GUC-00094512 IP18-00036709
Baby BHAVI
15-03-2023 3 Y 4 M 17 D (F)
Dr. NANDHINI G

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		1/8/24 @					
Activity Sheet update by Pharmacy		3PM 15-8					

ACTIVITY RECORD FOR BILLING

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Name: .....

UHID No: ..... IP No: . GUC-00094512 Baby BHAVI 15-03-2023 3 Y 4 M 17 D (F) Dr. NANDHINI G IP18-00036709 ..... Dept: .....

Date of Admission: ..... Tim arge: ..... Time: .....

Room / Bed No: ..... Ward ..... llable bed type: .....

WARD TRANSFERS

	Date	Time	From	To	Signature of Nurse
	01/08	8:30AM	ER	417	
	1/8	10:30	417	OT	
	11/08/26	2:00pm.	OT	4th FLOOR	

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
1/8/26	Medium Biopsy.		
	Gram stain		
	pus culture & Sensitivity.	26024623	
	AFB Stain		
	Chest xpat MTP.		

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature

ANY OTHER INFORMATION:

Procedure : Incision & Drainage (Right Cervical Abcess)

Surgeon : DR. Nandhini G.

Anaesthetist : DR. Muthan

Time in : 11:20 Am Time out : 11:50 Am

Date: 1/8/26 Time: 3 pm Prepared By:

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
Anitha 01/8/26			

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SURGERY DETAILS

Date : 01/08/26

Patient Name: Baby Bhavi Date of Birth: 15/03/23 Age: 3y

Gender: Female Ward : OT UHID No.: 9251218670 9

Date of Surgery: 01/08/26 ☑ OT -1 ☐ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : Incision & Drainage (Right cervical Abscess

Time in : 11:20 Am Time Out : 12:50pm

	NAME	AMOUNT
1. Surgeon	: DR. Nandhini Cs	
2. Anaesthetist	: DR. Mohan	
3. Assistant Surgeon	: —	
4. OT Technician	: Mr. Raja	
5. Circulating Nurse	: CN. Sangeetha	
6. Assistant Nurse	: CN. Sangeetha	

Special Equipment: ☐ Laparascopy ☐ Broncoscope ☐ Harmonic ☐ Morcelator
☐ C-ARM ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa
☐ Neuro Cusa ☐ Others .....

DR. Nandhini. Cs.
Signature of the Surgeon

Signature of Circulating Nurse

Record finalase done by Guid

Order No: ..... Order by: .....

Docu. No. : RCH /FRM / GENERAL / 114

Patient Sticker

I & D.

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CONSUMABLES OF OT

Circulating staff : Ms. Sangeeth Technician : Mr. Raja Date : ..... Time : .....

Anaesthesia Disposables	Qty Issued	Qty Used	Surgical Disposables	Qty Issued	Qty Used	Disposables (Baby Side)	Qty Issued	Qty Used
ET tube 4.5 Cuff		1	Major Pack			Inj Vit.K		
LMA			Sutures			Cord Clamp		
ECG leads : A / P / N		3				Suction Catheter		
HME filter : A / P / N						Feeding Tube 9F		1
Syringes : 10 cc		2+4				Vaccum Suction Set		
05 cc		3	Gloves P.F 5½		1	Surgical Gloves		
02 cc		3	P.F 6		1	Gauze Pack		1
01 cc						Syringe 1ml / 2ml		
Cautery plate : A / P / N			Surgical blade 11		1	Surgical Blade # 20		
~~IV set~~ DripSet		1	NG tube			Koochies (S)		
RL		1	Cautery pencil			needle 18G		10
NS : 10ml / 100ml / 500ml / 1000ml		1	Koochies			Dwater 1000ml		1
			Ointments			Ropin 0.2%		1
			Suction Catheter			Needle 26 1½		1
Fentanyl		1	Cap, Mask			Dexfrid 50mg		1
Morphine			Gauze Pack plain		4+2	Tazeim 500mg		1
Ketamine			Mop Pack			Antacil		1
Propofol		1	Steristrip			Dwater 10ml		2
Rocuronium			Underpad		1	1cm Vein-O-line		1
Glycopyrolate			Draw sheet					
Myopyrolate			Abgel					
Ondansetron			Foleys catheter					
Pencan 25g/ Spinal Needle 22			Urobag					
Bupivacaine 0.25%			Chest Drainage Catheter					
Bupivacaine 0.25%(Heavy)			Romodrain bag					
Antibiotics			Bandage					
			Tegaderm					
Suppositories			Ioban					
Anamol : 80mg / 250mg / 170 mg		1	Double J Stent					
Supridol : 100mg			Vaccum Suction set					
Justin : 12.5 mg / 25mg / 100mg			~~Plastic Bed Sheet~~ Apron		2			
Tab. Misoprost : 200mg			Betadine Solution		1			
			Microshield					
			Cotton Balls					
			Latex Gloves		5P			
			Ramdione Scrub					
			Saral					

Surgeon Anaesthesiologist Nurse OT Technician

Order No. : ..... Ordered by : .....

RAINBOW CHILDREN'S MEDICARE LIMITED

Rainbow Children's Hospital - Guindy

Door No.157 to 160, Anna Salai, Guindy, Guindy Chennai Tamil Nadu INDIA
600015
Tel No : 044-40122444

VAT TIN : 33AABCR4014M1ZK **CIN :** L85110TG1998PLC029914

DL NO :

Registered Office: 8-2-120/103/1,Survey No.403,Road No.2,Banjara Hills, Hyderabad 500034, Telangana.

INPATIENT ISSUES AGAINST ORDERS

IP No	IP18-00036709	**Ward**	8F-OT COMPLEX
Patient Name	Baby BHAVI	**Bed Name**	PRE OP 807
Age/Sex	3 Y 4 M 17 D / Female	**Order No**	18-0001735912
Date	01/08/2026 13:34	**Prescription No**	PRIP18-0630376
Payor	SELFPAY	**Dispensed Date**	01/08/2026 13:35
UHID	GUC-00094512		

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	DISPOSABLE APRONS STERILE XL	Mediblue		15072026	06/29	2	120.00	240.00
2	D WATER IV 1000 ML BOTTLE	Aculife Health Care Pvt.Ltd(Nirlif	H	2602074015	05/28	1	258.80	258.80
3	GAUZE 7.5X7.5 12 PLY (5 NOS) NON XRAY	Bapuji Surgicals	GENERAL	M2641119	04/30	6	100.00	600.00
4	NITRILE EXAMINATION GLOVES P F- MEDIUM	ELITE MEDICALS	GENERAL	011	12/28	10	18.75	187.50
5	NS 100ML ACCULIFE - EH	Aculife Health Care Pvt.Ltd(Nirlif		1C2613680	02/29	1	44.93	44.93
6	RAMADINE SOLUTION 10% 100 ML	RAMAN & WEIL PVT LTD		RC126036	04/28	1	103.00	103.00
7	SGLOVE # 6 (POWDER FREE)	ANSEL		260301001T	03/29	1	128.00	128.00
8	SGLOVE 5.5 SIGNATURE			250905391T	09/28	1	117.00	117.00
9	SURGICAL BLADE 11	Surgeon	GENERAL	O030925	08/30	1	7.10	7.10
10	UNDERPADS CARE 60 X 90 (FRIENDS)			18072026	12/30	1	205.00	205.00
						Total :	**1,102.58**	**1,891.33**

for RAINBOW CHILDREN'S MEDICARE LIMITED

Receiver Name

Authorized Signature

Pharmacist Name : GRACE PAUL RAJAN

Printed Time : 01-08-2026 13:36

RAINBOW CHILDREN'S MEDICARE LIMITED

Rainbow Children's Hospital - Guindy

Door No.157 to 160, Anna Salai, Guindy, Guindy Chennai Tamil Nadu INDIA 600015
Tel No : 044-40122444

VAT TIN : 33AABCR4014M1ZK CIN : L85110TG1998PLC029914

DL NO :

Registered Office: 8-2-120/103/1,Survey No.403,Road No.2,Banjara Hills, Hyderabad 500034, Telangana.

INPATIENT ISSUES AGAINST ORDERS

IP No	IP18-00036709	**Ward**	8F-OT COMPLEX
Patient Name	Baby BHAVI	**Bed Name**	PRE OP 807
Age/Sex	3 Y 4 M 17 D / Female	**Order No**	18-0001735911
Date	01/08/2026 13:34	**Prescription No**	PRIP18-0630375
Payor	SELFPAY	**Dispensed Date**	01/08/2026 13:35
UHID	GUC-00094512		

S.No	Item Name	Manufacture Name	Schedule	Batch No	Exp Date	Iss QTY	Unitprice	Net Amount
1	ARTACIL 25MG 2.5ML INJ	Neon Laboratories Ltd	H	130359	08/27	1	45.30	45.30
2	DEXTOMID INJ 50 MCG 0.5 ML	Neon Laboratories Ltd		1257022	11/27	1	383.40	383.40
3	DSYRINGE 10ML (NIPRO)	NIPRO	GENERAL	26E02K29	04/31	6	28.13	168.78
4	DSYRINGE 5ML.(NIPRO)	NIPRO	GENERAL	25GO2K57	06/30	3	21.56	64.68
5	DSYRINGS 2.5ML(NIPRO)	NIPRO	GENERAL	26B12K44	01/31	3	11.25	33.75
6	D WATER 10 ML AMPULE	Aculife Health Care Pvt.Ltd(Nirlif	H	2254585	11/28	2	2.58	5.16
7	E.C.G ELECTRODES (PAED)	Adilase	GENERAL	0716O326	02/28	3	40.00	120.00
8	ET TUBE - 4.0 CUFFED (WELCO LIFE)			2511222	10/28	1	891.00	891.00
9	INFANT FEEDING TUBE-9	ROMSONS	GENERAL	G25K010618	10/30	1	63.00	63.00
10	MCT-ROF 100MG 10ML	Neon Laboratories Ltd	H	NA1353005	10/27	1	69.10	69.10
11	NEEDLE 18 * 1 1 2	Dispovan	GENERAL	08634D	01/31	1	3.38	3.38
12	NEEDLE 26 1 2 INCH	Dispovan	GENERAL	21664D	04/31	1	2.66	2.66
13	NEOMOL SUPPOSITORIES 170 MG 5 S	Neon Laboratories Ltd	GENERAL	BLNP487051	11/28	1	8.46	8.46
14	PEDIADRIPSET PLUS	ROMSONS		G26A020267	12/30	1	311.00	311.00
15	RL 500 ML CLOSED SYSTEM	Fresenius Kabi India Pvt Ltd		1D262104	03/29	1	69.84	69.84
16	ROPIN INJ 0.2 % 20 ML	Neon Laboratories Ltd		1435134	03/28	1	189.30	189.30
17	TAXIM INJ 500 MG	Alkem Laboratories Ltd.	H1	25180986	05/28	1	26.03	26.03
18	VEIN-O-LINE 10CM ROMSONS		GENERAL	K26E010512	04/31	1	460.00	460.00
						Total :	**2,625.99**	**2,914.84**

for RAINBOW CHILDREN'S MEDICARE LIMITED

Receiver Name

Authorized Signature

Pharmacist Name : GRACE PAUL RAJAN

Printed Time : 01-08-2026 13:35

GUC-00094512
Baby BHAVI
15-03-2023
Dr. NANDHINI G
IP18-00036709
3 Y 4 M 17 D (F)

