ACTIVITY RECORD FOR BILLING

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

Name: ..... GUC-00093213 IP18-00036239 .....
Baby AADHAN VEL KRISHNAN
09-06-2025 1 Y 0 M 20 D (M)
Dr. NATARAJ PALANIAPPAN

UHID No: ..... IP No ..... Dept: .....

Date of Admission: ..... T :harge: ..... Time: .....

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
29.06.20	11 am	ER	HDU	

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
	CBC, CRP, S. Electrolytes		
29/06/2026	CFT, Densu NS1	26020589	
	Paracetamol levels		01527
29/06/2026	RBS	26020588	
aam	Electrolytes	26020609	
30/6/26 6AM	RBS	26020698	
	LFT	26020699	013457

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
29/6/20	Infusion pump	9am	30/6/20 @ 6am	1718979	[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
29/6/20	Iv placement	(1)	1718922	Joseph SR

ANY OTHER INFORMATION:

.....

.....

.....

.....

.....

.....

Date: ..... Time: ..... Prepared By: .....

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
Anuk 30/6/20 @ 11:30 am			

Tracking Sheet

DISCHARGE TRACKING SHEET – 2026

Date:

Name of Consultant : DR. N PALANIPPAN **Floor :** 4th FLOOR HDU **UHID :** 93213

S.No	Activity	Time		Name & Signature	Remarks
		In time	Out Time		
1	Dr. ANNOUNCE TIME	30/06 11AM		dey 0h30.	
2	ARRANGEMENT OF FILE BY NURSES				
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				

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 : IP18-00036239 **Admit Date** : 29-Jun-2026 **Admit Time** : 06:14 AM **UHID** : GUC-00093213

Patient Details :

Patient Name	: Baby AADHAN VEL KRISHNAN	**Age**	: 1 Y 0 M 20 D
Guardian	: HARI KRISHNAN	**DOB**	: 09-06-2025 01:00 AM
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: NO:1/17,LIG TNHB APPT,SENTHAMIL AGAR, MAIN ROAD,RAMA PURAM Agaram Chennai Tamil Nadu INDIA 600082	**Phone No**	: 9750867248
		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 : HARI KRISHNAN **Relationship** : Father

Contact Address : NO:1/17,LIG TNHB APPT,SENTHAMIL AGAR,MAIN ROAD,RAMA PURAM Agaram Chennai Tamil Nadu INDIA 600082 **Phone No** : 9750867248

Signature

Doctor Details :

Doctor Name : Dr. NATARAJ PALANIAPPAN **Specialisation** : PEDIATRIC INTENSIVE CARE

Referral Doctor : Dr KARTHIKEYAN EMMESS HOSPITAL **Phone No** :

Co-Consultant :

Payment Details :

Payment Mode : DC/CC Card **Deposit Amount** : 10000.00

Payor Name : SELFPAY

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GENERAL CONSENT FOR TREATMENT

Patient Name:	**Baby AADHAN VEL KRISHNAN**	**Age :**	**1 Y 0 M 20 D**
IP No:	**IP18-00036239**	**Sex:**	**Male**
Consultant:	**Dr. NATARAJ PALANIAPPAN**	**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 c of the patient.

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

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

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

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

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

Signature of Patient/Relative:

Name: HARI KRISHNAN.
Relationship: FATHER
Date: 29/06/26 Time: 06:14 PM
Witness Name: R Thamarai Selvan
Witness Signature:

Patient Address:

NO:1/17,LIG TNHB APPT,SENTHAMIL AGAR,MAIN ROAD,RAMA PURAM Agaram Chennai Tamil Nadu INDIA 600082

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BILLING POLICY

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

DECLARATION

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

Patient Name : Baby ADDHAV VSL KRISHNAN	UHID Number : 93213
Self/Attendant Name : HARI KRISHNAN .	Relation : FATHER
Self/ Attendant Signature : Phone Number :	Name & Signature of Financial Counselor

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BED SIDE CHECK LIST FOR NURSES

