Rainbow Children's Hospital

DISCHARGE TRACKING SHEET

GUC-00094269 IP18-00036611
Ms K.S.UTHRAA
31-03-2017 9 Y 3 M 25 D (F)
Dr. VAISHNAVI CHANDRAMOHAN

UHID- FLOOR- NAME OF CONSULTANT-

ACTIVITY	INTIME	OUT TIME	NAME & SIGNATURE	REMARKS	<To be filled by Admin >		
Activity Sheet update by Nursing		28/4/2017					
Activity Sheet update by Pharmacy		9.45am					

ACTIVITY RECORD FOR BILLING

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Name: .....

UHID No: ..... GUC-00094269 IP18-00036611 .... Consultant: ..... Dept: .....

Ms K.S.UTHRAA
31-03-2017 9 Y 3 M 25 D (F)
Dr. VAISHNAVI CHANDRAMOHAN

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
25/4/26.	1:40pm	ER	401	

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
25/7/26.	CBC, CRP, RBS.	26023880	17 (M)
	LFT.		
25/7/26	Urine routine and culture	26023897	

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
25/7/26	Infusion pumb	2.40pm	26/7/26 9AM	3 2924	[illegible] 0/4384

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
25/7/26	IV placement	(1)	1732754	
25/7/26	USG - Abdomen	(1)	10034	
25/7/26	CT - whole Abdomen	(1)	10057	

ANY OTHER INFORMATION:

.....

.....

.....

.....

.....

.....

Date: 26/7/26 Time: 9.45AM Prepared By: .....

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
OSBan			

Rainbow Children's Hospital | BirthRight

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Dr. VAISHNAVI CHANDRAMOHAN

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	26/5/260 9.45AM				
Preparation of Discharge Summary					
Finalization of discharge summary					
Transfer of file from Ward to Billing Dept					
Bill Processing					
Audit Clearance					
Billing Clearance					
Physical Clearance					

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Patient Name	Ms K.S.UTHRAA	Patient Ph.No	9884240985
Age	9 Y 3 M 25 D	Requisition No	R2618-010057
Gender	Female	Collected on	25-07-2026 01:37 PM
IP / Bill No.	IP18-00036611	Received On	25-07-2026 01:58 PM
UHID No.	GUC-00094269	Reported On	25-07-2026 01:58 PM
Ref. Doctor	VAISHNAVI CHANDRAMOHAN	Ward / Bed No	

CT REPORT - ABDOMEN AND PELVIS (PLAIN)

TECHNIQUE: Volume scan of the whole abdomen was made from xiphisternum to pubis without administration of IV Contrast.

OBSERVATION:

Liver is normal in size and shows uniform density. No obvious focal lesion is seen. CBD is not dilated.
GB - unremarkable.
Pancreas is normal in size and density. No calcification, obvious mass or peripancreatic fluid collection seen. The pancreatic duct is not dilated.
Spleen is normal in size and density.
Right kidney is normal in size. Pelvicalyceal system not dilated.
Ureter is not dilated. No calculus is seen. The vesico-ureteric junction appears normal.
Left kidney is normal in size. Pelvicalyceal system not dilated.
Ureter is not dilated. No calculus is seen. The vesico-ureteric junction appears normal.
Both adrenals appear normal in size and shape.
There is no mass or lymphadenopathy seen in the retro peritoneum.
No free fluid is seen in the peritoneal cavity.
No obvious bowel wall thickening / dilatation seen. No evidence of acute appendicitis.
Significant fecal loading of descending colon, sigmoid colon and rectum.
The **bladder** is empty. No evidence of diverticulum or calculus.
Pelvic soft tissues are normal.
Bilateral iliopsoas muscle appears normal.
No lytic or sclerotic lesion is seen in visualized bones.
Visualized lung fields are clear. No pleural effusion.

