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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

PATIENT DISCHARGE INTIMATION FROM NURSING STATION

CLEARANCE FOR DRUGS AND DISPOSABLES BILLING

Date: 8/7/26

Name of the Patient: GUC-00064132 IP18-00036354
Master P SHAUN GOODWIN
25-04-2016 10 Y 2 M 12 D (M)
Dr. NATARAJ PALANIAPPAN

UHID No: .....

Gender: .....

Ward: .....

Room No: .....

Certified that in respect of the above patient:

- ☐ a. There are no drugs for return
- ☐ b. Emergency cupboard issues have been replenished
- ☐ c. No pending indents are there against above patient
- ☐ d. Checked the bed side cupboard of the bed
- ☐ e. Checked by the patient's Mother / Father in the room

Patient Authorised Sign

Date: .....

Time: .....

Nurse Sign

Date: 8/7/26

Time: 11 AM

Pharmacy Sign

Date: 8/07/26

Time: 11.26 a.m.

Docu. No. : RCH /FRM / GENERAL / 117

GUC-00064132 IP18-00036354
Master P SHAUN GOODWIN
25-04-2016 10 Y 2 M 12 D (M)
Dr. NATARAJ PALANIAPPAN

BirthRight Children's Hospital

DISCHARGE TRACKING SHEET

UHID- FLOOR- NAME OF CONSULTANT-

ACTIVITY	INTIMATE	OUT TIME	NAME & SIGNATURE	REMARKS	<To be filled by Admin>		
Activity Sheet update by Nursing		8/7/26 at 11am					
Activity Sheet update by Pharmacy		11.26					

ACTIVITY RECORD FOR BILLING

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Name: .....

UHID No: ..... IP No: GUC-00064132 IP18-00036354
Master P SHAUN GOODWIN
25-04-2016 10 Y 2 M 11 D (M)
Dr. NATARAJ PALANIAPPAN

Dept: .....

Date of Admission: ..... Ti ..... arge: ..... Time: .....

Room / Bed No: ..... Ward: ..... illable bed type: .....

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
06/07/2026	6.30 Pm	ER	507	

CROSS CONSULTATION VISIT

	Doctor Name	Date	Order No.	Signature
1.	Dr Vivekanand. V.V	7/7/26	to be raised	
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

INVESTIGATIONS

Date	Investigations	Order No.	Signature
06/7/26	CBC, CRP, OT, PT Biofine	26021582	[signature]

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
06/7/26	IV placement	(1)	1722903	
06/7/26	Nebulization CO_2	(2)	1722912	
07/07/26	Neb CO_2	(2)	2316	
7/7/26	Neb CO_2	(2)	173538	
8/7/26	Neb CO_2	(3)	1725744	
			Total Neb	(10)

Total Neb-10

ANY OTHER INFORMATION:

Date: 8/7/26 Time: 11AM Prepared By:

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

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 : IP18-00036354 **Admit Date** : 06-Jul-2026 **Admit Time** : 04:42 PM **UHID** : GUC-00064132

Patient Details :

Patient Name : Master P SHAUN GOODWIN
Guardian : Mr PRATHAP
Gender : Male
Occupation :
Address (H) : prince greenwoods, WB 304, 66, vanagaram main road, ambattur industrial estate Ambattur Industrial Estat Chennai Tamil Nadu INDIA 600058

Age : 10 Y 2 M 11 D
DOB : 25-04-2016
Religion :
Martial Status :
Phone No : 9620550003
E-mail : prathap274@gmail.com

Admission Details :

Bed Type : DAY CARE **Bed No** : ER 101 **Ward Name** : 0F-EMERGENCY
Room No : ER 101 **Admission Type** : First Visit

Contact Details :

Name : Mr PRATHAP **Relationship** : FRIEND
Contact Address : prince greenwoods, WB 304, 66, vanagaram main road, ambattur industrial estate Ambattur Industrial Estat Chennai Tamil Nadu INDIA 600058 **Phone No** :

Signature

Doctor Details :

Doctor Name : Dr. NATARAJ PALANIAPPAN **Specialisation** : PEDIATRIC INTENSIVE CARE
Referral Doctor : Dr. Nataraj Palaniappan **Phone No** :
Co-Consultant :

Payment Details :

Payment Mode : Cash **Deposit Amount** : 0.00
Payor Name : SELFPAY

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

GENERAL CONSENT FOR TREATMENT

Patient Name:	**Master P SHAUN GOODWIN**	**Age :**	**10 Y 2 M 11 D**
IP No:	**IP18-00036354**	**Sex:**	**Male**
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 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: prathap
Relationship: Father
Date: 6/07/2026 Time: 4:42
Wittness Name: Jeevitha
Wittness Signature:

Patient Address:

prince greenwoods, WB 304, 66, vanagaram main road, ambattur industrial estate Ambattur Industrial Estat Chennai Tamil Nadu INDIA 600058

Rainbow Children's Hospital | BirthRight BY RAINBOW HOSPITALS

BILLING POLICY

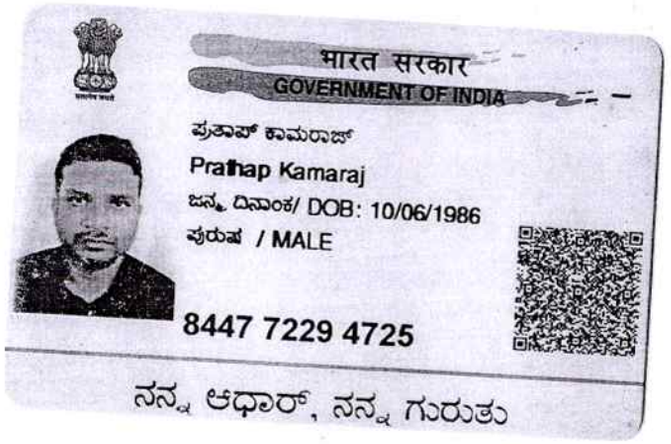
- Billing Cycle: - Bed charges will be calculated based on 12PM to 12PM checkout. Settlement post 12PM, room rent will be charged for half day extra & post 6PM, it will be charged for full day. Less than 24 hours stay will be considered as one day.
- Room Rent inclusive of Bed, Nursing, Consultation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

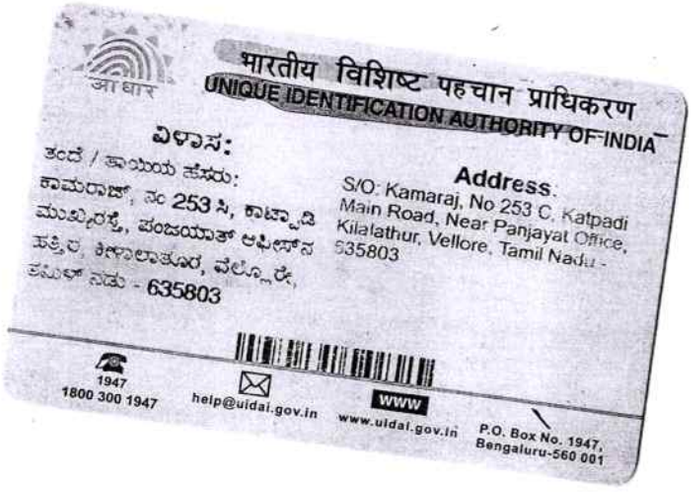
DECLARATION

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

Patient Name : Shaun Goodwin	UHID Number : GUC-000 64132
Self/Attendant Name : Prathap	Relation : Father
Self/ Attendant Signature :	Name & Signature of Financial Counselor
Phone Number : 9620550003	

