Rainbow Children's Hospital

GUC-00077195 IP18-00036738
Baby B/O PRIYANKA SHARWAN
04-04-2025 1 Y 3 M 30 D (M)
Dr. VAISHNAVI CHANDRAMOHAN

DISCHARGE TRACKING SHEET

NAME OF CONSULTANT-

ACTIVITY	INTIME	OUT TIME	NAME & SIGNATURE	REMARKS	<To be filled by Admin>		
Activity Sheet update by Nursing	4/8/26 8AM		4/8/26				
Activity Sheet update by Pharmacy							

ACTIVITY RECORD FOR BILLING

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Your Right to a Safe Delivery

Name: ... GUC-00077195 IP18-00036738
Baby B/O PRIYANKA SHARWAN
04-04-2025 1 Y 3 M 30 D (M)
Dr. VAISHNAVI CHANDRAMOHAN

UHID No: .....

Consultant: ..... Dept: .....

Date of A... ...me: ..... Date of Discharge: ..... Time: .....

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
3/8/26	4:10PM	ER	615	

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
3/8	CBC, CRP. RP₂	26024807	[signature]

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
3/8/26	Infusion pump	9.30 pm	04/08/26 at 11AM	1736716.	[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
3/8	IV Placement	1	1736642	

ANY OTHER INFORMATION:

.....

.....

.....

.....

.....

.....

.....

Date: 04.08.24 Time: 8A.M Prepared By: .....

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
	6th floor.		

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DISCHARGE TRACKING SHEET

UHID- FLOOR- NAME OF CONSULTANT-

6th floor

ACTIVITY	TIME		NAME & SIGNATURE	REMARKS	<To be filled by Admin>
Discharge Announcement	4/7/26 at 10.00 am				
	INTIME	OUT TIME			
Arrangement of File by Nursing	4/7/26	10.00 am	Sonaji		
Preparation of Discharge Summary					
Finalization of discharge summary					
Transfer of file from Ward to Billing Dept					
Bill Processing					
Audit Clearance					
Billing Clearance					
Physical Clearance					

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BED SIDE CHECK LIST FOR NURSES

Date:	3/8								
Doctor's Orders	yes								
Carried out or not	Yes								
Bed Side									
Structured Handover done	✓								
IV Site	✓								
Central Lines	X								
Arterial Lines	X								
Feeding Catheter	X								
Urinary Catheter	X								
Skin Care	✓								
Eye Care	✓								
Mouth Care	✓								
Sterillum Bottle, Stethoscope	✓								
Suction Bottle (Should be clean & empty)	✓								
Intubation Tray	X								
Emergency Tray (Loaded Syringes with Midazolam & Vecuronium and Flush) Ampoules of Adrenaline	X								
Ventilator Tubing,(Any Water, Blood)	X								
Humidification	✓								
Check all Infusion (Labelling,Correct Preparation)	✓								
Chest Physio & Neb	X								
Handed Over By Name :	Praveen								
Signature :									
Date & Time:	3/8/26 8 pm								
Hand Over Taken By Name :	Anupriya								
Signature :									
Date & Time:	3/8/26 8 pm								

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 : IP18-00036738 **Admit Date** : 03-Aug-2026 **Admit Time** : 03:04 PM **UHID** : GUC-00077195

Patient Details :

Patient Name : Baby B/O PRIYANKA SHARWAN
Guardian : Mr AZHAR ALI
Gender : Male
Occupation :
Address (H) : 220, B WING SIS SYMPHONY DASARAHALLI AMRUTHAHALLI Hebbal Agricultural Farm Bangalore Karnataka INDIA 560024

Age : 1 Y 3 M 30 D
DOB : 04-04-2025 04:40 PM
Religion :
Martial Status :
Phone No : 9326142318
E-mail : priyanka.shanwan@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 AZHAR ALI **Relationship** : Father
Contact Address : 220, B WING SIS SYMPHONY DASARAHALLI AMRUTHAHALLI Hebbal Agricultural Farm Bangalore Karnataka INDIA 560024 **Phone No** : 9326142318

Signature

Doctor Details :

Doctor Name : Dr. VAISHNAVI CHANDRAMOHAN **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
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GENERAL CONSENT FOR TREATMENT

Patient Name:	**Baby B/O PRIYANKA SHARWAN**	**Age :**	**1 Y 3 M 30 D**
IP No:	**IP18-00036738**	**Sex:**	**Male**
Consultant:	**Dr. VAISHNAVI CHANDRAMOHAN**	**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 care of the patient.

