Rainbow Children's

GUC-00094131 IP18-00036558
Baby YAAZH MUGILAN S
29-10-2023 2 Y 8 M 24 D (M)
Dr. GEETHA JAYAPATHY

DISCHARGE TRACKING SHEET

UHID- FLOOR- NAME OF CONSULTANT-

5th floor

ACTIVITY	INTIME	OUT TIME	NAME & SIGNATURE	REMARKS	<To be filled by Admin>		
Activity Sheet update by Nursing		11.30 am					
Activity Sheet update by Pharmacy							

ACTIVITY RECORD FOR BILLING

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Name: .....

UHID No: ..... IP I GUC-00094131 IP18-00036558
Baby YAAZH MUGILAN S
29-10-2023 2 Y 8 M 22 D (M)
Dr. GEETHA JAYAPATHY

: ..... Dept: .....

Date of Admission: .....

ischarge: ..... Time: .....

Room / Bed No: ..... W d Billable bed type: .....

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
21/7/26	12.45PM.	BR	511	

CROSS CONSULTATION VISIT

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

INVESTIGATIONS

Date	Investigations	Order No.	Signature
	CBC, CRP, Dengue Igm,	26023451	
24/7/26	OT, PT, Bld c/s SGOT,		
	RBS	26023452	
23/7th	CBC, CRP	23674	

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
21/7/24	Infusion pump	1pm	28/7/24 1pm	1731937	[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
21/7	IV Placement	(1)	1730800	Das 178894
21/7	Chest - x-Ray	(1)	9846	015345

ANY OTHER INFORMATION:

.....

.....

.....

.....

.....

.....

Date: ..... Time: ..... Prepared By: .....

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

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29-10-2023 2 Y 3 M 24 D (M)
Dr. GEETHA JAYAPATHY

DISCHARGE TRACKING SHEET

UHID- FLOOR- NAME OF CONSULTANT

5th floor

ACTIVITY	TIME		NAME & SIGNATURE	REMARKS	<To be filled by Admin>
Discharge Announcement					
	INTIME	OUT TIME			
Arrangement of File by Nursing					
Preparation of Discharge Summary		19.30 hrs			
Finalization of discharge summary					
Transfer of file from Ward to Billing Dept					
Bill Processing					
Audit Clearance					
Billing Clearance					
Physical Clearance					

Rainbow Children's Hospital

BirthRight by Rainbow

Rainbow Children's Hospital - Guindy

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

ADMISSION SHEET

Registration Details :

Admission No : IP18-00036558 **Admit Date** : 21-Jul-2026 **Admit Time** : 12:08 PM **UHID** : GUC-00094131

Patient Details :

Patient Name	: Baby YAAZH MUGILAN S	**Age**	: 2 Y 8 M 22 D
Guardian	: Mr SAIDEEPAK B	**DOB**	: 29-10-2023
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: NO:8A, ANBU NAGAR, ALWARTHIRU NAGAR Alwar Tirunagar Chennai Tamil Nadu INDIA 600087	**Phone No**	: 7871033387/ 8428691560
		E-mail	: NO@GMAIL.COM

Admission Details :

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

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

Contact Details :

Name : Mr SAIDEEPAK B **Relationship** : Father

Contact Address : NO:8A, ANBU NAGAR, ALWARTHIRU NAGAR Alwar Tirunagar Chennai Tamil Nadu INDIA 600087 **Phone No** :

Signature

Doctor Details :

Doctor Name : Dr. GEETHA JAYAPATHY **Specialisation** : GENERAL PEDIATRICS

Referral Doctor : FRIENDS **Phone No** :

Co-Consultant :

Payment Details :

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

Payor Name : SELFPAY

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GENERAL CONSENT FOR TREATMENT

Patient Name:	**Baby YAAZH MUGILAN S**	**Age :**	**2 Y 8 M 22 D**
IP No:	**IP18-00036558**	**Sex:**	**Male**
Consultant:	**Dr. GEETHA JAYAPATHY**	**Ward/Bed No:**	**0F-EMERGENCY/ER 101**

The undersigned patient and I or responsible relative or person hereby consent to and authorize Rainbow Hospitals doctors and medical personnel to perform medical examinations, conduct routine investigations and administer medical treatments, outpatient procedures, minor dressings, vaccinations and immunizations during the course of the patient's care, as in patient.

Patient, be deemed advisable or necessary.

I understand that the confidentiality of all medical records shall be protected to the full extent of the Law. The undersigned also consent to the use of health related information/ audiovisuals of the patient for research & training purpose or for insurance coverage and while doing so confidentiality of the patient will be maintained at all times and this will not affect the care of the patient.

In giving my general consent to treatment, I understand that I retain the right to refuse any particular examinations, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by treating doctors. I also understand that the practice of medicine is not an exact science and that no guarantee have been made to me as the results of my evaluation and I or treatment.

I understand that I shall not bring valuables to the Hospitals and that the Hospital will not be responsible for the loss, destruction or theft of my personal belongings. I assume full responsibility for all my personal items and release the Hospital from responsibility and liability for such personal items and valuables.

"I am aware that during the patient care it is inevitable that certain re-useable equipment shall be re-used after sterilization and disinfection. I am informed that the hospital assures maximum level of precaution and care in sterilizing and disinfecting the equipment and monitors the whole process as per evidence based guidelines".

