Rainbow Children's Hospital

DISCHARGE TRACKING SHEET

GUC-00044037 IP18-00036455
Baby AADHYANTH AANANDH
23-07-2021 4 Y 11 M 20 D (M)
Dr. NATARAJ PALANIAPPAN

UHID- FLOOR- NAME OF CONSULTAN

ACTIVITY	INTIMATE	OUT TIME	NAME & SIGNATURE	REMARKS	<To be filled by Admin>		
Activity Sheet update by Nursing							
Activity Sheet update by Pharmacy							

ACTIVITY RECORD FOR BILLING

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Your Right to a Safe Delivery

Name: .....

UHID No: ..... IP No GUC-00044037 IP18-00036455
Baby AADHYANTH AANANDH
23-07-2021 4 Y 11 M 20 D (M)
Dr. NATARAJ PALANIAPPAN
..... Dept: .....

Date of Admission: ..... T harge: ..... Time: .....

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
13/07	6:30 pm	ER	607	

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
13.07.2026	CBC, Calcium, electrolytes	26022530	
	Vit. D.		[signature] 01/07/26

MEDICAL EQUIPMENT (WARD & ICU)

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

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
13.07.26.	Duplacement	(1)	1786570.	

ANY OTHER INFORMATION:

.....

.....

.....

.....

.....

.....

Date: 14/7/26 Time: 1:30pm Prepared By: .....

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

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DISCHARGE TRACKING SHEET

GUC-00044037 IP18-00036455
Baby AADHYANTH AANANDH
23-07-2021 4 Y 11 M 20 D (M)
Dr. NATARAJ PALANIAPPAN

DOR- NAME OF CONSULTANT-

ACTIVITY	TIME		NAME & SIGNATURE	REMARKS	<To be filled by Admin>
Discharge Announcemënt	19/7/26 @ 1.30pm				
	INTIME	OUT TIME			
Arrangement of File by Nursing					
Preparation of Discharge Summary					
Finalization of discharge summary					
Transfer of file from Ward to Billing Dept					
Bill Processing					
Audit Clearance					
Billing Clearance					
Physical Clearance					

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23-07-2021 4 Y 11 M 20 D (M)
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BED SIDE CHECK LIST FOR NURSES

Date:	13/7	14/7							
Doctor's Orders	yes	YES							
Carried out or not	yes	YES							
Bed Side									
Structured Handover done	✓	✓							
IV Site	✓	✓							
Central Lines	✗	✗							
Arterial Lines	✗	✗							
Feeding Catheter	✗	✗							
Urinary Catheter	✗	✗							
Skin Care	✓	✓							
Eye Care	✓	✓							
Mouth Care	✓	✓							
Sterillum Bottle, Stethoscope	✓	✓							
Suction Bottle (Should be clean & empty)	✓	✓							
Intubation Tray	✗	✗							
Emergency Tray (Loaded Syringes with Midazolam & Vecuronium and Flush) Ampoules of Adrenaline	✗	✗							
Ventilator Tubing, (Any Water, Blood)	✗	✗							
Humidification	✓	✓							
Check all Infusion (Labelling, Correct Preparation)	✓	✓							
Chest Physio & Neb	✗	✗							
Handed Over By Name :	[illegible]	[illegible]							
Signature :	[illegible]	[illegible] 021875							
Date & Time:	13/7 8pm	14/7/26 4:30PM							
Hand Over Taken By Name :	Prakeela								
Signature :	[illegible]								
Date & Time:	13/7 8pm								

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 : IP18-00036455 **Admit Date** : 13-Jul-2026 **Admit Time** : 04:20 PM **UHID** : GUC-00044037

Patient Details :

Patient Name	: Baby AADHYANTH AANANDH	**Age**	: 4 Y 11 M 20 D
Guardian	: Mr AANANDH	**DOB**	: 23-07-2021
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: W/O MARUTHI 114 KAMAKOTI FLATS RAMESWARAM ROAD, T NAGAR, THIYAGARAYA NAGAR Thygaraya Nagar Chennai Tamil Nadu INDIA 600017	**Phone No**	: 9840391967
		E-mail	: nomail@gmail.com

Admission Details :

Bed Type : DAY CARE **Bed No** : ER 103 **Ward Name** : 0F-EMERGENCY

Room No : ER 103 **Admission Type** : First Visit

Contact Details :

