GUC-00094439 IP18-00036667
Ms KAYALVIZZHI
14-10-2010 15 Y 9 M 16 D (F)
Dr. GANESH R

BirthRight Rainbow Children's Hospital

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	30/7/26 12.30 pm						
Activity Sheet update by Pharmacy							

ACTIVITY RECORD FOR BILLING

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It takes a lot to treat the little.

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Name: .....

UHID No: ..... IP No: GUC-00094439 IP18-00036667 ..... Dept: .....
Ms KAYALVIZZHI
14-10-2010 15 Y 9 M 15 D (F)
Dr. GANESH R

Date of Admission: ..... Ti ..... harge: ..... Time: .....

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
29/4/26	10:50am	ER	6/4	

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
29. July. 96	CBC, CRP, electrolytes	26024960.	
	RBS	26024259	

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
28/7/26	Infrasronpum	9.45Am	30/11/2024 9AM	34628	[illegible]
29/7/26	oxygen	10.50AM	30/7/26 (4) 10AM	34628	[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
29.07.26	Nebulization $+O_2$	(3)	1734386	01:34
29.07.26	Duplacemente	(1)	1734387	
29.07.26	x Ray Chest	(1)	10208	01:34
29/7/26	Neb $+O_2$	(1)	1734414	
29/7/26	Nebulization	(4)	34629.	
30/7/26	Nebulization	(5)	34758	
30/7/26	Nebulization	(1)	734942	

ANY OTHER INFORMATION:

.....

.....

.....

.....

.....

.....

Date: 30/7/26 Time: 12.30 pm Prepared By: .....

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

GUC-00094439 IP18-00036667
Ms KAYALVIZZHI
14-10-2010 15 Y 9 M 15 D (F)
Dr. GANESH R

Rainbow Children's Hospital | BirthRight

DISCHARGE TRACKING SHEET

UHID- FLOOR- NAME OF CONSULTANT-

ACTIVITY	TIME		NAME & SIGNATURE	REMARKS	<To be filled by Admin>
Discharge Announcement					
	INTIME	OUT TIME			
Arrangement of File by Nursing					
Preparation of Discharge Summary		30/12/26 04 10:30PM			
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 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 : IP18-00036667 **Admit Date** : 29-Jul-2026 **Admit Time** : 09:06 AM **UHID** : GUC-00094439

Patient Details :

Patient Name	: Ms KAYALVIZZHI	**Age**	: 15 Y 9 M 15 D
Guardian	: Mr AM. RAMKUMAR	**DOB**	: 14-10-2010
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: NO; 38/2B, RAJAMBAL STREET, SEKAR NAGAR, JAFFERKHANPET, CHENNAI Ashok Nagar Chennai Tamil Nadu INDIA 600083	**Phone No**	: 9941246787/ 9841479225
		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 : Mr AM. RAMKUMAR **Relationship** : Father

Contact Address : NO; 38/2B, RAJAMBAL STREET, SEKAR NAGAR, JAFFERKHANPET, CHENNAI Ashok Nagar Chennai Tamil Nadu INDIA 600083 **Phone No** : 9941246787

Signature 29/07/26

Doctor Details :

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

Referral Doctor : DR. NAREESHKUMAR **Phone No** :

Co-Consultant :

Payment Details :

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

Payor Name : SELFPAY

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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:	**Ms KAYALVIZZHI**	**Age :**	**15 Y 9 M 15 D**
IP No:	**IP18-00036667**	**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 ca[illegible]f 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:...K.A.M. Ramkumar

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: K.A.M. Ramkumar

Name: Am. Ramkumar
Relationship: Father
Date: 29/07/2026 Time: 09.9 AM
Witness Name: Pavithra
Witness Signature:

Patient Address:

NO; 38/2B, RAJAMBAL STREET, SEKAR NAGAR, JAFFERKHANPET, CHENNAI
Ashok Nagar Chennai Tamil Nadu
INDIA 600083

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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 : MS. Kayal vizzhi	UHID Number : GUC-00094439
Self/Attendant Name :	Relation : Father
Self/ Attendant Signature : Phone Number : 9941246787	Name & Signature of Financial Counselor

सत्यमेव जयते

भारत सरकार

Government of India

आधार

Issue Date: 04/12/2013

அ மு ராம்குமார்

A M Ramkumar

பிறந்த நாள் / DOB: 28/11/1980

ஆண் / Male

2898 1215 4216

2898 1215 4216

मेरा आधार, मेरी पहचान

भारतीय विशिष्ट पहचान प्राधिकरण

Unique Identification Authority of India

AADHAAR

सत्यमेव जयते

முகவரி: S/O: முனிரத்தினம், 55, எல்லை
முத்தம்மன் கோவில் தெரு,
பழவந்தாங்கல், காஞ்சிபுரம், தமிழ் நாடு,
600114