RCH/GDY/FRM/CLINICAL/426


भारत सरकार
GOVERNMENT OF INDIA
ಪ್ರತಾಪ್ ಕಾಮರಾಜ್
Prathap Kamaraj
ಜನ್ಮ ದಿನಾಂಕ/ DOB: 10/06/1986
ಪುರುಷ / MALE
8447 7229 4725
ನನ್ನ ಆಧಾರ್, ನನ್ನ ಗುರುತು


आधार
भारतीय विशिष्ट पहचान प्राधिकरण
UNIQUE IDENTIFICATION AUTHORITY OF INDIA
ವಿಳಾಸ:
ತಂದೆ / ತಾಯಿಯ ಹೆಸರು:
ಕಾಮರಾಜ್, ನಂ 253 ಸಿ, ಕಾಟ್ಪಾಡಿ
ಮುಖ್ಯರಸ್ತೆ, ಪಂಜಯಾತ್ ಆಫೀಸ್‌ನ
ಹತ್ತಿರ, ಕಿಳಾಲಾತೂರ, ವೆಲ್ಲೂರೇ,
ತಮಿಳ್ ನಾಡು - 635803
Address:
S/O: Kamaraj, No 253 C, Katpadi
Main Road, Near Panjayat Office,
Kilalathur, Vellore, Tamil Nadu -
535803
1947
1800 300 1947
help@uidai.gov.in
WWW
www.uidai.gov.in
P.O. Box No. 1947,
Bengaluru-560 001

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

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: _____

UHID ID: _____

GUC-00064132 IP18-00036354
Master P SHAUN GOODWIN
25-04-2016 10 Y 2 M 11 D (M)
Dr. NATARAJ PALANIAPPAN

Department: _____

Consultant: _____

(P.T.O.)

Patient Sticker

Pediatric Multiorgan History & Physical Examination

Name: ______________________ Age/Sex ______

Information given by: ______________________ Relationship ______

Chief Presenting Complaints & Duration (Chronologically)

C/o cough x 1 week (↑ severity in last 3 days)
c/o fever x 5 days.
c/o fever (Afebrile) for 1 day

History of present illness :

(~~wet~~ associated c̄ PTV)
c/o cough - (~~wet cough~~) [Dry cough ⊕. x 1 week
c/o fever x 5 days
afebrile for 1 day

No c/o Blood tinged sputum / loose stools / vomiting / headache / altered sensorium
No h/o redness of eyes
Reduced oral intake ⊕
No c/o reduced urine output

c/o lethargy ⊕ x 1 day

Treated previously outside Hospital
c̄ (Azee / flu / steroids) x 3 days
[Antiflu given x 3 days]
CXR done 4/7/26 → B/L perihilar infiltrates + ? retro cardiac infiltrates

(Outside SpO2 - 92% ↓RA)

Patient Sticker

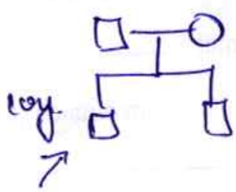
Past History : (Including details of any previous investigation or treatment)

1) Prev admission for Adenoviral LRTI (3yrs back)

Birth & Neonatal History:

Fullterm / NVD / CIAB / No NICU stay / Bwt: 3.2kgs

Family Chart



Birth & Socio Economic History:

About Father : 1) was treated c̄ Antiflu (LRTI) for past 1 days.

About Mother :

Any additional Information :

Developmental History :

Developmentally appropriate for age

Immunization History :

Immunized upto 5yrs of age

Anthropometry :

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

Weight (kgs) 45kg (Centile ________)

On Examination :

Temperature : 97.6°F Pulse Rate : 81/min B.P. 102/57 SPO2 100% @RA

Resp.rate and type of breathing : 26/min

Well looking
Alert / Active
CRT < 3sec
PP well felt
Warm peripheries

Rash

Lymphadenopathy — (-)

Oedema : — (-)

Allergies (if any): No Allergy

(P.T.O.)

Patient Sticker

Respiratory System :

Inspection (any s/o distress) :

Air entry & breath sounds : BLAE ⊕ / Bh crepts ⊕ (R>>L)

Any addes sounds :

Relevant data from outside (Chest X-Ray, ABG,etc.,) Bh
CXR: ~~[illegible]~~ / neither infiltrates ⊖.

Cardiovascular System :

Inspection of procordium :

Heart Sounds : S1S2 ⊕ / No murmur.

Any murmur :

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

Per Abdomen :

Inspection :

Palpation : Soft / NT

Ausculation : No organomegaly

Spine : Ⓝ External Genitelia : Ⓝ

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

Central Nervous System :

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

Cranial Nerves :

Motor System :

Nutriton :

Tone: Ⓝ Power ~~[illegible]~~ 5/5

Co-ordinator :

Posture :

Involuntary Movements :

Patient Sticker

Reflexes : 2+

Superficials:

DTR

Plantars

Sensory System :

Bladder / Bowel :

Clinical Summary & Diagnostic: Δ: LRTI (?viral / flu like illness / Adenoviral

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

Desired goals of the treatment :

Planned Labs:

- CBC ✓
- CRP ✓
- SGOT/PT ✓
- Resp. biofire ✓

Planned Management

~45kgs

1) Neb - LEVOLIN 1.25mg Q6h.
2) Neb - BUDECORT 0.5mg Q12H.
3) Inj CEFTRIAXONE 2g IV Q12H.
4) ~~Syp. AZEE~~ (T. AZEE 500mg Q24
5) Syp. MUCOLITE 5ml Q8h.
6) Cap. FLUVIR 75mg Q12H.
7) Dr. Vivek sir opinion (To decide on HRCT)

Signature of the Doctor: [signature] 203172

Name of the Doctor: LOKESH NEM. S

Date & Time: 6/7/26, 5:10 PM

Signature of the Consultant: ....

Name of the Consultant: ....

Date & Time: ....

(P.T.O.)

Patient Sticker

DISCHARGE PLANNING FORM

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

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

2. Destination Post Discharge: ☐ Home

   Family Members Notified (Person Contacted)

   ☐ Transfer

   Hospital Facilty Notified (Person Contacted)

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

   ☐ Needs Assistance In:

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

4. Nutritional Plan:

   ☐ Dietary Instruction Discussed with the:

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

5. Discharge Planning Discussed with the:

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

6. Patient/Family Educational Plan:

   ☐ Educational Topic/s: .....

