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

BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

PATIENT DISCHARGE INTIMATION FROM NURSING STATION

CLEARANCE FOR DRUGS AND DISPOSABLES BILLING

Date: 16/9/26

Name of the Patient: GUC-00067852 IP18-00036483
Baby DHASWIN MANIKANDAN S
15-08-2024 2Y1M0D (M)
Dr. GANESH R

UHID No: .....

Gender: .....

Ward: .....

Room No: .....

Certified that in respect of the above patient:

- ☐ a. There are no drugs for return
- ☐ b. Emergency cupboard issues have been replenished
- ☐ c. No pending indents are there against above patient
- ☐ d. Checked the bed side cupboard of the bed
- ☐ e. Checked by the patient's Mother / Father in the room

Patient Authorised Sign	Nurse Sign	Pharmacy Sign
Date:	Date: 16/9/26	Date: .....
Time:	Time: 8:30 AM	Time: .....

Docu. No. : RCH /FRM / GENERAL / 117

GUC-00067852 IP18-00036483
Baby DHASWIN MANIKANDAN S
15-06-2024 2 Y 1 M 0 D (M)
Dr. GANESH R

DISCHARGE TRACKING SHEET

UHID- FLOOR- NAME OF CONSULTANT-

ACTIVITY	INTIME	OUT TIME	NAME & SIGNATURE	REMARKS	<To be filled by Admin>		
Activity Sheet update by Nursing	16/7/24 8:30AM						
Activity Sheet update by Pharmacy							

ACTIVITY RECORD FOR BILLING

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BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Name: .....

UHID No: ..... IP No: . GUC-00067852 IP18-00036483 ..... Dept: .....

Baby DHASWIN MANIKANDAN S
15-06-2024 2 Y 1 M 0 D (M)
Dr. GANESH R

Date of Admission: ..... Tin arge: ..... Time: .....

Room / Bed No: ..... Warc llable bed type: .....

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
15/7/26.	2:30pm.	ER	UCS	

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
15.07.2026	CBC,	26028778.	01613

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
15/7	Infusion pumb	15/7/26. 3pm	15/7/26 at 8pm	728035.	018950

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
15.7.2026	Replacement	1	1727779	

ANY OTHER INFORMATION:

.....

.....

.....

.....

.....

.....

Date: 16/7/26 Time: 8.30AM Prepared By: .....

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
018900			

GUC-00067852 IP18-00036483
Baby DHASWIN MANIKANDAN S
15-06-2024 2 Y 1 M 0 D (M)
Dr. GANESH R

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

ISCHARGE TRACKING SHEET

DATE : 16/7/26

Floor : UHID :

Name of Consultant :

S.NO	Activity	TIME		Name & Signature	Remarks
		IN TIME	OUT TIME		
1	Dr. Announce Time	16/7/26 8.30Am		PS Anif 9 [illegible]	
2	Arrangement of File by Nurses				
3	Pharmacy Clearance				
4	Provisional Billing				
5	Audit Check				
6	Final Bill Prepared				
7	Sent to Insurance & Approval Received				
8	Handing Over & Bill Clearance				
9	Discharge Summary				
10	Physical Check Out				
11	Activity Sheet updated by Nursing				
12	Activity Sheet updated by Pharmacy				

Doc. No. : RCH / GDY / FRM / CLINICAL / 288

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 : IP18-00036483 **Admit Date** : 15-Jul-2026 **Admit Time** : 01:03 PM **UHID** : GUC-00067852

Patient Details :

Patient Name	: Baby DHASWIN MANIKANDAN S	**Age**	: 2 Y 1 M 0 D
Guardian	: Mr SHANMUGANATHAN	**DOB**	: 15-06-2024
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: c-301, HARMONY BLUEMOON, ARULMURUGAN NAGAR, OLD PALLAVARA, Bharathinagar Kanchipuram Tamil Nadu INDIA 600117	**Phone No**	: 9087597175
		E-mail	: shalumeena.nagarathinam@gmail.com

Admission Details :

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

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

Contact Details :

Name : Mr SHANMUGANATHAN **Relationship** : Baby/O

Contact Address : c-301, HARMONY BLUEMOON, ARULMURUGAN NAGAR, OLD PALLAVARA, Bharathinagar Kanchipuram Tamil Nadu INDIA 600117 **Phone No** : 9087597175

Signature

Doctor Details :

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

Referral Doctor : Dr. Mathangi Rajagopalan **Phone No** :

Co-Consultant :

Payment Details :

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

Payor Name : SELFPAY

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 DHASWIN MANIKANDAN S**	**Age :**	**2 Y 1 M 0 D**
IP No:	**IP18-00036483**	**Sex:**	**Male**
Consultant:	**Dr. GANESH R**	**Ward/Bed No:**	**0F-EMERGENCY/ER 101**

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

Patient, be deemed advisable or necessary.