Address: S/O: Munirathinam, 55,
ELLAIMUTHUAMMAN KOIL STREET,
Pazhavanthangal, Kancheepuram, Tamil
Nadu, 600114

Print Date: 26/06/2021

2898 1215 4216

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

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PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: _____ GUC-00094439 IP18-00036667 Ms KAYALVIZZHI 14-10-2010 15 Y 9 M 15 D (F) Dr. GANESH R _____

UHID ID: _____  _____

Department: _____

Consultant: _____

Patient Sticker

Pediatric Multiorgan History & Physical Examination

Name: _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

c/o → cough & cold x 3day
fast breath since morng.
fever x 1 dy

History of present illness :

H/o → cough & cold x 3days.
Wet cough.
Mild chest rattle (+) - More at Night

H/o - fever x 1 dy
Not documented

H/o - fast breath since morng.
H/o difficulty in lying down supine position.
Increased cough on lying down supine.

- No prev h/o chest / Nebulization
- No family h/o atopy / asthma.
- Not on any regular medication

GUC-00094439 IP18-00036667
Ms KAYALVIZZHI
14-10-2010 15 Y 9 M 15 D (F)
Dr. GANESH R

of any previous investigation or treatment)

No part admission

Birth & Neonatal History:

1st child / c-section / NICU / NonICU

Family Chart

Birth & Socio Economic History:

About Father :
About Mother :
Any additional Information :

No family h/o allergy/asthma

Developmental History :

(N)

Immunization History :

upto Age

Anthropometry :

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

Weight (kgs) 61 kg (Centile _____)

On Examination :

Temperature : 97°F Pulse Rate : 130/m B.P. 113/77(84) SPO2 94% on RA

Resp.rate and type of breathing : 35/m

P/A NAD

Rash

Lymphadenopathy

Oedema :

Allergies (if any):

(P.T.O.)

Patient Sticker

Respiratory System :

Inspection (any s/o distress) : SSR (+), ICR (+)

Air entry & breath sounds : bad AE ↓

Any addes sounds : Hi wheeze (+)

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

Cardiovascular System :

Inspection of procordium :

Heart Sounds : S1 S2 (+)

Any murmur : No Murmur

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

Per Abdomen :

Inspection :

Palpation : Soft, Non tender

Ausculation :

Spine : External Genitelia :

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

Central Nervous System :

Level of Consciousness : AVPU/GCS score : Alert

Cranial Nerves :

Motor System :

Nutriton :

Tone: N Power 5/5

Co-ordinator :

Posture :

Involuntary Movements :

GUC-00094439 IP18-00036667
Ms KAYALVIZZHI
14-10-2010 15 Y 9 M 15 D (F)
Dr. GANESH R

R

DTR

Superficials:

Plantars

Sensory System :

Bladder / Bowel :

Clinical Summary & Diagnostic: Viral triad wheeze - Acute exacerbation

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

Desired goals of the treatment :

Planned Labs:

CBC
CRP
Electrolytes
CXR

Planned Management

- Neb Duolin Levolin 1.25mg + 2cc NS Q3H
- Neb Ipratropium 500mcg + 2ml NS Q8H
- steroids after CXR
- Neb budesonide BD

Signature of the Doctor:

Name of the Doctor: Dr. Manasa

Date & Time: 29/7/26, 9 am

Signature of the Consultant:

Name of the Consultant: Dr. L. Vasanth

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: .....

GUC-00094439
Ms KAYALVIZZHI
14-10-2010
Dr. GANESH R
IP18-00036667
15 Y 9 M 15 D (F)

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
29/7/26 9.45AM	S/E Dr. Chandirdeg.	
	c/o cough x 3 days Fever - 1 episode Fast breathing since last evening H/o frequent sneezing in morning	
	Family H/o: H/o Asthma in paternal ~~mother~~ grandmother & grand father.	
	O/E Afebrile CVS - S1S2 (+) RS - B/L AE (+), ↓ on left - B/L wheeze RR - 20/min SpO2 - 99% @ 5L O2 mask.	chest x ray: Hyperaeration B/L Infiltrates.
	Adv: - monitor vitals - Inj Hydrocortisone 100mg QID - Neb Levolin 1.25mg Q3H - Neb Ipravent 500mcg+2ml NS Q8H - Neb Budecort 0.5mg BD - T. Flumix 75mg BD - Inj. pantoprazole 40mg OD	

