Rainbow Children's Hospital - Banjara Hills

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

ADMISSION SHEET

Registration Details :

Admission No : IP5-00176204 **Admit Date** : 10-Jul-2026 **Admit Time** : 10:37 AM **UHID** : BAH-00658650

Patient Details :

Patient Name	: Master VEMA AYAAN RANJAN	**Age**	: 11 Y 11 M 25 D
Guardian	: Mr VEMA PRIYA RANJAN RAO	**DOB**	: 15-07-2014
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	: Single
Address (H)	: FLAT NO 103, JR RESIDENCY, VENNALAGADDA, SUCHITRA Jeedimetla Hyderabad Telangana INDIA 500055	**Phone No**	: 9866655974/ 9010676660
		E-mail	: RANJANCHEM.RAO90@GMAIL.COM

Admission Details :

Bed Type : SEMI PRIVATE **Bed No** : SPVT 104 **Ward Name** : 1F-VIBGYOR

Room No : SPVT 104 **Admission Type** : First Visit

Contact Details :

Name : Mr VEMA PRIYA RANJAN RAO **Relationship** : Father

Contact Address : FLAT NO 103, JR RESIDENCY, VENNALAGADDA, SUCHITRA Jeedimetla Hyderabad Telangana INDIA 500055 **Phone No** : 9866655974

Signature

Doctor Details :

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

Referral Doctor : Self **Phone No** :

Co-Consultant : Dr. SANDHYA VADDADI

Payment Details :

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

Payor Name : ICICI LOMBARD GENERAL INSURANCE CO LTD

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ACTIVITY RECORD FOR BILLING

Name : BAH-00658650 IP5-00176204
Master VEMA AYAAN RANJAN
15-07-2014 11 Y 11 M 25 D (M)
Dr. SIRISHA RANI

UHID No. : __________ Consultant: __________ Dept : __________

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
10/7	11:30A	Ch	Onidey 4/04	Radey

Cross Consultation Visit

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

Docu. No. RCHBH/FRM/GENERAL/145

INVESTIGATIONS

Date	Investigations	Order No.	Signature
10/7/26	CBP, RBS, Fibrinogen	26071673	Priyanka
10/7/26	Bone Marrow Aspiration	26069108	[illegible]

MEDICAL EQUIPMENT (WARD & ICU)

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

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
	Lumbar Puncture			
10/7/26	Conscious Sedation			
	Chemotherapy	(4)	969668	
	Bone Marrow			

ANY OTHER INFORMATION

DO not Charge for NHA

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

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PEDIATRIC IN-PATIENT MEDICAL RECORD

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Master VEMA AYAAN RANJAN
15-07-2014 11 Y 11 M 25 D (M)
Dr. SIRISHA RANI

Patient Name: _____

UHID ID: _____

Department: _____

Consultant: _____

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Master VEMA AYAAN RANJAN
15-07-2014 11 Y 11 M 25 D (M)
Dr. SIRISHA RANI

Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

K/C/O B-cell ALL / on induction

Now came for LP + BMA + Chemotherapy.

History of present illness :

child is now having no H/O fever, cold, cough, vomitings, loose stools, fresh complaints

Patient Sticker

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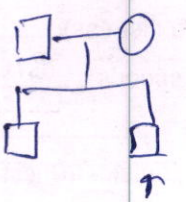
Master VEMA AYAAN RANJAN
15-07-2014 11 Y 11 M 25 D (M)
Dr. SIRISHA RANI

& Physical Examination

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

Birth & Neonatal History:

3kg | NVD | (N) transition



Birth & Socio Economic History:

About Father :
About Mother : upper middle class
Any additional Information :

Developmental History :

(N) development

Immunization History :

Vaccination till 5yrs age

(P.T.O.)

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Master VEMA AYAAN RANJAN
15-07-2014 11 Y 11 M 25 D (M)
Dr. SIRISHA RANI

Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs)) 46.5 kg (Centile _____)

On Examination :

Temperature : 97-9° F Pulse Rate : 120/min B.P. 119/62(76) SPO2 99% on RA

Resp.rate and type of breathing : RR = 20/min

Rash

Lymphadenopathy

Oedema : nil

Allergies (if any):

Respiratory System :

Inspection (any s/o distress) :

Air entry & breath sounds : BILAT (+)

Any addes sounds :

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

Cardiovascular System :

Inspection of procordium :

Heart Sounds : S1S2 (+)

Any murmur :

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

Per Abdomen :

Inspection

Palpation : Sft, NT

Ausculation :

Spine : External Genitelia :

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

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Master VEMA AYAAN RANJAN
15-07-2014 11 Y 11 M 25 D (M)
Dr. SIRISHA RANI

Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : N

Cranial Nerves : N

Motor System:

Nutriton :

Tone: Power

Co-ordinator : N

Posture :

Involuntary Movements :

Reflexes :

DTR **Superficials:**

Plantars

Sensory System : N

Bladder / Bowel :

Clinical Summary & Diagnostic:

B-cell ALL / on induction

↓

Came for LP + BMA + Chemotherapy

(P.T.O.)

