Rainbow Children's Hospital
BirthRight

GUC-00094300 IP18-00036617
Baby N. VARNIKA
04-12-2022 3 Y 7 M 22 D (F)
Dr. VAISHNAVI CHANDRAMOHAN

DISCHARGE TRACKING SHEET

UHID- FLOOR- NAME OF CONSULTANT-

ACTIVITY	INTIME	OUT TIME	NAME & SIGNATURE	REMARKS	<To be filled by Admin>		
Activity Sheet update by Nursing	27/7/26 @ 11am		Jasy				
Activity Sheet update by Pharmacy		11:50					

ACTIVITY RECORD FOR BILLING

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Name: GUC-00094300 IP18-00036617
Baby N. VARNIKA
04-12-2022 3 Y 7 M 21 D (F)
Dr. VAISHNAVI CHANDRAMOHAN

UHID No: ..... IP No: . ..... Dept: .....

Date of Admission: ..... Tir... arge: ..... Time: .....

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
25/07/26	9.40PM	ER	408	

CROSS CONSULTATION VISIT

	Doctor Name	Date	Order No.	Signature
1.	Dr. mohinish.	27/7/26.	3507.	
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

INVESTIGATIONS

Date	Investigations	Order No.	Signature
25/7/26	CBC, CRP, RBS	26025924	
	Ammonia, Lactate		

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
26/7/26	Infusion pumps	10pm.	27/7/26 @ 6am	1733166	AP

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
25/7	CT. Head Plain	(1)	10070	Das 17894
26/7/26	VEEG-2	(1)	10081	Duffs 015354

ANY OTHER INFORMATION:

.....

.....

.....

.....

.....

.....

Date: 25/7/26 Time: 2.30 pm Prepared By: .....

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
Anitta 015000			

Rainbow Children's Hospital | BirthRight

DISCHARGE TRACKING SHEET

4th Floor

UHID- FLOOR- NAME OF CONSULTANT-

409.

Baby. Varnik

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

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Patient Name	Baby N. VARNIKA	Patient Ph.No	7299710516
Age	3 Y 7 M 21 D	Requisition No	R2618-010070
Gender	Female	Collected on	25-07-2026 07:54 PM
IP / Bill No.	IP18-00036617	Received On	26-07-2026 10:04 PM
UHID No.	GUC-00094300	Reported On	26-07-2026 10:04 PM
Ref. Doctor	VAISHNAVI CHANDRAMOHAN	Ward / Bed No	

CT BRAIN PLAIN

FINDINGS:

Few calcific foci seen involving bilateral gangliocapsular region.

Third and Both lateral ventricles are normal.

Fourth ventricle is normal in size, shape and position.

Cisternal spaces and cerebral sulci are normal.

Attenuation values of rest of brain parenchyma are normal.

No shift of midline structures.

Cerebellum and brain stem are unremarkable.

Sellar and parasellar regions are normal.

No sub-dural / extra-dural hemorrhage seen.

No obvious fracture seen.

Visualised parts of orbits and paranasal sinuses appear normal.

Note: Clinically correlate , Kindly discuss if necessary

Rainbow Children's Medicare Limited

CHENNAI : No. 157 to 160, Anna Salai, Near Little Mount Metro Station, Guindy, Tamil Nadu - 600015

SHOLINGANALLUR : No. 493/42A2B, OMR ECR Link Road, Chennai, Tamilnadu - 600119

For Appointments call: 1800 2122

CIN : L85110TG1998PLC029914 info@rainbowhospitals.in www.rainbowhospitals.in

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Ref. Doctor	VAISHNAVI CHANDRAMOHAN	Ward / Bed No	

Impression

CT study of Brain shows Few calcific foci seen involving bilateral gangliocapsular region – likely lenticulostriate artery calcification.

Suggested clinical correlation.

Dr. PRASANNA KUMARAVEL
MBBS, MDRD
Reg No: 92729

Print Date/Time : 26-07-2026 10:04 PM Printed By : SURIYA N

Note: Clinically correlate , Kindly discuss if necessary

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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 : IP18-00036617 **Admit Date** : 25-Jul-2026 **Admit Time** : 06:33 PM **UHID** : GUC-00094300

Patient Details :

Patient Name	: Baby N. VARNIKA	**Age**	: 3 Y 7 M 21 D
Guardian	: K. NAVIN KUMAR	**DOB**	: 04-12-2022
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: 157, INDIRANAGAR , ST THOMAS MOUNT , CHENNAI Alandur Chennai Tamil Nadu INDIA 600016	**Phone No**	: 7299710516/ 9566037681
		E-mail	: NO@GMAIL.COM

Admission Details :

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

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

Contact Details :

Name : K. NAVIN KUMAR **Relationship** : Father

Contact Address : 157, INDIRANAGAR , ST THOMAS MOUNT , CHENNAI Alandur Chennai Tamil Nadu INDIA 600016 **Phone No** :

Signature

Doctor Details :

Doctor Name : Dr. VAISHNAVI CHANDRAMOHAN **Specialisation** : GENERAL PEDIATRICS

Referral Doctor : ST THOMAS HOSPITAL (BUTROAD) **Phone No** :

Co-Consultant :

Payment Details :

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

Payor Name : SELFPAY

Rainbow Children's Hospital

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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 N. VARNIKA**	**Age :**	**3 Y 7 M 21 D**
IP No:	**IP18-00036617**	**Sex:**	**Female**
Consultant:	**Dr. VAISHNAVI CHANDRAMOHAN**	**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 c[illegible]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: Navin Kumar

