

PATIENT DISCHARGE INTIMATION FROM NURSING STATION

CLEARANCE FOR DRUGS AND DISPOSABLES BILLING

QUC-00071483 IP18-00036644
Name of the Patient **Baby KRUTHVIK ANANTHAVEL** (M)
24-10-2023 2 Y 9 M 3 D
Dr. GEETHA JAYAPATHY
UHID No:
Ward:



Date:

Gender:

Room No:

Certified that in respect of the above patient:

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

Patient Authorised Sign

Date:

Time:

Nurse Sign

Date: 23/10/2023

Time: 9 AM

Pharmacy Sign

Date:

Time:



PATENT DISCHARGE
FROM THE
OFFICE OF THE
COMMISSIONER OF PATENTS

1911

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Rainbow
Children's
Hospital

QUC-00071483 IP18-00036644
Baby KRITHVIK ANANTHAVEL
24-10-2023 2 Y 9 M 3 D (M)
Dr. GEETHA JAYAPATHY



DISCHARGE TRACKING SHEET

UHID-

FLOOR-

NAME OF CONSULTANT

ACTIVITY	INTIM E	OUT TIME	NAME & SIGNATUR E	REMARKS	<To be filled by Admin >		
Activity Sheet update by Nursing		9AM	no outward				
Activity Sheet update by Pharmacy							

ACTIVITY RECORD FOR BILLING

UC-00071483 IP18-00036644
Name: ... by KRITHVIK ANANTHVEL
10-2023 2 Y 9 M 3 D (M)
GEETHA JAYAPATHY
UHID 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
27/7/26	9.55pm	ERL	L08	

CROSS CONSULTATION VISIT

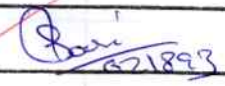
	Doctor Name	Date	Order No.	Signature
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

INVESTIGATIONS

[illegible]

[illegible][illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
27/1/26	stomach wash	①	1133859	

ANY OTHER INFORMATION:

.....

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.....

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Date: 28/1/26 Time: 2pm Prepared By:

Staff Nurse 	Shift / Ward	Billing Assistant	Billing Supervisor
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GUC-00071483 IP18-00036644
Baby KRITHVIK ANANTHAVEL
24-10-2023 2 Y 9 M 3 D (M)
Dr. GEETHA JAYAPATHY



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Your Right to a Safe Delivery

DISCHARGE TRACKING SHEET

DATE : 22/11/24

Name of Consultant :

Floor :

UHID :

S.NO	Activity	TIME		Name & Signature	Remarks
		IN TIME	OUT TIME		
1	Dr. Announce Time				
2	Arrangement of File by Nurses				
3	Pharmacy Clearance	22/11/24	9am	<i>Geetha</i>	
4	Provisional Billing				
5	Audit Check				
6	Final Bill Prepared				
7	Sent to Insurance & Approval Received				
8	Handing Over & Bill Clearance				
9	Discharge Summary				
10	Physical Check Out				
11	Activity Sheet updated by Nursing				
12	Activity Sheet updated by Pharmacy				

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ADMISSION SHEET

Registration Details :



Admission No : IP18-00036644

Admit Date : 27-Jul-2026

Admit Time : 08:58 PM UHID : GUC-00071483

Patient Details :

Patient Name : Baby KRITHVIK ANANTHAVEL

Age : 2 Y 9 M 3 D

Guardian : KUMARAVEL MANOHARAN

DOB : 24-10-2023

Gender : Male

Religion :

Occupation :

Martial Status :

Address (H) : 2/27,4TH LANE,SHASTRI NAGAR,ADYAR
 Adyar Chennai Tamil Nadu INDIA 600020

Phone No : 9962246721

E-mail : NO@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 : KUMARAVEL MANOHARAN

Relationship : Father

Contact Address : 2/27,4TH LANE,SHASTRI NAGAR,ADYAR
 Adyar Chennai Tamil Nadu INDIA 600020

Phone No : 9790290297

Signature

Doctor Details :

Doctor Name : Dr. GEETHA JAYAPATHY

Specialisation : GENERAL PEDIATRICS

Referral Doctor : FRIENDS

Phone No :

Co-Consultant :

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : SELFPAY

GENERAL CONSENT FOR TREATMENT

Patient Name: **Baby KRITHVIK ANANTHAVEL** Age : **2 Y 9 M 3 D**
 IP No: **IP18-00036644** Sex: **Male**
 Consultant: **Dr. GEETHA JAYAPATHY** 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 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: **KUMARASEL MANOHARAN**

