BAH-00655429 IP5-00174447
Master MD HASAN AKRAM
28-10-2019 6 Y 6 M 30 D (M)
Dr. SIRISHA RANI

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ACTIVITY RECORD FOR BILLING

Name :_____

UHID No. : _____ IP No : _____Consultant: _____ Dept : _____

Date of Admission: _____ Time : _____Date of Discharge : 28/5 Time: 10am

Room / Bed No : _____Ward : _____ Suggested Billable bed type : _____

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
27/5/26	1120pm	EL	148(B)	

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Signature

MEDICAL EQUIPMENT (WARD & ICU)

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

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
28/5	Blood transfusion	1	963353	
28/5	chemotherapy	1	963463	

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

Md. Hasan Alam
Patient Sticker
BAH DO 655429
Dr. Sirisha Rani

1/45

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DEFICIENCY CHECK LIST OF CASE SHEET

Sl.No.	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission sheet	1			
2	Discharge Summary	2			
3	Nursing Initial assessment	1			
4	Patient Transfer form	1			
5	In-patient Medical record				
6	Doctors progress sheets	1			
7	Nursing plan of care and handover sheets	7			
8	Consultation sheet				
9	General consent for treatment	1			
10	Consent for Surgery				
11	Consent for blood transfusion				
12	Consent for chemotherapy	1			
13	Consent for high risk				
14	Consent for Restraint				
15	LAMA consent				
16	Consent for special procedure / Sedation				
17	Consent for Formula feed				
18	Consent for MTP				
19	Consent for Radiological Investigations				
20	Consent for HIV test				
21	Anaestesia notes (Pre Anaesthesia& post)				
22	Neonatal Admission/Delivery/Physical Exam				
23	Medication Reconciliation	1			
24	Emergency Triage record	1			
25	Pre operative check list				
26	Surgical safety checklist				
27	Operation Theatre notes				
28	Nurses clinical Presentation				
29	TPR & BP chart	1			
30	Intake and Out take chart (fluid chart)	1			
31	Drug chart (Regular Prescription)	1+e)			
32	Investigation Values (result sheet)	1			
33	Nebulization chart				
34	Nutritional review chart				
35	Intensive care unit (ICU Charts)				
36	Consent for Admission in PICU / NICU				
37	The Humpty dumpty scale	1			
38	Braden Q Scale	1			
39	Bed side check list				
40	PICU bed formula Dilution feeds				
41	Gastro monitoring chart				
42	Rch ED doctors note	1			
43	BP Monitoring chart				
44	RBS monitoring chart				
	Entry	6			
	Total No. of Pages	26			

Signature and Date :
24/5/26

(P.T.O)

ERROR LOG

LOCATION : OT / Birthing Centre / BirthRight Premium / 3rd Floor (Zone A,B,C) / NICU / PICU / 2nd Floor Ward / Oncology / 1st Floor Wards.

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE

Rainbow Children's Hospital

BirthRight by Rainbow

Rainbow Children's Hospital - Banjara Hills

8-2-120/103/1,2,3,4 and 5,Road No: 2, Banjara Hills, Telangana, Hyderabad, INDIA Banjara Hills ,Hyderabad ,Telangana, India ,500034.
TEL NO :+91-40-4466 5555
WEB : https://rainbowhospitals.in

ADMISSION SHEET

Registration Details :

Admission No : IP5-00174447 **Admit Date** : 28-May-2026 **Admit Time** : 12:41 PM **UHID** : BAH-00655429

Patient Details :

Patient Name	: Master MD HASAN AKRAM	**Age**	: 6 Y 6 M 30 D
Guardian	: Mr MD IRSHAD AKRAM	**DOB**	: 28-10-2019
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	: Single
Address (H)	: DARUSSALAM RAMANA ROAD Bankipur Patna Bihar INDIA 800004	**Phone No**	: 9910405565/ 7569838222
		E-mail	: MDIRSHADAKRAM@GMAIL.COM

Admission Details :

Bed Type : SHARED WARD **Bed No** : SW148(B) **Ward Name** : 1F-VIBGYOR

Room No : SW148(B) **Admission Type** : First Visit

Contact Details :