Rainbow® Children's Hospital
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DISCHARGE TRACKING SHEET

DATE : 1/8/26

Name of Consultant :

Floor :

UHID :

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

GUC-00094512 IP18-00036709
Baby BHAVI
15-03-2023 3 Y 4 M 17 D (F)
Dr. NANDHINI G

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OPERATION NOTES

Surgeon : DR. Nandhini. G.	Asst. Surgeon : —
Anesthetist : DR. Mohan.	OT Nurse : Sis. Sangeetha.
Pre-Operative Diagnosis:	
Surgical Procedure : (R) cervical Abscess Incision drain	

Weight : 9.6 kg	Date : 1/8/26	Start Time : 11:20 Am	End Time : 11:50 Am

Post Operative Diagnosis: —

Peri-Operative Complications: —

Operation Notes: child in Supine / neck Extended posn

Findings:

- 18 g needle used to aspirate 3 ml pus from node

- Incision made in Submandibular Region & Necrotic node scooped out

- pus / node Sampled.

- H2O2 / Betadine wash given & Ceftriaxone given

Procedure Notes:

Amount of Blood Loss:	Blood Transfused (in ML) —

Name and Number of Surgical Specimen sent for examination: —

Doc. No. : RCH / FRM / CLINICAL / 099

(P.T.O.)

Patient Sticker

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POST-SURGICAL CARE PLAN FORM

Post-Operative Monitoring Parameters /Frequency:	Adv: 1) NPO till ~~12 noon~~ 1 pm
Wound Care:	2) Inj. Cefep (250mg) 5d
Drain /Special Lines/Catheters:	4ml tds. 3) Inj. Linezolid. x 3d
Special Patient Positioning and Requirements:	5ml — 0 — 5ml x 1wk.
Nutritional Instructions:	4) ~~[illegible]~~ mupirocin oint
When to Start Mobilization:	(1 — 0 — 1) x 1wk
Special Referrals:	Monitor vitals / up
The new order for all required medications documented in the doctor order/medication sheet: ☐ Yes ☐ No	
Any Other Post-Operative Care Needed including Required Follow Up	

Name of the Surgeon: .... Dr. [illegible]

Signature of the Surgeon: 65287

Date & Time: ....

GUC-00094512 IP18-00036709
Baby BHAVI
15-03-2023 3 Y 4 M 17 D (F)
Dr. NANDHINI G

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MEDICATION RECONCILIATION FORM

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

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

Shifting From: OT Shifted to: 4th FLOOR

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	2. PARIN	500mg	IV	STAT	4	☐C ☐DC
2	Paracetamol	120mg	PR	STAT	1	☐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 : .....

Date & Time : 01/08/26 at 12Pm

Nurse Name & Signature: Sis. Sangeetha

Date & Time : 01/08/26 at 12Pm.

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

SURGICAL SAFETY CHECKLIST

Surgeon : DR. Nandhini
Asst. Surgeon : .....
Anaesthetist : DR. mohan
Scrub Nurse : Sis Sangeeth

GUC-00094512 IP18-00036709
Baby BHAVI
15-03-2023 3 Y 4 M 17 D (F)
Dr. NANDHINI G

..... Age : ..... Gender : .....
. Surgery Name : .....
..... Out-time : .....

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Before Induction of Anaesthesia ➤➤

SIGN IN Time:.....

Patient Has Confirmed
- Identity ☑Yes ☐No
- Site ☑Yes ☐No
- Procedure ☑Yes ☐No
- Consent ☑Yes ☐No

Site Marked ☑Yes ☐No ☑NA

Anaesthesia Safety Check Completed ☑Yes ☐No

Pulse Oximeter on Patient & Functioning ☑Yes ☐No

Does Patient have a:
- Known Allergy? ☐Yes ☑No

Difficult Airway / Aspiration Risk?
- Yes, & Equipment / Assistance Available ☑Yes ☐No

Risk of > 500ml Blood Loss (7ml/kg In Children)?
- Yes, and Adequate Intravenous Access and Fluids Planned ☑Yes ☐No ☐NA
- Blood Units Reserved ☐Yes ☐No ☑NA

Has Antibiotic Prophylaxis been given within the last 60 minutes? ☑Yes ☐No ☐NA

Signature :.....

Name :.....

Before Skin Incision ➤➤

TIME OUT Time:.....

Confirm all team members have introduced themselves by Name and Role ☑Yes ☐No

Surgeon, Anaesthesia Professional and Nurse Verbally Confirm
- Correct Patient (Check ID Band) ☑Yes ☐No
- Correct Site ☑Yes ☐No
- Correct Procedure ☑Yes ☐No

Anticipated Critical Events

Surgeon Reviews:
- What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss? ☐Yes ☑No ☐NA

Anaesthesia Team Reviews:
- Are There Any Patient-specific Concerns? ☐Yes ☑No ☐NA

Nursing Team Reviews:
- Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns? ☐Yes ☑No
- **Is Essential Imaging Displayed?** ☐Yes ☑No
- Power Supply, Earthing, Power Backup and functioning of equipment checked. ☑Yes ☐No

Signature :.....

Name : DR. Nandhini G

Before Patient Leaves Operating Room

SIGN OUT Time:.....

Nurse Verbally Confirms with the Team:
- The Name of the Procedure Recorded ☑Yes ☐No
- That Instrument, Sponge and Needle Counts are Correct (or Not Applicable) ☑Yes ☐No ☐NA
- The Specimen is Labelled (including patient name) ☑Yes ☐No ☐NA
- Whether there are any Equipment Problems to be addressed ☐Yes ☑No ☐NA

To Surgeon, Anaesthetist and Nurse:
- What are the key concerns for recovery and management of this patient? ☑Yes ☐No

Signature :.....

Name : Sis Sangeetha

6 Type ISO 11140 | STEAM | Green = Sterilized | Man.: 2026 - 03 | Exp.: 2031 - 03 | Ref.: 106.303.0500 | Lot.: 14382 | SV: 121°C - 15 min. 134°C - 3,5 min. | Sterintech

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PATIENT TRANSFER FORM

GUC-00094512 IP18-00036709
Baby BHAVI
15-03-2023 3 Y 4 M 17 D (F)
Dr. NANDHINI G

Date & Time of Admission	Date & Time of Transfer Order
1/08/26 at 8:00Am	01/8/26 at 2:00Pm.

Treating Consultant Name	Transfer Ordered by	Reason for Transfer
DR. Nandhini G.	DR. Mohan	Further management

From Unit	To Unit	Information to Attendant
OT	4th FLOOR	Yes ☑ No ☐

Number of Sheets in Clinical File	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant
① Clinical file	—	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 ☐

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Sis. Sangeetha	DR. Mohan

Patient & Clinical Records Received by : Anitha

Date & Time of Patient Received : 1/8/26 @ 2p

If the transfer order time & Completion time is more than 30 minutes, please tick the reason mentioned below :

☐ Unavailable Bed ☐ Nurse not Available ☐ Available Bed not ready

GUC-00094512 IP18-00036709
Baby BHAVI
15-03-2023 3 Y 4 M 17 D (F)
Dr. NANDHINI G

BirthRight Children's Hospital

PATIENT TRANSFER NURSING HANDOVER CHECKLIST

Date & Time of Transfer: 11/08/26 at 2100hr From: OT TRANSFERRED TO: 4th Floor

		YES/NO	REMARKS
1	**Patient Identification**		
	a.Patient Identification Patient name, age, UHID/hospital number confirmed	YES	
	b.Surgical procedure & correct site verified	YES	
2	**Airway & Breathing**		
	a.Oxygen delivery (mask/cannula/ventilator) secured	NA	
	b.SpO_2 within safe range	YES	SpO_2 = 100%
	c.If ETT: position confirmed, ties secure, cuff inflated	NA	
3	**Circulation & Hemodynamic Stability**		
	a.IV lines secured & infusion running correctly	YES	
	b.No active uncontrolled bleeding	YES	
	c.Last vitals recorded before transfer	YES	
	d.Central line hubs are closed	NA	
	e.Dressing Intact	YES	
4	**Pain Assessment**		
	a.Pain score assessed & analgesia given	YES	
	b.Reassessment done	YES	
5	**Wound, Dressings & Drains**		
	a.Surgical dressing intact	YES	
	b.All drains fixed, output noted	NA	
	c.Catheter secure & urine output recorded	NA	
	d.Splints/casts/traction devices stabilized	NA	
6	**Medications Pre & Post-Op Orders**		
	a.Medications due time noted	YES	
	b.Pre & Post-op instructions (NPO, position, mobilization) communicated	YES	
	c.Emergency meds given in OT (time & dose documented)	YES	
7	**Equipment Safety & Transport Preparedness**		
	a.Oxygen cylinder full & ambu bag at bedside	NA	
	b.Bed/side rails up and brakes applied	YES	
	c.Special positioning maintained as per surgery	YES	
8	**High-Risk Patient Safety (if applicable)**		
	a.Chest tube: underwater seal below chest level	NA	
	b.Epidural catheter secure, infusion checked	NA	
	c.Pressure areas protected (heels/elbows)	NA	
9	**BLOOD AND BLOOD PRODUCTS TRANSFUSED**	NA	
10	**REPORTS AND LABS HANDED OVER**	YES	
11	**BIOPSY/HPE SENT**	YES	
12	**Documentation**		
	a.Documentation completeness	YES	
	Transferring Nurse:		
	Receiving Nurse :		
	Signature of Incharge:		

