Rainbow Children's Hospital

GUC-00042519 IP18-00036694
Baby JAI MITHRAN
22-06-2016 10 Y 1 M 9 D (M)
Dr. GANESH R

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		11:30AM					
Activity Sheet update by Pharmacy		1:45					

ACTIVITY RECORD FOR BILLING

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

BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Name: ..... Dept: .....

GUC-00042519 IP18-00036694
Baby JAI MITHRAN
22-06-2016 10 Y 1 M 9 D (M)
Dr. GANESH R

UHID No: ..... IP No: ... ge: ..... Time: .....

Date of Admission: ..... Time

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
31/07/16	1:15pm	E/L	404	17810

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
31/7/26	CBC, Electrolytes. Urea, Creat, Bicarbonate, Ionized calcium, RBS (LAB)	26024519 26024522.	[illegible] [illegible]

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
3/7/26	infusion pump	3/7/26 @ 1:15pm	1/8/26 7am.	1735616	[illegible] 01.8.7.26

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
31/7/26	IV placement	(1)	1735412	

ANY OTHER INFORMATION:

.....

.....

.....

.....

.....

.....

.....

Date: 1/8/26 Time: 11.30AM Prepared By: .....

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
outbwe			

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Your Right to a Safe Delivery

DISCHARGE TRACKING SHEET

DATE : 1/8/26

Name of Consultant :

Floor :

UHID :

S.NO	Activity	TIME		Name & Signature	Remarks
		IN TIME	OUT TIME		
1	Dr. Announce Time				
2	Arrangement of File by Nurses	1/8/26			
3	Pharmacy Clearance	11.30am			
4	Provisional Billing				
5	Audit Check				
6	Final Bill Prepared				
7	Sent to Insurance & Approval Received				
8	Handing Over & Bill Clearance				
9	Discharge Summary				
10	Physical Check Out				
11	Activity Sheet updated by Nursing				
12	Activity Sheet updated by Pharmacy				

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 : IP18-00036694 **Admit Date** : 31-Jul-2026 **Admit Time** : 12:29 PM **UHID** : GUC-00042519

Patient Details :

Patient Name	: Baby JAI MITHRAN	**Age**	: 10 Y 1 M 9 D
Guardian	: Mr MR. MUGUNDHAN A	**DOB**	: 22-06-2016
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: FLAT F3 KRSIHNA APPARTMENTS 4TH MAIN ROAD 2ND STREET RORE NAGAR KOVILAMBAKKAM, Bharathinagar Kanchipuram Tamil Nadu INDIA 600117	**Phone No**	: 9952897653
		E-mail	: MUGU.86@GMAIL.COM

Admission Details :

Bed Type : DAY CARE **Bed No** : ER 102 **Ward Name** : 0F-EMERGENCY

Room No : ER 102 **Admission Type** : First Visit

Contact Details :

Name : Mr MR. MUGUNDHAN A **Relationship** : S/O

Contact Address : FLAT F3 KRSIHNA APPARTMENTS 4TH MAIN ROAD 2ND STREET RORE NAGAR KOVILAMBAKKAM, Bharathinagar Kanchipuram Tamil Nadu INDIA 600117 **Phone No** : / 9952897653

Signature

Doctor Details :

Doctor Name : Dr. GANESH R **Specialisation** : GENERAL PEDIATRICS

Referral Doctor : Self **Phone No** :

Co-Consultant :

Payment Details :

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

Payor Name : SELFPAY

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 JAI MITHRAN**	**Age :**	**10 Y 1 M 9 D**
IP No:	**IP18-00036694**	**Sex:**	**Male**
Consultant:	**Dr. GANESH R**	**Ward/Bed No:**	**0F-EMERGENCY/ER 102**

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[redacted] 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: Mr. Mygundhan
Relationship: Father
Date: 31/07/2026 Time: 12:29 PM
Witness Name: A. Sivasankari
Witness Signature:

Patient Address:
FLAT F3 KRSIHNA APPARTMENTS 4TH MAIN ROAD 2ND STREET RORE NAGAR KOVILAMBAKKAM, Bharathinagar Kanchipuram Tamil Nadu INDIA 600117

Rainbow Children's Hospital | BirthRight BY RAINBOW HOSPITALS

BILLING POLICY

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

DECLARATION

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

Patient Name : Jai Mithran	UHID Number : GUC-00042519
Self/Attendant Name : Mugundhan. A	Relation : father
Self/ Attendant Signature : Phone Number :	Name & Signature of Financial Counselor A. R

