Rainbow Children's Hospital

GUC-00093329 IP18-00036362
Baby Of SIVASAKTHI .G
02-07-2026 0 Y 0 M 6 D (M)
Dr. PADMAPRIYA EKAMBARAM

UHID-

RGE TRACKING SHEET

NAME OF CONSULTANT-

ACTIVITY	INTIME	OUT TIME	NAME & SIGNATURE	REMARKS	<To be filled by Admin >		
	27/8						
Activity Sheet update by Nursing	11 AM	11.10 AM					
Activity Sheet update by Pharmacy		11.9					

OPD
7th Floor

ACTIVITY RECORD FOR BILLING

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Your Right to a Safe Delivery

GUC-00093329 IP18-00036362
Baby Of SIVASAKTHI .G
02-07-2026 0 Y 0 M 5 D (M)
Dr. PADMAPRIYA EKAMBARAM

IP No: ..... Consultant: ..... Dept: .....

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse

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
7/7/26	DAR	1723607	
7/7/26	Sr Bili / Albumin	26021777	
	Electrolyte		
8/7/26	SBR	26021820	

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
7/7/26	DSPT	1pm	8/7/26. 11am	1723402	Suf 607383.

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature

ANY OTHER INFORMATION:

.....

.....

.....

.....

.....

.....

Date: 8/7/16 Time: 11 am Prepared By: Sowmya

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
Sowmya 19088			

Rainbow Children's Hospital | BirthRight

GUC-00093329
Baby Of SIVASAKTHI .G
02-07-2026 0 Y 0 M 6 D
Dr. PADMAPRIYA EKAMBARAM (M)
IP18-00038362

DISCHARGE TRACKING SHEET

NAME OF CONSULTANT-

ACTIVITY	TIME		NAME & SIGNATURE	REMARKS	<To be filled by Admin>
Discharge Announcement	8/7/2026 11am				
	INTIME	OUT TIME			
Arrangement of File by Nursing	8/7/26 @ 11am				
Preparation of Discharge Summary					
Finalization of discharge summary					
Transfer of file from Ward to Billing Dept					
Bill Processing					
Audit Clearance					
Billing Clearance					
Physical Clearance					

TVA . 2 . 881 kg.

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BED SIDE CHECK LIST FOR NURSES

Date:	07/7	8/7/26							
Doctor's Orders	Yes	Yes							
Carried out or not	Yes	Yes							
Bed Side									
Structured Handover done	Yes	Yes							
IV Site	NA	NA							
Central Lines	NA	NA							
Arterial Lines	NA	NA							
Feeding Catheter	NA	NA							
Urinary Catheter	NA	NA							
Skin Care	Yes	Yes							
Eye Care	Yes	Yes							
Mouth Care	Yes	Yes							
Sterillum Bottle, Stethoscope	Yes	Yes							
Suction Bottle (Should be clean & empty)	Yes	Yes							
Intubation Tray	NA	NA							
Emergency Tray (Loaded Syringes with Midazolam & Vecuronium and Flush) Ampoules of Adrenaline	NA	NA							
Ventilator Tubing,(Any Water, Blood)	NA	NA							
Humidification	NA	NA							
Check all Infusion (Labelling,Correct Preparation)	NA	NA							
Chest Physio & Neb	NA	NA							
Handed Over By Name :	Swapna	[illegible]							
Signature :	[illegible]	[illegible]							
Date & Time:	7/7 8pm								
Hand Over Taken By Name :	[illegible]								
Signature :	[illegible]								
Date & Time:	8/7/26 8pm								

ELJAY
PROFESSIONALS IN HEARING CARE
SINCE 1976

NEWBORN HEARING SCREENING

1st Screening / 2nd Screening

Name: B/o Sivasakthi **Date:** 07/7/26

Age/Sex: 5D / Male **D.O.B:** 02/7/26

OP/IP No: 93329/36362

Hospital: Rainbow Hospital

High Risk Registers (if any)**:**

Test Done: DP-OAE

Results:

Right Ear: B/L Pass (5/5) Frequencies Present at 6 dB SNR

Left Ear: (4/5) Frequencies Present at 6 dB SNR

Clap Screening: PASS/FAIL

Plan:

- ☑ Counseled regarding Normal Auditory and Language Development.
- ☐ Follow up for 2nd Screening after 2 weeks, Date: Time:
  For Appointment Contact +91-
- ☐ Detailed Audiological Evaluation at 2 months of Age.
- ☑ Review with Pediatrician.