	M	E	N	M					
Date:	29/6	29/6	29/6	30/6					
Doctor's Orders	Yes	Yes	Yes	Yes					
Carried out or not	Carried	Carried	Carried out	Carried out					
Bed Side									
Structured Handover done	Yes	Yes	Yes	Yes					
IV Site	Yes	Yes	Yes	Yes					
Central Lines	NO	No	NO	NO					
Arterial Lines	NO	NO	NO	NO					
Feeding Catheter	NO	No	NO	NO					
Urinary Catheter	NO	No	NO	NO					
Skin Care	Yes	Yes	Yes	Yes					
Eye Care	Yes	Yes	Yes	Yes					
Mouth Care	Yes	Yes	Yes	Yes					
Sterillum Bottle, Stethoscope	Yes	Yes	Yes	Yes					
Suction Bottle (Should be clean & empty)	Yes	Yes	Yes	Yes					
Intubation Tray	NO	No	NO	NO					
Emergency Tray (Loaded Syringes with Midazolam & Vecuronium and Flush) Ampoules of Adrenaline	NO	No	NO	NO					
Ventilator Tubing,(Any Water, Blood)	NO	No	NO	NO					
Humidification	NO	No	NO	NO					
Check all Infusion (Labelling,Correct Preparation)	Yes	Yes	Yes	Yes					
Chest Physio & Neb	NO	No	NO	NO					
Handed Over By Name :	Abla	Rajesh	SAYAK	Abla					
Signature :	[signature] 0175	[signature] 610204	[signature] 51451	[signature]					
Date & Time:	29/6 2PM	29/6 @ 8pm	29/6/26 at 8AM	30/6					
Hand Over Taken By Name :	Rajesh	SAYAK	Abla						
Signature :	[signature] 61330N	[signature] 51451	[signature]						
Date & Time:	29/6 @ 2pm	29/6/26 8pm	29/6 @8a						

Doc. No. : RCH/ FRM / GENERAL / 088

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CONSENT FOR ADMISSION IN PEDIATRIC INTENSIVE CARE UNIT (PICU)

GUC-00093213 IP18-00036239
Baby AADHAN VEL KRISHNAN
09-06-2025 1 Y 0 M 20 D (M)
Dr. NATARAJ PALANIAPPAN

I ..... S/o Mr./ Ms .....
hereby declare that our patient Mr. / Ms ..... who is related to me as ..... is getting admitted in the Pediatric Intensive Care Unit (PICU) of Rainbow Children's Hospital on ..... with UHID No. : .....

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

.....

.....

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 give my consent to the team of doctors to go ahead and admit the child Mr. / Ms :.....
..... 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 : .....

Name : .....

Relationship with Patient: .....

Date & Time : .....

Doctor (who is taking the consent) :

Signature : .....

Name : .....

Date & Time : .....

Witness :

Signature : .....

Name : .....

Date & Time : .....

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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ADMISSION CRITERIA – PICU

Admission / Transfer from:

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

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

- ☐ 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: Dr. Chandrasekaran Date & Time: 29/6/25

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PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: _____ GUC-00093213 IP18-00036239 _____
Baby AADHAN VEL KRISHNAN
09-06-2025 1 Y 0 M 20 D (M)
Dr. NATARAJ PALANIAPPAN

UHID ID: _____ _____

Department: _____

Consultant: _____

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Baby AADHAN VEL KRISHNAN
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Dr. NATARAJ PALANIAPPAN

Pediatric Multiorgan History & Physical Examination

Name: ______ Age/Sex ______

Information given by: ______ Relationship ______

Chief Presenting Complaints & Duration (Chronologically)

History of present illness : H/o - fever x 1 day.

Child brought to the ER c̄ the
A/H/O: Accidental Overdose of Paracetamol
drops, overall - [P100 drops - 15ml] → totally
1.5g in 24hrs [29/06/25] in 4 divided dose
(172mg/kg) → Suprahepatic
- Child is active, alert, afebrile

- No h/o cough/cold
- No h/o vomiting / Loose stools
- Sick contact - Elder sibling
- 4 doses → 400mg in 24hrs →
Last dose given at 4pm

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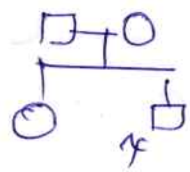
P... any previous investigation or treatment)

Nil

Birth & Neonatal History:

2nd child / C-section / B.Wt - 2.45 / Term / CFAB / No NICU stay

Family Chart



Birth & Socio Economic History:

About Father : (N)

About Mother :

Any additional Information :

Developmental History :

(N)

Immunization History :

uptodate

Anthropometry :

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

Weight (kgs) 9.3kg (Centile ____)

On Examination :

Temperature : 98.0°F Pulse Rate : 130/min B.P. 99/79mmHg SPO2 99% RA

Resp.rate and type of breathing : (N)

Rash (-)

Lymphadenopathy (-)

Oedema : (-)

Allergies (if any): (-)

(P.T.O.)