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

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

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

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

3 IP Guide book has been given to me and I have been explained about the Hospitals rules and policies.
4 Financial and billing counseling has been done to me.

Signature of Patient/Relative:

Name: Mr. Azhar Ali
Relationship: father
Date: 03/08/2026 Time: 03:04PM
Wittness Name: A. Sivasankari
Wittness Signature:

Patient Address:
220, B WING SIS SYMPHONY
DASARAHALLI AMRUTHAHALLI Hebbal
Agricultural Farm Bangalore
Karnataka INDIA 560024

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BILLING POLICY

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

Patient attendant can collect for Interim/provisional bill of the patient from the billing section on daily basis. Interim Bill shall be based on the acknowledged services in HIS. Final Bill of the patient may vary from the Interim bill based on actual update taken on the day of discharge. It is requested that patients/attendants enquire daily about the bill amount from billing section and pay the outstanding as on that day. You are requested to clear your outstanding amount on daily basis before 12 PM. **Patient bill outstanding should not be increase more than 10,000/-**

DECLARATION

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

Patient Name : RUMI RAAYAN	UHID Number : GUC-000 77195
Self/Attendant Name : AZHAR ALI M	Relation : FATHER
Self/ Attendant Signature : Phone Number : 9989098215	Name & Signature of Financial Counselor

RCH/GDY/FRM/CLINICAL/426

[redacted]

भारत सरकार
आधार

భారత ప్రభుత్వం
Government of India

భారత విశిష్ట గుర్తింపు ప్రాధికార సంస్థ
Unique Identification Authority of India

ఎన్రోల్మెంట్/ Enrolment No.: 2017/78029/60731

To
Mushtaq Ahmed Azhar Ali
S/O: Mushtaq Ahmed
311,Block-A Jewel Garden
Miyapur
Behind Andhra Bank
Miyapur
Miyapur
Hyderabad Telangana - 500049
[illegible]

మీ ఆధార్ సంఖ్య / Your Aadhaar No. :

3879 9224 6029

VID : 9199 1032 4351 4978

నా ఆధార్, నా గుర్తింపు

AADHAAR

INFORMATION

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

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

Government of India

Mushtaq Ahmed Azhar Ali
DOB: 19/11/1988
MALE

3879 9224 6029

VID : 9199 1032 4351 4978

నా ఆధార్, నా గుర్తింపు

Unique Identification Authority of India

Address:
S/O: Mushtaq Ahmed, 311,Block-A Jewel Garden, Miyapur, Behind Andhra Bank, Miyapur, Hyderabad, Telangana - 500049

3879 9224 6029

VID : 9199 1032 4351 4978

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

[redacted]

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Hospital
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PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: GUC-00077195 IP18-00036738
Baby B/O PRIYANKA SHARWAN
04-04-2025 1 Y 3 M 30 D (M)
Dr. VAISHNAVI CHANDRAMOHAN

UHID ID:

Department:

Consultant:

(P.T.O.)

Patient Sticker

Pediatric Multiorgan History & Physical Examination

Name: B/o priyanka sharvan. Age/Sex

Information given by: Relationship

Chief Presenting Complaints & Duration (Chronologically) - c/o vomitings x2days ago
- c/o fever x 2 days.
- c/o decreased intake of Sal foods.

History of present illness :

The child was apparently Normal 2 days ago. present illness started as vomitings 2 days ago. non projectile, non Bilious associated with food particle. was brought to ER treated and sent home following which he had fever, vomit continuous in nature, Not associated with rash/chills/rigors, max temperature recorded was

→ c/o decreased intake of Sal foods & dullness.
→ No c/o loose stools
→ NO c/o cold/cough
→ NO c/o decreased urine output.

