GUC-00078607 IP18-00036741
Baby NAKULA MAHATA
14-01-2023 3 Y 6 M 20 D (M)
Dr. GEETHA JAYAPATHY

Hospital

DISCHARGE TRACKING SHEET

UHID- FLOOR- NAME OF CONSULTANT-

ACTIVITY	INTIMATE	OUT TIME	NAME & SIGNATURE	REMARKS	<To be filled by Admin > .		
Activity Sheet update by Nursing		4/8/23 2pm					
Activity Sheet update by Pharmacy							

ACTIVITY RECORD FOR BILLING

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

Name: .....

UHID No: GUC-00078607 IP18-00036741
Baby NAKULA MAHATA
14-01-2023 3 Y 6 M 20 D (M)
Dr. GEETHA JAYAPATHY

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

Date of Admission: .....

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

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

Suggested Billable bed type: .....

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
3/8	5.05PM	ER	408	

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
3/8	CBC RP2	26024818	
3/8/26	stool R/E	26024833	
3/8/26	CRP	26024823	
3/8/26	Stool for Rotavirus	24840	

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
2/8/24	Infusion pump	5.20 pm	4/8/26 @2pm	1236693	

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
3/8	IV placement	(1)	1736684	

ANY OTHER INFORMATION:

Date: 4/8/26 Time: 2pm Prepared By: .....

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
AY/01890			

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Patient ID
GUC-00078607 IP18-00036741
Baby NAKULA MAHATA
14-01-2023 3 Y 6 M 20 D (M)
Dr. GEETHA JAYAPATHY

DISCHARGE TRACKING SHEET

DATE :_____

Name of Consultant :

Floor :

UHID :

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

Rainbow Children's Hospital

BirthRight by Rainbow

Rainbow Children's Hospital - Guindy

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

ADMISSION SHEET

Registration Details :

Admission No : IP18-00036741 **Admit Date** : 03-Aug-2026 **Admit Time** : 04:28 PM **UHID** : GUC-00078607

Patient Details :

Patient Name	: Baby NAKULA MAHATA	**Age**	: 3 Y 6 M 20 D
Guardian	: CHINMOY MAHATA	**DOB**	: 14-01-2023
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: DOOR NO 7/2 2NS CROSS STREET LKASHMI PURAM Velacheri Chennai Tamil Nadu INDIA 600042	**Phone No**	: 8637822996
		E-mail	: chinmoybesg@gmail.com

Admission Details :

Bed Type : DAY CARE **Bed No** : ER 102 **Ward Name** : 0F-EMERGENCY

Room No : ER 102 **Admission Type** : First Visit

Contact Details :

Name : CHINMOY MAHATA **Relationship** : Father

Contact Address : DOOR NO 7/2 2NS CROSS STREET LKASHMI PURAM Velacheri Chennai Tamil Nadu INDIA 600042 **Phone No** : 8637822996

< Chinmoy Mahata

Signature

Doctor Details :

Doctor Name : Dr. GEETHA JAYAPATHY **Specialisation** : GENERAL PEDIATRICS

Referral Doctor : Dr. Geetha Jayapathy **Phone No** :

Co-Consultant :

Payment Details :

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

Payor Name : SELFPAY

Rainbow Children's Hospital
BirthRight by Rainbow

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Door No.157 to 160, Anna Salai, Guindy, Guindy ,Chennai ,Tamil Nadu, INDIA ,600015.
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GENERAL CONSENT FOR TREATMENT

Patient Name:	**Baby NAKULA MAHATA**	**Age :**	**3 Y 6 M 20 D**
IP No:	**IP18-00036741**	**Sex:**	**Male**
Consultant:	**Dr. GEETHA JAYAPATHY**	**Ward/Bed No:**	**0F-EMERGENCY/ER 102**

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

Patient, be deemed advisable or necessary.

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

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

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

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

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

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: Chinmoy Mahata

Name: Chinmoy Mahata
Relationship: father
Date: 3/8/2026 Time: 4:28
Witness Name: Jeevith
Witness Signature:

Patient Address:
DOOR NO 7/2 2NS CROSS STREET
LKASHMI PURAM Velacheri Chennai
Tamil Nadu INDIA 600042

Rainbow Children's Hospital | BirthRight BY RAINBOW HOSPITALS

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 : Balcula Mahato	UHID Number : GDC-00078607
Self/Attendant Name : Chinmay Mahato	Relation : Father
Self/ Attendant Signature : Chinmoy Mahata Phone Number :	Name & Signature of Financial Counselor

RCH/GDY/FRM/CLINICAL/426

Rainbow®
Children's
Hospital
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PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: _____ GUC-00078607 IP18-00036741
Baby NAKULA MAHATA
14-01-2023 3 Y 6 M 20 D (M)
Dr. GEETHA JAYAPATHY

UHID ID: _____

Department: _____

Consultant: _____

Patient Sticker

Pediatric Multiorgan History & Physical Examination

Name: Baby Nakul Mehtha. Age/Sex

Information given by: Mother Relationship

Chief Presenting Complaints & Duration (Chronologically)

c/o loose stools x 2d (multiple episodes)

c/o fever x 1d.

