Rainbow Children's Hospital

HARGE TRACKING SHEET

GUC-00082396 IP18-00036462
Baby VIDYUTH V
12-09-2025 0 Y 10 M 2 D (M)
Dr. GANESH R

UHID-

NAME OF CONSULTANT-

ACTIVITY	INTIME	OUT TIME	NAME & SIGNATURE	REMARKS	<To be filled by Admin >		
Activity Sheet update by Nursing	15/9/25 @ 9am		dy				
Activity Sheet update by Pharmacy							

ACTIVITY RECORD FOR BILLING

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Name: .....

UHID No: ..... IP GUC-00082396 IP18-00036462 t: ..... Dept: .....
Baby VIDYUTH V
12-09-2025 0 Y 10 M 2 D (M)
Dr. GANESH R

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
14/7/26	8:15 am.	ER	703	

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
14/7/26	CBC, CRP, Blood c/s, Urea, creatinine, Electrolytes, calcium, Magnesium, OT, PT, Dengue N/S,	26022562	[signature] 17/7/26
14/7/26	Urine routine	26022678	[signature]

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
14/7/20	Infusion pump	9AM	15/7/20. 10AM	1726835.	[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
14/7/26	IV line placement	(1)	172686	

ANY OTHER INFORMATION:

.....

.....

.....

.....

.....

.....

.....

Date: 15/7/26 Time: 10am Prepared By: [signature]

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

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DISCHARGE TRACKING SHEET

GUC-00082396 IP18-00036462
Baby VIDYUTH V
12-09-2025 0 Y 10 M 2 D (M)
Dr. GANESH R

R- NAME OF CONSULTANT-

ACTIVITY	TIME		NAME & SIGNATURE	REMARKS	<To be filled by Admin>
Discharge Announcement	10.20 AM		10.20 AM		
	INTIME	OUT TIME			
Arrangement of File by Nursing		10.30 AM	P.V 607261		
Preparation of Discharge Summary					
Finalization of discharge summary					
Transfer of file from Ward to Billing Dept					
Bill Processing					
Audit Clearance					
Billing Clearance					
Physical Clearance					

GUC-00082396 IP18-00036462
Baby VIDYUTH V
12-09-2025 0 Y 10 M 2 D (M)
Dr. GANESH R

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) SIDE CHECK LIST FOR NURSES

Date:	14/9/25	15/9/25							
Doctor's Orders	Yes	yes							
Carried out or not	Yes	yes							
Bed Side									
Structured Handover done	Yes	yes							
IV Site	Yes	yes							
Central Lines	NA	NA							
Arterial Lines	NA	NA							
Feeding Catheter	NA	NA							
Urinary Catheter	NA	NA							
Skin Care	NA	NA							
Eye Care	NA	NA							
Mouth Care	NA	NA							
Sterillum Bottle, Stethoscope	Yes	yes							
Suction Bottle (Should be clean & empty)	Yes	NA							
Intubation Tray	NA	NA							
Emergency Tray (Loaded Syringes with Midazolam & Vecuronium and Flush) Ampoules of Adrenaline	NA	NA							
Ventilator Tubing,(Any Water, Blood)	NA	NA							
Humidification	NA	NA							
Check all Infusion (Labelling,Correct Preparation)	Yes	NA							
Chest Physio & Neb	NA	NA							
Handed Over By Name :	[illegible]	PBS							
Signature :	[illegible]	[illegible]							
Date & Time:	14/9/25 7:00 AM	15/9/25 8:00 AM							
Hand Over Taken By Name :	PBS								
Signature :	[illegible]								
Date & Time:	15/9								

703

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 : IP18-00036462 **Admit Date** : 14-Jul-2026 **Admit Time** : 02:54 AM **UHID** : GUC-00082396

Patient Details :

Patient Name	: Baby VIDYUTH V	**Age**	: 0 Y 10 M 2 D
Guardian	: Mr VIJITH KUMAR NANDANAM	**DOB**	: 12-09-2025 10:26 AM
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: 17/3 DWARAKA VEL NAGAR 3RD STREET EB COLONY ADAMBAKKAM Adambakkam Chennai Tamil Nadu INDIA	**Phone No**	: 8939846482
		E-mail	: VIJITHSRVV2@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 VIJITH KUMAR NANDANAM **Relationship** : Father

Contact Address : 17/3 DWARAKA VEL NAGAR 3RD STREET EB COLONY ADAMBAKKAM Adambakkam Chennai Tamil Nadu INDIA **Phone No** :

= N. Vijith
Signature

Doctor Details :

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

Referral Doctor : Dr. Ganesh R **Phone No** :

Co-Consultant :

Payment Details :

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

Payor Name : SELFPAY

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GENERAL CONSENT FOR TREATMENT

Patient Name:	**Baby VIDYUTH V**	**Age :**	**0 Y 10 M 2 D**
IP No:	**IP18-00036462**	**Sex:**	**Male**
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 [redacted] 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: > N Vijith

Name: > VIJITH KUMAR NANDANAM

Relationship: > FATHER

Date: 14-07-2026 Time: 2:57

Witness Name: Aswin

Witness Signature:

Patient Address:

17/3 DWARAKA VEL NAGAR 3RD STREET EB COLONY ADAMBAKKAM
Adambakkam Chennai Tamil Nadu
INDIA

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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 : > VIDYUTH. V	UHID Number : 82396
Self/Attendant Name : > VIJITH KUMAR NANDANAM	Relation : > FATHER
Self/ Attendant Signature : > N Vijith Phone Number : > 8939846482	Name & Signature of Financial Counselor

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PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: _____ GUC-00082396 IP18-00036462 Baby VIDYUTH V 12-09-2025 0 Y 10 M 2 D (M) Dr. GANESH R _____

UHID ID: _____ _____

Department: _____

Consultant: _____

(P.T.O.)