Rainbow Children's Hospital - Guindy
Door No.157 to 160, Anna Salai, Guindy, Guindy ,Chennai ,Tamil Nadu, INDIA ,600015.
044-40122444, info@rainbowhospitals.in

PatientName	: Baby BHAVI	**Outpatient No.**	: 2607-015328
Age/Gender	: 3 Y 4 M 16 D/ Female	**Admit Date**	: 31-07-2026
Ward/Bed	:	**Discharge Date**	: 31-07-2026

Investigation	Result	Unit	Biological Reference Interval
BLOOD GROUPING (Specimen : BLOOD)			TEST RESULT STATUS : REPORT AUTHORISED
			Order Date :31-07-2026 11:52
BLOOD GROUP	O		
RH (D) TYPE	NEGATIVE		

Rh type confirmed with Du test

Dr. LAWANYA G, MD, MBBS

Reg No : 80624

Investigation	Result	Unit		Biological Reference Interval
COMPLETE BLOOD PICTURE (Specimen : BLOOD)				TEST RESULT STATUS : REPORT AUTHORISED
				Order Date :31-07-2026 11:52
HEMOGLOBIN (Colorimetry)	**10.1**	**g/dL**	L	11.5 - 15.5
RBC COUNT (DC detection method)	**3.82**	**10^12/L**	L	3.9 - 5.3
PCV/HCT (Calculated)	**30**	**VOL%**	L	34 - 40
MCV (Calculated)	80	fL		75 - 87
MCH (Calculated)	27	pg/cells		24 - 30
MCHC (Calculated)	33	g/dL		32 - 36
RDW-CV (Calculated)	12.4	%		11.5 - 15
PLATELET COUNT (DC Detection Method)	**459**	**10^9/L**	H	150 - 450
MPV (Calculated)	7.9	fL		6.5 - 10
WBC COUNT (DC Detection Method)	11.92	10^9/L		5.5 - 15.5
Differential Count				
NEUTROPHILS (Microscopy, Leishman stain)	**61**	**%**	H	23 - 45
LYMPHOCYTES (Microscopy, Leishman stain)	**33**	**%**	L	35 - 65
MONOCYTES (Microscopy, Leishman stain)	4	%		4 - 10
EOSINOPHILS (Microscopy, Leishman stain)	2	%		1 - 6

Dr. LAWANYA G, MD, MBBS

Reg No : 80624

Investigation	Result	Unit		Biological Reference Interval
C REACTIVE PROTEIN (Specimen : SERUM)				TEST RESULT STATUS : REPORT AUTHORISED
				Order Date :31-07-2026 11:52
CRP (Immunoturbidimetry)	**12**	**mg/L**	H	<10

Rainbow Children's Hospital - Guindy
Door No.157 to 160, Anna Salai, Guindy, Guindy ,Chennai ,Tamil Nadu,
INDIA ,600015.
044-40122444, info@rainbowhospitals.in

PatientName	: Baby BHAVI	**Outpatient No.**	: 2607-015328
Age/Gender	: 3 Y 4 M 16 D/ Female	**Admit Date**	: 31-07-2026
Ward/Bed	:	**Discharge Date**	: 31-07-2026

Investigation	Result	Unit	Biological Reference Interval

Dr. PADMA KEERTHIGA B, MBBS, MD(BIO- CHEMISTRY)

CONSULTANT BIOCHEMIST, Reg No : 78510

Investigation	Result	Unit	Biological Reference Interval
PROTHROMBINE TIME & ACTIVATED PROTHROMBINE TIME (Specimen : PLASMA)			**TEST RESULT STATUS : REPORT AUTHORISED** Order Date :31-07-2026 11:52
PT (Optical Clot Detection)	12.6	Seconds	
PT Calculated Biological Reference Interval	12.5 - 14.5 secs		
INR	0.89		
APTT (Optical Clot Detection)	32.3	Seconds	
APTT Calculated Biological Reference Interval	28.5 - 35.1 secs		

Lanya.

Dr. LAWANYA G, MD, MBBS

Reg No : 80624

GUC-00094512 IP18-00036709
Baby BHAVI
15-03-2023 3 Y 4 M 17 D (F)
Dr. NANDHINI G

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Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

Name: Baby. Bhavi Age: 3Y 4M Sex: F UHID.No: 94512

Date: 31/7/26 Time: 12pm. Proposed Operation: I & D

Diagnosis: (R) submandibular abscess

B.P / CRT: ..... H.R: ..... Weight: 9.4 kg ASA Physical Status: ☐1 ☐2 ☐3 ☐4 ☐5

Laboratory Data:

Hgb: 10.1.	Glucose:	Protein:	HIV:	X-Ray:	
PCV:	Urea:	Alb:	HBS Ag:	ECG:	
WBC:	Creat:	Total Bil:	HCV:	2D Echo:	
Plate: 4.59.	Na:	Dir. Bil:	Blood group: O -ve	Stress/Anglo:	
PT: 12.6.	K:	LDH:	T3	Other:	
PTT: 22.3.	Ca++:	Alk phos:	T4		
INR: 0.89.	Mg++:	Amylase:	TSH		
	Cl-:	SGOT/SGPT:			

Allergies: NIL

Medical History: CVS: 2nd child, FTLS, B.W - 2.5 kg, cried immediately after birth

RESP: (N) developmental milestones

CNS: vaccinated till date

Renal:

Hepatic / GE: Physical Activity: active child

Others: nil comorbids

Past Anaesthetic History: nil prev ex.

Physical Exam:

Airway: MP 1 (2) 3 4 Mouth Opening: Adeq Mentohyoid Distance: (N) Neck: (N) Teeth: (N)

Lungs: B/L AE (+)

Heart: S1 S2 (+).

CNS: NFND.

Pregnant: ☐ Yes ☐ No ☐ NA | Venous Access Site: Accessible for regional: (N)

Anaesthetic Plan: ☐ MAC ☐ REGIONAL ☐ GA-ETT ☐ LMA

Peri-Operative Plan Explained to the Patient: ☐ Yes ☐ No

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions:

1. DVT Prophylaxis :
2. NIL ORAL → Water / ORS 2 Hours; Others 6 Hours
3. Informed Consent: ☐ Standard ☐ High Risk
4. Post Operative Pain Management: ☐ Discussed with Patient
5. Other Instructions:
   - To do CBC, PT, PTT, INR and show to OT anesthetist on the day of sx

Signature: 15462 Name: Dr Priyadharshini

Docu. No.: RCH /FRM / CLINICAL / 044

Patient Sticker

ANAESTHESIA CHART

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Pre Induction Assessment:

Change in Patient Condition:	☐ Yes ☑ No	Fasting Status: > 6 hrs	
Physical Status:	Patient Identified ✓	☑ Consent Present	✓ ☐ Chart Reviewed

H.R.: 90/min B.P / CRT: 70/90 SpO_2: 100% R.R.: 24/min Last Feed:

Pre-OP Diagnosis: (R) submandibular abscess Operation: I & D Date: 1/8

Surgeon: Dr Nandhini Anaesthesiologist: Dr Mohan / Dr Priya Technician: Mr Raja

TIME: 11.20 am 11.50 am

N_2O / AIR / O_2 LPM: 0.6 : 0.6

HALO / ISO / SEVO: 3%

Drugs:
Inj Propofol 50 + 20mg IV
Inj Fentanyl 20mcg IV.
Paracetamol suppository 120mg PR

Antibiotic: Inj Taxim 500mg IV
Suppository: Para 120mg PR
Blood Loss

FIO_2 / SaO_2: 0.5
$ETCO_2$: 35
ECG: normal rhythm
Temperature
Urine Output

Fluids / Blood: 90ml 1% DEL.

NOTES

B.P
V Systolic
Λ Diastolic
X Mean
• Heart Rate

Tourniquet on Time
Tourniquet off Time
Throat Pack In
Throat Pack Out

240 220 200 180 160 140 120 100 80 60 40 20 10 0

LAB Values: ABG / GRBS / Others

☑ Equipment Checked and Functional
☑ BP
☑ Cuff Site:
☐ Art Site:
☑ EKG Lead
☐ Temp Site
☑ FIO_2 Monitor
☑ Agent Monitor
☑ Pulse Oximeter
☑ Capnograph
☑ Ventilator
☐ Nerve Stimulator

Position: supine
☑ Pressure Points Checked

Eye Care:
☐ Oint
☑ Tape
☐ Padding
☐ Awake

Temp:
☐ HME ☐ Fluid Warmer
☐ Cling Film ☐ OH Warmer
☐ Hugger's ☐ Cotton Wool
☐ Other

Times:
Anaes Start: 11.20 am
OP Start:
OP End:
Leave OR: 11.50 am

Anaesthesia:
☑ GA
☐ Monitored Anaesthesia Care
☑ Regional

Line (Size & Location)
☐ CVP
☐ ART
☐ IV
☐ IV 22G (L) VL
☐ IV

Induction
☑ IV ☐ Inhal
☐ Pre O_2 ☐ RSI
☐ Others

☐ Mask ☐ SGA
☐ Airway ☐ Oral ☐ Nasal
☑ ETT# 4.5 at 10 cm
☑ Oral ☐ Nasal ☐ Cuff
☐ Tracheostomy ☐ Topical
☐ Drug:

☐ Awake ☑ Direct Vision
☐ Video Laryngoscopy ☐ Stylette / Bougie
☐ Fiberoptic
Blade# (2) Attempts (1).
Difficulty Why?