RCH/GDY/FRM/CLINICAL/426

सत्यमेव जयते
भारत सरकार

आधार

இந்திய அரசாங்கம்
Government of India

இந்திய தனிப்பட்ட அடையாள ஆணைய அமைப்பு
Unique Identification Authority of India

பதிவேட்டு எண்/ Enrolment No.: 2193/10805/16060

To
ஜெய் மித்ரன்
Jai Mithran
C/O: Mugundhan,
Krishna Apartments F3 A Block,
4th Main Road,
Near Chennai Interiors,
Rose Nagar,
VTC: Koilambakkam,
PO: Kovilambakkam,
Sub District: Tambaram,
District: Kancheepuram,
State: Tamil Nadu,
PIN Code: 600117,
Mobile: 9952897653

Signature Not Verified
Digitally signed by GS Unique Identification Authority of India
Date: 2024.03.20 11:54:53 GMT+05.30

உங்கள் ஆதார் எண் / Your Aadhaar No. :

6206 9996 6105

VID : 9145 0737 2667 0459

எனது ஆதார், எனது அடையாளம்

Aadhaar no. issued: 06/06/2023

இந்திய அரசாங்கம்
Government of India

ஜெய் மித்ரன்
Jai Mithran
பிறந்த நாள்/DOB: 2016
ஆண்/ MALE

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

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

6206 9996 6105

எனது ஆதார், எனது அடையாளம்

सत्यमेव जयते
Government of India

AADHAAR

தகவல் / INFORMATION

குழந்தைகள் 15 வயதை எட்டும்போது பயோமெட்ரிக் தகவல்களை புதுப்பிக்க வேண்டும்

Children on attaining 15 years of age need to update Biometric information.

- ஆதார் என்பது அடையாளத்திற்கான சான்று, குடியுரிமை அல்லது பிறந்த தேதிக்கான சான்றல்ல.
- இந்த ஆதார் கடிதத்தை UIDAI நியமித்த அங்கீகார நிறுவனத்தால் ஆன்லைன் அங்கீகாரம் அல்லது ஆப் ஸ்டோர்களில் கிடைக்கும் எம் ஆதார் அல்லது ஆதார் QR ஸ்கேனர் செயலியை பயன்படுத்தி QR குறியீடு ஸ்கேனிங் அல்லது www.uidai.gov.in ல் கிடைக்கும் பாதுகாப்பான QR குறியீடு ரீடர் செயலியை பயன்படுத்தி சரிபார்க்க வேண்டும்.
- ஆதார் தனித்துவமானது மற்றும் பாதுகாப்பானது.
- ஆதார் பதிவு செய்யப்பட்ட நாளிலிருந்து ஒவ்வொரு 10 வருடங்களுக்குப் பிறகும் ஆதாரில் அடையாளம் மற்றும் முகவரிக்கான ஆவணங்கள் புதுப்பிக்கப்பட வேண்டும்.
- பல்வேறு அரசு மற்றும் அரசு சாரா பலன்கள் / சேவைகளைப் பெற ஆதார் உங்களுக்கு உதவுகிறது.
- உங்கள் மொபைல் எண் மற்றும் மின்னஞ்சல் ஐடியை ஆதாரில் புதுப்பிக்கவும்.
- ஆதார் சேவைகளைப் பெற mAadhaar செயலியை பதிவிறக்கவும்.
- ஆதார்/பயோமெட்ரிக்ஸைப் பயன்படுத்தாதபோது பாதுகாப்பை உறுதிசெய்ய, ஆதார்/பயோமெட்ரிக்ஸ் லாக்/அன்லாக் அம்சத்தைப் பயன்படுத்தவும்.
- ஆதார் கோரும் நிறுவனங்கள் ஒப்புதலைப் பெற வேண்டிய கட்டாயம் உள்ளது.
- Aadhaar is proof of identity, not of citizenship or date of birth (DOB).
- This Aadhaar letter should be verified through either online authentication by UIDAI-appointed authentication agency or QR code scanning using mAadhaar or Aadhaar QR Scanner app available in app stores or using secure QR code reader app available on www.uidai.gov.in.
- Aadhaar is unique and secure.
- Documents to support identity and address should be updated in Aadhaar after every 10 years from date of enrolment for Aadhaar.
- Aadhaar helps you avail of various Government and Non-Government benefits/services.
- Keep your mobile number and email id updated in Aadhaar.
- Download mAadhaar app to avail of Aadhaar services.
- Use the feature of Lock/Unlock Aadhaar/biometrics to ensure security when not using Aadhaar/biometrics.
- Entities seeking Aadhaar are obligated to seek consent.

