

404

PATIENT DISCHARGE INTIMATION FROM NURSING STATION

CLEARANCE FOR DRUGS AND DISPOSABLES BILLING

SNC-00021894 IP18-00036382
Baby SAAVI SUJATA VAIBHAV SARJE
17-01-2025 1 Y 5 M 27 D (F)
Dr. GEETHA JAYAPATHY

Date:

Name of the P



UHID No:

Gender:

Ward:

Room No:

Certified that in respect of the above patient:

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

Patient Authorised Sign

Nurse Sign

Pharmacy Sign

Date:

Date: 15/7/26

Date: 15/7/26

Time:

Time: 15/7/26

Time:

1. 11. 1950

2. 12. 1950

3. 13. 1950

4. 14. 1950

5. 15. 1950

6. 16. 1950

7. 17. 1950

8. 18. 1950

9. 19. 1950

10. 20. 1950

11. 21. 1950

12. 22. 1950

13. 23. 1950

14. 24. 1950

15. 25. 1950

16. 26. 1950

SNC-00021894 IP18-00036382
Baby SAAVI SUJATA VAIBHAV SARJE
17-01-2025 1 Y 5 M 27 D (F)
Dr. GEETHA JAYAPATHY



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		18/2/26					
Activity Sheet update by Pharmacy							

ACTIVITY RECORD FOR BILLING

Name:

UHID No: IP# SNC-00021894 IP18-00036382
Baby SAAVI SUJATA VAIBHAV SARJE Dept:

Date of Admission: 17-01-2025 1 Y 5 M 21 D (F)
Dr. GEETHA JAYAPATHY Discharge: Time:

Room / Bed No: W. Billable bed type:

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
08/1/26	6:00 pm	GR	404	

CROSS CONSULTATION VISIT

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

INVESTIGATIONS

Date	Investigations	Order No.	Signature
03/7/26	CBC, CRP, Blood cl.		
	SuO ₂ , S _{CRP} , RP-2,		
	Dengue NS,	26021926	
08/7/26	wine R/E, cl		
8/7/26	Typhoid tgm	21930	Ding's
8/7/26	Paracetamol Levels	21941	Don
8/7/26	RBS	1950	Don
	LFT, VB ₆ , PT, INR	2023.	
	Electrolytes, Ammonia		
9/7/26	RBS	2069	Don
10/7/26	CBC, CRP, OT, PT	2192	Don
13/7/26	CBC, OT, PT, procal	22501	Don

ENDOBONE

[illegible]

PROCEDURE

[illegible]

ANY OTHER INFORMATION:

Date: 15/4/20

Time: 9:10

Prepared By:

Staff Nurse

Shift / Ward

Billing Assistant

Billing Supervisor

rain
arbo

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					
Preparation of Discharge Summary					
Finalization of discharge summary					
Transfer of file from Ward to Billing Dept					
Bill Processing					
Audit Clearance					
Billing Clearance					
Physical Clearance					



Patient Name	Baby SAAVI SUJATA VAIBHAV SARJE	Patient Ph.No	9423101816
Age	1 Y 5 M 22 D	Requisition No	R2618-009221
Gender	Female	Collected on	09-07-2026 12:08 PM
IP / Bill No.	IP18-00036382	Received On	09-07-2026 12:40 PM
UHID No.	SNC-00021894	Reported On	09-07-2026 12:40 PM
Ref. Doctor	GEETHA JAYAPATHY	Ward / Bed No	

ULTRASOUND ABDOMEN

LIVER : Normal in size and echotexture. No intra hepatic biliary duct dilatation. Portal vein is normal. No focal lesions.

GALL BLADDER : Distended well and appears normal. No evidence of calculi or wall thickening. Common bile duct appears normal.

SPLEEN : Normal in size and echotexture.

PANCREAS : Normal in size and echotexture. MPD not dilated. No calcification noted.

KIDNEYS : Right kidney :61 x 24 mm. Normal in size and echotexture and shows smooth contour. No hydronephrosis or calculi.

Left kidney : 60 x 28 mm. Normal in size and echotexture and shows smooth contour. No hydronephrosis or calculi.

URINARY BLADDER : Distended well and appears normal.

Minimal ascites.

Multiple enlarged mesenteric lymph nodes noted with preserved hilum, largest measuring around 17 x 12 mm.

No e/o bowel wall thickening / edema.

Print Date/Time : 09-07-2026 12:40 PM

Printed By : ARUN

Page: 1 of 2

Note: Clinically correlate , Kindly discuss if necessary

Rainbow Children's Medicare Limited

CHENNAI : No. 157 to 160, Anna Salai, Near Little Mount Metro Station, Guindy, Tamil Nadu - 600015

SHOLINGANALLUR : No. 493/42A2B, OMR ECR Link Road, Chennai, Tamilnadu - 600119

For Appointments call: 1800 2122

CIN : L85110TG1998PLC029914

info@rainbowhospitals.in

www.rainbowhospitals.in



Patient Name	Baby SAAVI SUJATA VAIBHAV SARJE	Patient Ph.No	9423101816
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UHID No.	SNC-00021894	Reported On	09-07-2026 12:40 PM
Ref. Doctor	GEETHA JAYAPATHY	Ward / Bed No	

Impression

Ultrasound features suggestive of
Multiple enlarged mesenteric lymph nodes.
Minimal ascites.
Suggested clinical correlation.

Dr. PRASANNA KUMARAVEL
MBBS, MDRD
Reg No: 92729

Print Date/Time : 09-07-2026 12:40 PM

Printed By : ARUN

Page: 2 of 2

Note: Clinically correlate , Kindly discuss if necessary

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info@rainbowhospitals.inwww.rainbowhospitals.in



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BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

[illegible]

1982-1983

1982-1983

1982-1983

1982-1983

1982-1983

1982-1983

1982-1983

ADMISSION SHEET

Registration Details :



Admission No : IP18-00036382

Admit Date : 08-Jul-2026

Admit Time : 05:00 PM UHID : SNC-00021894

Patient Details :

Patient Name : Baby SAAVI SUJATA VAIBHAV SARJE

Age : 1 Y 5 M 21 D

Guardian : VAIBHAV DEEPAK SANJE

DOB : 17-01-2025 01:46 AM

Gender : Female

Religion :

Occupation :

Martial Status :

Address (H) : 17TH ST, VENKATESH NAGAR, KOTTIVAKKAM
Palavakkam Kanchipuram Kanchipuram
Tamil Nadu INDIA 600041

Phone No : 9423101816/

E-mail : NO@GMAIL.COM

Admission Details :

Bed Type : DAY CARE

Bed No : ER 101

Ward Name : 0F-EMERGENCY

Room No : ER 101

Admission Type : First Visit

Contact Details :

Name : VAIBHAV DEEPAK SANJE

Relationship : Father

Contact Address : 17TH ST, VENKATESH NAGAR,
KOTTIVAKKAM Palavakkam Kanchipuram
Kanchipuram Tamil Nadu INDIA 600041

Phone No :

Signature

Doctor Details :

Doctor Name : Dr. GEETHA JAYAPATHY

Specialisation : GENERAL PEDIATRICS

Referral Doctor : Dr. Geetha Jayapathy

Phone No :

Co-Consultant :

Payment Details :

Payment Mode : Cash

Deposit Amount : 0.00

Payor Name : SELFPAY

GENERAL CONSENT FOR TREATMENT

Patient Name: **Baby SAAVI SUJATA VAIBHAV SARJE**

Age : **1 Y 5 M 21 D**

IP No: **IP18-00036382**

Sex: **Female**

Consultant: **Dr. GEETHA JAYAPATHY**

Ward/Bed No: **0F-EMERGENCY/ER 101**

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

Patient, be deemed advisable or necessary.

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

Relationship: **father**

Date: **8/07/2016**

Time: **5-00**

Witness Name: **Jeerith**

Witness Signature: **[Signature]**

Patient Address:

17TH ST, VENKATESH NAGAR,
KOTTIVAKKAM Palavakkam
Kanchipuram Kanchipuram Tamil
Nadu INDIA 600041

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 be applicable.
- ▶ 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 be 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 and 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 : <u>Swami Sushila Vaidhyanagar</u>	UHID Number : <u>Que 00021894</u>
Self/Attendant Name : <u>VRibhavan Beegum Sagar</u>	Relation : <u>Father</u>
Self/Attendant Signature : <u>[Signature]</u>	Name & Signature of Financial Counselor : <u>[Signature]</u>
Phone Number : _____	

Government of India

नोंदविण्याचा क्रमांक / Enrollment No 2017/90056/02461

To,

वैभव दिपक सारजे

Vaibhav Deepak Sarje

S/O: Deepak Sarje

09, vasant vihar

dindori road

b/n old petrol pump meri mhasrul

Nashik

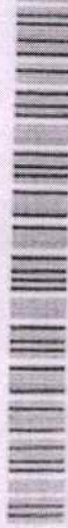
Meri Colony Nashik Nashik

Maharashtra 422004

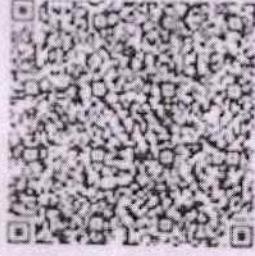
9423101816

16/02/2013

Ref: 544 / 05D / 400388 / 400559 / P



SH345643459DF



आपला आधार क्रमांक / Your Aadhaar No. :

6049 7082 5585

आधार — सामान्य माणसाचा अधिकार



भारत सरकार

GOVERNMENT OF INDIA

वैभव दिपक सारजे

Vaibhav Deepak Sarje



Rainbow[®] Children's Hospital

It takes a lot to treat the little.

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: _____

UHID ID: _____

Department: _____

Consultant: _____

SNC-00021894 IP18-00036382
Baby SAAVI SUJATA VAIBHAV SARJE
17-01-2025 1 Y 5 M 21 D (F)
Dr. GEETHA JAYAPATHY



Pediatric Multiorgan History & Physical Examination

Name: _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

C/o → fever x 3-4 days.
Reduced intake x 1 d

History of present illness :

H/o fever - high grade x 4 days
High grade
No chills/rigors
Relieved by antipyretics

H/o - poor oral intake x 1 d

No cough/cold / abdominal pain / vomiting / loose stool

No prior h/o UTI

- Recent travel to Maharashtra

- up - reduced

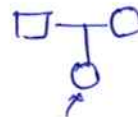
Past History : (Including details of any previous investigation or treatment)

No

Birth & Neonatal History:

1st Child / term / C/AB

B.W - 2.9 kg / No complications

Family Chart**Birth & Socio Economic History:**

About Father :

About Mother :

Any additional information :

Developmental History :

Runs, speak 1-2 words with Mean

Immunization History :

upto Age

Anthropometry :

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

Weight (kgs) 8.1 kg (Centile _____)**On Examination :**Temperature : 103°F Pulse Rate : _____ B.P. _____ SPO2 97.4% RA

Resp. rate and type of breathing : _____

PR 112

Rash _____

Lymphadenopathy _____

Oedema : _____

Allergies (if any): _____

Respiratory System :

Inspection (any s/o distress) : _____

Air entry & breath sounds : _____ NVRS ⊕

Any addes sounds : _____

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

Cardiovascular System :

Inspection of procordium : _____

Heart Sounds : _____ S1 S2 ⊕

Any murmur : _____

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

Per Abdomen :

Inspection : _____

Palpation : _____ Soft, Non-tender

Ausculation : _____

Spine : _____ External Genitalia : _____

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

Central Nervous System :

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

Cranial Nerves : _____

Motor System :

Nutriton : _____

Tone: ⓐ Power 9

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR

Superficials:

Plantars

Sensory System :

Bladder / Bowel :

Clinical Summary & Diagnostic:

AFC → ? Enteric ? UTI

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

Desired goals of the treatment :

Planned Labs:

CBC /
CRP

blood c/s

SGOT, SGPT

RD-2

Dengue NS-1

urine c/s

urine c/s (catheterized
sample)

Planned Management

- IVF

- Antibiotics, after
reports

Signature of the Doctor:



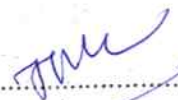
Name of the Doctor:

Dr. Manoma

Date & Time:

8/7/26, 5pm

Signature of the Consultant:



Name of the Consultant:

Dr. Gupta
1881

Date & Time:

8/7/26 @ 7pm

(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



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



BirthRight™
BY RAINBOW HOSPITALS
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Date:

Department:

Shift:

[illegible]



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/1/24 7:15pm	FTB Asymptotic Fever/ evaluation - 1 Enteric infection 22 Influenza female some dehydration ⊕ chest clear Abd. Soft	2 paracetamol succedore. 15ml/kg Q4H. 1 90ml/kg/day x3 days. ✓ Cont dehydration correction.
	CBC (N) - CRP 35 OT/PT - 233/189 HbO₂ - 16 Min RIE (N)	Dyspnea NS, Salmonella IgM neg. To do paracetamol level.
	✓ w/H paracetamol ✓ Syp. Ibuprofen 2.5ml Q4H ✓ Tepid sponge ✓ Dx @ 11 pm ✓ IVF 0.9 GNS 25ml/hr. ✓ JI. Pam 10mg IV OD.	

