GUC-00091423 IP18-00036520
Baby NIHARIKA
24-10-2024 1 Y 8 M 25 D (F)
Dr. GANESH R

DISCHARGE TRACKING SHEET

UHID- FLOOR- NAME OF CONSULTANT-

ACTIVITY	INTIME	OUT TIME	NAME & SIGNATURE	REMARKS	<To be filled by Admin>		
Activity Sheet update by Nursing		20/7/[illegible] 10:45Am		[illegible] 015384.			
Activity Sheet update by Pharmacy		12.00	[illegible]				

ACTIVITY RECORD FOR BILLING

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Name: .....

UHID No: ..... IP No: ..... GUC-00091423 Baby NIHARIKA 24-10-2024 Dr. GANESH R IP18-00036520 1 Y 8 M 24 D (F) ..... Dept: .....

Date of Admission: ..... Time: .... Time: .....

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
18/7/26	6.45pm	ER	402	

CROSS CONSULTATION VISIT

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

INVESTIGATIONS

Date	Investigations	Order No.	Signature
18/7/26	RBS, OT, PT, Blood Culture	260 23153	
18/7/26	Urine routin, urine culture	83167	

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
18/7.	Infusion pump.	7pm.	20/7/26 @ 6am	29515 ✓	Baluij/020685

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
18/7/26	Tube placement	(1)	1729481	[signature] 6049
20/7/26	UScr (Abd)	(1)	9765	[signature]

ANY OTHER INFORMATION:

....

....

....

....

....

....

Date: 20/7/26 Time: 10.45AM Prepared By: ....

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
[signature] 01890			

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DISCHARGE TRACKING SHEET

UHID- FLOOR- NAME OF CONSULTANT-

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ACTIVITY	TIME		NAME & SIGNATURE	REMARKS	<To be filled by Admin>
Discharge Announcement					
	INTIME	OUT TIME			
Arrangement of File by Nursing	20/[illegible]/26 P 10-45AM		[illegible] 01/3/24		
Preparation of Discharge Summary					
Finalization of discharge summary					
Transfer of file from Ward to Billing Dept					
Bill Processing					
Audit Clearance					
Billing Clearance					
Physical Clearance					

Rainbow Children's Hospital

Birthright 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 : IP18-00036520 **Admit Date** : 18-Jul-2026 **Admit Time** : 05:37 PM **UHID** : GUC-00091423

Patient Details :

Patient Name	: Baby NIHARIKA	**Age**	: 1 Y 8 M 24 D
Guardian	: MUKUNTHAN VAITHEESWARAN	**DOB**	: 24-10-2024 01:00 AM
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: 36/59, sakkaraikulam street, n.g.o colony road, Srivalliputtur H O Virudhunagar Tamil Nadu INDIA 626125	**Phone No**	: 8870980989
		E-mail	: no@gmail.com

Admission Details :

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

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

Contact Details :

Name : MUKUNTHAN VAITHEESWARAN **Relationship** : Father

Contact Address 36/59, sakkaraikulam street, n.g.o colony road, Srivalliputtur H O Virudhunagar Tamil Nadu INDIA 626125 **Phone No** :

Signature

Doctor Details :

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

Referral Doctor : Self **Phone No** :

Co-Consultant

Payment Details :

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

Payor Name : SELFPAY

Rainbow Children's Hospital

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GENERAL CONSENT FOR TREATMENT

Patient Name:	**Baby NIHARIKA**	**Age :**	**1 Y 8 M 24 D**
IP No:	**IP18-00036520**	**Sex:**	**Female**
Consultant:	**Dr. GANESH R**	**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:

Relationship:

Date: Time:

Witness Name:

Witness Signature:

Patient Address:

36/59, sakkaraikulam street, n.g.o colony road, Srivalliputtur H O Virudhunagar Tamil Nadu INDIA 626125

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BILLING POLICY

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

DECLARATION

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

Patient Name :	UHID Number :
Self/Attendant Name :	Relation :
Self Attendant Signature : Phone Number :	Name & Signature of Financial Counselor

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PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: _____

UHID ID: _____ GUC-00091423 IP18-00036520
Baby NIHARIKA
24-10-2024 1 Y 8 M 24 D (F)
Dr. GANESH R

Department: _____

Consultant: _____

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Baby NIHARIKA
24-10-2024 1 Y 8 M 25 D (F)
Dr. GANESH R

Pediatric Multiorgan History & Physical Examination

Name: Baby NIHARIKA Age/Sex 1Y8Mon/F.

Information given by: Relationship

Chief Presenting Complaints & Duration (Chronologically)

Fever x 2 days
vomiting x 1 day
loose stools x 1 day.

History of present illness :

A: 1Y8 months old female came with complaints of fever for 2 days, high grade intermittent, not associated with chills & rigor.

c/o vomiting x 4 episodes, non projectile, non blood stained

c/o loose stools 7-8 times/day, associated with mucous, non blood stained.

c/o decreased oral intake since morning.