இந்திய தனிப்பட்ட அடையாள ஆணைய அமைப்பு
Unique Identification Authority of India

Details as on: 20/03/2024

முகவரி:
கேர் ஆப்: முகுந்தன், கிருஷ்ணா அபார்ட்மெண்ட்ஸ் எ.ஃப்3 ஏ பிளாக், 4வது மெயின் ரோடு, சென்னை இன்டீரியர்ஸ் அருகில், ரோஸ் நகர், கோவிலம்பாக்கம், கோவிலம்பாக்கம், காஞ்சிபுரம், தமிழ் நாடு - 600117

Address:
C/O: Mugundhan, Krishna Apartments F3 A Block, 4th Main Road, Near Chennai Interiors, Rose Nagar, Koilambakkam, PO: Kovilambakkam, DIST: Kancheepuram, Tamil Nadu - 600117

6206 9996 6105

VID : 9145 0737 2667 0459

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

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

PEDIATRIC IN-PATIENT MEDICAL RECORD

Allergies
MILK

Patient Name: _____ GUC-00042519 Baby JAI MITHRAN 22-06-2016 Dr. GANESH R IP18-00036694 10 Y 1 M 9 D (M) _____

UHID ID: _____

Department: _____ _____

Consultant: _____

Patient Sticker

Pediatric Multiorgan History & Physical Examination

Name: _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

History of present illness :

C/O: Loose stools 8-9 episodes x (1d)
↓ since yesterday evening
watery
associated c̄ food intake
non-bloody

c/o. nausea x (1d)
fever
↓ intermittent
settled c̄ para
C/O: ↓ intake

HIV: travelling outside c̄ outside food intake

Child was initially treated as OPD still symptoms persisted

Child appears dull (+)
Dry tongue

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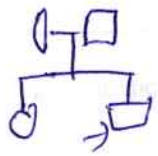
details of any previous investigation or treatment)

Nil

Birth & Neonatal History:

NVD | TERM | 2.5kg | CIAB | NAD I C V

Family Chart



Birth & Socio Economic History:

About Father :]
About Mother :] (A)

Any additional Information :

Developmental History : (A)

Immunization History :

Uptodate IAP

Anthropometry :

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

Weight (kgs) 21.5kg (Centile _____)

On Examination :

Temperature : 98.9°F Pulse Rate : 130/min B.P. 110/60 (71) SPO2 98% on RA

Resp.rate and type of breathing : (N)

Rash (A)

Lymphadenopathy (A)

Oedema : (A)

Allergies (if any): (-)

(P.T.O.)

Patient Sticker

Respiratory System :

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

Air entry & breath sounds : VBS(+)

Any addes sounds : (-)

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

Cardiovascular System :

Inspection of procordium : (N)

Heart Sounds : S1S2(+)

Any murmur : (-)

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

Per Abdomen :

Inspection : (N)

Palpation : SOFT

Ausculation : BS(+)

Spine : (N) External Genitelia : (N)

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

Central Nervous System :

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

Cranial Nerves :

Motor System :

Nutriton : (N)

Tone: Power

Co-ordinator :

Posture :

Involuntary Movements :

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R

DTR (F) Superficials:

Plantars

Sensory System :

Bladder / Bowel :

Clinical Summary & Diagnostic: Dcr. AGE & dehydration

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

Desired goals of the treatment :

Planned Labs:

CBC
RP-2

Planned Management

NS 750ml Over 4hrs
↓
0.7 IDNS 50ml/hr

Tr Emeset 2mg BSH
REDOTIL SACHET 2-2-2
Syp. PARA SOS
6.5ml if T>101°F
One in 6hrs

Signature of the Doctor:
Name of the Doctor: C. DEEPAK
Date & Time: 31/7/16 at 12:38 pm

Signature of the Consultant:
Name of the Consultant:
Date & Time: 31.7.16

(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. GANESH R

Docu. No. : RC

DOCTOR'S SHIFT CHANGE HANDOVER FORM

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Your Right to a Safe Delivery

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

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

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

GUC-00042519 IP18-00036694
Baby JAI MITHRAN
22-06-2016 10 Y 1 M 9 D (M)
Dr. GANESH R

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
31/7/26 4.30pm	S/B Dr. Chandiraleka	
	c/o Fever x 2 days	
	c/o loose stools x 2 days	
	nausea (+)	
	Activity ↓	
	After Admission :	
	no fever spikes	
	loose stools - 2 episodes	
	no vomiting	
	Urine voided - 3-4 times	
	O/E	
	Afebrile	
	CVS - S1S2 (+)	
	RS - clear	
	P/A - soft	
		BP - 100/55 mm Hg
	TC - 22820	PR - 102/min
	N/L - 81/13	
	Plt - 2,91,000	
	(RO) electrolytes	