Patient Sticker

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

→ was treated for vomitings 2 days ago in ER.

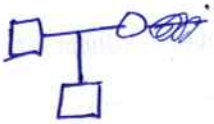
→ H/o Circumcision 1 week ago.

Birth & Neonatal History:

PT / NVD / LBN / BW - 1.675g /

NICU graduate (13 days).

Family Chart



Birth & Socio Economic History:

About Father : ~~NAD~~

About Mother :

Any additional Information :

Developmental History : - Normal.

Immunization History : Immunized as per IAP (Last Vaccine ~~18th~~ age).

Anthropometry :

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

Weight (kgs) ~~7.45~~ (Centile _____)

On Examination :

Temperature : 97.3F Pulse Rate : 132 B.P. _____ SPO2 98%

Resp.rate and type of breathing :

Rash Mosquito bites on BOth Legs

Lymphadenopathy

Oedema : –

Allergies (if any): –

(P.T.O.)

Patient Sticker

Respiratory System :

Inspection (any s/o distress) :

Air entry & breath sounds : B/L AE (+)

Any addes sounds : NO added sound.

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

Cardiovascular System :

Inspection of procordium :

Heart Sounds : S1, S2 (+)

Any murmur : (-)

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

Per Abdomen :

Inspection :

Palpation : Soft, No dganomegaly.

Ausculation : BS (+).

Spine : (N). External Genitelia :

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

Central Nervous System :

Level of Consciousness : AVPU/GCS score : GCS

Cranial Nerves :

Motor System :

Nutriton :

Tone: (N) Power 5/5 in all 4 limbs.

Co-ordinator :

Posture :

Involuntary Movements :

Patient Sticker

Reflexes :

DTR

Plantars

Superficials:

Sensory System :

Bladder / Bowel :

Clinical Summary & Diagnostic: Viral illness.

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

Desired goals of the treatment :

Planned Labs:

CBP
CRP
RP-2.
Sample preserved plain

Planned Management

-> As charted.

Signature of the Doctor:

Name of the Doctor: M. Navya

Date & Time: 31/8/26, 6:00PM

Signature of the Consultant:

Name of the Consultant: Dr. Vaishnavi

Date & Time: 31/8/26 - 6pm

(P.T.O.)

Patient Sticker

DISCHARGE PLANNING FORM

NOTE: * To be completed by a Doctor within (24) hours of admission.

1. Anticipated Date of Discharge: .....

2. Destination Post Discharge: ☐ Home

   Family Members Notified (Person Contacted)

   ☐ Transfer

   Hospital Facility Notified (Person Contacted)

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

   ☐ Needs Assistance In:

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

4. Nutritional Plan:

   ☐ Dietary Instruction Discussed with the:

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

5. Discharge Planning Discussed with the:

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

6. Patient/Family Educational Plan:

   ☐ Educational Topic/s: .....

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

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

Doctor Signature: .....

Doctor Name: .....

Date and Time: .....

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Baby B/O PRIYANKA SHARWAN
04-04-2025 1 Y 3 M 30 D (M)
Dr. VAISHNAVI CHANDRAMOHAN

B/O PRIYANKA SHARWAN 1yr 3M

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RESULT SHEET

Date	3/8/26					
Time						
Hb	13.1					
PCV	38					
RBC	5.15					
WBC	7750					
N/L						
Platelets	3.61					
CRP	19					
ESR						
PCT						
RBS	68					
Na	133					
K	4.6					
Cl	101					
Ca/Mg Ical / Biolab	1.17 / 17					
Phosphate						
Urea	17					
Creatinine	0.30					
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						

(P.T.O)