Note:
1 We do not allow use of medication brought from outside by the patient.
2 I have received attendant passes as per my room category. I understand that I have to return it back at the time of final bill clearance. In case of failing the submission, I will pay 200/- Rs.
(Receivers Signature:.................) [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: [signature]

Name: Mr. Saideepak
Relationship: Father
Date: 21/07/2026
Time: 12:08 Pm
Wittness Name: A. Sivasankari
Wittness Signature: [signature]

Patient Address:
NO:8A, ANBU NAGAR, ALWARTHIRU NAGAR Alwar Tirunagar Chennai Tamil Nadu INDIA 600087

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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 Yaazh Mugilan	UHID Number : Cuc-0007413J
Self/Attendant Name : K. MANORMANI	Relation : Mother
Self/ Attendant Signature : K. M Phone Number : 9710333387	Name & Signature of Financial Counselor

DAY CARE DIET SHEET

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

இந்திய அரசாங்கம்
Government of India
ஆதார்

Aadhaar no. issued: 28/01/2014

மனோர்மணி கு
Manormani K
பிறந்த நாள்/DOB: 19/12/1997
பெண்/ FEMALE

ஆதார் என்பது அடையாளத்திற்கான சான்றாகும். குடியுரிமை, அல்லது பிறந்த தேதிக்கான சான்றல்ல. இது சரியார்ப்புடன் மட்டுமே பயன்படுத்தப்பட வேண்டும் (ஆன்லைன் அங்கீகாரம் அல்லது ஒ குறிப்பிட்ட ஸ்கேன் செய்தல்-ஆப்லைன் XML)
Aadhaar is proof of identity, not of citizenship or date of birth. It should be used with verification (online authentication, or scanning of QR code / offline XML).

3683 0827 3833

எனது ஆதார், எனது அடையாளம்

இந்திய தனிப்பட்ட அடையாள ஆணைய அமைப்பு
Unique Identification Authority of India
ஆதார்

Details as on: 23/12/2025

முகவரி:
எண் 8A, அன்பு நகர் மெயின் ரோடு,
ஆழ்வார் திருநகர், ஆழ்வார்திருநகர்,
ஆழ்வார்திருநகர், திருவள்ளூர்,
தமிழ்நாடு - 600087

Address:
No 8A, Anbu Nagar Main Road, Alwar Thirunagar, Alwarthirunagar, PO: Alwarthirunagar, DIST: Tiruvallur, Tamil Nadu - 600087

3683 0827 3833
VID : 9150 4656 0141 5408

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

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PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: _____

UHID ID: _____

GUC-00094131 IP18-00036558
Baby YAAZH MUGILAN S
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Dr. GEETHA JAYAPATHY

Department: _____

Consultant: _____

(P.T.O.)

GUC-00094131 IP18-00036558
Baby YAAZH MUGILAN S
29-10-2023 2 Y 8 M 22 D (M)
Dr. GEETHA JAYAPATHY

Pediatric Multiorgan History & Physical Examination

Name: _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

History of present illness :

c/o fever x 5 days
high grade, Tmax - 104°F
c/o cough x 1 week
c/o vomiting x 2 days
c/o ↓ oral intake +
c/o lethargy +
c/o ↓ urine output +

Taken azithromycin x 3 days

Patient Sticker

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

No H/o previous admission

Birth & Neonatal History:

Family Chart

Term, BW - 2.7 kg, CIAB, No H/o NICU admission

Birth & Socio Economic History:

About Father :

About Mother :

Any additional Information :

Developmental History : (N)

Immunization History : (N) (NIS ✓)

Anthropometry :

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

Weight (kgs) 12.9 (Centile _____)

On Examination :

Temperature : 102.8°f Pulse Rate : 168 B.P. _____ SPO2 98%

Resp.rate and type of breathing : 30

Rash -

Lymphadenopathy - coated tongue + periorbital puffiness +

Oedema : -

Allergies (if any):

(P.T.O.)

Patient Sticker

Respiratory System :

Inspection (any s/o distress) : N

Air entry & breath sounds : B/L AE +

Any addes sounds : -

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

Cardiovascular System :

Inspection of procordium : N

Heart Sounds : S1, S2 +

Any murmur : -

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

Per Abdomen :

Inspection : N

Palpation : soft, liver 1 cm BCM

Ausculation : BS +

Spine : External Genitelia :

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

Central Nervous System :

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

Cranial Nerves : N

Motor System :

Nutriton : N

Tone: N Power N

Co-ordinator :

Posture : N

Involuntary Movements :

Patient Sticker

Reflexes :

DTR **Superficials:**

Plantars N

Sensory System : N

Bladder / Bowel :

Clinical Summary & Diagnostic: ? Viral URI ? Enteric fever

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

Desired goals of the treatment :

Planned Labs:

CBC
CRP
Blood Gp
Dengue IgM
SGOT / PT
Dx < 119 mg/dl.

Planned Management

Tab. P250
Inj. emeset 1.3 mg IV OST

Signature of the Doctor: 125882

Name of the Doctor: Keerthana. D

Date & Time: 21/7/25 12.30pm

Signature of the Consultant:

Name of the Consultant: TSSM

Date & Time: 21/7/25 @ 4 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 Facility Notified (Person Contacted)

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

   ☐ Needs Assistance In: Remarks

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

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

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

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

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

Doctor Signature: .....

Doctor Name: .....

Date and Time: .....

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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Dr. GEETHA JAYAPATHY

(1)

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
21/7/26. 4PM	S/B Dr. S. Mahalakshmi	
	Child reviewed	
	Rt UZ consolidation	
	febrile	
	cough (+)	
	vomiting settled / tolerated orally	
	No hypoxia / distress.	
		Cont IV Xone
		pan
		emeset
		IVF.

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
22/1/24	S/B Dr. DEEPAK	
6:10AM		
	Dx: (R) upper zone consolidation	
	Child reviewed	
	Child had c/o: fast breathing	
	last fever spike 101.6°F→98.0°F	
	O/E: (4:00AM)	
	alert, active, afebrile	
	CVS: S1S2 (+)	
	RS: BAE (+)	
	P/A: soft	
	CNS: NFND	
	RS: BAE (+)	
	VRS (+) / RR - 40/min	
	mild SCR (+)	
	SpO2 - 98% RA	
		Rx
		→ Continue as per chart
		→ TO monitor vitals / GCS / Sensorium
		→ Neb levolin 0.6mg (STAT)
		[signature] 1/1/24

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

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(2)

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/7/26 9:45AM	S/B Dr. S. Mahalakshmi.	
	Δ: (R) Upper zone pneumonia	
	2 fever spikes post admission 6pm – 103 F. 4AM – 101 F Oral intake – Good. ~~Off~~ IVF since 7AM. Urine output – Good. C/o cough ↓sed No further vomiting. @n INJ. CEFTRIAXONE – Day 2.	
	O/E: Alert, euthermic mild sCRE Hydration – fair	
	Vitals – stable.	
	S/E: RS – B/LAE (+), No added sounds other systems – (N).	
	Advice: TC same Rx Trace blood c/s report tomorrow.	

