GUC-00094454 IP18-00036672
Baby NAVILAN S. M
14-05-2024 2 Y 2 M 16 D (M)
Dr. KARTHIK NARAYANAN R

BirthRight Rainbow Children's Hospital

DISCHARGE TRACKING SHEET

UHID- FLOOR- NAME OF CONSULTANT-

ACTIVITY	INTIME	OUT TIME	NAME & SIGNATURE	REMARKS	<To be filled by Admin>		
Activity Sheet update by Nursing	30/7/26	12.15 pm					
Activity Sheet update by Pharmacy							

ACTIVITY RECORD FOR BILLING

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Name: .....

UC-00094454
aby NAVILAN S. M
-05-2024 2 Y 2 M 15 D (M)
r. KARTHIK NARAYANAN R
IP18-00036672

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

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
29/07	2:45 pm	ER	GG	

CROSS CONSULTATION VISIT

	Doctor Name	Date	Order No.	Signature
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

INVESTIGATIONS

Date	Investigations	Order No.	Signature
29.7.2021	CBC, RP, 2. Respiratory biofire	@608H291	

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
29/7/26	Infusion Pump	3.30pm	20/7/26 9am	34607.	[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
29.7.26	Dressing	(1)	1734527	
29/07	Neb C O2	(1)	1734538	
29/7/26	Neb with Oxygen	(1)	1734547	
29/7/26	Neb C O2	(2)	34607	
30/7/26	Neb C O2	4	34759.	
30/7/26	Neb C O2	(2)	34936	

ANY OTHER INFORMATION:

Date: 30/7/26 Time: 12.15 pm Prepared By: .....

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

Rainbow Children's Hospital | BirthRight BY RAINBOW HOSPITALS

DISCHARGE TRACKING SHEET

)R- NAME OF CONSULTANT-

GUC-00094454 IP18-00036672
Baby NAVILAN S. M
14-05-2024 2 Y 2 M 16 D (M)
Dr. KARTHIK NARAYANAN R

ACTIVITY	TIME		NAME & SIGNATURE	REMARKS	<To be filled by Admin>
Discharge Announcement	30/4/26 12.15 pm				
	INTIME	OUT TIME			
Arrangement of File by Nursing	30/4/26	12.15 pm			
Preparation of Discharge Summary					
Finalization of discharge summary					
Transfer of file from Ward to Billing Dept					
Bill Processing					
Audit Clearance					
Billing Clearance					
Physical Clearance					

GUC-00094454 IP18-00036672
Baby NAVILAN S. M
14-05-2024 2 Y 2 M 15 D (M)
Dr. KARTHIK NARAYANAN R

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

BED SIDE CHECK LIST FOR NURSES

Date:	29/7	30/7							
Doctor's Orders	YES	Yes							
Carried out or not	YES	yes							
Bed Side									
Structured Handover done	✓	✓							
IV Site	✓	✓							
Central Lines	X	X							
Arterial Lines	X	X							
Feeding Catheter	X	X							
Urinary Catheter	✓	X							
Skin Care	✓	✓							
Eye Care	✓	✓							
Mouth Care	✓	✓							
Sterillum Bottle, Stethoscope	✓	✓							
Suction Bottle (Should be clean & empty)	✓	✓							
Intubation Tray	✓	X							
Emergency Tray (Loaded Syringes with Midazolam & Vecuronium and Flush) Ampoules of Adrenaline	X	X							
Ventilator Tubing,(Any Water, Blood)	✓	X							
Humidification	✓	✓							
Check all Infusion (Labelling,Correct Preparation)	✓	✓							
Chest Physio & Neb	✓	✓							
Handed Over By Name :	Sathya	Praveen							
Signature :	Sathya	Praveen							
Date & Time:	29.7. 8PM	30/7/24							
Hand Over Taken By Name :	Praveen								
Signature :	Praveen								
Date & Time:	30/7/24								

Rainbow Children's Hospital

BirthRight by Rainbow

Rainbow Children's Hospital - Guindy

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

ADMISSION SHEET

Registration Details :

Admission No : IP18-00036672 **Admit Date** : 29-Jul-2026 **Admit Time** : 12:52 PM **UHID** : GUC-00094454

Patient Details :

Patient Name	: Baby NAVILAN S. M	**Age**	: 2 Y 2 M 15 D
Guardian	: Mr SURYA	**DOB**	: 14-05-2024
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: 76, GROUND FLOOR, ASHARKHANA STREET, OPP TO MONTFORT HR SEC SCHOOL, ALANDUR, CHENNAI Alandur Chennai Tamil Nadu INDIA 600016	**Phone No**	: 8778432383/ 6380384664
		E-mail	: no@gmail.com

Admission Details :

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

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

Contact Details :

Name : Mr SURYA **Relationship** : Father

Contact Address : 76, GROUND FLOOR, ASHARKHANA STREET, OPP TO MONTFORT HR SEC SCHOOL, ALANDUR, CHENNAI Alandur Chennai Tamil Nadu INDIA 600016 **Phone No** : 8778432383

Signature

Doctor Details :

Doctor Name : Dr. KARTHIK NARAYANAN R **Specialisation** : PEDIATRIC INTENSIVE CARE

Referral Doctor : DR.PRASANTH SHANKAR (PORUR) **Phone No** :

Co-Consultant :

Payment Details :

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

Payor Name : SELFPAY

Rainbow Children's Hospital
BirthRight by Rainbow

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

GENERAL CONSENT FOR TREATMENT

Patient Name:	**Baby NAVILAN S. M**	**Age :**	**2 Y 2 M 15 D**
IP No:	**IP18-00036672**	**Sex:**	**Male**
Consultant:	**Dr. KARTHIK NARAYANAN R**	**Ward/Bed No:**	**0F-EMERGENCY/ER 102**

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

Patient, be deemed advisable or necessary.

