



{ Birthplace: 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		15/7/26 at 1:15 PM		AM 01/24/26			
Activity Sheet update by Pharmacy							

[Handwritten signature]

ACTIVITY RECORD FOR BILLING

SNC-00024099 IP18-00036244
Baby AADHAV S
16-04-2025 1 Y 3 M 1 D (F)
Name: ...
Jr. SOMASHEKARA H R
UHD No.  Consultant: ... Dept: ...
Date of Admission: ... Time: ... Date of Discharge: ... Time: ...
Room / Bed No: ... Ward: ... Suggested Billable bed type: ...

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
8/7/26	1pm	ICU	7th Floor	Rajyogon.
08/07/2026	2:45 PM	7th	PICU	R. 2020264
10/7/26	3:30 PM	PICU	5th S05	Raj 0820264

CROSS CONSULTATION VISIT

	Doctor Name	Date	Order No.	Signature
1.				
2.				
3.				
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10.				

[illegible]

[illegible]

patient Name : Baby. Adhavi
Surgeon Name : Dr. Keerthiivasan.
Procedure : Endoscopy
Anesthetist Name : Dr. Mohanmurali
In 12.20pm
out 1:20pm
Date: 16/7/26 Time: 1pm
Prepared By:

Sharmila A
0122-16

505

Rajendra

Billing Supervisor

ACTIVITY RECORD FOR BILLING

5th Floor

Name:
UHID No:
Date of Admission:
Time:
Date of Discharge:
Time:
Room / Bed No:
Ward:
Suggested Billable bed type:

SNC-00024099
Baby AADHAVI S
08-04-2025
Dr. SOMASHEKARA
1 Y 3 M 4 D

Consultant: Dept:

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse

CROSS CONSULTATION VISIT

	Doctor Name	Date	Order No.	Signature
1.				
2.				
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4.				
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10.				

[illegible]

11/7/26

RBS

22232

plus
10A301

12/7/26

ERs

22384

h

12/8/26

electrolyte, mg, phosphorus 2417	
----------------------------------	--

Prof. P. P. P. P.

12726

Bicarbonate

2420

Peru

121 ≠ 124

RBS

22427

P. 10/12

12/7/26

RB3

22421

MEDICAL EQUIPMENT (WARD & ICU)

[illegible]

[illegible]

Date: 13/7/20

Time: 5:20 PM

Prepared By:

Staff Nurse

Shift / Ward

Billing Assistant

Billing Supervisor

DISCHARGE TRACKING SHEET

UHID-

FLOOR-

NAME OF CONSULTANT-

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

Endoscopy

Patient ID : SNC-00024099
Patient Name : BABY.AADHAVI S
Age/Gender : 1Yr, Female

Visit Date : 08/07/2026
Referred by : DR.SOMASEKHARA DNB, FPGHN(Eng)
Consulted by : DR.KEERTHIVASAN MD, DM

UPPER GI ENDOSCOPY Report

Premedication : IV SEDATION

Esophagus : Normal

OG Junction : Normal

Stomach :

Fundus : Normal

Body : Normal

Antrum : Normal

Pylorus : Normal

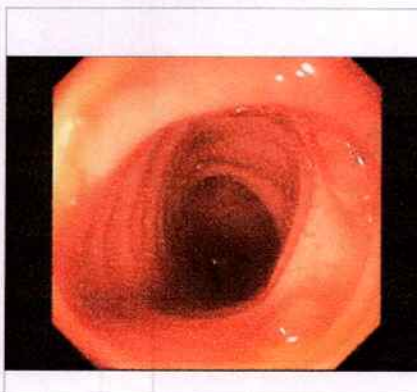
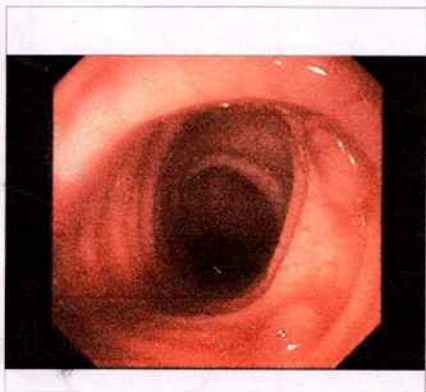
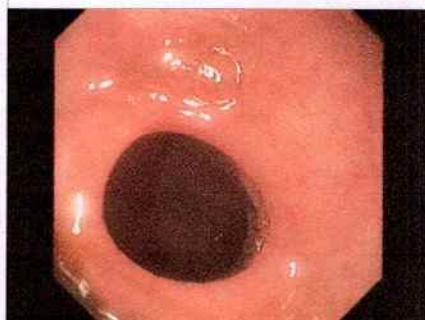
Duodenum :

D1 : Grooving seen

D2 : Thinned out folds, Grooving and non classical scalloping seen,
Cook 10F NJ tube inserted.

Biopsy : Taken from D1, D2

Impression : NJ tube insertion, Descriptive changes



DR.KEERTHIVASAN MD, DM

Rainbow Children's Hospital

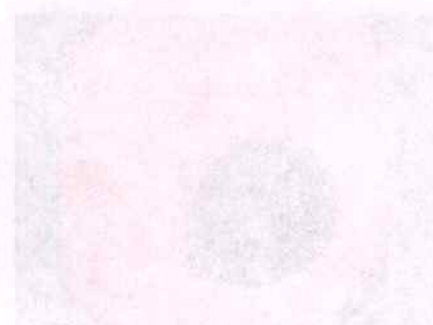
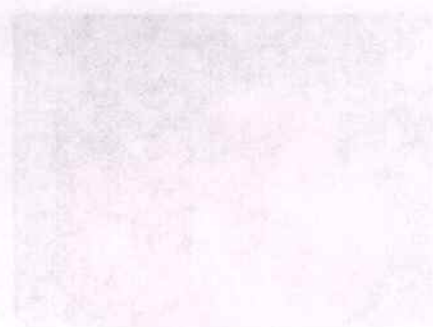
No. 157, Area 20, Guangzhou, 510015

Endoscopy

With the use of

the following equipment, the following

examinations were performed:



UPPER GI ENDOSCOPY REPORT

1. Indication: Abdominal pain

2. History: 3 years

3. Physical: Normal

4. Lab: Normal

5. X-ray: Normal

6. Ultrasound: Normal

7. CT: Normal

8. MRI: Normal

9. PET: Normal

10. Biopsy: Normal

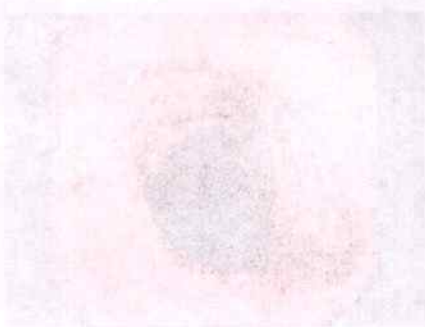
11. Endoscopy: Normal

12. Pathology: Normal

13. Follow-up: Normal

14. Conclusion: Normal

15. Recommendation: Normal



DISCUSSION AND CONCLUSION

1. The patient's symptoms are consistent with

Medication	Dose	frequency & Dilution
Syp. Domstal	1ml	6AM 12PM 6PM 12AM
Nexpro Sachet	1 1 sachet	Dilute in 4ml of water & give 2ml 6AM 6PM
T. Folvite	5mg	Dilute in 5ml give 5ml
T. Magnion 400mg	$\frac{1}{4}$	Dilute in 4ml and give 1ml 7AM 3PM 11PM
24 D Drops	1ml	3PM
Syp. ALTHROLIN	1ml	2AM 8AM 2PM 8PM (GIVE 20 mins BF)
ADDPHOS Sachet	1 1 sachet	Dilute in 4ml and give 2ml 12AM 12PM
C. CREON	7500 U (Before Feed)	Each feed
SIMYL MCT OIL	5ml	Each feed

1600

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ADMISSION SHEET

Registration Details :

Admission No : IP18-00036364

Admit Date : 07-Jul-2026

Admit Time : 01:20 PM UHID : SNC-00024099



Patient Details :

Patient Name : Baby AADHAVI S

Age : 1 Y 3 M 1 D

Guardian : Mr SATHIYANARAYANAN N

DOB : 06-04-2025 06:30 AM

Gender : Female

Religion :

Occupation :

Marital Status :

Address (H) : 58, kumaraguru aveue, mettukuppam
Karapakkam Kanchipuram Tamil Nadu INDIA
600097

Phone No : 9940210732/

E-mail : 9940210732@GMAIL.COM

Admission Details :

Bed Type : PICU-HDU

Bed No : PICU-HDU 211

Ward Name : 2F-PICU 2

Room No : PICU-HDU 211

Admission Type : First Visit

Contact Details :

Name : Mr SATHIYANARAYANAN N

Relationship : D/O

Contact Address : 58, kumaraguru aveue, mettukuppam
Karapakkam Kanchipuram Tamil Nadu INDIA
600097

Phone No : 7904336994


Signature

Referral Details :

Doctor Name : Dr. SOMASHEKARA H R

Specialisation : PEDIATRIC GASTROENTEROLOGY AND
HEPATOLOGY

Referral Doctor : Self

Phone No :

Co-Consultant :

Payment Details :

Payment Mode : Cash

Deposit Amount : 0.00

Payor Name : SELF PAY

GENERAL CONSENT FOR TREATMENT

Patient Name: Baby AADHAVI S

IP No: IP18-00036364

Consultant: Dr. SOMASHEKARA H R

Age : 1 Y 3 M 1 D

Sex: Female

Ward/Bed No: 2F-PICU 2/PICU-HDU 211

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 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.

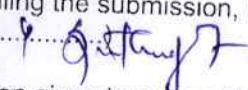
I understand that I shall not bring valuables to the Hospitals and that the Hospital will not be responsible for the loss, destruction or theft of my personal belongings. I assume full responsibility for all my personal items and release the Hospital from responsibility and liability for such personal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

Sathya narayanan. N

Relationship:

Father

Date:

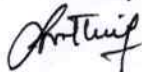
07/07/2026

Time: 1.26 pm

Witness Name:



Witness Signature:



Patient Address:

58, kumaraguru aveue, mettukuppam
Karapakkam Kanchipuram Tamil Nadu
INDIA 600097

10/10/1911

10/10/1911

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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 be applicable.
- ▶ 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 be 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 and 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 : <i>Baby . Aadharvi -S</i>	UHID Number : <i>GRH-000-24099</i>
Self/Attendant Name : <i>Y. Githy</i>	Relation : <i>Father</i>
Self/ Attendant Signature : <i>Y. Githy</i>	Name & Signature of Financial Counselor : <i>[Signature]</i>
Phone Number :	

भारत सरकार
Government of India

நா சத்தியநாராயணன்
N Sathiyarayanan
பிறந்த நாள் / DOB : 19/08/1995
ஆண் / Male

ஆதார் என்பது அடையாளத்திற்கான சான்றாகும், குடியரிமை, அல்லது பிறந்த தேதிக்கான சான்றல்ல. இது சரிபார்ப்புடன் மட்டுமே பயன்படுத்தப்பட வேண்டும் (ஆன்லைன் தரவரிசை அல்லது on குறியீட்டை ஸ்கேன் செய்தல்/ஆஃப்லைன் XML)

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).

4021 6613 1318

मेरा आधार, मेरी पहचान

भारतीय विशिष्ट पहचान प्राधिकरण
Unique Identification Authority of India

முகவரி: தந்தை / தாய் பெயர்: நாகராஜன்.
பழைய எண் இது புதிய எண் 35, அண்ணா தெரு, திருவள்ளூர் நகர், பெருங்குடி.
பெருங்குடி, காஞ்சிபுரம், தமிழ் நாடு. 600096
Address: S/O: Nagarajan, OLD NO 6E NEW NO 35, ANNA STREET, THIRUVALLUVAR NAGAR, PERUNGUDI, Perungudi, Kancheepuram, Tamil Nadu, 600096

Details as on 25/08/2024

4021 6613 1318

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



RBS CHART

Date	Time	RBS (mg/dl)	IVF %	Signature
6/7/26	9pm	150mg/dl	N/G Feed	AP 01621
7/7/26	3am	91mg/dl	N/G Feed	AP 01621
7/7/26	6pm	90mg/dl	N/G feed	Vuksovic
8/7/26	6am	87mg/dl	N/G feed	AP 01621
8/7/26	2pm	68mg/dl	N/G feed	AP 01621
9/7/26	6 AM	85mg/dl	N/G feed	AP 01621
10/7/26	6am	104mg/dl	N/G feed	AP 01621
11/7/26	6 AM	79mg/dl	N/G feed	AP 01621
12/7	6am	107mg/dl	N/G feed	AP 01621
12/7/26	3pm	106mg/dl	N/G feed	AP 01621
12/7/26	6:30am	122mg/dl	N/G feed	AP 01621

SNC-00024099

IP18-00

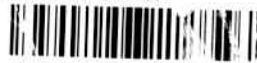
Baby AADHAVI S

08-04-2025

1 Y 3 M 1 D

Dr. SOMASHEKARA

PRE - OPERATIVE CHECK LIST



BirthRight

RAINBOW HOSPITALS
Your Right to a Safe Delivery
 Patient's Name : Aadhavi Age : 14 Date : 8/7/26
 Blood Group : O+ve UHID : _____ Gender : ☐ M ☒ F

 Planned Surgery : Endoscopy guided NT insertion Surgeon : _____
 Anesthetist : _____ Date & Time of Operation : 8/7/26 @ 12pm

Tick Appropriate Boxes

To be filled by Nurse Incharge / Senior Nurse :

S.No	INSTRUCTIONS	YES	NO	NA
1.	Weight checked and recorded?	☒	☐	☐
2.	Is the patient fasting for over 6 hours Pre-Operatively?	☒	☐	☐
3.	Check Pre-OP Investigations & Results (CBP, Blood Group, BT, CT, PT / APTT, Viral Screening, CXR etc) available before starting the procedure	☒	☐	☐
4.	Enema given / Bowel Preparation	☐	☒	☐
5.	Remove all ornaments, etc and sterile gown given	☒	☐	☐
6.	Is Blood arranged as required?	☐	☒	☐
7.	If Blood has been ordered - is Blood bag ready?	☐	☒	☐
8.	IV Cannula to be placed / IV fluids if Indicated	☒	☐	☐
9.	Pre Anesthetic consultation with anesthesiologist	☐	☒	☐
10.	Pre Medications Given? (Sedatives / etc)	☐	☒	☐
11.	Skin Preparation	☐	☒	☐
12.	Site is marked	☐	☒	☐
13.	Surgery consent / High Risk consent taken by surgeon? (Consent should be taken by the operating surgeon only)	☒	☐	☐
14.	Implants are available	☐	☒	☐
15.	Equipment is available	☐	☒	☐
16.	Other (if any)	☐	☒	☐

NOTE: if any of above is ticked "NO" Discuss with the registrar / consultant immediately

Billing Clearance taken

Billing Executive Name : M. Santhana Lakshmi Nurse In-Charge Name : Prof. J. J. J. J.Billing Executive Signature : M. Santhana Lakshmi Signature of Nurse In-Charge : J. J. J. J.Date & Time : 08/07/2026 12:00 pm Date & Time : 8/7/26 @ 12pm

Doc. No. : RCH / FRM / CLINICAL / 107

RE-OPERATIVE CHECK LIST

Date: 10/10/10
 Patient: [illegible]
 Surgeon: [illegible]
 Anesthetist: [illegible]
 Room: [illegible]

1	Is the patient's name correct?	
2	Is the patient's age correct?	
3	Is the patient's sex correct?	
4	Is the patient's weight correct?	
5	Is the patient's height correct?	
6	Is the patient's blood pressure correct?	
7	Is the patient's heart rate correct?	
8	Is the patient's respiratory rate correct?	
9	Is the patient's oxygen saturation correct?	
10	Is the patient's temperature correct?	
11	Is the patient's pulse correct?	
12	Is the patient's blood glucose correct?	
13	Is the patient's electrolyte panel correct?	
14	Is the patient's coagulation panel correct?	
15	Is the patient's renal panel correct?	
16	Is the patient's liver panel correct?	
17	Is the patient's acid-base panel correct?	
18	Is the patient's hematology panel correct?	
19	Is the patient's chemistry panel correct?	
20	Is the patient's toxicology panel correct?	

Signature: [illegible]
 Date: 10/10/10
 Location: [illegible]

SNC-00024099

IP18-0002

Baby AADHAV S

08-04-2025

1 Y 3 M 3 D

Dr. SOMASHEKARA H R



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

BirthRight[™]
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

BED SIDE CHECK LIST FOR NURSES

Date:	9/7	10/7	10/7	11/7	12/7	13/7			
Doctor's Orders	yes	yes	yes	✓	✓	✓			
Carried out or not	yes	yes	yes	✓	✓	✓			
Bed Side									
Structured Handover done	yes	yes	yes	✓	✓	✓			
IV Site	no	no	no	x	x	x			
Central Lines	yes	yes	yes	✓	✓	✓			
Arterial Lines	no	no	no	x	x	x			
Feeding Catheter (NJ tube)	yes	yes	yes	✓	✓	✓			
Urinary Catheter	no	no	no	x	x	x			
Skin Care	yes	yes	yes	✓	✓	✓			
Eye Care	yes	yes	yes	✓	✓	✓			
Mouth Care	yes	yes	yes	✓	✓	✓			
Sterillum Bottle, Stethoscope	yes	yes	yes	✓	✓	✓			
Suction Bottle (Should be clean & empty)	yes	yes	yes	✓	✓	✓			
Intubation Tray	no	no	no	x	x	x			
Emergency Tray (Loaded Syringes with Midazolam & Vecuronium and Flush) Ampoules of Adrenaline	no	no	no	x	x	x			
Ventilator Tubing, (Any Water, Blood)	no	no	no	x	x	x			
Humidification	no	no	no	x	x	x			
Check all Infusion (Labelling, Correct Preparation)	yes	yes	yes	✓	✓	✓			
Chest Physio & Neb	no	no	no	x	x	x			
Handed Over By Name :	Shamila	Shamila	Shamila	Shamila	Shamila	Shamila			
Signature :	Shamila	Shamila	Shamila	Shamila	Shamila	Shamila			
Date & Time:	10/7/26 2:00 PM	10/7/26 2:00 PM	10/7/26 2:00 PM	10/7/26 2:00 PM	10/7/26 2:00 PM	10/7/26 2:00 PM			
Hand Over Taken By Name :	Shamila	Shamila	Shamila	Shamila	Shamila	Shamila			
Signature :	Shamila	Shamila	Shamila	Shamila	Shamila	Shamila			
Date & Time:	10/7/26 2:00 PM	10/7/26 2:00 PM	10/7/26 2:00 PM	10/7/26 2:00 PM	10/7/26 2:00 PM	10/7/26 2:00 PM			