Activity - reduced.

urine output - good.

Evaluated & Treated as OPD basis.

TC - 5450
N/L - 41/46
Plts - 3,23,000
CRP - 85↑↑.

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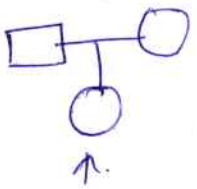
Past History : (Including details of any previous investigation or treatment)

—

Birth & Neonatal History:

Family Chart



Birth & Socio Economic History:

About Father : ?

About Mother : NCM.

Any additional Information :

Developmental History :

Milestones attained at appropriate age.

Immunization History :

Immunized upto age according to IAP guidelines.

Anthropometry :

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

Weight (kgs) 11kg. (Centile _____)

On Examination :

Temperature : 97.3F Pulse Rate : 138/min B.P. _____ SPO2 98% RA

Resp.rate and type of breathing : 24/min.

Rash -

Lymphadenopathy -

Oedema : -

Allergies (if any): -

(P.T.O.)

Respiratory System :

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

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

Any addes sounds : no added sounds

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

Cardiovascular System :

Inspection of procordium :

Heart Sounds : S1S2 (+)

Any murmur : no murmur.

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

Per Abdomen :

Inspection : (P)

Palpation : soft, non tender, no organomegaly

Ausculation :

Spine : External Genitelia :

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

Central Nervous System :

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

Cranial Nerves :

Motor System :

Nutriton : (N)

Tone: Power 5/5

Co-ordinator :

Posture :

Involuntary Movements :

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Reflexes :

DTR

Superficials:

Plantars

Sensory System :

Bladder / Bowel :

Clinical Summary & Diagnostic:

Acute ~~fever~~ gastroenteritis c̄ some dehydration
? enteric / ? UTI

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

Desired goals of the treatment :

Planned Labs:

RP2
SGOT
SGPT
Blood C/S
Urine C/S & Routine

Planned Management

IV Fluids.
IV Ceftriaxone.
IV Pantoprazole,
Enterogermina.
Redotil 10 mg 1 ~~[illegible]~~ TID.

Signature of the Doctor: [signature] 18/7/24

Name of the Doctor: Dr. Chandiralega

Date & Time: 18/7/24

Signature of the Consultant: [signature]

Name of the Consultant: Dr. R. Ganesh

Date & Time: 18/7/2024

(P.T.O.)

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Baby NIHARIKA
24-10-2024 1 Y 8 M 25 D (F)
Dr. GANESH R

DISCHARGE PLANNING FORM

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

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

2. Destination Post Discharge: ☐ Home

   Family Members Notified (Person Contacted)

   ☐ Transfer

   Hospital Facility Notified (Person Contacted)

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

   ☐ Needs Assistance In:

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

4. Nutritional Plan:

   ☐ Dietary Instruction Discussed with the:

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

5. Discharge Planning Discussed with the:

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

6. Patient/Family Educational Plan:

   ☐ Educational Topic/s: .....

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

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

Doctor Signature: .....

Doctor Name: .....

Date and Time: .....

GUC-00091423
Baby NIHARIKA
24-10-2024
Dr. GANESH R
IP18-00036520
1 Y 8 M 24 D
(F)

DOCTOR'S SHIFT CHANGE HANDOVER FORM

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

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

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

DOCTOR'S SHIFT CHANGE HANDOVER FORM

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

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

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Baby NIHARIKA
24-10-2024 1 Y 8 M 25 D (F)
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
18/7/26 9.PM.	S/B Dr chandiralega.	
	child reviewed	
	Dull looking	
	· Febrile	
	Loose stools ⊕	
	no vomiting	
	oral intake – minimal	
	urine output good.	
	O/E	Bp – 96/56 mm Hg
	CVS – S1S2 ⊕	PR – 124/min.
	RS – B/L AE ⊕	
	P/A soft	
	Hydration – PPWF, CRT<3sec	
		Adv
		– monitor vitals
		– continue iv fluids, ceftriaxone
		– w/f fever spikes, loose stools
		– Inform SOS
	S/f 19/24	

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/7/26 8 AM.	S/B Dr. Chandiralega	
	Δ – UTI	
	child reviewed	
	Alert, Activity – Improving	
	No fever spikes since Admission	
	loose stools – 4 episodes	
	oral intake – minimal	
	urine output – good,	
		BP – 95/49 mmHg
	O/E	PR – 120/min
	Afebrile	
	CVS – S1S2 ⊕	
	RS – B/L AE ⊕, clear	
	P/A – soft	
	Adv:	
	– monitor vitals	
	– W/F fever spikes, loose stools	
	– Inj. ceftriaxone 500mg IV Q12h	
	– Enterogermina 1 – 0 – 1	
	– Redotil 1 BBH (10mg)	
	– Inform (SOS)	
	Trace report	
[signature] 19/7/4	Cmrc/c	