Patient Sticker

Respiratory System :

Inspection (any s/o distress) : (N)

Air entry & breath sounds : VBS(P)

Any addes sounds : (-)

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

Cardiovascular System :

Inspection of procordium : (N)

Heart Sounds : S_1S_2(P)

Any murmur : (-)

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

Per Abdomen :

Inspection : (N)

Palpation : SOFT

Ausculation : BS(P)

Spine : (N) External Genitelia : (N)

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

Central Nervous System :

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

Cranial Nerves :

Motor System :

Nutriton : (N)

Tone: (N) Power (N)

Co-ordinator :

Posture : (N)

Involuntary Movements :

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Rel

DTR (+) Superficials:

Plantars

Sensory System : (+)

Bladder / Bowel :

Clinical Summary & Diagnostic: Acute Paracetamol intoxication

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

Desired goals of the treatment :

Planned Labs:

CBC ✓
CRP ✓
Dengue NS1 antigen ✓
S. Paracetamol levels
LFT ✓
Electrolytes.

Planned Management

NAC infusion
Inj Pan 10mg IV 12H
Inj Emeset 1mg IV 8H

Signature of the Doctor:

Name of the Doctor:

Date & Time:

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: .....

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(1)

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
29/6/25	S/B Dr Manomani	
8:50 am	A - Repeated supratherapeutic ingestion of paracetamol	
		CBG - 97 mg/dl
	Afebrile	OT - 50
	asleep	PT - 23
	No vomiting.	Paracetamol levels -> <10
	taken feeds well	
	PP - NF	HR - 136/m
	RS - NVBS (B)	BP - 109/76
	P/A - soft, Non tender.	SpO2 - 97%.
	Rx	
	-> W/F Vomiting / abd pain / lethargy.	
	- monitor vitals	
	- Decide on NAC after round.	
	- trace electrolyte report	
[signature] 15/6am		

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
29/6/26 9 Am.	S/B Dr. Chandiralega.	
	A - Accidental paracetamol overdose.	
	child conscious	
	F - On breast feeds - Tolerating well. On NAC infusion	
	R - B/L AE (+), no added sounds RR - 30/min SpO_2 - 98% RA.	
	I - TC - 5700 Dengue NS1 Negative CRP - 25	
	C - BP - 109/76 mm Hg PR - 134/min. RPWF < RT < 3 sec	
	H - NAD	
	M - paracetamol levels < 10	
	A - Soft, non tender no organomegaly	
	N - sensorium (N) plantar - Extensors DTR - 2+	
		SGOT - 50 SGPT - 23

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(2)

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	Adv:	
	- monitor vitals	
	- w/f vomiting, abd pain, irritability	
	- continue NAC infusion	
	- Adequate hydration	
	- Inform (SOS)	
	Sd/- 19/2/14	
29/6/26	Acute paracetamol overdose	
10 Am	(1) on NAC infusion	
	(2) Syp. Ibugen C. 3.5ml SOS.	
	(3) Syp. [illegible] 2.5 - 0 - 2.5ml x (5) days	
	(4) R/V SGOT LFT tomorrow	
		Sd/- 8/10

30

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
29/6/20 5PM.	S/B Dr. Chandirabegs	
	D - Acute paracetamol overdose.	
	Child recieved	
	Alert, Active	
	no c/o irritability, vomiting.	
	Tolerating oral feeds - Recent feed well.	
	passes urine - 3-4 hours once	
	stools passed -	
	O/E	BP - 103/70 mm/Hg
	Afebrile	PR - 85/min
	CVS - S1S2 (+).	
	RS - BL A E (+)	
	P/A - soft, no organomegaly	
	Adv:	
	- continue NAC infusion	
	- vitals monitoring.	
	- Repeat LFT in morning	
	SVP 29/6/20.	

GUC-00093213 IP18-00036239
Baby AADHAN VEL KRISHNAN
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Dr. NATARAJ PALANIAPPAN

(3)

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/6/25 8.00 AM	S/B Dr. Chandiralega	
	Δ Acute paracetamol overdose. (1.5 gm in 24 hrs).	
	child remained. no fever spikes for 16 hrs no new complaints Nasal block (+) Oral intake, Activity - good Tolerating oral feeds well. Hydration - peripheral pulses felt CRT < 3 secs	
	O/E	
	Afebrile CVS - S1S2 (+) RS - B/L AE (+) P/A - Soft.	BP - 95/62 mm Hg. PR - 112/min. RR - 38/min
	Adv: - continue NAC infusion - monitor vitals - Syp Flunir 2.5ml - 0 - 2.5ml. - Syp Ibugesic 3.5ml SOS QSHA - W/F vomiting, lethargy, irritability, Abd. pain / distension - Perform (SOS)	
	Sd/ 9 PM.	