☐ Bilat = BS
☐ Semi-Closed Circle
☐ Closed Circle
☐ Other

Regional:
Extremity Specify: USG guided
☐ Spinal ☐ Epidural ☐ Caudal
Others:
Position: (R) superficial
Site: cervical
Needle Size: plexus block Depth
Parasthesia ☐ Yes ☐ No
Catheter at skin: 5ml cm 0.2%
Drug Name & Conc: Ropin
Bolus:
Infusion:
Block Level:
Comments:

Transportation to
☐ PACU ☐ ICU ☐ Other
Relaxant Reversed ☐ Yes ☐ No ☐ NA

Name of the Doctor: Dr Priya
Signature of the Doctor: [signature]

Patient Sticker

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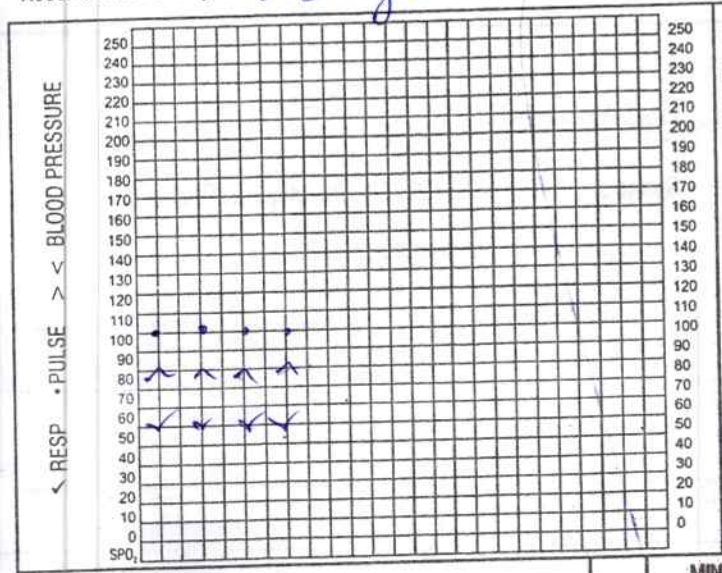
POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Sr. Sangeetha · Time Received : 1:30pm Time Discharged : 2:00pm



IV Cannula Site : .....

- ☐ O_2 Mask
- ☐ Tracheostomy
- ☐ Oral Airway
- ☐ Nasal Prongs
- ☐ T-Piece
- ☐ Nasal Airway

Vomiting : ☐ Yes ☐ No Drug: .....
NG Tube : ☐ Yes ☐ No
Drain: ☐ Yes ☐ No
Urinary Catheter: ☐ Yes ☐ No
Chest Tube: ☐ Yes ☐ No
Nil Oral ☐ Yes ☐ No
IV Fluids: .....
Oral Feeds: .....

POST ANAESTHESIA SCORE (Modified Aldrete Score)			IN	MINUTES 30	60	90	OUT	SCORING INTERPRETATION
Able to move 4 extremities voluntary or on command Able to move 2 extremities voluntary or on command Able to move 0 extremities voluntary or on command	= 2 = 1 = 0	ACTIVITY	2				2	A Minimum Total Score of 8 is Required for Discharge
Able to deep breathe & cough freely Dyspnea or limited breathing Apneic	= 2 = 1 = 0	RESPIRATION	2				2	Exceptions to this, are to be explained in the space below by the Discharging Physician:
BP ± 20 of Pre Anaesthetic leve BP ± 20-50 of Pre Anaesthetic leve BP ± 50 of Pre Anaesthetic leve	= 2 = 1 = 0	CIRCULATION	2				2	
Fully awake Arousable on calling Not responding	= 2 = 1 = 0	CONSCIOUSNESS	2				2	
Pink Pale, dusky, blotchy, jaundiced, other Cyanotic	= 2 = 1 = 0	COLOR	2				2	
		TOTAL	10				10	

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
1/8		0/10	NRS x 2 hours	Sr. Sangeetha
			Inj. Perinorm 100mg TDS.	

Pain Tool Used: ☐ N PASS ☐ FLACC ☐ Wong Baker ☐ NPS

Reassessment Frequency:
1. Every eight hours for all hospitalized patients.
2. For post surgical patient, patient with chronic pain, patient with severe pain
   a. Every 2 hours for first 24 hours
   b. After 24 hours every 4 hours
   c. Prior to pain reliving intervention
   d. With in 30-60 minutes after pain relief intervention

Anaesthesiologist Name : Dr Peiye
Anaesthesiologist Signature: Sr. Sangeetha
Date & Time: 1/8/26 .12pm

PACU Nurse Name : Sr. Sangeetha
PACU Nurse Signature: Sr. Sangeetha
*Date & Time: 1/8/26 at 1:30pm.

Transferred to Unit by (PACU): Sr. Sangeetha
Date & Time: 1/8/26 at 2:00pm.

Patient Sticker

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Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

Date: ..... Time: ..... Procedure done by .....

CSE /Spinal /Epidural Position : ..... Space :..... Technique (LOR/LOS) .....

Depth: ..... Catheter at Skin: ..... Attempts :.....

Parasthesia : Yes/No if yes details : .....

Solution Composition : .....

Any other issues :

a) .....

b) .....

Time	Infusion Rate (ml/hr)	Bolus (ml)	Level		Maternal		FHR	Comments
			Left	Right	BP	Pulse		

Delivery Details : Time : ..... APGAR: ..... SVD / Instrumental / LSCS (if LSCS Details)

Catheter Removed by and Tip Inspected : .....

Patient Satisfaction : .....

Discharge /Shifting ordered by

Doctor Signature: .....

Doctor Name: .....

Date and Time : .....

CONSENT FORM FOR ANAESTHESIA

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GUC-00094512 IP18-00036709
Baby BHAVI
15-03-2023 3 Y 4 M 17 D (F)
Dr. NANDHINI G

Patient Name : ..... Age : ..... Gender : Male ☐ Female ☐

UHID NO: .... Surgeon Name: .....

Anaesthesiologist : ..... . Operative procedure planned : I & D Incision & Drainage

PLEASE READ THIS BEFORE YOU CONSENT FOR ANAESTHESIA

General anaesthesia involves rendering a patient unconscious before an operation. This ensures the patient is not aware of events and does not feel pain during the operation. Drugs given through a vein and / or inhaled from an anaesthesia machine produce it. Regional anaesthesia involves using a local anaesthetic to numb a specific area of the body for surgery: Prolonged pain relief without numbness can be achieved by infusing weak solutions of local anesthetics arid narcotic drugs to particular parts of the body after surgery or injury, using catheters.

Specific High Risk (s) : The doctors have explained to me the details of the high risk involved due to the following medical problems and I have sought necessary clarification on all my doubts.

☐ Heart disease ☐ Hypertension ☐ Diabetes mellitus ☐ Renal failure

☐ Hepatic disorders ☐ Shock ☐ Multiple organ failure ☐ Polytrauma / Renal Tubular Aacidosis

☐ Incapacitating Cronic Obstructive Pulmonary Disease ☐ Others : —

- Doctor to document in medical record also if necessary (Cross-out if not applicable)

DECLARATION BY PATIENT / GUARDIAN / PROXY

I hereby authorize Rainbow Hospital & its authorized doctors to perform upon me / my patient the above mentioned operation / Diagnostic / Therapeutic procedures.

I authorize and give consent for anaesthesia (☐ Regional / ☐ General Anesthesia / ☐ Monitored Anesthesia Care as considered appropriate by the anaesthesia team.

I acknowledge that the anaesthetists have informed me about the anaesthetic procedure, risk, benefits and alternative treatments and answered my specific queries and concerns about this matter. I have read and understood the information provided in this form I acknowledge that I have discussed with the anaesthetists any significant risk and Complications specific to my individual circumstances, and I have considered them before Consenting for anesthesia.

I understand that there are some infrequent complications that can occur due to use of anaesthesia, these include pain or some injury at the site of injections, temporary breathing difficulties, asthmatic reactions, headaches.

I authorize the anaesthesia team to perform any additional procedures (for example, Central Venous Pressure line, arterial line, use of nerve blocks for pain relief, changing from regional to general anaesthesia etc), which are considered necessary by them during the course of surgery.

That I authorize and give consent to the team of doctors attending on me to administer blood products during the course of operative period and immediately thereafter in need arises.

I understand that the above mentioned consultant anesthesiologist or occasionally a colleague deputed by him / her will administer the Anaesthesia.

I have been explained all my queries in the language understood by me.

Patient / Patient Attendant :

Signature : Sonal.

Name : SONAL

Relationship with Patient: MOTHER

Date & Time : 1/8/26 at 11:00 A.M

Witness :

Signature : Sangeetha

Name : [illegible]

Date & Time : 1/8/26 at 11:00AM.

Doctor (who is taking the consent) :

Signature : Soh Name : SANGEETHA Date & Time : 1/8/26

Docu. No. : RCH / FRM / CLINICAL / 021

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

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GUC-00094512 IP18-00036709
Baby BHAVI
Patient Name : . 15-03-2023 3 Y 4 M 17 D (F) ..... Gender: ☐ Male ☐ Female Age : .....
Dr. NANDHINI G

UHID No : .... Date : .....

Instruction:

This consent form should be signed by Patient (If an adult 18 years or older) or by a parent / guardian, if the patient is a minor or lacks the ability to make an informed decision. The purpose of this form is to verify that you have received this information and have given your consent to the surgery or special procedure recommended to you.

I hereby authorize the performance of the following operation (s) or procedure (s) (use no abbreviation / Avoid technical terms)

..... D cervical Abscess .....

..... upon I & D .....

(Name of the Patient)

I have been advised of the benefits and reason of the procedure(s) as indicated by the clinical observations and / or diagnostics performed. I recognized that the practice of medicine is as much an art as a science and therefore acknowledge that no guarantees have been or can be made regarding the likelihood of success or outcomes. My questions regarding the condition, the proposed surgery and the outcome have been answered to my satisfaction prior to signing this form by the surgeon.

