BirthRight Rainbow Children's Hospital

GUC-00093197 IP18-00036233
Baby P.HIMANISH RAM
03-03-2023 3 Y 3 M 25 D (M)
Dr. VAISHNAVI CHANDRAMOHAN

DISCHARGE TRACKING SHEET

UHID- **FLOOR-** **NAME OF CONSULTANT-**

ACTIVITY	INTIME	OUT TIME	NAME & SIGNATURE	REMARKS	<To be filled by Admin>		
Activity Sheet update by Nursing		9:30AM					
Activity Sheet update by Pharmacy							

ACTIVITY RECORD FOR BILLING

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Your Right to a Safe Delivery

Name: GUC-00093197 IP18-00036233
Baby P.HIMANISH RAM
03-03-2023 3 Y 3 M 25 D (M)
Dr. VAISHNAVI CHANDRAMOHAN

UHID No: .....

Consultant: ..... Dept: .....

Date of Admission: .....

Date of Discharge: ..... Time: .....

Room / Bed No: .....

Ward: .....

Suggested Billable bed type: .....

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
28/6/20	5:40pm	ER	404	

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
28/6/26	CBC, CRP, RP2,	26020538	
	LFT.		
28/6/26	~~RBS~~.		

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
28/6/26	Infusion Pump	28/6/26 8pm	28/6/26 @ 7am	13769	n8/01801.

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
28/6/26	IV Placonet	(1)	1718749	

ANY OTHER INFORMATION:

.....

.....

.....

.....

.....

.....

Date: 28/6/26 Time: 11 pm Prepared By: .....

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

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DISCHARGE TRACKING SHEET

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Baby P.HIMANISH RAM
03-03-2023 3 Y 3 M 25 D (M)
Dr. VAISHNAVI CHANDRAMOHAN

UHID- FLOOR- NAME OF CONSULTAN

ACTIVITY	TIME		NAME & SIGNATURE	REMARKS	<To be filled by Admin>
Discharge Announcement					
	INTIME	OUT TIME			
Arrangement of File by Nursing		9.30AM			
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 : IP18-00036233 **Admit Date** : 28-Jun-2026 **Admit Time** : 04:57 PM **UHID** : GUC-00093197

Patient Details :

Patient Name	: Baby P.HIMANISH RAM	**Age**	: 3 Y 3 M 25 D
Guardian	: Mr P. SAMBASIVAIH	**DOB**	: 03-03-2023
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: PORUR , 14/6B MANGALAUR NAGAR , 18TH MAIN ROAD Alapakkam Kanchipuram Tamil Nadu INDIA 600116	**Phone No**	: 7041490378/ 7200710509
		E-mail	: NO@GMAIL.COM

Admission Details :

Bed Type : DAY CARE **Bed No** : ER 102 **Ward Name** : 0F-EMERGENCY

Room No : ER 102 **Admission Type** : First Visit

Contact Details :

Name : Mr P. SAMBASIVAIH **Relationship** : Father

Contact Address : PORUR , 14/6B MANGALAUR NAGAR , 18TH MAIN ROAD Alapakkam Kanchipuram Tamil Nadu INDIA 600116 **Phone No** :

P Sambasivaiah

Signature

Doctor Details :

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

Referral Doctor : self **Phone No** :

Co-Consultant :

Payment Details :

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

Payor Name : SELFPAY

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TEL NO :044-40122444
WEB : https://rainbowhospitals.in

GENERAL CONSENT FOR TREATMENT

Patient Name:	**Baby P.HIMANISH RAM**	**Age :**	**3 Y 3 M 25 D**
IP No:	**IP18-00036233**	**Sex:**	**Male**
Consultant:	**Dr. VAISHNAVI CHANDRAMOHAN**	**Ward/Bed No:**	**0F-EMERGENCY/ER 102**

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: P. Sambasivaih.

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: P. Sambasivaih.

