Rainbow Children's Hospital

GUC-00093296 IP18-00036272
Baby YUGAN KUMAR
05-04-2020 6 Y 2 M 27 D (M)
Dr. VAISHNAVI CHANDRAMOHAN

UH

SCHARGE TRACKING SHEET

NAME OF CONSULTANT-

ACTIVITY	INTIM E	OUT TIME	NAME & SIGNATUR E	REMARKS	<To be filled by Admin >		
Activity Sheet update by Nursing	2/7/20	10am					
Activity Sheet update by Pharmacy							

ACTIVITY RECORD FOR BILLING

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

Name: .....

UHID No: ..... IP I GUC-00093296 IP18-00036272
Baby YUGAN KUMAR
05-04-2020 6 Y 2 M 26 D (M)
Dr. VAISHNAVI CHANDRAMOHAN
..... Dept: .....

Date of Admission: .....

Room / Bed No: ..... Wa..... charge: ..... Time: .....

Suggested Billable bed type: .....

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
1/07/26	5:25pm	ER	606	

CROSS CONSULTATION VISIT

	Doctor Name	Date	Order No.	Signature
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

INVESTIGATIONS

Date	Investigations	Order No.	Signature
01/07/26	CBC, CRP, RP-2, LFT, RBS	26020894 26020895	

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
01/7/26	Infusion pump	5.30pm	2/7/26 @ 6Am.	20257	[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
01/07	IV Placement	(1)	1720236	

ANY OTHER INFORMATION:

.....

.....

.....

.....

.....

.....

Date: 2/7/26 Time: 06:00 pm Prepared By: .....

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

Rainbow Children's Hospital | BirthRight

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					

Rainbow Children's Hospital

BirthRight by Rainbow

Rainbow Children's Hospital - Guindy

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

ADMISSION SHEET

Registration Details :

Admission No : IP18-00036272 **Admit Date** : 01-Jul-2026 **Admit Time** : 04:45 PM **UHID** : GUC-00093296

Patient Details :

Patient Name	: Baby YUGAN KUMAR		
Guardian	: Mr .	**Age**	: 6 Y 2 M 26 D
Gender	: Male	**DOB**	: 05-04-2020
Occupation	:	**Religion**	:
Address (H)	: NO.9 VANDIKARAN STREET, VELACHERRY Velacheri Chennai Tamil Nadu INDIA 600042	**Martial Status**	:
		Phone No	: 9940071717
		E-mail	: roop.saranya@gmail.com

Admission Details :

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

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

Contact Details :

Name : Mr .

Relationship : Father

Contact Address : NO.9 VANDIKARAN STREET, VELACHERRY Velacheri Chennai Tamil Nadu INDIA 600042 **Phone No** : 9940071717

Signature

Doctor Details :

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

Referral Doctor : FRIENDS **Phone No** :

Co-Consultant :

Payment Details :

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

Payor Name : SELFPAY

Rainbow Children's Hospital
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TEL NO :044-40122444
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GENERAL CONSENT FOR TREATMENT

Patient Name:	**Baby YUGAN KUMAR**	**Age :**	**6 Y 2 M 26 D**
IP No:	**IP18-00036272**	**Sex:**	**Male**
Consultant:	**Dr. VAISHNAVI CHANDRAMOHAN**	**Ward/Bed No:**	**0F-EMERGENCY/ER 101**

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

Patient, be deemed advisable or necessary.

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

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

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

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

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

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

Signature of Patient/Relative:

Name:

Relationship:

Date:

Time: 01:45 PM

Witness Name: R Thamarai Selvan

Witness Signature:

Patient Address:

NO.9 VANDIKARAN STREET,
VELACHERRY Velacheri Chennai Tamil Nadu INDIA 600042

BILLING POLICY

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

DECLARATION

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

Patient Name Baby · YUVAAN KUMAR	UHID Number : 93296
Self/Attendant Name :	Relation : FATHER
Self/ Attendant Signature :	Name & Signature of Financial Counselor
Phone Number :	