7/7/26

(Audiologist and Speech Language Pathologist)

Head Office.: #A1, 1st Floor, Garden Apartments, No.68, Purasawalkam High Road, Purasawalkam, Chennai - 07. T : 2641 1095 / 2640 0578 E : sales@eljayhearing.com

Branch.: Door No. New 26 Old 15, North Vijaya Nagar, 100 Feet Bypass Road, Velachery, Chennai - 600 042. T : 4720 3644 M : 89397 20006 E : eljay.velachery@eljayhearing.com

www.eljayhearing.com

ADYAR • ALWARPET • AMBATTUR • NANGANALLUR • PURASAWALKAM • TAMBARAM • TONDIARPET • VELACHERY

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 : IP18-00036362 **Admit Date** : 07-Jul-2026 **Admit Time** : 12:13 PM **UHID** : GUC-00093329

Patient Details :

Patient Name	: Baby Of SIVASAKTHI .G		
Guardian	: Mr GANESH	**Age**	: 0 Y 0 M 5 D
Gender	: Male	**DOB**	: 02-07-2026 12:19 PM
Occupation	:	**Religion**	:
Address (H)	: no 2 A Annai indira gandhi st balaji nagar anakaputhur Anakaputhur Chennai Tamil Nadu INDIA 600070	**Martial Status**	:
		Phone No	: 7299880072/ 9600227762
		E-mail	: no@gmail.com

Admission Details :

Bed Type : NICU FAMILY CENTRIC ROOM **Bed No** : NICU-FCR 335 **Ward Name** : 3F-NICU 4

Room No : NICU-FCR 335 **Admission Type** : First Visit

Contact Details :

Name : Mr GANESH **Relationship** : Father

Contact Address : no 2 A Annai indira gandhi st balaji nagar anakaputhur Anakaputhur Chennai Tamil Nadu INDIA 600070 **Phone No** : 7299880072

Signature

Doctor Details :

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

Referral Doctor : Dr. Priyadharshini S M **Phone No** :

Co-Consultant :

Payment Details :

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

Payor Name : SELFPAY

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TEL NO :044-40122444
WEB : https://rainbowhospitals.in

GENERAL CONSENT FOR TREATMENT

Patient Name:	**Baby Of SIVASAKTHI .G**	**Age :**	**0 Y 0 M 5 D**
IP No:	**IP18-00036362**	**Sex:**	**Male**
Consultant:	**Dr. PADMAPRIYA EKAMBARAM**	**Ward/Bed No:**	**3F-NICU 4/NICU-FCR 335**

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: Ganesh
Relationship: Father
Date: 07/07/2026 Time: 12.14 Am
Witness Name: Ramathra
Witness Signature:

Patient Address:
no 2 A Annai indira gandhi st balaji nagar anakaputhur Anakaputhur
Chennai Tamil Nadu INDIA 600070

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 Ppoint of time after discharge. I promise to settle the claim with the hospital as per Hospital Cash Tariff.

Patient Name :	UHID Number :
Self/Attendant Name : Y GANESH	Relation :
Self/ Attendant Signature : Y Ahuja Phone Number : 7299800072	Name & Signature of Financial Counselor

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NEONATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

Mother's Name : Sivasakthi Age : ..... Father's Name : ..... Age : .....

Date of Birth : 2/7/26 Date of Admission : ..... UHID No.: .....

NICU Consultant : Dr. Padmapriya Referring Consultant : .....

