Name	: Dr. S . KEERTHIVASAN	Specialisation	: PEDIATRIC GASTROENTEROLOGY AND HEPATOLOGY
Referral Doctor	: DEEPAM MEDFIRSTHOAPITAL (PALLIKARANAI)	Phone No	:
Co-Consultant	:		

Payment Details :

Payment Mode	: Cash	Deposit Amount	: 0.00
		Payor Name	: SELFPAY

Rainbow Children's Hospital

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

GENERAL CONSENT FOR TREATMENT

Patient Name:	**Baby J.A RYAN MATHEW**	**Age :**	**1 Y 1 M 5 D**
IP No:	**IP18-00036530**	**Sex:**	**Male**
Consultant:	**Dr. S . KEERTHIVASAN**	**Ward/Bed No:**	**0F-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 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:.....) J.B.A.

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: J.B.A.

Name: Mr. Arockia Ruban
Relationship: father
Date: 19/07/2026 Time: 06:47 PM
Witness Name: A. Sivasankari
Witness Signature: A. Sr

Patient Address:
4/18, SOUTH ST, SILAKKUVARPATTI, DINDIGUL Siukuvarpatti Madurai Tamil Nadu INDIA 624215

Rainbow Children's Hospital | BirthRight BY RAINBOW HOSPITALS

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. Ryan Mathew	UHID Number : CUC-0009 24060
Self Attendant Name : B. Ar	Relation : father
Self Attendant Signature : B. Ar Phone Number : 8489 9003 76	Name & Signature of Financial Counselor

भारतीय विशिष्ट पहचान प्राधिकरण
भारत सरकार
Unique Identification Authority of India
Government of India

आधार

பதிவேட்டு எண்/Enrolment No.: 2040/80184/69804

Arockia Ruban Basker Antony (ஆரோக்கிய ரூபன் பாஸ்கர் ஆண்டனி)

S/O: Basker Antony, 4/18, south street, nilakottai taluk, Silukkuvarpatti, Dindigul, Tamil Nadu - 624215

Date: 22/03/2016

உங்கள் ஆதார் எண்/ Your Aadhaar No.:

7625 4075 9221

எனது ஆதார், எனது அடையாளம்.

1947 | help@uidai.gov.in | www.uidai.gov.in | www.uidai.gov.in

தகவல்

- ஆதார் அடையாளத்திற்கான சான்று, குடியுரிமைக்கு அல்ல.
- அடையாள சான்றை ஆன்லைன் ஆதன்டிகேஷன் மூலமாகப் பெறவும்.
- இது எலக்ட்ரானிக் செயல்முறை மூலம் தயாரிக்கப்பட்ட கடிதமாகும்.

INFORMATION

- Aadhaar is a proof of identity, not of citizenship.
- To establish identity, authenticate online.
- This is electronically generated letter.

Signature Not Verified
Digitally signed by UNIQUE IDENTIFICATION AUTHORITY OF INDIA
Date: 2016.03.22 10:20:47 IST

- ஆதார் நாடு முழுவதிலும் செல்லுபடியாகும்.
- ஆதார் அதார் சேவைகளுக்கு நீங்கள் விண்ணப்பத்தை பூர்த்தி செய்து பதிவு செய்ய வேண்டிய அவசியம் மற்றும்.
- தயவுசெய்து உங்களின் சமீபத்தைய புதிய மொபைல் நம்பர் மற்றும் இ-மெயில் முகவரியை பதிவு செய்யவும். இதனால் உங்களுக்கு பல்வேறு சேவைகளை பெற்றுக் கொள்ளும் சேவைகளை கிடைக்கும்.

- Aadhaar is valid throughout the country.
- You need to enrol only once for Aadhaar
- Please update your mobile number and e-mail address. This will help you to avail various services in future.

भारत सरकार
GOVERNMENT OF INDIA

ஆரோக்கிய ரூபன் பாஸ்கர் ஆண்டனி
Arockia Ruban Basker Antony
பிறந்த நாள்/ DOB: 15/05/1993
ஆண் / MALE

7625 4075 9221

भारतीय विशिष्ट पहचान प्राधिकरण
AADHAAR
UNIQUE IDENTIFICATION AUTHORITY OF INDIA

முகவரி:
தந்தை / தாய் பெயர்:
பாஸ்கர் ஆண்டனி, 4/18,
தெற்கு தெரு,
நிலக்கோட்டை தாலுகா,
சிலுக்குவார்பட்டி,
திண்டுக்கல்,
தமிழ் நாடு - 624215

Address:
S/O: Basker Antony, 4/18, south street, nilakottai taluk, Silukkuvarpatti, Dindigul, Tamil Nadu - 624215

7625 4075 9221

DAY CARE DIET SHEET

S.No	Date	Time	Food Item	Quantity	Name (Signature)

Rainbow®
Children's
Hospital

It takes a lot to treat the little.