Baby YUGAN KUMAR
05-04-2020 6 Y 2 M 26 D (M)
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BED SIDE CHECK LIST FOR NURSES

Date:	01/7								
Doctor's Orders	Dr. Vaishnavi								
Carried out or not	Yes								
Bed Side									
Structured Handover done	✓								
IV Site	✓								
Central Lines	X								
Arterial Lines	X								
Feeding Catheter	X								
Urinary Catheter	✓								
Skin Care	✓								
Eye Care	✓								
Mouth Care	✓								
Sterillum Bottle, Stethoscope	✓								
Suction Bottle (Should be clean & empty)	X								
Intubation Tray	X								
Emergency Tray (Loaded Syringes with Midazolam & Vecuronium and Flush) Ampoules of Adrenaline	X								
Ventilator Tubing,(Any Water, Blood)	X								
Humidification	X								
Check all Infusion (Labelling,Correct Preparation)	✓								
Chest Physio & Neb	X								
Handed Over By Name :	Anupriya								
Signature :									
Date & Time:	01/7 @ 6pm								
Hand Over Taken By Name :									
Signature :									
Date & Time:									

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Hospital
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PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: _____

UHID ID: _____

GUC-00093296 IP18-00036272
Baby YUGAN KUMAR
05-04-2020 6 Y 2 M 26 D (M)
Dr. VAISHNAVI CHANDRAMOHAN

Department: _____

Consultant: _____

(P.T.O.)

Patient Sticker

Pediatric Multiorgan History & Physical Examination

Name: _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

- c/o fever, vomiting, loose stools] x 1 day

History of present illness :

Apparently well child,

- c/o fever, high grade intermittent] x 1 day.

- c/o vomiting x 1 day, multiple episodes since morning, non-bilious, not blood stained undigested food particles (+).

- c/o loose stools x 1 day. 4 episodes, foul smelling, not blood stained

- c/o ↓ urine output

- c/o ↓ oral intake

- c/o ↓ decreased activity

Patient Sticker

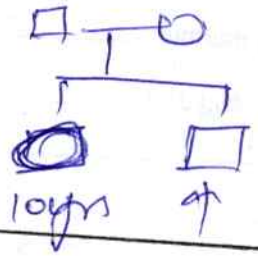
Past History : (Including details of any previous investigation or treatment)

No prev admission

Birth & Neonatal History:

NVD / Full Term / CIAB / BW - 3.8 kg
No NICU stay

Family Chart



Birth & Socio Economic History:

About Father : 4
About Mother : NCM
Any additional Information :

Developmental History : Dev - (N)

Immunization History : as per us immunisation schedule

(Last vaccine @ 5yrs)

Anthropometry :

Head Circum (cms) _____ (Centile _____) Height (cms): _____ (Centile _____)
Weight (kgs) 22.8 kg (Centile _____)

On Examination :

Temperature : 98.2°F Pulse Rate : 107/min B.P. 101/61 (74) SPO2 99%
Resp.rate and type of breathing : 28/min

Rash — Awake & Alert
Lymphadenopathy — PPWF (+)
Oedema : — CRT < 2sec
Allergies (if any): Not known Oral - drug

(P.T.O.)

Patient Sticker

Respiratory System :

Inspection (any s/o distress) :

Air entry & breath sounds : B/L AE (+) . NVBS (+)

Any addes sounds : (-)

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

Cardiovascular System :

Inspection of procordium :

Heart Sounds : S1S2 (+)

Any murmur : (-)

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

Per Abdomen :

Inspection :

Palpation : Soft, not tendee, no organomegaly

Ausculation :

Spine : (N) External Genitelia : (N)

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

Central Nervous System :

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

Cranial Nerves :

Motor System :

Nutriton :

Tone: (N) Power 5/5 in all 4 limbs

Co-ordinator :

Posture :

Involuntary Movements :

Patient Sticker

Reflexes :

DTR 2+ **Superficials:** 1+

Plantars ↓

Sensory System :

Bladder / Bowel :

Clinical Summary & Diagnostic: Δ : AGE c̄ some dehydration

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

Desired goals of the treatment :

Planned Labs:

- CBC ✓
- CRP ✓
- RP-2 ✓
- LFT ✓

Planned Management

- IVF 0.9% [illegible] RL 1000ml over 4hrs
- IV PAN
- IV EMESET
- IV XONE
- Z G D drops.

f/b IVF DNS

Signature of the Doctor: [signature]

Name of the Doctor: Dr. Gayathri

Date & Time: 1/7/26

Signature of the Consultant: [signature]

Name of the Consultant: Dr. Vaishnavi

Date & Time: 1/7/26, 6.30pm

(P.T.O.)