Transferring Unit : ☐ OT ☐ Labour Room ☐ ER ☐ Ward

Transported ? ☐ Yes ☐ No - If yes : ☐ Long (> 30 kms) ☐ Short (< 30 kms)

BIRTH INFORMATION

Name : B/O Sivasakthi

Gender : ☐ M ☐ F Blood Group : ~~A+ve~~ B+ve

Date of Birth : ..... Time of Birth : .....

Place of Birth : RCH Gindy

Mother's Blood Group : A+ve

Birth Weight (gms) : 2.833Kg Length (cms) : 49cm

OFC (cms) : .....

Estimated Gesth Age : 37 + 5/7 weeks

Current Obstetric History : (Booked / Unbooked Case)

Maternal Age : 28yrs Ht : ..... Wt : ..... BMI : ..... Married Life : ..... LMP : ..... EDD : .....

Conception : Spontaneous or with Rx. : Spontaneous

Booked at what GA. : 0 – AN Steroids Drugs / Doses : @

Last Scans Details : .....

TT Immunization and Iron / Folic Acid : Taken.

MATERNAL RISK FACTORS

Age : ☐ <18 yrs ☐ > 35yrs –

Consanguinity : ☐ Yes ☐ No

If yes, degree of consanguinity : ☐ 1 ☐ 2 ☐ 3

H/o PIH (after 20 weeks) / PE

How many Drugs / Doses / Since how long : .....

H/o value of recent BP recording, proteinuria, edema, oliguria, any investigations (LFT, platelet count) : .....

IUGR - when detected : .....

Doppler (Increased Resistence / ADEF / REDF / Redistrbution in MCA) / Ductus Venosus : .....

AFI : .....

H/o GDM/ pre GDM/ on diet or insulin

Controlled or not, recent values, HbA1 values : .....

Compliance with Rx : .....

Scans : LGA, TIFFA , Fetal Echo : .....

H/o Hypothyriodism : when diagnosed ? Medication?

1 Thyronorm 50 mcg

Any other Chronic Medical Problems, when detected drugs ? .....

(Anemia, SLE, Jaundice, CHD, Heart Disease)

Infection : H/O. Fever

(☐ Malaria ☐ UTI ☐ TORCH ☐ TB ☐ HIV ☐ HBV)

UTI : when : ..... Any culture : .....

PPROM : Duration : ..... ☐ Uterine Tenderness ☐ Foul Smelling Liquor ☐ HVS (if taken) - Results : .....

Medication during Pregnancy : ..... Duration : .....

Patient Sticker

PAST OBSTETRIC HISTORY

G: ..... P: ..... A: ..... L: .....

Sl. No.	Age	GA wks	B. W	Gender	Significant	Details
1.		Fnetum	3kgs	Boy	Alive (nearly	
2.					present pregnancy	

PERINATAL HISTORY

Treating Obstetrician : ..... Hospital : ..... ☐ Inborn ☐ Outborn

Duration of Labour VBAC +

First stage (> 18 hours sig)

Second stage (> 2 hours after dilation)

LSCS : ☐ Elective ☐ Emergency Indication : .....

Specify the reason : .....

Augmentation of Labour : ☐ Induced ☐ Assisted Vaginal

CTG : ☐ Normal ☐ Suspicious ☐ Pathological

MSL : .....

Resuscitaion : ☐ Yes ☐ No

Cord ABG : .....

Placenta : (weight, surface, No. of cotyledons, calcifications, malformations, clots etc : .....

NEONATAL RESCUSTITION DETAILS

APGAR SCORE

Gestational Age : ..... Weeks : .....