Patient Sticker

Pediatric Multiorgan History & Physical Examination

Name: _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

History of present illness :

c/o: fever x (2d)
high grade
continuous
not settled c paracetamol

had c/o: seizure in the form of
upwelling of eyes c loss of awareness
for < 1 min
↓
self arrested

K/C/O: vomiting yesterday - nonbilious
non projectile

Another sibling has H/O: febrile seizure
mother's younger brother has febrile seizure

NO c/o: cough
loose stools
crying during micturation

GUC-00082396 IP18-00036462
Baby VIDYUTH V
12-09-2025 0 Y 10 M 2 D (M)
Dr. GANESH R

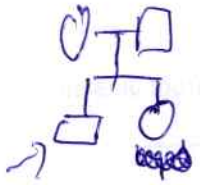
Pa ny previous investigation or treatment)

Nil

Birth & Neonatal History:

NVD | TERM | 2.8kg | CIAB | NBNICU

Family Chart



Birth & Socio Economic History:

About Father : (N)

About Mother :

Any additional Information :

Developmental History : (N)

Immunization History : upto date IAP Schedule

Anthropometry :

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

Weight (kgs) 8.9kg (Centile _____)

On Examination :

Temperature : 102.9°F Pulse Rate : 168/m B.P. Cry SPO2 RA

Resp.rate and type of breathing : (N)

Rash (-)

Lymphadenopathy (-)

Oedema : (-)

Allergies (if any): (-)

(P.T.O.)

Patient Sticker

Respiratory System :

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

Air entry & breath sounds : VBS (+)

Any addes sounds : (-)

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

Cardiovascular System :

Inspection of procordium : (N)

Heart Sounds : S_1S_2 (+)

Any murmur : (-)

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

Per Abdomen :

Inspection : (N)

Palpation : Soft

Ausculation : BS (+)

Spine : (N) External Genitelia : (N)

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

Central Nervous System :

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

Cranial Nerves :

Motor System :

Nutriton : (N)

Tone: (N) Power (N)

Co-ordinator :

Posture : (N)

Involuntary Movements : (-)

GUC-00082396 IP18-00036462
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Reflexes :

DTR (+) Superficials:

Plantars

Sensory System :

Bladder / Bowel :

Clinical Summary & Diagnostic: Dx: Fever evaluation ?: viral fever / Febrile seizure

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

Desired goals of the treatment :

Planned Labs:

CBC
CRP
Blood C/S
RFT, S Ca++, Mg2+
Liver enzymes
Dengue NS1
Urine ME

Planned Management

Syr. P 120mg/5ml
- 3.5ml - if T > 100°F Q4H

0.9% DNS
30ml/hr

Signature of the Doctor: [signature]

Name of the Doctor: C. Deepak

Date & Time: 14/7/25 @ 3:44am

Signature of the Consultant:

Name of the Consultant:

Date & Time:

(P.T.O.)

Patient Sticker

DISCHARGE PLANNING FORM

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

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

2. Destination Post Discharge: ☐ Home

   Family Members Notified (Person Contacted)

   ☐ Transfer

   Hospital Facility Notified (Person Contacted)

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

   ☐ Needs Assistance In: Remarks

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

4. Nutritional Plan:

   ☐ Dietary Instruction Discussed with the:

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

5. Discharge Planning Discussed with the:

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

6. Patient/Family Educational Plan:

   ☐ Educational Topic/s: .....

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

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

Doctor Signature: .....

Doctor Name: .....

Date and Time: .....

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
14/7/26 8:20	. S/B Dr. Manorama	
	A – 1st Episode febrile seizure	
	Reviewed	Elder sib – H/o febrile seizure
	febrile	
	alert, active	
	movement all 4 limbs	Dengue NS-1 – Negative
	H/o No vomiting	Hb – 8.8 / MCV – 53
	taking feeds well	Mentzer index – 10.7
	O/E	
	Ant	Mother H/o →
	No Neurocutaneous markers	β-Thalassemia trait
	PP – +/=	
	Systemic	Dev – (N)
		Sitting with support,
	Rx	babbling (+)
	→ Monitor	
	– para (SOS)	
	– w/f further seizures	
	– to evaluate for anemia (decide after rounds)	

