

ADMISSION SHEET



Registration Details :

Admission No : IP5-00176053

Admit Date : 06-Jul-2026

Admit Time : 08:43 PM UHID : BAH-00560913

Patient Details :

Patient Name : Baby LINGALA RITHWIK
Guardian : MR LINGALA NANDHA GOUD

Gender : Female

Occupation :
Address (H) : H NO 81/8/51 Bhiknoor Nizamabad
Telangana INDIA 503101

Age : 11 Y 4 M 20 D

DOB : 16-02-2015

Religion : Hindu

Marital Status : Single

Phone No : 9618035560 / 8790798905

E-mail : NOMAIL@GMAIL.COM

Admission Details :

Bed Type : GENERAL WARD

Ward Name : 1F-GENERAL WARD I

Room No : GW 117

Bed No : GW 117

Admission Type : First Visit

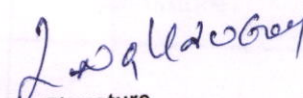
Contact Details :

Name : MR LINGALA NANDHA GOUD

Relationship : Father

Contact Address : H NO 81/8/51 Bhiknoor Nizamabad Telangana INDIA 503101

Phone No : 9618035560


Signature

Doctor Details :

Doctor Name : Dr. DR.V.V.R.SATYA PRASAD

Specialisation : PEDIATRIC NEPHROLOGY

Referral Doctor : Self

Phone No :

Co-Consultant : Dr. SRUTHI BALLA

Payment Details :

Payment Mode : Cash

Deposit Amount : 0.00

Payor Name : SELF PAY

PROCEDURE

[illegible]

ANY OTHER INFORMATION

X-ray - ①

USH - ①

Date :

Date: 11/30/2023 Time: 10/7

Prepared By :

Staff Nurse

Shift / Ward

Billing Assistant

Billing Supervisor



CMD



Rainbow[®] Children's Hospital

It takes a lot to treat the little.

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name:

Rithwika

UHID ID:

Department:

Consultant:

BAH-00580913 IP5-00178053
Baby LINGALA RITHWIKHA
16-02-2016 11 Y 4 M 20 D (F)
Dr. DR.V.V.R.SATYA PRASAD



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: _____

Desired goals of the treatment : _____

Planned Labs:

Blood Gs
 CRP

USG Abd - T/m

Planned Management

- Inj Ceftriaxone
- Inj Esomeprazole
- Inj Methylpred (After CRP report only)
- 1/2 DNS + 35ml Biceb (30ml/kg)
- 20% Albumin 100ml over 4hrs with midway & endway lab
- Neb Levofloxacin - 4th day
- Rfz - T/m

Signature of the Doctor: Ramya

Name of the Doctor: Dr. RAMYA

Date & Time: 6/7/26; 9:30pm

Signature of the Consultant: [Signature]

Name of the Consultant: Dr. Sree Prasad

Date & Time: 7/2/26; 10:00am

DR. V.V.R. SATYA PRASAD
 Registration No: 43599



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
7/7/26 9:45 AM	CL/B incident	
	RT	PLAN
	SDNS on MMF	
	UTI	IVF + H ₂ O ₂
	Relapse	Drugs as per chart ↳ Methyl pred @ 2mg/kg/day
	U/O = 400ml.	
	BP: WNL.	R/V ↑ H ₂ O ₂ ; Regular diuresis
	O/E Active	Plan
	pedal edema	
	intake - stable	100ml Albumin → @ 5pm
	Stc - NAD.	↑ Methyl pred - 150mg/OD. <i>Jahel RATHI</i>
	No ascites	1/2 D ₅ W + 35ml H ₂ O ₂ @ 40
	B/L AE +	Sy-larin 20mg 1Bx
		Send Urine CL.
		Sterile I/O charting
		B.P 03H
		RP ₂ 4m.
		DR. VVR SATYA PRASAD Registration No. 43599

BAH-00560913 IP5-00176053
 Baby LINGALA RITHWIK
 16-02-2015 11 Y 4 M 20 D (F)
 Dr. DR.V.V.R.SATYA PRASAD



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/2/24	CL/B Resident got SDNS on mmf & UTI Relapse.	
		plan
	CL - didn't pass stool since 3 days.	- Trace urine cl report - by ceftriaxone (D3)
	OLE P/A - soft.	- RIV about levosulbitalmol. - monitor vitals.
	Urine BP - 121/77 (89). Wt - 30.6 kg * Urine out pt - 1200ml over 24 hrs.	
8/2/26 10:30 AM	SIB Dr. Satya Prasad	
		plan.
		① Trace urine cl
		② 20l. Albumin at 3pm 100ml over 4hrs & midway latex midway
		③ DNS + 10ml NatCO ₃ at 50ml/hr
		④ RP ₂ T/m
		⑤ X-ray erect Abdomen now
	DR. V.V.R.SATYA PRASAD Registration No. 43589	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/12/26 8AM	SIB Resident 1. SDNS ε UPI	plan. ① Continue IV fluids. ② Rx to stop Bicarbonate ③ Continue medication as per chart ④ monitor vitals Strict No chalking Daily weight check
	wt - 30.6 → 30.3 kg (↓ 300g) BP - 112/64, 104/60. UO - 1700ml in 4.675 cc/kg/hr no fever no new issues	
	O/E: Child alert vitals stable Rt - 2LME ⊕ O/S - S, S2 ⊕ P/A - soft	
9/12/26 11:30AM	no growth 2LME	medline
9/12/26 11:30AM	SIB Dr. Satya Prasad	① continue DNS + 10ml H ₂ O ₂ ② 40ml/hr ③ Cerebin 1 th baby ④ RB tomorrow 6AM ⑤ Albumin 100ml over 4hrs ε later midway, at 2pm endway.

DR. VVR SATYA PRASAD
Registration No. 43508

BAH-00560913 IP5-00176053
 Baby LINGALA RITHWIKA
 16-02-2015 11 Y 4 M 24 D (F)
 Dr. DR.V.V.R.SATYA PRASAD



GRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/7/25 9:10 AM.	Seen by Resident	
	ASIS - SDNS & UTI	Plan
	T.Wt - 29.2 (30.3 kg)	1. Continue CEFTRIAXONE
	U/O - 200 ml @ 24 hrs.	LASIX
	- 3 cc/kg/hr.	METHYLPRED.
	O/E	2. R/V to make LEVOLIN 6 hrsly.
	child alert, afebrile	3. monitor vitals
	hemodynamically stable	Daily wt check
	no edema.	Input/output monitoring
	chest clear, abd. soft	
	hydration well maint.	
	Stools - not passed yesterday morning	
	oral intake - fair	
10/7/25 11 AM.	Seen by Dr. Satya Prasad.	Plan D/C today
		- Syp T. OMNACORTIL 30mg
		BD x 10d
	T. Lanxol 30mg OD.	1/2 Tab BD x 3d
		- T. LASIX 40mg daily OD.
		- T. STELCEL 500mg OD.
		R/V - after 1 week &
		9. SUBC.
	• CUE, RP2	
	• Syp ZIPRAX (5/100mg)	
	7.5ml BD x 3d.	

DR. VVR SATYA PRASAD
 Registration No. 43589



BAH-00560913 IP5-00176053
 Baby LINGALA RITHWIKA
 16-02-2015 11 Y 4 M 20 D (F)
 Dr. DR.V.V.R.SATYA PRASAD

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	5/7/26	7/7/26	8/7	9/7/26	10/7/26		
Time		7:00AM	7AM	8AM	7AM		
Hb	11.1						
PCV	37.4						
RBC	5.32						
WBC	16,030						
N/L	82/13						
Platelets	5.71L						
CRP	5	4					
ESR							
PCT							
RBS							
Na	125	127	130	131	132		
K	5.5	4.6 ↓	4	5.1 ↑	4.1		
Cl	95	94	92	98	100		
Ca/Mg							
Phosphate							
Urea	112	142 ↑	150 ↑	115 ↓	71 ↓		
Creatinine	2.1	2.1	1.1 ↓	0.8 ↓	0.7 ↓		
ALP							
SGPT							
SGOT							
T.Bill/Conj							
T.Protein							
S.Albumin	2.5						
S.Globulin							
A/G Ratio							
Uric Acid							
S.Amylase							
Sr.Lipase							
Blood Lactate							
S.Cholesterol							
PT/INR							
APTT							
CSF Protein / Sugar							
Cells							
N/L H/Ws	21	15	25	30	27		

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: Ward

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

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Ramya

Date & Time : 6/7/26 ; 9pm

Nurse Name & Signature : (Signature)

Date & Time : 06/7/26 @ 9pm



Sheet No:

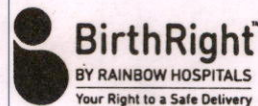
REGULAR PRESCRIPTIONS

Weight Ward

DRUG : <u>Inf. LASIX</u>				Date Time	<u>7/7</u>	<u>8/7</u>	<u>9/7</u>													
Dose	Route	Frequency	Start Dt.																	
<u>5mg</u>	<u>I.V</u>	<u>B.D</u>	<u>7/7</u>	<u>10AM</u>	<u>2 PM</u>	<u>10 PM</u>	<u>10 PM</u>													
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:				<u>10pm 5mg</u> <u>10pm 5mg</u> <u>10pm 5mg</u>																
Daily Doctor's Endorsement by a Sign																				
DRUG : <u>Syr. CALCIMAX - PLUS</u>				Date Time	<u>7/7</u>	<u>8/7</u>	<u>9/7</u>													
Dose	Route	Frequency	Start Dt.																	
<u>5ml</u>	<u>PO</u>	<u>B.D</u>	<u>7/7</u>	<u>10AM</u>	<u>2 PM</u>	<u>10 PM</u>	<u>10 PM</u>													
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:				<u>10pm 5mg</u> <u>10pm 5mg</u> <u>10pm 5mg</u>																
Daily Doctor's Endorsement by a Sign																				
DRUG : <u>Inf. METHYL PREDNISOLONE</u>				Date Time	<u>7/7</u>	<u>8/7</u>	<u>9/7</u>													
Dose	Route	Frequency	Start Dt.																	
<u>150mg</u>	<u>I.V</u>	<u>O.D</u>	<u>7/7</u>	<u>10AM</u>	<u>2 PM</u>	<u>10 PM</u>	<u>10 PM</u>													
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:				<u>10pm 5mg</u> <u>10pm 5mg</u> <u>10pm 5mg</u>																
Daily Doctor's Endorsement by a Sign																				
DRUG : <u>MUOUT POWDER</u>				Date Time	<u>8/7</u>	<u>9/7</u>														
Dose	Route	Frequency	Start Dt.																	
<u>Pls</u>	<u>PO</u>	<u>H/S</u>	<u>8/7/26</u>																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:				<u>10pm 5mg</u> <u>10pm 5mg</u> <u>10pm 5mg</u>																
Daily Doctor's Endorsement by a Sign																				
<u>to mix 3scoops in 180ml water</u>																				
Daily Doctor's Endorsement by a Sign																				

Ward

VERIFIED BY: Name



DRUG CHART

Date of Admission: 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:				

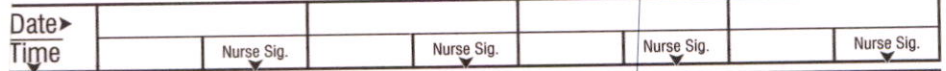
DRUG :				Date Time
Dose	Route	Frequency	Start Date	
Doctor's Signature		Valid Period	Pharm.	
Additional Instructions:				



REGULAR PRESCRIPTIONS

Weight. 30.3 kg Ward.