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

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

Signature of Patient/Relative: x

Name: Surya
Relationship: Father
Date: 29/07/2026
Time: 12.55 pm
Witness Name: Parthiba
Witness Signature:

Patient Address:
76, GROUND FLOOR, ASHARKHANA STREET, OPP TO MONTFORT HR SEC SCHOOL, ALANDUR, CHENNAI Alandur Chennai Tamil Nadu INDIA 600016

Rainbow Children's Hospital | BirthRight BY RAINBOW HOSPITALS

BILLING POLICY

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

DECLARATION

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

Patient Name : Baby. Navilan . S. M	UHID Number : GUC-00094454
Self/Attendant Name : Mr SURYA. S	Relation : Father
Self/ Attendant Signature : S. Surya Phone Number : 8778432383	Name & Signature of Financial Counselor

भारत सरकार

आधार

இந்திய அரசாங்கம்

Government of India

இந்திய தனிப்பட்ட அடையாள ஆணைய அமைப்பு

Unique Identification Authority of India

பதிவேட்டு எண்/ Enrolment No.: 2726/51151/01572

To
நவிலன் சூ மௌ
Navilan S M
C/O: Surya S,
D NO 3/5-161,
SEKKANUR,
NAVAPPATTI,
METTUR,
VTC: Navappatti,
PO: Navapatti,
Sub District: Mettur,
District: Salem,
State: Tamil Nadu,
PIN Code: 636452
Mobile: 8778432383

Signature Not Verified

Digitally signed by Unique Identification Authority of India
Date: 2026.04.14 09:20:43 IST

குழந்தைகள் ஆதார்

உங்கள் ஆதார் எண் / Your Aadhaar No. :

9479 9586 4399

VID : 9133 8589 7691 7763

எனது ஆதார், எனது அடையாளம்

Government of India

Aadhaar no. issued: 07/04/2026

நவிலன் சூ மௌ
Navilan S M
பிறந்த நாள்/DOB: 14/05/2024
ஆண்/ MALE

ஆதார் என்பது அடையாளத்திற்கான சான்றாகும், குடியுரிமை அல்லது பிறந்த தேதிக்கான சான்றல்ல. இது சரிபார்ப்புடன் மட்டுமே பயன்படுத்தப்பட வேண்டும் ஆன்லைன் அங்கீகாரம் அல்லது ஒ குறியீட்டை ஸ்கேன் செய்தல்/ ஆஃலைன் XML)

Aadhaar is proof of identity, not of citizenship or date of birth. It should be used with verification (online authentication, or scanning of QR code / offline XML).

9479 9586 4399

எனது ஆதார், எனது அடையாளம்

Government of India

AADHAAR

தகவல் / INFORMATION

ஆதார் 5 வயது வரை மட்டுமே செல்லுபடியாகும். 5 வயதை எட்டும்போது பயோமெட்ரிக்ஸ் புதுப்பிக்கப்பட வேண்டும். இல்லையெனில் அது செயலிழக்கப்படும்.

Aadhaar is valid till 5 years of age only. Biometrics are required to be updated on attaining 5 years of age, failing which, it will be deactivated.

- ஆதார் என்பது அடையாளத்திற்கான சான்றாகும். குடியுரிமை அல்லது பிறந்த தேதிக்கான சான்றல்ல. பிறந்த தேதி என்பது ஆதார் எண் வைத்திருப்பவரால் சமர்ப்பிக்கப்பட்ட விதிமுறைகளில் குறிப்பிடப்பட்டுள்ள பிறந்த தேதி ஆவணத்தின் ஆதாரம் மூலம் ஆதரிக்கப்படும் தகவலின் அடிப்படையில் அமைந்துள்ளது.
- இந்த ஆதார் கடிதத்தை UIDAI நியமித்த அங்கீகார நிறுவனத்தால் ஆன்லைன் அங்கீகாரம் அல்லது ஆப் ஸ்டோர்களில் கிடைக்கும் எம் ஆதார் அல்லது ஆதார் QR ஸ்கேனர் செயலியை பயன்படுத்தி QR குறியீடு ஸ்கேனிங் அல்லது www.uidai.gov.in ல் கிடைக்கும் பாதுகாப்பான QR குறியீடு ரீடர் செயலியை பயன்படுத்தி சரிபார்க்க வேண்டும்.
- ஆதார் தனித்துவமானது மற்றும் பாதுகாப்பானது.
- ஆதார் பதிவு செய்யப்பட்ட நாளிலிருந்து ஒவ்வொரு 10 வருடங்களுக்குப் பிறகும் ஆதாரில் அடையாளம் மற்றும் முகவரிக்கான ஆவணங்கள் புதுப்பிக்கப்பட வேண்டும்.
- பல்வேறு அரசு மற்றும் அரசு சாரா பலன்கள் / சேவைகளைப் பெற ஆதார் உங்களுக்கு உதவுகிறது.
- உங்கள் மொபைல் எண் மற்றும் மின்னஞ்சல் ஐடியை ஆதாரில் புதுப்பிக்கவும்.
- ஆதார் சேவைகளைப் பெற mAadhaar செயலியை பதிவிறக்கவும்.
- ஆதார்/பயோமெட்ரிக்ஸைப் பயன்படுத்தாதபோது பாதுகாப்பை உறுதிசெய்ய, ஆதார்/பயோமெட்ரிக்ஸ் லாக்/அன்லாக் அம்சத்தைப் பயன்படுத்தவும்.
- ஆதார் கோரும் நிறுவனங்கள் ஒப்புதலைப் பெற வேண்டிய கட்டாயம் உள்ளது.
- Aadhaar is proof of identity, not of citizenship or date of birth (DOB). DOB is based on information supported by proof of DOB document specified in regulations, submitted by Aadhaar number holder.
- This Aadhaar letter should be verified through either online authentication by UIDAI-appointed authentication agency or QR code scanning using mAadhaar or Aadhaar QR Scanner app available in app stores or using secure QR code reader app available on www.uidai.gov.in.
- Aadhaar is unique and secure.
- Documents to support identity and address should be updated in Aadhaar after every 10 years from date of enrolment for Aadhaar.
- Aadhaar helps you avail of various Government and Non-Government benefits/services.
- Keep your mobile number and email id updated in Aadhaar.
- Download mAadhaar app to avail of Aadhaar services.
- Use the feature of Lock/Unlock Aadhaar/biometrics to ensure security when not using Aadhaar/biometrics.
- Entities seeking Aadhaar are obligated to seek consent.