Patient Sticker

DISCHARGE PLANNING FORM

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

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

2. Destination Post Discharge: ☐ Home
   Family Members Notified (Person Contacted)
   ☐ Transfer
   Hospital Facility Notified (Person Contacted)

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

   ☐ Needs Assistance In:

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

4. Nutritional Plan:
   ☐ Dietary Instruction Discussed with the:
   ☐ Patient ☐ Family Member ☐ Others: .....

5. Discharge Planning Discussed with the:
   ☐ Patient ☐ Family Member ☐ Others: .....

6. Patient/Family Educational Plan:
   ☐ Educational Topic/s: .....

   ☐ Patient's Educational Topic/s discussed with the:
   ☐ Patient ☐ Family Member ☐ Others: .....

Doctor Signature: .....

Doctor Name: .....

Date and Time: .....

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

DOCTOR'S SHIFT CHANGE HANDOVER FORM

Rainbow® Children's Hospital
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Date: ..... Department: ..... Shift: .....

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

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

DOCTOR'S SHIFT CHANGE HANDOVER FORM

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BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

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

GUC-00093296 IP18-00036272
Baby YUGAN KUMAR
05-04-2020 6 Y 2 M 26 D (M)
Dr. VAISHNAVI CHANDRAMOHAN

(1)

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/7/26	S/B Dr. Gayathri	
5am	Δ - AGE c̄	some dehydration.
	Child afebrile	
	No of vomiting	abdominal pain
	loose stools	- 2 episodes
	Hydration - on	flow
	u/o - good	PPWF (+).
	intake - improved	
	O/E - Child asleep	
	CVS / RS | NAD	Abd - soft, not tender BS (+)
vitals	- stable	CNS - No FND
		Plan
		(1) cont IVF / pan / Emeset × Z&D drops / Enterogermina
		(2) I/O charting
		(3) Monitor vitals
	D/C Meds	IV line out.
	✓ oral cefixime	
	✓ Junior Lanzol	
	✓ Syp EMESET	
	✓ ENTEROGERMINA	
	✓ Z&D drops.	

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

Patient Sticker

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

BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	S/B Dr Gayathri	
2/7/26 10am	Δ - AGE & some dehydration	
	Called reviewed	
	afebrile	
	oral intake	SMF
	U/O	
	Hydration - fair	
	Vitals - stable	
	PPWF (+).	
		Plan
		D/c Today
	16575	

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RESULT SHEET

Date	11/26					
Time						
Hb	13.7					
PCV	40.					
RBC	5.17					
WBC	18510.					
N/L	86/9					
Platelets	3.04.					
CRP	19.					
ESR						
PCT						
RBS						
Na	135					
K	3.9					
Cl	101					
Ca/Mg ↑Ca-1.12						
Phosphate / HCO_3	20					
Urea	23					
Creatinine	0.39					
ALP						
SGPT	31					
SGOT	23					
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

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

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

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DRUG CHART

Date of Admission: 01/2/26 Drug Allergies: Nil ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

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

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

SOS / PRN (As Required Medication)

DRUG :				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 .....