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
30/6/26 10am	S/B Dr: Natasa	
	Syp. Ibugesic (100/5) 4ml.	
	Syp. P250 3ml	
	Discharge today	
	Review on Friday in opd	
	1-0-0 x (3) day	
	Neopro juice 10ml	Gautam 85783

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

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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RESULT SHEET

Aadhan vel krishnan.
1yr/M

Date	29/6/26					
Time						
Hb	10.9					
PCV	32					
RBC	4.55					
WBC	5.70					
N/L						
Platelets	3.15					
CRP	<5					
ESR						
PCT						
RBS						
Na	137					
K	4.5					
Cl	107					
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT	23					
SGOT	50					
T.Bill/Conj	0.3/0.2					
T.Protein	6.8					
S.Albumin	4.4					
S.Globulin	2.4					
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						
Dengue NS-1	Negative					
paracetamol level	<10	(10-20) µg				

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

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DRUG CHART

Date of Admission: 29/06/26 Drug Allergies: Nil ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

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

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

SOS / PRN (As Required Medication)

DRUG: SYP. IBUGESIC				Date / Time	29/6													
Dose	Route	Frequency	Start Date		6	MR												
3.5ml	PO	SOS	29/6		PM													
Doctor's Signature		Valid Period	Pharm.															
Additional Instructions: 100mg/5ml Q8H																		

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

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

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

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REGULAR PRESCRIPTIONS

Weight. 9.3kg Ward. PR

DRUG : INJ PANTOPRAZOLE

Dose	Route	Frequency	Start Date
10 mg	IV	OD	29/6/24

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time	29/6		30/6
	6:50 am	6 am	SM NS

DRUG : INJ ENEET

Dose	Route	Frequency	Start Date
1 mg	IV	TDS	29/6/24

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time	29/6		29/6	30/6
	6:50 am		6 am	SM NS
			3 pm	M.R SM
			11 pm	SM NS

DRUG : SYP OSELTAMIVIR

Dose	Route	Frequency	Start Date
2.5ml	PO	BD	29/6/24

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

12mg/ml

Daily Doctor's Endorsement by a Sign

Date / Time	29/6	30/6
1 am		SM NS
1 pm	BD NS	

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time	

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

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I.V. FLUIDS CHART

Weight. 9.3 kg 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
29/6/26	9am	NAC (150 mg/kg) 7 ml in 30 ml 0.9% NS. over 1 hr ↓	loading.				29/6 @ 9am		
Maintenance-	9am	NAC- 50 mg/kg (2.5 ml) in 70 ml NS over 4 hrs	as infusion.				29/6 @ 1pm		
	1pm	↓ NAC (100 mg/kg) 4.5 ml in 140 ml NS. over 16 hr					30/6/26 at 6AM		

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

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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: ..... Shifted to: .....

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. Manonai

Date & Time : 29/6/26, 7 am

Nurse Name & Signature: .....

Date & Time : 29/06/2026 6:00 AM

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

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NURSING SHIFT HAND OVER FORM

SITUATION

Diagnosis: Paracetamol Intoxication

Any Infection: ☐ Yes ☐ No ☑ Not Known
If Yes Specify: Nil

Surgery / Procedure:

Post OP Day:

BACKGROUND

Date / Shift	29/6 M	29/6 E	30/6 N	30/6 M		
Medical Condition (Any special condition to be noted):	Noted	No Red	Noted.	Noted		
Diet:	~~EBM~~	EBM.	DBF/SH	DBF/SH		

ASSESSMENT

Allergy:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No
Ventilation (RA, NP, NIV, VENTI):	RA	RA.	RA	RA		
Tubes/Drains/Catheter:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No
Vital Signs: Temp:	98.9F	97.3F	98.1F	98.4F		
Res:	40 bpm	36 bpm	38 bpm	32 bpm		
SpO_2:	96%	100%	99%	98%		
Pulse:	135 bpm	110 bpm	115 bpm	108 bpm		
BP:	103/70 (81)	95/54 (67)	96/60 (72)	108/60		
LOC:	15/15	M/15	15/15	15/15		
Fall Risk Score:	15	15	15	15		
Pain Score:	0/10	-/10	0/10	0/10		
Skin Integrity	Intact	Intact	Intact	Intact		

