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

BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

PATIENT DISCHARGE INTIMATION FROM NURSING STATION

CLEARANCE FOR DRUGS AND DISPOSABLES BILLING

Name of the Patient: GUC-00094504 Baby SHREYANSH IP18-00036689
01-11-2025 0 Y 8 M 30 D (M)
Dr. KARTHIK NARAYANAN R

UHID No: .....

Ward: .....

Date: .....

Gender: .....

Room No: .....

Certified that in respect of the above patient:

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

Patient Authorised Sign

Date: .....

Time: .....

Nurse Sign

Date: 1/8/26.

Time: 10 AM.

Pharmacy Sign

Date: 1/8/26

Time: .....

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

Rainbow Children's Hospital

DISCHARGE TRACKING SHEET

UHID-

FLOOR-

NAME OF CONSULTANT-

GUC-00094504 IP18-00036689
Baby SHREYANSH
01-11-2025 0 Y 8 M 30 D (M)
Dr. KARTHIK NARAYANAN R

ACTIVITY	INTIME	OUT TIME	NAME & SIGNATURE	REMARKS	<To be filled by Admin>		
Activity Sheet update by Nursing		10AM	no orders				
Activity Sheet update by Pharmacy							

ACTIVITY RECORD FOR BILLING

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Name: .....

UHID No: GUC-00094504 IP18-00036689
Baby SHREYANSH
01-11-2025 0 Y 8 M 29 D (M)
Dr. KARTHIK NARAYANAN R

onsultant: ..... Dept: .....

Date of Admission: .....

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

Room / Bed No: ..... Ward: .....

Suggested Billable bed type: .....

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
30/7/26	8.20PM	ER	HDU	158804
31/7/26	5.55pm	HDU	409	013776

CROSS CONSULTATION VISIT

	Doctor Name	Date	Order No.	Signature
1.	Dr. MOHNISH	31/7/26	1735420	02/23
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

INVESTIGATIONS

Date	Investigations	Order No.	Signature
30/7	CBC, RP_2, Ca^+, Mg^+, OT, PT	26024457	[illegible] 108894
30/7 @9pm	Lactate Ammonia	26024458	[illegible]
	RBS	24482	[illegible]

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
30/4/26	Infusion Pump.	8.45 pm	31/4/26 @6am	1735135	[signature] H 021553

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
30/7	IV Placement	(1)	H35120	17894
31/7	VEEG - 2	(1)	10322	01220

ANY OTHER INFORMATION:

.....

.....

.....

.....

.....

.....

Date: 31/7/26 Time: 4.50p.m. Prepared By: .....

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
Sharmila. A 018776	4th Floor. 409.		

GUC-00094504 IP18-00036689
Baby SHREYANSH
01-11-2025 0 Y 8 M 30 D (M)
Dr. KARTHIK NARAYANAN R

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DISCHARGE TRACKING SHEET

DATE : _____

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		10AM		
3	Pharmacy Clearance				
4	Provisional Billing				
5	Audit Check				
6	Final Bill Prepared				
7	Sent to Insurance & Approval Received				
8	Handing Over & Bill Clearance				
9	Discharge Summary				
10	Physical Check Out				
11	Activity Sheet updated by Nursing				
12	Activity Sheet updated by Pharmacy				

Rainbow Children's Hospital

BirthRight by Rainbow

Rainbow Children's Hospital - Guindy

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

ADMISSION SHEET

Registration Details :

Admission No : IP18-00036689 **Admit Date** : 30-Jul-2026 **Admit Time** : 07:36 PM **UHID** : GUC-00094504

Patient Details :

Patient Name : Baby SHREYANSH
Guardian : Mr MANIKANDAN
Gender : Male
Occupation :
Address (H) : NO:24, BUDDHAR STREET, NEW PERUNGALATHUR Old Perungalathur Kanchipuram Tamil Nadu INDIA 600063

Age : 0 Y 8 M 29 D
DOB : 01-11-2025 01:00 AM
Religion :
Martial Status :
Phone No : 8122979710/ 8344011004
E-mail : MANIGANESH3795@GMAIL.COM

Admission Details :

Bed Type : DAY CARE **Bed No** : ER 101 **Ward Name** : 0F-EMERGENCY
Room No : ER 101 **Admission Type** : First Visit

Contact Details :

Name : Mr MANIKANDAN
Contact Address : NO:24, BUDDHAR STREET, NEW PERUNGALATHUR Old Perungalathur Kanchipuram Tamil Nadu INDIA 600063

Relationship : Father
Phone No : 8122979710

v. manikandan.

Signature

Doctor Details :

Doctor Name : Dr. KARTHIK NARAYANAN R
Referral Doctor : DR PRASHANTHA KUMAR - SRI SAI CHILD CLINIC -TAMBARAM
Co-Consultant :

Specialisation : PEDIATRIC INTENSIVE CARE
Phone No :

Payment Details :

Payment Mode : Cash

Deposit Amount : 0.00
Payor Name : SELFPAY

Rainbow Children's Hospital
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GENERAL CONSENT FOR TREATMENT

Patient Name:	**Baby SHREYANSH**		
IP No:	**IP18-00036689**	**Age :**	**0 Y 8 M 29 D**
Consultant:	**Dr. KARTHIK NARAYANAN R**	**Sex:**	**Male**
		Ward/Bed No:	**0F-EMERGENCY/ER 101**

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

Patient, be deemed advisable or necessary.

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

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

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

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

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

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

Signature of Patient/Relative: V.manikandan

Name: Mr. Manikandan

Relationship: Father

Date: 30/7/26 Time: 1:36pm

Witness Name: Jothis

Witness Signature:

Patient Address:
NO:24, BUDDHAR STREET, NEW PERUNGALATHUR Old Perungalathur Kanchipuram Tamil Nadu INDIA 600063