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22.8kg

REGULAR PRESCRIPTIONS

Weight. ..... Ward. 606

DRUG : Inj. CEFTRIAXONE

Dose	Route	Frequency	Start Date
1.1g	I.V	Q12H	1/7

Name & Signature of the Doctor
Starting the Drugs: 16.5.25
Dr. Gayathri

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time	01/7	2/7
6 Am	✓	SG/MM
6 pm	PS/AA	
	D1	D2

DRUG : Inj. PAN

Dose	Route	Frequency	Start Date
20mg	I.V	Q24H	1/7

Name & Signature of the Doctor
Starting the Drugs:
Dr. Gayathri 16.5.25

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time	01/7		02/7
5pm	R.B S.S	6 Am	SG/MM

DRUG : Inj. EMESET

Dose	Route	Frequency	Start Date
2mg	I.V	Q8H	1/7

Name & Signature of the Doctor
Starting the Drugs:
Dr. Gayathri 16.5.25

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time	01/7		2/7
5pm	R.B S.S	6 Am	SG/MM
		10 pm	
		6 pm	

DRUG : Zyd D drops

Dose	Route	Frequency	Start Date
1ml	P/O	Q24H	1/7

Name & Signature of the Doctor
Starting the Drugs:
Dr. Gayathri 16.5.25

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time	01/7	2/7
7 pm	PS/AA	

Patient Sticker

Weight. 28.8kg Ward. 606

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

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses

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Baby YUGAN KUMAR
05-04-2020 6 Y 2 M 26 D (M)
Dr. VAISHNAVI CHANDRAMOHAN

22.8 kg 40b

I.V. FLUIDS CHART

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

Date	Time	Composition of Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
11/7/26	5pm	IVF RL (50ml/kg) 1000ml over 4 hours ↓	I.V	250ml per hr		R.B A.P	11/7/26 at 6.30pm		
11/7/26	7pm	IVF 0.9% DNS.	I.V	60ml/hr per					

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

GUC-00093296 IP18-00036272
Baby YUGAN KUMAR
05-04-2020 6 Y 2 M 26 D (M)
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MEDICATION RECONCILIATION FORM

Drug Allergies: nil

☐ Not known any Drug Allergies

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

Shifting From: ER

Shifted to: 606

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	Syp IBUGESIC plus	10ml	P/O	SOS	1/7/26 (morn)	☐C ☐DC
2						☐C ☐DC
3						☐C ☐DC
4						☐C ☐DC
5						☐C ☐DC
6						☐C ☐DC
7						☐C ☐DC
8						☐C ☐DC
9						☐C ☐DC
10						☐C ☐DC

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Gayathri 165959.

Date & Time : 1/7/26

Nurse Name & Signature: CC. Akshaya post ICU

Date & Time : 01/07/26 @ 4:30pm

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

GUC-00093296
Baby YUGAN KUMAR
IP18-00036272
05-04-2020
6 Y 2 M 26 D
(M)
Dr. VAISHNAVI CHANDRAMOHAN

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

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

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 01/12/20 Time:	6pm	8pm	9pm	12am	4am
Doctor / Nurse / Family Concern?					

Temperature (°F) — 104 / 103 / 102 / 101 / 100 / 99 / 98 / 97 / 96 / 95 / 94

97.2°F; 99.1°F; 98.6°F; 98.4°F; 98.5°F

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

Note: BP does not score in early warning scoring

99/64 (58); 98/66 (62); 100/70 (61); 99/72 (62)

Heart Rate (Number)	92 bpm	94 b/m	100 b/m	105 b/m

Resp. Rate (bpm) (Over 1 Minute) * — 70 / 60 / 50 / 40 / 30 / 2 / 1

Resp Rate (Number)	24 bm	26 bm	24 b/m	26 b/m
Resp Distress: Mod/ Severe / None / Mild	✓	—	✓	✓
Receiving O_2 (l/min)	RA	RA	RA	RA
O_2 Saturations (%)	100%	98%	100%	98%
Conscious Level: Normal / Altered	✓	✓	✓	✓
GCS *	15/15	15/15	15/15	15/15
TOTAL SCORE Number of shaded boxes	0	0	0	0
Pain Score	0	0	0	0
Observer's Initials	[illegible]	[illegible]	[illegible]	[illegible]

ACTIONS
NB: Scores 3 should be recorded overleaf

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

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

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

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FLUID CHART

Sheet No. : (1)