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

URGENT NOTES AND DOCTOR'S ORDER		
Date & Time	Progress Notes	Doctor's Order
17/10 5.30pm	S/B Dr Chandrasekhar	
	A - Acute febrile illness / Accidental paracetamol overdose.	
	childhood friend D/W Dr. Gnanapavan	
	Paracetamol levels - 17.	
	SGOT - 233	
	SGPT - 189	
	<u>Adv:</u>	
	- To start NAC infusion as per orders	
	- To discontinue IV fluids	
	- USS Abdomen in morning	
	- Pex. ceftriaxone @ 100mg/kg/day	
	- monitor vitals	
	- W/F Bleeding, Retching, Abd pain, Fever.	
	- Inform (SES)	
	<u>SNL</u> 19/10/24	

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

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/1/26 9:30AM	S/B - Dr. Yumary Δ - Acute yellow illness transaminitis Paracetamol overdose Child reviewed Fever spikes persist - Day 5 o/e alert, active sensuum (N) vitals stable No icterus PA - Soft, nontended, no organomegaly RS clear CVS / MAP CNS /	
	Plan - Continue NAC infusion - Trace blood & urine q/s D ₂ Xone 400mg Q12H Ecorux drops 1ml BD IV Pan 10mg OD Syp Ibuprofen 2.5ml Q8H - (505) Sent LFT @ 11AM today	IVF - 15cc/hr NAC infusion blood & urine q/s 400mg Q12H 1ml BD 10mg OD 2.5ml Q8H - (505)
		Ty/

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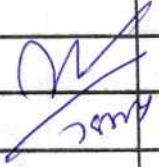
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 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/1/24 10.30 am	8/13 Agitate	
	fever day 5, high grade $\bar{c}$ chills. No focus has occasional nausea. tolerates only breast milk. urine good.	
	female. RR - 36/min chest - clear Abd - soft perineum cold because of fever. PP-WF.	(N) WOB
	paracetamol level 17mg/dl. $\rightarrow$ 9/0 multiple overdose over 3 days.	
	on NAC & ceftriaxone awaiting cultures.	
	To do LFT, VBG PT, INR, NH ₃ electrolytes USG abd.	to give one dose of Syg keftal P 2.5ml stat.
		Cont IVF / NAC.
	<i>Healer</i> 7.55 PM	

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/7/26 3:30 PM	S/B <u>Bongelie</u>	
	fever spike out	
	intake poor	
	irritable only on examination	
	Rpt - Inv OT/PT - ↓ PT/INR - (N) HCO ₃ - 18// NH ₃ 9. lac 1.49.	
	USG abd - Mild ascites	
	plan / complete NAC infusion. ↓	
	✓ IVF 0.9 GNS 25ml/hr. (1cc KCl / 100ml fluid)	
	✓ Symp. Antiflu 2.5ml - o - 2.5ml if next fever spikes.	
	Monitor urine output	
		



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BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Date & Time	Progress Notes	Doctor's Order
9/1/26 4 PM	SIB - Dr Yungraj Child increased sleeping, afebrile not stable, fever spike @ 1008 @ S/E - WNL.	
	Plan : - Complete NAC infection → start on GUS maintenance - Add oxetamini if fever persist - Encourage oral intake	T.21
	BI Cys - GNB wait for oseltamivir	

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
12/7/26 9 AM	S/B - Dr Yung	
	A - Enteric fever	
	Chief reviewed	
	- D6 of illness	
	fever spike @	
	3-4 episode loose stools in last 24 hrs	
	intake - good	
	O/E	
	Alert, active, irritable	
	PP-wf, CRT < 3 sec.	
	Hydration - good	
	U/O - good	
	PA - Soft, non-tender	Bowel 4s - ANB ⊕
	RS - Clear	
	CNS - NAD	
	CNS -	
	Plan	
	- Continue	IVF - DWS - @ 25cc/hr 2KCl
	(D3) Xone 400mg BD	
	1x Pan 10mg OD	
	Ecorva drops BD 1ml.	
	- Followup blood & urine 4s	
		T.Y.

SNC-00021894 IP18-00036382
 Baby SAAVI SUJATA VAIBHAV SARJE
 17-01-2025 1 Y 5 M 22 D (F)
 Dr. GEETHA JAYAPATHY



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 It takes a lot to treat the little.

BirthRight™
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 Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/7/25 12 noon	SIB <u>Dr. Gellu</u> Ceftriaxone + Entenex fam fewer spikes (✓) activity intake better Clinically stable	
		Cont Xone Pam Seoviva IVF 15ml/hr
10/7/26 4 PM	<u>Dr. Yamaraj</u> Child reviewed fewer spikes (✓) vital - stable intake - poor S/E - WNL	Hydration goal Plan - Continue, monitor, Xone, X IVF



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Date & Time	Progress Notes	Doctor's Order
10/1/26 7 pm	SIR Dr. Marengo	
	Asent Intake - reduced 4/6 - chat Hydrach fan fora spish @ ppst. pampin van P/A - off, Non tenan	
	R → nonhuman 176 - nr fora spish - cont IV Acv	
Q 1586 ~		



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Date & Time	Progress Notes	Doctor's Order
11/7/26 10 AM	S/B Dr. Yung A - Enteric fever Child reviewed alert, active, afebrile fever spacing out apls - 8h intake - good Loose stools ↓ RS - Clear RA - Soft, non tender CVS NAD CNS	
	Plan - Encourage oral intake - Taper IV if intake is good - Continue IV Ceftriaxone	
		T.Y.

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/07/26 10:15AM	S/B Dr. S. Mahalakshmi	
	S: Culture +ve enteric fever	
	C/o fever spikes (+) (Spacing out)	
	Last spike @ 1AM - 103.7 F.	
	Predominantly on DBF. avoid solid	
	prefers to sleep always more.	
	On IFA maintenance 15ml/hr.	
	On INTJ. CEFTRIAXONE - Day 4	
	Ecoriva drops.	
	passed stools twice yesterday (N)	
	S/E: Asleep, Euthermic	
	WOB (N)	
	Hydration - fair	
	Vitals - stable.	
	S/E: PA - soft, no distension, B&B	
	other systems - NAD	
	Advice:	
	To continue IVF & INTJ-XONE.	
		



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/1/25 12 noon	8/12 Argath Cullen + entire fem fem spain out Intake poor. Hydration (N) Abd - soft	
	OT/PT bath	Stop IV & Reassess
	12/1/25	
12/1/25 8:30 am	8/12 Argath Cullen + entire fem fem 3 spikes Appetite fair	
	12/1/25	✓ Cont Xone pan

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
12/1/26 9:30AM	S/B - Dr. Yuvaraj A - Typhoid fever	
	Child reviewed Fever spacing out O/E Splenomegaly ~ 8 cm intake - improving loose stools - yellowish alert, active	
	RS - Clear PA - Soft, non tender CVS NAB CNS	
	Plan : (DS) Xone 400mg BD IV Plan 10mg OD Ecorva drops 1ml BD	
	To do - CBC, Procalcitonin, SAOT, SEPT	
11:30am	fever on day 5 IV Xone activity / appetite better	T.Y.
	1 SIRS - to change to its generic after reports	

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
13/7/26 4 PM	S/B - Dr Yuvaraj	
	Child reviewed	
	fever spike @ 11 AM	
	intake - good	
	vitals stable	
	RS - Clear	CNS / NAD
	RA - Soft, non tender	CMS
- PCT - 3.07 ↑	<u>Plan</u> Continue	IV Kone &
- OT - 93		Ecarnadrop
- RT - 91		
- IL - 10870		
		T. 42.1
14/7/26 10 AM	S/B - Dr Yuvaraj	
	A - Typhoid fever	
	Child reviewed	
	Dg of illness	
	High grade fever spikes @ every 8-9 hrs hourly once	
	intake - good	
	O/E alert, active	
	vitals - stable	

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	RS - BL AE equal. No added sounds	
	PA - Soft, non-tender	
	CNS / NAR	
	CNS	
	<u>Plan:</u>	
	- Continue IV ceftriaxone 400 mg Q12H	
	Econv drops 1ml BD	
	IV Pan 10 mg OD	
14/7/26	8/8 Dr. Geetha	
10 300	Culture 7me enteric form	
	form (D) 3 spruces	
	intake	
	activity (2)	
	Alert	
	Clinically well	
		IV ceftriaxone
		if IV line extravasates
		or @ discharge
		Syp. Taxim O forte
		4ml - o - 4ml x 7 days
		typhoid vaccine after 1 month
	plan	
	(D) tomorrow	
	if feeding playing well.	

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
14/1/22 4pm	S/B - D. Yumang Child reviewed Sleeping comfortably vitals stable Afebrile since 5 AM feeding oral intake - improving	
	S/E - WMC	<u>Plan</u> Continue IV Koro We new IV line plan d/s tomorrow
		TJ

SNC-00021894 IP18-00036382
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RESULT SHEET

Date	8/1/26	9/1/26	10/7/26	13/7		
Time						
Hb	10.6		8.9	9.8		
PCV	32		26	29		
RBC			3.97	4.37		
WBC	13530		7.21	10870		
N/L	240 L 55 H 2		26/70	37/60/3		
Platelets	2.18 L		1.77	3.12		
CRP	35		40 ↑			
ESR						
PCT				3.07 ↑		
RBS		99.				
Na	134	131				
K	4.2	3.3				
Cl	100/16	103				
Ca/Mg	1.21					
Phosphate						
Urea	18					
Creatinine	0.33					
ALP						
SGPT	189 ↑	155	100 ↓	91		
SGOT	233 ↑	125	86 ↓	98		
T.Bill/Conj		0.4				
T.Protein		6.3				
S.Albumin		3.5				
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR		14.7 / 1.05				
APTT		35.9				
CSF Protein / Sugar						
Cells						
N/L						

Handwritten signature/initials

Date	8/7/20					
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones	+					
CUE - PUS Cells	2-4 cells					
CUE - RBC Cells						
CUE Blood	+					
Stool Pus Cell						
OVA / Cyst						
Occult Blood						
Dengue NI-1	Negative					
Typhoid IgM	Negative					
Sr. Paracetamol	17 (10-20)					
level						

Culture and Sensitivities : ~~Blood~~ ^{9/17} ~~qs~~ - ~~AND~~ VBG - T.35

Urine qs - PG₂ - 33.1

NH₄ - 9.

HCO₃ - 18.1

AG - 18.2

Lact - 1.49.

Radiology : USG : mild ascites, multiple enlarged mesenteric lymph nodes

X-Ray :

ECHO :

CT :

MRI :

Others (ECG, Contrast Studies etc.) :

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 17-01-2025 1 Y 5 M 21 D (F)
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MEDICATION RECONCILIATION FORM

Drug Allergies: nil ☒ 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: ICU Shifted to: 404

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. Manoj

Date & Time: 8/7/20, 5pm

Nurse Name & Signature: Rishi

Date & Time: 08/7/20 @ 5:30pm



DRUG CHART

Date of Admission: 08/7/26 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: <u>SYP PARA 120</u>				Date/Time
Dose	Route	Frequency	Start Date	
<u>5ml</u>	<u>P/O</u>	<u>Q6H</u>	<u>8/7/26</u>	
Doctor's Signature: <u>[Signature]</u>		Valid Period	Pharm.	
Additional Instructions: <u>et temp > 100°</u>				

DRUG: <u>SYP IBUGESIC</u>				Date/Time
Dose	Route	Frequency	Start Date	
<u>2.5ml</u>	<u>PO</u>	<u>Q8H</u>	<u>8/7/26</u>	
Doctor's Signature: <u>[Signature]</u>		Valid Period	Pharm.	
Additional Instructions: <u>if T > 100° F</u>				

DRUG: <u>SYP PARA 120</u>				Date/Time
Dose	Route	Frequency	Start Date	
<u>5ml</u>	<u>PO</u>	<u>Q8H</u>	<u>10/7/26</u>	
Doctor's Signature: <u>[Signature]</u>		Valid Period	Pharm.	
Additional Instructions: <u>only if T > 100° F Once daily</u>				

VERIFIED BY: Name



REGULAR PRESCRIPTIONS

Weight. 8.1 kgs Ward. 404

DRUG : <u>ECOVIVA DROPS</u>				Date	Time
Dose	Route	Frequency	Start Date	8/7	9/7
<u>1ml</u>	<u>PO</u>	<u>BD</u>	<u>8/7/26</u>	<u>8 AM</u>	<u>9 AM</u>
Name & Signature of the Doctor				10/7	11/7
Starting the Drugs:				12/7	13/7
				14/7	15/7
Additional Instructions:				16/7	17/7
Daily Doctor's Endorsement by a Sign				18/7	19/7

DRUG : <u>INT. PAN</u>				Date	Time
Dose	Route	Frequency	Start Date	8/7	9/7
<u>10mg</u>	<u>IV</u>	<u>Q24H</u>	<u>8/7/26</u>	<u>8 AM</u>	<u>9 AM</u>
Name & Signature of the Doctor				10/7	11/7
Starting the Drugs:				12/7	13/7
				14/7	15/7
Additional Instructions:				16/7	17/7
Daily Doctor's Endorsement by a Sign				18/7	19/7

DRUG : <u>INS. CEFTRIAXONE</u>				Date	Time
Dose	Route	Frequency	Start Date	8/7	9/7
<u>400mg</u>	<u>IV</u>	<u>Q12H</u>	<u>8/7/26</u>	<u>8 AM</u>	<u>9 AM</u>
Name & Signature of the Doctor				10/7	11/7
Starting the Drugs:				12/7	13/7
				14/7	15/7
Additional Instructions:				16/7	17/7
Daily Doctor's Endorsement by a Sign				18/7	19/7

DRUG :				Date	Time
Dose	Route	Frequency	Start Date		
Name & Signature of the Doctor					
Starting the Drugs:					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					

Patient Sticker

Weight. 8.1 lbs Ward. 204

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

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

STAT / ONCE ONLY DRUGS[illegible]

Weight. 8.1 Kg Ward.

[illegible]

VERIFIED BY : Name



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8 kg

[illegible]

SNC-00021894 IP18-00036382
 Baby SAAVI SUJATA VAIBHAV SARJE
 17-01-2025 1 Y 5 M 26 D (F)
 Dr. GEETHA JAYAPATHY



Northrup

8/10-13/7 (all).

DRUG NAME FREQUENCY DOCTORS	MEDICATION CHART AUDIT CHECKLIST - IP						
	DRUG 1	DRUG 2	DRUG 3	DRUG 4	DRUG 5	DRUG 6	DRUG 7
2. INCORRECT DRUG SELECTION	Beclon	Z.V.	Zul.				
2. NO/WRONG DOSE	200mg	pari	CEFTAZO				
3. NO/ WRONG UNIT OF MESUREMENT	BD	OD	BD				
4. NO/ WRONG FREQUENCY							
5. NO/WRONG ROUTE							
6. NO/ WRONG CONCENTRATION							
7. NO/WRONG RATE OF ADMINISTRATION							
8. ILLEGIBLE PRESCRIPTION							
9. NON APPROVED/ERROR PRONE ABBREVIATION USED							
10. NON- USAGE OF CAPITAL LETTERS FOR DRUG NAMES							
11. NON-USAGE OF GENERIC NAMES	✓	✓	✓				
12. DRUG-DRUG INTERACTION	X	X	✓				
13. DRUG- FOOD INTERACTION							
14. WRONG FORMULATION TRANSCRIBED							
15. WRONG DRUG TRANSCRIBED/INDENTED							
16. WRONG STRENGTH TRANSCRIBED/INDENTED							
PHARMACIST							
17. WRONG DRUG							
18. WRONG FORMULATION							
19. WRONG STRENGTH DISPENSED							
20. EXPIRED/NEAR EXPIRY DRUG DISPENSED							
21. NO/ WRONG LABELLING							
22. DELAY IN DISPENSE(<30 MINTS)							
23. GENERIC OR CLASS SUBSTITUTED DONE WITHOUT CONSULTATION WITH THE CONSULTANT							
NURSES							
24. WRONG PATIENT							
25. IMPROPER DOSE							
26. DOSE OMISSION							
27. WRONG DRUG							
28. WRONG FORMULATION							
29. WRONG ROUTE							
30. WRONG DURATION							
31. WRONG TIME							
32. NO DOCUMENTATION							
33. DOCUMENTATION WITHOUT ADMINISTRATION							
DISCREPANCY	1. NON-COMPLAINE YES/NO (if yes mention : Doctor/Pharmacist/Nurses), 2. MEDICATION ERROR FORM/INCIDENT FORM RAISED (YES/NO), 3. CAPA DONE (YES/NO), 4. (ERROR PRONE ABBREVIATION USED IN THE MEDICATION CHART (TICK IF USED).						
INTERVENTIONS							
TOTAL NUMBER OF OPPORTUNITIES							

