GUC-00061548 IP18-00036653
Baby MATHIVATHANI K
04-12-2023 2 Y 7 M 26 D (F)
Dr. KARTHIK NARAYANAN R

Rainbow Children's Hospital

DISCHARGE TRACKING SHEET

UHID- FLOOR- NAME OF CONSULTANT-

ACTIVITY	INTIME	OUT TIME	NAME & SIGNATURE	REMARKS	<To be filled by Admin>		
Activity Sheet update by Nursing	18-20 Pm	18-30 Pm					
Activity Sheet update by Pharmacy							

ACTIVITY RECORD FOR BILLING

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Name: .....

UHID No: .....

Date of Admission: .....

Room / Bed No: .....

SUC-00061548 IP18-00036653
Baby MATHIVATHANI K
4-12-2023 2 Y 7 M 24 D (F)
Dr. KARTHIK NARAYANAN R

Consultant: ..... Dept: .....

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

Ward: .....

Suggested Billable bed type: .....

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
28/7/20	1:25pm	ER	603	

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
28/7/26	CBC, CRP, RP-2, Blood c/s, Dengue NS, ~~chica~~	26024171	[signature]
28/07/26	Urine R/E, c/s	26024175	[signature]
~~30/7/26~~	~~CRP~~	~~24411~~	[signature]

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
28/7/26	Infusion pump	1.45pm	29/7/26 @ 7pm.	1734224.	

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
28/7/20	TV placement	1	1734076	[signature]
30/7/26	X-ray	1	10264	[signature]

ANY OTHER INFORMATION:

....

....

....

....

....

....

Date: 30/7/26 Time: 11.80 am Prepared By: [signature] 0C8872

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
[signature] 0C8872			

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Baby. Mathivathani
CRUC - 61548 -

DISCHARGE TRACKING SHEET

UHID- FLOOR- NAME OF CONSULTANT-

BRADDY

ACTIVITY	TIME		NAME & SIGNATURE	REMARKS	<To be filled by Admin>
Discharge Announcement					
	INTIME	OUT TIME			
Arrangement of File by Nursing					
Preparation of Discharge Summary		30/1/26 at 12PM			
Finalization of discharge summary					
Transfer of file from Ward to Billing Dept					
Bill Processing					
Audit Clearance					
Billing Clearance					
Physical Clearance					

GUC-00061548 IP18-00036653
Baby MATHIVATHANI K
14-12-2023 2 Y 7 M 24 D (F)
Dr. KARTHIK NARAYANAN R

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BED SIDE CHECK LIST FOR NURSES

Date:	28/1	29/1	30/1						
Doctor's Orders	Dr Keerti	Dr Keerthi	Dr. Karthik						
Carried out or not	✓	✓	✓						
Bed Side									
Structured Handover done	✓	✓	✓						
IV Site	✓	✓	✓						
Central Lines	X	X	X						
Arterial Lines	X	X	X						
Feeding Catheter	✓	X	X						
Urinary Catheter	✓	X	X						
Skin Care	✓	✓	✓						
Eye Care	✓	✓	✓						
Mouth Care	✓	✓	✓						
Sterillum Bottle, Stethoscope	✓	✓	✓						
Suction Bottle (Should be clean & empty)	✓	✓	✓						
Intubation Tray	X	X	X						
Emergency Tray (Loaded Syringes with Midazolam & Vecuronium and Flush) Ampoules of Adrenaline	X	X	X						
Ventilator Tubing,(Any Water, Blood)	X	X	X						
Humidification	✓	✓	✓						
Check all Infusion (Labelling,Correct Preparation)	✓	✓	✓						
Chest Physio & Neb	X	X	X						
Handed Over By Name :	Sruthi	Sruthi	Sruthi						
Signature :									
Date & Time:	28/1/2	29/1	30/1						
Hand Over Taken By Name :	Sruthi	Sruthi							
Signature :									
Date & Time:	28/1	30/1							

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

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 : IP18-00036653 **Admit Date** : 28-Jul-2026 **Admit Time** : 12:29 PM **UHID** : GUC-00061548

Patient Details :

Patient Name	: Baby MATHIVATHANI K	**Age**	: 2 Y 7 M 24 D
Guardian	: Mr KARTHICKEYAN	**DOB**	: 04-12-2023
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: 670, 4th street TNHB Nagar Velacheri Chennai Tamil Nadu INDIA 600042	**Phone No**	: 9962701616
		E-mail	: murugan.ommuruga@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 KARTHICKEYAN **Relationship** : Father

Contact Address : 670, 4th street TNHB Nagar Velacheri Chennai Tamil Nadu INDIA 600042 **Phone No** : 9962701616 / 9962701616

Signature

Doctor Details :

Doctor Name : Dr. KARTHIK NARAYANAN R **Specialisation** : PEDIATRIC INTENSIVE CARE

Referral Doctor : Rainbow Website **Phone No** :

Co-Consultant :

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash **Payor Name** : SELFPAY

Rainbow Children's Hospital
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Rainbow Children's Hospital - Guindy

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

GENERAL CONSENT FOR TREATMENT

Patient Name:	**Baby MATHIVATHANI K**	**Age :**	**2 Y 7 M 24 D**
IP No:	**IP18-00036653**	**Sex:**	**Female**
Consultant:	**Dr. KARTHIK NARAYANAN R**	**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:

IP Guide book has been given to me and I have been explained about the Hospitals rules and policies.
4 Financial and billing counseling has been done to me.