Name: Mr. P. Sambasivaih.
Relationship: Father
Date: 28/6/26 Time: 4:57pm
Witness Name: Jeevitha.
Witness Signature:

Patient Address:
PORUR , 14/6B MANGALAUR NAGAR , 18TH MAIN ROAD Alapakkam Kanchipuram Tamil Nadu INDIA 600116

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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 : P. Himanish Ram	UHID Number : Guc-00093197
Self/Attendant Name : Mr. Sambasivaih.	Relation : Father
Self/ Attendant Signature : P. Sambasivaih. Phone Number : 7041490378	Name & Signature of Financial Counselor

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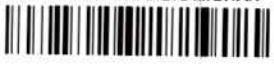
PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: _____ GUC-00093197 IP18-00036233 _____
Baby P.HIMANISH RAM
03-03-2023 3 Y 3 M 25 D (M)
UHID ID: _____ Dr. VAISHNAVI CHANDRAMOHAN _____



Department: _____ _____

Consultant: _____

(P.T.O.)

GUC-00093197 IP18-00036233
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03-03-2023 3 Y 3 M 25 D (M)
Dr. VAISHNAVI CHANDRAMOHAN

rediatric Multiorgan History & Physical Examination

Name: _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

C/o - fever x 2 dys
Vomy x 1 dy
poor oral intake

History of present illness :

H/o - fever x 1 dy
high grade
No chills/rigors.
Relieved by antipyretics

H/o - Vomy x 1 dy
Non bilious, Non projectile
settled with oral antiemetics

H/o - poor oral intake x 1 dy

- No H/o abd pain / loose stools.
- No prev H/o UTI
- No Sick contact

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Past History : (Including ... any previous investigation or treatment)

No

Birth & Neonatal History:

FT child/ NVD/ term/ CLAR/
No Neuro.

Family Chart

Birth & Socio Economic History:

About Father :

About Mother :

Any additional Information :

Developmental History :

N

Immunization History :

upto date

Anthropometry :

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

Weight (kgs) 14 kg. (Centile _____)

On Examination :

Temperature : 101.4°F Pulse Rate : 143/min B.P. 105/68 mmHg SPO2 98% on RA

Resp.rate and type of breathing : 32/min.

Rash

Lymphadenopathy

Oedema :

Allergies (if any):

PBS - 14 gm/dl
skin pink (N)
dry oral mucosa.
PP. nil

(P.T.O.)

Patient Sticker

Respiratory System :

Inspection (any s/o distress) :

Air entry & breath sounds : NVBS ⊕

Any addes sounds : AE ⊕

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

Cardiovascular System :

Inspection of procordium :

Heart Sounds : S1 S2 ⊕

Any murmur : No mm

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

Per Abdomen :

Inspection :

Palpation : Soft, Non tm

Ausculation :

Spine : External Genitelia : No phimosis

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

Central Nervous System :

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

Cranial Nerves :

Motor System :

Nutriton :

Tone: N Power 5/5

Co-ordinator :

Posture :

Involuntary Movements :

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Pa

Reflexes :

Superficials:

DTR

Plantars

Sensory System :

Bladder / Bowel :

Clinical Summary & Diagnostic: Viral fever with Gastritis + Bronchitis
? to r/o UTI.

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

Desired goals of the treatment :

Planned Labs:

CBC
CRP
RP-2
LFT

Planned Management

- IVF - DNS - 1.5 for maint
- Inj pan
- Inj emet
- IV paracetm

Signature of the Doctor:

Name of the Doctor: Dr. Manasa

Date & Time: 28/6/26, 5:30pm

Signature of the Consultant: Vaishnavi

Name of the Consultant: Dr. Vaishnavi

Date & Time: 28/6/26, 8pm

(P.T.O.)

Patient Sticker

DISCHARGE PLANNING FORM

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

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

2. Destination Post Discharge: ☐ Home

   Family Members Notified (Person Contacted)

   ☐ Transfer

   Hospital Facility Notified (Person Contacted)

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

   ☐ Needs Assistance In:

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

4. Nutritional Plan:

   ☐ Dietary Instruction Discussed with the:

   ☐ Patient ☐ Family Member ☐ Others: .....

5. Discharge Planning Discussed with the:

   ☐ Patient ☐ Family Member ☐ Others: .....

6. Patient/Family Educational Plan:

   ☐ Educational Topic/s: .....

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

   ☐ Patient ☐ Family Member ☐ Others: .....

Doctor Signature: .....

Doctor Name: .....

Date and Time: .....

