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

BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

PATIENT DISCHARGE INTIMATION FROM NURSING STATION

CLEARANCE FOR DRUGS AND DISPOSABLES BILLING

GUC-00091484 IP18-00036630
Baby KRISHVANTH H
Name of the Pa 31-01-2025 1 Y 5 M 28 D (M)
Dr. PADMAPRIYA EKAMBARAM
UHID No: .....

Date: .....

..... 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	Pharmacy Sign
Date:	Date: 26/1/26	Date: .....
Time:	Time: 8 AM	Time: .....

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

Rainbow Children's Hospital

GUC-00091484 IP18-00036630
Baby KRISHVANTH H
31-01-2025 1 Y 5 M 28 D (M)
Dr. PADMAPRIYA EKAMBARAM

DISCHARGE TRACKING SHEET

UHID- FLOOR- NAME OF CONSULTANT-

ACTIVITY	INTIM E	OUT TIME	NAME & SIGNATUR E	REMARKS	<To be filled by Admin >		
Activity Sheet update by Nursing		8 PM					
Activity Sheet update by Pharmacy							

ACTIVITY RECORD FOR BILLING

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Name: .....

GUC-00091484 IP18-00036630
Baby KRISHVANTH H
31-01-2025 1 Y 5 M 26 D (M)
Dr. PADMAPRIYA EKAMBARAM

UHID No: ..... Consultant: ..... Dept: .....

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
27/7	12.35PM	ER	405	

CROSS CONSULTATION VISIT

	Doctor Name	Date	Order No.	Signature
1.	Dr. Vinek	28/7/26		
2.			3975	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

INVESTIGATIONS

Date	Investigations	Order No.	Signature
	CBC/CRP, Bld c/s	26024001	
26/7	RBS	26024000	
27/7	Capillary Blood gas (CBG)	24032	

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
27/7/26	Infusion pump	1am	28/7/26 6am	1733402	AP
27/7/26	Oxygen.	4am	27/7/26 1pm	3701	Jay

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
26/7	IV Placement	1	1133366	[illegible] 17804
	Nebu c oxygen	2	1133365	
27/7/26	Neb c O2	3	1133409	[illegible]
27/7/26	Neb c O2	1	3698	[illegible] 02004
	Neb	1	3697	
27/7/26	Neb c O2	2	33824	[illegible]/019501
28/7/26	Neb c O2	4	1233913	[illegible]

Neb – (2) + (7) + (10)

ANY OTHER INFORMATION:

....

....

....

....

....

....

Date: 28/7/26 Time: 8.30 AM Prepared By: ....

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
[illegible] 007800			

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Baby KRISHVANTH H
31-01-2025 1 Y 5 M 28 D (M)
Dr. PADMAPRIYA EKAMBARAM

DISCHARGE TRACKING SHEET

UHID- FLOOR- NAME OF CONSULTANT-

ACTIVITY	TIME		NAME & SIGNATURE	REMARKS	<To be filled by Admin>
Discharge Announcement					
	INTIME	OUT TIME			
Arrangement of File by Nursing		8:30PM	[illegible]		
Preparation of Discharge Summary					
Finalization of discharge summary					
Transfer of file from Ward to Billing Dept					
Bill Processing					
Audit Clearance					
Billing Clearance					
Physical Clearance					

Rainbow Children's Hospital

BirthRight by Rainbow

Rainbow Children's Hospital - Guindy

Door No.157 to 160, Anna Salai, Guindy, Guindy ,Chennai ,Tamil Nadu, INDIA ,600015.
TEL NO :044-40122444
WEB : https://rainbowhospitals.in

ADMISSION SHEET

Registration Details :

Admission No : IP18-00036630 **Admit Date** : 26-Jul-2026 **Admit Time** : 11:20 PM **UHID** : GUC-00091484

Patient Details :

Patient Name	: Baby KRISHVANTH H	**Age**	: 1 Y 5 M 26 D
Guardian	: Mr HARIHARAN D	**DOB**	: 31-01-2025 10:26 AM
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: NO:16 ESWARI RATNA GARDEN APARTMENT, VANDIKARAN STREET, GUINDY Guindy Ind Estate Chennai Tamil Nadu INDIA 600032	**Phone No**	: 8072662156/ 8807420355
		E-mail	: hariwc21@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 HARIHARAN D **Relationship** : Father

Contact Address : NO:16 ESWARI RATNA GARDEN APARTMENT, VANDIKARAN STREET, GUINDY Guindy Ind Estate Chennai Tamil Nadu INDIA 600032 **Phone No** : 8072662156

Signature

Doctor Details :

Doctor Name : Dr. PADMAPRIYA EKAMBARAM **Specialisation** : GENERAL PEDIATRICS

Referral Doctor : DR.PADMAPRIYA EKAMBARAM **Phone No** :

Co-Consultant :

Payment Details :

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

Payor Name : SELFPAY

Rainbow Children's Hospital
BirthRight by Rainbow

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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 KRISHVANTH H**	**Age :**	**1 Y 5 M 26 D**
IP No:	**IP18-00036630**	**Sex:**	**Male**
Consultant:	**Dr. PADMAPRIYA EKAMBARAM**	**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 [illegible] of the patient.