SIGN	0	1	2
COLOUR	Blue or Pale	Acrocyanotic	Completely Pink
HEART RATE	Absent	< 100 Minutes	> Minutes
REFLEX IRRITABILITY	No Response	Grimace	Cry or Active Withdrawal
MUSCLE TONE	Limp	Some Flexion	Active Motion
RESPIRATION	Absent	Weak Cry; Hypoventilation	Good, Crying

1 Minute	5 Minutes	10 Minutes
TOTAL 8/10	7/10	

Resuscitation			
Minutes	1	5	10
Oxygen			
PPV / NCPAP			
ETT			
Chest Compressions			
Epinephrine			

Comments :

POSTNATAL / HISTORY OF PRESENT ILLNESS

Chief Complaints :

c/o Yellowish discoloration of eyes / skin

c/o Seizures upto one week

Patient Sticker

History of Present Illness:

Feeding well - am / No other specific complaints

No h/o passage of pink / orange coloured crystals in urine

Passed urine - 5 times a day

Passed stools daily - loose ⊖

Investigation details in previous Hospital :

SBr. done on OPD Bams → 20.3 (0.4) / 18.9 mg/dl

Feeding History :

DBF - am / well (regularly)

Patient Sticker

Past History :

Family History :

Mother Blood group – A +ve

Baby Blood group – B +ve

Socio Economic History :

–

GENERAL EXAMINATION ON ADMISSION

General Disposition :

Icterus (+).

Pink in colour

Warm peripheries CRT < 3 sec

VITALS : Temperature : 98.6°F HR : 140/min RR : 40/min NIBP : ..... CFT : .....

Color of the extremities : (N) – pink

Jaundice : Icterus (+) Pallor : – SpO2 : 98% @ RA

Anthropometry : Birth Weight : 2.833 kgs Length : ..... HC : ..... Present Weight : .....

Ponderal Index : ..... AGA : (N) ✓ SGA : ..... LGA : .....

Patient Sticker

HEAD TO TOE EXAMINATION

HEAD :	Fontanelles : Sutures Shape / Moulding : Edema / Bruising : Size - (H.C.) :	0
Facies : (Any Facial Dysmorphism)		0
NECK and CLAVICLES :	Range of Motion : Asymmetry : Masses :	0
EYES :	Symmetry : Red Reflex : Discharge :	0
EARS, NOSE MOUTH and THROAT :	Ear set / Shape : Periauricular Pits / Tags : Nasal shape / Patency : Palate : Gums : Lips : Tongue :	0
THORAX and BREASTS :	Shape of Thorax : Position of Nipples and Number :	0
ABDOMEN and UMBILICUS :	Shape : Organomegaly : Bowel Sounds : Umbilical Stump : Discharge :	0
GENITILIA :	Labia / Hymen : Testicles/penis : Anus :	0
HERNIAL ORIFICES		
TRUNK and SPINE :		
SKIN LESIONS :		
EXTREMETIES :	Fingers / Toes : Arms / Legs : Deformities : Mobility : Hip Joint Examination :	0

Patient Sticker

SYSTEMIC EXAMINATION

Respiratory System :

Breathing Pattern : ☑ Regular ☐ Periodic ☐ Shallow ☐ Gasping

Mention If baby has Respiratory distress : RR : 40/min SCR / ICR / See - Saw breating : –

Scoring of respiratory distress if present (Silverman or Downe's) :

Mention if baby is on : ☐ Hood box ☐ CPAP ☐ Ventilator

Settings :

Spo2 : 98% @RA Auscultation : BLBG ⊕ Breath Sounds : NVBS Added Sounds : –

Cardiovascular System :

HR : 130/min BP : Precordial Activity : (N)

Femoral Pulses : + Murmurs :

Other Peripheral Pulses : + Signs of Cardiac Failure :

Abdomen : Hernia orifice :

Shape : Anal Patency :

Palpation : SOFT NT, no masses Umbilical Cord :

Palpable masses : First urine passed :

Abdominal girth : Meconium passed :

Nervous System : Higher intellectual functions (Sensorium) :

State of wakefulness :

Prechtle Score :

Nerves :

(N)

Motor System :

Passive Tone : (N)

Active Tone : (N)

Neonatal Reflexes :

Grasp : ☐ Palmar ☐ Plantar ☐ Sucking ☐ Rooting ☐ Crossed adductor :

Moro's : DTR : 2+

ATNR : Skull and Spine :

Patient Sticker

Any Congenital Anomalies : .....

