

GUC-00093198 IP18-00036274
Baby B/O ROHINI VARSHA
28-06-2026 0 Y 0 M 4 D (F)
Dr. PADMAPRIYA EKAMBARAM



DISCHARGE TRACKING SHEET

UHID-

FLOOR-

NAME OF CONSULTANT-

ACTIVITY	INTIME	OUT TIME	NAME & SIGNATURE	REMARKS	<To be filled by Admin >		
Activity Sheet update by Nursing							
Activity Sheet update by Pharmacy							

ACTIVITY RECORD FOR BILLING

GUC-00093196 IP18-00036274
Baby B/O ROHINI VARSHA
28-06-2026 0 Y 0 M 4 D (F)
Dr. PADMAPRIYA EKAMBARAM



... IP No: Consultant: Dept:

Date of Admission: Time: Date of Discharge: Time:

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse

CROSS CONSULTATION VISIT

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

INVESTIGATIONS

[illegible]

RAJ-EDURE

[illegible]

02/7/20

6 AM

S/n. 202

ful
607302

7th Floor.

Billing Assistant

Billing Supervisor

GUC-00093196

IP18-00036274

Baby B/O ROHINI VARSHA

28-06-2026

0 Y 0 M 4 D

(F)

Dr. PADMAPRIYA EKAMBARAM



DISCHARGE TRACKING SHEET

FLOOR-

NAME OF CONSULTANT-

ACTIVITY	TIME		NAME & SIGNATURE	REMARKS	<To be filled by Admin>
Discharge Announcement					
	INTIME	OUT TIME			
Arrangement of File by Nursing		21/7/26 @ 10 AM			
Preparation of Discharge Summary					
Finalization of discharge summary					
Transfer of file from Ward to Billing Dept					
Bill Processing					
Audit Clearance					
Billing Clearance					
Physical Clearance					

02/7/26

Twt: 2.339kg

H - 34cm

L - 47cm



BED SIDE CHECK LIST FOR NURSES

Date:	1/7/26								
Doctor's Orders	yes								
Carried out or not	yes								
Bed Side									
Structured Handover done	yes								
IV Site	NA								
Central Lines	NA								
Arterial Lines	NA								
Feeding Catheter	NA								
Urinary Catheter	NA								
Skin Care	yes								
Eye Care	yes								
Mouth Care	yes								
Sterillum Bottle, Stethoscope	yes								
Suction Bottle (Should be clean & empty)	NA								
Intubation Tray	NA								
Emergency Tray (Loaded Syringes with Midazolam & Vecuronium and Flush) Ampoules of Adrenaline	yes								
Ventilator Tubing, (Any Water, Blood)	NA								
Humidification	NA								
Check all Infusion (Labelling, Correct Preparation)	NA								
Chest Physio & Neb	NA								
Handed Over By Name :	Vijayini								
Signature :	[Signature]								
Date & Time:	1/7/26 6:45 PM								
Hand Over Taken By Name :									
Signature :									
Date & Time:									

ADMISSION SHEET

Registration Details :



Admission No : IP18-00036274 Admit Date : 01-Jul-2026 Admit Time : 07:37 PM UHID : GUC-00093196

Patient Details :

Patient Name	: Baby B/O ROHINI VARSHA	Age	: 0 Y 0 M 3 D
Guardian	: RAMPRASATH	DOB	: 28-06-2026 03:43 PM
Gender	: Female	Religion	:
Occupation	:	Martial Status	:
Address (H)	: 10 SUNDAR NARAR 4 TH AVENUE EKKAOJTHANGAL Guindy Ind Estate Chennai Tamil Nadu INDIA 600032	Phone No	: 9597729575/ 7010713003
		E-mail	: NO@GMAIL.COM

Admission Details :

Bed Type	: NICU FAMILY CENTRIC ROOM	Bed No	: NICU-FCR 336	Ward Name	: 3F-NICU 4
Room No	: NICU-FCR 336	Admission Type	: First Visit		

Contact Details :

Name	: RAMPRASATH	Relationship	: Father
Contact Address	: 10 SUNDAR NARAR 4 TH AVENUE EKKAOJTHANGAL Guindy Ind Estate Chennai Tamil Nadu INDIA 600032	Phone No	: 9597729575

U. P. M.
Signature

Doctor Details :

