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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

PATIENT DISCHARGE INTIMATION FROM NURSING STATION

CLEARANCE FOR DRUGS AND DISPOSABLES BILLING

GUC-00093237 IP18-00036250
Baby ATHVIKA R
09-01-2025 1 Y 5 M 20 D (F)
Dr. GANESH R

Name of the Patient:

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: 1/7/26

Time: 11.15am

Pharmacy Sign

Date: .....

Time: .....

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

GUC-00093237 IP18-00036250
Baby ATHVIKA R
09-01-2025 1 Y 5 M 20 D (F)
Dr. GANESH R

Rainbow Children's Hospital

DISCHARGE TRACKING SHEET

UHID- FLOOR- NAME OF CONSULTANT-

ACTIVITY	INTIMATE	OUT TIME	NAME & SIGNATURE	REMARKS	<To be filled by Admin>		
Activity Sheet update by Nursing		4/7/26 @ 11.15am	Balaji 00685				
Activity Sheet update by Pharmacy							

ACTIVITY RECORD FOR BILLING

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Name: .....

UHID No: GUC-00093237 IP18-00036250
Baby ATHVIKA R
09-01-2025 1 Y 5 M 20 D (F)
Dr. GANESH R

nsultant: ..... Dept: .....

Date of Admission: ..... te of Discharge: ..... Time: .....

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
29/6	10.10PM.	ER	405	

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
	CBC, CRP. RP_2, P/s.		
20/6/26	Bld C/s. Dengue IgM,	26020670	78894
	RBS.	26020671	

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
29/6	IV Placement	(1)	1H9363	

ANY OTHER INFORMATION:

.....

.....

.....

.....

.....

.....

Date: 1/7/26 Time: 7AM Prepared By: .....

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

GUC-00093237 IP18-00036250
Baby ATHVIKA R
09-01-2025 1 Y 5 M 20 D (F)
Dr. GANESH R

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		11/2/26 11.15am	Balaji 02655		
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 : IP18-00036250 **Admit Date** : 29-Jun-2026 **Admit Time** : 09:29 PM **UHID** : GUC-00093237

Patient Details :

Patient Name : Baby ATHVIKA R
Guardian : Mr D RAM PRASAD
Gender : Female
Occupation :
Address (H) : G1 GROUND FLOOR NO 11 MURALI RAM SRI SAKTHI FLATS AMMAN KOIL STREET Madipakkam Chennai Tamil Nadu INDIA 600091

Age : 1 Y 5 M 20 D
DOB : 09-01-2025 01:00 AM
Religion :
Martial Status :
Phone No : 9095569169/ 8940808524
E-mail : N@M.M

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 D RAM PRASAD **Relationship** : Father
Contact Address : G1 GROUND FLOOR NO 11 MURALI RAM SRI SAKTHI FLATS AMMAN KOIL STREET Madipakkam Chennai Tamil Nadu INDIA 600091 **Phone No** : 9095569169

Signature

Doctor Details :

Doctor Name : Dr. GANESH R **Specialisation** : GENERAL PEDIATRICS
Referral Doctor : Dr Ganesh **Phone No** : 9491233704
Co-Consultant :

Payment Details :

Payment Mode : Cash **Deposit Amount** : 0.00
Payor Name : SELFPAY

Rainbow Children's Hospital
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GENERAL CONSENT FOR TREATMENT

Patient Name:	**Baby ATHVIKA R**	**Age :**	**1 Y 5 M 20 D**
IP No:	**IP18-00036250**	**Sex:**	**Female**
Consultant:	**Dr. GANESH R**	**Ward/Bed No:**	**0F-EMERGENCY/ER 101**

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

Patient, be deemed advisable or necessary.

I understand that the confidentiality of all medical records shall be protected to the full extent of the Law. The undersigned also consent to the use of health related information/ audiovisuals of the patient for research & training purpose or for [illegible]rance coverage and while doing so confidentiality of the patient will be maintained at all times and this will not affect the [illegible] 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.
([illegible]eivers 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: > D. Ram Prasad

Name: > D. Ram Prasad ~~R. Athivika~~

Relationship: > Father

Date: 29-06-2026 Time: 9:29

Witness Name: Asun

Witness Signature:

Patient Address:

G1 GROUND FLOOR NO 11 MURALI RAM SRI SAKTHI FLATS AMMAN KOIL STREET Madipakkam Chennai Tamil Nadu INDIA 600091

Rainbow Children's Hospital | BirthRight BY RAINBOW HOSPITALS

BILLING POLICY

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

DECLARATION

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

Patient Name : > R. Athavika	UHID Number : 93237
Self/Attendant Name : > D. Ramprasad	Relation : > Father
Self/ Attendant Signature : > D. Pr Phone Number : > 9095569169	Name & Signature of Financial Counselor

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PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: _____

UHID ID: _____

GUC-00093237 IP18-00036250
Baby ATHVIKA R
09-01-2025 1 Y 5 M 20 D (F)
Dr. GANESH R

Department: _____

Consultant: _____

Patient Sticker

Pediatric Multiorgan History & Physical Examination

Name: Athuila Age/Sex 1y 5mon

Information given by: Relationship

Chief Presenting Complaints & Duration (Chronologically)

c/o fever x 4days
Febrile seizure on day 1

History of present illness :

A 1yr 5months old female came with complaints of fever for 4 days, high grade, intermittent, not associated with chills & rigor.

c/o one episode of seizure in the BITCS of all 4 limbs, with vacant stare towards one side with post ictal drowsiness.

c/o loose stools on day 1 – 3 of illness – now resolved

no c/o vomiting,

no c/o cough, Rhinorrhoea.

no c/o irritability, altered sensorium..