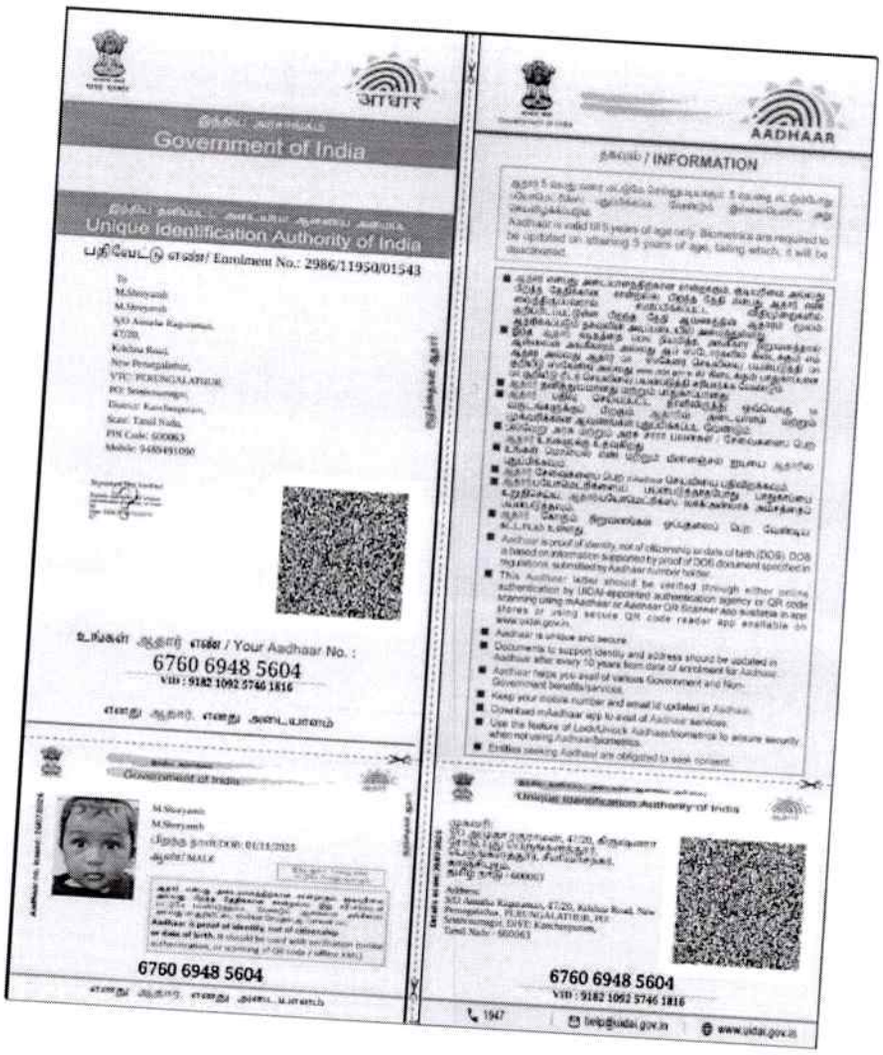
BILLING POLICY

- 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 : Shreyanth. M	UHID Number : GMC:00094504
Self/Attendant Name : MANIKANDAN.	Relation : Father
Self/ Attendant Signature : U. Manikandan. Phone Number : 8122979710	Name & Signature of Financial Counselor



GUC-00094504 IP18-00036689
Baby SHREYANSH
01-11-2025 0 Y 8 M 29 D (M)
Dr. KARTHIK NARAYANAN R

Rainbow Children's Hospital
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CROSS CONSULTATION FORM

Doctor Name : Dr. Mohnish Date : 31/7/26 Time : @ 12.45pm.

Diagnosis : Unprovoked Seizure

Hospital : RCH

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

Type of Referral :
☐ Emergency
☐ Urgent
☑ Non Urgent

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

Signature:

Findings and Recommendations : Thanks for Referral.

8 months, Dev. Normal child.

H/o child was crying followed by sudden episode of unresponsiveness noted, lasted for 2-3 min duration. (No uprolling eyeballs / tonic clonic movements)

Family h/o : Nil.

O/E : Conscious. No focal deficits.

Pallor (+)

Pulse N/N N/N

? REFLEX ANOXIC SEIZURE

Plan:

→ EEG (sleep study)

→ Syp. PIRACETAM 1ml—0-1ml (5ml / 500mg)

→ R/V.

Consultant :

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

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PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: _____

UHID ID: _____ GUC-00094504 IP18-00036689
Baby SHREYANSH
01-11-2025 0 Y 8 M 29 D (M) _____
Dr. KARTHIK NARAYANAN R

Department: _____ _____

Consultant: _____

Docu. No. : RCH/FRM / GENERAL / 065

(P.T.O.)

Patient Sticker

Pediatric Multiorgan History & Physical Examination

Name: _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

C/o → Unresponsiveness - 0 hr
Episode

History of present illness :

H/o → One episode of unresponsiveness at home at 5:30 pm → 2 episodes of Eyn. No GTCS, Had for 2-5 min - self aborted, child remained not conscious at that episode. taken to Hindu mission hospital → No fever
Eyn - (n)
↓
Referred here
- No h/o fever / vomit / diarrhea
- No h/o head injury
- No h/o cough / Vaccination
- No prev h/o seizures
- No h/o any exposure / dog bite

Patient Sticker

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

No past admission
ECHO - 12 day of life → (N) BV function, PFO (P), No PAH
At birth TSH → 15 u/l → Repeat TSH at 3 week of life → 4 μU/ml (N).

Birth & Neonatal History:

1st child / C-section / B.W - 4.9 kg / Neonatal ch

Family Chart

□—○ NCM
|
□

Birth & Socio Economic History:

About Father : } No family H/o Similar
About Mother :
Any additional Information :

Developmental History : No developmental delay Now
HC - 5 months, Rolls over - 4.5 M, Sits with support
bobbly (P)

Immunization History :

upto Age, → IAP.

Anthropometry :

Head Circum (cms) 46cm (Centile (+1 to +2 SD)) Height (cms): _____ (Centile _____)
Weight (kgs) 10.1 kg (Centile _____)

On Examination :

RR - 12 & regular

Temperature : 98.6°F Pulse Rate : 140/min B.P. 108/71 SPO2 98% on RA
Resp.rate and type of breathing :

Rash 1 cafe au lait spot on (P) Arm - post arm
Lymphadenopathy No other marks
Oedema : PP-NF-
Allergies (if any): Open mouth (P), protuberant tongue

(P.T.O.)

Patient Sticker

Respiratory System :

Inspection (any s/o distress) :

Air entry & breath sounds : NVBS D

Any addes sounds : Bl AE (B)

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

Cardiovascular System :

Inspection of procordium :

Heart Sounds : S1S2 (N)

Any murmur : No murm.

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

Per Abdomen :

Inspection :

Palpation : SOFT, Non tender

Ausculation : Bsx dcm & BCM

Spine : External Genitelia :

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

Central Nervous System :

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

Cranial Nerves :

Motor System :

Nutriton :

Tone: (N) Power 5 3/5

Co-ordinator :

Posture :

Involuntary Movements :

Patient Sticker

Reflexes : 2+

DTR

Superficials:

Plantars ↓| ↓

Sensory System :

Bladder / Bowel :

Clinical Summary & Diagnostic:

Unprovoked seizure ↓ evaluation

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

Desired goals of the treatment :

Planned Labs:

CBC /
RP-2 /
Ca^{2+}, Mg^{2+} /
OT, PT /

Planned Management

- HDU
- Hr further seizure
- IVF

Signature of the Doctor: .....

Name of the Doctor: Dr - Manoona

Date & Time: 30/7/26, 7:30pm

Signature of the Consultant: .....

Name of the Consultant: .....

Date & Time: .....

(P.T.O.)