Print Date/Time : 25-07-2026 01:58 PM
Printed By : SNEHA S SUSEELAN

Note: Clinically correlate , Kindly discuss if necessary

Rainbow Children's Medicare Limited

CHENNAI : No. 157 to 160, Anna Salai, Near Little Mount Metro Station, Guindy, Tamil Nadu - 600015

SHOLINGANALLUR : No. 493/42A2B, OMR ECR Link Road, Chennai, Tamilnadu - 600119

For Appointments call: 1800 2122

CIN : L85110TG1998PLC029914

info@rainbowhospitals.in

www.rainbowhospitals.in

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Ref. Doctor	VAISHNAVI CHANDRAMOHAN	Ward / Bed No	

Impression

- **Significant fecal loading of descending colon, sigmoid colon and rectum.**
- **No free fluid in abdomen.**
- **No abdominal mass or significant lymphadenopathy.**
- **No evidence of appendicitis. No renal calculi or hydroureteronephrosis.**

Dr. PRASANNA KUMARAVEL
MBBS, MDRD
Reg No: 92729

Print Date/Time : 25-07-2026 01:58 PM

Printed By : SNEHA S SUSEELAN

Note: Clinically correlate , Kindly discuss if necessary

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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 : IP18-00036611 **Admit Date** : 25-Jul-2026 **Admit Time** : 09:58 AM **UHID** : GUC-00094269

Patient Details :

Patient Name	: Ms K.S.UTHRAA		
Guardian	: Mr SHYAAM KUMAR	**Age**	: 9 Y 3 M 25 D
Gender	: Female	**DOB**	: 31-03-2017
Occupation	:	**Religion**	:
Address (H)	: NO-21/7, BAJANAI KOVIL ST, LAKSHMIPURAM, KOLATHUR, CHENNAI Kolathur-Cpt Chennai Tamil Nadu INDIA 600099	**Martial Status**	:
		Phone No	: 9884240985/ 9176664266
		E-mail	: NO@GMAIL.COM

Admission Details :

Bed Type : DAY CARE **Bed No** : ER 102 **Ward Name** : 0F-EMERGENCY

Room No : ER 102 **Admission Type** : First Visit

Contact Details :

Name : Mr SHYAAM KUMAR

Contact Address : NO-21/7, BAJANAI KOVIL ST, LAKSHMIPURAM, KOLATHUR, CHENNAI Kolathur-Cpt Chennai Tamil Nadu INDIA 600099

Relationship : Father

Phone No : / 9884240985

Signature

Doctor Details :

Doctor Name : Dr. VAISHNAVI CHANDRAMOHAN **Specialisation** : GENERAL PEDIATRICS

Referral Doctor : FRIENDS **Phone No** :

Co-Consultant :

Payment Details :

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

Payor Name : SELFPAY

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Door No.157 to 160, Anna Salai, Guindy, Guindy ,Chennai ,Tamil Nadu, INDIA ,600015.
TEL NO :044-40122444
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GENERAL CONSENT FOR TREATMENT

Patient Name:	**Ms K.S.UTHRAA**		
IP No:	**IP18-00036611**	**Age :**	**9 Y 3 M 25 D**
Consultant:	**Dr. VAISHNAVI CHANDRAMOHAN**	**Sex:**	**Female**
		Ward/Bed No:	**0F-EMERGENCY/ER 102**

The undersigned patient and I or responsible relative or person hereby consent to and authorize Rainbow Hospitals doctors and medical personnel to perform medical examinations, conduct routine investigations and administer medical treatments, outpatient procedures, minor dressings, vaccinations and immunizations during the course of the patient's care, as in patient.

Patient, be deemed advisable or necessary.

I understand that the confidentiality of all medical records shall be protected to the full extent of the Law. The undersigned also consent to the use of health related information/ audiovisuals of the patient for research & training purpose or for insurance coverage and while doing so confidentiality of the patient will be maintained at all times and this will not affect the care of the patient.