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:	—	—	DBF/SH			
Critical Lab Test / Values:	—	—	—			
Other Special Orders / Medications:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
PU Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
DVT Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
ADL (Dependent / Non Dependent):	Dependent	Dependent	Dependent	Dependent		
Post Operative Procedure Special Orders:		—	—			

Handed Over By Name :	Anila	Rajesh	SAYAK	Anila		
Signature / ID :						
Date:	29/6/26	29/6	30/6/26	30/6		
Time:	2pm	8pm	8AM	@8a		
Taken Over By Name :	Rajesh	SAYAK	Anila			
Signature / ID :						
Date:	29/6/26	29/6/26	30/6h			
Time:	2pm	8pm	@8a			

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NURSING CARE RECORD

Date: 29/6/25

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	* Assess the child condit * Monitor vital sigs * Maintain I/O chart * Administer medicat		Assessed the child condi * Monitored vital sigs * Maintained I/O chart * Administered medicati.	Child is stable	Reassessment done.	[illegible] 01237
Afternoon	2pm	⇒ Assess general condition ⇒ Monitor vitals. ⇒ Maintain I/O chart. Educate about medications.		⇒ Assessment done. ⇒ Vitals recorded. ⇒ Monitor I/O chart ⇒ Explained about medication safety.	Child is stable.	Reassessment done.	[illegible] 01304.
Night	8pm	Assess Baby genl condition Monitor vital sign Administer medi Maintain I/O Chart		Assessed Baby genl condi. Monitored vital sig Administered medication Maintained I/O Chart.	Provided medication and care Baby improved.	Re-assessment done	[illegible] 01551

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NURSING CARE RECORD

Date: 30/6/20

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8am	* Assess the child condit * Monitor vital sigs * Maintain I/O chart * Administerd medicatn		Assessed the child condit Monitored vital sigs Maintained I/O chart Administered medication	Child is stable.	Reassessment done.	[signature] -01bm
Afternoon							
Night							

Docu. No: RCH /FRM / CLINICAL / 148

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NURSES NOTES

(USE BALL POINT PEN ONLY)

☑ No Known Drug Allergies

☐ Drug Allergies .... Not known

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
29/6/26	7.10am.	Receiving Notes
		Child received from ER to HDU
		@ 7.10am. child is Having on Room
		air. No fever spikes. Conscious and
		alert. GCS 15/15 Both pupil
		equally reacted. PV @ IV line
		⊕.
		[signature] 521733.
29/6/26		→ Morning duty 29/6/26 ←
	8am	Child details taken over from
		night duty staff nurse, Child is on
		RA ventilation, PV 24, GCS 15/15
		B/L pupil equally reacting to light,
		EBM on demand, IV line ⊕,
		Inj. NAC 31ml infusion over 1 hour, RBS
		OD
		[signature]
		Inj. NAC infusion started @ 31ml/4
		on flow.
	9am	Vital signs checked and recorded
	10am	Dr. Nataraj sir seen the child
		advised syp. [illegible], Syp fluids
		added, tomorrow morning repeat
		LFT [signature]
		Monitor vital 4 hours once [signature]
	12pm	Child vital signs checked recorded [signature]

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

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

Patient Sticker

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NURSES NOTES

(USE BALL POINT PEN ONLY)

☑ No Known Drug Allergies

☐ Drug Allergies .... Nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
29/6/26	1pm	Medication given as per drug chart
	1.30pm	Child details handed over to next duty staff nurse.
		Evening duty on 29/6/26.
29/6/26	1:30pm	Child taken over from morning duty staff. ISBAR followed. While receiving the child is on RA, EBM, GCS-15/15, PV-2/1, CRT<3 sec, pupils reacting both side. IV line patent. INT. NAC 4.5ml in 140ml NS - 8.7ml/hr on flow. Due medicines given as per charted. Raj 018304.
	3pm	Dhal rice given, tolerated. No sign of vomiting/ aspiration. Raj 018304
	5pm	C/S/B. Dr. Yuvaraj, reviewed the child advise to cont NAC infusion, vitals monitor, T/m CFT. Raj/018304
	6pm	Orals encouraged, well tolerated. No signs of aspiration / vomiting. Raj/018304
	7:30pm	Child handover given to night duty staff. ISBAR followed. Raj/018304.
29/6/26	8pm	Night Duty on 29/6/26
		Baby's handing over details taken from evening duty