Signature of Patient/Relative:

Name: Karthickeyan
Relationship: Father
Date: 28/07/2026 Time: 12.30pm
Witness Name: Panthea
Witness Signature:

Patient Address:
670, 4th street TNHB Nagar Velacheri
Chennai Tamil Nadu INDIA 600042

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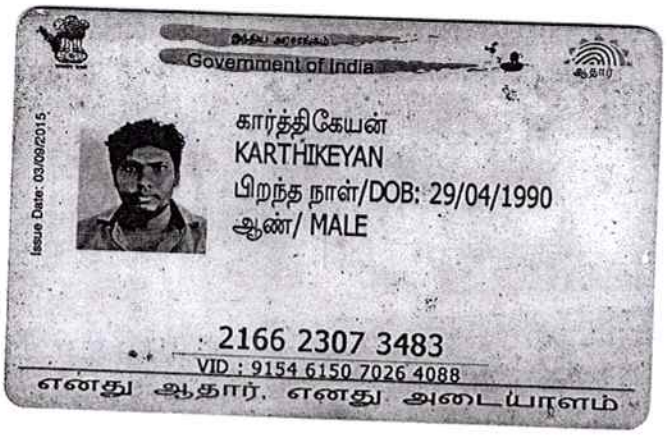
BILLING POLICY

- 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 : MATHIVATHANI	UHID Number : 2166 2307 3483
Self/Attendant Name : Y MEERA / Kanthikyan	Relation : Mother father
Self/ Attendant Signature : Y Meera Phone Number : 9962701616	Name & Signature of Financial Counselor


Government of India
ஆதார்
Issue Date: 03/09/2015
கார்த்திகேயன்
KARTHIKEYAN
பிறந்த நாள்/DOB: 29/04/1990
ஆண்/ MALE
2166 2307 3483
VID : 9154 6150 7026 4088
எனது ஆதார், எனது அடையாளம்


Unique Identification Authority of India
ஆதார்
முகவரி:
தந்தை / தாய் பெயர்: சுப்ரமணி, 96,எஸ் பிளாக், 17வது தெரு, அண்ணா நகர்,
சென்னை,
தமிழ் நாடு - 600040
Address:
S/O: Subramani, 96,S block, 17th street,
Anna Nagar, Chennai,
Tamil Nadu - 600040
2166 2307 3483
VID : 9154 6150 7026 4088
1947 | help@uidai.gov.in | www.uidai.gov.in

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PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: ____ :UC-00061548 IP18-00036653 _____
laby MATHIVATHANI K
4-12-2023 2 Y 7 M 24 D (F)
r. KARTHIK NARAYANAN R

UHID ID: ____ _____

Department: _____

Consultant: _____

(P.T.O.)

SUC-00061548 IP18-00036653
Baby MATHIVATHANI K
4-12-2023 2 Y 7 M 24 D (F)
Dr. KARTHIK NARAYANAN R

Pediatric Multiorgan History & Physical Examination

Name: _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

History of present illness :

2y 7m | F

c/o fever × 1 day
high grade, ass·c chills & rigors,
c/o crying during micturition
c/o abdominal pain +
c/o vomiting +
c/o lethargy +
c/o ↓ oral intake +

Patient Sticker

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

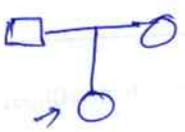
H/O UTI in April '26, given oral cefixime.
pus cells - 3 to 5, bacteria +, Cs - not sent.

No previous admission.

Birth & Neonatal History:

Term, BW - 2.3kg, CIAB, No H/O NICU admission

Family Chart



Birth & Socio Economic History:

About Father :

About Mother :

Any additional Information :

Developmental History : (N)

Immunization History : (N)

Anthropometry :

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

Weight (kgs) 11.4 (Centile _____)

On Examination :

Temperature : 101.6 °F Pulse Rate : 148 B.P. 99/64 SPO2 100%.

Resp.rate and type of breathing : 30

Rash –

Lymphadenopathy –

Oedema : –

Allergies (if any):

(P.T.O.)

Patient Sticker

Respiratory System :

Inspection (any s/o distress) : N

Air entry & breath sounds : B/L AE+

Any addes sounds : -

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

Cardiovascular System :

Inspection of procordium : N

Heart Sounds : S_1, S_2 +

Any murmur : -

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

Per Abdomen :

Inspection : N

Palpation : soft, not tender, no OM

Ausculation : BS+

Spine : External Genitelia : N

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

Central Nervous System :

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

Cranial Nerves : N

Motor System :

Nutriton : N

Tone: N Power N

Co-ordinator :

Posture : N

Involuntary Movements :

SUC-00061548 IP18-00036653
Baby MATHIVATHANI K
4-12-2023 2 Y 7 M 24 D (F)
Dr. KARTHIK NARAYANAN R

Reflexes :

DTR

Plantars N

Superficials:

Sensory System : N

Bladder / Bowel :

Clinical Summary & Diagnostic: ? UTI

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

Desired goals of the treatment :

Planned Labs:

CBC ✓
CRP ✓
RP-II
Dengue NSI, ✓
Blood ¼s
Urine R/E & ¼s ✓

Planned Management

IVF
Inj. xone
Inj. pan
Inj. emeset

Signature of the Doctor:

Name of the Doctor: KEERTHANA. D

Date & Time: 28/7/20 12.50 PM

Signature of the Consultant:

Name of the Consultant:

Date & Time:

(P.T.O.)

Patient Sticker

DISCHARGE PLANNING FORM

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

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

2. Destination Post Discharge: ☐ Home

   Family Members Notified (Person Contacted)

   ☐ Transfer

   Hospital Facilty Notified (Person Contacted)

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

   ☐ Needs Assistance In:

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

4. Nutritional Plan:

   ☐ Dietary Instruction Discussed with the:

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

5. Discharge Planning Discussed with the:

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

6. Patient/Family Educational Plan:

   ☐ Educational Topic/s: .....

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

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

Doctor Signature: .....

Doctor Name: .....

Date and Time: .....