Name : Mr MD IRSHAD AKRAM **Relationship** : Father

Contact Address : DARUSSALAM RAMANA ROAD Bankipur Patna Bihar INDIA 800004 **Phone No** : 9910405565 / 7569838222

Signature

Doctor Details :

Doctor Name : Dr. SIRISHA RANI **Specialisation** : HEMATO ONCOLOGY

Referral Doctor : Self **Phone No** :

Co-Consultant :

Payment Details :

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

Payor Name : MEDI ASSIST INSURANCE TPA PVT LTD

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28-10-2019 6 Y 6 M 30 D (M)
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
28/5/20 12:30pm	Seen by ER Resident: Dr Sanithi	
	K/C/O T- Lymphoblastic Lymphoma. with ongoing chemotherapy.	Plan: 1. Inj ONDANSETRON 4 mg IV BD. 2. FFP- 1 unit transfusion 3. Plan to give chemotherapy.
	No fever/cough/vomiting O/E child alert, afebrile Temp- 98.2°F PR - 110/min BP- 94/58 (68) mmHg RR - 24/min SpO_2 - 99% RA CVS- S1S2+ chest clear abdomen Soft	Sanithi
	NB Bhavani 28/5/20	

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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CONSENT FOR CHEMOTHERAPY

Patient Name : Hasan Akram Age : 6y 6m Gender : Male ☑ Female ☐

UHID No : 655429 Department : pmo Date : 28/5/26

Type of Chemotherapy : Intravenous

The type of reactions, nature of the major risks and complications arising from the treatment despite precautions has been explained to me. These can include Bone Marrow depression with subsequent infections, bleeding, nausea, vomiting, diarrhea, mouth ulcers, alopecia, fever, phlebitis, ulceration at the site of injection organ injuries etc. The doctor have explained to me about the benefits and alternative for this procedure that .....

nil

I understand that no promise of cure or freedom from risk can be given. During the course of treatment I will report any symptoms if they become bothersome.

I have read the above and have no further questions about the treatment to be given.

Patient Attendant :

Signature : .....

Name : Mohammed Ibrahim

Relationship with Patient: Father

Date & Time : 28/5/26 3pm

Witness :

Signature : .....

Name : .....

Date & Time : 28/5/26 @ 3pm

Doctor (who is taking the consent):

Signature : .....

Name : Dr. Sirisha

Date & Time : 28/5/26, 2pm

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కీమో థెరపీ కొరకు అంగీకారం

రోగి పేరు : ..... వయస్సు ..... లింగం పు ☐ స్త్రీ ☐

యు.హెచ్.ఐ.డి. ..... రిజిస్ట్రేషన్ నెం.: .....విభాగము .....

తేదీ .....

కెమోథెరపీ రకాలు: .....

ఈ చికిత్స చేయు సమయములో తగు జాగ్రత్తలు తీసుకున్న సంభవించు వివిధ రకములైన ప్రమాదాలు తలెత్తే సమస్యల నాకు డాక్టర్ వివరించబడింది. వీటిలో ఎముక మజ్జ మాంద్యం, తదుపరి అంటువ్యాధులు, రక్తస్రావం, వికారం, వాంతులు, విరేచనాలు, నోటి పూతల, అలోపేసియా, జ్వరం, ఫ్లేబిటిస్, అవయవ గాయాలు, ఇంజెక్షన్ ఉన్న ప్రదేశంలో పుండ్లు మొదలైనవి కలగవచ్చు ఈ విధానం యొక్క ప్రయోజనాలు మరియు ప్రత్యామ్నాయం గురించి డాక్టర్ నాకు వివరించారు.

డాక్టర్ నీకు ఈ ప్రక్రియ వల్ల కలుగు లాభాలు మరియు ప్రత్యామ్నాయాలు వివరించారు .....

.....

చికిత్స వల్ల కలుగు ఫలితాలు గురించి ఏ విధమైన వాగ్దానం ఇవ్వలేరని నేను అర్థం చేసుకున్నాను. చికిత్స సమయంలో ఏవైనా లక్షణాలు ఇబ్బందికరంగా ఉంటే నేను డాక్టర్ కి తెలియపరుస్తాను.