Relationship: Father

Date: 25/07/2026 Time: 6.33 pm

Wittness Name: Pavithra

Wittness Signature:

Patient Address:

157, INDIRANAGAR , ST THOMAS MOUNT , CHENNAI Alandur Chennai Tamil Nadu INDIA 600016

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BILLING POLICY

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

DECLARATION

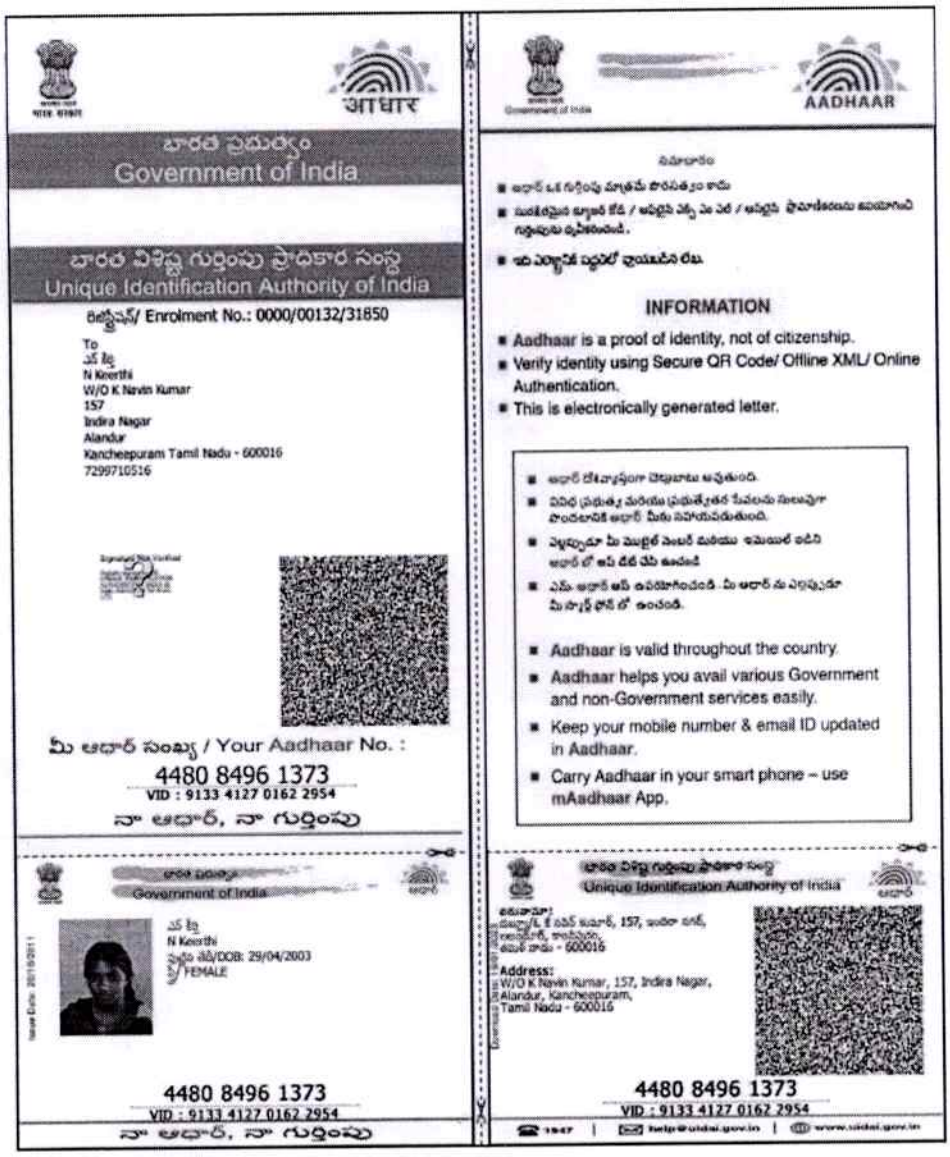
I have attended the Financial Counselling desk & understood the expected costs & other conditions applicable. In this case, the TPA/Insurance Company rejects the claim for whatsoever reasons at any point of time after discharge. I promise to settle the claim with the hospital as per Hospital Cash Tariff.

Patient Name : Baby • N • Vannika.	UHID Number : GUC-00094300
Self/Attendant Name : Navinkumar	Relation : father
Self/ Attendant Signature : Phone Number :	Name & Signature of Financial Counselor

RCH/GDY/FRM/CLINICAL/426

11:35 0.00 KB/S Vo LTE 5G 57

Keerthi aadhar.pdf



భారత ప్రభుత్వం
Government of India

భారత విశిష్ట గుర్తింపు ప్రాధికార సంస్థ
Unique Identification Authority of India

ఎన్రోల్‌మెంట్/ Enrolment No.: 0000/00132/31850

To
ఎన్ కీర్తి
N Keerthi
W/O K Navin Kumar
157
Indira Nagar
Alandur
Kancheepuram Tamil Nadu - 600016
7299710516

మీ ఆధార్ సంఖ్య / Your Aadhaar No. :
4480 8496 1373
VID : 9133 4127 0162 2954
నా ఆధార్, నా గుర్తింపు

ఎన్ కీర్తి
N Keerthi
పుట్టిన తేదీ/DOB: 29/04/2003
FEMALE

4480 8496 1373
VID : 9133 4127 0162 2954
నా ఆధార్, నా గుర్తింపు

AADHAAR

INFORMATION

- Aadhaar is a proof of identity, not of citizenship.
- Verify identity using Secure QR Code/ Offline XML/ Online Authentication.
- This is electronically generated letter.