Relationship: **FATHER**

Date: **27/6/24** Time: **08:58 PM**

Witness Name: **P. Thanani Shan**

Witness Signature: 

Patient Address:

2/27,4TH LANE,SHASTRI NAGAR,
 ADYAR Adyar Chennai Tamil Nadu
 INDIA 600020

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 attendant 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 : Baby KRITHICK ANANTHA VEL	UHID Number : 71483
Self/Attendant Name : GUMARANEL MANDARAN	Relation : FATHER
Self/ Attendant Signature : Phone Number : < 94488	Name & Signature of Financial Counselor [Signature]



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PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: _____

UHID ID: _____

Department: _____

Consultant: _____

UC-00071483

by KRITHVIK ANANTHAVEL

10-2023

GEETHA JAYAPATHY

IP18-00036644

(M)





Pediatric Multiorgan History & Physical Examination

Name: _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

AtHto consumption of 3ml of Syp. Levocetizine
(0.5mg/ml) at around 8:00PM.

History of present illness :

AtHto consumption of 3ml of Syp. Levocetizine
(0.5mg/ml) - 3ml taken at around 8:00PM.

No other complaints

Classic large (stomach work) smelly green
20ml work.



Past history: (including details of any previous investigation or treatment)

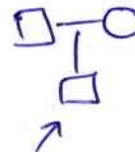
prev HbO admin for AS. whey at 2024

Has history of patent foramen ovale (+)

Birth & Neonatal History:

Birth
full term / LSCS / wt: 3.65 kgs / no meconium

Family Chart



Birth & Socio Economic History:

About Father: _____

About Mother: _____

Any additional Information: _____

Developmental History:

Immunization History:

Anthropometry:

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

Weight (kgs) 14.1 kgs (Centile _____)

On Examination:

Temperature: 97.8 F Pulse Rate: 106/min B.P. 83/53 mmHg SPO2 96% @ RA

Resp. rate and type of breathing: 32/min

Rash _____

Lymphadenopathy _____

Oedema: _____

Allergies (if any): _____

No Allergies

CRK 3x

PPwefest

Wan higher



Respiratory System :

Inspection (any s/o distress) : _____

Air entry & breath sounds : _____ *NUBS - no added sounds*

Any added sounds : _____

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

Cardiovascular System :

Inspection of precordium : _____

Heart Sounds : _____ *S1S2 @ 120 mm*

Any murmur : _____

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

Per Abdomen :

Inspection : _____

Palpation : _____ *soft 120 no organomegaly*

Auscultation : _____

Spine : _____ *(N)* External Genitalia : _____ *(N)*

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

Central Nervous System :

Level of Consciousness : AVPU/GCS score : _____ *15/15 / Alert*

Cranial Nerves : _____

Motor System :

Nutrition : _____ *(N)*

Tone : _____ *normal fine* Power _____ *9/5*

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____



Reflexes :

2+

DTR

Superficials:

Plantars

Sensory System :

Bladder / Bowel :

Clinical Summary & Diagnostic:

Accidental Ingestion of cetirizine (0.5mg/ml) = 30ml

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

Desired goals of the treatment :

Planned Labs:

Planned Management

- 1) TO do Heart rate / BP
- 2) w/f sedative effects /
drowsiness / constipation /
Tachycardia / rigors

Signature of the Doctor: Lucky Vinay

2023/11

Name of the Doctor: Lucky Vinay

Date & Time: 24/11/26, 9:30 PM

Signature of the Consultant: Dr. Geetha

Name of the Consultant: 78511

Date & Time: 24/11/26 @ 8 am

(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:

JC-00071483 IP18-00036644
by KRITHVIK ANANTHAVEL
-10-2023 2 Y 9 M 3 D (M)
GEETHA JAYAPATHY



Jocu. No. : RCH /FR

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

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

Patient Sticker



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PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

Patient Sticker



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PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

Patient Sticker



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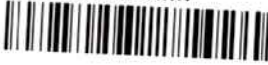
PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

Patient Sticker

RESULT SHEET

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



MEDICATION RECONCILIATION FORM

Drug Allergies: Nic ☒ 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: (Hoe)

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1						☐ C ☐ DC
2						☐ C ☐ DC
3						☐ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

* C - Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: Dr. [Signature]

Date & Time: 27/7/26 9:30pm

Nurse Name & Signature: M. [Signature]

Date & Time: 27/7/26 9:30pm

Date of Admission: Drug Allergies: ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

GENERAL DOCTOR	NURSES
- Ensure that all patient details are entered above. ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS. - 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 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 Hospital's Verbal Order Policy.