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
22/9/26	S/B Angelle	
1pm	Rt CAP	
	fever (+) spaig out	
	cough (+)	
	appetite better	
	NWOB (-)	
		Cont same
		Stop IVF
	[signature] 78m	
22/9/26	S/B Angelle	
6pm		
	Clinically better	
		plan
	CBC, CRP 23/9/26	(D) tomorrow
	6am if no fever	if no fever
		[signature] 78m

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

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
23/7/26 9AM	S/B - Dr Yuvaraj	
	Δ - (R) Upper Zone ^ pneumonia - Community Acquired	
	Nutritional anemia	
	Child reviewed	
	O/E alert, active.	
	afebrile >1 day	
	intake - good	
	WOB - (N)	
	RS - b/l AE equal, No added sounds	
	PA - soft, nontender	
	CNS / CVS | NAD	
	Plan:	
	- To do CBC, CRP → inform reports	
	- Followup blood c/s	
	- (D3) Ceftriaxone 600mg BD	
	IV. Pan 15mg OD	
	° Plan for discharge today after rounds	
	c oral Augmentin.	
	° Iron supplements on followup	
	T.Y.	

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
23/7/26	S/B Angeattu	
11 am	Rt UZ CAP	
	probable nutritional anaemia	
	Clinically well	
	afebrile 24 hours.	
	RS - (N)	
	(D) today	
	✓ Syp. Augmentin DDS	
	5ml — 0 — 5ml x 4 days.	
	R after 1 week	
	Iron supplements	
	vaccination	
	Milk 300ml/day	
	[signature]	

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

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RESULT SHEET

Date	21/07/26	23/7/26				
Time						
Hb	8	8				
PCV / MCV	24/57	25				
RBC	4.25					
WBC	24,300	15,090				
N/L	81/17	N50L45				
Platelets	4.76	5.09				
CRP	221					
ESR						
PCT						
RBS	119	67				
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT	13					
SGOT	24					
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						

MCV 57

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

Culture and Sensitivities : .....

✓Blood c/s - .....

.....

.....

Radiology : USG : .....

X-Ray : (R) Perihilar infiltrates (+) & upper zone haziness (+)

ECHO : .....

CT : .....

MRI .....

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

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29-10-2023 2 Y 8 M 22 D
Dr. GEETHA JAYAPATHY

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

DRUG CHART

☑ Not known any Drug Allergies

Date of Admission: 21/7 .... Drug Allergies: ....

FOR THE SAFETY OF THE PATIENT

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

DOCTOR - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).

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

NURSES - Nurses must follow strictly the FIVE RIGHTS before administration of medication.
1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time

- AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

SOS / PRN (As Required Medication)

DRUG: Syp. P250				Date / Time	21/7 6pm [illegible]	22/7 4:45 H.V [illegible]
Dose: 3.5ml	Route: PO	Frequency: SOS	Start Date: 21/7			
Doctor's Signature: [signature]	Valid Period	Pharm.				
Additional Instructions:						

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

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

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

Docu. No. : RCH /FRM / CLINICAL / 118

GUC-00094131 IP18-00036558
Baby YAAZH MUGILAN S
29-10-2023 2 Y 8 M 22 D (M)
Dr. GEETHA JAYAPATHY

REGULAR PRESCRIPTIONS

Weight. 12.9kg Ward. ....

DRUG : INJ. CEFTRIAXONE

Dose	Route	Frequency	Start Date	Date/Time		
600mg	IV	Q12H	21/7	21/7 6PM	22/7 RV/ML	23/7 SN/RV

Name & Signature of the Doctor Starting the Drugs: 125882

6PM 12pm

Additional Instructions:

Daily Doctor's Endorsement by a Sign D1 D2

DRUG : INJ. PAN

Dose	Route	Frequency	Start Date	Date/Time		
15mg	IV	Q24H	21/7	21/7 12.35 PM IKD	6AM RV/ML	22/7 23/7 SN/RV

Name & Signature of the Doctor Starting the Drugs: 125882

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG : INJ. EMESET

Dose	Route	Frequency	Start Date	Date/Time	
1.3mg	IV	Q8H	21/7	21/7 12.35 PM IKD	22/7 6AM RV/ML

Name & Signature of the Doctor Starting the Drugs: 125882

8³⁰ pm RV 2pm 10pm

Stop 7.45pm

Additional Instructions:

for 24 hours

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Date	Date/Time

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Patient Sticker

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

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

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
21/7	11.55 am	SYP. IBUGESIC	3.5 ml	PO		
21/7	4.00am	NEB. HEVOLIN	0.63 mg	P/N		RV

Patient Sticker

I.V. FLUIDS CHART

Weight. 12.9 ..... 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
21/7	1pm	0.9% DNS	IV	45		PST	22/7/26 at 8:00am		SA / PST

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

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MEDICATION RECONCILIATION FORM

Drug Allergies: ..... ☑ Not known any Drug Allergies

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

Shifting From: BR Shifted to: 511

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

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY Geetha 125882

Doctor Name & Signature : .....

Date & Time : 21/7/26 @ 12PM

Nurse Name & Signature: .....

