GUC-00094344 IP18-00036633
Baby P.B. AKIRA
04-03-2024 2 Y 4 M 24 D (F)
Dr. KARTHIK NARAYANAN R

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							
Activity Sheet update by Pharmacy		12.01					

ACTIVITY RECORD FOR BILLING

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Name: .....

UHID No: ..... GUC-00094344 IP18-00036633 ..... Consultant: ..... Dept: .....

Baby P.B. AKIRA
04-03-2024 2 Y 4 M 23 D (F)
Dr. KARTHIK NARAYANAN R

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
27/4/26.	11:40 Pm	ER	TOS	

CROSS CONSULTATION VISIT

	Doctor Name	Date	Order No.	Signature
1.	Dr. Nithya. R	28/07/26	To be raised.	
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

INVESTIGATIONS

Date	Investigations	Order No.	Signature
07.07.2026	CBC, CRP, Blood c/s.		
	RP-2	86084050	[illegible] 010134
27/7/26	Urine R/E, urine c/s	26024072	[illegible]
27/7/26.	Dengue NS,	26024077	[illegible]

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
27/7/26	Infusion pump.	27/7/26. at 1pm	1733699	28/7/26 at 12pm	Suf60783

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
27.07.26	Iuplacement	(1)	17333509	

ANY OTHER INFORMATION:

Date: 28/7/26 Time: 12pm Prepared By: Sumadhu/bam

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
Sumadhu BAM	7th floor		

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04-03-2024 2 Y 4 M 24 D (F)
Dr. KARTHIK NARAYANAN R

DISCHARGE TRACKING SHEET

FLOOR- NAME OF CONSULTANT-

ACTIVITY	TIME		NAME & SIGNATURE	REMARKS	<To be filled by Admin>
Discharge Announcement	28/7/26 at 12pm				
	INTIME	OUT TIME			
Arrangement of File by Nursing		28/7/26 at 2pm	Simuel 607383		
Preparation of Discharge Summary					
Finalization of discharge summary					
Transfer of file from Ward to Billing Dept					
Bill Processing					
Audit Clearance					
Billing Clearance					
Physical Clearance					

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BED SIDE CHECK LIST FOR NURSES

Date:	27/7	28/7							
Doctor's Orders	Yes	Yes							
Carried out or not	Yes	Yes							
Bed Side									
Structured Handover done	Yes	Yes							
IV Site	Yes	Yes							
Central Lines	NA	NA							
Arterial Lines	NA	NA							
Feeding Catheter	NA	NA							
Urinary Catheter	NA	NA							
Skin Care	NA	NA							
Eye Care	NA	NA							
Mouth Care	NA	NA							
Sterillum Bottle, Stethoscope	Yes	Yes							
Suction Bottle (Should be clean & empty)	Yes	Yes							
Intubation Tray	NA	NA							
Emergency Tray (Loaded Syringes with Midazolam & Vecuronium and Flush) Ampoules of Adrenaline	NA	NA							
Ventilator Tubing,(Any Water, Blood)	NA	NA							
Humidification	NA	NA							
Check all Infusion (Labelling,Correct Preparation)	NA	NA							
Chest Physio & Neb	NA	NA							
Handed Over By Name :	[illegible]	[illegible]							
Signature :	[illegible]	[illegible]							
Date & Time:	27/7 8pm	28/7 8 pm							
Hand Over Taken By Name :	[illegible]								
Signature :	[illegible]								
Date & Time:	7:30 pm								

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 : IP18-00036633 **Admit Date** : 27-Jul-2026 **Admit Time** : 11:05 AM **UHID** : GUC-00094344

Patient Details :

Patient Name	: Baby P.B. AKIRA	**Age**	: 2 Y 4 M 23 D
Guardian	: Mr PRABHU ANAND. M	**DOB**	: 04-03-2024
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: PLOT NO:14, 10th CROSS STREET, Ist LANE KAVIYA GARDEN, MANNAN NAGAR, PORUR, CHENNAI Porur Kanchipuram Tamil Nadu INDIA 600116	**Phone No**	: 9677268069/ 8825680838
		E-mail	: bhavikaa03@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 PRABHU ANAND. M **Relationship** : Father

Contact Address : PLOT NO:14, 10th CROSS STREET, Ist LANE KAVIYA GARDEN, MANNAN NAGAR, PORUR, CHENNAI Porur Kanchipuram Tamil Nadu INDIA 600116 **Phone No** : 9677268069

Signature

tor Details :

Doctor Name : Dr. KARTHIK NARAYANAN R **Specialisation** : PEDIATRIC INTENSIVE CARE

Referral Doctor : DR.PRASHANTH SANKAR (THE CHILD HEALTH CLINIC) **Phone No** :

Co-Consultant :

Payment Details :

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

Payor Name : SELFPAY

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

GENERAL CONSENT FOR TREATMENT

Patient Name:	**Baby P.B. AKIRA**	**Age :**	**2 Y 4 M 23 D**
IP No:	**IP18-00036633**	**Sex:**	**Female**
Consultant:	**Dr. KARTHIK NARAYANAN R**	**Ward/Bed No:**	**0F-EMERGENCY/ER 101**

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

Patient, be deemed advisable or necessary.