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

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

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

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

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

Signature of Patient/Relative:

Name: D. Hariharan
Relationship: Father
Date: 26-07-2026 Time: 11:20
Witness Name: ASWIN
Witness Signature:

Patient Address:
NO:16 ESWARI RATNA GARDEN APARTMENT, VANDIKARAN STREET, GUINDY Guindy Ind Estate Chennai Tamil Nadu INDIA 600032

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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 : > Krishvanth . M	UHID Number : 91484
Self/Attendant Name : > Hariharan D	Relation : > Father.
Self/ Attendant Signature : > Phone Number : > 8807420355	Name & Signature of Financial Counselor

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PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: _____ GUC-00091484 IP18-00036630 Baby KRISHVANTH H 31-01-2025 1 Y 5 M 26 D (M) Dr. PADMAPRIYA EKAMBARAM _____

UHID ID: _____ _____

Department: _____

Consultant: _____

(P.T.O.)

GUC-00091484 IP18-00036630
Baby KRISHVANTH H
31-01-2025 1 Y 5 M 26 D (M)
Dr. PADMAPRIYA EKAMBARAM

rediatric Multiorgan History & Physical Examination

Name: Baby Krishvanth, Age/Sex 1yr.

Information given by: Relationship

Chief Presenting Complaints & Duration (Chronologically)

c/o fever x2days (Temp undocumented)
↓oral intake x2days.
Fast breathing since morning

History of present illness :

A 1yr old male came with complaints of fever x 2days low grade, intermittent, not associated with chills.
c/o ↓ oral intake x2days
c/o Fast breathing

Initially treated as OPD basis with nebulizations in view of persistant Tachypnoea, resp distress the child was admitted

GUC-00091484
Baby KRISHVANTH H
31-01-2025
Dr. PADMAPRIYA EKAMBARAM
IP18-00036630
1 Y 5 M 26 D
(M)

Past History : (Incl... previous investigation or treatment)

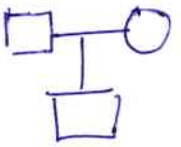
Admitted for bluish discoloration Tongue at 7 months

Admitted for bronchiolitis at 3 months of age.

H/o frequent respiratory Tract infections treated as OPD basis.

Birth & Neonatal History:

Family Chart



Emg LSCS - PH, Oligo | Late Preterm | B.wt - 1.8 Kg. | CIAB.
NICU stay for Hypoglycemia | Resp distress

Birth & Socio Economic History:

About Father : 7 NCM.

About Mother :

Any additional information :

Developmental History :

Stands with support, speaks one word, scribbles on own

Immunization History :

Immunized upto age according to NIS.

Anthropometry :

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

Weight (kgs) 8.7 Kg. (Centile _____)

On Examination :

Temperature : 100.3 F Pulse Rate : 165/min B.P. _____ SPO2 100.1 RA

Resp.rate and type of breathing : 70/min

Rash —

Lymphadenopathy —

Oedema : —

Allergies (if any): —

(P.T.O.)

Patient Sticker

Respiratory System :

Inspection (any s/o distress) :

Air entry & breath sounds : B/LAE(+), SLR(+), Nasal flaring(+)

Any addes sounds :

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

Cardiovascular System :

Inspection of procordium :

Heart Sounds : S1S2(+)

Any murmur :

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

Per Abdomen :

Inspection :

Palpation : Soft, non tender

Ausculation :

Spine : External Genitelia :

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

Central Nervous System :

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

Cranial Nerves :

Motor System :

Nutriton : (N)

Tone: Power 5/5

Co-ordinator :

Posture :

Involuntary Movements :

Patient Sticker

Reflexes :

DTR **Superficials:**

Plantars

Sensory System :

Bladder / Bowel :

Clinical Summary & Diagnostic:

Acute bronchiolitis

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

Desired goals of the treatment :

Planned Labs:

CBC
CRP
Resp Biofire – not done

Planned Management

IV Fluids
NOB 3:1 NaCl.
Syp. oseltamivir -

Signature of the Doctor:

Name of the Doctor: Dr. chandiraleya

Date & Time: 27/7/26

Signature of the Consultant: P. Padmapriya

Name of the Consultant: DR. PADMAPRIYA ELAMBARAM

Date & Time: 27/7/26 @ 11:30 am

(P.T.O.)

Patient Sticker

DISCHARGE PLANNING FORM

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

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

2. Destination Post Discharge: ☐ Home

Family Members Notified (Person Contacted)

☐ Transfer

Hospital Facilty Notified (Person Contacted)

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

☐ Needs Assistance In: Remarks

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

4. Nutritional Plan:

☐ Dietary Instruction Discussed with the:

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

5. Discharge Planning Discussed with the:

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

6. Patient/Family Educational Plan:

☐ Educational Topic/s: .....

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

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

Doctor Signature: .....

Doctor Name: .....

Date and Time: .....

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

DOCTOR'S SHIFT CHANGE HANDOVER FORM

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

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

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

DOCTOR'S SHIFT CHANGE HANDOVER FORM

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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-00091484 IP18-00036630
Baby KRISHVANTH H
31-01-2025 1 Y 5 M 26 D (M)
Dr. PADMAPRIYA EKAMBARAM

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CROSS CONSULTATION FORM

Doctor Name: Dr. Vivekanand Date: 28/7/26 Time: ....

Diagnosis: ....

Hospital: ....

Referred for: ☐ Opinion ☐ Co-Management ☐ Transfer of care

Type of Referral:
☐ Emergency
☐ Urgent
☐ Non Urgent

Reason for Referral: If for concurrent care specify the particular need, especially in the absence of a second diagnosis:

Signature:

Findings and Recommendations:

Thanks for referral

~~Bronchiectasis~~ ~~asthma~~

History noted

1st born · late preterm / 36 weeks / SGA

Normal transition

2 Brief episodes of URI c̄ nocturnal cough

1 central cyanosis at 7th month

Echo - ⊝

No stridor / No chronic respiratory symptoms

No FB aspiration / No contact TB.