CENTRAL LINE MAINTENANCE CARE BUNDLE CHECK LIST

Type of Line: ☐ PICC Line ☐ UAC ☐ UVC ☐ Other **RT ISV**

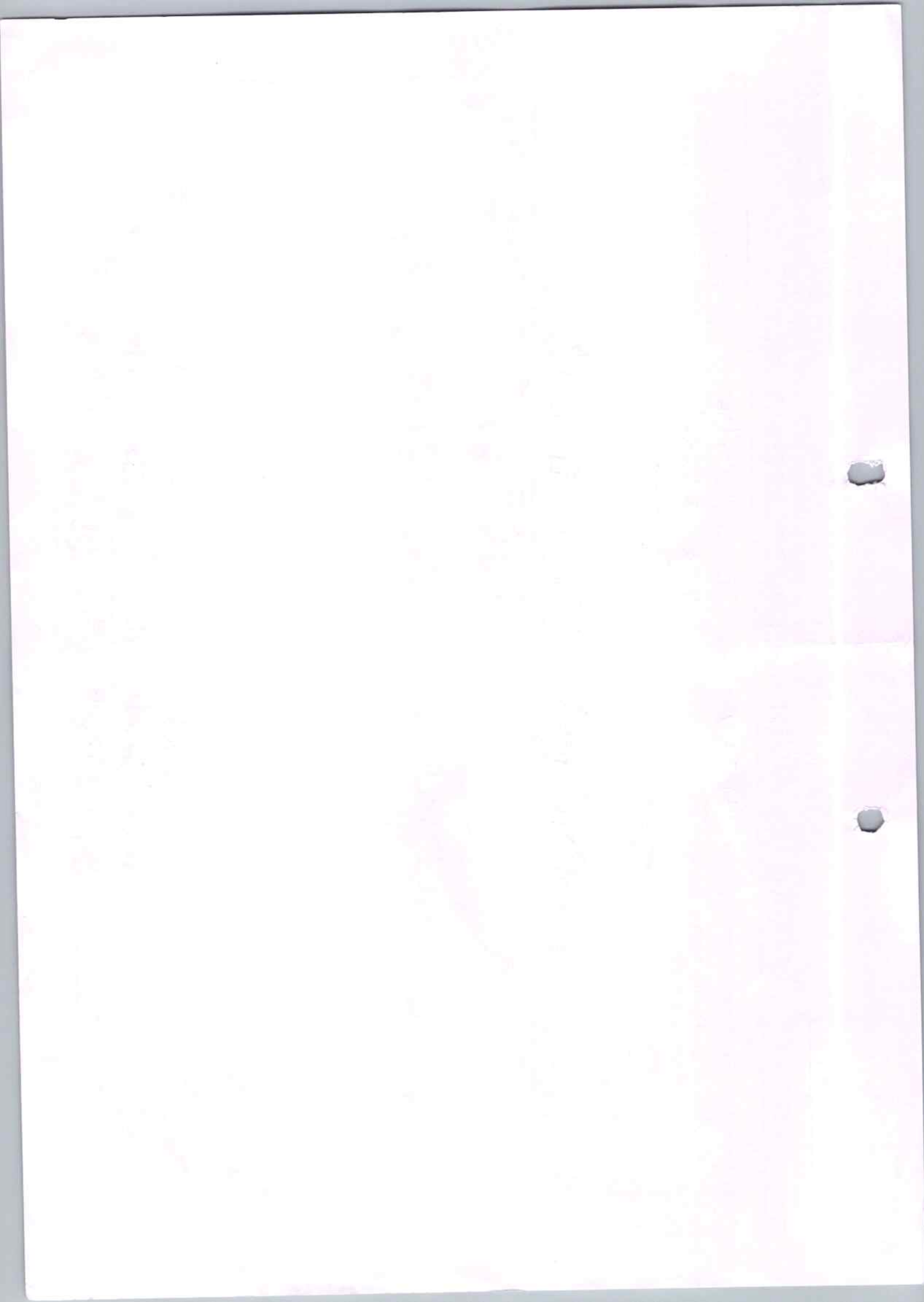
Date of Initial Line Insertion: **1/7/26**

Duration of Central Line:

**4 PR 2 lumen
 Dr. Mohan**

- Always perform hand hygiene before accessing central line
- Use Sterile gloves for handling central line
- Clean the hub with antiseptic solution every time before & after it is accessed
- Consider – antibiotic via central line before removal of the line
- Inspect Central line in each shift for the following

Parameters	Date	Shift Time	9/7/26 M	9/7/26 E	9/7/26 N	10/7/26 M	10/7/26 E		
Can we remove Central Line today (Discuss in the clinical round)			☒ Yes ☒ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Evidence of any inflammation at insertion site (Redness / Swelling (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No
Blood at insertion site (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No
Any peeling of dressing? (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No
Is dressing clean and dry? (If no inform the doctor)			☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Any leakage at insertion site? (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No
Is there any obstruction to the infusion flow? (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No
Dressing intact and labelled properly			☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Central line changed on			NIL	NIL	NIL	NIL	NIL		
Name of the Nurse			Dulky	Sharmila	Bhacethu	Amolke	Sharmila		
Signature of the Nurse			<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>		





**Rainbow
Children's
Hospital**



BirthRight
by Rainbow

CONSENT FOR ADMISSION IN PEDIATRIC INTENSIVE CARE UNIT (PICU)

It takes a...

INC-00024099

IP18-00036244

Baby AADHAVI S

18-04-2025

1 Y 3 M 1 D

(F)

Dr. SOMASHEKARA H R

I
patient Mr./I
Intensive



.. S/o Mr./ Ms hereby declare that our
..... who is related to me as is getting admitted in the Pediatric
Children's Hospital on with UHID No. :
.....

The doctors have explained to me in a language understood by me that my child has following health related issues :

*Severe malnutrition
Acute Gastroenteritis
Asplenic splenitis*

The doctors have clearly explained to me that my patient Mr./ Ms. during his / her stay in the PICU
may undergo various medical and surgical procedures like airway management, mechanical ventilation, central line insertion, PICC Line
and arterial line placements, chest drain, or peritoneal drain insertion etc.

I have been told by the doctors that while performing such procedures I will be informed and a separate consent for this procedure shall be
taken. However, in case of any life threatening emergency if the time is not available for taking informed consent it is implied that I give
consent for various invasive procedure to save the life of my child.

I understand that a sick child in PICU has life threatening medical conditions.

I understand that when a child is sick in the PICU with multiple medical and surgical procedures performed upon him / her, there are inherent
risks due to these high risk procedures, and high risk medications, in the form of infections, bleeding, air leaks, skin and other tissue
damage etc.

I have been informed that during our daily counseling by the treating team, the Hospital may perform audio-video recording of the
counseling session. The purpose of this recording is mainly to avoid any confusion in communication consent for the same.

I give my consent to the team of doctors to go ahead and admit the child Mr. / Ms : in
the PICU fully understanding the associated risks involved from various procedures, high risk medications and infections in the PICU and
treat him / her with all necessary means.

The doctors have explained to me in the language best understood to me.....

Patient Attendant :

Signature : *[Signature]*Name : *SANDHYA*Relationship with Patient: *MOTHER*Date & Time : *7/7/26 @ 9 AM*

Witness :

Signature :

Name :

Date & Time :

Doctor (who is taking the consent) :

Signature : *[Signature]*Name : *Dr. A. Ganesh*Date & Time : *7/7/26 @ 9 AM*



INC-00024099
Baby AADHAV S
18-04-2025 1 Y 3 M 1 D (F)
Dr. SOMASHEKARA H R



ADMISSION CRITERIA – PICU

Admission / Transfer from:

- ☐ Emergency
 ☐ Outpatient (OPD)
 ☐ Ward
 ☐ Operation Theater
 ☒ Others:

Tick (✓) any of the following criteria requiring admission / transfer to PICU

- ☐ All patients requiring mechanical ventilation;
 - ☐ Patients with impending respiratory failure;
 - ☐ Upper airway obstruction;
 - ☐ Lower airway obstruction;
 - ☐ Alveolar disease; and
 - ☐ Unstable airway;
 - ☐ All Paediatric patients after successful resuscitation;
 - ☐ Comatose Patients;
 - ☐ Meningitis, encephalitis; ☐ Hepatic encephalopathy; ☐ cerebral malaria;
 - ☐ Head injury; ☐ Poisonings; and ☐ Status epilepticus;
 - ☐ All types of shock/hemodynamic instability:
 - ☐ Septic shock;
 - ☐ Hypovolemic shock; (Bleeding emergencies such as gastrointestinal bleeding, bleeding diathesis, disseminated intravascular coagulation; Cardiogenic shock; myocarditis, cardiomyopathy, congenital heart disease; Neurogenic shock; and Multiple trauma;
 - ☐ Cardiac arrhythmias after consulting with the treating consultant
 - ☐ Hypertensive Emergencies;
 - ☐ Severe acid base disorders;
 - ☐ Severe electrolyte abnormalities;
 - ☐ Diabetic ketoacidosis (Ph < 7.2, altered sensorium, hyperglycemia)
 - ☐ Acute renal failure; Patients requiring acute hemodialysis, hemofiltration and peritoneal dialysis;
 - ☐ Post-Operative Patients;
 - ☐ Requiring ventilation;
 - ☐ Unstable patients; and
 - ☐ Post-operative patients after open heart surgery, neurosurgery, thoracic surgery and other patients after major general surgery with potential for respiratory/haemodynamic instability;
 - ☐ Patients requiring nitric oxide therapy;
 - ☐ Malignant hyperpyrexia;
 - ☐ Acute hepatic failure
 - ☐ Severe dehydration with mental status change;
 - ☐ Asthma requiring hourly nebulization/getting tired with increasing oxygen requirement/mental status change.
- "UNSTABLE" PATIENT IS DEFINED AS**
- ☐ HR < 50 or > 160 per minute or more than upper normal limit according to age. BP < 90 systolic and < 50 diastolic and/or requiring inotropic support. Arrhythmia or risk of sudden arrhythmia.
 - ☐ Signs of peripheral poor perfusion or suspicion of any type of shock.
 - ☐ Capillary refill time > 4 seconds.
 - ☐ Children Blood pressure (Syst.) < [70 + (2 × age "Years")].
- Respiratory failure or high risk of failure or airway obstruction:**
- ☐ Respiration rate < 5 per minute below the normal or > 10-15 per minute above the normal range for age.
 - ☐ O2 Saturation < 90 % or need for O2 > 4 Litres per minute by normal face mask. Abnormal ABG: PH < 7.25, PaO2 < 60 torr, PaCO2 > 50 torr.
 - ☐ Distress and risk of exhaustion
 - ☐ Change of level of consciousness: GCS < 13.
 - ☐ Persistent oliguria with acidosis.

Signature of the Doctor: *[Signature]* Name of the Doctor: *Dr. A. Gokar* Date & Time: *7/7/2025 @ 9pm*

Docu. No. : RCH / FRM / CLINICAL / 204

DISCHARGE CRITERIA – PICU

Discharge to:

☐ HDU / Step down ICU

☒ Ward

☐ Outside Facility

☐ Others:

Tick (✓) any of the following criteria requiring discharge / transfer from PICU

- ☒ Stable hemodynamic parameters.
- ☐ Stable respiratory status (patient extubated with stable arterial blood gases) and airway patency at least for 24 hours with no respiratory distress needing continuous monitoring.
- ☐ Minimal oxygen requirements that do not exceed patient care unit guidelines.
- ☐ Intravenous inotropic support, vasodilators, and antiarrhythmic drugs are no longer required or, when applicable, low doses of these medications can be administered safely in otherwise stable patients in a designated patient care unit.
- ☐ Cardiac dysrhythmias are controlled.
- ☐ Neurologic stability with control of seizures.
- ☐ Removal of all hemodynamic monitoring catheters.
- ☐ Routine peritoneal or hemodialysis with resolution of critical illness not exceeding general patient care unit guidelines.
- ☐ Patients with mature artificial airways (tracheostomies) who no longer require excessive suctioning.

Signature of the Doctor: A. Gopinath

Name of the Doctor: Dr. A. Gopinath

Date & Time: 10/07/26 / 1:40 PM



OPERATION NOTES

Surgeon : <u>Dr. Keerthivasan</u>		Asst. Surgeon :	
Anesthetist : <u>Dr. Mohanmurali</u>		OT Nurse : <u>Smt. Poolepa</u>	
Pre-Operative Diagnosis:			
Surgical Procedure : <u>OG surgery + NG/NJ insertion</u>			
Weight :	Date : <u>8/7/2026</u>	Start Time : <u>12:20pm</u>	End Time : <u>1:20pm</u>
Post Operative Diagnosis:			
Peri-Operative Complications:			
Operation Notes: <u>Esophagus - (R)</u>			
Findings: <u>OG junction (N)</u>			
<u>Stomach -</u>			
Fundus		<u>(P)</u>	
Body			
Antrum			
Pylorus			
Procedure Notes: <u>Duodenum</u>			
<u>D1 - grooving seen</u>			
<u>D2 - Thinned out folds,</u>			
<u>grooving & non-classical scalloping seen,</u>			
<u>Cook 10F NJ tube</u>			
<u>inserted</u>			
<u>Biopsy taken from D1, D2.</u>			
<u>Imp. - NJ tube insertion, descriptive changes</u>			
Amount of Blood Loss:		Blood Transfused (in ML)	
Name and Number of Surgical Specimen sent for examination:			

Patient Sticker

POST-SURGICAL CARE PLAN FORM

Post-Operative Monitoring Parameters /Frequency:

Wound Care:

Drain /Special Lines/Catheters:

Special Patient Positioning and Requirements:

Nutritional Instructions:

When to Start Mobilization:

Special Referrals:

The new order for all required medications documented in the doctor order/medication sheet:

☐ Yes ☐ No

Any Other Post-Operative Care Needed including Required Follow Up

Name of the Surgeon: Dr. KEERTHIVASAN

Signature of the Surgeon: [Signature]

Date & Time: 8/1/26 2pm

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Patient Sticker

ANAESTHESIA CHART

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Pre Induction Assessment:

Change in Patient Condition:

☐ Yes ☒ No

Fasting Status:

c/gh

Physical Status:

Patient Identified ☒☐ Consent Present ☒☐ Chart Reviewed

H.R.: 120/min

B.P./CRT: 100/60

SpO₂: 100%

R.R.: 12/min

Last Feed:

Pre-OP Diagnosis:

Operation:

Femoral interlock

Date: 8/17/26

Surgeon: Dr. [unclear]

Anaesthesiologist: [unclear]

Technician: [unclear]

TIME
N₂O / AIR (LPM) 6L/min
HALO / SOT / SEVO
Drugs:

2 Propofol 5 + 5
2 Fentanyl 2.5mg

FiO₂ / SaO₂ 100 / 100
ETCO₂ 40
ECG 80
Temperature
Urine Output

Fluids
Blood 30ml 20

B.P. 240
V Systolic 220
A Diastolic 200
X Mean 180
Heart Rate 180
Tourniquet on Time 180
Tourniquet off Time 140
Throat Pack In 120
Throat Pack Out 100

LAB Values

- ☐ Equipment Checked and Functional
☐ BP
☐ Cuff Site: e 16
☐ Art Site:
☐ EKG Lead
☐ Temp Site
☐ FIO₂ Monitor
☐ Agent Monitor
☐ Pulse Oximeter
☐ Capnograph
☐ Ventilator
☐ Nerve Stimulator

Position: 1/2 prone

☐ Pressure Points Checked

Eye Care: Plated

- ☐ Oint
☐ Tape
☐ Padding
☐ Awake

Temp:

- ☐ HME ☐ Fluid Warmer
☐ Cling Film ☐ OH Warmer
☐ Hugger's ☐ Cotton Wool
☐ Other

Times:

Anaesthesia Start:
OP Start:
OP End:
Leave OR:

Anaesthesia:

- ☒ GA
☐ Monitored Anaesthesia Care
☐ Regional

Line (Size & Location)

- ☒ CVP: 23 (in [unclear])
☐ ART:
☐ IV:
☐ IV:
☐ IV:

Induction

- ☒ IV ☐ Inhal
☐ Pre O₂ ☐ RSI
☐ Others

- ☐ Mask ☐ SGA
☐ Airway ☐ Oral ☐ Nasal
ETT# at cm
☐ Oral ☐ Nasal ☐ Cuff
☐ Tracheostomy ☐ Topical
☐ Drug

- ☐ Awake ☐ Direct Vision
☐ Video Laryngoscopy ☐ Stylette / Bougie
☐ Fiberoptic
Blade# Attempts:

Difficulty Why?

- ☐ Bilal = AS
☐ Semi-Closed Circle
☐ Closed Circle
☐ Other

Regional:

- Extremity
☐ Spinal ☐ Epidural ☐ Caudal

Others:

Position:

Site:

Needle Size: Depth:

Paresthesia ☐ Yes ☐ No

Catheter at skin cm

Drug Name & Conc:

Bolus:

Infusion:

Block Level:

Comments:

Transportation to

- ☐ PACU ☐ ICU ☐ Other
Relaxant Reversed ☐ Yes ☐ No ☐ NA

Name of the Doctor:

Signature of the Doctor:

Patient Sticker

POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : TharuTime Received : 12:20Time Discharged : 1:20

250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0 SPO ₂	250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0	IV Cannula Site : ☐ O ₂ Mask ☐ Nasal Prongs ☐ Tracheostomy ☐ T-Piece ☐ Oral Airway ☐ Nasal Airway					
		Vomiting : ☐ Yes ☐ No Drug: NG Tube : ☐ Yes ☐ No Drain: ☐ Yes ☐ No Urinary Catheter: ☐ Yes ☐ No Chest Tube: ☐ Yes ☐ No Nil Oral ☐ Yes ☐ No IV Fluids: Oral Feeds:					
POST ANAESTHESIA SCORE (Modified Aldrete Score)		IN	MINUTES			OUT	SCORING INTERPRETATION A Minimum Total Score of 8 is Required for Discharge Exceptions to this, are to be explained in the space below by the Discharging Physician:
			30	60	90		
Able to move 4 extremities voluntary or on command = 2 Able to move 2 extremities voluntary or on command = 1 Able to move 0 extremities voluntary or on command = 0		ACTIVITY	2				
Able to deep breathe & cough freely = 2 Dyspnea or limited breathing = 1 Apneic = 0		RESPIRATION	2				
BP = 20 of Pre Anaesthetic level = 2 BP = 20-50 of Pre Anaesthetic level = 1 BP = 50 of Pre Anaesthetic level = 0		CIRCULATION	2				
Fully awake = 2 Arousable on calling = 1 Not responding = 0		CONSCIOUSNESS	2				
Pink = 2 Pale, dusky, blotchy, jaundiced, other = 1 Cyanotic = 0		COLOR	2				
TOTAL			10/10				

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
			was in for 2 days	
			moderate pain.	

Pain Tool Used: ☐ N PASS ☐ FLACC ☐ Wong Baker ☐ NPS

Anaesthesiologist Name :

Anaesthesiologist Signature: TharuDate & Time: 8/7/12PACU Nurse Name : TharuPACU Nurse Signature: Tharu*Date & Time: 8/7/12 @ 12:20

Reassessment Frequency:

- Every eight hours for all hospitalized patients.
- For post surgical patient, patient with chronic pain, patient with severe pain
 - Every 2 hours for first 24 hours
 - After 24 hours every 4 hours
 - Prior to pain relieving intervention
 - Within 30-60 minutes after pain relief intervention

Transferred to Unit by (PACU):

Date & Time: 8/7/12 @ 1:20

EPIDURAL ANALGESIA RECORD

Date and Time :



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PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: _____

SNC-00024099

IP18-00036244

Baby AADHAVI S

06-04-2025

1 Y 3 M 1 D

(F)

Dr. SOMASHEKARA H R

UHID ID: _____



Department: _____

Consultant: _____



Pediatric Multisystem History & Physical Examination

Name: Aadhavi Age/Sex 1y3m / F

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

X/cp - DEEAH syndromeExocrine pancreatic insufficiencyAME SAM & FTT

History of present illness:

Underwent VGI scopy in ICH.Loose stools x 3 days in ICH.Rx = oral, IV antibiotics, IVFhad severe dehydration, ↓u/o↓Came to RCH

- Loose stools - large volume, 15-20 episodes/day, watery, purple, post each feeds passes stool

- Severe dehydration

- Lethargic

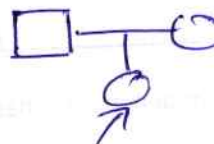


Past History: (including previous investigation or treatment)

Birth & Neonatal History:

Date PT / 2.36 kg / F / CIAB / 1 day Mew stay

Family Chart



Birth & Socio Economic History:

About Father: J NCM

Father? Fat malabsorption & lactose intolerance
(avoid fat & milk).