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

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

Doctor Signature: .....

Doctor Name: .....

Date and Time: .....

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

DOCTOR'S SHIFT CHANGE HANDOVER FORM

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

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Your Right to a Safe Delivery

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

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

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

DOCTOR'S SHIFT CHANGE HANDOVER FORM

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Your Right to a Safe Delivery

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

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

Patient Sticker

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CROSS CONSULTATION FORM

GUC-00064132 IP18-00036354
Master P SHAUN GOODWIN
25-04-2016 10 Y 2 M 12 D (M)
Dr. NATARAJ PALANIAPPAN

Doctor ..... Date : ..... Time : .....

Diagnosis .....

Hospital : .....

.....

Referred for : ☐ Opinion ☐ Co-Management ☐ Transfer of care

Type of Referral :
☐ Emergency
☐ Urgent
☐ Non Urgent

Reason for Referral : If for concurrent care specify the particular need, especially in the absence of a second diagnosis:

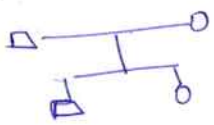
SIB. VINOL

Signature:

7/7/26 5pm

Findings and Recommendations :

— Thanks for referral



ANC : — N

PNC — N

N > D

— no Parental atopy

Late onset wheeze

> 3y

intermittent

severity LND : — 16/2/24

↓

ND PIBD

— only intermittent wheeze symptoms

Consultant :

Name : Dr. Vivek ..... Signature : ..... Date & Time : 7/7/26 at 4pm

Doc. No. : RCH / FRM / CLINICAL / 049

- admitted with

- another viral < adeno / b'v (+)

- mild episode

no chronic resp symptoms

wt gain ~ longer a year

vital: - N

S/E - N

CVS > N , P/A - soft
R/S

No clubbing.

CXR: - N

Labs: - N

GUC-00064132 IP18-00036354
Master P SHAUN GOODWIN
25-04-2016 10 Y 2 M 11 D (M)
Dr. NATARAJ PALANIAPPAN

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CROSS CONSULTATION FORM

Doctor Name : .... Date : .... Time : ....

Diagnosis : ....

Hospital : ....

Referred for : ☐ Opinion ☐ Co-Management ☐ Transfer of care

Type of Referral :
☐ Emergency
☐ Urgent
☐ Non Urgent

Reason for Referral : If for concurrent care specify the particular need, especially in the absence of a second diagnosis:

Signature:

Findings and Recommendations :

Assessment

- B/g intermittent wheeze
- 2nd episode of (ad ...) + flu - mild
- No chronic resp symptom

Stable

Advise

1) will not req CT
2) at d/s: foracort 100 MDI 1—0—1 x 12wks

Consultant :

Name : .... Signature : .... Date & Time : ....

Doc. No. : RCH / FRM / CLINICAL / 049

(3) Levolin SD MDI (SDS)

4puff 4 - 6 hrs once

× 3 - 5 days

(4) Zero stat spacer NO mask

(5) PFT after - 4wks

↓

skip forever for

24hrs

— rinse mouth

GUC-00064132 IP18-00036354
Master P SHAUN GOODWIN
25-04-2016 10 Y 2 M 11 D (M)
Dr. NATARAJ PALANIAPPAN

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Your Right to a Safe Delivery

(1)

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	S/B. Dr. Lakshminesh	
7/7/26 12:50 AM		
	Δ: LRTI (? viral - Influenza A1H-2009/Adenoviral)	
	child seen	
	cough (reduced)	
	c/o nausea ⊕ / No vomiting	
	Reduced intake	
	vitals: stable	
	RR - 30/min	
	SpO2 - 95-98% @RA	
	RS: BLAE ⊕ / minimal crepts ⊕.	
	other systems - ⓝ	
	11.8 > 5890 < 3.74 lakhs; 64/28/7/1	Advice
		1) Continue Inj ceftriaxone / fluids
	CRP - 28	2) Nebs Levolin 1.25mg q6h.
	Biofire	3) Nebs Budecort 0.5mg BD.
	Influenza A1-H 2009 +	4) If poor intake to start
	Adenovirus +	on IV fluids - 0.9NS at
		8 ml/hr
	CXR: 4/7	5) Dr. Vivek's opinion (Thoracic)
	B/L perihilar infiltrates (minimal).	6) w/f fever spikes / Resp distress /
		Abdominal pain / SpO2 < 92%.
		to start on O2 support
		7) monitor vitals

Lakshminesh
203377
7/7/26.

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
7/7/26	S/B Dr Kavitha	
9am		
	Δ - Influenza / Adenoviral illness	
	No fever since admission	
	Wet cough ↓ed.	
	Appetite - improved.	
	Slept comfortably.	
	O/E - Alert, active	
	PPWF, CRT < 3secs	
	Pulse volume - good	
	vitals - stable. - maintaining SpO2 ≥ 95%	
	RS - WOB (N)	
	No tachypnoea	
	B/L AE (+)	
	No added sounds	
	CVS - S1S2 (+)	
	no murmur	
	P/A - Soft	
	RUQ tenderness (+)	
	CNS - NFND	
Oral candy -	B/L tonsils (+)	
	(N)	
		Advice
		T/c Oseltamivir / Azithromycin / Ceftriaxone (D2)

GUC-00064132 IP18-00036354
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Dr. NATARAJ PALANIAPPAN

(2)

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
		Syp. Mucolite
		~~[illegible]~~
		T/c Neb. Levolin / Budecort.
		Dr. Vivek for opinion.
		[signature] 17/07/
7/7/26	S/B Dr. Natarajan ō 2° bacterial	
	Influenza / Adeno	
	to see	
	Dr. Vivek	
		[signature] 8/3/[illegible]
	Sgot, Sgpt to do	

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

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
7/7/26	S/B Dr Kavitha	
4.45pm		
	Child reviewed	
	No distress / tachypnoea	
	O/E - Alert, playful	
	Vitals - stable	
	SpO2 - 98%	
	RS - WOB (N)	
	B/L NVBS (+)	
	No added sounds	
	Other systems - WNL.	
		Advice
		T/c as charted
		Plan - discharge tomorrow
		after D/w Dr. Nataraj sir
		if stable.
		[signature] 78024
8/7/26	S/B Dr. Kavitha	
9.20am		
	Δ - LRTI - Influenza A / Adenoviral	
	No fever	
	Cough - better	

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	No breathing difficulty / distress.	
	O/E - Alert, active	
	PPWF	
	Vitals - stable	
	No tachypnoea	
	SpO2 - 98% RA	
	HR - 115/min.	
	RS - WOB (N)	
	B/L NVBS (+)	/ on Levolin /
	No added sounds	Budecort
	CVS - S1S2 (+)	
	P/A - soft,	
	non-tender	
	CNS - NFND.	
		Advice
		(D3) IV Xone / Ayee / Fluir
		Syp. MUCOLITE
		Neb. LEVOLIN / BUDECORT
	Plan - discharge	Monitor vitals.
	today after D/W	
	Dr. Nataraj sir.	
		[signature] 1188

