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

BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

PATIENT DISCHARGE INTIMATION FROM NURSING STATION

CLEARANCE FOR DRUGS AND DISPOSABLES BILLING

Date: 19/7/2026.

GUC:-00093994 IP18-00036505
Baby P.LITHVIK VARUN
01-08-2021 4 Y 11 M 17 D (M)
Dr. PADMAPRIYA EKAMBARAM

Name of the Pa .....

UHID No: ..... Gender: .....

Ward: ..... Room No: .....

Certified that in respect of the above patient:

- ☐ a. There are no drugs for return
- ☐ b. Emergency cupboard issues have been replenished
- ☐ c. No pending indents are there against above patient
- ☐ d. Checked the bed side cupboard of the bed
- ☐ e. Checked by the patient's Mother / Father in the room

Patient Authorised Sign

Date: .....

Time: .....

Nurse Sign

Date: 19/7/26

Time: 9AM

Pharmacy Sign

Date: 19/7/26

Time: .....

Docu. No. : RCH /FRM / GENERAL / 117

Rainbow Children's Hospital

DISCHARGE TRACKING SHEET

UHID-

FLOOR-

NAME OF CONSULTANT-

GUC:-00093994 IP18-00036505
Baby P.LITHVIK VARUN
01-08-2021 4 Y 11 M 17 D (M)
Dr. PADMAPRIYA EKAMBARAM

ACTIVITY	INTIME	OUT TIME	NAME & SIGNATURE	REMARKS	<To be filled by Admin>		
Activity Sheet update by Nursing							
Activity Sheet update by Pharmacy							

ACTIVITY RECORD FOR BILLING

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Name: .....

GUC-00093994 IP18-00036505
Master P.LITHVIK VARUN
01-08-2021 4 Y 11 M 16 D (M)
Dr. PADMAPRIYA EKAMBARAM

UHID No: .....

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

Date of Admission: .....

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

Room / Bed No: ..... Ward: .....

Suggested Billable bed type: .....

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
17/7/26	3.45pm	ER	509	

CROSS CONSULTATION VISIT

	Doctor Name	Date	Order No.	Signature
1.	Dr. Mohinith	18/7/26	29390	
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

INVESTIGATIONS

Date	Investigations	Order No.	Signature
	RBS	26023030	[illegible] 17894
17/7/26	CBC, CRP. electro, Ca	26023031	
	Mg	26023032	
17/7/26	Dengue NS1	023136	[illegible]

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
18/7/26	Infusion pum.	8pm	18/7/26 3pm	1729059	[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
17/7	IV Placement	(1)	1728900	[signature] 17854

ANY OTHER INFORMATION:

.....

.....

.....

.....

.....

.....

Date: 19/8/26 Time: 9AM Prepared By: .....

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
[signature]			

Rainbow Children's Hospital | BirthRight

5th floor.

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		9pm			
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 : IP18-00036505 **Admit Date** : 17-Jul-2026 **Admit Time** : 03:06 PM **UHID** : GUC-00093994

Patient Details :

Patient Name	: Baby P.LITHVIK VARUN	**Age**	: 4 Y 11 M 16 D
Guardian	: Mr PREMKUMAR	**DOB**	: 01-08-2021
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: NO: 1, 6th STREET, VEERASAMY NAGAR, PALLIKARANAI, CHENNAI Pallikaranai Kanchipuram Tamil Nadu INDIA 600100	**Phone No**	: 9626761981/ 8072228329
		E-mail	: Prem123786@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 PREMKUMAR **Relationship** : Father

Contact Address : NO: 1, 6th STREET, VEERASAMY NAGAR,PALLIKARANAI, CHENNAI Pallikaranai Kanchipuram Tamil Nadu INDIA 600100 **Phone No** : 9626761981

Signature

Doctor Details :

Doctor Name : Dr. PADMAPRIYA EKAMBARAM **Specialisation** : GENERAL PEDIATRICS

Referral Doctor : DEEPAM HOSPITAL **Phone No** :

Co-Consultant :

Payment Details :

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

Payor Name : SELFPAY

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

GENERAL CONSENT FOR TREATMENT

Patient Name:	**Baby P.LITHVIK VARUN**	**Age :**	**4 Y 11 M 16 D**
IP No:	**IP18-00036505**	**Sex:**	**Male**
Consultant:	**Dr. PADMAPRIYA EKAMBARAM**	**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:.....