About Mother:

Any additional Information:

Developmental History:

GM - Stand & support
FM - immature pinch grasp
Language - 1-2 word & meaning
Social - waves bye bye

Immunization History:

Only till 9 months of age - NIS

Anthropometry:

Head Circum (cms) (Centile) Height (cms): 59 cm (Centile) < 2nd centile

Weight (kgs) 4.7 kg (Centile < 2nd centile)

On Examination:

Temperature: 95°F Pulse Rate: 140/min B.P. 90/60 mmHg SPO2 100% O2 RA

Resp. rate and type of breathing: 30/min

Respiratory cold

PP - full felt

Rash

Drowsy

Lymphadenopathy

Sunken eyes

Oedema:

dry oral mucosa

Allergies (if any):

CRT ~ 3 sec

SNC-00024099

IP18-00036244

Baby AADHAVI S

08-04-2025

1 Y 3 M 1 D

(F)

Dr. SOMASHEKARA H R

**Respiratory System :**

Inspection (any s/o distress) : _____

Air entry & breath sounds : b/lc AE equalAny added sounds : No added sounds

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

Cardiovascular System :

Inspection of precordium : _____

Heart Sounds : S₁ S₂ ⊕Any murmur : No murmur

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

Per Abdomen :

Inspection : _____

Palpation : Soft, non tender, no organomegaly ⊕Auscultation : peristaltic sounds ⊕

Spine : _____ External Genitalia : _____

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

Central Nervous System :Level of Consciousness : AVPU/GCS score : LethargicCranial Nerves : ⊕**Motor System :**

Nutrition : _____

Tone : ⊕ Power : _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR

Superficials:

Plantars

Sensory System :

Bladder / Bowel :

Clinical Summary & Diagnostic: *DEEAN syndrome, Exocrine pancreatic insufficiency, SAM, FTT.*
AHE to ~~some~~ severe dehydration

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

Desired goals of the treatment :

Planned Labs:

Planned Management

Signature of the Doctor: *T. Yury*Name of the Doctor: *T. Yury*Date & Time: *6/7/26 @ 6pm*
(26/06/2026)

Signature of the Consultant:

Name of the Consultant:

Date & Time: *6/9/28 @ 6pm*

(P.T.O.)

DISCHARGE PLANNING FORM

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

1. Anticipated Date of Discharge:

2. Destination Post Discharge: ☐ Home

Family Members Notified (Person Contacted)

☐ Transfer

Hospital Facility Notified (Person Contacted)

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

☐ Needs Assistance In:

Remarks

☐ Medication ☐ Yes ☐ No

☐ Bathing ☐ Yes ☐ No

☐ Eating ☐ Yes ☐ No

☐ Walking ☐ Yes ☐ No

☐ Dressing ☐ Yes ☐ No

☐ Toileting ☐ Yes ☐ No

4. Nutritional Plan:

☐ Dietary Instruction Discussed with the:

☐ Patient

☐ Family Member

☐ Others:

5. Discharge Planning Discussed with the:

☐ Patient

☐ Family Member

☐ Others:

6. Patient/Family Educational Plan:

☐ Educational Topic/s:

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

☐ Patient

☐ Family Member

☐ Others:

Doctor Signature:

Doctor Name:

Date and Time:

Department:

Shift:

[illegible]

DOCTOR'S SHIFT CHANGE HANDOVER FORM

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



CROSS CONSULTATION FORM

Doctor Name: Date: Time:

Diagnosis:

Hospital:

Type of Referral :

☐ Emergency

☐ Urgent

☐ Non Urgent

Referred for: ☐ Opinion ☐ Co-Management ☐ Transfer of care

Reason for Referral: If for concurrent care specify the particular need, especially in the absence of a second diagnosis:

Signature:

Findings and Recommendations :

11/7/20
 10 AM

S/K JG. manottam

Moh f yf

fever malnutrition

clit

& DEEAH Synchro

(Der delay/ Endo/ Exocrine Anterior
 Healed of
 Anrad)

— (N) develop kill 1 non bak
 — stated on fuphan juic f non
 & shipped mtr achin- l
 dehydratic

Consultant :

Name: Signature: Date & Time: Beck

~~Admitted~~ Admitted - 100g J
near Stock

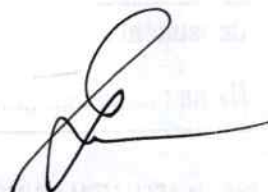
Hydrogen on.

1/2 : PA 1/2 mid distance
AS can be

Sm - water & solid
particles

ml 1/2
Dr. Solman

— NJ feeding
— nutrition / particles
— 2 10 h cells
— will call her of
upper GI study
to ducts then L
described as





(1)

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/11/26 19PM	S/B - Dr Yuvaraj Δ - DAEAH syndrome Exocrine pancreatic insufficiency SAM & FTT AGE & severe dehydration & Norovirus & EAE infection Child reviewed	
	F - on NG NG feeds - 60-90 ml Q4H - Neocate feeds & CREON Amnion - 3mg/kg/day - 6 mths Lipids - 2mg/kg/day - 2 mths	
	I - 431 ↓ Loose stool frequency ↓, consistency - improving	
	R - 100% on RA RR - 30/min HR AE equal, NO added work	
	I - No fever spikes Stool	Xone
	C - HR - 120/min BP - 97/80 mm Hg PR - up, CRT < 3 sec	

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
H-	Hb-10 (2 units PRBC given)	
M-	Euglycemic 139/3.4 107/18	Ca-1.14 Mg-1.7 P _{ab} -3.5 WBC/Plt-37/0.21
A-	Soft BSB Loose stool @ - 4 episode since morning yellow to green colour separated to mucoid consistency small volume	(Potklor) (Potphos) K ⁺ 4 mEq/kg P _{ab} 2 mmol/kg
	Vomiting - 4 times - not identifying feeds > 60 ml	
N-	NFND BIL PERL	Dominol / Nexpro
	<u>Plan:</u> - Continue I/O chart vitals Maintain Temperature maintain - Feed maintain around 60 ml to 90 ml today	
		T.Y.



(2)

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
7/7/26 9:20 AM	CMB & Gpils & paray & Scuprate (follows)	
	- DEATH Syndrome	
	- Failure to thrive developmental delay Regression	
	Severe Malnutrition / Exocrine pancreatic	
	- AGE - severe dehydration Insufficiency	
	(non-viable EAC &) - stop	
	Issues - (seminole)	
	- persistent diarrhea - ⑨ episodes	
	⑨ vomiting (yellowish)	
	⑦ - neonate feeds - 6ml/hr @ 20 cc/kg/day	
	wt Ammonium - @ 6ml/hr ③ g/kg/day	
	20 - Lipids - @ 2ml/hr ② g/kg/day	
	20 - Tylenol	
	20 - Aleve - paracetamol ⑨ times	
	⑧ - BAC ⑧ / clear	
	No weight No Rx	RR - 22/min
		SpO ₂ - 100% on RA
	⑨ - no fever	lyf. cephradine ⑧
	⑩ - SISO / hemodynamically stable	
		HR - 140/min
		WBP - 92/70 (20)

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
(Am)	po_g² - 3.5 KT - 3.4 def porphyr 1ml / 1hr	- megrion - porphyr - folate - Zn - wepro
(A)	neonate feeds ② loose stools - ⑨ times semisolid vomitting - ④ times	
(N)	seizure - (N) spont. limb movements - ④ Resp. Efforts - Gory	
	<u>plan</u>	
①	Continue neonate	
②	To add Erythromycin - ②	
③	Creon - ③	
④	Continue Amoxicillin and Cipids	
⑤	Lipids - stop ②	
⑥	central line - pay ⑦	of gelul



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
7/10/20 10 AM	CPIB Dr Nataraj sir	
(1)	feed thickening - c weanum rice	
(2)		L. G. P. L.
7/10/20 12 PM	CPIB Dr Somashekhar sir	
(1)	continuous feeds	(6m) 3H/1H or 6am/1pm @ 20ml/hr
(2)	Add Erythromycin	L. G. P. L.

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/7/26	ds/B dr. pava (yellow)	
	child xicand	
	K/ldo DEAAH syndrme E complicated SAM E GCHS (regulatory)	
F	on continuous nageals 20ml/hr x3hrs flb/hr gap Lipid - 2ml/hr U/O - passed E stools Anion - 6ml/hr	
R	on RA SpO ₂ 100% RR - 25/min BACD no added sounds	
T	on Ty xone no fever spikes	
C	HR - 118/min BP - 88/64 (MAP - 73) S/S 20 no Mxomany	



Date & Time	Progress Notes	Doctor's Order
H	Cast 115-10 gm ⁻¹	
M	wa - 134 lat - 3.4 wa - 27 Cast - 0.21	
A	Soft BSP stroke - 7 mm firm solid	
N	ca - 17.5 M m 1. wpo 2. phend fol NS tube Cautious 3. Monitor vitals	
		 198601

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/7/20	Fe deficit $\Rightarrow$ $\text{Total} \times (\text{Tager Hb} - \text{Actual Hb}) \times 2.4 + \text{Fe level (2pt)}$ $= 5 \times 2.4 \times 3.7 + 75$ $= 120\text{mg}$	
9/8/20 9 AM	CPLD Dr. Pankaj & Anjali & Pawan (Jellow) $\rightarrow$ DEFA syndrome / chronic malnutrition severe GER / Anemia - 2nd prob / vaccine preventable Dysrhythmias In sufficiency AGET severe dehydration (non-viral EAC) Issues:- NO fresh complaints. (F) NJ feeds - neonate timely cycle (3400/1400) IP - 503ml W - adequate stool - 5 times RPS - 8mg/dl Urine - 3g/kg/day Lipid - 2g/kg/day	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
(R)	no cough / no rx / clear	RA - 20/min SpO2 100% on RA
(I)	No fever	Ty ceptriaxone - (D3)
(C)	S, S, F / Hemodynamics - stable	
(H)	stable Hb - 8.3 S. Fe - 28 (↓) (50-120) pH - 7.39 kaks Tc - 8610 (53/43);	
(F)	tolerating NJ continuous feeds well Tummy soft - (no c/kg loss) stool (3) times no vomitings	
(N)	conscious (N) no FND	
	<u>plan</u>	
(1)	Continue NJ feeds	
(2)	Ty Ceptriaxone - Day (3)	
(3)	continue normal Erythromycin	
(4)	To give IV Fe today	
(5)	QAM - 00/800	

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

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	⑥ monitor v.o	
	⑦ w/ Vomitting abd distension / loose stools	
	⑧ Trace biopsy	
9/2/26 10 AM	C/S/D Dr. Nataraj sis	2. 40mg
	① stop lipids	
	② Continue Aminoacids	
	③ Fcm → prepared	
	④ oral add phos	
	⑤	
	C/S/D Dr. Sumancharan m	
9/1/26 11:40 PM	① ↑ feeds 100ml/9h (Target)	
	20ml/ cycle - night	
	↓	
	20ml/ cycle - Morning	
	② IV Iron -	
	③ stop Lipids	
	Continue Aminoacids	
	④	



6

PROGRESS NOTES AND DOCTOR'S ORDER

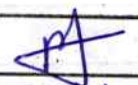
Date & Time	Progress Notes	Doctor's Order
9/7/26 8:30 PM	S/B - Dr. Yuvraj	
	Δ - DEEAH Syndrome / Chronic mastitis Severe GER / Anemia - 2 PRBC, Iron Carbonylation Exocrine pancreatic insufficiency / Dyselectrolytemia AGEI severe dehydration (Norovirus / EAEC)	
	F - NJ feed - Neocate feed - 82ml Q4h - (3hr / 1hr off) Aminozen infusion 6 ml/hr (391kcal/day)	
	I / 392 ml 0 / 88 Stool passed - semisolid. Urine - passed Lipid dropped	
	R - 100% on RA, Clear RR - 22/min	
	I no fever	DX None
	C - HR - 112/min, BP - 93/63 mm Hg S/S 2/4, no murmurs	
	H Hb - 8.3 S. Iron - 28 d	Iron Carbonylation 100mg Zn
	M - Euglycemic	
	A - soft, loose stool, 4 episodes	

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/1/26	NFNP	
	<u>Adv</u>	
	- ↑ feeds gradually	
	- Monitor vitals	
	- Followup biopsy report	
		Very
9/17/26	ds/B dr. pawa / Dr. Golub / Dr. Suryakala (follow)	
A	DEEAA Syndrome on PPN	ESAM complicated
F	on IV Aminover 6ml/hr 2gm/kg/day	
	NJ feeds - 33ml/hr x 3hrs	
	Balance + 660ml	
R	on RA	
	SPO ₂ - 98%	
	RR - 25/hr	
	BAFO NO added sounds	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
I	no fever spikes on Ty Nore (04)	
e	HR - 104/min BP - 84/54 (MAP - 64) SISA @ no normis	
H	Hb - 8.3 gm/dl	IV iron 50mg given yesterday
M	AB S - 104 mg/dl	lct - u.o
A	toilet 100ml / feed BSA Hooch - 9 episodes semi solid	
N	ACS - 15/15	
	<u>PLAN</u> 1. Contn Aminoac stop after the cont bottle. 2. Cont NG feeds 3. Monitor stools	
		 198607

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/2/26 12am	S/B Dr. Somashulani / Natraj	
	To stop TPN & plan ward shift Stop antibiotics	
		 T46M
10/7/26 4:30am	S/B - Dr. Yamaraj	
	Child reviewed	
	O/E alert, active	
	malnourished	
	Hydration - fair	
	loose stools @	
	perward. rash @	
	vitals stable	warm peripheries
	RS - clear	
	RA - soft	
	other system - WNL	
		Plan
		- Continue same
		- NT Food - 33ml / hr for 3 hrs as infusio. 1 hr break + continue
		- Daily weight check
		- arrange infusion pump & bag

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/7/26 7:20am	Reviewed Had 4 Episodes of loose stools since 6am 1 Episode - lg volume - Watery Greenish stools No blood in stool No vomiting Alert Temp 97°F perianal area, PP-H skin pink (2) AF	S/B Dr. Maranda
Re	- D/w Dr. Souchuk rx - to add oral 1/2 DWS + 5cc fcl qd (1/2 marantam) - low heme, Ig - No DBE - Continue Neocets feed.	mother had given breast milk to child at 6am today



9

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/7/26 9.20am	S/B Dr. Kavitha	
	Acute on chronic	
	Δ - SAM & dehydration/shock resolved	
	AGE - Norovirus (ve) → 22° lactose intolerance.	
	DEATH syndrome - Exocrine pancreatic insufficiency	
	Cl ₀ loose stools - watery since early morning watery to semi-solid. yellowish to greenish stools.	
	No vomit.	
	H/o passage of flatus ⊕.	
	Irritable crying ⊕ during feed free interval.	
	Obs - Alert, no mottu.	
	PPWF, Pulse volume - good	
	CRT < 3 sec	
On IVF 2/3rd maintenance (2.1ml/kg)	Hydration - skin pinch -	
	Oral mucosa - moist	
	Lips - dry.	
	U.O - 85ml + once voided	
	Vitals - HR - 115/min	
	BP - 86/48 mmHg	
	SpO ₂ - 100%.	
	No fever.	
	P/A - soft,	
	non-tender	
	no distension	
	AG - 33 cm	

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	CVS / RS / NAD CNS - AF Blk Tone - Hypotonic Blk Power > 3/5 Interacting c parents Sensorium (N) Not intubable now.	
	Wt - 4.84 → 4.689 kg (↓ 151g)	
	? Plan - to rpt electrolytes	Advice 1) IVF 1/2 DNS } @ 10 ml/hr + 5 ml Kcl 2) Continue Neocate feeds 33ml/hr q3h + 1 hr - feed free interval 3) MCT oil 3ml 3) T/c Folic acid / Magnesium / Glythron / Po₄³⁻ T/c album as charted Monitor vitals / I/O / sensorium / Wt. daily / stool volume.

SNC-00024099
 Baby AADHAVI S
 08-04-2025 1 Y 3 M 5 D (F)
 Dr. SOMASHEKARA H R



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/7/26 4:15pm	Slb Dr. Kanthig No further loose stools Only on Drop feeds q/4h Tolerated feeds. @ 33ml/hr for 3hr. <u>O/C</u> - Alert PPWT, Pulse volume - good Hydration - good. Vitals - stable. PIA - soft mm - tender B8(7). Other systems - WNL.	Advice T/c as directed Stop IV → SOS Neocate feeds @ 33ml/hr ↓ X 3hr 1hr feed free interval No Breast feeds Monitor vitals / T/c / breast output check wt. daily

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



SNC-00024099

IP18-00036244

Baby AADHAVI S

06-04-2025

1Y3M1D

(F)

Dr. SOMASHEKARA H B

Patient

Age : Gender ☒ Male ☐ Female - I.P. No. :

ATION SHEET

www.rainbowhospitals.in

SNC-00024099 IP18-00036244
 Baby AADHAVI S
 06-04-2025 1 Y 3 M 1 D (F)
 Dr. SOMASHEKARA H R



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RESULT SHEET

Date	6/7/26	8/7	9/7	12/7		
Time	7PM					
Hb		8.3				
PCV		26				
RBC		3.71				
WBC		8610				
N/L		53/43				
Platelets		5.79				
CRP						
ESR						
PCT						
RBS	85			106		
Na	139	138		131		
K	3.4	3.8	4.0 (↑)	3.3		
Cl / Bicarb	107/18	110		103/21		
iCa/Mg	1.14/1.7	1.5		1.2.0		
Phosphate / Bicarb	3.5			5.3		
Urea	37					
Creatinine	0.21					
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		8/9	9/2			
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						
CPR		20				
S. Iron		(2-134)	28 (↓)			
			(50-120)			

Culture and Sensitivities :

.....

.....

.....

Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI :

 Others (ECG, Contrast Studies etc.) :



DRUG CHART

Date of Admission: 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:																			

VERIFIED BY : Name Signature



REGULAR PRESCRIPTIONS

Weight. 4.7kg Ward. P100

DRUG : CREON				Date	Time
Dose	Route	Frequency	Start Date	6/7	6/7
7500 U	PO	Before feed	6/7	1 AM	5 PM
Name & Signature of the Doctor Starting the Drugs: T.Y. 16/6/24				5 AM	5 PM
Additional Instructions: (Before each feed)				9 AM	9 PM
Daily Doctor's Endorsement by a Sign				1 PM	1 PM

DRUG : Inj. CEFTRIAZONE				Date	Time
Dose	Route	Frequency	Start Date	7/7	8/7
220mg	IV	Q12H	6/7	6 AM	6 PM
Name & Signature of the Doctor Starting the Drugs: T.Y. 16/6/24				6 AM	6 PM
Additional Instructions: 100mg/kg/day				6 AM	6 PM
Daily Doctor's Endorsement by a Sign				6 AM	6 PM

DRUG : Syrup DOMSTAL				Date	Time
Dose	Route	Frequency	Start Date	7/7	8/7
1ml	PO	Q6H	6/7	10 AM	10 PM
Name & Signature of the Doctor Starting the Drugs: T.Y. 16/6/24				10 AM	10 PM
Additional Instructions: Before feed				10 AM	10 PM
Daily Doctor's Endorsement by a Sign				10 AM	10 PM

DRUG : Syrup POT KLOR				Date	Time
Dose	Route	Frequency	Start Date	7/7	8/7
2ml	NG	Q8H	6/7	10 AM	10 PM
Name & Signature of the Doctor Starting the Drugs: T.Y. 16/6/24				10 AM	10 PM
Additional Instructions: (15ml = 20 meq K ⁺)				10 AM	10 PM
Daily Doctor's Endorsement by a Sign				10 AM	10 PM



Sheet No: ① REGULAR PRESCRIPTIONS Weight 4.7kg Ward P.W.