I understand that the confidentiality of all medical records shall be protected to the full extent of the Law. The undersigned also consent to the use of health related information/ audiovisuals of the patient for research & training purpose or for 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 I Guide book has been given to me and I have been explained about the Hospitals rules and policies.
4 Financial and billing counseling has been done to me.

Signature of Patient/Relative:

Name: Prabhu Anand. M
Relationship: Father
Date: 27/07/2026 Time: 11.09 Am
Witness Name: Savithra
Witness Signature:

Patient Address:
PLOT NO:14, 10th CROSS STREET, Ist LANE KAVIYA GARDEN, MANNAN NAGAR, PORUR, CHENNAI Porur 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 : Baby. P.B. Akira	UHID Number : GUC-00094344
Self/Attendant Name :	Relation :
Self/ Attendant Signature : Phone Number : 9677268069.	Name & Signature of Financial Counselor

இந்திய அரசாங்கம்
Government of India

இந்திய தனித்துவ அடையாள ஆணையம்
Unique Identification Authority of India

பதிவேட்டு எண் / Enrollment No.: 0000/00610/40746

27/10/2013

To,
பிரபுஆனந்த் மு
Prabhu Anand M
C/O MURALIDHARAN,
NO 2/361D,
PERUMAL PURAM,
NATHAMMEDU, VTC: Thiruninravur,
PO: Tiruninravur Rs, District: Tiruvallur,
State: Tamil Nadu, PIN Code: 602024,
Mobile: 9884287102

Ref: 991 / 05X / 142158 / 142173 / P

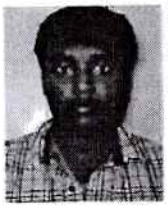
SB070874500FH

உங்கள் ஆதார் எண் / Your Aadhaar No. :

3475 7467 6063

எனது ஆதார், எனது அடையாளம்

இந்திய அரசாங்கம்
Government of India



பிரபுஆனந்த் மு
Prabhu Anand M
பிறந்த நாள் / DOB : 29/10/1992
ஆண்பால் / Male

3475 7467 6063

27/10/2013

எனது ஆதார், எனது அடையாளம்

Government of India

AADHAAR

தகவல்

- ஆதார் அடையாளத்திற்கான சான்று. குடியுரிமைக்கு அல்ல.
- பாதுகாப்பான QR குறியீடு/ ஆப்லைன் XML / ஆன்லைன் அங்கீகாரத்தைப் பயன்படுத்தி அடையாளத்தை சரிபார்க்கவும்.

INFORMATION

- Aadhaar is a proof of identity, not of citizenship.
- Verify identity using Secure QR Code / Offline XML / Online Authentication.

- ஆதார் நாடு முழுவதிலும் செல்லுபடியாகும்.
- பல்வேறு அரசு மற்றும் அரசு சாரா சேவைகளை எளிதில் பெற ஆதார் உதவுகிறது.
- உங்கள் மொபைல் எண் மற்றும் மின்னஞ்சல் ஐடியை ஆதாரில் புதுப்பிக்கவும்.
- mAadhaar செயலியைப் பயன்படுத்தி உங்கள் ஸ்மார்ட் போனில் ஆதாரை எடுத்துச் செல்லுங்கள்.
- Aadhaar is valid throughout the country.
- Aadhaar helps you avail various Government and non-Government services easily.
- Keep your mobile number & email ID updated in Aadhaar.
- Carry Aadhaar in your smart phone – use mAadhaar App.

05X / 142158

இந்திய தனித்துவ அடையாள ஆணையம்
Unique Identification Authority of India

முகவரி: முரளிதரன், எண் 2/361டி,
பெருமாள் புரம், நத்தம்மேடு, திருநின்றவூர்,
திருவள்ளூர், தமிழ் நாடு, 602024
Address: C/O MURALIDHARAN, NO 2/361D,
PERUMAL PURAM, NATHAMMEDU,
Thiruninravur, Tiruvallur, Tamil Nadu, 602024

3475 7467 6063

1947 help@uidai.gov.in www.uidai.gov.in

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Children's
Hospital
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PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: _____

UHID ID: _____

Department: _____

Consultant: _____

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Dr. KARTHIK NARAYANAN R

(P.T.O.)