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Master VEMA AYAAN RANJAN
15-07-2014 11 Y 11 M 25 D (M)
Dr. SIRISHA RANI

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

Desired goals of the treatment :

Planned Labs:

send CSF from line

CBP
RFSS
fibrinogen | from line

Planned Management

Tyrondem.
LP + BMA.
Chemotherapy.

noted by Radiology 10/7/26 at 11:20A

Signature of the Doctor: Ramya
Name of the Doctor: DR. RAMYA
Date & Time: 10/7/26 ; 10:50 am

Signature of the Consultant:
Name of the Consultant:
Date & Time:

Dr. Sirisha 10/7/26 @ 12.30pm

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Master VEMA AYAAN RANJAN
15-07-2014 11 Y 11 M 25 D (M)
Dr. SIRISHA RANI

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	Procedure Notes	
10/7/26 2:30pm	Procedure done + strict aseptic precautions. short sedation given. L.P + BMA - done. Clear CSF obtained. NO post procedure immediate complications	
10/7/26	B-ALL / CNS (-) / Induction	
	No fever No vomiting.	Plan 1. ct chemotherapy 2. ct supportive care 3. d/c Tlm F/u after 5 days c CBP. [signature]

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15-07-2014 11 Y 11 M 26 D (M)
Dr. SIRISHA RANI

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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RESULT SHEET

Date	7/7/24	10/7/24				
Time						
Hb		11.8				
PCV						
RBC						
WBC		10,420				
N/L		60/12				
Platelets		5.41 lakh				
CRP						
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

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

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

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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
1	Tab Pan 40	1tab	PO	OD	9/7/26	☐C ☐DC
2	Tab Dexa 4mg	1/2tab	PO	BD		☑C ☐DC
3	Tab Amlodipine 5mg	1/2tab	PO	OD		☑C ☐DC
4	Tab Septran DS	1/2tab	PO	BD		☐C ☐DC
5	Tab Zinnorit	1tab	PO	OD		☐C ☐DC
6	Tab Shelcal	1tab	PO	OD		☑C ☐DC
7						☐C ☐DC
8						☐C ☐DC
9						☐C ☐DC
10						☐C ☐DC

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Ramya

Date & Time : 10/7/26; 10:30 Am

Nurse Name & Signature: Randeep

Date & Time : 10/7/26 at 11:20A

BAH-00658650 IP5-00176204
Master VEMA AYAAN RANJAN
15-07-2014 11 Y 11 M 25 D (M)
Dr. SIRISHA RANI

CHEMOTHERAPY PRESCRIPTION

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

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Sheet No. : (1)	Weight (kg) : 46 kg	Body Surface Area: 1.4	Diagnosis: B-ALL	Protocol: Induction wk-4

DATE	TIME	Composition of Chemotherapy (if infusion, mention ml / hr = Mcg / kg / min. etc.)	DOSE	ROUTE	Flow Rate (ml/hr)	Doctor Sign.	Nurse Sign.	Date of Stopping	Doctor Sign.	Nurse Sign.
10/7/26	2pm.	inj METHOTREXATE inj CYTARABINE inj HYDROCORTISONE	12 mg 30 mg 15mg	IT	STAT	✓	Pooja Sravani	10/7	✓	Pooja Sravani
10/7/26	6:15 PM	inj DAUNORUBICIN in 30ml ½ NS	30mg	IV	60ml/hr	✓	Priyanka Smruthi			Krithi Anuma
11/7/26	8:42 PM	inj VINCRISTINE in 10ml NS	1.9 mg	IV	once 10 min	✓	Divya Sabitri			

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

CONSENT FOR CHEMOTHERAPY

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15-07-2014 11 Y 11 M 26 D (M)
Dr. SIRISHA RANI

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

UHID No : ..... rtment : Oncology Date : 11/7/26

Type of Chemotherapy : ..... V & IT .....

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

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

..... None .....

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

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

Patient Attendant :

Signature : .....

Name : .....

Relationship with Patient: .....

Date & Time : .....

Witness :

Signature : .....

Name : .....

Date & Time : .....

Doctor (who is taking the consent):

Signature : Dhanlekha

Name : Dhanlekha

Date & Time : 11/7/26

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15-07-2014 11 Y 11 M 25 D (M)
Dr. SIRISHA RANI

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DRUG CHART

Date of Admission: 10/X/26 Drug Allergies; .... ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

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

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

SOS / PRN (As Required Medication)

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

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

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

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

BAH-00658650
Master VEMA AYAAN RANJAN
15-07-2014 11 Y 11 M 25 D (M)
Dr. SIRISHA RANI

REGULAR PRESCRIPTIONS

Weight. 46.5kg Ward. ....

VERIFIED

DRUG : Inj ONDANSETRON				Date ▸ / Time ▾	10/7
Dose	Route	Frequency	Start Date		
8mg	IV	BD	10/7/26	10am	
Name & Signature of the Doctor Starting the Drugs: Dr Ramya				(2pm)	
Additional Instructions:				10pm	
Daily Doctor's Endorsement by a Sign					

DRUG : Syp. Tab DOMPERIDONE				Date ▸ / Time ▾
Dose	Route	Frequency	Start Date	
~~[illegible]~~	IV			
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

DRUG : Tab DOMPERIDONE				Date ▸ / Time ▾	10/7
Dose	Route	Frequency	Start Date		
1tab	PO	BD	10/7/26		
Name & Signature of the Doctor Starting the Drugs: Dr Ramya				10am	
Additional Instructions: (1tab = 10mg)				10pm	(8pm)
Daily Doctor's Endorsement by a Sign					