DRUG: NEXPRO SACHET				Date/Time	6/7	7/7	8/7	9/7	10/7	11/7	12/7	13/7
Dose	Route	Frequency	Start Dt.									
1/2	P/O	BD	6/7	10 AM	5L	WHT	3	V.S	B-B	6AM	TP	KS
Name & Signature of the Doctor Starting the Drugs: T.Y. L.G.M.												
Additional Instructions:												
Daily Doctor's Endorsement by a Sign												
DRUG: T. FOLVITE				Date/Time	6/7	7/7	8/7	9/7	10/7	11/7	12/7	13/7
Dose	Route	Frequency	Start Dt.									
5mg	P/O	OD	6/7	3 PM	M.V	J.L	AS	AS	R.V	TP		
Name & Signature of the Doctor Starting the Drugs: T.Y. L.G.M.												
Additional Instructions:												
Daily Doctor's Endorsement by a Sign												
DRUG: T. MAGNION 400 mg				Date/Time	6/7	7/7	8/7	9/7	10/7	11/7	12/7	13/7
Dose	Route	Frequency	Start Dt.									
1/4	N/A	Q 8H	6/7	10 AM	J.L	WHT	3	J.L	AS	AS	R.V	TP
Name & Signature of the Doctor Starting the Drugs: T.Y. L.G.M.												
Additional Instructions:												
Daily Doctor's Endorsement by a Sign												
DRUG: Z & D drops				Date/Time	6/7	7/7	8/7	9/7	10/7	11/7	12/7	13/7
Dose	Route	Frequency	Start Dt.									
1ml	P/O	Q 24 H	6/7	3 PM	M.V	J.L	AS	AS	R.V	TP		
Name & Signature of the Doctor Starting the Drugs: T.Y. L.G.M.												
Additional Instructions:												
Daily Doctor's Endorsement by a Sign												

Signature
 VERIFIED BY: Name

SNC-00024099

IP18-00036244

Baby AADHAVI S

06-04-2025 1Y3M1D (F)

Dr. SOMASHEKARA H R



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It takes a lot to treat the little.



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Sheet No: 2

REGULAR PRESCRIPTIONS

Weight 4.7kg Ward PICU

DRUG: <u>Inf POTPHOS</u>				Date/Time	6/7	7/7	8/7	8/7	9/7
Dose	Route	Frequency	Start Dt.		5 AM	5 AM	5 AM	5 AM	5 AM
1ml	IV	Q 8H	6/7		BB	BB	BB	BB	BB
Name & Signature of the Doctor Starting the Drugs: <u>T.Y.H</u> 16/6/24					1 PM	3 PM	5 PM	7 PM	9 PM
Additional Instructions: 1ml in 20ml NS over 3 hrs. C1ml = 4 meq of K ⁺ , 3.3 mval P ₂					1 PM	3 PM	5 PM	7 PM	9 PM
Daily Doctor's Endorsement by a Sign									

DRUG: <u>Syr. ACAROCIN</u>				Date/Time	7/7	8/7	8/7	9/7
Dose	Route	Frequency	Start Dt.		4 PM	4 PM	4 PM	4 PM
50mg	PO	TID	7/7		BB	BB	BB	BB
Name & Signature of the Doctor Starting the Drugs: <u>2ml</u> <u>Ch. Golu</u>					12 PM	3 PM	5 PM	7 PM
Additional Instructions: 5ml / 125mg Erythromycin 20 min before every cycle					12 PM	3 PM	5 PM	7 PM
Daily Doctor's Endorsement by a Sign								

DRUG: <u>ALTHROLIN</u>				Date/Time	8/7	9/7	10/7	11/7	12/7	13/7
Dose	Route	Frequency	Start Dt.		8 PM	2 PM	8 PM	8 PM	8 PM	8 PM
1ml	P.O	Q 6H	8/7		BB	BB	BB	BB	BB	BB
Name & Signature of the Doctor Starting the Drugs: <u>Sh</u> <u>14/6/24</u>					8 PM	2 PM	8 PM	8 PM	8 PM	8 PM
Additional Instructions: Total 5 days 125mg / 5ml 20 min before every feed					8 PM	2 PM	8 PM	8 PM	8 PM	8 PM
Daily Doctor's Endorsement by a Sign										

DRUG: <u>ADPPROX</u>				Date/Time	9/7	10/7	11/7	12/7	13/7
Dose	Route	Frequency	Start Dt.		12 PM	12 PM	12 PM	12 PM	12 PM
1 Salt PO	Q 12H	Q 12H	8/7		BB	BB	BB	BB	BB
Name & Signature of the Doctor Starting the Drugs: <u>Ch. Golu</u>					12 PM	12 PM	12 PM	12 PM	12 PM
Additional Instructions:					12 PM	12 PM	12 PM	12 PM	12 PM
Daily Doctor's Endorsement by a Sign									



Sheet No: (3)

REGULAR PRESCRIPTIONS

Weight 9.7 Ward PICU

DRUG :	Dose	Route	Frequency	Start Dt.	Date-Time															
C. CREON	7500 U	P/O	Before feed	6/7	10/7	11/7	12/7	13/7	14/7											
Name & Signature of the Doctor Starting the Drugs:					12 AM	6:30 AM	11 PM	TP	4 AM	TP	11 PM	KS	12/7	KS	13/7	KS				
Additional Instructions:					8 AM	AD						5 PM	PS	1 AM	KS					
Daily Doctor's Endorsement by a Sign					12 PM	MR						2 PM	TP							
					11:45 PM	KS														

DRUG :	Dose	Route	Frequency	Start Dt.	Date-Time															
SIMYL MCT OIL	3ml	NJ	in each feed	14/7	10/7	11/7	12/7													
Name & Signature of the Doctor Starting the Drugs:					8 PM	PS	4 AM	TP	KS	4 AM										
Additional Instructions:					11 PM	TP	8:20 PM	PS												
Daily Doctor's Endorsement by a Sign					11 PM	KS														

DRUG :	Dose	Route	Frequency	Start Dt.	Date-Time															
SIMYL MCT OIL	5ml	NJ	Q3-4H	12/7	12/7	13/7														
Name & Signature of the Doctor Starting the Drugs:					2 PM	TP	4	KS												
Additional Instructions:					4 PM	TP	AM													
Daily Doctor's Endorsement by a Sign					11:45 PM	KS	1 AM	KS												

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

Patient Sticker

REGULAR PRESCRIPTIONS

Weight Ward

Sheet No:						REGULAR PRESCRIPTIONS								Weight		Ward	
DRUG :					Date Time												
Dose	Route	Frequency	Start Dt.														
Name & Signature of the Doctor Starting the Drugs:																	
Additional Instructions:																	
Daily Doctor's Endorsement by a Sign																	
DRUG :					Date Time												
Dose	Route	Frequency	Start Dt.														
Name & Signature of the Doctor Starting the Drugs:																	
Additional Instructions:																	
Daily Doctor's Endorsement by a Sign																	
DRUG :					Date Time												
Dose	Route	Frequency	Start Dt.														
Name & Signature of the Doctor Starting the Drugs:																	
Additional Instructions:																	
Daily Doctor's Endorsement by a Sign																	
DRUG :					Date Time												
Dose	Route	Frequency	Start Dt.														
Name & Signature of the Doctor Starting the Drugs:																	
Additional Instructions:																	
Daily Doctor's Endorsement by a Sign																	

VERIFIED BY : Name

Patient Sticker

Weight. Ward.

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

VARIABLE DOSE		Date Time	Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.	
DRUG :	Route	Start Date	Dose		Dose		Dose		Dose	
			Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
			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.	
			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.	
			Dose		Dose		Dose		Dose	
			Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	

STAT / ONCE ONLY DRUGS

STAT / ONCE ONLY DRUGS

[illegible]



I.V. FLUIDS CHART

Weight. 215 Ward. PLW

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
7/12	12/2	201- Lipid	IV	2	ml/hr	Am	Am	8/9/26	Am	Am
7/12	1/2	101- Amiodone	IV	6	ml/hr	Am	Am	8/10/26	Am	Am
8/13/26	12pm	30ml DMS	iv				Am	8/17/26	Am	Am
11/12/26	7:40 AM	1/2 DMS + 500 fcl	IV	10	ml/hr	Am	Am	11/17/26	Am	Am

Patient Sticker

STAT / ONCE ONLY DRUGS

Name:

Weight: kgs

Sheet No:

[illegible]

SNC-00024099

IP18-00036364

Baby AADHAVI S

06-04-2025

1 Y 3 M 2 D

(F)

Dr. SOMASHEKARA H R



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

BirthRight[™]
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

MEDICATION RECONCILIATION FORM

Drug Allergies: Nil

☒ Not known any Drug Allergies

Medication Reconciliation will be done at the time of admission and also whenever there is change in the treating team or shifting from one unit to another unit.

(Example: at the time of admission shifting from ICU to Ward, or Ward to ICUs)

Shifting From: OT (7th floor)

Shifted to: ICU

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						
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

MEDICATION HISTORY RECORDED / VERIFIED BY

* C- Continue, DC - Discontinue

Doctor Name & Signature: [Signature]

Date & Time: 21/12/2024 12:30 PM

Nurse Name & Signature: Pradeepanarayan P. [Signature]

Date & Time: 21/12/2024 at 12:30 PM

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

SNC-00024099

IP18-00036244

Baby AADHAV S

06-04-2025

Dr. SOMASHEKARA H R

1Y3M1D

(F)



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

BirthRight[™]
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

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:

PICU

Shifted to:

5th floor

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 CREON	7500 units	P.O	Q4h Before feed	12pm	☒ C ☐ DC
2	SYP. DOMSTAL	1ml	P.O	Q6h	10am	☒ C ☐ DC
3	NEOPOPH Sachet	1/2	P.O	Q12h	3pm	☒ C ☐ DC
4	T. FOLVITE	5M	P.O	OD	3pm	☒ C ☐ DC
5	T. MAGNOLIN	100mg	P.O	Q8h	3pm	☒ C ☐ DC
6	2+D drops	1ml	P.O	OD	3pm	☒ C ☐ DC
7	ALITHRO CIN	1ml	P.O	Q6h	2pm	☒ C ☐ DC
8	ADPHOS Sachet	1/2	P.O	Q12h	12am	☒ C ☐ DC
9	MCT OIL	3ml	P.O	Q4h each feed	Q4h	☒ C ☐ DC
10						☐ C ☐ DC

MEDICATION HISTORY RECORDED / VERIFIED BY

* C - Continue, DC - Discontinue

Doctor Name & Signature:

Dr. Sanyal
14/07/18

Date & Time:

10/7/26 2pm

Nurse Name & Signature:

Sharmila A 10/7/26

Date & Time:

10/7/26 e 3:15pm

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

Medication History

Medication	Dose	Frequency	Route	Start Date	End Date	Notes
Aspirin	325 mg	Once daily	PO	1/1/00	12/31/00	
Ibuprofen	400 mg	As needed	PO	1/1/00	12/31/00	
Acetaminophen	650 mg	As needed	PO	1/1/00	12/31/00	
Warfarin	5 mg	Once daily	PO	1/1/00	12/31/00	
Simvastatin	40 mg	Once daily	PO	1/1/00	12/31/00	
Lisinopril	10 mg	Once daily	PO	1/1/00	12/31/00	
Metoprolol	50 mg	Once daily	PO	1/1/00	12/31/00	
Hydrochlorothiazide	25 mg	Once daily	PO	1/1/00	12/31/00	
Furosemide	40 mg	Once daily	PO	1/1/00	12/31/00	
Digoxin	0.125 mg	Once daily	PO	1/1/00	12/31/00	
Insulin	10 units	As needed	SC	1/1/00	12/31/00	
Albuterol	2 mg	As needed	INHALER	1/1/00	12/31/00	
Fluticasone	1 mg	As needed	INHALER	1/1/00	12/31/00	
Salbutamol	2 mg	As needed	INHALER	1/1/00	12/31/00	
Formoterol	12 mg	As needed	INHALER	1/1/00	12/31/00	
Budesonide	8 mg	As needed	INHALER	1/1/00	12/31/00	
Beclomethasone	40 mcg	As needed	INHALER	1/1/00	12/31/00	
Triamcinolone	5 mg	As needed	INHALER	1/1/00	12/31/00	
Flunisolide	1 mg	As needed	INHALER	1/1/00	12/31/00	
Albuterol	2 mg	As needed	INHALER	1/1/00	12/31/00	
Fluticasone	1 mg	As needed	INHALER	1/1/00	12/31/00	
Salbutamol	2 mg	As needed	INHALER	1/1/00	12/31/00	
Formoterol	12 mg	As needed	INHALER	1/1/00	12/31/00	
Budesonide	8 mg	As needed	INHALER	1/1/00	12/31/00	
Beclomethasone	40 mcg	As needed	INHALER	1/1/00	12/31/00	
Triamcinolone	5 mg	As needed	INHALER	1/1/00	12/31/00	
Flunisolide	1 mg	As needed	INHALER	1/1/00	12/31/00	

Signature: [Signature]
Date: 1/1/01

Patient Sticker

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:

Shifted to:

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2						☐ C ☐ DC
3						☐ C ☐ DC
4						☐ C ☐ DC
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6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

MEDICATION HISTORY RECORDED / VERIFIED BY

* C- Continue, DC - Discontinue

Doctor Name & Signature :

Date & Time :

Nurse Name & Signature:

Date & Time :

Patient Sticker

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Drug Allergies:

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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:

Shifted to:

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1						☐ C ☐ DC
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3						☐ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

MEDICATION HISTORY RECORDED / VERIFIED BY

* C- Continue, DC - Discontinue

Doctor Name & Signature :

Date & Time :

Nurse Name & Signature:

Date & Time :

ENC-00024399
Baby AADHAV S
08-04-2025 1 Y 3 M 4 D
Dr. SOMASHEKARA H R

IP10-0007

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

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

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

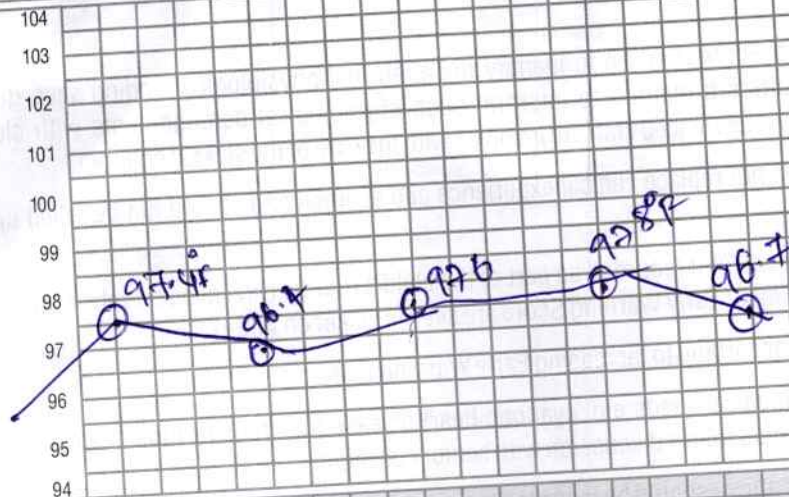
BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 10/7/26 Time: 4pm 8pm 12AM 4AM 6AM

Doctor / Nurse / Family Concern?

Temperature
(°F)



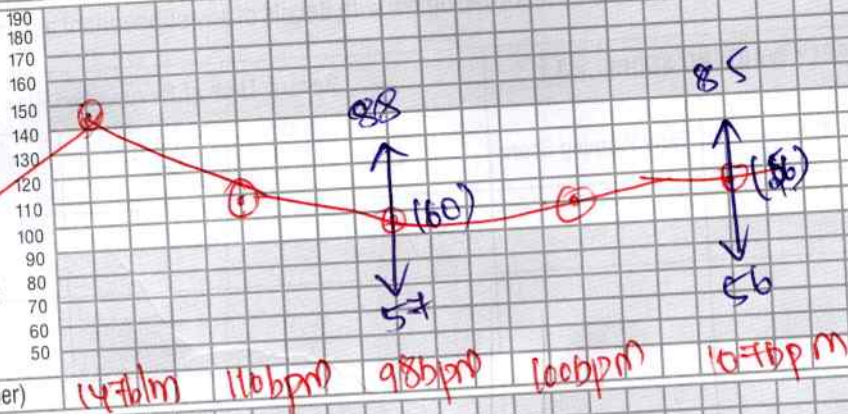
Heart Rate
(bpm)

and

Blood Pressure
(mmHg) *

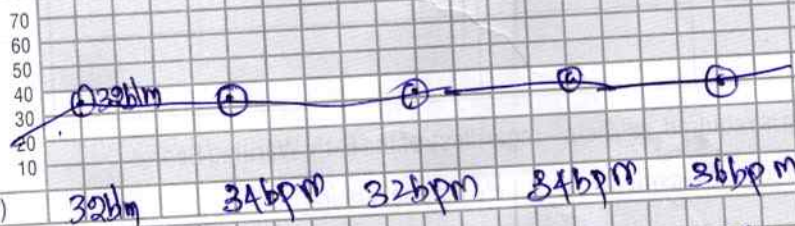
Note:

BP does not score
in early
warning scoring



Heart Rate (Number)

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



Resp Rate (Number)

Resp Mod/ Severe
Distress None / Mild

Receiving O₂ (l/min)
O₂ Saturations (%)

Conscious Normal
Level Altered

GCS *

TOTAL SCORE

Number of shaded boxes

Pain Score

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.

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 Is there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)



2

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date :	11/7/25	Time:	8am	12pm	4pm	8pm	12am	4am
Doctor / Nurse / Family Concern?								
Temperature (°F)	104							
	103							
	102							
	101							
	100							
	99							
	98							
Heart Rate (bpm)	190							
	180							
	170							
	160							
	150							
	140							
	130							
Blood Pressure (mmHg) *	120							
	110							
	100							
	90							
	80							
	70							
	60							
Heart Rate (Number)	115b/m	116b/m	120b/m	118b/m	110b/m	112b/m		
	86	79	88	85	92	90		
	115b/m	116b/m	120b/m	118b/m	110b/m	112b/m		
	86	79	88	85	92	90		
	115b/m	116b/m	120b/m	118b/m	110b/m	112b/m		
	86	79	88	85	92	90		
	115b/m	116b/m	120b/m	118b/m	110b/m	112b/m		
Resp. Rate (bpm) (Over 1 Minute) *	70							
	60							
	50							
	40							
	30							
	20							
	10							
Resp Rate (Number)	32b/m	30b/m	28b/m	28b/m	28b/m	28b/m		
	32b/m	30b/m	28b/m	28b/m	28b/m	28b/m		
	32b/m	30b/m	28b/m	28b/m	28b/m	28b/m		
	32b/m	30b/m	28b/m	28b/m	28b/m	28b/m		
	32b/m	30b/m	28b/m	28b/m	28b/m	28b/m		
	32b/m	30b/m	28b/m	28b/m	28b/m	28b/m		
	32b/m	30b/m	28b/m	28b/m	28b/m	28b/m		
Resp Mod/ Severe Distress None / Mild	✓	✓	✓	✓	✓	✓		
	✓	✓	✓	✓	✓	✓		
	✓	✓	✓	✓	✓	✓		
	✓	✓	✓	✓	✓	✓		
	✓	✓	✓	✓	✓	✓		
	✓	✓	✓	✓	✓	✓		
	✓	✓	✓	✓	✓	✓		
Receiving O ₂ (l/min) O ₂ Saturations (%)	100%	98%	98%	98%	98%	99%		
	100%	98%	98%	98%	98%	99%		
	100%	98%	98%	98%	98%	99%		
	100%	98%	98%	98%	98%	99%		
	100%	98%	98%	98%	98%	99%		
	100%	98%	98%	98%	98%	99%		
	100%	98%	98%	98%	98%	99%		
Conscious Level Normal / Altered	✓	✓	✓	✓	✓	✓		
	✓	✓	✓	✓	✓	✓		
	✓	✓	✓	✓	✓	✓		
	✓	✓	✓	✓	✓	✓		
	✓	✓	✓	✓	✓	✓		
	✓	✓	✓	✓	✓	✓		
	✓	✓	✓	✓	✓	✓		
GCS *	15/15	15/15	15/15	15/15	15/15	15/15		
	15/15	15/15	15/15	15/15	15/15	15/15		
	15/15	15/15	15/15	15/15	15/15	15/15		
	15/15	15/15	15/15	15/15	15/15	15/15		
	15/15	15/15	15/15	15/15	15/15	15/15		
	15/15	15/15	15/15	15/15	15/15	15/15		
	15/15	15/15	15/15	15/15	15/15	15/15		
TOTAL SCORE	0	0	0	0	0	0		
	0	0	0	0	0	0		
	0	0	0	0	0	0		
	0	0	0	0	0	0		
	0	0	0	0	0	0		
	0	0	0	0	0	0		
	0	0	0	0	0	0		
Pain Score	0	0	0	0	0	0		
	0	0	0	0	0	0		
	0	0	0	0	0	0		
	0	0	0	0	0	0		
	0	0	0	0	0	0		
	0	0	0	0	0	0		
	0	0	0	0	0	0		
Observer's Initials	AM	AM	PM	AM	AM	AM		
	AM	AM	PM	AM	AM	AM		
	AM	AM	PM	AM	AM	AM		
	AM	AM	PM	AM	AM	AM		
	AM	AM	PM	AM	AM	AM		
	AM	AM	PM	AM	AM	AM		
	AM	AM	PM	AM	AM	AM		

ACTIONS

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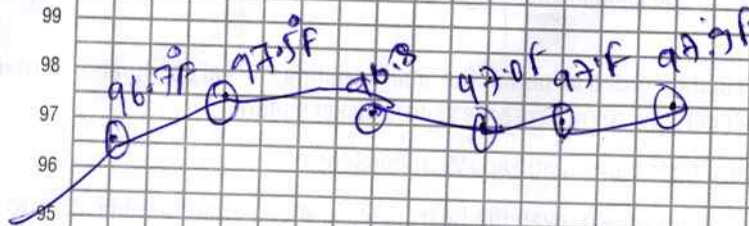
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EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 12/12/2020 Time: 8am 10am 4pm 8pm 12am 4am
Doctor / Nurse / Family Concern?