MEDICATION CHART AUDIT CHECKLIST - IP

	DRUG 1	DRUG 2	DRUG 3	DRUG 4	DRUG 5	DRUG 6	DRUG 7
DRUG NAME							
FREQUENCY							
DOCTORS							
1. INCORRECT DRUG SELECTION							
2. NO/WRONG DOSE							
3. NO/ WRONG UNIT OF MESUREMENT							
4. NO/ WRONG FREQUENCY							
5. NO/WRONG ROUTE							
6. NO/ WRONG CONCENTRATION							
7. NO/WRONG RATE OF ADMINISTRATION							
8. ILLEGIBLE PRESCRIPTION							
9. NON APPROVED/ERROR PRONE ABBREVIATION USED							
10. NON- USAGE OF CAPITAL LETTERS FOR DRUG NAMES							
11. NON-USAGE OF GENERIC NAMES							
12. DRUG-DRUG INTERACTION							
13. DRUG- FOOD INTERACTION							
14. WRONG FORMULATION TRANSCRIBED							
15. WRONG DRUG TRANSCRIBED/INDENTED							
16. WRONG STRENGTH TRANSCRIBED/INDENTED							
PHARMACIST							
17. WRONG DRUG							
18. WRONG FORMULATION							
19. WRONG STRENGTH DISPENSED							
20. EXPIRED/NEAR EXPIRY DRUG DISPENSED							
21. NO/ WRONG LABELLING							
22. DELAY IN DISPENSE(<30 MINTS)							
23. GENERIC OR CLASS SUBSTITUTED DONE WITHOUT CONSULTATION WITH THE CONSULTANT							
NURSES							
24. WRONG PATIENT							
25. IMPROPER DOSE							
26. DOSE OMISSION							
27. WRONG DRUG							
28. WRONG FORMULATION							
29. WRONG ROUTE							
30. WRONG DURATION							
31. WRONG TIME							
32. NO DOCUMENTATION							
33. DOCUMENTATION WITHOUT ADMINISTRATION							
DISCREPANCY	1. NON-COMPLAINE YES/NO (If yes mention : Doctor/Pharmacist/Nurses), 2. MEDICATION ERROR FORM/INCIDENT FORM RAISED (YES/NO), 3. CAPA DONE (YES/NO), 4. (ERROR PRONE ABBREVIATION USED IN THE MEDICATION CHART (TICK IF USED).						
INTERVENTIONS							
TOTAL NUMBER OF OPPORTUNITIES							

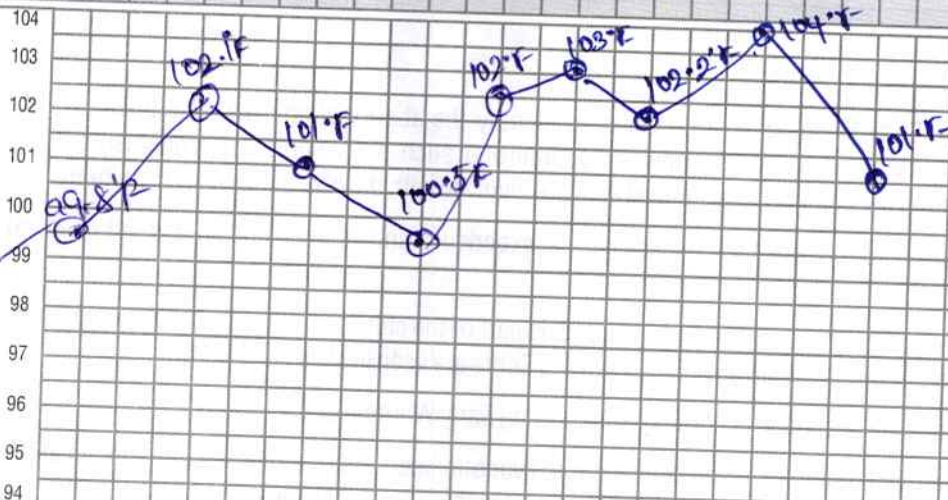


EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 21/01/25 Time: 6pm

Doctor / Nurse / Family Concern?

Temperature
 (°F)



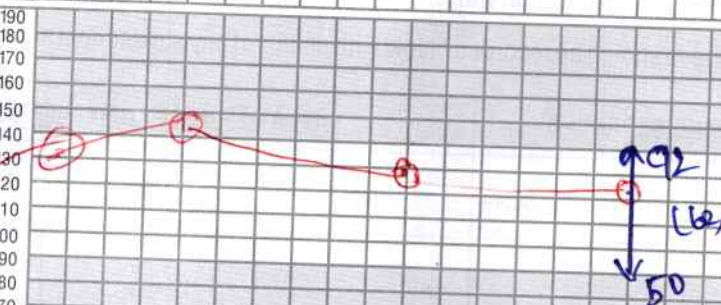
Heart Rate
 (bpm)

and

Blood Pressure
 (mmHg) *

Note:

BP does not score
 in early
 warning scoring



Heart Rate (Number)

136b 140b 130b 130b

Resp. Rate (bpm)
 (Over 1 Minute) *



Resp Rate (Number)

28b 30b 28b 30b

Resp Mod/ Severe
 Distress None / Mild

✓ ✓ ✓ ✓

Receiving O₂ (l/min)
 O₂ Saturations (%)

98% 99% 99% 99%

Conscious Level
 Normal Altered

✓ ✓ ✓ ✓

GCS *

15/15 15/15 15/15 15/15

TOTAL SCORE

Number of shaded boxes

0 0 0 0

Pain Score

0 0 0 0

Observer's Initials

AV AV AV AV

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.

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)

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 9/1/26 Time: 8am 10:20 am 11:40 am 2:00 pm 4:00 pm 6:00 pm 8:00 pm 10:00 pm 12:00 am 2:00 am 4:00 am

Doctor / Nurse / Family Concern? _____

Temperature (°F)	Heart Rate (bpm)	Blood Pressure (mmHg) *	Resp Rate (bpm) (Over 1 Minute) *	Resp Distress	Mod/ Severe None / Mild	Receiving O ₂ (l/min)	O ₂ Saturations (%)	Conscious Level	Normal / Altered	GCS *	TOTAL SCORE	Number of shaded boxes	Pain Score	Observer's Initials
101.5°F	140bpm	120/80	32bpm	✓	✓	98%	98%	✓	✓	15/15	0	0	0	8
103.8°F	136bpm	120/80	34bpm	✓	✓	99%	99%	✓	✓	15/15	0	0	0	PM
104.1°F	140bpm	120/80	34bpm	✓	✓	99%	99%	✓	✓	15/15	0	0	0	PM
101.2°F	132bpm	120/80	32bpm	✓	✓	99%	99%	✓	✓	15/15	0	0	0	PM
102.1°F	130bpm	120/80	30bpm	✓	✓	98%	98%	✓	✓	15/15	0	0	0	PM
104.1°F	126bpm	120/80	28bpm	✓	✓	99%	99%	✓	✓	15/15	0	0	0	PM

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
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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

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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)



EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 10/1/26 Time: 8am 10am 12noon 1:40pm 4:40pm 5:30pm 7pm 8pm 10am 2:30pm 4pm

Doctor / Nurse / Family Concern?

Temperature (°F)	Heart Rate (bpm)	Blood Pressure (mmHg) *	Resp. Rate (bpm) (Over 1 Minute) *	Resp Rate (Number)	Resp Distress	Mod/ Severe None / Mild	Receiving O ₂ (l/min)	O ₂ Saturations (%)	Conscious Level	Normal Altered	GCS *	TOTAL SCORE	Number of shaded boxes	Pain Score	Observer's Initials
103.9°F	90	120/61	32	32b/m	✓	✓	0.8	98.1	✓	✓	15/5	0	0	0	PR
98.8°F	95	120/66	30	30b/m	✓	✓	0.9	99.1	✓	✓	15/5	0	0	0	PR
102°F	95	120/66	30	30b/m	✓	✓	0.9	99.1	✓	✓	15/5	0	0	0	PR
101°F	95	120/66	30	30b/m	✓	✓	0.9	99.1	✓	✓	15/5	0	0	0	PR
101.2°F	95	120/66	30	30b/m	✓	✓	0.9	99.1	✓	✓	15/5	0	0	0	PR
104°F	95	120/66	30	30b/m	✓	✓	0.9	99.1	✓	✓	15/5	0	0	0	PR
99.4°F	95	120/66	30	30b/m	✓	✓	0.9	99.1	✓	✓	15/5	0	0	0	PR
98.6°F	95	120/66	30	30b/m	✓	✓	0.9	99.1	✓	✓	15/5	0	0	0	PR
103.7°F	95	120/66	30	30b/m	✓	✓	0.9	99.1	✓	✓	15/5	0	0	0	PR
98.8°F	95	120/66	30	30b/m	✓	✓	0.9	99.1	✓	✓	15/5	0	0	0	PR

ACTIONS

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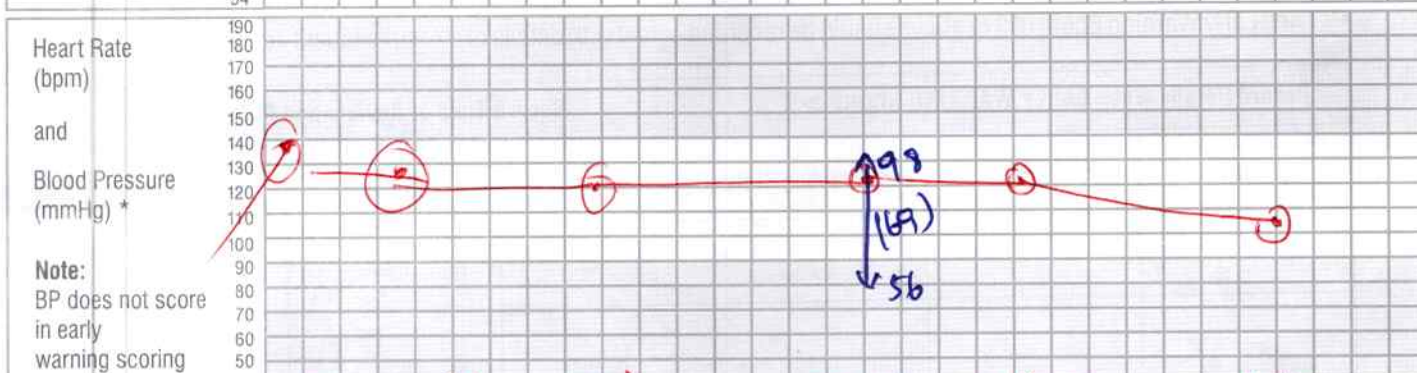
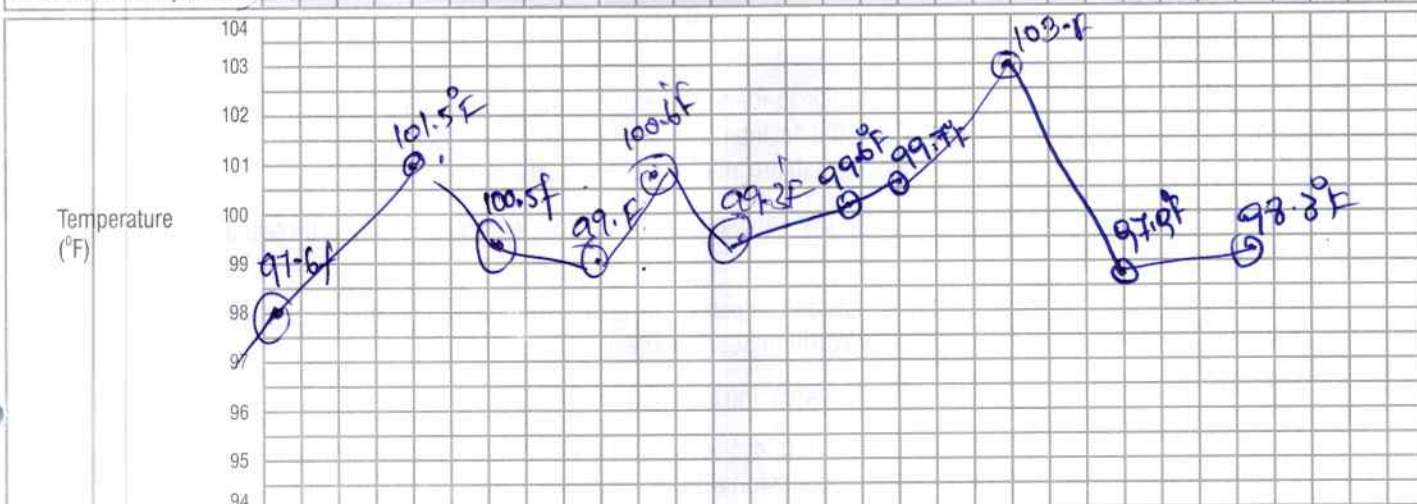
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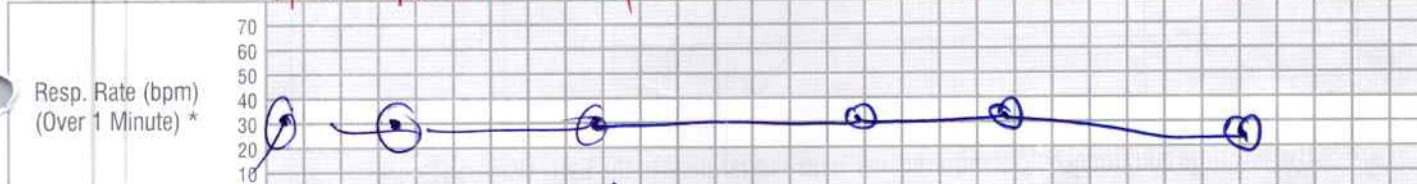
EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 11/1/25 Time: 8am 11-30am 1pm 4pm 6-30pm 7-11pm 9pm 10pm 12am 2AM 4AM

Doctor / Nurse / Family Concern?