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RESULT SHEET

Date	18/7/26.					
Time						
Hb	12.1					
PCV	35					
RBC	4.47					
WBC	5.45					
N/L	41/46					
Platelets	3,23,000					
CRP	85					
ESR						
PCT						
RBS	113					
Na	132					
K	3.4					
Cl	100					
Ca/Mg	1.21					
Phosphate / HCO3	/ 18					
Urea	18					
Creatinine	0.43					
ALP						
SGPT	17					
SGOT	33					
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

Date	18/7/26					
Time						
CUE - Alb	–					
CUE - Sugar	–					
CUE - Ketones.	1+					
CUE - PUS Cells.	10–12					
CUE - RBC Cells	1–2.					
CUE Leucocyte	1+					
nitrate	Negative					
Stool Pus Cell						
OVA / Cyst						
Occult Blood						

Culture and Sensitivities : Urine C/S – E.coli

Blood C/S – JFNG

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

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MEDICATION RECONCILIATION FORM

Drug Allergies: ..... NKA ☐ 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: 402

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

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : ..... Dr. Chandrasekar 18/7/2024

Date & Time : ..... 18/7/24 .....

Nurse Name & Signature: ..... Sangeeta Sangeeta .....

Date & Time : ..... 18/7/24 at 6pm .....

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

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DRUG CHART

Date of Admission: 18/7/26 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 I through it and a similar line through subsequent recording panels.
- The date and time of stopping the drug along with the doctors name and sign must be mentioned.
- Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.

NURSES - Nurses must follow strictly the FIVE RIGHTS before administration of medication.
1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time
- AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

SOS / PRN (As Required Medication)

DRUG : SYP PARACETAMOL 250				Date Time 20/7/26 845 am
Dose	Route	Frequency	Start Date	mf PN
3.5ml	PO	SOS	18/7/26	
Doctor's Signature	Valid Period	Pharm.		
Additional Instructions: (250mg/5ml) Q6H if Temp >100 F				

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. 11 kg Ward. ....

				Date / Time	18/7	19/7	20/7
DRUG : INJ CEFTRIAXONE				6am	/	PN/MA	PN/MA
Dose	Route	Frequency	Start Date	6pm	10³⁰pm PN/MA	BJ/PY	
550mg	IV	Q12H	18/7/26		D1	D2	D3
Name & Signature of the Doctor Starting the Drugs: [signature] 19/7/24							
Additional Instructions:							
Daily Doctor's Endorsement by a Sign							

				Date / Time	18/7/26	19/7	
DRUG : INJ. PANTOPRAZOLE				6pm	PS	PN	
Dose	Route	Frequency	Start Date		6am	MA	
10mg	IV	Q24H	18/7/26				
Name & Signature of the Doctor Starting the Drugs: [signature] 19/7/24							
Additional Instructions:							
Daily Doctor's Endorsement by a Sign							

				Date / Time	18/7	19/7	20/7
DRUG : ENTEROGERMINA				8am	/	PSP/SA	PS/RG
Dose	Route	Frequency	Start Date	2pm	/	BJ/PY	
1	PO	Q8H	18/7/26	10pm	PN/MA	MA/PN	
Name & Signature of the Doctor Starting the Drugs: [signature] 19/7/24							
Additional Instructions:							
Daily Doctor's Endorsement by a Sign							

				Date / Time	18/7	19/7	20/7
DRUG : REPOTIL SACHET				8am	/	PSP/SP	PSA/RG
Dose	Route	Frequency	Start Date	2pm	/	BJ/PY	
1	PO	Q8H	18/7/26	10pm	PN/MA	MA/PN	
Name & Signature of the Doctor Starting the Drugs: [signature] 19/7/24							
Additional Instructions: 1 Sachet - 10mg							
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.	

Signature .....

VERIFIED BY : Name .....

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses

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Dr. GANESH R

I.V. FLUIDS CHART

Weight. 11kg 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
18/7/26	6pm	0.9.1.DNS	IV	40ml/hr	19/12/24		19/7/26 11pm		18/7/26
19/7/26		0.9 Lnr	IV	25cc/hr					

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

GUC-00091423
Baby NIHARIKA
24-10-2024
Dr. GANESH R
IP18-00036520
1 Y 8 M 24 D (F)

I/ FRM / CLINICAL / 125

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

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...LY WARNING SCORE: CHILDREN'S UNIT

Date : 1/8/24 Time: 8pm 10pm. 12Am. 4am

Doctor / Nurse / Family Concern?