Unique Identification Authority of India

Details as on: 11/04/2026

முகவரி:
கேர் ஆப்: சூர்யா செ, எண் 3/5-161,
செக்கானூர், நவப்பட்டி, மேட்டூர்,
நவப்பட்டி, நவப்பட்டி, சேலம்,
தமிழ் நாடு - 636452

Address:
C/O: Surya S, D NO 3/5-161, SEKKANUR,
NAVAPPATTI, METTUR, Navappatti, PO: Navapatti,
DIST: Salem,
Tamil Nadu - 636452

9479 9586 4399

VID : 9133 8589 7691 7763

1947 | help@uidai.gov.in | www.uidai.gov.in

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

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: _____ UC-00094454 Baby NAVILAN S. M IP18-00036672 4-05-2024 2 Y 2 M 15 D (M) Dr. KARTHIK NARAYANAN R _____

UHID ID: _____ _____

Department: _____

Consultant: _____

Patient Sticker

Pediatric Multiorgan History & Physical Examination

Name: _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

History of present illness :

C/O: runny nose
cough on & off x 1 month
↓
aggravated for last 1 week.

H/O: fever 2 weeks back for 4 days settled now
Hb child had cough

cough → vigorous in nature
c post tussive vomiting
c/s 2 episodes

now child has c/o: fast breathing x (1d)
↓ intake x (5d)

Child was initially treated as OPD c
Oral meds still symptoms persisted

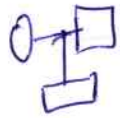
Patient Sticker

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

Nil

Birth & Neonatal History:
LSCS | PRETERM | CIAB | NICU x 5d
d/t ↓ Oligohydramnios
↑ RDS on O_2
B.W - 2.4 kg

Family Chart



Birth & Socio Economic History:

About Father : (N)
About Mother : Both parents has H/o Asthma

Any additional Information :

Developmental History : (N)

Immunization History : uptodate IAP Schedule

Anthropometry :

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

Weight (kgs) 13.4 kg (Centile ______)

On Examination :

Temperature : 98.0 F Pulse Rate : 127/min B.P. 91/59 mmHg SPO2 98% RA

Resp.rate and type of breathing : 48/min

Rash ⊖

Lymphadenopathy ⊖

Oedema : ⊖

Allergies (if any): ⊖

(P.T.O.)

Patient Sticker

Respiratory System :

Inspection (any s/o distress) : mild SOB, HR - 46/min

Air entry & breath sounds : BAE, B/L Wheeze

Any addes sounds :

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

Cardiovascular System :

Inspection of procordium :

Heart Sounds : S_1S_2

Any murmur :

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

Per Abdomen :

Inspection :

Palpation : Soft / NT

Ausculation : BS

Spine : External Genitelia :

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

Central Nervous System :

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

Cranial Nerves :

Motor System :

Nutriton :

Tone: Power

Co-ordinator :

Posture :

Involuntary Movements :

Patient Sticker

Reflexes :

Superficials:

DTR (+)

Plantars

Sensory System :

Bladder / Bowel :

Clinical Summary & Diagnostic: Δ Acute exacerbation of Wheeze

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

Desired goals of the treatment :

Planned Labs:

CBC ✓
RP-II ✓
Biopsy ✓

Planned Management

- IV fluids
- Duolin LD neb stat
- Levolin neb Q6H
- Ipravent neb Q8H
- Budecort neb Q12H
- Inj. hydrocort
- Inj. MgSO4
- X-ray

Signature of the Doctor: C. [signature]

Name of the Doctor: C. DEEPNA

Date & Time: 29/7/21

Signature of the Consultant:

Name of the Consultant:

Date & Time:

(P.T.O.)

Patient Sticker

DISCHARGE PLANNING FORM

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

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

2. Destination Post Discharge: ☐ Home

   Family Members Notified (Person Contacted)

   ☐ Transfer

   Hospital Facilty Notified (Person Contacted)

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

   ☐ Needs Assistance In:

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

4. Nutritional Plan:

   ☐ Dietary Instruction Discussed with the:

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

5. Discharge Planning Discussed with the:

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

6. Patient/Family Educational Plan:

   ☐ Educational Topic/s: .....

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

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

Doctor Signature: .....

Doctor Name: .....

Date and Time: .....

