



Rainbow
Children's
Hospital

DISCHARGE TRACKING SHEET

UHID-

FLOOR-

NAME OF CONSULTANT-

GUC-00079905 IP18-00036478
Baby SONAL TASHA
19-12-2023 2 Y 7 M 1 D (F)
Dr. GANESH R



ACTIVITY	INTIME	OUT TIME	NAME & SIGNATURE	REMARKS	<To be filled by Admin >		
Activity Sheet update by Nursing		20/12/2023 9 AM	<i>[Signature]</i>				
Activity Sheet update by Pharmacy			<i>[Signature]</i>				

ACTIVITY RECORD FOR BILLING

GUC-00079905 IP18-00036478
Baby SONAL TASHA 2 Y 6 M 26 D (F)
19-12-2023
Dr. GANESH R



Name: UHID No: Date of Admission: Room / Bed No: Ward: Consultant: Dept: Date of Discharge: Time: Suggested Billable bed type:

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
15.07.2026	11:05am	FR.	406	[Signature]

CROSS CONSULTATION VISIT

	Doctor Name	Date	Order No.	Signature
1.	Dr. Keerthivasan	15/7/26	✓ to be raised	[Signature]
2.	Dr. Geetha	15/7/26	728029 ✓	[Signature]
3.	Dr. Kauthik	15/7/26	28275 ✓	[Signature]
4.	Dr. Keerthivasan	16/7/26	✓ to be raised	[Signature]
5.				
6.				
7.				
8.				
9.				
10.				

INVESTIGATIONS			
Date	Investigations	Order No.	Signature
15.07.2026	CBC, CRP, RP-2 SGOT, SGPT Blood c/s.	06028748.	[Signature] 01/03/24
15/2/26	stool for occult blood. urine c/s	06022755	[Signature] 01/03/24
5/7/26	urine routine	26022766	[Signature] 01/03/24
2/7/26	serum. IgG, IgM, IgE, IgA, CRP, RA, ANA	2915	[Signature] 01/03/24
6/7/26	procalcitonin	28882	[Signature] 01/03/24
14/26	CRP	2915 23/95	[Signature] 01/03/24

Date
15.07.2026

Investitions

Order No.

Signature _____

15.07.2026

CBC, CRP, RP-2 SGOT, SGPT

১৬০১৪৭৫৪.

01/03/4

Blood c/s.

stool for occult blood.

06022755

W. L. L. L.

none c/s

2602276

Adm

15/2/26

Urinary routine

2215

Leopoldo

~~151#20~~

16/7/26

~~Specimen: IgG, IgM, IgE, IgA~~

22882

Drugs

IGA, CRP, Nat, Int

Procalcitonin

10/9/20

16 (7) 16.

1919126.

CRP

2915

W. J. J. J.

23.195

dy 1890

MEDICAL EQUIPMENT (WARD & ICU)	
Date	

[illegible]

PROCEDURE			
Date	Procedure	Quantity	Order No. Signature
15.07.2026	IV placement	①	1727499 ✓ @mms 01/01/24
15.07.2026	X Ray chest	①	9512 ✓ @mms 01/01/24
15.07.26	ECC.	①	9515 ✓ @mms 01/01/24
15/7/26	USC CAP2011	①	9534 ✓ Duf 501950
15/7/26	Echo	①	9567 ✓ Duf 5018950
16/7/26	IV placement	①	172825 ✓ Duf 5018950
19/7/26	I-V placement	①	9655 ✓ Duf 5018950

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Baby SONAL TASHA

19-12-2023

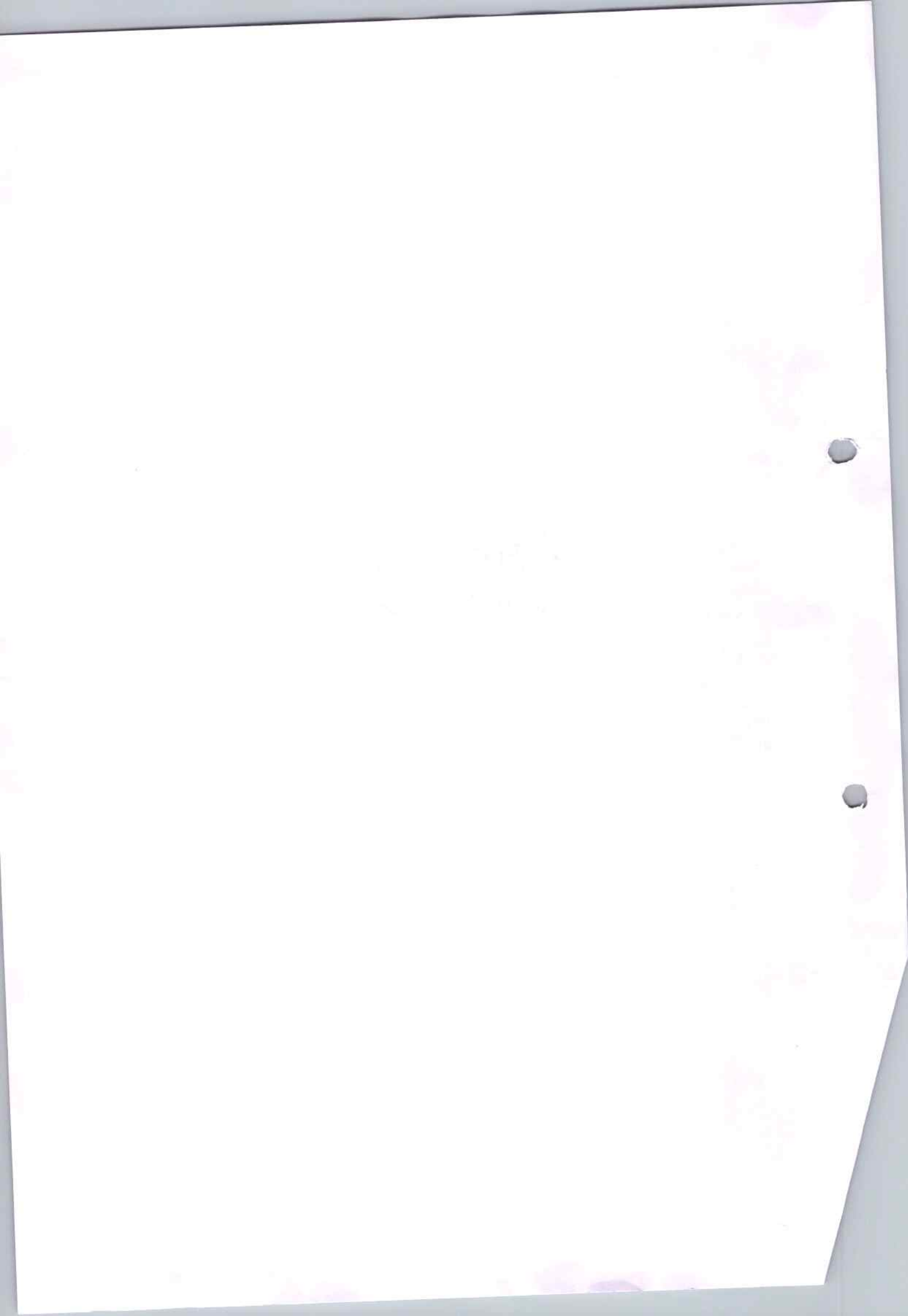
2 Y 7 M 1 D

(F)

Dr. GANESH R



ACTIVITY	TIME		NAME & SIGNATURE	REMARKS	<To be filled by Admin>
Discharge Announcement					
	INTIME	OUT TIME			
Arrangement of File by Nursing	20/12/2023		Durg		
Preparation of Discharge Summary	10-45 AM		29/12/23		
Finalization of discharge summary					
Transfer of file from Ward to Billing Dept					
Bill Processing					
Audit Clearance					
Billing Clearance					
Physical Clearance					



ADMISSION SHEET

Registration Details :



Admission No : IP18-00036478

Admit Date : 15-Jul-2026

Admit Time : 09:42 AM UHID : GUC-00079905

Patient Details :

Patient Name : Baby SONAL TASHA

Age : 2 Y 6 M 26 D

Guardian : Mr RAJASEKAR

DOB : 19-12-2023

Gender : Female

Religion :

Occupation :

Marital Status :

Address (H) : NO:16/20 NAGARATHIAMMAL COLONY WSET
MAMBALAM CHENNAI Saidapet West(mer
with sdp) Chennai Tamil Nadu INDIA 600015

Phone No : 9080578211

E-mail : no@gmail.com

Admission Details :

Bed Type : DAY CARE

Bed No : ER 101

Ward Name : 0F-EMERGENCY

Room No : ER 101

Admission Type : First Visit

Contact Details :

Name : Mr RAJASEKAR

Relationship : Father

Contact Address : NO:16/20 NAGARATHIAMMAL COLONY
WSET MAMBALAM CHENNAI Saidapet
West(mer with sdp) Chennai Tamil Nadu INDIA
600015

Phone No : 8637458297


Signature

Doctor Details :

Doctor Name : Dr. GANESH R

Specialisation : GENERAL PEDIATRICS

Referral Doctor : SELF

Phone No :

Co-Consultant :

Payment Details :

Payment Mode : Cash

Deposit Amount : 0.00

Payor Name : SELFPAY

GENERAL CONSENT FOR TREATMENT

Patient Name: **Baby SONAL TASHA**

IP No: **IP18-00036478**

Consultant: **Dr. GANESH R**

Age : **2 Y 6 M 26 D**

Sex: **Female**

Ward/Bed No: **0F-EMERGENCY/ER 101**

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

Patient, be deemed advisable or necessary.

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

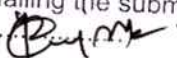
I understand that I shall not bring valuables to the Hospitals and that the Hospital will not be responsible for the loss, destruction or theft of my personal belongings. I assume full responsibility for all my personal items and release the Hospital from responsibility and liability for such personal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

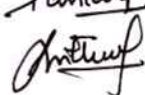
Signature of Patient/Relative: 

Name: **Raja Sekar**

Relationship: **Father**

Date: **15/07/2026**

Witness Name: **Panting**

Witness Signature: 

Time: **9.42 Am**

Patient Address:

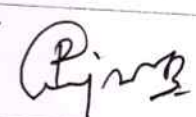
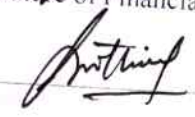
NO:16/20 NAGARATHIAMMAL COLONY
WSET MAMBALAM CHENNAI Saidapet
West(mer with sdp) Chennai Tamil
Nadu INDIA 600015

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 be applicable.
- ▶ 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 be 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 and amount permitted / approved by the TPA or total bill amount in case of denial from TPA, has to be paid by the patient.
- ▶ Two attendants are permitted with patients in Deluxe, Private Rooms and only one is permitted in the rest of the categories of rooms. No attendant is permitted in ICU's.
- ▶ All the refunds more than Rs.5,000/- will be refunded through NEFT within 7 Bank working days.
- ▶ Patient attendant can collect for Interim/provisional bill of the patient from the billing section on daily basis. Interim Bill shall be based on the acknowledged services in HIS. Final Bill of the patient may vary from the Interim bill based on actual update taken on the day of discharge. It is requested that patients/attendants enquire daily about the bill amount from billing section and pay the outstanding as on that day. You are requested to clear your outstanding amount on daily basis before 12 PM. **Patient bill outstanding should not be increase more than 10,000/-**

DECLARATION

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

Patient Name :	Baby. Sonal Tasha	UHID Number :	GWC-000 79905
Self/Attendant Name :	Y RAJASEKAR	Relation :	father
Self/Attendant Signature :		Name & Signature of Financial Counselor	
Phone Number :	9080578211		

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

**PEDIATRIC IN-PATIENT
MEDICAL RECORD**

Patient Name: _____

UHID ID: _____

Department: _____

Consultant: _____

GUC-00079905

IP18-00036478

Baby SONAL TASHA

19-12-2023

2 Y 6 M 26 D

(F)

Dr. GANESH R





Pediatric Multiorgan History & Physical Examination

Name: Sonal Tashg Age/Sex _____

Information given by: Father Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

C/o Cough - since yesterday
Dry in nature

C/o Vomiting - 3 episodes

History of present illness :

vomitus food contents
Re-swallowing the vomitus
non-bilious / non-blood
stained

since
yesterday
night.

C/o Abdominal pain -

all over the abdomen

Colicky, intermittent

since yesterday night

Nocturnal disturbance

A/o Passing pellet like stools → @ consistency stools & ? Blood

C/o Fever noted since yesterday night

Tmax - 100°F

assoc. Chills & rigors.

↓ 2 H/o crying while undressing

Came to ER at 6am & the above complaints -

o/c - Alert, Uneasiness noted.

HR - 180/min RR - 30/min SpO₂ - 100% Temp - 98°F

PPHF, Pulse volume - good, CRT < 3 sec

IM emeset 1mg given stat

↓

A/o Deworming
1 week back

Passed semi-solid stools & full of pin worms - multiple.
Developed fever → HR - 155/min SpO₂ - 98%.

↓



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

Nausea (D) HR - increased 180/min (even with the reduction of Temp.) & persistent during sleep also.
(Though Abdominal pain - settled to Esomeprazole)

No W/O
drug add

Hence, admitted for unexplained tachycardia,

H/O admission - March 2026 - AGE

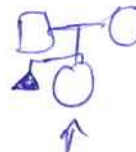
May 2026 - Dysentery.

Birth & Neonatal History:

Term / NVD / Bwt - 3.7 kgs

CIAB / no NICU stay

Family Chart



Birth & Socio Economic History:

About Father : _____

About Mother : _____

Any additional Information : _____

Developmental History :

Dev. (D)

Immunization History :

Vaccinated, up to date acc. to IAP schedule.

Anthropometry :

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

Weight (kgs) 10.5 kgs (Centile _____)

On Examination :

Temperature : 97°F Pulse Rate : 175/min B.P. 98/63 mmHg SPO2 96% LRA.

Resp. rate and type of breathing : _____

Rash _____

Lymphadenopathy _____

Oedema : _____

Allergies (if any): _____

Alert
PPWF, Pulse volume - good
CRT < 2 sec.



Respiratory System :

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

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

Any addes sounds : -

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

Cardiovascular System :

Inspection of procordium : _____

Heart Sounds : S1S2 (+)

Any murmur : _____

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

Per Abdomen :

Inspection : _____

Palpation : Soft, non-tender

Ausculation : BS (+) - increased

Spine : (N)

External Genitalia : (N)

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

Perianal Region - Worme (+)
(Pin)
Excystation (+)

Central Nervous System :

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

Cranial Nerves : _____

Motor System :

Nutriton : _____

Tone : (N)

Power

7/5

Co-ordinator : (N)

Posture : (N)

Involuntary Movements : _____



Reflexes :

DTR

Plantars

Sensory System :

Superficials:

Bladder / Bowel :

Clinical Summary & Diagnostic:

AFI ↓ evaluation - ? A/c gastritis
? Myocarditis
? Early sepsis
? Worm infestation & colic.
? Intestinal infection

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

Janilux / abdo pain / vomit / worms
in stool

Desired goals of the treatment :

To stop vom, which / 2 times

Planned Labs:

CBC ✓
CRP ✓
Blood clt / Urine clt
OT/PT ✓
RD2 ✓
Stool for occult blood

USG Abdomen ✓
ECG / CXR. ✓

Planned Management

NPO
✓ IV 0.9% DNS
✓ IV Ceftriaxone

✓ Ped Gastro opinion

Signature of the Doctor:

Name of the Doctor:

Date & Time:

Dr. Kanitha

15/7/26 9am

Signature of the Consultant:

Name of the Consultant:

Date & Time:

Dr. Ganesh R

15/7/26 10.30am

(P.T.O.)



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:

DOCTOR'S SHIFT CHANGE HANDOVER FORM

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

DOCTOR'S SHIFT CHANGE HANDOVER FORM

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-00079905

Baby SONAL TASHA

IP18-00036478

18-12-2023

2 Y 6 M 26 D

(F)

Dr. GANESH R



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

BirthRight[™]
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

CRUSS ION FORM

Doctor Name: Dr. Keerthi Varan Date: 15/7/26 Time:

Diagnosis:

Hospital:

Type of Referral :

☐ Emergency

☐ Urgent

☐ Non Urgent

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

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

Signature:

Findings and Recommendations :

Thanks for referral

History noted.