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: Prem kumar
Relationship: Father
Date: 17/7/2026 Time: 3.16 pm
Witness Name: Pavithra
Witness Signature:

Patient Address:
NO: 1, 6th STREET, VEERASAMY NAGAR,PALLIKARANAI, CHENNAI
Pallikaranai Kanchipuram Tamil Nadu
INDIA 600100

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 • Litavik Varun	UHID Number : GRUC-00093994
Self/Attendant Name : R. PREM KUMAR	Relation : Father
Self/ Attendant Signature : R. Prem Phone Number : 9626761981	Name & Signature of Financial Counselor

भारत सरकार

आधार

இந்திய அரசாங்கம்
Government of India

இந்திய தனித்துவ அடையாள ஆணையம்
Unique Identification Authority of India

பதிவேட்டு எண் / Enrollment No.: 0989/08212/01866

To

P. Lithvik Varun
S/O R Premkumar,
3/282,
Usilangulam,
VTC: Veeracholan, PO: Veeracholan,
Sub District: Tiruchuli, District: Virudhunagar,
State: Tamil Nadu,
PIN Code: 626612,
Mobile: 9626761981

91126258

KD911262585FL

உங்கள் ஆதார் எண் / Your Aadhaar No. :

3292 9385 0174

எனது ஆதார், எனது அடையாளம்

இந்திய அரசாங்கம்
Government of India

Aadhaar no. issued: 19/07/2025

P. Lithvik Varun
பிறந்த நாள் / DOB: 01/08/2021
ஆண் / Male

ஆதார் என்பது அடையாளத்திற்கான சான்றாகும், குடியுரிமை அல்லது பிறந்த தேதிக்கான சான்றல்ல. இது சரிபார்ப்புடன் மட்டுமே பயன்படுத்தப்பட வேண்டும் (ஆன்லைன் அங்கீகாரம் அல்லது QR குறியீட்டை ஸ்கேன் செய்தல் / ஆஃப்லைன் XML)

Aadhaar is proof of identity, not of citizenship or date of birth. It should be used with verification (online authentication, or scanning of QR code / offline XML).

3292 9385 0174

எனது ஆதார், எனது அடையாளம்

17 Jun 2024, 11:57 am

DEEPAM MEDFIRST HOSPITAL

MEDFIRST HOSPITAL

No.129, Velachery Main Road, Pallikaranai, Chennai - 600 100
+91 - 6380100 100 | 6380 101101

REFERRAL FORM

UHID No. : 1063429.

Date : 17/07/2024

PATIENT NAME: MST. LITHUIK VARUN,P **AGE:** 4y-11m. **Gender :** MALE
DOCTOR REFERRED TO: RAINBOW HOSPITAL, GUINDY SPECIALITY: PEDIATRICS ADDRESS: GUINDY PHONE NO. : **Patient Phone No.**
REFERRED BY: CMO, DEEPAM MEDFORT. HOSPITAL, PALLIKARANAI.

REASON FOR REFERRAL:

Dear Dr.

.....

Herewith referring this patient

..... A case of New onset Febrile Seizures .....

.....

CLINICAL SUMMARY OF THE PATIENT:

Diagnosis:- AFI - (A) / SIMPLE FEBRILE

Investigations if any:-

Other specific issues / comments:-

I would appreciate receiving a report of your findings.
Thanks for your help and advice.

Sincerely,

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

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: _____

UHID ID: _____ GUC-00093994 IP18-00036505 _____

Master P.LITHVIK VARUN
01-08-2021 4 Y 11 M 16 D (M)
Dr. PADMAPRIYA EKAMBARAM

Department: _____ _____

Consultant: _____

Patient Sticker

Pediatric Multiorgan History & Physical Examination

Name: _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

History of present illness :

c/o fever since morning
c/o 1 episode of seizure @ 11.45 am
lasted for 1½ mins, uprolling of eyeballs &
tonic posturing of all limbs f/b
post ictal drowsiness.
c/o vomiting - 2 episodes
non bilious, non projectile

Taken to Deepam hospital,
given paracetamol suppository (T-101.3°F),
? seizures & referred here.