UC-00061548 IP18-00036653
Baby MATHIVATHANI K (F)
4-12-2023 2 Y 7 M 24 D
Dr. KARTHIK NARAYANAN R

(1)

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
28/7/26 4:10 PM	S/B Dr. DEEPAK	
	Dx: ? UTI	
	Child reviewed	
	Child has no new concerns	
	O/E:	
	Alert, afebrile	
	CVS: S1S2 (+)	
	RS: NVBS (+)	Vitals
	P/A: Soft/NT	Stable
	CNS: NFND	
	IVF - 40ml/hr	
	CRP - 125	
	TC - 12,960	
		Rx
		Inj Xone 500mg Q12H
		Syp Pan 10mg Q24H
		To monitor vitals / sensorium
		To monitor fever spikes
		To trace Urine ME
		urine C/S
		Blood C/S
		(signature) 16/15

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
29/7/26 8:45Am	S/B Dr. DEEPAK	
	Δsis: Fever	Evaluation
		?UTI
	Child reviewed	
	Child had last fever spike yesterday	night 8:00pm evening 101.0°F
	intake better	
	passed urine	in the morning
	O/E: Alert, afebrile	
	CVS: S1S2 ⊕	
	RS: VBS ⊕	
	P/A: soft	
	CNS: NFND	
		Rx
		→ To monitor vitals / sensorium
		→ To trace Blood C/S
		Urine C/S
		To continue XONE 500mg Q12H
		To monitor fever spikes
		(signature) 107420

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

GUC-00061548 IP18-00036653
Baby MATHIVATHANI K
04-12-2023 2 Y 7 M 25 D (F)
Dr. KARTHIK NARAYANAN R

(2)

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	S/B Dr. [illegible]	
29/7/26	? UTI / ? AGE	
	Plan	
	– T/c Blood / urine C/S	
	– T/c home	
	– If afebrile, D/s tmrw	
		[signature]
29/7/26 4:25 PM	S/B Dr. DEEPAK	
	Δv: ? VTI / ? AGE	
	Child reviewed	
	Child has no new concern	
	O/E: alert, afebrile	
	CVS: S1S2 ⊕	Vitals stable
	RS: NVBS ⊕	
	P/A: soft	
	CNS: NFND	Rx
		→ Continue as per chart
	Tapes IVF ½ it intake is better	→ To trace blood & urine C/S
	No nausea / vomiting	→ If afebrile D/c tomorrow
		[signature] 10/7/4

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
30/7/16 9:30AM	S/B Dr. Deepak	
	Asis: ? VTI ? AGE	
	Child reviewed	
	Child has no new concerns	
	No fever spikes	
	O/E:	
	Alert, afebrile	
	CVS: S1S2 ⊕	
	RS: NVBS ⊕	
	P/A: Soft	
	CNS: NFND	
		Rx
	Blood C/S - sterile	
	Urine C/S - To trace	+ Continue as per chart
		+ To monitor vitals / sensorium
	Intake good	+ To trace urine c/s
	Y/O good	+ To plan D/C today
		[signature]
	Dr. Xavier Joseph D3	

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

GUC-00061548 IP18-00036653
Baby MATHIVATHANI K
04-12-2023 2 Y 7 M 26 D (F)
Dr. KARTHIK NARAYANAN R

(3)

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Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	S/B Dr Karthik	
30/7/2026		
	Plan	
	1) TO do chest X-ray	
	2) Syp Augmentin - DDS 3.5ml — 0 — 3.5ml	× (7) days
	3) Econorm Sachet 1 — 0 — 1	× (5) days
		Dr. Photon.

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

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

GUC:-00061548 IP18-0
Baby MATHIVATHANI K
04-12-2023 2 Y 7 M 24 D
Dr. KARTHIK NARAYANAN R

Rainbow Children's Hospital
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RESULT SHEET

Date	28/7/23					
Time						
Hb	11.6					
PCV	34					
RBC	4.72					
WBC	12,960					
N/L	79/17					
Platelets	2,78,000					
CRP	125					
ESR						
PCT						
RBS						
Na	133					
K	4.7					
Cl	99					
Ca/Mg	1.20/					
Phosphate / HCO_3^-	/14					
Urea	17					
Creatinine	0.43					
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

(P.T.O)

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						
Dengue NS1	-ve					

Culture and Sensitivities : Urine C/S

Blood C/S - Salmonella typhi

Radiology : USG :

X-Ray :

ECHO :

CT :

MRI

Others (ECG, Contrast Studies etc.,) :

SUC-00061548 IP18-00036653
Baby MATHIVATHANI K (F)
4-12-2023 2 Y 7 M 24 D
Dr. KARTHIK NARAYANAN R

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DRUG CHART

Date of Admission: 28/7/26 Drug Allergies: .... ☑ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

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

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

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

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

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

SOS / PRN (As Required Medication)

DRUG : Syp. P250				Date/Time	28/7												
Dose	Route	Frequency	Start Date	8:30 PM	SS MM												
3.5ml	PO	SOS	28/7														
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:																	

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

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

UC-00061548 IP18-00036653
Baby MATHIVATHANI K
4-12-2023 2 Y 7 M 24 D (F)
Dr. KARTHIK NARAYANAN R

REGULAR PRESCRIPTIONS

Weight. 11.4 kg Ward. 603

DRUG : INJ. XONE

Dose	Route	Frequency	Start Date
500mg	IV	Q12H	28/7

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date	28/7	29/7	30/7
Time			
	6 2.30pm	CS	SS
	Am SP SL	HM	MM
	6 SS SL		
	Pm MM PS		
	D1	D2	D3

DRUG : INJ. PAN

Dose	Route	Frequency	Start Date
10 mg	IV	Q24H	28/7

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date	28/7	29/7	30/7
Time			
	12:45 SS	6 CS	SS
	Pm PS	Am HM	MM

DRUG : INJ. EMESET

Dose	Route	Frequency	Start Date
2 mg	IV	Q8H	28/7

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date	28/7	28/7	29/7
Time			
	12:45 SS	6 /	CS
	Pm RD	Am	HM
	12 /		PS
	Pm		SP
	6 6pm		
	Pm SS		
	MM		

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

SUC-00061548 IP18-00036653
Baby MATHIVATHANI K
14-12-2023 2 Y 7 M 24 D (F)
Dr. KARTHIK NARAYANAN R

Weight. 11.4 kg Ward. 603

DRUG :	Date▸ Time		Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.
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
28/7	12.15 pm	NEOMOL SUPPOSITORY	170 mg	PR		SS / RB.

