



Birth: ... Rainbow Children's Hospital

GUC-00094615
M. DHATRI SREE
11-02-2016

IP18-00036725

10 Y 5 M 23 D

(F)

RGE TRACKING SHEET

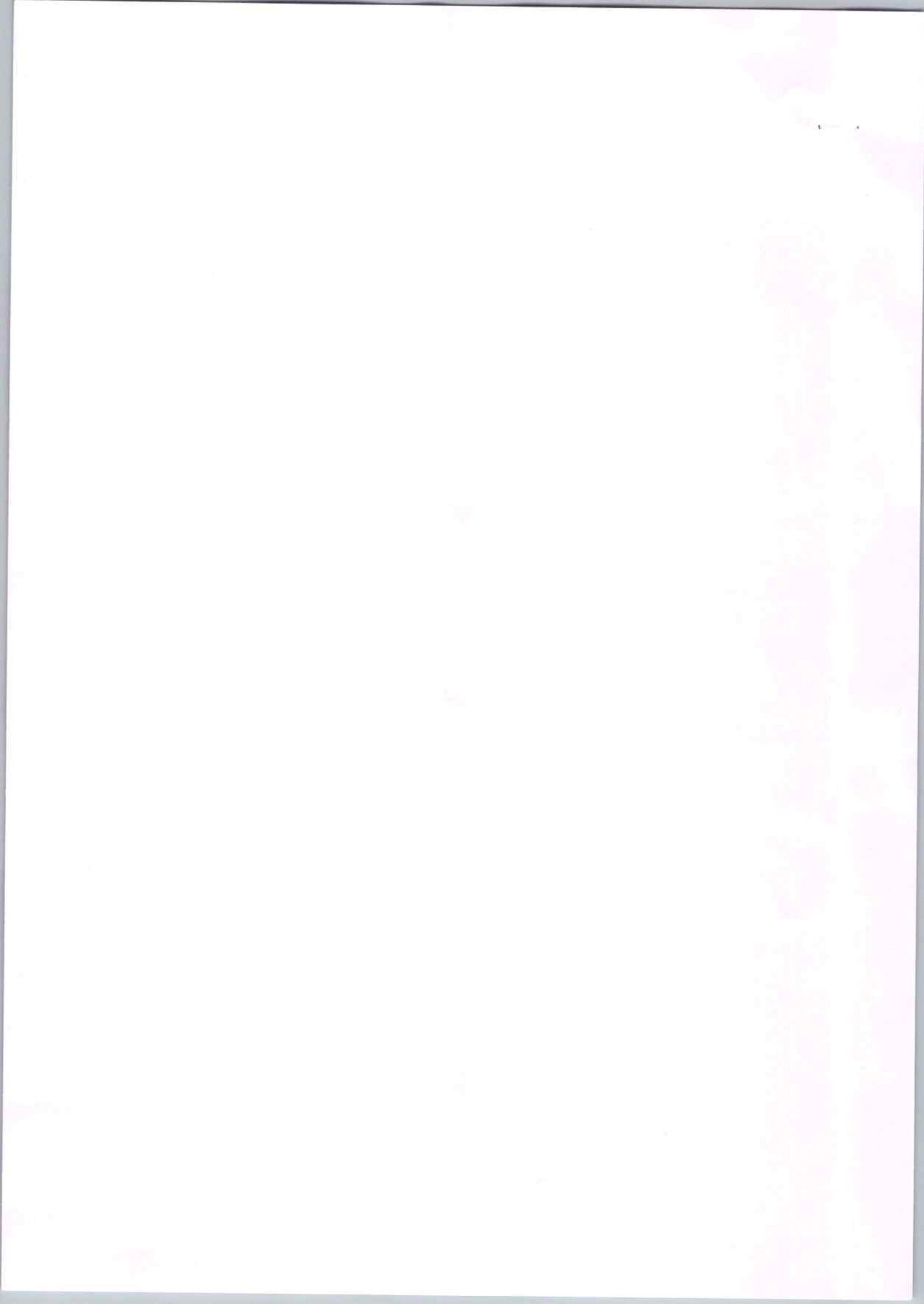
UHID-

Dr. NATARAJ PALANIAPPAN



NAME OF CONSULTANT-

ACTIVITY	INTIME	OUT TIME	NAME & SIGNATURE	REMARKS	<To be filled by Admin >		
Activity Sheet update by Nursing	31/8/2016	11:45 AM	[Signature]				
Activity Sheet update by Pharmacy			[Signature]				





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							
Activity Sheet update by Pharmacy							