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

GUC-00094439 IP18-00036667
Ms KAYALVIZZHI
14-10-2010 15 Y 9 M 15 D (F)
Dr. GANESH R

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
29/4/24 10:45 am	S/B Dr. Ganesh sir.	
	Acute exacerbation of wheeze	
	Reviewed	
	- Wheeze ↓	
	- distress - better.	
	- On O2, SpO2 - 97%.	
	Adv	
	- Continue Nebs as advised	
	- parents counselled	
	R. Waseem 72145	

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
29/7/26 5PM.	S/B Dr. Chandirakala.	
	Child received	
	Alert, Active	
	cough (+)	
	no c/o Resp distress, tachypnoea	
	mild tachycardia (PR - 134/min)	
	O/E	
	Afebrile	
	RS - B/L AE (+)	
	wheeze + +	
	RR - 16/min	
	SpO_2 - 100% @ 5L O_2	
	WOB - (N)	
	Adv:	
	- monitor vitals	
	- W/F Resp distress / tachypnoea	
	Hypoxia < 92% RA	
	- Nebulisations as per chart	
	- Tapper O_2 to 4L	
	- Neb Levolin 0.4 ml 1.25mg + 2cc NS	
29/7/26.	- Syp. Mucolite 5ml BD	
	- IV Fluids @20ml/hr	

GUC-00094439 IP18-00036667
Ms KAYALVIZZHI
14-10-2010 15 Y 9 M 15 D (F)
Dr. GANESH R

(2)

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	After reassessment	
	no Tachycardia / distress	
	RR - 22/min	
	SpO_2 - 99% 4L O_2 mask	
	WOB - (N).	
	[signature]	
30/7/26 12.30 am	S/B Dr. Gayathri	
	A - Acute exacerbation of wheeze.	
	Child on 2 litre O_2 Nasal prongs	
	No tachypnea	
	sleeping comfortably.	
	Chest - B/L AE (+) equal	
	No wheeze	
	Vitals - stable	
	PPWF (+), CRT < 2sec.	
	SpO_2 → 98% 2L O_2	
		Plan.
		(1) Monitor vitals
		(2) w/t distress
	[signature] 1 b5pm	(3) cont meds as per chart

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
30/4/26 8am	S/B Dr Gayathri	
	Δ - Acute exacerbation of wheeze.	
	· Child on 2LO₂ support	
	· No distress RR - 30/min	
	· maintaining 98% SpO₂ saturation on 2LO₂.	
	· Chest - clear No wheeze	
	· clinically better	
	· oral intake, u/o good	
	· cough - better	
	Plan	
	① Change to 1litre O₂ support	
	② change to Neb. Levolin Q6H	
	③ Stop Neb. Budecort & IV Hydrocort	
	④ Cont other drugs as per chart.	
	⑤ Monitor for distress.	
	If RR > 40/min (or) SpO₂ < 94%	Inform SOS.
		↑O₂ to 2litres.
		(signature) 165581 (Dr. Gayathri).

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

Ref. No. : F / HW / DC / INPR / 05

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Patient Name : Ms. Kayalvizhi. Age : 15yrs.

Gender ☐ M ☒ F Hospital No. : .....

Consultant : Dr. Ganesh.

Date of Admission : 29/7/26.

DRUG ALLERGIES :

FOR THE SAFETY OF THE PATIENT

GENERAL - Ensure that all patient details are entered above. **ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.**

DOCTOR - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).

- Use approved pharmaceutical names, **BLOCK LETTERS**, metric dosage. English instructions.
- Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
- Discontinue a drug by drawing a line *I* through it and a similar line through subsequent recording panels.
- The date and time of stopping the drug along with the doctors name and sign must be mentioned.
- Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.

NURSES - Nurses must follow strictly the **FIVE RIGHTS** before administration of medication.

1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time

- **AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR).** Follow Hospitals's Verbal Order Policy.

SOS / PRN (As Required Medication)

DRUG : T. PARACETAMOL

Dose	Route	Frequency	Start Dt.
650mg	PO	Q 6 H (SOS)	29/7/26

Doctor's Signature	Valid Period	Pharm.

Additional Instructions: Q6H (SOS) If Temp >100 F

Date / Time

DRUG :

Dose	Route	Frequency	Start Dt.

Doctor's Signature	Valid Period	Pharm.

Additional Instructions

Date / Time

DRUG :

Dose	Route	Frequency	Start Dt.

Doctor's Signature	Valid Period	Pharm.

Additional Instructions

Date / Time

GUC-00094439 IP18-00036667
Ms KAYALVIZZHI
14-10-2010 15 Y 9 M 15 D (F)
Dr. GANESH R

	I.P. No.	Sheet No.	Wards	Weight (kg)

REGULAR PRESCRIPTIONS

DRUG : NEB·LEVOLIN

Dose	Route	Frequency	Start Dt.
1.25mg + 2CC NS	P/N	Q3H	29/7/26

Name & Signature of the Doctor starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign.