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

11/7/22		Intake				Output (10080700)						
Date	Time	Nature of Fluid	Route			NG	~~Diarrhoea~~	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm	On Admission										Du
	06:00 pm	H	0	250ml								
	07:00 pm	H2O	100ml	250ml			✓			✓	0	DK
Total Intake :		100 ml + 500ml				Total Output :				1 time	0	
	08:00 pm			60ml			✓					
	09:00 pm	H2O	50ml	60ml								
	10:00 pm			60ml							0	Mythili
	11:00 pm			60ml						✓		
	12:00 am	H2O	100ml	60ml							0	Mythi
	01:00 am			60ml						✓		
Total Intake :		150ml + 360ml				Total Output :				2 times	0	Su/
	02:00 am			60ml								
	03:00 am			60ml						✓	0	Su/
	04:00 am	H2O	80ml	60ml								
	05:00 am			60ml						✓	0	Su/
	06:00 am	H2O	50ml	60ml								
	07:00 am			DC						✓	0	Su/
Total Intake :		80ml + 300ml				Total Output :				2 times		

Total 24 hrs. Intake	1,490ml

Total 24 hrs. Output	5 times

GUC-00093296 IP18-00036272
Baby YUGAN KUMAR (M)
05-04-2020 6 Y 2 M 26 D
Dr. VAISHNAVI CHANDRAMOHAN

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NURSES NOTES

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

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		Receiving Notes	
1/7/26	5:30pm	child received from ER child detail hand over taken from ER S/N child complaints of fever / vomitting loose stool x 1day. IV line ⊕ IVF RL 200ml/hr over 4 hours normal diet kept in RN	[signature]
	6pm	→ child intake & output chart maintained, vital signs checked & record. vitals are stable [CP PP CRT / ++ ++ <2sec]	[signature]
	7pm.	→ child detail due medication given as per order.	[signature]
	7:30pm	→ child detail hand over given to night duty S/N.	[signature]
		Night duty 1/7/26	
1/7/26	7:30pm	→ Patient handover taken by evening duty S/N → Patient clinically stable	[signature]
	8pm	→ Checked vital signs → patient vitals is stable [CRT / CP / PP — <3sec ++ ++]	[signature]
	10pm	→ Provide health education → Provide comfortable position	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

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

Patient Sticker

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NURSES NOTES

☐ No Known Drug Allergies

☐ Drug Allergies ....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
2/7/26	12am	→ again checked vitalsigns	
		→ Patient vitals is stable.	
		CRT <3sec | CP ++ | PP ++ →	[signature] OA179
	2am	→ IV fluids 0.9% DNS 60ml/hr continuesly going as per drug chart order →	[signature] OA179
	4am	→ again checked vitalsigns	
		→ Patient vitals is stable	
		CRT <3sec | CP ++ | PP ++ →	[signature] OA179
	6am	→ administered IV medicine as per drug chart order	
	7am	→ Monitored intake and output chart	
		→ patient IV line is out, Informed to DR. Gayathri mam, doctor advice encourage orals and remove IV line →	[signature] OA179
	7.30am	→ Patient IV line removed	
		→ Patient handover given to morning duty S/N →	[signature] OA179

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

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Patient's Name: GUC-00093296 IP18-00036272
MRD NO:. Baby YUGAN KUMAR (M)
05-04-2020 6 Y 2 M 26 D
Dr. VAISHNAVI CHANDRAMOHAN
Age :......... Sex: ☐ M ☐ F
Consultant :...................................

PHLEBITIS ASSESSMENT

CANNULA 1

Date : 01/07/26 Time: 7.38pm
Location : (A) metmoi)
Size : 22G S/N. Rishi
Cannula inserted by : S/N. Akshayamitra