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

DOCTOR'S SHIFT CHANGE HANDOVER FORM

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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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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
29/6/24 3:45AM	S/B Dr. DEEPAK	/ Dr Vaishnavi
	Dx: Viral fever c Gastritis & Some dehydration	
	Child reviewed	
	Child had One fever spike 101°F at: 1:5PM	
	O/E:	
	child as asleep	
	CVS: S1S2 ⊕	
	RS: NVBS ⊕	
	P/A: soft	
	CNS: NFND	
		Rx
		→ To continue as per chart
		→ To monitor vitals/GCS
		→ To monitor for fever spikes
		→ To continue IVF
	D/C today	[signature] 10:425
	1. Paracetamol	
	2. Mucolite 3 days	3. Sr.Langol 3 days
	Review on Wed	[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

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RESULT SHEET

Date	28/8/26					
Time						
Hb	12.6					
PCV	37					
RBC	5.02					
WBC	6,720					
N/L	79/15					
Platelets	2,51,000					
CRP	20					
ESR						
PCT						
RBS	123					
Na	139					
K	3.9					
Cl	103					
Ca/Mg	1.14					
Phosphate / HCO_3^-	/19					
Urea	23					
Creatinine	0.44					
ALP						
SGPT	16					
SGOT	36					
T.Bill/Conj	0.8/0.0					
T.Protein	7.8					
S.Albumin	4.4					
S.Globulin						
A/G Ratio	1.2					
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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ATION RECONCILIATION FORM

Drug Allergies: ..... ☐ Not known any Drug Allergies

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

Shifting From: ..... Shifted to: .....