Patient Sticker

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

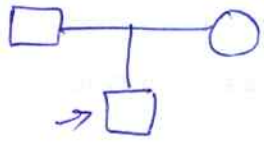
No H/o previous admissions

Birth & Neonatal History:

Term, BW - 3.205 kg, CMAB, H/O NICU Observation for 1 day i/l/o forceps delivery. H/O NNH for D_3, received PT

Family Chart

NCM



Birth & Socio Economic History:

About Father :

About Mother :

Any additional information : No family H/o febrile Sz / epilepsy

Developmental History :

(N)

Immunization History :

(N)

Anthropometry :

Head Circum (cms) 48cm (Centile _____) Height (cms): _____ (Centile) _____)

Weight (kgs) 18 (Centile _____)

On Examination :

Temperature : 97.9°F Pulse Rate : 132 B.P. 95/48 SPO2 97 %

Resp.rate and type of breathing : 25

Rash -

Lymphadenopathy -

Oedema : -

Allergies (if any):

(P.T.O.)

Patient Sticker

Respiratory System :

Inspection (any s/o distress) : N

Air entry & breath sounds : B/L AE+

Any addes sounds : -

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

Cardiovascular System :

Inspection of procordium : N

Heart Sounds : S1 S2 +

Any murmur : -

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

Per Abdomen :

Inspection : N

Palpation : soft, not tender, no OM

Ausculation : BS+

Spine : External Genitelia :

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

Central Nervous System :

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

Cranial Nerves : N

Motor System :

Nutriton : N

Tone: N Power N

Co-ordinator :

Posture : N

Involuntary Movements :

Patient Sticker

Reflexes :

DTR **Superficials:**

Plantars N

Sensory System :

N

Bladder / Bowel :

Clinical Summary & Diagnostic: Simple febrile seizure - 1st episode

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

Desired goals of the treatment :

Planned Labs:

CBC
CRP
S. electrolytes
Cal, Mg

Planned Management

- IV fluids
- Syp. P250

Signature of the Doctor:

Name of the Doctor: Keerthana. D

Date & Time: 14/4/26 3.30pm

Signature of the Consultant:

Name of the Consultant:

Date & Time:

(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-00093994 IP18-00036505
Baby P.LITHVIK VARUN
01-08-2021 4 Y 11 M 17 D (M)
Dr. PADMAPRIYA EKAMBARAM

Rainbow Children's Hospital
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CROSS CONSULTATION FORM

Doctor Name: DR. MOHNISH Date: 18/7/26 Time: 10:30AM

Diagnosis: .....

Hospital: .....

.....

Referred for: ☐ Opinion ☐ Co-Management ☐ Transfer of care

Type of Referral :
☐ Emergency
☐ Urgent
☐ Non Urgent

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

Signature:

Findings and Recommendations : Thanks for Referral.
4 yrs / Developmentally normal child.
H/o fever since yesterday morning, had ① episode of seizure i/H/o upping eyeballs, posturing all 4 limbs
lasted for ↓ 2 min, post ictal drowsiness.
No further episodes. No post ictal weakness.
O/E: Conscious. HC = 48 cm.
No NC weakness / Dysmorphism.
No focal deficits. No neck rigidity / Kernig sign (-)
Gait: Normal.

1st episode SIMPLE FEBRILE SEIZURE

Consultant :

Name: Dr. Mohnish Signature: ..... Date & Time: 18/7/26 at 10.30AM

Plan:

→ Advised intermittent clobazam prophylaxis.

→ W/F any danger signs: Acoc / Breathability / recurrent seizures / focal deficits.

→ Focus workup if indicated.

R/W.

DR. MOHNISH
11/2/25

GUC-00093994 IP18-00036505
Master P.LITHVIK VARUN
01-08-2021 4 Y 11 M 16 D (M)
Dr. PADMAPRIYA EKAMBARAM

(1)

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
17/7/26 4.45pm	S/B Dr. Padmapriya.	
	Δ: 1st episode febrile seizures.	
	child rained	
	fever spikes (+)	no family h/o seizures (febrile)
	No other complaints	
	No foods	
	vitals: Stable	
	CVS: S1S2 (N) no murmur	PA: soft NT, no organomegaly
	CNS: NFND.	RS: NVBS (N) no adventitia
	(N) tone in all 4 limbs	
	(+) Blinks (+)	
	DTR 2+	
		Padmapriya 44268
	1) Inj PCM 10mg IV SOS.	
	2) Inj EMESET 2mg SOS).	
	3) W/f fever spikes / seizures.	
Lethargic 20777		

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	S/B. Dr. LUCKY VIGNESH	
18/7/26 10:00AM		
	Δ: Simple febrile seizures / Fever ↓ Evaluation (viral)	
	child normal.	
	fever spikes ⊕	
	No other complaints	
	10.0 > 5900 / 83/7 < 2.00 lakhs	
	vitals - stable	
	CRP - <5	Temp: 101'2°F
	Sr. calcium - 10	
	Sr. Mg - 1.6	
	RS: clear	CVS: S1S2⊕/ No murmur
	PA: soft NT, no mass	CNS: NFND.
		(N) tone / DTR 2+ / B/L PERL⊕
	Plan: 1.) To continue paracetamol / clobazam	
	2.) W/f fever spikes.	
	~~2) 2D TO ALSO for operation~~	
	3) Neurologist opinion i/v/o febrile seizures.	