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

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

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



REGULAR PRESCRIPTIONS

Weight 14.5 kg Ward

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

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

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

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

VARIABLE DOSE		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.	

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Patient Sticker

I.V. FLUIDS CHART

Weight. 14.1 kg Ward.

[illegible]

GUC-00071483
 Baby KRITHVIK ANANTHAVEL
 24-10-2023 2 Y 9 M 3 D (M)
 Dr. GEETHA JAYAPATHY

IP18-00036644

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

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

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 22/2/2024 Time: 10 PM		12 PM	4 AM
Doctor / Nurse / Family Concern?			
Temperature (°F)	104	98.5°F	98.2°F
Heart Rate (bpm)	190	170	163
Blood Pressure (mmHg) *	130	120	110
Note: BP does not score in early warning scoring	110	100	90
Heart Rate (Number)	1128/m	100b/m	106b
Resp. Rate (bpm) (Over 1 Minute) *	70	60	50
Resp Rate (Number)	304/m	30b/m	30b/m
Resp Mod/ Severe Distress	None / Mild	✓	✓
Receiving O ₂ (l/min)	100%	100%	99%
O ₂ Saturations (%)	✓	✓	✓
Conscious Level	Normal	✓	✓
GCS *	15/15	15/15	15/15
TOTAL SCORE	0	0	0
Number of shaded boxes	0	0	0
Pain Score	0	0	0
Observer's Initials	Dr	Dr	Dr

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

GUC-00071483 IP18-00036644
 Baby KRITHVIK ANANTHAVEL
 24-10-2023 2 Y 9 M 3 D (M)
 Dr. GEETHA JAYAPATHY



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FLUID CHART

Sheet No. : 2

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
24/10/23	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												
	06:00 pm												
	07:00 pm												
	Total Intake :						Total Output :						
	08:00 pm												
	09:00 pm												
	10:00 pm	water 50ml											
	11:00 pm												
	12:00 am	water 20ml											
	01:00 am												
	Total Intake : 70ml						Total Output : 1 time urine passed						
	02:00 am												
	03:00 am	water 50ml											
	04:00 am												
	05:00 am	water 50ml											
	06:00 am												
	07:00 am	water 30ml											
	Total Intake : 130ml						Total Output : 2 time urine passed						
Total 24 hrs. Intake		200ml											
Total 24 hrs. Output		3 times											

Patient's

JC-00071483

IP18-00036644

JC-00071483
KRITHVIK ANANTHAVEL

by KRITI

2Y9M3D

(M)

MRD NO

GEETHA JAYAPATHY



Age :.....

Sex: ☐ M ☐ F

Consultant :

PHLEBITIS ASSESSMENT

CANNULA 1

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:

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:

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

Time:

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:

CANNULA 4

Time:

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:

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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THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	2/10/23	22/11			
	3 to less than 7 years old	3	4	1			
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	2	2			
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1			
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2	2	2			
	Oriented to own ability	1	1	2			
	History of Falls or Infant-Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	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			
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			
Total			13	13			

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		NA	-			
Other Intervention(s) Specify		NA	-			
Nurse's Name:		40 Jothi				
Signature:		[Signature]				
Date:		2/10/23 22/11				
Time:		10:20				

1. The first part of the report discusses the background of the project and the objectives of the study.

2. The second part of the report describes the methodology used in the study.

3. The third part of the report presents the results of the study.

4. The fourth part of the report discusses the conclusions of the study.

5. The fifth part of the report discusses the limitations of the study.

6. The sixth part of the report discusses the implications of the study.

7. The seventh part of the report discusses the future research.

8. The eighth part of the report discusses the acknowledgments.

9. The ninth part of the report discusses the references.

10. The tenth part of the report discusses the appendices.

11. The eleventh part of the report discusses the bibliography.

12. The twelfth part of the report discusses the index.

13. The thirteenth part of the report discusses the glossary.

14. The fourteenth part of the report discusses the list of figures.

15. The fifteenth part of the report discusses the list of tables.

16. The sixteenth part of the report discusses the list of abbreviations.

17. The seventeenth part of the report discusses the list of symbols.

18. The eighteenth part of the report discusses the list of units.

19. The nineteenth part of the report discusses the list of acronyms.

20. The twentieth part of the report discusses the list of initialisms.

21. The twenty-first part of the report discusses the list of contractions.

22. The twenty-second part of the report discusses the list of idioms.

23. The twenty-third part of the report discusses the list of proverbs.

24. The twenty-fourth part of the report discusses the list of sayings.

Patient Sticker



THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4					
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2					
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1					
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own ability	1					
	History of Falls or Infant-Toddler Placed in Bed	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					
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					
Total							