Temperature (°F)

104 103 102 101 100 99 98 97 96 95 94

100.6F 98.8F 99°F 98.4F

Heart Rate (bpm) and Blood Pressure (mmHg) *

Note: BP does not score in early warning scoring

190 180 170 160 150 140 130 120 110 100 90 80 70 60 50

(91) (61) 50 65 56 (58) 49

Heart Rate (Number) 130bpt 120bpt 120bpt

Resp. Rate (bpm) (Over 1 Minute) *

70 60 50 40 30 20 10

Resp Rate (Number) 30bpt 32bpt 30bpt

Resp Distress	Mod/ Severe / None / Mild	✓	✓
Receiving O_2 (l/min) O_2 Saturations (%)		98%	99%	98%
Conscious Level	Normal / Altered	✓	✓	✓
GCS *		15/15	15/15	15/15
TOTAL SCORE Number of shaded boxes		0	0	0
Pain Score		0	0	0
Observer's Initials		✓	PP.	✓

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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Dr. GANESH R

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

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

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date 19/7/26 Time:	9AM	12pm	4pm	8pm	12AM	4am
Doctor / Nurse / Family Concern?						
Temperature (°F) (94–104)	97.8°F	98°F	97.3F	97.6f	98°F	98.2f
Heart Rate (bpm) and Blood Pressure (mmHg) * (50–190)			98/56 (60)	96/58 (64)	91/51 (68)	
Heart Rate (Number)	120b/m	120b/m	112bm	120bt	116bt	110bt
Resp. Rate (bpm) (Over 1 Minute) * (10–70)						
Resp Rate (Number)	28b/m	26b/m	26b/m	26bt	24b/m	24bt
Resp Distress: Mod/ Severe / None / Mild	None / Mild ✓	None / Mild ✓	None / Mild ✓	None / Mild ✓	None / Mild ✓	None / Mild ✓
Receiving O_2 (l/min) / O_2 Saturations (%)	RA 98%	99%	99%	98%	99%	96%
Conscious Level: Normal / Altered	Normal ✓	Normal ✓	Normal ✓	Normal ✓	Normal ✓	Normal ✓
GCS *	15/15	15/15	15/15	15/15	15/15	15/15
TOTAL SCORE Number of shaded boxes	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0
Observer's Initials	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

Note: BP does not score in early warning scoring

ACTIONS

NB: Scores 3 should be recorded overleaf

Score 1	Continue normal observation by staff nurse
Score 2	Shift in charge nurse to be informed and continue hourly observations
Score 3	Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.
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* 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:

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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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Baby NIHARIKA
24-10-2024
Dr. GANESH R
IP18-00036520
1 Y 8 M 24 D (F)

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FLUID CHART

Sheet No. : 1

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

18/[illegible]/26		Intake				Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						**Total Output :**						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm	→ child received from ER to 4th Floor										
Total Intake :		Nil				**Total Output :**				Nil		
	08:00 pm	water 20ml		40ml			Loose Stool				0	nil
	09:00 pm			40ml			✓			✓	0	nil
	10:00 pm	water 10ml		40ml							0	nil
	11:00 pm			40ml			✓			✓	0	nil
	12:00 am	water 20ml		40ml							0	nil
	01:00 am	water 10ml		40ml							0	nil
Total Intake :		60ml		+ 240ml		**Total Output :**				2 times urine passed		
	02:00 am			40ml			✓			✓	0	nil
	03:00 am	water 10ml		40ml							0	nil
	04:00 am			40ml							0	nil
	05:00 am	water 20ml		40ml							0	nil
	06:00 am			40ml						✓	0	nil
	07:00 am	water 20ml		DC							0	nil
Total Intake :		50ml		+ 200ml		**Total Output :**				2 times urine passed		

Total 24 hrs. Intake	550ml

Total 24 hrs. Output	4 times urine passed

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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.

19/7/26		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	wats	50ml	DC							0	RA
	09:00 am	wats	20ml	40ml							0	RA
	10:00 am			40ml			Loose Stool				0	RA
	11:00 am			20ml			✓				0	RA
	12:00 pm			DC							0	RA
	01:00 pm	wats	50ml	DC						✓	0	RA
Total Intake :		120ml + 100ml							Total Output :		1 times wellpasal	
	02:00 pm	H2o	50ml	20ml							0	Jay
	03:00 pm	H2o	30ml	DC			Loose Stools			✓	0	Jay
	04:00 pm	H2o	50ml	DC							0	Jay
	05:00 pm	R.K.	50ml	DC							0	Jay
	06:00 pm	H2o	30ml	20ml			Watery Stools				0	Jay
	07:00 pm			20ml						✓	0	Jay
Total Intake :		210ml + 60ml							Total Output :		2 times Urine passed	
	08:00 pm										0	NS
	09:00 pm	H2o	50ml							✓	0	NS
	10:00 pm										0	NS
	11:00 pm	H2o	50ml							✓	0	NS
	12:00 am										0	NS
	01:00 am	Wat	80ml							✓	0	NS
Total Intake :		180ml							Total Output :		3 times	Urine pass
	02:00 am	Wat	50ml								0	NS
	03:00 am									✓	0	NS
	04:00 am										0	NS
	05:00 am										0	NS
	06:00 am										0	NS
	07:00 am	Wat	50ml							✓	0	NS
Total Intake :		100ml							Total Output :		2 times	Urine pass