Treated at outside hospital with IV antibiotics but Symptoms not settled, hence Admitted

GUC-00093237 IP18-00036250
Baby ATHVIKA R
09-01-2025 1 Y 5 M 21 D (F)
Dr. GANESH R

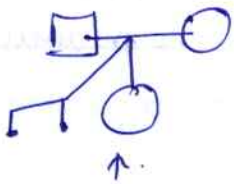
Past Hi revious investigation or treatment)

—

Birth & Neonatal History:

LSCS / 1st preg. - ectopic / B.wt - 2900gms
No NICU stay.

Family Chart



Birth & Socio Economic History:

About Father : 2 NCM

About Mother :

Any additional Information :

Developmental History :

Milestones attained at appropriate age

Immunization History :

Immunised upto age according to ~~IAP~~ NIS guidelines.

Anthropometry :

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

Weight (kgs) 9.8 kg (Centile _____)

On Examination :

Temperature : 98.3F Pulse Rate : 111 B.P. — SPO2 100

Resp.rate and type of breathing : 26.

Rash —

Lymphadenopathy —

Oedema : —

Allergies (if any): —

(P.T.O.)

Patient Sticker

Respiratory System :

Inspection (any s/o distress) : (N)

Air entry & breath sounds : B/L AE (P)

Any addes sounds : no added sounds

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

Cardiovascular System :

Inspection of procordium :

Heart Sounds : S1S2 (P)

Any murmur : no murmurs

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

Per Abdomen :

Inspection :

Palpation : Soft, non tender

Ausculation :

Spine : External Genitelia :

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

Central Nervous System :

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

Cranial Nerves :

Motor System :

Nutriton : (N)

Tone: Power 5/5

Co-ordinator :

Posture :

Involuntary Movements :

GUC-00093237 IP18-00036250
Baby ATHVIKA R
09-01-2025 1 Y 5 M 21 D (F)
Dr. GANESH R

Re

DTR

Superficials:

Plantars

Sensory System :

Bladder / Bowel :

Clinical Summary & Diagnostic:

Simple febrile seizure | Day 4-5 of fever | ? viral.

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

Desired goals of the treatment :

Planned Labs:

CBC & PS
CRP
RP2
Dengue Igm
Blood C/S

Planned Management

Inj. ceftriaxone 500mg IVBD

Signature of the Doctor:

Name of the Doctor: Dr. Chandralega

Date & Time: 29/6/24

Signature of the Consultant:

Name of the Consultant:

Date & Time:

(P.T.O.)

Patient Sticker

DISCHARGE PLANNING FORM

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

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

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

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

   ☐ Needs Assistance In:

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

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

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

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

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

Doctor Signature: .....

Doctor Name: .....

Date and Time: .....

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

DOCTOR'S SHIFT CHANGE HANDOVER FORM

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Date: ..... Department: ..... Shift: .....

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

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

DOCTOR'S SHIFT CHANGE HANDOVER FORM

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BirthRight™
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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

GUC-00093237 IP18-00036250
Baby ATHVIKA R
09-01-2025 1 Y 5 M 21 D (F)
Dr. GANESH R

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
29/6/26 10.30PM	S/B - Dr Yuvaraj	
	# Previously well child.	
	H/o - travel ⊕	
	C/o - Fever x Day 4	
	No cough, cold, vomiting, loose stools	
	No previous H/o UTI / or cry while passing urine	
	No obv focus.	
	~~O/E alert, active~~	
	Had febrile seizure on day 1	
	admitted in Neolife Hospital	
	Rx c IV Ceftriaxone + Taxobactum x 2days INF	
	No further episode of seizures	
	Cousin brother also had h/o fever 3 days back	
	Evaluation outside:	
	CBC - N	
	CRP - 9	
	LFT, RP-2 - N	
	WIDAL ⊖	
	Dengue IgM ⊖	

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	O/E alert, active, afebrile.	
	Vitals stable	
	intake - good	
	No PICCLE	
	ENT - N	
	RS - Clear	CVS, PNSP
	PA - Soft, non tender	CNS
	Reports - awaited	
	Probable - Viral fever.	
	Plan	
	- Trace blood reports	
	- Continue ~~[illegible]~~,	IV ceftriaxone.
	monitor vitals	
		T.Y