History of present illness :

→ 3y 6m 20D old male child. was brought to hospital.
child was apparently Normal 5 days ago present illness
Started as cold 5 days ago for which he was
given some ayurvedic syrup ~~and~~ stopped ~~baby~~ child started having
following that → child had loose stools x 2 days, yellow
coloured c̄ white specks, initially watery, now
associated c̄ mucus no Blood in stools, frequency more during day
→ multiple episodes
→ c/o fever x 1 day, intermittent, No chills/rigors
active inbetween.
→ ~~No~~ c/o decreased urine output → c/o tiredness
→ ~~No~~ c/o vomiting (+) 1 episode
→ ~~No c/o~~.
→ lethargy (+)
→ ↓ urine output

Patient Sticker

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

⇒ None.

Birth & Neonatal History:

Full term / NVD / AGA. / B.wt : 3.2 kg

NO NICU Stay

Family Chart

Birth & Socio Economic History:

About Father : Nothing of significance.

About Mother :

Any additional Information :

Developmental History :

- Normal.

Immunization History :

Not fully Immunized. till age. JE - Not taken

Anthropometry :

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

Weight (kgs) 12.4 kg (Centile _____)

RBG → 79 mg/dl

On Examination :

Temperature : 99.1°F Pulse Rate : 141 B.P. - SPO2 100.

Resp.rate and type of breathing : 28, regular.

- Sick looking
- Dry oral mucosa
- CRT < 2 sec
- PP NVPO

Rash —

Lymphadenopathy —

Oedema : —

Allergies (if any):

(P.T.O.)

Patient Sticker

Respiratory System :

Inspection (any s/o distress) :

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

Any addes sounds : No added sounds.

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

Cardiovascular System :

Inspection of procordium :

Heart Sounds : $S_1 S_2$ (+)

Any murmur : None.

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

Per Abdomen :

Inspection :

Palpation : Soft. No organomegaly

Ausculation : BS (+)

Spine : (N) External Genitelia :

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

Central Nervous System :

Level of Consciousness : AVPU/GCS score :

Cranial Nerves :

Motor System :

Nutriton :

Tone: Normal Power 5/5 in all 4 limbs

Co-ordinator :

Posture :

Involuntary Movements : None.

Patient Sticker

Reflexes :

DTR 2+ **Superficials:** 1+

Plantars ↓

Sensory System :

Bladder / Bowel :

Clinical Summary & Diagnostic: Acute Gastroenteritis. ? Some dehydration

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

Desired goals of the treatment :

Planned Labs:

CBC, CRP
RBS.
RP-2
Stool R/E.

Planned Management

IVs charted.

Signature of the Doctor: Dr. Nauys

Name of the Doctor: Dr. Nauys

Date & Time: 3/8/26

Signature of the Consultant:

Name of the Consultant:

Date & Time: 3/8/26 5.30 pm

(P.T.O.)

Patient Sticker

DISCHARGE PLANNING FORM

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

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

2. Destination Post Discharge: ☐ Home

Family Members Notified (Person Contacted)

☐ Transfer

Hospital Facility Notified (Person Contacted)

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

☐ Needs Assistance In:

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

4. Nutritional Plan:

☐ Dietary Instruction Discussed with the:

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

5. Discharge Planning Discussed with the:

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

6. Patient/Family Educational Plan:

☐ Educational Topic/s: .....

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

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

Doctor Signature: .....

Doctor Name: .....

Date and Time: .....