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
14/7/20 9:00 AM	S/B Dr. Chandrakala.	
	Δ - 1st episode simple febrile seizure.	
	Previously (N) kid.	
	Fever x 2 days	
	vomiting x 1 day	
	1 episode of GTCS c̄ uprolling of eye balls < 1 min self aborted.	
	no c/o cough, loose stools.	
	O/E	
	Afebrile, pallor ⊕	F/H/o febrile seizure in elder sister ⊕
	CVS - S1S2 ⊕	
	RS - B/L AE ⊕	
	P/A - soft	Mother - K/C/O
	CNS - Tone (N) in all (4) limbs	Thalassemia trait.
	B/L pupil RTL.	
	DTR 2+ 2+	
	TC - 8210 Hb - 8.8	
	CRP - 10 MCV - 53	
	N/L - 63/30 Mentzer Index - 10.7	
	Electrolytes, RFT, SGOT, SGPT } (N)	

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

GUC-00082396 IP18-00036462
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12-09-2025
Dr. GANESH R

(2)

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	Adv:	
	- monitor vitals	
	- W/F fever spikes	
	- continue paracetamol.	
	[signature] 19/12/24	
14/7/24 11AM	S/B Dr. Ganesh sir	
	Simple febrile seizure - 1st episode	
	[illegible]	Adv:
		- To do Hb electrophoresis tmrw 8AM.
		- To add IV ceftriaxone if fever spikes
		- To continue IV fluids.
	[illegible]	
	[signature]	

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
14/7/20 5pm	S/B Dr. chandiralega.	
	child semiconscious sleeping	
	no fever spikes	
	no further episodes of seizures	
	Oral intake - good.	
	O/E	
	Afebrile	
	CVS - S1S2 (+)	
	RS - B/L AE (+)	
	P/A - SOft	
	AF - Open.	
		Adv
		- W/F fever spikes, seizures
		- monitor vitals
		- continue IV fluids, Paracetamol
	19/12/20	

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
15/7/26 9am.	S/B Dr. Chandiralogs.	
	A- Febrile seizure - 1st episode.	
	Child seizured.	
	Afebrile for 24hrs	
	no seizures since Admission.	
	oral intake - good.	
	Activity - good.	
	O/E	
	Afebrile	PR - 122/min.
	CVS - S1 S2 (P)	
	RS - B/L AES (P)	
	PA - soft.	
	CNS - B/L Pupil RTL	
	Plantar - Extensor	
	Adv:	
	Blood c/s - no growth — monitor vitals.	
	Hb-electrophoresis - - W/F - fever spikes, seizures	
	- To stop IV fluids.	
	- Inform SOS	
	19/7/26	

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
18/7/2026		
11A	r/b Dr Ramesh	
	1st episode SFS.	
	Anaemia	
	no fresh/further complaints	
	D/s to day	
	R. on 18.7.2026	c̄ Hb electrophoresis reports
	(signature)	

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

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RESULT SHEET

Date	14/7/26					
Time						
Hb	8.8					
PCV	26					
RBC	4.91					
WBC	8.21					
N/L	68/30					
Platelets	3.95					
CRP	10					
ESR						
PCT						
RBS						
Na	134					
K	4.3					
Cl	105					
Ca/Mg	10.1/1.8					
Phosphate						
Urea	10					
Creatinine	0.31					
ALP						
SGPT	19					
SGOT	35					
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						
Dengue NS-1 Negative						

Culture and Sensitivities : .....

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.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

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DRUG CHART

☐ Not known any Drug Allergies

Date of Admission: 12/7/26 Drug Allergies: Nil

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. P 120mg				Date / Time
Dose	Route	Frequency	Start Date	
5ml	P/O	SOS		Stop 13/7/26
Doctor's Signature	Valid Period	Pharm.		
[signature]				
Additional Instructions: if T)100°F Once in 6hr				

DRUG: P100 drops				Date / Time
Dose	Route	Frequency	Start Date	14/7 9AM — 14/7 [illegible]
1.2ml	PO	SOS	14/7/26	
Doctor's Signature	Valid Period	Pharm.		
[signature]				
Additional Instructions:				

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

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

Docu. No. : RCH /FRM / CLINICAL / 118

GUC-00082396 IP18-00036462
Baby VIDYUTH V
12-09-2025 0 Y 10 M 2 D (M)
Dr. GANESH R

REGULAR PRESCRIPTIONS

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

DRUG : INJ. CEFTRIAXONE

Dose	Route	Frequency	Start Date
450mg	IV	Q12H	14/7/26

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time: Stopped

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

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

GUC-00082396 IP18-00036462
Baby VIDYUTH V
12-09-2025 0 Y 10 M 2 D (M)
Dr. GANESH R

I.V. FLUIDS CHART

Weight. 8.9kg Ward. ....

Date	Time	Composition of 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
14/7/[illegible]	[illegible]pm	0.9% DNS	Iv	30ml/hr	[signature]	[signature]			
		0.9% DNS	IV	20ml/hr	[signature] 19/7/[illegible]				

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

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Baby VIDYUTH V
12-09-2025 0 Y 10 M 2 D (M)
Dr. GANESH R

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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: 703

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 : .....

Date & Time : 14/7/25 @ 3:15 AM

Nurse Name & Signature: .....

Date & Time : 14/7/25 @ 4 am.