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

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

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

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

3 I 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: T. G. Uthra

Name: Mr. Shyaam kumar
Relationship: father
Date: 25/07/2026 Time: 09:58 Am
Witness Name: A. Sivasankari
Witness Signature: A. Sivasankari

Patient Address:
NO-21/7, BAJANAI KOVIL ST,
LAKSHMIPURAM, KOLATHUR, CHENNAI
Kolathur-Cpt Chennai Tamil Nadu
INDIA 600099

BILLING POLICY

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

DECLARATION

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

Patient Name :	UHID Number : GUC-00094269
Self/Attendant Name : KARTHIKA SHYAM	Relation : MOTHER
Self/ Attendant Signature : Phone Number :	Name & Signature of Financial Counselor A.

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PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: _____

UHID ID: GUC-00094269 IP18-00036611
Ms K.S.UTHRAA
31-03-2017 9 Y 3 M 25 D (F)
Dr. VAISHNAVI CHANDRAMOHAN

Department: _____

Consultant: _____

GUC-00094269
Ms K.S.UTHRAA IP18-00036611
31-03-2017 9 Y 3 M 25 D (F)
Dr. VAISHNAVI CHANDRAMOHAN

Pe 'hysical Examination

Name: Age/Sex

Information given by: Mother Relationship

Chief Presenting Complaints & Duration (Chronologically)

History of present illness :

c/o pain over lower abdomen - for the past ~~days~~ 15 minutes - sudden onset progressive in nature.
while waiting for her turn at Gymnastics national level competition.

H/o practising (50) somersaults yesterday.

~~[illegible]~~ . c/o vomit x 2 episodes after coming to ER.

vomitus - food contents (bluish-green electrolyte drink given).
non-bilious / non-blood stained

Appetite ↓ed yesterday.

No h/o loose stools / fever / burning micturition

Patient Sticker

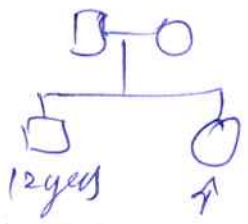
Past History : (Including details of any previous investigation or treatment)

H/o UTI - 5-6 episodes in the past - yearly one episode.
Started at 4 yrs of age
H/o leaking urine (while asked to hold urine for a while)
H/o nocturnal enuresis +
No H/o constipation

Birth & Neonatal History:

Preterm 35-36 wks NVD / Birth - 1.8 kgs
CIAB / NICU stay × 1 week

Family Chart



Birth & Socio Economic History:

About Father : _____

About Mother : _____

Any additional Information : _____

Developmental History :

Dev ✓

Immunization History :

Vaccinated as per date - IAP schedule.

Anthropometry :

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

Weight (kgs) 25 kgs (Centile _____)

On Examination :

RBS - 93 mg/dl

Temperature : 97.2°F Pulse Rate : 85/min B.P. 102/70 mmHg SPO2 100%

Resp.rate and type of breathing : _____

Crying in pain

Rash PPNS

Lymphadenopathy _____

Pulse volume - good

Oedema : _____

CRT < 3 sec

Allergies (if any): _____

(P.T.O.)

Patient Sticker

Respiratory System :

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

Air entry & breath sounds : B/L NVBS (P)

Any addes sounds : –

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

Cardiovascular System :

Inspection of procordium :

Heart Sounds : S1S2 (+)

Any murmur :

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

Per Abdomen :

Inspection :

Palpation : Soft, tenderness over R/F / L/F / Supra umbilical region

Ausculation : BS (+)

Spine : (N) External Genitelia :

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

Central Nervous System :

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

Cranial Nerves :

Motor System :

Nutriton : (N)

Tone: (N) Power 5/5

Co-ordinator : (N)

Posture : (N)

Involuntary Movements :

Patient Sticker

Reflexes :

DTR **Superficials:**

Plantars

Sensory System :

Bladder / Bowel :

Clinical Summary & Diagnostic:

Acute abdomen - ? A/c appendicitis
? Spasm
? Psoas muscle hematoma
? Ovarian torsion

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

Desired goals of the treatment :

Planned Labs:

CBC /
RBS /
LFT /
CRP /
USG Abdomen /
Urine R/E /
C/S /

Planned Management

NPO
NF DNS
IV Para stat

Plan - to start IV Abx after sending c/s

Signature of the Doctor: .....