I have been explained about the reuse of single use device after appropriate reprocessing. If required during the surgery or procedure in consonance with good clinical practices.

I have been explained the risks of this surgery /procedure and also about the reasonable alternative and the relevant risks, benefits and side effects related to such alternatives, including the possible results of not receiving care or treatment.

I have been explained that the following complications though rare are possible and will not hold Surgeon, Anesthesiologist or the hospital staff responsible for any untoward event thereof.

.....

.....

.....

My signature on this form indicates that

1. I have read and understood the information provided in this form
2. My doctor had adequately explained to me the operation or procedure along with the complications written above, along with the risks, benefits and other information.
3. I have had a chance to ask my surgeon questions.
4. I have received all the information I desire concerning the operation or procedure and
5. I authorize the consent to the performance of the operation or procedure.

Name of the Doctor who is performing the Surgery / Procedure: .....

Consentee :

Signature : .....

Name : .....

Date & Time : .....

Patient Attendant :

Signature : Sonal

Name : SONAL

Relationship with Patient: MOTHER

Date & Time : 1/8/2026 : 10:31 am

Witness :

Signature : .....

Name : Sangeetha

Date & Time : 1.8.26 at 10:30AM

Doctor (who is taking the consent) :

Signature : .....

Name : .....

Date & Time : .....

அறுவை சிகிச்சை அல்லது சிறப்பு சிகிச்சைக்கு தகவலறிந்த ஒப்புதல் படிவம்

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நோயாளியின் பெயர்:..... வயது:..... பாலினம்: ஆண்☐ பெண்☐

UHID எண் : ..... தேதி: .....

நிபந்தனைகள்:

இந்த ஒப்புதல் படிவத்தில் நோயாளி (18 வயதுக்கு மேற்பட்டவராக இருந்தால்) அல்லது நோயாளி மைனராக இருந்தால் (Minor) அல்லது தகவலறிந்து தகவலின் அடிப்படையில் முடிவு எடுக்கும் திறன் இல்லாதவராக இருந்தால், பெற்றோர் / பாதுகாவலர் கையொப்பமிடவேண்டும். இந்த தகவலை நீங்கள் பெற்றுள்ளீர்களா என்பதையும், உங்களுக்கு பரிந்துரைக்கப்பட்ட அறுவை சிகிச்சை அல்லது சிறப்பு சிகிச்சை நடைமுறைக்கு உங்கள் சம்மதத்தை அளித்துள்ளீர்களா என்பதை சரிபார்ப்பதே இந்தப் படிவத்தின் நோக்கமாகும்.

பின்வரும் செயல்பாடுகள் அல்லது சிகிச்சை நடைமுறைகளை செயல்படுத்துவதற்கு இதன்மூலம் நான் முழுஒப்புதல் அளிக்கிறேன் (மருத்துவ சுருக்கங்களைப் பயன்படுத்தவேண்டாம்/தொழில்நுட்ப சொற்களைத் தவிர்க்கவும்).

.....மேற்கொள்ளவுள்ள மருத்துவசெயல் முறைகளில் உள்ள நன்மைகள் மற்றும் இதன் தேவை காரணம் குறித்தும் எனக்கு அறிவுறுத்தப்பட்டுள்ளது. மருத்துவப்பயிற்சி என்பது ஒரு அறிவியல் மட்டுமன்றி ஒரு கலை என்பதை நான் அறிவேன், எனவே மருத்துவ சிகிச்சையின் வெற்றி அல்லது சிகிச்சையினால் குணமாகும் சாத்தியக்கூறு குறித்து எந்த உத்தரவாதமும் இல்லை அல்லது செய்யமுடியாது என்பதை ஒப்புக்கொள்கிறேன். நோயாளியின் (எனது) நிலை, பரிந்துரைக்கப்பட்ட அறுவை சிகிச்சை மற்றும் அதன் விளைவு குறித்த எனது கேள்விகளுக்கு இந்தப்படிவத்தில் அறுவை சிகிச்சை நிபுணர் கையொப்பமிடுவதற்கு முன்பே, நான் திருப்தி அடையும் வகையில் பதிலளிக்கப்பட்டுவிட்டது.

அறுவைச் சிகிச்சை அல்லது மருத்துவ நடவடிக்கையின் போது தேவையானால், நல்ல மருத்துவ நடைமுறைகளுக்கு ஏற்ப, ஒருமுறை பயன்படுத்தும் கருவிகளை சரியான முறையில் மறுசெயலாக்கி மீண்டும் பயன்படுத்தலாம் என்பதை எனக்கு விளக்கியுள்ளனர்.

இந்த அறுவை சிகிச்சை செயல்முறையில் உள்ள அபாயங்கள் மற்றும் இதற்கு உள்ள நியாயமான மாற்று சிகிச்சைகள் மற்றும் மாற்று சிகிச்சையில் தொடர்புடைய அபாயங்கள், பக்கவிளைவுகள் மற்றும் சிகிச்சையை தொடராமல் இருப்பதால் ஏற்படக்கூடிய விளைவுகள் குறித்து எனக்கு விளக்கப்பட்டது.

.....

.....

.....அதனால்.....

.....நோயாளியின் பெயர்.....

பின்வரும் சிக்கல்கள் அரிதானவை என்றாலும் சாத்தியமுள்ளது என்று எனக்கு விளக்கப்பட்டது. எனவே எந்தவொரு அசம்பாவிதத்திற்கும் அறுவை சிகிச்சைநிபுணர், மயக்கமருந்து நிபுணர் அல்லது மருத்துவமனை ஊழியர்களை நான் பொறுப்பாக்கமாட்டேன்.

.....

.....

.....

இந்தப்படிவத்தில் எனது கையொப்பம் கீழ்கண்டவற்றை குறிக்கிறது:

1. இந்தப்படிவத்தில் கொடுக்கப்பட்டுள்ள தகவல்களை நான் படித்துப் புரிந்துகொண்டேன்.
2. மேலே குறிப்பிட்ட அறுவை சிகிச்சை அல்லது சிகிச்சை செயல்முறையில் உள்ள மேற்குறிப்பிட்ட சிக்கல்கள் ஆகியவற்றோடு இதிலுள்ள அபாயங்கள், நன்மைகள் மற்றும் பிறதகவல்களை எனது மருத்துவர் எனக்குப் போதுமான அளவு விளக்கினார்.
3. எனது அறுவை சிகிச்சை நிபுணரிடம் கேள்விகளைக் கேட்க எனக்கு வாய்ப்பு அளிக்கப்பட்டது. அறுவை சிகிச்சை அல்லது மருத்துவசெயல்முறை குறித்து நான் விரும்பும் அனைத்து தகவல்களையும் பெற்றுள்ளேன.
4. அறுவை சிகிச்சை அல்லது மருத்துவ நடைமுறையைச் செயல்படுத்துவதற்கான ஒப்புதலை நான் வழங்குகிறேன்.

ஒப்புதல் அளிப்பவர்:

கையொப்பம்:.....

பெயர்:.....

தேதி / நேரம்:.....

சாட்சி:

கையொப்பம்:.....

பெயர்:.....

தேதி மற்றும் நேரம்:.....

நோயாளியின் பாதுகாவலர்:

கையொப்பம்:.....

பெயர்:.....

நோயாளியுடனான உறவு : .....

தேதி / நேரம்:.....

மருத்துவர் (ஒப்புதல் பெறுபவர்):

கையொப்பம்:.....

பெயர்:.....

தேதி / நேரம்:.....

GUC-00094512 IP18-00036709
Baby BHAVI
15-03-2023 3 Y 4 M 17 D (F)
Dr. NANDHINI G

Rainbow Children's Hospital | BirthRight

SSI PREVENTION CHECKLIST

S.No	INTERPRETATION	PERFORMED	
	PREOPERATIVE		
1	Do not remove hair at the surgical site unless the presence of hair will affect the procedure. Use clipper if necessary	Yes	
2	Decolonize surgical patients with skin antiseptic(Chlorhexidine bath /wipes)	Yes	
3	Antibiotic prophalaxis given within 60mts prior to skin incision	Yes	
4	Use a checklist based on the world health organization-19 item surgical checklist to ensure adherence to best practice	Yes	
	INTRAOPERATIVE		
5	Using chlorhexidine gluconate and alcohol-containing skin preparatory agent in combination	Yes	
6	Maintain normothermia during the surgical procedure (>36 deg C)	Yes.	
	POSTOPERATIVE		
7	Maintain and monitor blood glucose levels regardless of diabetes status between 110 and 150 mg/dl		
8	Application of incisional negative pressure wound dressing		

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Baby BHAVI
15-03-2023 3 Y 4 M 17 D (F)
Dr. NANDHINI G

PATIENT TRANSFER NURSING HANDOVER CHECKLIST

	Date & Time of Transfer:		TRANSFERRED TO :
1	**Patient Identification**	YES/NO	REMARKS
	a.Patient Identification Patient name, age, UHID/hospital number confirmed	Yes	
	b.Surgical procedure & correct site verified	Yes	
2	**Airway & Breathing**		
	a.Oxygen delivery (mask/cannula/ventilator) secured	NA	
	b.SpO_2 within safe range	Yes	
	c.If ETT: position confirmed, ties secure, cuff inflated	NA	
3	**Circulation & Hemodynamic Stability**		
	a.IV lines secured & infusion running correctly	NA	
	b.No active uncontrolled bleeding	NA	
	c.Last vitals recorded before transfer	Yes	
	d.Central line hubs are closed	NA	
	e.Dressing Intact	NA	
4	**Pain Assessment**		
	a.Pain score assessed & analgesia given	NA	
	b.Reassessment done	Yes	
5	**Wound, Dressings & Drains**		
	a.Surgical dressing intact	NA	
	b.All drains fixed, output noted	NA	
	c.Catheter secure & urine output recorded	NA	
	d.Splints/casts/traction devices stabilized	NA	
6	**Medications Pre & Post-Op Orders**		
	a.Medications due time noted	NA	
	b.Pre & Post-op instructions (NPO, position, mobilization) communicated	Yes	
	c.Emergency meds given in OT (time & dose documented)	NA.	
7	**Equipment Safety & Transport Preparedness**		
	a.Oxygen cylinder full & ambu bag at bedside	NA	
	b.Bed/side rails up and brakes applied	Yes	
	c.Special positioning maintained as per surgery	NA	
8	**High-Risk Patient Safety (if applicable)**		
	a.Chest tube: underwater seal below chest level	NA	
	b.Epidural catheter secure, infusion checked	NA	
	c.Pressure areas protected (heels/elbows)	NA	
9	**BLOOD AND BLOOD PRODUCTS TRANSFUSED**	NA	
10	**REPORTS AND LABS HANDED OVER**	Yes	
11	**BIOPSY/HPE SENT**	NA	
12	**Documentation**		
	a.Documentation completeness		
	Transferring Nurse: _____		
	Receiving Nurse : _____		
	Signature of Incharge:		