VERIFIED

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

BAH-00658650 IP-...
Master VEMA AYAAN RANJAN (M)
15-07-2014 11 Y 11 M 25 D
Dr. SIRISHA RANI

Weight 26 : 5Kg Ward. Oncology

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
10/7	2pm	Inj KETANINE	20mg	IV	Ak	Pooja Savitha
10/7	2pm	Inj MIDAZOLAM	2mg	IV	Ak	Pooja savitha

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

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Master VEMA AYAAN RANJAN
15-07-2014 11 Y 11 M 25 D (M)
Dr. SIRISHA RANI

I.V. FLUIDS CHART

Weight. ..... Ward. ONCOL

		n of I.V. Fluid /hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign

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

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15-07-2014 11 Y 11 M 26 D (M)
Dr. SIRISHA RANI

RCHBH/ FRM / CLINICAL / 126

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

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 11/7/26 Time:

Doctor / Nurse / Family Concern? 6AM

Temperature (F)

104 103 102 101 100 99 98 97 96 95 94

96°F

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

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

119/(95)/83

N/E

Note: BP does not score in early warning scoring

Heart Rate (Number) 113bl/M

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

70 60 50 40 30 20 10

Resp Rate (Number) 20bl/M

Resp Distress	Mod/ Severe / None / Mild
Receiving O_2 (l/min)	
O_2 Saturations (%)	99%
Conscious Level	Normal / Altered
GCS *	15/15

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

ACTIONS

NB: Scores 3 should be recorded overleaf

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

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

Patient Sticker

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

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Master VEMA AYAAN RANJAN
15-07-2014 11 Y 11 M 25 D (M)
Dr. SIRISHA RANI

Doc. No. : RCHBH/ FRM / CLINICAL / 126

SCHOOL AGE (5-12 years)

Children's Observation & Early Warning Scoring Chart

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 10/7

Date : .... Time:	12PM	6PM	10PM	2AM
Doctor / Nurse / Family Concern?				
Temperature (°F) (scale 94–104)	98.3F	97.5F	95.7°F	96°F
Heart Rate (bpm) and Blood Pressure (mmHg) * (scale 50–190) — Note: BP does not score in early warning scoring	110/71 (82)	123/70 (91)	90/73 (80)	105/76 (85)
Heart Rate (Number)	98 b/m	108 b/m	101 b/m	108 b/m
Resp. Rate (bpm) (Over 1 Minute) * (scale 10–70)				
Resp Rate (Number)	28 b/m	21 b/m	20 b/m	22 b/m
Resp Distress: Mod/ Severe / None / Mild				
Receiving O_2 (l/min)				
O_2 Saturations (%)	100%	100%	99%	98%
Conscious Level: Normal / Altered				
GCS *	15/15	15/15	15/15	15/15
TOTAL SCORE Number of shaded boxes	1	1	1	1
Pain Score	0	0	0	0
Observer's Initials	[illegible]	[illegible]	0	0

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

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

Patient Sticker

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

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FLUID CHART

Sheet No. : .....

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

Date	Time	Intake: Nature of Fluid	Intake: Route: Mouth	Intake: Route: I.V	Intake: Route: N.G	Output: NG	Output: Diarrhoea	Output: Vomit	Output: Drainage	Output: Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
10/7												
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am	1									0	
	12:00 pm	NO IVF									0	
	01:00 pm										0	
Total Intake :						**Total Output :**						
10/7	02:00 pm											
	03:00 pm											
	04:00 pm	Chemo therapy										
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						**Total Output :**						
10/7	08:00 pm											
	09:00 pm											
	10:00 pm	Chemo										
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						**Total Output :**						
11/7	02:00 am											
	03:00 am											
	04:00 am	NO IVF										
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						**Total Output :**						

Total 24 hrs. Intake		Total 24 hrs. Output	

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FLUID CHART

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Sheet No. : .....

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

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						**Total Output :**						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						**Total Output :**						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						**Total Output :**						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						**Total Output :**						

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

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NURSING CARE RECORD

Shift: ☑ Morning ☐ Afternoon ☐ Night

Date: 10/7/26

Assessment: Pt having chemotherapy

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
10AM	→ Assess the Pt General condition	11:30AM	→ Assessed Pt General condition	Pt condition is normal
12PM	→ monitor vital signs	12PM	→ monitored vital signs	
1PM	→ maintain I/O chart	1PM	→ maintained I/O chart	
2PM	→ Administer the medications as per doctors order	2PM	→ Administered the medications as per doctors orders	

Re-Assessment: Nill

Special Notes: Plan BMA / L.P. / chemotherapy

Nurse Signature: Sri Nurse Name: Sravanthi Date & Time: 10/7/26 2PM

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NURSING CARE RECORD

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Shift: ☐ Morning ☑ Afternoon ☐ Night

Date: 10/7/26

Assessment: 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
- ☐ Maintain Skin Integrity
- ☑ Patient & Family Education

Time	Plan of Care	Time	Implementation	Evaluation
3PM →	Assess general condition of the patient.	3:10 pm →	Assessed general condition of the patient.	By doneay implementation, or per doctor's order.
4PM →	To Send labs.	4:40 pm →	Sended CBP, fibrinogen & RBS to lab.	
5pm →	plan to start Chemotherapy.	6:50pm →	Provided Comfortable position to the patient.	
6pm →	Provide comfortable position to the patient.			
7pm →	Provide Supportive care.	7:30 pm →	Provided Supportive care.	