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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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/8/26 5.5pm	S/B Dr. Vaishnavi	
	No fever	
	Labs s/o dehydration	
	Ex: Afebrile	
		Tired but better than earlier
		Abd: soft
		Adv: - RL correction 300 ml over 4 hrs
		Vaishnavi
4/8/26 9am	S/B Dr. Gayathri	
	A - Acute Gastritis c̄ some dehydration.	
	child reviewed	
	concern: . Irritability (+) (d/t abdomen pain) . passage of flatus frequently (foul smelling) . abdomen	
	. No fever . No vomiting	

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

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	· No loose stools	
	· vitals - stable	
	· peripheries - warm	
	· PPWF (+). CRT < 2sec.	
	O/E : child asleep	
	CVS / RS — NAD.	
	Abd - soft, gaseous. no distension no OM.	
	CNS : NO FND	
	Plan	
	1) Cont IVF 0.9% DNS 30 ml/hr.	
	2) cont IV pan / iv emeset	
	3) I/O charting	
	4) Monitor vitals.	
	5) USG Abdomen - sos.	
	6) syp. Aristozyme · 3.5ml - 0 - 3.5ml. ×3 days	
	[signature]	

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

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04-04-2025 1 Y 3 M 30 D (M)
Dr. VAISHNAVI CHANDRAMOHAN

Weight. 7.45 Ward. 6th

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
4/8	9.20am	Inj pan	1 only	IV	L	Seen Disch

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

I.V. FLUIDS CHART

Weight. 7.45kg Ward. 6th Floor

		Composition of Fluid (If infusion, mention ml./hr = mg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
3/8	4.30pm	IVF. DNS @	IV	40ml/hr					
3/8	6 pm	Ringer Lactate 300ml over 4hr	IV	75		320ml	3/8/26 at 9.30 PM		
4/8		IVF 0.9% NS.	I.V	32ml/hr					

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

GUC-00077195 IP18-00036738
Baby B/O PRIYANKA SHARWAN
04-04-2025 1 Y 3 M 30 D (M)
Dr. VAISHNAVI CHANDRAMOHAN

(1)

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

PRESCHOOL (1-5 years)
Children's Observation & Early Warning Scoring Chart

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 3/8/26 Time:	4:30pm	8pm	12AM	4Am
Doctor / Nurse / Family Concern?				
Temperature (°F) (104–94)	97.6F	98.1°F	96.9F	96.8°F
Heart Rate (bpm) and Blood Pressure (mmHg) * (190–50). Note: BP does not score in early warning scoring				
Heart Rate (Number)	122bm	138bm	142bm	138 bm
Resp. Rate (bpm) (Over 1 Minute) * (70–10)				
Resp Rate (Number)	30bm	36bm	36bm	32bm
Resp Distress: Mod/ Severe / None / Mild	✓	✓	✓	✓
Receiving O_2 (l/min)		RA	RA	RA
O_2 Saturations (%)	98%	97%.	98%.	97%
Conscious Level: Normal / Altered	✓	✓	✓	✓
GCS *	15/15	15/15	15/15	15/15
TOTAL SCORE Number of shaded boxes	0	0	0	0
Pain Score	0	0	0	0
Observer's Initials	[illegible]	[illegible]	[illegible]	[illegible]

ACTIONS

NB: Scores 3 should be recorded overleaf

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

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

Patient Sticker

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

GUC-00077195 IP18-00036738
Baby B/O PRIYANKA SHARWAN
04-04-2025 1 Y 3 M 30 D (M)
Dr. VAISHNAVI CHANDRAMOHAN

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FLUID CHART

Sheet No. : 10

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.

3/8/26		Intake				Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						**Total Output :**						
	02:00 pm											
	03:00 pm	——				On receiving.			——			
	04:00 pm			40mL							0	RM
	05:00 pm	H_2O	10ml	40ml RL								
	06:00 pm	H_2O	30ml	75ml -			✓			✓	0	RM
	07:00 pm			75mL -								
Total Intake :			40ml + 230ml			**Total Output :**				4 - 1		
	08:00 pm	~~H2O~~	~~20ml~~	75 ml							0	RM
	09:00 pm			75ml								
	10:00 pm	~~H2O~~	20ml	DC						✓	0	RM
	11:00 pm	~~H2O~~	30ml	DNS 40ml								
	12:00 am			40ml							0	RM
	01:00 am			40ml								
Total Intake :		70ml	+ 270ml			**Total Output :**				1 time		
	02:00 am			40ml								
	03:00 am			40ml							0	RM
	04:00 am	RL Bag	20ml	40 ml								
	05:00 am			DC							0	RM
	06:00 am			DC								
	07:00 am	H_2O	50ml	DC						✓	0	RM
Total Intake :		70ml	+ 130ml			**Total Output :**				1 time		