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

GUC-00093994 IP18-00036505
Baby P.LITHVIK VARUN
01-08-2021 4 Y 11 M 17 D (M)
Dr. PADMAPRIYA EKAMBARAM

(2)

Rainbow® Children's Hospital
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BirthRight
BY RAINBOW HOSPITALS
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
18/7/2026 5:00 PM	S/B Dr LUCKY NIGNESH	
	A: Simple febrile seizure / viral fever	
	child remained	
	fever spikes (+)	
	NO complaints	
	vitals - stable	
	Dengue NS1 - Neg	
	RS: Clear	
	PA: SOFT NT, no mass/ organomegaly	
	other systemic - (N)	
	Plan:	
	1. Syp AZEE (200mg/5ml)	
		20mg/kg (D1) 9ml stat
		↓
		10mg/kg (D2-D5)
		4.5ml - 0 - 0 x 4days.
	2. w/f	fever spikes / further episode of seizures.
	Luckynigh 203377	

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

Patient Sticker

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

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Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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

DOCTOR'S SHIFT CHANGE HANDOVER FORM

Rainbow® Children's Hospital
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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

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

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-00093994 IP18-00036505
Master P.LITHVIK VARUN
01-08-2021 4 Y 11 M 16 D (M)
Dr. PADMAPRIYA EKAMBARAM

Rainbow Children's Hospital
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RESULT SHEET

Date	17/7/26					
Time						
Hb	10.0					
PCV	29					
RBC	3.76					
WBC	5900					
N/L	83/7					
Platelets	200					
CRP	<5					
ESR						
PCT						
RBS						
Na	132					
K	3.6					
Cl	100					
Ca/Mg	10.1/1.6					
Phosphate						
Urea						
Creatinine						
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

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.,) : .....

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DRUG CHART

Date of Admission: 17/7 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 / 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: Syp. P250				Date / Time	17/7	18/7
Dose	Route	Frequency	Start Date			
5 ml	PO	SOS	17/7	5:45 pm	RST	4:30 am KS
Doctor's Signature	Valid Period	Pharm.				9:30 am RST
[signature]						
Additional Instructions: if T >100F						

DRUG: Inj. EMSET				Date / Time	17/7
Dose	Route	Frequency	Start Date		
2 mg	IV	SOS	17/7	6pm	RST
Doctor's Signature	Valid Period	Pharm.			
[signature] 10:47 PM					
Additional Instructions:					

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

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

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REGULAR PRESCRIPTIONS

Weight. 18kg Ward. .....

DRUG : Syp. CLOBIUM

Dose	Route	Frequency	Start Date
2.5ml	Po.	Q12H	17/7/21

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions: 20337 (5mg/5ml)

Daily Doctor's Endorsement by a Sign

Date																
Time	17/7		18/7	19/7												
	8PM			PBT	PBT SN											
	8PM	7PM		PBT	PV											

DRUG : Inj PAN

Dose	Route	Frequency	Start Date
2mg	IV	OD	17/7

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions: 20337

Daily Doctor's Endorsement by a Sign

Date																
Time	17/7		18/7	19/7												
	6PM	6PM		PBT	IS	PV										

DRUG : Syp. AZEE (200mg/5ml)

Dose	Route	Frequency	Start Date
4.5ml	PO	Q24H	19/7

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions: 20337

Daily Doctor's Endorsement by a Sign

Date																
Time	19/7															
	8AM	PBT 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. 18.10kg 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.	

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
17/7/26	10.35	Syp IBUGESIC (100mg/5ml)	8ml.	Po	[signature] 20337N	[signature] SA/SN
18/7/26	6:30pm	Syp. ALEE (200mg/5ml)	9ml	Po	[signature] 20337N	

(P.T.O)

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I.V. FLUIDS CHART

Weight. 18 kg Ward. .....