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

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

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

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

Note:
1 We do not allow use of medication brought from outside by the patient.
2 I have received attendant passes as per my room category. I understand that I have to return it back at the time of final bill clearance. In case of failing the submission, I will pay 200/- Rs.
(Receivers Signature:.....)
3 IP Guide book has been given to me and I have been explained about the Hospitals rules and policies.
4 Financial and billing counseling has been done to me.

Signature of Patient/Relative:

Name: Sharmuganathan
Relationship: Father
Date: 15/07/2026 Time: 1.04 PM
Witness Name:
Witness Signature:

Patient Address:
c-301, HARMONY BLUEMOON, ARULMURUGAN NAGAR, OLD PALLAVARA, Bharathinagar Kanchipuram Tamil Nadu INDIA 600117

Rainbow Children's Hospital | BirthRight BY RAINBOW HOSPITALS

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 : Baby. Dhaswin Manikandan. S	UHID Number : GUC-00067852
Self/Attendant Name : P SHANMUGANATHAN	Relation : Father
Self/ Attendant Signature & Phone Number : 9087597175	Name & Signature of Financial Counselor

RCH/GDY/FRM/CLINICAL/426

भारत सरकार

आधार

இந்திய அரசாங்கம்

Government of India

இந்திய தனிப்பட்ட அடையாள ஆணைய அமைப்பு

Unique Identification Authority of India

பதிவேட்டு எண்/ Enrolment No.: 5115/57958/57660

To
தஸ்வின் மணிகண்டன்
Dhaswin Manikandan
C/O: Shalumeena Nagarathinam,
Old No 7 New No 13,
Valmiki Street,
VTC: Thiyagaraya Nagar,
PO: Thiyagaraya Nagar,
Sub District: Chennai,
District: Chennai,
State: Tamil Nadu,
PIN Code: 600017
Mobile: 9087597175

குத்தாதகன் ஆதார்

Signature Not Verified
Digitally signed by GS Unique Identification Authority of India
Date: 2025.07.15 12:28:49 GMT+05:30

உங்கள் ஆதார் எண் / Your Aadhaar No. :
9370 4198 3722
VID : 9123 1367 9648 5459

எனது ஆதார், எனது அடையாளம்

Government of India

தஸ்வின் மணிகண்டன்
Dhaswin Manikandan
பிறந்த நாள்/DOB: 15/06/2024
ஆண்/ MALE

ஆதார் எனது அடையாளத்திற்கான சான்றாகும், குடியுரிமை அல்லது பிறந்த தேதிக்கான சான்றல்ல. பிறந்த தேதி என்பது ஆதார் எண் வைத்திருப்பவரால் சமர்ப்பிக்கப்பட்ட விதிமுறைகளில் குறிப்பிடப்பட்டுள்ள பிறந்த தேதி ஆவணத்தின் ஆதாரம் மூலம் ஆதரிக்கப்படும் தகவலின் அடிப்படையில் அமைந்துள்ளது.

Aadhaar is proof of identity, not of citizenship or date of birth. It should be used with verification (online authentication, or scanning of QR code / offline XML).

9370 4198 3722

எனது ஆதார், எனது அடையாளம்

Aadhaar no. issued: 01/07/2026

Government of India

AADHAAR

தகவல் / INFORMATION

ஆதார் 5 வயது வரை மட்டுமே செல்லுபடியாகும். 5 வயதை எட்டும்போது பயோமெட்ரிக்ஸ் புதுப்பிக்கப்பட வேண்டும் இல்லையெனில் அது செயலிழக்கப்படும்.

Aadhaar is valid till 5 years of age only. Biometrics are required to be updated on attaining 5 years of age, failing which, it will be deactivated.

