Rainbow Children's Hospital

BirthRight BY RAINBOW HOSPITALS Your Right to a Safe Delivery

PATIENT DISCHARGE INTIMATION FROM NURSING STATION

CLEARANCE FOR DRUGS AND DISPOSABLES BILLING

Date: .....

Name of the Patient: GUC-00094568 Ms L SAMRITHA 18-05-2018 8 Y 2 M 14 D (F) Dr. GEETHA JAYAPATHY IP18-00036712

UHID No: .....

Gender: .....

Ward: .....

Room No: .....

Certified that in respect of the above patient:

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

Patient Authorised Sign	Nurse Sign 4018950	Pharmacy Sign
Date:	Date: 2.8.26	Date: 2.8.26
Time:	Time: 12 p.m	Time: 12.28 pm

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

GUC-00094568 IP18-00036712
Ms L SAMRITHA
18-05-2018 8 Y 2 M 14 D (F)
Dr. GEETHA JAYAPATHY

Rainbow Children's Hospital

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		2/8/26 @2pm					
Activity Sheet update by Pharmacy							

ACTIVITY RECORD FOR BILLING

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Name: .....

UHID No: GUC-00094568 IP18-00036712
Ms L SAMRITHA
18-05-2018 8 Y 2 M 14 D (F)
Dr. GEETHA JAYAPATHY

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

Date of Admission: .....

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

Room / Bed No: .....

Suggested Billable bed type: .....

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
21/08/26	4:20pm	ER	408	

CROSS CONSULTATION VISIT

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

INVESTIGATIONS

Date	Investigations	Order No.	Signature
01/08/26	CBC, CRP, Donquins,	2602A643	
	SGOT / SGPT		CK. [illegible] / 07u
	RBS	2464 2	

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
1/8/26	Infusion pump	4.30 pm	2/8/26 11:30am	1235992	AP 015380

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
01/08/26	IV placement	01	1735948	

ANY OTHER INFORMATION:

.....

.....

.....

.....

.....

.....

Date: 2/8/26 Time: 12 pm Prepared By: .....

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

GUC-00094568 IP18-00036712
Ms L.SAMRITHA
18-05-2018 8 Y 2 M 14 D (F)
Dr. GEETHA JAYAPATHY

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DISCHARGE TRACKING SHEET

DATE : 2/8/26.

Name of Consultant : Floor : UHID :

S.NO	Activity	TIME		Name & Signature	Remarks
		IN TIME	OUT TIME		
1	Dr. Announce Time				
2	Arrangement of File by Nurses		2/8/26 @12pm	Dr. 018900.	
3	Pharmacy Clearance				
4	Provisional Billing				
5	Audit Check				
6	Final Bill Prepared				
7	Sent to Insurance & Approval Received				
8	Handing Over & Bill Clearance				
9	Discharge Summary				
10	Physical Check Out				
11	Activity Sheet updated by Nursing				
12	Activity Sheet updated by Pharmacy				

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 : IP18-00036712 **Admit Date** : 01-Aug-2026 **Admit Time** : 03:25 PM **UHID** : GUC-00094568

Patient Details :

Patient Name	: Ms L.SAMRITHA	**Age**	: 8 Y 2 M 14 D
Guardian	: Mr V. LOHENDRA BABU	**DOB**	: 18-05-2018
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: FLAT B3B, 3 RD FLOOR, B- BLOCK, DAKSHINIS, VETTRI DAMANN, VANAGARAM Maduravoyal Tiruvallur Tamil Nadu INDIA 600095	**Phone No**	: 9382266611/ 8190064481
		E-mail	: no@gmail.com

Admission Details :

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

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

Contact Details :

Name : Mr V. LOHENDRA BABU **Relationship** : Father

Contact Address : FLAT B3B, 3 RD FLOOR, B- BLOCK, DAKSHINIS, VETTRI DAMANN, VANAGARAM Maduravoyal Tiruvallur Tamil Nadu INDIA 600095 **Phone No** : 9382266611

Signature

Doctor Details :

Doctor Name	: Dr. GEETHA JAYAPATHY	**Specialisation**	: GENERAL PEDIATRICS
Referral Doctor	: Dr. Geetha Jayapathy	**Phone No**	:
Co-Consultant	:		

Payment Details :

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

Payor Name : SELFPAY

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TEL NO :044-40122444
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GENERAL CONSENT FOR TREATMENT

Patient Name:	**Ms L.SAMRITHA**	**Age :**	**8 Y 2 M 14 D**
IP No:	**IP18-00036712**	**Sex:**	**Female**
Consultant:	**Dr. GEETHA JAYAPATHY**	**Ward/Bed No:**	**0F-EMERGENCY/ER 101**

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

Patient, be deemed advisable or necessary.