Diagnosis : Term (37+5/7) /AGA/ Any /2-833gms/NNJ

FOOT PRINTS

Left Side :

Right Side :

Resident Doctor :

Signature : .....

Name : Lucy Vilinem

Date & Time : 7/7/26

Consultant :

Signature : .....

Name : .....

Date & Time : .....

PLEASE FILL UP THE FOLLOWING DETAILS

1. Name of the referring Doctor : .....
2. Name of te referring Hospital : .....
   Address : .....
   Contact Numbers : .....
3. Contact Details of the referring Doctor : .....
   Mobile No. : ..... E-mail ID : .....
4. Name of the Doctor in Rainbow Team : .....
   ..... on whose name the patient is being referred.

Patient Sticker

AT THE TIME OF TRANSFER TO THE WARD

Final Diagnosis : .....

.....

.....

Present Issues : .....

.....

.....

Vital : ☐ HR : ..... ☐ RR : ..... ☐ BP : ..... ☐ SPO2 : ..... Weight : .....

Any Oxygen requirement : .....

Systemic : .....

.....

Medications : .....

.....

.....

.....

.....

.....

Plan during ward follow up :

.....

.....

.....

.....

.....

.....

Feeding Plan at the time of shifting : .....

.....

.....

Screenings done during NICU Stay :

NSG : .....

Hearing Screen : .....

ROP : .....

TFT : .....

NP2 : .....

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(1)

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
4/7/26 3.45pm.	S/B DR. Padmapriya	
	5 days old baby admitted from OPD	
	Term/37+5(M)/AGA/BOY	B. wt - 2.833 kg / NNH.
	for jaundice :-	S.BR - 20.3 mg/dl / 0.4
	Feeding ok.	
	Vaccine wine well.	
	Stools -	yellow.
	P/E Active, alert, afebrile., wt gain ++.	
	Hydration fair.	
B. wt - 2.83	Lungs - Clear	
TD wt - 2.5	No cardiac (M)	
Today wt 2.89 kg	Abd soft, no mass.	
	1) Cont DBF	
	2) DSPT / watch for nine buttons	
	3) Monitor vitals	
	4) Inj do.	
	S. Bilirubin. S. Albumin S. Electrolytes } @ 8pm today	
	repeat at 6 am tomorrow.	
	K. Padmapriya 4/26.	

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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

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Doc. No. : RCH/ FRM / CLINICAL / 124

INFANT (<1 year)

Children's Observation & Early Warning Scoring Chart

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 02/7/26 Time: 1:15PM 4PM 8PM 12AM 4AM

Doctor/Nurse/Family Concern?

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

On Admission

Heart Rate (bpm) and Blood Pressure (mmHg) *

Note: BP does not score in early warning scoring

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

Heart Rate (Number) 136bpm 140bpm 160 160 140

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

70 60 50 40 30 20 10

Resp Rate (Number) 40min 42bpm 40 44 30

Resp Distress	Mod/ Severe / None / Mild	✓	✓	✓	✓
Receiving O_2 (l/min) O_2 Saturations (%)		99% RA	100% RA	98 RA	100 RA
Conscious Level	Normal / Altered	Alert	Alert	RA	RA
GCS *				Alert	Alert
TOTAL SCORE Number of shaded boxes		0	0	0	0
Pain Score		0	0	0	0
Observer's Initials					

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

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

Patient Sticker

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

I	**IDENTITY:** I am (name), a nurse on ward (X). I am calling about (child X)
S	**SITUATION :** I am calling because I am concerned that ... (e.g. BP is low/high, pulse is XXX, Temperature is XX, Early Warning Score is XX)
B	**BACK GROUND :** Child (X) was admitted on (XX date) with (e.g. respiratory infection). They have had (X operation/ procedure/ investigation). Child (X)'s condition has changed in the last (XX mins). Their last set of observations were (XXX). The child's normal condition is ... (e.g. alert/ drowsy/ confused, pain free)
A	**ASSESSMENT :** I think the problem is (XXX) and I have ...(e.g. given O2/ analgesia, stopped the infusion), OR I am not sure what the problem is but child (X) is deteriorating, OR I don't know what's wrong but I am really worried.
R	**RECOMMENDATION :** I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