Total 24 hrs. Intake	710ml	Total 24 hrs. Output	8 times Urine passed

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NURSING CARE RECORD

Date: 18/7

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning		–		–	–	–	–
Afternoon	4pm.	Maintain fluid Balance.	7.30pm	→ Assess the child's condition → I/o chart maintained → Administer of IV fluids	Maintained fluid Balance.	Reassessment done.	Baby [signature] 0r06155
Night	8pm	maintain good Nutritional status		⇒ Assessed child condition. ⇒ maintain vital sign's and I/o chart ⇒ maintain Rx Medication.	Encourage oral intake	Reassessment was done vital are stable	[signature] 068950

Docu. No: RCH /FRM / CLINICAL / 148

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NURSING CARE RECORD

Date: 19/4/26

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	Prevent Infection		Assess child condition monitor vitals Administer Medication as per order	infection was reducing	Reassessment done	[illegible] 05780
Afternoon	2pm	To promote Health Hygiene		→ Assessed child condition → vitals monitoring → Administer medication → encourage oral & Hand Hygiene	To promote & maintain personal Hygiene	Reassessment done	[illegible] 05004
Night	8pm	To maintain Fluid Balance	9pm	To Asses the general condition. To monitor vital signs. To maintain I/o chart.	To maintained Fluid volume.	Reassessment was done.	[illegible] 05801

Docu. No: RCH /FRM / CLINICAL / 148

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NURSES NOTES

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

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		Receiving notes	
18/7	6.45pm	The child received from ER to 4th floor. Child details handing over taken from ER Staff. Child is conscious. IV line present and patency. IVF 0.9% DNS - 40ml/hr on flow. No other complaints →	Baby/020685
	7pm.	I/o chart maintained. Urine C/S pending →	Baby/020685
	7.30pm	The child details handing over given to night duty staff →	Baby/020685
		→ Night duty On: 18/7/86 ←	
	7.30pm	child details hand Over taken from evening duty staffs. Child is conscious & oriented. Child Rt cannula patten —	Dy 018900.
	8pm	Vital Bigg's checked and Recorded vital are Stable.	
		CP ++ / PP ++ / CRT <2sec —	Dy 018900.
		Rt fluid DNS 40ml per on flow	
	10pm	Child mine Sample given. Rt medication was given as per doctor's Orders —	Dy 018900.

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

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NURSES NOTES

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

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		→ continue 18/1/26 ←	
18/1/26		Due to medication was given as per doctor's Order. I/O chart maintained.	[signature] 018950
	12am	Vital Sign's checked and Recorded vital are stable. CP ++ / PP ++ / CRT <3sec	
		Continue IV fluid DNS 40ml per hr flow	[signature] 018950
	2am	Child sleeping pattern was good. I/O chart maintained. No any complaint's	
	4am	vital sign's checked and Recorded vital are stable. CP ++ / PP ++ / CRT <3sec	[signature] 018950
	6am	Due to medication was given as per doctor's Order. I/O chart maintained	
	7:30am	Child details hand over given to morning duty staff	[signature] 018950
		Morning duty Notes on 19/1/26	
	7.30am	The child details handover taken from the night duty staffs the child is conscious and active	[signature] [illegible]

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

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NURSES NOTES

☐ No Known Drug Allergies

☐ Drug Allergies .... NS I

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		contin (19/2/26)	
	8am	Administer the medication as per doctor's order	
		vitals are checked and recorded	[signature]
		temp is normal — PP ++, CP ++, CRT <2s	
	10am	I/O chart is maintained	
		No any other complaints	[signature]
	11am	Dr. Ganesh sir rounds was done	
		adv to plan discharge tomorrow	
	12pm	vitals are checked and recorded	
		temp is normal — PP ++, CP ++, CRT <2s	
	1.30pm	The baby details handover given to Evening duty staffs.	[signature]
		Evening Duty Notes:-	
19/2/26	1:30 pm	child details handing over taken from morning duty s/n. Child conscious, oriented. child activity are good. IV line no swelling pain. Due IVF 20ml/hr	
	2pm	Due medication are given as per drug chart order.	
		I/O chart maintained	[signature]