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/7/26	S/b D. Nataraj	
11am	Discharge	
	Feracort 100	1-0-1 x 3mo
	c spacer.	
	Levolin 50	2 puff sos.
	PFT after	4 wks
	Review Next	week wed/sat
	To get vaccin	card
	yearly	flu.
		[signature]
		8558

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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SHAUN GOODWIN

10y 2m / male

[Adenovirus / Influenza AH1 2009 ⊕]

RESULT SHEET

Date	6/7/16					
Time						
Hb	11.8					
PCV	36					
RBC	4.59					
WBC	5890					
N/L	64/28/7/1					
Platelets	3.74					
CRP	28					
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT	22					
SGOT	28					
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 : Respiratory Biofire → Influenza AH1 2009 ⊕
Adenovirus ⊕

Radiology : USG :

X-Ray :

ECHO :

CT :

MRI

Others (ECG, Contrast Studies etc.,) :

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RESULT SHEET

Date						
Time						
Hb						
PCV						
RBC						
WBC						
N/L						
Platelets						
CRP						
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

(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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DRUG CHART

Date of Admission: 06/7/26 Drug Allergies: Nil ☐ 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 / 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. DOLO				Date / Time
Dose	Route	Frequency	Start Date	
650mg	PO	SOS	6/7	
Doctor's Signature	Valid Period	Pharm.		
[signature]				
Additional Instructions: 20337				

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

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

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

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REGULAR PRESCRIPTIONS

Weight. 45kgs Ward. .....

DRUG : Inj CEFTRIAXONE

Dose	Route	Frequency	Start Date
2gm	IV	~~Q 24H~~ Q 12H	6/7

Name & Signature of the Doctor Starting the Drugs: Lucky

Additional Instructions: 203777

Daily Doctor's Endorsement by a Sign

Date	6/7	7/7	8/7
Time	8pm /	SD	SA
	8pm	7.45 pm PST	
		PST	
	D1	D2	D3

DRUG : T. AZEE

Dose	Route	Frequency	Start Date
500mg	PO	Q 24H	6/7

Name & Signature of the Doctor Starting the Drugs: Lucky

Additional Instructions: 203777

Daily Doctor's Endorsement by a Sign

Date	6/7	7/7	8/7
Time	8pm	SA	SD
	D1	D2	D3

DRUG : Cap. FLUVIR

Dose	Route	Frequency	Start Date
75mg	PO	Q 12H	6/7

Name & Signature of the Doctor Starting the Drugs: Lucky

Additional Instructions: 203777

Daily Doctor's Endorsement by a Sign

Date	6/7	7/7	8/7
Time	8pm /	RJ SN	KS
	8pm	SA	SD
	D4	D5	D6

DRUG : Syp. MUCOLITE

Dose	Route	Frequency	Start Date
5ml	PO	Q8H	6/7

Name & Signature of the Doctor Starting the Drugs: Lucky

Additional Instructions: 203777

Daily Doctor's Endorsement by a Sign

Date	6/7	7/7	8/7
Time	8pm /	RJ SN	KS
	8pm /	PST	
	10pm	SA	SD

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Sheet No: .... **REGULAR PRESCRIPTIONS** Weight 45kgs Ward ....

DRUG: Neb. LEVOLIN

Dose	Route	Frequency	Start Dt.
~~1.25mg~~ 0.63	P/N	Q8H	6/7

Date/Time: 6/7 – 5:30 pm R.B A.J; 10pm SA. 7/7 – 6am SA; 2pm; 10pm. Dose changed

Name & Signature of the Doctor Starting the Drugs: Leelapriya

Additional Instructions: 203377

Daily Doctor's Endorsement by a Sign

DRUG: Neb. BUDECORT

Dose	Route	Frequency	Start Dt.
0.5mg	P/N	Q12H	6/7

Date/Time: 6/7 – 5:40 pm R.B A.J. 7/7 – 5am SA; 5pm PST. 8/7 – SA

Name & Signature of the Doctor Starting the Drugs: Leelapriya

Additional Instructions: 203377

Daily Doctor's Endorsement by a Sign

DRUG: Levolin

Dose	Route	Frequency	Start Dt.
0.63mg	neb	Q8H	8/7

Date/Time: 7/6 – 6am; 2pm PST; 10pm SA. 8/7 – SA

Name & Signature of the Doctor Starting the Drugs: [signature]

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG:

Dose	Route	Frequency	Start Dt.

Date/Time:

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

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

Docu. No.: RCH /FRM / CLINICAL / 108

Patient Sticker

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Sheet No: ....

REGULAR PRESCRIPTIONS

Weight .... Ward ....

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

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

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REGULAR PRESCRIPTIONS

Weight .... Ward ....

Sheet No: ....

DRUG :				Date / Time
Dose	Route	Frequency	Start Dt.	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

DRUG :				Date / Time
Dose	Route	Frequency	Start Dt.	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

DRUG :				Date / Time
Dose	Route	Frequency	Start Dt.	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

DRUG :				Date / Time
Dose	Route	Frequency	Start Dt.	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

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

Docu. No. : RCH /FRM / CLINICAL / 108

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Sheet No: ....

REGULAR PRESCRIPTIONS

Weight .... Ward ....

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

DRUG :				Date/Time
Dose	Route	Frequency	Start Dt.	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

DRUG :				Date/Time
Dose	Route	Frequency	Start Dt.	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

DRUG :				Date/Time
Dose	Route	Frequency	Start Dt.	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

DRUG :				Date/Time
Dose	Route	Frequency	Start Dt.	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

Patient Sticker

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

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses

Signature .....

VERIFIED BY : Name .....

Patient Sticker

I.V. FLUIDS CHART

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

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign

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

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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: 507

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	Syp. ANTIFLU	12mg/ml	5ml (PO)	Q 6HH		☐ 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 : Lavanya

Date & Time : 6/7/26, 5:10PM 2033 hrs

Nurse Name & Signature: N. Anitha

Date & Time : 06/07/26 @ 5:00PM

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

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

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 6/7/26. Time:	6.30 pm	2pm	12pm	4am
Doctor / Nurse / Family Concern?				
Temperature (°F)	98.1 °F	97.2 F	98.2	98.2 F
Heart Rate (bpm) and Blood Pressure (mmHg) * Note: BP does not score in early warning scoring	100 / (72) / 60	103 / (142) / 62	100 / (80) / 60	98 / (69) / 52
Heart Rate (Number)	98 bpm	99 bpm	102 bpm	92 bpm
Resp. Rate (bpm) (Over 1 Minute) *				
Resp Rate (Number)	20 bpm	20 bpm	22 bpm	22 bpm
Resp Distress: Mod/ Severe / None / Mild	✓	—	—	✓
Receiving O_2 (l/min)		RA	RA	RA
O_2 Saturations (%)	97%	99%	97%	98%
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)