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

DOCTOR'S SHIFT CHANGE HANDOVER FORM

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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

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

DOCTOR'S SHIFT CHANGE HANDOVER FORM

Rainbow® Children's Hospital
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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

GUC-00078607 IP18-00036741
Baby NAKULA MAHATA
14-01-2023 3 Y 6 M 20 D (M)
Dr. GEETHA JAYAPATHY

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BY RAINBOW HOSPITALS
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/8/26 5:30 pm	S/B Angeeta	
	AGE c̄ some dehydration	
	dehydration Correction on flow.	
	- Reports awaited	
		Cont same
	(signature) 18/2 C/D/W Dr. GEETHA	
		Electrolytes 135 / 3.8, 18 / 101; Urea, Creatinine] (N)
	WBC - 16880 (71/18)	
	CRP - 129	
		Adv : 1) Inj CEFTRIAXONE 600mg IV Q12H. 2)
4/8/26 10:15 am	S/B Angeeta	
	Ac. colitis	
	fever settled.	
	intake fair.	
	loose stools better.	
	Clinically better	Syp. Taxim O forte 3ml BD.
	decide on discharge afternoon	IVF ↓ 25ml/hr.

(signature) 18/2

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

Patient Sticker

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Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

GUC-00078507 IP18-00036741
Baby NAKULA MAHATA
14-01-2023 3 Y 6 M 20 D (M)
Dr. GEETHA JAYAPATHY

Baby Nakula Mahata

Rainbow Children's Hospital
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RESULT SHEET

Date	3/8/24					
Time						
Hb	11.5					
PCV	34					
RBC	5.08					
WBC	16800					
N/L	71/18					
Platelets	4.27					
CRP	124					
ESR						
PCT						
RBS						
Na	135					
K	3.8					
Cl	101					
Ca/Mg	1.25					
Phosphate	/ 18					
Urea	26					
Creatinine	0.53					
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						

i.Ca / HCO3

(P.T.C

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.,) : .....

.....

Patient S... NAKULA MAHATA (M)
GUC-00078607 IP18-00036741
14-01-2023 1 Y 6 M 20 D
Dr. GEETHA JAYAPATHY

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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: 408 .....

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 : 3/8 @ 4.40PM
Nurse Name & Signature: Das 17894 / Iman
Date & Time : 3/8 @ 4.40PM

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

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DRUG CHART

Date of Admission: 31/8/26 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.

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

SOS / PRN (As Required Medication)

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

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

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

Signature .....

VERIFIED BY : Name .....

GUC-0007860 IP18-00036741
Baby NAKULA MAHATA
14-01-2023 3 Y 6 M 20 D (M)
Dr. GEETHA JAYAPATHY

REGULAR PRESCRIPTIONS

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

DRUG: Zeeclott Sachet.

Dose	Route	Frequency	Start Date
1 sachet	oral	BD	3/8

Name & Signature of the Doctor Starting the Drugs: [signature]

109221

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date	Time		
3/8	8	Am	CS / SA
	2	5:30 pm	SA
	10	pm	SA / CS
4/8			

DRUG: Enterogeeminal

Dose	Route	Frequency	Start Date
1 tubule	oral	BD.	3/8.

Name & Signature of the Doctor Starting the Drugs: [signature]

109221

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date	Time		
3/8	8	Am	CS / SA
	8	5:30 pm	SA
	pm		SA / CS
4/8			

DRUG: Z & D drops.

Dose	Route	Frequency	Start Date
1ml	oral	OD	3/8.

Name & Signature of the Doctor Starting the Drugs: [signature].

109221.

Additional Instructions:

20mg/ml

Daily Doctor's Endorsement by a Sign

Date	Time		
3/8	2	5:30 pm	SA
	pm		SA / CS
4/8			

DRUG: Inj. CEFTRIAXONE

Dose	Route	Frequency	Start Date
600mg	O(24)	IV	3/8/26

Name & Signature of the Doctor Starting the Drugs: [signature]

Additional Instructions: 20ml NS

Daily Doctor's Endorsement by a Sign

Date	Time		
3/8	6	Am	SA / CS
	6	6:30 pm	SA / CS
4/8			

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.

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses

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

(P.T.O)

GUC-00078607 IP18-00036741
Baby NAKULA MAHATA
14-01-2023 3 Y 6 M 20 D (M)
Dr. GEETHA JAYAPATHY

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
3/8	5.20 pm	IVF. 0.9% NS 350ml over 4hours.	IV	90ml/hr. for 4hours	[signature]	[signature] 015702	10.30 pm		[signature] 6 015
4/8/26	10.20 pm.	IVF 0.9% DNS	IV	45 ml/hr	[signature]	[signature] 015702	5/8/26 @ 10.30		[signature] 015
4/8/26	10.30 am	IVF- 0.9%. DNS	IV	25 ml/hr	[signature]	[signature] 015702			