ACTIVITY RECORD FOR BILLING

Name: GUC-00094615 IP18-00036725
 Ms DHATRI SREE
 11-02-2016 10 Y 5 M 22 D (F)
 UHID No: Dr. NATARAJ PALANIAPPAN
 Date of Admiss: Consultant: Dept:
 Date of Discharge: Time:
 Room / Bed No: Ward: Suggested Billable bed type:

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
08.08.2016	11pm	FR	707	<i>[Signature]</i> 016/34

CROSS CONSULTATION VISIT

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

INVESTIGATIONS

[illegible]

MEDICAL EQUIPMENT (WARD & ICU)

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
8.08.2026	Duploment	①	1736898	

ANY OTHER INFORMATION:

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Date: 8.8.2026 Time: 11.45am Prepared By: 

Staff Nurse 	Shift / Ward	Billing Assistant	Billing Supervisor
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GUC-00094615

IP18-00038725

DISCHARGE TRACKING SHEET

Ms DHATRI SREE

11-02-2016

10 Y 5 M 23 D

(F)

Uf

Dr. NATARAJ PALANIAPPAN

NAME OF CONSULTANT-



ACTIVITY	TIME		NAME & SIGNATURE	REMARKS	<To be filled by Admin>
Discharge Announcement	3/8/2016 11:45 am		DM		
	INTIME	OUT TIME			
Arrangement of File by Nursing	3/8/2016 11:45 am		By		
Preparation of Discharge Summary					
Finalization of discharge summary					
Transfer of file from Ward to Billing Dept					
Bill Processing					
Audit Clearance					
Billing Clearance					
Physical Clearance					

GUC-00094615

Ms DHATRI SREE

11-02-2018

Dr. NATARAJ PALANIAPPAN

IP18-00036725

10 Y 5 M 22 D

(F)



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

BirthRight[™]
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

BED SIDE CHECK LIST FOR NURSES

Date:	02/8								
Doctor's Orders	yes								
Carried out or not	yes								
Bed Side									
Structured Handover done	yes								
IV Site	yes								
Central Lines	NA								
Arterial Lines	NA								
Feeding Catheter	NA								
Urinary Catheter	NA								
Skin Care	NA								
Eye Care	NA								
Mouth Care	NA								
Sterillum Bottle, Stethoscope	yes								
Suction Bottle (Should be clean & empty)	yes								
Intubation Tray	NA								
Emergency Tray (Loaded Syringes with Midazolam & Vecuronium and Flush) Ampoules of Adrenaline	NA								
Ventilator Tubing, (Any Water, Blood)	NA								
Humidification	NA								
Check all Infusion (Labelling, Correct Preparation)	NA								
Chest Physio & Neb	N								
Handed Over By Name :	Smed								
Signature :	[Signature]								
Date & Time:	3/8/18 8AM								
Hand Over Taken By Name :									
Signature :									
Date & Time:									

ADMISSION SHEET

Registration Details :



Admission No : IP18-00036725

Admit Date : 02-Aug-2026

Admit Time : 10:01 PM UHID : GUC-00094615

Patient Details :

Patient Name : Ms DHATRI SREE

Guardian : MAHESH

Gender : Female

Occupation :

Address (H) : VINTAGE VISTA,NO:153,1ST FLOOR,05TH
STREET,ALS NAGAR,MADAMBAKKAM
Sithalapakkam Kanchipuram Tamil Nadu
INDIA 600126

Age : 10 Y 5 M 22 D

DOB : 11-02-2016

Religion :

Marital Status :

Phone No : 9000100722/ 9000100733

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 : MAHESH

Relationship : Father

Contact Address : VINTAGE VISTA,NO:153,1ST FLOOR,05TH
STREET,ALS NAGAR,MADAMBAKKAM
Sithalapakkam Kanchipuram Tamil Nadu INDIA
600126

Phone No : 9000100722



Signature

Doctor Details :

Doctor Name : Dr. NATARAJ PALANIAPPAN

Specialisation : PEDIATRIC INTENSIVE CARE

Referral Doctor : self

Phone No :

Co-Consultant :

Payment Details :

Payment Mode : DC/CC Card

Deposit Amount : 5000.00

Payor Name : SELF PAY

GENERAL CONSENT FOR TREATMENT

Patient Name: Ms DHATRI SREE

Age : 10 Y 5 M 22 D

IP No: IP18-00036725

Sex: Female

Consultant: Dr. NATARAJ PALANIAPPAN

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 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 chance. 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:

[Signature]

Name: MDHBSIA

Relationship: FATHER

Date: 02/08/2026

Time: 10:01 PM

Witness Name: P. Thangaraj Selvan

Witness Signature: *[Signature]*

Patient Address:

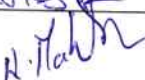
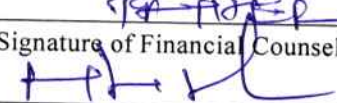
VINTAGE VISTA, NO:153, 1ST FLOOR,
05TH STREET, ALS NAGAR,
MADAMBAKKAM Sithalapakkam
Kanchipuram Tamil Nadu INDIA
600126

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 be applicable.
- ▶ 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 be 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 and 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 :	DHATRI SREE	UHID Number :	94605
Self/Attendant Name :	MDHARSH	Relation :	TPA ATTORNEY
Self/ Attendant Signature :		Name & Signature of Financial Counselor	
Phone Number :	94605		



It takes a lot to treat the little.

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name:

GUC-00094615

IP18-00036725

Ms DHATRI SREE

11-02-2016

10 Y 5 M 22 D

(F)

Dr. NATARAJ PALANIAPPAN

UHID ID:



Department:

Consultant:



Pediatric Multiorgan History & Physical Examination

Name: _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

History of present illness:

C/O: insect bite on 2/8/20
around 8:30 PM

LIE:

Bite mark visible
NO bleeding
NO swelling

B/L LL pulses well felt
CRTL 3 sec



of any previous investigation or treatment)

Nil

Birth & Neonatal History:

LSCS (Em) / L.Tg / (CAB) MINICU

Family Chart



Birth & Socio Economic History:

About Father : _____

About Mother : _____

Any additional information : _____

Developmental History :

Immunization History :

uptodate under IAP schedule last vacin

9y4

Anthropometry :

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

Weight (kgs) 46.9kg (Centile _____)

On Examination :

Temperature : 98.4 F Pulse Rate : 75/min B.P. 97/66 (77) SPO2 98.1% RA

Resp.rate and type of breathing : 26/min

Rash _____

Lymphadenopathy _____

Oedema : _____

Allergies (if any): _____

Respiratory System :Inspection (any s/o distress) : (N)Air entry & breath sounds : ✓BSØAny addes sounds : (=)

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

Cardiovascular System :Inspection of procordium : (N)Heart Sounds : S. S. ØAny murmur : (=)

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

Per Abdomen :Inspection : (N)Palpation : S Ø ØAusculation : BS ØSpine : (N) External Genitalia : (N)

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

Central Nervous System :Level of Consciousness : AVPU/GCS score : Aw / 15/15

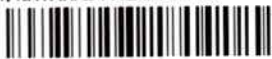
Cranial Nerves : _____

Motor System :Nutriton : (N)Tone : (N) Power (N)

Co-ordinator : _____

Posture : _____

Involuntary Movements : (=)



Re

DTR



Superficials:

Plantars

Sensory System :

Bladder / Bowel :

Clinical Summary & Diagnostic:

Acc. Insect bite / suspected Snake Bite

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

Desired goals of the treatment :

Planned Labs:

CBC ✓
SGOT ✓
SGPT ✓
Coagulation profile ✓
Blood grouping ✓

Planned Management

T. Cetizine 0.5mg
T. Paracetamol 500mg
once daily

Signature of the Doctor: C. D. G. Pan

Name of the Doctor: C. D. G. Pan

Date & Time: 2/8/26 at 10:45 AM

Signature of the Consultant:

Name of the Consultant:

Date & Time:

(P.T.O.)

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:



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/8/16 1:45AM	SIB BY DEGPAT	
	Agm. Insect bite	
	? Suspected Snake bite	
	Child reviewed	
	Child has no new concerns	
	OIC:	
	Alert, afebrile	
	CVS: S, S, @	
	Rx: VBS @	
	PCA: Sept	
	CNP: nFND	
	Lie:	
	Bite mark seen	
	mild redness	
		→ Continue apnea test
		→ TO monitor for vitals
		wound dressing / sewing
		Gd
		1/2mg

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/8/26 9am	8/8 Dr. Nalini <u>Insect bite ? Cause</u> no signs of local or systemic envenomation by 1-2pm to discharge Review in 4d on 4 Wednesday	<u>Globe eye</u> 8/8/8
3/8/26 9.15am	8/8 Dr. Gayathri Δ: Insect bite (Not witnessed) (? cause) H/o some insect bite / ? snake bite at 7pm (2/8/26) around warehouse in (R) Ankle. child developed localised swelling & mild redness not tender but bite mark present	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	No sign of bleeding	
	fatigue	
	muscle pain	
	paralysis	
	breathing difficulty	
	prosis	
	hemodynamically stable	
	BP - 100/60 mmHg	
	INR - 1.00 1.07	
	PT - 15	
	APTT - 37.8	
	n/e: CVS: S₁S₂ ⊕ No murmurs RS: B/L AE ⊕ NVBS ⊕ Abd: soft, not tender CNS: No FND No paralysis No pain	
	L/E: (R) Ankle,	
	Bite mark present over the (R) Ankle No redness Mild swelling ⊕	