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

Name: V LOHENDRA BABU

Relationship: FATHER.

Date: 01-08-2026 Time: 3:25

Witness Name:

Witness Signature:

Patient Address:

FLAT B3B, 3 RD FLOOR, B- BLOCK,
DAKSHINIS, VETTRI DAMANN,
VANAGARAM Maduravoyal Tiruvallur
Tamil Nadu INDIA 600095

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.
- 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 : > L. SAMRITHA	UHID Number : 94568
Self/Attendant Name : > V. DHENDRA BABU	Relation : > FATHER
Self/ Attendant Signature : > N Dhenu Babu Phone Number : > 9382266611	Name & Signature of Financial Counselor

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PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: _____

UHID ID: _____ GUC-00094568 IP18-00036712 _____
Ms L SAMRITHA
18-05-2018 8 Y 2 M 14 D (F)
Dr. GEETHA JAYAPATHY

Department: _____ _____

Consultant: _____

(P.T.O.)

GUC-00094568 IP18-00036712
Ms L SAMRITHA
18-05-2018 8 Y 2 M 14 D (F)
Dr. GEETHA JAYAPATHY

Pediatric Multiorgan History & Physical Examination

Name: Samritha Age/Sex 8y/F

Information given by: Relationship

Chief Presenting Complaints & Duration (Chronologically)

C/o - Fever. x 2 days
Throat pain.

History of present illness :

- Fever x days
High grade, intermittent fever, not associated c chills relieved c medication

- Throat pain occasionally.

On & off vomiting c/o. 4 months.

Now nausea (+), no vomiting.

↓ intake c some dehydration

Rx c oral Paracetamol, probiotics & Amoxyclav & emesis.

But had persistent symptoms

Patient Sticker

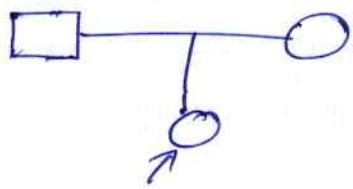
Past History : (Including details of any previous investigation or treatment)

3 ¼ yr admitted for Acute Gastritis

Birth & Neonatal History:

IVF / Term / LSCS / BW - 2.883 kg / CIAB / No NICU stay.

Family Chart



Birth & Socio Economic History:

About Father : NCM

About Mother :

Any additional information :

Developmental History :

adtd - 3rd.

Immunization History :

Up to date - IAP

Anthropometry :

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

Weight (kgs) 21 kg (Centile _____)

On Examination :

Temperature : 97.4°F Pulse Rate : 80/min B.P. 91/70 mm Hg SPO2 100 % @ RA

Resp.rate and type of breathing : 24/min.

Rash

Lymphadenopathy Sunken eyes, dull looking, dry tongue

Oedema :

Allergies (if any):

(P.T.O.)

GUC-00094568 IP18-00036712
Ms L.SAMRITHA
18-05-2018 8 Y 2 M 14 D (F)
Dr. GEETHA JAYAPATHY

Respiratory System :

Inspection (any s/o distress) :

Air entry & breath sounds : b/l. AE equal

Any addes sounds : No added sounds

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

Cardiovascular System :

Inspection of procordium :

Heart Sounds : $S_1 S_2$ (+)

Any murmur : No murmur

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

Per Abdomen :

Inspection :

Palpation : Soft, non tender, no organomegaly

Ausculation :

Spine : External Genitelia :

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

Central Nervous System :

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

Cranial Nerves :

Motor System :

Nutriton :

Tone: (N) Power 5/5

Co-ordinator :

Posture :

Involuntary Movements :

Patient label: GUC-00094568 IP18-00036712
Ms L SAMRITHA
18-05-2018 8 Y 2 M 14 D (F)
Dr. GEETHA JAYAPATHY

Reflexes :

DTR

Superficials:

Plantars

Sensory System :

Bladder / Bowel :

Clinical Summary & Diagnostic:

Viral fever - ? Dengue

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

Desired goals of the treatment :

Planned Labs:

CBC / CRP / SGOT / SGPT /
Dengue NS1

Planned Management

IV line.