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

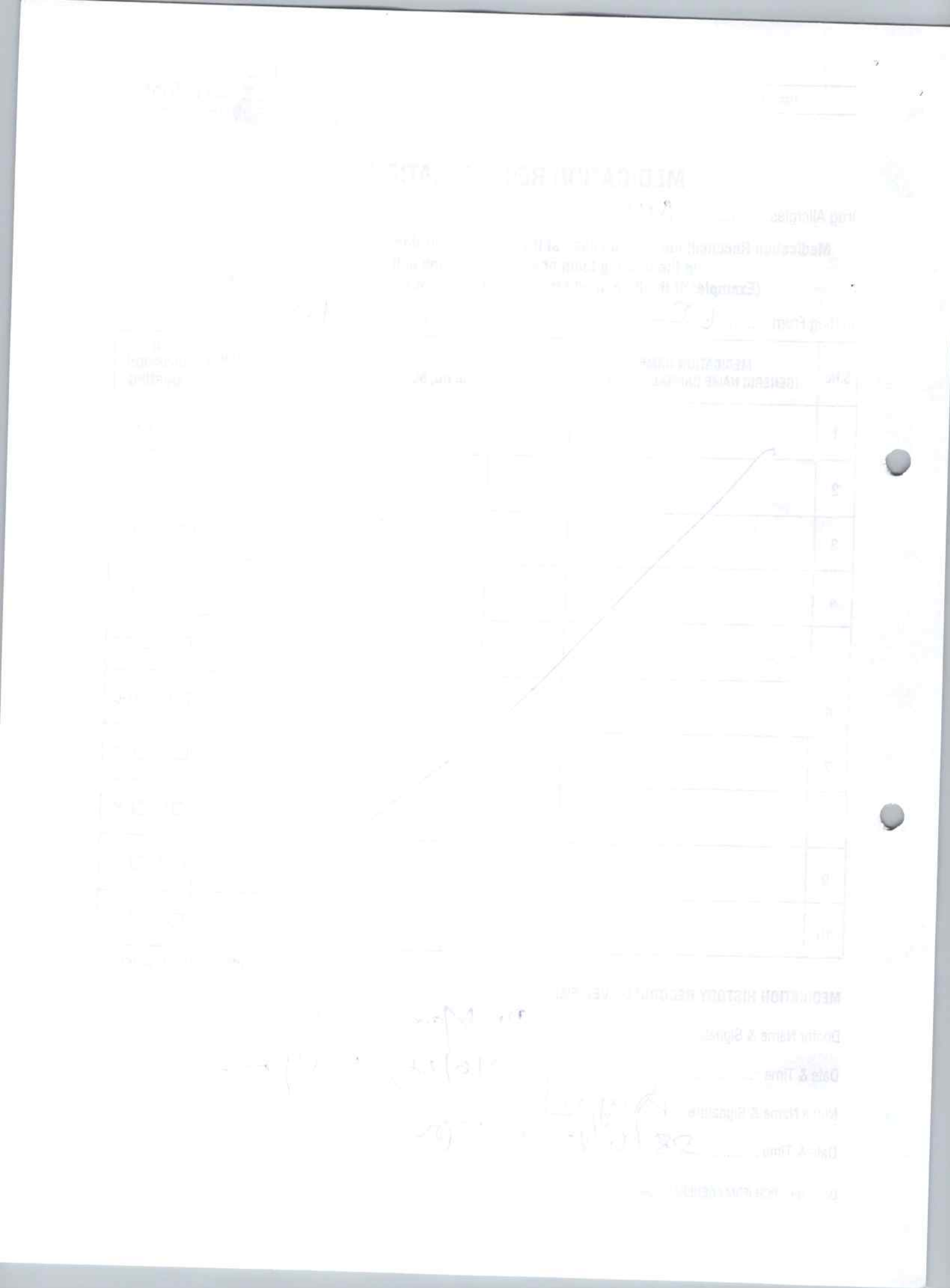
Doctor Name & Signature : Dr. Manoma

Date & Time : 28/6/24, 5:20 pm

Nurse Name & Signature: Suyan

Date & Time : 28/6/24 @5pm

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



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DRUG CHART

Date of Admission: 28/6/26 Drug Allergies: NIL ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

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

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

SOS / PRN (As Required Medication)

DRUG: INJ PARACETAMOL				Date/Time	28/6													
Dose	Route	Frequency	Start Date	2														
140 mg	IV	Q 6 H	28/6/26		PN MA													
Doctor's Signature		Valid Period	Pharm.															
Additional Instructions:																		

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

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

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

GUC-00093197 IP18-00036233
Baby P.HIMANISH RAM
03-03-2023 3 Y 3 M 25 D (M)
Dr. VAISHNAVI CHANDRAMOHAN

REGULAR PRESCRIPTIONS

Weight. 14kgs Ward. Ped

DRUG : INJ PANTOPRAZOLE

Dose	Route	Frequency	Start Date
15 mg	IV	OD	28/6/26

Name & Signature of the Doctor Starting the Drugs: 28/6/26

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date	28/6			29/6
Time	5 pm	SS OTS	6 Am	BA RJ

DRUG : INJ EMESET

Dose	Route	Frequency	Start Date
1.5 mg	IV	TDS	28/6/26

Name & Signature of the Doctor Starting the Drugs: 28/6/26

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date	28/6			29/6
Time	5 pm	SS OTS	6 Am 1 pm 7 pm	BA RJ

DRUG : Syp. MVCOLITE

Dose	Route	Frequency	Start Date
3ml	PO	TDS	28/6 9pm

Name & Signature of the Doctor Starting the Drugs: Vaishnavi

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date	28/6	29/6
Time	8 Am	VB VR
	2 pm	
	10 pm	BA RJ

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

GUC-00093197 IP18-00036233
Baby P.HIMANISH RAM
03-03-2023 3 Y 3 M 25 D (M)
Dr. VAISHNAVI CHANDRAMOHAN

Weight. 14.0kg Ward. 409

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 : Name

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses

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I.V. FLUIDS CHART

Weight. 16 Ward. NICU

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
28/6/26	5.20 pm	0.9% DNS x 3 hrs	IV	70 ml/hr		SS CTS	28/6/26 8.30pm		01840
28/6/26	9pm	0.9% DNS	IV	50 ml/hr					