No personal / parental atopy

exposure to smoke (Sambrani 2/7 days).

Consultant:

Name: .... Signature: .... Date & Time: ....

Doc. No.: RCH / FRM / CLINICAL / 049

presented c̄ fever c̄ disproportionate tachypnea

Tachypnea settled

RS: clear / no crepts / no added sounds. CVS - NAD.

PA: soft

Chest Xray - (N)

CBC / CRP - (N)

ABG showing Alkalosis

Assessment:

Symptom pattern not suggestive of chronic respiratory problems /

Breathlessness disproportionate to fever

1. Suggested to do screening Echo cardiography
2. In case of recurrent / persistent resp. symptoms
3. ↓ will plan for further Respiratory evaluation

Avoid sambrani exposure

To Review SOS.

– Parents counselled

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
27/7/26 2:00Am	S/B Dr Chandiralogr	
	A - Acute Bronchiolitis.	
	Child received	
	Alert, Active	
	on IVFluids.	
	Tachypnoea ⊕.	
	WOB Ⓝ, no retractions	
	But nasal flaring ⊕.	
	O/E	
	Afebrile	
	CVS - S1S2 ⊕	
	RS - B/L AE ⊕	
	RR - 70/min	
	SpO2 - 99% RA	
	Adv.	
	- monitor vitals / strict RR count.	
	- Nebulizations as per chart	
	- Inform (SOS) if saturation drops	
	Sd/-	
	1AM	

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
27/7/06 9:45 AM	S/B Dr. Lucky Vignesh	
	Δ: Acute Bronchiolitis	
	child required	
	Afebrile	No c/o fever (Temp - undocumented)
	complaints of tachypnea +	
No h/o choking / coughing / cyanosis	WOB ↑ (No nasal flare / grunting) oral intake - reduced	
	minimal SCR + / ICR +	hydration - Adequate
	RR = 64-66/min	CRT < 3 sec
	SpO2 - 99% @ 2LO2	PP - well felt
	No PICCLE	
	RS: B/L AE + / no added sounds.	
	PA: soft NT	
	CVS: S1 S2 ⊕ / no murmur	
	CNS: NFND	
		Adv
Lo-7 ⟩ 10830 ⟨ 3.88 / 70/28		1) Neb. 3% Nacl Q3H
		2) Syp. Fevrik 2ml PO Q12H.
	CXR: ⓝ	3) continue O2 - 2L on NP
	Chest xray: ⓝ	4) W/f desaturation / tachypnea / (<92% @ 2LO2)
	Capillary blood gas → [PH - 7.44, CO2 - ↓ 24.8, HCO3 - ↓ 16.]	
	Lucky Vignesh 20372	
	S/B Dr. Padmapriya	
11:30am	Child tachypnoea + 66/mt.	
	- SpO2 maintaining >92% in RA	c Padmapriya
	- ō salty DBF	44268
	- Kanji, liquids to start.	

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

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
		Dr. V. Vivekanand Opinion today evening (peds pulmonology)
		Dr. Priya. 44268
27/2/26 3.30pm	S/B Dr. Padmapriya. Off O2 x 3 hrs. no retractions / grunt / cyanosis. Oral intake better. no vomiting / Fever spike - 12 noon - 100.2 F. Lungs - clear.	RR ↓ - 50-60/mt. R/. 1) Cont same. 2) Inform me after Dr. Vivek sees. Dr. Padmapriya. 44268

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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KRISHVANTH

RESULT SHEET

Date	26/7/26.					
Time						
Hb	10.7					
PCV	32					
RBC	4.41					
WBC	10830					
N/L	70/28					
Platelets	3.88					
CRP	<5					
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

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

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : Chest Xray : A.

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: 405

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1						☐C ☐DC
2						☐C ☐DC
3						☐C ☐DC
4						☐C ☐DC
5						☐C ☐DC
6						☐C ☐DC
7						☐C ☐DC
8						☐C ☐DC
9						☐C ☐DC
10						☐C ☐DC