DRUG : <u>Ivj CEFTRIAXONE</u>				Date Time	<u>6/7</u>	<u>7/7</u>	<u>8/7</u>	<u>9/7</u>
Dose	Route	Frequency	Start Date					
<u>1.5gm</u>	<u>IV</u>	<u>BD</u>	<u>6/7/26</u>					
Name & Signature of the Doctor Starting the Drugs: <u>D. Ramey</u>				<u>10AM</u> <u>X</u> <u>10PM</u> <u>X</u> <u>Subs</u> <u>state</u> <u>state</u>				
Additional Instructions:				<u>10PM</u> <u>state</u> <u>10PM</u> <u>state</u> <u>10PM</u> <u>state</u>				
Daily Doctor's Endorsement by a Sign				<u>8</u> <u>8</u> <u>8</u> <u>8</u>				
DRUG : <u>Ivj METHYL PREDNIS</u>				Date Time	<u>6/7</u>			
Dose	Route	Frequency	Start Date					
<u>60mg</u>	<u>IV</u>	<u>OD</u>	<u>6/7/26</u>					
Name & Signature of the Doctor Starting the Drugs: <u>D. Ramey</u>				<u>11PM</u> <u>state</u> <u>Change</u> <u>dose</u> <u>7/7</u>				
Additional Instructions:				<u>11PM</u> <u>state</u>				
Daily Doctor's Endorsement by a Sign								
DRUG : <u>Ivj ESOMEPRAZOLE</u>				Date Time	<u>6/7</u>	<u>7/7</u>	<u>8/7</u>	<u>9/7</u>
Dose	Route	Frequency	Start Date					
<u>30mg</u>	<u>IV</u>	<u>OD</u>	<u>6/7/26</u>					
Name & Signature of the Doctor Starting the Drugs: <u>D. Ramey</u>				<u>6AM</u> <u>state</u> <u>10PM</u> <u>state</u> <u>10PM</u> <u>state</u>				
Additional Instructions:				<u>6AM</u> <u>state</u>				
Daily Doctor's Endorsement by a Sign				<u>8</u> <u>8</u> <u>8</u> <u>8</u>				
DRUG : <u>Neb ALBUTEROL</u>				Date Time	<u>6/7</u>	<u>7/7</u>	<u>8/7</u>	<u>9/7</u>
Dose	Route	Frequency	Start Date					
<u>1 respule</u>	<u>Nesd</u>	<u>4thly</u>	<u>6/7/26</u>					
Name & Signature of the Doctor Starting the Drugs: <u>D. Ramey</u>				<u>12AM</u> <u>state</u> <u>12AM</u> <u>state</u> <u>12AM</u> <u>state</u>				
Additional Instructions:				<u>12AM</u> <u>state</u> <u>12AM</u> <u>state</u> <u>12AM</u> <u>state</u>				
Daily Doctor's Endorsement by a Sign				<u>8</u> <u>8</u> <u>8</u> <u>8</u>				



VARIABLE DOSE	Date ▶					
	Time	Nurse Sig.		Nurse Sig.		Nurse Sig.

STAT / ONCE ONLY DRUGSPage: 3/4 (P.T.O)

Weight. 30.37kg Ward.

[illegible]



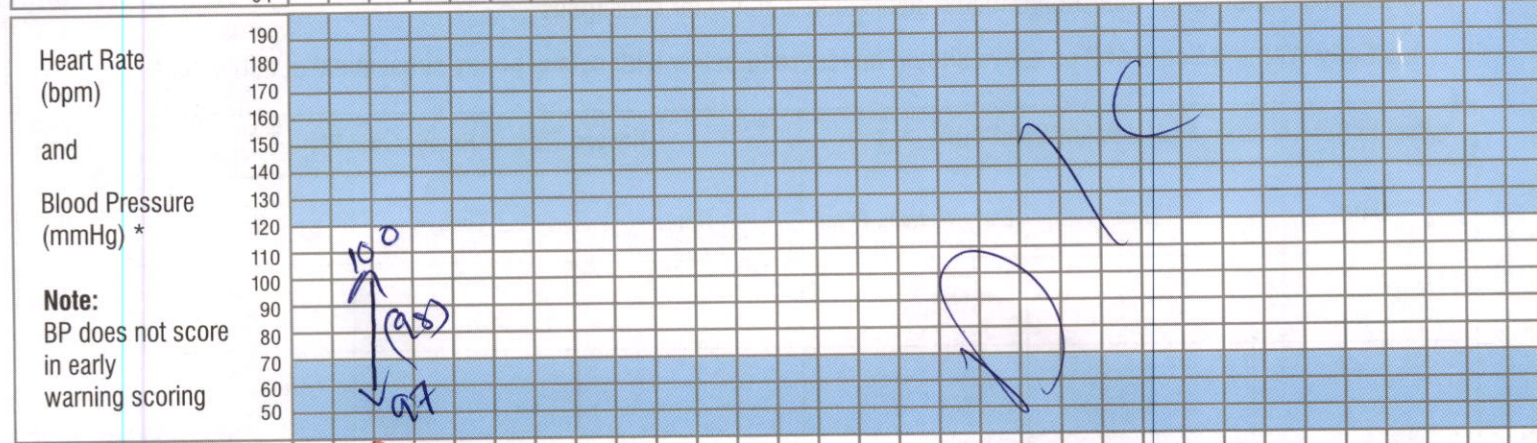
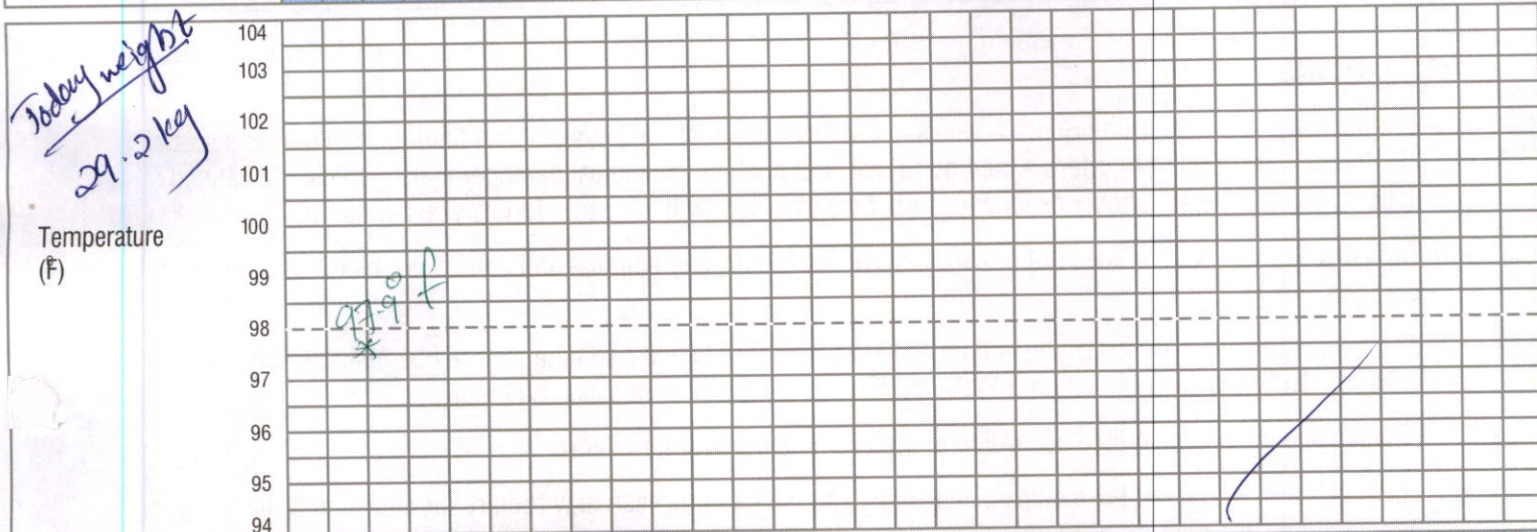
SCHOOL AGE (5-12 years)

Children's Observation & Early Warning Scoring Chart

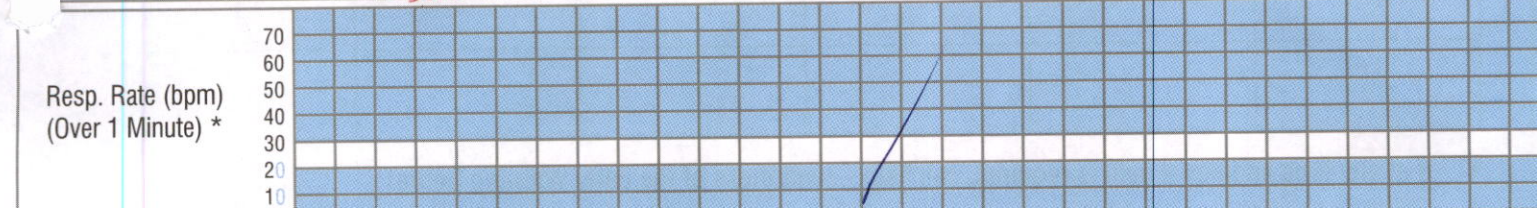
EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 10/11/26 Time: 6am

Doctor / Nurse / Family Concern?



Heart Rate (Number) 98 bpm



Resp Rate (Number) 29 bpm

Resp Mod/ Severe Distress None / Mild

Receiving O₂ (l/min) O₂ Saturations (%) 98%

Conscious Level Normal Altered

GCS * 15/15

TOTAL SCORE 1

Number of shaded boxes 1

Pain Score 0

Observer's Initials 0

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

- 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 Is there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)



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

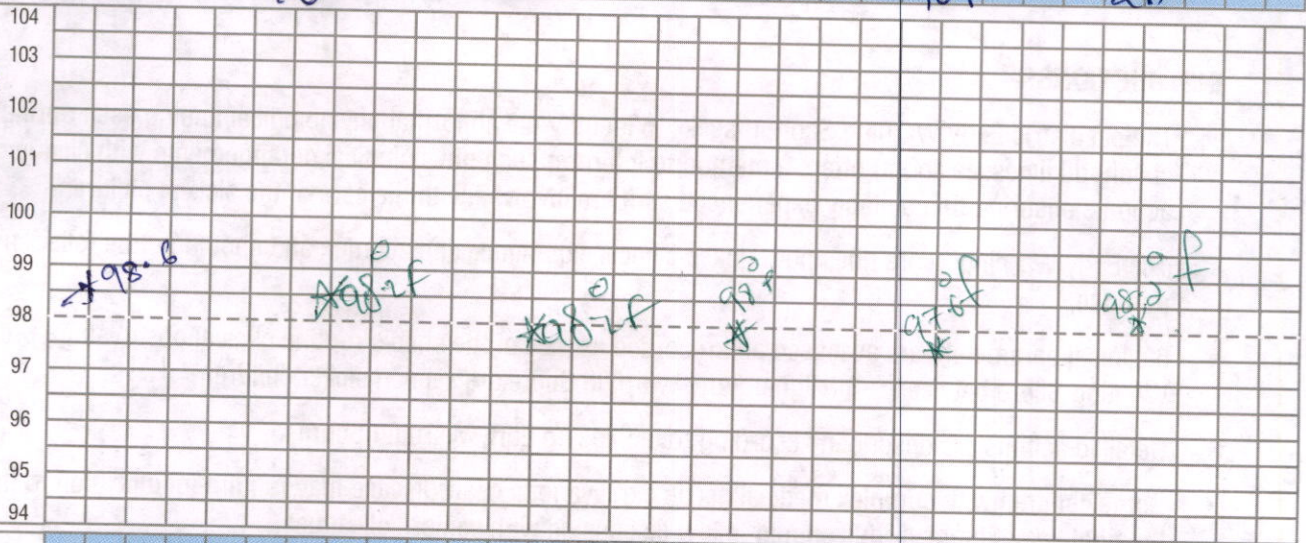
EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 9/2/25 Time: 10 am 1 pm 6 pm 10 pm 2 am

Doctor / Nurse / Family Concern?