GUC-00094454 IP18-00036672
Baby NAVILAN S. M
14-05-2024 2 Y 2 M 15 D (M)
Dr. KARTHIK NARAYANAN R

1

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

BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
29/7/24 4:10 PM	S/B Dr. DEEPAK	
	Δsis: Acute exacerbation of wheeze	
	Child reviewed Child has no new concerns	
	O/E: Alert, afebrile	
	CVS: S1S2 ⊕ RS: NVBS ⊕ P/A: Soft CNS: NFND	RR - 30/min No Retraction | No respiratory distress
		P1
	To trace Respiratory Bio fer	→ Continue as per chart → To monitor vitals / Serving SpO2 → To monitor for respiratory distress
	Inj. Xone 670mg IV Q12H Neb Levolin 0.63mg Neb Ipravent 250mcg Inj HYDROCORT 60mg IV Q6H Neb Budecort 0.5mg Q12H	C. [signature] 10342

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

Patient Sticker

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

BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
30/7/26	S/B Dr. DEEPAK	
9:15 AM		
	Dsm: Acute exacerbation of wheeze	
	Child reviewed	
	Child has c/o cough	
	O/E:	
	Child is alert, afebrile	
	CVS: S1 S2 (P)	
	RS: VBS(P), B/L minimal wheeze (+)	
	RR: 30/min	
	NO Retraction	NO distress
	SPO2: 98% RA	
	P/A: soft INT	
	CNS: NFND	
		Rx
		→ Inj HYDROCORT 60mg IV Q6H
		→ Inj Pan 15mg 1-0-0
	Q6H	Neb LEVOLIN 0.6mg
	Q8H	Neb Ipravent 250mcg
	Q12H	Neb Budecort 0.5mg
	D2 →	Inj Xone IV 650mg
		To monitor vitals/RR/Sensorium

103425

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

GUC-00094454 IP18-00036672
Baby NAVILAN S. M
14-05-2024 2 Y 2 M 16 D (M)
Dr. KARTHIK NARAYANAN R

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
30/7/24 12:18PM	C/S/B Dr. karthik	D/C today
		MDI Levolin 2puff x (3d)
		MDI Budecort 1puff 1week
		Syr. Omnacortil x (3d)
		[illegible signature]

Patient Sticker

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

Patient Sticker

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

Patient Sticker

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

Patient Sticker

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

BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

RESULT SHEET

Date	29/7/26					
Time						
Hb	11.5					
PCV	33					
RBC	4.43					
WBC	8,020					
N/L	54/36					
Platelets	3,73,000					
CRP						
ESR						
PCT						
RBS	86					
Na	138					
K	3.8					
Cl	105					
Ca/Mg	1.25					
Phosphate / HCO_3^-	/ 17					
Urea	22					
Creatinine	0.38					
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

(P.T.O)

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

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

UC-00094454 IP18-00036672
aby NAVILAN S. M
4-05-2024 2 Y 2 M 15 D (M)
r. KARTHIK NARAYANAN R

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

BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

DRUG CHART

Date of Admission: 29/04 Drug Allergies: NKA ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

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

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

SOS / PRN (As required Medication)

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

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

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

Signature .....

VERIFIED BY : Name .....

UC-00094454 IP18-00036672
aby NAVILAN S. M
4-05-2024 2 Y 2 M 15 D (M)
r. KARTHIK NARAYANAN R

REGULAR PRESCRIPTIONS

Weight. 13.4 kg Ward. 6th

DRUG : INJ. HYDROCORT

Dose	Route	Frequency	Start Date
60mg	IV	Q6H	29/7

Name & Signature of the Doctor Starting the Drugs: 125882

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date	29/7	30/7
1 AM		SS mm
7 AM		SS mm
1 PM		
7	SL	
AM	SP	

DRUG : INJ. PAN

Dose	Route	Frequency	Start Date
15mg	IV	OD	29/7

Name & Signature of the Doctor Starting the Drugs: 125882

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date	29/7	30/7
2PM	SD PB	
6 AM		SS mm

DRUG : LEVOLIN NEB

Dose	Route	Frequency	Start Date
0.63mg	neb	Q6H	29/7

Name & Signature of the Doctor Starting the Drugs: 125882

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date	29/7	30/7
2PM	SD PB	
8 PM	SS mm	
2 AM		SS mm
8 AM		PB SP

DRUG : IPRAVENT NEB

Dose	Route	Frequency	Start Date
250mcg	neb	Q8H	29/7

Name & Signature of the Doctor Starting the Drugs: 125882

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date	29/7	30/7
10 AM		SS mm
10 AM		PB SP
4 PM	PB SP	

UC-00094454 IP18-00036672
aby NAVILAN S. M
I-05-2024 2 Y 2 M 15 D (M)
r. KARTHIK NARAYANAN R

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Sheet No: .....

REGULAR PRESCRIPTIONS

Weight 14.3 kg Ward 6th Floor

DRUG : NEB BUDECORT

Dose	Route	Frequency	Start Dt.
0.5mg	PNN	Q12H	29/7

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time			
29/7	30/7		
3 AM	8S mm		
3 PM	PS SP		

DRUG : INJ CEFTRIAXONE

Dose	Route	Frequency	Start Dt.
650mg	IV	Q12H	29/7

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time			
29/7	30/7		
6 AM	4PM PS SP	SS mm	
6 PM	11PM 8S 10PM		
	D1	D2	

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

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

Patient Sticker

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Sheet No: ....

REGULAR PRESCRIPTIONS

Weight .... Ward ....