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: _____

UHID ID: GUC-00094060 IP18-00036530
Baby J.A RYAN MATHEW (M)
14-06-2025 1 Y 1 M 5 D
Dr. S. KEERTHIVASAN

Department: _____

Consultant: _____

(P.T.O.)

(P.T.O.)

Patient Sticker

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 Facility 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: .....

GUC-00094060 IP18-00036530
Baby J.A RYAN MATHEW
14-06-2025 1 Y 1 M 5 D (M)
Dr. S. KEERTHIVASAN

(1)

Rainbow® Children's Hospital
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Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/7/26 9.50pm	S/B Dr. Kanishq	
	1 episode of spitting drug (R)	
	No abd. pain / distension.	
	Tolerating feeds	
	O/E - Playful	
	PPWF	
	Vitals - stable	
	P/A - soft,	
	non-tender	
	Other systems - WNL	
	To do - X-ray abdomen @ 8am tomorrow.	Advice T/c as charted. NPO from 6am
20/7/26 8am	S/B Dr. Kavitha / Dr. Gayathri	
	A - Foreign Body ingestion (Button battery)	
	No vomit / abd. pain / abd. distension.	
	O/E - Alert	
	PPWF, Pulse volume - good, CRT < 3 sec,	
	Vitals - stable.	
	P/A - soft,	
	non-tender	
	Other systems - WNL.	

Patient Sticker

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	(20/7 9am) X-ray abdomen (supine) Button battery - stomach ↓ intestine	
	↓ Dw Dr. Keerthivasan sir, advised ① to start feeds now. ② w/f warning signs ③ continue Nexpro / Sucrafil-O	
20/7/24 9.30am	S/B Dr. Gayathri. Child passed the button battery in stools around 9.20 am, 20/7/24. Child is hemodynamically stable No abd pain. - Tolerating well. relieved vitals - stable	
	Plan	
	① today.	D/c Meds ① Syp. Sucrafil-O. 2.5ml BD x 3d ② Nexpro Junior sachet OD x 3d

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

GUC-00094060 IP18-00036530
Baby J.A RYAN MATHEW
14-06-2025 1 Y 1 M 5 D (M)
Dr. S. KEERTHIVASAN

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DRUG CHART

Date of Admission: 19/7/20 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:				

Signature .....

VERIFIED BY : Name .....

GUC-00094060 IP18-00036530
Baby J.A RYAN MATHEW
14-06-2025 1 Y 1 M 5 D (M)
Dr. S. KEERTHIVASAN

REGULAR PRESCRIPTIONS Weight. 7.6 kgs Ward. 511

DRUG : NEXPRO JUNIOR SACHET

Dose	Route	Frequency	Start Date
10mg	P/O	q12h	19/7/26

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time	19/7	20/7
9PM	RV	
6AM		
6PM		

changed 10th/nrs

DRUG : SYP. SUCRFIL-O

Dose	Route	Frequency	Start Date
2.5ml	P/O	q4h	19/7/26

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:
(5ml / 500mg)

Daily Doctor's Endorsement by a Sign

Date / Time	19/7	20/7
1AM		RV
5AM		RV
9AM		SR/SN
1PM		
5PM		
9PM	RV	

DRUG : NEXPRO JUNIOR Sachet

Dose	Route	Frequency	Start Date
10mg	P/O	q12h	20/7/26

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time	20/7
10AM	9AM
	SR/SN

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

Patient Sticker

Weight. 7.6kgs Ward. 511.

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.	

Signature .....

VERIFIED BY : Name .....

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses

(P.T.O)

Patient Sticker

I.V. FLUIDS CHART

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

Date	Time	Composition of I.v. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign

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

GUC-00094060 IP18-00036530
Baby J.A RYAN MATHEW
14-06-2025 1 Y 1 M 5 D (M)
Dr. S . KEERTHIVASAN

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Your Right to a Safe Delivery

MEDICATION RECONCILIATION FORM

Drug Allergies: NIL ☐ ~~Not known any Drug Allergies~~

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

Shifting From: ER Shifted to: 511

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. Kavitha

Date & Time : 19/7/26 6.50pm

Nurse Name & Signature:

Date & Time : 19/7/26 @6:50pm

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

GUC-00094060 IP18-00036530
Baby J.A RYAN MATHEW
14-06-2025 1 Y 1 M 5 D (M)
Dr. S. KEERTHIVASAN

(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 : 19/7 Time:	8PM	12AM	4AM
Doctor / Nurse / Family Concern?			
Temperature (°F)	98°F	98.2F	98.6°F
Heart Rate (bpm) and Blood Pressure (mmHg) *			
Note: BP does not score in early warning scoring			
Heart Rate (Number)	136 b/m	132 b/m	
Resp. Rate (bpm) (Over 1 Minute) *			
Resp Rate (Number)	32 b/m	32 b/m	30 b/m
Resp Distress: Mod/ Severe / None / Mild	✓	✓	✓
Receiving O_2 (l/min) O_2 Saturations (%)	97%	98%	99%
Conscious Level: Normal / Altered	✓	✓	✓
GCS *	15/15	15/15	15/15
TOTAL SCORE Number of shaded boxes	0	0	0
Pain Score	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.

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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.

19/7

Date	Time	Intake: Nature of Fluid	Intake: Route – Mouth	Intake: Route – I.V	Intake: Route – N.G	Output: NG	Output: Diarrhoea	Output: Vomit	Output: Drainage	Output: Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm	——				Passed						
	07:00 pm											
Total Intake :		NIL				Total Output :				NIL		
	08:00 pm	DBF									NO	
	09:00 pm											
	10:00 pm	ABO	30ml							✓	IV	
	11:00 pm											
	12:00 am	DBF								✓	line	
	01:00 am											
Total Intake :		2DBF + 30ml				Total Output :				2times		
	02:00 am	DBF									NO	
	03:00 am											
	04:00 am											
	05:00 am	DBF								✓	IV	
	06:00 am	NPO										
	07:00 am	NPO									line	
Total Intake :		2DBF				Total Output :				1times		

Total 24 hrs. Intake	3DBF + 30ml	Total 24 hrs. Output	3times

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NURSES NOTES

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☐ No Known Drug Allergies

☐ Drug Allergies .... Nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		← Received notes →	
19/7	7.25 pm	→ Child Received from ER to 5th floor Child detail Handing over given by ER S/N	019346
		→ child was conscious and alert Child was conscious and alert child was active & alert	019346
	7.30 pm	→ Child detail Handing over given to Night duty S/N	019346
19/7/26		Night duty on (19/7/26)	
	7.30pm	The child Handing over taken from evening duty staff the child was concious & active.	
	8pm	Vital signs are checked & Recorded vital signs are stable [8pm / CP ++ / PP ++ / CRT <3sec]	02113 / 02113
	9pm	Due medication was given as per drug chart order.	
	10pm	The was comfort-able position no any fresh complaints	02113
20/7/26	12 AM	Vital signs are checked & Recorded vital signs are	02113

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

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NURSES NOTES

☑ No Known Drug Allergies

☐ Drug Allergies ... Nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
20/7		continue.	
		Stable →	vit. 02/11/13
	1AM	Due medication was given as per drug chart orders.	
	2AM	The child was comfortable position no any fresh complaints →	vit. 02/11/13
	4AM	Vital signs are checked & Recorded vital signs are stable [4AM | CP ++ | PP ++ | CRT <3sec]	vit. 02/11/13
	1	The child was comfortable Position no any fresh complaints →	vit. 02/11/13
	5AM	Due medication was given as per drug chart orders →	vit. 02/11/13
	6AM	The child was up 6.	
	7AM	Maintained I/o chart & Recorded →	vit. 02/11/13
	7.30AM	The child Handing over given to morning duty Staff →	vit. 02/11/13

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NURSES NOTES

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☑ No Known Drug Allergies

☐ Drug Allergies ... nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
20/7/26		Morning duty 20/7/26	
	7:30am	The child details handing over from the night duty Staff nurse. child was conscious and oriented. no IV line present. child was well active	[illegible]
	8:00am	Vitals signs are checked and Recorded vitals signs are stable. 8am | HR | RR | CRT — | ++ | ++ | <3 sec	[illegible]
	8:00am	As per doctors order x-ray on Abdomen Supine done in 8:00am	[illegible]
	9:00am	Due to medication as per doctor order Sy. Scurfil 2.5ml and Nexpro Junior sachet 10mg as given in 9:00am	[illegible]
	~~[illegible]~~ 9.20 Am	~~Baby stool passed [illegible]~~ child passed the button battery In Stool around 9.20Am 20/7/26. Child is stable. no complaints. Having food.	[illegible]
		Doctor Gayathri man seen by Dcb Advice to Today DC plan. [illegible] sent to billing [illegible]	[illegible]

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☐ Drug Allergies .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE

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INTERDISCIPLINARY PATIENT / FAMILY EDUCAT

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Part - I.