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:						
Signature:						
Date:						
Time:						

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GUC-00071483

IP18-00036544

Baby KRUTHVIK ANANTHAVEL

24-10-2023

2 Y 9 M 3 D

(M)

Dr. GEETHA JAYAPATHY

BRADEN 'Q' SCALE


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 BirthRight
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				Date: 24/10/2023			
				Time: 11 AM			
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.	9	4	
"Activity The degree of physical activity"	1. Bedfast: Confined to bed	2. Chairfast: Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	9	4	
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	9	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.	9	4	
FRICTION-SHEAR Friction. Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times.	9	4	
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	9	4	
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.	9	4	
				TOTAL SCORE	28	22	
				Evaluator's Name	Dr. Jayapathy	Dr. Jayapathy	

Severe Risk : less than 9 | High Risk : 10-12 | Moderate Risk : 13-14 | Mild Risk : 15-18 | Not at Risk: 19-23

Docu. No. : RCH /FRM / CLINICAL / 119

Risk Score	Category	Action	Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice)
15-18	At Risk	⑩ Regular Turning Schedule ⑩ Enable as much activity as possible ⑩ Protect the heels ⑩ Use pressure redistribution surfaces ⑩ Manage moisture, friction and shear ⑩ Advance to a higher level of risk if other major risk factors are present	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	⑩ Use the Same Protocol as for "At Risk" Patients ⑩ Position patient at 30 degree lateral incline using foam wedges	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	⑩ Follow the same protocol as for "Moderate Risk" Patients ⑩ In addition to regular turning schedule ⑩ Make small shifts in their position frequently	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	⑩ Use same protocol as for "High Risk" Patients ⑩ Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

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PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
24/10/23	10pm	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NPI	by 015/20
28/10/23	11am	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NPI	by 015/20
27/11/23	9am	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NPI	by 015/20
				☐ 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		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

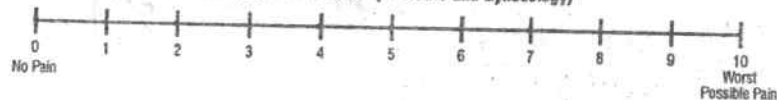
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 - 60 minutes after pain relief intervention.

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 brawn 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

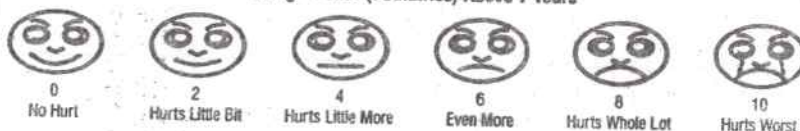
Numerical Pain Scale (Obstetric and Gynecology)



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, 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



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ATIENT / FAMILY EDUCATION RECORD



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

Identified Education Needs:

- | | | | |
|-----------------------|--|---------------------------------|---|
| 1. Diagnosis | Plan | 6. Discharge Medication | 10. Fall Risk Education |
| 2. Treatment and Care | 3. Pain Management | 7. Infection Control Measures | 11. Safe use of Medical Equipment / Implantable Devices |
| | 4. Informed Consent | 8. Diagnostic Test / Procedures | Safety |
| | 5. Medication / Therapy (safety, effects/ side effect, interactions) | 9. Nutrition / Diet | 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		
24/10/23	6pm	tail RPST education	explained about call bell & side rails	mother	No	oral	Respect verbalizes values understanding			AA 5/10/23

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									

Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 10 pm Mode of Arrival: walking Admitting From: ☐ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction Body Weight: 14 Kg
 Height: cm

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

Past Medical History	Past Surgical History	Previous Hospital Admission

Family History:

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: 14 kg Length: Head Circumference (< 2 years):
 Temp.: 98.5°F HR: 112 bpm RR: 30 bpm BP: 90/52/63

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

Fall Risk Assessment: ☐ Yes ☒ No Score: 12 (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: 0/10 Pain Tool Used: ☐ N Pass ☒ FLACC ☐ Wong Baker