Name of the Doctor: Dr. Kanika

Date & Time: 25/7/26 10.30am

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: .....

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

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

DOCTOR'S SHIFT CHANGE HANDOVER FORM

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

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

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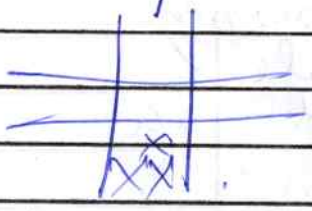
PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
25/4/26 5.50pm	S/B Dr. Gayathri S /Dr. Vaishnavi	
	A - Acute abdominal pain ↳ evaluation	
	? Muscle spasm	
	- H/o intensive gymnastic practice yesterday	
	- c/o lower abdomen pain started since today morning	
		
	• Hemodynamically stable.	
	• USG Abdomen • CT Abdomen	ⓝ except for fecal loading in the distal colon ↓ passed stools & supportive Inj Tin injection
	Abd • Pain subsided & tolerating well • child allowed orally	
	• c/o fwd	

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	Plan.	
	(1) Cont IVF / pan / emeset	
	(2) Monitor vitals	
	[signature] 165787 [signature]	
	S/B Dr. Vardhman	
26/7 9 am	And pain settled	
	No vomiting	
	Rx: Afebrile	
	Abd - soft.	
		Adv -
		- D/C today
		1. Emeset 1 day
		2. Lanzol 30mg 3days
		3. Paro SOS
		Review on Tuesday
		[signature]

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

Patient Sticker

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RESULT SHEET

Date	25/A					
Time						
Hb	11.9					
PCV	35					
RBC	4.26					
WBC	6630					
N/L	31/57					
Platelets	2.98					
CRP	<5					
ESR						
PCT						
RBS	105					
Na	141					
K	3.5					
Cl	107					
Ca/Mg	1.15					
Phosphate /HCO_3	/17					
Urea	26					
Creatinine	0.45					
ALP	209					
SGPT	17					
SGOT	30					
T.Bill/Conj						
T.Protein						
S.Albumin	4.4					
S.Globulin						
A/G Ratio						
Uric Acid /GGT	11					
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

Date	25/7					
Time						
CUE - Alb	Nil					
CUE - Sugar	Nil					
CUE - Ketones.	2+					
CUE - PUS Cells.	1-2					
CUE - RBC Cells	Absent					
CUE RBC's	Nil					
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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Dr. VAISHNAVI CHANDRAMOHAN

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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: ..... 401 .....

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 : 25/7/26 12pm

Nurse Name & Signature: .....

Date & Time : 25/7/26 @ 1 pm.

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

GUC-00094269 IP18-00036611
Ms K.S.UTHRAA
31-03-2017 9 Y 3 M 25 D (F)
Dr. VAISHNAVI CHANDRAMOHAN

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DRUG CHART

Date of Admission: 25/1/26 Drug Allergies: NIL ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

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

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

SOS / PRN (As Required Medication)

DRUG: Inj. PARA				Date / Time
Dose: 250mg	Route: IV	Frequency: SOS	Start Date: 25/1/26	
Doctor's Signature:		Valid Period	Pharm.	
Additional Instructions: 1 part @				

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

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

Signature .....

VERIFIED BY : Name .....

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REGULAR PRESCRIPTIONS

Weight. 25kg ..... Ward. 401

DRUG : Inj. PAN

Dose	Route	Frequency	Start Date
25mg	i.v	9 24h	25/7/26

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time		
25/7		26/7
9:30 AM	SS	
	AK	
6AM	SA	
	CS	

DRUG : Inj. EMESET

Dose	Route	Frequency	Start Date
2.5mg	IV	9 8h	25/7/26

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time			
25/7			26/7
9:30 AM	SS	6AM	SA
	AK		CS
2pm	NG		
1pm	ANA	1pm	
	PN		
		1pm	

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

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Weight. 25kg Ward. 401

	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.	