GUC-00094344 IP18-00036633
Baby P.B. AKIRA
04-03-2024 2 Y 4 M 23 D (F)
Dr. KARTHIK NARAYANAN R

Pediatric Multiorgan History & Physical Examination

Name: _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

⇒ C/o cough on & off for 2 weeks, occasionally dry type, not disturbing sleep.

History of present illness :

⇒ C/o fever x 2 days, high grade, intermittent, relieved ↓ medications, Tmax - 102F, active during afebrile period

⇒ C/o 2 episodes of vomiting yesterday (resolved).

⇒ C/o reduced urine output for 1 day

⇒ C/o reduced oral intake x 1 day.

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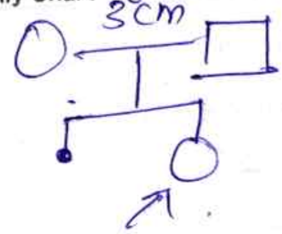
Past Hi[...]**evious investigation or treatment)**

→ H/o Acute otitis media 1 week ago for which SYP. AUGMENTIN for 1week.

Birth & Neonatal History:

Term / LSCS (failed induction) 2.7kg - B.wt, CTAB, No NICU stay

Family Chart



Birth & Socio Economic History:

About Father : } NCM.

About Mother :

Any additional Information :

H/o 1ll ~~r~~ illness in father.

No H/o recent travel.

Developmental History :

Appropriate for age.

Immunization History :

Upto date as per IAP.

Anthropometry :

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

Weight (kgs) 10.9kg (Centile ______)

On Examination :

Temperature : 101.4F Pulse Rate : 146/min B.P. 95/60 (71) SPO2 100% RA.

Resp.rate and type of breathing : 30/min, regular

Rash } No

Lymphadenopathy

Oedema :

Allergies (if any):

(P.T.O.)

Patient Sticker

Respiratory System :

Inspection (any s/o distress) :

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

Any addes sounds : (-)

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

Cardiovascular System :

Inspection of procordium :

Heart Sounds : S_1S_2 (+)

Any murmur : (-)

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

Per Abdomen :

Inspection :

Palpation : Soft, No distension, No organomegaly

Ausculation : BS (+)

Spine : External Genitelia : (NT)

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

Central Nervous System :

Level of Consciousness : AVPU/GCS score : NFND

Cranial Nerves :

Motor System :

Nutriton :

Tone: Power

Co-ordinator :

Posture :

Involuntary Movements :

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2 Y 4 M 23 D
(F)
Dr. KARTHIK NARAYANAN R

DTR

Superficials:

Plantars

Sensory System :

Bladder / Bowel :

Clinical Summary & Diagnostic:

Fever under evaluation - ? Viral. / ? UTI

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

Desired goals of the treatment :

Planned Labs:

CBC
CRP
Urine ME
RBS
Blood cs
Urine cs

Planned Management

① INF - 0.9% DNS @ 40ml/hr
② INJ. XONE 530g IV BD

Signature of the Doctor:

Name of the Doctor: Dr. S. Mahalakshmi

Date & Time: 27/07/26, 11 AM

Signature of the Consultant:

Name of the Consultant:

Date & Time:

(P.T.O.)

Patient Sticker

DISCHARGE PLANNING FORM

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

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

2. Destination Post Discharge: ☐ Home

   Family Members Notified (Person Contacted)

   ☐ Transfer

   Hospital 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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BirthRight BY RAINBOW HOSPITALS — Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
27/7/24 3:00PM	S/B Dr. DEEPAK	
	Ask: Fever ↓ evaluation	
	(-) ? viral	
	? UTI	
	Child reviewed	
	Child	
	O/E:	
	child is conscious, alert, oriented	
	CVS: $S_1 S_2$ ⊕	
	RS: NVBS ⊕	
	P/A: Soft	
	CNS: NFND	
	IVF 0.9%	℞
	↓	D_1 → Inj. Ceftriaxone 530mg Q12H
	40ml/hr	To monitor vitals / sensorium
		To continue as per chart
	Dengue NS1 in remaining sample	To trace Blood C/S & urine C/S
		[signature] 103415

Patient Sticker

Rainbow® Children's Hospital
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Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
28/7/H6 9:30AM	S/B Dr. DEEPAK	
	Dsx: viral fever	
	Child reviewed	
	child has no new concerns	
	O/E:	
	Alert, afebrile	
	CVS: S1S2 ⊕	
	RS: NVBS ⊕	
	PA: soft	
	CNS: NFND	
	No fever spikes	
	intake better	
		Rx
		To continue as per chart
		To monitor vitals / hydration
		To track fever spikes
		[signature] 1/12425