Patient Sticker

DISCHARGE PLANNING FORM

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

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

2. Destination Post Discharge: ☐ Home
   Family Members Notified (Person Contacted)
   ☐ Transfer
   Hospital Facility Notified (Person Contacted)

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

   ☐ Needs Assistance In:

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

4. Nutritional Plan:
   ☐ Dietary Instruction Discussed with the:
   ☐ Patient ☐ Family Member ☐ Others: .....

5. Discharge Planning Discussed with the:
   ☐ Patient ☐ Family Member ☐ Others: .....

6. Patient/Family Educational Plan:
   ☐ Educational Topic/s: .....

   ☐ Patient's Educational Topic/s discussed with the:
   ☐ Patient ☐ Family Member ☐ Others: .....

Doctor Signature: .....

Doctor Name: .....

Date and Time: .....

GUC-00094504 IP18-00036689
Baby SHREYANSH
01-11-2025 0 Y 8 M 29 D (M)
Dr. KARTHIK NARAYANAN R

(1)

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
30/7/20 10:30pm		S/B Dr. Maromei
	Reviewed	1- Unprovoked Seizure evaluate
	No further episodes	SGOT - 209 ↑
	b/l PERL (+)	Electrolytes - (N)
	Asleep, AF	Ammo, Lactate - (N)
	PP-1r, periph warm	
		HR - 110/min
	R	SpO₂ - 100%
	→ If further episode	BP - 98/48 mmHg
	- Neuro opinion, serum	

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
31/7/26 9.30 AM	S/B- Dr Yuvaraj.	
	- Previously well child.	
	Dev- Normal child	
	Normal permatal ~~hx~~ period	
	C/o - decrease activity, unresponsive, while giving food at 5.30 PM at home.	
	~~vitals stable~~ carried for 5 mins.	
	Settled on its own.	
	No incontinence of urine/stools.	
	Went to Hundai Mission Hospital - CBG - (N)	temp - (N)
	referred here	
O/E	alert, active, afebrile	
	vitals stable	
	CNS - BLE PERL. I	
	GCS - 15/15.	
	No facial nerve involvement	
	No focal deficit	tone - (N)
		power > 3/5
		DTR - 2+.
		BLE plantars - Flexor
	(R) Right hyperpigmented macule (L)	
	RS- Clear, PA - Soft, non tender	

GUC-00094504 IP18-00036689
Baby SHREYANSH
01-11-2025 0 Y 8 M 29 D (M)
Dr. KARTHIK NARAYANAN R

(2)

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	Mother had h/o 1 episode of syncope / seizure @ 2013. Not on any	medication / followup.
	Labs: Hb - 9.4	electrolytes - (N)
	TC - 12310	RFT - (N)
	Plt - 4.87L	SGOT - 204 ↑ ammonia & lactate (N)
		SGPT - 53.
	Impression: - Unprovoked Seizures - 1st episode.	
		↑ Transaminitis.
	- Nutritional Anemia.	
	Adv:	
	- IV Levipil 150 mg BD	
	- Vit. D drops 0.5ml OD	
	A to Z drops 0.5ml OD	
	• Plan to decide on EEG & Neuro opinion in rounds	
		T-Y
		Iddoo.

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
31/7/26 4PM	S/B - Dr Shivaraj Child reviewed O/E alert, active, afebrile Vitals - Stable Hydration - good No further seizures S/E - WNL CNS - NFND	Adv: D/w - Karthik sir - Shift to ward - wait for piracetam - Syp. Levipil 1.5ml BD - plan to discharge with oral iron supplement

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MCV - 71
MCHC - 34

RESULT SHEET

Date	30/7/26					
Time						
Hb	9.4 ↓					
PCV	27.5					
RBC	3.89					
WBC	12.31					
N/L	57/33					
Platelets	4.87					
CRP						
ESR						
PCT						
RBS						
Na	138					
K	3.9					
Cl	104					
Ca/Mg	1.27/2.1					
Phosphate (Hcy -	152					
Urea	16					
Creatinine	0.32					
ALP						
SGPT	53					
SGOT	204 ↑					
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

(P.T.O)

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						
Ammonia	30					
Lactate	1.90					

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

GUC-00094504 IP18-00036689
Baby SHREYANSH
01-11-2025 0 Y 8 M 29 D (M)
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DRUG CHART

Date of Admission: 30/7 Drug Allergies: ..... ☑ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

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

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

SOS / PRN (As Required Medication)

DRUG :				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-00094504 IP18-00036689
Baby SHREYANSH
01-11-2025 0 Y 8 M 29 D (M)
Dr. KARTHIK NARAYANAN R

REGULAR PRESCRIPTIONS

Weight. 10.1 kg Ward. HDU

DRUG : INJ LEVIPIL.

Dose	Route	Frequency	Start Date
150 mg	IV	BD	30/7/26

Name & Signature of the Doctor Starting the Drugs: Dr. ITEM

Additional Instructions: 30mg/kg/day

Daily Doctor's Endorsement by a Sign

Date / Time	31/7
8 AM	SY BS
8 PM	

Change to oral 31/7/26 @ 4 PM

DRUG : VITAMIN D3 DROPS (1ml/800IU)

Dose	Route	Frequency	Start Date
0.5ml	P/O	OD	30/7/26

Name & Signature of the Doctor Starting the Drugs: Dr. 154645

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time	30/7		31/7	1/8
11 PM	MM MR	GPC	BS	

DRUG : A to Z DROPS.

Dose	Route	Frequency	Start Date
0.5ml	P/O	OD	30/7/26

Name & Signature of the Doctor Starting the Drugs: Dr. 154645

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time	30/7		31/7	1/8
11 PM	MM MR	GPC	BS	

DRUG : Syp LEVIPIL

Dose	Route	Frequency	Start Date
1.5ml	PO	Q12H	31/7

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time	31/7	1/8
8 AM		MR BS
8 PM	BS	

Baby SHREYANSH
01-11-2025 0 Y 8 M 29 D (M)
Dr. KARTHIK NARAYANAN R

Weight. ...10.1Kg... Ward. ...HDU...

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
30/7/26	7:40 pm	Inj° Levipil	300mg	IV		Already Given
31/7/26	1pm	Syp PEDICHLORYL	5ml	PO	T.Y	

GUC-00094504 IP18-00036689
Baby SHREYANSH
01-11-2025 0 Y 8 M 29 D (M)
Dr. KARTHIK NARAYANAN R

I.V. FLUIDS CHART

Weight. 10.1Kg. Ward. HDU

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
29/7/25	7.40pm	0.9% DNS	IV	35 ml/hr ↓			30/7/26 @5.30 pm		
30/7/26	5.30 pm	0.9% DW	IV	20 ml/hr			31/7/26 @6am		

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

GUC-00094504 IP18-00036689
Baby SHREYANSH
01-11-2025 0 Y 8 M 29 D (M)
Dr. KARTHIK NARAYANAN R

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MEDICATION RECONCILIATION FORM

Drug Allergies: N.I.L ☑ 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: HDU

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	VITAMIN D3 DROPS 800IU	0.5ml	P/O	OD	29/7/26 8PM	☑C ☐DC
2	A to Z DROPS	0.5ml	P/O	OD	29/7/26 8PM	☑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 : 154645 Dr. S. Mahalakshmi.