Date & Time : 21/7 @ 12PM

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

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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 : 21/7/26 Time:	1pm	2pm	4pm	6pm	7.30pm	12AM	4AM
Doctor / Nurse / Family Concern?							
Temperature (°F)	100.8°F	99.2°F	98.7°F	103.8°F	99.5°F	98.2°F	101.1°F
Heart Rate (bpm) and Blood Pressure (mmHg) *	90 / (71) / 60	98 / (70) / 56	113 / 79 / 64	110 / 70 / 60	100 / 70 / 60		
Heart Rate (Number)	130 b/m	145 b/m	105 b/m	110 b/m	100 b/m		
Resp. Rate (bpm) (Over 1 Minute) *							
Resp Rate (Number)	30 b/m	30 b/m	32 b/m	30 b/m	36 b/m		
Resp Distress: Mod/ Severe / None / Mild	✓	✓ RD	✓ RD	✓ RD	✓ RD		
Receiving O_2 (l/min) O_2 Saturations (%)	99%	98%	100%	98%	98%		
Conscious Level: Normal / Altered	✓	✓	✓	✓	✓		
GCS *	15/15	15/15	15/15	15/15	15/15		
TOTAL SCORE Number of shaded boxes	0	0	0	0	0		
Pain Score	0	0	0	0	0		
Observer's Initials	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		

Note: BP does not score in early warning scoring

ACTIONS

NB: Scores 3 should be recorded overleaf

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

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

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-00094131 IP18-00036558
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(2)

Doc. No. : RCH/ FRM / CLINICAL / 125

PRESCHOOL (1-5 years)

Children's Observation & Early Warning Scoring Chart

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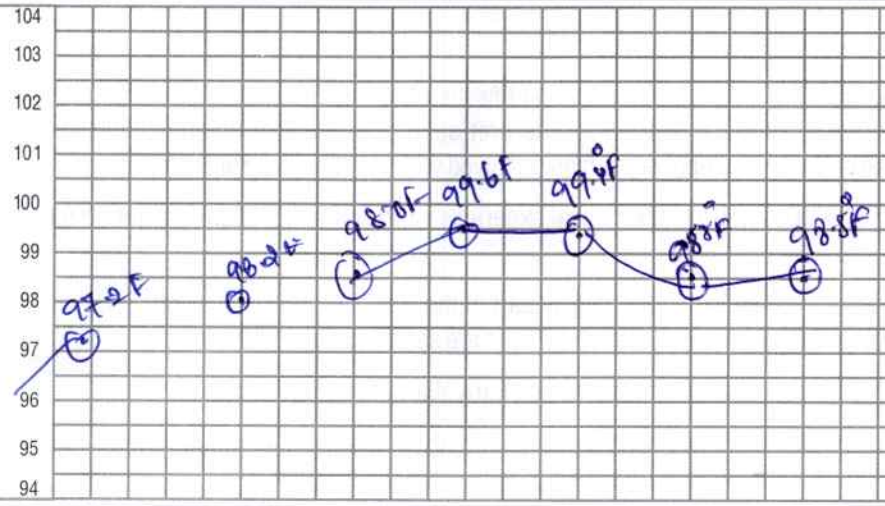
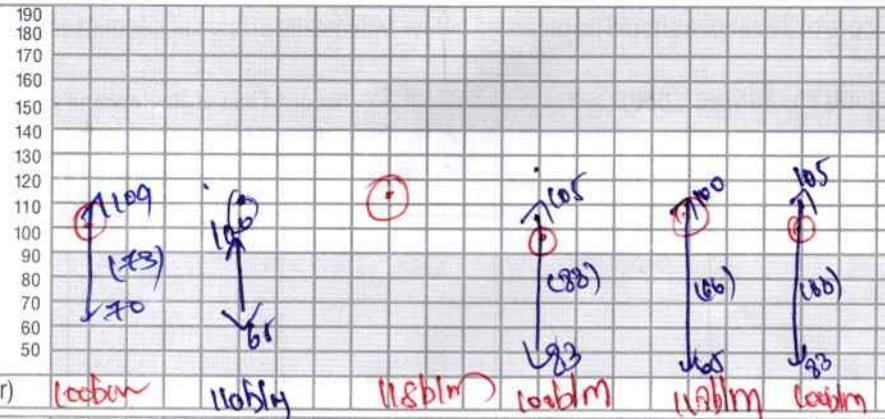
EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 22/10/23 Time: 8am 12pm 4pm 6pm 8pm 12pm 4am

Doctor / Nurse / Family Concern?





Heart Rate (Number)	100bpm	110bpm	118bpm	108bpm	110bpm	108bpm

Resp Rate (Number)	28bpm	28bpm	28bpm	28bpm	30bpm	30bpm
Resp Distress (Mod/ Severe / None / Mild)	✓	✓	✓	✓	✓	✓
Receiving O_2 (l/min)	RA					
O_2 Saturations (%)	97%	98%	99%	98%	99%	98%
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
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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.

21/7th		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			Receiving			Note					
	01:00 pm	H2O	10ml								0	[signature]
Total Intake :		10ml						Total Output :		—		
	02:00 pm	Rice.		45							0	[signature]
	03:00 pm	H2O	20ml	45							0	[signature]
	04:00 pm			45						✓	0	[signature]
	05:00 pm	H2O	20ml	45							0	[signature]
	06:00 pm			DC							0	[signature]
	07:00 pm			DC							0	[signature]
Total Intake :		110ml + 180ml						Total Output :		4 time		
	08:00 pm	H2O	50ml	45							0	[signature]
	09:00 pm			45						✓	0	[signature]
	10:00 pm	H2O	20ml	45							0	[signature]
	11:00 pm			45						✓	0	[signature]
	12:00 am	H2O	30ml	DC							0	[signature]
	01:00 am			DC							0	[signature]
Total Intake :		100ml + 180ml						Total Output :		2times		
	02:00 am	H2O	50ml								0	[signature]
	03:00 am									✓	0	[signature]
	04:00 am	H2O	50ml								0	[signature]
	05:00 am										0	[signature]
	06:00 am	H2O	20ml							✓	0	[signature]
	07:00 am										0	[signature]
Total Intake :		120ml						Total Output :		2times		

Total 24 hrs. Intake	590 ml	Total 24 hrs. Output	5times

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

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FLUID CHART

Sheet No. : (2)