Date	Time	Phlebitis	Infiltration	Nursing Intervention	Sign
01/7/26	5pm	☐Yes ☑No	☐Yes ☑No	patent	[signature]
	5:30pm	☐Yes ☑No	☐Yes ☑No	observe	[signature]
	7:30pm	☐Yes ☐No	☐Yes ☑No	observe	[signature]
	8pm	☐Yes ☑No	☐Yes ☑No	healthy	
	10pm	☐Yes ☑No	☐Yes ☑No	healthy	
2/7/26	12am	☐Yes ☑No	☐Yes ☑No	healthy	
	2am	☐Yes ☑No	☐Yes ☑No	healthy	
	4am	☐Yes ☑No	☐Yes ☑No	healthy	
	6am	☐Yes ☑No	☐Yes ☑No	healthy	
	7am	☑Yes ☐No	☑Yes ☐No	Removed	
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		

Cannula removed : ☑Yes ☐No, if yes date and time : 7am
RX any initiated : ☑Yes ☐No ☐NA If Yes specify- 7(?)
Phlebitis score: 1

CANNULA 2

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

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

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

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

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

PHLEBITIS ASSESSMENT AND MANAGEMENT RECORD

CANNULA 3

Date : Time:

Location :

Size :

Cannula inserted by :

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

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

CANNULA 4

Date : Time:

Location :

Size :

Cannula inserted by :

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

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

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

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

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

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①

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PAIN ASSESSMENT FORM

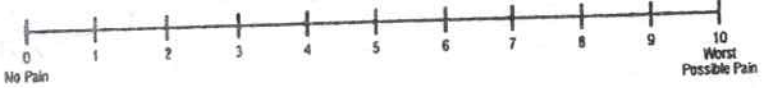
Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
01/7/29	6pm	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☑ No	Nil	[illegible]
01/7/26	10pm	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	Nil	[illegible]
02/7/26	8am	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	Nil	[illegible]
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

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

PAIN ASSESSMENT TOOLS

Numerical Pain Scale (Obstetric and Gynecology)



Wong - Baker (Pediatrics) Above 7 Years

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

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

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR RR, BP, SaO_2	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO_2 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO_2 less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

GUC-00093296 IP18-00036272
Baby YUGAN KUMAR
05-04-2020 6 Y 2 M 26 D (M)
Dr. VAISHNAVI CHANDRAMOHAN

INTERDISCI[PLINARY PATIENT / F]AMILY EDUCATION RECORD

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Part - I.

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

Identified Education Needs:

1. 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
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		
1/7/26	6pm	yes	explained about Encourage more oral liquids	mother	nil	oral	nil	yes	Good	[signature]
2/7/26	8am	yes	Explaind about hygeine	Mother	Nil	Oral	Nil	yes	Good	[signature] 01/7/2

Part - III: CODES

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

Learning Barriers:
1. No Learning Barriers
2. Physical Impairment
3. Emotional Barriers
4. Language Barrier
5. Educational Level
6. Desire / Motivate to Learn
7. Impaired Thought Process/Cognitive limitations
8. Responsibilities at Home
9. Cultural Differences
10. Financial Difficulties
11. Beliefs and Values
12. Impaired Vision/ or Hearing
13. Cultural/Religion Practice
14. Others (Specify ....

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

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

Understanding: 1. Verbalizes Understanding 2. Demonstrates Understanding 3. Needs Review

Doc No. : RCH / FRM / CLINICAL / 187

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Nursing General Admission Assessment Form For Pediatrics

Diagnosis: AGE & some dehydeation
Arrival Time: 5:30pm Mode of Arrival: walking Admitting From: ☑ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction ..... Nil ..... Body Weight: 22.8 Kg

..... Height: ..... cm

.....

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

Past Medical History	Past Surgical History	Previous Hospital Admission
Nil	Nil	Nil

Family History: .....
Nil

Has the child or close family member had recent contact with a communicable disease? ☐ Yes ☑ No

If yes please list, ...

Was the child's birth normal? ☑ Yes ☐ No If No, please describe problems: .....

.....

Are the child's immunization up to date? ☑ Yes ☐ No

Current Medication: ☑ None ☐ Yes, If Yes, fill reconciliation form

Observations: Weight: 22.8kg Length: ..... Head Circumference (< 2 years): ....

Temp.: ..... HR: ..... RR: ..... BP: .....