Frank worms noted in watery stools.

Unexplained tachycardia $\oplus$ - H₂ ↓ within few

? Acute colitis

? Worm infestation - ? Disseminated.

ADVICE

1. C. PREPROKID L 1 — 0 — 1
2. SYP RIFA~~X~~MIN (100mg/5ml) 5ml — 0 — 5ml
3. SYP. ALBENDAZOLE 400mg HS (B/E) x 3 days.
4. T_u & A_u:

Consultant :

Name: Dr. Keerthi Varan Signature: [Signature] Date & Time:

10-22-2014

10-22-2014

10-22-2014



10-22-2014



10-22-2014

10-22-2014

10-22-2014

10-22-2014

10-22-2014



CROSS CONSULTATION FORM

Doctor Name: Dr. Giridhar Date: 15/7/26 Time: 2:52

Diagnosis:

Hospital:

Type of Referral :

☐ Emergency

☐ Urgent

☐ Non Urgent

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

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

Signature:

Findings and Recommendations :

Situs solitus. Levocardia

AV/VA concordance

IVC collapsing $\approx$ 50% collapse during inspiration

Intact IAS / IVC.

Trivial TR. TR jet 20mmHg. No PAH.

Good biventricular systolic fn. No MR/AR.

④ Aortic arch $\approx$ normal branching.

No CoA/PDA. All pulm vns into LA.

ECG - NSR, HR 167/min

PR int 120 msec.

QRS axis $+50^\circ$

STc Normal.

$\uparrow$ septal forces. No chamber hypertrophy

Plan

- Can $\uparrow$ fluids.

Imp :- Structurally Normal heart
Good biventricular systolic fn.

Consultant :

Name : Dr. Giridhar

Signature : [Signature]

Date & Time : 15/7/26

2:52

CONSULTATION FORM

Name of Client _____
Address _____
City _____ State _____ Zip _____

Project Description _____
Date of Consultation _____

Consultant's Name _____
Firm Name _____

Project Address _____
City _____ State _____ Zip _____

Project Description _____
Date of Consultation _____

Consultant's Name _____
Firm Name _____

Project Address _____
City _____ State _____ Zip _____

Project Description _____
Date of Consultation _____

Consultant's Name _____
Firm Name _____

Project Address _____
City _____ State _____ Zip _____

Project Description _____
Date of Consultation _____

Consultant's Name _____
Firm Name _____

Project Address _____
City _____ State _____ Zip _____

Project Description _____
Date of Consultation _____

Consultant's Name _____
Firm Name _____

Project Address _____
City _____ State _____ Zip _____



CROSS CONSULTATION FORM

Doctor Name: Dr. Keerthi Varan Date: 16/7/26 Time:

Diagnosis:

Hospital:

Type of Referral :

- ☐ Emergency
☐ Urgent
☐ Non Urgent

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

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

Signature:

Findings and Recommendations :

16/7/26
5pm

child reviewed

Worm infestation (+)

HR - 130/min

CRP - 49 → 371

Procal - 24.8

C/E - Alert

PPWF, pulse volume - good, CRT < 3 sec.

PIA - soft,

non-tender



~~Advised~~ Suggested -

1. Continue Inj-PIPTAZ / Albendazole.
2. To start IV Metronidazole.
3. Sigmoidoscopy (SOS).
4. Trace Ig profile.

Consultant :

Name: Dr. Keerthi Varan Signature: Date & Time:

1001-2012

1001-2012

1001-2012

1001-2012

1001-2012

1001-2012

1001-2012

1001-2012

1001-2012

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1001-2012

1001-2012

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 Baby SONAL TASHA
 19-12-2023 2 Y 6 M 26 D (F)
 Dr. GANESH R



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 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
15/7/20 4.15pm.	S/B Dr. Chandrasekhar	
	A - Acute colitis (worm infestation, ? early sepsis)	
	sinus tachycardia	
	c/o vomiting x 3 episodes	
	c/o Abdominal pain x 1 day	
	c/o loose stools x 6 episodes	
	one episode of fever	
	O/E	BP - 104/56 mmHg
	Afebrile	PR - 174/min
	CVS - S1S2(P)	
	RS - clear	
	PIA - soft	
	perianal region - mild excoriation(P)	
	worms(P)	
	Chest Xray - (N)	
	Stool occult blood	
	- positive	
	TC - 2470	
	N/L - 32/b4	
	RH - 252,000	
	CRP - 49	USG Abdomen
		- Diffuse mild colitis
		with mesenteric lymphadenopathy
	Ser electrolytes	
	RFT	
	SerOT, SGP	
	urine routine	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	<u>Adv</u> - monitor vitals - W/F Fever spikes, loose stools, tachycardia - Dr. Kathik's opinion - continue ceftriaxone - Rifaximin prepusulid + Albendazole - Inform (OS)	
15/7/25 6pm	<u>821</u> <u>12/14</u> Reviewed Afebrile Alert passed urine once passed stool once PP-LF P/A-soft, Non tender Other systems unremarkable S, S, @, No mass R	Slr Dr. Manoj HR - 165-170b/min At rest BP - 90/50 mm Hg No edema
	→ monitor vitals, I/O → N/F tachycardia → plan → keep T/F at rest	let vitals myocardial

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2 Y 6 M 26 D

(F)

Dr. GANESH R



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
15/12/23 7:30pm	Spk Dr. Ganesh Sir Adm: - To add By piperacillin tazobactam + metronidazole - To do ECHO	
15/12/23 7:30pm	Fever x 1 day c omit & WBCs (normal in vhs) Has ↑ HR (160-170) always pulse were fast NBP. NO normal of 15 also @ no up to normal Hydro R @ Abd soft. no tenderness.	Spk Dr. Ganesh Sir Possible SIRS To do ECHO Pulse to Rpt 2
	ECHO: Low flow mildly congested - detail. To do ECHO	Handwritten signature 7/12

GUC-00079905 IP18-00036478
 Baby SONAL TASHA
 19-12-2023 2 Y 6 M 28 D (F)
 Dr. GANESH R



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
15/1/24	8/8 Ongeetha	
10 pm		
	Admitted with acute colic	3 rd episode colic
	with severe pinworm	3 months in a row
	infestation	H/o grip food
	Irritability / tachycardia	outside (sambhar, rice).
	ongoing watery loose stools	H/o eating raw
	(+) worms / straining	vegetables.
	urine twice - light colored	
	O/E afebrile	
	HR - 150/min	PP-WF
	chest clear	
	Abd - mild distension (+)	
	2,700	
	lymphocyte predominant	IVF 0.9 NS RL (30ml/kg)
	Hb = 12 (2 hemocrit)	300 over 4 hours
	MCV = 75 - (+)	↓
	Urine ketone 2+	0.9 GNS 40ml/hr
	132 / 3.4	[1 cc KCl / 100ml fluid]
	(15)	
	2 Irritability -> related to severe itching	Syp Allegra
	HR	3.5ml - 0 - 3.5ml.
		(vulva).

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16/1/26 12 am	S/B Dr. Keerthana <u>Acute colitis</u> & <u>warm infestation</u>	
	→ No watery stools - 5 episodes No vomiting No fever spike + Oral intake improved	
	→ Sinus tachycardia settled HR - 100/min < 131/min No signs of myocarditis Echo → (N) study	
	OE Hydration good vitals stable P/A - soft, not tender, BS + chest - clear	
	Adm: - Continue dehydration correction f/b IVF - Soft bland diet - ID charting - Hand hygiene	
	<i>[Signature]</i> 125882	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16/1/26 1am		S/R Dr Manomas
	Asleep	
	HR-145/min	
	Hydrocodone	
	passed once stool with urine	
	PP-NE	
	R1-clear	
	P/A-soft, Non tender	
	↓	
	→ Monitor HR, R/p	
	→ Cont IVF	
	→	
16/1/26 3:30pm		S/R Dr Chandimalage
	child reviewed	
	sleeping	
	one episode of fever spike @	
	loose stools - 1 episode	
	Took minimal feeds	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16/7/20 11:20 AM	S/B Dr. Ganesh R Reviewed Fever spikes spiking out Intensity ↓ HR - 130 to 135/min volume @ BP - (N) Intake - (N) Still passes worms in stools advice - - Do Ipecethinase sir semi - To do CRP, Na, K + - To do SGPT, A, E, M. Continue vitals monitoring Nallu (small) - 1st	
16/7/20 3pm.	S/B Dr. Ganesh R child reviewed no fever. Loose stools & worms @ urine output - improving	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	Heart rate 70 BP	
	Serum IgG - 274 ↑↑ K - 3.4 Na - 134 CRP - 371 ↑↑.	
	<u>Adv</u> - TO continue Piperacillin tazobactam - TO do Procalcitonin - monitor vitals -	
	<u>Sil</u> 10/12/23	
	Sl Dr. Chandimolga	
	child reviewed Alert no fever spikes 10:30 AM No loose stools since afternoon Oral intake - Improving urine output - good	
	O/E	
	Afebrile CVS - S1S2 RS - BILAEAD	

16/6/23
4:40 PM



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16/12/26 10:30 PM	S/B. Dr. Lukey <u>V. N. N. M.</u>	
	Δ : Acute colitis (? Infective)	
	afebrile / Acute	
	dehydration - Aseptic	
	5% - Aseptic	
	No further episodes of loose stools	
	HR: 127/min	
	BP: 93/51 mmHg	
	SpO ₂ - 98% @ RA	
	CRT < 3 sec.	
	oral intake - Improving	
	PA: 5 ft H ₂ O, no mass / organomegaly	
	One episode - @	
		<u>Advice</u>
		1) Continue paps / allgra / metronidazole / Albendazole / rifaximin / preprobiotic - sachet.
		2) w/f loose stools / dehydration (Inform SOS) - Tachycardia

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16/7/20 11:18 PM	ds/B pr. pawan / pr. Agay (yellow)	
	child xicand clinically better mild periorbital puffiness noted HR - Sleepy 115-120 / min pH - alkalemic low stool - 3 episodes	
	<u>Plan:</u>	
	1. Tape 10 flts	
	2. T oral intake (reactive ORS)	
	3. Anti U/O stool firming	
		 [28/6/20]

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
7/7/26 9 AM.	S/BDR-chandiralege.	
	Ch Acute colitis / sepsis	
	Child semi-conscious	
	Aleat, But activity not so good.	
	no fence spikes for 24hrs	
	no loose stools since emesis,	
	voided urine - one time	
	oral intake - minimal	
	OLE	
	apfelin	
	CVS-S1S2(+))	
	RS-B/LAE(+) , clear	
	PIA-soft	Bp-105/55 mmHg
		PR-114/min.
	Sr Tg A 26.2 ↓	
	Sr Tg G 446	
	Sr Tg M 89	
	Sr Tg E 244 ↑↑	
	Adv:	
	- monitor intake	
	- continue iv fluids @ 25ml/h.	
	- Sy. Piperacillin tazobactam 1gm Q8H	
	- Sy. metronidazole 100mg Q8H	
	- sy. Allegra 3.5ml BID	
	- sy. Rifaximin 5ml OD	
	- w/f fence spikes, loose stools	
	Blood c/s	
	urine c/s	
	<i>[Signature]</i>	





PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	O/E	
	Afebrile	Bp-100/62 mm Hg
	CVS-S2@	PR-108/min
	RS-B/LA@	
	PIA-Soft; distended	
	AB-44 cm	
	ad.	
	- monitor vitals	
	- Continue IV piperacillin tazobactam, metronidazole	
	- To stop albendazole, by night	
	- I/O monitoring	
	<i>[Signature]</i>	
	S/BDr-Chandiralege. / <i>[Signature]</i>	
	Δ - Acute colitis / SIRS in norm	
	Infestation	
	child reviewed	
	Aleat, Activity - Improving	
	no fever spikes for 48hrs	
	no loose stools	
	oral intake improving	
	urine output	

18/7/26
 9 AM

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	O/E	Bp-104/59mmHg PR-100/min
	Afebrile	
	CVS-S1S2Ⓢ	
	RS-B/LAEP, clear	
	PIA-soft	
	Hydration - PPWT, CRT & 3Ses	
	<u>Adv:</u>	
	- monitor vitals	
	- w/f fever spikes, loose stools	
	- Ty. piperacillin tazobactam 1gm Q8H	
	- syp. Allegra 3ml BID	
	- syp. Rifaximin 5ml Q24H	
	- Ty. Metronidazole 100mg Q8H	
	- preprobiotic sachet	
	- Infam (SOS)	
	<u>Sgt</u> 19/12/24	<u>h</u> Q 12hrs pro

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

18/7/26
4.30pm

Date & Time	Progress Notes	Doctor's Order
	SIB prochloralazine	
	child seemed well	
	Alert, Active	
	no fever spikes, loose stools	
	tolerating oral feeds well	
	OLE	
	afebrile	
	CUS - S/Sx ⊕	
	RS - B/LCPE ⊕	
	PIA - soft	
	Hydration - PPWF, LRT C3848	
	urine output - 2 times voided	
	Plan:	
	- To do CRP tomorrow morning	
	- monitor vitals	
	- w/F fever spikes, loose stool	
	- Drugs as per chart	
	- Inform SOS	
	<i>[Signature]</i>	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/12/23 8 AM	S/RDS-Chandisolega	
	D - Acute colitis SIRS & worm infestation	
	child reviewed	
	no fever spikes for 72 hrs.	
	no loose stools; vomiting	
	oral intake - good	
	stools - semisolid consistency - no worms	
	urine output - voided 2 times at night	
	O/E	
	Afebrile	Sp - 98/58 mmHg
	CVS - S1S2P2	PR - PR/min
	RS - B/LAET, clear	
	PIA - soft	
	<u>Adv</u>	
	- monitor intake	
	- to trace CRP reports	
	- By piperacillin tazobactam 1gm IV BSL	
	- By mebendazole 100mg OSL	
	- Syp. Rifaximin 5ml BSL	
	- nil F fever spikes, loose stools & worm	
	- Inform BOS	
	<u>SG</u> 19/12/23	

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/17/2014	1/2 2 Hannah	
10/18/14	D. ... worm	
	... PINWORM	INFESTATION
	... S.Rs	
	no fever	
	No loose stool	
	no @	
	no worm in stool	
	worm negative	
	in 1 @	
	also sign	
	Re a check	
	70 days	
	58	
		Hand
	Is Page	
	26 (70-400) milk	
	Is A 89 (40-230) milk	
	446 (100-1600) milk	
	h 274 (2-60)	
	E = 274	
		2 CVID
		might need 7000
		cytomeg.
		will do w/ parent

Bwt:
27/15

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RESULT SHEET

Date	15/7/26	16/7/26				
Time						
Hb	12					
PCV	35					
RBC	4.51					
WBC	2770					
N/L/M	32/64/4					
Platelets	252					
CRP	49	371↑↑	58			
ESR						
PCT		24.8↑				
RBS	118					
Na	132	134				
K	3.2	3.4				
Cl / HCO ₃ ⁻	100/16					
Ca/Mg	1.13					
Phosphate						
Urea	19					
Creatinine	0.33					
ALP						
SGPT	17					
SGOT	32					
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		16/7/26				
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood	(+ve)					
Serum IgE		274				
paracalcitonin		24.8				
Sr Ig A		20.2				
Sr Ig G		446				
Sr Ig M		89				

Culture and Sensitivities :

Blood c/s - No growth

WBC c/s - No growth

Radiology : USG :

X-Ray :

ECHO :

CT :

MRI :

Others (ECG, Contrast Studies etc.) :

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MEDICATION RECONCILIATION FORM

Drug Allergies: nil

☒ Not known any Drug Allergies

Medication Reconciliation will be done at the time of admission and also whenever there is change in the treating team or shifting from one unit to another unit.