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

GUC-00094344 IP18-00036633
Baby P.B. AKIRA
04-03-2024 2 Y 4 M 23 D (F)
Dr. KARTHIK NARAYANAN R

Rainbow® Children's Hospital
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Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
28/7/2026	S/B Dr Karthik	
	Viral fever c some dehydration	
	Rx	
	1) Syp P-250	3ml (Sos - if temp >100°F)
	2) Syp TAXIM-O	3ml — o — 3ml
		x (3) days
	3) Zincovit drops	1.0ml — o — o
		x (2) weeks
	ENT opinion	
		[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

GUC-00094344 IP18-00036633
Baby P.B. AKIRA
04-03-2024 2 Y 4 M 23 D (F)
Dr. KARTHIK NARAYANAN R

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RESULT SHEET

Date	27/4/24					
Time						
Hb	11.7					
PCV						
RBC	4.32					
WBC	16,150					
N/L	67/25					
Platelets	3,38,000					
CRP	16					
ESR						
PCT						
RBS	105					
Na	138					
K	4.2					
Cl	103					
iCa/Mg	1.20 /					
Phosphate | HCO_3^-	/ 17					
Urea	26					
Creatinine	0.45					
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

Date	27/7/26					
Time						
CUE - Alb	-ve					
CUE - Sugar	-ve					
CUE - Ketones	-ve					
CUE - PUS Cells	3 - 5cells					
CUE - RBC Cells	-ve					
CUE Mantu	-ve					
leucyte	-ve					
Stool Pus Cell						
OVA / Cyst						
Occult Blood	—					
Dengue NS1	-Ve					

Culture and Sensitivities : Blood Cls -
Urine Cls -

Radiology : USG :

X-Ray :

ECHO :

CT :

MRI

Others (ECG, Contrast Studies etc.,) :

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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: 708

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			NIL			☐ 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 : 154645 Dr. S. Mahalakshmi

Date & Time : 27/7/26, 11AM

Nurse Name & Signature: 01818

Date & Time : 27/07/2026 @. 11:20pm

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

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04-03-2024 2 Y 4 M 23 D (F)
Dr. KARTHIK NARAYANAN R

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DRUG CHART

Date of Admission: 27/7/26 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: Syp. P250				Date / Time	27/7 6pm BS
Dose: 3ml	Route: P/O	Frequency: SOS	Start Date: 27/7/26		
Doctor's Signature: [signature] 54645		Valid Period	Pharm.		
Additional Instructions: if Temp. >100 F					

DRUG: Syp. EMESET				Date / Time	
Dose: 4ml	Route: P/O	Frequency: SOS	Start Date: 27/7/26		
Doctor's Signature: [signature]		Valid Period	Pharm.		
Additional Instructions: if vomiting (+)					

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

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

GUC-00094344 IP18-00036633
Baby P.B. AKIRA (F)
04-03-2024 2 Y 4 M 23 D
Dr. KARTHIK NARAYANAN R

REGULAR PRESCRIPTIONS

Weight. 10.7 Ward. 708

DRUG : INJ. CEFTRIAXONE

Dose	Route	Frequency	Start Date
530mg	IV	Q12H	27/7/25

Name & Signature of the Doctor Starting the Drugs: [signature] 154645

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time	27/7	28/7
12AM	/	EP / P.K
12PM	SM / NS	
	D1	D2

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

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-00094344 IP18-00036633
Baby P.B. AKIRA
04-03-2024 2 Y 4 M 23 D
Dr. KARTHIK NARAYANAN R (F)

Weight. 10.7 Ward. 708

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

VARIABLE DOSE

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
27/12	10:35PM	PARACETAMOL SUPPOSITORY	170mg	P/R	[signature]	SS 149

GUC-00094344 IP18-00036633
Baby P.B. AKIRA
04-03-2024 2 Y 4 M 23 D (F)
Dr. KARTHIK NARAYANAN R

I.V. FLUIDS CHART

Weight. 10.7kg 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
27/7/26	1pm	IVF D/NS.	IV	40 ml		NS			

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

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Baby P.B. AKIRA
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Dr. KARTHIK NARAYANAN R

(1)

c. 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 : 27/7/26 Time:

	12pm	4pm	6pm	9pm	3PM	12pm	4pm
Doctor / Nurse / Family Concern?							
Temperature (°F)	On Admission 97.5	97.9	100.5°F	97.8	97.8	97.8	98.2
Heart Rate (bpm) and Blood Pressure (mmHg) *							
Heart Rate (Number)	138bpm	132bpm	127bpm	120bpm	119bpm		
Resp. Rate (bpm) (Over 1 Minute) *							
Resp Rate (Number)	32bpm	32bpm	30bpm	22bpm	20bpm		
Resp Distress: Mod/ Severe / None / Mild	~	RD	RA	RA	RA		
Receiving O_2 (l/min) O_2 Saturations (%)	99%	100%	100%	100%	100%		
Conscious Level: Normal / Altered	↑	↓	—	—	—		
GCS *	Alert	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							

NB: Scores 3 should be recorded overleaf

ACTIONS

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)

GUC-00094344 IP18-00036633
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04-03-2024 2 Y 4 M 23 D (F)
Dr. KARTHIK NARAYANAN R

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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.