Today wt 30.3kg

Temperature (°F)

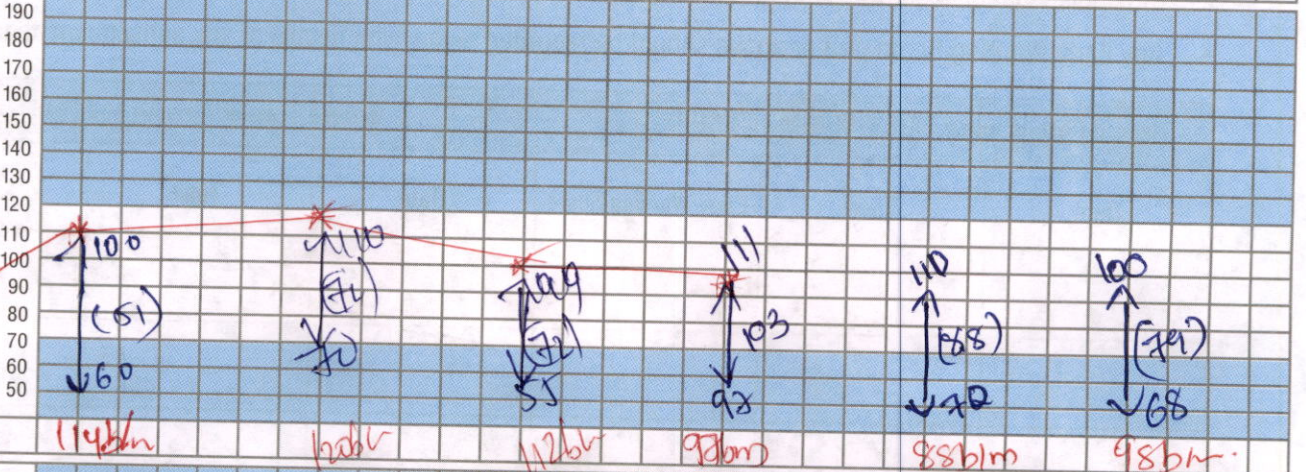


Heart Rate (bpm)

and

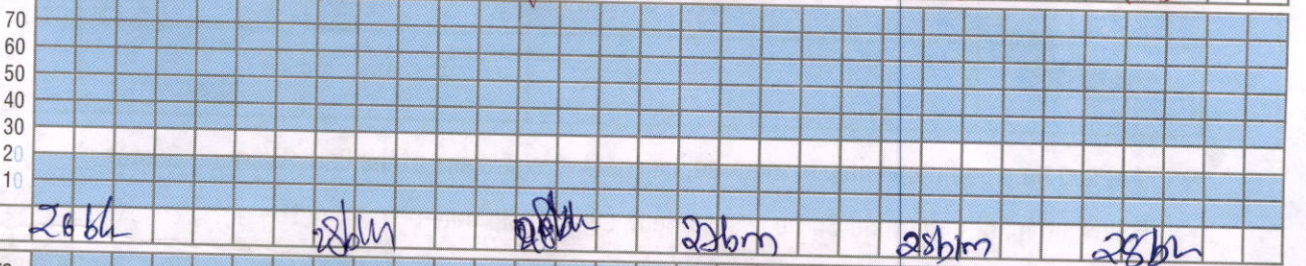
Blood Pressure (mmHg) *

Note: BP does not score in early warning scoring



Heart Rate (Number)

Resp. Rate (bpm) /er 1 Minute) *



Resp Rate (Number)

Resp Mod/ Severe Distress None / Mild

Receiving O₂(l/min) O₂Saturations (%)

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
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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)

BAH-00560913
 Baby LINGALA RITHWIK
 16-02-2015 11 Y 4 M 21 D
 Dr. DR.V.V.R.SATYA PRASAD (F)

No. : RCHBH/ FRM / CLINICAL / 126

SCHOOL AGE (5-12 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: 12.45 AM	6am	10 am	1 pm	6 pm	10 pm	2am
Doctor / Nurse / Family Concern?							
8/7 Today's wt - 30.6 kg Temperature (F)	104						
	103						
	102						
	101						
	100						
99							
98							
97							
96							
95							
94							
Heart Rate (bpm)	190						
and	180						
Blood Pressure (mmHg) *	170						
	160						
	150						
	140						
	130						
	120						
	110						
	100						
	90						
	80						
	70						
	60						
	50						
Note: BP does not score in early warning scoring							
Heart Rate (Number)	100 bpm	110 bpm	110 bpm	110 bpm	112 bpm	110 bpm	
Resp. Rate (bpm) "Over 1 Minute" *	22 bpm	22 bpm	22 bpm	22 bpm	24 bpm	24 bpm	
Resp Mod/ Severe Distress None / Mild							
Receiving O ₂ (l/min) O ₂ Saturations (%)	99%	98%	99%	100%	100%	99%	
Conscious Level Normal / Altered							
GCS *	15/15	15/15	15/15	15/15	15/15	15/15	
TOTAL SCORE	1	1	1	1	1	0	
Number of shaded boxes	1	1	1	1	1	0	
Pain Score	3	3	3	3	3	2	
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.

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.

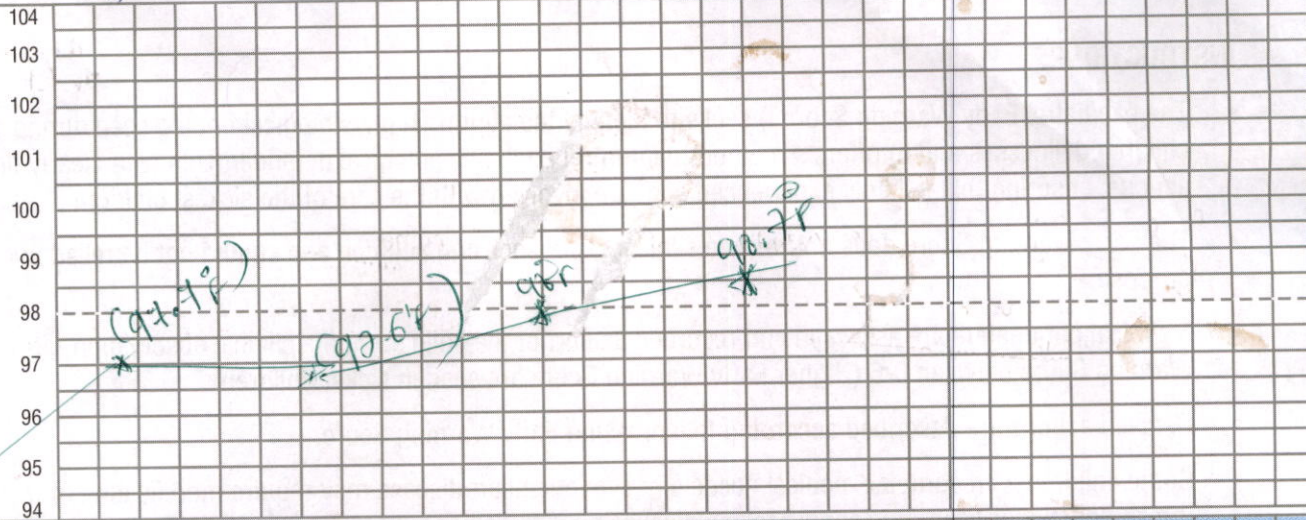
I	IDENTITY: I am (name), a nurse on ward (X). I am calling about (child X)
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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 7/2 Time: 10:10 pm 1:10 pm 6:10 pm 10:10 pm 10:20 pm 10:50 pm 11:50 pm
 Doctor / Nurse / Family Concern?

wt
 30.3 kg

Temperature
 (°F)

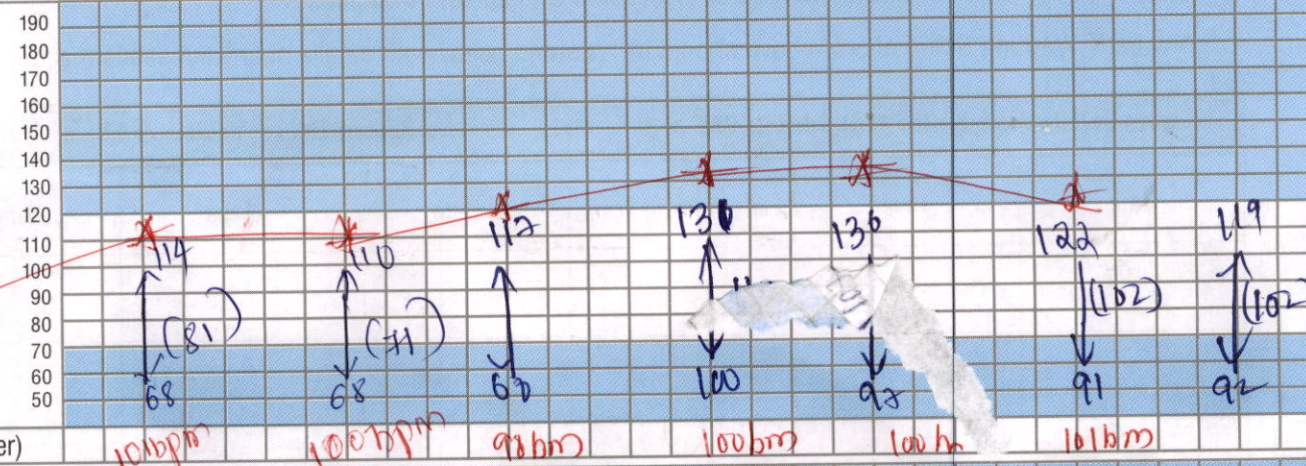


Heart Rate
 (bpm)

and

Blood Pressure
 (mmHg) *

Note:
 BP does not score
 in early
 warning scoring



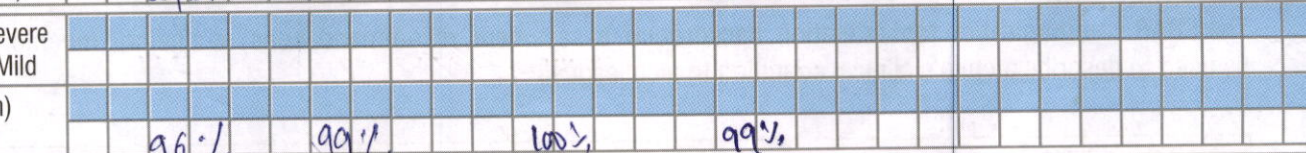
Resp. Rate (bpm)
 (Over 1 Minute) *

Resp Rate (Number)