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

GUC-00078607 IP18-00036741
Baby NAKULA MAHATA (M)
14-01-2023 3 Y 6 M 20 D
Dr. GEETHA JAYAPATHY

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

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

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 2/8/26 Time:	5.20pm~7pm	8pm	12AM
Doctor / Nurse / Family Concern?			
Temperature (°F) (104–94)	100.2°F	97.9°F / 97°F	97.4°F
Heart Rate (bpm) and Blood Pressure (mmHg) * (190–50)	102/63 (70)	100/60 (90)	104/62 (72)
Note: BP does not score in early warning scoring			
Heart Rate (Number)	118bt	110bpm	106b/mt.
Resp. Rate (bpm) (Over 1 Minute) * (70–10)	⊙	⊙	⊙
Resp Rate (Number)	26bt	24bpm	26b/mt
Resp Distress — Mod/ Severe / None / Mild	✓	✓	✓
Receiving O_2 (l/min) / O_2 Saturations (%)	99%	90%	98%
Conscious Level — Normal / Altered	✓	✓	✓
GCS *	15/15	15/15	15/15
TOTAL SCORE	0	0	0
Number of shaded boxes	0	0	0
Pain Score			
Observer's Initials	[illegible]	PV	[illegible]

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

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

Patient Sticker

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

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Baby NAKULA MAHATA
14-01-2023 3 Y 6 M 20 D (M)
Dr. GEETHA JAYAPATHY

NURSES NOTES

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☐ No Known Drug Allergies

☐ Drug Allergies ....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
3/8/2026		on Admission (3/8/26)	
	5.10 pm	The child details handover taken	
		from the ER staffs	
		The child is conscious and active -	[signature] 015780
		vitals are checked and recorded	
		temp is normal — PP ++	
		CP ++	
		CRT <3s	
	6 pm	Administer the medication as	
		per doctor's order	
		Dr. Geetha mam rounds was	[signature] 015780
		done adv! to do CRP in	
		previous sample	
		I/O chart is maintained	
		IV fluid 0.9% NS @ 90ml/hr on	
		flow.	
		No any other complaints	[signature] 015780
	6.10 pm	Dr. Geetha mam phone call	
		order adv! to give inj. Xone	
		600mg BD given @ 6.20pm	
	7.30 pm	The child details handover	
		given to night duty staff.	
	7.30 pm	Night duty note on 3/8/2026	
		Child details taken over from	[signature]
		evening duty staff nurse using	003945
		ISBAR method. On Assessment	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Patient Sticker

NURSES NOTES

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☐ No Known Drug Allergies
☐ Drug Allergies ......NOT Known......

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
3/10/26		← Continue notes →	
		Child is conscious, oriented and afebrile, GCS- 15/15. Skin Assessment done, N.line is present and patent no pain or redness r/on INF NS @ 90ml/hr	
	8PM	vitals checked and recorded, all are hemodynamically stable	[signature] 020149
		CP ++ / PP ++ / CRT <3sec	
	10PM	Due medication given as per the drug chart	[signature] 020149
	10PM	Regarding NS correction forms informed to Dr. [illegible] c/i, he advised to start DNS @ 40ml/hr, Stat order followed	
	12AM	vitals checked and recorded, all are hemodynamically stable	[signature] 020149
		CP ++ / PP ++ / CRT <3sec	
	2AM	child slept well, no specific complaints	[signature] 020149
	4AM	vitals checked and recorded all hemodynamically stable	
		CP ++ / PP ++ / CRT <3sec	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

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Patient's Name: ....
MR ... n No.: ....
Age ... Sex: ☐ M ☐ F
Consultant: ....

GUC-0007 8607 IP18-00036741
Baby NAKULA MAHATA (M)
14-01-2023 3 Y 6 M 20 D
Dr. GEETHA JAYAPATHY

PHLEBITIS ASSESSMENT

CANNULA 1

Date: 3/8 Time: 4.45pm
Location: (L) metacarpal
Size: 24G
Cannula inserted by: S/N - Iman