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

GUC-00082396 IP18-00036462
Baby VIDYUTH V
12-09-2025 0 Y 10 M 2 D (M)
Dr. GANESH R

c. 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 : 14/11/25 Time: 4am

Doctor / Nurse / Family Concern?

Temperature (°F): 104 103 102 101 100 99 98 97 96 95 94 — On admission 98.8F

Heart Rate (bpm) and Blood Pressure (mmHg) *: 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 — 120/80, (56), 50

Note: BP does not score in early warning scoring

Heart Rate (Number): 80/min

Resp. Rate (bpm) (Over 1 Minute) *: 70 60 50 40 30 20 10 — 30

Resp Rate (Number): 30/min

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

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

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

Patient Sticker

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

GUC-00082396 IP18-00036462
Baby VIDYUTH V
12-09-2025 0 Y 10 M 2 D (M)
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 : 14/7/26

Time:	9.30 AM	10.30 am	12pm	4pm	8pm	12am	4am
Doctor / Nurse / Family Concern?							
Temperature (°F)	102.8°F	98.4	98.5°F	98.8	99°F	98.7°F	97.9°F
Heart Rate (bpm) and Blood Pressure (mmHg) *							
Heart Rate (Number)	120 b/m	118 b/m	120 b/m	120 bpm	125 bm	120 bpm	127 bm
Resp. Rate (bpm) (Over 1 Minute) *							
Resp Rate (Number)	30/m	32/m	31/m	30 bpm	32 bpm	32 bpm	32 bpm
Resp Distress (Mod/ Severe; None / Mild)	✓	✓	✓	✓	✓	✓	✓
Receiving O_2 (l/min) / O_2 Saturations (%)	99% (RA)	99% (RA)	98% (RA)	99% RA	100%	100%	99%
Conscious Level (Normal; Altered)							
GCS *	15/15	15/15	15/15	15/15	15/15	15/15	15/15
TOTAL SCORE Number of shaded boxes	0	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0	0
Observer's Initials							

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

Note: BP does not score in early warning scoring

ACTIONS	
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: Scores 3 should be recorded overleaf

* 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

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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)

GUC-00082396 IP18-00036462
Baby VIDYUTH V
12-09-2025 0 Y 10 M 2 D (M)
Dr. GANESH R

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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.

Date	Time	Intake: Nature of Fluid	Intake: Route – Mouth	Intake: Route – I.V	Intake: Route – N.G	Output: NG	Output: Diarrhoea	Output: Vomit	Output: Drainage	Output: Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
12/7/25												
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						Total Output :						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						Total Output :						
	02:00 am											
	03:00 am	←		On admission					→			
	04:00 am	DBF		30ml							0	Dy
	05:00 am			30ml						Diaper Wet	0	Dy
	06:00 am	DBF		30ml							0	
	07:00 am			30ml								
Total Intake :				120ml		Total Output :				1 time		

Total 24 hrs. Intake	120ml + DBF @ 1 time	Total 24 hrs. Output	1 time

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Baby VIDYUTH V
12-09-2025 0 Y 10 M 2 D (M)
Dr. GANESH R

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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.

Date	Time	Intake: Nature of Fluid	Intake: Route – Mouth	Intake: Route – I.V	Intake: Route – N.G	Output: NG	Output: Diarrhoea	Output: Vomit	Output: Drainage	Output: Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
	08:00 am			30ml							0	P.C
	09:00 am	H2O	~~500~~	DC							0	P.C
	10:00 am	H2O	30ml	DC							0	P.C
	11:00 am	Soup	50ml	DC			✓			Diaper Chged	0	P.C
	12:00 pm			30ml							0	P.C
	01:00 pm			30ml							0	P.C
Total Intake : 130ml + 90ml => 230ml						Total Output : Diaper Changed						
	02:00 pm			30ml							0	SN
	03:00 pm	H20	30ml	30ml						Diaper Chge	0	SN
	04:00 pm			30ml							0	SN
	05:00 pm			30ml							0	SN
	06:00 pm	Ragi	20ml	30ml						20ml	0	SN
	07:00 pm			DC							0	SN
Total Intake : 50ml + 150ml = 200ml						Total Output : Diaper changed +20ml						
	08:00 pm	H20	20ml	30								
	09:00 pm	Milk	100ml	DC						✓	0	SN
	10:00 pm			30								
	11:00 pm	DBF		30						✓	0	SN
	12:00 am			30								
	01:00 am	DBF		30						✓	0	SN
Total Intake : 120ml + 150 + DBF						Total Output : Bfeed						
	02:00 am			30								
	03:00 am	DBF		30						✓		
	04:00 am			30							0	SN
	05:00 am			30						✓		
	06:00 am	Milk	100ml	30								
	07:00 am			30						✓	0	SN
Total Intake : 100ml + 180ml						Total Output :						

Total 24 hrs. Intake	950ml.	Total 24 hrs. Output	9 times.