Re-Assessment: - Chemotherapy -

Special Notes: Trace Reports.

Nurse Signature: RB Nurse Name: Priyanka Date & Time: 10/7/26 8pm

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NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☑ Night

Date: 10/7/26

Assessment: .....

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
8pm	Assess the general condition of the baby	8pm	Assessed the general condition of the baby	by done all these to improve baby condition.
9pm	chemo DAUNORUBICIN ongoing.	9pm	chemo DAUNORUBICIN ongoing	
10pm	monitor vital sing & recored.	10pm	monitored vital sings & recored	
12AM	Provid comfortable position	12AM	Provided comfortable position	
6AM	Administr medication as per doctor orders.	6AM	Administred medication as per doctor orders.	

Re-Assessment: .....

Special Notes: D/c t/m.

Nurse Signature: Aruna Nurse Name: Aruna Date & Time: 11/7/26

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NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☐ Night Date: .....

Assessment: .....

.....

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation

Re-Assessment: .....

.....

Special Notes: .....

.....

Nurse Signature: ..... Nurse Name: ..... Date & Time: .....

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THE HUMPTY DUMPTY SCALE 10/7 11/7

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			
	13 years old and above	1					
Gender	Male	2	2	2			
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1			
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	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			
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	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			
	TOTAL		10	10			

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

	Bed in low position		Yes	Yes			
	Call device within reach		Yes	Yes			
	Wheels Locked		Yes	Yes			
	Room free of clutter		Yes	Yes			
	Adequate Lighting		Yes	Yes			
	Wheel Chair Support		NA	NA			
	Other Intervention(s) Specify		NA	NA			
	Nurse's Name :		[illegible]	[illegible]			
	Signature :		[illegible]	[illegible]			
	Date :		10/7	11/7			
	Time :		11' 20	[illegible]			

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NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. SirEsharani Department: Pediatric Date of Admission: 10/7/26

SITUATION

Diagnosis: BCellALL

Any Infection: ☐ Yes ☐ No ☑ Not Known
If Yes Specify: .....

BACKGROUND

Area / Shift Time	8-2pm	1st Floor 2pm-8pm	1st Floor 8-8AM			
Medical Condition (Any special condition to be noted):	NA	ND	NS			

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:	98-6F	98.1°F	96°F			
Res:	26bpm	21bpm	20b/m			
SpO_2:	98%	100%	100%			
Pulse:	104bpm	104b/m	101			
BP:	92/62	110/78	99/60			
Fall Risk Score:	11	11	11			
Pain Score:	0/10	0/10	0/10			

Recommendations

Safety Needs:	NA	Side rails	yes			
Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Others Specify:	NA	ND	NS			
Special Diet:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Other Special Orders / Medications:	NA	ND	NS			
Post Operative Procedure Special Orders:	NA	ND	NS			
Handed Over By Name :	Rakshitha	Priyanka	Aruna			
Signature :	Raksh	Priy	Aruna			
Date:	10/7/26	10/7	11/7			
Time:	11:20	8pm	8AM			
Taken Over By Name :	Sowmya	Aruna	Sowmya			
Signature :		Aruna				
Date:	10/7/26	10/7	11/7			
Time:	2pm	8pm	8am			

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NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: ..... Department: ..... Date of Admission: .....

SITUATION	Diagnosis:				Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:		
BACKGROUND	Area / Shift Time						
	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:						
	Res:						
	SpO_2:						
	Pulse:						
	BP:						
	Fall Risk Score:						
	Pain Score:						
Recommendations	Safety Needs:						
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:						
	Special Diet:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:						
Post Operative Procedure Special Orders:							
Handed Over By Name :							
Signature :							
Date:							
Time:							
Taken Over By Name :							
Signature :							
Date:							
Time:							

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BRADEN 'Q' SCALE

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				Date :	1/2	11/7		
				Time :	C1:2P A	6Am		
Mobility	...le: Does not make even slight changes in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	**3. Slightly limited:** Makes frequent through slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.	4	4		
"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		
Sensory Perception	**1. Completely limited:** Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	**2. Very limited:** responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	**3. Slightly limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	**4. No impairment:** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4		
Moisture Degree to which skin is exposed to moisture	**1. Constantly moist:** Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	**2. Very moist:** Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	**3. Occasionally moist:** Skin is occasionally moist, requiring linen change every 12 hours.	**4. Rarely moist:** Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4		
FRICTION-SHEAR **Friction** Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another	**1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	**2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	**3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	**4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4		
Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	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		
				TOTAL SCORE	28	2[illegible]		
				Evaluator's Name	K[illegible]	Aruna		

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

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Risk Score	Category	Action	Support Surfaces **(Please Note:** Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice
15-18	At Risk	• Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • Advance to a higher level of risk if other major risk factors are present	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	• Use the Same Protocol as for **"At Risk"** Patients • Position patient at 30 degree lateral incline using foam wedges	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	• Follow the same protocol as for **"Moderate Risk"** Patients • In addition to regular turning schedule • Make small shifts in their position frequently	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	• Use same protocol as for **"High Risk"** Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

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PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
10/7	11:20 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[illegible]
10/7	6pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Aruna
11/7	9AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Aruna
				☐ 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		

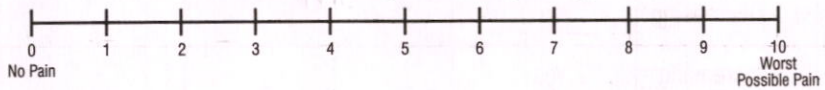
D/C

Re-assessment Frequency:

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

PAIN ASSESSMENT TOOLS

Numerical Pain Scale (Obstetric and Gynecology)



Wong - Baker (Pediatrics) Above 7 Years

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

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, SaO_2	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO_2 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO_2 less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

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INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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Part - I.