Date/Time	29/7	29/7	29/7
	9.15 pm	PS	12 Am
			3Am
			6Am
			9Am changed
			12pm SS/SP
			3pm SS/PS
			6pm
			9pm

DRUG : NEB·IPRAVENT

Dose	Route	Frequency	Start Dt.
500mcg 2ml NS	P/N	Q8H	29/7/26

Name & Signature of the Doctor starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign.

Date/Time	29/7	30/7
1 Am		SS/mm
9 Am		PS/SP
5 Pm	SL/SP	

DRUG : NEB·BUDECORT

Dose	Route	Frequency	Start Dt.
0.5mg	P/N	Q12H	29/7/26

Name & Signature of the Doctor starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign.

Date/Time	29/7	30/7
8 Am		
8 Pm	SS/mm	

Stop Cut 1.65pm 30/7/26

DRUG : C.FLUVIR

Dose	Route	Frequency	Start Dt.
75mg	PO	Q12H	29/7/26

Name & Signature of the Doctor starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign.

Date/Time	29/7	30/7
8 Am	10Am SP/PS	PS/SP
8 Pm	10pm SS/mm	

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Ms KAYALVIZZHI
14-10-2010 15 Y 9 M 15 D (F)
Dr. GANESH R

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Sheet No: .....

REGULAR PRESCRIPTIONS

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

DRUG : INJ HYDROCORT

Dose	Route	Frequency	Start Dt.
100mg	IV	Q6H	29/7

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time	29/7	30/7
4 Am	SS	
10 Am		
4 Pm	SL SP	
10 Pm	SS	

Stop CVL 16.5cm

DRUG : INJ PANTOPRAZOLE

Dose	Route	Frequency	Start Dt.
40mg	IV	OD	29/7/26

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time	29/7	30/7
9 Am	PS	
6 Am	SS	

DRUG : NEB LEVOLIN

Dose	Route	Frequency	Start Dt.
1.25mg 2cc NS	P/N	Q4H	29/7/26

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time	29/7	30/7
3 Am	SS	
7 Am	SP	
11 Am		
3 Pm		
7 Pm	SL SP	
11 Pm	SS	

Change to Q6H
CVL 15cm

DRUG : SYP MUCOLITE

Dose	Route	Frequency	Start Dt.
7ml	P/O	Q8H	29/7/26

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time	29/7	30/7
8 Am	PS SP	
2 Pm	SL SP	
10 Pm	SS	

Signature .....

VERIFIED BY : Name .....

Patient Sticker

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Sheet No: .....

REGULAR PRESCRIPTIONS

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

DRUG : Neb. LEVOLIN

Dose	Route	Frequency	Start Dt.
1.25mg+ 2cc NS	Neb	Q6H	30/7

Name & Signature of the Doctor Starting the Drugs:
Dr. Gayathri 16555

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG : T-Ambroxol

Dose	Route	Frequency	Start Dt.
20mg	PO	BD	30/7

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:
After food.

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG : Levolin MDI

Dose	Route	Frequency	Start Dt.
2 puff	PRN	Q4H	30/7

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

Signature .....

VERIFIED BY : Name .....

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
29/7/20	8.45am	NEB Levolin + Budecort 1.25mg 0.5m	x 2 Time	P/N		Seel 6/8/20
"	9 AM	Neb Ipravent	500mg	P/N		Seel 6/8/20
"	9.45AM	Inj. Hydrocortison	100mg	I/V		Seel 6/8/20

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	I.P. No.	Sheet No.	Wards	Weight (kg)

I.V. FLUIDS CHART

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.
29/7/26	9.45 PM	0.9% DNS	IV	20ml/hr			29/7/26 @ 1PM		
29/7/26	5PM	0.9% DNS		20ml/hr			29/7/26 @ 9PM		
			Stopped						

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RESULT SHEET

Date	24/7/26					
Time						
Hb	13.6					
PCV	41					
RBC	4,42.					
WBC	17,100					
N/L	78/16					
Platelets	3,31,000					
CRP	24.					
ESR						
PCT						
RBS	60					
Na	141					
K	3.2					
Cl	108					
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

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

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

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Ref. No. F/INPR/12

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NEBULISATION CHART

Date	Time	Drug	Nurse	Parents Signature
29/11	00.00	Nebulize Ipravent		
	3pm	Nebulize levolin		
	2pm	Nebulize levolin		
	8pm.	Neb- Budecort — (1)		
	1pm	Neb- levolin — (1)		
30/11	5.00 Am	Neb- Ipravent — (1)		
	3.00 Am	Neb- levolin — (1)		
	7.00 Am	Neb- levolin — (1)		
	8.00			
	9.00			
	10.00			
	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			