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

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NURSES NOTES

(USE BALL POINT PEN ONLY)

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

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
29/6/26	9pm	Staff nurse Using By TSBAR techniques. Monitored vital sign provided medication and care. Baby is on Room air CCS is alert and active. IV line is on path. NAC infusion → on flow tomorrow morning LFT Sample. 4.5ml NAC + 140ml NS → 8.7ml/hr over 16 hr. Baby is taking DBF + soft diet. oral intake and output is good. for Baby. paracetamol Gave less than 10. Dengue Negative. Sleeping path is normal. → Baby's all medication gave IV line is on path. No fem. Baby taking orally good. active and alert. Tomorrow morning after seeing LFT report dr. will decide. → Morning Care given for Baby morning RBS 102 mg/dl. morning LFT sample send to lab IV line is on path.
	11pm	
30/6/26	2Am.	
	4Am.	
	6Am.	

Sayan 01545
Sayan 01545
Sayan 01545

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

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NURSES NOTES
(USE BALL POINT PEN ONLY)

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

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
30/6/26	7am	Baby is active and alert.
		Baby sleeping pattern is
		normal → (Sayani 0?)
		Baby's handing over details
		given to morning duty staff
	7.48am	nurse using by ISBAR technique.
		→ Morning duty 30/6/26 ←
30/6/26	8am	Child details taken over from
		night duty staff nurse, Child is on
		RA ventilation PV 2+ GCS 15/15, B/L
		pupil equally reacting to light, LFT
		(P) awaited, RBS OD, — [signature]
	9am	Vital sign checked and recorded
	10am	Dr Chandralekha mam seen the Child
		advised to follow same orders — [signature]
	11am	Dr Nataraj sir seen the Child
		advised discharge today — [signature]
	11:30am	File closed and sent to billing
		department — [signature]

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

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

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NURSES NOTES

(USE BALL POINT PEN ONLY)

☐ No Known Drug Allergies

☐ Drug Allergies .....

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

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

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NURSES NOTES

(USE BALL POINT PEN ONLY)

☐ No Known Drug Allergies

☐ Drug Allergies .....

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

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

GUC-00093213 IP18-00036239
Baby AADHAN VEL KRISHNAN
09-06-2025 1 Y 0 M 20 D (M)
Dr. NATARAJ PALANIAPPAN

Rainbow® Children's Hospital
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NURSING INITIAL ASSESSMENT FOR PICU

Date of Admission: 29/6/26

Source of Admission: ☐ OPD ☐ Ward ☐ Other: ER

Reason for Admission: Accidental overdose of Paracetamol drops

Admission Diagnosis: Paracetamol Intoxicated

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: 9.3 kg. Length: Head Circumference (< 2 years):

Temp.: 98.F HR: 130 bpm RR: 28 bpm BP: 99/79 mmHg

Pain Score: 0 No Specify Site: – (Follow Pain Assessment Sheet & Document)

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

Risk of Pressure Sore (Braden Q Score 24) (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 .....

Siblings in household ☑ Yes ☐ No (if yes How Many?) ..... 1 .....

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: .....

Orientation not given Reason: .....

Nurse Name: Anushka ..... Nurse Signature : .....

Date & Time: 29/6/20 @ 9am

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: Parenteral poisoning

Nurse Name: Anushka ..... Nurse Signature : .....

Date & Time: 30/6/20 @ 10am

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Patient's Name:..

MRD NO:......... GUC-00093213 IP18-00036239
Baby AADHAN VEL KRISHNAN
09-06-2025 1 Y 0 M 20 D (M)
Dr. NATARAJ PALANIAPPAN

Age :................ M ☐ F

Consultant :..