Patient Sticker
GUC-00093237 IP18-00036250
Baby ATHVIKA R
09-01-2025 1 Y 5 M 21 D (F)
Dr. GANESH R

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GRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
30/6/20 6 Am.	S/B Dr. Chandiraleye	
	child reviewed.	
	sleeping	
	no fever spikes	
	no c/o cough, vomiting, loose stools.	
	no new complaints	
	O/E	
	Afebrile	
	CVS - S1S2 (+)	
	RS - B/L AE (+)	
	P/A - soft	
	Hydration - PPWT, CRT < 3secs	
		Adv
		- monitor vitals
	Sd/- 19/12/24.	- W/F fever spikes
		- Inform (SOS)

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
30/6/24		
9:25AM	S/B Dr. DEEPAK	
	Adv: Probable Viral fever / Simple febrile Seizure [D4-D5]	
	Child reviewed	
	Child has no fever spikes	
	no cough / loose stools	
	O/E:	
	Child is consious, alert, afebrile	
	CVS: S1S2 ⊕	
	R: NVBS ⊕	
	P/A: soft	
	CNS: NFND	
	TC - 3240	
	CRP - 5 - ve	
	Dengue IgM, Typhoid IgM] - ve	
	Urine R/E - (N)	D1 → Inj Trixone 500mg IV Q12H
		→ To monitor fever spikes / vitals / Seizures
		To trace Blood C/S
		C. [signature] 1/7/24

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

GUC-00093237 IP18-00036250
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09-01-2025 1 Y 5 M 21 D (F)
Dr. GANESH R

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;RESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
30/6/26		S/b c̄ [illegible]
11AM	[illegible]	
	[illegible]	
	[illegible]	
		[illegible]
30/6/26 2:10 PM	S/B Dr. DEEPAK	
	Asw. viral fever	
	Simple febrile seizure	
	Child reviewed	
	Child has no fever spikes	
	O/E: Child is alert, afebrile	
	CVS: S1S2 ⊕	T - 99.1°F
	RS: VBS⊕	PR: 106/min
	P/A: soft	
	CNS: NFND	
	Strict I/O	Rx
		D, -) To continue inj. xone 500mg IV R 12hr
		To monitor vitals / fever spikes
	Oral intake good	To trace B1ood C/S
	Urine passed thrice	C. [illegible]
	since morning	

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

GUC-00093237 IP18-00036250
Baby ATHVIKA R 1 Y 5 M 22 D (F)
09-01-2025
Dr. GANESH R

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
1/7/26 9AM	S/B Dr. Chandiralega	
	Δ - Probable viral fever (D5-6) / simple febrile seizure	
	child reviewed	
	Alert, Active	
	no fever spikes	
	Tolerating oral feeds well	
	Oral intake good.	
	O/E	BP - 92/68 mm Hg
	Afebrile	PR - 120/min
	CVS - S1S2 (+)	
	RS - B/L AE (+)	
	P/A - soft, no organomegaly	
	Hydration - Peripheries warm	
	Peripheral pulses felt CRT, <3secs	
1.7.26 10.45A	urine passed - 2-3 times at night	
S/B Dr. [illegible]		Adv:
	Blood c/s - STNG	- monitor vitals
		(D2) - Inj ceftriaxone 500mg IV BD
		- W/F fever spikes.
	Discharge today	- Pyform (SOS)
	R on 4/7/2026	
	[illegible] 7/7/24	
	[signature]	
	[illegible] 7/7/26	6 hrs

Syr P250 → 3 ml P/O if temp >100°F

[signature]

GUC-00093237 IP18-00036250
Baby ATHVIKA R
09-01-2025 1 Y 5 M 20 D (F)
Dr. GANESH R

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RESULT SHEET

Date	26/06/26	28/6/26	29/6/26			
Time						
Hb	11.2	11.3	11.8			
PCV	34	34	35			
RBC	4.6	4.6	4.70			
WBC	7300	4,900	3240			
N/L	76/20	52/42	59/37			
Platelets	2,36,000	2,85,000	2,35,000			
CRP	9.9	9.2	5			
ESR						
PCT						
RBS						
Na	137		138			
K	3.8		4.9			
Cl	105		102			
Ca/Mg			1.16			
Phosphate /HCO3	21		/22			
Urea	24					
Creatinine	0.6		0.38			
ALP						
SGPT	12					
SGOT	34					
T.Bill/Conj	0.5 / 0.2					
T.Protein	7					
S.Albumin	4.3					
S.Globulin	2.7					
A/G Ratio	1.5					
Uric Acid /ALP	227					
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	2–3					
CUE - RBC Cells	1–2					
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						
Dengue Tg IM.	0.59 (Neg)		Negative			
Widal	Negative					

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

GUC-00093237 IP18-00036250
Baby ATHVIKA R
09-01-2025 1 Y 5 M 20 D (F)
Dr. GANESH R

Rainbow® Children's Hospital
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DRUG CHART

Date of Admission: 29/6 Drug Allergies: — ☑ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

DOCTOR - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
- Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
- Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
- Discontinue a drug by drawing a line *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 : SYP PARACETAMOL 250				Date / Time	29/6
Dose	Route	Frequency	Start Date	2.30 am	SA
3ml	PO	SOS	29/6/25		
Doctor's Signature		Valid Period	Pharm.	4.30 pm	BJ
					6's
Additional Instructions: Q6H 250mg/5ml If Temp > 100F					

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

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

Signature

VERIFIED BY : Name

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REGULAR PRESCRIPTIONS Weight. .... Ward. ....