GUC-00094439 IP18-00036667
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14-10-2010 15 Y 9 M 15 D (F)
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Doc. No. : RCH/ FRM / CLINICAL / 127

1

TEENAGE (12 + years) Children's Observation & Early Warning Scoring Chart

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 29/7/26

Time:	12Am	4pm.	8pm	12Am.	4am
Doctor / Nurse / Family Concern?					
Temperature (°F) (scale 94–104)	98.4F	97.1F	97.5°F	97°F	97.2°F
Heart Rate (bpm) and Blood Pressure (mmHg) * (scale 50–190)	115/59 (62)	110/60 (72)	114/59 (63)	108/62 (68)	106/59 (63)
Heart Rate (Number)	120 b/m	112 b/m	115 b/m	101 b/m	105 b/m
Resp. Rate (bpm) (Over 1 Minute) (scale 10–70)					
Resp Rate (Number)	30 b/m	28 b/m	26 b/m	24 b/m	24 b/m
Resp Distress: Mod/ Severe					
Resp Distress: None / Mild	✓	✓	✓	✓	✓
Receiving O_2 (l/min)	O_2-5L	O_2 5L	O_2-2L	O_2-2L	O_2-2L
O_2 Saturations (%)	100%	100%	99%	100%	99%
Conscious Level: Normal	✓	✓	✓	✓	✓
Conscious Level: Altered					
GCS *	15/15	15/15	15/15	15/15	15/15
TOTAL SCORE Number of shaded boxes	01	01	02	01	01
Pain Score	0	0	0	0	0
Observer's Initials	[illegible]	[illegible]	Su	Su	Su

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.
	Score 4	: Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see
	Score 5 & 6	: Shift in charge AND PICU fellow or PICU consultant to be informed.

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

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

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FLUID CHART

Sheet No. : 1

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

Date	Time	Intake				Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
29/7/...		Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am				On Admission							
	11:00 am	H2O	50ml	60							O	[illegible]
	12:00 pm	Soup	100ml	60						✓	O	
	01:00 pm			40							O	[illegible]
Total Intake :		150ml + 160ml				**Total Output :**				1 time		
	02:00 pm	H2O	100ml	40ml							O	[illegible]
	03:00 pm	H2O	50ml	40ml						✓		
	04:00 pm	Soup	100ml	40ml							O	[illegible]
	05:00 pm			20ml								
	06:00 pm	H2O	50ml	20ml						✓	O	[illegible]
	07:00 pm			20ml								
Total Intake :		300ml + 180ml				**Total Output :**				2 times		
	08:00 pm			20ml								
	09:00 pm			20ml						✓	O	SS/OUR
	10:00 pm	H2O	200ml	Stop.								
	11:00 pm										O	SS/OUR
	12:00 am											
	01:00 am									✓	O	SS/OUR
Total Intake :		200ml. + 40				**Total Output :**				2 times		
	02:00 am											
	03:00 am										O	SS/OISSP
	04:00 am											
	05:00 am										O	SS/OUR
	06:00 am	H2O	200ml									
	07:00 am									✓	O	SS/OUR
Total Intake :		200ml.				**Total Output :**				1 times		

Total 24 hrs. Intake	850ml + 380 = 1230	Total 24 hrs. Output	6 times

Docu. No. : RCH /FRM / CLINICAL / 092

Patient Sticker

NURSING CARE RECORD

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Date: .....

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							
Night							

Patient Sticker

NURSING CARE RECORD

Rainbow® Children's Hospital
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Date: .....

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							
Night							

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Ms KAYALVIZZHI
14-10-2010 15 Y 9 M 15 D (F)
Dr. GANESH R

NURSES NOTES

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☐ No Known Drug Allergies

☐ Drug Allergies ....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		On Receiving Notes.	
29/7/25	10.50am	child Received from ER to 6th floor. 614. Child complaints of Fever, cough, cold. child details hand over taken from ER staff. child was Active and oriented →	[signature]
	11am	child vitals checked and Recorded. vitals Normal child Bl line pattern is healthy and observed. IVF - 60ml 0.9% on flow. O_2 - 5L in face mask →	[signature]
	12pm	Due medication given as per drug chart →	[signature]
		Maintained intake and output chart →	[signature]
	1Pm	Due medication given as per drug chart →	[signature]
	4pm	child vitals checked and Recorded vitals Normal	
		CP ++ / PP ++ / CRT <3sec	
	5pm	Due medication given as per drug chart. Dr. Chantra -lekha mam seen the child Advice from TD chart O_2 - 4L →	[signature]