DRUG :				Date/Time
Dose	Route	Frequency	Start Dt.	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

DRUG :				Date/Time
Dose	Route	Frequency	Start Dt.	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

DRUG :				Date/Time
Dose	Route	Frequency	Start Dt.	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

DRUG :				Date/Time
Dose	Route	Frequency	Start Dt.	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

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

GUC-00094454 IP18-00036672
Baby NAVILAN S. M
14-05-2024 2 Y 2 M 15 D (M)
Dr. KARTHIK NARAYANAN R

Weight. 13.9kg Ward. 6th

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
29/7	1 PM	INJ. HYDROCORT	100mg	IV		
29/7	12.45PM	DUOLIN LD	2 ml	neb		
29/7	1.15PM	INJ. MgSO4	600mg in 30ml NS over 30 mins	IV		

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

UC-00094454 IP18-00036672
aby NAVILAN S. M
t-05-2024 2 Y 2 M 15 D (M)
r. KARTHIK NARAYANAN R

I.V. FLUIDS CHART

Weight. 12.4kg Ward. 6th D

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
29/7	3.30PM	IVF - 0.9% DNS	IV	30					

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

GUC-00094454 IP18-00036672
Baby NAVILAN S. M
14-05-2024 2 Y 2 M 15 D (M)
Dr. KARTHIK NARAYANAN R

PR/12

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Patient Na

Registration No.:

NEBULISATION CHART

Date	Time	Drug	Nurse	Parents Signature
29/7	3pm	Neb Budecor ① } ①	[signature]	
	1.00	Neb Ipravent } ①	[signature]	
	2.00	Neb levolin }		[signature]
	8pm	Neb – Levolin. $\bar{c}$ O_2 – ①	[signature]	
30/7	12am	Neb – Ipravent – $\bar{c}$ O_2 – ①		
	2am	Neb – Levolin $\bar{c}$ O_2 – ①		
	3am	Neb – Budecort $\bar{c}$ O_2 – ①		
	7.00			
	8.00			
	9.00			
	10.00			
	11.00			
	12.00			
	13.00			
	14.00			
	15.00			
	16.00			
	17.00			
	18.00			
	19.00			
	20.00			
	21.00			
	22.00			
	23.00			

GUC-00094454 IP18-00036672
Baby NAVILAN S. M
14-05-2024 2 Y 2 M 15 D (M)
Dr. KARTHIK NARAYANAN R

60 I

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 : ..... Time:	3pm	8pm	12Am	4am
Doctor / Nurse / Family Concern?				
Temperature (°F)	97.5°F	97.7°F	97.5°F	97°F
Heart Rate (bpm) and Blood Pressure (mmHg) *	160 / 61 / 52	102 / (68) / 52	99 / (63) / 57	102 / (64) / 53
Note: BP does not score in early warning scoring				
Heart Rate (Number)	125 b/m	122 b/m	118 b/m	120 b/m
Resp. Rate (bpm) (Over 1 Minute) *				
Resp Rate (Number)	32 b/m	34 b/m	32 b/m	30 b/m
Resp Distress: Mod/ Severe / None / Mild	✓	✓	✓	✓
Receiving O_2 (l/min) O_2 Saturations (%)	98%	99%	100%	99%
Conscious Level: Normal / Altered	✓	—	—	—
GCS *	15/15	15/15	15/15	15/15
TOTAL SCORE Number of shaded boxes	0	0	0	0
Pain Score	0	0	0	0
Observer's Initials	SK	SK	SK	SK

ACTIONS
NB: Scores 3 should be recorded overleaf

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

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

Patient Sticker

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

GUC-00094454 IP18-00036672
Baby NAVILAN S. M
14-05-2024 2 Y 2 M 15 D (M)
Dr. KARTHIK NARAYANAN R

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

BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

FLUID CHART

Sheet No. : (1)

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

Date	Time	Intake: Nature of Fluid	Intake: Route – Mouth	Intake: Route – I.V	Intake: Route – N.G	Output: NG	Output: Diarrhoea	Output: Vomit	Output: Drainage	Output: Urine	IV Site Thrombophlebitis Score	Sign. Nurse
29/7/24												
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm	RGT										
Total Intake :						Total Output :						
	02:00 pm	Patient received ER to ward										
	03:00 pm			30ml							0	
	04:00 pm	H2O	200	30ml						✓		
	05:00 pm			30ml							0	
	06:00 pm	H2O	200	30ml								
	07:00 pm			DC							0	
Total Intake :		200ml + 120ml				Total Output :				1 time		
	08:00 pm			30ml								
	09:00 pm	H2O	100ml	30ml						✓	0	SS/OU
	10:00 pm			30ml								
	11:00 pm			30ml							0	SS/OU
	12:00 am	H2O	100ml	30ml						✓		
	01:00 am			30ml							0	SS/OU
Total Intake :		200 ml + 180ml				Total Output :				2 times		
	02:00 am			30ml								
	03:00 am	H2O	100ml	DC							0	SS/OU
	04:00 am			DC								
	05:00 am			DC							0	SS/OU
	06:00 am	Milk	100ml	30ml								
	07:00 am			30ml						✓	0	SS/OU
Total Intake :		200 ml + 90 ml				Total Output :				1 times		

Total 24 hrs. Intake	800ml + 390ml = 1190	Total 24 hrs. Output	4 times

Patient Sticker

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: .....

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon							
Night							

Patient Sticker

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: .....

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon							
Night							

GUC-00094454 IP18-00036672
Baby NAVILAN S. M
14-05-2024 2 Y 2 M 15 D (M)
Dr. KARTHIK NARAYANAN R

Rainbow® Children's Hospital — It takes a lot to treat the little.
BirthRight™ BY RAINBOW HOSPITALS — Your Right to a Safe Delivery

NURSES NOTES

☑ No Known Drug Allergies

☐ Drug Allergies ....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
29/6/26		Receiving notes.	
	2.40PM	Baby received from ER to 601. Handing over received from ER SIN. Nilmol, IVF 0.9 DNS @ 30ml/hr, nebulization continue.	[signature] 0200H6
	3PM	Vitals checked and recorded. PP +1, CP +-, CRT 4	[signature] 0200H6
	3.30PM	Due medication given as per orders. Baby had food. IVF 0.9 DNS @ 30ml/hr on flow.	[signature] 0200H6
	6PM	Baby sleep well. No new other complaints.	[signature] 0200H6
	7PM	Maintained I/O chart recorded. Due to medication given as per chart	
	7.30pm	Child details hand over given to night duty staff	[signature] 22
		Night duty notes.	
30/7/26	7.30pm	child details hand over taken form evening duty staff. child conscious & active. →	Sen [signature] 0452
	8pm	child vitals checked & record	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Patient Sticker