- Aadhaar is valid throughout the country.
- Aadhaar helps you avail various Government and non-Government services easily.
- Keep your mobile number & email ID updated in Aadhaar.
- Carry Aadhaar in your smart phone – use mAadhaar App.

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Unique Identification Authority of India

Address:
W/O K Navin Kumar, 157, Indira Nagar, Alandur, Kancheepuram, Tamil Nadu - 600016

4480 8496 1373
VID : 9133 4127 0162 2954

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

AI Assistant fo... Thumbnails/C... Convert All tools

Rainbow®
Children's
Hospital
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PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: _____ GUC-00094300 IP18-00036617
Baby N. VARNIKA
04-12-2022 3 Y 7 M 21 D (F)
Dr. VAISHNAVI CHANDRAMOHAN

UHID ID: _____

Department: _____

Consultant: _____

(P.T.O.)

Patient Sticker

Pediatric Multiorgan History & Physical Examination

Name: Varnika Age/Sex 3y 7m/F

Information given by: Relationship

Chief Presenting Complaints & Duration (Chronologically)

History of present illness :

Child was reffered from outside hospital
c the c/o: uprolling of eyes c stiffening
~~upon~~ of all 4 limbs lasting for
5 mins (approx)
↓
self aborted
c/o: vomiting 2-3 episodes

H/O: child fell down from bed ?
↓
history not clear -) parents did not
tell what happened

child on arrival is drowsy arousable to
stimuli - touch, pain

Patient Sticker

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

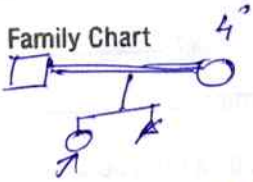
No h/o previous admission

Birth & Neonatal History:

late N PT (~36w) / BW - 1.70 kg / LSCS (Breech) / CIAB / NICU stay x 3 day.

PT x1 day

Family Chart



(Father mom Grandmother of child had 2 episode of seizure

Birth & Socio Economic History:

About Father : NO H/O: seizure

About Mother : NO H/O: seizure

Any additional Information :

Developmental History :

(N) for age - LKG.

Immunization History :

Up to date - UIP

Anthropometry :

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

Weight (kgs) 14.6 kg (Centile _____)

On Examination :

Temperature : 97.5°F Pulse Rate : 126/min B.P. 82/60 (68) SPO2 99% RA

Resp.rate and type of breathing : 30/min

Rash (-)

Lymphadenopathy (-)

Oedema : (-)

Allergies (if any): (-)

(P.T.O.)

Patient Sticker

Respiratory System :

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

Air entry & breath sounds : BAE

Any addes sounds : (-)

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

Cardiovascular System :

Inspection of procordium : (N)

Heart Sounds : S_1S_2 (+)

Any murmur : (-)

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

Per Abdomen :

Inspection : (N)

Palpation : Soft /NT

Ausculation : BS(+)

Spine : (N) External Genitelia : (N)

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

Central Nervous System :

Level of Consciousness : AVPU/GCS score : Pain responsive / $E_3V_3M_5$

Cranial Nerves :

Motor System :

Nutriton : (N)

Tone: (N) Power (N)

Co-ordinator : G

Posture : (N)

Involuntary Movements : (-)

Patient Sticker

Reflexes :

DTR

Superficials:

Plantars Flexor

Sensory System :

Bladder / Bowel :

Clinical Summary & Diagnostic: As.. Seizure ↓Evaluation → ? Trauma
? Encephalopathy

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

Desired goals of the treatment :

- Basal ganglia Calcification

Planned Labs:

- CBC / CRP
- RP-2
- Ammonia, lactate
- EEG tomorrow

Planned Management

- IV line
- IVF - DNS. - 40 cc/hr.
- Iv Pan 15mg OD

Watch for seizures

Mahimish sir opinion.

Signature of the Doctor: T. Yuvaraj

Name of the Doctor: T. Yuvaraj

Date & Time: 25/7/26 at 9 PM

Signature of the Consultant: Vardhman

Name of the Consultant: Dr. Vardhman

Date & Time: 25/7, 9 pm.

(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 Facilty Notified (Person Contacted)

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

   ☐ Needs Assistance In:

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

4. Nutritional Plan:

   ☐ Dietary Instruction Discussed with the:

   ☐ Patient ☐ Family Member ☐ Others: .....

5. Discharge Planning Discussed with the:

   ☐ Patient ☐ Family Member ☐ Others: .....

6. Patient/Family Educational Plan:

   ☐ Educational Topic/s: .....

   ☐ Patient's Educational Topic/s discussed with the:

   ☐ Patient ☐ Family Member ☐ Others: .....

Doctor Signature: .....

Doctor Name: .....

Date and Time: .....