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Patient Sticker

NURSES NOTES

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☒ No Known Drug Allergies

☐ Drug Allergies ....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
29/7	.	At 3pm. Change the O_2	
		informed to Dr- Ganesh sir	
		also →	[signature]
		Maintained Intake and	
		output chart →	[signature]
	6pm	Due medication given	
		as per drug chart →	[signature]
		child details handover	
	7:30 pm	given to night duty	[signature]
		staff	
		Night duty Notes.	
29/7/25	7:30pm	child details hand over	
		taken form every duty	
		Staff. child consious &	
		active. →	[signature]
	8pm	child vitals checked & recorded	
		temp is normal. CP ++, PP ++, CRT <3sec	
		Dr. Ganesh sir saw the	
		child Dr. Ganesh sir advised	
		to Reduce O_2- 2 liter and.	[signature]
		continue the other medication.	
	10pm.	child w line (+) IV line	
		observed & heavy. child IVF	
		20ml/hr. child intake is better	
		informed Dr. Gaythri mam	
		advised to stop IVF →	[signature]

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☐ No Known Drug Allergies

☐ Drug Allergies .....

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

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☐ Drug Allergies .....

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

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☐ Drug Allergies .....

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

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☐ Drug Allergies .....

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☐ Drug Allergies .....

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

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Patient's Name:...

MRD NO:........ GUC-00094439 IP18-00036667
Ms KAYALVIZZHI
14-10-2010 15 Y 9 M 15 D (F)
Dr. GANESH R

Age :.............. ☐ M ☐ F

Consultant :...

PHLEBITIS ASSESSMENT

CANNULA 1

Date : 29/7/26 Time: 9-35am
Location : (L) Metacarpl
Size : 22h
Cannula inserted by : Dr. Chandrabega

Date	Time	Phlebitis	Infiltration	Nursing Intervention	Sign
29/7/26	9.35am	☐Yes ☑No	☐Yes ☑No	observed	deyou
	11 Am	☐Yes ☑No	☐Yes ☑No	observ	Ruth
	1pm	☐Yes ☑No	☐Yes ☑No	observ	Ruth
	5pm	☐Yes ☑No	☐Yes ☑No	observ	Ruth
	7pm	☐Yes ☑No	☐Yes ☑No	Obs	Ruth
	9pm	☐Yes ☑No	☐Yes ☑No	Observ	S1/ou
30/7	1Am	☐Yes ☑No	☐Yes ☑No	Observ	S1/ou
	5Am	☐Yes ☑No	☐Yes ☑No	Obser	S1/ou
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐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

GUC-00094439
Ms KAYALVIZZHI IP18-00036667
14-10-2010 15 Y 9 M 15 D (F)
Dr. GANESH R

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THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE M. 29/7	DATE E 29/7	DATE N 29/7	DATE	DATE
Age	Less than 3 years old	4					
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1	1	1	1		
Gender	Male	2					
	Female	1	1	1	1		
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3	3	3	3		
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	[illegible]				
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own ability	1	1	1	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		
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	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		
	Total		9	9	9		

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		NA	NA	X		
Other Intervention(s) Specify		NA	NA	X		
Nurse's Name:		[illegible]	[illegible]	[illegible]		
Signature:		[signature]	[signature]	[signature]		
Date:		29/7	29/7	29/7		
Time:		2pm	[illegible]	8pm		

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

Patient Sticker

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THE HUMPTY DUMPTY SCALE

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

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

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

GUC-00094439 IP18-00036667
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Dr. GANESH R

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PAIN ASSESSMENT FORM

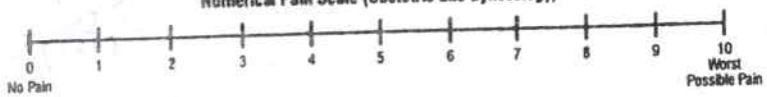
Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
29/7/26	11Am	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	nil	[illegible]
29/7/26	6Pm	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	nil	[illegible]
30/7	2Am	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	Nil	[illegible] 01392
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

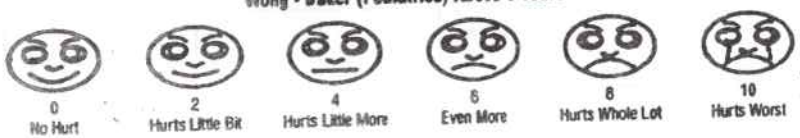
1. Every eight hours for all hospitalized patients.
2. For post-surgical patients, patients with chronic pain, patient with severe pain:
   a) At least every 2 hours for the first 24 hours
   b) Then every 4 hours.
   c) Prior to pain pain-relieving intervention.
   d) Within 30 – 60 minutes after pain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