CANNULA 2

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

Cannula 1

Date	Time	Phlebitis	Infiltration	Nursing Intervention	Sign
3/8	5PM	☐Yes ☑No	☐Yes ☑No	Pattern	[illegible]
	6pm	☐Yes ☑No	☐Yes ☑No	Reviewed	[illegible]
	8PM	☐Yes ☑No	☐Yes ☑No	Observed	[illegible]
	10PM	☐Yes ☑No	☐Yes ☑No	Observed	[illegible]
4/8	12AM	☐Yes ☑No	☐Yes ☑No	Observed	[illegible]
	2AM	☐Yes ☑No	☐Yes ☑No	Observe	[illegible]
	4AM	☐Yes ☑No	☐Yes ☑No	Observe	[illegible]
	6AM	☐Yes ☑No	☐Yes ☑No	Observed	[illegible]
	8am	☐Yes ☑No	☐Yes ☑No	Reviewed	[illegible]
	10am	☐Yes ☑No	☐Yes ☑No	Reviewed	[illegible]
	12pm	☐Yes ☑No	☐Yes ☑No	Reviewed	[illegible]
	2pm	☐Yes ☑No	☐Yes ☑No	Observed	[illegible]
	4pm	☐Yes ☑No	☐Yes ☑No	Observed	[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		
		☐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	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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BRADEN 'Q' SCALE

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					Date : 3/8	3/8	4/8	4/8
					Time : E	N	M	E
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	27
				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

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	• Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • 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	• Use the Same Protocol as for **"At Risk"** Patients • 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	• Follow the same protocol as for **"Moderate Risk"** Patients • In addition to regular turning schedule • 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	• Use same protocol as for **"High Risk"** Patients • 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:

Arrival Time: 5.10 pm Mode of Arrival: parents holding Admitting From: ☑ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction .....

Body Weight: 12.4 Kg

Height: ..... cm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
–	–	–

Family History: .....

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

If yes please list, ...

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

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

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

Observations: Weight: 12.4kg Length: – Head Circumference (< 2 years): –

Temp.: 98°F HR: 112 bpm BP: 100/50 (62) RR: 26 bpm

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

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

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

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

Character of Pain – Location – Frequency – Duration –

FUNCTIONAL SCREENING: ☐ No Abnormalities Detected

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

Inform consultant for positive criteria

NUTRITIONAL SCREENING: ☑ No Abnormalities Detected

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

Inform consultant for positive criteria

Psychological Screening: ☑ No Significant Findings

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

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

Social History: Lives With ..... family .....

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

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

Orientation has been given regarding the following aspects:

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

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

Patient Rights & Responsibilities: ☑ Yes ☐ No

Information given to .....

Nurse's Name: S. Abitha Lakshmi Date: 3/8/26 Time: 5.20 PM Signature

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Baby NAKULA MAHATA
14-01-2023 3 Y 6 M 20 D (M)
Dr. GEETHA JAYAPATHY

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INTE[...]NT / FAMILY EDUCATION RECORD

Willingness to Learn: ~~Yes~~ No   Healthcare Literacy: Yes ☑ No ☐

Part - I.
Patient's / Learner Language: .... Hindi   Patient / Learner Literacy: ☐ Read ☐ Write ☐ Speak

Identified Education Needs:

1. Diagnosis
2. Treatment and Care

Plan

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

Part - II

Date	Time	Need Identified	Information Taught	Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding	Comments	Designation / Signature
										Use codes from the list in part III (Person Taught – Understanding)
3/8/26	6pm	Fall risk education	Explained about call bell side rails	Father	Language Barrier	Oral	None	verbalizes understanding		[signature]
4/8/26	8Am	Treatment & care	Explained about treatment and Care	Mother	NO	oral	none	verbalized understanding	Good	[signature]

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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wt - 12.4 kg

AGENCY ROOM TRIAGE FORM

Name : NAKULA Mahata. Age : 3Y6M Gender: ☑ Male ☐ Female

3/8/26. Time of Arrival : 4.25PM

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

Source of Information : ☑ Parents ☐ Others (Specify)

Mode of Arrival : ☑ Ambulatory ☐ Wheelchair ☐ Ambulance

Initial Vital Signs: Temp: 99.1°F PR: 141 BP: 86/58(66) RR: 28 SpO_2: 100

Chief Complaints: loose stools × multiple epi × 2day c/o - fever × 2day

INITIAL PHYSIOLOGICAL CATEGORIZATION

Appearance: ☑ Normal ☐ Sick Looking

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

Circulation / Colour: ☑ Normal ☐ Abnormal ☐ Bleeding

INITIAL PHYSIOLOGICAL STATUS

☑ Stable

☐ Unstable :
- ☐ Not – Life - Threatening
- ☐ Life – Threatening

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

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

* CTAS - Canadian Triage and Acuity Scale

✓ Chinmoy Mahata
Signature of Parent / Guardian

Triage Completion Time : 2min

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 : Imam

Date & Time : 3/8 @ 4.30PM

Signature of Triage Nurse : Das 17894

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

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 3/8/26 Time of arrival : 4.25PM

Chief Complaints: C/O- Loose stools x 2 days / fever ⊕ RBS: 72

Height : — Weight : 12.4kg BMI : — Head Circumference (<2 years) —

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

If yes , identify —

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

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

RISK FOR FALL:

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

☐ If Patient is > 6 years
Assess the below parameters

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

Ambulatory Aids:

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

Gait/Transferring:

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

Mental Status: Forgets limitations ☐ Yes ☑ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening: ☑ No Abnormalities Detected

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

Inform consultant for positive criteria

.....