- ஆதார் என்பது அடையாளத்திற்கான சான்றாகும், குடியுரிமை அல்லது பிறந்த தேதிக்கான சான்றல்ல பிறந்த தேதி என்பது ஆதார் எண் வைத்திருப்பவரால் சமர்ப்பிக்கப்பட்ட விதிமுறைகளில் குறிப்பிடப்பட்டுள்ள பிறந்த தேதி ஆவணத்தின் ஆதாரம் மூலம் ஆதரிக்கப்படும் தகவலின் அடிப்படையில் அமைந்துள்ளது
- இந்த ஆதார் கடிதத்தை பல நியமித்த அங்கீகார நிறுவனத்தால் ஆன்லைன் அங்கீகாரம் அல்லது ஆப் ஸ்டோர்களில் கிடைக்கும் எம் ஆதார் அல்லது ஆதார் QR ஸ்கேனர் செயலியை பயன்படுத்தி QR குறியீடு ஸ்கேனிங் அல்லது www.uidai.gov.in ல் கிடைக்கும் பாதுகாப்பான QR குறியீடு ரீடர் செயலியை பயன்படுத்தி சரிபார்க்க வேண்டும்.
- ஆதார் தனித்துவமானது மற்றும் பாதுகாப்பானது
- ஆதார் பதிவு செய்யப்பட்ட நாளிலிருந்து ஒவ்வொரு 10 வருடங்களுக்குப் பிறகும் ஆதாரில் அடையாளம் மற்றும் முகவரிக்கான ஆவணங்கள் புதுப்பிக்கப்பட வேண்டும்.
- பல்வேறு அரசு மற்றும் அரசு சாரா பலன்கள் / சேவைகளைப் பெற ஆதார் உங்களுக்கு உதவுகிறது
- உங்கள் மொபைல் எண் மற்றும் மின்னஞ்சல் ஐடியை ஆதாரில் புதுப்பிக்கவும்
- ஆதார் சேவைகளைப் பெற mAadhaar செயலியை பதிவிறக்கவும்.
- ஆதார்பயோமெட்ரிக்ஸைப் பயன்படுத்தாதபோது பாதுகாப்பை உறுதிசெய்ய, ஆதார்பயோமெட்ரிக்ஸ் லாக்/அன்லாக் அம்சத்தைப் பயன்படுத்தவும்.
- ஆதார் கோரும் நிறுவனங்கள் ஒப்புகலைப் பெற வேண்டிய கட்டாயம் உள்ளது.
- Aadhaar is proof of identity, not of citizenship or date of birth (DOB). DOB is based on information supported by proof of DOB document specified in regulations, submitted by Aadhaar number holder.
- This Aadhaar letter should be verified through either online authentication by UIDAI-appointed authentication agency or QR code scanning using mAadhaar or Aadhaar QR Scanner app available in app stores or using secure QR code reader app available on www.uidai.gov.in.
- Aadhaar is unique and secure.
- Documents to support identity and address should be updated in Aadhaar after every 10 years from date of enrolment for Aadhaar.
- Aadhaar helps you avail of various Government and Non-Government benefits/services.
- Keep your mobile number and email id updated in Aadhaar.
- Download mAadhaar app to avail of Aadhaar services.
- Use the feature of Lock/Unlock Aadhaar/biometrics to ensure security when not using Aadhaar/biometrics.
- Entities seeking Aadhaar are obligated to seek consent.

Unique Identification Authority of India

முகவரி:
கேர் ஆப்: ஷாலுமீனா நாகரத்தினம், பழைய எண் 7 புதிய எண் 13, வால்மிகி தெரு, தியாகராய நகர், தியாகராய நகர், சென்னை, தமிழ் நாடு - 600017

Address:
C/O: Shalumeena Nagarathinam, Old No 7 New No 13, Valmiki Street, Thiyagaraya Nagar, PO: Thiyagaraya Nagar, DIST: Chennai, Tamil Nadu - 600017

Details as on: 15/07/2026

9370 4198 3722
VID : 9123 1367 9648 5459

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

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

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: _____

UHID ID: _____

GUC-00067852 IP18-00036483
Baby DHASWIN MANIKANDAN S
15-06-2024 2 Y 1 M 0 D (M)
Dr. GANESH R

Department: _____

Consultant: _____

(P.T.O.)