Date & Time : 30/7 @ 7.40PM.

Nurse Name & Signature: 17804 / Iman

Date & Time : 30/7 @ 7.40PM.

Patient Sticker

Baby. Shreyanth
UC-9409.

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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: ..... HDU ..... Shifted to: ..... 409 .....

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	Syp LEVIPIL	1.5ml	PO	BD	31/7/26 @3AM	☐C ☐DC
2	Vitamin D3 drops	0.5ml	P/o	OD	30/7/26 @ 11pm	☐C ☐DC
3	1 to 2 drops	0.5ml	P/o	OD	30/7/26 @11pm	☐C ☐DC
4						☐C ☐DC
5						☐C ☐DC
6						☐C ☐DC
7						☐C ☐DC
8						☐C ☐DC
9						☐C ☐DC
10						☐C ☐DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : ..... T. Yuvaraj & T.Y. .....

Date & Time : ..... 31/7/26 @ 4.30pm .....

Nurse Name & Signature: ..... Sharmila. A .....

Date & Time : ..... 31/7/26 @ 4:30pm .....

Baby. Shreyansh
8m/m
GRC: 94504

Patient Sticker

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 : 31/7/26 Time:	6pm	8pm	12am	4am
Doctor / Nurse / Family Concern?				
Temperature (°F)	98F	97.6F	98F	98F
Heart Rate (bpm) and Blood Pressure (mmHg) * Note: BP does not score in early warning scoring	102 (62) 56	90 58 50	90 58 45	88 58 50
Heart Rate (Number)	108/min	110/min	108/min	110/min
Resp. Rate (bpm) (Over 1 Minute) *				
Resp Rate (Number)	28b/m	30b/m	26b/m	32b/m
Resp Distress: Mod/ Severe / None / Mild	✓	✓	✓	✓
Receiving O_2 (l/min) O_2 Saturations (%)	99%	98%	99%	99%
Conscious Level: Normal / Altered	✓	✓	✓	✓
GCS *	15/15	15/15	15/15	15/15
TOTAL SCORE Number of shaded boxes	0	0	0	0
Pain Score	0	0	0	0
Observer's Initials		RJ	RJ	RJ

Received from NDU on 4pm

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)

Baby · Shreyansh

Patient Sticker

UHID-94504

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FLUID CHART

Sheet No. : (1)

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

Date	Time	Intake: Nature of Fluid	Intake: Route – Mouth	Intake: Route – I.V	Intake: Route – N.G	Output: NG	Output: Diarrhoea	Output: Vomit	Output: Drainage	Output: Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
31/2/26	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						**Total Output :**						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm	from HDU										
	07:00 pm	DBF								✓	0	S
Total Intake :		DBF				**Total Output :**				1 time		
	08:00 pm										0	DSD
	09:00 pm	wt. 2oml									0	DSD
	10:00 pm										0	DSD
	11:00 pm						Motion passed				0	DSD
	12:00 am	DBF								✓	0	DSD
	01:00 am										0	DSD
Total Intake :		DBF + 2oml				**Total Output :**				1 time wee passed		
	02:00 am	DBF									0	DSD
	03:00 am										0	DSD
	04:00 am										0	DSD
	05:00 am	DBF									0	DSD
	06:00 am										0	DSD
	07:00 am	DBF								✓	0	DSD
Total Intake :		2DBF				**Total Output :**				1 time wee passed		

Total 24 hrs. Intake	5 DBF + 2oml	Total 24 hrs. Output	3 times wee passed

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NURSING CARE RECORD

Date: 30/1/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon							
Night	8:30 pm	Assess the child Monitor the vitals Maintain I/o chart Administer the medication		Assessed the child Monitored the vitals Maintained I/o chart Administer the medication	child was stable	Re-assessment was done	

Docu. No: RCH /FRM / CLINICAL / 148

GUC-00094504 IP18-00036689
Baby SHREYANSH
01-11-2025 0 Y 8 M 29 D (M)
Dr. KARTHIK NARAYANAN R

NURSING CARE RECORD

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Date: 31/7/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8 am.	→ Assess the child Condition → Monitor Vitals → Administer medication → Maintain I/o chart → Provide Comfortable position.	2pm	• Assessed the child • Monitored Vitals • Administered medication • Maintained I/o chart • Provided Comfortable Position.	Child Stable Now No Seizure activities.	Reassessment done.	
Afternoon	2pm	• Assess the child condition • maintain I/O chart • monitor vital sign • Follow doctor Orders • Administer medication	7pm	• Assessed the child condition. • maintained I/o chart • monitored vital sign • Followed doctor orders • Administered medication	• Evaluated the child vitals Stable	• Re-assessment done	
Night	30 7pm	→ To maintain adequate fluid balance of the child	11.30 pm	→ Assess the fluid balance of the child → Monitored vital sign → Maintained I/o chart → Encourage to give frequent breastfeed	→ Improving & maintaining adequate fluid balance.	Child was Stable Reassessment was done.	

QUC-00094504 IP18-00036689
Baby SHREYANSH
01-11-2025 0 Y 8 M 29 D (M)
Dr. KARTHIK NARAYANAN R

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NURSES NOTES

☑ No Known Drug Allergies
☐ Drug Allergies ..... Nil .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		Recieving Notes	
30/7/26	8.30pm	child was recieved from ER, child is on Room Air,	
	9pm	Vitals are stable, GCS - 15/15, SpO2 - 98%, CFT - 2sec, Pupils are equally reacting, IV line Patent IVF 0.9% DNS 20ml/hr onflow, Ammonia, Lactate sample sended to lab, Normal diet, No other Complaints	
	10pm	IVF 0.9% DNS 20ml/hr onflow Vitals are stable, child takes food orally, No other Complaints	
	11pm	Vitals are stable, checked and recorded, No other Complaints	
31/7/26	12am	Due Medication are given as Per drug chart, No other Complaints, Urine Passed	
	2am	IVF 0.9% DNS 20ml/hr onflow, Vitals are stable, checked and recorded, No other Complaints	
	4am	IVF 0.9% DNS 20ml/hr onflow, Vitals are stable, No other Complaints	
	6am	RBS - 95 mg/dl, checked and recorded, IVF Fluids Stoped, Vitals are stable	
	7.30am	Child details handing over given to morning duty S/N	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Patient Sticker

NURSES NOTES

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☐ No Known Drug Allergies

☐ Drug Allergies ..... Nil.