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PATIENT TRANSFER FORM

GUC-00094512 IP18-00036709
Baby BHAVI
15-03-2023 3 Y 4 M 17 D (F)
Dr. NANDHINI G

	Date & Time of Admission	Date & Time of Transfer Order
	1/8/26 @ 8A	1/8/26 @ 10.30
Treating Consultant Name	Transfer Ordered by	Reason for Transfer
Dr. Nandhini	Dr. Manonmani	further managem
From Unit	To Unit	Information to Attendant
417	OT	Yes ☑ No ☐
Number of Sheets in Clinical File	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant.
30	—	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 ☐

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Jathiya Reddy (signature)	Dr. Manonmani

Patient & Clinical Records Received by : (signature)

Date & Time of Patient Received : 1/8/26 at 10:30Am

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

Docu. No. : RCH /FRM / CLINICAL / 102

GUC-00094512 IP18-00036709
Baby BHAVI
15-03-2023 3 Y 4 M 17 D (F)
Dr. NANDHINI G

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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: 4.17 Shifted to: OP

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 : .....

Date & Time : .....

Nurse Name & Signature: .....

Date & Time : 4/2/23 @ 8am

Rainbow Children's Hospital

BirthRight by Rainbow

Rainbow Children's Hospital - Guindy

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

ADMISSION SHEET

Registration Details :

Admission No : IP18-00036709 **Admit Date** : 01-Aug-2026 **Admit Time** : 08:04 AM **UHID** : GUC-00094512

Patient Details :

Patient Name	: Baby BHAVI	**Age**	: 3 Y 4 M 17 D
Guardian	: DEVENDER MEHTA .R	**DOB**	: 15-03-2023
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: 15/20,KAMARAJ AVENUE , 2ND ST, 1ST FLOOR , 1B ALDA AMOGH ADYAR Adyar Chennai Tamil Nadu INDIA 600020	**Phone No**	: 9962221500/ 9941779663
		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 : DEVENDER MEHTA .R **Relationship** : Father

Contact Address : 15/20,KAMARAJ AVENUE , 2ND ST, 1ST FLOOR , 1B ALDA AMOGH ADYAR Adyar Chennai Tamil Nadu INDIA 600020 **Phone No** :

Signature

Doctor Details :

Doctor Name : Dr. NANDHINI G **Specialisation** : PEDIATRIC SURGERY

Referral Doctor : SELF **Phone No** :

Co-Consultant :

Payment Details :

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

Payor Name : SELFPAY

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

GENERAL CONSENT FOR TREATMENT

Patient Name:	**Baby BHAVI**	**Age :**	**3 Y 4 M 17 D**
IP No:	**IP18-00036709**	**Sex:**	**Female**
Consultant:	**Dr. NANDHINI G**	**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 urance coverage and while doing so confidentiality of the patient will be maintained at all times and this will not affect the care of the patient.

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

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

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

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

Relationship:

Date: Time:

Witness Name:

Witness Signature:

Patient Address:

15/20,KAMARAJ AVENUE , 2ND ST, 1ST FLOOR , 1B ALDA AMOGH ADYAR Adyar Chennai Tamil Nadu INDIA 600020

BILLING POLICY

- Billing Cycle: - Bed charges will be calculated based on 12PM to 12PM checkout. Settlement post 12PM, room rent will be charged for half day extra & post 6PM, it will be charged for full day. Less than 24 hours stay will be considered as one day.
- Room Rent inclusive of Bed, Nursing, Consultation Charges and all other charges, like Diet, Investigations, IP or OP Procedures, Equipment, Cross Consultations, Blood/ Blood Products, Implants, Ward Consumables, Infection Preventive Measure Charges, Pharmacy and Consumables will be charged extra.
- 5% GST Charges applicable on more than INR 5,000/- Bed Charges which was effective from 18.07.2022 as per the GST Council.
- As per the G.O.I. guidelines, we can collect Rs 1,99,999/- only in cash mode, balance patient can pay through Credit Card/ Debit Card/ NEFT / RTGS / Demand Draft and Online Payment.
- In the event of TPA / Cashless denial or approval not received due to any reason then hospital tariff will be applicable and any discount or special rates given to TPA's / Corporate won't 9eapplicable.
- If the Surgery/ Procedures performed in emergency hours (8PM-6AM), Public Holiday and on Sunday will be charged 30% extra.
- Asst. Surgeon and Anesthetist Charges will be charged 30% on the Surgeon Charges.
- Admission will be done according to the ward category chosen by the patient; charges will be applicable as per the ward category. All charges vary as per Room category, except Pharmacy and consumables.
- Patient / Guardian Self Attested Government ID proof is mandatory to submit at the admission.
- TPA/Insurance Processing Fee applicable for all Insurance Cases.
- In our hospital there is "No Discounts Policy". Kindly co-operate.
- No Duplicate/ Second copy of OP or IP bill will be issued.
- In case the patient is shifted from lower category to higher category, all the charges like consultant visits, investigations, operations and procedures etc. from the date of admission will be charged according to the higher category.
- If the patient is shifted to the ICU, the attendant should vacate the room. If the attender occupies the room, it will be charged as per dual occupancy.
- Room eligibility is purely subject to TPA approval. Proportionate difference of the bill amount is applicable in case the patient opts for higher category higher than the TPA approved, which has to paid by the patient and may not be reimbursed by the TPA / Insurance Company at later stage.
- For Non - Medicals, Disposables, Consumables, Infusion Pump, Taxes, Implants, HIV/ HbsAg, Medical Records, Insurance Processing Fee, Double Occupancy and Registration Charges, Etc., credit cannot be extended. These items are not payable to us as per insurance company norms (Depends on the TPA/Insurance Co. T&C).
- It takes time for cash discharge is a minimum 3-4hrs. and in the case of insurance, it will take a minimum 6-7hrs.
- Difference, if any between the final bill amount arid amount permitted / approved by the TPA or total bill amount in case of denial from TPA, has to be paid by the patient.
- Two attendants are permitted with patients in Deluxe, Private Rooms and only one is permitted in the rest of the categories of rooms. No attendant is permitted in ICU's.
- All the refunds more than Rs.5,000/- will be refunded through NEFT within 7 Bank working days.
- Patient attendant can collect for Interim/provisional bill of the patient from the billing section on daily basis. Interim Bill shall be based on the acknowledged services in HIS. Final Bill of the patient may vary from the Interim bill based on actual update taken on the day of discharge. It is requested that patients/attendants enquire daily about the bill amount from billing section and pay the outstanding as on that day. You are requested to clear your outstanding amount on daily basis before 12 PM. **Patient bill outstanding should**
- **not be increase more than 10,000/-**

DECLARATION

I have attended the Financial Counselling desk & understood the expected costs & other conditions applicable. In this case, the TPA/Insurance Company rejects the claim for whatsoever reasons at any point of time after discharge. I promise to settle the claim with the hospital as per Hospital Cash Tariff.

Patient Name :	UHID Number :
Self/Attendant Name :	Relation :
Self/ Attendant Signature : Phone Number :	Name & Signature of Financial Counselor

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PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: _____ GUC-00094512 IP18-00036709 Baby BHAVI 15-03-2023 3 Y 4 M 17 D (F) Dr. NANDHINI G _____

UHID ID: _____ _____

Department: _____

Consultant: _____

Patient Sticker

Pediatric Multiorgan History & Physical Examination

Name: _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

History of present illness :

Apparently well child.

- c/o. (R) sided cheek swelling x 15 days
- had fever initially & settled
- was on Augmentin x 10 days.

O/E: (R) sided cheek swelling of size 5 x 5 cm.
- firm in consistency
- warmth (+)
- tenderness (+)

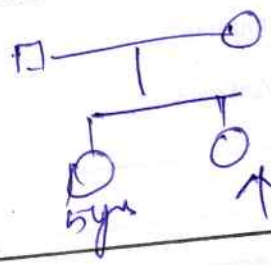
Oral cavity: uvula pushed to (L) side.
Tonsils pushed to L side
Grade II B/L tonsils.

Patient Sticker

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

Birth & Neonatal History:
LSCS | Full Term | cl AFB | BW - 2.1kg
No NICU stay

Family Chart



Birth & Socio Economic History:

About Father :

About Mother :

Any additional information :

Developmental History : Dev - (N)

Immunization History : as per IAP
Last vaccine @ 2 & 4 months.

Anthropometry :
Head Circum (cms) _____ (Centile _____) Height (cms): _____ (Centile _____)
Weight (kgs) 9.6kg (Centile _____)

On Examination :
Temperature : afebrile Pulse Rate : 115/min B.P. 92/64 (72) SPO2 98%.
Resp.rate and type of breathing : 28/min on NPO.
Rash – Child alert & active
Lymphadenopathy – PPWF (+)
Oedema : – CRT < 2 sec.
Allergies (if any): Not known. (R) sided neck swelling (+)

(P.T.O.)