Name : Mr AANANDH **Relationship** : Father

Contact Address : W/O MARUTHI 114 KAMAKOTI FLATS RAMESWARAM ROAD, T NAGAR, THIYAGARAYA NAGAR Thygaraya Nagar Chennai Tamil Nadu INDIA 600017 **Phone No** : 9840391967

Signature

Doctor Details :

Doctor Name : Dr. NATARAJ PALANIAPPAN **Specialisation** : PEDIATRIC INTENSIVE CARE

Referral Doctor : Dr. Nataraj Palaniappan **Phone No** :

Co-Consultant :

Payment Details :

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

Payor Name : SELFPAY

Rainbow Children's Hospital
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TEL NO :044-40122444
WEB : https://rainbowhospitals.in

GENERAL CONSENT FOR TREATMENT

Patient Name:	**Baby AADHYANTH AANANDH**	**Age :**	**4 Y 11 M 20 D**
IP No:	**IP18-00036455**	**Sex:**	**Male**
Consultant:	**Dr. NATARAJ PALANIAPPAN**	**Ward/Bed No:**	**0F-EMERGENCY/ER 103**

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

Patient, be deemed advisable or necessary.

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

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

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

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

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

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

Signature of Patient/Relative:

Name: Mr. Aanandh

Relationship: Father

Date: 13/7/26 Time: 4:20pm

Witness Name: Jothi M.D

Witness Signature:

Patient Address:

W/O MARUTHI 114 KAMAKOTI FLATS RAMESWARAM ROAD, T NAGAR, THIYAGARAYA NAGAR Thygaraya Nagar Chennai Tamil Nadu INDIA 600017

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BILLING POLICY

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

DECLARATION

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

Patient Name : Baby Aadhyanth Aanandh	UHID Number : AUC:000044037
Self/Attendant Name : SUKANYA. R.	Relation : Mother
Self/ Attendant Signature Phone Number : 9840391967	Name & Signature of Financial Counselor

भारत सरकार
Government of India

Issue Date: 12/02/2015

சுரபி ர
Surabhi R
பிறந்த நாள் / DOB: 17/11/1995
பெண் / FEMALE

3907 8082 2021

मेरा आधार, मेरी पहचान

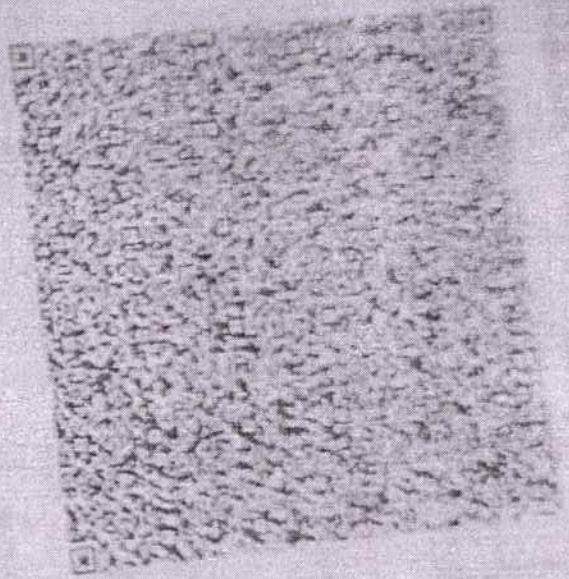
भारतीय विशिष्ट पहचान प्राधिकरण

Unique Identification Authority of India

முகவரி: C/O ஆனந்த் மாருதி, கே
114, காமகோடி பிளாட்ஸ், எண்
72, ராமேசுவரம் சாலை, தியாகராய
நகர், சென்னை, தமிழ் நாடு,
600017

Address: C/O Aanandh Maruthi, K 114,
KAMAKODI FLATS, NO 72,
RAMESWARAM ROAD, Thiyagaraya
Nagar, Chennai, Tamil Nadu, 600017

Print Date: 24/12/2020



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1947

help@uidai.gov.in

www.uidai.gov.in

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PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: _____ GUC-00044037 IP18-00036455
Baby AADHYANTH AANANDH
23-07-2021 4 Y 11 M 20 D (M)
Dr. NATARAJ PALANIAPPAN

UHID ID: _____

Department: _____

Consultant: _____

(P.T.O.)