PAIN ASSESSMENT TOOLS

Numerical Pain Scale (Obstetric and Gynecology)



Wong - Baker (Pediatrics) Above 7 Years



FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

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

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR RR, BP, SaO_2	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO_2 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO_2 less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

Patient Sticker

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PAIN ASSESSMENT FORM

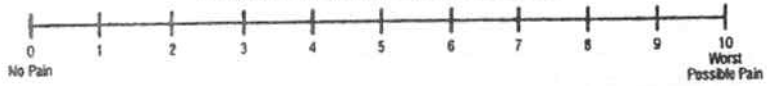
Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp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

Re-assessment Frequency:

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

PAIN ASSESSMENT TOOLS

Numerical Pain Scale (Obstetric and Gynecology)



Wong - Baker (Pediatrics) Above 7 Years

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

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

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR RR, BP, SaO_2	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO_2 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO_2 less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

GUC-00094439
Ms KAYALVIZZHI IP18-00036667
14-10-2010
Dr. GANESH R 15 Y 9 M 15 D (F)

BRADEN 'Q' SCALE

Rainbow Children's Hospital

BirthRight BY RAINBOW HOSPITALS Your Right to a Safe Delivery

				Date : 29/7 29/7 29/7
				Time : 8am 8pm 8pm
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
"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
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
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
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
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
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.	3	3	3
				TOTAL SCORE	27	27	27
				Evaluator's Name	Neel	Neel	Sul

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

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

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

Patient ID

BRADEN 'Q' SCALE

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					Date :				
					Time :				
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.					
"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.					
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.					
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.					
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."					
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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.					
					TOTAL SCORE				
					Evaluator's Name				

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

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
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Less than 9	Severe Risk	⓫ Use same protocol as for **"High Risk"** Patients ⓫ 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

GUC-00094439 IP18-00036667
Ms KAYALVIZZHI
14-10-2010 15 Y 9 M 15 D (F)
Dr. GANESH R

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Nursing General Admission Assessment Form For Pediatrics

Diagnosis: Δ viral hepat... wheeze ... exacerbation

Arrival Time: 10.50am. Mode of Arrival: wheel chair Admitting From: ☑ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction: Nil

Body Weight: 6 kg Kg

Height: .... cm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
Nil	Nil	nil.

Family History: Nil

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

If yes please list, ...

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

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

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

Observations: Weight: 6 l Length: .... Head Circumference (< 2 years): ....

Temp.: 98.1°F HR: 120bpm RR: 30bpm BP: 105/55

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

Fall Risk Assessment: ☐ Yes ☐ No Score: 9 (Document in the Humpty Dumpty Sheet)

Risk of Pressure Sore (Braden Q Score 27) (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
☐ Developmental Delay
☐ Walking Problem
☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING: ☑ No Abnormalities Detected

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

Inform consultant for positive criteria

Psychological Screening: ☐ No Significant Findings

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

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

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

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

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 ....Moter-..

Nurse's Name: ....Praveena.................... Date: ....[illegible].... Time: ....11Am.... Signature [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. Plan
4. Pain Management
5. Informed Consent
6. Medication / Therapy (safety, effects/ side effect, interactions)
7. Discharge Medication
8. Infection Control Measures
9. Diagnostic Test / Procedures
10. Nutrition / Diet
11. Fall Risk Education
12. Safe use of Medical Equipment / Implantable Devices Safety
13. Patient's / Family Rights
14. 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		
29/9	12pm	medication Action	Explained about medication Action & use.	Mother	Nil	Oral	Nil	Yes	Good	Paul

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

PATIENT TRANSFER FORM

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Ms KAYALVIZZHI
14-10-2010 15 Y 9 M 15 D (F)
Dr. GANESH R

Date & Time of Admission	Date & Time of Transfer Order
29/7/26 9-06am	29/7/26 @ 10-50am

Treating Consultant Name	Transfer Ordered by	Reason for Transfer
Dr. Ganesh	Dr. Manoranjan.	further management

From Unit	To Unit	Information to Attendant
ER	6/4	Yes ☑ No ☐

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

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	0.9% NS 50ml	(1)
2.	Infufix set	(1)
3.		
4.		
5.		