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(2)

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

SCHOOL AGE (5-12 years)

Children's Observation & Early Warning Scoring Chart

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 07/04 / Time:	8 Am	12pm	4pm	8pm	12am	4am
Doctor / Nurse / Family Concern?						
Temperature (°F)	97.2°F	98F	97.3F	97.6F	97.2°	98.1F
Heart Rate (bpm) and Blood Pressure (mmHg) *	92/59	100/70	102/68 (81)	103/69 (78)	100/56	103/59
Heart Rate (Number)	96 b/m	85 b/m	92 b/m	90 b/m	98 b/m	90 b/m
Resp. Rate (bpm) (Over 1 Minute) *	22 b/m	20 b/m	26 b/m	22 b/m	22 b/m	20 b/m
Resp Rate (Number)	22 b/m	20 b/m	26 b/m	22 b/m	22 b/m	20 b/m
Resp Distress — Mod/ Severe / None / Mild	✓	✓	✓	✓	✓	✓
Receiving O_2 (l/min)			RA	RA	RA	RA
O_2 Saturations (%)	97%	99%	96%	98%	99%	98%
Conscious Level — Normal / Altered	✓	✓	✓	✓	✓	✓
GCS *	15/15	15/15	15/15	15/15	15/15	15/15
TOTAL SCORE Number of shaded boxes	0	0	0	0	0	0
Pain Score	0	0	0	2		
Observer's Initials	[illegible]	[illegible]	[illegible]			

Temperature scale: 104, 103, 102, 101, 100, 99, 98, 97, 96, 95, 94

Heart Rate / Blood Pressure scale: 190, 180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60, 50

Note: BP does not score in early warning scoring

Resp. Rate scale: 70, 60, 50, 40, 30, 20, 10

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-00064132 IP18-00036354
Master P SHAUN GOODWIN
25-04-2016 10 Y 2 M 11 D (M)
Dr. NATARAJ PALANIAPPAN

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Your Right to a Safe Delivery

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	Intake: Nature of Fluid	Intake: Route – Mouth	Intake: Route – I.V	Intake: Route – N.G	Output: NG	Output: Diarrhoea	Output: Vomit	Output: Drainage	Output: Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
6/7/16												
	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	Dressing Role									0	JM
	07:00 pm											
Total Intake :	—					Total Output :	—					
	08:00 pm	H2O	100ml							L	0	
	09:00 pm	H2O	50ml							L	0	
	10:00 pm	H2O	100ml								0	
	11:00 pm										0	
	12:00 am										0	
	01:00 am										0	
Total Intake :	250ml					Total Output :	2 times					
	02:00 am										0	
	03:00 am										0	
	04:00 am										0	
	05:00 am										0	
	06:00 am										0	
	07:00 am	Milk	100ml								0	
Total Intake :	100ml					Total Output :	1 time					

Total 24 hrs. intake	350ml

Total 24 hrs. Output	3 times

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FLUID CHART

Sheet No. : (2)

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

7/8/16		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
	08:00 am	H20	50ml								0	
	09:00 am						✓			✓	0	
	10:00 am	Soup	100ml								0	
	11:00 am	H20	50ml								0	
	12:00 pm										0	
	01:00 pm	H20	100ml								0	
Total Intake :		300ml.				1 times.		Total Output :		1 times		
	02:00 pm										0	
	03:00 pm	H20	80ml								0	
	04:00 pm									✓	0	
	05:00 pm	Soup	100ml								0	
	06:00 pm	H20	80ml								0	
	07:00 pm										0	
Total Intake :		260ml						Total Output :		1 times.		
	08:00 pm	H20	100ml								0	SA
	09:00 pm	H20	200ml							✓	0	SA
	10:00 pm										0	SA
	11:00 pm										0	SA
	12:00 am									✓	0	SA
	01:00 am										0	SA
Total Intake :		200ml						Total Output :		2 times		
	02:00 am										0	SA
	03:00 am										0	SA
	04:00 am										0	SA
	05:00 am										0	SA
	06:00 am									✓	0	SA
	07:00 am	Milk	100ml								0	SA
Total Intake :		100ml						Total Output :		1 times		

Total 24 hrs. Intake	960ml.

Total 24 hrs. Output	5 times

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(1)

Patient Name : GUC-00064132 IP18-00036354 Master P SHAUN GOODWIN 25-04-2016 10 Y 2 M 11 D (M) Dr. NATARAJ PALANIAPPAN

Registration No.:

NEBULISATION CHART

Date	Time	Drug	Nurse	Parents Signature
6/7/26	100.00 pm	Neb - levolin — (1)	S. Amr 10193	
7/7	5.00 am	Neb - budecort — (1)	S. Amr 01938	
	8.00 am	Neb - levolin — (1)	S. Amr 01938	
7/7	5.00 pm	Neb - Budicort — (1)		
	8.00 pm	Neb - levolin — (1)		
	10.00 am	Neb - levolin — (1)	S. Amr	
8/7	6.00 am	Neb - budecort — (1)	S. Amr 01938	
	2.00 am	Neb - levolin — (1)	S. Amr 01938	
	8.00			
	9.00			
	10.00		Total Neb — (10)	
	11.00			
	12.00			
	13.00			
	14.00			
	15.00			
	16.00			
	17.00			
	18.00			
	19.00			
	20.00			
	21.00			
	22.00			
	23.00			

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(1)

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NURSING SHIFT HAND OVER FORM

SITUATION

Diagnosis: LRTD

Any Infection: ☐ Yes ☐ No ☐ Not Known
If Yes Specify: .....

Surgery / Procedure: Nil

Post OP Day:

BACKGROUND

Date / Shift	6/7 E	7/7 M	7/7 N	7/7 E	7/7 N	8/7 M
Medical Condition (Any special condition to be noted):	Noted	Noted	Noted	Noted	Noted	Noted
Diet:	(N) dr	(N) diet	(N) diet	(N) dr	(N) diet	(N) diet

ASSESSMENT

Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Ventilation (RA, NP, NIV, VENTI):	RA	RA	RA	RA	RA	RA
Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Vital Signs: Temp:	98.1°F	98.2	97.2°F	98.1°F	97.6F	98.6F
Res:	20/M	20bm	22b/m	26bm	24bm	22b/m
SpO_2:	95%	97%	97%	97%	98%	98.1%
Pulse:	98/M	99bm	—	90/M	90bm	115b/m
BP:	100/60	103/63	92/59	100/60	103/63	100/66
LOC:	conscious	conscious	conscious	conscious	conscious	conscious
Fall Risk Score:	10	10	10	10	10	10
Pain Score:	0/10	0/10	0/10	0/10	0/10	0/10
Skin Integrity	—	—	—	✓	—	—

Recommendations

Safety Needs:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Physiotherapy:	—	—	—	—	—	—
Others Specify:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Special Diet:	—	—	—	—	—	—
Critical Lab Test / Values:	—	—	—	—	—	—
Other Special Orders / Medications:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
PU Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
DVT Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
ADL (Dependent / Non Dependent):	non dep	non dependent	non dependent	non dep	dependent	dependent
Post Operative Procedure Special Orders:	—	—	—	—	—	—