NURSES NOTES

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

BirthRight BY RAINBOW HOSPITALS — Your Right to a Safe Delivery

☐ No Known Drug Allergies

☐ Drug Allergies ....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		no outher compiaints. →	
		Due medication given as	
		per drug chart. →	Sen 01/09/2
	10pm.	child IV line (+) IV line	
		Observed & necy. cut	
		IV F DNS 30ml/h on	
		flow. →	Sen 01/09/2
	11pm.	child medical. inj - xone giv	
	12am	child vitals checked & recon.	
		temp is normal. CP ++ / PP ++ / CRT <3s	
		I/O chart maintaind →	
	2am	child sleeping well. no outher	
		compiaints. →	Sen
	3am	child mediation neb Budecort	01/09/2
		given.	
	4am	child vitals check & recon.	
		temp is normal. CP ++ / PP ++ / CRT <3s	
		I/O chart maintaind →	
	6am	Administer mediation given	
		as per drug chart →	Sen
	7.30am	Hand over given to the	01/09/2
		morning duty staff. →	Sen 01/09

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Patient Sticker

NURSES NOTES

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

☐ No Known Drug Allergies

☐ Drug Allergies .....

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

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Patient Sticker

NURSES NOTES

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

☐ No Known Drug Allergies

☐ Drug Allergies .....

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

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Patient's N... GUC-00094454 IP18-00036672
Baby NAVILAN S. M
MRD NO:.. 14-05-2024 2 Y 2 M 15 D (M)
Dr. KARTHIK NARAYANAN R
Age :........ Sex: ☐ M ☐ F
Consultant :...

PHLEBITIS ASSESSMENT

CANNULA 1

Date : 29/7/2026. Time: 02:30 pm

Location : left Methacarpal.

Size : 24G

Cannula inserted by : S/N Ajith

Date	Time	Phlebitis	Infiltration	Nursing Intervention	Sign
29/7/26	2.30pm	☐Yes ☑No	☐Yes ☑No	pattern	[illegible]
	2PM	☐Yes ☑No	☐Yes ☑No	normal	[illegible]
	4PM	☐Yes ☑No	☐Yes ☑No	normal	[illegible]
	6PM	☐Yes ☑No	☐Yes ☑No	normal	[illegible]
	8pm	☐Yes ☑No	☐Yes ☑No	observ	S1/OU
	10pm	☐Yes ☑No	☐Yes ☑No	observ	S1/OU
30/7	12Am	☐Yes ☑No	☐Yes ☑No	observe	S1/OUS
	2Am	☐Yes ☑No	☐Yes ☑No	observe	S1/OUS
	4Am	☐Yes ☑No	☐Yes ☑No	observ	S1/OUS
	6Am	☐Yes ☑No	☐Yes ☑No	observ	S1/OUS
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		
		☐Yes ☐No	☐Yes ☐No		

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

CANNULA 2

Date : Time:

Location :

Size :

Cannula inserted by :

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

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

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

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

PHLEBITIS ASSESSMENT AND MANAGEMENT RECORD

CANNULA 3

Date :

Time:

Location :

Size :

Cannula inserted by :

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

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

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

Phlebitis score:

CANNULA 4

Date :

Time:

Location :

Size :

Cannula inserted by :

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

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

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

Phlebitis score:

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

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

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

Patient Sticker

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					
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2					
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1					
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own ability	1					
	History of Falls or Infant-Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2					
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours/ None	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						

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

Intervention:						
Bed in low position						
Call device within reach						
Wheels Locked						
Room free of clutter						
Adequate lighting						
Wheel chair support						
Other Intervention(s) Specify						
Nurse's Name:						
Signature:						
Date:						
Time:						

GUC-00094454 IP18-00036672
Baby NAVILAN S. M
14-05-2024 2 Y 2 M 15 D (M)
Dr. KARTHIK NARAYANAN R

Ref. No.: F/HW/BRD-Q/NSG/04

BRADEN 'Q' SCALE

(for Paediatric use)

Patient Name : .....

Age..... Gender : ☐ M ☐ F IP No. : .....

				Date :	29/1	29/2		
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 though slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4		
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during waking hours.	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		
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		
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		
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	3	3		
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		
				TOTAL SCORE	27	27		
				Evaluator's Name				

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

Rainbow® Children's Hospital | BirthRight® BY RAINBOW HOSPITALS

BRADEN 'Q' SCALE

(for Paediatric use)

Patient Name : .....

Age..... Gender : ☐ M ☐ F IP No. : .....

				Date :					
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.					
Activity The degree of physical activity	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.*	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during waking hours.					
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 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.*					
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.					
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.					
				TOTAL SCORE					
				Evaluator's Name					

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

GUC-00094454 IP18-00036672
Baby NAVILAN S. M
14-05-2024 2 Y 2 M 15 D (M)
Dr. KARTHIK NARAYANAN R

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Nursing General Admission Assessment Form For Pediatrics

Diagnosis: Acute exacerbation wheeze.

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

Allergy / Adverse Reaction ..... Body Weight: 13.4 ..... Kg

..... Height: ..... cm

.....

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

Past Medical History	Past Surgical History	Previous Hospital Admission
-	-	-

Family History: .....

.....