GUC-00082396 IP18-00036462
Baby VIDYUTH V
12-09-2025 0 Y 10 M 2 D (M)
Dr. GANESH R

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BirthRight BY RAINBOW HOSPITALS
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NURSING CARE RECORD

Date: 13/7/06

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon							
Night	8 pm	maintain good nutritional status.	8.30 am	maintained good nutritional status.	Engauge oral intake and output.	Reassessment done	Jaya cross

GUC-00082396 IP18-00036462
Baby VIDYUTH V (M)
12-09-2025 0 Y 10 M 2 D
Dr. GANESH R

NURSING CARE RECORD

Rainbow® Children's Hospital — It takes a lot to treat the little.
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Date: 04/7/24

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	7.30Am	- Assess the Child General condition - Teach the patient how to prevent Infection	11Am	- Assessed the child General condition - taught the patient how to prevent Infection	Taught the patient how to prevent Infection	Patient aware of Infection	[signature]
Afternoon	2pm	Assess the general condition Vital signs to be charted & Record maintain Dr orders	4pm	Assessed the general condition. Vital signs are charted & Record maintain Dr orders	Baby looks pink & active well	Vital signs are charted & Record	[signature]
Night	8pm	maintain good nutritional status.	8.30pm	maintained good nutritional status.	Baby clinically well. there is no other complaints	Reassessment done	[signature]

Docu. No: RCH /FRM / CLINICAL / 148

GUC-00082396 IP18-00036462
Baby VIDYUTH V
12-09-2025 0 Y 10 M 2 D (M)
Dr. GANESH R

(1)

NURSES NOTES

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☑ No Known Drug Allergies

☐ Drug Allergies ....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		Received Notes	
14/7/26	4AM	Handover Received from	[illegible]
		N: Staff. Child is active	
		and alerted. IV line	
		present. IVF 0.9% NS 30ml/hr	
		on flow.	
		Checked vital sign and	
		recorded.	
	6am	monitored I/O chart	[illegible]
		and recorded.	
	7.30am	Handover given to	
		Morning duty staff	
		Morning duty on 14/7/26	
	7.30am	Child details handing over	
		taken from night duty staff.	
		Child active and alert. Child	
		IV line pattern. To do urine	[illegible]
		Route. 0.9% NS 30ml/h on flow	
		of the [illegible].	
	8Am	Vital sign checked and	[illegible]
		Recorded	
			CP	PD	IFT	
			++	++	2sec		
	9.30Am	Temperature 102.8°F Informed Dr. Deepak	
		sir advised by give syp-100 drops	[illegible]
		give slow	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

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

Patient Sticker

NURSES NOTES

Rainbow® Children's Hospital
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Your Right to a Safe Delivery

☐ No Known Drug Allergies

☐ Drug Allergies ....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
14/7/2	9.00am	D-100 drops 1.2ml given oral route.	[signature]
	10.30am	Dr. Ganesh sir seen the child by tomorrow to do Hb Hb electrophoresis, & add IV ceftriaxone if fever spike, to continue IV fluids, to do same routine.	[signature]
	12pm	Maintain intake and output chart. Vital signs checked & recorded.	[signature]
		CP ++, PP ++, LFT in (1pm)	
	1.30pm	Child details handing over on evening duty staff.	[signature]
		Evening duty 14/7/26	
	1.30pm	Child report taking over from (M) duty staff.	[signature]
	2pm	Child was conscious & oriented, was taking orally & sleeping well. Vital signs are checked & recorded. I/O chart maintained. General condition is fair.	[signature]
	4pm	Child afebrile, taking orally & sleeping well, has no specific complaints at present. Voiding freely.	[signature]

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Patient's Name:..

MRD NO:............ GUC-00082396 IP18-00036462
Baby VIDYUTH V
12-09-2025 0 Y 10 M 2 D (M)
Dr. GANESH R

Age :.................... I ☐ F

Consultant :..

PHLEBITIS ASSESSMENT

CANNULA 1

Date : 14/7/26 Time: 3 am
Location : (L) metadorsal
Size : 24 G
Cannula inserted by : S/N Ashray perith

Date	Time	Phlebitis	Infiltration	Nursing Intervention	Sign
14/7	3am	☐Yes ☑No	☐Yes ☑No	observe	[illegible]
	5am	☐Yes ☑No	☐Yes ☐No	obs	[illegible]
	7am	☐Yes ☑No	☐Yes ☑No	obs	[illegible]
14/7	8am	☐Yes ☑No	☐Yes ☑No	obs	[illegible]
	10 AM	☐Yes ☑No	☐Yes ☑No	observe	[illegible]
	12pm	☐Yes ☑No	☐Yes ☑No	obs	[illegible]
	2pm	☐Yes ☑No	☐Yes ☑No	obs	[illegible]
	4pm	☐Yes ☑No	☐Yes ☑No	obs	[illegible]
	6pm	☐Yes ☑No	☐Yes ☑No	obs	[illegible]
	8pm	☐Yes ☑No	☐Yes ☑No	obs	[illegible]
	10pm	☐Yes ☑No	☐Yes ☑No	obs	[illegible]
15/7	12am	☐Yes ☑No	☐Yes ☑No	obs	[illegible]
	2am	☐Yes ☑No	☐Yes ☑No	obs	[illegible]
	4am	☐Yes ☑No	☐Yes ☑No	obs	[illegible]
	6am	☐Yes ☑No	☐Yes ☑No	obs	[illegible]
	8am	☐Yes ☑No	☐Yes ☑No	observe	[illegible]
	10am	☐Yes ☑No	☐Yes ☑No	obsev	P.G
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐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-00082396 IP18-00036462
Baby VIDYUTH V
12-09-2025 0 Y 10 M 2 D (M)
Dr. GANESH R