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Dr. VAISHNAVI CHANDRAMOHAN

Docu. No

DOCTOR'S SHIFT CHANGE HANDOVER FORM

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

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

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

DOCTOR'S SHIFT CHANGE HANDOVER FORM

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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

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
27/7/26 10.00	S/B Dr. Chandiralege	
	Δ - Seizure + evaluation | ? Trauma	
	? encephalopathy.	
	Child reviewed	
	no further seizures | LOC.	
	Tolerating oral feeds well	
	Activity - good	
	ⓝ sensorium	
	O/E	
	Afebrile	
	CVS - S1S2 (+)	
	RS - B/L AE (+)	
	P/A soft	
	CNS - Tone N/N | N/N	
	DTR - 2+ 2+	
	plantar flexor	
		Adv
	CT Brain - few calcific foci in B/L ganglio capsular region	- monitor vitals
		- to trace EEG reports
		- [illegible]
	[signature]	

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

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
27/1/26 9 AM	S/B - Dr. Yuvaraj	
	Δ - Seizure under evaluation - (? Acute Symptomatic seizures)	
	Child renewed alert, active	
	D/E No further seizures	
	intake - good	
	vitals stable	
	No vomiting / signs of raised ICP	
	CNS- GCS - 15/15	Dev - (N) for age
	Tone - (N)	
	power - 5/5	
	DTR (N)	
	plantars (F) - extensor	
	(F) - extensor	
	Plan :- Trace EEG report	
	- Neurologist (Dr Mohini) opinion /	
		Tg

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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RESULT SHEET

Date	26/7/24					
Time						
Hb	12.1					
PCV	37					
RBC	5.03					
WBC	7.74					
N/L	63/34					
Platelets	2,38,000					
CRP	<5					
ESR						
PCT						
RBS	93					
Na	141					
K	5.0					
Cl	105					
Ca/Mg	1.16					
Phosphate / HCO_3	/ 23					
Urea	19					
Creatinine	0.60					
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.,) : .....

GUC-00094300 IP18-00036617
Baby N. VARNIKA
04-12-2022 3 Y 7 M 21 D (F)
Dr. VAISHNAVI CHANDRAMOHAN

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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: ..... Shifted to: .....

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1						☐C ☐DC
2						☐C ☐DC
3						☐C ☐DC
4						☐C ☐DC
5						☐C ☐DC
6						☐C ☐DC
7						☐C ☐DC
8						☐C ☐DC
9						☐C ☐DC
10						☐C ☐DC

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Yuvaraj

Date & Time : 25/7 @ 7PM

Nurse Name & Signature: Shibu

Date & Time : 25/07/22 @ 7pm

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

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DRUG CHART

Date of Admission: 25/07/2022 Drug Allergies: NKA ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

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

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

SOS / PRN (As Required Medication)

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

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

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

Signature .....

VERIFIED BY : Name .....

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REGULAR PRESCRIPTIONS

Weight. 14.6 kg Ward. .....

DRUG : Inj PANTOPRAZOLE

Dose	Route	Frequency	Start Date
15mg	IV	OD	25/7

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time	25/7	26/7	27/7
6	9 PM	CS	SA
Am	SA CS	SA	CS

DRUG : Inj EMESET

Dose	Route	Frequency	Start Date
1.5mg	IV	Q8H	25/7

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time	25/7	26/7	27/7
6		CS	SA
Am		SA	CS
1 pm		PSA MA	
2 pm	9 PM SA CS	BL PP	

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Patient Sticker

Weight. [illegible] Ward. ....

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses

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

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I.V. FLUIDS CHART

Weight. 14.6kg Ward. .....

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
25/2/24	10 pm	DNS	IV	40			26/2/24		

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

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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: 25/7/22 Time:	10PM	12AM	4AM	8
Doctor / Nurse / Family Concern?				
Temperature (°F) (104–94)	97.5F	97.4F	97.5F	
Heart Rate (bpm) and Blood Pressure (mmHg) * (190–50). Note: BP does not score in early warning scoring	102/68 (76)	108/62 (70)	90/51 (54)	
Heart Rate (Number)	120b/m	108b/m	110b/m	
Resp. Rate (bpm) (Over 1 Minute) * (70–10)	30	30	30	
Resp Rate (Number)	30b/m	30b/m	30b/m	
Resp Distress: Mod/ Severe				
Resp Distress: None / Mild	✓	✓	✓	
Receiving O_2 (l/min)				
O_2 Saturations (%)	99%	98%	98%	
Conscious Level: Normal	✓	✓	✓	
Conscious Level: Altered				
GCS *	15/15	15/15	15/15	
TOTAL SCORE Number of shaded boxes	0	0	0	
Pain Score	0	[illegible]	0	
Observer's Initials	[illegible]	[illegible]	[illegible]	

ACTIONS

NB: Scores 3 should be recorded overleaf

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

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

Patient Sticker

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

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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 : 26/7/26 Time: 8am 12pm 4pm 8pm 12AM 4AM

Doctor / Nurse / Family Concern?