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	Plan.	
	① T. Cetzine 5mg HS.	
	② Monitor vitals.	
	③ w/t signs of envenomation	
	Cut	
	12/17/19	
	Dr. Gagnier	



MEDICATION RECONCILIATION FORM

Drug Allergies: NIL ☒ 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: ICU Shifted to: ICU

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: C. A.

Date & Time: 2/8/20

Nurse Name & Signature: Preetha

Date & Time: 2/8/20 @ 10pm

100	100
90	90
80	80
70	70
60	60
50	50
40	40
30	30
20	20
10	10
0	0

100
 90
 80
 70
 60
 50
 40
 30
 20
 10
 0



DRUG CHART

Date of Admission: Drug Allergies: ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

- GENERAL** - Ensure that all patient details are entered above. ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.
- DOCTOR** - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
 - Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
 - Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
 - Discontinue a drug by drawing a line **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 : T. Pilsong				Date Time	3/8														
Dose	Route	Frequency	Start Date		12AM	SM	VA												
Doctor's Signature		Valid Period	Pharm.																
Additional Instructions:																			
Once in bow if pain																			

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

Weight. 46.9 kg Ward. 701

Page: 2/4

Patient Sticker

Weight. 46.9 Ward. 707

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

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

STAT / ONCE ONLY DRUGS[illegible]

VERIFIED BY : Name Signature

Patient Sticker

I.V. FLUIDS CHART

Weight. 46.9 kg. Ward.

[illegible]

Signature:

VERIFIED BY : Name :

GUC-00094615 IP18-00036725
 Ms DHATRI SREE
 11-02-2016 10 Y 5 M 22 D (F)
 Dr. NATARAJ PALANIAPPAN



RESULT SHEET

Date	21/8/20				
Time					
Hb	12.1				
PCV	35				
RBC	4.29				
WBC	8,130				
N/L	43/146				
Platelets	3,28,000				
CRP					
ESR					
PCT					
RBS					
Na					
K					
Cl					
Ca/Mg					
Phosphate					
Urea					
Creatinine					
ALP					
SGPT	15				
SGOT	22				
T.Bill/Conj					
T.Protein					
S.Albumin					
S.Globulin					
A/G Ratio					
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR	15.0/1.07				
APTT	37.8				
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 :

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Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI :

 Others (ECG, Contrast Studies etc.) :



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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: <u>28/2/20</u>	Time: <u>11PM</u>	<u>4AM</u>
Doctor / Nurse / Family Concern?		
Temperature (°F)		
Heart Rate (bpm) and Blood Pressure (mmHg) *		
Note: BP does not score in early warning scoring		
Heart Rate (Number)		
Resp. Rate (bpm) (Over 1 Minute) *		
Resp Rate (Number)		
Resp Mod/ Severe Distress None / Mild		
Receiving O ₂ (l/min) O ₂ Saturations (%)		
Conscious Level Normal / Altered		
GCS *		
TOTAL SCORE		
Number of shaded boxes		
Pain Score		
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.

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)

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.

Date		Time	Nature of Fluid	Intake Route			Output					IV Site Thrombophlebitis Score	Sign. Nurse
				Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
2/8/26		08:00 am											
		09:00 am											
		10:00 am											
		11:00 am											
		12:00 pm											
		01:00 pm											
Total Intake :							Total Output :						
		02:00 pm											
		03:00 pm											
		04:00 pm											
		05:00 pm											
		06:00 pm											
		07:00 pm											
Total Intake :							Total Output :						
		08:00 pm											
		09:00 pm											
		10:00 pm											
		11:00 pm											
		12:00 am											
		01:00 am	iso	200ml								0	bst
Total Intake : 200ml							Total Output : 100ml						
		02:00 am										0	bst
		03:00 am	iso	100ml								0	bst
		04:00 am										0	bst
		05:00 am	iso	200ml								0	bst
		06:00 am										0	bst
		07:00 am	iso	100ml								0	bst
Total Intake : 400ml							Total Output : 200ml						
Total 24 hrs. Intake		600ml											
Total 24 hrs. Output		300ml motion-Nil											

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The following table shows the number of students who appeared for the examination in the year 2020. The number of students who appeared for the examination in the year 2020 is 100. The number of students who appeared for the examination in the year 2020 is 100.

