Rainbow Children's Hospital

GUC:-00094268 IP18-00036676
Ms MAIRA
18-09-2017 8 Y 10 M 12 D (F)
Dr. KUMAR M

DISCHARGE TRACKING SHEET

UHID- FLOOR- NAME OF CONSULTANT-

ACTIVITY	INTIME	OUT TIME	NAME & SIGNATURE	REMARKS	<To be filled by Admin>		
Activity Sheet update by Nursing							
Activity Sheet update by Pharmacy			31/7/26 11:40 am				

ACTIVITY RECORD FOR BILLING

Rainbow Children's Hospital
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BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Name: .....

UHID No: GUC-00094268 IP18-00036676
Ms MAIRA
18-09-2017 8 Y 10 M 11 D (F)
Dr. KARTHIK NARAYANAN R

Consultant: ..... Dept: .....

Date of Admission: .....

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

Room / Bed No: .....

Suggested Billable bed type: .....

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
20/7	8.30PM	ER	512	17894

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

MEDICAL EQUIPMENT (WARD & ICU)

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

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
29/7/26.	Neb c O2	1	34787	
30/7/26	Neb c O2	1	34922	
30/7/26	Neb c O2	1	1735186	
30/7/26	Ambulance charge	1	1734900	
31/7	Neb c O2	1	2353094	

ANY OTHER INFORMATION:

.....

.....

.....

.....

.....

.....

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

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

Rainbow Children's Hospital | BirthRight

DISCHARGE TRACKING SHEET

UHID- _____ FLOOR- _____ NAME OF CONSULTANT- _____

ACTIVITY	TIME		NAME & SIGNATURE	REMARKS	<To be filled by Admin>
Discharge Announcemënt					
	INTIME	OUT TIME			
Arrangement of File by Nursing			Sig/Signature		
Preparation of Discharge Summary					
Finalization of discharge summary					
Transfer of file from Ward to Billing Dept					
Bill Processing					
Audit Clearance					
Billing Clearance					
Physical Clearance					

Rainbow Children's Hospital

BirthRight by Rainbow

Rainbow Children's Hospital - Guindy

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

ADMISSION SHEET

Registration Details :

Admission No : IP18-00036676 **Admit Date** : 29-Jul-2026 **Admit Time** : 07:44 PM **UHID** : GUC-00094268

Patient Details :

Patient Name	: Ms MAIRA	**Age**	: 8 Y 10 M 12 D
Guardian	: Mr ARUN DHARIWAL	**DOB**	: 18-09-2017
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: 60/81, E.K.D. ST, ALANDUR, CHENNAI Alandur Chennai Tamil Nadu INDIA 600016	**Phone No**	: 9840024901/ 9677206576
		E-mail	: dhariwalinfotech@gmail.com

Admission Details :

Bed Type : SEMI PRIVATE **Bed No** : SPVT 512 **Ward Name** : 5F-SEMI PRIVATE

Room No : SPVT 512 **Admission Type** : First Visit

Contact Details :

Name : Mr ARUN DHARIWAL **Relationship** : Father

Contact Address : 60/81, E.K.D. ST, ALANDUR, CHENNAI Alandur Chennai Tamil Nadu INDIA 600016 **Phone No** : / 9840024901

Signature

Doctor Details :

Doctor Name : Dr. KUMAR M **Specialisation** : GENERAL PEDIATRICSS

Referral Doctor : DR.KUMAR (ADAMBAKKAM) **Phone No** :

Co-Consultant : Dr. KARTHIK NARAYANAN R

Payment Details :

Payment Mode : Cash **Deposit Amount** : 5000.00

Payor Name : SELFPAY

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

GENERAL CONSENT FOR TREATMENT

Patient Name:	**Ms MAIRA**	**Age :**	**8 Y 10 M 12 D**
IP No:	**IP18-00036676**	**Sex:**	**Female**
Consultant:	**Dr. KUMAR M**	**Ward/Bed No:**	**5F-SEMI PRIVATE/SPVT 512**

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 [illegible]urance coverage and while doing so confidentiality of the patient will be maintained at all times and this will not affect the care of the patient.

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

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

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

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

Relationship:

Date: Time:

Wittness Name:

Wittness Signature:

Patient Address:

60/81, E.K.D. ST, ALANDUR, CHENNAI
Alandur Chennai Tamil Nadu INDIA
600016

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PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: _____

UHID ID: _____ GUC-00094268 IP18-00036676
Ms MAIRA
18-09-2017 8 Y 10 M 11 D (F)
Dr. KARTHIK NARAYANAN R

Department: _____

Consultant: _____

(P.T.O.)

Patient Sticker

Pediatric Multiorgan History & Physical Examination

Name: _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

- c/o fever.

History of present illness :

Δ - (R) Bronchial vascular malformation
& AV shunting.

S/P - Glue embolisation
done on 28/7/21.

POD # 1
↓
transferred for post op care.