Doctor Name	: Dr. PADMAPRIYA EKAMBARAM	Specialisation	: GENERAL PEDIATRICS
Referral Doctor	: self	Phone No	:
Co-Consultant	:		

Payment Details :

Payment Mode	: Cash	Deposit Amount	: 0.00
		Payor Name	: SELFPAY

706

GENERAL CONSENT FOR TREATMENT

Patient Name: Baby B/O ROHINI VARSHA

Age : 0 Y 0 M 3 D

IP No: IP18-00036274

Sex: Female

Consultant: Dr. PADMAPRIYA EKAMBARAM

Ward/Bed No: 3F-NICU 4/NICU-FCR 336

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

Patient, be deemed advisable or necessary.

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

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

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

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

Note:

1 We do not allow use of medication brought from outside by the patient.

2 I have received attendant passes as per my room category. I understand that I have to return it back at the time of final bill clearance. In case of failing the submission, I will pay 200/- Rs.

(Receivers Signature: *U. R. P. J.*)

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:

U. R. P. J.

Name:

Relationship:

Date:

Time:

Witness Name:

Witness Signature:

Patient Address:

10 SUNDAR NARAR 4 TH AVENUE
EKKAOJTHANGAL Guindy Ind Estate
Chennai Tamil Nadu INDIA 600032

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 :	UHID Number :
Self/Attendant Name : RAMPRASATH	Relation :
Self/ Attendant Signature : [Signature]	Name & Signature of Financial Counselor
Phone Number : 9597727575	

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28-06-2026
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IP18-00036274
OYO M4D
(F)

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

AL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

Mother's Name: Rohini Varsha Age: 26 yrs Father's Name: _____ Age: _____
Date of Birth: 28/06/2026 Date of Admission: _____ UHID No.: _____
NICU Consultant: Dr. Padmapriya Referring Consultant: _____
Transferring Unit: ☐ OT ☐ Labour Room ☐ ER ☐ Ward
Transported? ☐ Yes ☐ No - If yes: ☐ Long (> 30 kms) ☐ Short (< 30 kms)

BIRTH INFORMATION

Name: B/o Rohini Varsha Mother's Blood Group: O+
Gender: ☐ M ☒ F Blood Group: O+ Birth Weight (gms): 2.525 kg Length (cms): _____
Date of Birth: 28/06/2026 Time of Birth: 3:43pm OFC (cms): _____
Place of Birth: Reti, Cunnady Estimated Gesth Age: 37+5 weeks

Current Obstetric History: ☒ Booked / ☐ Unbooked Case

Maternal Age: 26 yrs Ht: _____ Wt: _____ BMI: _____ Married Life: _____ LMP: _____ EDD: _____
Conception: ☒ Spontaneous or with Rx: _____
Booked at what GA: _____ AN Steroids Drugs / Doses: _____
Last Scans Details: (A)

TT Immunization and Iron / Folic Acid: _____

MATERNAL RISK FACTORS

Age: ☐ <18 yrs ☐ >35yrs

Consanguinity: ☐ Yes ☐ No

If yes, degree of consanguinity: ☐ 1 ☐ 2 ☐ 3

H/o PIH (after 20 weeks) / PE

How many Drugs / Doses / Since how long: _____

H/o value of recent BP recording, proteinuria, edema,

oliguria, any investigations (LFT, platelet count): _____

IUGR - when detected: _____

Doppler (Increased Resistance / ADEF / REDF /

Redistribution in MCA) / Ductus Venosus: _____

AFI: _____

H/o GDM/ pre GDM/ on diet or insulin

Controlled or not, recent values, HbA1 values: _____

Compliance with Rx: _____

Scans: LGA, TIFFA, Fetal Echo: _____

H/o Hypothyroidism: when diagnosed? Medication?