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

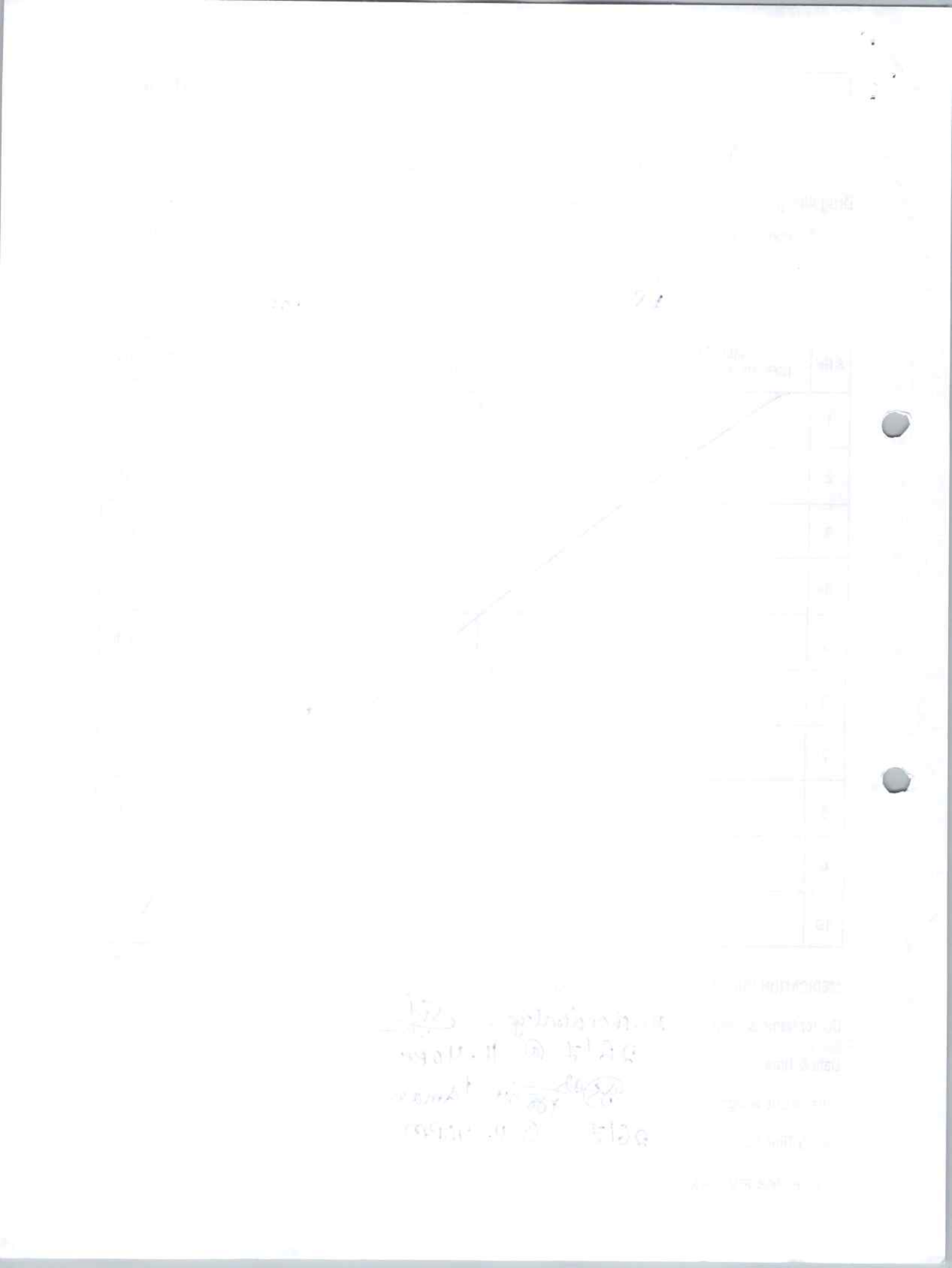
Doctor Name & Signature : Dr. Chandralega.

Date & Time : 26/7 @ 11.40PM

Nurse Name & Signature: 10894 / Sman

Date & Time : 26/7 @ 11.40PM.

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



GUC-00091484 IP18-00036630
Baby KRISHVANTH H
31-01-2025 1 Y 5 M 26 D (M)
Dr. PADMAPRIYA EKAMBARAM

Rainbow® Children's Hospital
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DRUG CHART

Date of Admission: 28/7 Drug Allergies: ..... ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

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

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

SOS / PRN (As required Medication)

DRUG : SYP. PARACETAMOL				Date / Time	27/7												
Dose	Route	Frequency	Start Date	12.30 pm	BJ VN												
2.5ml	PO	SOS	27/7/26														
Doctor's Signature		Valid Period	Pharm.	8.30 PM	CS SA												
Additional Instructions: 250mg/5ml BBH if Temp >100F.																	

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

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

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

GUC-00091484 IP18-00036630
Baby KRISHVANTH H
31-01-2025 1 Y 5 M 26 D (M)
Dr. PADMAPRIYA EKAMBARAM

REGULAR PRESCRIPTIONS

Weight. 8.7kgs. Ward. 4th floor

DRUG : 3-1 NACL NEB.

Dose	Route	Frequency	Start Date
3ml+2ml NS	RIN	Q3H	27/7

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time	27/7	28/7
1am	SA	
4am	SA	
7am	SA	
10am	BL VB	
1pm	BL VB	
4pm	PM VB	
7pm	DA VB	
10pm	VB SA	

DRUG : SYPOSELTAMIVIR.

Dose	Route	Frequency	Start Date
2ml	PO	Q12H	27/7

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time	27/7	28/7
8	BL	
Am	VB	
8	CS	
pm	SA	
	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	

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Weight. 8.7kg Ward. 4th floor

VARIABLE DOSE	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
27/7/26	7.15PM	Neb. Levolin	0.63	P/N		
27/7/26	9.20 PM	Syp. Omnacortil	4.5 ml	PO		
27/7/26	10.15 PM	Neb Duolin	1 tsp.	P/N		

GUC-00091484 IP18-00036630
Baby KRISHVANTH H
31-01-2025 1 Y 5 M 26 D (M)
Dr. PADMAPRIYA EKAMBARAM

I.V. FLUIDS CHART

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

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
27/7/25	12.40 pm	0.9.1 DNS	32ml/hr	32ml/hr					

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

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Ref. No. F/INPR/12

GUC-00091484 IP18-00036630
Baby KRISHVANTH H
31-01-2025 1 Y 5 M 27 D (M)
Patient Name : Dr. PADMAPRIYA EKAMBARAM