Heart Rate (Number)



Resp Rate (Number)

Resp Mod/ Severe Distress None / Mild

Receiving O₂ (l/min) O₂ Saturations (%)

Conscious Level Normal / Altered

GCS *

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

ACTIONS

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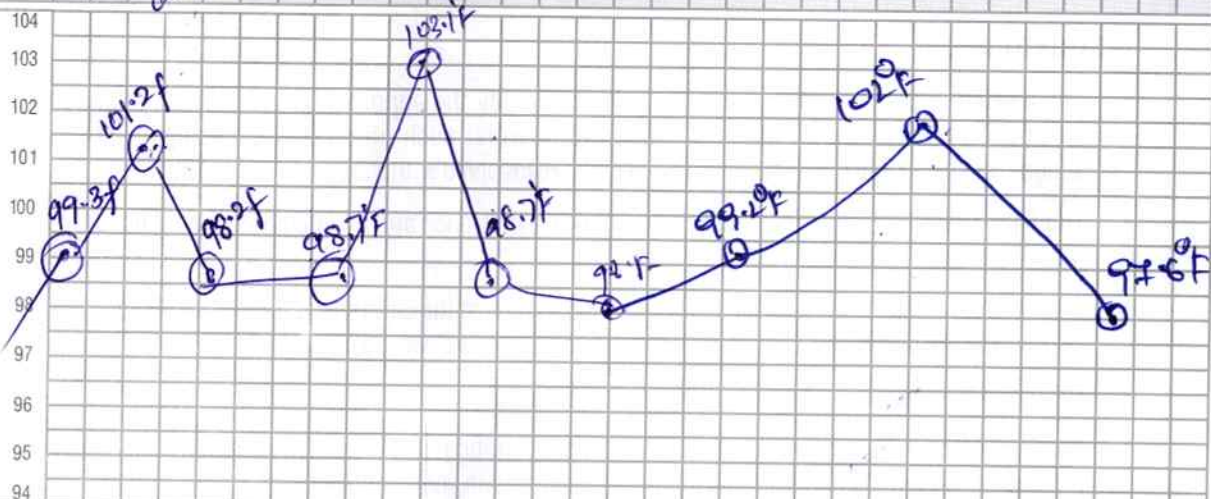
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EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 12/1/26 Time: 8am 9:30 am 12pm 4pm 5:30pm 7pm 8pm 12am 2AM 4AM
 Doctor / Nurse / Family Concern? _____

Temperature (°F)



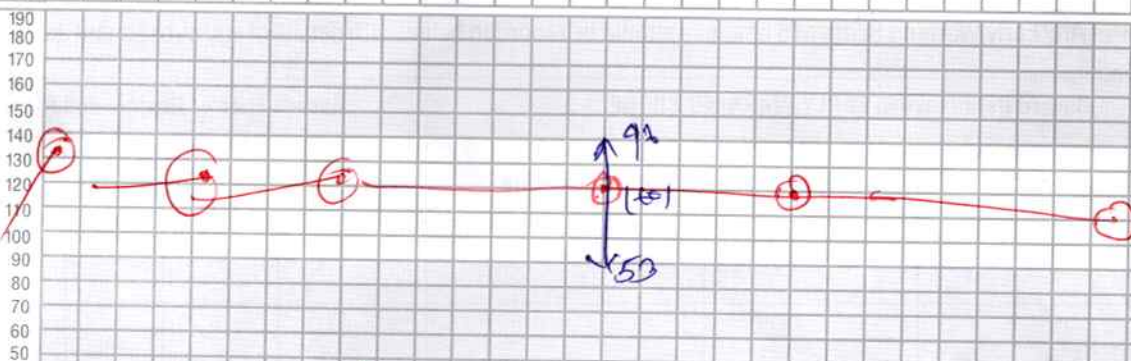
Heart Rate (bpm)

and

Blood Pressure (mmHg) *

Note:

BP does not score in early warning scoring



Heart Rate (Number)

138bpm 128bpm 126bpm 125bpm 120bpm 122bpm

Resp. Rate (bpm) (Over 1 Minute) *



Resp Rate (Number)

28bpm 28bpm 26bpm 26bpm 26bpm 26bpm

Resp Mod/ Severe Distress None / Mild

✓ ✓ ✓ ✓ ✓ ✓

Receiving O₂ (l/min) O₂ Saturations (%)

98% 98% 100% 99% 97% RA 98% RA

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

2 2 2 2 2 2

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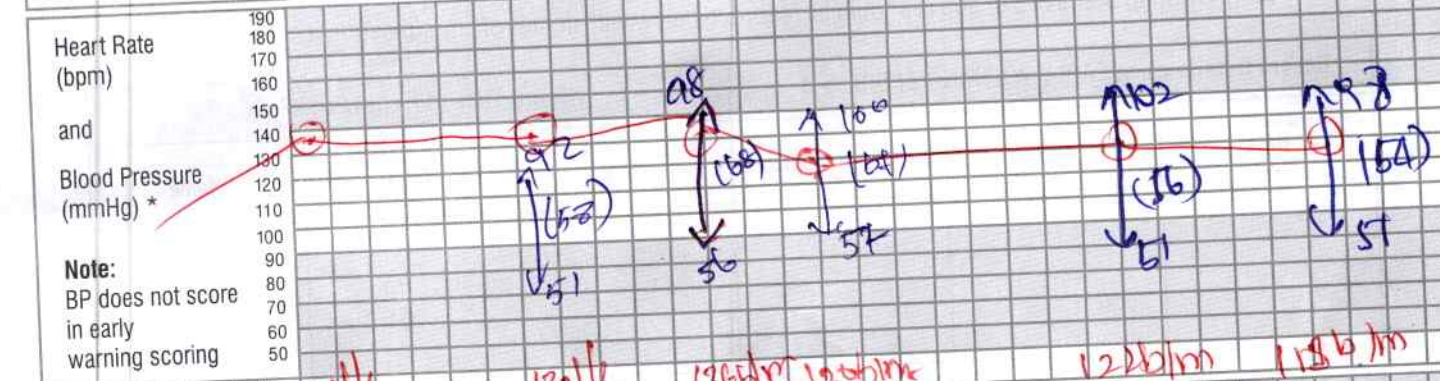
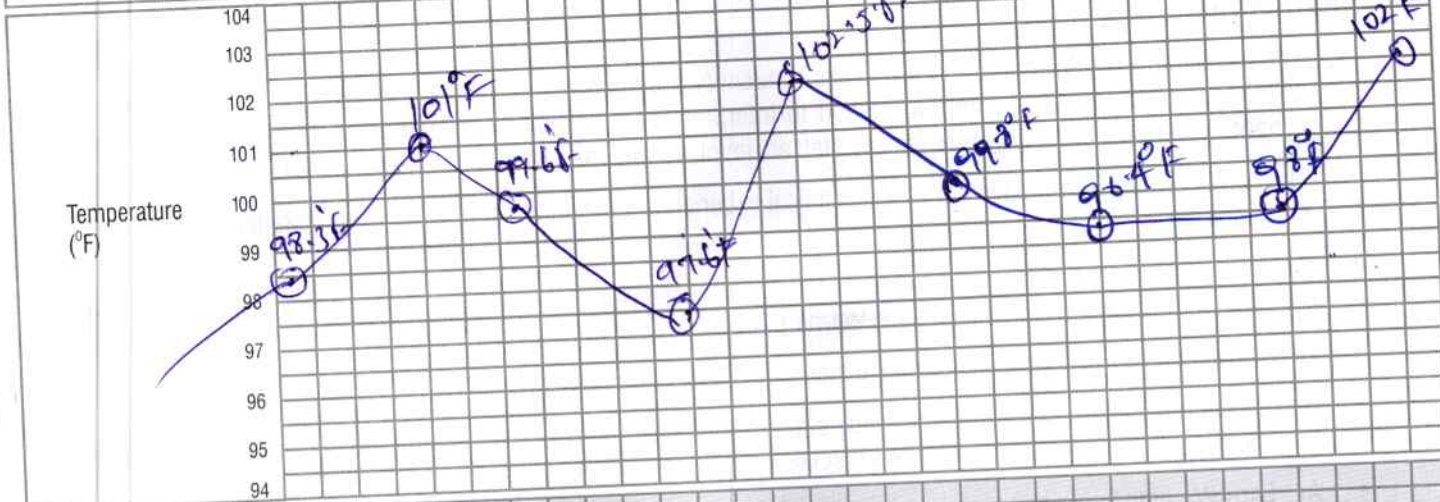
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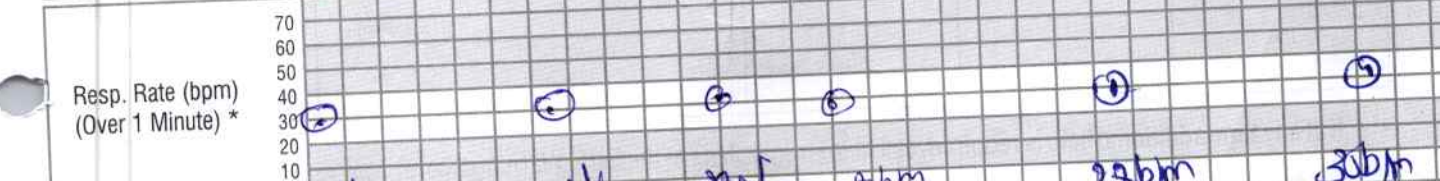
EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 13/1/25 Time: 8am 11am 12pm 4pm 7pm 10pm 12AM 4AM 5.30AM

Doctor / Nurse / Family Concern?



Heart Rate (Number) 136bpm 136bpm 136bpm 122bpm 118bpm



Resp Rate (Number) 30bpm 30bpm 28bpm 24bpm 28bpm 30bpm

Resp Distress	Mod/ Severe	None / Mild
✓	✓	✓
Receiving O ₂ (l/min)	99%	99%
O ₂ Saturations (%)	✓	✓
Conscious Level	✓	✓
GCS *	15/15	15/15

TOTAL SCORE	Number of shaded boxes	Pain Score	Observer's Initials
0	0	0	0
0	0	0	0
0	0	0	0
0	0	0	0
0	0	0	0
0	0	0	0

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SNC-00021894
Baby SAAVI SUJATA VAIBHAV SARJE
17-01-2025 1 Y 5 M 27 D (F)
Dr. GEETHA JAYAPATHY



RCM / FRM / CLINICAL / 125

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

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

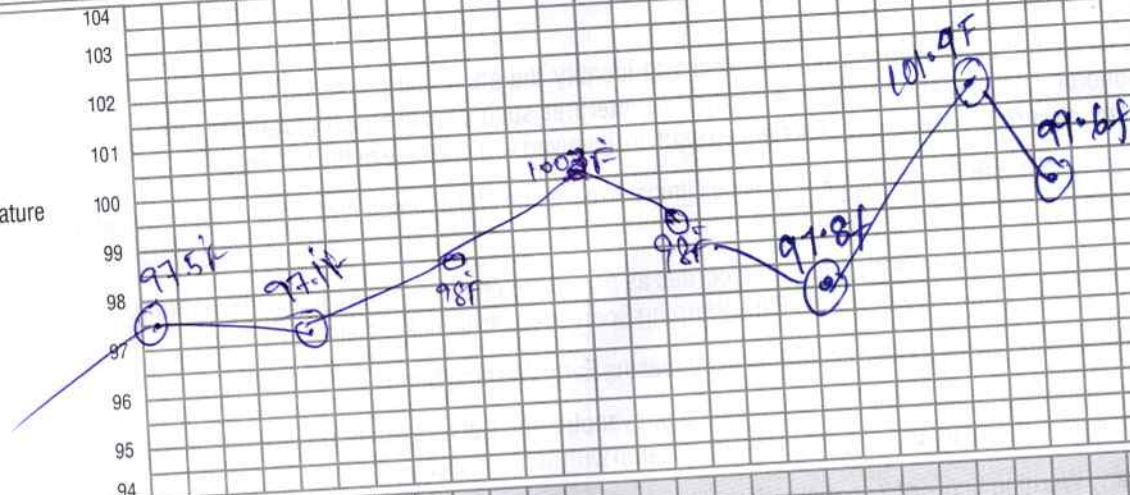
EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 17/1/26 Time: 3am 12pm 4pm 5pm 7pm 8pm 12am 4am 6:45 am

Doctor / Nurse / Family Concern?

Temperature
(°F)

104
103
102
101
100
99
98
97
96
95
94



Heart Rate
(bpm)

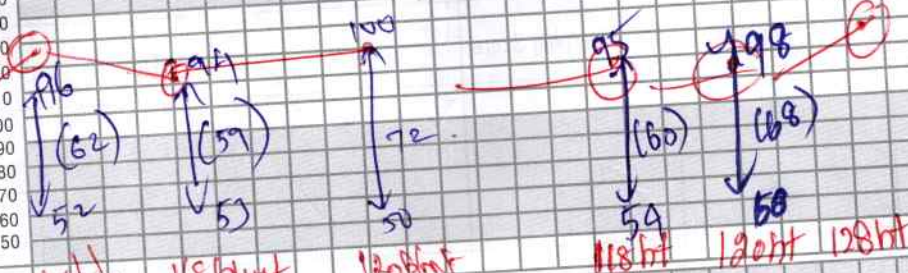
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50

and

Blood Pressure
(mmHg) *

Note:

BP does not score
in early
warning scoring

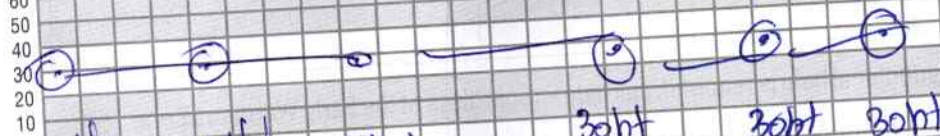


Heart Rate (Number)

120b/min 118b/min 120b/min 118b/min 120b/min 120b/min

Resp. Rate (bpm)
(Over 1 Minute) *

70
60
50
40
30
20
10



Resp Rate (Number)

30b/min 30b/min 30b/min 30b/min 30b/min 30b/min

Resp Distress Mod/ Severe
None / Mild

✓

Receiving O₂ (l/min)
O₂ Saturations (%)

99%

Conscious Level Normal
Altered

✓

GCS *

15/15

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

0

0

0

0

0

0

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SNC-00021894 IP18-00036382
 Baby SAAVI SUJATA VAIBHAV SARJE
 17-01-2025 1 Y 5 M 21 D (F)
 Dr. GEETHA JAYAPATHY



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	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	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	CBG											
	06:00 pm	DBF		62ml									
	07:00 pm	DBF		62ml									
Total Intake : 2 DBF + 124ml						Total Output : NIL							
	08:00 pm			62ml									
	09:00 pm	DBF		62ml									
	10:00 pm			15ml + 25ml									
	11:00 pm			15ml + 10ml									
	12:00 am	DBF		15ml + 10ml									
	01:00 am			15ml + 10ml									
Total Intake : 2 HMD DBF + 184 + 55						Total Output : 1 time urine							
	02:00 am			15ml + 10ml									
	03:00 am	DBF		15ml + 5									
	04:00 am			15ml + 5									
	05:00 am			15ml + 5									
	06:00 am	DBF		15ml + 5									
	07:00 am			15ml + 5									
Total Intake : 2 time DBF + 90 + 25						Total Output : 2 time urine							
Total 24 hrs. Intake			478ml + 6 times DBF			Total 24 hrs. Output			2 times urine passed.				