PHLEBITIS ASSESSMENT

CANNULA 1

Date : 29/06/2026 Time: 6:35 am.
Location : (L) metadorsal
Size : 24G
Cannula inserted by : S/N Ajith

Date	Time	Phlebitis	Infiltration	Nursing Intervention	Sign
29/6/26	6:35am	☐Yes ☑No	☐Yes ☐No	patent	[illegible] 01527
	8am	☐Yes ☑No	☐Yes ☑No	patent	[illegible]
	10am	☐Yes ☑No	☐Yes ☑No	patent	[illegible]
	12pm	☐Yes ☑No	☐Yes ☑No	patent	[illegible]
	2pm	☐Yes ☑No	☐Yes ☑No	patent	[illegible] 01530
	4pm	☐Yes ☑No	☐Yes ☑No	patent	[illegible] 01530
	6pm	☐Yes ☑No	☐Yes ☑No	patent	[illegible] 01530
	8pm	☐Yes ☑No	☐Yes ☑No	patent	@ 01545
	10pm	☐Yes ☑No	☐Yes ☑No	patent	@ 01545
30/6	12AM	☐Yes ☑No	☐Yes ☑No	patent	@ 01545
	2AM	☐Yes ☑No	☐Yes ☑No	patent	@ 01545
	4AM	☐Yes ☑No	☐Yes ☑No	patent	@ 01545
	6AM	☐Yes ☑No	☐Yes ☑No	patent	@ 01545
	8a	☐Yes ☑No	☐Yes ☑No	patent	[illegible]
	10a	☐Yes ☑No	☐Yes ☑No	patent	[illegible]
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐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		
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		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐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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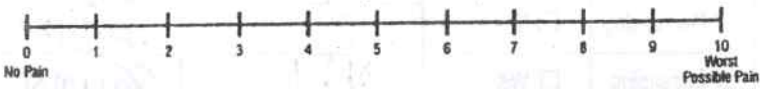
PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
29/6	8am	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	[signature]
29/6	4pm	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NIL	[signature]
29/6/26	11pm	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	[signature]
30/6/26	3Am	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	[signature]
30/6h	11	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	[signature]
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

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

PAIN ASSESSMENT TOOLS

Numerical Pain Scale (Obstetric and Gynecology)



Wong - Baker (Pediatrics) Above 7 Years

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

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

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

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THE HUMPTY DUMPTY SCALE

M E N M

PARAMETER	CRITERIA	SCORE	DATE 29/6	DATE 29/6	DATE 29/6	DATE 30/6	DATE
Age	Less than 3 years old	4	4	4	4	4	
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	2	2	2	2	
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1	1	1	
Cognitive Impairments	Not aware of Limitations	3	3				
	Forget Limitations	2					
	Oriented to own ability	1		1	1	1	
	History of Falls or Infant-Toddler Placed in Bed	4		4	4	4	
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2				
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours/ None	1	1	1	1	1	
Medication Usage	Sedatives (Excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1	1	1	
	Total		14	14	14	14	

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		✓	✓	X	X
	Wheels Locked		✓	✓	✓	✓
	Room free of clutter		✓	✓	✓	✓
	Adequate lighting		✓	✓	✓	✓
	Wheel chair support		X	X	X	X
	Other Intervention(s) Specify		X	X	X	X
	Nurse's Name:					
	Signature:					
	Date:		29/6	29/6	30/6/25	30/6
	Time:		8am	2pm	10pm	8am

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BRADEN 'Q' SCALE

(for Paediatric use)

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09-06-2025 1 Y 0 M 20 D (M)
Dr. NATARAJ PALANIAPPAN

HW/BRD-Q/NSG/04

Patient Name : .....

Age..... Gender

				Date :	M 29/6	E 29/6	M 30/6	
Mobility	1. Completely Immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4	4	
"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.	2	3	3	
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.	3	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.	2	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."	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	4	4	
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	
				TOTAL SCORE	21	27	27	
				Evaluator's Name		Rai		

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

GUC-00093213 IP18-00036239
Baby AADHAN VEL KRISHNAN
09-06-2025 1 Y 0 M 20 D (M)
Dr. NATARAJ PALANIAPPAN

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RBS CHART

Date	Time	RBS (mg/dl)	IVF %	Signature
29/06/26	6:35 am	97 mg/dl.	-	J. mary Rell
30/6/26	6 Am	102 mg/dl.	Maintain on DBF + Softdil	Sou 87327 / 93457

Docu. No. : RCH /FRM / CLINICAL / 185

PATIENT TRANSFER FORM

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Date & Time of Admission	Date & Time of Transfer Order
29/06/2026 @ b:[illegible] am	29/06/2026 @ 7am.

Treating Consultant Name	Transfer Ordered by	Reason for Transfer
Dr. Nataraj	Dr. Deepak	Fall's medical

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
18	Nil	Yes ☐ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	Inj. NAC	3
2.		
3.		
4.		
5.		