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
[signature]	Dr. Manoranjan

Patient & Clinical Records Received by : [signature] 0320

Date & Time of Patient Received : 29/7/26 @ 10.50AM

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

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

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MEDICATION RECONCILIATION FORM

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

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

Shifting From: .... ER Shifted to: 6l4

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. Manana

Date & Time : .... 29/7/26, 9:30 pm

Nurse Name & Signature: .... Samuel

Date & Time : .... 29/7/26 at 9:30am

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

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RBS CHART

Date	Time	RBS (mg/dl)	IVF %	Signature
29/7/26	9.45am	138 mg/dl	–	[illegible]

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Ms KAYALVIZZHI
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Docu. No. :

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

GUC-00094439 IP18-00036667
Ms KAYALVIZZHI
14-10-2010 15 Y 9 M 15 D (F)
Dr. GANESH R

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EMERGENCY ROOM TRIAGE FORM

wt: 61 kg

Patient's Name : Kayal Vizhi Age : 15yrs Gender: ☐ Male ☑ Female

Date : 29/7/26 Time of Arrival : 8.40am

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

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

Mode of Arrival : ☐ Ambulatory ☑ Wheelchair ☐ Ambulance

Initial Vital Signs: Temp: 96.5°F PR: 130 BP: 113/71(85) RR: 36 SpO_2: 94%

Chief Complaints: C/o: fever x 1 day, fast breathing x 1 day, cold cough hx 3 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 : 8.40am

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 : Soniya

Signature of Triage Nurse : Soniya

Date & Time : 29/7/26 at 8.40am

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

29/7/26
8.45am. Neb. Budecort 0.5mg + Neb levolin 1.25mg back to back 2 times. Sd/- Sharon

9.05am Neb. Ipravent 1.2ml NS is given Sd/- 10:20 / X9

9.15am Neb. Levolin 1.25mg + 2ml NS is given Sd/- Sharon

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 29/7/26 Time of arrival : 8:40 am.

Chief Complaints: fever x 1 day, fast breathing x 1 day. RBS: 138 mg/dl

Height : – Weight : 61 kg 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: 0/10 Pain Tool Used: ☐ N Pass ☐ FLACC ☑ Wong Baker

☐ Character – ☐ Location – ☐ Frequency – ☐ Duration –

RISK FOR FALL:

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

☑ If Patient is > 6 years
Assess the below parameters

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

Ambulatory Aids:

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

Gait/Transferring:

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

Mental Status: Forgets limitations ☐ Yes ☑ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening: ☑ No Abnormalities Detected

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

Inform consultant for positive criteria

NIL

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: NIL (Date/Time): –

Social History: Lives With Parents

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

Time of Initial assessment completed by ER Nurse : 8:45 am.

Time	Nursing Notes
29/7/26 @ 9:15 am	patient came for ER with the complaint of fever x 1 day, fast breathing x 1 day. Dr. Ganesh sir advised to put an admission. IV line placement done, Samples are collected.

Samples collected by: S/N Ajith Time: 9:35 am

Samples sent by: S/N Seejin Time: 9:37 am

Medication given in ER:

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

Condition of patient at time of shift - out :	Details of Shift - out
HR: 130/min BP: 113/77 CFT: <2s RR: 32/min SPO_2: 94% in RA GCS: 15/15 Temperature: 96.5°F Pain Score: 0/10 Repeat RBS (if applicable):	Shift - out from ER to: GIC Time of Shift - out: 10:30AM Handover given to: SN Praveena (Nurse's Name)

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any): IV line placement done in (L) metadorsal in 22G is placed.

Name of the Nurse : J. Ajith Signature of the Nurse :

Date & Time : 29/7/26 @ 9:17 am

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PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : Dr. Chandiralage Date : 29/7/26

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

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

Allergic History: ....

Chief Complaints:
viral triggered acute exacerbation of wheeze

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: 20/min SpO$_2$ on FiO$_2$ 99% RA

Rhythm: ....

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

Respiratory Noises: ☐ Stridor ☐ Wheezing ☐ Grunting

Air Entry: B/L AE⊕, ↓ on left, wheeze⊕

Palpation Findings (If necessary) ....

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

Circulation

HR: 112/min CFT [Central ..... Peripheral .....]

Any urgent interventions needed: ☐ Yes ☐ No

If Yes .....

BP: ..... mmHg

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

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

Muffled Heart Sound: ☐ Yes ☐ No

Engorged Neck Veins: ☐ Yes ☐ No

Murmurs: ☐ Yes ☐ No

Liver Span: .....

ECG: .....

Any Signs of Heart Failure: ☐ Yes ☐ No

Disability

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

Any urgent interventions needed: ☐ Yes ☐ No

If Yes .....

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

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

Signs of Neurological compromise .....

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Exposure

Temp.: 98.F

Any urgent interventions needed: ☐ Yes ☐ No

If Yes .....

Any Rash: ☐ Yes ☐ No,

If yes describe the rash .....

Active bleed .....

Lacerations ☐ Abrasions ☐ bruises ☐

Describe: .....

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

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

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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: .....

Signature: .....

Date & Time: 29/2/.....

Sr. Doctor on Duty (If necessary)

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

Signature: .....

Date & Time: .....