Resp Mod/ Severe
 Distress None / Mild

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



Conscious Level
 Normal Altered

GCS *

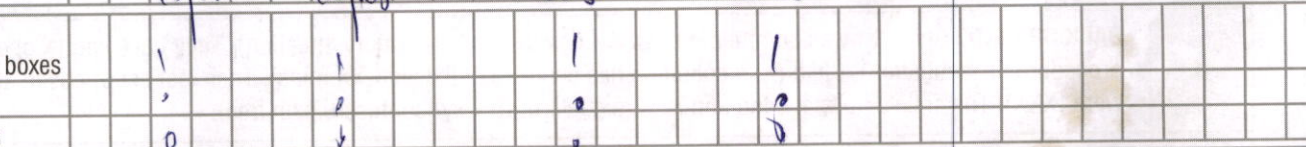


TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials



ACTIONS

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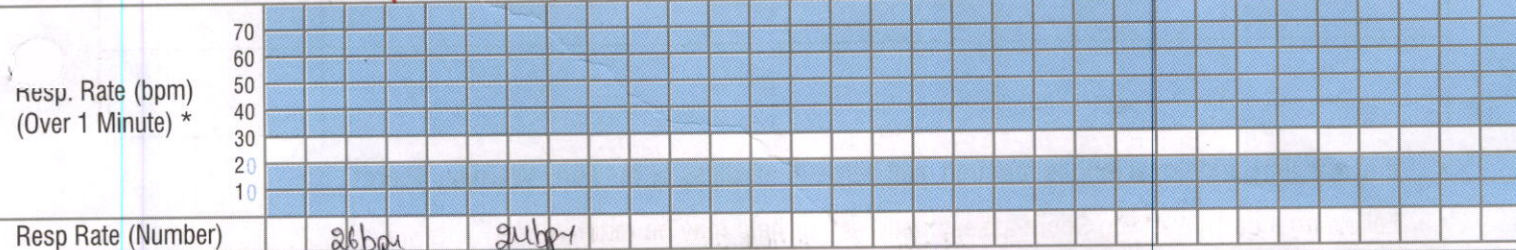
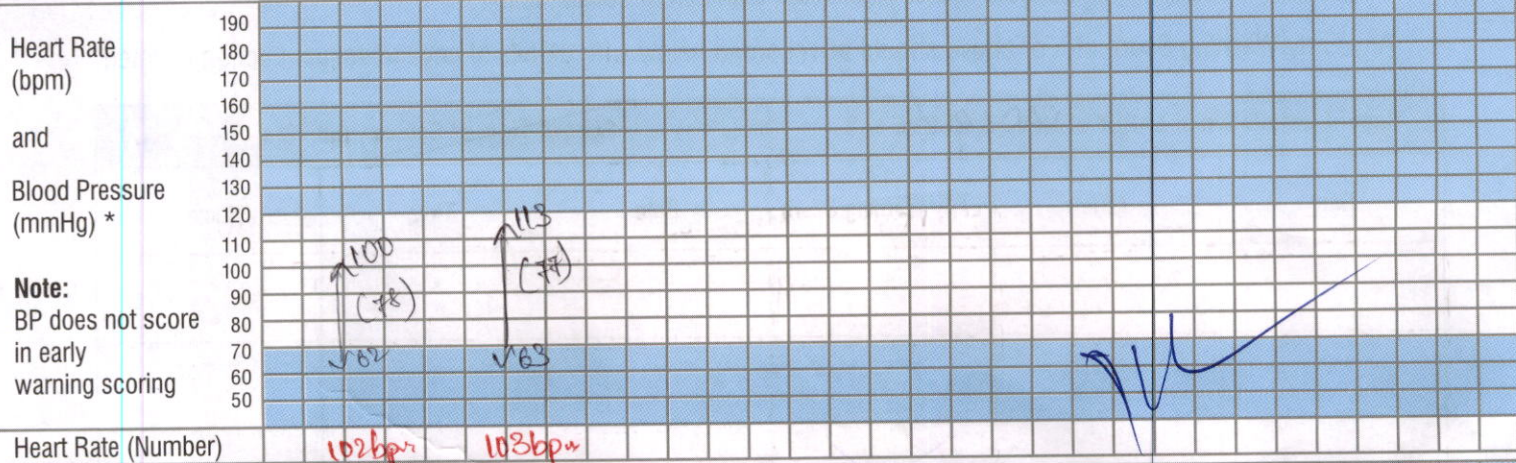
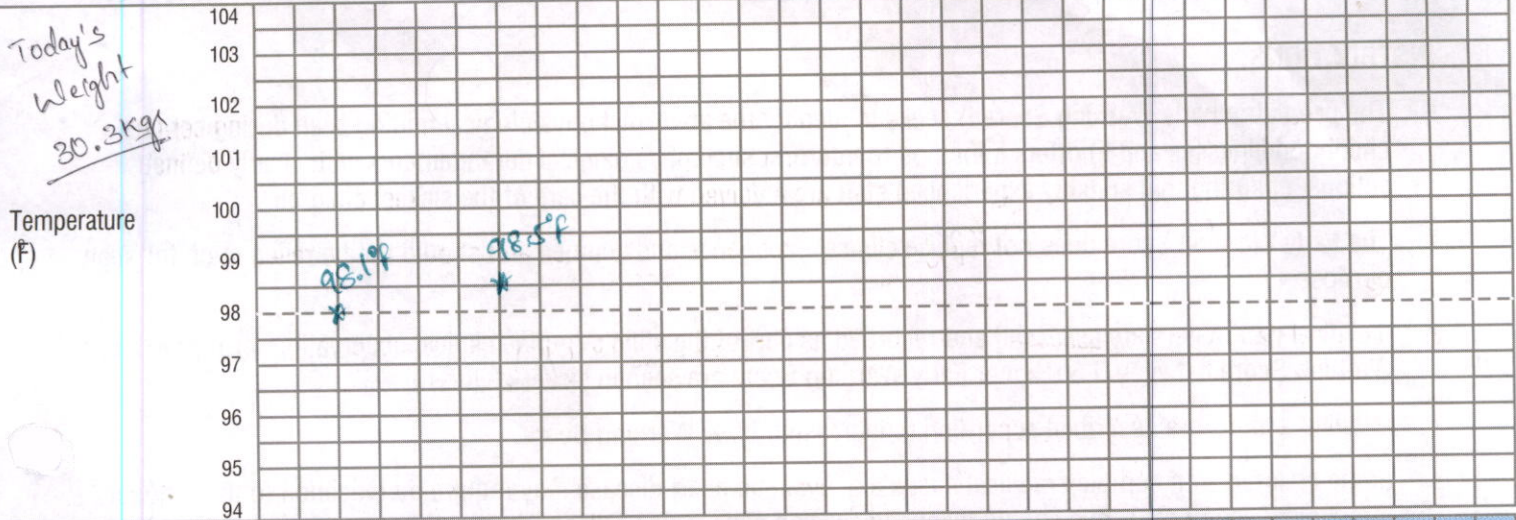
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SCHOOL AGE (5-12 years)
Children's Observation &
Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 01/01/21 Time: 2am 6am

Doctor / Nurse / Family Concern?



Resp Distress	Mod/ Severe	
	None / Mild	
Receiving O ₂ (l/min)		
O ₂ Saturations (%)		
Conscious Level	Normal	
	Altered	
GCS *		

TOTAL SCORE	
Number of shaded boxes	1
Pain Score	0
Observer's Initials	

ACTIONS

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BAH-00560913 IP5-00176053
 Baby LINGALA RITHWIKA
 16-02-2016 11 Y 4 M 20 D (F)
 Dr. DR.V.V.R.SATYA PRASAD

Patient St



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.

		Intake			Output					IV Site Thrombo- phlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage			Urine
			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	Albumin	Albumin									
	01:00 am	Albumin	Albumin									
Total Intake :						Total Output :						
	02:00 am		Albumin									
	03:00 am	Albumin	Albumin									
	04:00 am		Albumin									
	05:00 am		30ml									
	06:00 am		30ml									
	07:00 am		30ml									
Total Intake :						Total Output :						

Total 24 hrs. Intake

Total 24 hrs. Output

FLUID CHART

Sheet No. : 9

1. All measurements in ml.
2. Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.
3. 24 hrs. total to be entered in the kardex in RED.

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
7/7	08:00 am	↑		30ml		/		/		0	J. S.	
	09:00 am	30ly	30ml						0			
	10:00 am	1/2 DNS + H ₂ O	-		200ml				0			
	11:00 am	35ml	40ml		0							
	12:00 pm	HCO ₃	40ml		0							
	01:00 pm	↓			0							
Total Intake :						Total Output :						
7/7	02:00 pm	↑		40ml		/		/		0	J. S.	
	03:00 pm		40ml						250ml	0		
	04:00 pm	1/2 DNS + 35ml	40ml						0			
	05:00 pm	HCO ₃	-		0							
	06:00 pm		-		0							
	07:00 pm	↓			0							
Total Intake :						Total Output :						
7/7	08:00 pm	↑		40ml		/		/		0	J. S.	
	09:00 pm		40ml						250	0		
	10:00 pm	1/2 DNS + 35ml	-		150ml				0			
	11:00 pm	HCO ₃	-		0							
	12:00 am		40ml		0							
	01:00 am	↓	40ml		0							
Total Intake :						Total Output :						
8/7	02:00 am	↑		40ml		/		/	100	0	J. S.	
	03:00 am		40ml						0			
	04:00 am	1/2 DNS + 35ml	40ml		0							
	05:00 am	HCO ₃	40ml		0							
	06:00 am		40ml		0							
	07:00 am	↓	40ml		250				0			
Total Intake :						Total Output : 1200						
Total 24 hrs. Intake			Total 24 hrs. Output									



FLUID CHART

Sheet No. : 13

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.

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
8/07/16	08:00 am										0	sh
	09:00 am	12 pps 35ml HCO3		40ml							0	sh
	10:00 am			40ml						250ml	0	sh
	11:00 am			40ml							0	
	12:00 pm			40ml							0	
	01:00 pm										0	
Total Intake :						Total Output :						
8/07	02:00 pm	↑ : Ripe DNS + 10ml HCO3		50ml							0	sh
	03:00 pm			50ml							0	sh
	04:00 pm									250ml	0	sh
	05:00 pm										0	sh
	06:00 pm			50ml						250ml	0	sh
	07:00 pm			50ml						100ml	0	sh
Total Intake :						Total Output :						
8/7	08:00 pm			50ml						250ml	0	Chand
	09:00 pm			50ml						350ml	0	
	10:00 pm	DNS 10ml HCO3									0	Chand
	11:00 pm									250ml	0	
	12:00 am			50ml							0	Chand
	01:00 am			50ml							0	
Total Intake :						Total Output :						
9/7	02:00 am			50ml							0	Chand
	03:00 am			50ml							0	Chand
	04:00 am			50ml							0	Chand
	05:00 am	DNS 10ml HCO3		50ml							0	Chand
	06:00 am			50ml							0	Chand
	07:00 am			50ml							0	Chand
Total Intake :						Total Output :						

Total 24 hrs. Intake

Total 24 hrs. Output

4.675cc/kg



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.