- IVF - DNS - 60cc/hr
- IV Pan 20mg OD
- IV Emeset 2mg Q8H
- Syp P-250 6ml (SOS)
- Syp Mucaine gel 5ml TDS
- Syp Allegra 5ml BD

Signature of the Doctor: T. Y.

Name of the Doctor: T. Yumary

Date & Time: 1/8/26 @ 4PM

Signature of the Consultant:

Name of the Consultant: Dr Geetha 7884

Date & Time: 1/8/26 @ 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

GUC-00094568 IP18-00036712
Ms L.SAMRITHA
18-05-2018 8 Y 2 M 14 D (F)
Dr. GEETHA JAYAPATHY

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
1/8/26 6 PM	S/B Dr Chandrakala.	
	Δ - Flu like illness	
	child received.	
	Alert, responds to oral commands	
	no fever spikes since admission	
	Throat pain (+)	
	no c/o vomiting, loose stools.	
	Oral intake - minimal.	
	Urine output - voided one time	
	O/E	
	Afebrile	Bp - 99/58 mm Hg
	CVS-S1S2(+)	PR - 112/min.
	RS - clear	
	P/A - soft	
		Adv:
		- monitor vitals
	Investigations	- continue IV Fluids @ 60 ml/hr.
		- Inj. Pantoprazole 20mg IVOD
	TC - 2,730 cu/l	- Inj. Emeset 2mg IV TDS
	N/L - 38/54.	- Syp. mucaine gel 5ml TDS
	Plt - 1,71,000	- Syp. Allegra 5ml BD
	CRP - <5	- W/f fever spikes -
	(N) SGOT SGPT	
	19/26	

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
1/8/26 8pm	S/B Dr. ...	
	prob viral illness	
	afebrile since admission	
	poor oral intake	
	urine ✓	
	afebrile	
	sys - WNL	
		Adv
		Cont IVF
		Syp. Mucaine gel 5ml tds
	[signature]	
2/8/26 7:45am	S/B Dr. Manoma	
	A - Post viral illness	
	Afebrile since admission	
	Intake reduced	
	passed urine twice	
	No oth complaints	
	O/E Asleep	
	PP - LH	
	RS - NVBS (B)	
	P/A - soft, Non tender	

GUC-00094588
Ms L.SAMRITHA IP18-00036712
18-05-2018 8 Y 2 M 14 D (F)
Dr. GEETHA JAYAPATHY

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	R	
	- Encourage oral feeds	
	- 0.9% DNS @ 60ml/hr	
	- Inj pan, Inj Emset	
	- Syp. Mucaugel TDS	
	- Syp. Allyxe 5ml TDS	
[signature] 1:50pm		
2/8/18 8.20am	SIB Angalta	
	Viral illness	
	hydration better	
	occ cough.	
	Clinically well.	
		IVF 30ml/hr & stop if intake good.
	[signature] 7:50am	

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

GUC-00094568 IP18-00036712
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RESULT SHEET

Date	1/8/26					
Time						
Hb	12.2					
PCV	36					
RBC	4.43					
WBC	2.73					
N/L	38/54					
Platelets	1,71,000					
CRP	<5					
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT	12					
SGOT	42					
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						

(P.T.O)

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

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

GUC-00094568 IP18-00036712
Ms L SAMRITHA
18-05-2018 8 Y 2 M 14 D (F)
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MEDICATION RECONCILIATION FORM

Drug Allergies: ....

☑ Not known any Drug Allergies

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

Shifting From: ER Shifted to: 408

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	Syp Augmentin DDS	3.5ml	P/o	BP	01/8/26 10:30am	☐ C ☑ DC
2	Enter[illegible]	1	P/o	OP	01/8/26 9:30am	☐ C ☑ DC
3	Syp P-250	5ml	P/o	Q8H		☑ 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 : T. Yuvaraj & T.Y [signature]

Date & Time : ....