27/7/24		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			40	On Admission						0	SH
	01:00 pm	H20	100	40							0	SH
Total Intake :		100 + 80ml = 180ml				Total Output :				Nil.		
	02:00 pm											
	03:00 pm	H20	50ml							✓	0	
	04:00 pm											
	05:00 pm										0	
	06:00 pm	H20	50ml							✓		
	07:00 pm										0	
Total Intake :		100ml				Total Output :				2 time.		
	08:00 pm	100ml		40							0	
	09:00 pm			40							0	
	10:00 pm	100ml		40						✓	0	
	11:00 pm		one	40							0	
	12:00 am	100ml	30	40							0	
	01:00 am			40						✓	0	
Total Intake :		570 ML				Total Output :				2 times		
	02:00 am			40							0	
	03:00 am	100	50	40						100ml	0	
	04:00 am			40							0	
	05:00 am			40							0	
	06:00 am			40						✓	0	
	07:00 am	150	50	40							0	↑
Total Intake :		340 ML				Total Output :				1 time		

Total 24 hrs. Intake	1010 ML	Total 24 hrs. Output	5 time diapers changed

Bowel : - Nil

GUC-00094344 IP18-00036633
Baby P.B. AKIRA
04-03-2024 2 Y 4 M 23 D (F)
Dr. KARTHIK NARAYANAN R

(1)

NURSES NOTES

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☐ No Known Drug Allergies

☐ Drug Allergies .... Nil.

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		Admission Notes	
27/7/26	11:40AM	child details Hand over taken from ER staff. child vitals are stable maintained hydration level, c/o Fever x 2 days, vomiting x 2 Episode in yesterday, ↓ intake, ↓ out put, IV line secure, CBC CRP, RP2, Blood c/s, urine R/E, urine c/s pending to do collect, IVF DNS 40ml/hr, Inj. Xone 530mg IV start, →	Suf 607383
	12PM	child vital signs checked and recorded. vitals are stable. maintain I/O chart. Inj. Xone 530mg IV given as per order, IVF 40ml/hr on flow →	Suf 607383
	1:30pm	child details Hand over given to Evening duty staff. →	Suf 607383
		Evening Duty Notes.	
	1:30pm	Handover Received from morning duty staff. child is active and oriented. IV line present. IVF - 0.9% DNS - 40ml/hr on flow. urine culture and Routine sample sended to morning duty staff.	Sowmya 0P1559
	3pm.	Dr. Karthik sir came and seen the baby. advice to trace urine R/E Report and to do. old sample.	Sowmya OP1559.

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Patient Sticker

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NURSES NOTES

☐ No Known Drug Allergies

☐ Drug Allergies ....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		Dengue NS1. informed lab person.	
		Dengue NS, Blood test bill raised.	
27/7/26.	4pm.	checked vital sign and	
		Recorded (PP ++, CP ++, CPT <3sec)	[signature]
	6pm	checked temperature 100.3F	
		syp:- P250 -3ml. given as	
		per drug chart orderly.	
	7pm	monitored input and	
		output chart and Recorded.	
	7:30pm	Handover given to	[signature]
		night Duty staff	
		Night duty on 27/7/2026	
	7:30PM	child condition and details	
		handing over taken from	
		Evening duty staff Nurse	
		child is conscious oriented	
		GCS 15/15	[signature] 021873
	8PM	Child vital signs are Monitored	
		& Recorded done H:D Stab	
		CP PP CFT	
		++ ++ +++	
	10PM	Encourage orals	
	12AM	Recheked vitals mooniterd	
		done H.D stable.	
	1AM	Medications will be given	
		as per the Drug chart follow	[signature] 021873

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

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Patient's N SUC-00094344 Baby P.B. AKIRA IP18-00036633 ....
MRD NO:. 04-03-2024 2 Y 4 M 23 D (F) Dr. KARTHIK NARAYANAN R ....
Age :................................ Sex: ☐ M ☐ F
Consultant :..