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

22/11		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	H2o	20ml								0	SA
	09:00 am									✓	0	SA
	10:00 am	Water	50ml								0	SA
	11:00 am									✓	0	SA
	12:00 pm	H2o	50ml							✓	0	SA
	01:00 pm										0	SA
Total Intake :		120ml.				Total Output :				3times		
	02:00 pm	Rice									0	SA
	03:00 pm	F/20	30ml							✓	0	SA
	04:00 pm	F/20	50ml								0	SA
	05:00 pm										0	SA
	06:00 pm	F/20	50ml							✓	0	SA
	07:00 pm										0	SA
Total Intake :		130ml				Total Output :				2times		
	08:00 pm										0	SA
	09:00 pm	water	20ml								0	SA
	10:00 pm									✓	0	SA
	11:00 pm	water	20ml								0	SA
	12:00 am										0	SA
	01:00 am										0	SA
Total Intake :						Total Output :						
	02:00 am										0	SA
	03:00 am	water	20ml							✓	0	SA
	04:00 am										0	SA
	05:00 am	water	50ml								0	SA
	06:00 am									✓	0	SA
	07:00 am										0	SA
Total Intake :		120ml.				Total Output :						

Total 24 hrs. Intake	370ml	Total 24 hrs. Output	8 times.

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NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: Viral LRI			Any Infection: ☐ Yes ☑ No ☐ Not Known If Yes Specify:			
	Surgery / Procedure:			Post OP Day:			
BACKGROUND	Date / Shift	21/7 M	21/7 E	21/7 N	22/7 M+E	22/7 N	23/7 M
	Medical Condition (Any special condition to be noted):	Noted	Noted	Noted	Noted	Noted	Noted
	Diet:	(N) diet	(N) diet	(N) diet	(N) diet	(N) diet	(N) diet
ASSESSMENT	Allergy:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
	Ventilation (RA, NP, NIV, VENTI):	RA	RA	RA	RA	RA	RA
	Tubes/Drains/Catheter:	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
	Vital Signs: Temp:	100.8°F	98.9F	98.8°F	98.2	98.2	98.2°F
	Res:	20m	30b/m	28b/m	28b/m	28b/m	28b/m
	SpO_2:	98%	99%	100%	97%	98%	97%
	Pulse:	130b/m	125b/m	156b/m	100bm	100b/m	100bm
	BP:	90/60	98/56	113/68	109/60	105/83	100/70
	LOC:	consu	conscious	conscious	conscious	Consu	consu
	Fall Risk Score:	11	11	11	11	11	11
	Pain Score:	0/10	0/10	0/10	0/10	0/10	0/10
	Skin Integrity	—	—	—	—	—	—
Recommendations	Safety Needs:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
	Physiotherapy:		—	—	—	—	—
	Others Specify:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
	Special Diet:	—	—	—	—		
	Critical Lab Test / Values:	—	—	—	—	—	—
	Other Special Orders / Medications:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
	PU Prophylaxis:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
	DVT Prophylaxis:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
	ADL (Dependent / Non Dependent):	Dependent	dependent	dependent	Dependent	dependent	depend
Post Operative Procedure Special Orders:		—	—	—	—	—	
Handed Over By Name :		Thulasi	Sreeja	Vishnu	S.Preet	Swetha	Preeti
Signature / ID :		[illegible]	40134	021584	80104	[illegible]	[illegible]
Date:		21/7	21/7	22/7	22/7	23/7	23/7
Time:		1:30pm	1:30PM	7:30AM	1:30am	8am	2pm
Taken Over By Name :		Sreeja	R.Jyothi	S.Preet	Swetha	Sreeja	
Signature / ID :		40134	R.[illegible]	80104	[illegible]	40134	
Date:		21/7	21/7	22/7	22/7	23/7	
Time:		7:30PM	8pm	7:30am	@8pm	8am	

Docu. No. : RCH /FRM / CLINICAL / 097

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NURSING CARE RECORD

Rainbow® Children's Hospital — It takes a lot to treat the little.
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Date: 21/7/24

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	1pm	TO maintain the Nutrition/ Level.	1pm	> Assess the child condition > check the vital > monitor I/O	child was stable	child was active	02:00
Afternoon	1:30 pm	> Maintain fluid Balance	2 pm	Provide IVF encouraged to take Raf	Maintained Hydration	child stable	01:34
Night	9:30 pm	→ Assess the general condition of the baby. → Monitor vitals. → Maintain I/O → Administer Medication as per drug chart.		→ Assessed the general condition of the baby. → Monitored Vitals. → Maintained I/O → Administered Medication as per drug chart.	Child's Vitals stable	Re-assessment done	02:50

GUC-00094131 IP18-00036558
Baby YAAZH MUGILAN S
29-10-2023 2 Y 3 M 22 D (M)
Dr. GEETHA JAYAPATHY

NURSING CARE RECORD

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

Date: 22/7/26

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	⇒ To Maintain Nutritional Status.		⇒ To Maintain proper personal hygiene.	⇒ To improved personal hygiene	⇒ The child Vitals Signs	
Afternoon		→		Continue ←			
Night	8 pm	Promote Cleanliness and Comforts		Assess the oral cavity, daily change linen maintain hand hygiene	maintain Intake & output Chart	Child Clinically Stable	

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Baby YAAZH MUGILAN S
29-10-2023 2 Y 8 M 22 D (M)
Dr. GEETHA JAYAPATHY

(1)

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

BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

NURSES NOTES

☑ No Known Drug Allergies

☐ Drug Allergies .... nil.