DRUG : INJ. CEFTRIAXONE

Dose	Route	Frequency	Start Date
500mg	IV	BD	29/6/26

Name & Signature of the Doctor Starting the Drugs: [illegible] 29/12/24

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date ▸ / Time ▾	29/6	30/6	1/7
6 am	/	~~SA~~	~~[illegible]~~
6 pm	10.20 pm SA	Bt C.S	
	D1	D2	D3

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Patient Sticker

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

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

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses

Patient Sticker

I.V. FLUIDS CHART

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

Date	Time	Composition of I.v. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign

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

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09-01-2025 1 Y 5 M 20 D (F)
Dr. GANESH R

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

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

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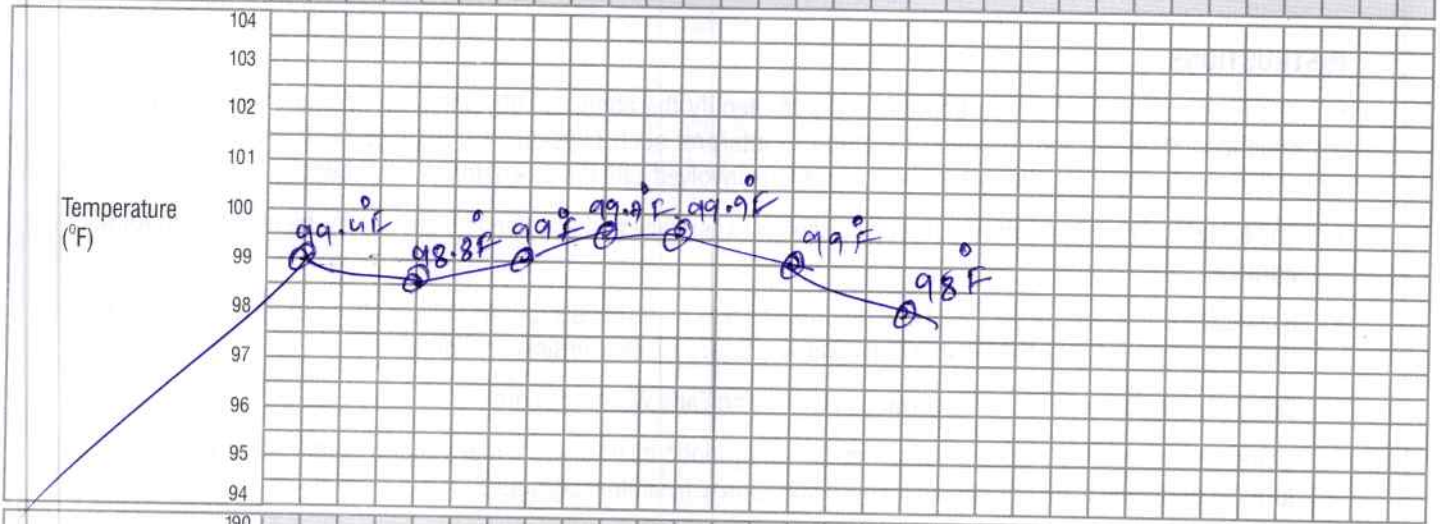
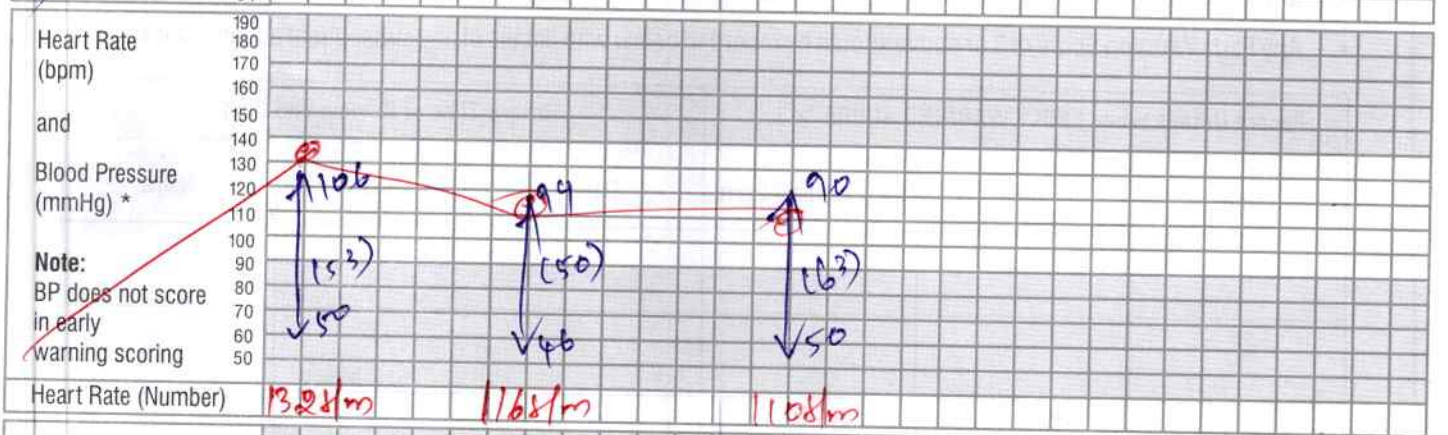
EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 29/6/26 Time: 10.30pm 11pm 12am 1am 2.30am 4am 6am.