Patient Sticker

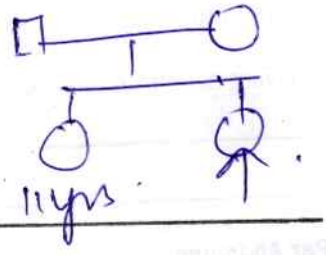
Past History : (Including details of any previous investigation or treatment)

- Child had H/O hemoptysis x 3 days & melena
↓
On evaluation Bronchoscopy (27/07/26) → endobronchial vascular malformation

Birth & Neonatal History:

LSCS | Term | (1AB) BW - 2.75 Kg
NO NICU stay

Family Chart



Birth & Socio Economic History:

About Father :

About Mother :

Any additional Information :

Developmental History : Dev - (N)

Immunization History : as per IAP

Anthropometry :

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

Weight (kgs) 35.5 Kg (Centile _____)

On Examination :

Temperature : 97.5 F Pulse Rate : 87/min B.P. 112/75 (87) SPO2 99%

Resp.rate and type of breathing : 28/min Child looking well.

Rash - CRT < 2sec

Lymphadenopathy - PPWF (+)

Oedema :

Allergies (if any): Not Known

(P.T.O.)

Patient Sticker

Respiratory System :

Inspection (any s/o distress) :

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

Any addes sounds : NVBS (+)

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

Cardiovascular System :

Inspection of procordium :

Heart Sounds : S_1S_2 (+)

Any murmur : (-)

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

Per Abdomen :

Inspection :

Palpation : ~~soft~~, not tender.

Ausculation : BS (+)

Spine : (N) External Genitelia : (N)

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

Central Nervous System :

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

Cranial Nerves :

Motor System :

Nutriton :

Tone: (N) Power 5/5

Co-ordinator :

Posture :

Involuntary Movements :

Patient Sticker

Reflexes :

Superficials: 1+

DTR 2+

Plantars ↓

Sensory System :

Bladder / Bowel :

Clinical Summary & Diagnostic: 4 – (R) Bronchial vascular malformation
c AV shunting
S/P – Glue embolisation (28/7/26)
for post op care.

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

Desired goals of the treatment :

Planned Labs:

Planned Management

- Syp. Azithromycin 8.5ml OD.
- Neb. Budecort 0.5mg ✓-0-✓
- Syp. Chericoff 5ml ✓-0-✓
- Tab. Trapic SOS

Signature of the Doctor:

Name of the Doctor: Dr. Gayatri

Date & Time: 29/8/26

Signature of the Consultant:

Name of the Consultant:

Date & Time:

(P.T.O.)

Patient Sticker

DISCHARGE PLANNING FORM

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

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

2. Destination Post Discharge: ☐ Home

   Family Members Notified (Person Contacted)

   ☐ Transfer

   Hospital Facilty Notified (Person Contacted)

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

   ☐ Needs Assistance In:

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

4. Nutritional Plan:

   ☐ Dietary Instruction Discussed with the:

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

5. Discharge Planning Discussed with the:

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

6. Patient/Family Educational Plan:

   ☐ Educational Topic/s: .....

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

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

Doctor Signature: .....

Doctor Name: .....

Date and Time: .....

GUC-00094268 IP
Ms MAIRA
18-09-2017 8 Y 10 M
Dr. KUMAR M

Doc

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

DOCTOR'S SHIFT CHANGE HANDOVER FORM

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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

GUC:-00094268 IP18-
Ms MAIRA
18-09-2017 8 Y 1 M
Dr. KUMAR M

(1)

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/7/26 12:30am	S/B Dr. Gayathri	
	Δ - (R) Bronchial vascular malformation ± AV shunting	
	S/P - Glue embolisation (28/7/26).	
	POD # 2.	
	• Child reviewed	
	• c/o burning sensation over the chest	
	• No fever	
	• peripheries - warm & pink	
	• PPWF (+) CRT < 2sec	
	• hemodynamically stable.	
	BP - 100/64 mmHg	O/E: CVS | NAD.
	HR - 90/min	RS |
	RR - 20/min	Abd: soft
	SpO2 - 98% in RA	tenderness (+) in epigastrium
	Plan	CNS: NAD.
•	IV pan 40mg stat	
-	Cont chups as per chart	
•	Monitor vitals	

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
30/7/26 10AM	S/B -	Dr Yuvaraj
	A - Right Brondial Vasular Malformation	± AV shunting embolization
	POD - (2) S/P - Glue	
	Child reviewed	
	O/E alert, active	
	vitals stable	
	Has pain over	(R) elbow + (R) thigh. due to procedure
		edema ↓
	Not moving (R) UL & LL due to pain	
	- peripheral perfusion & sensation - (N)	
	RS - Clear	
	PA - Soft, non tender	CVS/RSAD CNS
	Adv.	
	Neb Budecort	0.5ml BD
	Syp Cheracof	5ml BD
	T. Trapsi	tab BD
		T.3

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18-09-2017 8 Y 10 M 12 D (F)
Dr. KARTHIK NARAYANAN R

(2)

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
30/1/2026	S/B Dr Karthik	
	Plan	
	1) Syp Augmentin - BDS	7.5ml — 0 — 7.5ml × (5) days
	2) T-Bact oint	✓ — ✓ — ✓ × (5) days
	3) Stop T. Trapic	
30/1/26 4PM	S/B - Dr Yuvaraj	
	Child reviewed about, adm Well Hb/c WBC - (N) No hemoptysis	
	RS - Clear PA - Soft, non tender	
		Plan Continue same plan discharge tomorrow