.....

Nutritional Screening: ☑ No Abnormalities Detected

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

Inform consultant for positive criteria

Psychological Screening: ☑ No Significant Findings

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

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

Social History: Lives With —

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

Time of Initial assessment completed by ER Nurse : 15 min.

(P.T.O.)

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

Time	Nursing Notes
4.30 PM	- Pt come to ER c complaints of loose stools x2 days & fevers.
	- All vitals checked & recorded.
	- ER Dr. assessed the child & Admitted ↓ Dr. Geetha.
	- IV line done & Bld sample collected.
	- Pt shifted to ward for further mgt.

Samples collected by: /

Samples sent by : Iman

Time: /

Time: 4.45PM

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: 141 BP: 86/58 CFT: <3sec	Shift - out from ER to: 408
RR: 26 SPO_2 : 100	Time of Shift - out: @ 5.05PM
GCS: 15/15 Temperature : 99°F	Handover given to: S/N- Abhitha (Nurse's Name)
Pain Score: 0/10	
Repeat RBS (if applicable): -	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any): IV line done.

① Metacarpal 22G

Name of the Nurse : Iman

Signature of the Nurse : [signature] 17894

Date & Time : 3/8/26 @ 4.35PM

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PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : Dr. Navya Date : .....

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

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

Allergic History: .....

Chief Complaints: c/o: Loose stools X2d
c/o fever X1d.

Pediatric Assessment Triangle

A Appearance - TICLS .....

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

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

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

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

Significant Past History: None

Medication History: None

Relevant Investigations: .....

Primary Assessment

Airway
- ☑ Open
- ☐ Maintainable
- ☐ Not Maintainable

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

Breathing

Rate: 28 SpO_2 on FiO_2 100

Rhythm: Regular

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

Respiratory Noises: ☐ Stridor ☐ Wheezing ☐ Grunting

Air Entry: B/L AE (+)

Palpation Findings (If necessary).....

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

(P.T.O.)

Circulation HR: 141 CFT [Central ..... Peripheral .....]

Any urgent interventions needed: ☐ Yes ☐ No

If Yes .....

BP: ..... mmHg

Pulse Volume: [Central ..... Peripheral .....]

If in Shock: [Compensated ..... Hypotensive .....]

Muffled Heart Sound: ☐ Yes ☐ No

Engorged Neck Veins: ☐ Yes ☐ No

Murmurs: ☐ Yes ☐ No

Liver Span: .....

ECG: .....

Any Signs of Heart Failure: ☐ Yes ☐ No

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

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

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

Signs of Neurological compromise .....

.....

Any urgent interventions needed: ☐ Yes ☐ No

If Yes .....

Exposure Temp.: .....

Any Rash: ☐ Yes ☐ No,

If yes describe the rash .....

Active bleed .....

Lacerations ☐ Abrasions ☐ bruises ☐

Describe: .....

Any urgent interventions needed: ☐ Yes ☐ No

If Yes .....

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

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

.....

.....

Labs Planned: .....

As charted

.....

.....

.....

.....

.....

Treatment Planned: .....

As charted

.....

.....

.....

.....

.....

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

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

Assessment done by

Name of the Doctor: Dr. Navya

Signature: .....

Date & Time: 3/8/26.

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
	3/8 @ 4.28PM	3/8 @ 5.05PM
Treating Consultant Name	**Transfer Ordered by**	**Reason for Transfer**
Dr Geetha.	Dr. Navya.	treatment
From Unit	**To Unit**	**Information to Attendant**
RR	408	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.	NS 500 ml	1
2.	Intraflow	1
3.		
4.		
5.		

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

4 - AGE c̄ some dehydration.

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
[signature] 17894 / Iman	[signature]

Patient & Clinical Records Received by : Anitha 015180

Date & Time of Patient Received : 3/8/24 @ 5.10pm

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
3/8	4.50PM	72	—	Das 17894