(Example: at the time of admission shifting from ICU to Ward, or Ward to ICUs)

Shifting From: ER

Shifted to: UO2

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

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Karisha

Date & Time : 15/7/26 9:30am

Nurse Name & Signature : Rishi

Date & Time : 15/07/26 @ 11:05am

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

Page 1 of 1

1

Drug Name:

Indication:
 Dose:
 Frequency:
 Route:

Start Date:

Stop Date:

Ref:

Charting Form:

Time	1	2	3	4	5	6	7	8	9	10
08:00										
09:00										
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										
24:00										

Signature: _____

Medication History:

Doctor Name & Specialty:

Date & Time:

Nurse Name & Specialty:

Date & Time:

Signature: _____

Ref:

12/01/00 @ 11:00 AM



DRUG CHART

Date of Admission: 15.07.2026 Drug Allergies: Not known any 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 : <u>SYP. P250</u>				Date Time	15/7	16/7	17/7	18/7												
Dose <u>3ml</u>	Route <u>P/O</u>	Frequency <u>QOS</u>	Start Date <u>15/7/26</u>	<u>9pm</u>	<u>PM</u>	<u>QAM</u>														
Doctor's Signature <u>[Signature]</u>		Valid Period	Pharm.		<u>MA</u>	<u>MA</u>														
Additional Instructions: <u>if Temp > 100°F (38°C)</u>					<u>PM</u>	<u>PM</u>														

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 _____



REGULAR PRESCRIPTIONS

Weight. 10.3kg Ward.

DRUG : <u>Sw. CEFTRIAXONE</u>				Date Time	<u>1st</u>
Dose <u>500mg</u>	Route <u>i.v</u>	Frequency <u>q12h</u>	Start Date <u>15/7/26</u>	<u>12:45 PM</u>	
Name & Signature of the Doctor Starting the Drugs: <u>[Signature]</u>				<u>1st</u>	<u>changed</u>
Additional Instructions:				<u>stop</u>	
Daily Doctor's Endorsement by a Sign					
DRUG : <u>Sw. EMESET</u>				Date Time	<u>1st</u>
Dose <u>1mg</u>	Route <u>i.v</u>	Frequency <u>q8h</u>	Start Date <u>15/7/26</u>	<u>1st</u>	
Name & Signature of the Doctor Starting the Drugs: <u>[Signature]</u>				<u>2nd</u>	<u>stop</u>
Additional Instructions:				<u>stop</u>	
Daily Doctor's Endorsement by a Sign					
DRUG : <u>Sw. PAN</u>				Date Time	<u>1st</u>
Dose <u>10mg</u>	Route <u>i.v</u>	Frequency <u>q24h</u>	Start Date <u>15/7/26</u>	<u>11:00 AM</u>	
Name & Signature of the Doctor Starting the Drugs: <u>[Signature]</u>				<u>1st</u>	<u>stop</u>
Additional Instructions:				<u>stop</u>	
Daily Doctor's Endorsement by a Sign					
DRUG : <u>E-PREPROKID SACHET</u>				Date Time	<u>1st</u>
Dose <u>1</u>	Route <u>PO</u>	Frequency <u>Q12H</u>	Start Date <u>15/7/26</u>	<u>8 AM</u>	
Name & Signature of the Doctor Starting the Drugs: <u>[Signature]</u>				<u>8 AM</u>	<u>stop</u>
Additional Instructions:				<u>stop</u>	
Daily Doctor's Endorsement by a Sign					

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Sheet No:

REGULAR PRESCRIPTIONS

Weight Ward

DRUG: SYP. RIFAXIMIN				Date Time	15/7 16/7 17/7 18/7 19/7															
Dose	Route	Frequency	Start Dt.																	
5ml	PO	Q24H	15/7/23																	
Name & Signature of the Doctor Starting the Drugs:				8pm 5pm 8pm 5pm 8pm 5pm 8pm 5pm 8pm 5pm 8pm 5pm 8pm 5pm 8pm 5pm 8pm 5pm 8pm 5pm																
Additional Instructions:				(100mg/5ml) 8pm																
Daily Doctor's Endorsement by a Sign																				
DRUG: SYP. ALBENDAZOLE				Date Time	15/7 16/7 17/7 18/7															
Dose	Route	Frequency	Start Dt.																	
10ml	PO	Q24H	15/7/23																	
Name & Signature of the Doctor Starting the Drugs:				8pm 5pm 8pm 5pm 8pm 5pm 8pm 5pm 8pm 5pm 8pm 5pm 8pm 5pm 8pm 5pm 8pm 5pm 8pm 5pm																
Additional Instructions:				(Empty stomach) 8pm, for 3 days (200mg/10ml)																
Daily Doctor's Endorsement by a Sign																				
DRUG: INT. PIPERAZ				Date Time	15/7 16/7 17/7 18/7 19/7 20/7															
Dose	Route	Frequency	Start Dt.																	
1g	IV	Q8H	15/7/23																	
Name & Signature of the Doctor Starting the Drugs:				8pm 5pm 8pm 5pm 8pm 5pm 8pm 5pm 8pm 5pm 8pm 5pm 8pm 5pm 8pm 5pm 8pm 5pm 8pm 5pm																
Additional Instructions:				slow iv over 1 hour as given																
Daily Doctor's Endorsement by a Sign																				
DRUG: SYP ALLEGRA				Date Time	15/7 16/7 17/7 18/7															
Dose	Route	Frequency	Start Dt.																	
3.5ml	PO	BD	15/7/23																	
Name & Signature of the Doctor Starting the Drugs:				8pm 5pm 8pm 5pm 8pm 5pm 8pm 5pm 8pm 5pm 8pm 5pm 8pm 5pm 8pm 5pm 8pm 5pm 8pm 5pm																
Additional Instructions:				15864																
Daily Doctor's Endorsement by a Sign																				

GUC-00079905
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 19-12-2023 2 Y 6 M 26 D (F)
 Dr. GANESH R

Signature
 VERIFIED BY : Name

Weight 10.3 kg Ward 4th floor

VERIFIED BY : Name Signature

Weight. Ward.

VARIABLE DOSE		Date > Time		Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.
		DRUG :			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[illegible]

19-12-2023

2 Y 6 M 26 D

(F)

Dr. GANESH R



Weight. 10.3kg Ward.

Date	Time	Composition of Fluid (If infusion, mention ml/hr = Mcg/kg/min, etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
15/7/26	11:30 AM	WF 0.9% DNS	iv	40ml/hr		DS AS			
	10 PM	RL - 300ml over 4 hr	iv	75 ml/hr		DS AS	16/7/26 2:45 AM		DS AS
16/7/26	2:45 AM	0.9% DNS (500ml) + 5cc KCl	iv	40 ml/hr		DS AS	16/7/26 9 AM		DS AS
16/7/26	12 PM	0.9% DNS. (500ml) + 5cc KCl	iv	30ml/hr		DS AS	16/7/26 1 PM		DS AS
17/7/26	1 PM	0.9% DNS	iv	25cc/hr		DS AS	17/7/26 12 PM		DS AS
18/7/26		STOP IV here							

Page: 4/4

Signature

VERIFIED BY : Name

GUC-00079905 IP18-00036478

Baby SONAL TASHA

19-12-2023 2 Y 6 M 27 D (F)

Dr. GANESH R



MEDICATION CHART AUDIT CHECKLIST - IP

DRUG NAME	DRUG 1	DRUG 2	DRUG 3	DRUG 4	DRUG 5	DRUG 6	DRUG 7
FREQUENCY	I.V.	Sup.	Syp.	I.V.	I.V.		
DOCTORS	pan	Rifampin	Albendazole	Pipenz	Motrinol		
2. INCORRECT DRUG SELECTION	OD	OD	OD	TDS	TDS		
2. NO/WRONG DOSE							
3. NO/ WRONG UNIT OF MESUREMENT							
4. NO/ WRONG FREQUENCY							
5. NO/WRONG ROUTE							
6. NO/ WRONG CONCENTRATION							
7. NO/WRONG RATE OF ADMINISTRATION							
8. ILLEGIBLE PRESCRIPTION							
9. NON APPROVED/ERROR PRONE ABBREVIATION USED							
10. NON- USAGE OF CAPITAL LETTERS FOR DRUG NAMES	✓	✓	✓	✓	✓		
11. NON-USAGE OF GENERIC NAMES	X	✓	✓	X	✓		
12. DRUG-DRUG INTERACTION							
13. DRUG- FOOD INTERACTION							
14. WRONG FORMULATION TRANSCRIBED							
15. WRONG DRUG TRANSCRIBED/INDENTED							
16. WRONG STRENGTH TRANSCRIBED/INDENTED							
PHARMACIST							
17. WRONG DRUG							
18. WRONG FORMULATION							
19. WRONG STRENGTH DISPENSED							
20. EXPIRED/NEAR EXPIRY DRUG DISPENSED							
21. NO/ WRONG LABELLING							
22. DELAY IN DISPENSE(<30 MINTS)							
23. GENERIC OR CLASS SUBSTITUTED DONE WITHOUT CONSULTATION WITH THE CONSULTANT							
NURSES							
24. WRONG PATIENT							
25. IMPROPER DOSE							
26. DOSE OMISSION							
27. WRONG DRUG							
28. WRONG FORMULATION							
29. WRONG ROUTE							
30. WRONG DURATION							
31. WRONG TIME							
32. NO DOCUMENTATION							
33. DOCUMENTATION WITHOUT ADMINISTRATION							

1. NON-COMPLAINE YES/NO (If yes mention : Doctor/Pharmacist/Nurses), 2. MEDICATION ERROR FORM/INCIDENT FORM RAISED (YES/NO), 3. CAPA DONE (YES/NO), 4. (ERROR PRONE ABBREVIATION USED IN THE MEDICATION CHART (TICK IF USED)).

DISCREPANCY

INTERVENTIONS

TOTAL NUMBER OF OPPORTUNITIES

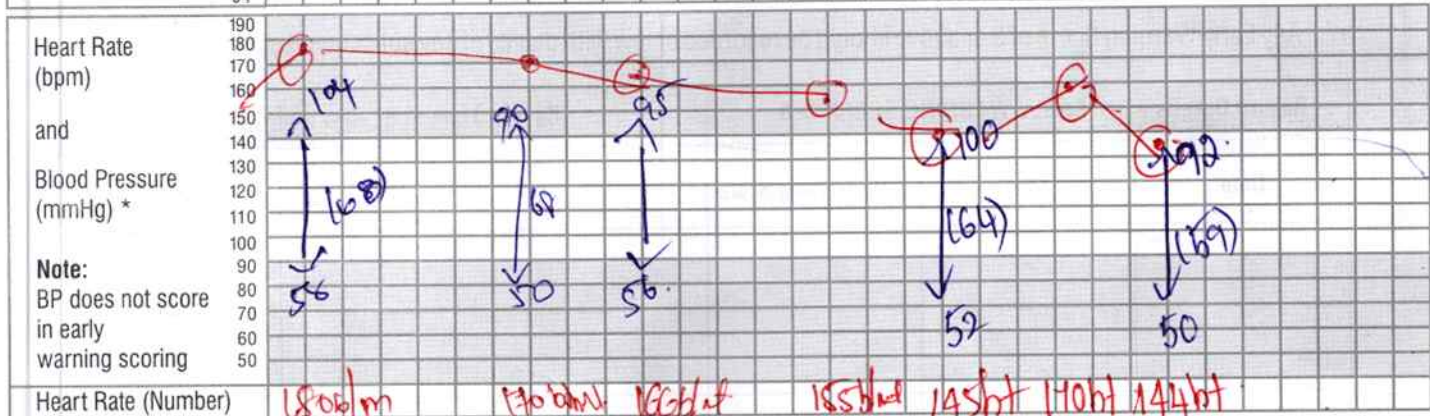
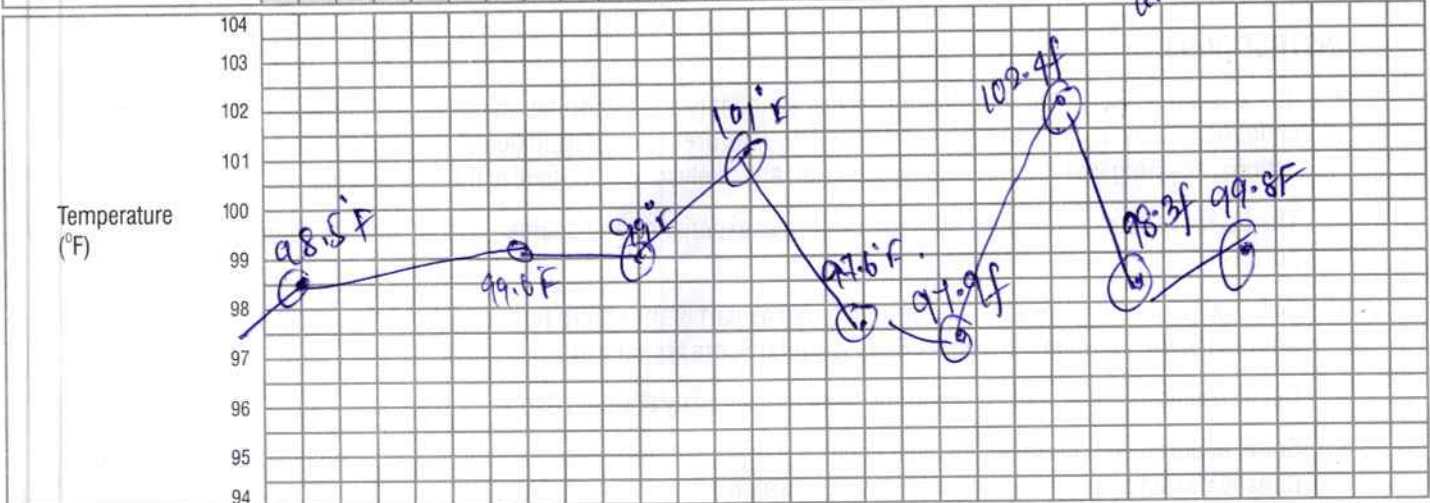
MEDICATION CHART AUDIT CHECKLIST - IP

	DRUG 1	DRUG 2	DRUG 3	DRUG 4	DRUG 5	DRUG 6	DRUG 7
DRUG NAME							
FREQUENCY							
DOCTORS							
1. INCORRECT DRUG SELECTION							
2. NO/WRONG DOSE							
3. NO/ WRONG UNIT OF MESUREMENT							
4. NO/ WRONG FREQUENCY							
5. NO/WRONG ROUTE							
6. NO/ WRONG CONCENTRATION							
7. NO/WRONG RATE OF ADMINISTRATION							
8. ILLEGIBLE PRESCRIPTION							
9. NON APPROVED/ERROR PRONE ABBREVIATION USED							
10. NON- USAGE OF CAPITAL LETTERS FOR DRUG NAMES							
11. NON-USAGE OF GENERIC NAMES							
12. DRUG-DRUG INTERACTION							
13. DRUG- FOOD INTERACTION							
14. WRONG FORMULATION TRANSCRIBED							
15. WRONG DRUG TRANSCRIBED/INDENTED							
16. WRONG STRENGTH TRANSCRIBED/INDENTED							
PHARMACIST							
17. WRONG DRUG							
18. WRONG FORMULATION							
19. WRONG STRENGTH DISPENSED							
20. EXPIRED/NEAR EXPIRY DRUG DISPENSED							
21. NO/ WRONG LABELLING							
22. DELAY IN DISPENSE(<30 MINTS)							
23. GENERIC OR CLASS SUBSTITUTED DONE WITHOUT CONSULTATION WITH THE CONSULTANT							
NURSES							
24. WRONG PATIENT							
25. IMPROPER DOSE							
26. DOSE OMISSION							
27. WRONG DRUG							
28. WRONG FORMULATION							
29. WRONG ROUTE							
30. WRONG DURATION							
31. WRONG TIME							
32. NO DOCUMENTATION							
33. DOCUMENTATION WITHOUT ADMINISTRATION							
DISCREPANCY	1. NON-COMPLAINE YES/NO (If yes mention : Doctor/Pharmacist/Nurses), 2. MEDICATION ERROR FORM/INCIDENT FORM RAISED (YES/NO), 3. CAPA DONE (YES/NO), 4. (ERROR PRONE ABBREVIATION USED IN THE MEDICATION CHART (TICK IF USED).						
INTERVENTIONS							
TOTAL NUMBER OF OPPORTUNITIES							



EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 18/12 Time: 11:30 am 4pm 8pm 9pm 11pm 12am 2am 4:30 am 7:30 am
 Doctor / Nurse / Family Concern?