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THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
			N	M	E	14/7	15/7
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	2	2		2	2
	Female	1					
Diagnosis	Neurological Diagnosis	4	4	4	4	4	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	2	2	2	2	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	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		15	15	15	15	15

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	NA	NA	NA
Other Intervention(s) Specify		NA	NA	NA	NA	NA
Nurse's Name:						
Signature:						
Date:		14/7	14/7	14/7	14/7	15/7
Time:		8am	8am	8pm	8pm	8am

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

GUC-00082396 IP18-00036462
Baby VIDYUTH V
12-09-2025 0 Y 10 M 3 D (M)
Dr. GANESH R

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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-00082396 IP18-00036462
Baby VIDYUTH V
12-09-2025 0 Y 10 M 2 D (M)
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
14/7/26	4am	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	nil	Sony
14/7/26	8am	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	Nil	[illegible]
14/7/26	2pm	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☑ No	NA	[illegible]
14/7/26	8pm	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	nil	Sony
15/7/26	4am	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	nil	Sony
15/7/26	10am	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	Nil	[illegible] 602278
				☐ 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		

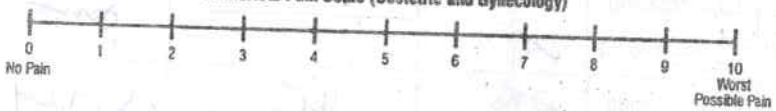
Re-assessment Frequency:

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.

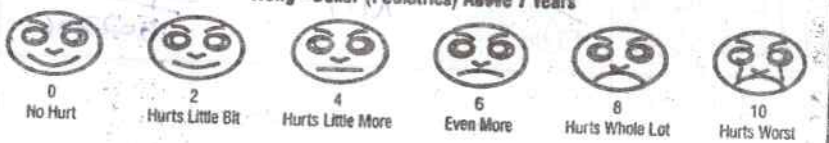
(P.T.O)

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:

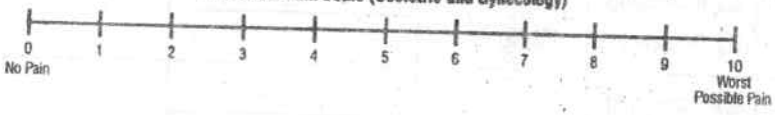
1. Every eight hours for all hospitalized patients.
2. For post-surgical patients, patients with chronic pain, patient with severe pain:
   - a) At least every 2 hours for the first 24 hours
   - b) Then every 4 hours.
   - c) Prior to pain pain-relieving intervention.
   - d) Within 30 – 60 minutes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

(P.T.O)

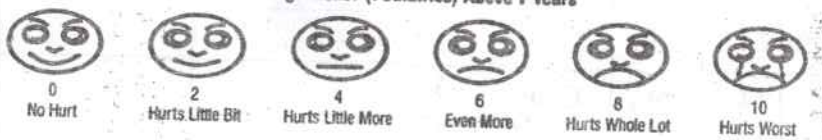
Docu.No: RCH /FRM / CLINICAL / 152

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-00082396 IP18-00036462
Baby VIDYUTH V
12-09-2025 0 Y 10 M 2 D (M)
Dr. GANESH R

BRADEN 'Q' SCALE

(for Paediatric use)

Patient Name : .....

Age..... Gender : ☐ M ☐ F IP No. : .....

				Date :	N 14/7	M 14/7	2	N 14/7
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 though 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 lift 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	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4
				TOTAL SCORE	27	27	28	28
				Evaluator's Name				

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

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Ref. No.: F/HW/BRD-Q/NSG/04

GUC-00082396 IP18-00036462
Baby VIDYUTH V
12-09-2025 0 Y 10 M 3 D (M)
Dr. GANESH R

BRADEN 'Q' SCALE

(for Paediatric use)

Pati.....

Age.

IP No. : .....

					M			
					15/7/25			
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 though slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	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			
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			
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			
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 lift up completely during move. Maintains good position in bed or chair at all times."	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			
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			
				TOTAL SCORE	28			
				Evaluator's Name	[signature] 607771			

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

GUC-00082396 IP18-00036462
Baby VIDYUTH V
12-09-2025 0 Y 10 M 2 D (M)
Dr. GANESH R

INTERI… T / FAMILY EDUCATION RECORD

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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
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

Plan

Part - II

Date	Time	Need Identified	Information Taught	Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding	Comments	Designation / Signature
				Use codes from the list in part III						
14/7/26	4am	IV fluid	started IV management and education	Mother	nil	oral	nil	yes	good	[signature]
14/7/26	8pm	fall risk	Side rail awareness	M…	No learning barriers	Oral	None	Yes	good	[signature]
15/7/26	8Am	fall risk	Side rail awareness	Mother	nil	oral	Nil	yes	good	[signature] 607778

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

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Dr. [illegible]

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Nursing General Admission Assessment Form For Pediatrics

Diagnosis: febrile seizure.
Arrival Time: 4am Mode of Arrival: carrying Admitting From: ☑ ER ☐ OPD ☐ Direct
Allergy / Adverse Reaction: Nil
Body Weight: .... 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: .... Length: .... Head Circumference (< 2 years): ....
Temp.: 98.2°F HR: 120bpm RR: 32bpm BP: 90/50(56).