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The following table shows the number of students who appeared for the examination in the year 2020. The number of students who appeared for the examination in the year 2020 is 100. The number of students who appeared for the examination in the year 2020 is 100.

NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
	Surgery / Procedure:		Post OP Day:					
BACKGROUND	Date	Shift						
	Medical Condition (Any special condition to be noted):							
	Diet:							
ASSESSMENT	Allergy:		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Ventilation (RA, NP, NIV, VENTI):							
	Tubes/Drains/Catheter:		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs:		Temp:					
			Res:					
			SpO ₂ :					
			Pulse:					
			BP:					
			LOC:					
			Fall Risk Score:					
		Pain Score:						
		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):								
Post Operative Procedure Special Orders:								
Handed Over By Name :								
Signature / ID :								
Date:								
Time:								
Taken Over By Name :								
Signature / ID :								
Date:								
Time:								



WORKING SHEET

Continuation

1980-1981

Approximate

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Patient Sticker

NURSING CARE RECORD

Date:

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon							
Night							

Patient Sticker

NURSING CARE RECORD



Date:

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon							
Night							



THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	2/8	3/8			
	3 to less than 7 years old	3					
	7 to less than 13 years old	2	2	2			
	13 years old and above	1					
Gender	Male	2					
	Female	1	1	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			
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own ability	1	1	1			
	History of Falls or Infant-Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2					
	Outpatient Area	1	1	1			
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	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					
Total			8	8			

Intervention:

-Fall Risk: Low Humpty Dumpty Score = 7-11,

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		✓	✓			
Call device within reach		✓	✓			
Wheels Locked		✓	✓			
Room free of clutter		✓	✓			
Adequate lighting		✓	✓			
Wheel chair support		X	NA			
Other Intervention(s) Specify		X	NA			
Nurse's Name:		Smey	SH			
Signature:		SH	DEPSE			
Date:		3/8	3/8			
Time:		12M	8PM			

Patient Sticker

THE HUMPTY DUMPTY SCALE

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

Intervention:

-Fall Risk: Low Humpty Dumpty Score = 7-11,

High Risk Humpty Dumpty Score = 12 or above

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

NATIONAL BIRTH AND DEATH REGISTRATION AND VITAL STATISTICS ACT, 1969

PART I - GENERAL INFORMATION		PART II - DETAILS OF THE EVENT		PART III - SIGNATURES	
Sl. No.	Name of the Person	Date of Birth	Place of Birth	Signature of the Registrar	Signature of the Informant
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①

PAIN ASSESSMENT FORM

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
3/8/26	12Am	0/10	NPL	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NPL	Smooth 6/25/26
3/8/26	8am	0/10	NPL	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NPL	Smooth 6/25/26
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

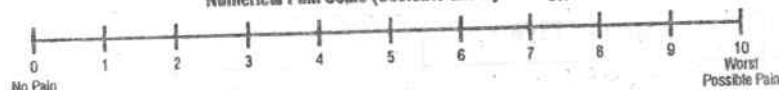
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 - 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
	0	1	2
Face	No Particular expression or smile	Occasional Grimace or Frown, withdraw, Disoriented	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs drawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, rigid, or Jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams or sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

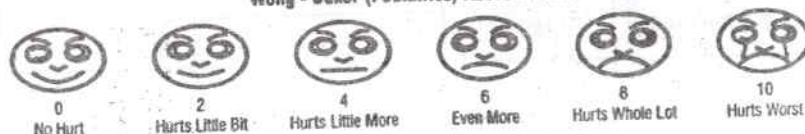
Numerical Pain Scale (Obstetric and Gynecology)



Neonatal Pain, Agitation and Sedation Scale (upto 1 Month)

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not Irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR RR, BP, SaO ₂	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO ₂ 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

Wong - Baker (Pediatrics) Above 7 Years



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

1. Every eight hours for all hospitalized patients.

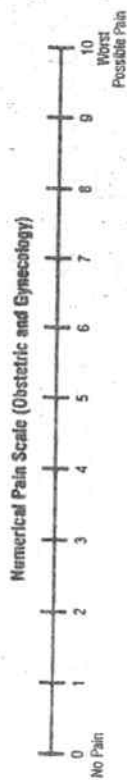
2. For post-surgical patients, patients with chronic pain, patient with severe pain:

- | | |
|--|---|
| a) At least every 2 hours for the first 24 hours | b) Then every 4 hours. |
| c) Prior to pain relieving intervention. | d) Within 30 - 60 minutes after pain relief intervention. |