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

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

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

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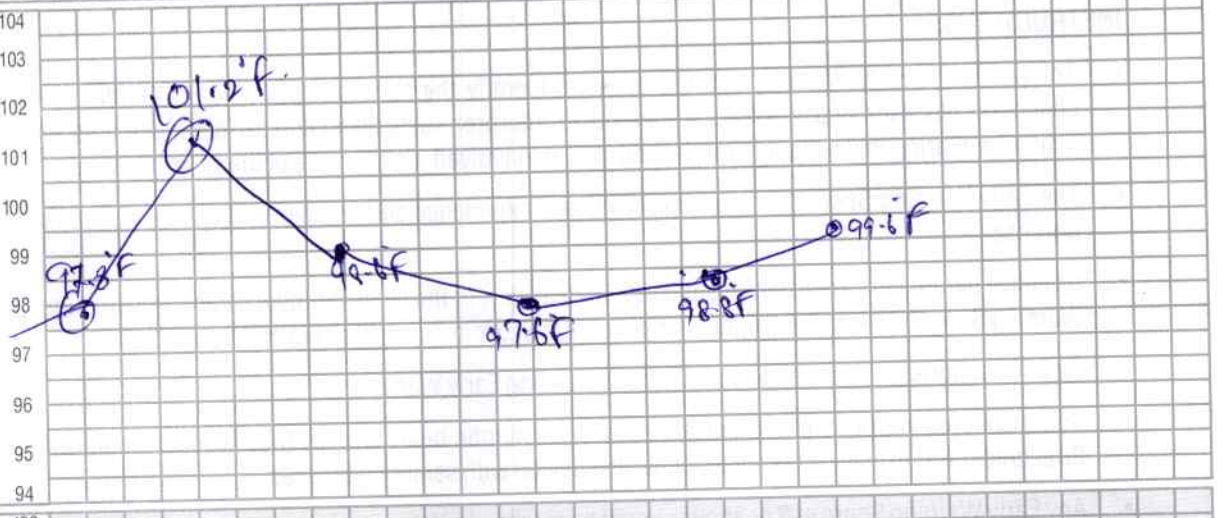
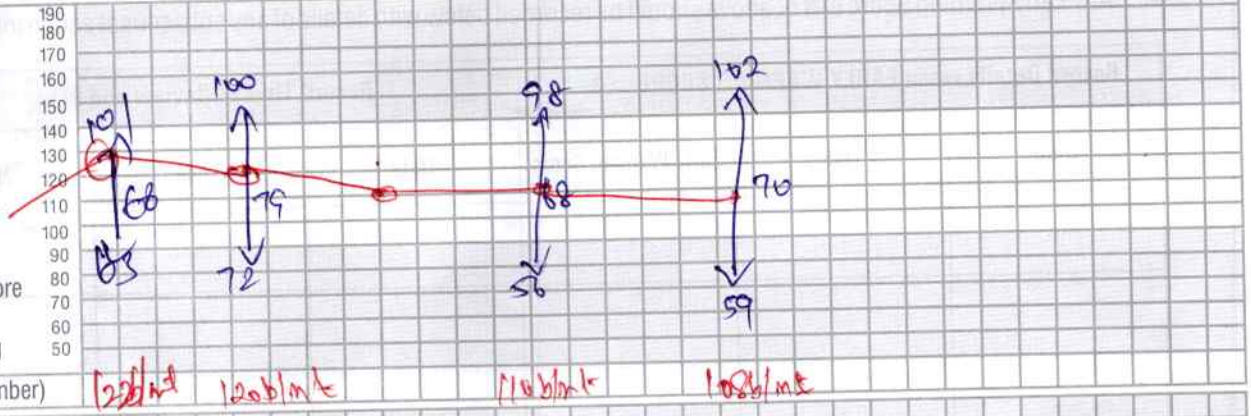
EARLY WARNING SCORE: CHILDREN'S UNIT

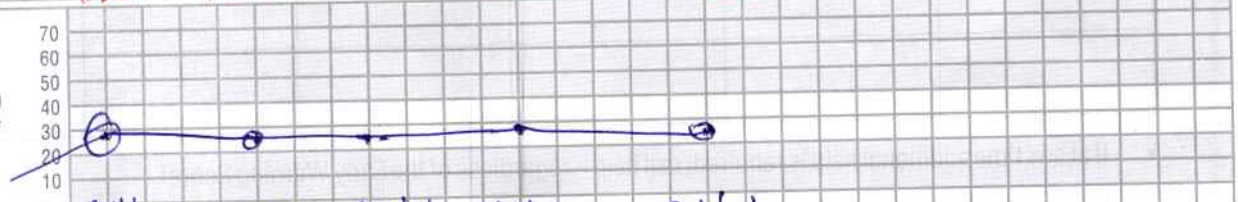
Date : 28/6/26 Time: 6pm 3pm 10pm 12am 4am 6am

Doctor / Nurse / Family Concern?