2019-1-10



FLUID CHART

Sheet No. : 2

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	IV	NG	Diarrhoea	Vomit	Drainage	Urine				
9/7/25													
	08:00 am	DBF		15ml	5ml							0	dy
	09:00 am	water 30ml		15ml	5ml					✓		0	dy
	10:00 am	DBF		15ml	5ml							0	dy
	11:00 am	water 30ml		15ml	5ml							0	dy
	12:00 pm	DBF		15ml	5ml							0	dy
	01:00 pm			15ml	5ml					✓		0	dy
Total Intake :			3 times DBF + 60ml + 90ml + 30ml			Total Output :			2 times urine passed				
	02:00 pm	water 30ml		15ml	5ml							0	dy
	03:00 pm	DBF		15ml	5ml							0	dy
	04:00 pm			15ml	5ml							0	dy
	05:00 pm	water 30ml		15ml	5ml					✓		0	dy
	06:00 pm	DBF		15ml	5ml			✓				0	dy
	07:00 pm	water 30ml		15ml	5ml					✓		0	dy
Total Intake :			7 times DBF + 90ml + 30ml			Total Output :			2 times urine passed				
	08:00 pm	water 30ml		15ml	5ml							0	dy
	09:00 pm	DBF		15ml	5ml					✓		0	dy
	10:00 pm	water 30ml		15ml	5ml							0	dy
	11:00 pm			15ml	5ml							0	dy
	12:00 am	DBF		15ml	5ml					✓		0	dy
	01:00 am			15ml	5ml							0	dy
Total Intake :			4 times DBF + 90ml + 30ml			Total Output :			2 times urine passed				
	02:00 am	DBF		15ml	5ml					✓		0	dy
	03:00 am			15ml	5ml							0	dy
	04:00 am	DBF		15ml	5ml							0	dy
	05:00 am			25ml	80ml							0	dy
	06:00 am			25ml						✓		0	dy
	07:00 am	water 30ml		25ml								0	dy
Total Intake :			20ml + 120ml + 15			Total Output :			2 times urine passed				
Total 24 hrs. Intake			69.5ml + 9 times DBF			Total 24 hrs. Output			8 times urine passed				

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FLUID CHART

Sheet No. : 3

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	08:00 am	Wate	20ml	25ml						✓	0	MR	
	09:00 am	Wate	20ml	25ml							0	MR	
	10:00 am	soup	20ml	25ml							0	MR	
	11:00 am			25ml							0	MR	
	12:00 pm	DRF		25ml						✓	0	MR	
	01:00 pm	DRF		DL							0	MR	
Total Intake : 70ml + 25ml DRF = 125ml						Total Output : 2 times urine							
	02:00 pm	H2O	10ml	15ml							0	MR	
	03:00 pm	DRF	✓	15ml						✓	0	MR	
	04:00 pm	A20	20ml	DL							0	MR	
	05:00 pm	DRF	✓	DL							0	MR	
	06:00 pm			15ml						✓	0	MR	
	07:00 pm	DRF	✓	15ml							0	MR	
Total Intake : 3 times DRF + 60ml						Total Output : 2 times urine passed							
	08:00 pm	Water	20ml	15ml							0	MR	
	09:00 pm	DRF		DL						✓	0	MR	
	10:00 pm	Wate	20ml	15ml							0	MR	
	11:00 pm			15ml						✓	0	MR	
	12:00 am	DRF		15ml							0	MR	
	01:00 am			15ml							0	MR	
Total Intake : 50ml + 75ml						Total Output : 2 times urine passed							
	02:00 am	DRF		15ml							0	MR	
	03:00 am	Wate	20ml	15ml						✓	0	MR	
	04:00 am			15ml							0	MR	
	05:00 am	DRF		15ml							0	MR	
	06:00 am			15ml							0	MR	
	07:00 am	DRF		DL						✓	0	MR	
Total Intake : 30ml + 75ml						Total Output : 2 times urine passed							
Total 24 hrs. Intake		485ml + 10 times DRF				Total 24 hrs. Output		8 times urine passed					

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FLUID CHART

Sheet No. : 4

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	Nature of Fluid	Intake			Output							Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo- phlebitis Score		
11/4/20	08:00 am	DBF											
	09:00 am												
	10:00 am	water 50ml									0	dy	
	11:00 am	DBF								✓	0	dy	
	12:00 pm	water 50ml									0	dy	
	01:00 pm	DBF								✓	0	dy	
Total Intake : 3 times DBF + 100ml			Total Output : 2 times urine passed										
	02:00 pm	water 20ml									0	dy	
	03:00 pm	DBF									0	dy	
	04:00 pm	TC water 50ml								✓	0	dy	
	05:00 pm	water 20ml									0	dy	
	06:00 pm	DBF ✓									0	dy	
	07:00 pm	DBF								✓	0	dy	
Total Intake : 3 times DBF + 90ml			Total Output : 2 times urine passed										
	08:00 pm	water 50ml									0	no	
	09:00 pm	DBF									0	no	
	10:00 pm	water 50ml								✓	0	no	
	11:00 pm	DBF									0	no	
	12:00 am										0	no	
	01:00 am	DBF								✓	0	no	
Total Intake : 3 DBF + 100ml			Total Output : 2 times										
	02:00 am	water 50ml									0	no	
	03:00 am	DBF									0	no	
	04:00 am										0	no	
	05:00 am	DBF								✓	0	no	
	06:00 am										0	no	
	07:00 am	DBF									0	no	
Total Intake : 3 DBF + 50ml			Total Output : 1 times										
Total 24 hrs. Intake			Total 24 hrs. Output										
12 DBF + 340ml			7 times										



FLUID CHART

Sheet No. : 5

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
12/7/26	08:00 am	Water 50ml								✓	0	net
	09:00 am	DBF									0	net
	10:00 am										0	net
	11:00 am	DBF								✓	0	net
	12:00 pm	Water 30ml									0	net
	01:00 pm	DBF								✓	0	net
Total Intake :			2 times DBF + 80ml			Total Output :			3 times urine			
	02:00 pm	DBF									0	DBF
	03:00 pm	Water 30ml								✓	0	DBF
	04:00 pm	DBF									0	DBF
	05:00 pm	Water 20ml								✓	0	DBF
	06:00 pm	DBF									0	DBF
	07:00 pm	DBF								✓	0	DBF
Total Intake :			4 times DBF + 100ml			Total Output :			3 times urine			
	08:00 pm	DBF									0	DBF
	09:00 pm	Water 50ml								✓	0	DBF
	10:00 pm	DBF									0	DBF
	11:00 pm	Water 50ml									0	DBF
	12:00 am	DBF								✓	0	DBF
	01:00 am										0	DBF
Total Intake :			3 DBF + 100ml			Total Output :			2 times			
	02:00 am										0	DBF
	03:00 am	DBF								✓	0	DBF
	04:00 am										0	DBF
	05:00 am	DBF									0	DBF
	06:00 am										0	DBF
	07:00 am	DBF								✓	0	DBF
Total Intake :			3 DBF			Total Output :			2 times			
Total 24 hrs. Intake			13 DBF + 230ml			Total 24 hrs. Output			10 times			

CHIEF OF BUREAU

(2)

Sheet No.

1. All measures must be taken to prevent the spread of disease.
2. And up each case of disease is reported.

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FLUID CHART

Sheet No. : 1

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	08:00 am	DRF											
	09:00 am	water 20ml								✓	0		
	10:00 am	DRF									0		
	11:00 am	water 20ml									0		
	12:00 pm	DRF								✓	0		
	01:00 pm	DRF									0		
Total Intake : 4 times DRF + 40ml			Total Output : 2 times urine passed										
	02:00 pm	DRF 30ml									0		
	03:00 pm	DRF ✓								✓	0		
	04:00 pm										0		
	05:00 pm	DRF ✓								✓	0		
	06:00 pm	DRF 20ml									0		
	07:00 pm	DRF ✓								✓	0		
Total Intake : 50ml + 80 DRF			Total Output : 3 times urine passed										
	08:00 pm	water 50ml									0		
	09:00 pm	DRF									0		
	10:00 pm	water 50ml								✓	0		
	11:00 pm	DRF									0		
	12:00 am										0		
	01:00 am	DRF								✓	0		
Total Intake : 30 DRF + 100ml			Total Output : 2 times										
	02:00 am										0		
	03:00 am	DRF									0		
	04:00 am									✓	0		
	05:00 am	DRF									0		
	06:00 am										0		
	07:00 am	DRF								✓	0		
Total Intake : 2 DRF			Total Output : 2 times										
Total 24 hrs. Intake		130 DRF + 190ml											
Total 24 hrs. Output		9 times											

TRANSFUSION



Form 100

Patient Name:
 Room:
 Date:
 Time:
 Physician:
 Nurse:
 Transfused:
 Blood Type:
 Rh Factor:
 Cross Match:
 Comments:

Unit	Volume	Time	Remarks
1	100 ml	10:00	Initial
2	100 ml	10:30	
3	100 ml	11:00	
4	100 ml	11:30	
5	100 ml	12:00	
6	100 ml	12:30	
7	100 ml	1:00	
8	100 ml	1:30	
9	100 ml	2:00	
10	100 ml	2:30	
11	100 ml	3:00	
12	100 ml	3:30	
13	100 ml	4:00	
14	100 ml	4:30	
15	100 ml	5:00	
16	100 ml	5:30	
17	100 ml	6:00	
18	100 ml	6:30	
19	100 ml	7:00	
20	100 ml	7:30	
21	100 ml	8:00	
22	100 ml	8:30	
23	100 ml	9:00	
24	100 ml	9:30	
25	100 ml	10:00	
26	100 ml	10:30	
27	100 ml	11:00	
28	100 ml	11:30	
29	100 ml	12:00	
30	100 ml	12:30	
31	100 ml	1:00	
32	100 ml	1:30	
33	100 ml	2:00	
34	100 ml	2:30	
35	100 ml	3:00	
36	100 ml	3:30	
37	100 ml	4:00	
38	100 ml	4:30	
39	100 ml	5:00	
40	100 ml	5:30	
41	100 ml	6:00	
42	100 ml	6:30	
43	100 ml	7:00	
44	100 ml	7:30	
45	100 ml	8:00	
46	100 ml	8:30	
47	100 ml	9:00	
48	100 ml	9:30	
49	100 ml	10:00	
50	100 ml	10:30	
51	100 ml	11:00	
52	100 ml	11:30	
53	100 ml	12:00	
54	100 ml	12:30	
55	100 ml	1:00	
56	100 ml	1:30	
57	100 ml	2:00	
58	100 ml	2:30	
59	100 ml	3:00	
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73	100 ml	10:00	
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75	100 ml	11:00	
76	100 ml	11:30	
77	100 ml	12:00	
78	100 ml	12:30	
79	100 ml	1:00	
80	100 ml	1:30	
81	100 ml	2:00	
82	100 ml	2:30	
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86	100 ml	4:30	
87	100 ml	5:00	
88	100 ml	5:30	
89	100 ml	6:00	
90	100 ml	6:30	
91	100 ml	7:00	
92	100 ml	7:30	
93	100 ml	8:00	
94	100 ml	8:30	
95	100 ml	9:00	
96	100 ml	9:30	
97	100 ml	10:00	
98	100 ml	10:30	
99	100 ml	11:00	
100	100 ml	11:30	

Total Volume:
 Comments:

Total Volume:
 Comments:

FLUID CHART

Sheet No. : 4

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	Nature of Fluid	Intake			Output						IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
19/1/26	08:00 am	DBF										0	Di
	09:00 am	Water 10ml										0	Di
	10:00 am	DBF										0	Di
	11:00 am	Water 30ml										0	Di
	12:00 pm	DBF										0	Di
	01:00 pm	DBF										0	Di
Total Intake : 4 times DBF + 40ml						Total Output : 2 times							
	02:00 pm	DBF										0	Di
	03:00 pm	Water 30ml										0	Di
	04:00 pm	DBF										0	Di
	05:00 pm	Water 30ml										0	Di
	06:00 pm											0	Di
	07:00 pm	DBF										0	Di
Total Intake : 3 times DBF + 60ml						Total Output : 3 times urine passed							
	08:00 pm											0	Di
	09:00 pm	DBF										0	Di
	10:00 pm	Water 50ml										0	Di
	11:00 pm	DBF										0	Di
	12:00 am	Water 50ml										0	Di
	01:00 am											0	Di
Total Intake : 2 times DBF + 100ml						Total Output : 2 times urine passed							
	02:00 am	Water 30ml										0	Di
	03:00 am	DBF										0	Di
	04:00 am											0	Di
	05:00 am	DBF										0	Di
	06:00 am											0	Di
	07:00 am	DBF										0	Di
Total Intake : 3 times DBF + 30ml						Total Output : 1 time urine passed							
Total 24 hrs. Intake			12 times DBF + 230ml			Total 24 hrs. Output						8 time urine passed	

2. c/f: Pt

SNC-00021894
 Baby SAAVI SUJATA VAIBHAV SARJE
 17-01-2025 1 Y 5 M 21 D
 Dr. GEETHA JAYAPATHY (F)

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

BirthRight[™]
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

NURSING SHIFT HAND OVER FORM

SITUATION		Diagnosis: <u>AFI - ? Entail ? UTI</u>					
BACKGROUND		Surgery / Procedure:					
ASSESSMENT		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
RECOMMENDATIONS		Post OP Day:					
Date	Shift	8/1/25 E	8/1/25 N	9/1/25 Morning	9/1/25 Evening	9/1/25 N	10/1/25 M
Medical Condition (Any special condition to be noted):		Noted	Noted	Noted	Noted	Noted	Noted
Diet:		Soft diet	Soft diet	Soft diet	Soft diet	Soft diet	Soft diet
Allergy:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
Ventilation (RA, NP, NIV, VENTI):		RA	RA	RA	RA	RA	RA
Tubes/Drains/Catheter:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
Vital Signs:		Temp: 99.8 F Res: 28b/m SpO ₂ : 98% Pulse: 136b/m BP: - LOC: conscious	Temp: 98.9 F Res: 30b/m SpO ₂ : 99% Pulse: 99b/m BP: 123/61 LOC: conscious	Temp: 101.5 F Res: 32b/m SpO ₂ : 98% Pulse: 98b/m BP: 140/61 LOC: conscious	Temp: 98.5 F Res: 30b/m SpO ₂ : 98% Pulse: 98b/m BP: 138/61 LOC: conscious	Temp: 99.5 F Res: 30b/m SpO ₂ : 99% Pulse: 99b/m BP: 136/61 LOC: conscious	Temp: 98.8 F Res: 32b/m SpO ₂ : 98% Pulse: 98b/m BP: 126/61 LOC: conscious
Fall Risk Score:		12	12	12	12	12	12
Pain Score:		0/10	0/10	0/10	0/10	0/10	0/10
Skin Integrity		-	-	-	-	-	-
Safety Needs:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
Physiotherapy:		-	-	-	-	-	-
Others Specify:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
Special Diet:		-	-	-	-	-	-
Critical Lab Test / Values:		-	-	-	-	-	-
Other Special Orders / Medications:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
PU Prophylaxis:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
DVT Prophylaxis:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
ADL (Dependent / Non Dependent):		Dependent	Dependent	Dependent	Dependent	Dependent	Dependent
Post Operative Procedure Special Orders:		-	-	-	-	-	-
Handed Over By Name :		Angel	Angel	Angel	Angel	Angel	Angel
Signature / ID :		Angel	Angel	Angel	Angel	Angel	Angel
Date:		8/1/25	8/1/25	9/1/25	9/1/25	9/1/25	10/1/25
Time:		7:30pm	7:30pm	7:30pm	7:30pm	7:30pm	1:30pm
Taken Over By Name :		Angel	Angel	Angel	Angel	Angel	Angel
Signature / ID :		Angel	Angel	Angel	Angel	Angel	Angel
Date:		8/1/25	8/1/25	9/1/25	9/1/25	9/1/25	10/1/25
Time:		8pm	1:30pm	1:30pm	7:30pm	7:30pm	1:30pm

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NURSING SHIFT HAND OVER FORM