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	Adv:	
	- monitor intake	
	- W/F fever spikes, loose stools	
	- IV Fluids	
	- Rodotil 2OBH (1 sachet 10mg)	
	- Inj Ameset 8mg IV OBH	
	- Inform (SOS)	
	Sd/ PHNZH	
1/8/16 9 PM.	S/B Dr. Chandralega.	
	Δ - AGE & Some dehydration	
	child reviewed	
	Alert, Active	
	no fever spikes	
	loose stools - Reduced in frequency.	
	semisolid in consistency.	
	no vomiting	
	Oral intake - good.	
	Urine output - voided 3 times / night.	
	O/E	BP - 100/80 mm Hg.
	Afebrile	PR - 98/min
	CVS - S1S2 (+)	
	RS - clear.	
	P/A - soft	

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	Adv:	
	- monitor vitals	
	- IV Fluids @25ml/hr.	
	- Redotil sachet 2TDS	
	- W/F fever spikes, loose stools.	
	- Inform (SRS)	
	SW 1/8/22	
11.45AM 01.08.22	S/B Dr. Ganesh sir.	
	Plan discharge.	ALE SOME DEHYDRATION
	Adv:	
	- Redotil 2 sachet TDS X 2 days	
	- SR Wednesday Monday 3.8.22	
		Diet as advised
	Dr	

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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RESULT SHEET

Date	31/7/26					
Time						
Hb	13.7					
PCV	39					
RBC	4.72					
WBC	22820					
N/L	81/13					
Platelets	2,91,000					
CRP						
ESR						
PCT						
RBS						
Na	138					
K	3.4					
Cl	103					
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

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

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

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MEDICATION RECONCILIATION FORM

Drug Allergies: ..... Nil MILK ..... ☐ Not known any Drug Allergies

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

Shifting From: ..... ER ..... Shifted to: ..... 405 .....

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

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : .....

Date & Time : 31/7/16 @ 12:50PM

Nurse Name & Signature: .....

Date & Time : 31/07/16 @ 2PM

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

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DRUG CHART

Date of Admission: 31/7/26. Drug Allergies: ~~NIL~~ MILK ☐ 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: SYRUP PARACETAMOL				Date / Time	31/7															
Dose	Route	Frequency	Start Date	5.15 PM	CS															
6.5ml	PO	SOS			SA															
Doctor's Signature		Valid Period	Pharm.																	
C.S [illegible]																				
Additional Instructions: If T>100°F Once in 6hrs																				

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 .....

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REGULAR PRESCRIPTIONS

Weight. 21.5 Ward. .....

DRUG : I/ EMESET

Dose	Route	Frequency	Start Date
2mg	IV	QID	31/7

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time: 31/7 1/8 — 7AM PK — 1pm CS — 7pm — stopped

DRUG : REDOTIL SACHET

Dose	Route	Frequency	Start Date
2 Sachet	PO	2-2-2	31/7

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions: 1 - Sachet - 10 mg

Daily Doctor's Endorsement by a Sign

Date / Time: 31/7 1/8 — 8AM BL VK — 2pm CS SA — 10pm PSD AD

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time:

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time:

Patient Sticker

Weight. ..... 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.	

Signature .....

VERIFIED BY . Name .....

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses

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I.V. FLUIDS CHART

Weight. 21.5 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
31/7/1	1.15pm	NS 750ml over 4hrs	IV	187/hr	[signature] 10am	[signature]	31/7/26 @ 5.20pm		[signature]
31/7	5.30 pm	0.9% DNS	IV	50ml/hr	[signature]	[signature]			
1/8/26		0.9% DNS	IV	25ml/hr	[signature] 19am				

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

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Doc. No. : RCH/ FRM / CLINICAL / 126