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

Paracetamol intoxication

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
[signature] 515251	Dr. Deepak

Patient & Clinical Records Received by : [signature] 02/735

Date & Time of Patient Received : 29/6/26 @ 7.05 am.

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

4.00 AM P100 drop 5ml (P/O) [signature] 01345

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wt: 9.3 kg

EMERGENCY ROOM TRIAGE FORM

Patient's Name : Baby. Adhevel Krishnan Age : 1y Gender: ☑ Male ☐ Female

Date : 29/06/2026 Time of Arrival : 5.40 AM

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: 98.3° PR: 130 (183) /min BP: 98/74 RR: 36/min SpO₂: 98% RA

Chief Complaints: c/o fever since x1 day, Paracetamol over dose

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

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

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

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian: [signature]

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 : T. Mary. [signature]

Date & Time : 29/06/2026 @ 5.43 AM

Signature of Triage Nurse : T. Mary [signature] 01521

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

CBC
CRP
ECG
LFT

NS1 AgM

Pan BD
NAC IUG

HDV

N-Ace

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 29/09/2020 Time of arrival : 5:40 AM overdose ē fever x 1 day

Chief Complaints: Accidental ingestion of Paracetamol RBS: ....

Height : — Weight : 9.3 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: 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 Parent's

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

Time of Initial assessment completed by ER Nurse : Jeny [signature] @ 5.50 AM 0152k

Docu. No. : RCH /FRM / CLINICAL / 120

(P.T.O.)

Time	Nursing Notes
6.00 PM	child Brought to ER c̄ c/o Acc Paracetamol
	over dose, c̄ fever x 1 day.
	Vital's checked and Recd
	seen by Dr. Deepak advised admission
	For HDU observation ↓ Dr. Nataraj
	Iv line Initiated and patten
	Blood sample collected and send to lab

Samples collected by: S/N mary Prethi Time: 6.30 PM

Samples sent by : S/N Ajith Time: 6.40 PM

Medication given in ER:

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

Condition of patient at time of shift - out :	Details of Shift - out
HR: 130 BP: 98/74 (83) CFT: <3S.	Shift - out from ER to: HDU
RR: 36 SPO$_2$: 99%	Time of Shift - out: 7 pm.
GCS: 15/15 Temperature : 98.3 F	Handover given to: S/N Yamuna (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 placement done in (L) metadorsal 24 G is placed.

Name of the Nurse : T. mary Prethi 07527 Signature of the Nurse : T. mary Preth 07527

Date & Time : 29/06/2026 @ 5.45AM

Patient Sticker

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PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : Dr: DEEPAK Date : 29/6/20

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

Start Time of Assessment: ..... Weight: 9.3 kg

Allergic History: Nil

Chief Complaints:
Accidental Overdose of paracetamol

Pediatric Assessment Triangle

A Appearance - TICLS Alert

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

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

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

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

Significant Past History: .....

Medication History: .....

Relevant Investigations: .....

Primary Assessment

Airway
- ☑ Open
- ☑ Maintainable
- ☐ Not Maintainable

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

Breathing
Rate: 30/m SpO_2 on FiO_2 98% on RA
Rhythm: .....
Retractions: ☐ Suprasternal ☐ ICR ☐ SCR ☐ Sternal ☐ Supraclavicular ☐ Nasal Flaring
Respiratory Noises: ☐ Stridor ☐ Wheezing ☐ Grunting
Air Entry: BAE (+)
Palpation Findings (If necessary).....

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

Circulation

HR: 141/min CFT — Central ⊕ — Peripheral ⊕

Any urgent interventions needed: ☐ Yes ☑ No

If Yes ....

BP: .... mmHg

Pulse Volume: — Central .... — Peripheral ....

If in Shock: — Compensated .... — Hypotensive ....

Muffled Heart Sound: ☐ Yes ☐ No

Engorged Neck Veins: ☐ Yes ☐ No

Murmurs: ☐ Yes ☐ No

Liver Span: ....

ECG: ....

Any Signs of Heart Failure: ☐ Yes ☐ No

Disability

GCS: 15/15 AVPU: Alert

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.: 98.0F

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: ....

Treatment Planned: ....

As charted

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

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

Assessment done by

Name of the Doctor: C. DEEPAK

Signature: C. [signature]

Date & Time: 27/6/22 06:10AM

Sr. Doctor on Duty (If necessary)

Name of the Sr. Doctor: ....

Signature: ....

Date & Time: ....