Registration N

NEBULISATION CHART

Date	Time	Drug	Nurse	Parents SIgnature
27/7	1am 00.00	ER — (2) Neb 3% Nacl EO_2 — (1)		
	1.00 4am	Neb 3% Nacl EO_2 — (1)		
	2.00 7am	Neb 3% Nacl EO_2 — (1)		
	~~3.00~~ 10am	Neb 3% Nacl — (1)		
	~~4.00~~ 1pm	Neb 3% Nacl EO_2 — (1)		
	~~5.00~~ 4pm	Neb 3% Nacl EO_2 — (1)		
	~~6.00~~ 7pm	Neb. 3% Nacl EO_2 — (1)		
	7.00 10pm	Neb 3% Nacl EO_2 — (1)		
28/7	8.00 1am	Neb 3% Nacl EO_2 — (1)		
	9.00 4am	Neb 3% Nacl EO_2 — (1)		
	10.00			
	11.00			
	12.00			
	13.00	Total — (13)		
	14.00			
	15.00			
	16.00			
	17.00			
	18.00			
	19.00			
	20.00			
	21.00			
	22.00			
	23.00			

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Baby KRISHVANTH H
31-01-2025 1 Y 5 M 27 D (M)
Dr. PADMAPRIYA EKAMBARAM

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

PRESCHOOL (1-5 years)

Children's Observation & Early Warning Scoring Chart

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 22/2/26

Time:	1AM	4AM
Doctor / Nurse / Family Concern?		
Temperature (°F) (scale 94–104)	98.1°F	98.3°F
Heart Rate (bpm) and Blood Pressure (mmHg) * (scale 50–190)	121 / 52 (59)	117 / 59 (62)
Heart Rate (Number)	130/m	130/m
Resp. Rate (bpm) (Over 1 Minute) * (scale 10–70)		
Resp Rate (Number)	70	63/m
Resp Distress: Mod/ Severe / None / Mild	99%	100%
Receiving O_2 (l/min) / O_2 Saturations (%)	✓	✓
Conscious Level: Normal / Altered	✓	✓
GCS *	15/15	15/15
TOTAL SCORE Number of shaded boxes	0	0
Pain Score	0	0
Observer's Initials	[illegible]	[illegible]

Note: BP does not score in early warning scoring

(Handwritten across chart: Recieved from HDU to [illegible])

ACTIONS

NB: Scores 3 should be recorded overleaf

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

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

Patient Sticker

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

GUC-00091484
Baby KRISHVANTH H
IP18-00036630
31-01-2025
1 Y 5 M 27 D
(M)
Dr. PADMAPRIYA EKAMBARAM

No. : RCH/ FRM / CLINICAL / 125

PRESCHOOL (1-5 years)

Children's Observation & Early Warning Scoring Chart

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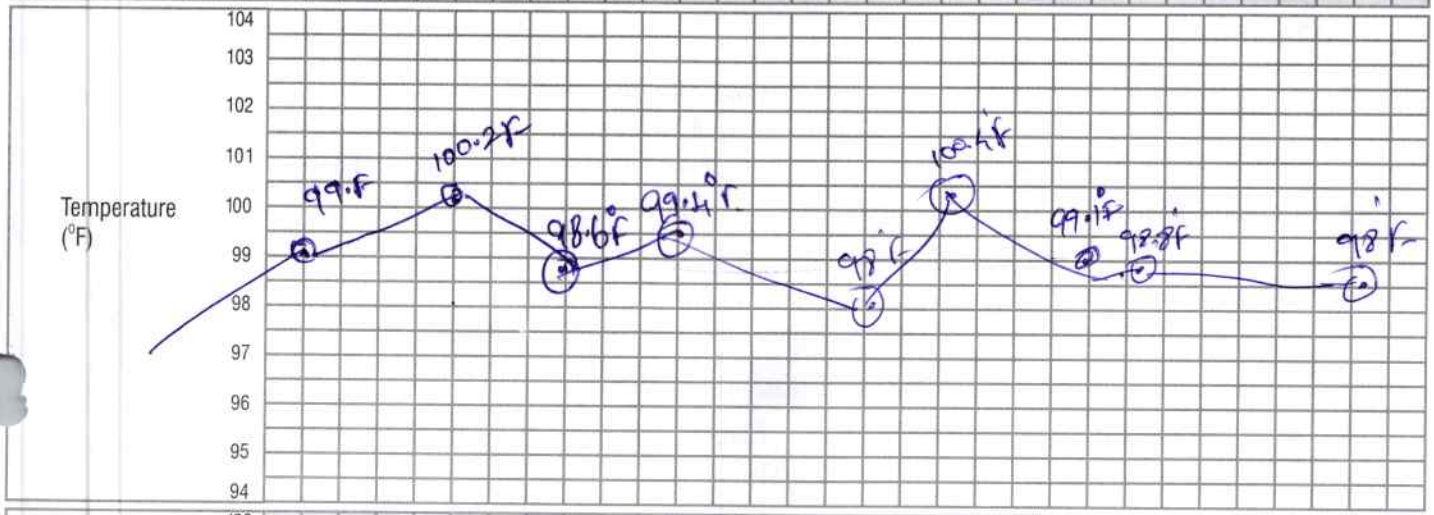
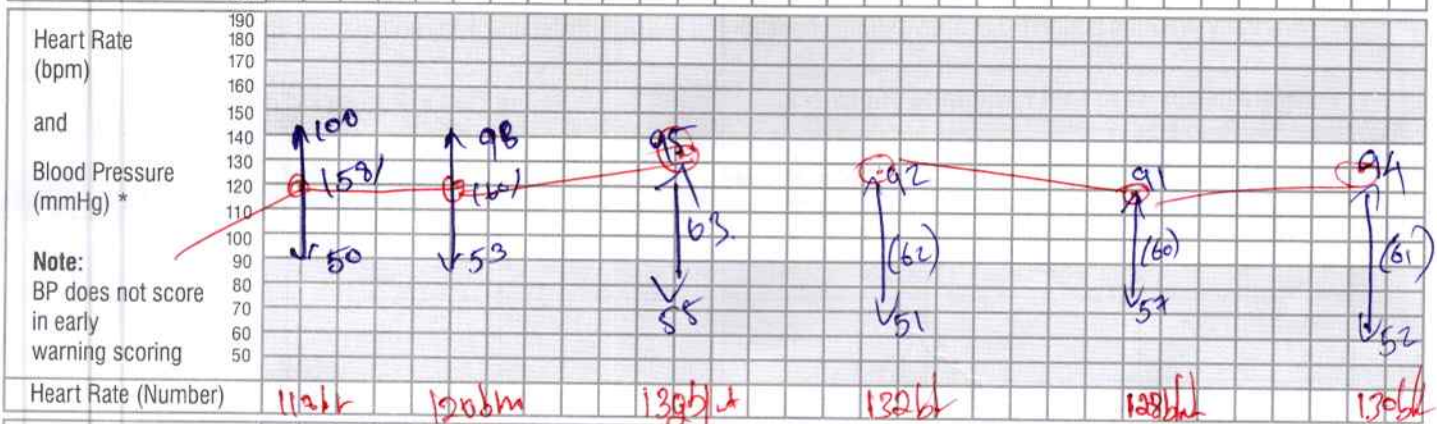
EARLY WARNING SCORE: CHILDREN'S UNIT