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

Identified Education Needs:

1. Diagnosis
2. Treatment and Care Plan
3. Pain Management
4. Informed Consent
5. Medication / Therapy (safety, effects/ side effect, interactions)
6. Discharge Medication
7. Infection Control Measures
8. Diagnostic Test / Procedures
9. Nutrition / Diet
10. Fall Risk Education
11. Safe use of Medical Equipment / Implantable Devices Safety
12. Patient's / Family Rights
13. Risk / Safety
14. Activity / Exercise
15. Social & Rehabilitation Needs
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		
10/7	11:20 am	2 7	Infection control measures	M	1	O	4	2	—	[illegible]
10/7/26	11:40 am	9	Normal high protein diet	M	1	O	1	1	—	Nikitha

Part - III: CODES

Who was taught: PT: Patient F: Father M: Mother S: Spouse Sn: Son D: Daughter C Caregiver O: Other (Specify) .....

Learning Barriers:

1. No Learning Barriers
2. Physical Impairment
3. Emotional Barriers
4. Language Barrier
5. Educational Level
6. Desire / Motivate to Learn
7. Impaired Thought Process/Cognitive limitations
8. Responsibilities at Home
9. Cultural Differences
10. Financial Difficulties
11. Beliefs and Values
12. Impaired Vision/ or Hearing
13. Cultural/Religion Practice
14. Others (Specify .....

Teaching Tools Used: A: Audio D: Demonstration V: Video O: Oral P: Printed

Mechanism/s to overcome barrier/s:

1. None
2. Obtain translator
3. Reassurance & Support
4. Teach Family / Others
5. Respect values & beliefs
6. Respect Cultural / Religion Preference
7. Other, Specify .....

Understanding: 1. Verbalizes Understanding 2. Demonstrates Understanding 3. Needs Review

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MULTI-DISCIPLINARY PLAN OF CARE FORM

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Dia

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
10/7/26	☑ Medical ☐ Nursing ☐ Others:	☑ Initial ☐ Modified ☐ Per-Op ☐ Post Op	B-cell ALL	Hemodynamic stability	Chemotherapy	[signature]	☐ Nursing ☐ Others:
10/7/25 11:20	☐ Medical ☑ Nursing ☐ Others:	☑ Initial ☐ Modified ☐ Per-Op ☐ Post Op	B cell ALL	H. stable	→ HP → NPO → chemotherapy	[signature]	☐ Medical ☑ Others:
10/7/26 11:40 am	☐ Medical ☐ Nursing ☑ Others: Dietitian	☑ Initial ☐ Modified ☐ Per-Op ☐ Post Op	B cell ALL	Normal high protein diet	RDA E - 1700 kcal/d P - 80g/d	Nikitha	☐ 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:

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CONSENT FOR SPECIAL PROCEDURES

Patient Name : Ayan Ranjan. Gender: ☑ Male ☐ Female

UHID No : ..... Department : Oncology Date : 10/7/16

I ..... S/D/W/O parent of Ayan.

Here by give consent for procedure of : LP + chemotherapy. + BMA.

For my patient, Named : .....

The doctors have clearly explained to me that the procedure has following possible complications:

pain, bleeding, headache

The doctor have explained to me about the alternatives, risks and benefits for this procedure that :

None.

I have understood the matter mentioned above in language known to me and give consent for the procedure.

Name of the Doctor performing the procedure: .....

Patient Attendant :

Signature : V. Ayaan Ranjan

Name : Ayaan Ranjan.

Relationship with Patient: F

Date & Time : .....

Witness :

Signature : .....

Name : .....

Date & Time : .....

Doctor (who is taking the consent) :

Signature : Ahanbekar

Name : Ahanbekar

Date & Time : 10/7/16

ప్రత్యేక విధానాలకు సమ్మతి

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రోగి పేరు ..... లింగం ☐ పురుషుడు ☐ స్త్రీ

యు.హెచ్.ఐ.డి ..... విభాగం ..... తేదీ .....

నేను ..... S/D/W/O .....

ప్రత్యేక విధానాలకు సమ్మతి ఇవ్వడం ద్వారా .....

నా రోగికి, పేరు : .....

ఈ ప్రక్రియ కోసం ప్రత్యామ్నాయాలు, నష్టాలు మరియు ప్రయోజనాలు గురించి డాక్టర్ నాకు తెలిసిన భాషలో వివరించా

.....

.....

.....

నాకు తెలిసిన భాషలో పైన పేర్కొన్న విషయాన్ని నేను అర్థం చేసుకున్నాను మరియు ప్రక్రియకు సమ్మతిని తెలియజేస్తున్నాను.

ప్రక్రియ చేస్తున్న వైద్యుని పేరు : .....