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

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

Risk of Pressure Sore (Braden Q Score 28) (Document in the Braden Q Assessment Sheet)

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

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

FUNCTIONAL SCREENING: ☑ No Abnormalities Detected

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

Inform consultant for positive criteria

NUTRITIONAL SCREENING: ☑ No Abnormalities Detected

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

Inform consultant for positive criteria

Psychological Screening: ☑ No Significant Findings

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

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

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

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

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

Orientation has been given regarding the following aspects:

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

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

Patient Rights & Responsibilities: ☑ Yes ☐ No

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

Nurse's Name: ..... A. Aneepriya ..... Date: ..... 1/7/26 ..... Time: ..... 6pm ..... Signature ..... Priy .....

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PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : Dr. Gayathri Date : 1/7/26.

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

Start Time of Assessment: ..... Weight: 22.8 kg

Allergic History: .....

Chief Complaints: .....

→ C/O vomiting loose stools ×1 day
fever

Pediatric Assessment Triangle

A Appearance - TICLS awake & alert

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

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

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

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

Significant Past History: .....

Medication History: .....

Relevant Investigations: .....

Primary Assessment

Airway
- ☐ Open
- ☑ Maintainable
- ☐ Not Maintainable

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

Breathing
Rate: 28/min SpO_2 on FiO_2 98.1%
Rhythm: .....
Retractions: ☐ Suprasternal ☐ ICR ☐ SCR ☐ Sternal ☐ Supraclavicular ☐ Nasal Flaring
Respiratory Noises: ☐ Stridor ☐ Wheezing ☐ Grunting
Air Entry: B/L AE ⊕
Palpation Findings (If necessary) .....

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

Circulation

HR: 107/min

CFT: Central .... Peripheral ....

BP: 101/61mm mmHg

Pulse Volume: Central +++ Peripheral ++

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

Muffled Heart Sound: ☐ Yes ☐ No

Engorged Neck Veins: ☐ Yes ☐ No

Murmurs: ☐ Yes ☐ No

Liver Span: ....

ECG: ....

Any Signs of Heart Failure: ☐ Yes ☐ No

Any urgent interventions needed: ☐ Yes ☑ No

If Yes ....

Disability

GCS: 15/15 AVPU: ....

Pupils: Responsive ☑ Non-Responsive ☐

Size: Right .... Left ....

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

Signs of Neurological compromise ....

Any urgent interventions needed: ☐ Yes ☑ No

If Yes ....

Exposure

Temp.: 98.2°F.

Any Rash: ☐ Yes ☐ No,

If yes describe the rash ....

Active bleed ....

Lacerations ☐ Abrasions ☐ bruises ☐

Describe: ....

Any urgent interventions needed: ☐ Yes ☑ No

If Yes ....

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

☐ Shock - Compensated ☐ Hypotensive ☐

☐ Cardiopulmonary Arrest ☑ Hemodynamically Stable

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

Labs Planned: ....

Treatment Planned: ....

as per chart

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

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

Assessment done by

Name of the Doctor: ....

Signature: Dr. Gayathri 65379

Date & Time: 1/1/26

Sr. Doctor on Duty (If necessary)

Name of the Sr. Doctor: ....

Signature: ....

Date & Time: ....

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EMERGENCY ROOM TRIAGE FORM

wt - 22.8 kg

Patient's Name : Master. Yugan Kumar Age : 6y

Gender: ☑ Male ☐ Female

Date : 01/7/26 Time of Arrival : @ 4:20pm

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

Source of information : ☑ Parents ☐ Others (Specify)

Mode of Arrival : ☑ Ambulatory ☐ Wheelchair ☐ Ambulance

Initial Vital Signs: Temp: 98.2F PR: 107 BP: 101/61 (74) RR: 28 SpO_2: 99%

Chief Complaints: c/o loose stool, vomiting, fever, ↓ intake.