Temperature
(°F)



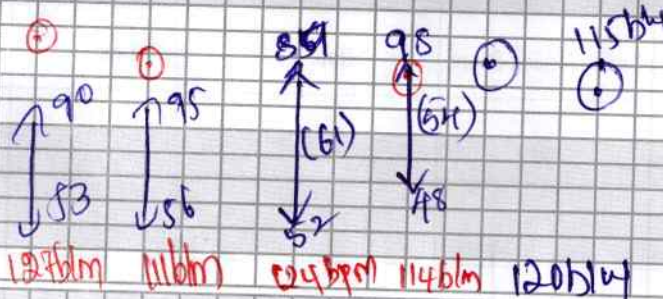
Heart Rate
(bpm)

and

Blood Pressure
(mmHg) *

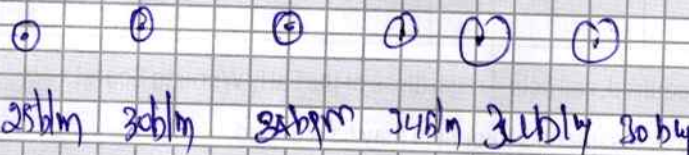
Note:
BP does not score
in early
warning scoring

Heart Rate (Number)



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

Resp Rate (Number)



Resp Mod/ Severe
Distress None / Mild

Receiving O₂ (l/min)
O₂ Saturations (%)

Conscious Level
Normal Altered

GCS *

TOTAL SCORE

Number of shaded boxes

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FLUID CHART

Sheet No. : 1

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

Date	Time	Intake			Output					IV Site Thrombo- phlebitis Score	Sign. Nurse	
		Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G							
	08:00 am				NG feed							
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :					Total Output :							
	02:00 pm				Receiving Note					0		
	03:00 pm									0		
	04:00 pm									0		
	05:00 pm				38ml					0		
	06:00 pm				38ml					0		
	07:00 pm				38ml					0		
Total Intake : 99ml					Total Output : 1 time							
	08:00 pm									0		
	09:00 pm									0		
	10:00 pm									0		
	11:00 pm				33ml					0		
	12:00 am				33ml					0		
	01:00 am				33ml					0		
Total Intake : 99ml					Total Output : 25ml							
	02:00 am									0		
	03:00 am									0		
	04:00 am				38ml					0		
	05:00 am				33ml					0		
	06:00 am				33ml					0		
	07:00 am									0		
Total Intake : 99ml					Total Output : 80ml							
Total 24 hrs. Intake					Total 24 hrs. Output							
297ml					85ml + 1 time							

SNC-00024099
Baby AADHAVI S
06-14-2025 Y 3 M 5 D
Dr. SOMASHEKARA H R (F)



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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

FLUID CHART

Y.Wt - 4.840 kg
T.Wt - 4.689 kg
A.G. - 33cm (15 kg ↓)

Sheet No. : (2)

- All measurements in ml.
- 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			NG	Diarrhoea	Vomit	Output			IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G				Drainage	Urine			
	08:00 am	M20		10ml	50					110ml	0	SA	
	09:00 am	feed		10	33						0	SA	
	10:00 am			10	33						0	SA	
	11:00 am			10	33					30ml	0	SA	
	12:00 pm			10							0	SA	
	01:00 pm			10	33ml						0	SA	
Total Intake :			+ 60ml + 82			Total Output :			240ml				
	02:00 pm				33ml					48ml	0	SA	
	03:00 pm				33ml						0	SA	
	04:00 pm										0	SA	
	05:00 pm			3	33ml						0	SA	
	06:00 pm				33ml						0	SA	
	07:00 pm				33ml		2.5ml			✓	0	SA	
Total Intake :			66 + 99ml			Total Output :			148ml + 4.8me				
	08:00 pm						Scrub				0	SA	
	09:00 pm									40ml	0	SA	
	10:00 pm	feed			33ml		Scrub				0	SA	
	11:00 pm	feed			33ml						0	SA	
	12:00 am	no cab			33ml					58ml	0	SA	
	01:00 am										0	SA	
Total Intake :			99ml			Total Output :			98ml				
	02:00 am									62ml	0	SA	
	03:00 am										0	SA	
	04:00 am				33ml					80ml	0	SA	
	05:00 am	feed			33ml						0	SA	
	06:00 am	no cab			33ml						0	SA	
	07:00 am						✓			✓	0	SA	
Total Intake :			99ml			Total Output :			92ml				
Total 24 hrs. Intake			605ml			Total 24 hrs. Output			378ml + 21ml				

FLUID CHART

AG - 34
 Y.wt - 4.689 kg
 T.wt - 4.6 kg (89.1)

Sheet No. : 3

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			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombophlebitis Score	Sign. Nurse
				Mouth	I.V	N.S							
12/7/26		08:00 am	H ₂ O	10ml				Stem			34	0	2
		09:00 am				33ml						0	2
		10:00 am				33ml					✓	0	2
		11:00 am				33ml						0	2
		12:00 pm										0	2
		01:00 pm										0	2
Total Intake :				10ml + 99ml			Total Output : 34 + 1 time						
		02:00 pm				40ml						0	2
		03:00 pm				40ml					44ml	0	2
		04:00 pm				40ml						0	2
		05:00 pm										0	2
		06:00 pm										0	2
		07:00 pm				40ml						0	2
Total Intake :				160ml			Total Output : 44ml						
		08:00 pm				40ml						0	2
		09:00 pm				40ml						0	2
		10:00 pm									65	0	2
		11:00 pm									80	0	2
		12:00 am				210ml					66	0	2
		01:00 am				210ml						0	2
Total Intake :				160ml			Total Output : 211						
		02:00 am				210ml						0	2
		03:00 am										0	2
		04:00 am									60	0	2
		05:00 am				210						0	2
		06:00 am				210					80	0	2
		07:00 am				210ml						0	2
Total Intake :				160ml			Total Output : 90ml						
Total 24 hrs. Intake				579ml			Total 24 hrs. Output				379ml		

NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: <u>KUO DEEAH SYNDROME,</u> <u>SEVERE ANEMIA</u>		Any Infection: ☐ Yes ☒ No ☐ Not Known If Yes Specify: _____					
	Surgery / Procedure: _____		Post OP Day: _____					
BACKGROUND	Date	Shift	10/7/25 N	10/7 MHE	11/7 N	12/7 MHE	12/7 E	12/7 N
	Medical Condition (Any special condition to be noted):		Noted	Noted	Noted	Noted	Noted	Noted
ASSESSMENT	Diet:		NG feed	NG feed	NG feed	NG feed	NG feed	NG feed
	Allergy:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Ventilation (RA, NP, NIV, VENTI):		LD	RA	RA	RA	RA	RA
	Tubes/Drains/Catheter:		☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No
	Vital Signs:		Temp: 97.6°F	97.4°F	96.9°F	98.2°F	98.6°F	96.9°F
	Res:		26b/m	26b/m	26b/m	20b/m	24b/m	30b/m
	SpO ₂ :		99%	100%	98%	95%	99%	98%
	Pulse:		123b/m	115b/m	112b/m	124b/m	124b/m	110b/m
	BP:		90/52	86/48	88/52	90/60	89/52	98/48
	LOC:		conscious	conscious	conscious	conscious	conscious	conscious
RECOMMENDATIONS	Fall Risk Score:		10	10	10	10	10	10
	Pain Score:		0/10	0/10	0/10	0/10	0/10	0/10
	Skin Integrity		intact	intact	intact	intact	intact	intact
	Safety Needs:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Physiotherapy:		Nil	Nil	-	-	-	-
	Others Specify:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Special Diet:		normal	normal	normal	normal	normal	normal
	Critical Lab Test / Values:		-	-	-	-	-	-
	Other Special Orders / Medications:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	PU Prophylaxis:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
DVT Prophylaxis:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
ADL (Dependent / Non Dependent):		dependent	dependent	dependent	dependent	dependent	dependent	
Post Operative Procedure Special Orders:								
Handed Over By Name :			D. Vith					
Signature / ID :			D. Vith					
Date:			11/7/25					
Time:			7:30 AM					
Taken Over By Name :			D. Vith					
Signature / ID :			D. Vith					
Date:			12/7/25					
Time:			7:30 AM					

NURSING SHIFT HAND OVER FORM

SITUATION		Any Infection: ☐ Yes ☒ No ☐ Not Known If Yes Specify: <u>NIL</u>						
Diagnosis: <u>KIC/O. DEEAH SYNDROME</u> <u>SEVERE ANEMIA ACUTE ON CHRONIC</u> <u>SAM / AVE NOVAVIRLY DEHYDRATION</u>		Surgery / Procedure: <u>-</u>						
Post OP Day: <u>-</u>								
BACKGROUND	Date	6/7/26	7/7/26	7/7/26	7/7/26	8/7/26	8/7/26	
	Shift	N	M	E	N	M	E	
	Medical Condition (Any special condition to be noted):	Noted	Noted	Noted	Noted	Noted	Noted	
ASSESSMENT	Diet:	Noted	Noted	Noted	Noted	Noted	Noted	
	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Ventilation (RA, NP, NIV, VENTI):	RA	RA	RA	RA	RA	RA	
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Vital Signs:	Temp:	98°F	97.5°F	97.9°F	98.9°F	98.2°F	97.1°F
		Res:	27mb	20b/m	18b/m	20b/m	20b/m	24b/m
		SpO ₂ :	100%	99%	97%	98%	100%	100%
		Pulse:	130b/m	130b/m	127b/m	124b/m	122b/m	118b/m
		BP:	100/60	94/66/15	81/55/64	87/55/66	81/61/21	85/60/60
		LOC:	15/15	15/15	15/15	15/15	15/15	15/15
		Fall Risk Score:	16	16	16	16	16	16
	Pain Score:	0/10	0/10	0/10	0/10	0/10	0/10	
	Skin Integrity	Intact	Intact	Intact	Intact	Intact	Intact	
	Safety Needs:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
		Physiotherapy:	-	-	-	-	-	-
Others Specify:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
Special Diet:		Neocate	Neocate	Neocate	Neocate	NPO	Neocate	
Recommendations	Critical Lab Test / Values:	-	-	-	-	-	-	
	Other Special Orders / Medications:	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	
	PU Prophylaxis:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	DVT Prophylaxis:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	ADL (Dependent / Non Dependent):	Dependent	Dependent	Dependent	Dependent	Dependent	Dependent	
	Post Operative Procedure Special Orders:	-	-	-	-	-	-	
Handed Over By Name :	Speers	Logeshan	Vishu	Speers	Pravitha	Logeshan		
Signature / ID :	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]		
Date:	7/7/26	7/7/26	7/7/26	8/7/26	8/7/26	8/7/26		
Time:	8AM	2PM	6PM	8PM	2PM	8PM		
Taken Over By Name :	Logeshan	Vishu	Speers	Pravitha	Logeshan	Shanku		
Signature / ID :	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]		
Date:	7/7/26	7/7/26	7/7/26	8/7/26	8/7/26	8/7/26		
Time:	8AM	2PM	8PM	2PM	2PM	8PM		



NURSING SHIFT HAND OVER FORM

SITUATION							
Diagnosis: <u>K/CLO DEEPA SYNDROME, SEVERE ANEMIA ACUTE ON CHRONIC SAM/AUC</u>		Any Infection: ☐ Yes ☒ No ☐ Not Known If Yes Specify: <u>NIL</u>					
Surgery / Procedure: <u>NIL</u>		Post OP Day: <u>-</u>					
BACKGROUND	Date	8/1/26 N	9/1/26 M	9/7/26 E	9/1/26 N	10/1/26 M	10/7/26 E
	Shift						
	Medical Condition (Any special condition to be noted):	<u>noted</u>	<u>Noted</u>	<u>Noted</u>	<u>noted</u>	<u>Noted</u>	<u>Noted</u>
	Diet:	<u>Nu Feed</u>	<u>Nu feed</u>	<u>Nu Feed</u>	<u>Nu Feed</u>	<u>Nu feed</u>	<u>Nu Feed</u>
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Ventilation (RA, NP, NIV, VENTI):	<u>RA</u>	<u>RA</u>	<u>RA</u>	<u>RA</u>	<u>RA</u>	<u>RA</u>
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:						
	Temp:	<u>97.1 F</u>	<u>98.2 F</u>	<u>98.2 F</u>	<u>97.4 F</u>	<u>99.8 F</u>	<u>9</u>
	Res:	<u>26 blm</u>	<u>27 blm</u>	<u>29 blm</u>	<u>20 blm</u>	<u>28 bpm</u>	<u>26 blm</u>
	SpO ₂ :	<u>100%</u>	<u>100%</u>	<u>100%</u>	<u>99%</u>	<u>99%</u>	<u>100%</u>
	Pulse:	<u>119 blm</u>	<u>122 blm</u>	<u>117 blm</u>	<u>122 blm</u>	<u>126</u>	<u>136 blm</u>
	BP:	<u>96/61 (75)</u>	<u>83/58 (63)</u>	<u>96/61 (33)</u>	<u>92/62 (72)</u>	<u>86/60 (63)</u>	<u>88/62 (61)</u>
	LOC:	<u>15/15</u>	<u>16/15</u>	<u>15/15</u>	<u>15/15</u>	<u>16/15</u>	<u>16/15</u>
	Fall Risk Score:	<u>16</u>	<u>16</u>	<u>16</u>	<u>16</u>	<u>16</u>	<u>10</u>
	Pain Score:	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>
	Skin Integrity	<u>Intact</u>	<u>Intact</u>	<u>Intact</u>	<u>Intact</u>	<u>Intact</u>	<u>Intact</u>
Recommendations	Safety Needs:	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No
	Physiotherapy:	<u>NIL</u>	<u>NIL</u>	<u>NIL</u>	<u>NIL</u>	<u>NIL</u>	<u>NIL</u>
	Others Specify:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Special Diet:	<u>neocate</u>	<u>neocate</u>	<u>neocate</u>	<u>neocate</u>	<u>Neocate</u>	<u>Neocate</u>
	Critical Lab Test / Values:	<u>NIL</u>	<u>NIL</u>	<u>NIL</u>	<u>NIL</u>	<u>NIL</u>	<u>NIL</u>
	Other Special Orders / Medications:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	PU Prophylaxis:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	DVT Prophylaxis:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	ADL (Dependent / Non Dependent):	<u>Dependent</u>	<u>Dependent</u>	<u>Dependent</u>	<u>Dependent</u>	<u>Dependent</u>	<u>Dependent</u>
Post Operative Procedure Special Orders:		<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>
Handed Over By Name :		<u>Bhaarti</u>	<u>Bhaarti</u>	<u>Sharmila</u>	<u>Bhaarti</u>	<u>Bhaarti</u>	<u>Sharmila</u>
Signature / ID :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>
Date:		<u>8/1/26</u>	<u>9/1/26</u>	<u>9/7/26</u>	<u>10/1/26</u>	<u>10/1/26</u>	<u>10/7/26</u>
Time:		<u>8 am</u>	<u>2 pm</u>	<u>8 pm</u>	<u>2 am</u>	<u>2 pm</u>	<u>3 pm</u>
Taken Over By Name :		<u>Alex</u>	<u>Sharmila</u>	<u>Bhaarti</u>	<u>Sharmila</u>	<u>Sharmila</u>	<u>Sharmila</u>
Signature / ID :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>
Date:		<u>9/1/26</u>	<u>9/7/26</u>	<u>9/7/26</u>	<u>10/1/26</u>	<u>10/1/26</u>	<u>10/7/26</u>
Time:		<u>8 am</u>	<u>2 pm</u>	<u>2 pm</u>	<u>8 am</u>	<u>2 pm</u>	<u>3 pm</u>



NURSING CARE RECORD

Goals

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

Date: 6/7/26

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon							
Night				Admission			
	8pm	Assess the child Monitor vital's maintain Itochat provide medication		Assessed the child Monitored vital's maintain Itochat provided the medication	child vital's are Normal	Reassessment done	8pm S. S. S. S.