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G								
09/07/26	08:00 am	Dust + 10ml NaHCO3	idly			/	/	/	/		0	chiku	
	09:00 am			50ml						250ml	0		
	10:00 am			50ml							0		
	11:00 am			50ml							0		
	12:00 pm									150ml	0		
	01:00 pm										0		
Total Intake :						Total Output :							
9/7/26	02:00 pm	Dust + 10ml NaHCO3				/	/	/	/	250ml	0	chiku	
	03:00 pm										0		
	04:00 pm										0		
	05:00 pm									400ml	0		
	06:00 pm									not mtr	0		
	07:00 pm										0		
Total Intake :						Total Output :							
9/7/26	08:00 pm	Dust + 10ml NaHCO3		hom		/	/	/	/	250ml	0	chiku	
	09:00 pm		rice	hom							0		
	10:00 pm									300ml	0		
	11:00 pm			hom							0		
	12:00 am			hom							0		
	01:00 am			hom							0		
Total Intake :						Total Output :							
10/7/26	02:00 am	Dust + 10ml NaHCO3		hom		/	/	/	/	300ml	0	chiku	
	03:00 am			hom							0		
	04:00 am			hom							0		
	05:00 am			hom							0		
	06:00 am									200ml	0		
	07:00 am										0		
Total Intake :						Total Output :							
Total 24 hrs. Intake						Total 24 hrs. Output							

2.946575celley



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 06/07/2026

Assessment: Baby having lower limbs pain & pedal edema

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
10pm	→ Assess the baby general condition and monitor the vitals and record.	10:10 PM	→ Assessed the baby general condition and monitored the vitals and recorded.	By doing all above procedure baby condition improving well
11pm	→ Doctor advice 1/2 DNLs + 35ml Bicarbonate @ 30ml/hr.	11:10 PM	→ Doctor advised 1/2 DNLs + 35ml HCO ₃ @ 30ml/hr.	
12am	→ Advice injr- Ceftriaxone, injr- esomeproazole Injr- methylpred - see after CRP report	12:10 AM	→ Advised injr- Ceftriaxone, injr- esomeproazole, injr- Methylpred. (after report CRP)	
2am	→ Neb. Levoflox - 4th hrly (0.63mg)	2:10 AM	→ Neb. Levoflox 0.63mg 4th hrly.	
3am	→ RP ₂ Tlm (Collection), USG Abdomen, Tlm.	3:30 AM	→ 20.6 Albumen Transfusion plan.	
6am	→ 20.6 Albumen Transfusion	6:10 AM	→ Collect RP ₂ , USG Abdomen Tlm.	
4am	→ Provide Comfortable position	4:10 AM	→ Provided comfortable position	
8am	→ Ensure the safety needs	8:10 AM	→ Ensured the safety needs	

Re-Assessment: Re assessment done

Special Notes: RP₂ Tlm 6am, USG Abdomen Tlm (Neb. Levoflox 0.63mg 4th hrly, 1/2 DNLs + 35ml Bicarbonate @ 30ml/hr. After seeing CRP report injr Methylpred plan.

Nurse Signature: Nikitha Nurse Name: Nikitha I.D. 605570 Date & Time: 07/07/2026 @ 6am

NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 07/04/2026

Assessment: Baby having decreased urine output and edema in body

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8am	→ Assess the baby General condition	8am	→ Assessed the baby general condition	By doing the all procedures the baby condition is improved slowly.
9am	→ provide comfort position	9am	→ provided comfortable position	
10am	→ Doctor come for rounds and doctor advised to increase IV fluid 40ml/hr and	10am	→ IV fluid increased 40ml/hr and	
4pm	Send urine culture	11am	→ Urine culture need to send	
12pm		12pm	→ Albumin today at 5pm	
1pm	→ Doctor advised to give	1pm	→ Strict I/O charting	
2pm	IV albumin at 5pm today	2pm	→ Ensured the Safety side rails	

Re-Assessment:

Special Notes:

Done by giving albumin today. Strict I/O charting.
 albumin Transfusion today @ 5pm and mid night end night lasix and
 Baby having Urine culture need to send.

Nurse Signature:

Nurse Name:

Date & Time:

07/04/26 (2pm)



NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 07/07/16

Assessment: pt having some activity

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	*Assess The pt General condition	2:30 pm	*Assessed The pt General Condition	pt is stable
3pm	*check the pt vitals	3:30 pm	*checked the pt vitals	
4pm	*maintain Ileo chart	4:30 pm	*maintained Ileo chart	
5pm	*provide comfortable position	6pm	*provided comfortable position	
7pm	*administer all medication given as per doctor order	8pm	*administered all medication given as per doctor order	

Re-Assessment:

Special Notes:

PR TOMORROW

Nurse Signature: [Signature]

Nurse Name: shanthi

Date & Time: 7/07/16 28 pm

BAH-00560913
Baby LINGALA RITHWIK
16-02-2015 11 Y 4 M 21 D (F)
Dr. DR.V.V.R.SATYA PRASAD

IP5-00176053

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

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 7/7/26

Assessment: Baby having dull Activity

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	Assess the general condition of the patient	10pm	Assessed the general condition of the patient	Baby Condition is good
11pm	monitor the vitals signs	12a	monitored the vitals signs	
2am	maintain I/O chart	4am	maintained I/O chart	
5am	maintain fluid Balance	6am	maintained fluid Balance	
	Administer medication as per as chart		Administer medication as per as chart	
7am	Ensure the patient safety	8am	Ensured the patient safety	

Re-Assessment:

Special Notes:

Nurse Signature: M

Nurse Name: Nikita

Date & Time: 8/7/26 @ 8am

NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 8/7/26

Assessment: Baby having dull activity?

- 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
 - ☒ Patient & Family Education
 - ☐ Maintain Skin Integrity

Time	Plan of Care	Time	Implementation	Evaluation
8am	Assess PT General condition	8:10am	Assessed PT General condition	PT condition is normal
9am	Monitor vitals and check record	9:10am	monitored vitals and recorded	
10am	Administer medications as per doctor's order	10:30am	Administered IV fluids as per doctor's order	
4pm	Ensure provide comfortable	4:10pm	provided comfortable position	
2pm	encourage PT to intake oral fluids	2:10pm	encouraged PT to intake oral fluids	

Re-Assessment:

Nil

Special Notes:

Boit Albumin @ 3:00pm

Nurse Signature:

[Signature]

Nurse Name:

shanthi

Date & Time:

8/7/26 @ 2pm

BAH-00560913
 Baby LINGALA RITHWIK
 16-02-2015 11 Y 4 M 21 D (F)
 Dr. DR.V.V.R.SATYA PRASAD

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

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 08/04/2026

Assessment: Baby having edema in body and decreased urine output

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
2Pm	Assessed PT General condition	2:10Pm	Assessed PT General condition	By doing the all the procedures the PT condition is normal
3Pm	Monitor vitals & record	3:10Pm	Monitored vitals & recorded	
4Pm	Maintain ILO chart	4:10Pm	Maintained ILO chart	
6Pm	Administer I fluids as per doctor's order	6:10Pm	Administered I fluids as per doctor's order	
8Pm	Provide comfortable position	8:10Pm	Provided comfortable position	

Re-Assessment:

Re-assessment is done by giving

Special Notes:

Nurse Signature: 

Nurse Name: Shailaja (605567)

Date & Time: 8/2/26 @ 8pm

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 8/7/26

Assessment: pt having dull activity

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	→ Assess the pt General Condition	8:10pm	→ Assessed the pt General Condition	pt is stable
10pm	→ Check the vital signs	10:10pm	→ Checked the vital signs	
12am	→ plan for Administration medication	12:10am	→ Providing Medication as per doctor Order	
2am	→ plan for strictly I/O chart	2:10am	→ Strictly I/O chart	
6am	→ plan for daily wt check	6:10am	→ providing Comfortable position	
	→ plan Rpr 6am			
	→ plan Ensure Safety			

Re-Assessment: Re-Assessment Every 4th hrly

Special Notes: Rpr 6am

Nurse Signature: [Signature]

Nurse Name: Chendana

Date & Time: 9/7/26 28am



NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 9/6/26

Assessment: pt. having well activity

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
☒ Patient & Family Education

Time	Plan of Care	Time	Implementation	Evaluation
8am	* Assess The pt General condition	8:30am	* ASSESSED The pt General condition	pt is stable
9am	* check the pt all vitals	9:30am	* checked the pt all vitals	
10am	* maintain iso chart	10:30am	* maintained iso chart	
11am	* provide comfortable position	11pm	* provided comfortable position	
12pm	* administer all medication given as per doctor orders	12pm	* administered all medication given as per doctor orders	

Re-Assessment:

Special Notes: pt. albumin 2pm RPR TONORMA

Nurse Signature:

Nurse Name: Shanthi

Date & Time: 9/6/26 2am

NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 9/7/26

Assessment: Baby having edema

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	Assess the general condition of the patient	2:30 pm	Assessed the general condition of the patient	Baby condition is good
3pm	monitor the vitals signs	3:30 pm	monitored the vitals signs	
4pm	100ml Albumen Transfusion		→ 100ml Albumen Transfusion plan	
	RP2. Tlm collection	4:30 pm	Collect RP2 Tlm. 6am	
5pm	Administer medication	5:30 pm	Administered medication as per as per chart	
6pm	as per as per chart	7pm		

Re-Assessment:

Special Notes:

RP2, Tlm 6am Nebi-levolin 0.63mg q4hly

Nurse Signature: Al

Nurse Name: Nikita

Date & Time: 9/7/26 @



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 9/7/26

Assessment: Baby having dull activity

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	* Assess the baby general condition. monitor vital signs	8pm	* assessed the baby general condition. monitored vital signs	Baby condition is improving slowly
10pm	* provide comfortable position	10pm	* provided comfortable position	
12AM	* given nebulization	12AM	* given nebulization	
4AM	* monitor urine output	4AM	* monitored urine output	
6AM	* Administered medication as per doctor orders	6AM	* Administered medication as per doctor orders	
7AM	* ensure safety side rails.	8AM	* ensured safety side rails.	

Re-Assessment:

Special Notes: Strict D/o chugging, daily weight checking, RPa tomorrow

Nurse Signature: [Signature]

Nurse Name: Sreecha (021086)

Date & Time: 10/7/26 @ 8AM



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. VVR - S.P. Department: Neuro Date of Admission: 06/07/20

SITUATION		Diagnosis:		Any Infection: ☐ Yes ☐ No ☒ Not Known		If Yes Specify:		
BACKGROUND	Area							
	Shift Time							
ASSESSMENT	Medical Condition (Any special condition to be noted):							
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Vital Signs:	Temp:	98.0 F	98.0 F	98.0 F	98.0 F	98.0 F	98.0 F
		Res:	22 br	22 br	24 br	22 br	22 br	22 br
		SpO ₂ :	99%	99%	99%	99%	99%	99%
		Pulse:	102 bpm	102 bpm	106 bpm	106 bpm	106 bpm	106 bpm
	BP:	112/63	100/60	114/62	100/60	101/69	100/60	
	Fall Risk Score:	9	9	9	9	9	9	
Pain Score:	0	0/10	0/10	0/10	0/10	0/10		
Recommendations	Safety Needs:	Yes	Yes	Yes	Yes	Yes	Yes	
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:	NR	NR	NR	NR	NR	NR	
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Other Special Orders / Medications:	NR	NR	IV albumin today	NR	NR	NR	
Post Operative Procedure Special Orders:								
Handed Over By Name :								
Signature :								
Date:								
Time:								
Taken Over By Name :								
Signature :								
Date:								
Time:								



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Satya Prasad Department: Nephrology Date of Admission: 6/2/20

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:				
	SPNIS						
BACKGROUND	Area	Shift Time	1st Floor 8 to 8 pm	1st Floor 8 pm - 8 am	1st Floor 8 am - 2 pm	1st Floor 2 pm - 8 pm	1st Floor 8 pm - 8 am
	Medical Condition (Any special condition to be noted):		NA	NA	NA	NA	NA
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:	Temp:	98.0	98.3°F	98.1°F	98.5	
	Res:	26b/m	26b/m	28b/m	27		
	SpO ₂ :	99%	100%	99%	99%		
	Pulse:	115bpm	111b/m	110b/m	112b		
	BP:	110/60	98/64	100/60	99/60		
	Fall Risk Score:	09	0110	0110	9	9	
Pain Score:	0110	0110	0110	0110	0110		
Recommendations	Safety Needs:	Yes	Yes	Yes	Yes	Yes	
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:	NA	NA	NA	NA	NA	
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Other Special Orders / Medications:	NA	NA	NA	NA	NA	
Post Operative Procedure Special Orders:		NA	NA	NA	NA	NA	
Handed Over By Name :		Shariya	Chandana	Shubh	Nikita	Sneha	
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	
Date:		8/2/20	9/2/20	9/2/20	9/2/20	10/2/20	
Time:		8pm	8am	2pm	8pm	8am	
Taken Over By Name :		Chandana	Shubh	Nikita	Sneha	Sirisha	
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	
Date:		8/2/20	9/2/20	9/2/20	9/2/20	9/2/20	
Time:		8pm	8am	2pm	8pm	8am	