Heart Rate (Number)	128/mt	120b/mt	118b/mt	108b/mt	



Resp Rate (Number)	28b/A	28b/mt	26b/mt	28b/mt	24b/mt
Resp Distress: Mod/ Severe / None / Mild	✓	✓	✓	✓	✓
Receiving O_2 (l/min) O_2 Saturations (%)	99%	98%	97%	99%	98%
Conscious Level: Normal / Altered	✓	✓	✓	✓	✓
GCS *	15/15	15/15	15/15	15/15	15/15
TOTAL SCORE Number of shaded boxes	0	0	0	0	0
Pain Score	0	0	0	0	0
Observer's Initials	pv	RS	RS	RS	RS

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.

22/6/25		Intake				Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
Date	Time	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	← Receiving from ER to 4th floor → Out 5pm									0	
	06:00 pm			70ml								
	07:00 pm	Tomato soup		70ml							0	
Total Intake :		soup + 140ml				Total Output :						
	08:00 pm	Tomato	100ml	DC							0	
	09:00 pm			50ml							0	
	10:00 pm	H20	50ml	50ml						✓	0	
	11:00 pm			50ml							0	
	12:00 am			50ml							0	
	01:00 am			50ml							0	
Total Intake :		150ml + 250ml				Total Output :					1 time	
	02:00 am			50ml							0	
	03:00 am			50ml							0	
	04:00 am			50ml							0	
	05:00 am			50ml							0	
	06:00 am	H20	50ml	50ml						✓	0	
	07:00 am			DC							0	
Total Intake :		50ml + 250ml				Total Output :					1 time	

Total 24 hrs. Intake	840ml	Total 24 hrs. Output	2 times

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NURSES NOTES

☐ No Known Drug Allergies

☐ Drug Allergies ......NIL

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		← Receiving Notes →	
28/6	5.45 PM.	The child details receiving from ER to 4th floor. The child is conscious and oriented. Pr line present. no pain, no swelling. Pr line pattern. vital are checked and recorded. IVF 0.9 DNS followed Dr on floor	[signature]
	6PM	D/o chart was maintaining no other complaints of pain, vomiting.	[signature]
	7.30 pm	The child details handing over given to night duty staff.	[signature]
		Night duty Notes on 28/6/26	
	7.30 pm	The child details handover taken from the Evening duty staffs The child is conscious and active	[signature]
	8 pm	Administer the medication as per doctor's order vitals are checked and recorded temp is normal	
		PP / ft / S / ft / CRT / L2S	
	9.10 pm	Dr. vaishnavi mam rounds done	[signature]

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Patient Sticker

NURSES NOTES

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☑ No Known Drug Allergies

☐ Drug Allergies ..... NOT KNOWN .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		continue (29/6/26)	
	10pm	Iv fluid 0.9%.NS @ 50ml/hr on flow	
		Iv line patient and good	
29/6/26	8AM	vitals checked and recorded all are hemodynamically stable	

GP	BP	CRT
++	++	<3sec

2PM	child slept well. no specific complaints	
4PM	vitals checked and recorded. all are hemodynamically stable	

GP	BP	CRT
++	++	<3sec

6PM	Due medication given as per the drug chart	
7PM	Strict I/o chart	
7:30PM	The child details handover given to morning duty staffs.	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

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Nursing General Admission Assessment Form For Pediatrics

Diagnosis: Viral fever & Gastritis & Sone dehydration

Arrival Time: 5 pm Mode of Arrival: Self Admitting From: ☑ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction ..... Body Weight: 14 Kg

Height: ..... cm

Nil.

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

Past Medical History	Past Surgical History	Previous Hospital Admission
-	-	-

Family History: -

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

If yes please list, ...

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

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

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

Observations: Weight: 14 Length: ..... Head Circumference (< 2 years): .....

Temp.: 97.8 F HR: 122 b/m RR: 22 b/m BP: 101/63 (68)

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

Fall Risk Assessment: ☐ Yes ☐ No Score: 11 (Document in the Humpty Dumpty Sheet)

Risk of Pressure Sore (Braden Q Score 17) (Document in the Braden Q Assessment Sheet)

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

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

FUNCTIONAL SCREENING:

☐ No Abnormalities Detected

☐ Mobility Problem ☐ Walking Problem

☐ Developmental Delay ☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING:

☐ No Abnormalities Detected

☐ Underweight ☐ Overweight ☐ Special Feeding Method

☐ Feeding Problem ☐ Special diet ☐ No Abnormality Detected

Inform consultant for positive criteria

Psychological Screening: ☐ No Significant Findings

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

If Yes Consultant Notified: ..... (Date/Time): 27/6/26 at 5.45pm

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 ..... parents .....