SUC-00061548 IP18-00036653
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4-12-2023 2 Y 7 M 24 D (F)
Dr. KARTHIK NARAYANAN R

I.V. FLUIDS CHART

Weight. 11.4kg Ward. 6th

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
28/7	11pm	0.9% DNS	IV	40		R.B / A.P			

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

UC-00061548 IP18-00036653
Baby MATHIVATHANI K
4-12-2023 2 Y 7 M 24 D (F)
Dr. KARTHIK NARAYANAN R

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

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

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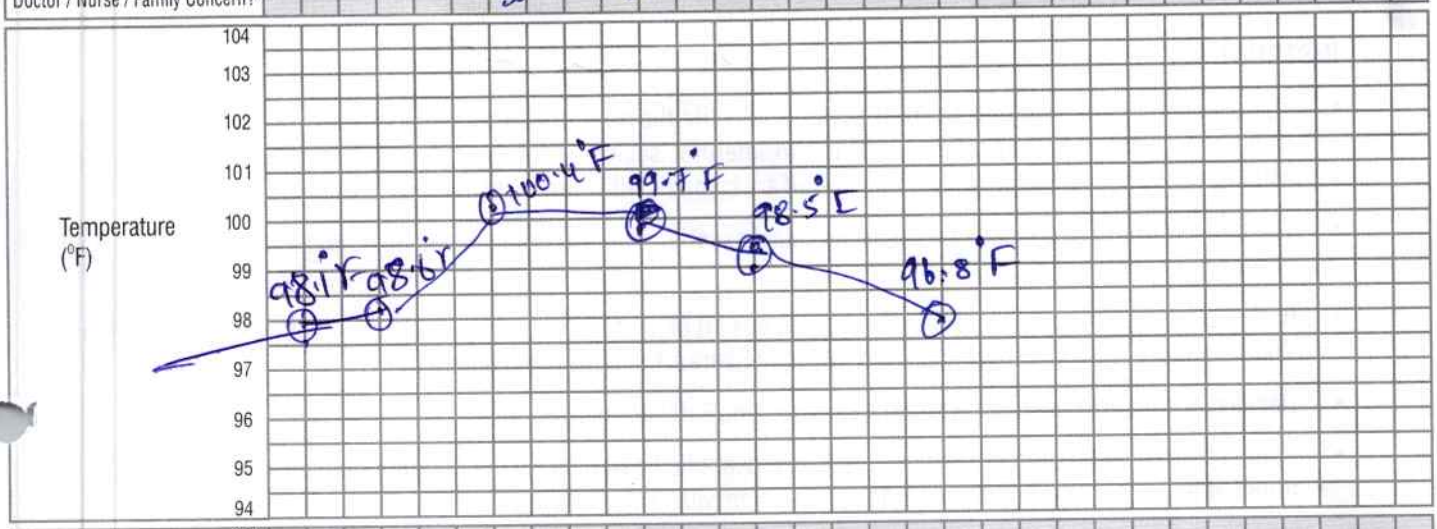
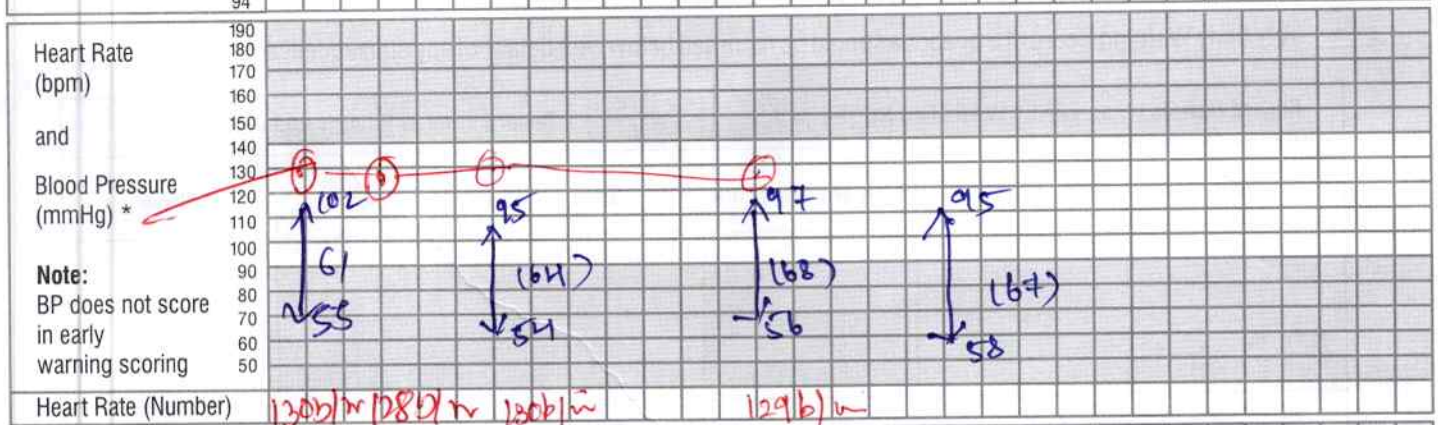
EARLY WARNING SCORE: CHILDREN'S UNIT