Any other Chronic Medical Problems, when detected

drugs? _____

(Anemia, SLE, Jaundice, CHD, Heart Disease)

Infection: H/O, Fever

(☐ Malaria ☐ UTI ☐ TORCH ☐ TB ☐ HIV ☐ HBV)

UTI: when: _____ Any culture: _____

PPROM: Duration: _____ ☐ Uterine Tenderness ☐ Foul Smelling Liquor ☐ HVS (if taken) - Results: _____

Medication during Pregnancy: _____ Duration: _____

Patient Sticker

PAST OBSTETRIC HISTORY

G: prme P: A: L:

Sl. No.	Age	GA wks	B. W	Gender	Significant	Details

PERINATAL HISTORY

Treating Obstetrician : Hospital : ☐ Inborn ☐ Outborn

Duration of Labour

First stage (> 18 hours sig)

Second stage (> 2 hours after dilation)

LSCS : ☐ Elective ☐ Emergency Indication : NVD

Specify the reason :

Augmentation of Labour : ☐ Induced ☐ Assisted Vaginal

CTG : ☐ Normal ☐ Suspicious ☐ Pathological

MSL :

Resuscitation : ☐ Yes ☐ No

Cord ABG : normal OK

Placenta : (weight, surface, No. of cotyledons, calcifications, malformations, clots etc :

NEONATAL RESCUSTITATION DETAILS

APGAR SCORE

Gestational Age : Weeks :

SIGN	0	1	2
COLOUR	Blue or Pale	Acrocyanotic	Completely Pink
HEART RATE	Absent	< 100 Minutes	> Minutes
REFLEX IRRITABILITY	No Response	Grimace	Cry or Active Withdrawal
MUSCLE TONE	Limp	Some Flexion	Active Motion
RESPIRATION	Absent	Weak Cry: Hypoventilation	Good, Crying

TOTAL

1 Minute	5 Minutes	10 Minutes
8/10	9/10.	

Resuscitation			
Minutes	1	5	10
Oxygen			
PPV / NCPAP			
ETT			
Chest Compressions			
Epinephrine			

Comments :

POSTNATAL / HISTORY OF PRESENT ILLNESS

Chief Complaints :

History of Present Illness:

3 day old baby is brought with
S. bilirubin 16.63 mg/dl, done as routine check

Baby on exclusive breast feed
every 2nd hly

short
viral | @.

S. bilirubin is in phototherapy range, hence
admitted.

NBS / OAE due.

Investigation details in previous Hospital :

Feeding History :

Patient Sticker

Past History :

no past history of any kind. No previous surgery. No chronic illness. No drug use. No alcohol use. No tobacco use. No family history of any kind.

Family History :

no family history of any kind. No chronic illness. No drug use. No alcohol use. No tobacco use. No family history of any kind.

Socio Economic History :

no socio economic history. No chronic illness. No drug use. No alcohol use. No tobacco use. No family history of any kind.

GENERAL EXAMINATION ON ADMISSION

General Disposition :

cyt activity - good

VITALS : Temperature : 36.5°C HR : 148/min RR : 48/min NIBP : 130/80 CFT : 23u

Color of the extremities :

Jaundice : Pallor : SpO2 :

Anthropometry : Birth Weight : 2.5 kg Length : HC : Present Weight :

Ponderal Index : Admision weight - 2.3732 AGA : SGA : LGA :

1.71 kg - 6.7%

HEAD TO TOE EXAMINATION

HEAD :

Fontanelles :

Sutures

Shape / Moulding :

Edema / Bruising :

Size - (H.C.) :

| 0

Facies :

(Any Facial
Dysmorphism)NECK and
CLAVICLES :

Range of Motion :

Asymmetry :

Masses :

| 0

EYES :

Symmetry :

Red Reflex :

Discharge :

EARS, NOSE
MOUTH and
THROAT :

Ear set / Shape :

Periauricular Pits / Tags :

Nasal shape / Patency :

Palate :

Gums :

Lips :

Tongue :

| 0

THORAX and
BREASTS :

Shape of Thorax :

Position of Nipples and Number :

ABDOMEN and
UMBILICUS :

Shape :

Organomegaly :

Bowel Sounds :

Umbilical Stump :

Discharge :

| 0

GENITALIA :

Labia / Hymen :

Testicles / penis :

Anus :

| 0

HERNIAL ORIFICES

TRUNK and SPINE :

SKIN LESIONS :

mild ween +

EXTREMITIES :

Fingers / Toes :

Arms / Legs :

Deformities :

Mobility :

Hip Joint Examination :

| 0

SYSTEMIC EXAMINATION

Respiratory System :

Breathing Pattern: ☒ Regular ☐ Periodic ☐ Shallow ☐ GaspingMention If baby has Respiratory distress : RR : 48/min SCR / ICR / See - Saw breathing :

Scoring of respiratory distress if present (Silverman or Downe's) :

Mention if baby is on : ☐ Hood box ☐ CPAP ☐ Ventilator

Settings :