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
31/7/26	8am.	Morning Duty on 31/7/26	
		Child details Handing over taken from night duty staff Nurse.	
		child is on Afebrile without	
		antibiotics and on Room air.	
		GCS 15/15 pr (2) Both pupil	
		equally reacted to the light.	
		IV fluid Stop. IV line @ 8 patent.	
		Day (2). Inj. Levepil 12th Hourly going	
		on. child's taking DBF and Soft	
		diet. No distress. Urine motion	
		Passed Normally. Extremities activity	
		good. Vital Signs monitored and	
		Recorded.	
	10am	Dr. Yuvaraj seen the child	
		and advised to watch for seizure	
		episodes and plan to EEG and	
		Neuro opinion on Rounds	
	12.30pm	Seen by Dr. Karthik sir and	
		advised to take Neuro opinion	
	12.45pm.	Seened by Dr. Mohinish and	
		advised to do Video EEG and	
		to add Syp. Piracetam BD.	
	1pm	Child's I/o Chart maintaining	
		Haemodynamically Stable	
	1.30pm.	Child details Handing over	
		given to evening duty staff.	

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Baby SHREYANSH
01-11-2025 0 Y 8 M 29 D (M)
Dr. KARTHIK NARAYANAN R

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NURSES NOTES

☑ No Known Drug Allergies
☐ Drug Allergies ..... Nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		Evening duty on - 3/7/26	
3/7/26	1:30pm.	child details handing over taken from morning duty staff nurse. child is on room air ventilator, child is on hemodynamically stable checked and recorded. PR 120, GCS 15/15, BL pupil equally reacting to the light. NO IV fluid, IV line @ R palm, child is on soft diet and DBF. child passed urine and motion. Today plan Redio EEG. →	Sha 6PM
	1:40pm	child is shift to EEG department.	
	3:30pm	child is on hemodynamically stable checked and recorded, child active & alert. EEG printed Report collected & (P) is normal. →	Sha 01377
	4pm	child is active and alert, child passed urine. Dr. Kauthick Siva advised. child shift to ward informed parents →	
	5pm.	child had. rice ganji & carrot puree, child is active & alert. child is on hemodynamically stable checked and recorded. →	
	6pm	child details handing over given to 4th floor staff nurse EEG report handing over given to 4th floor staff nurse →	

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Patient Sticker

NURSES NOTES

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☐ No Known Drug Allergies

☐ Drug Allergies ..... NOT KNOWN

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
31/7/26		Receiving Notes on 31/7/26	
	6pm	The child received from HDU staffs. The child is conscious and active	
		Vitals are checked and recorded	
		temp is normal. PP ++ CP ++ CRT <2s	
			01/5/26
	7pm	Administers the medication as per doctor's orders	
	7.30pm	The child details handovered to night duty staffs	
			01/5/26
31/7/26	7pm	Night duty notes on 31/7/26	
		Child details taken over from evening duty staff nurse using SBAR method. On Assessment child is conscious, oriented and afebrile, Cvs-RS, Cns Assessment done, IV line is present and Patent, no pain or redness	RF 022749
	8pm	Vitals checked and recorded all are hemodynamically stable. CP ++ PP ++ CRT <3sec.	RF 022749
	9pm	Iv medication given as per the drug chart	RF 022749

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

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BRADEN 'Q' SCALE

(for Paediatric use)

GUC-00094504 IP18-00036689
Baby SHREYANSH
01-11-2025 0 Y 8 M 29 D (M)
Dr. KARTHIK NARAYANAN R

RD-Q/NSG/04

Patient Name : .....

Age..... Gender : ☐ M

				Date :	N 30/4	M 31/2/25	E 31/01/25	N 31/7
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	3	4	4	4
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during waking hours.	1	1	1	2
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	4
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	4
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times."	3	3	4	4
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	3	3	3	3
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4
				TOTAL SCORE	22	23	24	25
				Evaluator's Name				

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

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
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		
31/7/24	7pm	Treatment & care	Explained about treatment and Care	mother	No	Oral	none	verbalized understood	Good	Raa' 02/8/24

Part - III: CODES

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

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

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

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

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

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Baby SHREYANSH
01-11-2025 0 Y 8 M 29 D (M)
Dr. KARTHIK NARAYANAN R

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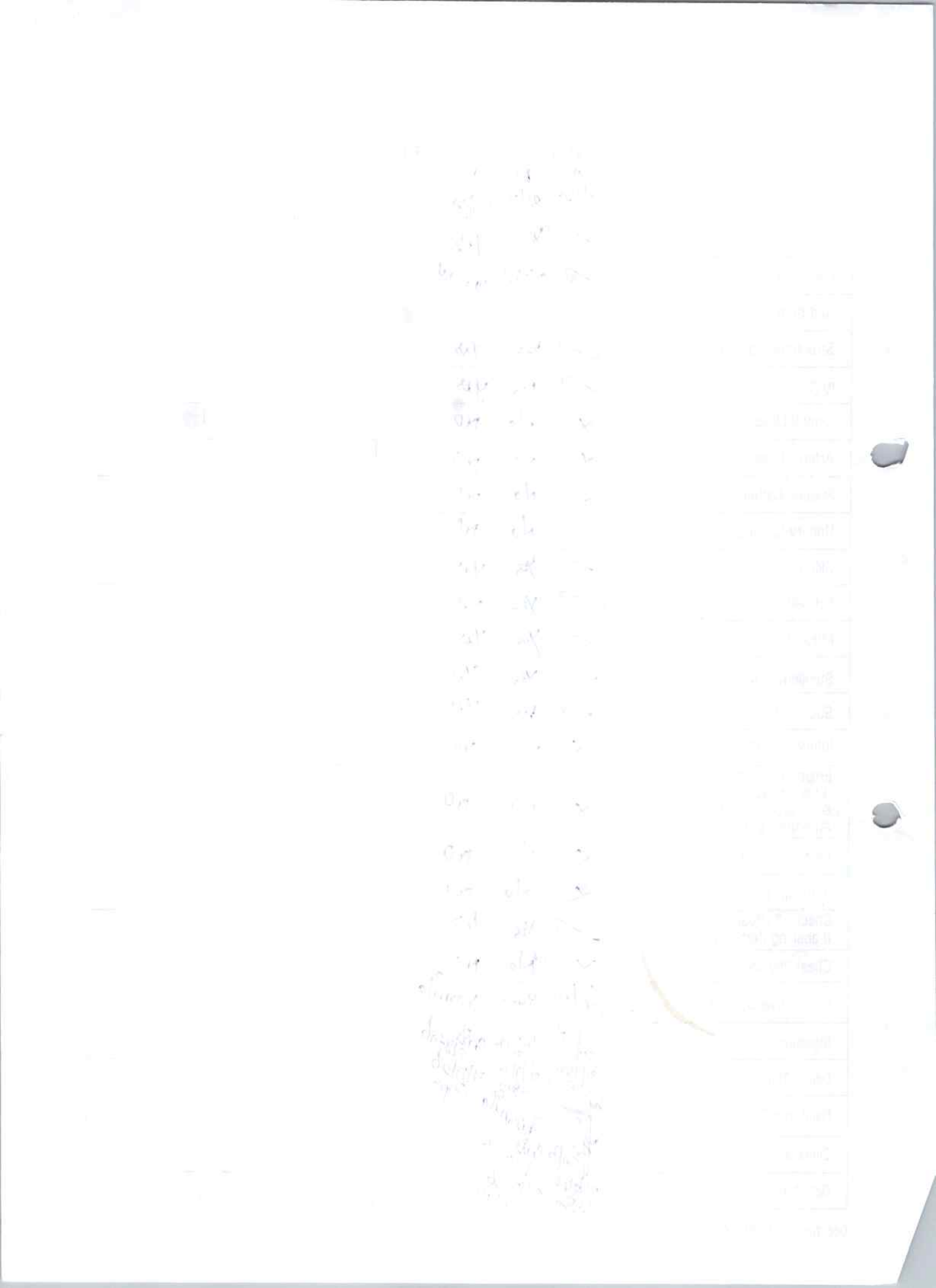
BED SIDE CHECK LIST FOR NURSES