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
30/7/26		
8 pm	S/B Dr. Manoma	
	Reviewed No cough / Hemoptysis Has passed stool after 2 days ↓ black coloured stool (melena) PP-NF, pemphigus vulgaris. RI-clear Oxygen-RA	RP-100/60mmHg
	Rx → Informed Dr. Kartik Sir, Advised to watch for hemoptysis - watch vitals - M/E Cough/hemoptysis	
1st		

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

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18-09-2017 8 Y 10 M 12 D (F)
Dr. KARTHIK NARAYANAN R

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
31/1/26 9 AM	S/B - Dr Yuvaraj.	
	Δ - Right Bronchial Vascular Malformation with AV shunting -	
	POD (3) S/P - Glue embolization	
	- 1 episode of melena @ yesterday.	
	- No hemoptysis / hematemesis or other bleeding manifestations	
	- Limb edema settled	
	Vitals - BP - 100/62 mm Hg	
	HR - 78/min.	
	R.S - Clear	
	PA - Soft, non tender	
	CVS - S_1S_2 @, no murmurs	
	C.N.S - NFND	
	Adv: - Syp Augmentin DDS 7.5ml BD	
	- T. Bact ointment V — V — V	
	Neb Budecord 0.5mg BD	
	Syp Chericoff 5ml BD	
	- Plan discharge today after rounds	
	- Plan to do genetic testing - WES.	

T. Yuvaraj

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

GUC:-00094268
Ms MAIRA 8 Y 10 M
18-09-2017
Dr. KUMAR M

(1)

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RESULT SHEET

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

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

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

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DRUG CHART

Date of Admission: 29/8 Drug Allergies: ← ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

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

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

SOS / PRN (As Required Medication)

DRUG: Syp. P-500				Date / Time
Dose: 5.5ml	Route: P/O	Frequency: SOS	Start Date: 29/8	
Doctor's Signature	Valid Period	Pharm.		
Additional Instructions: 5ml/500mg				

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 .....

Patient Sticker

REGULAR PRESCRIPTIONS Weight. 35.5K Ward. .....

DRUG : Syp. AZITHROMY (IV)

Dose	Route	Frequency	Start Date
8.5ml	P/O	Q24H	29/7

Name & Signature of the Doctor Starting the Drugs: Dr. Gayathri 165555

Additional Instructions: 5ml/200mg

Daily Doctor's Endorsement by a Sign

Date	30/7																
Time	10AM																
	TP																
	MR																
	DS																

Stop 1/8 (12583)

DRUG : Neb. BUDECORT

Dose	Route	Frequency	Start Date
0.5ml	Neb	Q12H	29/7

Name & Signature of the Doctor Starting the Drugs: Dr. Gayathri 165555

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date	29/7	30/7	31/7
Time	9PM		
	RW	KS	
	SN		
	9PM	P&T	P&T

DRUG : Syp. CHEACOFF

Dose	Route	Frequency	Start Date
5ml	P/O	Q12H	29/7

Name & Signature of the Doctor Starting the Drugs: Dr. Gayathri 165555

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date	29/7	30/7	31/7
Time	8PM		
	TP	KS	
	MR	SN	
	8PM	P&T	P&T

DRUG : Tab. TRAPIC.

Dose	Route	Frequency	Start Date
1Tab	P/O	QBN	29/7

Name & Signature of the Doctor Starting the Drugs: Dr. Gayathri 165555

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date	30/7		
Time	8PM		
	P&T		
	8PM		
	10PM		

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Sheet No: .....

REGULAR PRESCRIPTIONS

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

DRUG : SYP AUGMENTIN DRS.

Dose	Route	Frequency	Start Dt.
7.5ml	PO	Q12H	30/7/17

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date ▸ Time	30/7 8 pm	31/7 8 am	1pm	1/8 8 am
	DST	DST	TP	SN

DRUG : T-BACT ointment

Dose	Route	Frequency	Start Dt.
—	L/A	TDS	30/7

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date ▸ Time	30/7 6 pm	31/7 6 am	2 pm	10 pm
	DST	DST	TP	DST

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date ▸ Time

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date ▸ Time

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

Patient Sticker

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BY RAINBOW HOSPITALS
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REGULAR PRESCRIPTIONS

Weight .... Ward ....

Sheet No: ....

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

DRUG :

Dose	Route	Frequency	Start Dt.

Date / Time

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Dt.

Date / Time

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Dt.

Date / Time

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Dt.

Date / Time

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

GUC-00094268 ID18-00036676

Ms MAIRA 8 Y 10 M 11 D (F)

18-09-2017

Dr. KARTHIK NARAYANAN R

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

Signature .....

VERIFIED BY : Name .....

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
29/9	12 Am	Inj. PAN	40mg	I.V		

Patient Sticker

I.V. FLUIDS CHART

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

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign

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

GUC-00094268 IP18-00036676
Ms MAIRA
18-09-2017 8 Y 10 M 11 D (F)
Dr. KARTHIK NARAYANAN R

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MEDICATION RECONCILIATION FORM

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

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

Shifting From: ER Shifted to: 512

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

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : .....

Date & Time : 29/7/24 @ 8PM

Nurse Name & Signature: ..... Iman

Date & Time : 29/7 @ 8PM.

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

Ref. No. F/INPR/12

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Patient Name : GUC-00094268 IP18-00036676
Ms MAIRA
18-09-2017 8 Y 10 M 12 D (F)
Dr. KARTHIK NARAYANAN R

Registration No.