Spo2 : 98% RA Auscultation : Breath Sounds : BAET Added Sounds : —

Cardiovascular System :

HR : 148/min BP : Precordial Activity : S₁+Femoral Pulses : B/L femoral (+) Murmurs : —

Other Peripheral Pulses : Signs of Cardiac Failure :

Abdomen :

Shape : inc Hernia orifice :Palpation : Anal Patency : 1GPalpable masses : 1G Umbilical Cord : 1G

Abdominal girth : First urine passed :

Meconium passed :

Nervous System : Higher intellectual functions (Sensorium) :

State of wakefulness :

Prechtle Score : cry & activity - good

Nerves :

Motor System :

Passive Tone : 1G all 4 limbs

Active Tone :

Neonatal Reflexes :

Grasp : ☐ Palmar ☐ Plantar ☐ Sucking ☐ Rooting ☐ Crossed adductor :

Moro's : DTR :

ATNR : Skull and Spine :

Any Congenital Anomalies :

Diagnosis :

Day 3 / NR LTB

FOOT PRINTS

Left Side :

Right Side :

Resident Doctor :

Signature : V. Anapuran 76744

Name : Dr. V. Anapuran

Date & Time : 1/9/2026

Consultant :

Signature :

Name :

Date & Time :

PLEASE FILL UP THE FOLLOWING DETAILS

1. Name of the referring Doctor :
2. Name of the referring Hospital :
Address :
Contact Numbers :
3. Contact Details of the referring Doctor :
Mobile No. : E-mail ID :
4. Name of the Doctor in Rainbow Team :

..... on whose name the patient is being referred.

AT THE TIME OF TRANSFER TO THE WARD

Final Diagnosis :

Present Issues :

Vital : ☐ HR : ☐ RR : ☐ BP : ☐ SPO2 : Weight :

Any Oxygen requirement :

Systemic :

Medications :

Plan during ward follow up :

Feeding Plan at the time of shifting :

Screenings done during NICU Stay :

NSG :

Hearing Screen :

ROP :

TFT :

NP2 :

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RESULT SHEET

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

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

Culture and Sensitivities :

.....

.....

.....

Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI :

 Others (ECG, Contrast Studies etc.) :



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/07/2024	S/B Dr. Shreeprasad	
	S. bilirubin (Day 3) - 16.63 mg/dl.	
	(Cmt: 16.6 mg/dl)	
	on exclusive breast-feeding	
	thru	
	urine / @	
	M/Dx	Birth weight - 2.525 kg
	B/Dx	Admission weight - 2.373 kg
		% wt loss - 6.7%
	o/c cry + activity - good	
	mod alert +	
	neuro exam, vital stable	
	CH - G ₂ + R - BAE +	
	P/A - (71) - CNS - (71) -	
	NRE (11)	
	Plan - 1) To start SSP	
	2) To continue DBT Q2 nd hly +	
	3) To repeat S. bilirubin + electrolytes	
	to ensure rising (1 am).	
		V. Shreeprasad
		76744

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/21/26 9:40 AM	SIR Dr. LUCY VIGAN	
	Δ: Primipara (term 37+5 wks) / 1st / Neonatal (Day 4 of life)	M / One hyperbilirubinemia B / One
	none - pancy stools - pancy	
	B.Wt: 2.545 kgs	
	Admin wt: 2.373 kgs	
	F.Wt: 2.339 kgs	
	Δ: 8.09 l.	
	Body round	
	vitals: stable	
	heart: in air	
	liver: palpable	
	PP: unremarkable	
	Idioms ⊕	
	RS: clear	CNS: 5/1/20 / no men
	PA: soft / no mass	CNS: NMD / @ 12/1/20 / daily
	not in range	Asine
	SBR: 13.7 (11.4 / 0.6)	1) continue SSPT
	Electrolytes - K - 6.2	2) DBF - 0.21 / 2.01 / formula feeds (50S)
	Na - 128	3) watch for dehydration
	Cl - 109	
	<u>Lucy Vigan</u>	
	2023/24	

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

[illegible]

Patient Sticker



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PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

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PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