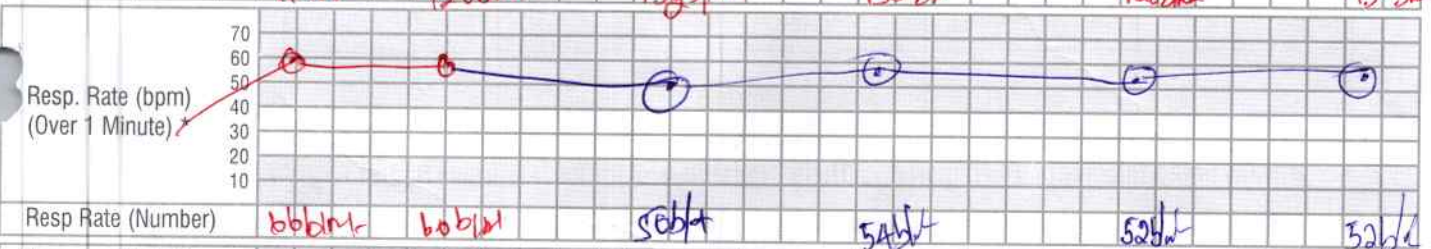
Date : 27/1/26 Time: 8am 12pm 4pm 8pm 8:30pm 11pm 12Am 4Am

Doctor / Nurse / Family Concern?





Heart Rate (Number): 112bpm | 120bpm | 139bpm | 132bpm | 128bpm | 130bpm



Resp Rate (Number): 66bpm | 60bpm | 50bpm | 54bpm | 52bpm | 52bpm

Resp Distress	Mod/ Severe / None / Mild	✓	✓	✓	✓	✓	✓
Receiving O_2 (l/min)		02-2l/l	RA	RA			
O_2 Saturations (%)		98%	100%	95%	98%	99%	98%
Conscious Level	Normal / Altered	✓	✓	✓	✓	✓	✓
GCS *		15/15	15/15	15/15	15/15	15/15	15/15
TOTAL SCORE Number of shaded boxes		0	0	0	0	0	0
Pain Score		0	0	0	0	0	0
Observer's Initials		JH	JH	PM			

ACTIONS

NB: Scores 3 should be recorded overleaf

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Patient Sticker

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- 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

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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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Baby KRISHVANTH H
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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
22/2/26	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						**Total Output :**						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						**Total Output :**						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am			On	Admission from ER to						405	
	01:00 am			~~30~~ 32							0	
Total Intake :				32		**Total Output :**	Nil					
	02:00 am			32						✓	0	
	03:00 am			32							0	
	04:00 am	water	20	32							0	
	05:00 am			32						✓	0	
	06:00 am			DC							0	
	07:00 am			32						✓	0	
Total Intake :				20 + 160ml		**Total Output :**						