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

If yes please list, ...

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

.....

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

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

Observations: Weight: 13.4. Length: - Head Circumference (< 2 years): .....

Temp.: 97.5 F HR: 105/M RR: 34/M BP: 100/52

Pain Score: 0/10 Specify Site: 0/10 (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 21) (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

Patient Rights & Responsibilities: ☑ Yes ☐ No ☐ Others

Information given to mother

Nurse's Name: Sathya Date: 09.07.106 Time: 3.16PM Signature [signature]

UC-00094454 IP18-00036672
aby NAVILAN S. M (M)
I-05-2024 2 Y 2 M 15 D
r. KARTHIK NARAYANAN R

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

BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

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: 601

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 Deepak

Date & Time: 29/07/26 @ 12:30 pm

Nurse Name & Signature: Godwin Basis [signature] 018133

Date & Time: 29/7/26 @ 12.30pm

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

UC-00094454 IP18-00036672
aby NAVILAN S. M
I-05-2024 2 Y 2 M 15 D (M)
r. KARTHIK NARAYANAN R

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

RBS CHART

Date	Time	RBS (mg/dl)	IVF %	Signature
29/07	1:20pm.	90mg/dl	-	[signature] 17890

UC-00094454 IP18-00036672
aby NAVILAN S. M
I-05-2024 2 Y 2 M 15 D (M)
r. KARTHIK NARAYANAN R

DOCTOR'S SHIFT CHANGE HANDOVER FORM

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Date: ..... Department: ..... Shift: .....

S.No	Patient Identification	Diagnosis / Procedure	Clinical Findings Problems	Special Concerns / Investigations / Abnormal Results	Recommendations / Follow up needed	Handing Over Doctor	Receiving Over Doctor

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

DOCTOR'S SHIFT CHANGE HANDOVER FORM

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Date: ..... Department: ..... Shift: .....

S.No	Patient Identification	Diagnosis / Procedure	Clinical Findings Problems	Special Concerns / Investigations / Abnormal Results	Recommendations / Follow up needed	Handing Over Doctor	Receiving Over Doctor

GUC-00094454 IP18-00036672
Baby NAVILAN S. M (M)
14-05-2024 2 Y 2 M 15 D
Dr. KARTHIK NARAYANAN R

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

BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

wt. 13.4kg

EMERGENCY ROOM TRIAGE FORM

Gender: ☑ Male ☐ Female

Patient's Name : Baby. Navilan. Age : 2y2m.

Date : 29. July. 2026 Time of Arrival : 12.25pm. ☑ Not known

Allergies: ☑ No ☐ Yes ☐ Food ☐ Medications ☐ Blood Transfusion ☐ Other (Specify): Nil

Source of Information : ☑ Parents ☐ Others (Specify)

Mode of Arrival : ☑ Ambulatory ☐ Wheelchair ☐ Ambulance

Initial Vital Signs: Temp: 97.8°F PR: 127/min BP: 91/59 (69) RR: 30br SpO₂: 98%. RA.

Chief Complaints: Cold. x 1 month. On & off.

INITIAL PHYSIOLOGICAL CATEGORIZATION

Appearance: ☑ Normal ☐ Sick Looking

Circulation / Colour: ☑ Normal ☐ Abnormal ☐ Bleeding

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

K. G. Narayanan

Signature of Parent / Guardian

Triage Completion Time : 2min.

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

Communicable Disease Triage Screening

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

1. Have you had fever (elevated temperature) in the past 2 weeks ☐ Yes ☑ No
2. Have you had cough or a rash in the past 2 weeks ☐ Yes ☑ No
3. Have you had shortness of breath or difficulty breathing in the past 2 weeks ☐ Yes ☑ No

PART B. For patients reporting fever and respiratory/rash symptoms: ☐ **Not applicable**

1. Have you travelled outside the INDIA? or had close contact with someone who has recently travelled outside the INDIA, in the past two weeks? ☐ Yes ☑ No

   If yes, State Location:
2. Are your parents / close contacts at home is/a healthcare worker? {please encircle the choices} (e.g., nurse, physician, ancillary services personnel, allied health services personnel, hospital volunteer, or laboratory worker, others) who has had a recent exposure to an individual with a highly communicable disease or unexplained, severe febrile respiratory or rash disease? ☐ Yes ☑ No

PART C. A positive communicable disease triage screening is considered for any patient who meets one of the two following criteria:

☐ Any patient with Fever / Rash / Vesicles / Discharge from Eyes and Cough

☐ Any patient with fever and respiratory symptoms who answered "YES" to any of the questions on epidemiologic risk factors in "PART B" of the triage screening above.

PART D. ACTION / INTERVENTION: (for positive suspected communicable disease triage screening)

☐ Patients should be immediately isolated in a negative pressure room or a single room (as appropriate) for pending evaluation.

☐ The patient should be given a surgical mask immediately, if not already wearing one.

☐ Both patient and triage staff should perform hand hygiene.

☐ The staff should use PPE (as appropriate).

Signature of Triage Nurse : [signature]

Name of Triage Nurse : A. Ajith

Date & Time : 29/7/26 @ 12:27pm

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

29/7/24 @ 12:45pm. Neb. Duolin LD. 8 hrt [signature]

GUC-00094454 IP18-00036672
Baby NAVILAN S. M
14-05-2024 2 Y 2 M 15 D (M)
Dr. KARTHIK NARAYANAN R

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

BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 29/7/2026. Time of arrival : 19.35pm

Chief Complaints: Cold & Cough. on & off RBS: 90mg/dl.