Doctor / Nurse / Family Concern?





Heart Rate (Number)	132/m	116/m	110/m

Resp Rate (Number)	30/m	30/m	30/m
Resp Distress: Mod/ Severe / None / Mild	✓	✓	✓
Receiving O_2 (l/min) O_2 Saturations (%)	100%	100%	99%
Conscious Level: Normal / Altered	✓	✓	✓
GCS *	15/15	15/15	15/15
TOTAL SCORE Number of shaded boxes	0	0	0
Pain Score	0	0	0
Observer's Initials	[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.

Patient Sticker

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

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Dr. GANESH R

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

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

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 20/6/26

Time:	8am	12pm	4pm	1.30am	8pm	9.30pm	10pm	12am	4am	6am
Doctor / Nurse / Family Concern?										
Temperature (°F) (scale 94–104)	97.8°F	99.1°F	98.1°F	99.7°F	97.°F	99.9°F	99.4°F	99.7°F	98.8°F	98.5°F
Heart Rate (bpm) and Blood Pressure (mmHg) * (scale 50–190)	92/54	91/67 (72)	98/56 (67)	120/83 (92)				98/68 (78)		
Heart Rate (Number)	124b/m	106b/m	110b/m	120b/m				138b/m	120b/m	
Resp. Rate (bpm) (Over 1 Minute) * (scale 10–70)										
Resp Rate (Number)	28b/m	26b/m	28b/m	28b/m				28b/m	24b/m	
Resp Distress — Mod/ Severe / None / Mild	✓	✓	✓					✓	✓	
Receiving O_2 (l/min) / O_2 Saturations (%)	99%	99%	98%	99.1%				98%	100%	
Conscious Level — Normal / Altered	✓	✓	✓	✓				✓	✓	
GCS *	15/15	15/15	15/15	15/15				15/15	15/15	
TOTAL SCORE Number of shaded boxes	0	0	0	0				0	0	
Pain Score	0	0	0	0				0	0	
Observer's Initials	PN	PN	[illegible]	[illegible]				PSR	PSR	

Note: BP does not score in early warning scoring

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

Patient Sticker

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A	**ASSESSMENT :** I think the problem is (XXX) and I have ...(e.g. given O2/ analgesia, stopped the infusion), OR I am not sure what the problem is but child (X) is deteriorating, OR I don't know what's wrong but I am really worried.
R	**RECOMMENDATION :** I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

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FLUID CHART

Sheet No. : 1

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

Date	Time	Intake: Nature of Fluid	Intake: Route: Mouth	Intake: Route: I.V	Intake: Route: N.G	Output: NG	Output: Diarrhoea	Output: Vomit	Output: Drainage	Output: Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
21/1/25			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											
	06:00 pm											
	07:00 pm											
Total Intake :						Total Output :						
	08:00 pm											
	09:00 pm											
	10:00 pm	On Admission @ 10.10 pm										
	11:00 pm	H20	50ml								0	Ady
	12:00 am								✓	✓	0	Ady
	01:00 am		DBF								0	Ady
Total Intake :		DBF + 50ml				Total Output :			1 time			
	02:00 am										0	Ady
	03:00 am										0	Ady
	04:00 am		DBF								0	Ady
	05:00 am										0	Ady
	06:00 am		DBF							✓	0	Ady
	07:00 am	H20	50ml								0	Ady
Total Intake :		DBF 2 times + 50ml				Total Output :			1 time			