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		Receiving Notes.	
21/7th			
	12:45 pm.	child details hand over taken	
12:45 pm		from the ER staff. child	
		was conscious & oriented	
		Dr line pattern. child	[signature]
		complain for fever in 5 days.	
	1pm	Check the vital sign	
		vitals are the stable	
		monitor I/O	
		chart — CP ++, PP ++, CRT <3s	[signature]
		conective the Inj. xone 600mg	
	1:30pm	child details handover	
		given to the next the	
		evening duty staff	[signature]
		← Evening duty →	
	1:30 pm	-) Child detail Handing	
		Over taken by Morning	
		duty s/o	[signature]
		-) Child was Conscious and	01534
		directed Child was active,	
		alert Iv line patten	
	2pm	Chest - x-Ray done	
		-) Inf- 0.9% DNS 45ml/hr	
		connected	[signature] 01534
	4pm	Dr. Geetha mam saw the patient	
		and gave advice to attenders	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Patient Sticker

NURSES NOTES

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Your Right to a Safe Delivery

☐ No Known Drug Allergies

☐ Drug Allergies ....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
20/7		Doctor advice to continue same	
		and explain about Blood Reports	
		and if intake good Reduce IVF	→ [signature] 019344
	6pm	→ vitals are checked and	
		Recorded vitals are stable	
		Re-assessment done temperature	
		Reduced	
		Time / CRT / CP / PP	
		<3sec / +ve / +ve	→ [signature] 019344
	5:30 pm	→ Temperature checked 103.5°F	
		Syp pcm given	
	7pm	→ Re-assessed the temperature	
		Reduced	
	7pm	→ Maintaining Records & Reports	
		→ patient detail Handling over	
		one give to Night duty s/n →	[signature] 019346
		Night duty 21/7	
21/7/2[illegible]	7:30pm	→ child details handling over	
		taken from Evening duty	
		Staff Nurse ISBAR method	
		of handover followed	→ M. Vishnu 021584
		→ child is conscious and	
		oriented	
	8pm	Vital monitored and	M. Vishnu 021584
		recorded. IV line patent	
		Due medication was given as per drug	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

GUC-00094131 IP18-00036558
Baby YAAZH MUGILAN S
29-10-2023 2 Y 3 M 22 D (M)
Dr. GEETHA JAYAPATHY

(2)

NURSES NOTES

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

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

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		continue.	
	~~10PM~~	Chart Orders.	
	10 PM	The child was comfortable. Position no any fresh complaints →	c/t. 02113.
	12AM	Vital Signs are checked & Recorded vital signs are. Stable (12 AM | CP + | PP + | CRT <3sec) →	c/t. 02113.
	2AM	The child was sleeping pattern was any fresh complaints →	c/t. 02113
	4AM	Vital Signs are checked & recorded →	M. Nisha 021584.
	6AM	Due Medication given as per drug chart →	M. Nisha 021584.
	7AM	Maintaining I/O Chart & Recorded	
	7.30AM	The child Handing over given to morning duty staff →	c/t. 02113
22/7	7.30am	Morning duty ⇒ The child hand over from night duty staff child is consciously oriented. RR	

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Patient Sticker

NURSES NOTES

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

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☑ No Known Drug Allergies

☐ Drug Allergies ...Nil...

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		line pattern. child is under roomair.	
	8:00am	The child vital sign cheery Record | PP ++ | CP ++ | CRT 3sec.	
	10:00am	The child is no any other complaints.	[signature]
	12pm	The child vital sign cheery Record. | PP ++ | CP ++ | CRT 3sec	
	2pm	-) Dr. George mam saw the child and gave advice to attender Doctor advice to continue same and If stop if child stable discharge tomorrow	[signature] 019340
	4pm	Vitals are Checked and Recorded vitals are stable [TIME | CRT <3sec | CP +ve | PP +ve]	[signature] 0114
	6pm	-) Due medication are given as per day Chart Duly -) Dr George mam saw the child and gave advice to attender Doctor advice to CBC, CRP Case of no fever, if fever present no need to collect sample If no fever plan discharge	[signature] 0114
	7pm	-) Maintaining Intake & output	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

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

Patient Sticker Baby- yogi mahilu
Aue- 94131

NURSES NOTES

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☐ No Known Drug Allergies

☐ Drug Allergies ....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
22/8	7.30 pm	Child handing over given to Night duty sn	[signature]
		Night Duty	
22/8/28	7.30 Pm	child details handover taken from eveningduty Staff IV line healthy(+) Child Conscious & oriented	
	8pm	child vital signs checked & Recorded. [RR / e] [PP / ep] [CRT / <3]	[signature]
		Tommorrow plan discharge child othesno Complaint IVF Stop	[signature]
	10.00 pm	child was stable and well arriving.	[signature]
	11.00pm	The child was no any other complaints	[signature]
	12.00pm	Reassessment the vital signs. vital signs are recorded & checked	
		12pm [CRT / <3sec] [CP / ++] [PP / ++]	[signature]
	12.30pm	The child is no any others complaints	[signature]
	2.00PM	child was sleep and any other fresh complaints	[signature]

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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
22/7	4 AM	Vitals are checked and recorded vitals are stable	
		4AM | PP ++ | CP ++ | CRT <3(s)	[signature]
	6am	→ Due to medication as per doctor order inj. Ceftriaxone [illegible] as per drug chart order	[signature]
		→ Due to medication as per doctor order inj. pan [illegible]mg as per drug chart order	[signature]
		→ Due to medication as per doctor order inj emeset 1.3mg as per drug chart order	[signature]
	7.00 am	Child was active and stable and IV line pattern	[signature]
	7:30am	Child details handing given to morning duty staff nurse	[signature]
		Morning duty	
	7:30AM	Child details handover taken from the Night duty staff child was conscious & oriented IV line pattern.	[signature]

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Patient's Name:..

MRD NO:........... GUC-00094131 IP18-00036558
Baby YAAZH MUGILAN S
29-10-2023 2 Y 8 M 22 D (M)
Dr. GEETHA JAYAPATHY

Age :................ M ☐ F

Consultant :..