Date	Time	Composition of 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
17/7	4pm	0.9% DNS	IV	58					

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: 509

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 : .....

Date & Time : 1/7 @ 3PM

Nurse Name & Signature: 13894 / Iman

Date & Time : 1/7 @3PM

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

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(1)

Doc. 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: 17/7th

Time	4pm	5pm	5:30pm	7pm	8pm	10:30pm	12am	2am	4:30am	6am	7:30am
Doctor / Nurse / Family Concern?											
Temperature (°F)	98.4F	99.1F	100F	101.2F	101.6F	102.6F	99.8F	99.1F	101.9F	99.7	100.5F
Heart Rate (bpm) and Blood Pressure (mmHg) *	130/60 (91)				88/75 (80)	102/65 (81)			100/68 (78)		
Heart Rate (Number)	130bpm				148bpm	120b/m			130b/m		
Resp. Rate (bpm) (Over 1 Minute) *											
Resp Rate (Number)	20/m				30b/m	30b/m			30b/m		
Resp Distress: Mod/ Severe / None / Mild	✓				✓	✓			✓		
Receiving O_2 (l/min) / O_2 Saturations (%)	97%				98%	98%			95%		
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	[illegible]				[illegible]	[illegible]			[illegible]		

Note: BP does not score in early warning scoring

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.

15/7/21		Intake				Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
	02:00 pm											
	03:00 pm				Receiving		Note					
	04:00 pm										0	[illegible]
	05:00 pm	H2O	50ml	58ml				✓			0	[illegible]
	06:00 pm	H2O	50ml	58ml						✓	0	[illegible]
	07:00 pm			58ml							0	[illegible]
Total Intake :		100ml + 174ml				Total Output :				1 times		
	08:00 pm	[illegible]									0	[illegible]
	09:00 pm	H2O	20ml								0	[illegible]
	10:00 pm										0	[illegible]
	11:00 pm	H2O	20ml							✓	0	[illegible]
	12:00 am										0	[illegible]
	01:00 am	H2O	10ml								0	[illegible]
Total Intake :		50 ml				Total Output :				1 time		
	02:00 am	H2O	30ml								0	[illegible]
	03:00 am										0	[illegible]
	04:00 am	H2O	20ml								0	[illegible]
	05:00 am										0	[illegible]
	06:00 am										0	[illegible]
	07:00 am										0	[illegible]
Total Intake :		50 ml				Total Output :				—		

Total 24 hrs. Intake	200ml + 174ml	Total 24 hrs. Output	2 times

Docu. No. : RCH /FRM / CLINICAL / 092

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FLUID CHART

Sheet No. : (2)

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.

18/7		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										0	
	09:00 am	H2O	100ml							✓	0	
	10:00 am										0	
	11:00 am	H2O	50ml							✓	0	
	12:00 pm										0	
	01:00 pm	H2O	50ml							✓	0	
Total Intake :		200ml				Total Output :				3 times		
	02:00 pm	H2O	100ml								0	
	03:00 pm									✓	0	
	04:00 pm	Milk Boost	150ml								0	
	05:00 pm									✓	0	
	06:00 pm	H2O	50ml							✓	0	
	07:00 pm										0	
Total Intake :		300ml				Total Output :				3 times		
	08:00 pm	H2O	30ml								0	
	09:00 pm										0	
	10:00 pm	H2O	20ml							✓	0	
	11:00 pm										0	
	12:00 am	H2O	50ml								0	
	01:00 am										0	
Total Intake :		100 ml				Total Output :				1 times		
	02:00 am	H2O	30ml								0	
	03:00 am										0	
	04:00 am	H2O	40ml								0	
	05:00 am										0	
	06:00 am	H2O	50ml								0	
	07:00 am										0	
Total Intake :		110ml				Total Output :				nil		

Total 24 hrs. Intake	710 ml	Total 24 hrs. Output	7 times

Patient Sticker

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FLUID CHART

Sheet No. : .....