Total 24 hrs. Intake	812 ml	Total 24 hrs. Output	3 times urine Passed

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

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FLUID CHART

Sheet No. : 2

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

Date	Time	Intake: Nature of Fluid	Intake: Route – Mouth	Intake: Route – I.V	Intake: Route – N.G	Output: NG	Output: Diarrhoea	Output: Vomit	Output: Drainage	Output: Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
22/2/25												
	08:00 am			32ml						✓	0	Jay
	09:00 am	water	30ml	32ml							0	Jay
	10:00 am			32ml							0	MB
	11:00 am	soup	50ml	32ml							0	MB
	12:00 pm			DC						✓	0	MB
	01:00 pm	milk	20ml	DC							0	MB
Total Intake :		100ml + 128ml								Total Output :		2 times urine passed
	02:00 pm	khola	30ml	32ml							0	MB
	03:00 pm			32ml						✓	0	MB
	04:00 pm	khola	20ml	32ml							0	MB
	05:00 pm			DC						✓	0	MB
	06:00 pm	kaya	20ml	DC							0	MB
	07:00 pm			32ml						✓	0	MB
Total Intake :		70ml + 128ml								Total Output :		3 times urine.
	08:00 pm			32ml							0	Ji
	09:00 pm	water	20ml	32ml							0	Ji
	10:00 pm			32ml						✓	0	Ji
	11:00 pm	DBF		32ml							0	Ji
	12:00 am			32ml							0	Ji
	01:00 am	water	30ml	32ml							0	Ji
Total Intake :		50ml + DBF + 192								Total Output :		1 time urine Passed
	02:00 am	water	30ml	32ml							0	Ji
	03:00 am	DBF		32ml						✓	0	Ji
	04:00 am			32ml							0	Ji
	05:00 am	water	20ml	32ml							0	Ji
	06:00 am			DC						✓	0	Ji
	07:00 am	water	20ml	DC							0	Ji
Total Intake :		70ml + 1 time DBF + 128								Total Output :		2 times urine Passed

Total 24 hrs. Intake	866ml + 2 times DBF	Total 24 hrs. Output	8 times urine Passed

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NURSING CARE RECORD

Rainbow® Children's Hospital
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Date: .....

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon							
Night	1am	maintain Airway & oxygenation		Asses child condition monitors vitals Administers medication as per orders	breathing pattern improving	Reassessment done	

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NURSING CARE RECORD

Rainbow® Children's Hospital — It takes a lot to treat the little.
BirthRight BY RAINBOW HOSPITALS — Your Right to a Safe Delivery

Date: 27/7/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8am	TO promote Health Hygiene		→ Assessed child condition. → Monitored Vital Signs. → monitored I/O chart.	TO improve child condition	Improving child condition	NS [illegible]
Afternoon	2pm	TO maintain. Airway and oxygenation.	3pm	TO assess the general condition. TO monitor. vital signs. TO. maintain I/O chart.	maintained Airway and oxygenation.	Reassessment was done.	[illegible] (01980)
Night	8pm	maintain good nutritional status		Assess child condition monitor vitals Administer medication as per orders	Encouraged to take more oral intake	Reassessment done	[illegible] 01980

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NURSES NOTES

☐ No Known Drug Allergies
☐ Drug Allergies ..... nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		on Admission (31/1/26)	
	12.40am	The child details handover taken from the ER staffs	
		The child is conscious and active	
	1am	vitals are checked and recorded	
		temp is normal	
		RR - 70 s/m.	
		Administer the medication as per doctor orders	
	2am	Npo chart is maintained	
		No any other complaints	
	4am	vitals are checked and recorded	
		temp is normal	
	6am	Administer the medications as per doctor's orders	
		Iv fluid 0.9% NS @ 30ml/hr on Hold	
	7.30am	The child details handover given to morning duty staffs.	
		Morning Duty Notes :-	
	7.30 am	Child details	
		handing over taken from night duty s/n. child conscious & oriented. child activity are good. Iv line @	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Patient Sticker

NURSES NOTES

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☐ No Known Drug Allergies

☐ Drug Allergies .... N.T.

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
27/7/26	〃	O2 - 2lit ongoing RR - 66b/mt.	
		IVF - 32ml/hr.	
	8.00 am	vital signs checked & recorded	
		vitals are stable now	
		CP / PP / CRT	
		++ / ++ / 2sec	
		Due medication are given	
		as per drug chart order	Jency 02004
	10AM	Neb 3% NaCl given as	
		per doctor's order.	
	12PM	Dr. Padma priya seen	
		child Advised to stop	
		O_2.	
		Vital signs checked &	
		recorded.	[illegible]
		PP / CP / CRT	
		++ / ++ / 2sec	
		Good input maintained	
	1.30 pm	Child handing over given	
		to evening duty staff	[illegible]
		← 27/7/2026 ON. Evening Duty →	
	1.30pm	The child details handing over	
		taken from morning Duty to	
		Evening Duty. The child is	
		conscious and oriented. Pulse	[illegible]
		present. no pain no swelling IV line pattern.	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

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

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BRADEN 'Q' SCALE
(for Paediatric use)

F/HW/BRD-Q/NSG/04

Patient Name : ....
Age.......................... Gen

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				Date :	27/7 N	27/7	E 27/7.	M 27/7
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 walking hours.	4	4	4	4
Sensory Perception	**1. Completely limited:** Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	**2. Very limited:** responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	**3. Slightly limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	**4. No impairment:** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	4
Moisture Degree to which skin is exposed to moisture	**1. Constantly moist:** Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	**2. Very moist:** Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	**3. Occasionally moist:** Skin is occasionally moist, requiring linen change every 12 hours.	**4. Rarely moist:** Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4.	4
FRICTION-SHEAR **Friction** Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another	**1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	**2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	**3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	**4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life 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	4	4	4.
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4
				TOTAL SCORE	27	28	28.	28
				Evaluator's Name	[signature]	[signature]	[signature]	[signature]

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

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INT IENT / FAMILY EDUCATION RECORD

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

Identified Education Needs:

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

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
22/1/26	1 am	fall risk education	Explained about call bell. side rails	Mother	No	Oral	Respect values	verbalizes understanding	-	

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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Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 12.40am Mode of Arrival: parents holding Admitting From: ☑ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction .....

Body Weight: 8.2 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: 8.7 Length: - Head Circumference (< 2 years): .....