Nurse Name & Signature: CH. Akshaya [illegible] / CH [signature]

Date & Time : 01/08/26 @ 5:[illegible]pm.

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

GUC-00094568 IP18-00036712
Ms L SAMRITHA
18-05-2018 8 Y 2 M 14 D (F)
Dr. GEETHA JAYAPATHY

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DRUG CHART

Date of Admission: 01/08/26 Drug Allergies: ..... ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

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

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

SOS / PRN (As Required Medication)

DRUG: Syp P-250				Date Time
Dose: 6ml	Route: PO	Frequency: Q6H	Start Date: 1/8	
Doctor's Signature: T.Y	Valid Period	Pharm.		
Additional Instructions: If temp >100°F				

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

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

Signature .....

VERIFIED BY : Name .....

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Dr. GEETHA JAYAPATHY

REGULAR PRESCRIPTIONS

Weight. 21 Kg Ward. .....

DRUG : Inj PANTOPRAZOLE

Dose	Route	Frequency	Start Date
20mg	IV	OD	1/8

Name & Signature of the Doctor Starting the Drugs: T.Y

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date	Time		
01/8	3:50 pm	R.B A.K	PSA RJ

DRUG : Inj EMESET

Dose	Route	Frequency	Start Date
2mg	IV	Q8H	1/8

Name & Signature of the Doctor Starting the Drugs: T.Y

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date	Time			
01/8	3:50 pm	A.B AJ	7 pm 1	2/8 PSA RJ
	10 pm	PSA RJ	pm 7 pm	

DRUG : Syp MUCAINE gel

Dose	Route	Frequency	Start Date
5ml	P/O	Q8H	1/8

Name & Signature of the Doctor Starting the Drugs: TY

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date	Time			
1/8	6 Am			2/8 PSA RJ
	2 pm	5pm SA CS		
	10 pm	PSA RJ		

DRUG : Syp ALLEGRA

Dose	Route	Frequency	Start Date
5ml	P/O	BD	1/8

Name & Signature of the Doctor Starting the Drugs: T.Y

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date	Time			
1/8	8 Am			2/8 MA BL
	8 pm	5pm SA CS		

Patient Sticker

Weight. 21 kg 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 : Nan...

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses

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I.V. FLUIDS CHART

Weight. 21 Kg. Ward. .....

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
01/8/26	4pm	0.9% GNS	IV	60 ↓	T.Y	R.B / A.J	2/8/26		
1				30					

Signature .....

VERIFIED BY : Name .....

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18-05-2018 8 Y 2 M 14 D (F)
Dr. GEETHA JAYAPATHY