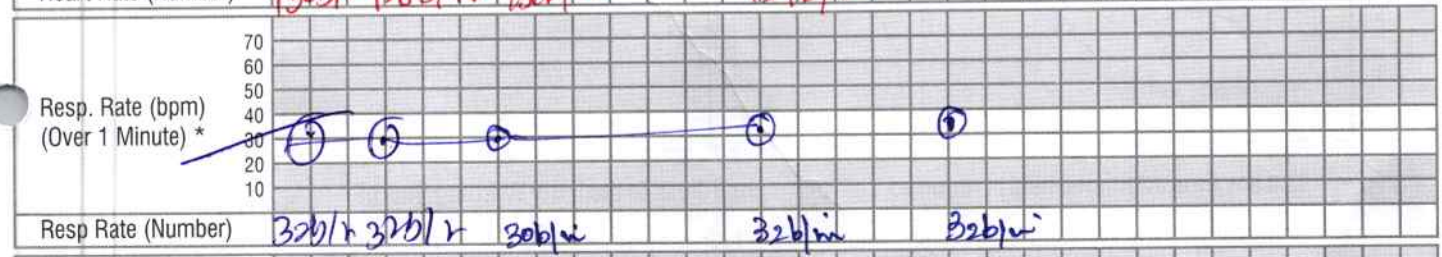
Date : 28/4/24 Time:	2pm	4pm	8pm	10:30pm	12am	4am
Doctor / Nurse / Family Concern?						





Note: BP does not score in early warning scoring

Heart Rate (Number)	130b/m	128b/m	130b/m	129b/m	



Resp Rate (Number)	32b/m	32b/m	30b/m	32b/m	32b/m
Resp Distress: Mod/ Severe / None / Mild	✓	✓	✓	✓	✓
Receiving O_2 (l/min) O_2 Saturations (%)	98%	98%	98%	98%	98%
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.

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-00061548 IP1...
Baby MATHIVATHAN. K
04-12-2023 2 Y ? M 24 ...
Dr. KARTHIK NARAYANAN R

(2)

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

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

Rainbow® Children's Hospital
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BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 29/7/26 Time: 8Am 12Pm 4pm 8pm 12Am 4am

Doctor / Nurse / Family Concern?

Temperature (°F)

104 103 102 101 100 99 98 97 96 95 94

98°F 98.2 97.2° 98°F 97°F 97.2°F

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

Note: BP does not score in early warning scoring

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

105 (76) 68 | 102 55 | 99 (63) 57 | 102 (63) 57

Heart Rate (Number) 110b/m 102b/m 115b/m 108b/m 102b/m 118b/m

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

70 60 50 40 30 20 10

Resp Rate (Number) 30b/m 30b/m 28b/m 28b/m 30b/m 30b/m

Resp Distress	Mod/ Severe / None / Mild	✓	✓	✓	✓	✓	✓
Receiving O_2 (l/min) O_2 Saturations (%)		98%	98%	99%	100%	99%	100%
Conscious Level	Normal / Altered	✓	✓	✓	✓	✓	✓
GCS *		15/15	15/15	15/15	15/15	15/15	15/15
TOTAL SCORE Number of shaded boxes		0	0	0	0	0	0
Pain Score		0	0	0	0	0	0
Observer's Initials		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

ACTIONS

NB: Scores 3 should be recorded overleaf

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Patient Sticker

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R	**RECOMMENDATION :** I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

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Baby MATHIVATHANI K
4-12-2023 2 Y 7 M 24 D (F)
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FLUID CHART

Sheet No. : 1

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

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
29/7/26												
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :	ON ADMISSION					Total Output :						
	02:00 pm			40ml						✓	0	Sr
	03:00 pm	H2O	10ml	40ml								
	04:00 pm			DC			✓				0	Sr
	05:00 pm			40ml						✓		
	06:00 pm	H2O	50ml	40ml			✓				0	Sr
	07:00 pm			40ml								
Total Intake :	60ml 200ml					Total Output :	2 times					
	08:00 pm	H2O	20ml	DC							0	
	09:00 pm			DC						✓		
	10:00 pm	Milk	50ml	DC							0	
	11:00 pm			DC								
	12:00 am	H2O	30ml	40ml							0	
	01:00 am			40ml								
Total Intake :	70ml + 80ml					Total Output :	1 time urine passed					
	02:00 am			40ml							0	
	03:00 am	H2O	30ml	40ml								
	04:00 am			40ml						-	0	
	05:00 am			40ml								
	06:00 am	H2O	20ml	40ml							0	
	07:00 am			DC								
Total Intake :	50ml + 200ml					Total Output :						

Total 24 hrs. Intake	660ml

Total 24 hrs. Output	U - 3 ; M - 2

GUC-00061548 IP18-00036653
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BirthRight BY RAINBOW HOSPITALS
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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.

29/7/26		Intake				Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
	08:00 am	H2o	50ml	40ml						✓	0	Rel o
	09:00 am			40ml								
	10:00 am	Soup	100ml	DC						✓	0	Rel.
	11:00 am	H2o	30ml	DC								
	12:00 pm			DC							0	Rel
	01:00 pm	H2o	50ml	40ml						✓		
Total Intake :		230ml + 120ml.				Total Output :				3 times		
	02:00 pm			40ml							0	SS
	03:00 pm	H2o	50ml	40ml						✓		
	04:00 pm			DC								
	05:00 pm	H2o	100ml	DC						✓	0	SS
	06:00 pm			40ml								
	07:00 pm	H2o	50ml	40ml						✓	0	SS
Total Intake :		200ml + 160ml.				Total Output :				3 times.		
	08:00 pm			Stop								
	09:00 pm	H2O	50ml							✓	0	SS/Ors
	10:00 pm											
	11:00 pm										0	SS/Ors
	12:00 am	H2O	100ml							✓		
	01:00 am										0	SS/Ors
Total Intake :		150 ml				Total Output :				2 times		
	02:00 am											
	03:00 am	H2O	50ml								0	SS/Ors
	04:00 am											
	05:00 am									✓	0	SS/Ors
	06:00 am	H2O	50ml									
	07:00 am										0	SS/Ors
Total Intake :		100ml				Total Output :				1 times		

Total 24 hrs. Intake	680 + 280 = 940	Total 24 hrs. Output	9 times

GUC-00061548 IP1
Baby MATHIVATHANI K
04-12-2023 2 Y 7 M 24 D
Dr. KARTHIK NARAYANAN R

(1)

NURSING CARE RECORD

Rainbow® Children's Hospital
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BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Date: 28/04/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning		—		—	—	—	—
Afternoon	2 pm	Promote cleanliness & Comforts.		Assess the cleanliness & maintain hand hygiene	monitor intake & output (Chart	Reassessed done.	
Night	8 pm	Prevents falls and injury	10 pm	→ keep the bed in low lying position.	Baby was kept in bed with side rails up.	Prevented falls.	