Character of Pain Location Frequency Duration

FUNCTIONAL SCREENING: ☒ No Abnormalities Detected
☐ Mobility Problem ☐ Walking Problem
☐ Developmental Delay ☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING: ☒ No Abnormalities Detected
☐ Underweight ☐ Overweight ☐ Special Feeding Method
☐ Feeding Problem ☐ Special diet ☐ No Abnormality Detected

Inform consultant for positive criteria

Psychological Screening: ☒ No Significant Findings

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

If Yes Consultant Notified: (Date/Time):

Social History: Lives With

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

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

Orientation has been given regarding the following aspects:

Call Bell in Reach : ☒ Yes ☐ No

Waste Disposal Explained: ☒ Yes ☐ No

Infusion Pump : ☒ Yes ☐ No

Hand hygiene Explained: ☒ Yes ☐ No

☐ Others

Patient Rights & Responsibilities: ☒ Yes ☐ No

Information given to Mother

Nurse's Name: S. Anitha Lakshmi Date: 24/2/26 Time: 10.30pm Signature: [Signature]
015/20

UC-00071483

IP18-00036644

aby KRITHVIK ANANTHAVEL

1-10-2023 2 Y 9 M 3 D

(M)

r. GEETHA JAYAPATHY



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It takes a lot to treat the little.

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date: 27/7/26 Time of arrival: 8:40 PM RBS: 0:7:50 pm

Chief Complaints: Accidental ingestion of syp-Levo, etc (30ml)

Height: Weight: 14.1kg BMI: - Head Circumference (<2 years)

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

If yes, identify

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

☐ Character ☐ Location ☐ Frequency ☐ Duration

RISK FOR FALL:

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

☐ If Patient is > 6 years

Assess the below parameters

History of Falling: within past 3 months

Ambulatory Aids:

- ☐ Wheelchair
- ☐ Uses furniture for support

Gait/Transferring:

- ☐ Bedrest / immobile
- ☐ Weak
- ☐ Impaired

Mental Status: Forgets limitations

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening: ☒ No Abnormalities Detected

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

Inform consultant for positive criteria

Nutritional Screening: ☒ No Abnormalities Detected

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

Inform consultant for positive criteria

Psychological Screening: ☐ No Significant Findings

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

If Yes Consultant Notified:

(Date/Time): 27/7/26 @ 8:40pm

Social History: Lives With

Parents

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

Time of Initial assessment completed by ER Nurse: 8:55pm

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

(P.T.O.)

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

Time	Nursing Notes
9:00pm	Baby came to ER @ 9:00 of Accidental Ingestion of syrup - Lorcet. 30ml @ 7:30 pm.
	Baby vital signs & reviewed.
	16 Dr. Kanitha. Inform to Dr. Greetha.
	Advised for stomach wash. 200ml NS.
	Given, after. Baby was stable shift to Ward.
	pts of pile going to Point Admission. Over the 24 hours for observation.

Samples collected by:

Samples sent by:

/nil

Time:

Time:

/nil

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: 106 ⁵ /m BP: 83/51 CFT: 122cc	Shift - out from ER to: (2108)
RR: 30 ² /m SPO ₂ : 97%	Time of Shift - out: 9:55pm
GCS: 15/15 Temperature: 97.6°C	Handover given to: Abithalakshmi
Pain Score: 0/10	(Nurse's Name)
Repeat RBS (if applicable):	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any):

nil

Name of the Nurse: 27/7/26 A. S. 45pm

Signature of the Nurse:

Date & Time:

11



PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor: Dr. GEETHA

Date: 27/11/26

Type of Admission: ☐ OPD ☒ ER ☐ Referral (if referral, Doctor's Name: _____)

Start Time of Assessment: _____

Weight: 14 kgs

Allergic History: No Allergy

Chief Complaints: _____

Abdo taking some of
Sp. Ilexanthine (0.5mg/ml)

Pediatric Assessment Triangle

A Appearance - TICLS Alert

B _____ C Circulation ☒ Normal

☐ Abnormal

Breathing

☐ ↑ WOB

☐ ↓ WOB

☒ Normal

☐ Gasping / Apnea

☐ 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: prev. admitted at 2024 for AE wheeze