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

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

Total 24 hrs. Intake		**Total 24 hrs. Output**	

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(1)

NURSES NOTES

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

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		Receiving Notes.	
17/1/-	3.45pm	Child details handover taken from the ER staff. Child complaint for 1st episode of simple seizure, child was conscious & oriented. IV line patent.	[signature]
	4pm	Check the vital signs vitals are the stable. [CP ++ / PP ++ / CRT <3s]	[signature]
		Dr. Padmam mam see the child mam advised. Continue IVF & Add syp. clobazam 2.5ml Add. par.	
	5pm	Check the Temp - 99.1°F. Child was stable. No other complaint	[signature]
	530pm	Reassess the child condition child was stable. Temp → 100°F. Child was 1 episod of vomiting. Inform to the Doctor.	[signature]
	5.45pm.	P-250 - 5ml given as per the drug chart order for high grade of fever	[signature]

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Patient Sticker

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NURSES NOTES

☑ No Known Drug Allergies

☐ Drug Allergies .... nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
17/7	6pm	Due medication as given for the drug chart order.	
	7pm	Reassess the child condition. Tem → 101.2°F. given sponging. Due medication monitor the chart. IV line patent on the IV fluid.	[signature]
		Due medication as given for the drug chart order.	[signature] 02025
	7:30pm	child details handover given to the Night duty Staff	[signature] 02050
		Night duty	
	7:30 pm	→ child detail handing over taken by day duty s/n	[signature] 01394
		→ Child was conscious and oriented. child was active & alert. IV line patent	
	8pm	→ vitals are checked and recorded	
		Temp / CRT / CP / PP <3sec / +ve / +ve	[signature] 01394
	10:45 pm	→ Temperature 102.8 F informed to Dr. [illegible] [illegible] phone call order	[signature] 01394

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Docu. No. : RCH /FRM / CLINICAL / 089

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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
1/7/		→ Dr advice to give Ibugesic	
		And again give 2ml ;	0A
		→ Ibugesic as given as per	
		Dr Chart Order	019346
		→ Cold Sponge given.	
		→ Dr Consultation came and	
		explain the reports to attender	
		attender wants to request to do	
		ECG and neurologist opinion	
	12am	vitals are checked and	019346
		recorded	
		Time / CRT <3sec / CP +ve / PP +ve	
	1am	→ Re-assessed the temperature	
		temperature reduced 99.4F	
	2am	Child was sleeping well no	019346
		complaints of sleeping disturbances	
	4:30 am	→ vitals are checked and recorded	0117
		vitals are stable, Temperature 101.9F	
		Syp. pcm given	
		Time / CRT <3sec / CP +ve / PP +ve	019346
	6am	→ Re-assessment done temperature	
		reduced,	
	6am	→ Due medication as given as	
		per day Chart Order	
	7am	→ Maintaining records & reports	01934

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

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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
16/5	2.30 am	Temperature Checked 100.5°F	
		Cold Sponge applied	
	7.20 am	→ Child handing over giving	
		to Morning duty S/N	01834
		Morning duty	
	7:30pm	child details handover taken	
		from the Night duty staff	
		Child was conscious & oriented	
		& Dline pattern.	02058
	8AM	Check the vital sign. vitals	
		are the stable.	
		Tem = 99.1°F. SPO_2 = 98%.	
		HR - 130b/m Cp ff / PP ff / CRT 3sec	02058
	9.20AM	Reasses the child condition	
		Tem - 101.1F. given to	
		The syp. P-250 5ml as	
		per the drug chart order.	02058
	10.30AM	Reasses the child	
		condition child was	
		Stable. Tem → 100.9°F.	
		Dr. mobinish sir see the	
		child sir Advised continue	
		same w/f fever spike.	0205
	12pm	Check the vital sign	
		Vitals are the stable.	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

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Patient's Name:. GUC-00093994 IP18-00036505 Master P.LITHVIK VARUN
MRD NO:........... 01-08-2021 4 Y 11 M 16 D (M)
Dr. PADMAPRIYA EKAMBARAM
Age :.................. M ☐ F
Consultant :..

PHLEBITIS ASSESSMENT

CANNULA 1

Date : 17/7 Time: 3.20PM
Location : (L) metacarpal.
Size : 22G.
Cannula inserted by : SN. Iman