Handed Over By Name :	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Signature / ID :	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Date:	6/7	7/7	7/7	7/7	8/7	8/7
Time:	8pm	7:30am	7:30AM	7:30pm	7:30am	
Taken Over By Name :	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	
Signature / ID :	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	
Date:	6/7	7/7	7/7	7/7	8/7	
Time:	7:30pm	7:30AM	1:30pm	7:30pm	1:30pm	

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NURSING CARE RECORD (P)

Date: 6/7/06

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon	8pm	maintain the good Nutrition state.	8 pm	> Assess the condition > check vital signs > monitor I/O chart.	child was stable	child was active	[signature]
Night	8pm	=> To Maintain breathing pattern.		=> To Assess child condition. => To Monitored saturation	To improve Breathing pattern.	The child vital sign stable.	[signature]

Docu. No: RCH /FRM / CLINICAL / 148

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NURSING CARE RECORD

Date: 07/7/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8AM	Maintain good nutritional status	9AM	To maintained good Nutritional status.	The child was stable	The child vital signs are stable	R. USL 021113.
Afternoon	2PM	To prevent the infection		=> Assess the child condition => To strictly hand washing	The child was stable	Re assessment done	[signature]
Night	8pm	=> To maintain fluid balance.		=> To adequate increase oral feeds accordingly => To ensure proper dose	=> To improved fluid balance	The child vital sign stable	[signature]

Docu. No: RCH /FRM / CLINICAL / 148

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(1)

NURSES NOTES

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☑ No Known Drug Allergies

☐ Drug Allergies .... nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		Receiving Notes	
6/7	6.30 pm	child details handover taken from the ER staff. Child was conscious & oriented. IV line patent.	[signature]
	7.15 pm	Due medication as given for the drug chart order. monitor vital sign. vitals are the stable SpO2 - 95 to 96%.	[signature]
	7.20 pm	monitor I/O chart. No other complaints. IV line patent.	[signature]
	7.30 pm	Child details handover given to the Night duty staff	[signature]
7/7	7.30 pm	Night duty. → The Baby is hand over from evening duty staff. child is conscious oriented. IV line is patent. child is under room air.	
	8.00 pm	→ The child vital sign duly record. → Due Medication is	[signature]

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

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

Patient Sticker

NURSES NOTES

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☑ No Known Drug Allergies
☐ Drug Allergies Nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
6/7		Given as per drug chart maintain ly doument	
	10:00pm	→ Nebulisation is given as per drug chart maintain ly doument	
		Due medication is given as per drug chart maintaind ly doument.	S.Anoop 0/1986
7/7	12:00am	→ The child vital sign cheny recored / PP ++ / CP ++ / CRT <3sec	S.Anoop 0/1987
	2:00am	→ The child is sleeping is well. IV line pattern	
	4:00am	→ The child vital signs cheny recored / PP ++ / CP ++ / CRT <3sec	0/1986
	5:00am	→ Nebulisation is given as per drug chart maintaind ly doument	
	6:00A	→ Due medication is given as per drug chart maintaind ly doument → The child to chart maintainy doument	0/1986
	7:30pm	→ The child hand over from morning duty staff	0/1984

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

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NURSES NOTES

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

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		Morning Duty on (07/7/26).	
7/7/26	7.30AM	The child Handing over taken from night duty staff the child was conscious & oriented IV line was Present & patency →	sri. 02113
	8AM	Due to medication as per drug chart order Vital Signs are checked & recorded vital Signs are Stable [8AM | CP ++ | PP ++ | CRT <3SEC] →	sri. 02113
	10AM	DR. Nataraj sir seen the child advice to continue. Same →	sri. 02113.
	12pm	Vital Signs are checked & recorded vital Signs are Stable [12pm | CP ++ | PP ++ | CRT <3SEC] →	sri. 02113.
	1pm	Maintained I/O chart & recorded.	
	1.30pm	The child Handing over given to evening duty staff →	sri. 02113

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Patient Sticker

NURSES NOTES

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

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		Evening duty.	
	1.30pm	child details handover taken	
		from the Morning duty	
		staff. child was	
7/7/24		conscious & oriented.	[signature]
		Iv line patten.	
	2pm	Due medication as given for	
		the drug chart order.	
		Iv line pattern.	[signature]
		Neb given as per the order.	
	4pm	check the vital sign. vitals	
		are the stable [Cp / H] [PP / H] [CRT / <2s]	
		No fever spike	[signature]
	6pm	Due medication as given	
		for the drug chart	
		order. Inj xone 2g.	
		Iv line patten.	[signature]
	7pm	monitor I/O chart no	
		other complaint.	
		Iv line patten.	
	7.30pm	Child details handover given	
		to the Night duty	[signature]
		staff	
8/7	7:30pm		

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(3)

NURSES NOTES

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

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
7/7/26	7.30pm	Night duty	
		=> The child hand over from evening duty staff. child is conscious oriented. IV line pattern. child is under room air	S. Amol 01935
	8.00pm	=> The child vitals sign closely recorded | PP ++ | CP ++ | CRT d3g	
		=> Due medication is given as per drug chart maintain & document.	S. Amol 01935
	10.00pm	=> Nebulisation is given as per drug chart maintain & document. Due medication is given as per drug chart maintained & document.	S. Amol 01935
8/7/26	12.00AM	The child vital sign closely recorded | PP ++ | CP ++ | CRT d3	
	2.00am	=> The child is sleeping is well.	S. Amol 01935
	4.00am	=> The child vital sign closely recorded | PP ++ | CP ++ | CRT d	
	6.00am	=> Due medication is given as per drug chart maintain & document	

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Patient Sticker

NURSES NOTES

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

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
8/7	6.00 am	due medications are given as maintain ay Lamont	
	7.30 am	→ The Baby is hand over from morning duty staff.	[signature] 9628
		← Morning duty →	
	7.30 am	→ child details Handing over taken by Night duty staff	[signature] 019340
		→ child was conscious and Started child was active alert Iv line patten	
	8 am	→ vitals are checked and Recorded vitals are stable	[signature] 019340
		TIME / CFT / CP / PP — <3sec / +ve / +ve	
		→ Due Medications are given as per day chart done	[signature] 019340

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Patient's Name:........ GUC-00064132 IP18-00036354
Master P SHAUN GOODWIN
MRD NO:...... 25-04-2016 10 Y 2 M 11 D (M)
Dr. NATARAJ PALANIAPPAN
Age :.............. ☐M ☐F
Consultant :..