Patient Sticker

Respiratory System :

Inspection (any s/o distress) :

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

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, NT Not tender, NO OM

Ausculation : BS (+)

Spine : External Genitelia :

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

Central Nervous System :

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

Cranial Nerves :

Motor System :

Nutriton :

Tone: (N)

Co-ordinator : Power 5/5

Posture :

Involuntary Movements :

Patient Sticker

Reflexes :

DTR 2+ ↓ **Superficials:** +

Plantars

Sensory System :

Bladder / Bowel :

Clinical Summary & Diagnostic: Δ - (R) submandibular abscess

Plan: I & D ↓ sedation

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

Desired goals of the treatment :

Planned Labs:

Planned Management

Signature of the Doctor:

Name of the Doctor: Dr. Gayathri

Date & Time: 1/8/26

Signature of the Consultant:

Name of the Consultant:

Date & Time:

(P.T.O.)

Patient Sticker

DISCHARGE PLANNING FORM

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

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

2. Destination Post Discharge: ☐ Home

   Family Members Notified (Person Contacted)

   ☐ Transfer

   Hospital Facilty Notified (Person Contacted)

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

   ☐ Needs Assistance In: Remarks

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

4. Nutritional Plan:

   ☐ Dietary Instruction Discussed with the:

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

5. Discharge Planning Discussed with the:

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

6. Patient/Family Educational Plan:

   ☐ Educational Topic/s: .....

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

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

Doctor Signature: .....

Doctor Name: .....

Date and Time: .....

GUC-00094512
Baby BHAVI
15-03-2023
Dr. NANDHINI G
IP18-00036709
3 Y 4 M 17 D
(F)

Docu. No. : RCH

DOCTOR'S SHIFT CHANGE HANDOVER FORM

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

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

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

DOCTOR'S SHIFT CHANGE HANDOVER FORM

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

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

GUC-00094512 IP18-00036709
Baby BHAVI
15-03-2023 3 Y 4 M 17 D (F)
Dr. NANDHINI G

417

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/8/26 8PM	S/b Dr. NANDHINI	
	checked mild leakage +	
	[illegible]	

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

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

GUC-00094512 IP18-00036709
Baby BHAVI
15-03-2023 3 Y 4 M 17 D (F)
Dr. NANDHINI G

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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: ER Shifted to: 417

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. Gayathri 165575

Date & Time :

Nurse Name & Signature: Shibu 17880

Date & Time : 01/08 8:30am

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

GUC-00094512 IP18-00036709
Baby BHAVI
15-03-2023 3 Y 4 M 17 D (F)
Dr. NANDHINI G

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DRUG CHART

Date of Admission: 01/08 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 :				Date / Time
Dose	Route	Frequency	Start Date	
Doctor's Signature		Valid Period	Pharm.	
Additional Instructions:				

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

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

Signature .....

VERIFIED BY : Name .....

GUC-00094512 IP18-00036709
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REGULAR PRESCRIPTIONS

Weight. 9.6 kg Ward. ....

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				

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				

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				

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. ..... Ward. .....

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

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

Signature .....

VERIFIED BY : Name .....

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
1/8	11:30Am	INJ TARIM	Stony	IV	RN	0203H.
1/8	11:30Am	PARA SUPPOSITORY	1tony	PR	RN	0203H.

GUC-00094512 IP18-00036709
Baby BHAVI
15-03-2023 3 Y 4 M 17 D (F)
Dr. NANDHINI G

I.V. FLUIDS CHART

Weight. 9.6kg Ward. .....

Date	Time	Composition of Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
1/8	11:20pm to 11:50am	IVF 1/2 DNS 50ml	IV	Guided			1/8		

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

GUC-00094512 IP18-00036709
Baby BHAVI
15-03-2023 3 Y 4 M 17 D (F)
Dr. NANDHINI G

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

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

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 11/3/26 Time: 8:30 am 12pm 2pm

Doctor / Nurse / Family Concern?

Temperature (°F) — 104 103 102 101 100 99 98 97 96 95 94 — 98°F

Heart Rate (bpm) and Blood Pressure (mmHg) * — 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 — 90/60 90/60 90/60

Note: BP does not score in early warning scoring

Heart Rate (Number) — 120bpm 120bpm 120bpm

Resp. Rate (bpm) (Over 1 Minute) * — 70 60 50 40 30 20 10 — 30 bpm

Resp Rate (Number) — 30 bpm 30bpm 30bpm

Resp Distress	Mod/ Severe / None / Mild	✓	✓	✓
Receiving O_2 (l/min) O_2 Saturations (%)		97%	97%	97%
Conscious Level	Normal / Altered	✓		
GCS *		15/15	15/15	15/15
TOTAL SCORE Number of shaded boxes		0	0	0
Pain Score		0	0	0
Observer's Initials				

ACTIONS

NB: Scores 3 should be recorded overleaf

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

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

Patient Sticker

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

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FLUID CHART

Sheet No. : ......(1)......

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

1/3/24		Intake				Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
	08:00 am	N									NO	Jey
	09:00 am	P									2d	Jey
	10:00 am	O									11hr	Jey
	11:00 am											
	12:00 pm			ORL 90ml						-	-	Ramya 20388
	01:00 pm											
Total Intake :						Total Output :						
	02:00 pm	water	100ml								0	Sly
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						Total Output :						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						Total Output :						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						Total Output :						

Total 24 hrs. Intake		Total 24 hrs. Output	

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NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: RHD			Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:			
	Surgery / Procedure:			Post OP Day:			
BACKGROUND	Date / Shift	1/3 M	1/8/26 Evening				
	Medical Condition (Any special condition to be noted):	Not at	Noted				
	Diet:	NPO	NPO				
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Ventilation (RA, NP, NIV, VENTI):	RA	RA				
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:	97 F.	98 F				
	Res:	20 b	30 br				
	SpO_2:	99 %	98 %				
	Pulse:	120 b	109 bt				
	BP:	90/50	98/56				
	LOC:	conv	Conscious				
	Fall Risk Score:		—				
	Pain Score:	0/10	0/10				
	Skin Integrity	—	—				
Recommendations	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				
Post Operative Procedure Special Orders:		—	—				
Handed Over By Name :		Jayaraja	Angel				
Signature / ID :		Jayaraja	Ang				
Date:		1/8/26	1/8/26				
Time:		10	7:30pm				
Taken Over By Name :		Angel					
Signature / ID :		Ang 01895					
Date:		1/8/26					
Time:		1:30pm	—				

Docu. No. : RCH /FRM / CLINICAL / 097

Patient Sticker

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NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:					Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:	
	Surgery / Procedure:					Post OP Day:	
BACKGROUND	Date / Shift						
	Medical Condition (Any special condition to be noted):						
	Diet:						
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Ventilation (RA, NP, NIV, VENTI):						
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:						
	Res:						
	SpO_2:						
	Pulse:						
	BP:						
	LOC:						
	Fall Risk Score:						
	Pain Score:						
	Skin Integrity						
Recommendations	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):						
Post Operative Procedure Special Orders:							
Handed Over By Name :							
Signature / ID :							
Date:							
Time:							
Taken Over By Name :							
Signature / ID :							
Date:							
Time:							

Patient Sticker

Baby. Bavi

NURSING CARE RECORD

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Date: .....

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8am	TO promote Health Hygiene		→ Assessed child condition → Vital monitoring → Q10 maintained. → educed. Hand hyg	maintained personal hygiene	Reassessment done	Jay 8am
Afternoon		maintain fluid Balance		Assessed child condition. vital sign's and. Q10 chart → maintain hand hygiene.	Improved fluid volume	Treatment was done vital were Stable	Jay 04pm
Night							

Patient Sticker

NURSING CARE RECORD

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Date: .....

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon							
Night							

GUC-00094512 IP18-00036709
Baby BHAVI
15-03-2023 3 Y 4 M 17 D (F)
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NURSES NOTES

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☐ No Known Drug Allergies

☐ Drug Allergies Nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
7/8/26	9.50 am	Received notes :- child received from 4th floor. c/o check swelling. came for I&D procedure. child conscious & oriented. child activity are good n/Dr line. vital signs checked & Recorded vitals are stable now. CP ++ PP ++ CRT 2sec	Jeny 02009
	10.30 am	child shifted to OT handing over given to OT s/Nr.	
		OT Notes.	
1/8/26	10:30AM	Baby hand over taken from 4th FLOOR staff. while receiving the patient is conscious	Ranjani 02034
	11:00AM	& oriented. vitals checked & recorded. pulse: 84b/m, Rr = 20b/m, BP = 90/50mmHg	
	11:20AM	Temp (N), SPO2 = 100%. General Anaesthesia given by DR. Mohan. procedure	Ranjani 02034
	11:30AM	done by DR. Nandhini G. Vitals on monitoring. pulse: 82 b/m, Rr=20b/m BP = 90/50 mmHg, Temp (N), SPO2=100% Gauze count collected. pus C/S. Gram stain & Biopsy sent to lab. Baby Dressing done. Baby	Ranjani 02034 Ranjani 02034

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

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

Patient Sticker

NURSES NOTES

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☐ No Known Drug Allergies

☐ Drug Allergies ....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
1/08/26	11:00Am	Shifted form OT to OT recovery	Puspa 0203
		at 11:50Am. Baby fully awake.	
	12:00Pm.	Baby shifted form OT recovery	
		to 4th Floor at 2:00pm. Baby	
	2:00pm	documents & details hand over	Puspa 0203
		given to 4th FLOOR staff	
		→ Receiving Notes On:- 31/1/26	
	2pm	child Received from from	
		OT to 4th Flood child is	
		conscious & oriented	
		child Iv cannula patten	0C8900
		child vital are stable	
		No any complaint's	
		child intake was good	
		child Dr. Nandhini mam	0C8900
		seen the child mam advise	
	3pm	child discharge today	
		file send to billing process	
			0C8900.

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Patient Sticker

NURSES NOTES

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☐ No Known Drug Allergies

☐ Drug Allergies .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Patient Sticker

NURSES NOTES

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☐ No Known Drug Allergies

☐ Drug Allergies .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

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Patient's Name: GUC-00094512 IP18-00036709
Baby BHAVI
MRD NO:....... 15-03-2023 3 Y 4 M 17 D (F)
Dr. NANDHINI G
Age :............ ☐ M ☐ F
Consultant :...