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

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

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

Pain Screening: ☐ Yes ☑ No If Yes, Pain Score: .... 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

(P.T.O)

Psychological Screening: ☑ No Significant Findings

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

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

Social History: Lives With ..... parents .....

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

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

Orientation has been given regarding the following aspects:

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

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

Patient Rights & Responsibilities: ☑ Yes ☐ No

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

Nurse's Name: ..... Date: 14/7/26 Time: 4am Signature

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RBS CHART

Date	Time	RBS (mg/dl)	IVF %	Signature

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EMERGENCY ROOM TRIAGE FORM

wt : 8.9kg

Patient's Name : Baby. Vidyuth. Age : 1 month. Gender: ☑ Male ☐ Female

Date : 14/7/26 Time of Arrival : 2:45am

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

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

Mode of Arrival : ☑ Ambulatory ☐ Wheelchair ☐ Ambulance

Initial Vital Signs: Temp: 102.9°F PR: 165/min BP: cry RR: 32/min SpO_2: 98%

Chief Complaints: fever x 2 days. & seizure - 1 min.

INITIAL PHYSIOLOGICAL CATEGORIZATION

Appearance: ☑ Normal ☐ Sick Looking

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

Circulation / Colour: ☑ Normal ☐ Abnormal ☐ Bleeding

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 : 2 min

Communicable Disease Triage Screening

Para 200 - 2ml - 1.2 ml given

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).

Signature of Triage Nurse : .....

Name of Triage Nurse : .....

Date & Time : 14/7/26 @ 2:47am.

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

PATIENT TRANSFER FORM

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GUC-00082396 IP18-00036462 Baby VIDYUTH V 12-09-2025 0 Y 10 M 2 D (M) Dr. GANESH R	Date & Time of Admission 14/7/26 @ 2:59 am.	Date & Time of Transfer Order 14/7/26 @ 3:15 am
Treating Consultant Name Dr. Ganesh	Transfer Ordered by Dr. Deepak.	Reason for Transfer further management
From Unit ER	To Unit 703	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File 15	Number of Imaging Films Nil	Personal belongings including clinical documents. If any handed over to attendant Yes ☑ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	Nil	
2.		
3.		
4.		
5.		

Shifting Summary / Notes Written by Doctor : Yes ☑ No ☐
Δ: ? Viral fever / Febrile seizure

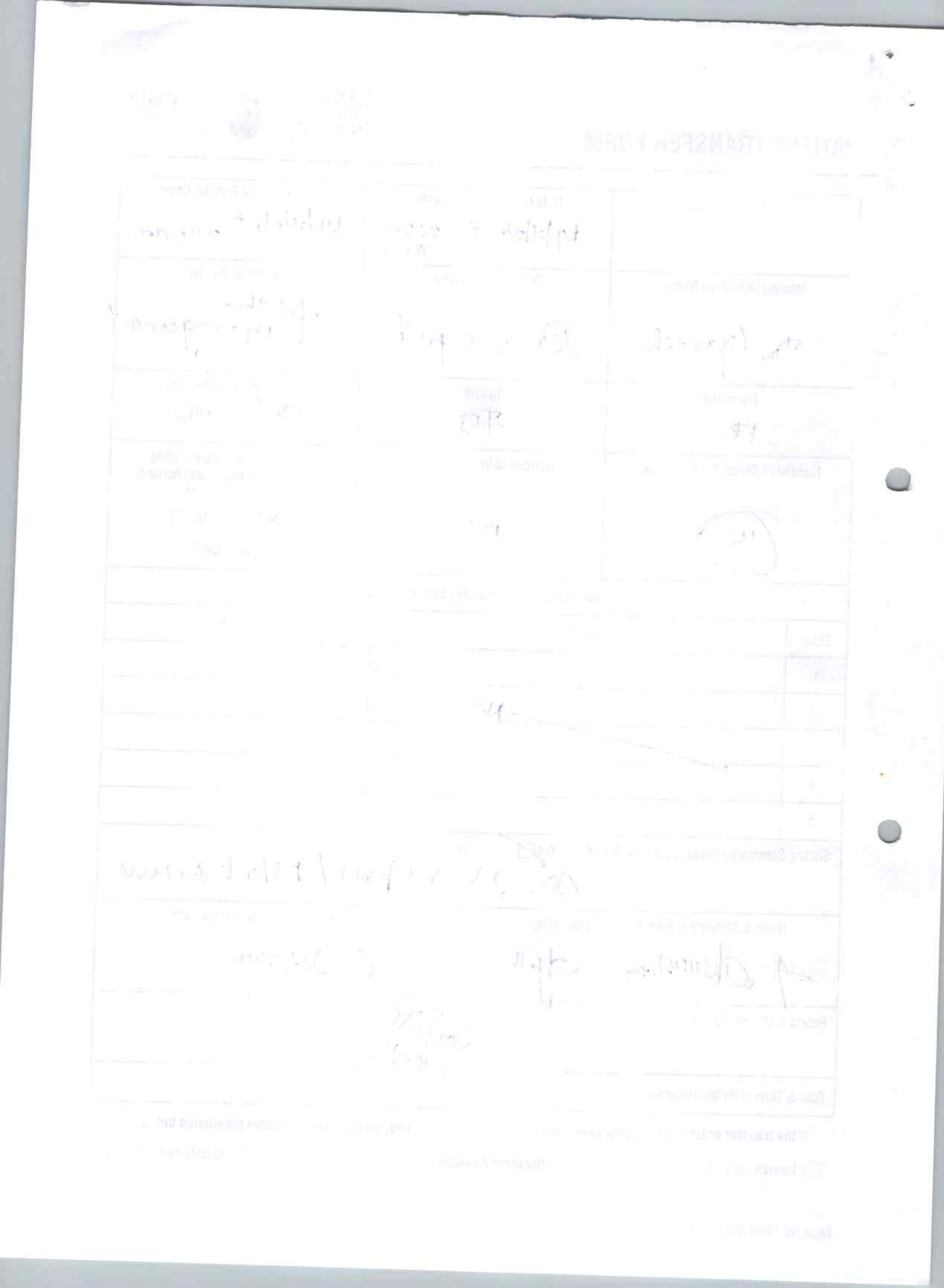
Name & Signature of Person who is Transferring J. Aleena, 1704 [signature]	Name of Person Ordered Transfer C. DEEPAK