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

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

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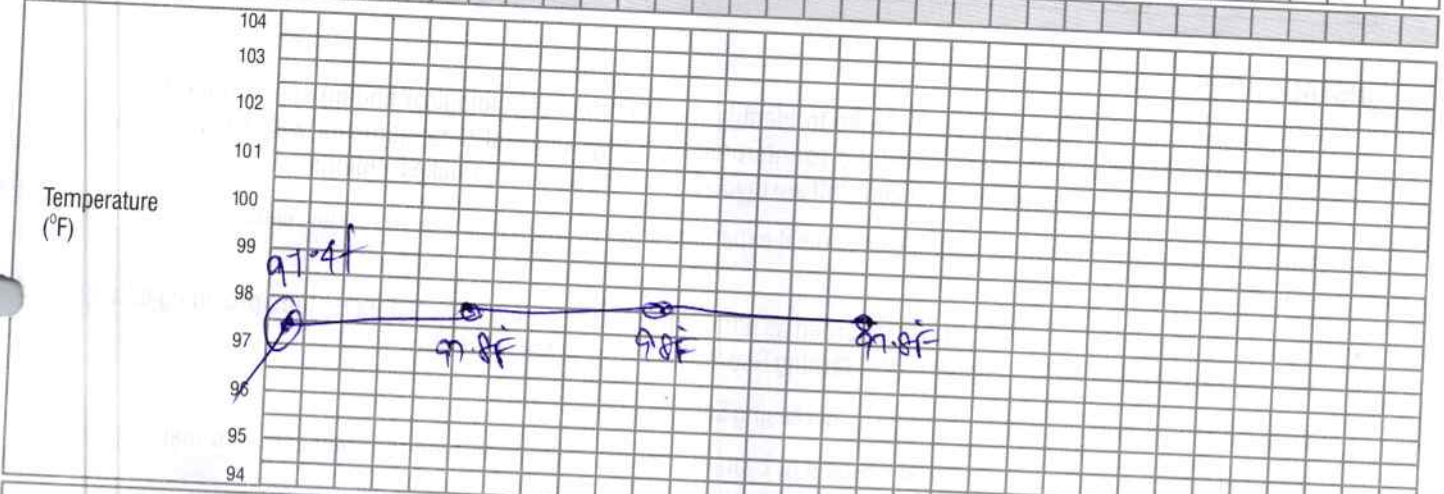
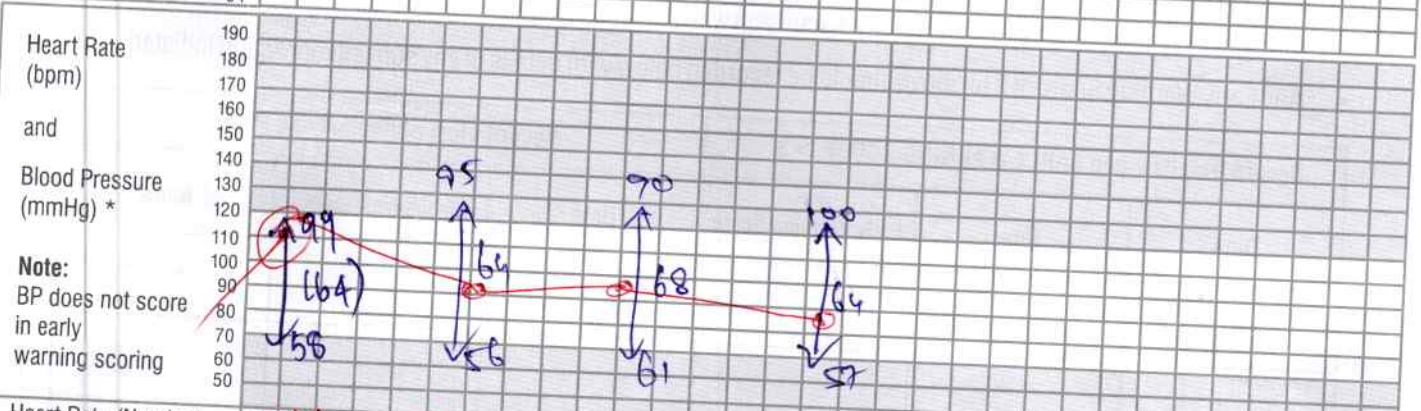
EARLY WARNING SCORE: CHILDREN'S UNIT

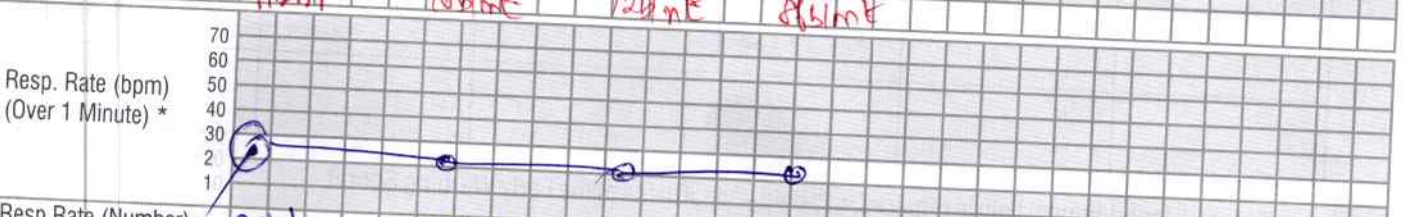
Date : 7/8/18 Time: 4PM 8PM 12MN 4AM

Doctor / Nurse / Family Concern?





Heart Rate (Number)	112bt	96b/mt	92b/mt	88b/mt



Resp Rate (Number)	24bt	22b/mt	26b/mt	22b/mt
Resp Distress: Mod/ Severe				
Resp Distress: None / Mild	✓	✓	✓	✓
Receiving O_2 (l/min) / *O_2 Saturations (%)*	98%	99%	98%	99%
Conscious Level: Normal	✓	✓	✓	✓
Conscious Level: 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]	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.