THE HUMPTY DUMPTY SCALE

06/02/2017 2/12 8/12 9/12 10/12

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	2	2	2	2	2
	13 years old and above	1					
Gender	Male	2					
	Female	1	1	1	1	1	1
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1	1	1	1
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	1	1	1	1	1	1
	History of Falls or Infant - Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2	2	2	2	2
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	1	1	1	1	1
Medication Usage	Sedatives (excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1	1	1	1
TOTAL			9	9	9	9	9

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position	Yes	Yes	Yes	Yes	Yes
Call device within reach	Yes	Yes	Yes	Yes	Yes
Wheels Locked	Yes	Yes	Yes	Yes	Yes
Room free of clutter	Yes	Yes	Yes	Yes	Yes
Adequate Lighting	Yes	Yes	Yes	Yes	Yes
Wheel Chair Support	No	No	No	No	No
Other Intervention(s) Specify	No	No	No	No	No
Nurse's Name :	ganga	Nikh	Archi	Chand	sunil
Signature :	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date :	06/02/17	2/12	8/12	9/12	10/12
Time :	9 PM	6 AM	6 AM	6 AM	6 AM

Patient ID

BRADEN 'Q' SCALE

					Date :	07/26			
					Time :	6a			
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 e.tremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	7				
"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.	5				
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.	5				
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.	5				
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."	5				
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 meat and dairy products. Occasionally eats between meals. Does not require supplementation.	5				
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.	5				
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23					TOTAL SCORE	28			
Docu. No. : RCHBH /FRM / CLINICAL / 119					Evaluator's Name	Suh			

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

BAH-00560913 IP5-00176053
 Baby LINGALA RITHWIK
 16-02-2015 11 Y 4 M 20 D (F)
 Dr. DR.V.V.R.SATYA PRASAD



BRADEN 'Q' SCALE

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

					Date :	06/02	27/2	8/2	9/2
					Time :	9 AM	6 AM	6 AM	6 AM
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 e.tremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.		4	4	4	4
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.		4	4	4	4
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.		4	4	4	4
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.		4	4	4	4
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."		4	4	4	4
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.		4	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be < 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.		4	4	4	4
					TOTAL SCORE	28	28	28	28
					Evaluator's Name	meel	to	to	Qy

Severe Risk : less than 9 | High Risk : 10-12 | Moderate Risk : 13-14 | Mild Risk : 15-18 | Not at Risk: 19-23

Docu. No. : RCHBH /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

PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
10/7/26	6am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	B NA	Swatch
				☐ 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		
				☐ 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:

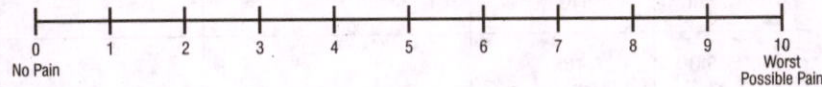
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

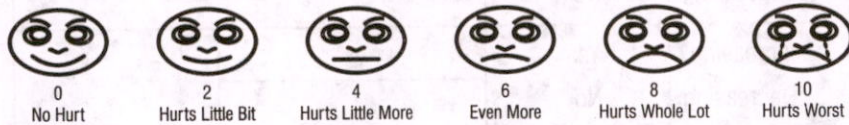
Numerical Pain Scale (Obstetric and Gynecology)



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

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	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, SaO₂	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





PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
6/6/17	9m	0	Q ^u	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	up in	reused
7/7	Sam	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	nikita
7/07	1pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	shankh
7/7	9pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	nikita
8/7	5am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	nikita
8/7	1pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Chord
8/7	11pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Chordane
9/7	6am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Chordane
9/07	2pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	ell
9/7	10pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	Surek

Re-assessment Frequency:

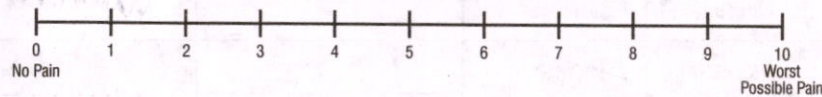
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

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CATEGORY	SCORING		
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Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, right, 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

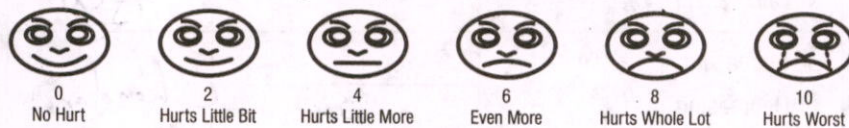
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Wong - Baker (Pediatrics) Above 7 Years

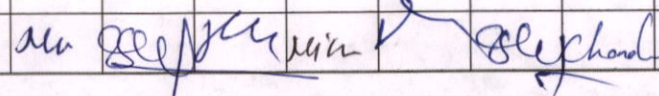


BAH-00580913 IP5-00176053
 Baby LINGALA RITHWIK
 16-02-2015 11 Y 4 M 21 D (F)
 Dr. DR. V. R. SATYA PRASAD

CHECKLIST FOR THROMBOPHLEBITIS

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	6/2 DAY-1			7/2 DAY-2			8/2 DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0			0	0	0	0	0	0		
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1			-	-	-	-	-	-		
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2			-	-	-	-	-	-		
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3	Er		-	-	-	-	-	-		
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4			-	-	-	-	-	-		
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord pyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5			-	-	-	-	-	-		
Signature of the Nurse													

NOTE : Phlebitis greater than grade 2 should be reported to physicians and other appropriate health care personal ongoing observation of the site should continue for 48 hours post removal to detect post infusion phlebitis.

Signature of Shift In Charge :

Signature : Anurban Name : Anurban

Signature of Ward In Charge :

Signature : Neeraja Devi Name : Neeraja Devi

CHECKLIST FOR THROMBOPHLEBITIS

09/07/16 10/7

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0	0	0	0							
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1	—	—	—	—						
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	—	—	—	—						
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3	—	—	—	—						
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4	—	—	—	—						
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord pyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5	—	—	—	—						
Signature of the Nurse				[Signature]			[Signature]			[Signature]			

NOTE : Phlebitis greater than grade 2 should be reported to physicians and other appropriate health care personnel ongoing observation of the site should continue for 48 hours post removal to detect post infusion phlebitis.

Signature of Shift In Charge :

Signature : [Signature] Name : [Signature]

Signature of Ward In Charge :

Signature : [Signature] Name : Neeraj a.

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Part - I.

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

Identified Education Needs:

- | | | | |
|----------------------------|--|--|---|
| 1. Diagnosis | 5. Medication / Therapy (safety, effects/ side effect, interactions) | 9. Nutrition / Diet | 13. Risk / Safety |
| 2. Treatment and Care Plan | 6. Discharge Medication | 10. Fall Risk Education | 14. Activity / Exercise |
| 3. Pain Management | 7. Infection Control Measures | 11. Safe use of Medical Equipment / Implantable Devices Safety | 15. Social & Rehabilitation Needs |
| 4. Informed Consent | 8. Diagnostic Test / Procedures | 12. Patient's / Family Rights | 16. Special Discharge / Follow-up Education / Coping Skills |
| | | | 17. Others |

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		
06/07	9pm	5	medication	F	1	0	1	1	nic	Uthas
7/7/16	8AM	9	Normal low salt diet	F	1	0	1	1	-	monika

Part - III: CODES

Who was taught: PT: Patient F: Father M: Mother S: Spouse Sn: Son D: Daughter C: Caregiver O: Other (Specify)									
Learning Barriers:									
1. No Learning Barriers	4. Language Barrier	7. Impaired Thought Process/Cognitive limitations	10. Financial Difficulties	13. Cultural/Religion Practice					
2. Physical Impairment	5. Educational Level	8. Responsibilities at Home	11. Beliefs and Values	14. Others (Specify)					
3. Emotional Barriers	6. Desire / Motivate to Learn	9. Cultural Differences	12. Impaired Vision/ or Hearing						
Teaching Tools Used: A: Audio D: Demonstration V: Video O: Oral P: Printed									
Mechanism/s to overcome barrier/s:									
1. None	3. Reassurance & Support	5. Respect values & beliefs	7. Other, Specify						
2. Obtain translator	4. Teach Family / Others	6. Respect Cultural / Religion Preference							
Understanding:									
1. Verbalizes Understanding	2. Demonstrates Understanding	3. Needs Review							



MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis: SPNS

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
6/2/16	☒ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op	SPNS	1/ study.	- 1 UF - 10 weeks		☒ Nursing ☐ Others:
06/02/16	☐ Medical ☒ Nursing ☐ Others:	☐ Initial ☒ Modified ☐ Per-Op ☐ Post Op	SPNS	1/ study.	- 10 weeks - Albumin Tx		☐ Medical ☐ Others:
7/7/16 8 AM	☐ Medical ☐ Nursing ☒ Others: Dietitian	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	SPNS & MENUS	Normal low Salt diet	RDA E: 1800 kcal/d P: 32g/d		☐ Medical ☐ Nursing ☒ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:

CONSENT FOR BLOOD TRANSFUSION

BAH-00560913 IP5-00176053

Baby UNGALA RITHWIK

16-02-2015 11 Y 4 M 21 D (F)

Dr. DR.V.V.R.SATYA PRASAD

Name: ...

Age: 11.5

Gender: Male ☐ Female ☒

UHID.No



Date: 7/07/26

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

..... 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: [Signature]

Name: nandha cross

Date & Time: 07/07/26 4 PM

Doctor (Who is talking the consent)

Signature: [Signature]

Name: M. Rahul Anar

Date & Time: 7/7/26 4 PM

Witness

Signature: [Signature]

Name: shanthi

Date & Time: 7/7/26 @ 4 PM

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 ఫ్లేటిలెట్స్ | ☐ Whole Blood |
| ☐ మొత్తం రక్తం | ☐ ఎర్ర రక్త కణం | ☐ ఇతరులు..... |

నేను ఇందు మూలముగా రెయిన్ఫో ఆసుపత్రిలో అడ్మిట్ అయి ఉన్నప్పుడు పూర్తి చికిత్సలో భాగంగా నాకు గాని/ నా రోగికి గాని రక్తమార్పిడికై/ రక్త రక్త ఉత్పత్తుల మార్పిడికి అంగీకారం తెలుపుతున్నాను. దాత రక్తాన్ని హెచ్ ఐ వి యాంటీ బడిస్, హైపటెటిస్ జ సర్వేస్ యాంటిజన్, హైపటెటిస్ యాంటిబడిస్, మలేరియా మరియు సిఫ్లిస్ లక్షణాలు లేవని పరీక్షించి బడినది అని వివరించడమైనది. రక్త పరీక్ష నిర్ణయ కాల పరిమితి లో జరిగినప్పటికీ 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 ఉత్పత్తులు ప్యాక్ చేయబడిన ఎర్ర రక్త కణాలు, ఎర్ర రక్త కణాలు, ప్లేట్ లెట్స్, ప్లేప్ ప్లాజెన్ ప్లాస్మా, క్రయోప్రెసిపిటేట్ మొదలైనవి) నా అంగీకారము తెలుపుతున్నాను. నాకు పూర్తిగా అర్థమగు భాషలో నాకు నా రోగికి వివరించారు మరియు నేను దానిని సమ్మతిస్తున్నాను