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

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NURSES NOTES

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

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
19/7/26	4pm	Vital signs checked & Recorded Vitals are stable now CP ++ | PP ++ | CRT <2sec	
	6pm	Due medication are given as per drug chart order.	
	7pm	Iv chart maintained	
	7:30pm	Child details handed over to night duty staff nurse with Issue noted.	
		← 19/7/2026. ON Night duty →	
19/7.	7:30pm.	The child details handing over taken from Evening duty to night duty. The child is conscious and oriented. Iv line present. no pain, no swelling Iv line pattern.	
	8pm.	Vital signs are checked and recorded. Vital are stable CP ++ | PP ++ | CRT <2sec	
	10pm	Due medication. Loos given as per doctor's order. order.	
20/7	12am	Vital. signs are checked and recorded. vital signs are stable. CP ++ | PP ++ | CRT <2sec	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

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Patient's	GUC-00091423 IP18-00036520
	Baby NIHARIKA
MRD NO	24-10-2024 1 Y 8 M 24 D (F)
	Dr. GANESH R
Age :.....	Sex: ☐ M ☐ F
Consultant :..	

PHLEBITIS ASSESSMENT

CANNULA 1

Date : 18/7/26 Time: 5.55pm
Location : (L) Metacarpal
Size : 24G
Cannula inserted by : Sr. Chandralega.

Date	Time	Phlebitis	Infiltration	Nursing Intervention	Sign
18/7/26	5.55pm	☐Yes ☑No	☐Yes ☑No	observed	[illegible]
	8pm	☐Yes ☑No	☐Yes ☑No	observed	[illegible]
	10pm	☐Yes ☑No	☐Yes ☑No	Observed	[illegible]
19/7/26	12am	☐Yes ☑No	☐Yes ☑No	observed	[illegible]
	2am	☐Yes ☑No	☐Yes ☑No	observed	[illegible]
	4am	☐Yes ☑No	☐Yes ☑No	observed	[illegible]
	6am	☐Yes ☑No	☐Yes ☑No	observed	[illegible]
	8am	☐Yes ☑No	☐Yes ☑No	observed	[illegible]
	10am	☐Yes ☑No	☐Yes ☑No	observed	[illegible]
	12pm	☐Yes ☑No	☐Yes ☑No	observed	[illegible]
	2pm	☐Yes ☑No	☐Yes ☑No	observed	[illegible]
	4pm	☐Yes ☑No	☐Yes ☑No	observed	[illegible]
	6pm	☐Yes ☑No	☐Yes ☑No	observed	[illegible]
	8PM	☐Yes ☑No	☐Yes ☑No	observed	[illegible]
	10PM	☐Yes ☑No	☐Yes ☑No	observed	[illegible]
20/7	12AM	☐Yes ☑No	☐Yes ☑No	observed	[illegible]
	2AM	☐Yes ☑No	☐Yes ☑No	observed	[illegible]
	4AM	☐Yes ☑No	☐Yes ☑No	observed	[illegible]
	6AM	☐Yes ☑No	☐Yes ☑No	observed	[illegible]
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		

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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Baby NIHARIKA
24-10-2024 1 Y 8 M 24 D (F)
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HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	E DATE 18/7	N DATE 19/7	M DATE 19/7	E DATE 19/7	N DATE 19/7
Age	Less than 3 years old	4	4	4	4	4	4
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2					
	Female	1	1	1	1	1	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	3	3	3	3	3
	Forget Limitations	2					
	Oriented to own ability	1					
Environmental Factors	History of Falls or Infant-Toddler Placed in Bed	4					
	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2					
	Outpatient Area	1	1	1	1	1	1
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours/ None	1	1	1	1	1	1
Medication Usage	Sedatives (Excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1	1	1	1
	Total		13	13	13	13	13

Intervention: -Fall Risk: Low Humpty Dumpty Score = 7-11, High Risk Humpty Dumpty Score = 12 or above

Intervention						
Bed in low position		✓	✓	✓	✓	✓
Call device within reach		✓	✓	✓	✓	✓
Wheels Locked		✓	✓	✓	✓	✓
Room free of clutter		✓	✓	✓	✓	✓
Adequate lighting		✓	✓	✓	✓	✓
Wheel chair support		–	–	NA	–	NA
Other Intervention(s) Specify		–	–	NA	–	NA
Nurse's Name:		Bab[illegible]	Angel	A[illegible]	[illegible]	Nisha
Signature:		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Date:		18/7	18/7	19/7	19/7	19/7
Time:		7pm	8pm	@ 8am	2pm	@ 8p

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

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NSG/04

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BRADEN 'Q' SCALE

(for Paediatric use)

Patient Name : ....