Date	Time	Phlebitis	Infiltration	Nursing Intervention	Sign
17/7	3.30 pm	☐Yes ☐No	☐Yes ☐No	Pattern	[illegible]
	4pm	☐Yes ☐No	☐Yes ☐No	obsvd	[illegible]
	6pm	☐Yes ☐No	☐Yes ☐No	Obsvd	[illegible]
	8pm	☐Yes ☐No	☐Yes ☐No	Obsvd	[illegible]
	10pm	☐Yes ☐No	☐Yes ☐No	Obsvd	[illegible]
18/7	12am	☐Yes ☐No	☐Yes ☐No	obsvd	[illegible]
	2am	☐Yes ☐No	☐Yes ☐No	observd	[illegible]
	4am	☐Yes ☐No	☐Yes ☐No	Observd	[illegible]
	6am	☐Yes ☐No	☐Yes ☐No	Obsvd	[illegible]
	8AM	☐Yes ☐No	☐Yes ☐No	obsvd	[illegible]
	10AM	☐Yes ☐No	☐Yes ☐No	obsvd	[illegible]
	12PM	☐Yes ☐No	☐Yes ☐No	Obsv	[illegible]
	2pm	☐Yes ☐No	☐Yes ☐No	observd	[illegible]
	4pm	☐Yes ☐No	☐Yes ☐No	obser	[illegible]
	6pm	☐Yes ☐No	☐Yes ☐No	obser	[illegible]
	8PM	☐Yes ☐No	☐Yes ☐No	observed	[illegible]
	10PM	☐Yes ☐No	☐Yes ☐No	observd	[illegible]
19/7	12AM	☐Yes ☐No	☐Yes ☐No	Obsrvd	[illegible]
	2AM	☐Yes ☐No	☐Yes ☐No	Observd	[illegible]
	4AM	☐Yes ☐No	☐Yes ☐No	observd	[illegible]
	6AM	☐Yes ☐No	☐Yes ☐No	observed	
		☐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		
		□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)

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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BRADEN 'Q' SCALE

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					Date :	17/7	17/7	18/7	18/7
					Time :	E	P	M	E
Mobility	**1. Completely immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	**3. Slightly limited:** Makes frequent through slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.		4	4	4	4
"Activity The degree of physical activity"	**1. Bedfast :** Confined to bed	**2. Chairfast :** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	**3. Walks occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. All patients too young to ambulate; OR walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.		4	4	4	4
Sensory Perception	**1. Completely limited:** Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	**2. Very limited:** responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	**3. Slightly limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	**4. No impairment:** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.		4	4	4	4
Moisture Degree to which skin is exposed to moisture	**1. Constantly moist:** Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	**2. Very moist:** Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	**3. Occasionally moist:** Skin is occasionally moist, requiring linen change every 12 hours.	**4. Rarely moist:** Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.		4	4	4	4
FRICTION-SHEAR **Friction** . Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another	**1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	**2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	**3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	**4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."		4	4	4	4
Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.		4	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.		4	4	4	4
					TOTAL SCORE	28	28	28	28
					Evaluator's Name				

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

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

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Nursing General Admission Assessment Form For Pediatrics

Diagnosis: Febrile seizure

Arrival Time: 3:45 PM Mode of Arrival: Wheelchair Admitting From: ☑ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction: Nil

Body Weight: 18 Kg

Height: ..... cm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
–	–	–

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: 18 kg Length: ..... Head Circumference (< 2 years): .....

Temp.: 98.4° HR: 130 bpm RR: 30 bpm BP: 90/60 mmHg

Pain Score: ..... Specify Site: – (Follow Pain Assessment Sheet & Document)

Fall Risk Assessment: ☐ Yes ☐ No Score: High (13) (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: 0 hr Pain Tool Used: ☐ N Pass ☑ FLACC ☐ Wong Baker

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

FUNCTIONAL SCREENING: ☑ No Abnormalities Detected

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

Inform consultant for positive criteria

NUTRITIONAL SCREENING: ☑ No Abnormalities Detected

- ☐ Underweight
- ☐ Feeding Problem
- ☐ Overweight
- ☐ Special diet
- ☐ Special Feeding Method
- ☐ 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: Dr. Padmapriya (Date/Time): 19/7/24

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: Thulasi Date: 19/7/24 Time: 4PM 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~~ 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		
17/7	2pm	10	Explain about the Fall Risk Education	Mothe	NO	Oral	none	Vaible	good	
18/7	8am	1	Explain about the fall Risk Education	mothe	no	oral	none	Vaibh	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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BED SIDE CHECK LIST FOR NURSES

Date:	17/7	18/7						
Doctor's Orders	✓	✓						
Carried out or not	✗	✗						
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 :	Thas	[illegible]						
Signature :	[illegible]	[illegible]						
Date & Time:	[illegible]	S. Nisha						
Hand Over Taken By Name :	[illegible]	[illegible] 60293						
Signature :	18/7	18/7						
Date & Time:	7-30 pm	2pm						

Doc. No. : RCH/ FRM / GENERAL / 088

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EMERGENCY ROOM TRIAGE FORM

Wt - 18kg

Patient's Name : Lithvik Age : 4Y11M Gender: ☑ Male ☐ Female

Date : 17/7/26 Time of Arrival : 2.45pm

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: 97.9°F PR: 133 BP: 95/48 (62) RR: 26 SpO2: 97 RBS - 101?.