	N	M	E						
Date:	30/7/26	31/7	31/7						
Doctor's Orders	✓	Yes	Yes						
Carried out or not	✓	carried.	carried						
Bed Side									
Structured Handover done	✓	Yes	Yes						
IV Site	✓	Yes	Yes						
Central Lines	X	No	NO						
Arterial Lines	X	No	NO						
Feeding Catheter	X	No	NO						
Urinary Catheter	X	No	NO						
Skin Care	✓	Yes	Yes						
Eye Care	✓	Yes	Yes						
Mouth Care	✓	Yes	Yes						
Sterillum Bottle, Stethoscope	✓	Yes	Yes						
Suction Bottle (Should be clean & empty)	✓	Yes	Yes						
Intubation Tray	X	No	NO						
Emergency Tray (Loaded Syringes with Midazolam & Vecuronium and Flush) Ampoules of Adrenaline	X	No	NO						
Ventilator Tubing,(Any Water, Blood)	X	No	NO						
Humidification	X	No	NO						
Check all Infusion (Labelling,Correct Preparation)	✓	Yes	Yes						
Chest Physio & Neb	X	No	NO						
Handed Over By Name :	Cuchan	Yamuna	Sharmila						
Signature :									
Date & Time:	31/7/26 @8am	31/7/26 @2pm	31/7/26 @8pm						
Hand Over Taken By Name :	Yamuna	Sharmila							
Signature :									
Date & Time:	31/7/26 @8am.	31/7/26 @2pm							



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NURSING INITIAL ASSESSMENT FOR PICU

Date of Admission: 30/7/26

Source of Admission: ☐ OPD ☐ Ward ☑ Other: .....

Reason for Admission: one episode of unresponsiveness

Admission Diagnosis: Unprovoked seizure ↓ evaluation

Accompanied By: ☑ Parent ☐ Guardian ☐ Other Name: .....

Primary Language: ☐ Telugu ☐ English ☐ Hindi ☑ Other Specify Tamil

Do you require an interpreter? ☐ Yes ☑ No

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

If yes, identify .....

Source of Information : ☑ Family ☐ Patient ☐ Others, Specify .....

	Past Medical History	Past Surgical History	Last Hospital Admission
SIGNIFICANT HISTORY	–	–	–

Family History: –

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

If yes please list, ...

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

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

CURRENT MEDICATIONS

Taking Medications? ☐ Yes ☑ No

If yes, Fill the reconciliation form

Medicine brought to the hospital? ☐ Yes ☐ No

Observations: Weight: 10.1 Kg Length: ..... Head Circumference (< 2 years): .....

Temp.: 98.1°F HR: 127 RR: 23 BP: 96/57 (70)

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

Fall Risk Assessment: ☑ Yes ☐ No Score: 15 (Document in the Humpty Dumpty Sheet)

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

Patient Sticker

Behavioural Status on Admission:

☐ Sleeping ☑ Crying ☐ Calm ☐ Distressed/Consolate ☐ Drowsy

FUNCTIONAL SCREENING: If a patient needs assistance with any of the following inform consultant

☐ Mobility problem ☐ Walking Problem ☑ No Abnormality Detected

☐ Developmental Delay ☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING:

☐ Underweight ☐ Overweight ☐ Special Feeding Method

☐ Feeding Problem ☐ Special diet ☑ No Abnormality Detected

Inform consultant for positive criteria

Psychological Screening: ☑ No Significant Findings

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

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

Social History: Lives With ..... Family .....

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

Orientation has been given regarding the following aspects:

☑ ID Band in situ

☑ Bedside safety explained

☑ PICU Routine: Doctor's rounds/Medication time

☑ Visiting policy explained

Orientation given to: ☑ Family ☐ Others specify .....

Name of Person Orientation was given to: Mr. Manikandan.

Orientation not given Reason: —

Nurse Name: Cuchon. M Nurse Signature: .....

Date & Time: 30/4/26 @ 8.45 pm.

DISCHARGE PLAN

Source of Information: ☑ Family ☐ Friend

Will patient require transportation arrangements to go home: ☐ Yes ☑ No

Will Physiotherapy require at home: ☐ Yes ☑ No

Is home medical equipment anticipated: ☐ Yes ☑ No

Is home oxygen therapy anticipated: ☐ Yes ☑ No

Are dressing needs at home anticipated: ☐ Yes ☑ No

Any other needs anticipated: ☐ Yes ☐ No If Yes Specify .....

Discharge Medications: ☑ Yes ☐ No

Details: .....

Final Diagnosis: .....

Nurse Name: Cuchon. M Nurse Signature: .....

Date & Time: 30/4/26 @ 8.45p

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RBS CHART

Date	Time	RBS (mg/dl)	IVF %	Signature
30/7	7.10PM	128	-	[signature] 17894.
31/4	6am	95mg/dl	0.9% DNS	[signature]

PATIENT TRANSFER FORM

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Baby SHREYANSH
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Dr. KARTHIK NARAYANAN R

Date & Time of Admission	Date & Time of Transfer Order
30/7 @ 7.36PM	30/7 @ 8.20PM.

Treating Consultant Name	Transfer Ordered by	Reason for Transfer
Dr. Karthik	Dr.Manonmani	treatment

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

Number of Sheets in Clinical File	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant
(11)	–	Yes ☐ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

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

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

a unprovoked seizure ↓ evaluation

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Iman.	Dr.Manonmani.