SITUATION		Diagnosis: <u>AFS - ? Enteric - ?UTI</u>		Any Infection: ☐ Yes ☐ No ☐ Not Known			
		Surgery / Procedure:		If Yes Specify:			
		Post OP Day:					
BACKGROUND	Date	10/1/26	10/1/26	11/1/26	11/1/26		
	Shift	G	N	M	G	N	
	Medical Condition (Any special condition to be noted):	Noted	Noted	Noted	Noted	Noted	
ASSESSMENT	Diet:	Soft diet	Soft diet	Soft diet	Soft diet	Soft diet	
	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Ventilation (RA, NP, NIV, VENTI):	RA	RA	RA	RA	RA	
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Vital Signs:	Temp:	97.8F	98.9F	97.6F	98F	98F
		Res:	30b/m	30b/m	30b/m	30b/m	30b/m
		SpO ₂ :	99%	98%	98%	99%	98% RA
		Pulse:	120b/m	122b/m	140b/m	136b/m	126b/m
		BP:	90/50	92/16(60)	-	-	92/56(60)
	LOC:	Conscious	Conscious	Conscious	Conscious	Conscious	
Fall Risk Score:		12	12	12	12	12	
Pain Score:		0/10	0/10	0/10	0/10	0/10	
Skin Integrity		27	27	27	27	27	
Recommendations		Safety Needs:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Physiotherapy:	-	-	-	-	-	
	Others Specify:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Special Diet:	-	-	-	-	-	
	Critical Lab Test / Values:	-	-	-	-	-	
	Other Special Orders / Medications:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	PU Prophylaxis:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	DVT Prophylaxis:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	ADL (Dependent / Non Dependent):	Dependent	Dependent	Dependent	Dependent	Dependent	
	Post Operative Procedure Special Orders:	-	-	-	-	-	
Handed Over By Name :	R. S. Rao	V. S. Rao	A. S. Rao	J. S. Rao	V. S. Rao		
Signature / ID :	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]		
Date:	10/1/26	10/1/26	11/1/26	11/1/26	12/1/26		
Time:	7:30 AM	7:30 AM	7:30 AM	7:30 AM	7:30 AM		
Taken Over By Name :	V. S. Rao	A. S. Rao	A. S. Rao	V. S. Rao	A. S. Rao		
Signature / ID :	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]		
Date:	10/1/26	10/1/26	11/1/26	11/1/26	12/1/26		
Time:	7:30 AM	7:30 AM	7:30 AM	7:30 AM	7:30 AM		

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APPROXIMATE DATES

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URSING SHIFT HAND OVER FORM

SITUATION		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
Surgery / Procedure: ✓		Post OP Day:					
BACKGROUND	Date	12/17	12/18	13/17	13/18	13/18	14/18
	Shift	E	N	M	E	N	M
ASSESSMENT	Medical Condition (Any special condition to be noted):	Noted	Noted.	Noted.	Noted.	Noted.	Noted.
	Diet:	Soft diet	Soft diet	Soft diet	Soft diet	Soft diet	Soft diet
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Ventilation (RA, NP, NIV, VENT):	RA	RA	RA	RA	RA	RA
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:	Temp: 97.8F	98.1F	98.3F	98.2F	98.4F	97.5F
	Res: 20	20b/m	20b/m	20b/m	20b/m	20b/m	
	SpO ₂ : 99%	99%	99%	99%	99%	99%	
	Pulse: 126b/m	124b/m	130b/m	126b/m	123b/m	124b/m	
	BP: -	98/52	-	98/50	102/58/69	96/52/62	
	LOC: conscious	conscious	conscious	conscious	conscious	conscious	
	Fall Risk Score: 12	12	12	12	12	12	
Recommendations	Pain Score: 0/10	0/10	0/10	0/10	0/10	0/10	
	Skin Integrity: 27	27	27	27	27	27	
	Safety Needs:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Physiotherapy:	-	-	-	-	-	
	Others Specify:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Special Diet:	-	-	-	-	-	
	Critical Lab Test / Values:	-	-	-	-	-	
	Other Special Orders / Medications:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	PU Prophylaxis:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	DVT Prophylaxis:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
ADL (Dependent / Non Dependent):	Dependent	Dependent	Dependent	Dependent	Dependent		
Post Operative Procedure Special Orders:		-	-	-	-	-	
Handed Over By Name :		Jeevar	Jathin	Anoop	Nisha	Vijay	Anoop
Signature / ID :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date:		12/17/26	13/18/26	13/18/26	13/18/26	14/18/26	14/18/26
Time:		07:30 PM	2 PM	01:30 PM	07:30 PM	07:30 AM	01:30 PM
Taken Over By Name :		Vijay	Anoop	Anoop	Vijay	Anoop	Balraj
Signature / ID :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date:		12/17/26	13/18/26	13/18/26	13/18/26	14/18/26	14/18/26
Time:		07:30 AM	07:30 AM	12:30 PM	07:30 PM	07:30 AM	02 PM

SNC-00021884 IP18-00036352
 Baby SAAVI SUJATA VAIBHAV SARJE (F)
 17-01-2025 1 Y 5 M 21 D
 Dr. GEETHA JAYAPATHY



NURSING CARE RECORD



Date: 8 Feb

- 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	2pm Assess neck's head & feet		Assess the circulation for pain & vitals Administer neck's restraint - Special	reassessed it's ok	Reassess ment Done	Arts asn
Night	4pm to promote head's hygiene.		→ maintain oral hand hygiene → changed bedsheet dress.		reassessed done	day day

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

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

Date: 9/1/26

Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning 8am	maintain fluid Balance		Assessed child condition Maintain vital signs and check Administer IV medication	Improved fluid volume	Reassessment was done vital are stable	dy 08400
Afternoon 1-30 Pm	Maintain Personal Hygiene	2pm	Assessed child condition monitor vitals maintain Hair and nail hygiene	Maintained Personal Hygiene	Reassessed Done	dy 02100
Night 8pm	Ensure safety		Assessed child condition. → adequate rights → placed bedside siderails.	child on safety.	Reassessment done	dy

SNC-00021894 IP18-00036382
 Baby SAAVI SUJATA VAIBHAV SARJE
 17-01-2023 1 Y 5 M 22 D (F)
 Dr. GEETHA JAYAPATHY



NURSING CARE RECORD

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

BirthRight®
 BY RAINBOW HOSPITAL
 Your Right to a Safe Delivery

Date: 18/12/20

- 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	Prevent Infection		Assess child condition monitor vitals Administer Medication as per orders	infection was reducing	Reassessment done	dp 015/20
Afternoon	2pm 1pm	→ To maintain fluid balance of the child	3pm	→ Assessed the fluid balance of the child → monitored vital signs. → recorded in chart. → Administered IV fluids as per doctor's orders	Improving and maintaining adequate fluid balance	child was stable Reassessment was done	RJG 020/24
Night	7:30pm	To maintain personal hygiene.	9pm	→ Assessed general condition → monitored vital signs → monitored Biochart	To Improve child condition.	Improving child condition	ne 017/20



NURSING CARE RECORD

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

Date: 11/2/26

Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning 8am	Prevent Infection	1pm	Assess child condition monitor vitals Administer Medication as per orders	infection was reducing	deaths not done	APD 015/2001
Afternoon 12pm	→ TO maintain fluid balance of the child		→ assessed the fluid balance of the child. → monitored vital signs → maintained I/O chart → provided per oral fluids as ordered	Improving and maintaining adequate fluid Balance	child was stable Reassessment was done	Rfer 00749
Night 7-30pm	TO maintain good Nutritional status.	9pm	→ Monitored general condition. → Monitored vital signs → Monitored I/O chart.	TO improve Child nutritional status	Improving nutritional status	no on 2/26



NURSING CARE RECORD

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

Date: 12/2/26

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8am	Assess child condition monitors vitals Administer medication S/O chart maintaining	1PM	Assessed child condition monitors vitals Administer medication S/O chart maintained	Encouraged to take more oral intake	Reassessment done	Deep 21580
Afternoon	3PM	→ to maintain adequate fluid balance of the child	✓	→ Assessed the fluid balance of the child → monitor vital signs → maintained S/O chart → Encouraged to take more oral fluids	Improving and maintaining adequate fluid balance	child was stable Reassessment oral done	Deep 2049
Night	8PM	to, promote to Health Hygiene:	✓	Assessed child condition Vitals monitoring Encourage oral Hand Hygiene	maintained personal Hygiene	Reassessment done	Deep 2009

SNC-00021894 IP18-00036382
 Baby SAAVI SUJATA VAIBHAV SARJE
 17-01-2025 1 Y 5 M 25 D (F)
 Dr. GEETHA JAYAPATHY



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: 13/4/26

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	Prevent infection		Assess child condition monitors vitals Administer Medication as per orders	Infection was reducing	Reassessment done	Shr 05/06/26
Afternoon	2pm	TO maintain fluid balance.	2pm	TO assess the general condition. TO monitor vital signs TO maintain I/O chart	maintain fluid volume.	Reassess med very done.	mp 05/06/26
Night	7:30pm	TO maintain good nutritional status.		→ Assessed general condition. → monitored vital signs → monitored I/O chart	TO improve nutritional status	Improving child condition & nutrition status	mp 05/06/26



NURSES NOTES

☐ No Known Drug Allergies

☐ Drug Allergies

nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
8/7/25	9.00 pm	Temp: 102.1°F. Syp. Ibuprofen 2.5ml po given as per drug chart order.	
		Vital signs checked & recorded.	
9/7/25	12am	Recorded vitals are stable now. CP PP CR 44 44 22	Jacey 20/07/25
		IVF - DMS - 15ml/hr ongoing. NAC infusion 20ml/hr ongoing. Child sleeping well good no special complaints.	
	1am	Temp: 102°F. Informed Dr. Chandraloga mam.	
		advised. To give tepid sponging.	Jacey 20/07/25
	2am	continuous tepid sponging given. IVF - 15ml/hr on going.	
	2.30 am	2nd NAC and infusion finished.	
	3am	Inf. NAC 4ml + 20ml 5% D. over 16hr. 5ml/hr start.	
	4am	Vital signs checked & recorded. vitals are stable now. CP PP CR 44 44 22	Jacey

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

NURSES NOTES

☐ No Known Drug Allergies

☐ Drug Allergies Nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE						
9/17/26	5am	Temp: 104°F Syp. Ibuprofen 2.5ml po given. as per drug chart order. Septd Spong given.							
	6am	Due medication are given as per drug chart order. I/O chart maintained							
	7:30 am	Handing over given to morning duty staff	Jay 08950						
		→ morning duty on: 9/17.							
	7:30am	Child details band over taken from night duty. Stays Child is conscious & oriented. Child Ix cannula patien-	Jay 08950						
	8am	vital signs and Rechecked vital are stable							
		<table border="1"> <tr> <td>CP</td><td>PP</td><td>CRT</td></tr> <tr> <td>++</td><td>++</td><td>48ec</td></tr> </table>	CP	PP	CRT	++	++	48ec	
CP	PP	CRT							
++	++	48ec							
		Due to medication was given per doctor's order Inj. Nac 4ml in 80ml 5% D. @ 5ml per over 16hr	Jay 08950						
	10am	Iv. fluid 200-15ml per on flow child intake was good No any complaints							

NOTE: DO NOT WRITE OUTSIDE THE MARGINS

SNC-00021894 IP15-00036352
 Baby SAAVI SUJATA VAIBHAV SARJE
 17-01-2025 1 Y 5 M 22 D (F)
 Dr. GEETHA JAYAPATHY



NURSES NOTES

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BirthRight[™]
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

☐ Drug Allergies Nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
9/1/26	10 ³⁰	→ continue 9/1/26 Dr. Geetha mom seen by a child she advised to send LFT, VBG, PT/INR, NHs	nil/000801
	12pm	vital signs are checked and recorded. vital are stable	nil/000801
		CP PP CRT ++ ++ L380	
	1 ³⁰ pm	Re child details handing over given to evening duty staff	nil/000801
9/1/26		Evening Duty	
	1.30pm	The child details handing over taken from morning duty & staff. child is conscious and oriented. child is on room air. Iv line present	Bani 001893
		Iv line pattern	
	2pm	Inj. Nac and in 80ml 5% D @ 5ml/hr on flow. no any other complaints. child is stable.	
		vital signs are checked and recorded vital signs are stable	
		CP PP CRT ++ ++ L380	Bani 001893

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

NURSES NOTES

☐ No Known Drug Allergies☐ Drug Allergies nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		→ continue notes ←	
9/11/20	3.30pm	Dr. Heather Mann seen & checked advice to let next fever spike to add Ryp-Fluix 2.5ml BD out add Inf-DNS + ice per added. If completed no infection again no need. Monitor the urine output and continue other medication.	P.S. Duffs 19354
	4pm	Vitals are checked second. Vitals are stable. [ppp/cet] T-10.2 to give 1/4 1/2 c3u Ryp-Fluix 2.5ml D to give as per drug chart order.	P.S. Duffs 19354
	4.30pm	Dr. Heather Mann came & seen the child again to with the Ryp-Fluix and continue treatment.	
	6pm	All medication given as per drug chart order. Reassessed 1/2 chart.	P.S. Duffs 19354
	1.30pm	Baby details handing over given to the Night duty N.	
		Night duty notes:-	
	4.30pm	child details handing over taken from evening duty S/N. child conscious & oriented. child	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



NURSES NOTES

☐ No Known Drug Allergies

☐ Drug Allergies NSI

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE						
9/1/26		activity are good. Pv like to No swelling & pain IVF - DND + KCl 15ml/hr on going. Inf - NAC. 4ml + 2ml 5:0 5ml/hr ongoing.							
	8pm	vital signs checked & Recorded vitals are stable now <table><tr><td>CP</td><td>PP</td><td>CRR</td></tr><tr><td>++</td><td>++</td><td>23</td></tr></table>	CP	PP	CRR	++	++	23	
CP	PP	CRR							
++	++	23							
		Temp: 104° F. Deped sponge given. Due medication are given as per day chart order.	Jay 020048						
10/1/26	12am	vital signs checked & Recorded vitals are stable now <table><tr><td>CP</td><td>PP</td><td>CRR</td></tr><tr><td>++</td><td>++</td><td>23</td></tr></table>	CP	PP	CRR	++	++	23	
CP	PP	CRR							
++	++	23							
		Temp: 104° F. Syf. Abgex 2.5ml given child sleeping was good no special complaints.	Jay 020048						
	4am	vital signs checked & recorded vitals are stable now <table><tr><td>CP</td><td>PP</td><td>CRR</td></tr><tr><td>++</td><td>++</td><td>23</td></tr></table>	CP	PP	CRR	++	++	23	
CP	PP	CRR							
++	++	23							
	6am	Due medication are given as per day chart order.							