నేను చికిత్స గురించి పూర్తిగా తెలుసుకున్నాను, చికిత్స గురించి తదుపరి ప్రశ్నలు లేవు.

సహాయకుడు(అటెండెంట్)

సంతకము .....

పేరు .....

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము .....

పేరు .....

సాక్షి

సంతకము .....

పేరు .....

తేదీ మరియు సమయము .....

IP5-00174447
HASAN AKRAM
6 Y 6 M 30 D (M)
RISHA RANI

CHEMOTHERAPY PRESCRIPTION

All the chemotherapy medications are high risk / high alert drugs.
While administering chemotherapy drugs watch for nausea, vomiting, rashes, urine output and any local extravasation of the drug.

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Sheet No. : 1	Weight (kg) : 18.6	Body Surface Area: 0.8	Diagnosis: T. lymphoblastic lymphoma	Protocol: Induction

DATE	TIME	Composition of Chemotherapy (if infusion, mention ml / hr = Mcg / kg / min. etc.)	DOSE	ROUTE	Flow Rate (ml/hr)	Doctor Sign.	Nurse Sign.	Date of Stopping	Doctor Sign.	Nurse Sign.
28/5/26	3:30 pm	2g. VINCRISTINE in 15ml NS	1mg	IV	over 15 min		Sumita	28/5/26		Mary Soosan
28/5/26	3:45pm	2g. DAUNORUBICIN in 20ml NS	18 mg	IV	@ 50 ml/hr		Sumita			

Docu. No. : RCHBH /FRM / CLINICAL / 082

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BLOOD PRODUCTS TRANSFUSION MONITORING FORM

Date: 28/5/26 Time: 2.40pm

Blood Group of the Patient: ..... Blood Group on the Blood Bag: .....

Blood Bank Issue No: ..... Date of Collection: ..... Date of Expiry: .....

Date & Time of Starting Transfusion: 28/5/26 Planned duration of Transfusion: 3 hrs

Check for Correct Unit: ☐ Correct Patient: ☐

Blood products cross checked by: Nurse 1: Sowmya Nurse 2: mithu

fore starting transfusion vitals: Temp: 98.1°F HR 112 RR: 28 BP: 102/60 SpO ....

PLEASE MONITOR THE FOLLOWING:

Date	Time	HR	Temperature	Blood Pressure	SpO_2	Any Rash	Any Rigors	Any Breathlessness	Any Other Problem
	15 Min	112bpm	98.1°F	112/62	100%	NA	NA	NA	N/A
	15 Min	112bpm	98.4°F	104/72	100%	NA	NA	NA	NA
	30 Min								
	30 Min								
	30 Min								
	1 Hr								
	1 Hr								

Comments: No Reaction

Name of the Incharge-Nurse: Sow Name of the Nurse: Mth

Signature of the Incharge-Nurse: Sow Signature of the Nurse: mthu

Date & Time: 28/5/26 2.40pm Date & Time: 28/5/26 2.40pm

CONSENT FOR BLOOD TRANSFUSION

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Dr. SIRISHA RANI

Name: ..... Age: ..... Gender: Male ☐ Female ☐

UHID.No : ..... Date: .....

Type of Blood Product:

- ☑ Fresh Frozen Plasma
- ☐ Packed Red Blood Cells
- ☐ Random Donor Platelets
- ☐ Cryoprecipitate
- ☐ Single Donor Platelet
- ☐ Whole Blood
- ☐ Albumin
- ☐ Red Blood Cell
- ☐ Others .....

I ..... hereby give my consent for whole blood transfusion or the blood components as part of treatment of myself / my patient while being admitted at Rainbow Hospital. I have been explained all the known risks of transfusion reactions. I have also been explained that the donor blood has been screened for Human Immuno-deficiency Virus antibodies, Hepatitis B surface antigen, Hepatitis C antibodies, Malaria and Syphilis. I have also been explained that transfusion transmitted infections occur even with screened blood, especially if it is in. The "window period" and also due to various other infections which have not been screened for. I also understand that any blood components transfusions carries risk of transfusion associated reactions, fluid overload etc. which are generally rare. The same risks apply for multiple transfusions too.