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
25/7/26	9:50AM	Inj. PARA	250mg	iv	[signature]	SS / Ajith
~~25/7/26~~		~~Inj. TRAMADOL in 100ml NS~~	~~25~~	~~iv~~	~~[signature]~~	
25/7/26	11:30AM	Inj. DROTIN	20mg	iv	[signature]	SS / Ajith
25/7/26	3pm	RINGER LACTATE	500ml over 4hrs	IV	[signature]	MA / PN
25/7/26	3pm	DULCOLAX	suppository 10mg	P/R	[signature]	MA / PN

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I.V. FLUIDS CHART

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

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
25/7	11 PM	0.9% DNS	IV	65		SS / AK			
25/7	11.50am	NS - 250 ml over 1 hour (for USG abdomen)	IV	250		SS / DNS	25/7/24 @ 1 Pm.		SS / AK.

Signature .....

VERIFIED BY : Name .....

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IP18-00036611

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

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

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 31/3/26 Time:	3pm	5pm	8pm	12Am	4Am
Doctor / Nurse / Family Concern?					
Temperature (°F)	98.2F	97.9F	98F	98F	97.4F
Heart Rate (bpm) and Blood Pressure (mmHg) * **Note:** BP does not score in early warning scoring	110 (78) 62	106 (68) 60	92 (61) 50	101 (61) 54	101 (75) 60
Heart Rate (Number)	108bpm	108bpm	98bpm	110bpm	102bpm
Resp. Rate (bpm) (Over 1 Minute) *					
Resp Rate (Number)	26bpm	26bpm	26bpm	26bpm	26bpm
Resp Distress: Mod/ Severe / None / Mild	✓	✓	✓	✓	✓
Receiving O_2 (l/min) O_2 Saturations (%)	99%	98%	99%	98%	99%
Conscious Level: Normal / Altered	✓	✓	✓	✓	✓
GCS *	15/15	15/15	15/15	15/15	15/15
TOTAL SCORE Number of shaded boxes	0	0	0	0	0
Pain Score	0	0	0	0	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.

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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.

25/4/21 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											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm	→ On admission ER				to	4th	stool	→			
Total Intake :				DNS		Total Output :						
	02:00 pm	Tsatu	200ml	65ml							0	
	03:00 pm			RL 125ml			motion passed			✓	0	
	04:00 pm	water	50ml	125ml							0	
	05:00 pm			125ml							0	
	06:00 pm	water	100ml	125ml						✓	0	
	07:00 pm	water	50ml	125ml						✓	0	
Total Intake :		400ml	+	690ml		Total Output :				3 times urine passed		
	08:00 pm			65ml							0	
	09:00 pm	water	20ml	65ml						✓	0	
	10:00 pm	water	50ml	65ml							0	
	11:00 pm	water	50ml	65ml							0	
	12:00 am			65ml							0	
	01:00 am	water	90ml	65ml							0	
Total Intake :		140ml	+	390ml		Total Output :				1 time urine Passed		
	02:00 am			65ml						✓	0	
	03:00 am			65ml							0	
	04:00 am			65ml							0	
	05:00 am			65ml							0	
	06:00 am	water	100ml	65ml						✓	0	
	07:00 am	milk water	200ml	65ml						✓	0	
Total Intake :		300ml	+	390ml		Total Output :				2 times urine Passed		