NEBULISATION CHART

Date	Time	Drug	Nurse	Parents SIgnature
29/7/	8pm	Budicort Neb c O_2 → ①		
30/7/26	11.00 AM	Budecort+Neb c O_2 → ①		
	2.00	Budecort Neb c O_2 →		
	3.00	Neb c O_2 — ①		
	4.00			
	5.00			
	6.00			
	7.00			
	8.00			
	9.00			
	10.00			
	11.00			
	12.00			
	13.00			
	14.00			
	15.00			
	16.00			
	17.00			
	18.00			
	19.00			
	20.00			
	21.00			
	22.00			
	23.00			

GUC-00094268 IP18-00036676
Ms MAIRA
18-09-2017 8 Y 10 M 11 D (F)
Dr. KARTHIK NARAYANAN R

(1)

No. : RCH/ FRM / CLINICAL / 126

SCHOOL AGE (5-12 years)
Children's Observation & Early Warning Scoring Chart

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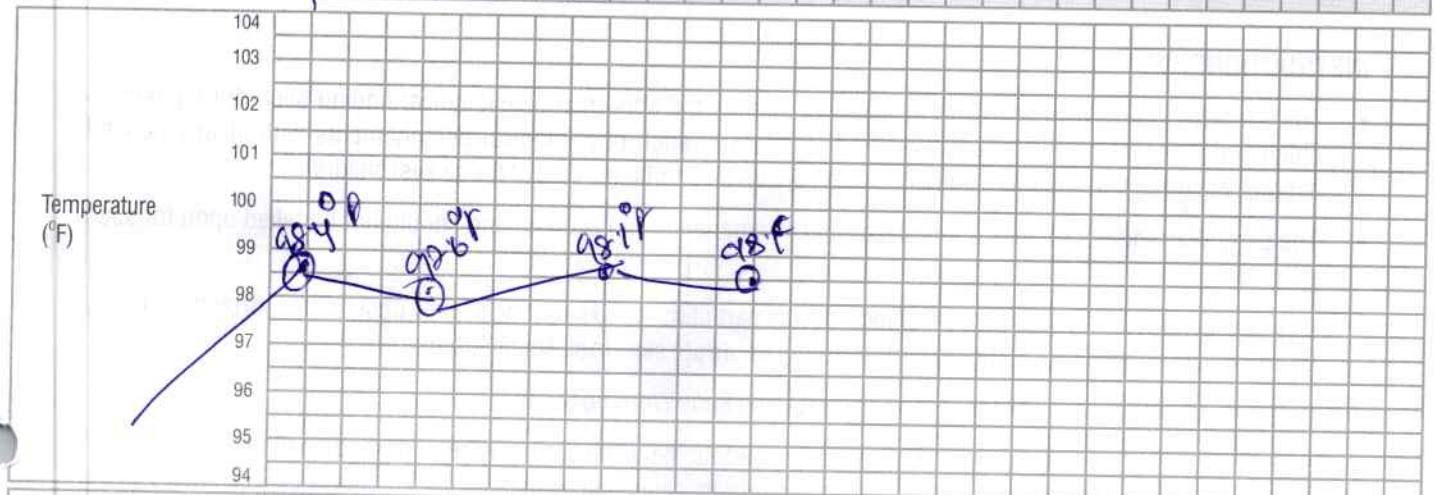
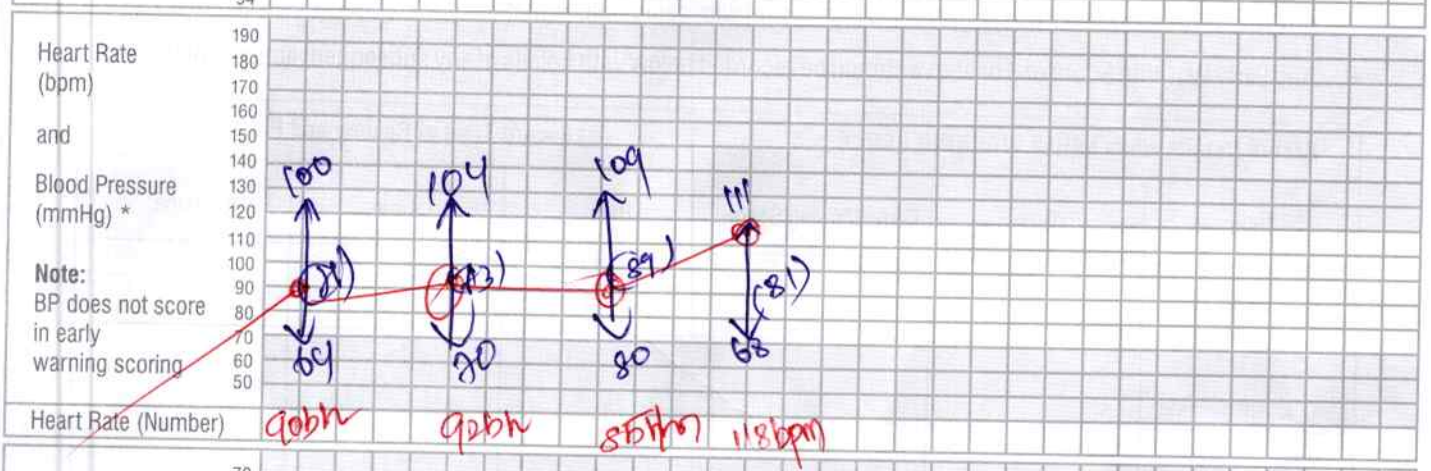
EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 29/7/26 Time:	8.30 pm	12 am	4 am	8 AM
Doctor / Nurse / Family Concern?				