SCHOOL AGE (5-12 years)
Children's Observation & Early Warning Scoring Chart

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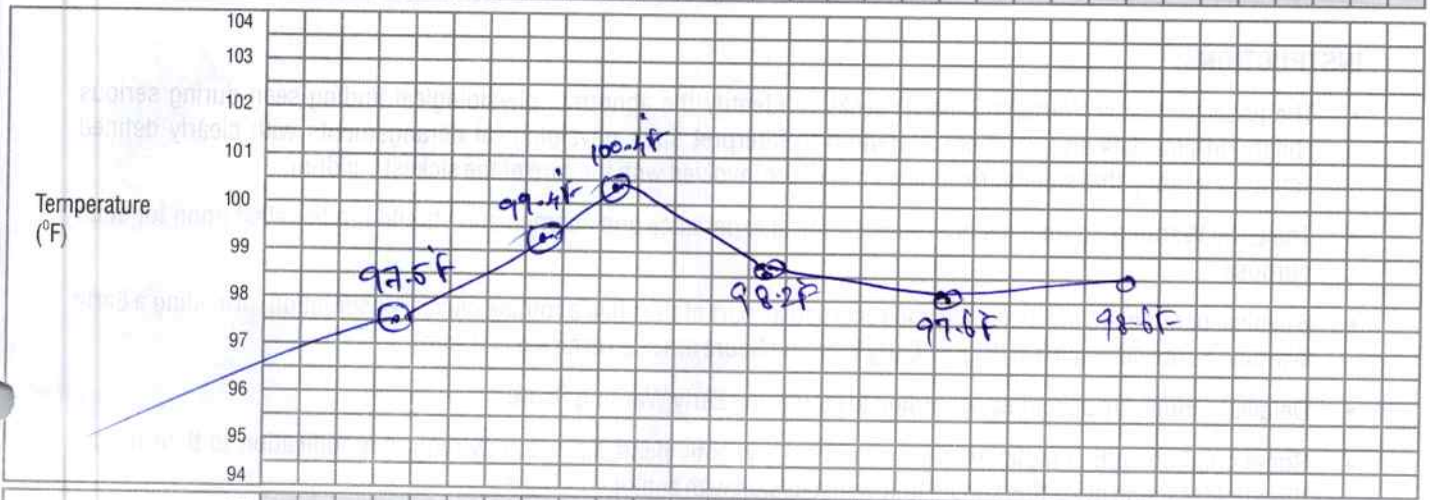
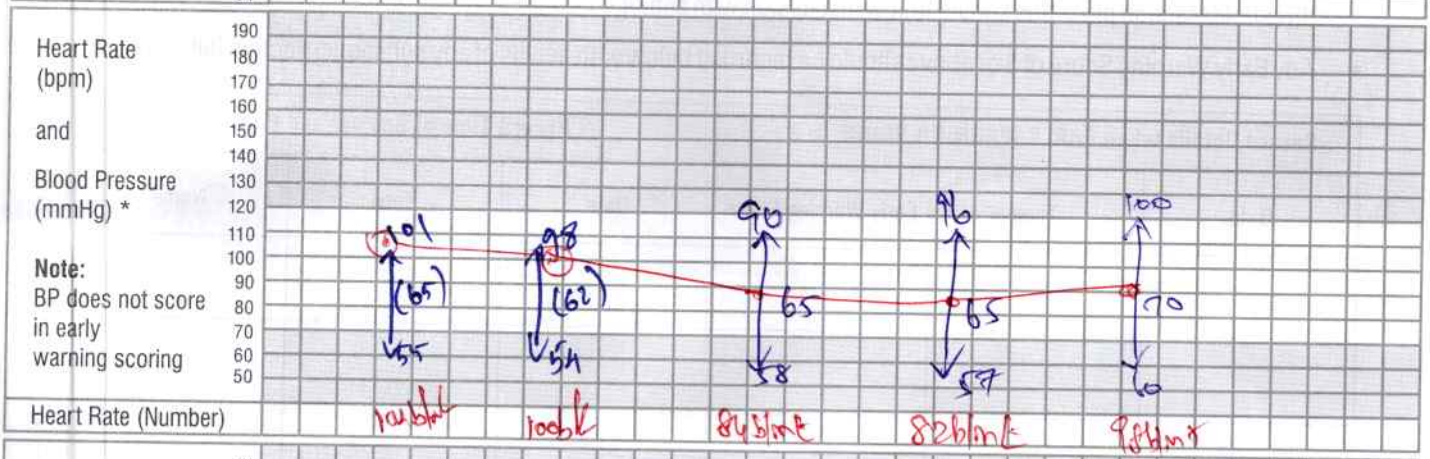
EARLY WARNING SCORE: CHILDREN'S UNIT