Medication History: _____

Relevant Investigations: _____

Primary Assessment

Airway ☒ Open

☐ Maintainable

☐ Not Maintainable

Any urgent interventions needed: ☐ Yes ☒ No

If Yes _____

Breathing

Rate: 32/min SpO₂ on FiO₂: 98% @ RA

Rhythm: _____

Retractions: ☐ Suprasternal ☐ ICR ☐ SCR

☐ Sternal ☐ Supraclavicular ☐ Nasal Flaring

Respiratory Noises: ☐ Stridor ☐ Wheezing ☐ Grunting

Air Entry: BLAE @ LWS added rods

Palpation Findings (If necessary): _____

Any urgent interventions needed: ☐ Yes ☒ No

If Yes _____

**Circulation**HR: 106CFT ☐ Central
☐ PeripheralAny urgent interventions needed: ☐ Yes ☐ NoBP: 83/55 mmHgPulse Volume: ☐ Central
☐ PeripheralIf in Shock: ☐ Compensated
☐ HypotensiveMuffled Heart Sound: ☐ Yes ☒ NoEngorged Neck Veins: ☐ Yes ☒ NoMurmurs: ☐ Yes ☒ No

Liver Span:

ECG:

Any Signs of
Heart Failure: ☐ Yes ☒ No

If Yes

**Disability**GCS: 15/15AVPU: AlertAny urgent interventions needed: ☐ Yes ☒ NoPupils: ☐ Responsive ☒ Non-Responsive ☐
Size ☐ Right
☐ LeftActive Seizures: ☐ Yes ☒ No Sugars:

Signs of Neurological compromise

If Yes

ExposureTemp.: 97.8°FAny 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:

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: Lucky SinghSignature: Lucky SinghDate & Time: 27/11/2016 9:30 PM

Sr. Doctor on Duty (If necessary)

Name of the Sr. Doctor:

Signature:

Date & Time:

PATIENT TRANSFER FORM

JC-00071483 IP18-00036644
by KRITHVIK ANANTHAVEL
10-2023 2 Y 9 M 3 D (M)
GEETHA JAYAPATHY



Date & Time of Admission <i>27/1/26 01:58 pm</i>		Date & Time of Transfer Order <i>27/1/26 @ 9.55 PM</i>
Treating Consultant Name <i>Dr. Geetha</i>	Transfer Ordered by <i>Dr. Vignesh</i>	Reason for Transfer <i>fulfill management</i>
From Unit <i>ED</i>	To Unit <i>(108)</i>	Information to Attendant Yes ☒ No ☐
Number of Sheets in Clinical File <i>(10)</i>	Number of Imaging Films <i>NIL</i>	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 ☐ <i>Accidental ingestion of Levetiracetam (5mg/ml) = 30ml</i>		
Name & Signature of Person who is Transferring <i>[Signature]</i>		Name of Person Ordered Transfer <i>Ludwig 20/2/26</i>
Patient & Clinical Records Received by : <i>[Signature]</i>		
Date & Time of Patient Received : <i>27/1/26 10pm</i>		

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

1. Name	2. Date	3. Referral Source
4. Age	5. Sex	6. Ethnicity
7. Marital Status	8. Employment	9. Education
10. Presenting Problem	11. History of Present Illness	12. Past Psychiatric History
13. Medical History	14. Family History	15. Social History
16. Mental Status Exam	17. Physical Exam	18. Laboratory Tests
19. Assessment	20. Treatment Plan	21. Follow-up

2nd = (1st) by the 1st = 1st

1/2

1/2



EMERGENCY ROOM TRIAGE FORM

Patient's Name: Krithvik Age: 2Y8M Gender: ☒ Male ☐ Female

Date: 27/6/26 Time of Arrival: 8.40pm

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

Source of Information: ☒ Parents ☐ Others (Specify):

Mode of Arrival: ☒ Ambulatory ☐ Wheelchair ☐ Ambulance

Initial Vital Signs: Temp: 97.8°F PR: 106 BP: 83/55(64)28 RR: 28 SpO₂: 96

Chief Complaints: Accidental ingestion of syp. Levo. etz. (30ml) @ 7.50 PM

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

☐ Level 1: Resuscitation

☐ Level 2: EMERGENT: Life or limb threatening

☐ Level 3: URGENT: Significant illness / injury with potential to become life or limb threatening

☐ Level 4: LESS URGENT: Significant illness but not life threatening

☐ Level 5: NON - URGENT: May receive care when convenient

CTAS

☐ Immediate

☐ < 15 min

☐ 30 min

☒ 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: 2 min

Communicable Disease Triage Screening

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

- Have you had fever (elevated temperature) in the past 2 weeks ☐ Yes ☒ No
- Have you had cough or a rash in the past 2 weeks ☐ Yes ☒ No
- 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

- 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:

- 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: Jman

Date & Time: 27/6 @ 8.45 PM

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

Signature of Triage Nurse: [Signature]

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