Heart Rate (Number)	90bpm	92bpm	85bpm	118bpm

Resp Rate (Number)	20bpm	20bpm	22bpm	24bpm
Resp Distress: Mod/ Severe / None / Mild	✓	✓	✓	✓
Receiving O_2 (l/min) O_2 Saturations (%)	98%	98%	96%	98%
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	SN	SN	SN	SN

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

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

Patient Sticker

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

GUC-00094268
Ms MAIRA
IP18-00036676
18-09-2017
8 Y 10 M 11 D (F)
Dr. KARTHIK NARAYANAN R

(2)

Doc. No. : RCH/ FRM / CLINICAL / 126

SCHOOL AGE (5-12 years)
Children's Observation & Early Warning Scoring Chart

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date 20/7/06 Time: 8AM | 12pm | 4pm | 8pm | 12am | 4am

Doctor / Nurse / Family Concern?

Temperature (°F)

98F | 98.6°F | 98.5°F | 97.8F | 98.4°F | 97.5°F

Heart Rate (bpm) and Blood Pressure (mmHg) *

Note: BP does not score in early warning scoring

(81) 68 | (70) 110 66 | (72) 103 66 | (80) 100 60 | (69) 98 58 | 68 100 62

Heart Rate (Number)

118bpm | 100 b/m | 110 b/m | 100 b/m | 98 b/m | 100 b/m

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

Resp Rate (Number)

24 b/m | 24 b/m | 24 b/m | 24 b/m | 20 b/m | 18 b/m

Resp Distress: Mod/ Severe / None / Mild	✓	✓	✓	✓	✓	✓
Receiving O_2 (l/min) O_2 Saturations (%)	98%	97%	98%	96%	97%	98%
Conscious Level: Normal / Altered	✓	✓	✓	✓	✓	✓
GCS *	15/15	15/15	15/15	15/15	15/15	15/15
TOTAL SCORE Number of shaded boxes	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0
Observer's Initials						

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:

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

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

GUC-00094268 IP18-00036676
Ms MAIRA
18-09-2017 8 Y 10 M 11 D (F)
Dr. KARTHIK NARAYANAN R

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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.

29/7/18 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
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :		Receiving Now				Total Output :						
	08:00 pm										0	
	09:00 pm	H2O	100ml							L	0	
	10:00 pm	H2O	50ml								0	
	11:00 pm	milk	120ml								0	
	12:00 am										0	
	01:00 am	H2O	50ml							L	0	
Total Intake :		320ml				Total Output :					0	
	02:00 am										2 times	
	03:00 am										0	
	04:00 am										0	
	05:00 am										0	
	06:00 am										0	
	07:00 am										0	
Total Intake :		—				Total Output :					0	

Total 24 hrs. Intake	320ml	Total 24 hrs. Output	2 times

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Dr. KARTHIK NARAYANAN R

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FLUID CHART

Sheet No. : (2)

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

Date	Time	Intake: Nature of Fluid	Intake: Route – Mouth	Intake: Route – I.V	Intake: Route – N.G	Output: NG	Output: Diarrhoea	Output: Vomit	Output: Drainage	Output: Urine	IV Site Thrombophlebitis Score	Sign. Nurse
30/7/26												
	08:00 am	H2O	100ml							✓	NO	
	09:00 am	H2O	110ml									
	10:00 am									✓	IV	
	11:00 am	H2O	200ml									
	12:00 pm	H2O	160ml							✓	Pain	
	01:00 pm											
Total Intake :		570 ml				**Total Output :**				3 times		
	02:00 pm	RTC										
	03:00 pm	H2O	80ml							✓	NO	
	04:00 pm	H2O	100ml								IV	
	05:00 pm									✓		
	06:00 pm	H2O	100ml								Pain	
	07:00 pm									✓		
Total Intake :		280ml				**Total Output :**				3 times		
	08:00 pm											
	09:00 pm	H2O	100ml							✓	NO	
	10:00 pm	milk	120ml								IV	
	11:00 pm											
	12:00 am	H2O	100ml							✓	Pain	
	01:00 am											
Total Intake :		320ml				**Total Output :**				2 times		
	02:00 am										NO	
	03:00 am										IV	
	04:00 am											
	05:00 am										Pain	
	06:00 am											
	07:00 am											
Total Intake :		—				**Total Output :**				—		

Total 24 hrs. Intake	1,170ml	Total 24 hrs. Output	8 times

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NURSING CARE RECORD

Date: 24/7/17

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	6pm	To maintain The personal hygein	10pm	> Assess The condition > check vital sign > monitor I/O output Administer med-	child was stable	child was active	

Docu. No: RCH /FRM / CLINICAL / 148

GUC:-00094268 IP18-00036676
Ms MAIRA
18-09-2017 8 Y 10 M 12 D (F)
Dr. KARTHIK NARAYANAN R

NURSING CARE RECORD

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Date: 30/9/26

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	7-30 AM	TO Maintain fluid Balance	8-30 AM	Maintain by Administer IV fluid	Evaluate by Input & output Chart	Maintained fluid Balance well	
Afternoon	2pm	TO Maintain good nutritional Status	3pm	To Maintained good Nutritional Status	The child was Stable	The child Vital Signs are Stable	
Night	8pm	TO maintain The personal hygiene.	8 pm	> Assess The condition > check vital sign > monitor BP > Administered.	child was Stable	child was active	