Patient's / Learner Language: English 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. Pain Management
4. Informed Consent
5. Medication / Therapy (safety, effects/ side effect, interactions)
6. Discharge Medication
7. Infection Control Measures
8. Diagnostic Test / Procedures
9. 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		
19/7	7.40 pm	2	Explain about Treatment and Cal	Mother	LO	Bal	nil	Yes	good	
20/7	7.30 am	8	Explain about maintain personal hygiene	mother	nil	Verbal	Nil	Yes	Good	

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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Nursing General Admission Assessment Form For Pediatrics

Diagnosis: Foreign (button battery) ingestion.
Arrival Time: 7.20PM Mode of Arrival: Walking Admitting From: ☑ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction: No allergic reaction.

Body Weight: 7.6 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: —

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: 7.6 Length: ..... Head Circumference (< 2 years): .....

Temp.: 98.2°F HR: 130 b/m RR: 32 b/m BP: —

Pain Score: — Specify Site: O/C (Follow Pain Assessment Sheet & Document)

Fall Risk Assessment: ☐ Yes ☑ No Score: 02 (Document in the Humpty Dumpty Sheet)

Risk of Pressure Sore (Braden Q Score 28) (Document in the Braden Q Assessment Sheet)

Pain Screening: ☐ Yes ☑ No If Yes, Pain Score: O/C 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 ..... Parent .....

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

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: R. Vaishnavi Date: 19/7/26 Time: 7.45pm Signature

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BED SIDE CHECK LIST FOR NURSES

Date:	19/7	20/7							
Doctor's Orders	Followed	Followed							
Carried out or not	Carried	Carried							
Bed Side									
Structured Handover done	✓	✓							
IV Site	✓	✓							
Central Lines	✓	✓							
Arterial Lines	✓	✓							
Feeding Catheter	✓	✓							
Urinary Catheter	✓	✓							
Skin Care	✓	✓							
Eye Care	✓	✓							
Mouth Care	✓	✓							
Sterillum Bottle, Stethoscope	✓	✓							
Suction Bottle (Should be clean & empty)	✓	✓							
Intubation Tray	✓	✓							
Emergency Tray (Loaded Syringes with Midazolam & Vecuronium and Flush) Ampoules of Adrenaline	✓	✓							
Ventilator Tubing,(Any Water, Blood)	✓	✓							
Humidification	✓	✓							
Check all Infusion (Labelling,Correct Preparation)	✓	✓							
Chest Physio & Neb	✓	✓							
Handed Over By Name :	Rishi	S. Usha							
Signature :	Rishi	Asha							
Date & Time:	19/7 @ 7.30 AM	20/7 8am							
Hand Over Taken By Name :									
Signature :									
Date & Time:	20/7 7.30								

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PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : Dr. Keerthivasan Date : 19/7/26

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

Start Time of Assessment: 6:20pm Weight: 7.6 kgs

Allergic History:

Chief Complaints:
C/o accidental ingestion of button battery at 5pm

Pediatric Assessment Triangle

A Appearance - TICLS Alert

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 ☐

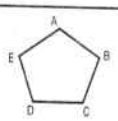
Any urgent interventions needed: ☐ Yes ☐ No
If Yes

Significant Past History:

Medication History:

Relevant Investigations:

Primary Assessment



Airway

- ☑ Open
- ☐ Maintainable
- ☐ Not Maintainable

Any urgent interventions needed: ☐ Yes ☑ No
If Yes

Breathing

Rate: 30/min SpO$_2$ on FiO$_2$ RA 99%
Rhythm: regular
Retractions: ☐ Suprasternal ☐ ICR ☐ SCR ☐ Sternal ☐ Supraclavicular ☐ Nasal Flaring
Respiratory Noises: ☐ Stridor ☐ Wheezing ☐ Grunting
Air Entry: equal
Palpation Findings (If necessary)

Any urgent interventions needed: ☐ Yes ☐ No
If Yes

Circulation

HR: 140/min CFT Central ..... Peripheral ..... <3sec

Any urgent interventions needed: ☐ Yes ☑ No

If Yes .....

BP: ..... mmHg

Pulse Volume: Central ..... Peripheral ..... good

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: 15/15 AVPU: Alert

Any urgent interventions needed: ☐ Yes ☐ No

If Yes .....

Pupils: Responsive ☐ Non-Responsive ☐

Size: Right ..... Left .....

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

Signs of Neurological compromise .....

.....

Exposure

Temp.: 97.8°F

Any urgent interventions needed: ☐ Yes ☑ No

If Yes .....

Any Rash: ☐ Yes ☐ No,

If yes describe the rash .....