Total 24 hrs. Intake	2,310ml	Total 24 hrs. Output	7 times Urine passed

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NURSES NOTES

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☐ No Known Drug Allergies

☐ Drug Allergies .... Nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
25/7/26	2pm	Rechived notes:	
		Child rechived	
		from ER to 4th floor. child	
		consious & oriented. Child	
		activity are good. RL 1the	
		⊕ no swelling & pain	
		vital signs checked & recorded	
		vitals are stable now	
		CP | PP | CRT	
		++ | ++ | 2s	
		Handing over given to evening	[signature]
		duty s/n.	00642.
		→ Evening duty On: 25/7/26	
	1:30pm	child details hand over taken	
		from morning duty s/n	
		child is conscious & oriented	[signature]
		child IV cannula pattern	018950.
	2pm	IV fluid DNS 65ml per on flow.	
		child intake was good.	
	3pm	child Dr. Vaishnavi mam seen the	[signature]
		child mam advise Sup. Pulcolac 10mg	01890
		given IV fluid RL @ 4hours need	
		to follow	
	3:15pm	IV fluid RL 125ml over 4hour on flow.	
		No any complaints	[signature]
			018950.

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

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

Patient Sticker

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NURSES NOTES

☐ No Known Drug Allergies

☐ Drug Allergies .... Nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		→ continue 25/7/26	
25/7/26	4pm	vital sign's checked and Recorded vital are stable	
		[CP ++ / PP ++ / CRT <3sec]	018950
		continue IV fluid RL on flow	
	7pm	Due to medication was given as per doctor's Order	018950
		No any complaint's	
		I/O chart maintained	
	7:30pm	Child details hand Over given to night duty staff	018950
		Night duty Notes on 25/7/26	
	7.30pm	The child details handover Taken from the evening duty staffs	015800
		the child is conscious and active	
	8pm	Administer the medication as per doctor's order	
		vitals are checked and recorded	
		temp is normal [PP ++ / CP ++ / CRT <2s]	
	10pm	The child had soft diet	
		IV fluid 0.9% NS @ 65ml/hr on flow	
		IV the pattern and good	015800
		no any other complaints	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

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PHLEBITIS ASSESSMENT

Patient's Name:
MRD NO: GUC-00094269 IP18-00036611
Ms K.S.UTHRAA
31-03-2017 9 Y 3 M 25 D (F)
Dr. VAISHNAVI CHANDRAMOHAN
Age :
Sex: ☐ M ☐ F
Consultant

CANNULA 1

Date: 25/7/26 Time: 9 Am.
Location: (D) metacarpal
Size: (D) 22G
Cannula inserted by: S/N Ajith Kumar

Date	Time	Phlebitis	Infiltration	Nursing Intervention	Sign
25/7	9 AM	☐Yes ☐No	☐Yes ☐No	Patent	
	10 pm	☐Yes ☐No	☐Yes ☐No	Patent	
	12 pm	☐Yes ☐No	☐Yes ☐No	patent	
	2pm	☐Yes ☐No	☐Yes ☐No	obser	
	4 pm	☐Yes ☐No	☐Yes ☐No	observed	
	6 pm	☐Yes ☐No	☐Yes ☐No	Observed	
	8 pm	☐Yes ☐No	☐Yes ☐No	observed	
	10 pm	☐Yes ☐No	☐Yes ☐No	observed	
26/7	12 am	☐Yes ☐No	☐Yes ☐No	observed	
	2 am	☐Yes ☐No	☐Yes ☐No	Obser	
	4 am	☐Yes ☐No	☐Yes ☐No	Obser	
	6 am	☐Yes ☐No	☐Yes ☐No	Obser	
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		

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

CANNULA 2

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

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

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

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

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

PHLEBITIS ASSESSMENT AND MANAGEMENT RECORD

CANNULA 3

Date : Time:

Location :

Size :

Cannula inserted by :

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

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

CANNULA 4

Date : Time:

Location :

Size :

Cannula inserted by :

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

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

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

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

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

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Ms K.S.UTHRAA
31-03-2017 9 Y 3 M 25 D (F)
Dr. VAISHNAVI CHANDRAMOHAN

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INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Part - I.