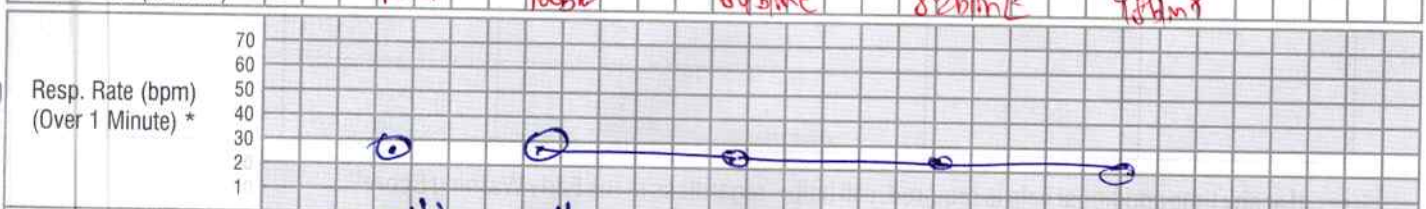
Date : 31/7/26 Time: 1-15Pm | 4Pm-5-10Pm | 8Pm | 12Pm | 4Pm

Doctor / Nurse / Family Concern?





Heart Rate (Number): 104b/mt | 106b/mt | 86b/mt | 82b/mt | 98b/mt



Resp Rate (Number): 24b/mt | 22b/mt | 20b/mt | 22b/mt | 20b/mt

Resp Distress	Mod/ Severe / None / Mild	✓	✓	✓	✓	✓
Receiving O_2 (l/min) O_2 Saturations (%)		97%	99%	98%	99%	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						

ACTIONS
NB: Scores 3 should be recorded overleaf

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

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

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

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FLUID CHART

Sheet No. : (1)

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

31/8/18

Date	Time	Intake: Nature of Fluid	Intake: Route – Mouth	Intake: Route – I.V	Intake: Route – N.G	Output: NG	Output: Diarrhoea	Output: Vomit	Output: Drainage	Output: Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm		ON ADMission from ER to 408									
Total Intake :						Total Output :						
	02:00 pm	H2o	100ml	187ml						✓	0	AVD
	03:00 pm			187ml			✓				0	AVD
	04:00 pm	H2o	80ml	187ml						✓	0	AVD
	05:00 pm			187ml			✓				0	AVD
	06:00 pm	Tender	150ml	50ml			✓			✓	0	AVD
	07:00 pm			50ml			✓				0	AVD
Total Intake :		320ml + 850ml				Total Output : 4 times						
	08:00 pm	water	100ml	50ml						✓	0	PSD
	09:00 pm			50ml		1 pack stools					0	PSD
	10:00 pm	water	100ml	50ml			✓			✓	0	PSD
	11:00 pm			50ml							0	PSD
	12:00 am			50ml							0	PSD
	01:00 am			50ml						✓	0	PSD
Total Intake :		200 ml	300ml			6 times loose stools					0	PSD
	02:00 am			50ml		Total Output :	3 times passed					
	03:00 am			50ml							0	PSD
	04:00 am			50ml						✓	0	PSD
	05:00 am			50ml							0	PSD
	06:00 am	water	100m	50ml		2 times stools					0	PSD
	07:00 am			50ml						✓	0	PSD
Total Intake :		100ml + 300ml									0	PSD
						Total Output :	2 times passed					

Total 24 hrs. Intake	2170ml	Total 24 hrs. Output	9 times passed

Baby. Jai Mithran

Patient Sticker

10y/M

CRUC:. 42519

NURSES NOTES

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☐ No Known Drug Allergies

☐ Drug Allergies ..... Milk Allergy .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
31/7/26		Recieving Notes	
	1.15pm	The child recieved from ER to 408. The child details handing over taken from ER staff. child is conscious and oriented. child is on room air. Iv line present Iv line patterm.	Jai' 021893
	1.30pm	vital sign are checked and recorded. vital sign are stable.	Jai' 021893

CP	PP	CRT
++	++	<3sec

Iv fluids NS @ 750 ml 187ml/hr on flow. over 4 hrs.

3pm	No chart is maintained No any sthes complaints
4pm	Iv fluid NS @ 187ml/hr on flow Iv line patteen and good
6pm	Administer the medication as per. doctor's order.
7.30pm	The child details handover given to night duty staffs.

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Patient Sticker

NURSES NOTES

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☐ No Known Drug Allergies

☐ Drug Allergies ......NKC......