Temp.: 98°F HR: 124/m RR: 32/m BP: 98/53(60)

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

Fall Risk Assessment: ☐ Yes ☑ No Score: 14 (Document in the Humpty Dumpty Sheet)

Risk of Pressure Sore (Braden Q Score 23) (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. Arithelakshmi...... Date: ......27/7/26...... Time: ......1am......   Signature [signature]

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PATI[...]M

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
	26/7/26 @ 11.20AM	27/7/26 @ 12.35AM
Treating Consultant Name	**Transfer Ordered by**	**Reason for Transfer**
Dr Padmapriya	Dr Chandiralega	treatment
From Unit	**To Unit**	**Information to Attendant**
ER	405	Yes ☑ No ☐
Number of Sheets in Clinical File	**Number of Imaging Films**	**Personal belongings including clinical documents. If any handed over to attendant**
①	① CXR OP basis	Yes ☐ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	DNS 500ml	①
2.	Intraflow	①
3.		
4.		
5.		

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

Acute Bronchiolitis

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
[signature] 78894 Iman.	Dr Chandiralega [signature] 19124

Patient & Clinical Records Received by : [signature]

Date & Time of Patient Received : 27/7/26 @ 12.40am.

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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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 26/7/26 Time of arrival : 7PM

Chief Complaints: C/O - fever x 2days / fast breathing RBS: 106.

Height : — Weight : 8.7kg 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 : 15min

(P.T.O.)

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

Time	Nursing Notes
11.30 pm	- Pt come to ER c complaints of fever > 2days & fast breathing (+)
	-All vitals checked & recorded.
	- ER Dr. assessed the Child & Admitted ↓ Padmapriya.
	- IV line done & B/d Sample collected.
	- Neb given. & Pt shifted to ward for further mgt.

Samples collected by: Iman Time: 12. AM

Samples sent by : Time:

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1
7.15pm	Neb. Levolin.	P/N	0.63 mg		
9.20 pm	Syp. Omnacortil.	P/o	5.5ml.		
10.15pm	Neb. Duolin LD	P/N	2ml.		

Condition of patient at time of shift - out :

HR: 151 BP: - CFT: <3Sec

RR: 70 SPO_2 : 98

GCS: 15/15 Temperature : 98.2°F

Pain Score: 0/10

Repeat RBS (if applicable): .....

Details of Shift - out

Shift - out from ER to: 405

Time of Shift - out: 12.35 AM

Handover given to: S. Nisha (Nurse's Name)

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

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

Name of the Nurse : Iman Signature of the Nurse : 17894

Date & Time : 26/7 @ 11.30PM

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PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : Dr. Chandiralaga Date : .....

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

Start Time of Assessment: ..... Weight: 8.7 kg

Allergic History: .....

Chief Complaints: .....

Acute bronchiolitis

Pediatric Assessment Triangle

A Appearance - TICLS .....

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

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

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

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

Significant Past History: H/o Previous Admission for Bronchiolitis

Medication History: .....

Relevant Investigations: —

Primary Assessment

Airway
- ☑ Open
- ☐ Maintainable
- ☐ Not Maintainable

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

Breathing
Rate: 40/min SpO2 on FiO2 99:1: RA
Rhythm: .....
Retractions: ☐ Suprasternal ☐ ICR ☑ SCR ☐ Sternal ☐ Supraclavicular ☐ Nasal Flaring
Respiratory Noises: ☐ Stridor ☐ Wheezing ☐ Grunting
Air Entry: B/L AE (+)
Palpation Findings (If necessary).....

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

Circulation HR: 165/min CFT [Central ..... / Peripheral .....]

Any urgent interventions needed: ☐ Yes ☐ No

If Yes .....

BP: ..... mmHg

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

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

Muffled Heart Sound: ☐ Yes ☐ No

Engorged Neck Veins: ☐ Yes ☐ No

Murmurs: ☐ Yes ☐ No

Liver Span: .....

ECG: .....

Any Signs of Heart Failure: ☐ Yes ☐ No

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

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 100.3F

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 per chart.....

.....

.....

.....

.....

Treatment Planned: .....

.....

.....as per chart.....

.....

.....

.....

.....

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

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

Assessment done by

Name of the Doctor: Dr Chandiralega

Signature: .....

Date & Time: 27/7/26, 19hrs

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	12.05 Am	106	–	[signature] 17894

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wt - 8.7kg

EMERGENCY ROOM TRIAGE FORM

Patient's Name : Baby. Krishvanth Age : 1 yrs Gender: ☑ Male ☐ Female

Date : 26/7/26 Time of Arrival : @ 7pm

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: 100.3 F PR: 165 BP: — RR: 90 SpO_2: 99%

Chief Complaints: c/o fever x 2days, ↓ intake, H/o. Fast breathy since morning

INITIAL PHYSIOLOGICAL CATEGORIZATION

Appearance
☑ Normal
☐ Sick Looking

Circulation / Colour
☑ Normal ☐ Abnormal ☐ Bleeding

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

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

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

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

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian

Triage Completion Time : 2 min

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 : Sr. Rishi

Signature of Triage Nurse : Rishi

Date & Time : 26/07/26 @ 7.05pm

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

26/07/26 7pm - P250 - (2.5ml)

7.15pm

7. Neb. Levolin 0.63 mg + 2ml NS given @ 7.45pm

@ 9.20pm. Syp. Omnacortil 5.5ml. (P/O). given - CW

@ 10.15pm. Neb. Duolin LD - (P/N) - given

CBC
CRP
Biofire
Blood c/s

IV Hydn

$\frac{1}{2}$ Fluids

Para

Neb

3.1. Saline