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

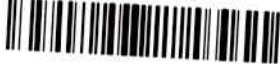
NURSES NOTES

☐ No Known Drug Allergies

☐ Drug Allergies Nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE						
10/21/26	7:30AM	Handing over given to morning duty SN	Jared						
		Morning duty Notes 10/21/26							
	7:30am	The child details handover/takes from the night duty staffs the child is conscious and active	Jared						
	8am	Administers the medication as per doctor's orders vitals are checked and recorded temp is normal							
		<table><tr><td>PP</td><td>++</td></tr><tr><td>CP</td><td>++</td></tr><tr><td>CRF</td><td>++</td></tr></table>	PP	++	CP	++	CRF	++	
PP	++								
CP	++								
CRF	++								
	10am	Ho chart is maintained Ev fluid 0.9% 4mls 500ml + 5ml/kg @ 0.5ml/hr on flow	Jared						
	12pm	vitals are checked and recorded temp is 102°F informed to Dr. Geetha adv! to give P120-5ml given @ 12:00pm							
	12:30pm	Dr. Geetha's name is done adv! to give 1-15ml/hr							
	1:30pm	The child details handover given to evening duty staffs.	Jared						

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



NURSES NOTES

- ☒ No Known Drug Allergies
☐ Drug Allergies **NOT Known**

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE						
10/7/26	1:30 pm	Evening duty NOT on 10/7/2026 Child details taken over from evening duty staff nurse using IPBAR method. On Assessment, child is conscious, oriented and mobile. GCS-15/15, SpO2 Assessment done. IV line is present and patent, on IVF DRS 500ml + 5ml/hr @ 25ml/hr on Flow, no pain or tenderness.	R Jeyaraj 080749						
	2pm.								
	4pm.	Vitals checked and recorded, all are hemodynamically stable	R Jeyaraj 080749						
		<table border="1"><tr><td>Q</td><td>PP</td><td>CR</td></tr><tr><td>11</td><td>11</td><td>C3Sec</td></tr></table> T- 100.3F.	Q	PP	CR	11	11	C3Sec	
Q	PP	CR							
11	11	C3Sec							
	5.20pm	Dr. Geetha Raman came and been informed about the child condition advised to give Syp. Ibuprofen now. That order followed	R Jeyaraj 080749						
	6pm	all medications given as per the drug chart	R Jeyaraj 080749						
	7pm	the drug chart maintained							
	7.30pm	Child details handed over to night duty staff nurse using IPBAR method	R Jeyaraj 080749						

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

NURSES NOTES

☐ No Known Drug Allergies

☐ Drug Allergies

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		→ Night duty ←	
10/7/26	7:30PM	child taken over from evening duty staff conscious	MD D.M. Suro
	8PM	vital signs checked & recorded NO other complaints.	MD D.M. Suro
		PP / CP / CRT # / # / 1300	
	9PM	child on line out informed Dr. Keetha & Dr. Manonmani through phone call Dr. Manonmani advised to do CBL, CRP, OT, PT & to secure new SV time.	MD D.M. Suro
	9:30PM	SV line done. 24 CT Metacarpal, sample sent to lab.	MD D.M. Suro
		due medications are given as per doctor's order	
11/7/26	12AM	vital signs checked & recorded. NO other complaints	MD D.M. Suro
		PP / CP / CRT # / # / 1300	
	2AM	SV line ⊕ present p pattern IVF 0.9 DNS 25ml/hr on flow Child sleeping. NO other complaints.	MD D.M. Suro

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



NURSES NOTES

☒ No Known Drug Allergies

☐ Drug Allergies

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
2011/1/20		→ Night duty ←	
	1:30pm	child taken over from evening duty staff conscious & awake	no issues
	3pm	vital signs checked & recorded No other complaints	no issues
		PP UP CRT ++ ++ 1300	
		child taken over. No other complaints	
	9pm	due medication's are given as per doctor's order.	no issues
	10pm	PR line & present & palpable. No other complaints.	
	12AM	vital signs checked & recorded - No other complaints.	
		PP UP CRT ++ ++ 1300	
	2AM	child sleeping - No other complaints.	no issues
	4AM	vital signs checked & recorded. No other complaints.	
		PP UP CRT ++ ++ 1300	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

NURSES NOTES

☐ No Known Drug Allergies

☐ Drug Allergies

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE						
P#126		→ continue ←							
	6am	due medication's are given as per doctor's order.							
		No chart maintained							
	7:30am	child handing over given to morning duty staff.							
		Morning duty. Notes on 12/1/26							
	7:30am	the child details handover taken from the night duty staffs							
		The child is conscious and active							
	8am	Administer the medication as per doctor's order							
		vitals are checked and recorded							
		Temp is normal							
		<table><tr><td>PP</td><td>++</td></tr><tr><td>CP</td><td>++</td></tr><tr><td>CR</td><td>++</td></tr></table>	PP	++	CP	++	CR	++	
PP	++								
CP	++								
CR	++								
	8:40am	Dr. Yeates room rounds was done adv to continue the same							
	10am	No chart is maintained							
		No any other complaints							
	12pm	vital signs are checked and recorded. vital are stable							
		<table><tr><td>PP</td><td>++</td><td>CR</td></tr><tr><td>CP</td><td>++</td><td>CR</td></tr></table>	PP	++	CR	CP	++	CR	
PP	++	CR							
CP	++	CR							
		No chart was maintained.							

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



NURSES NOTES

☐ No Known Drug Allergies

☐ Drug Allergies

XIP1

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		continue note	
12/1/26	1:30pm	The child details handing over given to evening duty staff	NS/0499
12/1/2026	1:30pm	Evening duty notes on 12/1/2026 Child details taken over from morning duty staff nurse using ISBAR method. On Assessment child is conscious, oriented and alert, CVP-1015, SpO2 Assessment done, IV line is patent and patent, no pain or distress.	R. Sreenivas 070749
	2pm	Child was happy, well. No any fever complaints.	
	4pm	Vitals are checked. Succeeded. Vitals are stable PP/CP/CPT	P. S. Suresh 059354
	5:30pm	Checked the temperature T-102.1°F to groin. Syp- Ibuprofen 2.5ml po.	
	6pm	Drug Medication given as per drug chart order.	
	7pm	rechecked the temperature was recorded. Maintained flat.	P. S. Suresh 059354
	8:30pm	Baby details handing over given to the night duty staff.	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

NURSES NOTES

☐ No Known Drug Allergies

☐ Drug Allergiesall

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
12/12/20	1:30 pm	Night Duty notes:- Child details Handing over taken from evening duty s/n. child conscious & oriented. child activity are good. Lu line @. no swelling &	Jay / 2004
	6:00 pm	vital signs checked & recorded vitals are stable now CP TT PP TT CAN 235	Jay / 2004
		One medication are given as per drug chart order. Child sleeping was good no special complaints. Lu maintained	Jay / 2004
12/12/20	12:00	vital signs checked & recorded vitals are stable now CP TT PP TT CAN 235	
	2:00 PM	Child sleeping was good no special complaints. Lu chart maintained	
	4:00 PM	vital signs checked & recorded vitals are stable now CP TT PP TT CAN 235	Jay / 2004

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



NURSES NOTES

☐ NO KNOWN Drug Allergies

☐ Drug Allergies

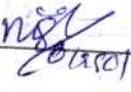
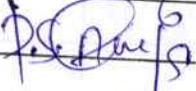
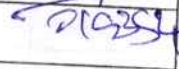
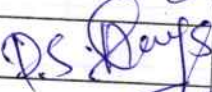
DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE						
13/1	6am	Deco medication are given as per drug chart order Deco chart maintained 7:30am child handover given to morning duty staff.	Jee 13/01/25						
		Morning duty Notes on 13/1/25							
	7:30am	The child details handover taken from the night duty staff The child is conscious and active	Jee 13/01/25						
	8am	Administer the medication as per doctor's order vitals are checked and recorded Temp is normal							
		<table><tr><td>PP</td><td>++</td></tr><tr><td>CP</td><td>++</td></tr><tr><td>CRT</td><td><2s</td></tr></table>	PP	++	CP	++	CRT	<2s	
PP	++								
CP	++								
CRT	<2s								
	10am	No chart is maintained No any other complaints	Jee 13/01/25						
	11:30am	Dr. Geetha mom phone call order a dv! to do CBC, CT, PT, POCAL							
	12pm	Dr. Geetha mom rounds was done a dv! to recieve the reports after change to temp hyperic vitals are checked and recorded Temp is normal							
		<table><tr><td>PP</td><td>++</td></tr><tr><td>CP</td><td>++</td></tr><tr><td>CRT</td><td><2s</td></tr></table>	PP	++	CP	++	CRT	<2s	Jee 13/01/25
PP	++								
CP	++								
CRT	<2s								

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

NURSES NOTES

☐ No Known Drug Allergies

☐ Drug Allergies

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
13/7/26	1:30pm	Continue (13/7/26) The child details handed over to evening duty staff.	
	1:30pm	13/07/2026 on Monday The child details handing over taken from morning duty to evening duty. The child is conscious and oriented. IV line present. no pain, no swelling. IV line pattern.	
	2pm	Child was active is good. No any fever complaints.	
	4pm	Vitals all checked. Seeded. Vitals are stable (PP/CP/CAT/NOO/Febr). (TT/CSC)	
	4:30pm	Dr. Geetha Mann came seen the Baby while to continue treatment & if no fever spikes. to man or Wednesday D's plan.	
	6pm	Due medication given as per drug chart order. Maintained I/O chart.	
	1:30pm	Baby details handing over given to the Night duty staff.	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

NURSES NOTES

☐ Drug Allergies

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE						
		→ Night duty ←							
13/11/20	7-30pm	child taken over from evening duty staff							
		conscious & awake	no other						
	8pm	vital signs checked & recorded. No other complaints							
		<table border="1"><tr><td>PR</td><td>CP</td><td>QTS</td></tr><tr><td>++</td><td>++</td><td>1300</td></tr></table>	PR	CP	QTS	++	++	1300	
PR	CP	QTS							
++	++	1300							
		due medications are given as per doctor's order.	no other						
	10pm	IV line @ present & patent. No other complaints. child had dinner - no other complaints							
	12AM	vital signs checked & recorded. No other complaints	no other						
		<table border="1"><tr><td>PR</td><td>CP</td><td>QTS</td></tr><tr><td>++</td><td>++</td><td>1300</td></tr></table>	PR	CP	QTS	++	++	1300	
PR	CP	QTS							
++	++	1300							
	2AM	child sleeping. No other complaints	no other						
	4AM	vital signs checked & recorded. No other complaints							

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

NURSES NOTES

☐ No Known Drug Allergies

☐ Drug Allergies

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE						
14/7/20		→ continue ←							
		<table border="1"><tr><td>PP</td><td>Q</td><td>CRS</td></tr><tr><td>H</td><td>ff</td><td>18h</td></tr></table>	PP	Q	CRS	H	ff	18h	
PP	Q	CRS							
H	ff	18h							
	6AM	due medication's are given as per doctor's order							
	7-30AM	No chart maintained child handing over given to morning duty staff	no outcome						
		Morning duty Notes on 14/7/20							
	7.30am	The child details handed over from the night duty staff							
	8am	The child is conscious and oriented Administer the medication as per doctor's order							
		vitals are checked and recorded temp is normal							
		<table border="1"><tr><td>PP</td><td>++</td></tr><tr><td>Q</td><td>++</td></tr><tr><td>CRS</td><td>12s</td></tr></table>	PP	++	Q	++	CRS	12s	
PP	++								
Q	++								
CRS	12s								
		The child had soft stool No chart is maintained No any other complaints							
	10.30 AM	The child condition seen by Dr goetha main advised to Discharge tomorrow							

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

SNC-00021894 IP18-00036382
 Baby SAAVI SUJATA VAIBHAV SARJE
 17-01-2025 1 Y 5 M 21 D (F)
 Dr. GEETHA JAYAPATHY



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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	8/7	8/7	9/7	9/7	9/7
	3 to less than 7 years old	3	4	4	4	4	4
	7 to less than 13 years old	2					
	13 years old and above	1					
		2					
Gender	Male	1	1	1	1	1	1
	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	1	1	1	1	1
		3					
Cognitive Impairments	Not aware of Limitations	2					
	Forget Limitations	1					
	Oriented to own ability	4	4	4	4	4	4
	History of Falls or Infant-Toddler Placed in Bed	3					
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	2					
	Patient Placed in Bed	1					
	Outpatient Area	3					
Response to Surgery / Sedation Anesthesia	Within 24 hours	2					
	Within 48 hours	1	1	1	1	1	1
	More than 48 hours / None	3					
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	1	1	1	1	1
	Other Medications / None	1					
Total			12	12	12	12	12

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:		Avis	Jathin	Angel	Sanjay	Jathin
Signature:		Pmk	Jathin	dy	Jathin	Jathin
Date:		8/7/24	8/7	9/7	9/7	9/7
Time:		6:30pm	2:10pm	8am	8pm	8pm

SNC-00021894 IP18-00036382
 Baby SAAVI SUJATA VAIBHAV SARJE
 17-01-2025 1 Y 5 M 22 D (F)
 Dr. GEETHA JAYAPATHY



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

BirthRight[™]
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	10/2/10	10/7/10	10/7/10	11/2/11	11/7/11
	3 to less than 7 years old	3	4	4	4	4	4
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2					
	Female	1	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	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	4	4	4	4	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	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					
Total			1/2	1/2	1/2	1/2	1/2

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		NA	NA	NA	NA	NA
Other Intervention(s) Specify		NA	NA	NA	NA	NA
Nurse's Name:		Amita	Seena	Rajima	Amita	Seena
Signature:		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date:		10/2/10	10/7/10	10/7/10	11/2/11	11/7/11
Time:		2pm	2pm	7:30pm	8am	2pm

BRADEN 'Q' SCALE (for Paediatric use)

Patient Name:

Age: Gender: U M F

SNC-00021894 IP-18-00036382
BABY SAAV SUJATA VAIBHAV SARJE
17-01-2025 1 Y 5 M 21 D (F)
D. GEETHA JAYAPATHY
M/RD-Q/MSG/04



Date:

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.
'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.
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.
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.
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, rigidity, 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.
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 (meal, 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 meat and dairy products. Occasionally eats between meals. Does not require supplementation.
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.

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

TOTAL SCORE	87	87	97	97
Evaluator's Name	Dr. Jay	Dr. Jay	Dr. Jay	Dr. Jay

1. 1000

2. 1000

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BRADEN 'Q' SCALE

(for Paediatric use)

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

SNC-00021894 IP18-00036382
Baby SAAVI SUJATA VAIBHAV SARJE
17-01-2023 1 Y 5 M 22 D (F)
Dr. GEETHA JAYAPATHY

F/HW/BRD-Q/NSG/04



						N	M	C	N
					Date :	9/2	10/2	10/2	10/2
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 of 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 meat 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						Dr. Geetha Jayapathy	Dr. Geetha Jayapathy	Dr. Geetha Jayapathy	Dr. Geetha Jayapathy

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

BRADEN 'Q' SCALE (for Paediatric use)

SNC-00021894 IP18-00036382
Baby SAAVI SUJATA VAIBHAV SARJE
17-01-2025 1 Y 5 M 23 D (F)
Dr. GEETHA JAYAPATHY

W/BRD-Q/NSG/04

Patient Name :

Age..... Gender.....