Total 24 hrs. Intake	DBF 3 times + 100ml	Total 24 hrs. Output	2 times

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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	Intake: Nature of Fluid	Intake: Route – Mouth	Intake: Route – I.V	Intake: Route – N.G	Output: NG	Output: Diarrhoea	Output: Vomit	Output: Drainage	Output: Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
30/6/26			Mouth	I.V	N.G							
	08:00 am	b/fast	20ml								0	nur
	09:00 am										0	nur
	10:00 am						motion			✓	0	nur
	11:00 am	b/fast	30ml								0	nur
	12:00 pm										0	nur
	01:00 pm	b/fast	30ml								0	nur
Total Intake :		30ml				Total Output :				1 time urine voided		
	02:00 pm	water	30ml							✓	0	dej
	03:00 pm										0	dej
	04:00 pm	DBF								✓	0	dej
	05:00 pm	water	30ml								0	dej
	06:00 pm										0	dej
	07:00 pm	DBF					motion			✓	0	dej
Total Intake :		60ml + 2times DBF				Total Output :				3 times urine passed		
	08:00 pm	water	30ml								0	PSA
	09:00 pm										0	PSA
	10:00 pm	DBF									0	PSA
	11:00 pm	water	50ml							✓	0	PSA
	12:00 am										0	PSA
	01:00 am										0	PSA
Total Intake :		DBF + 100ml				Total Output :				1 times urine passed		
	02:00 am										0	PSA
	03:00 am									✓	0	PSA
	04:00 am	DBF									0	PSA
	05:00 am										0	PSA
	06:00 am	DBF									0	PSA
	07:00 am									✓	0	PSA
Total Intake :		2 DBF				Total Output :				2 times urine passed		

Total 24 hrs. Intake	240ml + 5 DBF	Total 24 hrs. Output	7 times urine passed

Docu. No. : RCH /FRM / CLINICAL / 092

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NURSING CARE RECORD

Date: 29/6/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	10.30 pm	prevent infection		Given mild condition monitor vitals Administer medication as per order	Infection was reducing	Reassessment done	Abitha
Afternoon							
Night							

Docu. No: RCH /FRM / CLINICAL / 148

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NURSING CARE RECORD

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Date: 30/6/26

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8 AM	TO maintain fluid Balance.	8am	⇒ TO Asses the general condition. ⇒ TO monitor vital signs ⇒ TO Encourage oral fluids.	maintained fluid Balance.	Reassessment was done.	
Afternoon	1.30 Pm	Maintain Personal Hygiene	2Pm	Maintain hair and nail hygiene Maintain strict Hand hygiene	maintained Personal Hygiene	Reassessment Done	
Night	8 PM	→ TO maintain good nutritional status		→ Assessed the nutritional status of the child → monitored vital sign → maintained the chart → Administered medication as per doctor's ordered	Improving and maintaining good nutritional status	child was stable Reassessment was done.	

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NURSES NOTES

☐ No Known Drug Allergies

☐ Drug Allergies ..... Nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		on Admission (25/6/26)	
	10.10pm	The child details handover taken from the ER staffs	
		The child is conscious and active Rr line pattern and good	01/5/26
	10.30pm	vitals are checked and recorded temp is normal	
		BP ++ / CP ++ / CRT <2s	
	12pm	Administer the medication as per doctor's order	
	2pm	The child is sleeping well No chart is maintained	01/5/26
	4am	vitals are checked and recorded temp is normal	
		BP ++ / CP ++ / CRT <2s	
	6am	Administer the medication as per doctor's orders	
	7.30am	The child details handover given to morning duty staffs	
		← 30/6/26 to N morning duty →	01/5/26
	7.30am	The child details handing over taken from night duty to morning duty. The child is conscious and oriented. Rr line present. no pain, no swelling. Rr line patten.	01/5/26

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Patient Sticker

NURSES NOTES

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☐ No Known Drug Allergies

☐ Drug Allergies ......Nil.

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		continue nots	
30/6/26	8AM	vital, signs are checked and recorded. vital are stable [CP ++ / PP ++ / CRT <3sec]	[signature]
	10:30am.	DR. Ganesh sir seen by a child. he adviced contie antibiotic. If no fever spike tomarrow disch the child.	[signature]
	12pm.	vital signs are checked and recorded. vital are stable [CP ++ / PP ++ / CRT <3sec]	[signature]
	1pm.	I/O chart was maintaining. no other complaint of pain vomit	[signature]
	1:30pm	The child details handing over given to evening duty staff	[signature]
30/6/26		Evening Duty	
	1.30pm	The child details handing over taken from morning Duty Staff. Child is on room air. child is conscious and alert. IV line Present. IV line Pattern.	[signature]
	2pm	The child is sleeping well. no any other new complaints child is stable	[signature]

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

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

10

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THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE 29/6 (N)	DATE 30/6 (M)	DATE 30/6 (E)	DATE 30/6 (N)	DATE 1/7 (M)
Age	Less than 3 years old	4	4	4	4	4	4
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2					
	Female	1	1	1	1	1	1
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1	1	1	1
Cognitive Impairments	Not aware of Limitations	3	3	3	3	3	3
	Forget Limitations	2					
	Oriented to own ability	1					
Environmental Factors	History of Falls or Infant-Toddler Placed in Bed	4					
	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2	2	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	1	1	1
Medication Usage	Sedatives (Excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1	1	1	1
	Total		13	13	13	13	13

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

Intervention						
Bed in low position		✓	✓	✓	✓	✓
Call device within reach		✓	✓	✓	✓	✓
Wheels Locked		✓	✓	✓	✓	✓
Room free of clutter		✓	✓	✓	✓	✓
Adequate lighting		✓	✓	✓	✓	✓
Wheel chair support		NA	NA	NA	NA	NA
Other Intervention(s) Specify		NA	NA	NA	NA	NA
Nurse's Name:		Anitha	NISHA	Savitha	[illegible]	[illegible]
Signature:		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Date:		29/6	30/6	30/6	30/6	1/7/25
Time:		@ 11pm	@ 8am	@ 2pm	@ 8pm	@ 8AM

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

GUC-00093237 IP18-00036250
Baby ATHVIKA R
09-01-2025 1 Y 5 M 20 D (F) 3RD-Q/NSG/04
Dr. GANESH R

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BRADEN 'Q' SCALE

(for Paediatric use)

Patient Name : .....