GUC-00093329 IP18-00036362
Baby Of SIVASAKTHI .G (M)
02-07-2026 0Y0M6D
Dr. PADMAPRIYA EKAMBARAM

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FLUID CHART

Sheet No. : 1

Admn · 2 · 8.9kg

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

Date	Time	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
04.7.26	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm	DBF ← on Admission								NIL		
Total Intake : 1 time DBF						Total Output : Nil						
	02:00 pm											AA
	03:00 pm	DBF									No	AA
	04:00 pm									diaper change	SV	AA
	05:00 pm	DBF									line	AA
	06:00 pm											AA
	07:00 pm	DBF										AA
Total Intake : 3 time DBF						Total Output : 1 time diaper change						
	08:00 pm										No	SN
	09:00 pm	DBF								diaper change	SV	
	10:00 pm											SN
	11:00 pm					✓					line	
	12:00 am	DBF										SN
	01:00 am											
Total Intake : 2 time						Total Output :						
	02:00 am											
	03:00 am	DBF				✓				diaper change	No	
	04:00 am										SV	
	05:00 am										line	
	06:00 am	DBF				✓				diaper change		
	07:00 am											
Total Intake : 2 time						Total Output :						

Total 24 hrs. Intake	1 time DBF	Total 24 hrs. Output	M - 3 U - 5

GUC-00093329 IP18-00036362
Baby Of SIVASAKTHI .G
02-07-2026 0 Y 0 M 5 D (M)
Dr. PADMAPRIYA EKAMBARAM

(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
		Admission notes	
07/7/26	1pm	Baby details Hand over taken from OPD staff. Baby active and alert. Baby today SBR - 20×3. Dr. Padmapriya, Mom A/B DSPT repeat 8pm S. Bilirubin / S. Albumin / S. Electrolytes U/M/passed. DBF 2 Hrly. →	Staff 607362.
	1:15pm	Baby vital signs checked and recorded. Vitals are stable. Maintained Flo chart. DSPT Continue, DBF + EBM U/M/passed. →	Staff 607362.
	1:30pm	Baby details Hand over given to Evening Duty staff →	Staff 607362
		Evening duty Notes	
07/7/26	1.30pm.	Baby details Hand Over taken from Morning duty Staff. → Bed side Assessment done. Conscious & Oriented. No IV line.	
	2pm.	Baby vitals sign checked & Recorded vitals are Stable. Flo chart monitored. DBF 2 hourly Continue. DSPT Continue No any Other Complaints. → Baby Voice & Motion passed.	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Patient Sticker

NURSES NOTES

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☑ No Known Drug Allergies
☐ Drug Allergies Nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
7/7/26	4PM.	Baby vitals signchecked & Recorded. Vitals are stable T/o chart monitored. DBF Continue the Q2 hourly.	[signature]
	6PM.	Baby T/m plan. RPT SBR. Baby vitals are stable. T/o chart monitored. Continue the DBPT	[signature]
	7:30PM.	Baby details handing over to Night duty staff.	[signature]
		Night duty on 7/7/26	
	7:30 pm	Baby report taken over from E duty staff	[signature]
	8pm	Baby was on Q2H DBF sucking well & receiving well, maintaining Ho chart. Baby under phototherapy. Baby last urine & stool passed	[signature]
	12am	Vital signs are checked & received feed tolerating well	[signature]
	4am	NO vomiting, mothers DBPT continued as per orders	[signature]
	6am	Sr. Albumin, Sr. Bili sample send as per orders. Baby on phototherapy	[signature]
	7:30 am	Baby report handing over to M duty staff	[signature]