సహాయకుడు(అటెండెంట్)

సాక్షి

సంతకము

సంతకం

పేరు

పేరు

తేదీ మరియు సమయము

తేదీ మరియు సమయము

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము

పేరు

ALBUMIN

2

CONSENT FOR BLOOD TRANSFUSION



BAH-00560913 IP5-00176053
Baby LINGALA RITHWIK
16-02-2015 11 Y 4 M 21 D (F)
Dr. DR.V.V.R.SATYA PRASAD

Name: Age: Gender: Male ☐ Female ☒
UHID.No : Date: 7/7/26

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: [Signature]
Name: L. N. N. N.
Date & Time 7/7/26 @ 12:40 am

Doctor (Who is talking the consent)

Signature: [Signature]
Name: M. R. R.
Date & Time 7/7/26 @ 12:40 am

Witness

Signature: [Signature]
Name: N. N. N.
Date & Time 7/7/26 @ 12:40 pm

రక్త మార్పిడి కొరకు అంగీకార పత్రము

రోగి పేరు: వయస్సు: లింగము ☐ పురుషుడు ☐ స్త్రీ
UHID. సంఖ్య: తేదీ:

రక్త ఉత్పత్తి రకాలు:

- | | | |
|---|---|--|
| ☐ తాజా ఘనీభవించిన ప్లాస్మా | ☐ ప్లాక్ చేయబడిన ఎర్ర రక్త కణాలు | ☒ Random Donor Platelets |
| ☐ క్రయో ప్రెసిపిటేట్ | ☐ ఒకే ధాత ప్లేటిలెట్స్ | ☐ Whole Blood |
| ☐ మొత్తం రక్తం | ☐ ఎర్ర రక్త కణం | ☐ ఇతరులు..... |

నేను ఇందు మూలముగా రెయిన్ఫో ఆసుపత్రిలో అడ్మిట్ అయి ఉన్నప్పుడు పూర్తి చికిత్సలో భాగంగా నాకు గాని/ నా రోగికి గాని రక్తమార్పిడికై/ రక్త రక్త ఉత్పత్తుల మార్పిడికి అంగీకారం తెలుపుతున్నాను. ధాత రక్తాన్ని హెచ్ బి వి యాంటీ బడిస్, హైపటెటిస్ జి సర్వేస్ యాంటిజన్, హైపటెటిస్ యాంటిబడిస్, మలేరియా మరియు సిఫ్లిస్ లక్షణాలు లేవని పరీక్షించి బడినది అని వివరించడమైనది. రక్త పరీక్ష నిర్ణీత కాల పరిమితి లో జరిగినప్పటికీ 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 ఉత్పత్తులు ప్లాక్ చేయబడిన ఎర్ర రక్త కణాలు, ఎర్ర రక్త కణాలు, ప్లేట్ లెట్స్, ప్లాస్మా ప్రోథెజిన్ ప్లాస్మా, క్రయో ప్రెసిపిటేట్ మొదలైనవి) నా అంగీకారము తెలుపుతున్నాను. నాకు పూర్తిగా అర్థమగు భాషలో నాకు నా రోగికి వివరించారు మరియు నేను దానిని సమ్మతిస్తున్నాను

సహాయకుడు(అటెండెంట్)

సాక్షి

సంతకము

సంతకం

పేరు

పేరు

తేదీ మరియు సమయము

తేదీ మరియు సమయము

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము

పేరు



②

ALBUMIN

BLOOD PRODUCTS TRANSFUSION MONITORING FORM

Date: 7/2/26 Time: 12:40am

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: Planned duration of Transfusion:

Check for Correct Unit: ☒ Correct Patient: ☐

Blood products cross checked by: Nurse 1: Prigyanika Nurse 2: Nichitha

Before starting transfusion vitals: Temp: 98.5 HR 103 RR: 22 BP: 131/69 SpO₂ 98.5

PLEASE MONITOR THE FOLLOWING:

Date	Time	HR	Temperature	Blood Pressure	SpO ₂	Any Rash	Any Rigors	Any Breathlessness	Any Other Problem
<u>7/2</u>	15 Min	<u>103</u>	<u>98.5</u>	<u>131/69 (85)</u>	<u>98.5</u>	-	-	-	-
	15 Min	<u>112</u>	<u>98.5</u>	<u>120/69</u>	<u>99%</u>	-	-	-	-
	30 Min	<u>102</u>	<u>98.5</u>	<u>112/69</u>	<u>99%</u>	-	-	-	-
	30 Min	<u>100</u>	<u>98.5</u>	<u>120/70</u>	<u>98%</u>	-	-	-	-
	30 Min	<u>120</u>	<u>98.5</u>	<u>122/69</u>	<u>100%</u>	-	-	-	-
	1 Hr	<u>112</u>	<u>98.5</u>	<u>119/70</u>	<u>99%</u>	-	-	-	-
	1 Hr								

Comments:

Name of the Incharge-Nurse: Nenu

Name of the Nurse: Nichitha

Signature of the Incharge-Nurse: Nenu

Signature of the Nurse: Nichitha

Date & Time: 7/2/26 @ 12:40 PM

Date & Time: 7/2/26 @ 1:40 PM

BAH-00560913 IP5-00176053
Baby LINGALA RITHWIK
16-02-2015 11 Y 4 M 21 D (F)
Dr. DR.V.V.R.SATYA PRASAD



3



CONSENT FOR BLOOD TRANSFUSION

BAH-00560913 IP5-00176053
Baby LINGALA RITHWIK
16-02-2015 11 Y 4 M 21 D (F)
Dr. DR.V.V.R.SATYA PRASAD



Name: Age: Gender: Male ☐ Female ☐

UHID.No Date: 08/7/26 3p

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: L. Akshaya

Name: L. Akshaya

Date & Time: 08/7/26 @ 3:10pm

Doctor (Who is talking the consent)

Signature: Dr. Ramelenshu

Name: Dr. Ramelenshu

Date & Time: 8/7/26 @ 3pm

Witness

Signature: Swarna

Name: Swarna

Date & Time: 8/7/26 @ 3pm

రోగి పేరు: వయస్సు: లింగము ☐ పురుషుడు ☐ స్త్రీ

UHID. సంఖ్య: తేదీ:

రక్త ఉత్పత్తి రకాలు:

- | | | |
|---|---|--|
| ☐ తాజా ఘనీభవించిన ప్లాస్మా | ☐ ప్లాక్ చేయబడిన ఎర్ర రక్త కణాలు | ☒ Random Donor Platelets |
| ☐ క్రయోప్రెసిపిటేట్ | ☐ ఒకే ధాత ప్లేటిలెట్స్ | ☐ Whole Blood |
| ☐ మొత్తం రక్తం | ☐ ఎర్ర రక్త కణం | ☐ ఇతరులు..... |

నేను ఇందు మూలముగా రెయిన్ఫో ఆసుపత్రిలో అడ్మిట్ అయి ఉన్నప్పుడు పూర్తి చికిత్సలో భాగంగా నాకు గాని/ నా రోగికి గాని రక్తమార్పిడికై/ రక్త రక్త ఉత్పత్తుల మార్పిడికి అంగీకారం తెలుపుతున్నాను. ధాత రక్తాన్ని హెచ్ ఐ వి యాంటీ బడిస్, హైపటెటిస్ జనర్వేస్ యాంటిజన్, హైపటెటిస్ యాంటిబడిస్, మలేరియా మరియు సిఫ్లిస్ లక్షణాలు లేవని పరీక్షించి బడినది అని వివరించడమైనది. రక్త పరీక్ష నిర్ణయ కాల పరిమితి లో జరిగినప్పటికీ 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 ఉత్పత్తులు ప్లాక్ చేయబడిన ఎర్ర రక్త కణాలు, ఎర్ర రక్త కణాలు, ప్లేట్ లెట్స్, ప్లెష్ ప్రోజెన్ ప్లాస్మా, క్రయోప్రెసిపిటేట్ మొదలైనవి) నా అంగీకారము తెలుపుతున్నాను. నాకు పూర్తిగా అర్థమగు భాషలో నాకు నా రోగికి వివరించారు మరియు నేను దానిని సమ్మతిస్తున్నాను

సహాయకుడు(అటెండెంట్)

సాక్షి

సంతకము

సంతకం

పేరు

పేరు

తేదీ మరియు సమయము

తేదీ మరియు సమయము

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము

పేరు

3

BLOOD PRODUCTS TRANSFUSION MONITORING FORM

Date: 08/07/26 Time:

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: Planned duration of Transfusion:

Check for Correct Unit: ☒ Correct Patient: ☒

Blood products cross checked by: Nurse 1: Swarna Nurse 2: Pintu

Before starting transfusion vitals: Temp: 98.0 HR 128bpm RR: 24b/m BP: 116/70 SpO2 100

PLEASE MONITOR THE FOLLOWING:

Date	Time	HR	Temperature	Blood Pressure	SpO ₂	Any Rash	Any Rigors	Any Breathlessness	Any Other Problem
8/07	15 Min	80b/m	98.0°F	116/81	98%	-	-	-	-
	15 Min	98b/m	98.0°F	110/80	98%	-	-	-	-
	30 Min	92b/m	97.6°F	110/80	99%	-	-	-	-
	30 Min	98b/m	97.8°F	112/60	99%	-	-	-	-
	30 Min	98b/m	98.0°F	110/60	98%	-	-	-	-
	1 Hr	80b/m	96°F	112/60	98%	-	-	-	-
	1 Hr	98b/m	98.4°F	110/80	100%	-	-	-	-

Comments:

Name of the Incharge-Nurse: Neeraj

Name of the Nurse: Shalaja

Signature of the Incharge-Nurse: Neeraj

Signature of the Nurse: Shalaja

Date & Time: 8/7/26 3pm

Date & Time: 8/7/26 @ 4pm

4

Albumin

CONSENT FOR BLOOD TRANSFUSION



BAH-00580913 IP5-00176053

Baby LINGALA RITHWIK

16-02-2015 11 Y 4 M 24 D (F)

Dr. DR.V.V.R.SATYA PRASAD

Name:

Age: 114

Gender: Male ☐ Female ☒

UHID.No:



Date: 9/7/26

- 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 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):

Doctor (Who is talking the consent)

Signature: J. Nalavara

Signature: T. Pawan

Name: J. Nalavara

Name: T. Pawan

Date & Time: 9/7/26 2:45pm

Date & Time: 9/7/26

Witness

Signature: Nikita

Name: Nikita

Date & Time: 9/7/26 2:45pm

రక్త మార్పిడి కొరకు అంగీకార పత్రము

రోగి పేరు: వయస్సు: లింగము ☐ పురుషుడు ☐ స్త్రీ
UHID. సంఖ్య: తేదీ:

రక్త ఉత్పత్తి రకాలు:

- ☐ తాజా ఘనీభవించిన ప్లాస్మా ☐ ప్లాక్ చేయబడిన ఎర్ర రక్త కణాలు Random Donor Platelets
☐ క్రయాప్రెసిటివేట్ ☐ ఒకే ధాత స్టేటిలట్స్ ☐ Whole Blood
☐ మొత్తం రక్తం ☐ ఎర్ర రక్త కణం ☐ ఇతరులు

నేను ఇందు మూలముగా రెయిన్ఫీ ఆసుపత్రిలో అడ్మిట్ అయి ఉన్నప్పుడు పూర్తి బికిత్తులో భాగంగా నాకు గాలి/ నా రోగికి గాలి రక్తమార్పిడికి/ రక్త రక్త ఉత్పత్తుల మార్పిడికి అంగీకారం తెలుపుతున్నాను. దాత రక్తాన్ని హెచ్ ఐ యాంటీ బడిస్, హైపటెటిస్ జె సర్వేస్ యాంటిజెన్, హైపటెటిస్ యాంటిబడిస్, మలేరియా మరియు సిపిజిన్ లక్షణాలు లేవని పరీక్షించి బడినది అని వివరించడమైనది. రక్త పరీక్ష నిర్ణీత కాల పరిమితి లో జరిగినప్పటికీ పరీక్షలో కనబడని అనేక ఇతర ఇన్ఫెక్షన్ ద్వారా అతి అరుదుగా ఇన్ఫెక్షన్లు సోక వచ్చునని కూడా తెలియపరచడమైనది. ఏదైన రక్త ఉత్పత్తుల మార్పిడికి సంబంధించిన ప్రతిపర్కాలు సోకే ప్రమాదం వుందని, ప్రసరణ వ్యవస్థలో అదనపు ద్రవం మొదలగు అరుదైనది పర్యవసానాలు తెల్లత్వవచ్చు అని నేను అర్థం చేసుకున్నాను.