PHLEBITIS ASSESSMENT

CANNULA 1

Date : 27.07.2026 Time: 11:30am
Location : left Methacarpal
Size : 22G
Cannula inserted by : S/N Sugandhra

Date	Time	Phlebitis	Infiltration	Nursing Intervention	Sign
27/7/26	11:30AM	☐Yes ☑No	☐Yes ☑No	Pattern	[signature]
	1:30AM	☐Yes ☑No	☐Yes ☑No	pattern	[signature]
	2 PM	☐Yes ☑No	☐Yes ☑No	Observe	[signature]
	4 pm	☐Yes ☑No	☐Yes ☑No	Observe	[signature]
	6pm	☐Yes ☑No	☐Yes ☑No	observe	[signature]
	8PM	☐Yes ☑No	☐Yes ☑No	pattern	[signature]
	10PM	☐Yes ☑No	☐Yes ☑No	pattern	[signature]
28/7/21	2 AM	☐Yes ☑No	☐Yes ☑No	pattern	[signature]
	4AM	☐Yes ☑No	☐Yes ☑No	pattern	[signature]
	6 AM	☐Yes ☑No	☐Yes ☑No	pattern	[signature]
	8AM	☐Yes ☑No	☐Yes ☑No	observe	[signature]
	10AM	☐Yes ☑No	☐Yes ☑No	observe	[signature]
	12pm	☐Yes ☑No	☐Yes ☑No	observe	[signature]
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐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

BUC-00094344 IP18-00036633
Baby P.B. AKIRA
14-03-2024 2 Y 4 M 23 D (F)
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(1)

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THE HUMPTY DUMPTY SCALE

M B N M

PARAMETER	CRITERIA	SCORE	DATE 27/7	DATE 27/7	DATE 27/7	DATE 28/7	DATE
Age	Less than 3 years old	4	4	4	4	4	
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2					
	Female	1	1	1	1	1	
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1	1	1	
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2		2	2	2	
	Oriented to own ability	1	1				
	History of Falls or Infant-Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2					
	Outpatient Area	1	1	1	1	1	
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours/ None	1	1	1	1	1	
Medication Usage	Sedatives (Excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1	1	1	
	Total		10	11	11	11	

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

Bed in low position		✓	✓	—	✓
Call device within reach		✓	✓	—	✓
Wheels Locked		✓	✓	—	✓
Room free of clutter		✓	✓	✓	—
Adequate lighting		✓	NA	✓	✓
Wheel chair support		✓	NA	✓	✓
Other Intervention(s) Specify					
Nurse's Name:		Sinu	Dy	[illegible]	[illegible]
Signature:		[illegible]	[illegible]	[illegible]	[illegible]
Date:		27/7	27/7	27/7	28/7
Time:		10am	9pm	1.30	8am

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

Patient Sticker

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THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4					
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2					
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1					
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own ability	1					
	History of Falls or Infant-Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2					
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours/ None	1					
Medication Usage	Sedatives (Excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	2					
	One of the Meds listed above	1					
	Other Medications / None						
	Total						

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

Bed in low position						
Call device within reach						
Wheels Locked						
Room free of clutter						
Adequate lighting						
Wheel chair support						
Other Intervention(s) Specify						
Nurse's Name:						
Signature:						
Date:						
Time:						

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aby P.B. AKIRA
4-03-2024 2 Y 4 M 23 D (F)
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Ref. No.: F/HW/BRD-Q/NSG/04

M ☐F IP No. :

BRADEN 'Q' SCALE

(for Paediatric use)

				Date :	M 27/7	E 27/7	N 27/7	M 28/7
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4	4	4
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during waking hours.	4	4	4	4
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	4
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	4
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times."	4	4	4	4
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	3	3	3	3
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4
				TOTAL SCORE	27	27	27	27
				Evaluator's Name	SD	DD	[illegible]	SS

Highest Risk : 7 | High Risk : 8-16 | Mild Risk : 17-21 | No Risk : 22-23

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aby P.B. AKIRA
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PAIN ASSESSMENT FORM

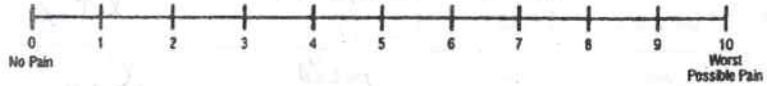
Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
27/7/26	12pm	0/10	Nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	Nil.	[signature] 607353
27/7/26	6pm	0/10	NPC.	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	NPC	Sony [illegible]
27/7/26	2Am	0/10	nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	Nil	[signature]
28/7/26	8Am	0/10	Nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	Nil	[signature] 607353
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

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

PAIN ASSESSMENT TOOLS

Numerical Pain Scale (Obstetric and Gynecology)



Wong - Baker (Pediatrics) Above 7 Years

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
	0	1	2
Face	No Particular expression or smile	Occasional Grimace or Frown, withdraw, Disoriented	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs drawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, right, or Jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams of sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

Neonatal Pain, Agitation and Sedation Scale (upto 1 Month)

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR RR, BP, SaO_2	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO_2 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO_2 less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

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aby P.B. AKIRA
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WELL'S CRITERIA FOR ASSESSING DVT

NOTE: Assign a **score of 1** if **'YES'** in **parameter 1 to 9** and **Assign a score** of **-2** if **'YES'** in **parameter No 10**