Total 24 hrs. Intake	800 ml	Total 24 hrs. Output	3 time

GUC-00077195 IP18-00036738
Baby B/O PRIYANKA SHARWAN
04-04-2025 1 Y 3 M 30 D (M)
Dr. VAISHNAVI CHANDRAMOHAN

NURSES NOTES

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☑ No Known Drug Allergies

☐ Drug Allergies .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		On admission notes.	
3/8/26	4:10pm	Child Received from ER to 6th Floor. Child details hand overs taken from ER staff.	
		Child complaints of Fever, Vomiting, decreased oral intake	Paul Dr.
	4:30pm	Child Ex line Pattern is healthy and observed. Child Ex fluid 0.9% DNS 40ml/h. on flow	Paul Dr.
		Child vitals checked and Recorded. Vitals Normal	Paul Dr.
		Maintained Intake and Output Chart	Paul Dr.
	6pm	Dr. Vaishnavi seen the Child Advice given To change fluid Ex some correction Ex fluid - RL - 300ml over 5hr. 75ml/hr on flow.	Paul Dr.
	7pm	Maintained I/O chart.	
	7:30pm	Child vitals are handing over given to Night duty staff	Paul Dr.

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Patient Sticker

NURSES NOTES

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☐ No Known Drug Allergies
☐ Drug Allergies .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		Night duty Notes	
03/8/26	7:30pm	→ child detail hand over taken from evening duty SIN child conscious & oriented IV line @ IVF RL 300ml over 4hrs. 75 ml/hr. and DNS 40 ml/hr	Duty Dr
	8pm	→ child vital signs checked and record. vitals are stable 9pm RL comeed completed.	Duty Dr
	10pm	→ child due medication given as per order chart. IVF DNS 40ml/hr on flow	Duty Dr
4/8/26	12AM	→ child vitals are stable	Duty Dr
		IVF @ DNS @ 80ml/hr. No Vomiting new other complaints.	
	2AM	→ child sleeping well. no other complaints. IV line is checked & healthy	Duty Dr
	4pm	→ child vital signs checked and record. vitals are stable	Duty Dr
	6AM	→ child due medication given as per order chart R/O chart maintained & record IVF DNS @ ml/hr on flow	Duty Dr

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

GUC-00090590 IP18-00036739
Baby S.PUGAZHINI
11-03-2020 6 Y 4 M 23 D (F)
Dr. GIRIDHAR S

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NURSES NOTES

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

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
04/8/20	7.30Am	→ child discharge card was given to morning duty SIN	Staff Nurse

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Patient Sticker

NURSES NOTES

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☐ No Known Drug Allergies

☐ Drug Allergies .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

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Patient's Name: GUC-00077195 IP18-00036738
Baby B/O PRIYANKA SHARWAN (M)
04-04-2025 1 Y 3 M 30 D
Dr. VAISHNAVI CHANDRAMOHAN
MRD ... n No.: ....
Age ... Sex: ☐ M ☐ F
Consultant : ....