Docu. No: RCH /FRM / CLINICAL / 148

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NURSING CARE RECORD

Rainbow® Children's Hospital
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BirthRight
BY RAINBOW HOSPITALS
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Date: 29/7/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8am	Maintaine Fluid Balance.		Assess nutritional Status.	To Encourage. oral Intake. continue IV fluid.	Child was Clinically Normal.	
Afternoon	2pm	Maintain good nutritional. Status.		IV F. 0.9% DNS 40 ml/hr is going on.	To Encourage oral Intake Output	Child was Clinically Normal	
Night	8pm	Ensure hydration & electrolyte	10pm	Monitor child intake & output → child intake is better.	child clinicy better & even	child vitals Stable	

GUC-00061548 IP18-
Baby MATHIVATHANI K
04-12-2023 2 Y 7 M 24
Dr. KARTHIK NARAYANAN R

(11)

Rainbow Children's Hospital
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NURSES NOTES

☑ No Known Drug Allergies

☐ Drug Allergies ....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		Received notes	
28/7/26	2pm	child Received from	
		ER to 6th floor floor	[signature]
		complaints of abdominal	
		pain, lethargy, one day	
		fever	
		child IV line healthy (+)	
		IV 0.9% DNS 40ml/hr	
		going on	
	4pm	child vital signs	[signature]
		checked & Recorded	
		CP ++ / PP ++ / CRT <3	
	6pm	maintain I/O chart	
		Due to medication given	
		as per charts.	
		IV line healthy (+)	
	7:30pm	Hand over given from	[signature]
		Night duty Staff.	
		Night duty Notes.	
	7:30pm	child details are handing over	
		taken from Evening duty staff.	
		IV line (+). IV fluid 40ml/hr	
		is on flow. child was in Normal del →	[signature] 60774
	8:30pm	child vitals are checked and	
		recorded. Vitals are stabled.	
		CP ++ / PP ++ / CRT <3sec →	[signature] 607784

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

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

Patient Sticker

NURSES NOTES

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

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
	8:30pm	T - 100.4°F. SO Para - 250 mg (3.5 ml) is given to the child →	[illegible] 60772
	10:30pm	Temperature rechecked. T. 99.7°F. Temperature was reduced →	[illegible] 607484.
29/7/26	12 am	Baby vitals are checked and recorded. Vitals are stabled.	
		CP: ++ | PP: ++ | CRT: <3sec →	[illegible] 607484
		T - 98.5°F was reduced.	
	2Am	child is sleeping well no any other fresh complaints child is stable.	
	4Am	vital signs are checked and recorded. vital signs are stable.	
		CP: ++ | PP: ++ | CRT: <3sec	Rani 621893
	6am	Due medications are given as per Doctor's	
	7am	order. I/O chart maintained.	
	7.30am	Hand over given to the morning duty staff →	Rani 021895

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

GUC-00061548 IP18-00036653
Baby MATHIVATHANI K
04-12-2023 2 Y 7 M 25 D (F)
Dr. KARTHIK NARAYANAN R

(2)

NURSES NOTES

Rainbow® Children's Hospital — It takes a lot to treat the little.
BirthRight™ BY RAINBOW HOSPITALS — Your Right to a Safe Delivery

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

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		Morning duty Notes.	
29/7/18	7:30Am	Child details hand over taken from Night duty Staff. Child was Active and oriented	[signature]
	8Am	Child vitals checked and Recorded. vitals Normal	
		CP ++ / PR ++ / CFT <3sec	[signature]
		Child Ex lie pattern is healthy and observed. Child EV Fluid oral only quick	[signature]
	11:30Am	Dr. Karthik sir seen the child advice from TO collect Blood CRS and urine CRS report tomorrow Discharge plan.	[signature]
	12pm	Due medication given as per drug chart	[signature]
		child vital's checked and Recorded. vital's Normal	
		CP ++ / PR ++ / CFT <3sec	
	1pm	Maintained Intake and output chart	[signature]
	2pm	child had food No vomiting inj Emeset stop	[signature]

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Patient Sticker

NURSES NOTES

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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
29/7/26	4pm	Child vitals checked and Recorded vitals Normal CP ++ / PP ++ / CFT <2s →	[signature]
	6pm	Due medication given as per drug chart Maintained intake and output chart →	[signature]
	7.30 pm	Child details handover given to night duty Staff	[signature]
		Night duty Notes.	
29/7/26	7.30pm	Child details hand over taken form evening duty Staff. Child consious & active. →	[signature]
	8pm	Child vitals checked & record temp is normal. CP ++ / PP ++ / CRT <2sec	
	10pm	Child IV line (+) IV line observed & heay. →	[signature]
		Child IV fluids stop child intake was bette →	
	12am	Child vitals check & record temp is normal. CP ++ / PP ++ / CRT <2sec I/O chart maintaind →	[signature]

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

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

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PHLEBITIS ASSESSMENT

Patient's Name:
MRD NO: UC-00061548 IP18-00036653
Baby MATHIVATHANI K
4-12-2023 2 Y 7 M 24 D (F)
Dr. KARTHIK NARAYANAN R
Age : Sex: ☐ M ☐ F
Consultant:

CANNULA 1

Date : 28/7/26 Time: @ 12:40pm
Location : Metacarpal (L)
Size : 24 G
Cannula inserted by : S/N Suganthi

Date	Time	Phlebitis	Infiltration	Nursing Intervention	Sign
28/7/26	12:40pm	☐Yes ☑No	☐Yes ☑No	patent	[illegible]
	2pm	☐Yes ☑No	☐Yes ☑No	observe	S2n
	4pm	☐Yes ☑No	☐Yes ☑No	observ	S2n
	6pm	☐Yes ☑No	☐Yes ☑No	Obser	S2n
	8pm	☐Yes ☑No	☐Yes ☑No	observe	[illegible]
	10pm	☐Yes ☑No	☐Yes ☑No	observe	[illegible]
29/7/26	12am	☐Yes ☑No	☐Yes ☑No	Observe	[illegible]
	2am	☐Yes ☑No	☐Yes ☑No	observed	[illegible]
	4am	☐Yes ☑No	☐Yes ☑No	Obsa	[illegible]
	6am	☐Yes ☑No	☐Yes ☑No	observ	[illegible]
	8AM	☐Yes ☑No	☐Yes ☑No	obs	[illegible]
	10AM	☐Yes ☑No	☐Yes ☑No	obs	[illegible]
	12P	☐Yes ☑No	☐Yes ☑No	obs	[illegible]
	2pm	☐Yes ☑No	☐Yes ☑No	obse	S2n
	4pm	☐Yes ☑No	☐Yes ☑No	obser	S2n
	6pm	☐Yes ☑No	☐Yes ☑No	obse	S2n
	10pm	☐Yes ☑No	☐Yes ☑No	Observe	SS/own
30/7	2am	☐Yes ☑No	☐Yes ☑No	Observe	SS/own
	6am	☐Yes ☑No	☐Yes ☑No	Observe	SS/own
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐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

UC-00061548 IF
Baby MATHIVATHANI K
04-12-2023 2 Y 7 M 24
Dr KARTHIK NARAYANAN R

(D)

Rainbow® Children's Hospital
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THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	E DATE 28/7	N DATE 28/7	M DATE 29/7	E DATE 29/7	N DATE 29/7
Age	Less than 3 years old	4	4	4	4	4	4
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2					
	Female	1	1	1	1	1	1
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1	1	1	1
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own ability	1	1	1	1	1	1
Environmental Factors	History of Falls or Infant-Toddler Placed in Bed	4					
	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2					
	Outpatient Area	1	1	1	1	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		10	10	10	10	10

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

	Bed in low position		✓	✓	✓	✓	✓
	Call device within reach		✓	✓	✓	✓	✓
	Wheels Locked		✓	✓	✓	✓	✓
	Room free of clutter		✓	✓	✓	✓	✓
	Adequate lighting		✓	✓	✓	✓	✓
	Wheel chair support		X	X	X	X	X
	Other Intervention(s) Specify		X	X	X	X	X
	Nurse's Name:		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	Signature:		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	Date:		28/7	28/7	29/7	29/7	29/7
	Time:		@ 4pm	@ 8pm	@ 8pm	@ 2pm	@ 8pm

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

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GUC:-00061518 IP18
Baby MATHIVATHANI K
04-12-2023 2 Y 7 M 24
Dr. KARTHIK NARAYANAN R

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

BRADEN 'Q' SCAI

(for Paediatric use)

me : .....

..... Gender : ☐ M ☐ F IP No. : .....

					E	N	M	R
Date :					28/7	28/7	29/7	29/7
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4	4	4
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4	4	4
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	4
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	4
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	4
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	3	3	3	3
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4
TOTAL SCORE					28	27	29/7	29/7
Evaluator's Name						MATHI EXTRA		

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

GUC-00061548 IP18-
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PATIENT / FAMILY EDUCATION RECORD

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Part - I.
Patient's / Learner Language: English. Patient / Learner Literacy: ☐ Read ☐ Write ☐ Speak Willingness to Learn: Yes No Healthcare Literacy: Yes ☐ No ☐

Identified Education Needs:

1. Diagnosis
2. Treatment and Care
3. Plan
4. Pain Management
5. Informed Consent
6. Medication / Therapy (safety, effects/ side effect, interactions)
7. Discharge Medication
8. Infection Control Measures
9. Diagnostic Test / Procedures
10. Nutrition / Diet
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		
28/12	4pm	medi cin	Explained about medication administration	Mother	Nil	verbal	Nil	yes	good	
29/12	8 Am.	Fluid manage ment	Explained about FLuid management	Mother	Nil	Oral	Nil	yes	good	

Part - III: CODES

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

Learning Barriers:
1. No Learning Barriers
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

GUC-00061548 IP1
Baby MATHIVATHANI K
04-12-2023 2 Y 7 M
Dr. KARTHIK NARAYANAN R

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Nursing General Admission Assessment Form For Pediatrics

Diagnosis: ? UTI

Arrival Time: 1.50pm Mode of Arrival: Carrying Admitting From: ☑ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction Nil Body Weight: 11.6kg 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: 11.4 kg Length: ..... Head Circumference (< 2 years): .....

Temp.: 98.1 HR: 130bl/m RR: 32b/m BP: 102/55 61)

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

Fall Risk Assessment: ☐ Yes ☐ No Score: 10 (Document in the Humpty Dumpty Sheet)

Risk of Pressure Sore (Braden Q Score 27) (Document in the Braden Q Assessment Sheet)

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

Character of Pain ..... Location ..... Frequency ..... Duration .....

FUNCTIONAL SCREENING: ☑ No Abnormalities Detected

☐ Mobility Problem ☐ 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?) .....