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		Night Duty 31/7/26	
31/7/26	7.30pm	Child details handing over taken from evening duty S/N. Child was conscious & accepted. Dr low pesents pattern. child wake the room ac. child taken soft diet.	P.S [illegible] 019338
	8pm.	Vitals are checked send. Vitals are stable. PP/CD/CRT ++/++/C3] No fever.	
	9pm	Dr. [illegible] sir came & seen the child advice to continue further treatment	P.S [illegible] 01935[illegible]
	10pm.	Due the medication given as per drug chart order.	
1/8/26	12Am	Vitals are checked send. Vitals are stable PP/CD/CRT ++/+/C3 No fever.	P.S [illegible] 019354
		Child sleeping well. No any fresh complaints. Pt was room1 in room14 on gay.	
	4AM	Vitals are checked send. Vitals are stable PP/CP/CRT ++/++/C3	P.S [illegible] 019354

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

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INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Part - I.
Patient's / Learner Language: Tamil Patient / Learner Literacy: ☐ Read ☐ Write ☐ Speak Willingness to Learn: Yes No Healthcare Literacy: Yes ☐ No ☐

Identified Education Needs:

1. Diagnosis
2. Treatment and Care
3. Pain Management
4. Informed Consent
5. Medication / Therapy (safety, effects/ side effect, interactions)
6. Discharge Medication
7. Infection Control Measures
8. Diagnostic Test / Procedures
9. Nutrition / Diet
10. Fall Risk Education
11. Safe use of Medical Equipment / Implantable Devices Safety
12. Patient's / Family Rights
13. Risk / Safety

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
31/7/16	31/7/16	Treatment & care	Explained about treatment and care	mother	NO	Oral	None	Verbalized understood	Good	
1/8	9am	medicine	Explained about medication	mother	no	oral	none	Verbalize understood	good	

Part - III: CODES

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

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

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

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

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

Baby. Jai Nithran
10y/M

Patient Sticker

OUC:- 42519

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Nursing General Admission Assessment Form For Pediatrics

Diagnosis: Acute Gastroenteritis with Dehydration

Arrival Time: 1.15 Pm Mode of Arrival: walking Admitting From: ☐ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction: —

Body Weight: 21.5 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: 21.5kg Length: — Head Circumference (< 2 years): —

Temp.: 97.5°F HR: 104bpm RR: 22bpm BP: 101/55 (65)

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

Fall Risk Assessment: ☒ Yes ☐ No Score: 10 (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: 0/10 Pain Tool Used: ☐ N Pass ☐ FLACC ☐ Wong Baker

Character of Pain — Location — Frequency — Duration —

FUNCTIONAL SCREENING:

☒ No Abnormalities Detected

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

Inform consultant for positive criteria

NUTRITIONAL SCREENING:

☐ No Abnormalities Detected

☐ Underweight
☐ Feeding Problem
☐ Overweight
☐ Special diet
☐ Special Feeding Method
☐ No Abnormality Detected

Inform consultant for positive criteria

Psychological Screening: ☐ No Significant Findings

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

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

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

Siblings in household ☑ Yes ☐ No (if yes How Many?) ..... 1 .....

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: ..... Date: ..... Time: ..... Signature

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Baby JAI MITHRAN
22-06-2016 10 Y 1 M 9 D (M)
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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 31/7/26. Time of arrival : 12:20pm.

Chief Complaints: Loose Stools x 5 episodes. RBS: 105 mg/dl.

Height : — Weight : 21.5 Kg BMI : — Head Circumference (<2 years) —

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

If yes , identify NKA MILK.

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

NA

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: NA (Date/Time): —

Social History: Lives With Parents

Siblings in household ☑ Yes ☐ No (if yes How Many?) 01

Time of Initial assessment completed by ER Nurse : 12:25pm

(P.T.O.)

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

Time	Nursing Notes
1:05 pm	patient come to the ER with the H/O loose stool x 8-9 episodes. ↓ oral intake, nausea x 1 day. Monitored the vital signs. Recorded Dextrose - IV line placement in - Blood sample collected and pt shifted to bed ward -

Samples collected by: SIN Sruthi

Samples sent by :

Time: 7:00 pm

Time:

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1

nil

Condition of patient at time of shift - out :	Details of Shift - out
HR: 130/m BP: 110/60 CFT: <3 sec	Shift - out from ER to: 408
RR: 20/m SPO$_2$: 100%	Time of Shift - out: 1:15 pm
GCS: 15/15 Temperature : 98.6 F	Handover given to: SIN Sruthi (Nurse's Name)
Pain Score: 0/10	
Repeat RBS (if applicable): 105mg/dl.	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any): IV line placement (D) metrocarpate 2g

Name of the Nurse : Shibu Deborah

Signature of the Nurse : Shibu 1869

Date & Time : 31/07/24 & 1:10 pm

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PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : Dr. DGRPAM Date : 31/7/18

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

Start Time of Assessment: ..... Weight: 21.5 kg

Allergic History: NKDA

Chief Complaints:
fever
vomiting
nausea

Pediatric Assessment Triangle

A Appearance - TICLS Alert

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

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

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

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

Significant Past History: .....