Temperature (°F): 97.4F | 98F | 97.6F | 97.5F | 97.4F | 98.6F

Heart Rate (bpm) and Blood Pressure (mmHg) * — **Note:** BP does not score in early warning scoring

	8am	12pm	4pm	8pm	12AM	4AM
BP	94 (67) 57	98 (63) 54	98 (76) 70	95 (63) 51	94 (67) 53	97 (60) 54
Heart Rate (Number)	114bpm	110bpm	102bpm	106bpm	102bpm	100bpm
Resp. Rate (bpm) (Over 1 Minute) *						
Resp Rate (Number)	30bpm	30bpm	28bpm	30bpm	30bpm	30bpm
Resp Distress: Mod/ Severe / None / Mild	✓	✓	✓	✓	✓	✓
Receiving O_2 (l/min) O_2 Saturations (%)	98%	98%	100%	100%	100%	99%
Conscious Level: Normal / Altered	✓	✓	✓	✓	✓	✓
GCS *	15/15	15/15	15/15	15/15	15/15	15/15
TOTAL SCORE Number of shaded boxes	0	0	0	0	0	0
Pain Score	0	0	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.
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Score 5 & 6	: Shift in charge AND PICU fellow or PICU consultant to be informed.

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

Patient Sticker

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

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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.

25/7/26		Intake				Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						**Total Output :**						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						**Total Output :**						
	08:00 pm											
	09:00 pm			ON	Admission from ER to 408							
	10:00 pm	water	10ml	40ml							0	
	11:00 pm	water	30ml	40ml							0	
	12:00 am			40ml							0	
	01:00 am	water	30ml	40ml							0	
Total Intake :		60ml + 160ml				**Total Output :**						
	02:00 am			40ml							0	
	03:00 am			40ml							0	
	04:00 am			40ml							0	
	05:00 am			40ml							0	
	06:00 am	water	50ml	40ml							0	
	07:00 am			40ml						✓	0	
Total Intake :		50ml + 240ml				**Total Output :**				1 time urine Passed		

Total 24 hrs. Intake	510ml	Total 24 hrs. Output	1 time urine passed

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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.

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
			Mouth	I.V	N.G							
	08:00 am	water	100ml								0	dy
	09:00 am	milk	150ml							✓	0	dy
	10:00 am										0	dy
	11:00 am	water	100ml								0	dy
	12:00 pm									✓	0	dy
	01:00 pm	water	100ml								0	dy
Total Intake :		450ml				Total Output :				2 time urine passed		
	02:00 pm	water	50ml	DNS							0	dy
	03:00 pm			40ml						✓	0	dy
	04:00 pm	water	100ml	40ml							0	dy
	05:00 pm	milk	150ml	40ml						✓	0	dy
	06:00 pm			40ml							0	dy
	07:00 pm	water	50ml	40ml						✓	0	dy
Total Intake :		300ml +	150ml			Total Output :				2 Time urine pass		
	08:00 pm			40ml							0	dy
	09:00 pm	water	50ml	40ml						✓	0	dy
	10:00 pm	milk	150ml	40ml							0	dy
	11:00 pm	water	50ml	40ml							0	dy
	12:00 am	water	50ml	40ml						✓	0	dy
	01:00 am			40ml							0	dy
Total Intake :		300ml +	240ml			Total Output :				2 time urine Passed		
	02:00 am			40ml							0	dy
	03:00 am			40ml						✓	0	dy
	04:00 am			40ml							0	dy
	05:00 am			40ml						✓	0	dy
	06:00 am			40ml							0	dy
	07:00 am	water	100ml	40ml						✓	0	dy
Total Intake :		100ml +	240ml			Total Output :				3 time urine passed		

Total 24 hrs. Intake	1,790ml	Total 24 hrs. Output	10 times urine passed

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NURSING CARE RECORD

Date: 25/7/26

Goals

- ☐ Maintain Airway and Oxygenation
- ☐ Maintain Personal Hygiene
- ☐ Identify Potential Complications
- ☐ Relieve Pain & Discomfort
- ☐ Prevent Infection
- ☐ Any Others. Specify.....
- ☑ Maintain Fluid Balance
- ☐ Meet Elimination Needs
- ☐ Improve Activity Tolerance
- ☐ Ensure Safety
- ☐ Maintain Good Nutritional Status
- ☐ Early Ambulation Reduce Anxiety
- ☐ Maintain Skin Integrity
- ☐ Patient & Family Education

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon							
Night	10 Pm	maintain fluid Balance.		Assessed child condition monitored vitals maintained I/o Administered IV fluids	maintaining fluid Balance	Re assessment Done.	02/8/26

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NURSING CARE RECORD

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Date: 26/7/26

Goals

- ☐ Maintain Airway and Oxygenation
- ☑ Maintain Personal Hygiene
- ☐ Identify Potential Complications
- ☐ Relieve Pain & Discomfort
- ☐ Prevent Infection
- ☐ Any Others. Specify.....
- ☐ Maintain Fluid Balance
- ☐ Meet Elimination Needs
- ☑ Improve Activity Tolerance
- ☐ Ensure Safety
- ☑ Maintain Good Nutritional Status
- ☐ Early Ambulation Reduce Anxiety
- ☐ Maintain Skin Integrity
- ☐ Patient & Family Education

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8am	Maintain good Nutritional Status.		Assessed child condition ⇒ Maintain vital Sign's and Flochart ⇒ Maintain IV fluids.	Nutritional Pattern was improved.	Reassessment was done Vital are stable	
Afternoon	2pm	TO promote Health Hygiene.		→ Assessed child condition → Vitals monitoring → Encouraging oral & Hand Hygiene	maintained posong Hygiene	Reassessment done	
Night	8pm	improve activity tolerance		Asses child condition monitor vitals Administer medication as per orders.	Activity is improving	Reassessment done	