S.No	Assessment Criteria	Score	Date: 27/7 Time: M	Date: 27/7 Time: E	Date: 27/7 Time: N	Date: 28/7 Time: M	Date: Time:	Date: Time:
1	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)	1	0	0	0	0		
2	Bedridden recently >3 days or major surgery within four weeks	1	0	0	0	0		
3	Calf swelling >3cm compared with asymptomatic side, measured at 10 cm below tibial tubercle (Assess for both legs)	1	0	0	0	0		
4	Collateral (non varicose) superficial veins present (Assess for both legs)	1	0	0	0	0		
5	Entire leg swollen (Assess for both legs)	1	0	0	0	0		
6	Localized tenderness along the deep venous system (Assess for both legs)	1	0	0	0	0		
7	Pitting edema, greater in the symptomatic leg (Assess for both legs)	1	0	0	0	0		
8	Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs)	1	0	0	0	0		
9	Previously documented DVT (Assess for both legs)	1	0	0	0	0		
10	Alternative diagnosis to DVT as likely or more likely (Assess for both legs)/ Co-morbidity like ESLD /Renal disease, Renal failure, CCF Cellulitis (commonly mistaken as DVT), Dependent (stasis) oedema, Lymphatic obstruction.	-2	0	0	0	0		
	Total Score		0	0	0	0		
	Signature of the Nurse							

Intervention: _____

_____

_____

High Risk = >2 Score

Moderate Risk = 1-2 Score

Low Risk = <1 Score

Note : Daily assessment shall be carried out once every 24 hours and documented

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INTERDIS / FAMILY EDUCATION RECORD

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Part - I.

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

Identified Education Needs:

1. Diagnosis
2. Treatment and Care
3. Pain Management
4. Informed Consent
5. Medication / Therapy (safety, effects/ side effect, interactions)
6. Discharge Medication
7. Infection Control Measures
8. Diagnostic Test / Procedures
9. Nutrition / Diet
10. Fall Risk Education
11. Safe use of Medical Equipment / Implantable Devices
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		
27/7/26	12pm	Yes	Explain about pain management	mother	No	Oral	None	Verbal	Good	Sign 607383
28/7/26	8AM	Yes	Explain about pain managenat	mother	No	Oral	None	Verbal	Good	Sign 607383

Part - III: CODES

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

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

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

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

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

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Baby P.B. AKIRA
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Dr. KARTHIK NARAYANAN R

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Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 11:40AM Mode of Arrival: walking Admitting From: ☑ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction Nil. Body Weight: 10.9kg Kg

Height: ..... cm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
Nil.	Nil	H/o Acute otitis media 1 week ago

Family History: Nil.

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

If yes please list, Nil

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: 10.9kg Length: – Head Circumference (< 2 years): .....

Temp.: 98.8°F HR: 120bpm RR: 28bpm BP: 96/64 mmHg

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

Fall Risk Assessment: ☑ Yes ☐ No Score: 0 to 0 (Document in the Humpty Dumpty Sheet)

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

Pain Screening: ☑ Yes ☐ No If Yes, Pain Score: 0 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): 27/7/26

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: ..... Sinodhumitha ..... Date: 27/7/26 ..... Time: 12pm Signature 607303

PATIENT TRANSFER FORM

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GUC-00094344 IP18-00036633
Baby P.B. AKIRA
04-03-2024 2 Y 4 M 23 D (F)
Dr. KARTHIK NARAYANAN R

Date & Time of Admission	Date & Time of Transfer Order
07.07.2026 @ 11:05 AM	07.07.2026 @ 11:40 AM

Treating Consultant Name	Transfer Ordered by	Reason for Transfer
Dr. Karthik.	Dr. Mahalakshmi	further Management

From Unit	To Unit	Information to Attendant
ER	708	Yes ☑ No ☐

Number of Sheets in Clinical File	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant
Total Sheets 14	—	Yes ☐ No ☑ If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	① NS 500ml	(1)
2.	D set	(1)
3.	Inj: Xone 1gm	(1)
4.		
5.		

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

Fever under evaluation - ? Viral / ? UTI

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
01613h	1511615

Patient & Clinical Records Received by : Sumedha 607313 at 11:40AM

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

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04-03-2024 2 Y 4 M 23 D (F)
Dr. KARTHIK NARAYANAN R

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EMERGENCY ROOM TRIAGE FORM

wt. 10.7Kg.

Patient's Name: Baby. Akira. Age: 2y 4m Gender: ☐ Male ☑ Female

Date: 27/7/26. Time of Arrival: 10:30Am

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: 101.4°F PR: 146bpm BP: 95/60(71). RR: 30bpm. SpO₂: 100% RA

Chief Complaints: C/o. Fever x 2days. Cough & cold x 2 weeks.

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

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

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

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian

Triage Completion Time: 2 mins

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: Swanthra.