Chief Complaints: C/o - Fever × 1 day / Seizure × 1 epi @ 2 min / Vomit × 2 epi.

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

V. Lithvik
Signature of Parent / Guardian

Triage Completion Time : 2 min.

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 : .....

Date & Time : 17/7 @ 2.50pm.

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

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Dr. PADMAPRIYA EKAMBARAM

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 17/7/26 Time of arrival : 2.45PM

Chief Complaints: C/o- fever x 1day / Seizure x1 epi RBS: 117

Height : ..... Weight : 18Kg 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

.....

.....

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 : 15min.

Time	Nursing Notes
3PM	- Pt come to ER ō complaints of
	fever × 1 day & seizure × 1 epi. (@ 2 min)
	- All vitals checked & recorded
	- ER Dr. assessed the child & Adviced
	Admission. ↓ Dr. Padmapriya.
	- IV line done & Bld sample collected.
	- Pt shifted to ward for further mgt.

Samples collected by: Iman　　Time: 3.20PM

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: 120　BP: 95/48　CFT: <3sec	Shift - out from ER to: 509
RR: 26　SPO$_2$: 99	Time of Shift - out: @ 3.45 PM
GCS: 15/15　Temperature : 97.9°F	Handover given to: S/N Tulsi (Nurse's Name)
Pain Score: 0/10	
Repeat RBS (if applicable):	

Tick as applicable: ☐ MLC　☐ LAMA　☐ BROUGHT DEAD

Procedures done with details (if any): IV line done 22G Ⓛ Metacarpal.

Name of the Nurse : Iman　　Signature of the Nurse : [signature] 178894

Date & Time : 1/7 @ 3PM

GUC-00093994 IP18-00036505
Master P.LITHVIK VARUN
01-08-2021 4 Y 11 M 16 D (M)
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PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : Dr. Padmapriya Date : 17/7/20

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

Start Time of Assessment: ..... Weight: 18 kg

Allergic History: .....

Chief Complaints:
% fever - D1
% seizure - 1 episode

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: 25 SpO_2 on FiO_2 97 %
Rhythm: N
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 .....

(P.T.O.)

Circulation

HR: 133

CFT — Central: <3 — Peripheral: <3

Any urgent interventions needed: ☐ Yes ☑ No

If Yes .....

BP: 95/48 mmHg

Pulse Volume: Central: 2+ — Peripheral: 2+

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: A

Any urgent interventions needed: ☐ Yes ☑ No

If Yes .....

Pupils: Responsive ☑ Non-Responsive ☐

Size — Right: 2mm — Left: 2mm

Active Seizures: ☐ Yes ☑ No Sugars: 117

Signs of Neurological compromise .....

Exposure

Temp.: 97.9°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: .....

Details inside

Treatment Planned: .....

Details 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: Keerthana. D

Signature: 125882

Date & Time: 17/7/26 3.15pm

Sr. Doctor on Duty (If necessary)

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

Signature: .....

Date & Time: .....

PATIENT TRANSFER FORM

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Treating Consultant Name	Date & Time of Admission	Date & Time of Transfer Order
Dr. Padmapriya	17/7/26 @ 3.06PM	17/7/26 @ 3.45PM
Transfer Ordered by	**Reason for Transfer**	
Dr. Keerthana	treatment.	
From Unit	**To Unit**	**Information to Attendant**
ER	509	Yes ☑ No ☐
Number of Sheets in Clinical File	**Number of Imaging Films**	**Personal belongings including clinical documents. If any handed over to attendant**
(11)	—	Yes ☐ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	DNS 500 ml	(1)
2.	Intraflow	(1)
3.		
4.		
5.		

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

Simple febrile sz - 1st episode

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
[signature] / Iman.	[signature]

Patient & Clinical Records Received by : Shelly over

Date & Time of Patient Received : 17/7/26 at 3.45pm

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

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

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RBS CHART

Date	Time	RBS (mg/dl)	IVF %	Signature
17/7	2.45PM	117	—	[signature]