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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: Nature of Fluid	Intake: Route – Mouth	Intake: Route – I.V	Intake: Route – N.G	Output: NG	Output: Diarrhoea	Output: Vomit	Output: Drainage	Output: Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
	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	Kanji	50ml	60ml	ON ADMISSION FROM ER to 408							
	06:00 pm	water	50ml	60ml						✓	0	
	07:00 pm			60ml							0	
Total Intake :		100ml + 180ml				Total Output :				1 time urine passed		
	08:00 pm	Hzo	50ml	60ml							0	
	09:00 pm	Hzo	50ml	60ml						✓	0	
	10:00 pm	Soup	100ml	60ml							0	
	11:00 pm			60ml							0	
	12:00 am	Hzo		60ml							0	
	01:00 am			60ml						✓	0	
Total Intake :		200ml + 360ml				Total Output :					0	
	02:00 am			60ml								
	03:00 am	Hzo	200ml	60ml							0	
	04:00 am			60ml							0	
	05:00 am			60ml							0	
	06:00 am			60ml							0	
	07:00 am			60ml							0	
Total Intake :		200ml + 360ml				Total Output :				✓	0	
										1 time		

Total 24 hrs. Intake	1120ml	Total 24 hrs. Output	4 time urine passed

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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
1/8/26		on Admission (1/8/26)	
	4.30pm	The child details handovertaken from the ER staffs	[signature] 015760
		The child is conscious and active vitals are checked and recorded temp is normal	
		PP ++ / CP ++ / CRT <2s	
	5pm	I/O chart is maintained No any other complaints	
	6pm	Administer the medication as per doctor's order	
		IV fluid 0.9% NS @ 60ml/hr on flow	
	7.30pm	The child details handover given to night duty staffs	[signature] 015760
		Night duty notes on 1/8/2026	
1/8/26	7.30pm	Child details taken over from evening duty staff nurse using ISBAR method. On Assessment: child is conscious oriented and afebrile. Over-all skin assessment done. IV line is present and patent, no pain or redness, on INF DNS @ 60ml/hr, on flow	[signature] 020749
	8pm	vitals checked and recorded: all are stable	[signature] 020749

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
1/8/26		← Continue notes →	
		GP ++ / PP ++ / CRT <3 sec	
	8:30 pm	Dr. Geetha ma'am came and seen informed about the child condition, advised to follow as per progress notes	[signature] 020749
	9 pm	Due medication given as per the drug chart	[signature] 020749
	12 am	Vitals checked and recorded, all are hemodynamically stable	[signature] 020749
		GP ++ / PP ++ / CRT <3 sec	
	2 am	Child slept well, no specific complaints	[signature] 020749
	4 am	Vital checked and recorded all are hemodynamically stable	[signature] 020749
		GP ++ / PP ++ / CRT <3 sec	
	6 am	Due medication given as per the drug chart	[signature] 020749
	7 am	Strict I/O chart maintained	
	7:30 am	Child details handed over to morning duty staff nurse	[signature]

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

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

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Patient's Na
GUC-00094568 IP18-00036712
Ms L SAMRITHA
MRD NO:.... 18-05-2018 8 Y 2 M 14 D (F)
Dr. GEETHA JAYAPATHY
Age :.......... : ☐ M ☐ F
Consultant :..

PHLEBITIS ASSESSMENT

CANNULA 1

Date : 01/08/26 Time: 8.40pm.
Location : (LT) metacar)
Size : 22G
Cannula inserted by : S/N. Ajithkumar

Date	Time	Phlebitis	Infiltration	Nursing Intervention	Sign
01/8/26	4pm	☐Yes ☑No	☐Yes ☑No	patient	[illegible]
	6pm	☐Yes ☑No	☐Yes ☑No	observed	[illegible]
	8pm	☐Yes ☑No	☐Yes ☑No	observed	[illegible]
	10pm	☐Yes ☑No	☐Yes ☑No	observed	[illegible]
2/8/26	12am	☐Yes ☑No	☐Yes ☑No	observed	[illegible]
	2am	☐Yes ☑No	☐Yes ☑No	observed	[illegible]
	4am	☐Yes ☑No	☐Yes ☑No	observed	[illegible]
	6am	☐Yes ☑No	☐Yes ☑No	observed	[illegible]
	8am	☐Yes ☑No	☐Yes ☑No	observed	[illegible]
	10am	☐Yes ☑No	☐Yes ☑No	observed	[illegible]
	12pm	☐Yes ☑No	☐Yes ☑No	observed	[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		

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-00094568 IP18-00036712
Ms L.SAMRITHA
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Nursing General Admission Assessment Form For Pediatrics

Diagnosis: viral fever ? dengue.