Patient Sticker

Pediatric Multiorgan History & Physical Examination

Name: ______________________ Age/Sex ______

Information given by: ______________________ Relationship ______

Chief Presenting Complaints & Duration (Chronologically)

K/c/o → Holocord spinal tumor
s/p - Subtotal resection + VP shunt.
C/o - seizure - 1 episode

History of present illness :

H/o → seizure in the form of uprolling of eyes, deviation of angle of mouth - 1 1/2 min, self aborted at 1:30 pm →

- No h/o fever/headache/vomiting.
- On Lepomec 25mg BD.
- drug compliance good
- Not missed dose / No change in dose

- Last seizure - 2024 (Admitted in RCH → had Hyponatremia → ? SIADH)
- taken to SRM hospital & referred here

In ER

- No active seizure
- Bowel/sensorium ⓝ
- b/l PERL ⓝ

CBG - 98 mg/dl

→ Last month MRI - done (June 2026) → Post op changes with Residual tumor.
- Prev on Levipil, from Jan 2026 → started on Toporac.

Patient Sticker

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

At 1 yr of Age → Had deviation of head → evaluated MRI brain → showed holocord spinal cord tumor

Had Cardiac arrest at 1 yr of Age → ROSC achieved ventilated x 1 month → tracheostomy done → on ...

2022 → Subtotal resection of tumor, 2021 → Hydrocephalus - VP shunt done

2024 → Removal procedure

Birth & Neonatal History: ANl scan normal

1st child / NVD / B.W. - 3 kg /

No NICU stay

Family Chart

Birth & Socio Economic History:

About Father : ______

About Mother : ______

Any additional Information : ______

Developmental History : Ⓝ → till 1 yr of Age → At 1 yr - able to stand with support

Now → bedridden, speaks 3-4 words sentence, self talk Φ.

Do not indicate bowel & bladder need.

Immunization History :

upto Age. On physiotherapy

Anthropometry :

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

Weight (kgs) 29 kg (Centile > 97th centile → Obese.

On Examination :

Temperature : 97.8°F Pulse Rate : 112/min B.P. ______ SPO2 100% RA

Resp.rate and type of breathing : 24/min

Elbow flexed, wrist extension, knee flexed,

Rash ______

Lymphadenopathy ______

Oedema : ______

Allergies (if any): ______

(P.T.O.)

Patient Sticker

Respiratory System :

Inspection (any s/o distress) :

Air entry & breath sounds : NVBS (+), BILAT D

Any addes sounds :

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

Cardiovascular System :

Inspection of procordium :

Heart Sounds : S1S2 (+)

Any murmur : No murmur

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

Per Abdomen :

Inspection :

Palpation : Soft, Non tender

Ausculation : VP shunt - scar (+)

Spine : External Genitelia :

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

Central Nervous System :

Level of Consciousness : AVPU/GCS score : Alert, Bowel sounds (+).

Cranial Nerves : B/L PERL (+)

Motor System :

Nutriton :

Tone: ↑ in all 4 limbs Power

	R	L
U	3/5	3/5
L	2/5	2/5

Co-ordinator :

Posture :

Involuntary Movements : Ankle clonus (+)

Patient Sticker

Reflexes : 2+

DTR

Plantars ______ **Superficials:**

Sensory System :

Able to pass urine

Bladder / Bowel :

Clinical Summary & Diagnostic:

K/c/o → Infantile Myofibromatosis / Holocord spinal tumor s/p subtotal resection c VP (R) shunt / Admitted with breakthrough seizures ? Dyselectrolyte. ? shunt block.

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

Desired goals of the treatment :

Planned Labs:

CBC ✓
Electrolyte ✓
Vit D ✓
Ca^{2+} ✓.

(EEG - tomorrow)
Air needed

Planned Management 29 kg

→ Dr. Mohesh sir (O)
↓
decide on EEG

D/w Dr. Mohesh sir → to start on IV Levipil 20mg/kg.

- Continue to pass
- Monitor vitals, Seizure
- W/F further seizure

Signature of the Doctor: [signature]

Name of the Doctor: Dr. Manoma

Date & Time: 13/7/26, 6pm

Signature of the Consultant:

Name of the Consultant:

Date & Time:

(P.T.O.)

Patient Sticker

DISCHARGE PLANNING FORM

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

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

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

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

   ☐ Needs Assistance In:

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

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

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

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

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

Doctor Signature: .....