CI

RCH/ FRM / CLINICAL / 124

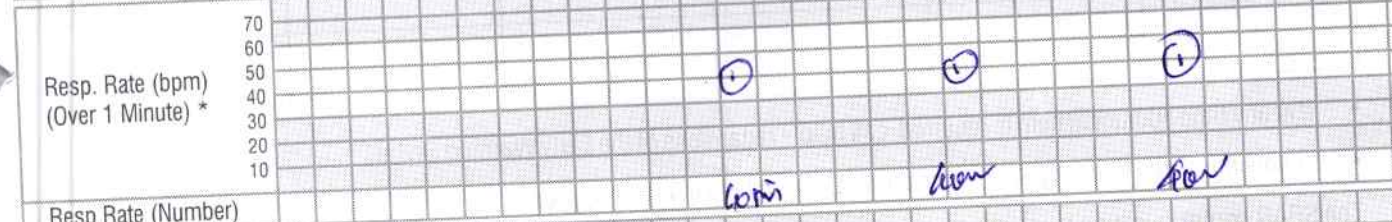
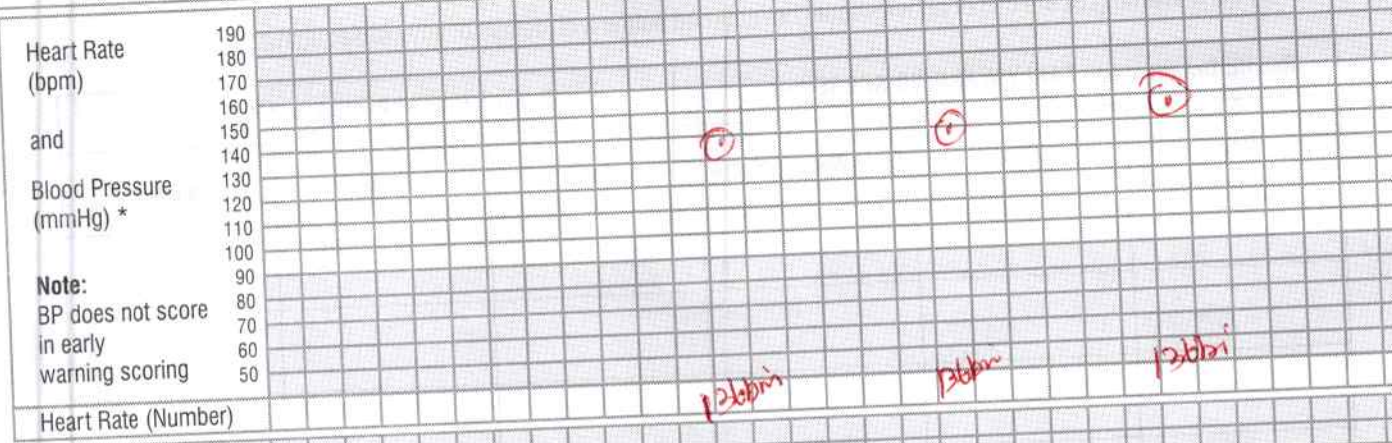
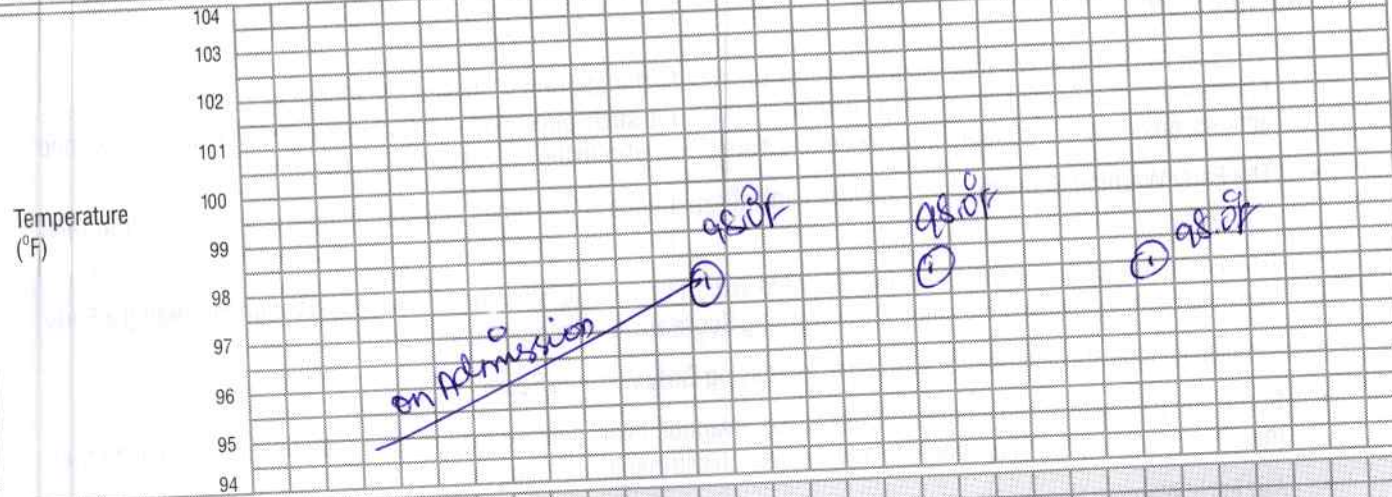
INFANT (<1 year) Children's Observation & Early Warning Scoring Chart



EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 01/7/20 Time: 8pm 12pm 4pm

Doctor/Nurse/Family Concern?



Resp Mod/ Severe Distress None / Mild

Receiving O₂ (l/min) O₂ Saturations (%)

Conscious Level Normal / Altered

GCS *

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

ACTIONS

NB: Scores 3 should be recorded overleaf

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

- 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-00093196
Baby B/O ROHINI VARSHA
28-06-2026 0 Y 0 M 4 D
Dr. PADMAPRIYA EKAMBARAM

IP18-00036274

(F)

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FLUID CHART

Sheet No. : 1

RWT: 2, 3441g

- 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	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
11/7/26	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
	Total Intake :						Total Output :						
02:00 pm													
03:00 pm													
04:00 pm													
05:00 pm													
06:00 pm													
07:00 pm													
Total Intake :						Total Output :							
08:00 pm			Admission									Sw	
09:00 pm	DBF										NO	Sw	
10:00 pm											IV	Sw	
11:00 pm	DBF								30		Sw	Sw	
12:00 am											Urine	Sw	
01:00 am	EBM 15											Sw	
Total Intake : 2 times DBF + EBM 15ml						Total Output : 30ml							
02:00 am									30		NO	Sw	
03:00 am	EBM 30										IV	Sw	
04:00 am												Sw	
05:00 am	DBF								30		Urine	Sw	
06:00 am												Sw	
07:00 am	DBF											Sw	
Total Intake : 2 times DBF + EBM 30						Total Output : 60ml							
Total 24 hrs. Intake		4 times DBF EBM 2 times											
Total 24 hrs. Output		U - 3 times M - 5 times											

REPORT

1. Title

2. Date

3. Objectives

Time	Temp	Humidity	Wind	Pressure
08:00	25.0	65%	10 km/h	1013 hPa
09:00	26.0	60%	12 km/h	1012 hPa
10:00	27.0	55%	15 km/h	1011 hPa
11:00	28.0	50%	18 km/h	1010 hPa
12:00	29.0	45%	20 km/h	1009 hPa

Time	Temp	Humidity	Wind	Pressure
13:00	30.0	40%	22 km/h	1008 hPa
14:00	31.0	35%	25 km/h	1007 hPa
15:00	32.0	30%	28 km/h	1006 hPa
16:00	33.0	25%	30 km/h	1005 hPa
17:00	34.0	20%	32 km/h	1004 hPa

Time	Temp	Humidity	Wind	Pressure
18:00	35.0	15%	35 km/h	1003 hPa
19:00	36.0	10%	38 km/h	1002 hPa
20:00	37.0	5%	40 km/h	1001 hPa
21:00	38.0	0%	42 km/h	1000 hPa
22:00	39.0	0%	45 km/h	999 hPa

Time	Temp	Humidity	Wind	Pressure
23:00	40.0	0%	48 km/h	998 hPa
00:00	41.0	0%	50 km/h	997 hPa
01:00	42.0	0%	52 km/h	996 hPa
02:00	43.0	0%	55 km/h	995 hPa
03:00	44.0	0%	58 km/h	994 hPa

Time	Temp	Humidity	Wind	Pressure
04:00	45.0	0%	60 km/h	993 hPa
05:00	46.0	0%	62 km/h	992 hPa
06:00	47.0	0%	65 km/h	991 hPa
07:00	48.0	0%	68 km/h	990 hPa
08:00	49.0	0%	70 km/h	989 hPa



THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	17/2/21	4			
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	2	2			
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.)	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1			
Cognitive Impairments	Not aware of Limitations	3	1	1			
	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	1	1			
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2	2	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	1	1			
Total			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		X	NO				
Other Intervention(s) Specify		X	NA				
Nurse's Name:		MM: E. Suman					
Signature:		[Signature]					
Date:		17/2/21					
Time:		8pm					

Continued

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Table with multiple columns and rows, containing faint handwritten data.