Patient & Clinical Records Received by : [signature]

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



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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 14/07/26 Time of arrival : 2:45 am

Chief Complaints: H/o. fever x 2 days 2 seizure - 21 min RBS: .....

Height : - Weight : 8.29 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 : 5 min

Time	Nursing Notes
2:45 am	patient came for ER c the complaints of fever x 2 days, ? seizure x 1 min. Dr. Ganesh sir advised to put an IV line Sample are collected medication are given as per Order. vitals are checked all are stable, shifted to ward - TOS.

Samples collected by: S/N Akshaya priya Time: 3:00 am

Samples sent by : S/N. Jyothi Time: 3:00 am.

Medication given in ER:

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

Condition of patient at time of shift - out :	Details of Shift - out
HR: 128/min BP: Ung CFT: 2s	Shift - out from ER to: TOS
RR: 32/min SPO_2: 98%	Time of Shift - out: 3:25 am
GCS: 14/15 Temperature : 97.2 °F	Handover given to: S/N Sowmiya (Nurse's Name)
Pain Score: 0/10	
Repeat RBS (if applicable):	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any): IV line placement done in (L) metadorsal line 24 G is placed

Name of the Nurse : Jyothi Signature of the Nurse :

Date & Time : 14/7/26 @ 2:45 am.

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PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : Dr. DEEPAK

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

Date : .....

Start Time of Assessment: .....

Weight: 8.9 kg

Allergic History: Nil

Chief Complaints:

C/o. fever x 2d
seizure x 1 min

Pediatric Assessment Triangle

A Appearance - TICLS Alert

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

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

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

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

Significant Past History: -

Medication History: -

Relevant Investigations: -

Primary Assessment

Airway
- ☑ Open
- ☐ Maintainable
- ☐ Not Maintainable

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

Breathing

Rate: .....
SpO_2 on FiO_2 98% / RA
Rhythm: .....
Retractions: ☐ Suprasternal ☐ ICR ☐ SCR ☐ Sternal ☐ Supraclavicular ☐ Nasal Flaring
Respiratory Noises: ☐ Stridor ☐ Wheezing ☐ Grunting
Air Entry: BAE
Palpation Findings (If necessary).....

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

(P.T.O.)

Circulation

HR: 168/min   CFT [Central / Peripheral] (P)

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

Any urgent interventions needed: ☐ Yes ☑ No

If Yes ....

Disability

GCS: 15/15   AVPU: Alert

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

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

Signs of Neurological compromise ....

Any urgent interventions needed: Yes ☑ No

If Yes ....

Exposure

Temp.: 102.9°F

Any Rash: ☐ Yes ☑ No,

If yes describe the rash ....

Active bleed ....

Lacerations ☐   Abrasions ☐   bruises ☐

Describe: ....

Any urgent interventions needed: ☐ Yes ☑ No

If Yes ....

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

☐ Shock - Compensated ☐ Hypotensive ☐

☐ Cardiopulmonary Arrest ☑ Hemodynamically Stable

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

Labs Planned: ....

Treatment Planned: ....

Attached

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

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

Assessment done by

Name of the Doctor: C.DGFMK

Signature: [signature]

Date & Time: 24/7/24 @ 3:45AM

Sr. Doctor on Duty (If necessary)

Name of the Sr. Doctor: ....

Signature: ....

Date & Time: ....