GUC-00067852 IP18-00036483
Baby DHASWIN MANIKANDAN S
15-06-2024 2 Y 1 M 0 D (M)
Dr. GANESH R

Pediatric Multiorgan History & Physical Examination

Name: Baby Dhaswin Age/Sex 2yrs/M.

Information given by: Relationship

Chief Presenting Complaints & Duration (Chronologically)

Accidental ingestion of ~~Phen~~ Freshnol.

History of present illness :

A 2 yrs old male came with complaints of accidental ingestion of mysore sandal freshnol at home, around 11 am.

no c/o drooling of saliva, vomiting.

no c/o Altered sensorium, seizures.

Patient Sticker

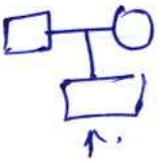
Past History : (Including details of any previous investigation or treatment)

—

Birth & Neonatal History:

NVD | Term | B.wt - 3.390g |
NO NICU stay

Family Chart



Birth & Socio Economic History:

About Father : 1 yr CM

About Mother :

Any additional Information :

Developmental History :

milestones attained at appropriate age

Immunization History :

Immunization done upto age

Anthropometry :

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

Weight (kgs) 12.5kg (Centile _____)

On Examination :

Temperature : 98F Pulse Rate : 120/min B.P. : _____ SPO2 99% RA

Resp.rate and type of breathing : 28/min

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 (P)

Any addes sounds :

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

Cardiovascular System :

Inspection of procordium :

Heart Sounds : S1S2 (P)

Any murmur :

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

Per Abdomen :

Inspection :

Palpation : Soft, non tender

Ausculation :

Spine : External Genitelia :

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

Central Nervous System :

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

Cranial Nerves :

Motor System :

Nutriton : (N)

Tone: Power 5/5

Co-ordinator :

Posture :

Involuntary Movements :

Pati

GUC-00057852 IP18-00036483
Baby DHASWIN MANIKANDAN S
15-06-2024 2 Y 1 M 0 D (M)
Dr. GANESH R

Reflexes :

DTR **Superficials:**

Plantars

Sensory System :

Bladder / Bowel :

Clinical Summary & Diagnostic:

Accidental Ingestion of mysore sandal freshner
(? Hydrocarbon poisoning)

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

Desired goals of the treatment :

Planned Labs:

CBC

Planned Management

At IV Fluids.
Pantoprazole.
NPO x 4 hours

Signature of the Doctor: 15/6/24

Name of the Doctor: Dr. Chandiraleya

Date & Time: 15/0 hrs

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: .....

GUC-00067852 IP18-00036483
Baby DHASWIN MANIKANDAN S
15-06-2024 2Y1M0D (M)
Dr. GANESH R

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Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
15/7/24 4PM	S/B Dr. chandiralega.	
	child received.	
	sleeping	
	no c/o vomiting, drooling of saliva.	
	no seizures, fast breathing	
	vitals stable.	
	O/E	
	afebrile	
	CVS - S1 S2 (+)	
	RS - B/L AE (+)	
	PA - Soft	
		Adv
		- To start orals liquids s/B solids.
		- W/F vomiting, desaturation, drooling of saliva.
		- Inform (SOS)
	SN 15/7/24	

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
15/7/26	S/B Dr. Manoma?	
6pm		
	Alert, active	
	No cough / drooling of saliva	
	No vomiting	
	Tolerated liquids	
	PP-+F	
	Chest - clear	
	P/A - soft, Non tender	
	Rx	
	→ Monitoring	
	?? cough / distension / vomiting /	
	drooling of saliva	
[signature] 15/7		

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

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

GUC-00067852 IP18-00036483
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RESULT SHEET

Date	15/7/26					
Time						
Hb	9.8					
PCV	29					
RBC	4.32					
WBC	12,490					
N/L	45/45					
Platelets	457					
CRP						
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

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

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

GUC-00057852 IP18-00036483
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15-06-2024 2Y1M0D (M)
Dr. GANESH R

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MEDICATION RECONCILIATION FORM

Drug Allergies: NKA ☐ Not known any Drug Allergies

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

Shifting From: ER Shifted to: 408

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 : 15/7/26 1.15 pm

Nurse Name & Signature: praveen.