PHLEBITIS ASSESSMENT

CANNULA 1

Date : 21/7 Time: 12.30pm
Location : Ⓛ metacarpal.
Size : 24G
Cannula inserted by : S/N - Subhadip

Date	Time	Phlebitis	Infiltration	Nursing Intervention	Sign
21/7	12.45 pm	☐Yes ☑No	☐Yes ☑No	Pattern	[illegible]
	1pm	☐Yes ☑No	☐Yes ☑No	obsv	[illegible]
	2pm	☐Yes ☑No	☐Yes ☑No	obsv	[illegible]
	4pm	☐Yes ☑No	☐Yes ☑No	observd	[illegible]
	6pm	☐Yes ☑No	☐Yes ☑No	observed	[illegible]
	8pm	☐Yes ☑No	☐Yes ☑No	patten	[illegible]
	10pm	☐Yes ☑No	☐Yes ☑No	Observd	[illegible]
22/7	12AM	☐Yes ☑No	☐Yes ☑No	Observd	[illegible]
	2AM	☐Yes ☑No	☐Yes ☑No	observd	[illegible]
	4AM	☐Yes ☑No	☐Yes ☑No	Observd	[illegible]
	6AM	☐Yes ☑No	☐Yes ☑No	Observd	[illegible]
	8am	☐Yes ☑No	☐Yes ☑No	observe	[illegible]
	12pm	☐Yes ☑No	☐Yes ☑No	observe	[illegible]
	2pm	☐Yes ☑No	☐Yes ☑No	obsd	[illegible]
	6pm	☐Yes ☑No	☐Yes ☑No	obsd	[illegible]
	10pm	☐Yes ☑No	☐Yes ☑No	observ	[illegible]
	2Am	☐Yes ☑No	☐Yes ☑No	Observ	[illegible]
	6Am	☐Yes ☑No	☐Yes ☑No	obser	[illegible]
	8pm	☐Yes ☑No	☐Yes ☑No	obsn	[illegible]
	10pm	☐Yes ☑No	☐Yes ☑No	obsn	[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		

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

CANNULA 2

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

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

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

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

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

PHLEBITIS ASSESSMENT AND MANAGEMENT RECORD

CANNULA 3

Date : Time:

Location :

Size :

Cannula inserted by :

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

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

CANNULA 4

Date : Time:

Location :

Size :

Cannula inserted by :

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

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

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

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

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

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BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

THE HUMPTY DUMPTY SCALE

M F N M F

PARAMETER	CRITERIA	SCORE	DATE 21/7	DATE 21/7	DATE 21/7	DATE 22/7	DATE 22/7
Age	Less than 3 years old	4	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	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	1
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own ability	1	1	1	1	1	1
Environmental Factors	History of Falls or Infant-Toddler Placed in Bed	4					
	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	1
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours/ None	1	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	1
	Total		11	11	11	11	11

-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:		21/7	21/7	21/7	22/7	22/7
Time:		1pm	2pm	8pm	8AM	2pm

GUC-00094131 IP18-00036558
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29-10-2023 2 Y 8 M 22 D (M)
Dr. GEETHA JAYAPATHY

BRADEN 'Q' SCALE

Rainbow Children's Hospital — It takes a lot to treat the little
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(1)

	1. Completely immobile:	2. Very limited:	3. Slightly limited:	4. No limitations:	Date: 21/7	21/7	21/7	22/7
					Time: M	E	N	M
Mobility	Does not make even slight changes in body or extremity position without assistance.	Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	Makes frequent through slight changes in body or extremity position independently.	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.	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	27	29	29	28
				Evaluator's Name				

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

Docu. No. : RCH /FRM / CLINICAL / 119

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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Baby YAAZH MUGILAN S
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Dr. GEETHA JAYAPATHY

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

BirthRight BY RAINBOW HOSPITALS Your Right to a Safe Delivery

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 Plan
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		
21/7/23	1pm	1	Explain about the Diagnosis & Treatment	mother	No	Oral	none	Verbal	good	
22/7	8am	9	Health education Teach about Nutritional Status.	mother	No	oral	none	Verbal	Good	
23/7	9am	7	Health education about Infection control	mother	No	oral	none	Verbal	good	
24/7										

Part - III: CODES

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

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

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

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

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

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BED SIDE CHECK LIST FOR NURSES

Date:	21/7	22/7	23/7						
Doctor's Orders	✓	✓	✓						
Carried out or not	✓	✓	✓						
Bed Side									
Structured Handover done	✓	✓	✓						
IV Site	✓	✓	✓						
Central Lines	X	X	X						
Arterial Lines	X	X	X						
Feeding Catheter	X	X	X						
Urinary Catheter	X	X	X						
Skin Care	X	X	X						
Eye Care	X	X	X						
Mouth Care	X	X	X						
Sterillum Bottle, Stethoscope	X	X	X						
Suction Bottle (Should be clean & empty)	X	X	X						
Intubation Tray	X	X	X						
Emergency Tray (Loaded Syringes with Midazolam & Vecuronium and Flush) Ampoules of Adrenaline	X	X	X						
Ventilator Tubing,(Any Water, Blood)	X	X	X						
Humidification	X	X	X						
Check all Infusion (Labelling,Correct Preparation)	✓	✓	X						
Chest Physio & Neb	X	X	X						
Handed Over By Name :	[illegible]	[illegible]	[illegible]						
Signature :	[illegible]	[illegible]	[illegible]						
Date & Time:	21/7	22/7	23/7						
Hand Over Taken By Name :	[illegible]	[illegible]							
Signature :	[illegible]	[illegible]							
Date & Time:	21/7 @8PM	22/7							

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

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 21/7/26 Time of arrival : 11.35AM.

Chief Complaints: fever×5days/cough⊕ RBS: 119.

Height : — Weight : 12.9kg BMI : — Head Circumference (<2 years) .....

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

If yes , identify .....

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

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

RISK FOR FALL:

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

☐ If Patient is > 6 years
Assess the below parameters

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

Ambulatory Aids:

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

Gait/Transferring:

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

Mental Status: Forgets limitations ☐ Yes ☑ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening: ☑ No Abnormalities Detected

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

Inform consultant for positive criteria

.....

.....

Nutritional Screening: ☑ No Abnormalities Detected

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

Inform consultant for positive criteria

Psychological Screening: ☑ No Significant Findings

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

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

Social History: Lives With .....

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

Time of Initial assessment completed by ER Nurse : 15 min

Time	Nursing Notes
11.45 AM	- Pt come to ER ⓒ complaints of fever x5 days. / cough x1 wk.
	- All vitals checked + recorded.
	- ER Dr. assessed the child & Dr. Geetha. Seen the child in OPD + Admitted @ ward.
	- IV line done & Bld Sample collected
	- Pt Shifted to ward for further mgt.