PHLEBITIS ASSESSMENT

CANNULA 1

Date : 03/08/26. Time: 3.40PM
Location : Ⓛ Metacarpal
Size : 24G
Cannula inserted by : S/N Arthi

Date	Time	Phlebitis	Infiltration	Nursing Intervention	Sign
3/8	4PM	☐Yes ☑No	☐Yes ☑No	Pattern	[illegible]
	6pm	☐Yes ☑No	☐Yes ☑No	obv	[illegible]
	8 PM	☐Yes ☑No	☐Yes ☑No	Observ	[illegible]
	10 PM	☐Yes ☑No	☐Yes ☑No	Observ	[illegible]
04/8	12 AM	☐Yes ☑No	☐Yes ☑No	healthy	[illegible]
	2 AM	☐Yes ☑No	☐Yes ☑No	healthy	[illegible]
	4 AM	☐Yes ☑No	☐Yes ☑No	healthy	[illegible]
	6 AM	☐Yes ☑No	☐Yes ☑No	healthy	[illegible]
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		

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

CANNULA 2

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

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

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

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

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

PHLEBITIS ASSESSMENT AND MANAGEMENT RECORD

CANNULA 3

Date : Time:

Location :

Size :

Cannula inserted by :

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

Cannula removed : ☐Yes ☐No, if yes date and time :

RX any initiated : ☐Yes ☐No ☐NA If Yes specify-

Phlebitis score:

CANNULA 4

Date : Time:

Location :

Size :

Cannula inserted by :

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

Cannula removed : ☐Yes ☐No, if yes-date and time :

RX any initiated : ☐Yes ☐No ☐NA If Yes specify-

Phlebitis score:

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

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

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

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04-04-2025 1 Y 3 M 30 D (M)
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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 03/08/26 Time of arrival : 2:30 pm.

Chief Complaints: c/o fever x 2days, Vomiting initially RBS: 75

Height : – Weight : 7.45kg BMI : – Head Circumference (<2 years) –

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

If yes , identify –

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

–

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: Yes. (Date/Time): 3/8/26 at 2pm.

Social History: Lives With parents

Siblings in household ☐ Yes ☐ No (If yes How Many?) 1 sister –

Time of Initial assessment completed by ER Nurse : 15mins

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

Time	Nursing Notes
2:30pm.	Patient came to ER for c/o fever × 2 day, Vomiting initially After investigation. DR. Vaishnavi advised for admission Vitals are checked and recorded IV line placement done samples are collected and sended to lab Patient shifted to ward.

Samples collected by:

Samples sent by : Iman

Time:

Time: 3.55PM

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: 132 BP: — CFT: <3sec	Shift - out from ER to: ICU
RR: 30 SPO_2 : 98%	Time of Shift - out: @ 4.10PM
GCS: 15/15 Temperature : 97.3°F	Handover given to: SN. Praveena (Nurse's Name)
Pain Score: 0/10	
Repeat RBS (if applicable): —	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any): IV line placement done

① Metacarpal 24G

Name of the Nurse : Praveen

Signature of the Nurse : Praveen

Date & Time : 3/8/26 at 2:32pm

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Baby B/O PRIYANKA SHARWAN
04-04-2025 1 Y 3 M 30 D (M)
Dr. VAISHNAVI CHANDRAMOHAN

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PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : Dr. Navya. Date : .....

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

Start Time of Assessment: ..... Weight: .....

Allergic History: .....

Chief Complaints: .....
- c/o fever x 2 days.
- c/o vomiting initially 2 days ago.

Pediatric Assessment Triangle

A Appearance - TICLS .....

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

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

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

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

Significant Past History: - Surgical - 1 st day → circumcised 1 week ago.

Medication History: .....

Relevant Investigations: .....

Primary Assessment

Airway
- ☑ Open
- ☑ Maintainable
- ☐ Not Maintainable

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

Breathing

Rate: 30 SpO_2 on FiO_2 98

Rhythm: Regular.

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

Respiratory Noises: ☐ Stridor ☐ Wheezing ☐ Grunting

Air Entry: B/L AE (+)

Palpation Findings (If necessary).....

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

Circulation HR: ..... 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: ..... AVPU: .....

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

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

Signs of Neurological compromise .....

.....

Any urgent interventions needed: ☐ Yes ☐ No

If Yes .....

Exposure

Temp.: .....

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: .....

As charted

Treatment Planned: .....

As charted

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

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

Assessment done by

Name of the Doctor: Dr. Nancy Sree.