Resp. Rate (bpm) (Over 1 Minute) *	28b/m	28b/m	36b/m	38b/m	36b/m	36b/m	35b/m
Resp Rate (Number)	28b/m	28b/m	36b/m	38b/m	36b/m	36b/m	35b/m
Resp Mod/ Severe Distress None / Mild	✓	✓	✓	✓	✓	✓	✓
Receiving O ₂ (l/min) O ₂ Saturations (%)	RA 98%	RA 98%	99%	97%	98%	98%	98%
Conscious Level Normal / Altered	✓	✓	✓	✓	✓	✓	✓
GCS *	15/15	15/15	15/15	15/15	15/15	15/15	15/15
TOTAL SCORE	0	0	0	0	0	0	0
Number of shaded boxes	0	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0	0
Observer's Initials	PR	RS	PR	PR	PR	PR	PR

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.

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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- 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

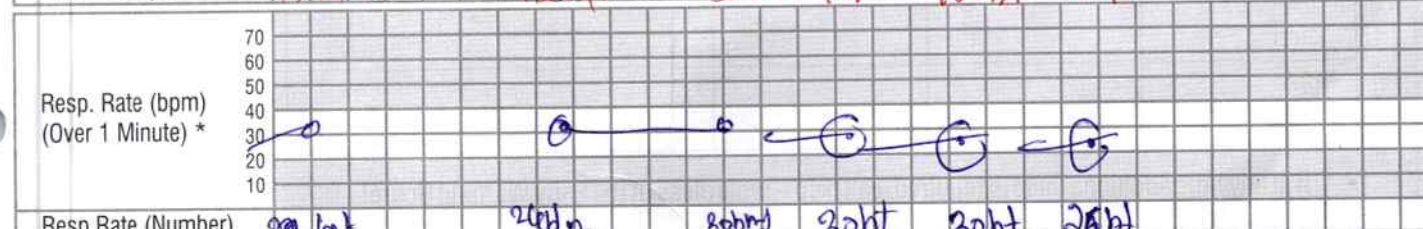
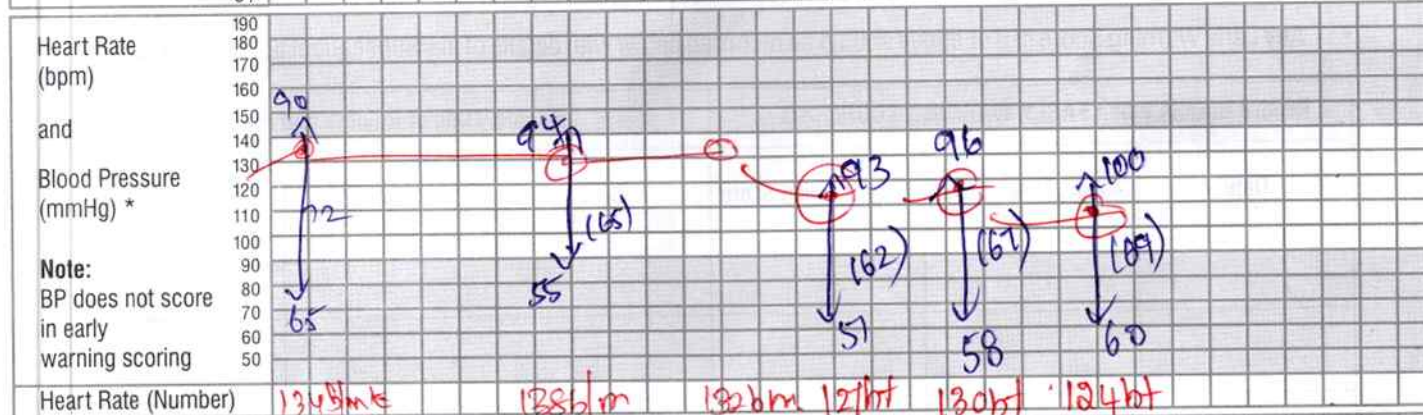
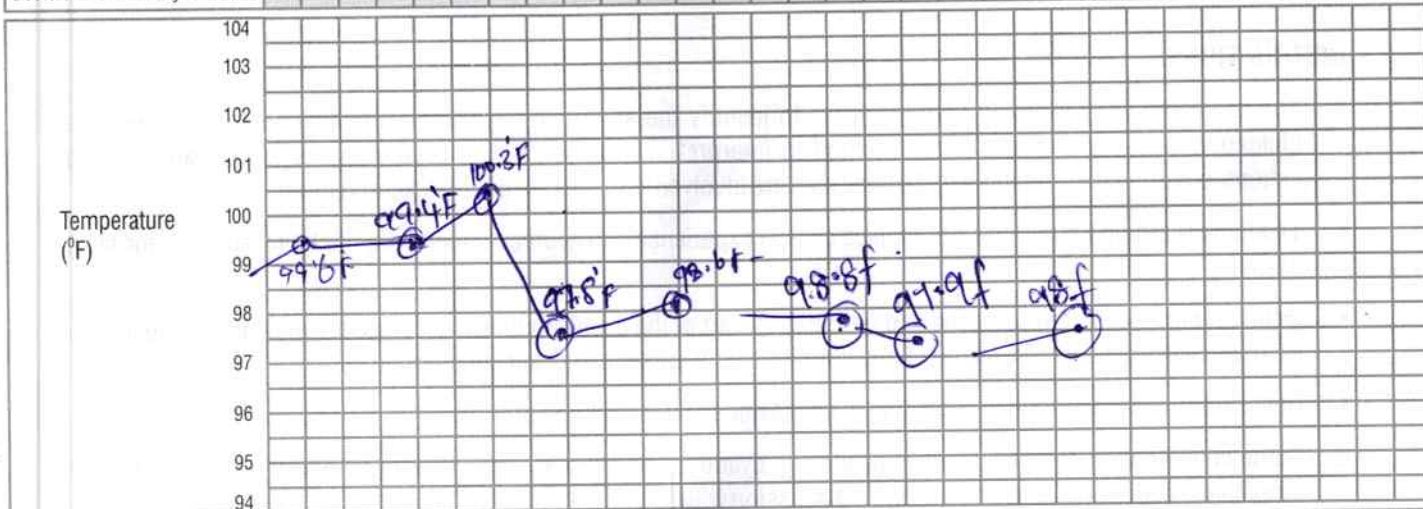
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- Following a Early Warning Score assessment, senior help may be required

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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)

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 16/1/26 Time: 8am 9:30am 10:30am 12pm 4pm 6pm 12am 1am
Doctor / Nurse / Family Concern?



Resp Distress	Mod/ Severe	None / Mild	✓	✓	✓	✓	✓
Receiving O ₂ (l/min)	O ₂ Saturations (%)	98%	98%	99%	98%	98%	98%
Conscious Level	Normal / Altered	✓	✓	✓	✓	✓	✓
GCS *		15/5	15/5	15/5	15/5	15/5	15/5
TOTAL SCORE	Number of shaded boxes	0	0	0	0	0	0
Pain Score		0	0	0	0	0	0
Observer's Initials		RS	RS	RS	RS	RS	RS

ACTIONS

NB: Scores 3 should be recorded overleaf

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* 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.

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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-00079905 IP18-00036478
 Baby SONAL TASHA
 19-12-2023 2 Y 6 M 27 D (F)
 Dr. GANESH R



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

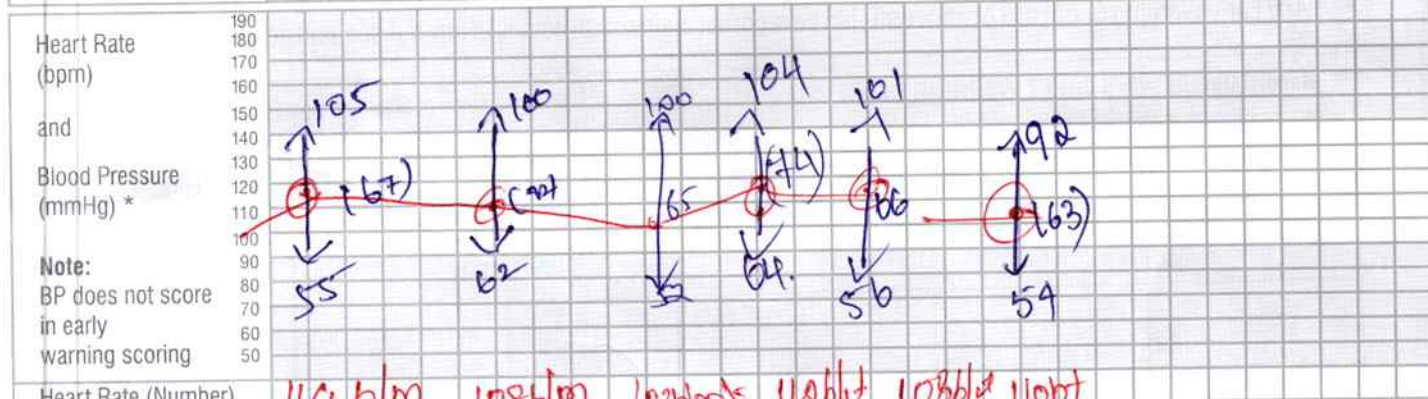
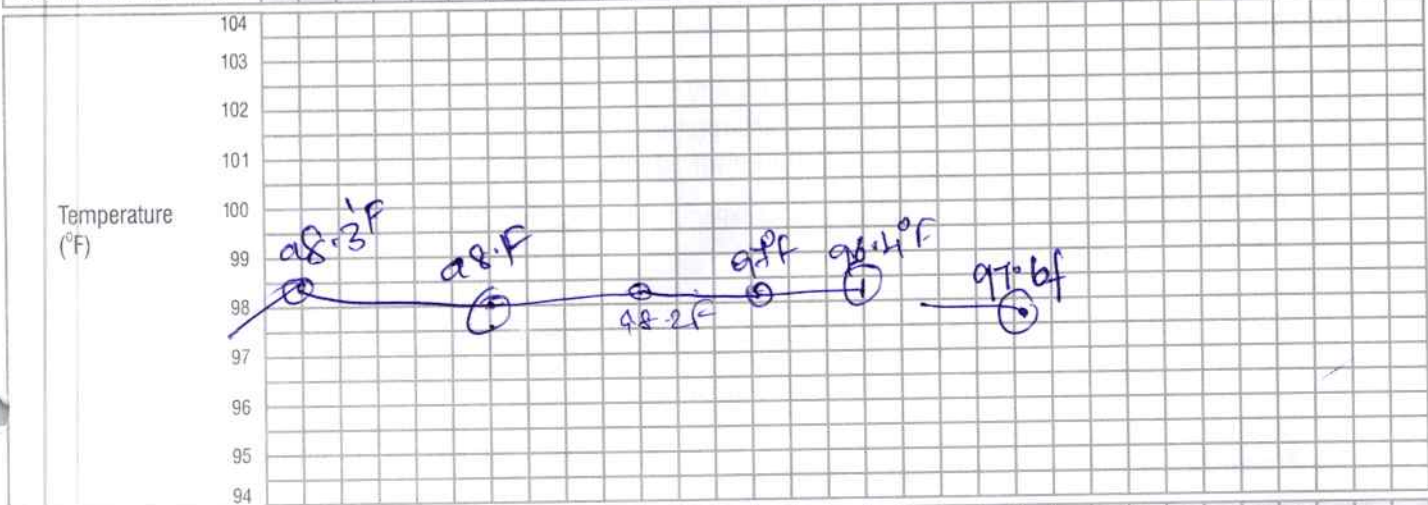
PRESCHOOL (1-5 years)
Children's Observation & Early Warning Scoring Chart

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

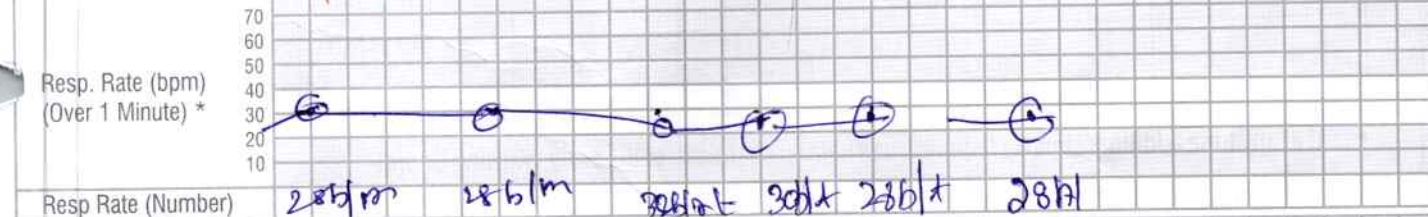
BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 17/6 Time: 8AM 12PM 4PM 8PM 12AM 4AM
 Doctor / Nurse / Family Concern?



Heart Rate (Number) 114b/m 108b/m 102b/m 112b/m 108b/m 110b/m



Resp Distress	Mod/ Severe	None / Mild	✓	✓	✓	✓
Receiving O ₂ (l/min)	RA	RA	RA	RA	RA	RA
O ₂ Saturations (%)	98%	98%	99%	98%	99%	98%
Conscious Level	Normal	Normal	✓	✓	✓	✓
GCS *	15/5	15/5	15/5	15/5	15/5	15/5
TOTAL SCORE	6	6	6	6	6	6
Number of shaded boxes	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0
Observer's Initials	PS	PS	PS	PS	PS	PS

ACTIONS

NB: Scores 3 should be recorded overleaf

- Score 1 : Continue normal observation by staff nurse
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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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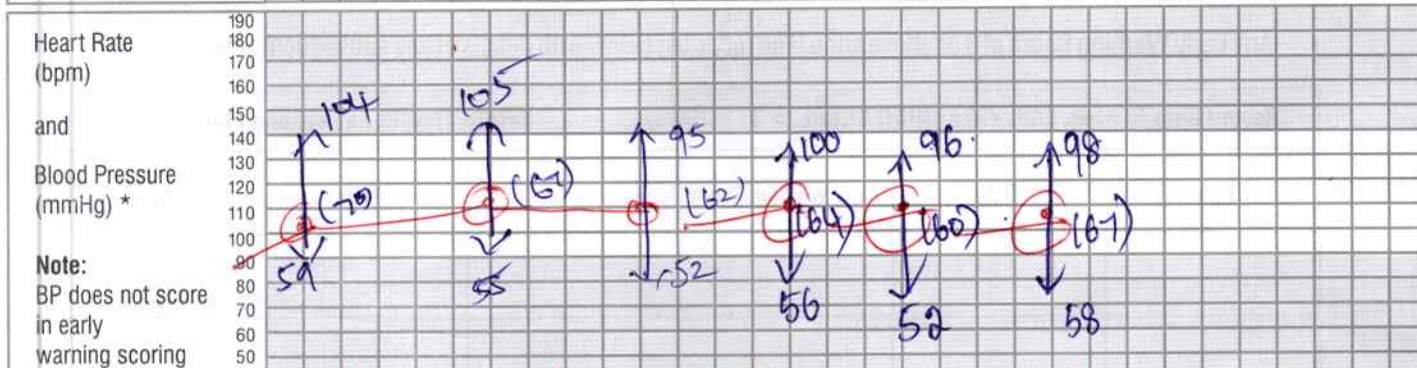
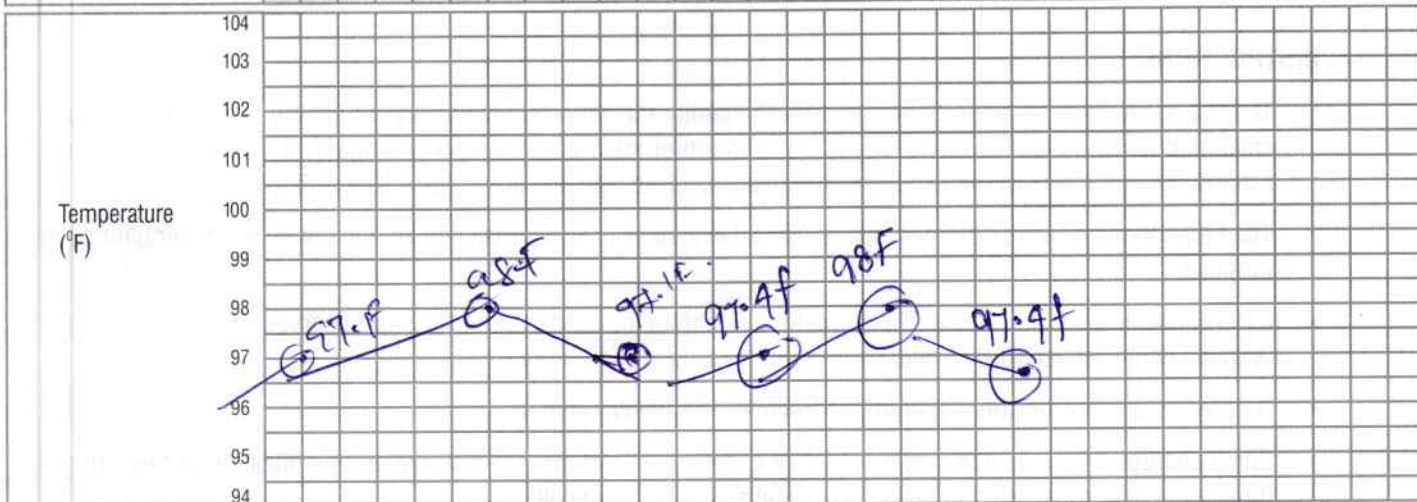
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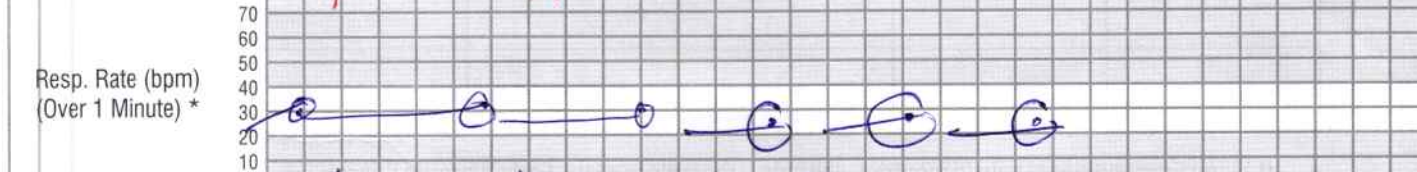


EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 18/1 Time: 8am 12pm 4pm 8pm 12Am 4am
 Doctor / Nurse / Family Concern?