Date & Time : 15/7/26 at 1:15pm

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

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15-06-2024 2 Y 1 M 0 D (M)
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DRUG CHART

Date of Admission: 15/7/24 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 :				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:				

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

Signature .....

VERIFIED BY : Name .....

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Baby DHASWIN MANIKANDAN S
15-06-2024 2 Y 1 M 0 D (M)
Dr. GANESH R

REGULAR PRESCRIPTIONS

Weight. 12.5Kg Ward. ....

DRUG : INJ. PANTOPRAZOLE				Date / Time	15/7/24	15/7
Dose	Route	Frequency	Start Date	2pm.		
15mg	IV	OD	15/7	PK		
Name & Signature of the Doctor Starting the Drugs:						
Additional Instructions:						
Daily Doctor's Endorsement by a Sign						

DRUG :				Date / Time
Dose	Route	Frequency	Start Date	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

DRUG :				Date / Time
Dose	Route	Frequency	Start Date	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

DRUG :				Date / Time
Dose	Route	Frequency	Start Date	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

Patient Sticker

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

VARIABLE DOSE	Date▸ / Time		Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.
DRUG :		Dose		Dose		Dose		Dose	
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Route / Start Date		Dose		Dose		Dose		Dose	
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Name & Signature of the Doctor		Dose		Dose		Dose		Dose	
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Additional Instructions:		Dose		Dose		Dose		Dose	
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	

VARIABLE DOSE	Date▸ / Time		Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.
DRUG :		Dose		Dose		Dose		Dose	
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Route / Start Date		Dose		Dose		Dose		Dose	
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Name & Signature of the Doctor		Dose		Dose		Dose		Dose	
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Additional Instructions:		Dose		Dose		Dose		Dose	
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses

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Baby DHASWIN MANIKANDAN S
15-06-2024 2 Y 1 M 0 D (M)
Dr. GANESH R

I.V. FLUIDS CHART

Weight. 12.5kg Ward. ....

Date	Time	Composition of Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
15/7	2pm.	0.9% DNS	450ml/hr	IV	[signature] 9124	Pon 1894 / Subham	15/7 8pm		[signature] D0895

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

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15-06-2024 2 Y 1 M 0 D (M)
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C. No. : RCH/ FRM / CLINICAL / 125

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

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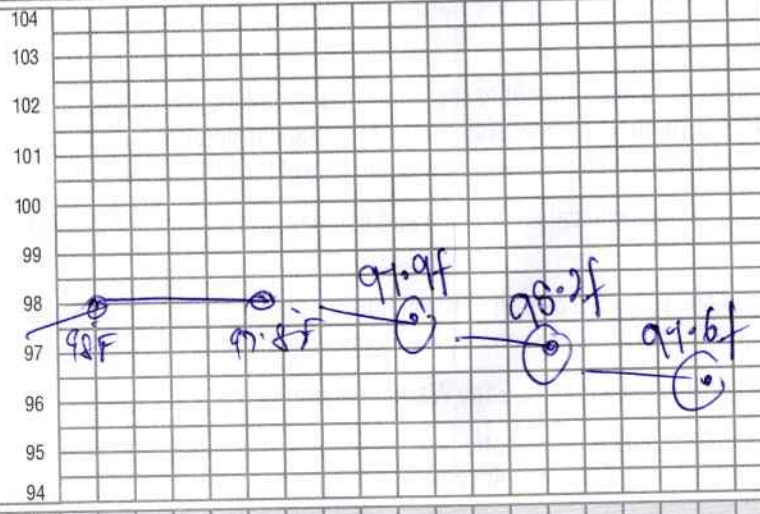
EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 15/7/26 Time: 2pm 4pm 8pm 12am 4am

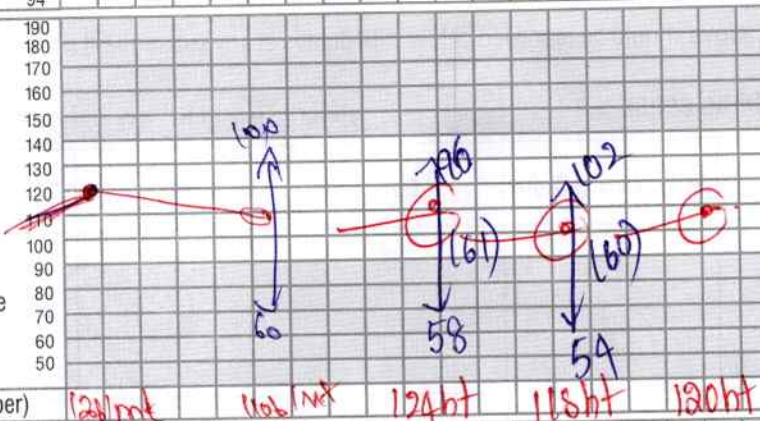
Doctor / Nurse / Family Concern?