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
	0	1	2
Face	No Particular expression or smile	Occasional Grimace or Frown, withdrawn, Disoriented	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs drawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, rigid, or Jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams of sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort



Neonatal Pain, Agitation and Sedation Scale (upto 1 Month)

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Archng, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR, RR, Sp, SaO ₂	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO ₂ 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

Wong - Baker (Pediatrics) Above 7 Years





BRADEN 'Q' SCALE

		Date : 2/8/18 Time : N Y	
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance. 2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently. 3. Slightly limited: Makes frequent through slight changes in body or extremity position independently. 4. No limitations: Makes major and frequent changes in position without assistance.	4	4
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
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
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
FRICION-SHEAR Friction. Occurs when skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction. 2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. 3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down. 4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times.	4	4
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 of 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 meat and dairy products. Occasionally eats between meals. Does not require supplementation.	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
TOTAL SCORE		24	24
Evaluator's Name		Shilpa	Shilpa

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

Patient ID

BRADEN 'Q' SCALE

					Date :				
					Time :				
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					TOTAL SCORE				
					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

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PHLEBITIS ASSESSMENT

CANNULA 1

Date: 2/8/26 Time: 10pm

Location:  metacarpal

Size : 224

Cannula inserted by: o/w Dr. Sumanth C.

[illegible]

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

Patient's Name:.....

MRD NO

GUC-00094615

IP18-00036725

Ms DHATRI SREE

11-02-2016

10 Y 5 M 22 D

(F)

Dr. NATARAJ PALANIAPPAN

Age :.....

Sex: ☐ M ☐ F

Consultant :

CANNULA 2

Date :

Time:

Location :

Size :

Cannula inserted by :

[illegible]

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 :

CANNULA 4

Date :

Time:

Location :

Size :

Cannula inserted by :

[illegible]

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

[illegible]

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



1

WELL'S CRITERIA FOR ASSESSING DVT

NOTE: Assign a score of 1 if 'YES' in parameter 1 to 9 and Assign a score of -2 if 'YES' in parameter No 10

S.No	Assessment Criteria	Score	Date:	Date:	Date:	Date:	Date:	Date:
			Time:	Time:	Time:	Time:	Time:	Time:
			N	M				
1	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)	1	0	0				
2	Bedridden recently >3 days or major surgery within four weeks	1	0	0				
3	Calf swelling >3cm compared with asymptomatic side, measured at 10 cm below tibial tubercle (Assess for both legs)	1	0	0				
4	Collateral (non varicose) superficial veins present (Assess for both legs)	1	0	0				
5	Entire leg swollen (Assess for both legs)	1	0	0				
6	Localized tenderness along the deep venous system (Assess for both legs)	1	0	0				
7	Pitting edema, greater in the symptomatic leg (Assess for both legs)	1	0	0				
8	Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs)	1	0	0				
9	Previously documented DVT (Assess for both legs)	1	0	0				
10	Alternative diagnosis to DVT as likely or more likely (Assess for both legs)/ Co-morbidity like ESLD /Renal disease, Renal failure, CCF Cellulitis (commonly mistaken as DVT), Dependent (stasis) oedema, Lymphatic obstruction.	-2	0	0				
Total Score			0	0				
Signature of the Nurse			Sindhu	60932				

Intervention: _____

High Risk = >2 Score

Moderate Risk = 1-2 Score

Low Risk = <1 Score

Note : Daily assessment shall be carried out once every 24 hours and documented



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 | Plan | 6. Discharge Medication | 10. Fall Risk Education |
| 2. Treatment and Care | 3. Pain Management | 7. Infection Control Measures | 11. Safe use of Medical Equipment / Implantable Devices Safety |
| | 4. Informed Consent | 8. Diagnostic Test / Procedures | 12. Patient's / Family Rights |
| | 5. Medication / Therapy (safety, effects/ side effect, interactions) | 9. Nutrition / Diet | 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		
3/8/16	8pm	Yes	Explain about pain management	mother	no	oral	none	verbal	Good	S. Srinivasan

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	4. Language Barrier	7. Impaired Thought Process/Cognitive limitations		10. Financial Difficulties		13. Cultural/Religion Practice			
2. Physical Impairment	5. Educational Level	8. Responsibilities at Home		11. Beliefs and Values		14. Others (Specify)			
3. Emotional Barriers	6. Desire / Motivate to Learn	9. Cultural Differences		12. Impaired Vision/ or Hearing					
Teaching Tools Used:		A: Audio	D: Demonstration	V: Video	O: Oral	P: Printed			
Mechanism/s to overcome barrier/s:									
1. None	3. Reassurance & Support	5. Respect values & beliefs		7. Other, Specify					
2. Obtain translator	4. Teach Family / Others	6. Respect Cultural / Religion Preference							
Understanding:									
1. Verbalizes Understanding	2. Demonstrates Understanding	3. Needs Review							