Signature: .....

Date & Time: 3/8/26

Sr. Doctor on Duty (If necessary)

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

Signature: .....

Date & Time: .....

GUC-00077195 IP18-00036738
Baby B/O PRIYANKA SHARWAN
04-04-2025 1 Y 3 M 30 D (M)
Dr. VAISHNAVI CHANDRAMOHAN

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Nursing General Admission Assessment Form For Pediatrics

Diagnosis: Δ viral illness.

Arrival Time: 4.10pm Mode of Arrival: carrying Father. Admitting From: ☑ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction Nil

Body Weight: 7.45 Kg

Height: ..... cm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
Nil	Circumcision 1 week ago.	Nil.

Family History: Nil

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: 7.45kg Length: - Head Circumference (< 2 years): .....

Temp.: 98.6°F HR: 120bpm RR: 30bpm BP: -

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

Fall Risk Assessment: ☐ Yes ☐ No Score: 13 (Document in the Humpty Dumpty Sheet)

Risk of Pressure Sore (Braden Q Score 26) (Document in the Braden Q Assessment Sheet)

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

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

FUNCTIONAL SCREENING: ☑ No Abnormalities Detected

☐ Mobility Problem ☐ Walking Problem

☐ Developmental Delay ☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING: ☑ No Abnormalities Detected

☐ Underweight ☐ Overweight ☐ Special Feeding Method

☐ Feeding Problem ☐ Special diet ☐ No Abnormality Detected

Inform consultant for positive criteria

Psychological Screening: ☑ No Significant Findings

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

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

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

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

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

Orientation has been given regarding the following aspects:

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

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

Patient Rights & Responsibilities: ☑ Yes ☐ No

Information given to ..... Mother .....

Nurse's Name: ..... Poonam ..... Date: 3/8/26 Time: 4.25pm Signature .....

PATIENT TRANSFER FORM

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Treating Consultant Name	Date & Time of Admission	Date & Time of Transfer Order
Dr. Vaishnavi	03/8/26 @ 3.04	03/8/26 @ 4.10pm.
	Transfer Ordered by: Dr. Nauga	Reason for Transfer: Further management
From Unit: ER	To Unit: 615	Information to Attendant: Yes ☑ No ☐
Number of Sheets in Clinical File: (9)	Number of Imaging Films: –	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.	DNS 500ml	1
2.	Intraflow	1
3.		
4.		
5.		

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

Viral illness.

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Praveen	M. Nauga Sree

Patient & Clinical Records Received by : Praveen

Date & Time of Patient Received : 3/8/26 4.10pm.

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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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: ER Shifted to: 615

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

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. M. Navya Sree. (MD)

Date & Time : 3/8/26. @ 3PM

Nurse Name & Signature: Praveen

Date & Time : 3/8/26 at 3pm.

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

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Baby B/O PRIYANKA SHARWAN
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DOCTOR'S SHIFT CHANGE HANDOVER FORM

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

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

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

DOCTOR'S SHIFT CHANGE HANDOVER FORM

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

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

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EMERGENCY ROOM TRIAGE FORM

WT: 7.45kg

Patient's Name : B/O priyanka sharwan Age : 1y3m. Gender: ☑ Male ☐ Female

Date : 03/08/26. Time of Arrival : 2:30 pm.

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: 97.3°F PR: 132. BP: - RR: 30. SpO_2: 98%. RBS: 75mg/dl.

Chief Complaints: c/o. fever x 2days ; Vomiting initially.

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.

Signature of Parent / Guardian

* CTAS - Canadian Triage and Acuity Scale

Triage Completion Time : 2 min.

Communicable Disease Triage Screening

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

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

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

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

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

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

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

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

Name of Triage Nurse : Praveen.

Signature of Triage Nurse : .....

Date & Time : 03/08/26 at 2:38 pm.

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RBS CHART

Date	Time	RBS (mg/dl)	IVF %	Signature
3/8/25	2:50pm.	75 mg/dl	–	

Docu. No. : RCH /FRM / CLINICAL / 185