Temperature (°F)



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

Note: BP does not score in early warning scoring



Heart Rate (Number)	124bpm	116bpm	124bpm	118bpm	120bpm
Resp. Rate (bpm) (Over 1 Minute) *					
Resp Rate (Number)	28bpm	28bpm	28bpm	28bpm	28bpm
Resp Distress: Mod/ Severe / None / Mild	✓	✓	✓	✓	✓
Receiving O_2 (l/min) O_2 Saturations (%)	98%	97%	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	KB	KB	[illegible]	[illegible]	[illegible]

ACTIONS
NB: Scores 3 should be recorded overleaf

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

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

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

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FLUID CHART

Sheet No. : ......①......

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

Date	Time	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
15/7/26	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						**Total Output :**						
	02:00 pm	→ [illegible] received			Fn	to	4th	floor.	@	2.30pm		
	03:00 pm			DNS 45ml							0	[signature]
	04:00 pm			45ml						✓	0	[signature]
	05:00 pm	Juice	100ml	45ml							0	[signature]
	06:00 pm	H2O	50ml	45ml							0	[signature]
	07:00 pm			45ml						✓	0	[signature]
Total Intake : 150ml + 225ml						**Total Output :** 2 times urine passed						
	08:00 pm			45ml							0	[signature]
	09:00 pm	K/at	80ml.	45ml.						✓	0	[signature]
	10:00 pm			48ml.							0	[signature]
	11:00 pm	K/at	80ml								0	[signature]
	12:00 am									✓	0	[signature]
	01:00 am										0	[signature]
Total Intake : 70ml + 138ml						**Total Output :** 2 times void						
	02:00 am										0	[signature]
	03:00 am									✓	0	[signature]
	04:00 am	K/at	20ml								0	[signature]
	05:00 am									✓	0	[signature]
	06:00 am										0	[signature]
	07:00 am	Milk	50ml							✓	0	[signature]
Total Intake : 70ml.						**Total Output :** 3 times void						

Total 24 hrs. Intake	650ml.

Total 24 hrs. Output	7 times void.

GUC-00067852 IP18-00036483
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15-06-2024 2 Y 1 M 0 D (M)
Dr. GANESH R

NURSES NOTES

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

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
15/7/26	2.30 pm	Receiving notes	
		Child Received from OR to	
		4th floor 408 via walking, while	[signature]
		receiving, child is conscious, oriented	02074 9
		and afebrile. Pain score- 15/15, Skin	
		Assessment done. IV line is present and	
		patent. no pain or redness. on	
		IVF DNS @ 45ml/hr.	
	2.45 pm	vitals checked and recorded, all	[signature]
		are hemodynamically stable	02074 9
		CP ++ / PP ++ / CRT <3sec	
	4 pm	NPO breaked. Sips of	
		water given. IVF- DNS 45ml/hr	
		on going.	
	7 pm	I/O chart maintained.	
	7.30 pm	Handing over given to	
		night duty S/N	[signature] 00078.
		→ Night duty On:- 15/7/26	
	7.30pm	Child details hand Over taken	
		from evening duty staff	
		Child is conscious & oriented	
		Child IV cannula patten.	[signature]
	8pm	Vital Sign's checked and—	008950.

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Patient Sticker

NURSES NOTES

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☐ No Known Drug Allergies

☐ Drug Allergies ..... Nil .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		→ continue 15/7/26 ←	
16/7/26.		Recorded vital are stable.	
		CP: ++ PP: ++ CRT: <3sec —	Dy 0890
		Dr. Ganesh Sir seen the child Sir advise if child intake better means IV fluid stop —	
	10am	child intake was good —	Dy 0890
		No any complaints —	
	12am	vital Sign's checked and Recorded vital are stable	
		CP: ++ PP: ++ CRT: <3sec —	Dy 0890.
	2am	Child sleeping pattern was good No chart Maintained —	
		vital Sign's checked and Recorded vital are stable	
		CP: ++ PP: ++ CRT: <3sec —	Dy 0890
	6am	Due to medication was given as per doctor's Order No any complaint's —	
		No chart Maintained —	Dy 0890.
	7:30am	child details band Over given to morning duty Staff.	Dy 0890.