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: Snehamay Kolur Date: 28/7/26 Time: 2:15pm Signature

PATIENT TRANSFER FORM

Rainbow Children's Hospital
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UC-00061548 IP18-00036653
aby MATHIVATHANI K
4-12-2023 2 Y 7 M 24 D (F)
r. KARTHIK NARAYANAN R

Date & Time of Admission	Date & Time of Transfer Order
28/7/26 @ 12.29pm	28/7/26 @ 1:25 pm

Treating Consultant Name	Transfer Ordered by	Reason for Transfer
DR. Karthik	DR. Keerthana	further Management

From Unit	To Unit	Information to Attendant
ER	603.	Yes ☑ No ☐

Number of Sheets in Clinical File	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant
11	—	Yes ☐ No ☑ If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	Dns 500ml	0
2.	Iv set	0
3.		
4.		
5.		

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

? UTI

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Rishi	

Patient & Clinical Records Received by :

Date & Time of Patient Received : 28/7/26 @ 1.35 Pm

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

Unavailable Bed | Nurse not Available | Available Bed not ready

SUC-00061548 IP18-00036653
Baby MATHIVATHANI K
14-12-2023 2 Y 7 M 24 D (F)
Dr. KARTHIK NARAYANAN R

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MEDICATION RECONCILIATION FORM

Drug Allergies: ..... ☑ 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: 603

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 : 28/7/26 12.30pm

Nurse Name & Signature: Rishi .....

Date & Time : 28/7/26 @ 1pm

ꟷUC-00061548 IP18-00036653
ꟷaby MATHIVATHANI K
ꟷ4-12-2023 2 Y 7 M 24 D (F)
ꟷr. KARTHIK NARAYANAN R

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RBS CHART

Date	Time	RBS (mg/dl)	IVF %	Signature
28/7/26	12:40pm	70mg/dl	←	[signature] 01(6L70

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

1 mol Suppository (170mg)

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Wt-11.4kg

EMERGENCY ROOM TRIAGE FORM

Patient's Name : Baby. MathivaThani Age : 2y 7mon Gender: ☐ Male ☐ Female

Date : 28/7/26 Time of Arrival : @ 12:10pm

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

Source of Information : ☐ Parents ☐ Others (Specify)

Mode of Arrival : ☐ Ambulatory ☐ Wheelchair ☐ Ambulance

Initial Vital Signs: Temp: 101.6F PR: 153 BP: 94/64 (75) RR: 32 SpO2: 100%

Chief Complaints: c/o fever, x 1 day, dull Activity

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

M. Mathi
Signature of Parent / Guardian

Triage Completion Time : 2mins

Communicable Disease Triage Screening

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

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

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

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

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

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

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

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

Name of Triage Nurse : Rinku

Signature of Triage Nurse : (1020336)

Date & Time : 28/7/26 @ 12:12pm

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

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 28/7/26 Time of arrival : @ 12:20pm

Chief Complaints: fever x 1 day. Dull Activity RBS: Tongsell

Height : — Weight : 11.412g BMI : — Head Circumference (<2 years) : —

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

If yes , identify —

Pain Screening: ☐ Yes ☑ No If Yes, Pain Score: — 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 Parents

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

Time of Initial assessment completed by ER Nurse : 30 mins

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

Time	Nursing Notes
12:30 pm	child came for emergency planned for admission DR. Karthick seen in OPD Basis. advised to admission. vitals Maintained in normal limits. s/b DR. Keerthana. IV. cannulation done. Samples collected and Sended to labs. child shift to ward for further Management.

Samples collected by: J Sugathra Time: 12:50 PM

Samples sent by : Time:

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: 145 BP: 99/64 (75) CFT: < 3 sec	Shift - out from ER to: 603
RR: 30 SPO_2 : 100 %	Time of Shift - out: 1:25 pm
GCS: 15/15 Temperature :	Handover given to: S/N Praveena. (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 cannulation done (L) metacarpal 24 G

Name of the Nurse : Rishi Signature of the Nurse : Rishi (103936)

Date & Time : 28/7/26 @ 1 pm

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PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : Dr. Karthik Date : 28/7/26

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

Start Time of Assessment: 12.10pm Weight: 11.6 kg

Allergic History: .....

Chief Complaints: .....

40 fever x 2 day

Pediatric Assessment Triangle

A Appearance - TICLS .....

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

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

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

Any urgent interventions needed: ☐ Yes ☑ No

If Yes .....

Significant Past History: .....

Medication History: .....

Relevant Investigations: .....

Primary Assessment

Airway
- ☑ Open
- ☐ Maintainable
- ☐ Not Maintainable

Any urgent interventions needed: ☐ Yes ☑ No

If Yes .....

Breathing

Rate: 26 SpO_2 on FiO_2 100%

Rhythm: N

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

Respiratory Noises: ☐ Stridor ☐ Wheezing ☐ Grunting

Air Entry: equal

Palpation Findings (If necessary) .....

Any urgent interventions needed: ☐ Yes ☑ No

If Yes .....

(P.T.O.)

Circulation

HR: 142 CFT Central <3 Peripheral <3

Any urgent interventions needed: ☐ Yes ☑ No

If Yes .....

BP: 99/64 mmHg

Pulse Volume: Central 2+ Peripheral 2+

If in Shock: Compensated ..... Hypotensive .....

Murmurs: ☐ Yes ☑ No

Liver Span: .....

ECG: .....

Any Signs of Heart Failure: ☐ Yes ☑ No

Muffled Heart Sound: ☐ Yes ☑ No

Engorged Neck Veins: ☐ Yes ☑ No

Disability

GCS: 15/15 AVPU: A

Pupils: Responsive ☑ Non-Responsive ☐

Size: Right 2mm Left 2mm

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

Signs of Neurological compromise .....

Any urgent interventions needed: ☐ Yes ☑ No

If Yes .....

Exposure

Temp.: 101.6 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: .....

Details inside

Treatment Planned: .....

Details 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: Keerthana. D

Signature: .....

Date & Time: 28/4/26 12.15pm

Sr. Doctor on Duty (If necessary)

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

Signature: .....

Date & Time: .....