The doctor have explained to me about the alternative for this procedure that .....

.....

All the above-mentioned risk, benefits and alternatives have been explained to me by the doctor treating me / my patient in the language that I fully understand and I accept the same and give my consent for all transfusions (the whole blood / or blood components Packed Red Blood Cells, Red Blood Cell, Platelets, Fresh Frozen Plasma, Cryoprecipitate etc.) to me / my Patient during he present hospital stay and treatment.

Patient (Or Patient Relative / Guardian):

Signature: .....

Name: Md Irshad Akram

Date & Time 25/05/26 @ 1448 Hrs

Doctor (Who is talking the consent)

Signature: BVK Soi

Name: Dr Soi

Date & Time 28/5/26; 6.30 p.m.

Witness

Signature: Hindhendu Saha

Name: Hindhendu Saha

Date & Time 28/5/26 6.30 p.m.

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రక్త మార్పిడి కొరకు అంగీకార పత్రము

రోగి పేరు: ..... వయస్సు: ..... లింగము ☐ పురుషుడు ☐ స్త్రీ

UHID. సంఖ్య : ..... తేదీ: .....

రక్త ఉత్పత్తి రకాలు:

☐ తాజా ఘనీభవించిన ప్లాస్మా ☐ ప్యాక్ చేయబడిన ఎర్ర రక్త కణాలు ☐ Random Donor Platelets

☐ క్రయోప్రెసిపిటేట్ ☐ ఒకే ధాత ప్లేటిలెట్స్ ☐ Whole Blood

☐ మొత్తం రక్తం ☐ ఎర్ర రక్త కణం ☐ ఇతరులు.....

నేను ..... ఇందు మూలముగా రెయిన్బో ఆసుపత్రిలో అడ్మిట్ అయి ఉన్నపుడు పూర్తి చికిత్సలో భాగంగా నాకు గాని/ నా రోగికి గాని రక్తమార్పిడికై/ రక్త రక్త ఉత్పత్తుల మార్పిడికి అంగీకారం తెలుపుతున్నాను. దాత రక్తాన్ని హెచ్ ఐ వి యాంటీ బడీస్, హైపటైటీస్ బి సర్ఫేస్ యాంటిజన్, హైపటైటీస్ యాంటిబడీస్, మలేరియా మరియు సిఫ్లిస్ లక్షణాలు లేవని పరీక్షించి బడినది అని వివరించడమైనది. రక్త పరీక్ష నిర్ణిత కాల పరిమితి లో జరిగినప్పటికి పరీక్షలో కనబడని అనేక ఇతర ఇన్ఫెక్షన్ ద్వారా అతి అరుదుగా ఇన్ఫెక్షన్లు సోక వచ్చునని కూడా తెలియపరచడమైనది. ఏదైన రక్త ఉత్పత్తుల మార్పిడికి సంబంధించిన ప్రతిచర్యలు సోకే ప్రమాదం వుందని, ప్రసరణ వ్యవస్థలో అదనపు ద్రవం మొదలగు అరుదైనది పర్యవసానాలు తెలెత్తవచ్చు అని నేను అర్థం చేసుకున్నాను.

ఈ ప్రక్రియకు ప్రత్యామ్నాయం గురించి డాక్టర్ నాకు వివరించారు .....

.....

పైన పేర్కొన్న అన్ని ప్రమాదాలు, ప్రయోజనాలు మరియు ప్రత్యామ్నాయాలు నాకు / నా రోగికి చికిత్స చేస్తున్న డాక్టర్ ద్వారా నాకు వివరించబడ్డాయి. చికిత్స చేస్తున్న సమయంలో అన్ని రకముల రక్తమార్పిడులకు (మొత్తం రక్తం / లేదా రక్త ఉత్పతులు ప్యాక్ చేయబడిన ఎర్ర రక్త కణాలు, ఎర్ర రక్త కణాలు, ప్లేట్ లెట్స్, ఫ్రెష్ ఫ్రోజెన్ ప్లాస్మా, క్రయోప్రెసిపిటేట్ మొదలైనవి) నా అంగీకారము తెలుపుతున్నాను. నాకు పూర్తిగా అర్థమగు భాషలో నాకు నా రోగికి వివరించారు మరియు నేను దానిని సమ్మతిస్తున్నాను

సహాయకుడు(అటెండెంట్)

సంతకము .....