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

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Patient's Name:..

MRD NC GUC-00067852 IP18-00036483 D.:.....................
Baby DHASWIN MANIKANDAN S
15-06-2024 2 Y 1 M 0 D (M)
Age :..... Dr. GANESH R Sex: ☐ M ☐ F

Consult: ....

PHLEBITIS ASSESSMENT

CANNULA 1

Date : 15/7/26 Time: 1:40pm.
Location : (L) metacarpel
Size : 24G.
Cannula inserted by : S/N Subhadip

Date	Time	Phlebitis	Infiltration	Nursing Intervention	Sign
15/7/26	1:40pm.	☐Yes ☑No	☐Yes ☑No	pattern	[illegible] 8pm
	3pm	☐Yes ☑No	☐Yes ☑No	patent	[illegible]
	5pm	☐Yes ☑No	☐Yes ☑No	observed	[illegible]
	7pm	☐Yes ☑No	☐Yes ☑No	observed	[illegible]
	9pm	☐Yes ☑No	☐Yes ☑No	Observed	Dy
	10pm	☐Yes ☑No	☐Yes ☑No	Observed	Dy
16/7.	12am	☐Yes ☑No	☐Yes ☑No	Observed	Dy
	2am	☐Yes ☑No	☐Yes ☑No	Observed	Dy
	4am	☐Yes ☑No	☐Yes ☑No	Observed	Dy
	6am	☐Yes ☑No	☐Yes ☑No	Observed	Dy
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		

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

CANNULA 2

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

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

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

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

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

PHLEBITIS ASSESSMENT AND MANAGEMENT RECORD

CANNULA 3

Date : Time:

Location :

Size :

Cannula inserted by :

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

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

CANNULA 4

Date : Time:

Location :

Size :

Cannula inserted by :

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

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

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

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

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

GUC-00067852 IP18-00036483
Baby DHASWIN MANIKANDAN S
15-06-2024 2 Y 1 M 0 D (M)
Dr. GANESH R

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Nursing General Admission Assessment Form For Pediatrics

Diagnosis: ? Hydrocephalus Poisoning

Arrival Time: 14/2/24 @ 2 PM Mode of Arrival: walking Admitting From: ☑ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction ..... Nil ..... Body Weight: 12.5 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: 12.5kg Length: - Head Circumference (< 2 years): ....

Temp.: 97°F HR: 126b/mt RR: 28b/mt BP: 100/60mmHg

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

Fall Risk Assessment: ☑ Yes ☐ No Score: 15 (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

(P.T.O)

Psychological Screening: ☑ No Significant Findings

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

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

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

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 ....Family....................................

Nurse's Name: ....R. Seena.................... Date: ....15/7/26.......... Time: 2:30 P.M....

020749

Signature

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EMERGENCY ROOM TRIAGE FORM

Wt - 12.5 kg

Patient's Name : Baby · Dhanwin Age : 2 yrs Gender: ☑ Male ☐ Female

Date : 15/7/26 Time of Arrival : @ 12:40pm

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: 98.2°F PR: 120bt BP: RR: 28br SpO_2: 99% RA.

Chief Complaints: 2 Accidental ingestion of Mysore Sandal Soap.

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 : 2min

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 : Poovizhi Saran.

Signature of Triage Nurse : .....

Date & Time : 15.07.2026 @ 12.45pm.