ఈ ప్రక్రియకు ప్రత్యామ్నాయం గురించి డాక్టర్ నాకు వివరించారు

పైన పేర్కొన్న అన్ని ప్రమాదాలు, ప్రయోజనాలు మరియు ప్రత్యామ్నాయాలు నాకు / నా రోగికి బికిత్తు చేస్తున్న డాక్టర్ ద్వారా నాకు వివరించబడ్డాయి. బికిత్తు చేస్తున్న సమయంలో అన్ని రక్తముల రక్తమార్పిడులకు (మొత్తం రక్తం / లేదా రక్త ఉత్పత్తులు ప్లాక్ చేయబడిన ఎర్ర రక్త కణాలు, ఎర్ర రక్త కణాలు, ప్లేట్ లెట్స్, ప్లెస్ ప్రోజెన్ ప్లాస్మా, క్రయాప్రెసిటివేట్ మొదలైనవి) నా అంగీకారము తెలుపుతున్నాను. నాకు పూర్తిగా అర్థమగు భాషలో నాకు నా రోగికి వివరించారు మరియు నేను దానిని సమ్మతిస్తున్నాను

సహాయకుడు(అటెండెంట్)

సాక్షి

సంతకము

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తేదీ మరియు సమయము

తేదీ మరియు సమయము

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము

పేరు

(4)

Albumin

BLOOD PRODUCTS TRANSFUSION MONITORING FORM

Date: 9/5/26 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: Planned duration of Transfusion:

Check for Correct Unit: ☐ Correct Patient: ☐

Blood products cross checked by: Nurse 1: Priyanka Nurse 2: Nikhitha

Before starting transfusion vitals: Temp: 98.2 HR RR: BP: SpO2 99%

PLEASE MONITOR THE FOLLOWING:

Date	Time	HR	Temperature	Blood Pressure	SpO2	Any Rash	Any Rigors	Any Breathlessness	Any Other Problem
9/5/26	15 Min	120h	98.2	111/69	98%	—	—	—	—
9/5/26	15 Min	112h	98.2	104/60	98%	—	—	—	—
9/5/26	30 Min	104h	98.2	118/69	100%	—	—	—	—
9/5/26	30 Min	104h	98.2	100/65	100%	—	—	—	—
9/5/26	30 Min	110h	98.2	112/68	99%	—	—	—	—
9/5/26	1 Hr	109h	98.2	111/67	100%	—	—	—	—
9/5/26	1 Hr	102h	98.2	100/69	99%	—	—	—	—

Comments:

Name of the Incharge-Nurse: Neeraja

Name of the Nurse: Nikhitha

Signature of the Incharge-Nurse: Neeraja

Signature of the Nurse: Nikhitha

Date & Time: 9/5/26 @ 2:40pm

Date & Time: 9/5/26 @ 2:40pm

BAH-00560913

IP5-00176053

Baby LINGALA RITHWIK

16-02-2015 11 Y 4 M 21 D (F)

Dr. DR.V.V.R.SATYA PRASAD

DISCHARGE PLANNING FORM

Nationality: Indian

NOTES: * To be completed by a NURSE within (24) hours of admission.

1. Anticipated Date of Discharge:

2. Destination Post Discharge:

☒ Home

Family Members Notified (Person Contacted)

☒ Transfer

Hospital Facility Notified (Person Contacted)

3. Discharge Status:

☐ Self Care
☒ Family Home Care
☐ Home Professional Assistance

☐ Needs Assistance In:

Remarks

☐ Medication
☒ Yes
☐ No

☐ Bathing
☐ Yes
☒ No

☐ Eating
☐ Yes
☒ No

☐ Walking
☐ Yes
☒ No

☐ Dressing
☐ Yes
☒ No

☐ Toileting
☐ Yes
☒ No

explan to mother

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: Hand Hygiene

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

☐ Patient
☒ Family Member
☐ Others:

Nurse Signature: Nil

Nurse Name: Nishi

Date and Time: 6.17.20 @ 10pm

PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00560913 IP5-00176053 Baby LINGALA RITHWIKA 16-02-2016 11 Y 4 M 20 D (F) Dr. DR.V.V.R.SATYA PRASAD 		Date & Time of Admission 06/07/26 @ 8:43 PM	Date & Time of Transfer Order 06/07/26 @ 9:00 AM
		Transfer Ordered by Dr. Ranga.	Reason for Transfer Admission.
From Unit ER.	To Unit 117	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 19	Number of Imaging Films nil	Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ If yes, what? of Alex	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring Mr. Ranga.		Name of Person Ordered Transfer Dr. Ranga.	
Patient & Clinical Records Received by : Nithin 10pm			
Date & Time of Patient Received :			

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

- ☐ Unavailable Bed ☐ Nurse not Available ☐ Available Bed not ready



NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 7/7/26 Time: 8 AM

Weight: 30.37 kgs Centile: 10th

Height: 138 cm Centile: 7^{10th}

Inference: underweight child

RDA: — Calories: 1700 kcal/d Protein: 30g/d

Diet Recommendations: Normal low salt diet

Re-Assessment: Avoid spicy, chilled, and outside foods

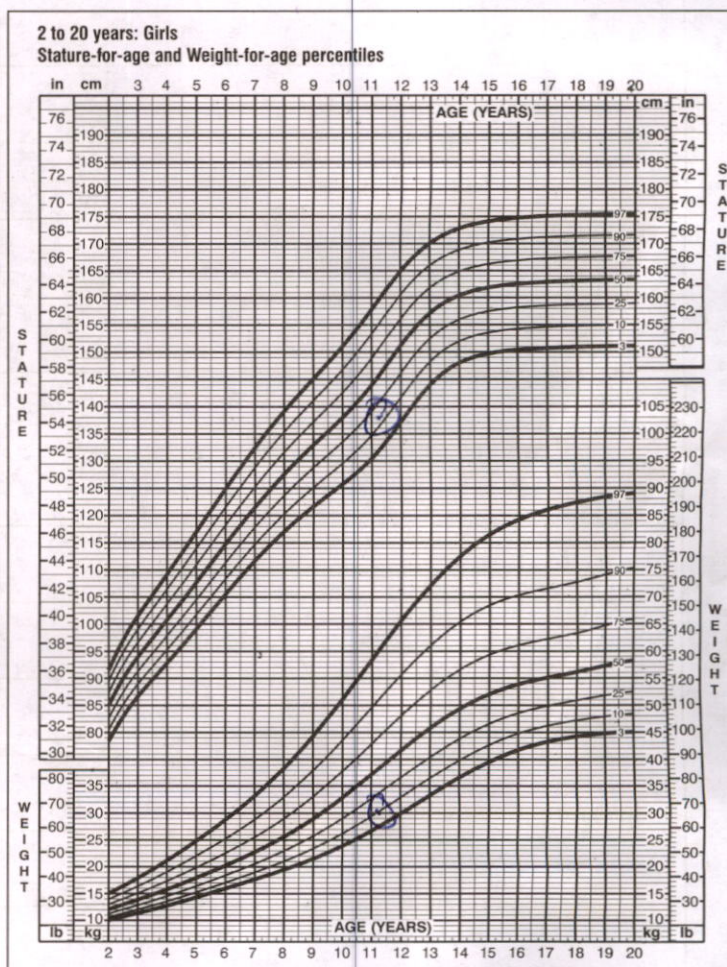
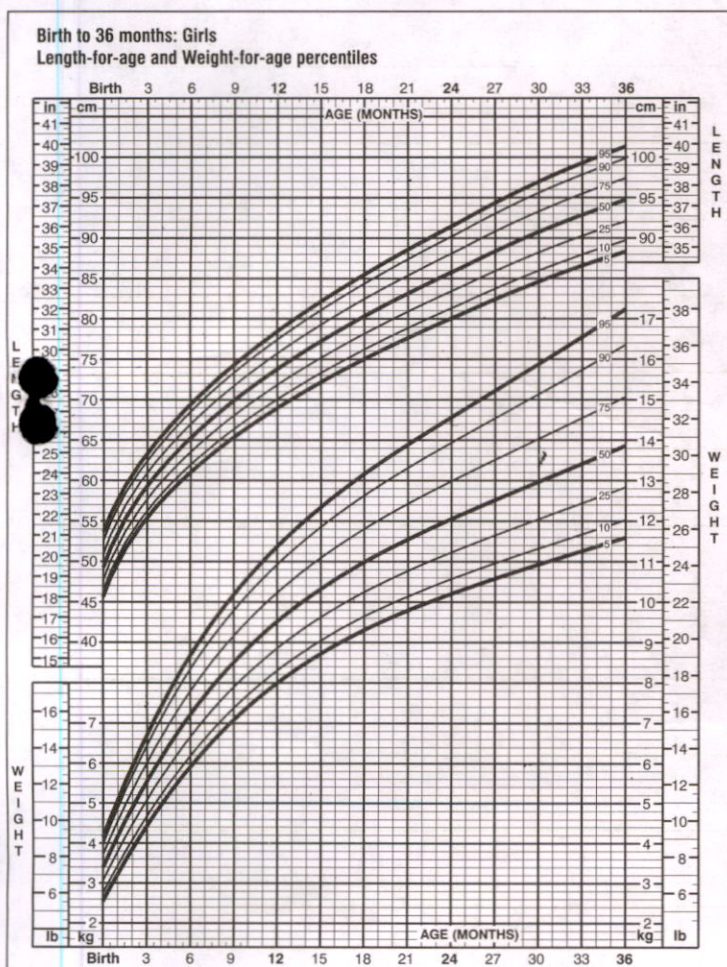
Food Allergies: no Veg/Non-veg: non-veg

Diagnosis: SDNS, MCNS

Nutritional Intervention - ☒ Oral nasal ☐ Enteral ☐ Parenteral

Patient's Signature: _____

GROWTH CHART (GIRLS)



Dietician's Name: monica

Dietician's Signature: monica

Daily Notes:

8/7/26
10:30am

Child is stable Oral Intake is Better
Continue to Normal low salt diet. ~~normal~~

9/2/26
8am

Child is stable. Intake is improving
continue to normal low salt diet ~~normal~~

10/7/26
8:30am

Child is stable Oral Intake is normal
Continue to Normal low salt diet ~~normal~~