Patient Sticker

NURSING CARE RECORD

Date: 7/7/22

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	8 AM	* Assess the child condition * Monitor vital sign * To provide protein rich feed. * To maintain body fluid level	8 AM	* Assessed the child condition * Monitored vital sign * To provided protein rich feed * To maintained body fluid level	* child vitals sign are stable	* Reassessment on done	<i>[Signature]</i> 01/2/22
	2 PM	* Assess the child condition * Monitor vitals * To provide protein rich diet. * To Maintain body fluid level.	2 PM	* Assessed the child condition * Monitored vitals. * provided protein rich diet. * to maintained body fluid level	* child vitals signs stable	* Reassessment done	<i>[Signature]</i> 02/5/22
	8 PM	- Assess the child - Monitor vitals. - Maintain DPO - provide medication.		- Assessed the child - Monitored vitals. - Maintained DPO - provided medication.	Child vitals are stable	Reassessment done	<i>[Signature]</i> 01/02/22

SNC-00024099
Baby AADHAV S
06-04-2025 1 Y 3 M 1 D
Dr. SOMASHEKARA H R



NURSING CARE RECORD

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Date: 8/7/26

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	* Administer the medication as per doctor's order.	8AM	* Administered the medication	* baby stable.	* Re assessment done	
	to	* Assess the baby condition	to	* assessed the baby condition			
	8PM	* Follow the doctors order.	2PM	* Followed the doctors order.			
Afternoon	2PM	Assess the child condition & vital sign monitor		* Assessed the child condition.	* Baby vital core stable	Re assessment done	
		* Bio chart maintain.		* Vital sign monitored			
		* Administer medication as per drug chart		* Bio chart maintained			
				* Administer medication			
Night	8PM	* Child condition assessment		* Child condition assessment	child vital stable	Re-assessment done	
		* Vital monitor		* Vital monitored			
		* Comfort Position		* Comfortable position			

NURSING CARE RECORD

Date: 9/7/26

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	* Assess the child condition * Monitor vital signs * Maintain I/O chart * Administer medication.	2pm	* Assessed the child condition * Monitored vital signs * Maintained I/O chart * Administered medication.	Child is stable.	Re-assessment done.	deep 01387
Afternoon	2pm	* Assess the child condition * maintain I/O chart * monitor vital sign * Follow doctor's order * Administer medication	8pm	* Assessed the child condition * maintained I/O chart * monitored vital sign * Followed doctor's order * Administered medication	* Evaluated child vitals stable	* Re-assessment done	Shabe 013776 9/7/26 8pm
Night	8pm	* Assess the child condition. * vital sign monitor * I/O chart maintain * Administer medication given as per day chart		* Assessed the child condition * vital sign monitored * I/O chart maintained. * Administered medication as per day chart.	* child's vitals are stable	* Re-assessment done	Rthy 011042



NURSING CARE RECORD

Date: 10/7/26

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	* Assess the child condition * Monitor vital signs * Maintain I/O chart * Administer medication.		* Assess the child condition * Monitor vital signs * Maintain I/O chart * Administer medication.	Child is stable	Re-assessment done	Jay 04/26
Afternoon	2pm	* Assess the child condition * maintain I/O chart * monitor vital signs * Follow doctor order * Administer medication		* Assess the child condition * maintained I/O chart * monitored vital signs * Followed doctor order * Administered medication	* Evaluated child is vital & stable	* Re-assessment done	Jay 04/26 10/7/26
Night	8pm	promote health hygiene.		→ Encourage oral & Hand hygiene → daily change of bedsheet & cloths.	maintain personal hygiene	Reassessment done	Jay 04/26

Patient Sticker

NURSING CARE RECORD

Date: 11/17/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning		To maintain 8am good nutritional status	9AM	Assess child condition Monitor vital signs maintain I/O chart	The child was stable	The child's vital signs are stable	P. Vel. 021113
Afternoon		2pm Prevent infection	4pm	Prevented infection Assess the child's monitor vials	Prevented infection	Reassessment done Baby was stable	Ay's an
Night		7:30 pm maintain personal hygiene	8 PM	Maintain strict hand hygiene	To prevent infection	Child stable	Sy



NURSES NOTES



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- ☐
- No Known Drug Allergies

- ☐ Drug Allergies *nil*

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		Night duty 6/7/26	
	7:30 pm.	Child handing over taken from Evening duty staff nurse. OCS → 15mls pupil both eye equally reactive. Not tube SFr present Not Feed Mleocate 60ml @ 4H once Before feed. T-CREON Alced to give central line (+). HFr 2umen Day life. D6. Back Flow present. Central line site No Leakage No Redness Abdomen soft loose Stool present. (Semisolid) vomiting (+). urine passed Diapers rash (+). B applied Bu Nappi cream.	
	8pm.	RBS 6th hly over night IVF Aminoclon 10% → 6ml/hr continue. Intralipid 2ml/hr continue.	
	9pm.	RBS Checked → 150mg/dl T-uron given before feed Feeding given → 55ml	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

NURSES NOTES

☐ No Known Drug Allergies

☐ Drug Allergies Nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		→ Continue ←	
	9 ³⁰ pm	Dry - potphos 1ml + 19ml nls over 3hrs connected sup. potphos w/ff for further order.	<u>Sp</u> <u>01/02/24</u>
	10pm	medication given as per cs doctor's order. w/ff sensorium & vitals	<u>Sp</u> <u>01/02/24</u>
	12am	Sleeping pattern is good Continue monitoring. No complaint. Loose stool (#).	<u>Sp</u> <u>01/02/24</u>
	1am	Feeding given 60ml. No vomiting and no complain	<u>Sp</u> <u>01/02/24</u>
	3am	Stool passed: Semisolid vitals are normal.	<u>Sp</u> <u>01/02/24</u>
	4am	SLP - Domstol given Amnover & Dntalipid Continue the same order.	<u>Sp</u> <u>01/02/24</u>
	5am	Feeding given 60ml Dry - potphos over 3hrs given.	<u>Sp</u> <u>01/02/24</u>
	6am	morning care given. Nose tube position checked mouth & eye care given. Dry xone over 30mint's given.	<u>Sp</u> <u>01/02/24</u>

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NURSES NOTES

☐ No Known Drug Allergies

☐ Drug Allergies

NIL

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
7/7/26	7:30 AM	Continue child details handing over given to morning duty s/n	[Signature]
7/7/26		Morning Duty Notes (7/7/26)	
7/7/26	7:30 AM	child details handing over taken from night duty s/n. Nuthupriya child is on PR, PR-24, GUS 15/15, pupil BLO equal reacting 2mm; CRT <3sec central line (Ph) R'Div Apr 2 lumen, Nu tube 8Fr Ph, IV Aminoxen 10.1 - 6ml/hr on flow, IV Intralipid 10.1 - 2ml/hr on flow, PRS 6thyr, Nu feed 80ml 80ml, child vital sign are recorded	[Signature]
7/7/26	8:30 AM	DLO chart monitored Nu feed 80ml on given no vomiting (Neocate Formula), Dose medicine on given as per drug chart order	[Signature]
7/7/26	10:00 AM	Dr. Nataraj sir seen the child advice. Continue the same, feed change any advice, Dr. Somashekar sir seen the child advice Nu feed Infusion start 20ml/hr over 2 hours, one hour off again re start 2 hours - 20ml/hr	[Signature]

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NURSES NOTES

☐ No Known Drug Allergies

☐ Drug Allergies

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		child on stool passed ^{light yellow} , urine passed	
		Diapers on changed.	
12:40 pm		child vital signs are recorded, PO chart monitored	
1:00 pm		Due medicine on given as per drug chart order	
		child details handing over given to evening duty. <i>Shil Vishwa</i>	
		<i>Evening duty Note</i> <i>17/7/20.</i>	
7/7/20	1:30 pm	child details hand over taken from morning duty S/N Logeshwari. G & DSBAR method of Bandover followed. child is on RA, PV = (2+), GCS = 15/15 pupils reacting to light. PVF Aminorex 10% - 6ml/hr, Drg: Intralipid (SMOP) 2ml/hr is on flow, RBS - BD, N/G feed Neocate 20ml/hr on 3 hours and 1 hr off	
	2 pm	child has (P) BIV 4 hr 24mm DZ pattern, N/G tube 8 Fr (D4) pattern. Vitals monitored and recorded	<i>M. Vishwa</i> 011584.

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☒ No Known Drug Allergies

☐ Drug Allergies Nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
8/7/26	2pm	Due Medication give as per drug chart through NG. Vitals monitored and recorded	M. Vals 021584
	4pm	Due Medication given as per drug chart. Vitals monitored and recorded	M. Vals 021584
	6pm	Due Medication give as per drug chart. Vitals monitored and recorded.	M. Vals 021584
	7:30pm	Baby details handover given to Night duty Staff Nurse	M. Vals 021584
		Night duty 8/7/26	
	7:30pm	Handing over taken from Evening duty Staff Nurse Child GCS 15/15. Not tube fed. Not Feed bml over 3hrs 4hr. Cxbr. Pupil reactive both eye equally. Central line @ LFR 8umen. Back flow was present. IVF Aminoven bml/hr. Intralipid 2ml/hr. 2ohms 4hr Stop. Abdomen soft. No bowel sound. Diaper clean @. To Apply BH Nappi.	Spang 0216249

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NURSES NOTES

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☐ Drug Allergies *Nil*

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		→ continue ←	
	8 ⁰⁰ pm	Syp - erythromycin 2ml given. Continue the same treat ^{ment}	<i>[Signature]</i> 01/02/15
	9pm	Feed connected 20ml/hr. on Infusion. No loose stool last 3hrs	<i>[Signature]</i> 01/02/15
	11pm	medication given as per as doctor's order. Follow the drug chart medications	<i>[Signature]</i> 01/02/15
	12am	Sleeping pattern is good continue monitoring. No any other complaints.	<i>[Signature]</i> 01/02/15
	2am	T-magvion given 100mg 1/4 for Nubabe.	
	4am	Stool passed Diaper changed. Morning care given Central line Dressing done Eye & mouth care given. Simpler Send CBC, CRP pot, Phos, mag, Electrolytes	<i>[Signature]</i> 01/02/15
	7am	continue monitoring. Child ON NPO at 7am D/E 0.9% NaCl → 10ml/hr. connected.	<i>[Signature]</i> 01/02/15
	7 ³⁰ am	Handing over given to morning duty staff nurse	<i>[Signature]</i> 01/02/15

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NURSES NOTES

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- ☐ No Known Drug Allergies
☐ Drug Allergies

Nil

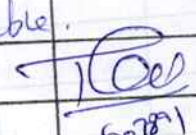
DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
8/2	8am	* <u>Morning duty notes on shift</u> baby hand over taken from night duty staff child is on room air ventilation spo maintaining vitals stable oral nro for procedure, vitals 15/15, CRT, 23 pulse volume present, peripheral warm, baby has central line & nro tube present oral nro, Dnf Dns 10ml/hr Dnf Dofalopid 2ml/hr, Di amunover 6ml/hr. * RBS BP monitoring. daily weight checking	
	9am	* details checked & monitored No chart monitoring stool passed large quantity yellow colour	
	10am	* Doctors rounds followed * Bi fluids continue * Billing clearance given by Mr. Delli	
	12pm	* details stable baby shifted to Endoscopy room @ 12:15pm	

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NURSES NOTES

☒ No Known Drug Allergies

☐ Drug Allergies Nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		<u>on notes</u>	
8/7/26	12 pm	=> Baby received from PICU to Endoscopy room, patient vital stable BP-100/80 SpO2-100. => Anaesthesia given by Dr. Mohan under. => Endoscopy done by Dr. Karthiyanan. => NG Tube insert done pasting and chest X-ray done.	
	1:20 pm	=> Baby received to Recovery area for observation, patient vitals are stable. => Baby shifted to PICU and	
8/7/26	2:40 pm	hand over to PICU staff	 607891
<u>Notes</u> <u>Evening Duty 08/07/26</u>			
8/7/26	3:40 pm	child received from 7th floor (Endoscopy room), child is on RA, PR-2+, GRS 1/15, pupil B/L equal reacting 2mm, CRT <3sec, Central line PL 4Fr 8lymen, Nu tube 10Fr 50cm fixed child vital sign are recorded, Pto chart monitored, IVF Aminocor 10.1-6ml/hr, not potphos-5ml/hr on flow, PBS 68mg/dl →	
	4:10 pm	Start NU feed (Nerocate Infusion)	 0623

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NURSES NOTES

☒ No Known Drug Allergies

☐ Drug Allergies Nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
8/7/26		WE intra lipid similar on flow	<i>[Signature]</i>
	5:00 pm	child vital sign are recorded.	<i>[Signature]</i>
		P/O chart monitored	<i>[Signature]</i>
	6:00 pm	due medicine are given as per drug	<i>[Signature]</i>
		chart order	<i>[Signature]</i>
	7:00 pm	stop Nu ped, child stool passed	<i>[Signature]</i>
		diaper on changed	<i>[Signature]</i>
	7:30 pm	child details handing over given to	<i>[Signature]</i>
		night duty sh.	<i>[Signature]</i>
		Night duty 8/7/26	
	8 pm	child details handing	
		over taken from evening	
		duty staff child is	
		conscious and active	
		child is on room air	
		PR20, GCS 15/15, CRT235.	
		central line present	
		Aminoven 6ml/hr, lipid	
		2ml/hr on flow, Nst tube	
		present. Alcolate tube for	
		3hr next stop. Skin Intat	
		diaper trash present.	
		daily weight check	<i>[Signature]</i>
	9 pm	child vital stable P/O	<i>[Signature]</i>
		chart monitor on other	
		compliant	<i>[Signature]</i>

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NURSES NOTES

- ☒ No Known Drug Allergies
☐ Drug Allergies Nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
8/7/26	10pm	due medication given as per drug chart order vital monitor & recorded	
	11pm	Inj. Potphos 5ml/hr child vital monitor & recorded no other complaint	<i>[Signature]</i> 60130
	1 Am	due medication given as per drug chart order monitor vital No chart monitor no other complaint	<i>[Signature]</i> 60130
	4 Am	morning care given no bed sore due medication given as per drug chart no no other complaint	<i>[Signature]</i> 60130
	6 Am	child vital monitor & recorded No chart monitor	<i>[Signature]</i> 60130
	7.30pm	morning potassium sample send Inj. Potphos 5ml/hr on flow child details handing over given from morning duty staff	<i>[Signature]</i> 60130

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NURSES NOTES

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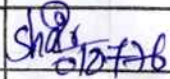
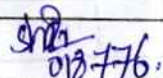
- ☒ No Known Drug Allergies
☐ Drug Allergies NIL

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
9/1/25		<u>→ Morning duty 9/1/25 ←</u>	
	8am	Child details taken over from night duty staff nurse, child is on RA ventilation PV 2t, dycs 16/6 B/c pupil equally reacting to light, N/A 3rd hourly feeds routine, (R) ISV line @ E. Anderson @ 6ml/h, Intubated @ 2ml/h, Tj. PO @ 2ml on flow, Abdomen soft tender, RBS BD, daily weight monitoring.	<u>duf 09/01/25</u>
	8:00am	Medication given through NG per doctors order.	<u>duf 09/01/25</u>
	9am	Vital signs checked and recorded.	<u>duf 09/01/25</u>
	10am	Administered the medication as per doctors order.	<u>duf 09/01/25</u>
	11am	Doctors rounds followed.	<u>duf 09/01/25</u>
	12pm	Dr. Ferric started @ 12:00pm as per doctors order.	
		No any allergic reactions	
		Vitals stable / D/c chart monitored	<u>duf 09/01/25</u>
	12:30pm	NG feed increased to 25ml for 3rd hour 1 hr gap.	
	1pm	Handover given to next duty staff.	<u>duf 09/01/25</u>

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NURSES NOTES

☒ No Known Drug Allergies
☒ Drug Allergies N/A

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		← Evening duty 9/7/26 →	
9/7/26	8:30pm	child details taken over from morning duty staff nurse. child is on room air. child is on hemodynamically stable checked and recorded. T ₁ 36.5°C, PR 2(+) , BL pupils equally reacting to light 2mm(+) , NFI tube (F) 10 Fr. 50cm (fixed) NS Feed Niocatt infusion 25ml/hr over 3 rd hly. ITR(+) 4Fr - 2 lumen (Dg) . IVF Amnion 6ml/hr, IVF Intra lipid 2ml/hr on flow, RBS OD, Daily weight monitoring, Abdomen soft, No bed sore →	
	2pm	child is on hemodynamically stable, Due medication given as per drug chart	
	2:10pm	IVF Intra Lipids stop Admin by Dr. Mukul Sir. →	
	3pm	Due medication given as per drug chart.	
	4pm	child is on hemodynamically stable checked and recorded, child passed urine and motion, Feed Niocatt 25ml/hr on flow over three hours →	
	6pm	Due medication given as per drug chart	
	7pm	child passed urine and motion →	
	7:30pm	child details handing over to night duty staff nurse Bharathi. →	

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NURSES NOTES

☒ No Known Drug Allergies

☒ Drug Allergies

0
nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		← Night Duty → 9/4/26	
	8pm	Child handing over taken from evening duty staff nurse child is on RA, pulse volume normal 20, pupils reacting to light 2mm, CRT 2s, central line patent. NG tube present, child vital signs monitor & recorded & chart maintained, Amnoren 6ml/m on flow, Due medication given as per drug chart NG Feeding 2ml over 3hr on flow, one hr Feeding stopped. RES OD, →	Blue 01002
	10pm	Due medication given as per drug chart vital are stable →	Blue 01002
	11pm	NG Feeding one hour stopped Due medication given as per drug chart →	Blue 01002
	12am	NG Feeding Start 2ml vital are stable & chart maintain, Due medication given as per drug chart →	Blue 01002
	2am	Due medication given as per drug chart	Blue 01002
	5am	Child side all nursing care given Bath given central line dressing changed vital are stable →	Blue 01002

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NURSES NOTES

☒ No Known Drug Allergies

☐ Drug Allergies NIL

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
10/1	6am	Due medication given as per drug chart →	Blay 10/30/42
	8am	child handing over given to morning duty shift nurse →	Blay 10/30/42
10/1/20		→ Morning duty 10/1/20 ←	
	8am	Child details taken over from night duty shift nurse, Child is on RA ventilation, PV 2+, U/GS 16/15 BIL pupil equally reacting to light, NG tube (+) reconst feed 9ml over 30min, next 1 hour grip, (+) ISV line (+) Ij. Ammonia @ 6ml/6, Abdomen soft, bowel opened, RBS @ D, today plan discharge, Biopsy (+) awaited	Blay 10/30/42
		Medication given through NG as per doctors order	Blay 10/30/42
	9pm	Vital signs checked and recorded	Blay 10/30/42
	10am	Medication given through NG as per doctors order	Blay 10/30/42
	11am	cls/b. m. Nataraj. assessed the child, advise to shift the child to ward.	Blay 10/30/42

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NURSES NOTES

☒ No Known Drug Allergies

☐ Drug Allergies NIL

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
10/7/26	12pm	cls/b. Dr. Somashekara. advised the child, advise to shift to ward and ped sx opinion to Dr. Nandhini. Stop aminocor. Remove central line, some peripheral line →	Raj/018309.
	1:30 pm	Systemwise transfer done. → child handover given to evening duty staff. Dr. Nandhini followed →	Raj/018309.
10/7/26		← Evening duty 10/7/26 →	Raj/018309.
	1:30pm	child details taken over from morning duty staff nurse, child is on room air pr 20, wts 15/15, BL pupils equally reacting to light 2mm, NJ tube ⊕ Newborn feed 99ml over 3 hour, After one hour gap, (R+) IJr line ⊕ Inj Aminocor 0.6ml/hr onflow, RBS OD, Abdomen soft, today plan shift to ward, Biopsy ⊕ to be collect →	Shr/018309
	2pm	Due medication given as per drug chart	
	3pm	Child passed urine and motion, Due medication given as per drug chart, child is on hemodynamically stable checked and recorded →	Shr/018309
	3:30pm	child details handing over given to 5th Floor staff nurse →	Shr/018309

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NURSES NOTES

☐ No Known Drug Allergies

☐ Drug Allergies nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE						
10/12/26	7:30 pm	Night duty notes :- Child details handing over taken from evening duty s/n. Child conscious & oriented. Child activity are good. Ax fine @ NG @							
	8:00 pm	Vital signs checked & recorded Vitals are stable now <table><tr><td>CP</td><td>PR</td><td>CNR</td></tr><tr><td>H</td><td>H</td><td>CR</td></tr></table>	CP	PR	CNR	H	H	CR	
CP	PR	CNR							
H	H	CR							
	8pm	Due medication are given as per drug chart order							
	9pm	NG feeding complete and no other complaints	Jacy 02004						
	10pm	Due medication given as per drug chart order & documented							
	10.41 pm.	Sr. Manonmani mam through phone advice to monitor temperature, RR	pdip 0108m						
11/12/26	12pm	Vitals are monitored & recorded and vitals are stable	pdip 1008m						
	12.10 PM	while giving medication he gets black and after that removed	pdip 0108m						

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NURSES NOTES

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☐ Drug Allergies

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE								
11/9/26	2 AM	Due medication given as per drug chart order & documented.									
	4 AM	Vitals are monitored and recorded and vitals are stable.									
		<table border="1"> <tr> <td></td><td>CP</td><td>PP</td><td>CRT</td></tr> <tr> <td>4 AM</td><td>+</td><td>+</td><td>Box</td></tr> </table>		CP	PP	CRT	4 AM	+	+	Box	
	CP	PP	CRT								
4 AM	+	+	Box								
	6 AM	Due medication given as per drug chart order & documented. Baby weight checked & documented and PBS checked & documented. Monitored Input & output chart.	Paul 06307								
	6:30 AM	Child had complaint of loose stool inform Dr. Manonmani Mam and advice to check vitals & inform.									
	6:35 AM	Vitals checked & inform and Dr. Manonmani Mam came & seen the child and advice to contract 1/2 DNST 5cc. and monitor baby warming sign.	Paul 06307								

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NURSES NOTES

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☐ Drug Allergies NIL

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE								
	11AM	Monitored Input & output chart & documented	polu								
		child handed over to	021113								
11/7	7:30 AM	Morning duty staff Nurse									
		Morning Duty on (11/7/26)	polu								
	7:30AM	The child Handing over	021113								
		taken from night duty staff									
		the child was conscious &									
		active IV line present &									
		Pattern IV fluid 1/2 D5 & KCl									
		See 10ml/hr on flow									
8AM		Vital signs are checked &	vir								
		Recorded vital are stable	021113								
		<table border="1"> <tr> <td>8AM</td><td>CP</td><td>PP</td><td>CRT</td></tr> <tr> <td></td><td>++</td><td>++</td><td>13sec</td></tr> </table>	8AM	CP	PP	CRT		++	++	13sec	vir
8AM	CP	PP	CRT								
	++	++	13sec								
			021113								
8:20AM		Due to medication as per									
		drug chart order.									
		feed 32 ml 3/hr on flow	vir								
10AM		DR. Nandhini mams seen	021113								
		the child advice to									
		continue same	vir								
12pm		Vital signs are checked &	021113								
		Recorded vital signs									
		are stable									
		<table border="1"> <tr> <td>12pm</td><td>CP</td><td>PP</td><td>CRT</td></tr> <tr> <td></td><td>++</td><td>++</td><td>13sec</td></tr> </table>	12pm	CP	PP	CRT		++	++	13sec	vir
12pm	CP	PP	CRT								
	++	++	13sec								
			021113								
1PM		Maintained I/O chart	vir								
			021113								

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NURSES NOTES

☒ No Known Drug Allergies

☐ Drug Allergies ... Nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
11/7/26		Continue	
		DR. Samasharkar Sir seen	
		the child advice to	
		Continue same →	Wk 021103
	1:30pm	the child handling over	
		given to evening duty staff →	Wk 021103
		→ Evening Duty ←	
	1:30pm	Baby details Handing over	
		taken from evening duty s/n	
		Baby was conscious. A line	
		Desent & pattern. No tube	
		present. Baby under the room	
		air. Baby had no feed.	Wk 021103
	2pm	Due Mebberin given as per	
		duty chart order.	
	3pm	Due Mebberin given	
		Feed given	
	4pm	Vitals are checked send.	
		Vitals are stable PP/CP/CR	
		HR RR Cx	
	5pm	Feed given.	
	6pm	Due Mebberin given as per	
		chart. Maintain Hctm	Wk 021103
	7:30pm	Baby details Handing over	
		to the night duty s/n.	