Age.......... Gender : ☐ M ☐

	1	2	3	4	E	M	M	E
				Date :	18/7	18/7	19/7	19/7
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	4	4
'Activity The degree of physical activity'	**1. Bedfast :** Confined to bed	**2. Chairfast :** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.'	**3. Walks occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. All patients too young to ambulate; OR walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4	4	4
Sensory Perception	**1. Completely limited:** Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	**2. Very limited:** responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	**3. Slightly limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	**4. No impairment:** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	4
Moisture Degree to which skin is exposed to moisture	**1. Constantly moist:** Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	**2. Very moist:** Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	**3. Occasionally moist:** Skin is occasionally moist, requiring linen change every 12 hours.	**4. Rarely moist:** Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	4
FRICTION-SHEAR **Friction** Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another	**1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	**2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	**3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	**4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times.'	4	4	4	4
Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	3	3	3	3
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4
				TOTAL SCORE	27	27	27	27
				Evaluator's Name	[illegible] 02068	[illegible] 01898	[illegible]	[illegible]

Highest Risk : 7 | High Risk : 8-16 | Mild Risk : 17-21 | No Risk : 22-28

GUC-00091423 IP18-00036520
Baby NIHARIKA
24-10-2024 1 Y 8 M 24 D (F)
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Nursing General Admission Assessment Form For Pediatrics

Diagnosis: Acute gastroenteritis.

Arrival Time: ..... Mode of Arrival: Parent Taking Admitting From: ☑ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction ..... Nil ..... Body Weight: ..... 11 ..... Kg

..... Height: ..... cm

.....

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

Past Medical History	Past Surgical History	Previous Hospital Admission
-	-	-

Family History: .....

.....

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

If yes please list, ...

Was the child's birth normal? ☑ Yes ☐ No If No, please describe problems: .....

.....

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

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

Observations: Weight: 11kg Length: ..... Head Circumference (< 2 years): .....

Temp.: 98.1 HR: 130 bl/mt RR: 24 bl/mt BP: -

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

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

Risk of Pressure Sore (Braden Q Score 22) (Document in the Braden Q Assessment Sheet)

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

Character of Pain - Location - Frequency - Duration -

FUNCTIONAL SCREENING: ☑ No Abnormalities Detected

☐ Mobility Problem ☐ Walking Problem

☐ Developmental Delay ☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING: ☑ No Abnormalities Detected

☐ Underweight ☐ Overweight ☐ Special Feeding Method

☐ Feeding Problem ☐ Special diet ☐ No Abnormality Detected

Inform consultant for positive criteria

Psychological Screening: ☐ No Significant Findings

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

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

Social History: Lives With ..... Family Members .....

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

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

Orientation has been given regarding the following aspects:

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

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

Patient Rights & Responsibilities: ☑ Yes ☐ No

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

Nurse's Name: ..... Balaperiyanga ..... Date: ..... 18/7/26 ..... Time: ..... 7pm ..... Signature: Balaperiyanga

GUC-00091423 IP18-00036520
Baby NIHARIKA
24-10-2024 1 Y 8 M 24 D (F)
Dr. GANESH R

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

BirthRight BY RAINBOW HOSPITALS
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Part - I.

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

Identified Education Needs:

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

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III: Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding	Comments	Designation / Signature
18/7	7pm.	Treatment and care	Explained about treatment.	Mother	No	Oral	None.	Verbalizes understanding	good.	Baby [illegible]
19/7/20	8am.	Fall risk education	Explained about call bell, side rails	Mother	No	Oral	None	verbalizes understanding	-	[illegible]

Part - III: CODES

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

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

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

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

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

Doc No. : RCH / FRM / CLINICAL / 187

GUC-00091423 IP18-00036520
Baby NIHARIKA (F)
24-10-2024 1 Y 8 M 24 D
Dr. GANESH R

4:30pm.

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EMERGENCY ROOM TRIAGE FORM

Wt: 11kg

Patient's Name: Baby. Niharika Age: 1yrs8m Gender: ☐ Male ☑ Female

Date: 18/7/26 Time of Arrival: 5.30pm

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

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

Mode of Arrival: ☐ Ambulatory ☑ Wheelchair ☐ Ambulance

Initial Vital Signs: Temp: 97.3°F PR: 138 BP: 98/72(68 BR: 34 SpO_2: 98%.

Chief Complaints: C/o Fever x2days, Vomiting x 5episodes, loose motion x 6episodes.

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

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

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

* CTAS - Canadian Triage and Acuity Scale

M. Dhanalakshmi
Signature of Parent / Guardian

Triage Completion Time: 5:40pm

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: Sirisha 015049

Signature of Triage Nurse: Sirisha 015049

Date & Time: 18/7/26 at 5:32pm

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

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Your Right to a Safe Delivery

NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 18/7/26 Time of arrival : 2.30pm

Chief Complaints: c/o fever x 2 days, vomiting x 3 episodes, loose motions x 2 episodes RBS: 116mg/dl

Height : — Weight : 11kg BMI : — Head Circumference (<2 years) —

Allergies: ☐ Yes ☐ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other: .....