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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
25/7/26		Recieving Notes	
	9.40 Pm	The child recieved from ER to 404. The child details handing over taken from evening duty staff child is on room air child is Conscious and oriented. ~~child~~ Iv line present. Iv line pattern	Sasi 021893
	10 Pm	vital signs are checked and recorded vital signs are stable. CP ++ PP ++ CRT <3sec	Sasi 021893
		Iv fluid 0.9% DNS 40ml/h on flow. no any other fresh complaints child is stable.	
26/7/26	12 Am	vital signs are checked and recorded vital signs are stable CP ++ PP ++ CRT <3sec	Sasi 021893
	2 Am	child is sleeping well no any other fresh complaints. child is stable vitals checked and recorded. [illegible]	Sasi 021893

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Patient Sticker

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NURSES NOTES

☐ No Known Drug Allergies

☐ Drug Allergies ....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
26/7/26	4Am	vital signs are checked recorded vital signs are stable. CP ++ / PP ++ / CRT <3sec	Sasi 021893
	6Am	Due medications are given as per Doctor's order. I/o chart maintained	Sasi 021893
	7.30Am	The child details handing over given to morning duty staff.	
		→ morning duty On: 26/7/26.	
	1.30pm	child details hand Over taken from night duty staff. Child is conscious & oriented. Child iv cannula patten	dy 018900
	8am	vital sign's checked and Recorded vital are stable. CP ++ / PP ++ / CRT <3sec	dy 018900
	9am	child intake was good. Dr Vaishnavi mam seen the child mam advise. EEG today. Syp pedicloryl 7ml given as per doctor's order	dy 018900
	10.30am	Child shifted to EEG	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Patient Sticker: Baby Varnitca
40C: 94300
Dr. Vaishnavi

NURSES NOTES

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☐ No Known Drug Allergies

☐ Drug Allergies .... Nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		→ continue 26/1/26 c	
26/1/26	12pm	Vital sign's checked and Recorded vital are stable [CP ++ / PP ++ / CRT <3sec]	dy 018950
		Child I/o chart maintained. No any complaint's	
	1:30pm	child details hand Over given to evening duty Staff.	dy 018950
		Evening Duty Note:	
	1:30 pm	Child details handing over taken from morning duty S/N. Child conscious & oriented. child activity are good. IV line ⊕ no swelling & pain.	
	2pm	IVF- DNS- 40ml/hr ongoing. child stable no special complaints.	Jeep 20004
	4pm	vital signs checked & recorded vitals are stable now [CP ++ / PP ++ / CRT <3s]	
	7pm	All medication are given as per drug chart order. I/O chart maintained	Jeep 20004
	7:30 pm	Handing over given to night duty S/N	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Patient Sticker

NURSES NOTES

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☐ No Known Drug Allergies

☐ Drug Allergies .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		Night duty Notes on 26/7/26	
	2.30pm	The child details handover taken from the Evening duty staffs the child is conscious and active	01/5/26
	8pm	Administer the medication as per doctor's orders	
		vitals are checked and recorded temp is normal	
		PP ++ / CP ++ / CRT < 2S	
	10pm	The child had soft diet & his pattern and good	01/5/26
27/7/26	12am	The baby is sleeping well vitals are checked and recorded temp is normal	
		PP ++ / CP ++ / CRT < 2S	
	2Am	The child is sleeping well. no any other fresh complaints child is stable	02/8/26
	4Am	vital sigs are checked and recorded. vital sigs are stable.	
		PP +++ / CP ++ / CRT < 2S	
		RI fluid 0.9% 4ms @ 40ml/hr on flow	01/7/26

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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

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Patient's Name: GUC-00094300 IP18-00036617
Baby N. VARNIKA
MRD NO:.......... 04-12-2022 3 Y 7 M 21 D (F)
Dr. VAISHNAVI CHANDRAMOHAN
Age :.................. M ☐ F
Consultant :..

PHLEBITIS ASSESSMENT

CANNULA 1

Date : 25/07/2025 Time: 5:00pm
Location : (L) metacarpals
Size : 22 G
Cannula inserted by : outside line

Date	Time	Phlebitis	Infiltration	Nursing Intervention	Sign
25/07	6pm	☐Yes ☑No	☐Yes ☑No	Path	[illegible]
	8pm	☐Yes ☑No	☐Yes ☑No	observ	[illegible]
	10pm	☐Yes ☑No	☐Yes ☑No	observ	[illegible]
26/7	12Am	☐Yes ☑No	☐Yes ☑No	observ	[illegible]
	2Am	☐Yes ☑No	☐Yes ☑No	observed	[illegible]
	4Am	☐Yes ☑No	☐Yes ☑No	observ	[illegible]
	6Am	☐Yes ☑No	☐Yes ☑No	observe	[illegible]
	8am	☐Yes ☑No	☐Yes ☑No	observed	[illegible]
	10am	☐Yes ☑No	☐Yes ☑No	observed	[illegible]
	12pm	☐Yes ☑No	☐Yes ☑No	observed	[illegible]
	2pm	☐Yes ☑No	☐Yes ☑No	observe	[illegible]
	4pm	☐Yes ☑No	☐Yes ☑No	observe	[illegible]
	6pm	☐Yes ☑No	☐Yes ☑No	observe	[illegible]
	8pm	☐Yes ☑No	☐Yes ☑No	observed	[illegible]
	10pm	☐Yes ☑No	☐Yes ☑No	observed	[illegible]
27/7	12am	☐Yes ☑No	☐Yes ☑No	observe	[illegible]
	2am	☐Yes ☑No	☐Yes ☑No	observed	[illegible]
	4am	☐Yes ☑No	☐Yes ☑No	observed	[illegible]
	6am	☐Yes ☑No	☐Yes ☑No	observed	[illegible]
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		