Arrival Time: 4.20pm Mode of Arrival: walking Admitting From: ☐ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction ..... Body Weight: 21 Kg

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

.....

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

Past Medical History	Past Surgical History	Previous Hospital Admission

Family History: .....

.....

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

If yes please list, ...

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

.....

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

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

Observations: Weight: 21kg Length: ..... Head Circumference (< 2 years): .....

Temp.: 97.4F HR: 112/m RR: 24/m BP: 99/58 (64)

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

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

Risk of Pressure Sore (Braden Q Score 22) (Document in the Braden Q Assessment Sheet)

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

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

FUNCTIONAL SCREENING: ☐ No Abnormalities Detected

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

Inform consultant for positive criteria

NUTRITIONAL SCREENING: ☐ No Abnormalities Detected

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

Inform consultant for positive criteria

Psychological Screening: ☑ No Significant Findings

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

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

Social History: Lives With ....

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

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

Orientation has been given regarding the following aspects:

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

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

Patient Rights & Responsibilities: ☑ Yes ☐ No

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

Nurse's Name: S. Abirtelakshmi Date: 1/8/26 Time 1:30pm , Signature

GUC-00094568 IP18-00036712
Ms L.SAMRITHA
18-05-2018 8 Y 2 M 14 D (F)
Dr. GEETHA JAYAPATHY

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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

Identified Education Needs:

1. Diagnosis
2. Treatment and Care
Plan
3. Pain Management
4. Informed Consent
5. Medication / Therapy (safety, effects/ side effect, interactions)
6. Discharge Medication
7. Infection Control Measures
8. Diagnostic Test / Procedures
9. Nutrition / Diet
10. Fall Risk Education
11. Safe use of Medical Equipment / Implantable Devices Safety
12. Patient's / Family Rights
13. Risk / Safety

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
1/8/26	5pm	Fall risk education	Explained about side rails call bell	Mother	NO	oral	None	verbalizing understanding		[illegible]
2/8/26	8am	treatment & care	explain about treatment & care	mother	no	oral	non	verbal understand	good	[illegible]

Part - III: CODES

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

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

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

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

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

Doc No. : RCH / FRM / CLINICAL / 187

GUC-00094568
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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 01/08/26 Time of arrival : 3.30pm

Chief Complaints: H/o. Fever x 2 day H/o. Less oral Intake, H/o. Throat pain RBS: .....

Height : ..... Weight : 21Kg BMI : ..... Head Circumference (<2 years) .....

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

If yes , identify NIL

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

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

RISK FOR FALL:

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

☒ If Patient is > 6 years
Assess the below parameters

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

Ambulatory Aids:

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

Gait/Transferring:

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

Mental Status: Forgets limitations ☐ Yes ☒ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening: ☒ No Abnormalities Detected

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

Inform consultant for positive criteria

NIL

Nutritional Screening: ☒ No Abnormalities Detected

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

Inform consultant for positive criteria

Psychological Screening: ☒ No Significant Findings

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

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

Social History: Lives With Parents

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

Time of Initial assessment completed by ER Nurse : 10 mins

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

Time	Nursing Notes
01/08 3.45pm	The pt came for ER c c/o. Fever x 2 days.
	c/o ↓ Intake. c/o Throat pain. Vitals me
	checked, recorded. d/b Dr. Geetha is
	opp. To advice the admission. IV line
	Secure. blood sample sent to lab
	pt shifted to ward

Samples collected by: s/n. Rishi Time: 3.45pm

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: 80min BP: 90/70(77) CFT: <2 sec	Shift - out from ER to: 408
RR: 26 SPO₂: 100%	Time of Shift - out: 4:20pm
GCS: 15/15 Temperature: 97.4F	Handover given to: S/N
Pain Score: 0/10	(Nurse's Name)
Repeat RBS (if applicable): —	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any): - IV placement done (L) median cubital
venflon - 22G

Name of the Nurse : CH. Akshaya [illegible] Signature of the Nurse : CH. [signature]

Date & Time : 01/08/26 @ 3.40pm.