Patient & Clinical Records Received by : Ciuhan. M

Date & Time of Patient Received : 30/7/25 @ 8.25pm

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

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
Baby . Shreyansh	30/7/26 @ 7:30 pm	31/7/26 @ 5:50 pm
Treating Consultant Name	**Transfer Ordered by**	**Reason for Transfer**
Dr. Karthik	Dr. Yuvaraj	observation
From Unit	**To Unit**	**Information to Attendant**
NBU	409	Yes ☑ No ☐
Number of Sheets in Clinical File	**Number of Imaging Films**	**Personal belongings including clinical documents. If any handed over to attendant**
82	EEG printed (1) - (1)	Yes ☐ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	Sq. Furycil	1
2.	Diapar	1
3.		
4.		
5.		

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Sharmila-N/018706	Dr. Yuvaraj.

Patient & Clinical Records Received by :

Date & Time of Patient Received :

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

Unavailable Bed ☐ Nurse not Available ☐ Available Bed not ready

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BirthRight by Rainbow

CONSENT FOR ADMISSION IN PEDIATRIC INTENSIVE CARE UNIT (PICU)

I ..... Amrutha ..... W/o ~~S/o Mr./ Ms~~ ..... Mr. Manikandan ..... hereby declare that our patient Mr. / Ms ..... Shreyansh ..... who is related to me as ..... son ..... is getting admitted in the Pediatric Intensive Care Unit (PICU) of Rainbow Children's Hospital on ..... HDU ..... with UHID No. : ..... CHC-000 94504 .....

The doctors have explained to me in a language understood by me that my child has following health related issues : ..... Seizures .....
.....
.....

The doctors have clearly explained to me that my patient Mr./ Ms. ..... during his / her stay in the PICU may undergo various medical and surgical procedures like airway management, mechanical ventilation, central line insertion, PICC Line and arterial line placements, chest drain, or peritoneal drain insertion etc.

I have been told by the doctors that while performing such procedures I will be informed and a separate consent for this procedure shall be taken. However, in case of any life threatening emergency if the time is not available for taking informed consent it is implied that I give consent for various invasive procedure to save the life of my child.

I understand that a sick child in PICU has life threatening medical conditions.

I understand that when a child is sick in the PICU with multiple medical and surgical procedures performed upon him / her, there are inherent risks due to these high risk procedures, and high risk medications, in the form of infections, bleeding, air leaks, skin and other tissue damage etc.

I have been informed that during our daily counseling by the treating team, the Hospital may perform audio-video recording of the counseling session. The purpose of this recording is mainly to avoid any confusion in communication consent for the same.

I give my consent to the team of doctors to go ahead and admit the child Mr. / Ms : ..... Shreyash ..... in the PICU fully understanding the associated risks involved from various procedures, high risk medications and infections in the PICU and treat him / her with all necessary means.

The doctors have explained to me in the language best understood to me.....

Patient Attendant :

Signature : ..... R. Amutha .....

Name : ..... Amudha .....

Relationship with Patient: ..... Mother .....

Date & Time : ..... 30/1/26 @ 10pm .....

Witness :

Signature : ..... V manikandan .....

Name : ..... Manigandan .....

Date & Time : ..... 30/1/26 @ 10pm .....

Doctor (who is taking the consent) :

Signature : .....

Name : .....

Date & Time : ..... 30/1/26 @ 9.30AM .....

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ADMISSION CRITERIA – PICU

Admission / Transfer from:

☑ Emergency ☐ Outpatient (OPD) ☐ Ward ☐ Operation Theater ☐ Others: .....

Tick (✓) any of the following criteria requiring admission / transfer to PICU

Unprovoked
1 Seizure

- ☐ All patients requiring mechanical ventilation;
- ☐ Patients with impending respiratory failure;
  - ☐ Upper airway obstruction;
  - ☐ Lower airway obstruction;
  - ☐ Alveolar disease; and
  - ☐ Unstable airway;
- ☐ All Paediatric patients after successful resuscitation;
- ☐ **Comatose Patients;**
  - ☐ Meningitis, encephalitis; ☐ Hepatic encephalopathy; ☐ cerebral malaria;
  - ☐ Head injury; ☐ Poisonings; and ☐ Status epilepticus;
- ☐ **All types of shock/hemodynamic instability:**
  - ☐ Septic shock;
  - ☐ Hypovolemic shock; (Bleeding emergencies such as gastrointestinal bleeding, bleeding diathesis, disseminated intravascular coagulation; Cardiogenic shock; myocarditis, cardiomyopathy, congenital heart disease; Neurogenic shock; and Multiple trauma;
- ☐ Cardiac arrhythmias after consulting with the treating consultant
- ☐ Hypertensive Emergencies;
- ☐ Severe acid base disorders;
- ☐ Severe electrolyte abnormalities;
- ☐ Diabetic ketoacidosis (Ph<7.2, altered sensorium, hyperglycemia)
- ☐ Acute renal failure; Patients requiring acute hemodialysis, hemofilteration and peritoneal dialysis;
- ☐ **Post-Operative Patients;**
  - ☐ Requiring ventilation;
  - ☐ Unstable patients; and
  - ☐ Post-operative patients after open heart surgery, neurosurgery, thoracic surgery and other patients after major general surgery with potential for respiratory/haemodynamic instability;
- ☐ Patients requiring nitric oxide therapy;
- ☐ Malignant hyperpyrexia;
- ☐ Acute hepatic failure
- ☐ Severe dehydration with mental status change;
- ☐ Asthma requiring hourly nebulization/getting tired with increasing oxygen requirement/mental status change.

"UNSTABLE" PATIENT IS DEFINED AS

- ☐ HR < 50 or > 160 per minute or more than upper normal limit according to age. BP<90 systolic and < 50 diastolic an or requiring ionotropic support. Arrhythmia or risk of sudden arrhythmia.
- ☐ Signs of peripheral poor perfusion or suspicion of any type of shock.
- ☐ Capillary recall time > 4seconds.
- ☐ Children Blood pressure (Syst.) < [70 + (2× age "Years"].

Respiratory failure or high risk of failure or airway obstruction:

- ☐ Respiration rate < 5 per minute below the normal or > 10-15 per minute above the normal range for age.
- ☐ O2 Saturation <90 % or need for O2 >4 Litres per minute by normal face mask. Abnormal ABG: PH < 7.25, PaO2 < 60 torr, PaCO2 > 50 torr.
- ☐ Distress and risk of exhaustion
- ☐ **Change of level of consciousness: GCS < 13.**
- ☐ **Persistent oliguria with acidosis.**

Signature of the Doctor: ..... Name of the Doctor: ..... Date & Time: 30/1/26 6PM

Patient Sticker

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DISCHARGE CRITERIA – PICU

Discharge to:

☐ HDU / Step down ICU ☐ Ward ☐ Outside Facility ☐ Others: .....