Cannula removed : ☑Yes ☐No, if yes date and time : 27/7 @6am
RX any initiated : ☐Yes ☑No ☐NA If Yes specify-
Phlebitis score: 0/5

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

GUC-00094300 IP18-00036617
Baby N. VARNIKA
04-12-2022 3 Y 7 M 21 D (F)
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BRADEN 'Q' SCALE

				Date : 25/7	26/7	26/7	26/7
				Time : N	M	E	N
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	23	28	28	28
				Evaluator's Name		08950		

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:

Arrival Time: 9.45 pm Mode of Arrival: with attender Admitting From: ☑ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction ..... Body Weight: 14.6 Kg

Height: ..... cm

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

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

Family History: .....

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

If yes please list, ...

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

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

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

Observations: Weight: 14.6kg Length: ..... Head Circumference (< 2 years): .....

Temp.: 98°F HR: 122 b/m RR: 30 b/m BP: 102/62 mmHg

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

Fall Risk Assessment: ☑ Yes ☐ No Score: 12 (Document in the Humpty Dumpty Sheet)

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

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

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

FUNCTIONAL SCREENING:

☑ No Abnormalities Detected

☐ Mobility Problem ☐ Walking Problem

☐ Developmental Delay ☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING:

☑ No Abnormalities Detected

☐ Underweight ☐ Overweight ☐ Special Feeding Method

☐ Feeding Problem ☐ Special diet ☐ No Abnormality Detected

Inform consultant for positive criteria

Psychological Screening: ☐ No Significant Findings

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

If Yes Consultant Notified: ..... (Date/Time): .....

Social History: Lives With ..... Parents .....

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

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

Orientation has been given regarding the following aspects:

Call Bell in Reach : ☑ Yes ☐ No Waste Disposal Explained: ☑ Yes ☐ No

Infusion Pump : ☑ Yes ☐ No Hand hygiene Explained: ☑ Yes ☐ No ☐ Others

Patient Rights & Responsibilities: ☑ Yes ☐ No

Information given to ..... mother .....

Nurse's Name: C. Sasikala Date: 25/7/26 Time: 10 Pm Signature

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RBS CHART

Date	Time	RBS (mg/dl)	IVF %	Signature
25/7	6PM	97	–	[signature] 17894

PATIENT TRANSFER FORM

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GUC-00094300 IP18-00036617
Baby N. VARNIKA
04-12-2022 3 Y 7 M 21 D (F)
Dr. VAISHNAVI CHANDRAMOHAN

	Date & Time of Admission	Date & Time of Transfer Order
	25/07/26 @ 6.33PM	25/07/26 @ 9.40PM
Treating Consultant Name	**Transfer Ordered by**	**Reason for Transfer**
Dr. vaishnavi	Dr. Deepak	treatment
From Unit	**To Unit**	**Information to Attendant**
ER	U08	Yes ☑ No ☐
Number of Sheets in Clinical File	**Number of Imaging Films**	**Personal belongings including clinical documents. If any handed over to attendant**
(12)	(1) CT Head plain	Yes ☑ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

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

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Shibu [signature] 1H 8910	

Patient & Clinical Records Received by : [signature] 010180

Date & Time of Patient Received : 25/07/26 @ 10p

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

Unavailable Bed Nurse not Available Available Bed not ready

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

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 25/07/24 Time of arrival : 5:50

Chief Complaints: H/O Fall down, Seizure RBS: 97mg/dl.

Height : — Weight : 14.6kg 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 Fall/dem ☐ Location Head ☐ Frequency on & off ☐ Duration 1 hr.

RISK FOR FALL:

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

☐ If Patient is > 6 years
Assess the below parameters

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

Ambulatory Aids:

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

Gait/Transferring:

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

Mental Status: Forgets limitations ☐ Yes ☑ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening: ☑ No Abnormalities Detected

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

Inform consultant for positive criteria

.....

.....

Nutritional Screening: ☑ No Abnormalities Detected

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

Inform consultant for positive criteria

Psychological Screening: ☑ No Significant Findings

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

If Yes Consultant Notified: — (Date/Time): —

Social History: Lives With Parents.

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

Time of Initial assessment completed by ER Nurse : 6:00pm

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

Time	Nursing Notes
6.30 pm	Patient came to the ER with the H/O fall down, seizure, vomiting x 4-5 days, monitored the vital signs. Recorded D. Deepak sir, Blood sample collected to the ward.

Samples collected by: SN - Iman Time:

Samples sent by : Time: 9.30PM

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: 109/m BP: CFT: <2 sec	Shift - out from ER to: 408
RR: 28/m SPO_2 : 100 %	Time of Shift - out: @ 9.40PM
GCS: 14/15 Temperature : 98.2°F	Handover given to: SN - Abhitha (Nurse's Name)
Pain Score: 2/10	
Repeat RBS (if applicable): 98 mg/dl	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any): -

Name of the Nurse : Shibu Debnath. Signature of the Nurse :

Date & Time : 25/07/25 @ 6:32pm

GUC-00094300 IP18-00036617
Baby N. VARNIKA
04-12-2022 3 Y 7 M 21 D (F)
Dr. VAISHNAVI CHANDRAMOHAN

Rainbow® Children's Hospital — It takes a lot to treat the little.
BirthRight BY RAINBOW HOSPITALS — Your Right to a Safe Delivery

PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor: Dr. DEEPAK   Date: 25/7/26

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

Start Time of Assessment: ....   Weight: 14.6 kg

Allergic History: ⊝

Chief Complaints: C/o uprolling of eyes c̄ spasm of all 4 limbs

Pediatric Assessment Triangle

A Appearance - TICLS: Drowsy arousable

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

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

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

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

Significant Past History: ....