Heart Rate (Number) 100b/m 104b/m 102b/m 106b/m 100b/m 100b/m



Resp Rate (Number) 28b/m 26b/m 26b/m 26b/m 26b/m 28b/m

Resp Mod/ Severe Distress None / Mild ✓ ✓ ✓ ✓ ✓ ✓

Receiving O₂ (l/min) 2.2 2.2 2.2 2.2 2.2 2.2
 O₂ Saturations (%) 98% 100% 99% 98% 98% 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 PR PR PR PR PR PR

ACTIONS
 NB: Scores 3 should be recorded overleaf

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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)

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 19/12/2023	Time: 8AM	12PM	4PM	8PM	12AM	4AM
Doctor / Nurse / Family Concern?						
Temperature (°F)	104					
	103					
	102					
	101					
	100					
	99					
	98	98.8 F	98.8 F	98.8 F	98.8 F	98.8 F
97						
96						
95						
94						
Heart Rate (bpm)	190					
	180					
	170					
	160					
	150					
	140					
	130					
120						
110						
100						
90						
80						
70						
60						
50						
Blood Pressure (mmHg) *	140					
	130					
	120					
	110					
	100					
	90					
	80					
70						
60						
50						
Note: BP does not score in early warning scoring	140					
	130					
	120					
	110					
	100					
	90					
	80					
70						
60						
50						
Heart Rate (Number)	100b/m	106b/m	98b/m	117b/m	100b/m	108b/m
Resp. Rate (bpm) (Over 1 Minute) *	70					
	60					
	50					
	40					
	30					
	20					
	10					
Resp Rate (Number)	28b/m	26b/m	28b/m	26b/m	28b/m	26b/m
Resp Mod/ Severe Distress None / Mild	✓	✓	✓	✓	✓	✓
Receiving O ₂ (l/min) O ₂ Saturations (%)	RA	RA	RA	RA	RA	RA
	100%	98%	99%	98%	98%	98%
Conscious Normal Level Altered	✓	✓	✓	✓	✓	✓
GCS *	15/15	15/15	15/15	15/15	15/15	15/15
TOTAL SCORE	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0
Observer's Initials	RS	RS	RS	RS	RS	RS

ACTIONS

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FLUID CHART

Sheet No. : ①

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

Date	Time	Intake			Output					IV Site Thrombo- phlebitis Score	Sign. Nurse	
		Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am	chased	received from ER to ltr blow - HAN									
	11:00 am	2		40ml								
	12:00 pm	2		40ml						✓	0	PSD
	01:00 pm	0		40ml							0	R
Total Intake :			120ml			Total Output :			1 time uris passed			
	02:00 pm			40ml							0	Jan
	03:00 pm			40ml							0	Jan
	04:00 pm			40ml							0	Jan
	05:00 pm	H2O 20ml		40ml							0	Jan
	06:00 pm	H2O 10ml		40ml					✓		0	Jan
	07:00 pm	H2O 10ml		40ml							0	Jan
Total Intake :			40ml + 200ml			Total Output :			1 time uris passed			
	08:00 pm			40ml					✓		0	Jan
	09:00 pm	H2O 20ml		40ml					✓		0	Jan
	10:00 pm			DC					✓		0	Jan
	11:00 pm			40ml					✓		0	Jan
	12:00 am	H2O 10ml		75ml							0	Jan
	01:00 am			75ml							0	Jan
Total Intake :			20ml + 305ml			Total Output :			2 time uris passed			
	02:00 am			75ml							0	Jan
	03:00 am	H2O 20ml		40ml							0	Jan
	04:00 am			40ml							0	Jan
	05:00 am	H2O 10ml		40ml							0	Jan
	06:00 am			40ml							0	Jan
	07:00 am	H2O 10ml		DC					✓		0	Jan
Total Intake :			40ml + 35ml			Total Output :			2 time uris passed			
Total 24 hrs. Intake			970ml			Total 24 hrs. Output			5 time uris passed			



FLUID CHART

Sheet No. : 9

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	Nature of Fluid	Intake Route			Output					IV Site Thrombophlebitis Score	Sign. Nurse
				Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
16/12/26		08:00 am	water	10ml				Loose 1 gm				0	RA
		09:00 am	water	20ml				Loose 1 gm				0	RA
		10:00 am	water	10ml				Loose 1 gm				0	RA
		11:00 am										0	RA
		12:00 pm	water	10ml	30ml			Loose 1 gm			150ml	0	RA
		01:00 pm			30ml							0	RA
Total Intake :				50 ml + 60 ml			Total Output :				150 ml		
		02:00 pm	water	50ml	30ml			Loose 1 gm				0	RA
		03:00 pm			30ml							0	RA
		04:00 pm			30ml							0	RA
		05:00 pm			30ml							0	RA
		06:00 pm			30ml							0	RA
		07:00 pm			DC							0	RA
Total Intake :				50 ml + 150 ml			Total Output :				240 ml Urine passed.		
		08:00 pm	water	20ml	DC							0	RA
		09:00 pm			25ml						80ml	0	RA
		10:00 pm	water	50ml	25ml							0	RA
		11:00 pm			25ml							0	RA
		12:00 am	water	20ml	25ml						120ml	0	RA
		01:00 am			25ml							0	RA
Total Intake :				90 ml + 125 ml			Total Output :						
		02:00 am	water	50ml	25ml							0	RA
		03:00 am			25ml							0	RA
		04:00 am			25ml							0	RA
		05:00 am			25ml							0	RA
		06:00 am			25ml						150ml	0	RA
		07:00 am	water	50ml	DC							0	RA
Total Intake :				100 ml + 125 ml			Total Output :				150 ml		
Total 24 hrs. Intake		750 ml											
Total 24 hrs. Output		500 ml + 2 times urine passed											

GUC-00079905

IP18-00036478

Baby SONAL TASHA

19-12-2023

2 Y 6 M 27 D

(F)

Dr. GANESH R



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Children's
Hospital**
It takes a lot to trust the little.

BirthRight[™]
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

FLUID CHART

 Sheet No. : 3

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	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
19/12/23	08:00 am										0	DDA	
	09:00 am										0	DDA	
	10:00 am	water 20ml									0	DDA	
	11:00 am	water 20ml									0	DDA	
	12:00 pm	water 20ml	25ml						50ml		0	DDA	
	01:00 pm		25ml								0	DDA	
Total Intake :			60ml + 50ml			Total Output :						50ml	
	02:00 pm	water 20ml	25ml								0	DDA	
	03:00 pm		25ml								0	DDA	
	04:00 pm	water 10ml	25ml								0	DDA	
	05:00 pm		25ml								0	DDA	
	06:00 pm	water 20ml	25ml								0	DDA	
	07:00 pm		25ml								0	DDA	
Total Intake :			50ml + 150ml			Total Output :						120ml + 1 time urine passed	
	08:00 pm	water 20ml	25ml								0	DDA	
	09:00 pm	water 50ml	25ml								0	DDA	
	10:00 pm		25ml								0	DDA	
	11:00 pm	water 50ml	25ml								0	DDA	
	12:00 am		DL								0	DDA	
	01:00 am		DL								0	DDA	
Total Intake :			120ml + 100ml			Total Output :						2 time urine passed	
	02:00 am	water 50ml									0	DDA	
	03:00 am										0	DDA	
	04:00 am										0	DDA	
	05:00 am										0	DDA	
	06:00 am	water 50ml									0	DDA	
	07:00 am										0	DDA	
Total Intake :			100ml			Total Output :						1 time urine passed	
Total 24 hrs. Intake			630ml			Total 24 hrs. Output			4 time urine passed + 110ml				



FLUID CHART

Sheet No. : 4

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

Date	Time	Intake			Output					IV Site Thrombo- phlebitis Score	Sign. Nurse	
		Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G							
	08:00 am									0	no	
	09:00 am	water 50ml							✓	0	no	
	10:00 am	water 50ml								0	no	
	11:00 am	water 50ml								0	no	
	12:00 pm								✓	0	no	
	01:00 pm									0	no	
Total Intake :		150ml			Total Output : 2 times urine passed							
	02:00 pm	water 50ml								0	yes	
	03:00 pm	water 50ml							✓	0	yes	
	04:00 pm	water 50ml								0	yes	
	05:00 pm								✓	0	yes	
	06:00 pm	water 50ml								0	yes	
	07:00 pm								✓	0	yes	
Total Intake :		180ml			Total Output : 3 times urine passed							
	08:00 pm									0	yes	
	09:00 pm	water 100ml							✓	0	yes	
	10:00 pm									0	yes	
	11:00 pm	water 100ml								0	yes	
	12:00 am								✓	0	yes	
	01:00 am	water 50ml								0	yes	
Total Intake :		250ml			Total Output : 2 times urine passed							
	02:00 am									0	yes	
	03:00 am	water 50ml							✓	0	yes	
	04:00 am									0	yes	
	05:00 am	water 50ml								0	yes	
	06:00 am								✓	0	yes	
	07:00 am	water 50ml								0	yes	
Total Intake :		150ml			Total Output : 2 times urine passed							
Total 24 hrs. Intake		730ml			Total 24 hrs. Output		9 times urine passed					



FLUID CHART

Sheet No. : 5

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	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
19/12	08:00 am										0	PSP
	09:00 am	water 50ml								✓	0	PSP
	10:00 am	water 50ml									0	PSP
	11:00 am										0	PSP
	12:00 pm	water 50ml									0	PSP
	01:00 pm	water 50ml								✓	0	PSP
Total Intake :			200ml			Total Output :					2 times urine passed	
	02:00 pm	water 30ml									0	PSP
	03:00 pm	water 50ml								✓	0	PSP
	04:00 pm	water 50ml									0	PSP
	05:00 pm										0	PSP
	06:00 pm	water 50ml								✓	0	PSP
	07:00 pm										0	PSP
Total Intake :			150ml			Total Output :					2 times urine passed	
	08:00 pm										0	PSP
	09:00 pm	water 50ml								✓	0	PSP
	10:00 pm	water 30ml									0	PSP
	11:00 pm										0	PSP
	12:00 am	water 50ml								✓	0	PSP
	01:00 am										0	PSP
Total Intake :			130ml			Total Output :					2 times urine passed	
	02:00 am	water 30ml								✓	0	PSP
	03:00 am										0	PSP
	04:00 am	water 30ml									0	PSP
	05:00 am										0	PSP
	06:00 am										0	PSP
	07:00 am	water 100ml								✓	0	PSP
Total Intake :			150ml			Total Output :					2 times urine passed	
Total 24 hrs. Intake		640ml										
Total 24 hrs. Output		8 times urine passed										



FL-10 HART

Sheet No. 1

Date		Time	Locality	Remarks
10/1/50		0800	...	...
10/1/50		0900	...	...
10/1/50		1000	...	...
10/1/50		1100	...	...
10/1/50		1200	...	...
10/1/50		1300	...	...
10/1/50		1400	...	...
10/1/50		1500	...	...
10/1/50		1600	...	...
10/1/50		1700	...	...
10/1/50		1800	...	...
10/1/50		1900	...	...
10/1/50		2000	...	...
10/1/50		2100	...	...
10/1/50		2200	...	...
10/1/50		2300	...	...
10/1/50		2400	...	...
10/1/50		2500	...	...
10/1/50		2600	...	...
10/1/50		2700	...	...
10/1/50		2800	...	...
10/1/50		2900	...	...
10/1/50		3000	...	...
10/1/50		3100	...	...
10/1/50		3200	...	...
10/1/50		3300	...	...
10/1/50		3400	...	...
10/1/50		3500	...	...
10/1/50		3600	...	...
10/1/50		3700	...	...
10/1/50		3800	...	...
10/1/50		3900	...	...
10/1/50		4000	...	...
10/1/50		4100	...	...
10/1/50		4200	...	...
10/1/50		4300	...	...
10/1/50		4400	...	...
10/1/50		4500	...	...
10/1/50		4600	...	...
10/1/50		4700	...	...
10/1/50		4800	...	...
10/1/50		4900	...	...
10/1/50		5000	...	...
10/1/50		5100	...	...
10/1/50		5200	...	...
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10/1/50		6700	...	...
10/1/50		6800	...	...
10/1/50		6900	...	...
10/1/50		7000	...	...
10/1/50		7100	...	...
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10/1/50		8600	...	...
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10/1/50		9100	...	...
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10/1/50		9300	...	...
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10/1/50		9600	...	...
10/1/50		9700	...	...
10/1/50		9800	...	...
10/1/50		9900	...	...
10/1/50		10000	...	...



NURSING SHIFT HAND OVER FORM

SITUATION		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
Surgery / Procedure:		Post OP Day:					
BACKGROUND	Date	15/7/26	15/7/26	15/7/26	16/7/26	16/7/26	16/7/26
	Shift	M	R	N	M	F	Night
	Medical Condition (Any special condition to be noted):	-	-	-	Noted	Noted	Noted
Diet:			NPO	Soft diet	Soft diet	Soft diet	
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Ventilation (RA, NP, NIV, VENTI):	RA	RA	RA	RA	RA	RA
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:						
	Temp:	98.5F	98.1F	99.1F	99.5F	98.2F	98.8F
	Res:	22b/m	20b/m	26b/m	22b/m	20b/m	20b/m
	SpO ₂ :	98%	99%	99%	98%	99%	98%
	Pulse:	180b/m	170	166b/m	134b/m	130b/m	127b/m
	BP:	104/68/62	100/62		90/60		93/57/62
	LOC:	conscious	conscious	conscious	conscious	conscious	conscious
	Fall Risk Score:	11	11	11	11	11	11
	Pain Score:	0/10	0/10	0/10	0/10	0/10	0/10
	Skin Integrity	Intact	Intact	Intact	Intact	Intact	Intact
	Safety Needs:	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No
	Physiotherapy:	-	-	-	-	-	-
Others Specify:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
Special Diet:	-	-	-	-	-	-	
Recommendations	Critical Lab Test / Values:	-	-	-	-	-	-
	Other Special Orders / Medications:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	PU Prophylaxis:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	DVT Prophylaxis:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	ADL (Dependent / Non Dependent):	Dependent	Dependent	Dependent	Dependent	Dependent	Dependent
	Post Operative Procedure Special Orders:	-	-	-	-	-	-
Handed Over By Name :		Angel	Angel	Nisha	Teena	Angel	Angel
Signature / ID :		Angel	Angel	Nisha	Teena	Angel	Angel
Date:		15/7/26	15/7/26	15/7/26	16/7/26	16/7/26	16/7/26
Time:		1:30pm	8pm	4:30am	@ 1:30pm	2pm	7:30pm
Taken Over By Name :		Angel	Angel	Angel	Angel	Angel	Angel
Signature / ID :		Angel	Angel	Angel	Angel	Angel	Angel
Date:		15/7/26	15/7/26	16/7/26	16/7/26	16/7/26	16/7/26
Time:		2pm	7:30pm	7:30am	1:30pm	1:30pm	@ 2:30

Handwritten notes at top left.