If yes , identify Nil

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

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

RISK FOR FALL:

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

☐ If Patient is > 6 years
Assess the below parameters

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

Ambulatory Aids:

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

Gait/Transferring:

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

Mental Status: Forgets limitations ☐ Yes ☑ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening: ☑ No Abnormalities Detected

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

Inform consultant for positive criteria

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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: 18/7/26 (Date/Time): 5:30pm

Social History: Lives With parents

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

Time of Initial assessment completed by ER Nurse : 5.40pm

(P.T.O.)

Time	Nursing Notes
5.30pm-	ER come to the child chief
	complaint of fever x 2days, vomiting x 5 episode,
	loose motion x 6 episode. Doctor advised
	admitted to the patient. vitals signs
	checked and recorded - IV line placement
	Done. Blood sample collected. ER shifted
	to the ward.

Samples collected by: S/N Ajila Time: 5.55pm

Samples sent by : S/N Akshaya prith Time: 6pm

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: 136 BP: 98/72(66) CFT: <2sec	Shift - out from ER to: 4A
RR: 34 SPO₂ : 98%	Time of Shift - out: 6.45pm
GCS: 15/15 Temperature : 98.2°F	Handover given to: (Nurse's Name) S/N Lathika
Pain Score: 0/10	
Repeat RBS (if applicable): —	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any): IV line placement Done (L) metacarpal 24G

Name of the Nurse : Sonjuul Signature of the Nurse : Sonjuul 250092

Date & Time : 18/2/2026 at 5.30pm 250047

GUC-00091423 IP18-00036520
Baby NIHARIKA
24-10-2024 1 Y 8 M 24 D (F)
Dr. GANESH R

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PEDIATRIC ED DUCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : Dr: chandiralegen Date : 18/7

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

Start Time of Assessment: ..... Weight: 11 kg

Allergic History: .....

Chief Complaints: .....

Fever x 2 days

loose stools x 1 day

Pediatric Assessment Triangle

A Appearance - TICLS .....

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

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

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

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

Significant Past History: —

Medication History: —

Relevant Investigations: —

Primary Assessment

Airway
- ☑ Open
- ☐ Maintainable
- ☐ Not Maintainable

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

Breathing

Rate: 34/min SpO$_2$ on FiO$_2$ 99 on RA

Rhythm: .....

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

Respiratory Noises: ☐ Stridor ☐ Wheezing ☐ Grunting

Air Entry: B/L AE (P)

Palpation Findings (If necessary).....

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

Circulation

HR: 138/min CFT [Central ..... / Peripheral .....]

Any urgent interventions needed: ☐ Yes ☐ No

If Yes .....

BP: 1..... mmHg

Pulse Volume: [Central ..... / Peripheral .....]

If in Shock: [Compensated ..... / Hypotensive .....]

Muffled Heart Sound: ☐ Yes ☐ No

Engorged Neck Veins: ☐ Yes ☐ No

Murmurs: ☐ Yes ☐ No

Liver Span: .....

ECG: .....

Any Signs of Heart Failure: ☐ Yes ☐ No

Disability

GCS: 15/15 AVPU: .....

Any urgent interventions needed: ☐ Yes ☐ No

If Yes .....

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

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

Signs of Neurological compromise .....

.....

Exposure

Temp.: 97.3F.....

Any urgent interventions needed: ☐ Yes ☐ No

Any Rash: ☐ Yes ☐ No,

If Yes .....

If yes describe the rash .....

Active bleed .....

Lacerations ☐ Abrasions ☐ bruises ☐

Describe: .....

Final Physiological Status:

☐ Respiratory Distress ☐ Respiratory Failure ☐ Respiratory Arrest

☐ Shock - Compensated ☐ Hypotensive ☐

☐ Cardiopulmonary Arrest ☑ Hemodynamically Stable

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

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Labs Planned: .....

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As per chart

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Treatment Planned: .....

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As per chart

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

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

Assessment done by

Name of the Doctor: Dr. Chandrasekaran.....

Signature: .....

Date & Time: 18/7/26.....

Sr. Doctor on Duty (If necessary)

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

Signature: .....

Date & Time: .....

PATIENT TRANSFER FORM

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Date & Time of Admission	Date & Time of Transfer Order
18/7/26 @ 5:37pm	18/7/26 @ 6:45pm

Treating Consultant Name	Transfer Ordered by	Reason for Transfer
Dr. Ganesh	Dr. Chandiralega	Further management

From Unit	To Unit	Information to Attendant
ER	402	Yes ☑ No ☐

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

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	0.9% Nacl 500ml Infusion set	(1)
2.		
3.		
4.		
5.		

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

AGE C some dehydration | ? enteric | ? UTI

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
	Dr. Chandiralega 19/7/26

Patient & Clinical Records Received by : 18/7/26 @ 6.45pm

Date & Time of Patient Received :

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

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

Pati

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RBS CHART

Date	Time	RBS (mg/dl)	IVF %	Signature