PHLEBITIS ASSESSMENT

CANNULA 1

Date : 06/07/26 Time: 5:30PM
Location : (L) Metacarpal.
Size : 22G venflon
Cannula inserted by : S/N: Ajith

Date	Time	Phlebitis	Infiltration	Nursing Intervention	Sign
06/7/26	5:30 PM	☐Yes ☐No	☐Yes ☐No	patten	[signature]
	6 pm	☐Yes ☐No	☐Yes ☐No	obsw	[signature]
	7pm	☐Yes ☐No	☐Yes ☐No	obs	[signature]
	8pm	☐Yes ☐No	☐Yes ☐No	observe	[signature]
7/7	12am	☐Yes ☐No	☐Yes ☐No	observe	[signature]
	2 am	☐Yes ☐No	☐Yes ☐No	obser	[signature]
	4 am	☐Yes ☐No	☐Yes ☐No	obse	[signature]
	8 am	☐Yes ☐No	☐Yes ☐No	observe	[signature]
	10 am	☐Yes ☐No	☐Yes ☐No	observe	[signature]
	12pm	☐Yes ☐No	☐Yes ☐No	observed	[signature]
	2pm	☐Yes ☐No	☐Yes ☐No	observe	[signature]
	4pm	☐Yes ☐No	☐Yes ☐No	observe	[signature]
	6pm	☐Yes ☐No	☐Yes ☐No	observe	[signature]
	8pm	☐Yes ☐No	☐Yes ☐No	observe	[signature]
	10pm	☐Yes ☐No	☐Yes ☐No	obseo	[signature]
8/7	12am	☐Yes ☐No	☐Yes ☐No	observe	[signature]
	4 am	☐Yes ☐No	☐Yes ☐No	obser	[signature]
		☐Yes ☐No	☐Yes ☐No	obsev	[signature]
	4am Jay	☐Yes ☐No	☐Yes ☐No	obsed	[signature]
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐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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THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE 6/7 (E)	DATE 6/7 (N)	DATE 7/7 (M)	DATE 7/7 (E)	DATE 7/7 (N)
Age	Less than 3 years old	4					
	3 to less than 7 years old	3					
	7 to less than 13 years old	2	2	2	2	2	2
	13 years old and above	1					
Gender	Male	2	2	2	2	2	2
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3	3	3	3	3	3
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1					
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own ability	1	1	1	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	1	1	1
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours/ None	1	1	1	1	1	1
Medication Usage	Sedatives (Excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1	1	1	1
	Total		11	11	11	11	11

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	NA	X	X
Other Intervention(s) Specify		X	NA	NA	X	X
Nurse's Name:		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Signature:		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Date:		6/7	6/7	7/7	7/7	7/7
Time:		2pm	8pm	8am	2pm	8pm

Docu. No. : RCH /FRM / CLINICAL / 005

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BRADEN 'Q' SCALE

(1)

	1. Completely immobile:	2. Very limited:	3. Slightly limited:	4. No limitations:	Date: 6/7	6/7	7/7	8/7
					Time: 6pm	8pm	8am	2pm
Mobility	Does not make even slight changes in body or extremity position without assistance.	Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	Makes frequent through slight changes in body or extremity position independently.	Makes major and frequent changes in position without assistance.	4	4	4	4
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4	4	4
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	4
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	4
FRICTION-SHEAR Friction. Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	4
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4
				TOTAL SCORE	28	28	28	28
				Evaluator's Name	JM	JM	RMA	JM

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

Risk Score	Category	Action	Support Surfaces (**Please Note:** Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice
15-18	At Risk	• Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • Advance to a higher level of risk if other major risk factors are present	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	• Use the Same Protocol as for **"At Risk"** Patients • Position patient at 30 degree lateral incline using foam wedges	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	• Follow the same protocol as for **"Moderate Risk"** Patients • In addition to regular turning schedule • Make small shifts in their position frequently	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	• Use same protocol as for **"High Risk"** Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

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BRADEN 'Q' SCALE

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					Date : 7/5	8/5		
					Time : 8 pm	M		
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		
FRICTION-SHEAR **Friction** . Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another	**1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	**2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	**3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	**4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4		
Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4		
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	28	28		
				Evaluator's Name				

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

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

Risk Score	Category	Action	Support Surfaces **(Please Note:** Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice
15-18	At Risk	• Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • Advance to a higher level of risk if other major risk factors are present	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
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Nursing General Admission Assessment Form For Pediatrics

Diagnosis: 2 RDF
Arrival Time: 6:30 PM Mode of Arrival: walk Admitting From: ☑ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction: nil

Body Weight: 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
Adenoid.	—	RCH Guind.

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: 45 Length: ..... Head Circumference (< 2 years): .....
Temp.: 98.1°F HR: 92 RR: 20 BP: 100/60
Pain Score: 0/10 Specify Site: OW (Follow Pain Assessment Sheet & Document)
Fall Risk Assessment: ☐ Yes ☐ No Score: 11 (Document in the Humpty Dumpty Sheet)
Risk of Pressure Sore (Braden Q Score 28) (Document in the Braden Q Assessment Sheet)

Pain Screening: ☑ Yes ☐ No If Yes, Pain Score: 0/10 Pain Tool Used: ☐ N Pass ☐ FLACC ☐ Wong Baker
Character of Pain ..... Location ..... Frequency ..... Duration .....

FUNCTIONAL SCREENING: ☑ No Abnormalities Detected
☐ Mobility Problem ☐ Walking Problem
☐ Developmental Delay ☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING: ☑ No Abnormalities Detected
☐ Underweight ☐ Overweight ☐ Special Feeding Method
☐ Feeding Problem ☐ Special diet ☐ No Abnormality Detected

Inform consultant for positive criteria

Psychological Screening: ☐ No Significant Findings

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

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

Social History: Lives With Parents

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

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 Father.

Nurse's Name: R S. Thulasi Date: 6/7h Time: at 6:30 PM Signature

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INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Part - I.

Patient's / Learner Language: Tamil Patient / Learner Literacy: ☑ Read ☐ ~~Write~~ ☐ ~~Speak~~ Willingness to Learn: Yes ☑ No ☐ Healthcare Literacy: ~~Yes~~ ☑ No ☐

Identified Education Needs:

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

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
6/7	6.30 pm	1	Explain about the Diagnosis	~~Father~~ Mother	NO	Oral	none	Verb	Good	
7/7	8am	1	Explain about the Infection control programme.	~~Father~~ Mother	No	Oral	none	Verb	Good	
8/7	8am	1	Explain about Medication/ Therapy Safety Effects/ Side Effects	~~Father~~ Mother	no	Oral	none	Yes	Good	

Part - III: CODES

Who was taught:	**PT:** Patient	**F:** Father	**M:** Mother	**S:** Spouse	**Sn:** Son	**D:** Daughter	**C:** Caregiver	**O:** Other (Specify)	
Learning Barriers:									
1. No Learning Barriers	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						

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BED SIDE CHECK LIST FOR NURSES