Samples collected by: / Iman

Samples sent by :

Time: / 12.35PM

Time:

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1
21/7 11.55 AM	Syp. Ibugesic	P/O	3.5ml	Dr Keerthana	17894
			Nil		

Condition of patient at time of shift - out :

HR: 161 BP: — CFT: 3Sec

RR: 30 SPO$_2$: 98

GCS: 15/15 Temperature : 102°F

Pain Score: 0/10

Repeat RBS (if applicable): —

Details of Shift - out

Shift - out from ER to: 511

Time of Shift - out: @ 12.45PM

Handover given to: S/N - Thulasi
(Nurse's Name)

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any): IV line done
24G Ⓛ Metacarpal

Name of the Nurse : Iman

Signature of the Nurse : 17894

Date & Time : 21/7/26 @ 11.50 AM

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Nursing General Admission Assessment Form For Pediatrics

Diagnosis: Viral LRI 2. Enteric fever.
Arrival Time: 12.45pm Mode of Arrival: walk Admitting From: ☑ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction Nil. Body Weight: 12.9 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: There is No 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: 12.9 Length: ..... Head Circumference (< 2 years): .....
Temp.: 100.8°F HR: 130bm RR: 30bm BP: 90/44
Pain Score: 0/10 Specify Site: ..... (Follow Pain Assessment Sheet & Document)
Fall Risk Assessment: ☑ Yes ☐ No Score: 11 (Document in the Humpty Dumpty Sheet)
Risk of Pressure Sore (Braden Q Score 21) (Document in the Braden Q Assessment Sheet)

Pain Screening: ☑ Yes ☐ No If Yes, Pain Score: 0/10 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

(P.T.O)

Psychological Screening: ☑ No Significant Findings

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

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

Social History: Lives With Parent

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: T Thulasi Date: 21/7/21 Time: 1.30pm Signature

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PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : Dr. Geetha Date : 21/7/26

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

Start Time of Assessment: 12.30 pm Weight: 12.9 kg

Allergic History: -

Chief Complaints:
90 fever - D5

Pediatric Assessment Triangle

A Appearance - TICLS .....

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

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

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

Any urgent interventions needed: ☐ Yes ☑ No

If Yes .....

Significant Past History: .....

Medication History: .....

Relevant Investigations: .....

Primary Assessment

Airway ☑ Open ☐ Maintainable ☐ Not Maintainable

Any urgent interventions needed: ☐ Yes ☑ No

If Yes .....

Breathing

Rate: 30 SpO_2 on FiO_2 98%

Rhythm: N

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

Respiratory Noises: ☐ Stridor ☐ Wheezing ☐ Grunting

Air Entry: equal

Palpation Findings (If necessary).....

Any urgent interventions needed: ☐ Yes ☑ No

If Yes .....

(P.T.O.)

Circulation HR: 168 CFT Central <3 Peripheral <3 Any urgent interventions needed: ☐ Yes ☑ No

BP: ..... mmHg

Pulse Volume: Central 2+ Peripheral 2+

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

Muffled Heart Sound: ☐ Yes ☑ No

Engorged Neck Veins: ☐ Yes ☑ No

Murmurs: ☐ Yes ☑ No

Liver Span: .....

ECG: .....

Any Signs of Heart Failure: ☐ Yes ☑ No

If Yes .....

Disability GCS: 15/15 AVPU: A

Pupils: Responsive ☑ Non-Responsive ☐

Size: Right 2mm Left 2mm

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

Signs of Neurological compromise .....

Any urgent interventions needed: ☐ Yes ☑ No

If Yes .....

Exposure Temp.: 102.8°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: Details inside

Treatment Planned: Details inside

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

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

Assessment done by

Name of the Doctor: Keerthana. D

Signature: .....

Date & Time: 21/9/26 12.30pm

Sr. Doctor on Duty (If necessary)

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

Signature: .....

Date & Time: .....

PATIENT TRANSFER FORM

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Date & Time of Admission	Date & Time of Transfer Order
21/7 @ 12.08pm	21/7 @ 12.45PM

Treating Consultant Name	Transfer Ordered by	Reason for Transfer
Dr. Geetha	Dr Keerthana	treatment

From Unit	To Unit	Information to Attendant
ER	511	Yes ☒ No ☐

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

Medications / Consumables / Surgicals / Hand over

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

Shifting Summary / Notes Written by Doctor : Yes ☐ No ☐
? Viral LRI

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
178894 / Iman.	Geetha

Patient & Clinical Records Received by : Thulasi 020422

Date & Time of Patient Received : 21/7/22 at 1pm

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

10AM - 3.5ml
P-250

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EMERGENCY ROOM TRIAGE FORM

wt - 12.9 kg

Patient's Name : Yaazh Mugilan Age : 2Y8M Gender: ☑ Male ☐ Female

Date : 21/7/26 Time of Arrival : 11.35AM

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: 102.8°F PR: 168 BP: — RR: 30 SpO_2: 98

Chief Complaints: C/o - fever × 5 days | Cough × 1 wks.

INITIAL PHYSIOLOGICAL CATEGORIZATION			INITIAL PHYSIOLOGICAL STATUS
Appearance ☑ Normal ☐ Sick Looking	Circulation / Colour ☑ Normal ☐ Abnormal ☐ Bleeding	Work of Breathing ☑ Normal ☐ Increased ☐ Decreased ☐ Gasping / Apnea	☑ Stable ☐ Unstable : ☐ Not – Life - Threatening ☐ Life – Threatening

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

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

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian: ✓ [signature]

Triage Completion Time : 2min

Communicable Disease Triage Screening

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

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

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

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

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

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

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

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

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

Name of Triage Nurse : Aman

Signature of Triage Nurse : [signature] 13894.

Date & Time : 21/7/26 @ 11.40AM

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

@ 11.55AM. Syp. Ibugesic 3.5ml - given
P/o

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RBS CHART

Date	Time	RBS (mg/dl)	IVF %	Signature
21/7	12.35PM	110.	–	[signature] 17894.