Handwritten notes at top center.

Main body of handwritten notes, organized in columns.

Handwritten notes at bottom left.

Handwritten notes at bottom center.

Form with multiple sections and checkboxes, including labels like 'APPROVED', 'RECEIVED', and 'DATE'.

NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: <u>Age 2 AFI Acute colitis</u>	Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
	Surgery / Procedure:	Post OP Day:					
BACKGROUND	Date	17/12	17/12	17/12	18/12	18/12	18/12
	Shift	M	E	N	M	E	Night
	Medical Condition (Any special condition to be noted):	Noted	Noted	Noted	Noted	Noted	Noted
	Diet:	Soft bland diet	Soft bland diet	Soft bland diet	Soft bland diet	Soft bland diet	Soft bland diet
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Ventilation (RA, NP, NIV, VENTI):	RA	RA	RA	RA	RA	RA
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:	Temp: 98.2F	98.2F	98.2F	98.1F	98.1F	98F
	Res:	28b/m	30b/m	28b/m	28b/m	24b/m	24b/m
	SpO ₂ :	98%	99%	99%	98.1%	97.1%	98.1%
	Pulse:	114b/m	100b/m	112b/m	100b/m	100b/m	110b/m
	BP:	105/56	105/56	90/61	104/59	102/6	98/54
	LOC:	conscious	conscious	conscious	conscious	conscious	conscious
	Fall Risk Score:	11	11	11	11	11	11
	Pain Score:	0/10	0/10	0/10	0/10	0/10	0/10
	Skin Integrity	Intact	Intact	Intact	Intact	Intact	Intact
	Safety Needs:	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No
	Physiotherapy:	-	-	-	-	-	-
	Others Specify:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
Special Diet:	-	-	-	-	-	-	
Recommendations	Critical Lab Test / Values:	-	-	-	-	-	-
	Other Special Orders / Medications:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	PU Prophylaxis:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	DVT Prophylaxis:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	ADL (Dependent / Non Dependent):	Dependent	Dependent	Dependent	Dependent	Dependent	Dependent
	Post Operative Procedure Special Orders:	-	-	-	-	-	-
Handed Over By Name :	Durg	R. Sreen	Nisha	Vaishnavi	Jayashree	Angel	
Signature / ID :	18/12/26	18/12/26	18/12/26	18/12/26	18/12/26	18/12/26	
Date:	17/12/26	17/12/26	18/12/26	18/12/26	18/12/26	19/12/26	
Time:	1:30pm	@ 7:30pm	@ 7:30am	1:30pm	11:30pm	7:30am	
Taken Over By Name :	Vaishnavi	Angel	Vaishnavi	Angel	Angel	Angel	
Signature / ID :	18/12/26	18/12/26	18/12/26	18/12/26	18/12/26	18/12/26	
Date:	17/12/26	17/12/26	18/12/26	18/12/26	18/12/26	19/12/26	
Time:	1:30pm	7:30pm	7:30am	@ 1:30pm	7:30pm	@ 7:30pm	

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NURSING CARE RECORD

Date: 15/12/2023

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	11 AM	Check - in Fluid Balance	1 PM	Assess the child's neurological Administer Medication Maintain I/O chart	Maintain Fluid Balance Check chart NPO Weight output good	Reassessment Done	Dr. S G. S.
Afternoon	2 PM	To promote Health Education		→ Assessed child condition → vitals monitoring → educate on Hand Hygiene method	Maintained personal Hygiene	Reassessment done	Jay B. S.
Night	7 PM	To Improve Activity tolerance.	8 PM	To check the general condition. To monitor vital signs To maintain I/O chart.	Improved activity level.	Reassessment done	N. S. C. S.

GUC-00079905 IP18-00036478
 Baby SONAL TASHA
 19-12-2023 2 Y 6 M 26 D (F)
 Dr. GANESH R



NURSING CARE RECORD

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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

Date: 16/1/26

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	7am	→ to maintain fluid balance		→ Assessed the fluid balance of the child → Monitored vital signs → Maintained I/O chart → Administered IV fluids as per doctor's order	Employing & maintaining fluid balance.	Child was stable Reassessment was done	Reen 02749
Afternoon	3pm	to promote Health Hygiene		→ Assessed child condition → Encourage oral & Hand Hygiene → Educate Handwash	Maintainance of personal Hygiene	Reassessment done	Jenp 02007
Night	8pm	Maintain good Nutritional Status		→ Assessed child condition → Maintain vital signs and I/O chart → Maintain hand hygiene	Encourage oral intake nutrition pattern was improved	Reassessment was done vital are stable	dy 01890

GUC-00079905

IP18-00036478

Baby SONAL TASHA

19-12-2023

2 Y 6 M 27 D (F)

Dr. GANESH R



NURSING CARE RECORD

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Date: 14.1.24

Goals

- ☐ Maintain Airway and Oxygenation
☐ Maintain Personal Hygiene
☐ Identify Potential Complications

- ☐ Relieve Pain & Discomfort
☐ Prevent Infection
☐ Any Others. Specify.....

- ☒ Maintain Fluid Balance
☒ Meet Elimination Needs

- ☐ Improve Activity Tolerance
☐ Ensure Safety

- ☒ Maintain Good Nutritional Status
☒ Early Ambulation Reduce Anxiety

- ☐ Maintain Skin Integrity
☐ Patient & Family Education

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8am	Maintain Nutritional Status	9am	Assess child condition Monitor vitals Administered medicine Maintain Hydration	Maintain good nutrition status Engaged the child enter.	Reassessment done child well enter is good	Dr. S. 19/12/23
Afternoon	3pm	→ to maintain fluid balance of the child		→ assessed the fluid balance of the child → monitored vital signs → maintained on chart → Administered fluids as per doctor's order	→ Improving and maintaining fluid balance of the child	child was stable Reassessment was done	R. S. 01/01/24
Night	8pm	to prevent infection.	9pm	→ Assess the general condition. to monitor vital signs. to maintain hand hygiene.	Infection will be prevented.	Reassessment was done.	Dr. S. 01/01/24

GUC-00079905 IP18-00036478
 Baby SONAL TASHA
 19-12-2023 2 Y 6 M 28 D (F)
 Dr. GANESH R



NURSING CARE RECORD

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Date: 12/7/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	7:30am	To prevent infection	8am	= assessed general condition. = monitored vital signs = monitored I/O chart	To Improve child condition	Improving child condition	no over
Afternoon	2pm	To promote Health Hygiene		- Assessed child condition - vital monitoring - encourage oral & Hand Hygiene	maintained personal Hygiene	Reassessment done	deep
Night	8pm	maintain good Nutritional Status		Assessed child condition => maintain vital signs and I/O chart => maintain I.V. medication	Improved fluid volume	Reassessment was done vital are stable	Shy 6/8/2026



NURSES NOTES

☐ No Known Drug Allergies

☐ Drug Allergies Nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		→ Receiving Notes ←	
	11.5 Am	Child received from ER to 4th Floor. Child details Handing over taken from ER duty S/N. Child was conscious & oriented. Appear pleasant & cooperative. Child cough the room air. Child appear from morning.	PS Durg 19/12/24
	11.30 Am	Vitals are checked & noted. Vitals are stable / RR / CP / CR / No AR / PR - 180b/m.	
	12.30 pm.	CVF - DRS - 500ml to 400ml/hr. Urine culture send to the Labu.	PS Durg 19/12/24
	12.45m	Inf x one - strong IV green s/s in s/s. No any allergic reaction. Dr. Kaethirasan Sir came & seen the child advised beds the needles.	
	1.30pm.	Dr. Ganesh sir phone call Bedd. Dr. Kaethir Sir open vgs. Done. Child details Hand over given to the ER duty S/N.	PS Durg 19/12/24

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



NURSES NOTES

☐ No Known Drug Allergies

☐ Drug Allergies Nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE						
19/12/23	1.30 pm	Evening Duty Notes :- child details handing over taken from morning duty s/n - child conscious & oriented. Child activity are good & lively. @ no swelling, pain. I.V.F - D.W.S - 10ml/hr							
	3pm	Due medication are given as per drug chart order. I.V.F - D.W.S - 10ml/hr ongoing vital signs checked & recorded vitals are stable now <table><tr><td>Cp</td><td>pp</td><td>CHT</td></tr><tr><td>++</td><td>++</td><td>23</td></tr></table>	Cp	pp	CHT	++	++	23	
Cp	pp	CHT							
++	++	23							
	4pm	Dr. Karthik sir seen by child/ advised by to do urine routine. Due medication are given as per drug chart order.							
	5.15 pm	Dr. Chandrasekhar mam seen by child advised by NPO broken. NPO broken water given as per order.							
	7pm	SlO chart maintained. Handing over given to night duty s/n							
	7:30 pm		Jeeva George						

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



NURSES NOTES

☒ No Known Drug Allergies

☐ Drug Allergies

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE						
15/12	7.30pm	13/12/2026. ON Night duty → The child depik's handing over taken from evening duty shift. Night duty shift. The child is conscious and oriented. I/v line present. no pain no swelling. I/v line pattern.	nsg / 019801						
	7.30pm	DR. Ganesh sir seen by a child he advised to do Echo. for HR-168b/min and to check Antibiotic Ds-piphe. and continue monitoring the child.	nsg / 019801						
	8pm	vital signs are checked and recorded. vital are stable.	nsg / 019801						
		<table><tr><td>AP</td><td>PP</td><td>CP</td></tr><tr><td>11</td><td>11</td><td>15</td></tr></table>	AP	PP	CP	11	11	15	
AP	PP	CP							
11	11	15							
	9pm	child had fever spike T-101°F. sup-cadol 150mg (3ml) P/O given. v/s per drug chart order.	nsg / 019801						
	10.30pm	DR. Greethe. mam. seen by a child. v/s per DR. Ganesh sir advised. man advised. I/v PL. 300ml over 4hrs. followed by, I/v 0.9DMS 100ml/hour (500ml add. to add Allerga 8mg. 3.5ml BP order. followed.	nsg / 019801						

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



NURSES NOTES

☐ No Known Drug Allergies

☐ Drug Allergies

191.

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
16/12/26	12am	continue note 16/12/26 vital signs are checked and record. vital are stable CP PP CRT ++ ++ 18cc	ng 018901
	1:30am	Rx fluid continue RI 300ml order 4hr @ 75ml per hr on flow Child sleeping pattern was good child Rx cannula pattern - Child Glo chart maintained -	dy 018902
	2am	Temp 102.4 Syp. p250 3ml given as per doctor's order Heart rate 170b/min informed to Dr. Geetha mam advise watch for fever spike.	dy 018902
	2:45am	Rx fluid DNS 500ml + 5ccel @ 40ml per hr on flow Dr. manonmani mam seen the child continue same medication.	
	4am	vital signs checked and Recorded vital are stable CP PP CRT ++ ++ 18cc	dy 018902
	6am	Due to medication was given as per doctor's order Glo chart maintained	dy 018902

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



NURSES NOTES

☐ No Known Drug Allergies

☐ Drug Allergies

Nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE						
16/1/26	7:30 AM	→ continue 16/1/26 ← The child details handed over given to morning duty staff nurse.	ms/02149						
16/1/26	7:30 AM	Morning duty notes on 16/1/2026 child details handed over from night duty staff nurse using IPBAS method. on Assessment child is conscious, oriented and well perfused. O2 - 15%, Skin assessment done no rashes present and no pain at suture on IVF line + Endo @ 40ml/hr	Rfer 02149						
	9 AM	Vitals checked and recorded all are haemodynamically stable <table border="1"><tr><td>CP</td><td>PP</td><td>CRF</td></tr><tr><td>18</td><td>11</td><td>13 Sec</td></tr></table>	CP	PP	CRF	18	11	13 Sec	Rfer 02149
CP	PP	CRF							
18	11	13 Sec							
	9 AM	Due medication given as per the drug chart	Rfer 02149						
	11 AM	Dr. Anand su. came and seen informed about the patient condition advised to follow as per previous notes	Rfer 02149						
	11:45 AM	Under Arpie technique. 24A Keflon was inserted by Shivan Sealed with patent and flushings done							

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



NURSES NOTES



☒ No Known Drug Allergies

☐ Drug Allergies Not known

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		← continue note →	
16/12/23	12pm	Vitals checked and recorded, all are hemodynamically stable	Rfery 020149
		QP 1x NP 1x GR 1x C2500	
		Infuse + mil fed @ 2ml/hr	
		Skid on flow	
	1pm	Shift to shift maintained	Rfery
	130pm	child details handed over to evening duty staff nurse wing	020149
		Evening duty staff nurse wing	
		Evening duty notes :-	
	1.30pm	child details handing over taken from morning duty S/N. child conscious & oriented. child activity are good. In line @. No swelling & pain	
	2pm	Due medication are given as per drug chart order. Dr. Ganesh sir seen by child advised by to do paracetamol.	
		paracetamol done 1st. 1st sample. @ followed.	Jay 020149

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



NURSES NOTES

☐ No Known Drug Allergies

☐ Drug Allergies

nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
16/12/26	4pm	vital signs checked & recorded vitals are stable now cp pp crt tt tt 220	Jay 020042
	5pm	Dr. Keerthirajan sir seen by child advised by add Phy- metrogel. informed Dr. Ganesh sir advised by add phy. metrogel.	
	6pm	Due medication are given as per drug chart orders. Bio chart maintained	Jay 020042
	7.30 P	Handing over given to night duty staff nurse	
		→ Night duty On: 16/12/26 ←	
	12.30pm	child details band over taken from evening duty staff child is conscious & oriented	Dy 018950
	8pm	Child IV cannula patteen — vital signs checked and Recorded vitals are stable. cp pp crt tt tt 230	Dy 018950
		Dr. Ganesh sir. seen the child/ sir advise to fluid continue same medication	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



NURSES NOTES

☐ No Known Drug Allergies

☐ Drug Allergies

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
16/1/26		→ continue 16/1/26 ← Due to medication was as per doctor's Order - child take soft bland diet -	dy 018950
	10pm	IV fluid DNS 500ml + 500ml @ 40 ml per hr flow -	
	12am	vital Sign's checked and Recorded vital are stable CP PP CRT TT TT L3cc	dy 018950
		child IV cannula patteen - child Bleeping patteen was good No any complaints -	
	4am	vital Sign's checked and Recorded vital are stable CP PP CRT TT TT L3cc	dy 018950
	6am	Due to medication was given as per doctor's Order - Glo chart maintained -	
	7:30am	Child details hand Over given to morning duty staff -	dy 018950

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



NURSES NOTES

Known Drug Allergies

☐ Drug Allergies *Nil.*

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
17/12/23	7.39 AM	<i>→ Morning Duty 17/12/23 ←</i> child details Handing over taken from night duty S/N. Child was conscious, oriented & eye present & pattern. Child under the loose air and had left hand dilt.	<i>PS Durg 21/9/24</i>
	8 AM	Vitals are checked & recorded. Vitals are stable / PP / CP / CRT / Free neebletm / H / H / C3S / given as per drug chart order.	<i>PS Durg 21/9/24</i>
	10 AM	encouraged the oral intake.	
	10 AM	Maintained the flow chart.	
	11.30 AM	Dr. Ganesh sir. came & seen the child advise to encourage the oral intake continue further treatment	
	12 PM	Vitals are checked & recorded. Vitals are stable / PP / CP / CRT / Maintained flow chart / H / H / C3S /	<i>PS Durg 21/9/24</i>
	1	NP - DMS - 500ml to 1000ml - 20ml/hr.	
	1.30 PM	child details Handing over given to the evening duty.	<i>PS Durg 21/9/24</i>