For use only by the patient

Patient Information		Visit Information		Referral Information		Insurance Information		Signature	
Name	DOB	Visit Date	Visit Time	Referral Date	Referral Time	Insurance Type	Insurance ID	Physician Signature	Patient Signature
John Doe	12/12/1980	01/15/2024	10:00 AM	01/15/2024	10:00 AM	Blue Cross	123456789	[Signature]	[Signature]
Chief Complaint: [Blank] History of Present Illness: [Blank] Past Medical History: [Blank] Social History: [Blank] Family History: [Blank] Review of Systems: [Blank] Physical Examination: [Blank] Vital Signs: [Blank] Diagnosis: [Blank] Plan: [Blank] Follow-up: [Blank]									



General Admission Assessment Form For Pediatrics

Diagnosis:

 Arrival Time: 11 PM Mode of Arrival: Walked Admitting From: ☒ ER ☐ OPD ☐ Direct

 Allergy / Adverse Reaction: N/A Body Weight: 46.9 Kg

 Height: - cm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
<u>N/A</u>	<u>N/A</u>	<u>N/A</u>

 Family History: N/A

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

 If yes please list, N/A

 Was the child's birth normal? ☒ Yes ☐ No If No, please describe problems: N/A

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

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

 Observations: Weight: 46.9 Length: - Head Circumference (< 2 years): -

 Temp.: 98.1°F HR: 100b/min RR: 26b/min BP: 100/62mmHg

 Pain Score: 0 Specify Site: N/A (Follow Pain Assessment Sheet & Document)

 Fall Risk Assessment: ☒ Yes ☐ No Score: 0 (Document in the Humpty Dumpty Sheet)

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

 Pain Screening: ☒ Yes ☐ No If Yes, Pain Score: 0 Pain Tool Used: ☐ N Pass ☒ FLACC ☐ Wong Baker

 Character of Pain: - Location: - Frequency: - Duration: -

 FUNCTIONAL SCREENING: ☒ No Abnormalities Detected

☐ Mobility Problem

☐ Walking Problem

☐ Developmental Delay

☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

 NUTRITIONAL SCREENING: ☒ No Abnormalities Detected

☐ Underweight

☐ Overweight

☐ Special Feeding Method

☐ Feeding Problem

☐ Special diet

☐ No Abnormality Detected

Inform consultant for positive criteria

Psychological Screening: ☐ No Significant Findings

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

If Yes Consultant Notified: (Date/Time): 3/8/26 at 12am

Social History: Lives With

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: S. madhuvilla Date: 3/8/26 Time: 12Am

Signature Sul
607303

NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date: 02/8/26 Time of arrival: 9:30pm
Chief Complaints: clo. insect bites RBS: —
Height: — Weight: 46.9 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?) 10

Time of Initial assessment completed by ER Nurse: 9:40pm

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

Time	Nursing Notes
9:30pm	child come for ER. Insect bites. child conscious & oriented. Vitals checked & Koronas Vitals stable. Dr. Deepak sir to discuss about Dr. Nataraj to admission further beyond. Dr. placement done. Sample send to lab. child shifted to ward

Samples collected by: S/n. Suganthi.

Time: 9:32pm

Samples sent by: O/n. Subhik

Time: 9:10pm

Medication given in ER:

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

Condition of patient at time of shift - out :	Details of Shift - out
HR: 75b/min BP: CFT: 1250cc RR: 24b/min SPO ₂ : 100% GCS: 15/15 Temperature: 97.5°F Pain Score: 0 Repeat RBS (if applicable): Nil	Shift - out from ER to: 707 Time of Shift - out: 11pm Handover given to: S/n. Madhuvitha (Nurse's Name)

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any): ☒ metacarpal 2007.