PHLEBITIS ASSESSMENT

CANNULA 1

Date : Time:
Location :
Size :
Cannula inserted by :

Date	Time	Phlebitis	Infiltration	Nursing Intervention	Sign
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		

Cannula removed : ☐Yes ☐No, if yes date and time :
RX any initiated : ☐Yes ☐No ☐NA If Yes specify-
Phlebitis score:

CANNULA 2

Date : Time:
Location :
Size :
Cannula inserted by :

Date	Time	Phlebitis	Infiltration	Nursing Intervention	Sign
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		

Cannula removed : ☐Yes ☐No, if yes date and time :
RX any initiated : ☐Yes ☐No ☐NA If Yes specify-
Phlebitis score:

NOTE : ❋ To be assessed within 30 minutes of insertion.
❋ Every 2 hours if on fluid infusion.
❋ Every 4 hours if only on IV medication.

V.I.P. SCORE (VISUAL INFUSION PHLEBITIS SCORE)........ Next page

PHLEBITIS ASSESSMENT AND MANAGEMENT RECORD

CANNULA 3

Date : Time:

Location :

Size :

Cannula inserted by :

Date	Time	Phlebitis	Infiltration	Nursing Intervention	Sign
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		

Cannula removed : ☐Yes ☐No, if yes date and time :

RX any initiated : ☐Yes ☐No ☐NA If Yes specify-

Phlebitis score:

CANNULA 4

Date : Time:

Location :

Size :

Cannula inserted by :

Date	Time	Phlebitis	Infiltration	Nursing Intervention	Sign
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		

Cannula removed : ☐Yes ☐No, if yes-date and time :

RX any initiated : ☐Yes ☐No ☐NA If Yes specify-

Phlebitis score:

NOTE : ❋ To be assessed within 30 minutes of insertion.
❋ Every 2 hours if on fluid infusion.
❋ Every 4 hours if only on IV medication.

V.I.P. SCORE (VISUAL INFUSION PHLEBITIS SCORE)

0	1	2	3	4	5
IV site appears healthy	ONE of the following is evident: ❋ Slight pain near I.V. site or slight redness near I.V site	TWO of the following is evident: ❋ Pain near I.V. Site ❋ Erythema ❋ Induration	ALL of the following is evident: ❋ Pain along path of cannula ❋ Erythema ❋ Induration	ALL of the following is evident and extensive: ❋ Pain along path of cannula ❋ Erythema ❋ Induration ❋ Palpable venous cord	ALL of the following is evident and extensive: ❋ Pain along path of cannula ❋ Erythema ❋ Induration ❋ Palpable venous cord ❋ Pyrexia
OBSERVE CANNULA	OBSERVE CANNULA	RESITE / REMOVE CANNULA	RESITE / REMOVE CANNULA CONSIDER TREATMENT	RESITE / REMOVE CANNULA CONSIDER TREATMENT	INITIATE TRETMENT RESITE / REMOVE CANNULA

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Baby BHAVI
15-03-2023 3 Y 4 M 17 D (F)
Dr. NANDHINI G

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THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE 1/2	DATE 1/8	DATE	DATE	DATE
Age	Less than 3 years old	4					
	3 to less than 7 years old	3	3	3			
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2					
	Female	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			
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2	2	2			
	Oriented to own ability	1	1				
Environmental Factors	History of Falls or Infant-Toddler Placed in Bed	4					
	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2					
	Outpatient Area	1	1	1			
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours/ None	1	1	1			
Medication Usage	Sedatives (Excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1			
	Total		10	10			

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:		Jathiya	Angel				
Signature:		[illegible]	[illegible]				
Date:		1/2	1/8				
Time:		9a	9pm				

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

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BRADEN 'Q' SCALE

				Date : 1/8			
				Time :	11:8		
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	
"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	
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	
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	
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	
Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	1	1	
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	
				TOTAL SCORE	25	25	
				Evaluator's Name			

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

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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	⓫ Regular Turning Schedule ⓬ Enable as much activity as possible ⓭ Protect the heels ⓮ Use pressure redistribution surfaces ⓯ Manage moisture, friction and shear ⓰ 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	⓱ Use the Same Protocol as for **"At Risk"** Patients ⓲ 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	⓳ Follow the same protocol as for **"Moderate Risk"** Patients ⓴ In addition to regular turning schedule ㉑ 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	㉒ Use same protocol as for **"High Risk"** Patients ㉓ 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

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PAIN ASSESSMENT FORM

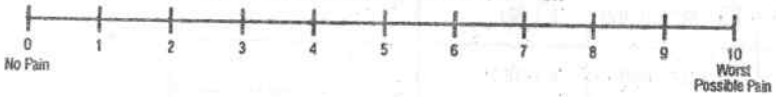
Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
11/2/21	9a	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	[illegible]
1/8/26	2pm	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	Nil	[illegible]
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

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

(P.T.O)

PAIN ASSESSMENT TOOLS

Numerical Pain Scale (Obstetric and Gynecology)



Wong - Baker (Pediatrics) Above 7 Years

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

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

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

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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

Identified Education Needs:

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

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
1/8/24	9am	Treatm & care	explain about treatments care	mothe	NO	oral	None	verbalizes understanding		

Part - III: CODES

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

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

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

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

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

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PATIENT TRANSFER FORM

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Baby BHAVI
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Dr. NANDHINI G

Treating Consultant Name: Dr Nandhini	Date & Time of Admission: 1/8/26 8:04am	Date & Time of Transfer Order: 1/8/26 08:30AM
From Unit: ER	Transfer Ordered by: Dr Gayathri	Reason for Transfer: Further Management
Number of Sheets in Clinical File: (13)	To Unit: 47	Information to Attendant: Yes ☑ No ☐
	Number of Imaging Films: Nil	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 ☐

A - (R) submandibular abscess. for I & D

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer

Patient & Clinical Records Received by :

Date & Time of Patient Received : 1/8/26 @ 8:40 hrs

If the transfer order time & Completion time is more than 30 minutes, please tick the reason mentioned below :

☐ Unavailable Bed ☐ Nurse not Available ☐ Available Bed not ready

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RBS CHART

Date	Time	RBS (mg/dl)	IVF %	Signature

BG → O(+)

NPO – 7:20 pm liquid.
10:00 pm solid

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wt 9.6 kg

EMERGENCY ROOM TRIAGE FORM

Patient's Name : BABY. BHAVI Age : 3y 4m Gender: ☐ Male ☑ Female

Date : 01/08/26 Time of Arrival : 7:55 pm

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

Source of Information : ☑ Parents ☐ Others (Specify) NA

Mode of Arrival : ☑ Ambulatory ☐ Wheelchair ☐ Ambulance

Initial Vital Signs: Temp: 97.5°F PR: 115/m BP: 92/64 (72) RR: 28/m SpO2: 98% @RA.

Chief Complaints: H/O came for I & D.

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

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

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

Sonal.
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 : Shibu Debnath.

Signature of Triage Nurse : [signature]

Date & Time : 01/08/26 & 7:57 pm

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

GUC-00094512 IP18-00036709
Baby BHAVI
15-03-2023 3 Y 4 M 17 D (F)
Dr. NANDHINI G

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 01/08/25 Time of arrival : 7:55 am

Chief Complaints: H/O I & D. RBS: —

Height : — Weight : 9.6 kg BMI : — Head Circumference (<2 years) .....

Allergies: ☐ Yes ☑ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other: .....

If yes , identify ..... Nil

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

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

RISK FOR FALL:

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

☐ If Patient is > 6 years
Assess the below parameters

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

Ambulatory Aids:

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

Gait/Transferring:

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

Mental Status: Forgets limitations ☐ Yes ☑ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening: ☑ No Abnormalities Detected

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

Inform consultant for positive criteria

.....

.....

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?) 01

Time of Initial assessment completed by ER Nurse : 8:05 am

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

Time	Nursing Notes
8:20	patient come to the ER with the
am	c/o swelling over the (R) cheek.
	monitored the vital signs recorded
	Dr. Gayathri ma'am and patient
	shifted to the ward.

Samples collected by: nil Time: nil

Samples sent by : Time:

Medication given in ER:

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

Condition of patient at time of shift - out :	**Details of Shift - out**
HR: 115/m BP: .... CFT: <3sec	Shift - out from ER to: 417
RR: 20/m SPO$_2$: 100%	Time of Shift - out: 8:50am
GCS: 15/15 Temperature : 97.5 F	Handover given to: (Nurse's Name) Sr. Latika
Pain Score: 0/10	
Repeat RBS (if applicable): —	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any): —

Name of the Nurse : Shibu Debnath Signature of the Nurse : [signature]

Date & Time : 1/8/20 (8:30am

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PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : Dr. Gayathri Date : 1/8/26

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

Start Time of Assessment: ..... Weight: 9.6 kg

Allergic History: .....

Chief Complaints:

1. (R) submandibular abscess
↓
for I & D.

Pediatric Assessment Triangle awake & alert.

A Appearance - TICLS .....

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

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

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

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

Significant Past History: .....

Medication History: .....

Relevant Investigations: .....

Primary Assessment

Airway
- ☑ Open
- ☐ Maintainable
- ☐ Not Maintainable

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

Breathing
Rate: 28/min SpO_2 on FiO_2 98/

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 .....

Circulation

HR: 115/min CFT [Central ..... / Peripheral .....]

BP: 92/64 (72) 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

Any urgent interventions needed: ☐ Yes ☑ No

If Yes .....

Disability

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

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

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

Signs of Neurological compromise .....

.....

Any urgent interventions needed: ☐ Yes ☐ No

If Yes .....

Exposure

Temp.: afebrile

Any Rash: ☐ Yes ☐ No,

If yes describe the rash .....

Active bleed .....

Lacerations ☐ Abrasions ☐ bruises ☐

Describe: .....

Any urgent interventions needed: ☐ Yes ☑ No

If Yes .....

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

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

Labs Planned: .....

as per chart

Treatment Planned: .....

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 Gayathri

Signature: .....

Date & Time: 1/8/26

Sr. Doctor on Duty (If necessary)

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

Signature: .....

Date & Time: .....