Active bleed .....

Lacerations ☐ Abrasions ☐ bruises ☐

Describe: .....

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: .....

.....

Mentioned inside

.....

.....

.....

.....

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: Dr. Kavitha

Signature: .....

Date & Time: 19/1/26 6.30pm

Sr. Doctor on Duty (If necessary)

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

Signature: .....

Date & Time: .....

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last food @ 4:45pm

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EMERGENCY ROOM TRIAGE FORM

wt. 7.6Kg

Patient's Name : Baby. Ryan Mathew Age : 1y/m Gender: ☑ Male ☐ Female
Date : 19/7/26 Time of Arrival : 6:20pm
Allergies: ☐ No ☐ Yes ☐ Food ☐ Medications ☐ Blood Transfusion ☐ Other (Specify): ☐ Not known
Source of Information : ☑ Parents ☐ Others (Specify)
Mode of Arrival : ☐ Ambulatory ☐ Wheelchair ☐ Ambulance
Initial Vital Signs: Temp: 97.8F PR: 140/m BP: - RR: 26/m SpO_2: 99% RA.
Chief Complaints: C/o accidental ingestion of button battery. @ 5pm

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	
☐ Level 2 : EMERGENT : Life or limb threatening	☐ Immediate
☐ Level 3 : URGENT : Significant illness / injury with potential to become life or limb threatening	☐ < 15 min
☐ Level 4 : LESS URGENT : Significant illness but not life threatening	☐ 30 min
☐ Level 5 : NON – URGENT : May receive care when convenient	☑ 60 min
	☐ 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 : 9mins

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 : Suganthi
Signature of Triage Nurse : Suganthi 018275
Date & Time : 19/7/26 @ 6:20pm

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

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 19/7/25 Time of arrival : 6:20pm

Chief Complaints: C/o accidental ingestion of button battery RBS: .....

Height : — Weight : 7.6 kg. BMI : — Head Circumference (<2 years) —

Allergies: ☐ Yes ☐ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other: —

If yes , identify —

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

☐ Character — ☐ Location — ☐ Frequency — ☐ Duration —

RISK FOR FALL:

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

☐ If Patient is > 6 years
Assess the below parameters

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

Ambulatory Aids:

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

Gait/Transferring:

- Bedrest / Immobile ☐ Yes ☐ No
- Weak ☐ Yes ☐ No
- Impaired ☐ Yes ☐ No

Mental Status: Forgets limitations ☐ Yes ☐ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening: ☐ No Abnormalities Detected

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

Inform consultant for positive criteria

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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 —

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

Time of Initial assessment completed by ER Nurse : 6:30pm.

Time	Nursing Notes
6:20pm	Chief come for ER. Chief conscious & oriented
	Vitals Checked & Records taken Stable
	Dr. Kasthuri Saw advice to admitted
	for further Procedure. No Duty. No
	Space tomorrow Procedure.
	& Chief Shifted to Cabins.

Samples collected by: T Time: T

Samples sent by : T Time: T

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: 140bm BP: — CFT: <3sec	Shift - out from ER to: ICU
RR: 26bm SPO_2: 99%	Time of Shift - out: 4:20pm
GCS: 15/15 Temperature : 97.8F	Handover given to: Sr. Sireesha (Nurse's Name)
Pain Score: 0	
Repeat RBS (if applicable): Nil	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any): Nil

Name of the Nurse : Jayanthi Signature of the Nurse : Jayanthi

Date & Time : 19/7/20 @ 8:30pm 018475.

GUC-00094060 IP18-00036530
Baby J.A RYAN MATHEW
14-06-2025 1 Y 1 M 5 D (M)
Dr. S . KEERTHIVASAN

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

RBS CHART

Date	Time	RBS (mg/dl)	IVF %	Signature

PATIENT TRANSFER FORM

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Your Right to a Safe Delivery

GUC-00094060 IP18-00036530
Baby J.A RYAN MATHEW
14-06-2025 1 Y 1 M 5 D (M)
Dr. S . KEERTHIVASAN

Date & Time of Admission	Date & Time of Transfer Order
19/7/26 @ 6:47pm	19/7/26 @ 7:20pm

Treating Consultant Name	Transfer Ordered by	Reason for Transfer
Dr. Keerthisan	ER	further mayement

From Unit	To Unit	Information to Attendant
ER	SI	Yes ☐ No ☐

Number of Sheets in Clinical File	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant
10	—	Yes ☐ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

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

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

Foreign body ingestion

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
01827	

Patient & Clinical Records Received by : 01934 19/7/26 @ 7.20pm

Date & Time of Patient Received : 19/7/26 @ 7:20 pm

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