INITIAL PHYSIOLOGICAL CATEGORIZATION

Appearance
☑ Normal
☐ Sick Looking

Circulation / Colour
☑ Normal ☐ Abnormal ☐ Bleeding

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

INITIAL PHYSIOLOGICAL STATUS
☐ Stable
☑ Unstable :
- ☐ Not – Life - Threatening
- ☐ Life – Threatening

Triage Classification	CTAS
☐ Level 1 : Resuscitation	
☐ Level 2 : EMERGENT : Life or limb threatening	☐ Immediate
☐ Level 3 : URGENT : Significant illness / injury with potential to become life or limb threatening	☐ < 15 min
☐ Level 4 : LESS URGENT : Significant illness but not life threatening	☐ 30 min
☐ Level 5 : NON – URGENT : May receive care when convenient	☑ 60 min
	☐ 120 min

NOTE : All immunocompromised children and preterm babies to be considered Level 2.
All Children less than 2 years age with high fever to be considered Level 3.

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian

Triage Completion Time : 2min

Communicable Disease Triage Screening

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

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

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

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

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

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

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

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

Name of Triage Nurse : Rishi

Signature of Triage Nurse : Rishi

Date & Time : 01/7/26 @ 4:22pm

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

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 01/07/26 Time of arrival : 4:20pm

Chief Complaints: H/o vomiting x H/o loose stool x Intake RBS: .....

Height : ..... Weight : 22.8kg BMI : ..... Head Circumference (<2 years) .....

Allergies: ☐ Yes ☒ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other: NIL

If yes , identify NIL

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

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

RISK FOR FALL:

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

☐ If Patient is > 6 years
Assess the below parameters

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

Ambulatory Aids:

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

Gait/Transferring:

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

Mental Status: Forgets limitations ☐ Yes ☒ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening: ☒ No Abnormalities Detected

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

Inform consultant for positive criteria

NIL

Nutritional Screening: ☒ No Abnormalities Detected

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

Inform consultant for positive criteria

Psychological Screening: ☒ No Significant Findings

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

If Yes Consultant Notified: NIL (Date/Time): — —

Social History: Lives With Parents

Siblings in household ☒ Yes ☐ No (if yes How Many?) 1 child

Time of Initial assessment completed by ER Nurse : 10 mins

(P.T.O.)

Time	Nursing Notes
01/07 4.30pm.	The pt came for ER c̄ c/o. vomiting x H/o. loose stool
	fever x 1 IA tep. Vitals me Chart's Recorded.
	c/s/b mo. Claishun in o PD. To Advice the
	Admission. IV line secu. blood sample
	taken. pt shift to com d.
	RBS - 102 mg/dl.

Samples collected by: / Rishi   Time: / 4:40pm

Samples sent by :   Time:

Medication given in ER:

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

Condition of patient at time of shift - out :	Details of Shift - out
HR: 107 BP: 101/61 CFT: <2sec	Shift - out from ER to: 606
RR: 28 SPO$_2$: 99%	Time of Shift - out: 5:25 pm
GCS: 15/15 Temperature : 98.2°F	Handover given to: S/N Sathya (Nurse's Name)
Pain Score: 0/10	
Repeat RBS (if applicable): –	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any): - IV placement done: (R) arm venflon - 22G.

Name of the Nurse : CH Akshaya smith   Signature of the Nurse : CH [signature]

Date & Time : 1/07/26 @ 4:25pm

PATIENT TRANSFER FORM

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	Date & Time of Admission	Date & Time of Transfer Order
	01/07/26 @ 4.14pm	01/07/26 @ 5:25 pm
Treating Consultant Name	Transfer Ordered by	Reason for Transfer
Dr. Vaishnavi	Dr. Gayathri	Further management
From Unit: ER	To Unit: 606	Information to Attendant: Yes ☑ No ☐
Number of Sheets in Clinical File: (9)	Number of Imaging Films: –	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 ☐

A - AGE c̄ some dehydration

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
C.K. Aksheyanistu CK 01102	16559

Patient & Clinical Records Received by :

Sathy 4 00046

Date & Time of Patient Received : 1/7/26 at 5.30PM

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

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

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RBS CHART

Date	Time	RBS (mg/dl)	IVF %	Signature
01/07/26	4.55pm.	102 mg/dl.	IVF. RL 1000ml @ 4 hrs	

Docu. No. : RCH /FRM / CLINICAL / 185