Doctor Name: .....

Date and Time: .....

GUC-00044037 IP18-00036455
Baby AADHYANTH AANANDH
23-07-2021 4 Y 11 M 20 D (M)
Dr. NATARAJ PALANIAPPAN

Docu. No

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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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

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Baby AADHYANTH AANANDH
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Dr. NATARAJ PALANIAPPAN

(1)

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
13/7/26		
11:30pm		S/B Dr. Maran
	Reviewed	
	Asleep	Na^+ - 136
	No further seen	
	Intake fair	
	PP-LF, Sno ⊕.	
	RI-clear.	
	Rx	
	- contd IV Levipil	
	- EEG, Dr. Mohan B/O tomorrow.	
	- W/F further seen	
[signature]		

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

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
14/7/22 9'20AM	S/B Dr. DEEPAK	
	Asm: Infantile myofibromatosis Holocord spine tumor	
	S/P	Subtotal resection + (R) VP shunt
	Breakthrough seizure	
	Child reviewed	
	child has no new concerns	
	O/E:	
	Child is alert, looking around	
	CVS: S1S2 (+)	
	RS: VBS (+)	
	P/A: Soft	
	CNS:	
	BP & RL (+)	
	Tone ↑/N ↑/N	
	(R) (L)	
	Power UL 3/5 | 3/5	DTR-2 (+)
	LL 2/5 2/5	
	Ankle clonus	

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
		℞
		I. levipill 500mg IV Q12H
		T. Topomac 25mg P/O Q12H
	TO DO:	TO Monitor vitals / GCS / seizures
	EEG	
	Dr. Mohinish sir ® today	
14/1/26	S/B D. Nataraj	
		T. melatonin
	Syp. pedicloryl 7.5ml +	3mg.
		D. Mohinish to see
	EEG	
	midazolam nasal spray	
		8500

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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AADHYANTH

RESULT SHEET

Date	13/7/26					
Time						
Hb	11.7					
PCV	35					
RBC	4.49					
WBC	10,000					
N/L	59/33					
Platelets	4.09					
CRP						
ESR						
PCT						
RBS						
Na	136					
K	4.3					
Cl	100					
Ca/Mg	9.5/					
Phosphate						
Urea						
Creatinine						
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

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

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

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MEDICATION RECONCILIATION FORM

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

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

Shifting From: ..... ER ..... Shifted to: ..... 607 .....

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	T-TOPAMAC	25g	P/o	BD	13/07 8pm.	☑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. Manasa

Date & Time : 13/7/26, 8pm

Nurse Name & Signature: ..... Godwin

Date & Time : ..... 13.07.2026 @. 6.10pm

GUC-00044037 IP18-00036455
Baby AADHYANTH AANANDH
23-07-2021 4 Y 11 M 20 D (M)
Dr. NATARAJ PALANIAPPAN

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DRUG CHART

Date of Admission: 13/07 Drug Allergies: NKDA ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

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

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

SOS / PRN (As required Medication)

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

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

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

Signature .....

VERIFIED BY : Name .....

GUC-00044037 IP18-00036455
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REGULAR PRESCRIPTIONS

Weight. 29kg Ward. 607

DRUG : INJ LEVIPIL

Dose	Route	Frequency	Start Date
580 mg	IV	BD	13/7/24

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date	13/7	14/7
Time	SP	SS / SP
	5PM	5PM

DRUG : T. TOPAMAC

Dose	Route	Frequency	Start Date
25mg	P/o	BD	12/7/24

Name & Signature of the Doctor Starting the Drugs:

(TOPIRAMATE)

Additional Instructions:

1 — 0 — 1

Daily Doctor's Endorsement by a Sign

Date	13/7	14/7
Time	9AM	9PM SS / SP

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

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.	

Signature .....

VERIFIED BY : Na...