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

Identified Education Needs:

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

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
25/4	2pm	treatment & care	explain about treatment & care	mother	No	oral	Respect value	Verbalize	Good	

Part - III: CODES

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

Learning Barriers:
1. No Learning Barriers
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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Nursing General Admission Assessment Form For Pediatrics

Diagnosis: fever abdomen pain

Arrival Time: 2pm Mode of Arrival: walking Admitting From: ☐ ER ☑ OPD ☐ Direct

Allergy / Adverse Reaction Nil Body Weight: 25 Kg

Height: ..... cm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
–	–	–

Family History: 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: 25kg Length: – Head Circumference (< 2 years): .....

Temp.: 99.6 F HR: 100bpm RR: 24 b/m BP: 104/60 mmhg

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

Fall Risk Assessment: ☑ Yes ☐ No Score: 0 (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: 0 Pain Tool Used: ☐ N Pass ☑ FLACC ☐ Wong Baker

Character of Pain – Location – Frequency – Duration –

FUNCTIONAL SCREENING: ☑ No Abnormalities Detected

☐ Mobility Problem ☐ Walking Problem

☐ Developmental Delay ☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING: ☑ No Abnormalities Detected

☐ Underweight ☐ Overweight ☐ Special Feeding Method

☐ Feeding Problem ☐ Special diet ☐ No Abnormality Detected

Inform consultant for positive criteria

Psychological Screening: ☑ No Significant Findings

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

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

Social History: Lives With .....

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

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

Orientation has been given regarding the following aspects:

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

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

Patient Rights & Responsibilities: ☑ Yes ☐ No

Information given to ..... mother .....

Nurse's Name: ..... Jathiga. B ..... Date: ..... 25/7/21 ..... Time: ..... 2pm ..... Signature .....

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PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : Dr. Vaishnavi Date : 25/7/16

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

Start Time of Assessment: 9.25am Weight: 25kgs

Allergic History: .....

Chief Complaints: .....
A/c abd. pain

Pediatric Assessment Triangle

A Appearance - TICLS Alert - in pain

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: 25/min SpO$_2$ on FiO$_2$ RA 100%

Rhythm: regular

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

Respiratory Noises: ☐ Stridor ☐ Wheezing ☐ Grunting

Air Entry: normal

Palpation Findings (If necessary).....

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

Circulation

HR: 85/min

CFT — Central: <3sec / Peripheral: .....

Any urgent interventions needed: ☐ Yes ☐ No

If Yes .....

BP: 100/70 mmHg

Pulse Volume: Central: ..... / Peripheral: good

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: Alert

Any urgent interventions needed: ☐ Yes ☑ No

If Yes .....

Pupils: Responsive ☑ Non-Responsive ☐

Size — Right: ..... / Left: 2mm

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

Signs of Neurological compromise .....

.....

Exposure

Temp.: 97.2F

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: .....

.....

.....

Labs Planned: .....

.....

.....

.....

.....

.....

.....

Treatment Planned: .....

.....

.....

Mentioned inside

.....

.....

.....

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

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

Assessment done by

Name of the Doctor: Dr. Vaishnavi

Signature: .....

Date & Time: 25/7/26 9.30am

Sr. Doctor on Duty (If necessary)

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

Signature: .....

Date & Time: .....

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 25/7/26. Time of arrival : 9:25AM.

Chief Complaints: c/o. Stomach pain & vomiting RBS: 93mg/dl.

Height : — Weight : 25kg BMI : — Head Circumference (<2 years) —

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

If yes , identify —

Pain Screening: ☑ Yes ☐ No If Yes, Pain Score: 5/10 Pain Tool Used: ☐ N Pass ☐ FLACC ☑ Wong Baker

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

RISK FOR FALL:

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

☑ If Patient is > 6 years
Assess the below parameters

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

Ambulatory Aids:

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

Gait/Transferring:

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

Mental Status: Forgets limitations ☐ Yes ☑ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening: ☑ No Abnormalities Detected

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

Inform consultant for positive criteria

.....

.....