Date:	6/7	7/7							
Doctor's Orders	✓	✓							
Carried out or not	✓	✓							
Bed Side									
Structured Handover done	✓	✓							
IV Site	✓	✓							
Central Lines	X	X							
Arterial Lines	X	X							
Feeding Catheter	X	X							
Urinary Catheter	X	X							
Skin Care	X	X							
Eye Care	X	X							
Mouth Care	X	X							
Sterillum Bottle, Stethoscope	✓	✓							
Suction Bottle (Should be clean & empty)	X	X							
Intubation Tray	X	X							
Emergency Tray (Loaded Syringes with Midazolam & Vecuronium and Flush) Ampoules of Adrenaline	X	X							
Ventilator Tubing,(Any Water, Blood)	X	X							
Humidification	X	X							
Check all Infusion (Labelling,Correct Preparation)	✓	✓							
Chest Physio & Neb	X	X							
Handed Over By Name :	Hm	S.A Vth							
Signature :	Hm	[signature]							
Date & Time:	6/7	7/7							
Hand Over Taken By Name :	S.Hm	S.Vth							
Signature :	[signature]	[signature]							
Date & Time:	6/7 8pm	7/7 8pm							

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

GUC-00064132 IP18-00036354
Master P SHAUN GOODWIN
25-04-2016 10 Y 2 M 11 D (M)
Dr. NATARAJ PALANIAPPAN

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 06/07/2026 Time of arrival : 4:40PM

Chief Complaints: C/o fever x 4 day, & cold, cough x day RBS: –

Height : .... Weight : 40 kgs 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

	Yes	No
History of Falling: within past 3 months	☐	☑
Ambulatory Aids:		
• Wheelchair	☐	☑
• Uses furniture for support	☐	☑
Gait/Transferring:		
• Bedrest / immobile	☐	☑
• Weak	☐	☑
• Impaired	☐	☑
Mental Status: Forgets limitations	☐	☑

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): 06/07/26 @ 4:40 PM

Social History: Lives With Parents

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

Time of Initial assessment completed by ER Nurse : 4:50PM

Docu. No. : RCH /FRM / CLINICAL / 120

(P.T.O.)

Time	Nursing Notes
5:00pm	pts came to ER. C/o. fever x 4days, cold & cough x 4 days.
	checked vital sigs & recorded S/b Dr. Natarajan
	Admited for Admission. IV line placement done. & Blood sample collected & Cas.
	pts was Stable Shift to Ward.
	OP file given to parent.

Samples collected by: S/N: Ajith Time: 5:30pm

Samples sent by : S/N: Rishi Time:

Medication given in ER:

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

Condition of patient at time of shift - out :	Details of Shift - out
HR: 81/M BP: 102/57 CFT: <3sec	Shift - out from ER to: 507
RR: 20b/M SPO$_2$: 100%	Time of Shift - out: 6:05pm
GCS: 15/15 Temperature : 97.6°F	Handover given to: S/N Thulasi (Nurse's Name)
Pain Score: 01/10	
Repeat RBS (if applicable): -	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

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

(1) Metacarpal 22G venflon 06/07/26 01:45pm

Name of the Nurse : M. Ajithi Signature of the Nurse :

Date & Time : 06/07/26 01:45pm.

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PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : Dr-NATRAJ PALANIAPPAN Date : 6|7|26

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

Start Time of Assessment: 6.|7|26, 5:00PM Weight: 45kgs

Allergic History: No Allergy

Chief Complaints:

c/o fatigue since morning
c/o fever x 7days.
(Afebrile for last 1day)

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: Adenoidal LRTI - prev admission → 3yrs back

Medication History: ....

Relevant Investigations: ....

Primary Assessment

Airway
- ☑ Open
- ☐ Maintainable
- ☐ Not Maintainable

Any urgent interventions needed: ☐ Yes ☑ No

If Yes ....

Breathing

Rate: 26/min SpO$_2$ on FiO$_2$ 100% @RA

Any urgent interventions needed: ☐ Yes ☑ No

If Yes ....

Rhythm: ....

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

Respiratory Noises: ☐ Stridor ☐ Wheezing ☐ Grunting

Air Entry: B/L AE ⊕ / B/L Crepts (R>L)

Palpation Findings (If necessary) ....

Circulation HR: 81/min

BP: 102/57 mmHg

Pulse Volume: Central (P) / Peripheral (P)

If in Shock: Compensated (N) – / Hypotensive (N) –

Muffled Heart Sound: ☐ Yes ☑ No

Engorged Neck Veins: ☐ Yes ☑ No

CFT: Central (P) / Peripheral (P)

Murmurs: ☐ Yes ☑ No

Liver Span: ....

ECG: ....

Any Signs of Heart Failure: ☐ Yes ☑ No

Any urgent interventions needed: ☐ Yes ☑ No

If Yes ....

Disability

GCS: 15/15 AVPU: Alert

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.: 97.6F

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: Lakshmipriya

Signature: Lucky Vilan 203372

Date & Time: 6/7/26, 5:00PM

Sr. Doctor on Duty (If necessary)

Name of the Sr. Doctor: ....

Signature: ....

Date & Time: ....

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EMERGENCY ROOM TRIAGE FORM

Wt - 45 kg

Patient's Name : Master. P shaun goodwin Age : 10y 2mon Gender: ☑ Male ☐ Female

Date : 06/07/26 Time of Arrival : @ 4:45pm

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: 97.6F PR: 81 BP: 102/57(70) RR: 28 SpO_2: 100%

Chief Complaints: c/o fever, cold, cough, x 2 days

INITIAL PHYSIOLOGICAL CATEGORIZATION

Appearance: ☑ Normal ☐ Sick Looking

Circulation / Colour: ☑ Normal ☐ Abnormal ☐ Bleeding

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

INITIAL PHYSIOLOGICAL STATUS

☑ Stable

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

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

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

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian

Triage Completion Time : 2mins

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 : Ruby

Signature of Triage Nurse : (102334)

Date & Time : 06/7/26 @ 4:44pm

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

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PATIENT TRANSFER FORM

GUC-00064132 IP18-00036354
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Dr. NATARAJ PALANIAPPAN

	Date & Time of Admission	Date & Time of Transfer Order
	06/07/26 @ 4:42 pm	06/07/26 @ 6:35 pm
Treating Consultant Name	**Transfer Ordered by**	**Reason for Transfer**
Dr. Natarajan	Dr. Chandralega	further management
From Unit	**To Unit**	**Information to Attendant** Yes ☑ No ☐
ED	507	
Number of Sheets in Clinical File	**Number of Imaging Films**	**Personal belongings including clinical documents. If any handed over to attendant** Yes ☐ No ☐ If yes, what ?
6	x-ray chest	

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	Inj. Xone (1gm)	2
2.		
3.		
4.		
5.		

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

LRTI – ? Adenoviral / Influenza

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
M. Rishi (C020326)	[signature] 203372

Patient & Clinical Records Received by : [signature] 020W

Date & Time of Patient Received : 6/7/26 at 6:20 pm

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

☐ Unavailable Bed ☐ Nurse not Available ☐ Available Bed not ready

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RBS CHART

Date	Time	RBS (mg/dl)	IVF %	Signature
06/7/26	5:45pm	105 mg/dl	–	[signature]