Age..... Gender : F

				Date :	29/6	30/6	30/6	30/6
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 though slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	N 4	M 4	E 4	N 4
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4	4	4
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	4
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	4
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times."	4	4	4	4
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	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.	4	4	4	4
				TOTAL SCORE	28	28	28	28
				Evaluator's Name				

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

GUC-00093237 IP18-00036250
Baby ATHVIKA R
09-01-2025 1 Y 5 M 20 D (F)
Dr. GANESH R

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...neral Admission Assessment Form For Pediatrics

Diagnosis:

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

Allergy / Adverse Reaction ..... Body Weight: 9.8 Kg

Height: ..... cm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
–	–	–

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: 9.8 Kg Length: – Head Circumference (< 2 years): –

Temp.: 98°F HR: 132/m RR: 30/m BP: 106/70

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

Fall Risk Assessment: ☐ Yes ☐ No Score: 13 (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 ..... Mothers .....

Nurse's Name: S. Arithelakshmi Date: 29/6/26 Time: 11 pm Signature

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INTERDISCIPLINARY PROGRESS / FAMILY EDUCATION RECORD

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

Identified Education Needs:

1. Diagnosis
2. Treatment and Care
3. 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		
29/6/26	11pm	Medication	Explained about antibiotic	Mother	N/o	oral	respect values	verbalizes understanding	—	
30/6/26	8am	infection control	Explain about hand hygiene and hand washing tech	mother	NO	oral	None	verbalizing understanding good		
1/7/26	8AM	Nutrition diet.	Health education given about Nutrition / diet to patient.	Mother	NO	oral	None	Verbalize good		

Part - III: CODES

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

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

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

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

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

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EMERGENCY ROOM TRIAGE FORM

wt - 9.8kg

Patient's Name : Athvika. Age : 1Y5M Gender: ☐ Male ☑ Female

Date : 29/6/26. Time of Arrival : 8.45PM.

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

Source of Information : ☑ Parents ☐ Others (Specify)

Mode of Arrival : ☑ Ambulatory ☐ Wheelchair ☐ Ambulance

RBS - 783.

Initial Vital Signs: Temp: 98.3°F PR: 111 BP: — RR: 26 SpO_2: 100

Chief Complaints: C/o - fever x 4 days / H/o - Seizure x 1 epi (friday)

INITIAL PHYSIOLOGICAL CATEGORIZATION	INITIAL PHYSIOLOGICAL STATUS
Appearance: ☑ Normal ☐ Sick Looking Circulation / Colour: ☑ Normal ☐ Abnormal ☐ Bleeding Work of Breathing: ☑ Normal ☐ Decreased ☐ Increased ☐ Gasping / Apnea	☑ Stable ☐ Unstable : ☐ Not – Life - Threatening ☐ Life – Threatening

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

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

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian

Triage Completion Time : 2min

Communicable Disease Triage Screening

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

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

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

1. Have you travelled outside the INDIA? or had close contact with someone who has recently travelled outside the INDIA, in the past two weeks? ☐ Yes ☑ No

   If yes, State Location:

2. Are your parents / close contacts at home is/a healthcare worker? {please encircle the choices} (e.g., nurse, physician, ancillary services personnel, allied health services personnel, hospital volunteer, or laboratory worker, others) who has had a recent exposure to an individual with a highly communicable disease or unexplained, severe febrile respiratory or rash disease? ☐ Yes ☑ No

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

☐ Any patient with Fever / Rash / Vesicles / Discharge from Eyes and Cough

☐ Any patient with fever and respiratory symptoms who answered "YES" to any of the questions on epidemiologic risk factors in "PART B" of the triage screening above.

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

☐ Patients should be immediately isolated in a negative pressure room or a single room (as appropriate) for pending evaluation.

☐ The patient should be given a surgical mask immediately, if not already wearing one.

☐ Both patient and triage staff should perform hand hygiene.

☐ The staff should use PPE (as appropriate).

Name of Triage Nurse : Iman

Signature of Triage Nurse : [signature] 78094

Date & Time : 29/6/26 @ 8.50PM

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

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 29/6/26 Time of arrival : 8.45PM

Chief Complaints: C/O - fever x 4 day RBS: 73.

Height : — Weight : 9.8kg BMI : — Head Circumference (<2 years) —

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

If yes , identify .....