Nutritional Screening: ☑ No Abnormalities Detected

☐ Underweight
☐ Overweight
☐ Feeding Problem
☐ Special diet
☐ Special feeding method

Inform consultant for positive criteria

Psychological Screening: ☑ No Significant Findings

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

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

Social History: Lives With —

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

Time of Initial assessment completed by ER Nurse : 9:25PM.

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

Time	Nursing Notes
9:25AM	child come for stomach pain & vomiting child
	Conscious & oriented. vitals checked & records
	vitals stable. Dr. Kavitha mam see the child
	to discuss about Dr. vaishnavi toadmitted for
	further management. IV placement done. sample
	send to lab. child shifted to wards.

Samples collected by: S/N Ajith   Time: 10AM

Samples sent by S/N Sojin   Time: 10:02AM

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1
9:40AM	Inj: Pan 30mg	IV.	30mg	[signature]	[signature]
	Inj: emeet 4g	IV.	4mg	[signature]	[signature]
	Inj: Para	IV	250mg	[signature]	[signature]

Condition of patient at time of shift - out :	Details of Shift - out
HR: 85bm. BP: 102/70(80) CFT: <3sec	Shift - out from ER to: 401
RR: 20b/m SPO$_2$: 100%	Time of Shift - out: 1:52pm
GCS: 15/15 Temperature: 97.2°F	Handover given to: S/N Anuja (Nurse's Name)
Pain Score: 0	
Repeat RBS (if applicable): Nil	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any): IV placement done. (L) metacarpal area.

Name of the Nurse: Sujanthra.   Signature of the Nurse: [signature] 0186

Date & Time: 25/1/20 @ 10AM.

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EMERGENCY ROOM TRIAGE FORM

Wt : 25 kg.

Patient's Name : Ms. Uthra. Age : 10 yrs. Gender: ☐ Male ☑ Female

Date : 25/7/26. Time of Arrival : 9:25am.

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

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

Mode of Arrival : ☑ Ambulatory ☐ Wheelchair ☐ Ambulance

RBS: 93 mg/dl

Initial Vital Signs: Temp: 97.2° F. PR: 85/min BP: 102/70 80 RR: 20/m. SpO_2: 100%.

Chief Complaints: Stomach pain & Vomiting

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 : 2 min.

Communicable Disease Triage Screening

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

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

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

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

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

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

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

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

Signature of Triage Nurse : .....

Name of Triage Nurse : .....

Date & Time : 25/7/26 @ 9:27am

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

25/7/26
9:40Am

IV Line Secure 22G.
inj: Pan 80mg IV.
inj: Omeprazole 4mg IV.
DNS 500ml 60ml/hr

Payel
0180.

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RBS CHART

Date	Time	RBS (mg/dl)	IVF %	Signature
25/7/[illegible]	9am	93mg/dl	–	[signature]

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PATIENT TRANSFER FORM

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Ms K.S.UTHRAA
31-03-2017 9 Y 3 M 25 D (F)
Dr. VAISHNAVI CHANDRAMOHAN

	Date & Time of Admission	Date & Time of Transfer Order
	25/7/20 @ 9:58 am	25/7/20 @ 1:50pm
Treating Consultant Name	**Transfer Ordered by**	**Reason for Transfer**
Dr. Vaishnavi	Dr. Keerthana.	further mangement
From Unit	**To Unit**	**Information to Attendant**
ER	Ad	Yes ☑ No ☐
Number of Sheets in Clinical File	**Number of Imaging Films**	**Personal belongings including clinical documents. If any handed over to attendant**
10	-	Yes ☐ No ☑ If yes, what ?

Medications / Consumables / Surgicals / Hand over

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

Shifting Summary / Notes Written by Doctor : Yes ☐ No ☐ Acute abdomen + evaluation

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
[signature] 018270	[signature]

Patient & Clinical Records Received by : [signature] 943841

Date & Time of Patient Received : 25/7/20 1:40pm

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

Docu. No. : RCH /FRM / CLINICAL / 102