సహాయకుడు(అటెండెంట్)

సంతకము .....

పేరు .....

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము .....

పేరు .....

సాక్షి

సంతకము .....

పేరు .....

తేదీ మరియు సమయము .....

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CONSENT FOR PROCEDURAL SEDATION

Authorization By: ☐ Patient ☑ Patient Attendant

I, the undersigned do hereby acknowledge the following:

- I have been made aware by the doctors in language known to me the details of sedation planned for the procedure
  short sedation.
- I have been made aware of the possible complications from the procedure of sedation as follows:
- Changes in heart rate, blood pressure, need for oxygen supplementation, allergic reactions, upper airway obstruction, laryngospasm, conversion to general anaesthesia
- I have been made aware that the sedation is being advised to relieve pain and anxiety during the procedure. It will help me remain calm, comfortable, and cooperative, allowing the procedure to be performed smoothly and safely.

  I have been clearly explained about the benefits, risk, and alternative of the sedation which is General Anaesthesia.
- I authorize Dr. Sirisha and his / her team to perform the procedural sedation upon the patient / myself.
- I acknowledge that I fully understand the above information. I have had the opportunity to ask questions, and they have been answered to my satisfaction in a language I understand. I affirm that this consent is given by me in my full senses.

Patient / Patient Attendant:
Signature: .....
Name: A. Tanusree
Relationship with patient: Mother
Date & Time: 10/7/26 — 13:57

Witness:
Signature: .....
Name: .....
Date & Time: .....

Doctor (who is taking consent):
Signature: ..... Name: Dhanushree Date 10/7/26 Time: .....

Patient Sticker

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ప్రొసీజరల్ సెడేషన్‌కు అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

నేను, దిగువ సంతకం చేసిన వ్యక్తి, క్రింది విషయాలను అంగీకరిస్తున్నాను:

నాకు తెలిసిన భాషలో, వైద్యులు ఈ క్రింది ప్రొసీజర్‌కు ఇచ్చే సెడేషన్ గురించి పూర్తి వివరాలు నాకు తెలిపారు:

_____

- సెడేషన్ వల్ల సంభవించగల సాధ్యమైన క్రింది సమస్యలు/ప్రమాదాలు గురించి నాకు తెలిపారు:
  గుండె వేగం మారడం, రక్తపోటు మారడం, ఆక్సిజన్ అవసరం, అలర్జీ ప్రతిచర్యలు, ఎగువ శ్వాసనాళ అడ్డంకి, లారింజోస్పాసమ్, జనరల్ అనస్థీషియాగా మారాల్సిన అవకాశం.
- ప్రొసీజర్ సమయంలో నొప్పి, భయం, ఆందోళన తగ్గించేందుకు సెడేషన్ ఇవ్వడం అవసరం అని నాకు వివరించారు. ఇది ప్రొసీజర్ సజావుగా, సురక్షితంగా జరగడానికి సహాయపడుతుంది.
- సెడేషన్కు సంబంధించిన ప్రయోజనాలు, ప్రమాదాలు, ప్రత్యామ్నాయం (జనరల్ అనస్థీషియా) గురించి నాకు స్పష్టంగా వివరించారు.
- డాక్టర్ _____ గారిని మరియు వారి బృందాన్ని, రోగి/నాపై ఈ ప్రొసీజర్ సెడేషన్ చేయడానికి నేను అనుమతిస్తున్నాను.
- పై సమాచారాన్ని నేను పూర్తిగా అర్థం చేసుకున్నాను. నాకు ఉన్న ప్రశ్నలన్నీ, నాకు అర్థమయ్యే భాషలో సమాధానమిచ్చారు. ఈ అనుమతిని నేను పూర్తి జ్ఞానస్థితిలో స్వచ్ఛందంగా ఇస్తున్నానని ధృవీకరిస్తున్నాను.

రోగి / రోగి అటెండెంట్:

సంతకం: .....

పేరు: .....

రోగితో సంబంధం: .....

తేదీ & సమయం: .....

సాక్షి:

సంతకం: .....

పేరు: .....

తేదీ & సమయం: .....

డాక్టర్ :

సంతకం: ..... పేరు: ..... తేదీ & సమయం: .....

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Moderate Sedation Flow-Sheet

Immediate Pre-Sedation Assessment

B.P	P.R	R.R	Temp	SPO_2	Pain Score	Weight
100/70	90	20	Afebrile	98%	0	45kg

Diagnosis: ALL

Procedure: LP + ITthema + BMA

Comorbidities: .....

.....

- ☑ Risk, benefits & alternatives discussed;
- ☑ Patient understand & elects to proceed
- ☑ Consents for procedure and sedation signed and dated

ASA Physical Status

- ☐ ASA PS 1: Healthy Patient
- ☑ ASA PS 2: Mild Systemic Disease, no functional limitations
- ☐ ASA PS 3: Severe Systemic Disease, functional limitations
- ☐ ASA PS 4: Severe Systemic Disease, constant threat to life
- ☐ ASA PS 5: Moribund Patient unlikely to survive 24 hrs.
- ☐ ASA PS 6: A declared braindead patient whose organs are being removed for donor purposes
- ☐ E: Emergency procedure

GCS: E M V

☑ IV Site: Gauge:

Sedation Plan: Short

Allergies:

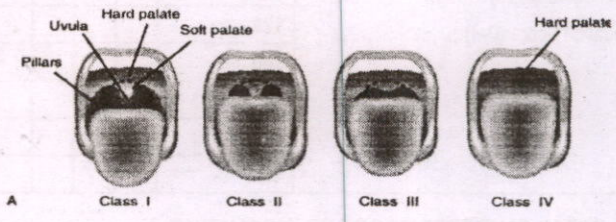
AIRWAY EVALUATION

Mouth:

- ☑ Normal
- ☐ Loose Teeth
- ☐ Small Mouth
- ☐ Protruding Incisors
- ☐ Receding Lower Jaw
- ☐ Dentures

Neck:

- ☑ Normal
- ☐ Decreased ROM
- ☐ Thyromental Distance Less Than 6 cm
- ☐ Short Neck



Mallampati Class: ☐ I ☑ II ☐ III ☐ IV

Monitoring of Patient Intra – Procedure

Procedure Monitoring

Heart Rate (HR), Respiratory Rate (RR), Oxygen Saturation (O_2 Sat) continuously monitored, and Level of Consciousness (LoC) to be monitored and recorded minimally every 15 minutes until 15 minutes after the last administration of any sedation, then every 30 minutes, then every 1 hour until stable. Respiratory status to be monitored continuously.

Level of Consciousness (LOC):

- ☑ A - Alert
- ☐ V - Verbally Responsive
- ☐ P - Painfully Responsive
- ☐ U - Unresponsive

Observation to be documented every 15 mins

TIME	BP	PR	RR	O_2 Sat%	O_2 Supplementation	Comments / Initials
Baseline	100/60	104b/m	28b/m	100%		
	100/60	108b/m	20b/m	100%	✓	

DRUG & IV Fluid: (including Nitrous Oxide)	ROUTE	DOSE	TIME GIVEN	SUBSEQUENT DOSES AND TIME
Ketamine	IV	20mg	2pm	
Midazolam.	IV	2mg	2pm	—
				–

Doctor Notes: Uneventful.

Time of transportation to post sedation care room: 104   LOC: Alert

Doctor Name: Akanksha   Signature: Akanksha

Post Sedation Care Room

Time		
Monitoring ECG NBP Oximeter	180	
Pain Score (0-10)	160	
Sedation Score (0-4)	140	
	120	
	100	x x
	80	
	60	v x
	40	

TOTAL ALDRETTE SCORE AT DISCHARGE =
(If 9 and more patient can discharge from post Sedation care unit

Activity :	Consciousness:	Respiration:	Oxygen Saturation:	Circulation:
Four extremities = 2	Fully awake = 2	Breathe Deep= 2	Sat O_2>92 % on room air = 2	BP +/- 20 mm hg of pre-op = 2
Two extremities = 1	Arousal oncalling=1	Dyspnea, limited breathing = 1	Needs oxygen to maintain Sat 0^2>90% = 1	BP +/- 20-50 mm hg of pre-op = 1
No extremities = 0	Unresponsive=0	Apnea = 0	Saturation <90% with oxygen = 0	Bp +/-50 mm hg of Pre-Op = 0

Patient Discharge Time: 2:30pm

Nurse Name: Pooja   Signature: [signature]

Date: 10/7/26   Time: 2:30pm

Consultant Name: Dr. Sandhya   Signature: [signature]

Stamp

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DISCHARGE PLANNING FORM

Nationality: Indian

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

1. Anticipated Date of Discharge: as per doctors order

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	explain to mother
☐ Walking	☐ Yes	☐ No	
☐ Dressing	☐ Yes	☐ No	
☐ Toileting	☐ Yes	☐ No	

4. Nutritional Plan:
   ☐ Dietary Instruction Discussed with the:
   ☐ Patient ☑ Family Member ☐ Others: .....

5. Discharge Planning Discussed with the:
   ☐ Patient ☑ Family Member ☐ Others: .....

6. Patient/Family Educational Plan:
   ☐ Educational Topic/s: Personal hygiene
   ☐ Patient's Educational Topic/s discussed with the:
   ☐ Patient ☐ Family Member ☐ Others: .....

Nurse Signature: Si

Nurse Name: Saraswathi

Date and Time: 10/7/26 11:30AM

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NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 10/7/26 Time: 11:40am