GUC-00094268 IP18-00036676
Ms MAIRA
18-09-2017 8 Y 10 M 11 D (F)
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(1)

NURSES NOTES

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

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		Receiving Notes.	
29/7	8.30pm	child details handover taken from the ER staff. Child was conscious & oriented old Dr line. child complaint for ~~had~~ came for the Glue Embolisation post op care. check the vital vitals are the stable. CP ++ PP ++ CRT <2sec.	
	10pm	Due medication as given for the drug chart order. child was stable No other complaints.	
30/7	12AM	child was complain for ~~the~~ chest pain. Inform to the Dr Gayathri mam. ~~mam~~ Advi given Inj. Pan 40mg. follow the advical. check the vital sign. vitals are the stable. CP ++ PP ++ CRT <2s no fever spike	
	2AM	child was well sleeping No other complaints. Iv line patten.	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Patient Sticker

NURSES NOTES

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☑ No Known Drug Allergies

☐ Drug Allergies .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
	4AM	Check the vital sign. vitals are the stable. CP ++ PP ++ CRT <2sec. Dr line patten	
	6AM	Due medication as given for the drug chart order.	
30/7/25	7AM	monitor Plo chart NO other complaints Dr line patten	
	7:30AM	child details handover given to the Morning duty Staff Nurse.	
		Morning duty (30/7/25)	
	7.30 AM	child Handover taken from night duty staff Nurse child was concious & oriented and IV line present and child under room air	
	8AM	vitals are monitored and recorded and vitals are stable. SAM CP ++ PP ++ CRT 1.38sec	
	9:15AM	Due medication given as per dues chart order &	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

GUC-00094268 IP18-00036676
Ms MAIRA
18-09-2017 8 Y 10 M 12 D (F)
Dr. KARTHIK NARAYANAN R

(2)

NURSES NOTES

Rainbow® Children's Hospital
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☐ No Known Drug Allergies
☐ Drug Allergies ..... Nil .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		documented	
30/7	11AM	Dr. Karthik Sir seen the child and advice to stop T. Trapic Add. Augumentin and T. Bact ointment	Pduty OD 30/7
	12pm	vitals are monitored and recorded and vitals are stable	
	1pm	Monitored Input & output chart & documented	Pduty 01 30/7
	1.05 pm	Syp. Augmentin and T. Bact given as per consultant order & document	Pduty OD 30/7
	1.30 pm	child handed over to evening duty staff Nurse	
30/7/26		Evening Duty on (30/7/26)	
	1.30pm	The child Handing over taken from morning Duty Staff The child was conscious & Oriented →	Uh. 02 H3
	2pm	The child was comfortable Position no any fresh complaints →	Uh. 02 H3
	4pm	vital Signs are checked & Recorded vital signs are stable.	Uh. 02 H3

4pm	CP	PP	CRT
	++	++	<3sec

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Patient Sticker

NURSES NOTES

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☐ No Known Drug Allergies

☐ Drug Allergies .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
30/7	9pm	-) Maintaining records & reports	
	7.30 pm	→ Child details handling over given to Night duty's SN	01/9240
		Night duty.	
	7:30pm	child details handover taken from the Evening duty staff child was comfort & oriented Dr line pattern. No other complaints.	
	8pm	check the vital sign vitals are the stable No fever spike.	
	10pm	Give medication as given for Drug chart order. No Dr line.	
31/7/24	12am	check the vital sign vitals are the stable No fever spike	
	2am	child was well sleeping No other complaints No Dr line	

CP	PP	CRT
++	++	<3sec

CP	PP	CRT
++	++	<3sec

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

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Patient's Name:..
MRD NO:............... GUC-00094268 Ms MAIRA 18-09-2017 IP18-00036676 8 Y 10 M 11 D (F) Dr. KARTHIK NARAYANAN R ......
Age :....................... ☐ F
Consultant :.. ....

PHLEBITIS ASSESSMENT

CANNULA 1

Date : 28/7 Time: 9AM
Location : (R) metacarpal.
Size : 22G
Cannula inserted by : outside.

CANNULA 2

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

Cannula 1

Date	Time	Phlebitis	Infiltration	Nursing Intervention	Sign
29/7	8.30PM	☐Yes ☑No	☐Yes ☑No	Pattern	[signature]
	10pm	☐Yes ☑No	☐Yes ☑No	Obsoy	[signature]
30/2	2AM	☐Yes ☑No	☐Yes ☑No	obsu	[signature]
	4AM	☐Yes ☑No	☐Yes ☑No	obsu	[signature]
	6AM	☐Yes ☑No	☐Yes ☑No	obsn	[signature]
	8AM	☐Yes ☑No	☐Yes ☑No	obreu	[signature]
	9AM	☐Yes ☑No	☐Yes ☑No	obru	[signature]
	10pm	☐Yes ☑No	☐Yes ☑No	Obreu	[signature]
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		

removed 10.30AM 30/2/20

Cannula removed : ☑Yes ☐No, if yes date and time : 30/2/20 @ 10.30AM
RX any initiated : ☐Yes ☐No ☐NA If Yes specify-
Phlebitis score: 1/5