Medication History: ....

Relevant Investigations: ....

Primary Assessment

Airway
- ☑ Open
- ☐ Maintainable
- ☐ Not Maintainable

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

Breathing

Rate: .... SpO_2 on FiO_2: 99% RA

Rhythm: ....

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

Respiratory Noises: ☐ Stridor ☐ Wheezing ☐ Grunting

Air Entry: BAE ⊕

Palpation Findings (If necessary) ....

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

Circulation

HR: 126/min CFT — Central (+) — Peripheral (+)

BP: 82/60 (88) mmHg

Pulse Volume: — Central (+) — Peripheral (+)

If in Shock: — Compensated .... — Hypotensive ....

Muffled Heart Sound: ☐ Yes ☐ No

Engorged Neck Veins: ☐ Yes ☐ No

Murmurs: ☐ Yes ☑ No

Liver Span: ....

ECG: ....

Any Signs of Heart Failure: ☐ Yes ☑ No

Any urgent interventions needed: ☐ Yes ☑ No

If Yes ....

Disability

GCS: $E_3V_3M_5$ AVPU: Pain responsive

Pupils: — Responsive ☑ Non-Responsive ☐ — Size — Right .... — Left ....

Active Seizures: ☐ Yes ☑ No Sugars: 97 mg/dl

Signs of Neurological compromise ....

Any urgent interventions needed: ☐ Yes ☑ No

If Yes ....

Exposure

Temp.: 98.0 F

Any Rash: ☐ Yes ☑ No,

If yes describe the rash ....

Active bleed ....

Lacerations ☐ Abrasions ☐ bruises ☐

Describe: ....

Any urgent interventions needed: ☐ Yes ☑ No

If Yes ....

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

☐ Shock - Compensated ☐ Hypotensive ☐

☐ Cardiopulmonary Arrest ☑ Hemodynamically Stable

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

Labs Planned:	**Treatment Planned:** ....
As charted	

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: C. Deepak

Signature: [signature]

Date & Time: 25/7/20 @ 6:45 PM

Sr. Doctor on Duty (If necessary)

Name of the Sr. Doctor: ....

Signature: ....

Date & Time: ....

GUC-00094300 IP18-00036617
Baby N. VARNIKA
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wt: 14.8kg.

EMERGENCY ROOM TRIAGE FORM

Patient's Name : Baby. Varnika. Age : 3yrs 6mon. Gender: ☐ Male ☑ Female

Date : 25. 7. 2026. Time of Arrival : 5.50pm

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: 97.5°F PR: 126 bt BP: 82/60 (68) RR: 28/m SpO₂: 99% RA. GRBS: 97mg/dl

Chief Complaints: Vomiting 3 to 4 episodes. fall down drawn from bed

INITIAL PHYSIOLOGICAL CATEGORIZATION	INITIAL PHYSIOLOGICAL STATUS
Appearance: ☐ Normal ☑ Sick Looking Work of Breathing: ☑ Normal ☐ Increased ☐ Decreased ☐ Gasping / Apnea Circulation / Colour: ☑ Normal ☐ Abnormal ☐ Bleeding	☐ 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

N. Keerthi
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 : Gokila Parks.

Signature of Triage Nurse : [signature] 016134

Date & Time : 25.07.2026 @ 5:52pm.

5:40pm Semisel Img. ⟶ 01

![St. Thomas Hospital logo: "Service to Mankind, Service to God"]

ST. THOMAS HOSPITAL

ST. THOMAS MOUNT, CHENNAI - 600 016.

OP INITIAL ASSESSMENT RECORD

Date: 25/07/2026			UHID No:
Patient Name: baby: Varnika			Age / Sex: 3 year 6 month.
Height:		Weight:	Pain Score: 0 1 (2) 3 4 5 6 7 8 9 10 — No Pain 0, Mild 1-3, Moderate 4-6, Severe, Very Severe 7-9, Worst Pain Possible 10
Temp: 97.6F		Pulse: 120/min.	
RR:		BP:	
CBG:		SPO2: 99%.	
Allergic History (Food / Medicine / ADR): If Yes mention. Nil.			

Chief Complaints:

pt attender said, c/o vomiting (3-4 episodes),

Present Medication: - no H/o Fever /

Clinical Finding & Suggestions: - no K/c/o BA / Fits.

> c/o upward movement eye ball

Investigation Findings: (If available)

> c/o stiffness over all limbs.

Treatment Plan

1: ? Convulsive Encephalopathy

(R/o Brain space occupying lesion)

? Aspiration pneumonitis.

Rx:

> DEC

> O2 Support ✓

> oral Suction given.

> Inj vomikind IV

> poor and guarded prognosis

explained attender

> pt refer to higher centre

for further management

25/07/2026

Medical Officer

Registration No. / Seal