Signature of Triage Nurse: [signature] 0108

Date & Time: 27/7/26 @ 10:30Am

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

07. 07. 2026.

10:35AM Neomol Suppository. 170mg Start

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 27/4/26 Time of arrival : 10:30AM.

Chief Complaints: c/o. fever x 2 days. cough & cold x 2 wks RBS: 115mg/dl

Height : — Weight : 10.1 BMI : — Head Circumference (<2 years) —

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

If yes , identify —

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

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

RISK FOR FALL:

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

☐ If Patient is > 6 years
Assess the below parameters

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

Ambulatory Aids:
- Wheelchair ☐ Yes ☒ No
- Uses furniture for support ☐ Yes ☒ No

Gait/Transferring:
- Bedrest / immobile ☐ Yes ☒ No
- Weak ☐ Yes ☒ No
- Impaired ☐ Yes ☒ No

Mental Status: Forgets limitations ☐ Yes ☒ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:
- ☐ Escort while ambulating
- ☐ Assist Patient
- ☐ Educate patient and family on fall precautions/prevention

Functional Screening: ☐ No Abnormalities Detected
- ☐ Mobility Problem
- ☐ Walking Problem
- ☐ Developmental Delay
- ☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

.....

.....

Nutritional Screening: ☑ No Abnormalities Detected
- ☐ Underweight
- ☐ Overweight
- ☐ Feeding Problem
- ☐ Special diet
- ☐ Special feeding method

Inform consultant for positive criteria

Psychological Screening: ☑ No Significant Findings

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

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

Social History: Lives With —

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

Time of Initial assessment completed by ER Nurse : 10:35PM

(P.T.O.)

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

Time	Nursing Notes
10:30 Am	child come for fever, cough & cold x 2weeks
	child conscious & mental. vitals checked
	& records vitals stable. Dr. Mahalakshmi
	mam see the child to discuss about Dr. Karthik
	Sir to advice to admitted father neyment.
	IV placement done. Sample send to lab.
	child shifted to ward.

Samples collected by: S/N Suganthure. Time: 11:30m

Samples sent by: S/N. Godwin Time: 11:32am

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: 146 b/m BP: 95/60(71) CFT: <3 sec	Shift - out from ER to: 708
RR: 30 b/m SPO₂: 100% RA	Time of Shift - out: @ 11:40am
GCS: 15/15 Temperature: 101.4F	Handover given to: (Nurse's Name) S/N Madhumitha
Pain Score: 0	
Repeat RBS (if applicable): Nil	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any): IV placement done. (L) metacarpal 22G.

Name of the Nurse: Suganthure

Signature of the Nurse: [signature] 01827

Date & Time: 27/4/20 @ 11:30am

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PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : Dr kathik Date : 27/7/26

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

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

Allergic History: .....

Chief Complaints:
c/o fever x 2days., Tmax-102F
c/o 2 episodes of vomiting (resolved)
c/o Cough

Pediatric Assessment Triangle

A Appearance - TICLS: Alert

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: No.
Medication History: NO
Relevant Investigations: NO.

Primary Assessment

Airway
- ☑ Open
- ☐ Maintainable
- ☐ Not Maintainable

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

Breathing
Rate: 30/min SpO_2 on FiO_2 100% on RA
Rhythm: Regular
Retractions: ☐ Suprasternal ☐ ICR ☐ SCR ☐ Sternal ☐ Supraclavicular ☐ Nasal Flaring
Respiratory Noises: ☐ Stridor ☐ Wheezing ☐ Grunting
Air Entry: B/L AE (+), No added sounds.
Palpation Findings (If necessary) .....

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

Circulation

HR: 146/min CFT Central <3S Peripheral <3S

Any urgent interventions needed: ☐ Yes ☑ No

If Yes .....

BP: 95/60 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 NFND

.....

Any urgent interventions needed: ☐ Yes ☑ No

If Yes .....

Exposure

Temp.: 101.4

Any Rash: ☐ Yes ☑ No,

If yes describe the rash .....

Active bleed .....

Lacerations ☐ Abrasions ☐ bruises ☐

Describe: .....

Any urgent interventions needed: ☑ Yes ☐ No

If Yes .....

PARACETAMOL SUPPOSITORY 170mg P/R stat

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: (N)

Labs Planned:

As per drug chart

Treatment Planned:

As per drug chart

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

Final Diagnosis with possible Differential Diagnosis (If necessary): Fever under evaluation — ? Viral & Some dehydration.

Assessment done by

Name of the Doctor: Dr. S. Mahalakshmi

Signature: 15645

Date & Time: 27/07/26, 11AM

Sr. Doctor on Duty (If necessary)

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

Signature: .....

Date & Time: .....

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RBS CHART

Date	Time	RBS (mg/dl)	IVF %	Signature
27/7/26	11:30am	115mg/dl	–	[signature]