	Date : 11/2 11/7 11/7 12/2			
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.
'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.
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.
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.
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.
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 meat and dairy products. Occasionally eats between meals. Does not require supplementation.
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.
TOTAL SCORE				7 27 27 27
Evaluator's Name				Dr. Geetha Jayapathy

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

SNC-00021894
 Baby SAAVI SUJATA VAIBHAV SARJE
 17-01-2025 1 Y 5 M 25 D (F)
 Dr. GEETHA JAYAPATHY

IP18-00036382



BRADEN 'Q' SCALE

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

					Date :	E	N	M	F
					Time :	12/1	13/1	13/2	13/7
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	
FRICITION-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 of 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 meat 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					19	21	24	27	
Evaluator's Name					[Signature]				

Severe Risk : less than 9 | High Risk : 10-12 | Moderate Risk : 13-14 | Mild Risk : 15-18 | Not at Risk: 19-23

Docu. No. : RCH /FRM / CLINICAL / 119

Risk Score	Category	Action	Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice)
15-18	At Risk	⑩ Regular Turning Schedule ⑩ Enable as much activity as possible ⑩ Protect the heels ⑩ Use pressure redistribution surfaces ⑩ Manage moisture, friction and shear ⑩ Advance to a higher level of risk if other major risk factors are present	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	⑩ Use the Same Protocol as for "At Risk" Patients ⑩ Position patient at 30 degree lateral incline using foam wedges	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	⑩ Follow the same protocol as for "Moderate Risk" Patients ⑩ In addition to regular turning schedule ⑩ Make small shifts in their position frequently	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	⑩ Use same protocol as for "High Risk" Patients ⑩ Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
8/1/26	6:30pm	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	Nil	Dys
8/1/26	8pm	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	darhags
9/1/26	4am	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	day
9/1/26	8am	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	Nil	day
9/1/26	2pm	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	Nil	darhags
9/1/26	8pm	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	Nil	day
10/1/26	4am	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	Nil	day
10/1/26	8am	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	Nil	day
10/1/26	2pm	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	Nil	day
10/1/26	10pm	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	Nil	day

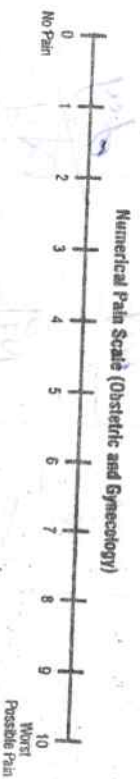
Re-assessment Frequency:

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

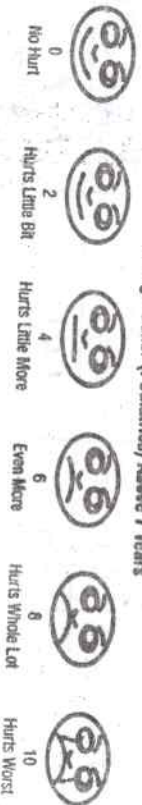
PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
	0	1	2
Face	No Particular expression or smile	Occasional Grimace or Frown, withdrawn, 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, rigid, or jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams or sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort



Wong - Baker (Pediatrics) Above 7 Years



Neonatal Pain, Agitation and Sedation Scale (up to 1 Month)

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1		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- 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 RR, BP, SaO ₂	No variability with stimuli Hyperventilation 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

PAIN ASSESSMENT FORM										
Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
11/1/26	4 AM	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	Nil	NP
11/2/26	2 AM	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NP	NP 015m
11/7/26	2 PM	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NP	NP 027u9
11/17/26	3 PM	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NP	NP 027u9
12/7/26	2 AM	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	NP 027u9
12/2/26	2 AM	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NP	NP 027u9
12/7/26	2 PM	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NP	NP 027u9
12/17/26	2 PM	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NP	NP 027u9
12/17/26	3 PM	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NP	NP 027u9
12/17/26	4 PM	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NP	NP 027u9
12/27/26	8 AM	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NP	NP 015m

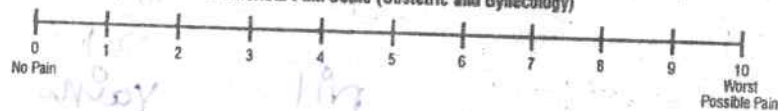
1. Every eight hours for all hospitalized patients.
2. For post-surgical patients, patients with chronic pain, patient with severe pain:
 - a) At least every 2 hours for the first 24 hours
 - b) Then every 4 hours.
 - c) Prior to pain relieving intervention.
 - d) Within 30 – 60 minutes after pain relief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

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Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, rigid, or Jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams or sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

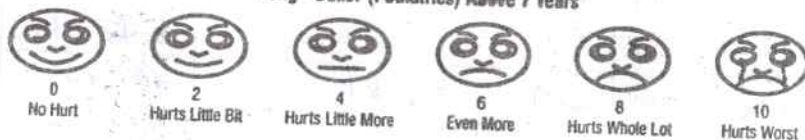
Numerical Pain Scale (Obstetric and Gynecology)



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)
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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

Wong - Baker (Pediatrics) Above 7 Years



IN



PATIENT / FAMILY EDUCATION RECORD

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 | Plan | 6. Discharge Medication | 10. Fall Risk Education |
| 2. Treatment and Care | 3. Pain Management | 7. Infection Control Measures | 11. Safe use of Medical Equipment / Implantable Devices |
| | 4. Informed Consent | 8. Diagnostic Test / Procedures | 12. Patient's / Family Rights |
| | 5. Medication / Therapy (safety, effects/ side effect, interactions) | 9. Nutrition / Diet | 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		
8/1/26	6:30pm	Teachn' can	explained the parent to best parent & can	Mother Parth	no learning barriers	Oral	none	Verbal understanding	Good	PG
9/1/26	8am	injection control	explain about hand hygiene and hand washing technique	mother	NO	Oral	none	Verbal understanding	good	dy
10/1/26	8am	Fall risk education	explained about call bell & side rail	mother	NO	Oral	none	Verbal understanding	-	AN
11/2/26	8am	Nutrition	Encouraged to take more oral intake	mother	NO	Oral	none	Verbal understanding	-	AN

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	4. Language Barrier	7. Impaired Thought Process/Cognitive limitations	10. Financial Difficulties	13. Cultural/Religion Practice
2. Physical Impairment	5. Educational Level	8. Responsibilities at Home	11. Beliefs and Values	14. Others (Specify)
3. Emotional Barriers	6. Desire / Motivate to Learn	9. Cultural Differences	12. Impaired Vision/ or Hearing	

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

Mechanism/s to overcome barrier/s:

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

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



Nursing General Admission Assessment Form For Pediatrics

Diagnosis:
 Arrival Time: 6pm Mode of Arrival: Parent Care Admitting From: ☒ ER ☐ OPD ☐ Direct
 Allergy / Adverse Reaction: Body Weight: 8.1 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: NIL

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

If yes please list,

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

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

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

Observations: Weight: 8.1 Length: Head Circumference (< 2 years):

Temp.: 99.8°F HR: 126/min RR: 28 BP: 90/60

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

Fall Risk Assessment: ☒ Yes ☐ No Score: 12 (Document in the Humpty Dumpty Sheet)

Risk of Pressure Sore (Braden Q Score 27) (Document in the Braden Q Assessment Sheet)

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

Character of Pain Location Frequency Duration

FUNCTIONAL SCREENING: ☒ No Abnormalities Detected

☐ Mobility Problem

☐ Walking Problem

☐ Developmental Delay

☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING: ☒ No Abnormalities Detected

☐ Underweight

☐ Overweight

☐ Special Feeding Method

☐ Feeding Problem

☐ Special diet

☐ No Abnormality Detected

Inform consultant for positive criteria

Psychological Screening: ☒ No Significant Findings

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

If Yes Consultant Notified: (Date/Time):

Social History: Lives With parents

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

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

Orientation has been given regarding the following aspects:

Call Bell in Reach : ☒ Yes ☐ No

Waste Disposal Explained: ☒ Yes ☐ No

Infusion Pump : ☒ Yes ☐ No

Hand hygiene Explained: ☒ Yes ☐ No

☐ Others

Patient Rights & Responsibilities: ☒ Yes ☐ No

Information given to parents

Nurse's Name: Alys Date: 8/7/06 Time: 6:30pm

Signature

POD
dgn



EMERGENCY ROOM TRIAGE FORM

Patient's Name: Baby. Saavi sujata vaibhav Age: 1y

Gender: ☐ Male ☒ Female

Date: 08/07/26 Time of Arrival: @ 4:55pm

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: 99.4 PR: 132 BP: any RR: 30 SpO₂: 99%

Chief Complaints: no fever, ↓ oral intake, Activity

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

- ☐ Level 1: Resuscitation
☐ Level 2: EMERGENT: Life or limb threatening
☐ Level 3: URGENT: Significant illness / injury with potential to become life or limb threatening
☐ Level 4: LESS URGENT: Significant illness but not life threatening
☐ Level 5: NON - URGENT: May receive care when convenient

CTAS

- ☐ Immediate
☐ < 15 min
☐ 30 min
☒ 60 min
☐ 120 min

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

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian

Triage Completion Time: 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: Richi

Date & Time: 08/07/26 @ 4:57pm

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

Signature of Triage Nurse: (Signature) (020536)

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date: 08/07/26 Time of arrival: 4:55pm
 Chief Complaints: c/o fever x 3 days, ↓ intake, Activity RBS: 100mg/dl
 Height: - Weight: 8.1kg 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 parents

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

Time of Initial assessment completed by ER Nurse: 30mins

Time	Nursing Notes
5:30pm	child come for emergency planned for admission. DR. Creetha seen in OPD Basis advised for Blood test, antibiotics case sheet written By DR. Manonmani IV placement done. Samples collected and send to lab. child shift to ward for further Management.

Samples collected by:

Samples sent by:

J. R. K. i. h. i

Time:

Time:

5:40 pm.

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1

Condition of patient at time of shift - out :	Details of Shift - out
HR: 120 ^{b/m} BP: 100/60 CFT: 1.8cc RR: 30 ^{b/m} SPO ₂ : 99% GCS: 15/15 Temperature: 97.9°F Pain Score: 0/10 Repeat RBS (if applicable): -	Shift - out from ER to: (404) Time of Shift - out: 6:05pm. Handover given to: N. N. Thuja. (Nurse's Name)

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any):

IV cannulation placed @ metacarpal 24 in'

Name of the Nurse :

Rishi

Signature of the Nurse :

Rishi (cousin)

Date & Time :

08/07/26 @ 5:30pm



PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor: Dr. Geetha

Date: 8/7/20

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

Start Time of Assessment: _____

Weight: 8.1 kg

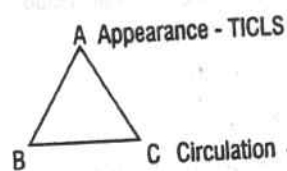
Allergic History: _____

Chief Complaints: _____

fever x 2-4 dx

2 entice

Pediatric Assessment Triangle



Breathing

☐ ↑ WOB

☐ ↓ WOB

☒ Normal

☐ Gasping / Apnea

C Circulation

☒ Normal

☐ Abnormal

Pallor ☐

Cyanosis ☐

Mottling ☐

Bleeding ☐

Initial Physiological Status: ☒ Stable ☐ Unstable

☐ Life Threatening

☐ Non Life Threatening

Any urgent interventions needed: ☐ Yes ☐ No

If Yes _____

Significant Past History: _____

Medication History: _____

Relevant Investigations: _____

Primary Assessment



Airway

☐ Open

☐ Maintainable

☐ Not Maintainable



Breathing

Rate: _____

SpO₂ on FiO₂ _____

Rhythm: _____

Retractions: ☐ Suprasternal ☐ ICR ☐ SCR

☐ Sternal ☐ Supraclavicular ☐ Nasal Flaring

Respiratory Noises: ☐ Stridor ☐ Wheezing ☐ Grunting

Air Entry: _____

Palpation Findings (if necessary) _____

Any urgent interventions needed: ☐ Yes ☒ No

If Yes _____

Any urgent interventions needed: ☐ Yes ☒ No

If Yes _____



Circulation

HR:

CFT ☐ Central
☐ Peripheral

Any urgent interventions needed: ☐ Yes ☒ No

BP: mmHg

Pulse Volume: ☐ Central
☐ Peripheral

If in Shock: ☐ Compensated
☐ Hypotensive

Muffled Heart Sound: ☐ Yes ☐ No

Engorged Neck Veins: ☐ Yes ☐ No

Murmurs: ☐ Yes ☐ No

Liver Span:

ECG:

Any Signs of Heart Failure: ☐ Yes ☐ No



Disability

GCS: AVPU:

Pupils: ☐ Responsive ☐ Non-Responsive ☐
Size ☐ Right
☐ Left

Active Seizures: ☐ Yes ☐ No Sugars:

Signs of Neurological compromise

Any urgent interventions needed: ☐ Yes ☒ No

If Yes

Exposure



Temp.:

Any Rash: ☐ Yes ☐ No,

If yes describe the rash

Active bleed

Lacerations ☐ Abrasions ☐ bruises ☐

Describe:

Any urgent interventions needed: ☐ Yes ☒ No

If Yes

Final Physiological Status: ☐ Respiratory Distress

☐ Shock - Compensated ☐

☐ Cardiopulmonary Arrest

☐ Respiratory Failure

☐ Hypotensive ☐

☐ Hemodynamically Stable

☐ Respiratory Arrest

Secondary Assessment: Head to toe examination with positive findings:

Labs Planned:

As charted

Treatment Planned:

As charted

Need for Oxygen: ☐ Yes ☒ No if yes Low Flow ☐

High Flow ☐ PPV ☐

Final Diagnosis with possible Differential Diagnosis (If necessary):

Assessment done by

Name of the Doctor: *Dr. Manma*

Signature: *[Signature]*

Date & Time: *8/7/20, 5pm*

Sr. Doctor on Duty (If necessary)

Name of the Sr. Doctor:

Signature:

Date & Time:

PATIENT TRANSFER FORM

SNC-00021894 IP18-00036382
Baby SAAVI SUJATA VAIBHAV SARJE
17-01-2025 1 Y 5 M 21 D (F)
Dr. GEETHA JAYAPATHY



Date & Time of Admission <i>08/7/26 @ 5:00pm</i>		Date & Time of Transfer Order <i>08/7/26 @ 6:05 pm</i>
Treating Consultant Name <i>DR. Geetha</i>	Transfer Ordered by <i>DR. Manonmani</i>	Reason for Transfer <i>Further Management</i>
From Unit <i>ER</i>	To Unit <i>404</i>	Information to Attendant Yes ☒ No ☐
Number of Sheets in Clinical File <i>10</i>	Number of Imaging Films <i>-</i>	Personal belongings including clinical documents. If any handed over to attendant. Yes ☐ No ☐ If yes, what ?
Medications / Consumables / Surgicals / Hand over		
Sl.No.	Item Name	Quantity
1.		
2.		
3.		
4.		
5.		
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐ <i>AFE / ? enterc ? UTI</i>		
Name & Signature of Person who is Transferring <i>P. S. D. S.</i>		Name of Person Ordered Transfer <i>Dr. Manonmani</i>
Patient & Clinical Records Received by : <i>P. S. D. S.</i>		
Date & Time of Patient Received : <i>8/6/26 @ 6pm.</i>		

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