Name of the Nurse : _____ Signature of the Nurse : _____

Date & Time : 2/8/26 @ 10pm



PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : C. Deppan

Date :

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

Start Time of Assessment:

Weight: 14.6 kg

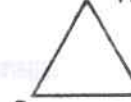
Allergic History: G

Chief Complaints:

c/o: insect bite

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: SpO₂ on FiO₂ 98% on RA
 Rhythm:
 Retractions: ☐ Suprasternal ☐ ICR ☐ SCR
 ☐ Sternal ☐ Supraclavicular ☐ Nasal Flaring
 Respiratory Noises: ☐ Stridor ☐ Wheezing ☐ Grunting
 Air Entry: BAE ⊕
 Palpation Findings (if necessary):

Any urgent interventions needed: ☐ Yes ☒ No
 If Yes

 Circulation	HR: <u>75/min</u>	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: <u>15/15</u>	AVPU: <u>Alert</u>	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.: <u>98.4</u>	Any Rash: ☐ Yes ☐ No, If yes describe the rash Active bleed Lacerations ☐ Abrasions ☐ bruises ☐ Describe:
Any urgent interventions needed: ☐ Yes ☒ No If Yes		

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

 ☐ Shock - Compensated ☐ Hypotensive ☐

 ☐ Cardiopulmonary Arrest
 ☒ Hemodynamically Stable

Secondary Assessment: Head to toe examination with positive findings:

Labs Planned:	Treatment Planned:
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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. DEEPAN
 Signature: [Signature]
 Date & Time: 21/8/26 9:00M

Sr. Doctor on Duty (If necessary)
 Name of the Sr. Doctor:
 Signature:
 Date & Time:

wt - 46.9 kg

EMERGENCY ROOM TRIAGE FORM

Patient's Name : DHATRI SREE Age : 10Y Gender: ☐ Male ☒ Female
Date : 2/8/26 Time of Arrival : 9.30pm
Allergies: ☒ No ☐ Yes ☐ Food ☐ Medications ☐ Blood Transfusion ☐ Other (Specify): - ☐ Not known
Source of Information : ☒ Parents ☐ Others (Specify) -
Mode of Arrival : ☒ Ambulatory ☐ Wheelchair ☐ Ambulance
Initial Vital Signs: Temp: 97.5° PR: 75 BP: 97/66(77) RR: 22b/m SpO₂: 100% P/A
Chief Complaints: c/o insect bites.

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

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: Misra
Triage Completion Time : 2m

Communicable Disease Triage Screening

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

- Have you had fever (elevated temperature) in the past 2 weeks ☐ Yes ☒ No
- Have you had cough or a rash in the past 2 weeks ☐ Yes ☒ No
- 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

- 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: -
- 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 : Subhadip

Signature of Triage Nurse : [Signature]

Date & Time : 2/8/26 @ 9.32pm

PATIENT TRANSFER FORM

GUC-00094615
Ms DHATRI SREE
11-02-2016 10 Y 5 M 22 D (F)
Dr. NATARAJ PALANIAPPAN


IP18-00036725

Date & Time of Admission <i>2/8/20 @ 10:01pm</i>		Date & Time of Transfer Order <i>2/8/20 @ 11pm</i>
Treating Consultant Name <i>Dr. Nataraj</i>	Transfer Ordered by <i>Dr. Deepak</i>	Reason for Transfer <i>febrile rigors</i>
From Unit <i>ER</i>	To Unit <i>ICU</i>	Information to Attendant Yes ☒ No ☐
Number of Sheets in Clinical File <i>(10)</i>	Number of Imaging Films <i>—</i>	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☐ If yes, what ?
Medications / Consumables / Surgicals / Hand over		
Sl.No.	Item Name	Quantity
1.		
2.		
3.		
4.		
5.		
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐ <i>Doc. Insect bite</i>		
Name & Signature of Person who is Transferring <i>[Signature]</i> <i>08275</i>		Name of Person Ordered Transfer <i>C. DEEPAN</i>
Patient & Clinical Records Received by : <i>Simeonmiller</i> <i>602373</i>		
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



PATIENT TRIAL

Patient Name	Age	Sex	Referral Source
John Doe	25	M	Dr. Smith
Room No.	101	Ward	ICU
Admission Date	10/1/20	Time	10:00 AM
Physician	Dr. Smith	Nurse	Ms. Jones
Diagnosis	Myocardial Infarction		
Treatment	Aspirin, Beta-blockers, ACE inhibitors		
Prognosis	Good		
Follow-up	1 week		
Discharge Date	10/8/20	Time	10:00 AM
Discharge Location	Home		
Discharge Instructions	Take medications as prescribed, rest, and follow-up in 1 week.		
Physician Signature	Dr. Smith		
Nurse Signature	Ms. Jones		
Pharmacist Signature	Mr. Brown		
Other			



RBS CHART

[illegible]

10/10/11

1

11

12

13

14

IP18-00036725

11-02-2016 10 Y 5 M 22 D (F)

Dr. NATARAJ PALANIAPPAN

Docl



DOCTOR'S SHIFT CHANGE HANDOVER FORM



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



BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Date:

Department:

Shift:

[illegible]