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses

(P.T.O)

GUC-00044037 IP18-00036455
Baby AADHYANTH AANANDH
23-07-2021 4 Y 11 M 20 D (M)
Dr. NATARAJ PALANIAPPAN

I.V. FLUIDS CHART

Weight. 29kg Ward. 607

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

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

GUC-00044037 IP18-00036455
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Dr. NATARAJ PALANIAPPAN

(1)

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 : 18/7/26 Time:	7pm	8pm	12am	4am
Doctor / Nurse / Family Concern?				
Temperature (°F) (scale 94–104)	97.9F	98.1F	96.8F	97.5°F
Heart Rate (bpm) and Blood Pressure (mmHg) * (scale 50–190) Note: BP does not score in early warning scoring	110/69 (72)	103/67 (76)	109/71 (82)	101/64
Heart Rate (Number)	115 b/m	107 b/m	115 b/m	107 b/m
Resp. Rate (bpm) (Over 1 Minute) * (scale 10–70)				
Resp Rate (Number)	24 b/m	24 b/m	26 b/m	26 b/m
Resp Distress: Mod/ Severe / None / Mild	✓	✓	✓	✓
Receiving O_2 (l/min)	RA			
O_2 Saturations (%)	100%	99%	98%	98%
Conscious Level: Normal / Altered	✓	✓	✓	✓
GCS *	15/15	15/15	15/15	15/15
TOTAL SCORE Number of shaded boxes	0	0	0	0
Pain Score	0	0	0	0
Observer's Initials	[illegible]	[illegible]	[illegible]	[illegible]

ACTIONS

NB: Scores 3 should be recorded overleaf

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

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

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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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				Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
13/7/26		Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			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	→ Received										
	06:00 pm											
	07:00 pm	Kanji	200ml								0	Suponog
Total Intake :		200ml				Total Output :				Nil		
	08:00 pm	H2O	100ml									
	09:00 pm	H2O	50ml							✓	0	SS/ow
	10:00 pm	Milk	150ml									
	11:00 pm										0	SS/ow
	12:00 am	H2O	50ml							✓		
	01:00 am										0	SS/ow
Total Intake :		350ml				Total Output :				2 times		
	02:00 am											
	03:00 am										0	SS/ow
	04:00 am									✓		
	05:00 am										0	SS/ow
	06:00 am											
	07:00 am									✓	0	SS/ow
Total Intake :		Nil				Total Output :				2 times		

Total 24 hrs. Intake	350ml

Total 24 hrs. Output	4 times

GUC-00044037 IP18-00036455
Baby AADHYANTH AANANDH
23-07-2021 4 Y 11 M 20 D (M)
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NURSES NOTES

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☐ NO KNOWN Drug ...

☐ Drug Allergies .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		Received notes 13/7/26	
13/7	6.15pm	⇒ Patient received From ER to 6th Floor (607) →	Cmyy 6/13/26
		⇒ Patient clinically normal.	
		⇒ Provide health education	
		⇒ Checked IV dine, line pattern only →	Cmyy 6/13/26
	7pm	⇒ Checked vital signs	
		⇒ Patient vitals is Stable.	
		CRT / CP / PP: Used ++ / ++ →	Cmyy 6/13/26
		⇒ Monitored I/O Chart	
	7.30 pm	⇒ patient Handover given to night duty S/N → Night duty Noted.	Cmyy 6/13/26
13/7/26	7.30pm	Patient details Hand over taken from Evening duty Staff. patient consious & Oriented. →	Praveena Staff Nurse
	8pm	Child vitals Checked and Recorded. vitals Normal.	
		CP: ++ / PP: ++ / CFT →	Praveena Staff Nurse.
		child IV line pattern is healthy and Observed →	Praveena SN
	9pm	Due medication given as per doctor chart →	Praveena Staff Nurse

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Patient Sticker

NURSES NOTES

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☑ No Known Drug Allergies

☐ Drug Allergies ....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
14/7/26	12Am	Child vitals checked and Recorded. vitals Normal. CP ++, PP ++, CFT <3sec →	Praveen Ozon
	2Am	maintained intake and output chart. tomorrow Dr. Mohinich sir opinion and EEG is there. →	Praveen Ozon
		Child was sleeping well No any other complaints →	Praveen Ozon
	4Am	Child vitals checked and Recorded. vitals Normal. CP ++, PP ++, CFT <3sec →	Praveen Oz
	5Am	Due medication given as per drug chart →	Praveen Ozon
	7Am	Maintained intake and output chart →	Praveen Ozon
	7:30Am	Hand over given from morning duty staff →	Praveen
14/7/2026		Morning duty ON 14/7/2026. child Condition and details handing Over taken from night duty staff Nurse.	
		CNS: child is Conscious Oriented GCS E4 V5 M6 15/15.	
		CVS: - S1 and S2 heart sounds are hearing good.	02:18:75

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

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

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Patient's Name: GUC-00044037 IP18-00036455
Baby AADHYANTH AANANDH
MRD NO: 23-07-2021 4 Y 11 M 20 D (M)
Dr. NATARAJ PALANIAPPAN
Age : .... ☐ M ☐ F
Consultant : ....