Height : — Weight : 13.4kg. BMI : — Head Circumference (<2 years) —

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

If yes , identify —

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

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

RISK FOR FALL:

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

☐ If Patient is > 6 years
Assess the below parameters

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

Ambulatory Aids:
- Wheelchair ☐ Yes ☐ No
- Uses furniture for support ☐ Yes ☐ No

Gait/Transferring:
- Bedrest / immobile ☐ Yes ☐ No
- Weak ☐ Yes ☐ No
- Impaired ☐ Yes ☐ No

Mental Status: Forgets limitations ☐ Yes ☐ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:
- ☐ Escort while ambulating
- ☐ Assist Patient
- ☐ Educate patient and family on fall precautions/prevention

Functional Screening: ☐ No Abnormalities Detected
- ☐ Mobility Problem
- ☐ Walking Problem
- ☐ Developmental Delay
- ☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

—

Nutritional Screening: ☐ No Abnormalities Detected
- ☐ Underweight
- ☐ Overweight
- ☐ Feeding Problem
- ☐ Special diet
- ☐ Special feeding method

Inform consultant for positive criteria

Psychological Screening: ☐ No Significant Findings

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

If Yes Consultant Notified: ..... (Date/Time): 29.7.2026

Social History: Lives With Parents

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

Time of Initial assessment completed by ER Nurse : 19.35pm

(P.T.O.)

Time	Nursing Notes
1.30pm	child Camo with ER with Complaints Cold & cough
	on and off Monitored Vitals,
	Dr Keerthana assessed and admitted
	IV placement Done Samples Collected
	and sended to lab.
	Shifted for further Management

Samples collected by: } Ajith.
Samples sent by :

Time: } 1:30pm
Time:

Medication given in ER:

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

Condition of patient at time of shift - out :

HR: 127 bt BP: 91/59/ 67 CFT: <2sec
RR: 30 br SPO₂: 98 % RA.
GCS: 15/15 Temperature : 97.8°F
Pain Score: 0/10
Repeat RBS (if applicable): 90mg/dl

Details of Shift - out

Shift - out from ER to: 601
Time of Shift - out: 2:45 pm
Handover given to: S/N Sally
(Nurse's Name)

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any): IV line placement done. ⓤ mefacampole 24G.

Name of the Nurse : Shibu Debnath.

Date & Time : 29/07/hrs : 1:40pm

Signature of the Nurse : [signature] 17890

UC-00094454 IP18-00036672
aby NAVILAN S. M
4-05-2024 2 Y 2 M 15 D (M)
r. KARTHIK NARAYANAN R

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

BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Date : .....

Admitting Doctor : .....

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

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

Allergic History: .....

Chief Complaints: .....

Pediatric Assessment Triangle

A Appearance - TICLS ... Alert

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

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

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

Any urgent interventions needed: ☐ Yes ☐ No

If Yes .....

Significant Past History: KICU. wheezy on neb

Medication History: .....

Relevant Investigations: .....

Primary Assessment

Airway
- ☐ Open
- ☐ Maintainable
- ☐ Not Maintainable

Any urgent interventions needed: ☐ Yes ☐ No

If Yes .....

Breathing

Rate: ..... SpO_2 on FiO_2 98 % on RA

Rhythm: .....

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

Respiratory Noises: ☐ Stridor ☐ Wheezing ☐ Grunting

Air Entry: .....

Palpation Findings (If necessary).....

Any urgent interventions needed: ☐ Yes ☐ No

If Yes .....

(P.T

Circulation

HR: ..... CFT [Central ..... / Peripheral .....]

Any urgent interventions needed: ☐ Yes ☐ No

If Yes .....

BP: ..... mmHg

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

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

Muffled Heart Sound: ☐ Yes ☐ No

Engorged Neck Veins: ☐ Yes ☐ No

Murmurs: ☐ Yes ☐ No

Liver Span: .....

ECG: .....

Any Signs of Heart Failure: ☐ Yes ☐ No

Disability

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

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

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

Signs of Neurological compromise .....

.....

Any urgent interventions needed: ☐ Yes ☐ No

If Yes .....

Exposure

Temp.: .....

Any Rash: ☐ Yes ☐ No,

If yes describe the rash .....

Active bleed .....

Lacerations ☐ Abrasions ☐ bruises ☐

Describe: .....

Any urgent interventions needed: ☐ Yes ☐ No

If Yes .....

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

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

.....

Labs Planned: .....

.....

.....

.....

.....

.....

.....

Treatment Planned: .....

.....

.....

.....

.....

.....

.....

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

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

Assessment done by

Name of the Doctor: .....

Signature: .....

Date & Time: .....

Sr. Doctor on Duty (If necessary)

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

Signature: .....

Date & Time: .....

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

PATIENT TRANSFER FORM

GUC-00094454 IP18-00036672
Baby NAVILAN S. M (M)
14-05-2024 2 Y 2 M 15 D
Dr. KARTHIK NARAYANAN R

Treating Consultant Name: Dr Kaarthik	Date & Time of Admission: 29.7.2026 @.12.59pm	Date & Time of Transfer Order: 29.07.2026 @ 2.40PM
From Unit: ER.	Transfer Ordered by: Dr. Keerthana	Reason for Transfer: further Management
Number of Sheets in Clinical File: Total Sheet 14	To Unit: 601	Information to Attendant: Yes ☑ No ☐
	Number of Imaging Films: NIL	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.	0.9%-DNS 100ml	1
2.	Tantafix	1
3.		
4.		
5.		

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

Name & Signature of Person who is Transferring: 01/01/24

Name of Person Ordered Transfer: DR. Deepak.

Patient & Clinical Records Received by : Sathya

Date & Time of Patient Received : 29.7.26 @ 2.45 PM

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

☐ Unavailable Bed ☐ Nurse not Available ☐ Available Bed not re