పేరు .....

తేదీ మరియు సమయము .....

సాక్షి

సంతకం .....

పేరు .....

తేదీ మరియు సమయము .....

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము .....

పేరు .....

BAH-00855429 IP5-00174447
Master MD HASAN AKRAM
28-10-2019 6 Y 6 M 30 D (M)
Dr. SIRISHA RANI

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MEDICATION RECONCILIATION FORM

Drug Allergies: ..... ☑ Not known any Drug Allergies

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

Shifting From: ER Shifted to: Oncoward.

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	Syp. SEPTRAN.	5 ml	PO	BD alt. day.	28/5 10AM	☑ C ☐ DC
2	Syp MOKTEL	5ml	PO	OD.		☐ C ☑ DC
3	Syp CALCIMAX PLUS.	5 ml	PO	OD.		☑ C ☐ DC
4	~~BOMSTAL Suspension~~	~~3ml.~~	~~PO~~			☐ 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 : Sahithi

Date & Time : 28/5/26 12:30 Pm.

Nurse Name & Signature: Bhavani

Date & Time : 28/5/26 @ 12:30pm

BAH-00655429 IP5-00174447
Master MD HASAN AKRAM
28-10-2019 6 Y 6 M 30 D (M)
Dr. SIRISHA RANI

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RESULT SHEET

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

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

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

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DRUG CHART

Date of Admission: 28/5/26 Drug Allergies: ..... ☑ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

DOCTOR - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
- Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
- Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
- Discontinue a drug by drawing a line *I* through it and a similar line through subsequent recording panels.
- The date and time of stopping the drug along with the doctors name and sign must be mentioned.
- 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:				

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

Master MD HASAN AKRAM
28-10-2019 6 Y 6 M 30 D (M)
Dr. SIRISHA RANI

REGULAR PRESCRIPTIONS

Weight. 18.5 kg Ward. .....

DRUG : Inj ONDANSETRON

Dose	Route	Frequency	Start Date
4mg	IV	BD	28/5

Name & Signature of the Doctor Starting the Drugs: Lahithi

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG : Syp SEPTRAN

Dose	Route	Frequency	Start Date
5ml	PO	BD	28/5

Name & Signature of the Doctor Starting the Drugs: Lahithi

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

Weight. 18.5kg Ward. .....

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
28/5	2.40pm	FFP	1 unit over 30 min.	IV	Jayasri	Sourav

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

28-10-2019 6 Y 6 M 30 D (M)
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BAH-0065542 IP5-0017444?
Master MD HASAN AKRAM

I.V. FLUIDS CHART

Weight. 18.5kg Ward. .....

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

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

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. : RCHBH/ FRM / CLINICAL / 126

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

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 28/5 Time: 2pm

Doctor / Nurse / Family Concern?

Temperature (F)
104 103 102 101 100 99 98 97 96 95 94

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

Note:
BP does not score in early warning scoring

190 180 170 160 150 140 130 120 110 100 90 80 70 60 50

Heart Rate (Number)

Resp. Rate (bpm) (Over 1 Minute) *
70 60 50 40 30 20 10

Resp Rate (Number)

Resp Distress: Mod/ Severe; None / Mild

Receiving O_2(l/min)
O_2Saturations (%)

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 in charge AND PICU fellow or PICU consultant to be informed.

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

Patient Sticker

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

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FLUID CHART

Sheet No. : 2

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

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
	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			PRP								
	04:00 pm											
28/8	05:00 pm	NS		30cc							R	
	06:00 pm			50cc							NO	
	07:00 pm										Fever	
Total Intake :						**Total Output :**						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						**Total Output :**						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						**Total Output :**						

Total 24 hrs. Intake		Total 24 hrs. Output	

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FLUID CHART

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Sheet No. : .....

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.
3. 24 hrs. total to be entered in the kardex in RED.

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
	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											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						**Total Output :**						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						**Total Output :**						

Total 24 hrs. Intake		**Total 24 hrs. Output**	