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



NURSES NOTES

☒ No Known Drug Allergies

☐ Drug Allergies NOT KNOWN

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE						
17/12/26	1:30 pm	<u>Evening duty notes on 17/12/26</u> Child details taken over from morning duty staff nurse during ISBAR received. on Assessment, child is conscious, oriented and afebrile. Card. RHR 115, SpO2 Assessment done. IV line is present and patent, no pain at site, on INF Drip @ 25ml/hr on flow.							
	2 pm	Drug medication given as per the drug chart	Rfer OSRUG						
	3 pm	Drug medication given as per the drug chart							
	4 pm	Vitals checked and recorded, all are haemodynamically stable	Rfer OSRUG						
		<table border="1"><tr><td>Q</td><td>PP</td><td>CR</td></tr><tr><td>TS</td><td>TS</td><td>C3B0</td></tr></table>	Q	PP	CR	TS	TS	C3B0	
Q	PP	CR							
TS	TS	C3B0							
	4:30 pm	Dr. Chandrasekhar came and seen informed about the child condition, advised to follow as per progress note	Rfer OSRUG						
	7 pm	Strict I/O chart maintained							
	7:30 pm	Child details handed over to night duty staff nurse	Rfer OSRUG						

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



NURSES NOTES

☐ No Known Drug Allergies

☐ Drug Allergies

NP 1

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
17/1	7:30pm	← 17/12/23 ON Night duty → The child details handing over taken from evening duty to night duty. The child is conscious and oriented. Dr line Present. no pain, no swelling. Dr line pattern 8pm vital signs are checked and recorded. vital are stable CP PP CRT AT HT CSE	NP 1 09/01 NP 1 09/01
	10pm	Dr medication was given as per doctor's order. Dr f DMS given. Dr on follow up. vital signs are checked and recorded. vital are stable. CP PP CRT AT HT CSE	NP 1 09/01
18/1	12AM	2AM child sleeping well. no other complains pain, vomiting. 4AM vital signs are checked and recorded. vital are stable CP PP CRT AT HT CSE	NP 1 09/01 NP 1 09/01
	6AM	Dr medication was given as per doctor's order. Dr chart was maintaining	NP 1 09/01

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

NURSES NOTES

☐ No Known Drug Allergies

☐ Drug Allergies

NP 1

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		continue notes	
12/1	7:30am	The child details handing over given to morning duty staff.	ms/001
		→ morning duty ←	
	7:30am	child taken over from night duty staff conscious & awake.	ms/001
	8am	vital signs checked & recorded No other complaints.	
		PP UP CRT H H 1300	
	9am	two medication's are given as per doctor's order.	ms/001
	10am	IV line @ present & patent.	
	12pm	vital signs checked & recorded No other complaints.	
		PP UP CRT H H 1300	
		No chart maintained.	ms/001
		Dr. Ganesh see the advised to stop oral medication syp. Allegra & sal. Preprokid IVF stop. TOM - CRP (19/12/26)	ms/001
	1:30pm	child handing over given to evening duty staff	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



NURSES NOTES

☐ No Known Drug Allergies

☐ Drug Allergies

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE						
12/12	1.30 pm	Evening Duty Notes :- child detail							
		handing over taken from morning duty staff. child conscious & oriented. child activity are good. In 1pm @ No swelling & pain. WIF- stop.	Jay 20/12/23						
	2pm	vital signs checked & recorded one medication one given as per drug chart order.							
	4pm	vital signs checked & recorded vital are stable now <table><tr><td>CP</td><td>PP</td><td>CHR</td></tr><tr><td>11</td><td>11</td><td>12</td></tr></table>	CP	PP	CHR	11	11	12	Jay 20/12/23
CP	PP	CHR							
11	11	12							
	5pm	Ho chart is maintained No any other complaints							
	6pm	Administer the medication as per doctor's order							
	7.30pm	The child details handover given to night duty staffs	Jay 01/01/24						
		→ Night duty On: 18/12/23 ←							
	1-30pm	child details hand over taken from evening duty staff. child is conscious & oriented	Jay 01/01/24						

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



NURSES NOTES

☐ No Known Drug Allergies

☐ Drug Allergies Nil.

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
18/11/26	8pm	→ continue 18/11/26 + vital sign's checked and Recorded vital are stable CP PP LRT ++ ++ 13ec	dy 01890
		Dr. Ganesh Bir seen the child Bir advise from CRP need to send continue same medication child intake was good	
	10pm	Due to medication was given as per doctor's order. No chart maintained	
	12am	vital sign's checked and Recorded vital are stable CP PP CRT ++ ++ 13ec	dy 01890
	2am	child sleeping pattern was good IV cannula pattern no any complaint's	dy 01890
	4am	Vital sign's checked and Recorded vital are stable CP PP LRT ++ ++ 13ec	
		morning sample CRP send Report need to follow	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



NURSES NOTES

☐ No Known Drug Allergies

☐ Drug Allergies

N91

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE						
19/1/26	6am	→ Continue 19/1/26 Due to medication was given as per doctor's order Sp chart Maintained No any complaints	dy 01890						
	7:30am	Child details hand over given to morning duty staff	dy 01890						
		Morning duty Notes on 19/1/26							
	7:30am	The child details handover taken from the night duty staff The child is conscious and active	dy 015260						
	8am	Administer the medication as per doctor's order vitals are checked and recorded temp is normal							
		<table><tr><td>PP</td><td>++</td></tr><tr><td>CP</td><td>++</td></tr><tr><td>CRT</td><td>CRS</td></tr></table>	PP	++	CP	++	CRT	CRS	
PP	++								
CP	++								
CRT	CRS								
	10am	Sp chart is maintained No any other complaints	dy 015260						
	10:40am	Dr. Ganesh's rounds was done adv! to plan discharge tomorrow							
	12pm	vitals are checked and recorded temp is normal							
		<table><tr><td>PP</td><td>++</td></tr><tr><td>CP</td><td>++</td></tr><tr><td>CRT</td><td>CRS</td></tr></table>	PP	++	CP	++	CRT	CRS	
PP	++								
CP	++								
CRT	CRS								
	1:30pm	The baby details handover given to Evening duty staff	dy 015260						

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



NURSES NOTES

☐ No Known Drug Allergies

☒ Drug Allergies Not Known

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
19/12/26	1:30 PM	Evening duty notes on 19/12/2026 child details taken over from morning duty staff nurse using ISBAR method. on Assessment, child is conscious, oriented and alert. vital signs stable. no pain or tenderness and patient.	Rfer 02/12/26
	2 PM	Due medication given as per the drug chart	Rfer 02/12/26
	3 PM	Due medication given as per the drug chart	Rfer 02/12/26
	4 PM	vitals checked and recorded all are haemodynamically stable	Rfer 02/12/26
		G PP CRT H A C3sec	
	7 PM	Child Eto chart maintained	Rfer 02/12/26
	7:30 PM	Child details handed over to night duty staff nurse	
19/12	7:30 PM	19/12/26 ON Night duty The child details handing over taken from evening duty to night duty staff. The child is conscious and oriented. Dr lie dressed. no pain, no swelling Dr lie pattern.	Rfer 02/12/26

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Patier¹¹ - Alamo

GUC-00079905

IP18-00036478

Baby SONAL TASHA

MRD

19-12-2023

2 Y 6 M 26 D

(F)

No.:.....

Age :



.....Sex: ☐ M ☐ F

Consultant :

PHLEBITIS ASSESSMENT

CANNULA 1

Date : 15-07-2026.

Time: 10:30am

Location: left Metacarpal

Size : 24 C

Cannula inserted by : Dr Kavitha

CANNULA 2

Date : 16/7/22

Time: 11:00

Location: 21st - Mukampel

Size : 240

Cannula inserted by: S/N 100240mm

[illegible]

Cannula removed : ☐ Yes ☐ No, if yes date and time : 10/12/26
RX any initiated : ☐ Yes ☐ No ☐ NA If Yes specify-
Phlebitis score: 9. 30Am

Date	Time	Phlebitis	Infiltration	Nursing Intervention	Sign
16/7	12pm	☐ Yes ☒ No	☐ Yes ☒ No	observe	Red
	2pm	☐ Yes ☒ No	☐ Yes ☒ No	observe	Red
	3pm	☐ Yes ☒ No	☐ Yes ☒ No	observe	Red
	6pm	☐ Yes ☒ No	☐ Yes ☒ No	observe	Red
	8pm	☐ Yes ☒ No	☐ Yes ☒ No	observe	Red
	10pm	☐ Yes ☒ No	☐ Yes ☒ No	observe	Red
17/7	12am	☐ Yes ☒ No	☐ Yes ☒ No	observe	Red
	2am	☐ Yes ☒ No	☐ Yes ☒ No	observe	Red
	4am	☐ Yes ☒ No	☐ Yes ☒ No	observe	Red
	6am	☐ Yes ☒ No	☐ Yes ☒ No	observe	Red
	8am	☐ Yes ☒ No	☐ Yes ☒ No	observe	Red
	10am	☐ Yes ☒ No	☐ Yes ☒ No	observe	Red
	12pm	☐ Yes ☒ No	☐ Yes ☒ No	observe	Red
	2pm	☐ Yes ☒ No	☐ Yes ☒ No	observe	Red
	4pm	☐ Yes ☒ No	☐ Yes ☒ No	observe	Red
	6pm	☐ Yes ☒ No	☐ Yes ☒ No	observe	Red
	8pm	☐ Yes ☒ No	☐ Yes ☒ No	observe	Red
	10pm	☐ Yes ☒ No	☐ Yes ☒ No	observe	Red
18/7	12AM	☐ Yes ☒ No	☐ Yes ☒ No	observe	Red
	2AM	☐ Yes ☒ No	☐ Yes ☒ No	observe	Red
	4AM	☐ Yes ☒ No	☐ Yes ☒ No	observe	Red
	6AM	☐ Yes ☒ No	☐ Yes ☒ No	observe	Red
	8am	☐ Yes ☒ No	☐ Yes ☒ No	observe	Red
	10am	☐ Yes ☒ No	☐ Yes ☒ No	observe	Red
	12pm	☐ Yes ☒ No	☐ Yes ☒ No	observe	Red
	2pm	☐ Yes ☒ No	☐ Yes ☒ No	observe	Red
	4pm	☐ Yes ☒ No	☐ Yes ☒ No	observe	Red

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 :

[illegible]

Gannula removed: ☒ Yes ☐ No, if yes date and time: 1/9/7/20
RX any initiated: ☐ Yes ☒ No ☐ NA If Yes specify-
Phlebitis score: 105 ac pan

CANNULA 4

Date : 19/5/26 .

Time: 6ams

Location : (1) Brachial .

Size : 22G

Cannula inserted by: S/N. Goolwin.

[illegible]

Cannula removed : ☐Yes ☐No, if yes-date and time :
RX any initiated : ☐Yes ☐No ☐NA If Yes specify-
Phlebitis score: 183

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



THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	N DATE	E DATE	N DATE	M DATE	E DATE
Age	Less than 3 years old	4	15/7	15/7	15/7	15/7	16/7
	3 to less than 7 years old	3	4	4	4	4	4
	7 to less than 13 years old	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	2	2	2	2	2
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	1	1	1	1	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			11	11	11	11	11

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		-	-	N/A	N/A	-
Other Intervention(s) Specify		-	-	N/A	N/A	-
Nurse's Name:		Arish Jadhav	NISHA	Jessica	Jadhav	
Signature:		Arish Jadhav	NISHA	Jessica	Jadhav	
Date:		15/7	15/7	15/7	16/7	16/7
Time:		8pm	8pm	8pm	8pm	8pm

GUC-00079905

IP18-00036478

Baby SONAL TASHA

19-12-2023

2 Y 6 M 27 D

(F)

Dr. GANESH R



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

BirthRight[™]
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	16/1	17/1	17/1	17/1	18/1
	3 to less than 7 years old	3	4	4	4	4	4
	7 to less than 13 years old	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	4	4	4	4	4
	History of Falls or Infant-Toddler Placed in Bed	4	4	4	4	4	4
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2	2	2	2	2
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	1	1	1	1	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			14	14	14	14	14

Intervention:

-Fall Risk: Low Humpty Dumpty Score = 7-11,

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		✓	✓	✓	✓	✓
Call device within reach		✓	✓	✓	✓	✓
Wheels Locked		✓	✓	✓	✓	✓
Room free of clutter		✓	✓	✓	✓	✓
Adequate lighting		✓	✓	✓	✓	✓
Wheel chair support		✓	✓	✓	✓	✓
Other Intervention(s) Specify		✓	✓	✓	NA	NA
Nurse's Name:		Angel	Auf	Esra	NISHA	Kalpana
Signature:		Angel	Auf	Esra	NISHA	Kalpana
Date:		16/12/2023	17/12	17/12	17/12	17/12
Time:		8pm	8am	2pm	8pm	8am



THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	12/1	18/1	19/2	19/2	19/1
	3 to less than 7 years old	3	4	4	4	4	4
	7 to less than 13 years old	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					
Cognitive Impairments	Not aware of Limitations	3	1	1	1	1	1
	Forget Limitations	2					
	Oriented to own ability	1					
	History of Falls or Infant-Toddler Placed in Bed	4	4	4	4	4	4
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2	2	2	2	2
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	1	1	1	1	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					
Total			14	14	14	14	14

Intervention:

-Fall Risk: Low Humpty Dumpty Score = 7-11,

High Risk/Humpty Dumpty Score = 12 or above

Bed in low position		✓	✓	✓	✓	✓
Call device within reach		✓	✓	✓	✓	✓
Wheels Locked		✓	✓	✓	✓	✓
Room free of clutter		✓	✓	✓	✓	✓
Adequate lighting		✓	✓	✓	✓	✓
Wheel chair support		✓	✓	NA	NA	NA
Other Intervention(s) Specify		✓	✓	NA	NA	NA
Nurse's Name:		Jatige	Angel	Artho	Seena	Nisha
Signature:		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date:		12/1	18/1	19/2	19/2	19/1
Time:		2pm	8pm	2am	2pm	8pm

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GUC-00079905

IP18-00036478

Baby SONAL TASHA

19-12-2023 2 Y 6 M 28 D (F)

Dr. GANESH R



BRADEN 'Q' SCALE

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

 BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

					Date :	15/12	15/12	15/12	16/12
					Time :	10pm	10am	8pm	8am
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 of 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 meat and dairy products. Occasionally eats between meals. Does not require supplementation.	1	1	2	2	
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					28	25	26	26	
Evaluator's Name					P. D. G. S. R.	J. S. R.	M. S. R.	P. S. R.	

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	⑩ Regular Turning Schedule ⑩ Enable as much activity as possible ⑩ Protect the heels ⑩ Use pressure redistribution surfaces ⑩ Manage moisture, friction and shear ⑩ 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	⑩ Use the Same Protocol as for "At Risk" Patients ⑩ 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	⑩ Follow the same protocol as for "Moderate Risk" Patients ⑩ In addition to regular turning schedule ⑩ 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	⑩ Use same protocol as for "High Risk" Patients ⑩ 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

IP18-00036478

(F)

GUC-00070805
BABY SONAL TASHA
2 Y 6 M 28 D
19-12-2023
Dr. GANESH R



BRADEN 'Q' SCALE (for Paediatric use)

☐ M ☐ F IP No. : 16KT 16/11/2019

E N M

Date :

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 lim Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	16KT 16/11/2019	1257
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
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
1. Consistently 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
1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times.	4	4
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 of 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 meat and dairy products. Occasionally eats between meals. Does not require supplementation.	2	3
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
Moisture Degree to which skin is exposed to moisture	Friction-SHEAR Friction Occurs: when skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	Nutritional Usual food intake pattern	Tissue Perfusion & Oxygenation	26	27
TOTAL SCORE				26	27
Evaluator's Name				Dr. Ganesh R	20/11/19

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

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Ref. No.: FHW/BRD-0/NSG/04

Activity	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.
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.
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.
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.
FRICTION-SHEAR Friction Occurs when skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problems: Statically, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problems: 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 problems: 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 problems: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to lie up completely during move. Maintains good position in bed or chair at all times.
Nutritional Usual food intake pattern	1. Very Poor: NP/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 of 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 meat and dairy products. Occasionally eats between meals. Does not require supplementation.
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.