Tick (✓) any of the following criteria requiring discharge / transfer from PICU

- ☐ Stable hemodynamic parameters.
- ☐ Stable respiratory status (patient extubated with stable arterial blood gases) and airway patency at least for 24 hours with no respiratory distress needing continuous monitoring.
- ☐ Minimal oxygen requirements that do not exceed patient care unit guidelines.
- ☐ Intravenous inotropic support, vasodilators, and antiarrhythmic drugs are no longer required or, when applicable, low doses of these medications can be administered safely in otherwise stable patients in a designated patient care unit.
- ☐ Cardiac dysrhythmias are controlled.
- ☐ Neurologic stability with control of seizures.
- ☐ Removal of all hemodynamic monitoring catheters.
- ☐ Routine peritoneal or hemodialysis with resolution of critical illness not exceeding general patient care unit guidelines.
- ☐ Patients with mature artificial airways (tracheostomies) who no longer require excessive suctioning.

Signature of the Doctor: .....

Name of the Doctor : .....

Date & Time: .....

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wt. 10.1 kgs.

EMERGENCY ROOM TRIAGE FORM

Patient's Name : Baby. Shreyansh. Age : 8mon. Gender: ☑ Male ☐ Female

Date : 30.07.2025 Time of Arrival : 7.05 P m

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

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

Mode of Arrival : ☑ Ambulatory ☐ Wheelchair ☐ Ambulance

Initial Vital Signs: Temp: 98.6°F PR: 140bt BP: — RR: 30br SpO_2: 98% RA GRBS: 128 mg/dl

Chief Complaints: Fever Seizure activities

INITIAL PHYSIOLOGICAL CATEGORIZATION

Appearance
☑ Normal
☐ Sick Looking

Circulation / Colour
☑ Normal ☐ Abnormal ☐ Bleeding

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

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

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

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

* CTAS - Canadian Triage and Acuity Scale

D. Anitha
Signature of Parent / Guardian

Triage Completion Time : 8 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 : Godwin Jacob.

Signature of Triage Nurse : 01/8/25

Date & Time : 30.07.2025 @ 7.10 P m

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

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 30/7/26 Time of arrival : 7.05PM

Chief Complaints: C/o - Seizure Activity x 1 epi. RBS: ~~198~~ 128

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

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

If yes , identify —

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

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

RISK FOR FALL:

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

☐ If Patient is > 6 years
Assess the below parameters

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

Ambulatory Aids:

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

Gait/Transferring:

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

Mental Status: Forgets limitations ☐ Yes ☑ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening: ☑ No Abnormalities Detected

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

Inform consultant for positive criteria

.....

.....

Nutritional Screening: ☑ No Abnormalities Detected

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

Inform consultant for positive criteria

Psychological Screening: ☑ No Significant Findings

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

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

Social History: Lives With —

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

Time of Initial assessment completed by ER Nurse : 15 min

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

Time	Nursing Notes
7.30 PM	- Pt come to ER c complaints of seizures x 1 epi.
	- All vitals checked. & recorded.
	- ER Dr. assessed the child & Admitted ↓ Dr. Karthik.
	- IV line done. & Bld sample collected.
	- IV Medication given to ER.
	- Pt Shifted to HDU for further mgt.

Samples collected by: / Godwin

Samples sent by :

Time:

Time: / 7.40PM

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1
30/7 7.40 PM	Inj. levipil	I/V	300mg	Dr.Manoranjan	[signature]

Condition of patient at time of shift - out :	Details of Shift - out
HR: 140 BP: — CFT: 2 Sec	Shift - out from ER to: HDU
RR: 30 SPO_2: 98°F	Time of Shift - out: @ 8.20PM
GCS: 15/15 Temperature : 98.6°F	Handover given to: S/N. Gurgan (Nurse's Name)
Pain Score: 0/10	
Repeat RBS (if applicable): —	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any): IV line done 24G ⓛ metacarpal.

Name of the Nurse : Iman

Signature of the Nurse : [signature]

Date & Time : 30/7 @ 7.40PM

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

DOCTOR'S SHIFT CHANGE HANDOVER FORM

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

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

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GUC-00094504 IP18-00036689
Baby SHREYANSH
01-11-2025 0 Y 8 M 29 D (M)
Dr. KARTHIK NARAYANAN R

Rainbow® Children's Hospital
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PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : ..... Date : .....

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

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

Allergic History: .....

Chief Complaints: .....
.....
.....
.....
.....
.....
.....
.....

Pediatric Assessment Triangle

A Appearance - TICLS .....

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

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

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

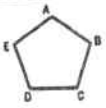
Any urgent interventions needed: ☐ Yes ☐ No
If Yes .....
.....

Significant Past History: .....

Medication History: .....

Relevant Investigations: .....
.....
.....

Primary Assessment



Airway

- ☐ Open
- ☐ Maintainable
- ☐ Not Maintainable

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

Breathing

Rate: ..... SpO_2 on FiO_2 .....

Rhythm: .....

Retractions: ☐ Suprasternal ☐ ICR ☐ SCR
☐ Sternal ☐ Supraclavicular ☐ Nasal Flaring

Respiratory Noises: ☐ Stridor ☐ Wheezing ☐ Grunting

Air Entry: .....

Palpation Findings (If necessary).....

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

(P.T.O.)

Circulation

HR: .....

CFT — Central ..... / Peripheral .....

Any urgent interventions needed: ☐ Yes ☐ No

If Yes .....

BP: ..... mmHg

Pulse Volume: Central ..... / Peripheral .....

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

Muffled Heart Sound: ☐ Yes ☐ No

Engorged Neck Veins: ☐ Yes ☐ No

Murmurs: ☐ Yes ☐ No

Liver Span: .....

ECG: .....

Any Signs of Heart Failure: ☐ Yes ☐ No

.....

.....

.....

.....

Disability

GCS: ..... AVPU: .....

Pupils: Responsive ☐ Non-Responsive ☐

Size — Right ..... / Left .....

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

Signs of Neurological compromise .....

.....

Any urgent interventions needed: ☐ Yes ☐ No

If Yes .....

.....

.....

.....

.....

Exposure

Temp.: .....

Any Rash: ☐ Yes ☐ No,

If yes describe the rash .....

Active bleed .....

Lacerations ☐ Abrasions ☐ bruises ☐

Describe: .....

Any urgent interventions needed: ☐ Yes ☐ No

If Yes .....

.....

.....

.....

Final Physiological Status: ☐ Respiratory Distress ☐ Respiratory Failure ☐ Respiratory Arrest

☐ Shock - Compensated ☐ Hypotensive ☐

☐ Cardiopulmonary Arrest ☐ Hemodynamically Stable

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

.....

.....

Labs Planned: .....

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.....

.....

.....

.....

.....

Treatment Planned: .....

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.....

.....

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: .....

Signature: .....

Date & Time: .....

Sr. Doctor on Duty (If necessary)

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

Signature: .....

Date & Time: .....