PHLEBITIS ASSESSMENT

CANNULA 1

Date : 13/07/22 Time: 4 pm
Location : (R) foot
Size : 24 G
Cannula inserted by : DR. Manonmani

Date	Time	Phlebitis	Infiltration	Nursing Intervention	Sign
13/7	4 pm	☐Yes ☐No	☐Yes ☐No	path	[illegible]
	7pm	☐Yes ☐No	☐Yes ☐No	[illegible]	[illegible]
	9 pm	☐Yes ☑No	☐Yes ☑No	observe	[illegible]
	11 Pm	☐Yes ☑No	☐Yes ☑No	observe	[illegible]
14/7	3 Am	☐Yes ☑No	☐Yes ☐No	Observe	[illegible]
	7 Am	☐Yes ☑No	☐Yes ☑No	obs	[illegible]
	9 AM	☐Yes ☐No	☐Yes ☐No	path	[illegible]
	11 AM	☐Yes ☐No	☐Yes ☐No	path	[illegible]
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		

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

CANNULA 2

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

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

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

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

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

PHLEBITIS ASSESSMENT AND MANAGEMENT RECORD

CANNULA 3

Date : Time:

Location :

Size :

Cannula inserted by :

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

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

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

Phlebitis score:

CANNULA 4

Date : Time:

Location :

Size :

Cannula inserted by :

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

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

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

Phlebitis score:

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

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

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

GUC-00044037 IP18-00036455
Baby AADHYANTH AANANDH
23-07-2021 4 Y 11 M 20 D (M)
Dr. NATARAJ PALANIAPPAN

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

BirthRight BY RAINBOW HOSPITALS Your Right to a Safe Delivery

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
12. Patient's / Family Rights
13. Risk / Safety

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
13/7/21	7pm	Yes	explained about feeding/ cold point	Mother	None	oral	Nil	yes	Good	
14/7/21	9pm	YES	Explained the risk of hospital infection	mother	none	Oral	Nil	yes	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

GUC-00044037 IP18-00036455
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Nursing General Admission Assessment Form For Pediatrics

Diagnosis: Breakthrough Seizure

Arrival Time: 6.15pm Mode of Arrival: Bed Admitting From: ☑ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction ..... Nil ..... Body Weight: 29 Kg

..... Height: — cm

.....

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

Past Medical History	Past Surgical History	Previous Hospital Admission
K/C/O - infantile myofibromatosis/ H/O cord spinal tumor		

Family History: Nil

.....

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

If yes please list, ...

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

.....

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

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

Observations: Weight: 29 kg Length: — Head Circumference (< 2 years): .....

Temp.: 97.9°F HR: 125 b/m RR: 24 b/m BP: 110/64 (70)

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

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

Risk of Pressure Sore (Braden Q Score .....) (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 ..... Parents .....

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. Lavanya Devi Date: 13/7/26 Time: 6.34 pm Signature Lavanya 017189

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PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : Dr. Nataraj Date : 13/7/26

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

Start Time of Assessment: ..... Weight: 29 kgs.

Allergic History: .....

Chief Complaints: .....

Pediatric Assessment Triangle

A Appearance - TICLS Acut, Intoxicated.

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: ..... SpO_2 on FiO_2 .....

Rhythm: .....

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

Respiratory Noises: ☐ Stridor ☐ Wheezing ☐ Grunting

Air Entry: .....

Palpation Findings (If necessary).....

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

Circulation

HR: .....

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: ..... AVPU: Alert

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

Active Seizures: ☐ Yes ☐ No Sugars: 98 mg/dl

Signs of Neurological compromise .....

.....

Any urgent interventions needed: ☐ Yes ☐ No ✓

If Yes .....

Exposure

Temp.: .....

Any Rash: ☐ Yes ☐ No,

If yes describe the rash .....

Active bleed .....

Lacerations ☐ Abrasions ☐ bruises ☐

Describe: .....

Any urgent interventions needed: ☐ Yes ☐ No ✓

If Yes .....