Cannula 2

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

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

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

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

PHLEBITIS ASSESSMENT AND MANAGEMENT RECORD

CANNULA 3

Date : Time:

Location :

Size :

Cannula inserted by :

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

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

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

Phlebitis score:

CANNULA 4

Date : Time:

Location :

Size :

Cannula inserted by :

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

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

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

Phlebitis score:

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

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

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

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Dr. KARTHIK NARAYANAN R

(1)

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THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE 29/7	DATE 30/7	DATE 30/7	DATE 30/7	DATE 31/7
			N	N	E	N	M
Age	Less than 3 years old	4					
	3 to less than 7 years old	3					
	7 to less than 13 years old	2	2	2	2	2	2
	13 years old and above	1					
Gender	Male	2					
	Female	1	1	1	1	1	1
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1	1	1	1
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own ability	1	1	1	1	1	1
	History of Falls or Infant-Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2					
	Outpatient Area	1	1	1	1	1	1
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours/ None	1	1	1	1	1	1
Medication Usage	Sedatives (Excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1	1	1	1
	Total		8	8	8	8	8

Intervention: -Fall Risk: Low Humpty Dumpty Score = 7-11, High Risk Humpty Dumpty Score = 12 or above

Bed in low position		✓	✓	✓	✓	✓
Call device within reach		✓	✓	✓	✓	✓
Wheels Locked		✓	✓	✓	✓	✓
Room free of clutter		✓	✓	✓	✓	–
Adequate lighting		✓	✓	✓	✓	✓
Wheel chair support		X	–	–	X	–
Other Intervention(s) Specify		X	–	–	X	–
Nurse's Name:		TBJ	PLG	RMS	TBJ	PLG
Signature:		TBJ	PLG	RMS	TBJ	PLG
Date:		29/7	29/7	30/7	30/7	31/7
Time:		9pm	8AM	2pm	6pm	6PM

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BRADEN 'Q' SCALE

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					Date :	N 29/7	M 30/7	E 30/7	N 30/7
					Time :				
Mobility	**1. Completely immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	**3. Slightly limited:** Makes frequent through slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.		4	4	4	4
"Activity The degree of physical activity"	**1. Bedfast :** Confined to bed	**2. Chairfast :** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	**3. Walks occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. All patients too young to ambulate; OR walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.		4	4	4	4
Sensory Perception	**1. Completely limited:** Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	**2. Very limited:** responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	**3. Slightly limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	**4. No impairment:** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.		4	4	4	4
Moisture Degree to which skin is exposed to moisture	**1. Constantly moist:** Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	**2. Very moist:** Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	**3. Occasionally moist:** Skin is occasionally moist, requiring linen change every 12 hours.	**4. Rarely moist:** Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.		4	4	4	4
FRICTION-SHEAR **Friction** Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another	**1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	**2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	**3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	**4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."		4	4	4	4
Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.		3	3	3	3
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.		4	4	4	4
					TOTAL SCORE	27	27	27	28
					Evaluator's Name				

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

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

Risk Score	Category	Action	Support Surfaces **(Please Note:** Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice
15-18	At Risk	⓫ Regular Turning Schedule ⓬ Enable as much activity as possible ⓭ Protect the heels ⓮ Use pressure redistribution surfaces ⓯ Manage moisture, friction and shear ⓰ Advance to a higher level of risk if other major risk factors are present	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	⓱ Use the Same Protocol as for **"At Risk"** Patients ⓲ Position patient at 30 degree lateral incline using foam wedges	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	⓳ Follow the same protocol as for **"Moderate** Risk" Patients ⓴ In addition to regular turning schedule ㉑ Make small shifts in their position frequently	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	㉒ Use same protocol as for **"High Risk"** Patients ㉓ Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

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Nursing General Admission Assessment Form For Pediatrics

Diagnosis: Bronchial Vascular malformation. Consult

Arrival Time: 8.30 Mode of Arrival: Wheelchair Admitting From: ☑ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction NIL

Body Weight: 35.5 Kg

Height: ..... cm

Past Medical History: Obtained From ☐ Patient ☐ Family Member ☐ Medical Record ☐ Other (specify) .....

Past Medical History	Past Surgical History	Previous Hospital Admission
Hemoptysis 3 days Back.	–	3 days Back RCH Guindy.

Family History: NIL

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

If yes please list, ...

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

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

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

Observations: Weight: 35.5 Kg. Length: ..... Head Circumference (< 2 years): .....

Temp.: 98.4°F HR: 98bpm RR: 20pm BP: 100/64

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

Fall Risk Assessment: ☑ Yes ☐ No Score: 8 (Document in the Humpty Dumpty Sheet)

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

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

Character of Pain ..... Location ..... Frequency ..... Duration .....

FUNCTIONAL SCREENING: ☑ No Abnormalities Detected

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

Inform consultant for positive criteria

NUTRITIONAL SCREENING: ☑ No Abnormalities Detected

- ☐ Underweight
- ☐ Overweight
- ☐ Special Feeding Method
- ☐ Feeding Problem
- ☐ Special diet
- ☐ No Abnormality Detected

Inform consultant for positive criteria

Psychological Screening: ☑ No Significant Findings

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

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

Social History: Lives With Parent

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

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

Orientation has been given regarding the following aspects:

Call Bell in Reach: ☑ Yes ☐ No Waste Disposal Explained: ☑ Yes ☐ No

Infusion Pump : ☑ Yes ☐ No Hand hygiene Explained: ☑ Yes ☐ No ☐ Others

Patient Rights & Responsibilities: ☑ Yes ☐ No

Information given to mother.