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

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

RISK FOR FALL:

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

☐ If Patient is > 6 years
Assess the below parameters

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

Ambulatory Aids:

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

Gait/Transferring:

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

Mental Status: Forgets limitations ☐ Yes ☑ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening: ☑ No Abnormalities Detected

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

Inform consultant for positive criteria

.....

.....

Nutritional Screening: ☑ No Abnormalities Detected

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

Inform consultant for positive criteria

Psychological Screening: ☑ No Significant Findings

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

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

Social History: Lives With .....

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

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

Time	Nursing Notes
9.30 pm	- Pt came to ER c complaint of fever × 4 days / H/o - Seizure × 1 epi.
	- All vitals checked & recorded.
	- ER Dr. assessed the Child & Admitted ↓ Dr. Ganesh
	- IV line done & Bld sample collected
	- Pt shifted to ward for further mgt.

Samples collected by: Iman Time: 10 PM

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: 111 BP: — CFT: <3sec	Shift - out from ER to: 405
RR: 26 SPO_2 : 100	Time of Shift - out: @ 10.10 PM
GCS: 15/15 Temperature : 98°F	Handover given to: S/N · Abhitha (Nurse's Name)
Pain Score: 0/10	
Repeat RBS (if applicable): —	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any): IV line done 24G (R) Metacarpal

Name of the Nurse : Iman Signature of the Nurse : 137894

Date & Time : 29/6 @ 9.30 PM.

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PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : Dr. Chandiralega Date : 29/6/25

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

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

Allergic History: .....

Chief Complaints: .....
Fever x 4 days
Febrile seizure on day 1

Pediatric Assessment Triangle

A Appearance - TICLS .....

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

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

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

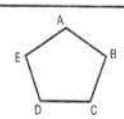
Any urgent interventions needed: ☐ Yes ☐ No
If Yes .....

Significant Past History: —

Medication History: —

Relevant Investigations: —

Primary Assessment



Airway

☑ Open
☐ Maintainable
☐ Not Maintainable

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

Breathing

Rate: 28/min SpO_2 on FiO_2 98:1: RA
Rhythm: .....
Retractions: ☐ Suprasternal ☐ ICR ☐ SCR ☐ Sternal ☐ Supraclavicular ☐ Nasal Flaring
Respiratory Noises: ☐ Stridor ☐ Wheezing ☐ Grunting
Air Entry: B/L AEP
Palpation Findings (If necessary) .....

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

Circulation HR: 118/min CFT [Central ..... Peripheral .....]

Any urgent interventions needed: ☐ Yes ☐ No

If Yes .....

BP: ..... mmHg

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

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

Muffled Heart Sound: ☐ Yes ☐ No

Engorged Neck Veins: ☐ Yes ☐ No

Murmurs: ☐ Yes ☐ No

Liver Span: .....

ECG: .....

Any Signs of Heart Failure: ☐ Yes ☐ No

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

Any urgent interventions needed: ☐ Yes ☐ No

If Yes .....

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

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

Signs of Neurological compromise .....

.....

Exposure Temp.: 98.3F

Any urgent interventions needed: ☐ Yes ☐ No

If Yes .....

Any Rash: ☐ Yes ☐ No,

If yes describe the rash .....

Active bleed .....

Lacerations ☐ Abrasions ☐ bruises ☐

Describe: .....

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

☐ Shock - Compensated ☐ Hypotensive ☐

☐ Cardiopulmonary Arrest ☑ Hemodynamically Stable

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

.....

.....

Labs Planned: .....

.....

As per chart

.....

.....

.....

.....

Treatment Planned: .....

.....

As per chart

.....

.....

.....

.....

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

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

Assessment done by

Name of the Doctor: Dr. Chandiralega

Signature: 29/12/25

Date & Time: 29/6/26

Sr. Doctor on Duty (If necessary)

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

Signature: .....

Date & Time: .....

PATIENT TRANSFER FORM

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	Date & Time of Admission	Date & Time of Transfer Order
	29/6 @ 9.20 PM	29/6 @ 10.10PM.
Treating Consultant Name: Dr. Ganesh.	Transfer Ordered by: Dr. chandirasekaga	Reason for Transfer: treatment
From Unit: ER	To Unit: 405	Information to Attendant: Yes ☑ No ☐
Number of Sheets in Clinical File: (11)	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.	Nil	
3.		
4.		
5.		

Shifting Summary / Notes Written by Doctor : Yes ☑ No ☐ AFI
simple febrile seizure | ? viral

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
138894 Sman.	Dr. Chandirasekaga 19/24

Patient & Clinical Records Received by : Anitha 29/6/25

Date & Time of Patient Received : @10.10pm

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

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MEDICATION RECONCILIATION FORM

Drug Allergies: ..... ☑ Not known any Drug Allergies

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

Shifting From: ER Shifted to: 405

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. chandralega 9/12/24

Date & Time : 29/6/26 @ 10PM

Nurse Name & Signature: [illegible] / Imran

Date & Time : 29/6/26 @ 10PM

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

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RBS CHART

Date	Time	RBS (mg/dl)	IVF %	Signature
29/6/26	10PM	73	—	