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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

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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

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

GUC-00093329 IP18-00036362
Baby Of SIVASAKTHI .G
02-07-2026 0 Y 0 M 5 D (M)
Dr. PADMAPRIYA EKAMBARAM

(1)

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THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE 7/7	DATE 7/7	DATE 7/7	DATE 8/7	DATE
Age	Less than 3 years old	4	4	4	4	4	
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	2	2	2	2	
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1	1	1	
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own ability	1	1	1	1	1	
	History of Falls or Infant-Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2					
	Outpatient Area	1	1	1	1	1	
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours/ None	1	1	1	1	1	
Medication Usage	Sedatives (Excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1	1	1	
	Total		11	11	11	11	

Intervention: -Fall Risk: Low Humpty Dumpty Score = 7-11, High Risk Humpty Dumpty Score = 12 or above

	Bed in low position		✓	✓	✓	✓
	Call device within reach		✓	✓	✓	✓
	Wheels Locked		✓	✓	✓	✓
	Room free of clutter		✓	✓	✓	✓
	Adequate lighting		✓	✓	✓	✓
	Wheel chair support		X	X	X	X
	Other Intervention(s) Specify		X	X		X
	Nurse's Name:		Sf		Rio	
	Signature:		Sf			
	Date:		7/7	7/7	7/7	8/7
	Time:		1pm	4pm	9	8am

Docu. No. : RCH /FRM / CLINICAL / 005

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THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4					
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2					
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1					
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own ability	1					
	History of Falls or Infant-Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2					
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours/ None	1					
Medication Usage	Sedatives (Excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1					
	Total						

-Fall Risk: Low Humpty Dumpty Score = 7-11, High Risk Humpty Dumpty Score = 12 or above

Intervention:						
Bed in low position						
Call device within reach						
Wheels Locked						
Room free of clutter						
Adequate lighting						
Wheel chair support						
Other Intervention(s) Specify						
Nurse's Name:						
Signature:						
Date:						
Time:						

Patient Sticker

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THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4					
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Medication Usage	Sedatives (Excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1					
	Total						

Intervention: -Fall Risk: Low Humpty Dumpty Score = 7-11, High Risk Humpty Dumpty Score = 12 or above

Bed in low position						
Call device within reach						
Wheels Locked						
Room free of clutter						
Adequate lighting						
Wheel chair support						
Other Intervention(s) Specify						
Nurse's Name:						
Signature:						
Date:						
Time:						

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GUC-00093329 IP18-00036362
Baby Of SIVASAKTHI .G
02-07-2026 0 Y 0 M 5 D (M)
Dr. PADMAPRIYA EKAMBARAM

er : ☐ M ☐ F IP No. : .....

BRADEN 'Q' SCALE

(for Paediatric use)

					ite :	M 7/7	E 7/7	N 7/7	N 8/7
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 though 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.		3	3	3	3
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 lift 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.		3	3	3	3
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	26	26	26	26
					Evaluator's Name				

Highest Risk : 7 | High Risk : 8-16 | Mild Risk : 17-21 | No Risk : 22-28

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BRADEN 'Q' SCALE

(for Paediatric use)

Patient Name : .....

Age..... Gender : ☐ M ☐ F IP No. : .....

				Date :				
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 though slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.				
"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 waking hours.				
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.				
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.				
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."				
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.				
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				TOTAL SCORE				
				Evaluator's Name				

Highest Risk : 7 | High Risk : 8-16 | Mild Risk : 17-21 | No Risk : 22-28

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Baby Of SIVASAKTHI .G
02-07-2026 0 Y 0 M 5 D (M)
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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. 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		
7/7/26	1PM	Yes	Health education about DBF Q2HRly.	mother	NO	Oral	Verbal	none	SP Tamil	
8/7/26	9am	Yes	Education about Breast feeding	Mother	no	Oral	no	Yes	SP Tamil	SOW

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