Nurse's Name: Thulasi Date: 29/7th Time: 8.30pm Signature

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Dr. KARTHIK NARAYANAN R

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INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Part - I.
Patient's / Learner Language: Tamil & English. 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		
29/7/20	8.30 am	2	Explain about the Treatment & Care.	Mother	no	Oral	none	verbal	good	
30/7/20	8AM	9	Health education given about Nutrition Diet	Mother	no	Oral	None	verbal	good	
31/7	8am	4	Explain about Infection control measure	Mother	No	Oral	None	verbal	Good	31/7/20

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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EMERGENCY ROOM TRIAGE FORM

wt - 35.5kg

Patient's Name : Maira Age : 8Y Gender: ☐ Male ☑ Female

Date : 29/7/26 Time of Arrival : 7.40PM

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: 97.5°F PR: 81 BP: 112/75 (87) RR: 28 SpO_2: 99

Chief Complaints: Come for. post of care.

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.

✓ Signature of Parent / Guardian

* CTAS - Canadian Triage and Acuity Scale

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 : Iman

Signature of Triage Nurse : [signature] 738094

Date & Time : 29/7 @ 7.45PM

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

GUC-00094268 IP18-00036676
Ms MAIRA
18-09-2017 8 Y 10 M 11 D (F)
Dr. KARTHIK NARAYANAN R

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 29/7/18 Time of arrival : 7:40pm.

Chief Complaints: Came for post OP- care s/p-Glue embolization 28/7/18 RBS: —

Height : — Weight : 35kg 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): 29/7/18 @ 7:40pm.

Social History: Lives With Parents.

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

Time of Initial assessment completed by ER Nurse : 7:52pm

Time	Nursing Notes
8:00pm	Pts came to ER c/o post op case.
	Procedure done. Glue embolization.
	Checked vital sigs & record.
	S/b Dr. Gayathri inform to Dr. Fawzia.
	Advise for. Admission. IV antibiotics
	and observation 48hrs to Home.
	Pts was stable shift to ward.
	OP file given to parents.

Samples collected by: / Time: /

Samples sent by : Nil Time: Nil

Medication given in ER:

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

Condition of patient at time of shift - out :	Details of Shift - out
HR: 81 b/m BP: 112/75 CFT: <1 sec	Shift - out from ER to: ICU
RR: 23 b/m SPO_2 : 97%	Time of Shift - out: @ 8.30PM.
GCS: 15/15 Temperature : 97.6°F	Handover given to: S/N - Thulasi (Nurse's Name)
Pain Score: 0/10	
Repeat RBS (if applicable): -	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any): Nil

Name of the Nurse : Ann Signature of the Nurse : Ann

Date & Time : 29/7/26 @ 7:45pm

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PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : Dr. Gayathri Date : 29/9/26. 7.

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

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

Allergic History: .....

Chief Complaints: .....
S/P (R) Bronchial valvular malformation & A-V shunting came

Pediatric Assessment Triangle

A Appearance - TICLS awake.

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 .....

Circulation

HR: 81/min

CFT — Central: 3 sec; Peripheral: .....

Any urgent interventions needed: ☐ Yes ☐ No

If Yes .....

BP: 112/75 (87) 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: .....

Any urgent interventions needed: ☐ Yes ☐ No

If Yes .....

Pupils: Responsive ☑ Non-Responsive ☐

Size: Right ..... Left .....

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

Signs of Neurological compromise .....

.....

Exposure

Temp.: afebrile

Any urgent interventions needed: ☐ Yes ☐ No

If Yes .....

Any Rash: ☐ Yes ☐ No,

If yes describe the rash .....

Active bleed .....

Lacerations ☐ Abrasions ☐ bruises ☐

Describe: .....

Final Physiological Status:

☐ Respiratory Distress ☐ Respiratory Failure ☐ Respiratory Arrest

☐ Shock - Compensated ☐ Hypotensive ☐

☐ Cardiopulmonary Arrest ☑ Hemodynamically Stable

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

.....

.....

Labs Planned: .....

.....

.....

.....

as per chart

.....

.....

Treatment Planned: .....

.....

.....

.....

.....

.....

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

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

Assessment done by

Name of the Doctor: .....

Signature: Dr. Gurpreet

Date & Time: 29/8/16

Sr. Doctor on Duty (If necessary)

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

Signature: .....

Date & Time: .....

PATIENT TRANSFER FORM

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Date & Time of Admission	Date & Time of Transfer Order
29/7 @ 7.44 PM	29/7 @ 8.30 PM.

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

From Unit	To Unit	Information to Attendant
ER	512	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.		
2.	Nil	
3.		
4.		
5.		

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

A - (R) Bronchial vascular malformation c Ar shunting
S/P - GWE embolisation (28/7/26

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
18894 / Iman	16:11.

Patient & Clinical Records Received by : Anuj Gopsen

Date & Time of Patient Received : 29/7/26 at 8.30 pm.

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

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

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RBS CHART

Date	Time	RBS (mg/dl)	IVF %	Signature