Nurse's Name: ..... Date: 27/6/26 Time: 5.45pm Signature

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 28/6/26 Time of arrival : 4:50 PM.

Chief Complaints: C/o fever x 2 days, vomiting x 4 episodes RBS: 141 mg/dl

Height : – Weight : 14 Kg. 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?) One boy.

Time of Initial assessment completed by ER Nurse : 5:00 PM.

Time	Nursing Notes
4:50pm	Chief cone for fever x2days, vomiting x4episodes. Chief conscious & oriental vitals Checked & Records. Dr. Manomani mam See the chief Sono advice to chief attender to Discuss about. Dr. vaishnavi mam admitted for further management. Dr planned done. Sample send to lab. Due to medication given. Chief shifted to ward.

Samples collected by: S/N Aadhavi Time: 5:20pm

Samples sent by: S/N Priyanthiga Time: 5:21pm

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: 148b/m BP: 105/65(74) CFT: <2sec	Shift - out from ER to: Ward.
RR: 26b/m SPO_2: 98% - RA	Time of Shift - out: 5:40pm.
GCS: 15/15 Temperature: 101.1F	Handover given to: S/N Nisha. (Nurse's Name)
Pain Score: 0	
Repeat RBS (if applicable): NIL	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any): Dr Planned done. (L) metacarpal duct

Name of the Nurse : Priyanthiga Signature of the Nurse : Priya

Date & Time : 25/6/22 @ 5pm 01827

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PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : ..... Date : .....

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

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

Allergic History: .....

Chief Complaints: .....

.....

.....

.....

.....

.....

.....

.....

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: ..... 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 .....
.....
.....
.....
.....

(P.T.O.)

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: .....

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

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

Signs of Neurological compromise .....

.....

Any urgent interventions needed: ☐ Yes ☐ No

If Yes .....

.....

.....

.....

.....

Exposure

Temp.: .....

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: .....

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Treatment Planned: .....

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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: .....

Date & Time: .....

Sr. Doctor on Duty (If necessary)

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

Signature: .....

Date & Time: .....

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EMERGENCY TRIAGE FORM

wt. 14. kg

Patient's Name : Baby. Himanish Ram Age : 3yrs Gender: ☑ Male ☐ Female

Date : 28. Jun. 2026 Time of Arrival : 4. 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: 101.1°F PR: 143bt BP: 105/68 (79) RR: 26br SpO2: 98% RA GRBS: 141mg/dl

Chief Complaints: Fever. 2 days, Vomiting, 4 episodes

INITIAL PHYSIOLOGICAL CATEGORIZATION

Appearance: ☑ Normal ☐ Sick Looking

Circulation / Colour: ☑ Normal ☐ Abnormal ☐ Bleeding

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

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

P. Sandeep.
Signature of Parent / Guardian

Triage Completion Time : 0min

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 Sarin.

Signature of Triage Nurse : .....

Date & Time : 28.06.2026. @. 4.55pm.

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

PATIENT TRANSFER FORM

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Dr. VAISHNAVI CHANDRAMOHAN

	Date & Time of Admission	Date & Time of Transfer Order
	28/6/26 4:57pm	28/6/26 5:40pm
Attending Consultant Name: Dr Vaishnavi	Transfer Ordered by: Dr. Manomai	Reason for Transfer: fever monitoring
From Unit: ER	To Unit: 404	Information to Attendant: Yes ☐ No ☐
Number of Sheets in Clinical File: 10	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.	IV NS 500ml	1
2.	IV set	1
3.		
4.		
5.		

Shifting Summary / Notes Written by Doctor : Yes ☐ No ☐

AFI 2 Gaurav

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Rajesh	Dr. Manomai

Patient & Clinical Records Received by : S/N. Angel/018900 28/6/26 @ 6pm

Date & Time of Patient Received :

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

GUC-00093197 IP18-00036233
Baby P.HIMANISH RAM
03-03-2023 3 Y 3 M 25 D (M)
Dr. VAISHNAVI CHANDRAMOHAN

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

RBS CHART

Date	Time	RBS (mg/dl)	IVF %	Signature
28/06	4:30p	[illegible]	–	[signature]