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12/7	7:30 PM	← night duty → -) child detail handing over taken by Evening duty SW -) Child was Conscious and Awake child was active & alert Dr in patient	 0189
8 PM		-) vitals are checked and Recorded vitals are stable	 0189
8 PM		-) One Medication as given as per day Chart entry	
11 PM		-) Neonate 99ml provided and heavy, cop. Creon, given	 0189
12 PM		-) vitals are checked and Recorded vitals are stable	
		-) One medication as given	
		-) child sleeping well no Complaints of sleeping disturbance	 0189
1 AM		Vitals signs checked & recorded. Vitals are stable now CP PP CR +1 +1 22.	
		F.R. should be continued on infusion going. no complaints. child sleeping was good. O2 chart maintained	 Jay

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NURSES NOTES

☐ No Known Drug Allergies

☐ Drug Allergies Nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE						
12/17/20	6am	Due medication are given as per drug chart order. No chart maintained							
	7:30 am	Handing over given to morning duty S/N.	J. Jeyaraj						
		Morning duty.							
	7:30am	child details. handover from the Night duty staff. child was Alert. Conscious & orrendal. Dr line pattern.							
	8am	check the vital signs vitals are the stable no fever spike.	J. Jeyaraj						
		<table><tr><td>cp</td><td>pp</td><td>CRP</td></tr><tr><td>++</td><td>++</td><td>Low</td></tr></table>	cp	pp	CRP	++	++	Low	
cp	pp	CRP							
++	++	Low							
		Due medication as given for the drug chart order.	J. Jeyaraj						
	8:30am	given to feed. New rate 33ml/hr total 99ml. monitor No chart							
	10am	Dr. Somasegaran sir phone call advised. feed Increase 100ml + MCT oil 10ml Dr advised.	J. Jeyaraj						

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

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
12/7/26	12pm	Dec medication as given for the drug chart order. No other complaints.	<i>[Signature]</i>
	1pm	Dec medication as given for the drug chart order. No other complaints Dr line patten.	<i>[Signature]</i>
	1230pm	child details handover given to the Evening duty staff	<i>[Signature]</i>
12/7/26		Evening duty (12/7/26)	
	1.30pm	child Handover taken from morning duty staff Nurse and child was conscious & oriented and w line present & child under room air & child N&S present and child was normal	<i>[Signature]</i> 012804
	2pm	NJ feed 120ml over 3hrs and child normal	
	4pm	vitals are monitored & recorded and vitals are stable	<i>[Signature]</i> 012804
	4.10pm	child had complaints of	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

NURSES NOTES

☒ No Known Drug Allergies

☐ Drug Allergies

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
12/7/26		loose stool very watery informed Doctor lucky vishesh sir	
	4pm	Again RBS checked 106mg/dl and informed	
	5pm	Dr. Vignesh sir seen the child and advice continue the same	Dr. Vignesh
	5:20 pm	Dr. Somasekhar sir advice to do electrolyte, ms, phosphorus order followed	Dr. Somasekhar
	5:30 pm	Sample taken & sende to lab & documented	
	6pm	Due medication given per drug chart order & documented	
	6:30 pm	Monitored. Input & output chart & documented.	
	7:30 pm	child handed over to night duty staff Nurse	Dr. Vignesh
		← Night duty →	
	7:30 pm	child detail handing over taken by Evening duty staff	Dr. Vignesh
		→ child was conscious and alert child was active & alert in line pattern	Dr. Vignesh
	8pm	→ vitals all checked and	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



NURSING INITIAL ASSESSMENT FOR PICU

Date of Admission: 8/7/26Source of Admission: ☐ OPD ☐ Ward ☒ Other: _____Reason for Admission: Loose stool 3 days, severe dehydration.Admission Diagnosis: Deebah syndromeAccompanied By: ☒ Parent ☐ Guardian ☐ Other Name: _____Primary Language: ☐ Telugu ☐ English ☐ Hindi ☒ Other Specify TamilDo you require an interpreter? ☒ Yes ☐ NoAllergies: ☐ Yes ☒ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other: _____If yes, identify NilSource of Information: ☐ Family ☐ Patient ☐ Others, Specify _____

	Past Medical History	Past Surgical History	Last Hospital Admission
SIGNIFICANT HISTORY	<u>K/clo Deebah syndrome</u>	<u>NIL</u>	<u>6/7/26 Rainbow Hospital</u>
	Family History: <u>NIL</u>		
	Has the child or close family member had recent contact with a communicable disease? ☒ Yes ☐ No If yes please list, <u>Nil</u>		
	Was the child's birth normal? ☒ Yes ☐ No If No, please describe problems: <u>Nil</u>		
CURRENT MEDICATIONS	Are the child's immunization up to date? ☒ Yes ☐ No <u>Nil</u>		
	Taking Medications? ☐ Yes ☒ No If yes, Fill the reconciliation form Medicine brought to the hospital? ☐ Yes ☒ No		
Observations: Weight: <u>4.7kg</u> L: <u>h</u> Head Circumference (< 2 years): _____ Temp.: <u>98°F</u> HR: <u>113/min</u> RR: <u>20/min</u> BP: <u>100/60mmHg</u> Pain Score: <u>0/10</u> Specify Site: _____ (Follow Pain Assessment Sheet & Document) Fall Risk Assessment: ☒ Yes ☐ No Score: <u>16</u> (Document in the Humpty Dumpty Sheet) Risk of Pressure Sore (Braden Q Score <u>20</u>) (Document in the Braden Q Assessment Sheet)			

Behavioural Status on Admission:

☐ Sleeping
 ☐ Crying
 ☐ Calm
 ☐ Distressed/Console
 ☒ Drowsy

FUNCTIONAL SCREENING: If a patient needs assistance with any of the following inform consultant

☐ Mobility problem
 ☐ Walking Problem
 ☒ No Abnormality Detected
☐ Developmental Delay
 ☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING:

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

Inform consultant for positive criteria

Psychological Screening: ☒ No Significant FindingsUnusual concerns about patient's Psychological Status: ☐ Yes ☒ No

If Yes Consultant Notified: (Date/Time):

Social History: Lives With *nil*Siblings in household ☐ Yes ☒ No (if yes How Many?)

Orientation has been given regarding the following aspects:

- ☒ ID Band in situ
☒ Bedside safety explained
☒ PICU Routine: Doctor's rounds/Medication time
☒ Visiting policy explained

Orientation given to: ☒ Family ☐ Others specify *nil*Name of Person Orientation was given to: *Mother*Orientation not given Reason: *nil*Nurse Name: *S. Muthu Pragas*Nurse Signature: *[Signature]*Date & Time: *6/11/26*

DISCHARGE PLAN

Source of Information: ☐ Family ☐ FriendWill patient require transportation arrangements to go home: ☐ Yes ☐ NoWill Physiotherapy require at home: ☐ Yes ☐ NoIs home medical equipment anticipated: ☐ Yes ☐ NoIs home oxygen therapy anticipated: ☐ Yes ☐ NoAre dressing needs at home anticipated: ☐ Yes ☐ NoAny other needs anticipated: ☐ Yes ☐ No If Yes SpecifyDischarge Medications: ☐ Yes ☐ No

Details:

Final Diagnosis:

Nurse Name:

Nurse Signature:

Date & Time:

PHLEBITIS ASSESSMENT

CANNULA 1

Date: 6/7/26 Time:

Location: RT IIV

Size: 4F 2lumen

Cannula inserted by: DR. Mohan

Date	Time	Phlebitis	Infiltration	Nursing Intervention	Sign
6/7	8pm	☒ Yes ☒ No	☒ Yes ☒ No	observe	8/10/2023
	10pm	☒ Yes ☒ No	☒ Yes ☒ No	observe	8/10/2023
7/7	12am	☒ Yes ☒ No	☒ Yes ☒ No	observe	8/10/2023
	2am	☒ Yes ☒ No	☒ Yes ☒ No	observe	8/10/2023
	4am	☒ Yes ☒ No	☒ Yes ☒ No	observe	8/10/2023
	6am	☒ Yes ☒ No	☒ Yes ☒ No	observe	8/10/2023
	8am	☒ Yes ☒ No	☒ Yes ☒ No	observe	8/10/2023
	10am	☒ Yes ☒ No	☒ Yes ☒ No	observe	8/10/2023
	12pm	☒ Yes ☒ No	☒ Yes ☒ No	observe	8/10/2023
	2p	☒ Yes ☒ No	☒ Yes ☒ No	patient	8/10/2023
	4p	☒ Yes ☒ No	☒ Yes ☒ No	patient	8/10/2023
	6p	☒ Yes ☒ No	☒ Yes ☒ No	patient	8/10/2023
	8pm	☒ Yes ☒ No	☒ Yes ☒ No	observe	8/10/2023
	10pm	☒ Yes ☒ No	☒ Yes ☒ No	observe	8/10/2023
8/7	12am	☒ Yes ☒ No	☒ Yes ☒ No	observe	8/10/2023
	2am	☒ Yes ☒ No	☒ Yes ☒ No	observe	8/10/2023
	4am	☒ Yes ☒ No	☒ Yes ☒ No	observe	8/10/2023
	6am	☒ Yes ☒ No	☒ Yes ☒ No	observe	8/10/2023
	8am	☒ Yes ☒ No	☒ Yes ☒ No	observe	8/10/2023
	10am	☒ Yes ☒ No	☒ Yes ☒ No	observe	8/10/2023
	12pm	☒ Yes ☒ No	☒ Yes ☒ No	observe	8/10/2023
	2pm	☒ Yes ☒ No	☒ Yes ☒ No	observe	8/10/2023
	4pm	☒ Yes ☒ No	☒ Yes ☒ No	observe	8/10/2023
	6pm	☒ Yes ☒ No	☒ Yes ☒ No	observe	8/10/2023
	8pm	☒ Yes ☒ No	☒ Yes ☒ No	observe	8/10/2023
	10pm	☒ Yes ☒ No	☒ Yes ☒ No	observe	8/10/2023
	12am	☒ Yes ☒ No	☒ Yes ☒ No	observe	8/10/2023

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

CANNULA 2

Date: 26/3/26 Time: 3pm

Location : Lt Brachial

Size : 24' 4"

Cannula inserted by: D/c Salame

[illegible]

Cannula removed : ☒ Yes ☐ No, if yes date and time : 7/7/26
RX any initiated : ☒ Yes ☐ No ☐ NA If Yes specify :
Phlebitis score: 2/4 at bar

NOTE :

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

PHLEBITIS ASSESSMENT AND MANAGEMENT RECORD

CANNULA 3

Date: 6/7/26 Time:

Location : RE ISV

Size: HF 2 lum @n

Cannula inserted by : Dr. Mohan

[illegible]

Cannula removed : ☐ Yes ☒ No, if yes date and time :

RX any initiated : ☐ Yes ☒ No ☐ NA If Yes specify-

Phlebitis score: 0/6

CANNULA 4

Date: 10/7/26 Time: 02:30pm

Location : (R) cephalic.

Size : $24 \times 4 (P_1)$

Cannula inserted by: S/N Sharmula

Date	Time	Phlebitis	Infiltration	Nursing Intervention	Sign
10/26	230pm	☐ Yes ☒ No	☐ Yes ☒ No	pullbm	800m
	4pm	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
	6pm	☐ Yes ☒ No	☐ Yes ☒ No	obsd	
	8pm	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
	10pm	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
11/2	12AM	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
	4AM	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
	8AM	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
	2AM	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
	10AM	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
	12pm	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
	2pm	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
	4pm	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
	6pm	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
	8pm	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
12/1	12AM	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
	2AM	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
	4AM	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
	6AM	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
	8AM	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
	10AM	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
	12pm	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
	2pm	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
	4pm	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
	6pm	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
	8pm	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
12/7	12AM	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
	2AM	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
	4AM	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
	6AM	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
	8AM	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
	10AM	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
	12pm	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
	2pm	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
	4pm	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
	6pm	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
	8pm	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
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	4AM	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
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	8AM	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
	10AM	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
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	4AM	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
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	8AM	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
	10AM	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
	12pm	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
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	4pm	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
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	8AM	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
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	12pm	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
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	4pm	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
	6pm	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
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	12AM	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
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	4AM	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
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	12pm	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
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	4pm	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
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	10AM	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
	12pm	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
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	4pm	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
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	4AM	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
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	6AM	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
	8AM	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
	10AM	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
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	2pm	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
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	8pm	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
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	12AM	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
	2AM	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
	4AM	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
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	4pm	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
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	8pm	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
	10pm	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
	12AM	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
	2AM	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
	4AM	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
	6AM	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
	8AM	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
	10AM	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
	12pm	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
	2pm	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
	4pm	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
	6pm	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
	8pm	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
	10pm	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
	12AM	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
	2AM	☐ Yes ☒ No	☐ Yes ☒ No	obsd	800m
	4AM	☐ 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 TREATMENT RESITE / REMOVE CANNULA

PHLEBITIS ASSESSMENT

CANNULA 1

Date : 10/11/26

Time: 2.30 PM

Location: (R) cephalic

Size : 24 a

Cannula inserted by: S/N Sharmila

[illegible]

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 :

[illegible]

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

Patient's Name:.....

MRD NO:.....Room No:.....

Age : Weight : Sex: ☐ M ☐ F

Consultant :

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 :

CANNULA 4

Date :

Time:

Location :

Size :

Cannula inserted by :

[illegible]

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

[illegible]

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 TREATMENT RESITE / REMOVE CANNULA



PAIN ASSESSMENT FORM

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
6/7/26	8pm	0/10	NIL	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NIL	Spa 0624
7/7/26	4am	0/10	NIL	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NIL	Spa 0624
7/7/26	12p	0/10	NIL	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NIL	Spa 0624
7/7/26	4pm	0/10	NIL	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NIL	Spa 0624
7/7/26	11pm	0/10	NIL	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NIL	Spa 0624
8/7/26	4am	0/10	NIL	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NIL	Spa 0624
8/7/26	12pm	0/10	NIL	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NIL	Spa 0624
8/7/26	8pm	0/10	NIL	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NIL	Spa 0624
9/7/26	4am	0/10	NIL	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NIL	Spa 0624
9/7/26	12pm	0/10	NIL	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NIL	Spa 0624

Re-assessment Frequency:

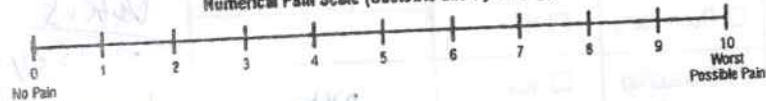
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 - 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

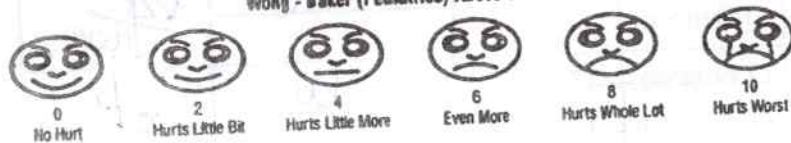
Numerical Pain Scale (Obstetric and Gynecology)



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

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

Wong - Baker (Pediatrics) Above 7 Years





2

PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
9/7	3pm	0/10	NIL	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☒ No	NIL	Blue 50042
10/7	4am	0/10	NIL	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☒ No	NIL	Blue 010042
10/7	12pm	0/10	NIL	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☒ No	NIL	Par 018304
10/7	2pm	0/10	NPI	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☒ No	NPI	Comp born
10/7	8pm	0/10	NIL	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☒ No	NIL	dey 010 -
11/7	4AM	0/10	NIL	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☒ No	NIL	dey 018304
11/7	8AM	0/10	NIL	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☒ No	NIL	dey 021113
11/7	2pm	0/10	NIL	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NIL	dey 018304
11/7	8pm	0/10	NIL	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NIL	dey 018304
12/7	12am	0/10	NIL	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NIL	dey 018304

Re-assessment Frequency:

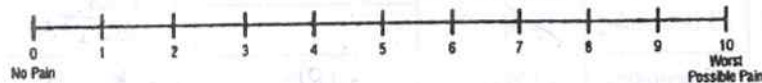
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 - 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

Numerical Pain Scale (Obstetric and Gynecology)



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

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1		1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression Intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR, RR, BP, SaO₂	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO ₂ 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

Wong - Baker (Pediatrics) Above 7 Years



THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	6/7	7/7	7/7	7/7	8/7
	3 to less than 7 years old	3	4	4	4	4	4
	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	3	3	3	3	3
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1					
Cognitive Impairments	Not aware of Limitations	3	3				
	Forget Limitations	2		2	2		2
	Oriented to own ability	1					
	History of Falls or Infant-Toddler Placed in Bed	4	4	4	4	4	4
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2				
	Outpatient Area	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			16	16	16	16	16

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		x	x	x	x	x
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:		Spencer	Spencer	Spencer	Spencer	Spencer
Signature:		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date:		6/7	7/7	7/7	7/7	8/7
Time:		8pm	8pm	2pm	8pm	2pm



(2)

THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	N	M	F	N	M
	3 to less than 7 years old	3	4	4	4	4	4
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2					
	Female	1					
Diagnosis	Neurological Diagnosis	4	1	1	1	1	1
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia, Syncope / Dizziness, etc.)	3	3	3	3	3	3
	Psych / Behavioral Disorders	2				3	3
	Other Diagnosis	1					
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2	2	2	2	2	2
	Oriented to own ability	1					
	History of Falls or Infant-Toddler Placed in Bed	4	4	4	4	4	4
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2					
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	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			16	16	16	16	16

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		x	x	x	x	x
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:		Bhaskar	Shella	Shanika	Shanika	Shella
Signature:		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date:		8/7/26	9/7	9/7/26	9/7/26	9/7/26
Time:		8pm	8pm	8pm	8pm	8pm



THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	10/12	10/12	10/12	11/12	12/12
	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	3	3	3	3	3
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1					
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2	2	2	2	2	2
	Oriented to own ability	1					
	History of Falls or Infant-Toddler Placed in Bed	4	4	4	4	4	4
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2					
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours/ None	1	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			16	16	16	16	16

Intervention:

-Fall Risk: Low Humpty Dumpty Score = 7-11,

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		✓	✓	✓	✓	✓
Call device within reach		✓	✓	✓	✓	✓
Wheels Locked		✓	✓	✓	✓	✓
Room free of clutter		✓	✓	✓	✓	✓
Adequate lighting		✓	✓	✓	✓	✓
Wheel chair support		✓	✓	✓	✓	✓
Other Intervention(s) Specify		✓	✓	✓	✓	✓
Nurse's Name:		Shamika	Shamika	Shamika	Shamika	Shamika
Signature:		Shamika	Shamika	Shamika	Shamika	Shamika
Date:		10/12/25	10/12/25	10/12/25	11/12/25	12/12/25
Time:		02M	02M	08M	08M	2M

BRADEN 'Q' SCALE

(for Paediatric use)

SNC-00024099 IP18-00036244
Baby AADHAVI S
08-04-2025 1 Y 3 M 1 D (F)
Dr. SOMASHEKARA H R



N/BRD-Q/NSG/04

Patient Name :

Age: Gender: ☐ M ☐ F IP No.:

Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.
*Activity The degree of physical activity	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.
FRICTION-SHEAR Friction Occurs when skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times.
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 of 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 meat and dairy products. Occasionally eats between meals. Does not require supplementation.
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.
TOTAL SCORE				20
Evaluator's Name				Dr. Somashekara H R

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

10/10/2020

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10/10/2020

BRADEN 'Q' SCALE (for Paediatric use)

Patient Name :

Age :

Gender :

		Date : 8/2 8/2 8/2		N M		9/7	
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
'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 waking hours.	1	1	1
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: Responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	3	3	3
Friction-Shear Friction Occurs: when skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times.	4	4	4
Nutritional Usual food intake pattern	1. Very Poor: NPO/for 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 meat and dairy products. Occasionally eats between meals. Does not require supplementation.	2	2	2
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
TOTAL SCORE				22			
Evaluator's Name				Dr. Somashekara H R			

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



BRADEN 'Q' SCALE

(for Paediatric use)

Patient Name :
Age : Gender :

Date : <u>9/7/24</u>		F N M E		
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.
'Activity The degree of physical activity'	1. Bedfast: Confined to bed	2. Chairfast: Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate: OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: Responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.
FRICITION-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. Problems: 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.
Nutritional Usual food intake pattern	1. Very Poor: NPO/for 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 of 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 meat and dairy products. Occasionally eats between meals. Does not require supplementation.
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be < 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.
TOTAL SCORE				22
Evaluator's Name				<u>Dr. Somashekara H R</u>

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

BRADEN 'Q' SCALE

(for Paediatric use)

4

Patient Name :
Age..... G.....

SNC-0002409
Baby AADHA'S
08-04-2023
Dr. SOMASHEKARA H R

IP18-0003

Vo.: F/HW/BRD-Q/NSG/04

1 Y 3 M 4 D



Date : 10/2/23 11/2 12/2 12/2				
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.
'Activity The degree of physical activity'	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.
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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 meat and dairy products. Occasionally eats between meals. Does not require supplementation.
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.
TOTAL SCORE				
Evaluator's Name				

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

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

SNC-00024099

Baby AADHAVI S

06-14-2025

Dr. SOMASHEKARA H R

IP18-00036364

1 Y 3 M 6 D

(F)



Diagnosis

2. Treatment and Care

Plan

3. Pain Management

4. Informed Consent

5. Medication / Therapy (safety, effects/ side effect, interactions)

6. Discharge Medication

7. Infection Control Measures

8. Diagnostic Test / Procedures

9. Nutrition / Diet

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Tamil / English

Patient / Learner Literacy: ☒ Read ☒ Write ☒ Speak

Willingness to Learn: Yes ☒ No ☐

Healthcare Literacy: Yes ☐ No ☒

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		
13/7/25	8am	1	Explain about the Infection Control programme	Mother	Nil	oral	none	understand	Good	Adhitya

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	4. Language Barrier	7. Impaired Thought Process/Cognitive limitations	10. Financial Difficulties	13. Cultural/Religion Practice
2. Physical Impairment	5. Educational Level	8. Responsibilities at Home	11. Beliefs and Values	14. Others (Specify)
3. Emotional Barriers	6. Desire / Motivate to Learn	9. Cultural Differences	12. Impaired Vision/ or Hearing	

Teaching Tools Used: A: Audio D: Demonstration V: Video O: Oral P: Printed

Mechanism/s to overcome barrier/s:

1. None	3. Reassurance & Support	5. Respect values & beliefs	7. Other, Specify
2. Obtain translator	4. Teach Family / Others	6. Respect Cultural / Religion Preference	

Understanding:

1. Verbalizes Understanding	2. Demonstrates Understanding	3. Needs Review
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CENTRAL LINE MAINTENANCE CARE BUNDLE CHECK LIST

Type of Line: ☐ PICC Line ☐ UAC ☐ UVC ☐ Other RT TTV Date of Initial Line Insertion: 1/7/26 Duration of Central Line: 48h 8 Lumen Dr. Nohah.

- Always perform hand hygiene before accessing central line
- Use Sterile gloves for handling central line
- Clean the hub with antiseptic solution every time before & after it is accessed
- Consider – antibiotic via central line before removal of the line
- Inspect Central line in each shift for the following

Parameters	Date	Shift Time	6/7/26 N	7/7/26 M	7/7/26 E	7/7/26 N	8/7/26 M	8/7/26 E	8/7/26 N
Can we remove Central Line today (Discuss in the clinical round)			☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☒ Yes ☐ No
Evidence of any inflammation at insertion site (Redness / Swelling (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☒ No
Blood at insertion site (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☒ No
Any peeling of dressing? (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
Is dressing clean and dry? (If no inform the doctor)			☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☒ Yes ☐ No
Any leakage at insertion site? (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No
Is there any obstruction to the infusion flow? (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
Dressing intact and labelled properly			☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☒ Yes ☐ No
Central line changed on			NIL	NIL	NIL	NIL	NIL	NIL	NIL
Name of the Nurse			Speers	Logeshwari	Vidya	Speers	Logeshwari	Logeshwari	Shanthi
Signature of the Nurse			[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]

CONSENT FOR SPECIAL PROCEDURES AND SEDATION

Ref. No. : F / HW / CON / SP / 06

Patient Name

SNC-00024099

IP18-000

Gender : I

Baby AADHAVI S

08-04-2025

1 Y 3 M 1 D

Age :

Dr. SOMASHEKARA

Date :



I, S/DW/O.....

hereby consent for the procedure of.....

For my patient / myself named.....UHID NO.....

The doctors have clearly explained to me in language known to me about the following possible complications of the procedure:

The doctors have explained to me about the alternative to the procedure as :

During the procedure myself / my patient will receive intravenous medications for sedation using the following medications : JEANMEDOT MIBINE, PROPOFOL, KETAMINE

I have been explained about possible complication of sedation such as: fall in blood pressure ☒

Fall in heart rate ☐, suppression of spontaneous breathing ☒, others..... hypoxemia, desaturation

I have been explained about the alternative to the sedatives as : Need for intubation

I have understood the matter mentioned above and give consent for the procedure as well as sedation.

Name of the Doctor performing the procedure :

Name of the Doctor administering the sedation:

Patient Attendant :

Witness :

Signature : Sandhya

Signature :

Name : SANDHYA

Name :

Relationship with Patient: MOTHER

Date & Time :

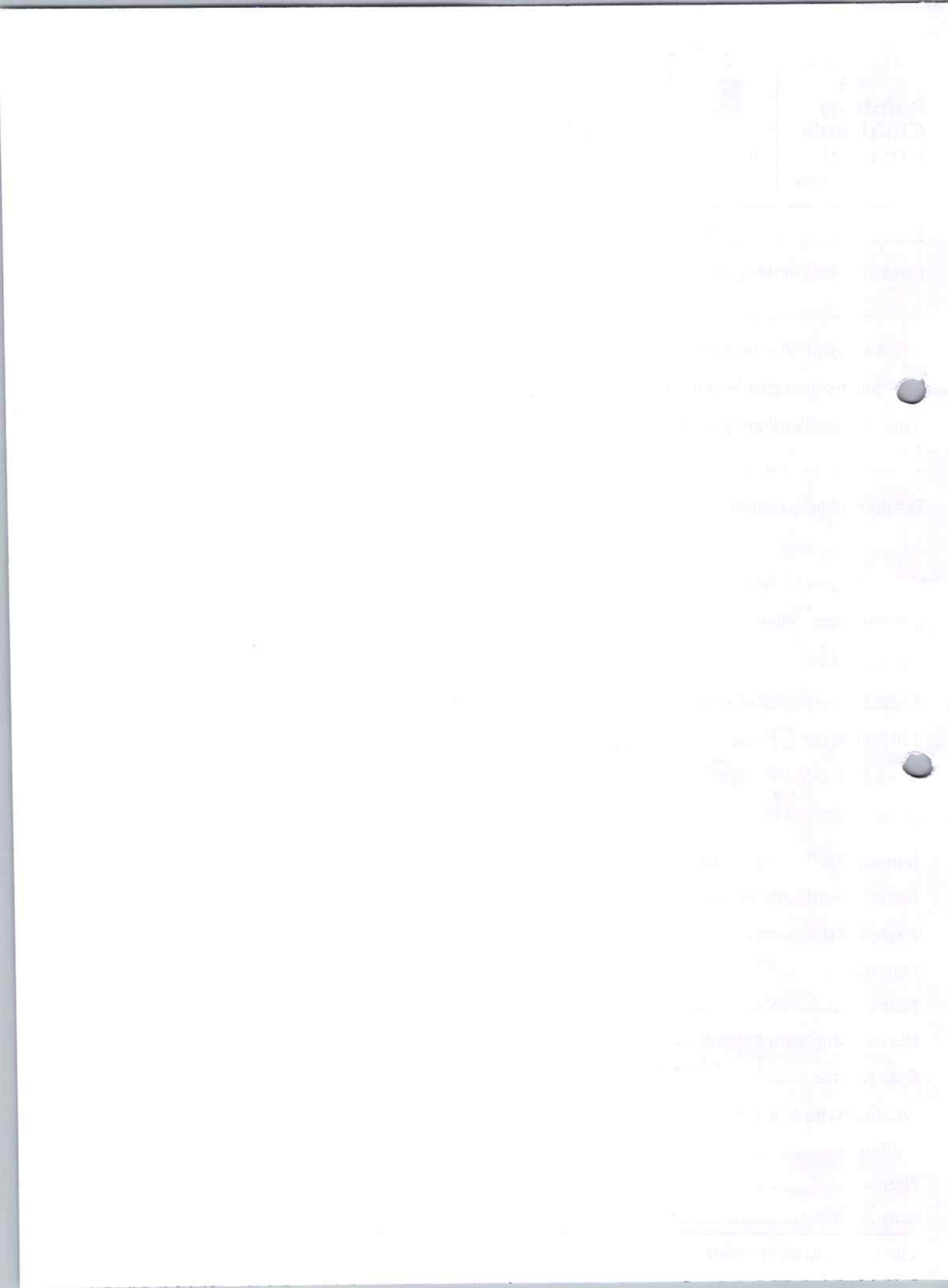
Date & Time : 8/7/2024 At 10.10 PM

Doctor (who is taking the consent) :

Signature : [Signature]

Name : Dr. Mohan Datta

Date & Time : 08/07/24 12.10 PM



CONS

SNC-00024099

Baby AADHAVI S

06-04-2025

1 Y 3 M 1 D

Dr. SOMASHEKARA H R



IP18

GI ENDOSCOPYRainbow
Children's
HospitalBirthRight
BY RAINBOW HOSPITALS
YOUR BABY IS A BORN DOCTOR

Patient No:

Consultant

2:

ard & Bed No.:

Sex: M / F

UHID:

Description of the Procedure

Upper GI endoscopy or oesophago gastroduodenoscopy (OGD) is a visual examination of the lining of the oesophagus, stomach and the first part of the intestine (duodenum). This is performed by passing a long flexible tube through the mouth. The doctor will be able to look for any abnormalities which may be present. If necessary small tissue samples (biopsies) can be taken during the examination for detailed laboratory analysis.

Treatment can also be done through the endoscope. This includes dilatation and/or stenting of narrowed areas, removal of polyps and swallowed objects and treatment of bleeding vessels and ulcers by injection or the application of heat, and procedures such as banding. You / Your child will have to lie on your left side and a guard will be placed to protect your teeth and the scope. A local anaesthetic may be sprayed on your throat to make it numb and occasionally you / your child may be given a sedative injection. The doctor will then pass the scope through your mouth and down the throat while you make a swallowing movement. The instrument will not affect you / your child breathing or cause pain. The examination takes about five minutes on an average.

Precautions

1. You / Your child's stomach must be empty so do not eat or drink anything after midnight.
2. If you / your child are undergoing the procedure in the afternoon, you / your child can have a light breakfast before 8 AM and clear liquids till 11 AM and nil after that.
3. You must inform the doctor or nurse if you / your child have any allergies or have had previous endoscopic procedures or surgeries. Please bring all previous reports.
4. You / Your child must remove your eyeglasses and dentures.

Risks

Endoscopy can result in complications, such as reactions to medications, perforation (tear) of the food passage and bleeding. These are very rare (less than 1 in 1000 examinations), but may require urgent treatment including, rarely, surgery. The possibility of complications is increased when the scope is used for treatment.

CONSENT FOR THE PROCEDURE

1. My questions and concerns about my / my child's condition, the procedure, cost, risks, and treatment options have been discussed with the doctor and answered to my satisfaction.
2. I have been advised of my / my child's medical condition, the benefits and reason for the procedure as indicated by the clinical observations and/or diagnostics performed, the risks of not having the procedure, alternative tests I could have and their risks.
3. I recognize that no guarantees have been made regarding likelihood of success or outcomes and also whether the procedure will give the doctor any further information and that further tests may be needed. I also give consent for treatment through the scope if the situation warrants it.
4. I authorize Dr. Kaesthivasan and such assistants and associates as may be selected by him/her to perform any part of the above procedure upon myself / my child.
5. As with any procedure, I am aware that risks such as blood loss, infection, change in blood pressure, heart failure, anesthetic/ allergic reactions, etc., may arise necessitating attention. Therefore, besides consenting to the performance of the procedure, I also consent and authorize the rendering of such other care and treatment as my Doctor or his designee reasonably believes necessary.
6. I understand that biopsy tissues taken during this procedure will be kept for tests for a period of time.
7. I consent and agree to the administration of sedation by Dr. Kaesthivasan for the performance of this procedure. I am aware of the risks of the sedation and also consent to supplementation with any other mode of anaesthesia if necessary.

CONSENT FOR UPPER GI ENDOSCOPY

Rainbow
Children's
Hospital

BirthRight
BY RAINBOW HOSPITALS
Your Point in a Safe Delivery

8. I have informed the Doctor of all my / mychild's previous illnesses, allergies, drug reactions, surgical procedures and all other facts relevant to my treatment. I shall not hold the Hospital or the Doctor responsible for the consequences which may arise from the non-disclosure of the same.
9. I give my consent for the administration of blood product transfusion during this procedure if required. I have been informed that despite careful screening in accordance with national and international regulations, there are rare instances of life-threatening infections such as AIDS, Hepatitis and other viruses or diseases as yet unknown for which screening tests do not exist. I also understand that unpredictable reactions may occur which include but are not limited to rash and shortness of breath, shock and in rare occasions death.
10. I consent to the photography or television of the procedure to be performed for the purpose of advancing medical education, or its publication in scientific journals provided my / mychild's identity is not revealed by the pictures or descriptions in the accompanying texts. I also consent to and authorize the presence and observation of this procedure by qualified observers, as may be authorized by the Rainbow childrens Hospitals Chennai and its regulatory laws and agencies.
11. The investigation samples (blood or tissue) obtained for diagnostic tests from you may be used by research scientists or scientists affiliated with Rainbows research for the advancement of medical sciences to serve humanity for better preventive or therapeutic purpose. This will happen only if there is any sample left over after its intended medical use. Similarly, data associated with your treatment can be shared with research scientists without disclosing your identity. This research will not benefit you financially but may help in better understanding of diseases and better treatment for future patients.

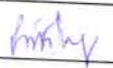
You have the option to disallow us from such research use of your sample and data.

I confirm that I have read and understood the information and I consent to participate.

12. CONSENT OF PARENT / PARENT REPRESENTATIVE / SURROGATE

Having understood the above I give my consent for me / mychild's undergoing the above said procedure at Rainbow childrens Hospitals, Chennai and absolve the said Hospital, its doctors and the staff in the event of any complication. I acknowledge that I have had an opportunity to discuss this procedure, as stated above, with the doctor or doctor's designee, and thereby consent to this procedure.

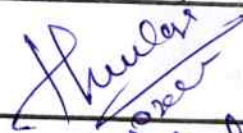
I, ----- (name / relationship to the patient) therefore, consent for the procedure to performed on me / my child.

	Signature	Name	Date	Time
Patient Representative with relationship		SANDHYA	8/7/26	12.10pm
Witness				
Doctor		Dr. Keerthi	8/7/26	12.10pm
Interpreter				

(Authorization of patient/patient representative surrogate)

	Signature	Name	Date	Time
Patient				
Witness				
Doctor				
Interpreter				

PATIENT TRANSFER FORM

Patient Name & UHID No. SNC-00024099 IP18-000: Baby AADHAV S 06-04-2025 1 Y 3 M 4 D Dr. SOMASHEKARA H R 		Date & Time of Admission 7/7/26 E 1:20pm	Date & Time of Transfer Order 10/7/26 E 3:30pm
		Transfer Ordered by Dr. Somashukara	Reason for Transfer observation
From Unit PICU	To Unit SOS	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File	Number of Imaging Films 2 x-ray reports.	Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	/		
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☐ No ☐			
Name & Signature of Person who is Transferring Sharmila A 018726		Name of Person Ordered Transfer Dr. Somashukara	
Patient & Clinical Records Received by : 			
Date & Time of Patient Received : 10/7/26 at 3:30pm			

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

IP18-00036364

1Y3M2D

1-04-2025

r. SOMASHEKARA H R

(F



Answer 1

P.T.O.

COUNSELLING CHART

Rainbow Children's Hospital It takes a lot to love the little ones.		BirthRight BY RAINBOW HOSPITALS Your Right to a Safe Delivery		DATE			
RESPIRATORY SYSTEM		26 8/2 9/2/07					
HIGH FREQUENCY OSCILLATION VENTILATOR							
INHALED NITRIC OXIDE							
NON-INVASIVE VENTILATION							
CPAP							
HFNC							
OXYGEN							
ROOM AIR							
CARDIOVASCULAR SYSTEM							
INOTROPES (Y/N)							
HYPOTENSION (Y/N)							
ABDOMEN:							
FEED INTOLERANCE (Y/N)							
FLUIDS							
TPN							
PPN							
ONLY FLUIDS							
INFECTION (Y/N)							
GENERAL CONDITION							
MORIBUND							
CRITICALLY ILL							
SICK							
IMPROVING							
STABLE							

DATE	REMARKS	DOCTOR'S SIGN	PARENT'S SIGN
7/2	DEBAT Syndrome Severe GERD ON CONTINUOUS FEEDS + Anti reflux med		
	Needle at NJ tube Need post surgical input	E	Gustaf
8/2	previous problems as listed. Planned for NJ feeds	E	Gustaf
9/2	on NJ feeds tolerating feeds low iron for Iron Intake	E	Gustaf
10/2	on NJ feeds tolerating feeds Plan: to remove central line	E	Gustaf