Weight: 46.5kgs Centile: >75th

Height: 154 cms Centile: >75th

Inference: Overweight child

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

Diet Recommendations: Normal high protein diet

Re-Assesment: Avoid spicy, chilled, outside foods

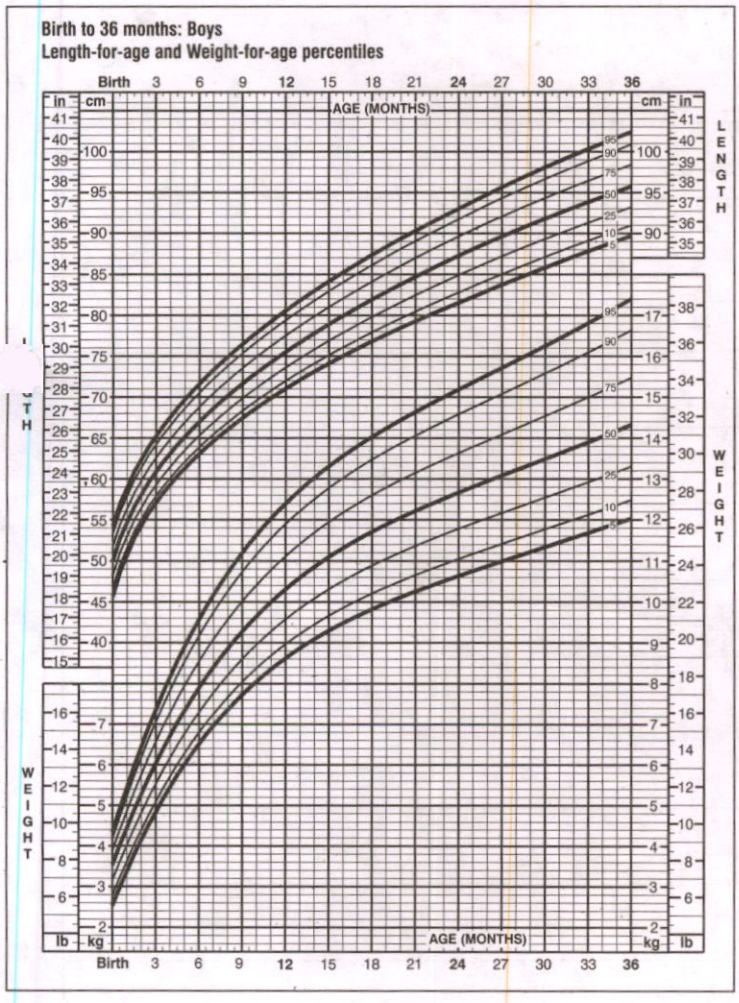
Food Allergies: NO Veg/Non-veg Non veg

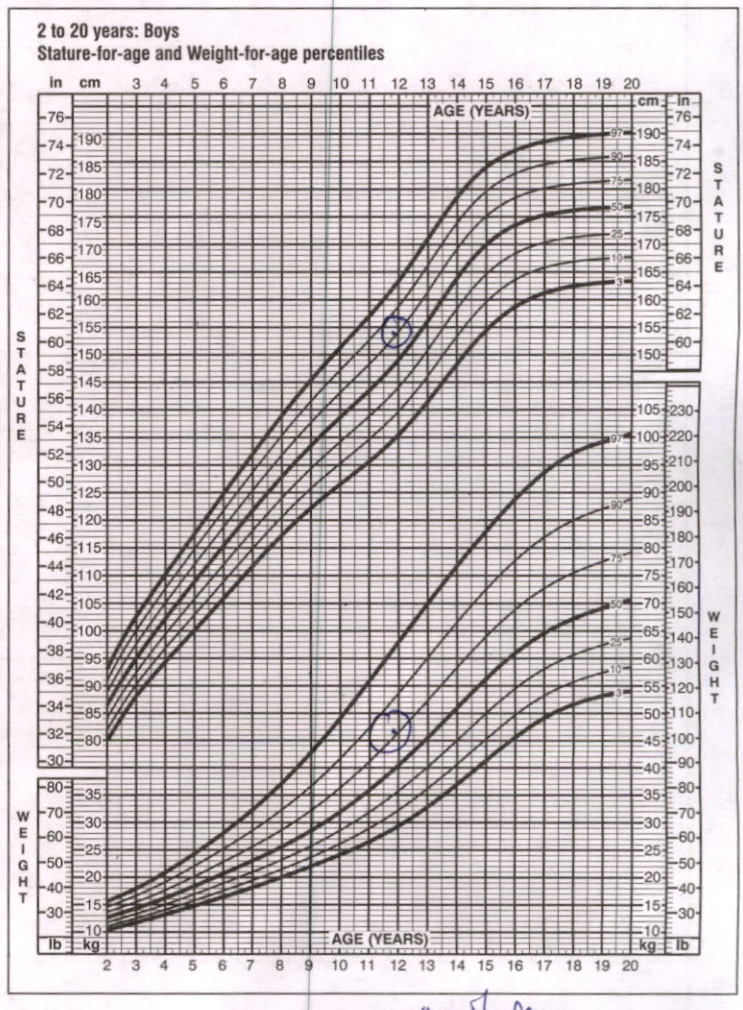
Diagnosis: B cell ALL

Nutritional Intervention - ☑ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: Parents don't want dietitian. Do not charge for NHA

GROWTH CHART (BOYS)





Dietician's Name Nikitha

Dietician's Signature

Daily Notes:

PATIENT TRANSFER FORM

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

BAH-00658650 IP5-00176204
Master VEMA AYAAN RANJAN
15-07-2014 11 Y 11 M 25 D (M)
Dr. SIRISHA RANI

Treating Consultant	Date & Time of Admission: 10/7/26 @ 10'37 AM	Date & Time of Transfer Order: 10/7/26 @ 11:20 AM
	Transfer Ordered by: Dr. Ranya	Reason for Transfer: Admission
From Unit: CR	To Unit: ~~oncology~~ first floor	Information to Attendant: Yes ☑ No ☐
Number of Sheets in Clinical File: 21	Number of Imaging Films: NA	Personal belongings including clinical documents. If any handed over to attendant: Yes ☑ No ☐ (optic) If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.		
2.		
3.	NA	
4.		
5.		

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Sandeep	Ranya

Patient & Clinical Records Received by : Sowmithi

Date & Time of Patient Received : 10/7/26 11:30 AM

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

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