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 15.07.2026 Time of arrival : 12.40pm

Chief Complaints: c/o ? Accidental ingestion of mysore sandal freshner RBS: -

Height : - Weight : 12.5kg BMI : - Head Circumference (<2 years) -

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

If yes , identify -

Pain Screening: ☑ Yes ☐ No If Yes, Pain Score: 0/10 Pain Tool Used: ☐ N Pass ☑ FLACC ☐ Wong Baker

☐ Character - ☐ Location - ☐ Frequency - ☐ Duration -

RISK FOR FALL:

☑ If patient is < 6 years
tick below fall risk intervention directly
☐ If Patient is > 6 years
Assess the below parameters

History of Falling: within past 3 months	☐ Yes	☑ No
Ambulatory Aids:		
• Wheelchair	☐ Yes	☑ No
• Uses furniture for support	☐ Yes	☑ No
Gait/Transferring:		
• Bedrest / immobile	☐ Yes	☑ No
• Weak	☐ Yes	☑ No
• Impaired	☐ Yes	☑ No
Mental Status: Forgets limitations	☐ Yes	☑ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening: ☑ No Abnormalities Detected

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

Inform consultant for positive criteria

-

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: Yes (Date/Time): 15/7/26. 2pm.

Social History: Lives With parents

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

Time of Initial assessment completed by ER Nurse : 15mins.

Docu. No. : RCH /FRM / CLINICAL / 120

(P.T.O.)

Time	Nursing Notes
12:40pm.	Patient came to ER for c/o
	? Accidental ingestion of Mysore sandal
	fresheal after investigation. Dr. Ganesh
	advised for admission. vitals
	are checked and recorded. IV line
	placement done samples are collected
	and sended to lab. patient shifted to
	ward.

Samples collected by: S/N praveen.

Samples sent by: S/N Subhadip

Time: 1:40pm.

Time: 1:40pm.

Medication given in ER:

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

Condition of patient at time of shift - out :	**Details of Shift - out**
HR: 120. BP: - CFT: <3sec	Shift - out from ER to: 400
RR: 28 SPO$_2$: 99%	Time of Shift - out: 2:30pm.
GCS: 15/15 Temperature: 98.2°F	Handover given to: S/N Lathika (Nurse's Name)
Pain Score: 0/10.	
Repeat RBS (if applicable): -	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any): IV line placement done (R) metacarpal 24 G.

Name of the Nurse: Praveen

Signature of the Nurse: Praveena.

Date & Time: 15/7/24 at 12:41pm.

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PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Date : 15/7

Admitting Doctor : Dr. chandiralega

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

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

Allergic History: ....

Chief Complaints: Accidental ingestion of mysore sandal freshner.

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

Rhythm: ....

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

Respiratory Noises: ☐ Stridor ☐ Wheezing ☐ Grunting

Air Entry: B/L NAE(=)

Palpation Findings (If necessary) ....

Any urgent interventions needed: ☐ Yes ☐ No

If Yes ....

(P.T.O.)

Circulation

HR: 128/m. CFT [Central ..... / Peripheral .....]

Any urgent interventions needed: ☐ Yes ☐ No

If Yes .....

BP: ..... mmHg

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

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

Muffled Heart Sound: ☐ Yes ☐ No

Engorged Neck Veins: ☐ Yes ☐ No

Murmurs: ☐ Yes ☐ No

Liver Span: .....

ECG: .....

Any Signs of Heart Failure: ☐ Yes ☐ No

Disability

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

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

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

Signs of Neurological compromise .....

.....

Any urgent interventions needed: ☐ Yes ☐ No

If Yes .....

Exposure

Temp.: 98F

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: .....

As per chart

Treatment Planned: .....

As per chart

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. Chandiralegs

Signature: .....

Date & Time: 25/7/2...

Sr. Doctor on Duty (If necessary)

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

Signature: .....

Date & Time: .....

PATIENT TRANSFER FORM

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GUC-00067852 IP18-00036483
Baby DHASWIN MANIKANDAN S
15-06-2024 2Y1M0D (M)
Dr. GANESH R

	Date & Time of Admission	Date & Time of Transfer Order
	15/7/26 at 1:03pm.	15/7/26 at 2:30pm.
Treating Consultant Name	**Transfer Ordered by**	**Reason for Transfer**
Dr. Ganesh	Dr. Keerthana.	Further management
From Unit	**To Unit**	**Information to Attendant**
ER	40S	Yes ☒ No ☐
Number of Sheets in Clinical File	**Number of Imaging Films**	**Personal belongings including clinical documents. If any handed over to attendant** Yes ☐ No ☐ If yes, what ?
(9)	—	

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	DNS 500ml	(1)
2.		
3.		
4.		
5.		

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

? Hydrocarbon poisoning

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

Patient & Clinical Records Received by : Jathija. B

Date & Time of Patient Received : 15/7/2026 2:30

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