Final Physiological Status:

☐ Respiratory Distress ☐ Respiratory Failure ☐ Respiratory Arrest

☐ Shock - Compensated ☐ Hypotensive ☐

☐ Cardiopulmonary Arrest ☐ Hemodynamically Stable

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

.....

.....

Labs Planned: .....

.....

.....

.....

.....

.....

.....

Treatment Planned: .....

.....

.....

.....

.....

.....

.....

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

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

Assessment done by

Name of the Doctor: .....

Signature: Dr. Manan

Date & Time: .....

Sr. Doctor on Duty (If necessary)

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

Signature: .....

Date & Time: .....

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 12/07/24 Time of arrival : 3:50 pm

Chief Complaints: H/O Seizure RBS: 98 mg/dl.

Height : — Weight : 29 kg BMI : — Head Circumference (<2 years) .....

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

If yes , identify Nil

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

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

RISK FOR FALL:

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

☐ If Patient is > 6 years
Assess the below parameters

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

Ambulatory Aids:

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

Gait/Transferring:

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

Mental Status: Forgets limitations ☐ Yes ☑ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening: ☐ No Abnormalities Detected

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

Inform consultant for positive criteria

.....

.....

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 parents

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

Time of Initial assessment completed by ER Nurse : 4:00 pm

Time	Nursing Notes
6 pm	patient came to the ER with
	the h/o seizure. monitored the
	vital signs. recorded Dr.
	[illegible] mam. IV line placement
	done - Blood sample collected and
	pt shifted to the ward.

Samples collected by: / S/N Shibu Time: / 4:20pm

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: 112/m BP: — CFT: <3sec	Shift - out from ER to: 607
RR: 24/m SPO_2: 100% -RA	Time of Shift - out: 6:30pm
GCS: 15/15 Temperature : 97.8°F	Handover given to: (Nurse's Name) S/N [illegible]
Pain Score: 0/10	
Repeat RBS (if applicable): 98mg/dl	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

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

Name of the Nurse : Shibu

Signature of the Nurse : [signature] 7880

Date & Time : 13/07/26 6pm

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EMERGENCY ROOM TRIAGE FORM

wt: 29/g/

Patient's Name : Mast. Aadhyanth Age : 5yrs. Gender: ☑ Male ☐ Female

Date : 13. July. 2021 Time of Arrival : 3.50pm

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: 112 bpm BP: — RR: 24 bpm SpO_2: 100% RA. GRBS: 98mg/dl

Chief Complaints: Seizure.

INITIAL PHYSIOLOGICAL CATEGORIZATION

Appearance
☐ Normal
☑ Sick Looking

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

Circulation / Colour
☑ Normal ☐ Abnormal ☐ Bleeding

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

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

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

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian

Triage Completion Time : 2min

Communicable Disease Triage Screening

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

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

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

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

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

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

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

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

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

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

☐ Both patient and triage staff should perform hand hygiene.

☐ The staff should use PPE (as appropriate).

Name of Triage Nurse : Godwin Savio.

Signature of Triage Nurse : 016137

Date & Time : 13. July. 2021 @ 3.50pm

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

G/ectu
Ca
Vit D
CBC

tmw
↓
Mohinesh

EEG

Canula -
Topiramate.

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PATIENT TRANSFER FORM

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	Date & Time of Admission	Date & Time of Transfer Order
	13.7.26 @ 4.20pm	13.7.26 @ 6:30pm
Treating Consultant Name	**Transfer Ordered by**	**Reason for Transfer**
Dr Nataraj	Dr Manonmani	Treatment
From Unit	**To Unit**	**Information to Attendant**
ER	607	Yes ☑ No ☐
Number of Sheets in Clinical File	**Number of Imaging Films**	**Personal belongings including clinical documents. If any handed over to attendant**
(12)	Nil	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 ☐

Infantile Myofibromatosis / breakthrough pain

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
[signature] 016134 Godwin	Dr. Manonmani

Patient & Clinical Records Received by : S. Ilayathal 017179

Date & Time of Patient Received : 13/7/26 6.45pm.

If the transfer order time & Completion time is more than 30 minutes, please tick the reason mentioned below :

☐ Unavailable Bed ☐ Nurse not Available ☐ Available Bed not ready

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

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RBS CHART

Date	Time	RBS (mg/dl)	IVF %	Signature

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