GUC-00094568 IP18-00036712
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PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : Dr Geetha

Date : 1/8/26

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

Start Time of Assessment: .....

Weight: 21 kg

Allergic History: .....

Chief Complaints:
c/o fever x 2 days
c throat pain

Pediatric Assessment Triangle

A Appearance - TICLS (N)

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: 24/min SpO_2 on FiO_2 100% @ RA
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: 85/min CFT [Central ..... / Peripheral .....] <2sec

Any urgent interventions needed: ☐ Yes ☐ No

If Yes .....

BP: 91/70 mmHg

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

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

Muffled Heart Sound: ☐ Yes ☐ No

Engorged Neck Veins: ☐ Yes ☐ No

Murmurs: ☐ Yes ☐ No

Liver Span: .....

ECG: .....

Any Signs of Heart Failure: ☐ Yes ☐ No

Disability

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

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.: 97.4°F

Any Rash: ☐ Yes ☐ No,

If yes describe the rash .....

Active bleed .....

Lacerations ☐ Abrasions ☐ bruises ☐

Describe: .....

Any urgent interventions needed: ☐ Yes ☐ No

If Yes .....

Final Physiological Status: ☐ Respiratory Distress ☐ Respiratory Failure ☐ Respiratory Arrest ☐ Shock - Compensated ☐ Hypotensive ☐ ☐ Cardiopulmonary Arrest ☑ Hemodynamically Stable

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

.....

.....

Labs Planned: .....

As charted

Treatment Planned: .....

as charted

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

Final Diagnosis with possible Differential Diagnosis (If necessary): Fever ↓ evaluation

Assessment done by

Name of the Doctor: T. Yuvaraj

Signature: T. Y

Date & Time: 1/8/26 @ 4PM

Sr. Doctor on Duty (If necessary)

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

Signature: .....

Date & Time: .....

PATIENT TRANSFER FORM

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GUC-00094568
Ms L SAMRITHA IP18-00036712
18-05-2018 8 Y 2 M 14 D (F)
Dr. GEETHA JAYAPATHY

Treating Consultant Name	Date & Time of Admission	Date & Time of Transfer Order
Dr. Geetha	01/08/26 @ 3:25pm	01/08/26 @ 4:20pm
	Transfer Ordered by	**Reason for Transfer**
	DR. Yuvaraj	Further management
From Unit	**To Unit**	**Information to Attendant**
ER	408	Yes ☑ No ☐
Number of Sheets in Clinical File	**Number of Imaging Films**	**Personal belongings including clinical documents. If any handed over to attendant**
9	–	Yes ☑ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.		
2.		
3.		
4.		
5.		

Shifting Summary / Notes Written by Doctor : Yes ☑ No ☐
Viral fever - ? Dengue

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
CC: Aashayasmitha CIC [signature] 01/04	T. Yuvaraj

Patient & Clinical Records Received by : Abitha 015780

Date & Time of Patient Received : 1/8/26 @ 4:20p

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-00094568 IP18-00036712
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18-05-2018 8 Y 2 M 14 D (F)
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RBS CHART

Date	Time	RBS (mg/dl)	IVF %	Signature
01/8/26	4pm	78mg/dl	—	[signature]

GUC-00094568 IP18-00036712
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EMERGENCY ROOM TRIAGE FORM

Wt : 21 Kg.

Patient's Name : MS. SAMRITHA Age : 8yrs
Date : 1/08/26 Time of Arrival : 3.30pm
Gender: ☐ Male ☑ Female

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

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

Mode of Arrival : ☐ Ambulatory ☐ Wheelchair ☐ Ambulance

Initial Vital Signs: Temp: 97.4F PR: 80/min BP: RR: 24/min SpO_2: 100%

Chief Complaints: H/o. Fever x 2 days, H/o Intake, H/o Throat pain wet cough.

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

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

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian

Triage Completion Time : .....

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 : CH. Aishayamitha

Signature of Triage Nurse : CH Aishayamitha

Date & Time : 01/08/26 @ 3.35pm

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