Medication History: .....

Relevant Investigations: .....

Primary Assessment

Airway
- ☑ Open
- ☐ Maintainable
- ☐ Not Maintainable

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

Breathing
Rate: ..... SpO_2 on FiO_2 98% / RA

Rhythm: .....

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

Respiratory Noises: ☐ Stridor ☐ Wheezing ☐ Grunting

Air Entry: BAEP

Palpation Findings (If necessary) .....

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

Circulation HR: 130/min CFT [Central (+) / Peripheral (+)]

Any urgent interventions needed: ☐ Yes ☐ No

If Yes .....

BP: ..... 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

Disability GCS: 15/15 AVPU: Alert

Any urgent interventions needed: ☐ Yes ☐ No

If Yes .....

Pupils: [Responsive ☐ Non-Responsive ☐ / Size [Right ..... / Left .....]]

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

Signs of Neurological compromise .....

.....

Exposure Temp.: 97.6°F

Any urgent interventions needed: ☐ Yes ☐ No

If Yes .....

Any Rash: ☐ Yes ☐ No,

If yes describe the rash .....

Active bleed .....

Lacerations ☐ Abrasions ☐ bruises ☐

Describe: .....

Final Physiological Status: ☐ Respiratory Distress ☐ Respiratory Failure ☐ Respiratory Arrest ☐ Shock - Compensated ☐ Hypotensive ☐ ☐ Cardiopulmonary Arrest ☑ Hemodynamically Stable

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

.....

.....

Labs Planned: .....

.....

.....

.....

.....

.....

.....

Treatment Planned: .....

.....

.....

.....

.....

.....

.....

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. DCE Pork

Signature: .....

Date & Time: 31/7/26 @ 12:15pm

Sr. Doctor on Duty (If necessary)

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

Signature: .....

Date & Time: .....

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EMERGENCY ROOM TRIAGE FORM

wt : 21.5 kg

Patient's Name : Jai mithran Age : 10y Gender: ☑ Male ☐ Female

Date : 31/7/26 Time of Arrival : 12:20pm

Allergies: ☐ No ☑ Yes ☑ Food ☐ Medications ☐ Blood Transfusion ☐ Other (Specify): Milk ☐ Not known

Source of Information : ☑ Parents ☐ Others (Specify) .....

Mode of Arrival : ☑ Ambulatory ☐ Wheelchair ☐ Ambulance

Initial Vital Signs: Temp: 97.6°F PR: 130 BP: 110/60(71) RR: 24 SpO_2: 95%

Chief Complaints: c/o loose stools x 5 episode

INITIAL PHYSIOLOGICAL CATEGORIZATION

Appearance: ☑ Normal ☐ Sick Looking

Circulation / Colour: ☑ Normal ☐ Abnormal ☐ Bleeding

Work of Breathing: ☑ Normal ☐ Increased ☐ Decreased ☐ Gasping / Apnea

INITIAL PHYSIOLOGICAL STATUS

☑ Stable
☐ Unstable :
- ☐ Not – Life - Threatening
- ☐ Life – Threatening

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

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

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian

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 : Praveen

Signature of Triage Nurse : .....

Date & Time : 31/7/26

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

PATIENT TRANSFER FORM

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Date & Time of Admission	Date & Time of Transfer Order
31/07 @ 12:29pm	31/07 @ 1:15pm
Treating Consultant Name	**Transfer Ordered by**	**Reason for Transfer**
Dr. Ganesh	Dr. Deepak	Treatment
From Unit	**To Unit**	**Information to Attendant**
ER	408	Yes ☐ No ☐
Number of Sheets in Clinical File	**Number of Imaging Films**	**Personal belongings including clinical documents. If any handed over to attendant**
1	Nil	Yes ☐ No ☐
		If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	O-9+ NS 500ml	1
2.	Intrafix	1
3.		
4.		
5.		

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

Dx : AGE & Dehydration

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Shibu 17790	C. Deepak

Patient & Clinical Records Received by : Anitha 01500 31/7/16 @ 1:15p

Date & Time of Patient Received :

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

Unavailable Bed Nurse not Available Available Bed not ready

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RBS CHART

Date	Time	RBS (mg/dl)	IVF %	Signature
21/07	1pm	105	—	