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

TOTAL SCORE		Evaluator's Name	
27	27	ms	ms
28	28	ms	ms



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
15/12	12pm	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	Nil	Dr. S. 01/12/24
15/12/26	4pm	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	Dr. S. 01/12/24
15/12/26	10pm	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	Dr. S. 01/12/24
16/12/26	9am	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	Nil	Dr. S. 01/12/24
16/12/26	10am	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	Nil	Dr. S. 01/12/24
16/12/26	2pm	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	Dr. S. 01/12/24
16/12/26	8pm	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	Nil	Dr. S. 01/12/24
17/12/26	4am	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	Nil	Dr. S. 01/12/24
17/12/26	8am	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	Nil	Dr. S. 01/12/24
17/12/26	2pm	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	Nil	Dr. S. 01/12/24

Re-assessment Frequency:

- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 - 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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



Wong - Baker (Pediatrics) Above 7 Years



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

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

GUC-00079905

IP18-00036478

Baby SONAL TASHA

19-12-2023 2 Y 6 M 27 D (F)

Dr. GANESH R



PAIN ASSESSMENT FORM

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

BirthRight[™]
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
17/1/26	8pm	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NPI	ngt/019001
18/1/26	4am	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NPI	ngt/008001
18/1/26	8am	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NPI	ngt/008001
12/1	2pm	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NPI	ngt/008001
18/1	8pm	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NPI	ngt/018900
19/1	4am	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NPI	ngt/018900
19/1/26	8am	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NPI	ngt/018900
19/1/26	2pm	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NPI	ngt/018900
19/1/26	8pm	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NPI	ngt/018900
20/1/26	4pm	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NPI	ngt/018900

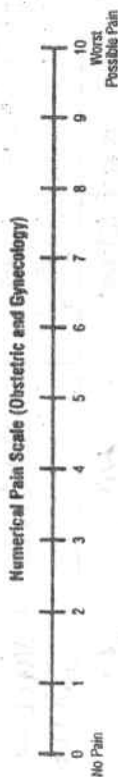
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- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours.
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.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

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

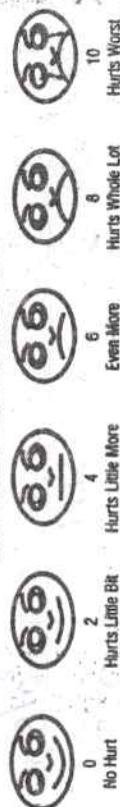
CATEGORY	SCORING		
	0	1	2
Face	No Particular expression or smile	Occasional Grimace or Frown, withdrawn, Disoriented	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs drawn up
Activity	Laying quietly normal position, moves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



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

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

Wong - Baker (Pediatrics) Above 7 Years



GUC-00079805 IP18-00036478
 Baby SONAL TASHA
 19-12-2023 2 Y 6 M 26 D (F)
 Dr. GANESH R



INTERDISCIPLINARY

IT / FAMILY EDUCATION RECORD

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Part - I.

Patient's / Learner Language: Tamil Patient / Learner Literacy: ☐ Read ☒ Write ☒ Speak Willingness to Learn: Yes ☒ No Healthcare Literacy: ☐ Yes ☒ No

Identified Education Needs:

- | | | | |
|-----------------------|--|---------------------------------|---|
| 1. Diagnosis | Plan | 6. Discharge Medication | 10. Fall Risk Education |
| 2. Treatment and Care | 3. Pain Management | 7. Infection Control Measures | 11. Safe use of Medical Equipment / Implantable Devices |
| | 4. Informed Consent | 8. Diagnostic Test / Procedures | 12. Patient's / Family Rights |
| | 5. Medication / Therapy (safety, effects/ side effect, interactions) | 9. Nutrition / Diet | 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		
15/7	12pm	Feetus care	explained about the paediatric treatment & care.	Mother	No Learning Barriers	Oral	None	Verbalize understanding	Good	Dr. Ganesh R
16/7	8am	Drugging care	explained about the importance of drugging care.	Mother	None	Oral	None	Verbalize understanding	Good	Dr. Ganesh R
17/7	8am	Nutrition	encouraged the oral intake advised to avoid oral feeds.	Mother & Father	No Learning Barriers	Oral	None	Verbalize understanding	Good	Dr. Ganesh R
18/7	8am	Infection control measure	Health education given about infection control measures	Mother	NO	Oral	None	Verbalize good	Good	Dr. Ganesh R

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							

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

QUC-00079905
Baby SONAL TASHA
19-12-2023
Dr. GANESH R
IP18-00036478
2 Y 7 M 0 D
(F)

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Part - I.

Patient's / Learner Language: Patient / Learner Literacy: ☐ Read ☐ Write ☐ Speak Willingness to Learn: No Healthcare Literacy: Yes ☐ No ☐

Identified Education Needs:

- | | | | |
|-----------------------|--|---------------------------------|---|
| 1. Diagnosis | Plan | 6. Discharge Medication | 10. Fall Risk Education |
| 2. Treatment and Care | 3. Pain Management | 7. Infection Control Measures | 11. Safe use of Medical Equipment / Implantable Devices |
| | 4. Informed Consent | 8. Diagnostic Test / Procedures | Safety |
| | 5. Medication / Therapy (safety, effects/ side effect, interactions) | 9. Nutrition / Diet | 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		
17/12/23	8am	Nutrition	Encouraged to take more oral intake	Mother	no	oral	None	keeps like understanding	-	5/15/23
20/12/23	8am	Infection control	Explained the parents in hand hygiene & hand washing technique	Mother & Father	None	Oral	None	keeps like understanding	Good	Dr. Ganesh R.

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		4. Language Barrier		7. Impaired Thought Process/Cognitive limitations		10. Financial Difficulties		13. Cultural/Religion Practice					
2. Physical Impairment		5. Educational Level		8. Responsibilities at Home		11. Beliefs and Values		14. Others (Specify)					
3. Emotional Barriers		6. Desire / Motivate to Learn		9. Cultural Differences		12. Impaired Vision/ or Hearing							
Teaching Tools Used: A: Audio D: Demonstration V: Video O: Oral P: Printed													
Mechanism/s to overcome barrier/s:													
1. None		3. Reassurance & Support		5. Respect values & beliefs		7. Other, Specify							
2. Obtain translator		4. Teach Family / Others		6. Respect Cultural / Religion Preference									
Understanding: 1. Verbalizes Understanding 2. Demonstrates Understanding 3. Needs Review													



Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 11:57 AM Mode of Arrival: Private car Admitting From: ☒ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction

Nil

Body Weight: 10.3 Kg

Height: cm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
<u>HRB 2026, March, 2026, 2026, 2026</u>	<u>—</u>	<u>PCH 2026</u>

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:

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

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

Observations: Weight: 10.3 kg Length: 86 cm Head Circumference (< 2 years):
 Temp: 98.6 F HR: 180 bpm RR: 28 bpm BP: 104/58/60 mmHg

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

Fall Risk Assessment: ☒ Yes ☐ No Score: 11 (Document in the Humpty Dumpty Sheet)

Risk of Pressure Sore (Braden Q Score 25) (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 parents

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 parents

Nurse's Name: P.S. Ruyjs Date: 15/12/26 Time: 12pm

Signature

P.S. Ruyjs
0693524



NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date: 15/07/26 Time of arrival: 6.00am
 Chief Complaints: H/O Vomiting x 8 episodes stomach pain RBS: 101 mg/dl
 Height: Weight: 10.3kg BMI: Head Circumference (<2 years)
 Allergies: ☐ Yes ☒ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other: NIL
 If yes, identify
 Pain Screening: ☐ Yes ☒ No If Yes, Pain Score: 0 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): 15.07.2026

Social History: Lives With Patient

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

Time of Initial assessment completed by ER Nurse: 6.10 PM

Time	Nursing Notes
9.50pm	Child Come with Complaints of fever, 1 day Unsettling, episodes, Stomach pain. Monitored vital Signs & Recorded. D/v Placement Done Samples Collected and Sent to Lab. Shifted for further Management

Samples collected by: Dr/Kawitha
 Samples sent by: Godwin

Time: 10:30am
 Time: 10:35am

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1
6.25am	inj. Emeset	IM	1mg		
6.45am	Nexpro Junior	P/O	1 Sac		
7.20am	Syp. Ibuprofen	P/O	0.5 ml.		
8.30am	Syp. P-850	P/O	0 ml.		

Condition of patient at time of shift - out :	Details of Shift - out
HR: 175b/min BP: CFT: 2.2cm RR: 30b/min SPO ₂ : 100% RA GCS: 15/15 Temperature: 101.5°F Pain Score: 02 Repeat RBS (if applicable): -	Shift - out from ER to: 206. Time of Shift - out: 11AM Handover given to: S/M Anuja (Nurse's Name)

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any): D/v Placement Done
 Left Mettra Cappel. etc.

Name of the Nurse: Godwin Anur.
 Signature of the Nurse:
 Date & Time: 15.07.2026 @ 10:00PM

Admitting Doctor : Dr. Ganesh Date : 15/7/26

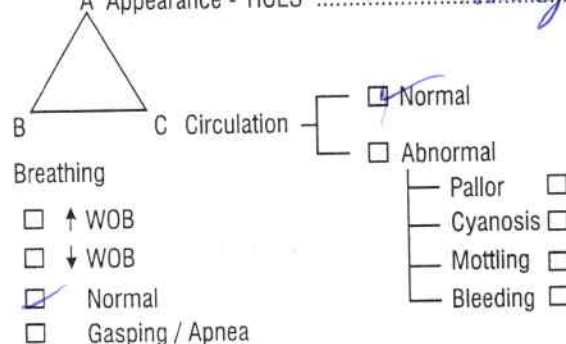
Type of Admission: ☐ OPD ☒ ER ☐ Referral (if referral, Doctor's Name: _____)

Start Time of Assessment: 6am Weight: 10.3kg

Allergic History: _____

clo vomit
Abd. pain
Fever

A Appearance - TICLS Dull looking.....



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:

Airway

☒ Open
☐ Maintainable
☐ Not Maintainable

Any urgent interventions needed: ☐ Yes ☒ No

If Yes

Breathing

Rate: 30 ml/h SpO₂ on FiO₂ 100% 1 ml

Rhythm: *regular*

Retractions: ☐ Suprasternal ☐ ICR ☐ SCR

☐ Sternal ☐ Supraclavicular ☐ Nasal Flaring

Respiratory Noises: ☐ Stridor ☐ Wheezing ☐ Grunting

Air Entry: equal

Palpation Findings (if necessary).....

Any urgent interventions needed: ☐ Yes ☒ No

If Yes

**Circulation**

HR: 100/min

CFT ☐ Central ☒ Peripheral *13 sec*Any urgent interventions needed: ☐ Yes ☒ No

BP: 98/63 mmHg

Pulse Volume: ☐ Central ☒ Peripheral *1 grad*If in Shock: ☐ Compensated ☐ HypotensiveMuffled Heart Sound: ☐ Yes ☐ NoEngorged Neck Veins: ☐ Yes ☐ NoMurmurs: ☐ Yes ☐ No

Liver Span:

ECG:

Any Signs of Heart Failure: ☐ Yes ☐ No

If Yes

**Disability**

GCS: 15/15

AVPU: *Dull looking*Any urgent interventions needed: ☐ Yes ☒ NoPupils: ☒ Responsive ☐ Non-ResponsiveSize: ☐ Right ☒ Left *3 mm*Active Seizures: ☐ Yes ☐ No Sugars:

Signs of Neurological compromise

If Yes

Exposure

Temp: 98.1°F

Any Rash: ☐ Yes ☐ No

If yes describe the rash

Active bleed

Lacerations ☐ Abrasions ☐ bruises ☐

Describe:

Any urgent interventions needed: ☐ Yes ☒ No

If Yes

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

Head to toe examination with positive findings:

Labs Planned:**Treatment Planned:***Mentioned inside*Need for Oxygen: ☐ Yes ☐ Noif yes Low Flow ☐High Flow ☐PPV ☐

Final Diagnosis with possible Differential Diagnosis (If necessary):

Assessment done by

Name of the Doctor: *Dr. Kavitha*Signature: *[Signature]*

Date & Time: 15/7/26 6:15am

Sr. Doctor on Duty (If necessary)

Name of the Sr. Doctor:

Signature:

Date & Time:

[illegible]

Baby SONAL TASHA

19-12-2023 2 Y 6 M 26 D (F)

Dr. GANESH R



EMERGENCY ROOM TRIAGE FORM

Patient's Name: Baby: sonal TashaDate: 1st DecAge: 24 mthGender: ☐ Male ☒ FemaleTime of Arrival: 6:00 AMAllergies: ☒ No ☐ Yes ☐ Food ☐ Medications ☐ Blood Transfusion ☐ Other (Specify): NICSource of Information: ☒ Parents ☐ Others (Specify): NICMode of Arrival: ☒ Ambulatory ☐ Wheelchair ☐ AmbulanceInitial Vital Signs: Temp: 98.1F BP: 180/90 RR: 24Work of Breathing: ☒ Normal ☐ IncreasedCirculation / Colour: ☒ Normal ☐ Decreased ☐ Gasping / ApneaBleeding: ☐ Normal ☐ Abnormal ☐ BleedingChief Complaints: clo vomiting & sepsisSpO2: 100%

Stomach pain, fever, 1 day

RBS - 12/12/17

INITIAL PHYSIOLOGICAL CATEGORIZATION

Appearance

☒ Normal☐ Sick Looking

Work of Breathing

☒ Normal☐ Decreased

Increased

☐ Gasping / Apnea

INITIAL PHYSIOLOGICAL STATUS

☒ Stable☐ Unstable☒ Not - Life - Threatening☐ Life - Threatening

Triage Classification

☐ Level 1: Resuscitation☐ Level 2: EMERGENT: Life or limb threatening☐ Level 3: URGENT: Significant illness / injury with potential to become life or limb threatening☐ Level 4: LESS URGENT: Significant illness but not life threatening☐ Level 5: NON - URGENT: May receive care when convenient

CTAS

☐ Immediate☐ < 15 min☐ 30 min☒ 60 min☐ 120 min

NOTE: All immunocompromised children and preterm babies to be considered Level 2.

All Children less than 2 years age with high fever to be considered Level 3.

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian: RajniTriage Completion Time: 8:00 PM

Communicable Disease Triage Screening

PART A. The following questions should be asked to all patients at the initial screening:

- Have you had fever (elevated temperature) in the past 2 weeks? ☐ Yes ☒ No
- Have you had cough or a rash in the past 2 weeks? ☐ Yes ☒ No
- 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

- 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:

- 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 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: ShwethaSignature of Triage Nurse: ShwethaDate & Time: 1st Dec 6:00 PM

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

15/07/26
6.25pm

→ ~~Tr:~~ Enset ing given @ 6.25pm ⇒ OK. Druf
11pm - 1 sac given @ 6.45pm ⇒ OK

7:20 > dyp. bugeste & 5th dle guu
Am

Repeat Temp: 101.4F @ 7.25pm

8.30pm Repeat Temp: 103.3°F

dyp. P: 550: 3me. Given:

9.00 am. Temp: 101.5°F

CBc
Cf

Blood c/s

Occult blood

USG Abd.

Red. Cult O

PATIENT TRANSFER FORM

GUC-00079905 IP18-00036478
Baby SONAL TASHA
19-12-2023 2 Y 6 M 26 D (F)
Dr. GANESH R



Date & Time of Admission 15/07/26 @ 9:42 am		Date & Time of Transfer Order 15/07/26 @ 11:05 am
Treating Consultant Name DR. Ganesh	Transfer Ordered by DR. KaviTha	Reason for Transfer Further Management
From Unit ER	To Unit 402	Information to Attendant Yes ☒ No ☐
Number of Sheets in Clinical File 10	Number of Imaging Films CXR - 1 ECG - 1	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☒ If yes, what ?
Medications / Consumables / Surgicals / Hand over		
Sl.No.	Item Name	Quantity
1.	DNS	1
2.	In set	1
3.	Inj. xone (500mg)	1
4.		
5.		
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐		
Name & Signature of Person who is Transferring Rishi [Signature]		Name of Person Ordered Transfer Kavi [Signature]
Patient & Clinical Records Received by : [Signature]		
Date & Time of Patient Received : 15/7/26 @ 11:5 AM		

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

☐ Unavailable Bed

☐ Nurse not Available

☐ Available Bed not ready