GUC-00093196 IP18-00036274
 Baby B/O ROHINI VARSHA (F)
 28-08-2026 0 Y 0 M 4 D
 Dr. PADMAPRIYA EKAMBARAM



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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							

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									
Nurse's Name:									
Signature:									
Date:									
Time:									



10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

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GUC-00093196

IP18-00036274

Baby B/O ROHINI VARSHA

28-06-2026 0 Y 0 M 4 D (F)

Dr. PADMAPRIYA EKAMBARAM

BRADEN 'Q' SCALE

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		Date: 17/06/26			
		Time: 9pm			
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
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.	1
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
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
FRICION-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
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.	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
TOTAL SCORE				24	
Evaluator's Name				24	

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	• Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • Advance to a higher level of risk if other major risk factors are present	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	• Use the Same Protocol as for "At Risk" Patients • Position patient at 30 degree lateral incline using foam wedges	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	• Follow the same protocol as for "Moderate Risk" Patients • In addition to regular turning schedule • Make small shifts in their position frequently	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	• Use same protocol as for "High Risk" Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

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 Baby BIO ROHINI VARSHA
 28-06-2026 0 Y 0 M 4 D (F)
 Dr. PADMAPRIYA EKAMBARAM



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
17/06	9pm	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	nil	Agon
02/07/20	2AM	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	nil	Agon
21/10/20	9pm	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	nil	Agon
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

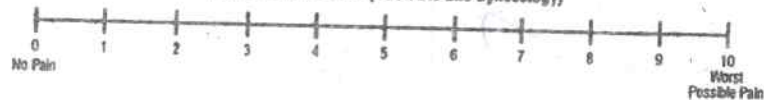
Re-assessment Frequency:
 1. Every eight hours for all hospitalized patients.
 2. For post-surgical patients, patients with chronic pain, patient with severe pain:
 a) At least every 2 hours for the first 24 hours
 b) Then every 4 hours
 c) Prior to pain pain-relieving intervention
 d) Within 30 - 60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

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
	0	1	2
Face	No Particular expression or smile	Occasional Grimace or Frown, withdraw, Disoriented	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs drawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, 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

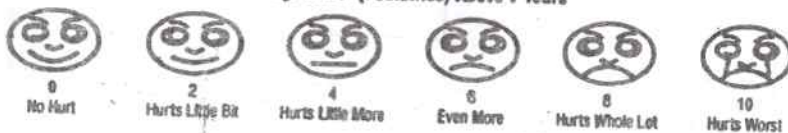
Numerical Pain Scale (Obstetric and Gynecology)



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

Assessment Criteria	Sedation		Normal	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	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR, RR, BP, SaO ₂	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO ₂ 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

Wong - Baker (Pediatrics) Above 7 Years



GUC-00093198 IP18-00036274
 Baby B/O ROHINI VARSHA
 28-06-2026 0 Y 0 M 4 D (F)
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PARENT / FAMILY EDUCATION RECORD



INT

Part - I.
 Patient's / Learner Language: Patient / Learner Literacy: ☐ Read ☐ Write ☐ Speak Willingness to Learn: Yes No Healthcare Literacy: Yes ☒ No ☐

Identified Education Needs:

1. Diagnosis
2. Treatment and Care
3. Pain Management
4. Informed Consent
5. Medication / Therapy (safety, effects/ side effect, interactions)

6. Discharge Medication
7. Infection Control Measures
8. Diagnostic Test / Procedures
9. Nutrition / Diet

10. Fall Risk Education
11. Safe use of Medical Equipment / Implantable Devices
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		
11-7-26	9pm	practise	educate about the proper use of eye drops.	family	no learning barriers	oral	none	adequate understanding	good	60088

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



Министерство
образования
и науки
Республики
Казахстан

Учредитель

№ 10

10.10.2010

УТВЕРЖДАЮ: Директор школы № 10, [Signature]

10.10.2010

10.10.2010

10.10.2010

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10.10.2010

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10.10.2010