

ACTIVITY RECORD FOR BILLING

Name : _____

UHID No.: _____

BAH-00417599 IP5-00176225
Master BASANI RIYAN RAYAPU
20-03-2017 9 Y 3 M 20 D (M)
Dr. DR.V.V.R.SATYA PRASAD

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
10/12/16	6:10 PM	ER	Ward	[Signature]

Cross Consultation Visit

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

INVESTIGATIONS

[illegible]

MEDICAL EQUIPMENT (WARD & ICU)

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
10/7	Iron Placenta	(1)	6607	Samyly
10/7	Albumin Transfusion	(1)	9697327	@y
11/7	NHA	(1)	961520	St
11/07	albumin transfusion	(1)	96531	T

ANY OTHER INFORMATION

.....

.....

..... 11/4

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.....

Date : 12/07/16

Time : 12:00pm

Prepared By : shankh

Staff Nurse shankh	Shift / Ward Guro 4	Billing Assistant	Billing Supervisor
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**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 : IP5-00176225

Admit Date : 10-Jul-2026

Admit Time : 05:03 PM UHID : BAH-00417599

Patient Details :

Patient Name : Master BASANI RIYAN RAYAPU REDDY Age : 9 Y 3 M 20 D
Guardian : Mr MR BASANI BALA VAMSHI DOB : 20-03-2017
Gender : Male Religion :
Occupation : Martial Status : Single
Address (H) : H NO 9-5-167/101/A/1, FLAT NO 101 , BK GOLDEN HOMES -2, SREE NIVASAM ENCLAVE
BANDLAGUDA JAGIR Hyderabad Telangana INDIA 500086 Phone No : 9000464747/ 9030464747
E-mail : basanivamshi30@gmail.com

Admission Details :

Bed Type : GENERAL WARD

Bed No : GW 119

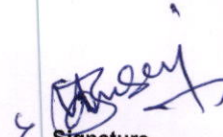
Ward Name : 1F-GENERAL WARD I

Room No : GW 119

Admission Type : First Visit

Contact Details :

Name : Mr MR BASANI BALA VAMSHI Relationship : Father
Contact Address : H NO 9-5-167/101/A/1, FLAT NO 101 , BK GOLDEN HOMES -2, SREE NIVASAM
ENCLAVE BANDLAGUDA JAGIR Hyderabad Telangana INDIA 500086 Phone No : 9000464747


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 : NIVA BUPA HEALTH INSURANCE
COMPANY LTD



119

DEFICIENCY CHECK LIST OF CASE SHEET

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

ERROR LOG

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

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE



It takes a lot to treat the little.

PEDIATRIC IN-PATIENT MEDICAL RECORD

BAH-00417599 IP5-00176225
Master BASANI RIYAN RAYAPU
20-03-2017 9 Y 3 M 20 D (M)
Dr. DR.V.V.R.SATYA PRASAD



Patient Name:

BASANI RIYAN RAYAPU REDDY.

UHID ID:

Department:

Consultant:



Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

Case of Steroid dependent Epileptic
syncope
40 generalized Seizures.
Admitted for Plasma exchange.

History of present illness :

No H/o fever, cough, cold.

No H/o vomiting.

H/o Fever 5 days ago. - 1 episode.

10/11/26 - Urea - 33, Creatinine 0.6.

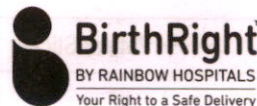
Albumin 2.2

Na/K/Cl - 128/45/100.

Bicarbonate 26

UPCR - 13.74

WE - Protein +.

[illegible]

Date & Time	Progress Notes	Doctor's Order
11/12/26 2pm	SIB Dr. Senthikavalli no new issues vitals stable Cvs Rt P/a <u>normal</u>	plan: 1) Albumin as per chart at 5pm 2) cont. same 3) monitor vitals strict No chesting Daily wt check 4) Blood urea T/m 6am
11/12/26 4:30pm	SIB Resident d: SDNS & relapse U/O - scan at 12:45pm no new issues O/C - Chest alert vitals stable Cvs Rt P/a <u>normal</u>	Plan: 1) Albumin as per chart at 5pm 2) cont. same 3) monitor vitals strict No chesting Daily wt check 4) Blood urea tomorrow 6am 5) cont. IV fluids
DR. VVR SATYA PRASAD Registration No: 43599		

Patient

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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	11/12/26	12/7				
Time						
Hb						
PCV						
RBC						
WBC						
N/L						
Platelets						
CRP						
ESR						
PCT						
RBS						
Na	128	130				
K	4.5	3.9				
Cl	100	99				
Ca/Mg						
Phosphate						
Urea	33	36	32 +			
Creatinine	0.6	0.5				
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin	2.2					
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L	26	26				

Date	10/2/26					
Time						
CUE - Alb	4+					
CUE - Sugar	1+2					
CUE - Ketones						
CUE - PUS Cells	2-4					
CUE - RBC Cells	4-5					
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						
	CV PIC ratio - 13:24					

Culture and Sensitivities :

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.....

Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI :

 Others (ECG, Contrast Studies etc.,) :

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Patient



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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: ICU

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	T. omniacid	30mg	po	12H		☐ C ☒ DC
2	T. pantoprazole	40mg	po	24H		☐ C ☒ DC
3	Syr. calcimex plus	5ml	po	24H		☐ C ☒ DC
4	Tab. Tamsin	1-5mg	po	12H		☐ C ☒ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : N. Praveen N. Praveen

Date & Time : 10/7/26, 5:20pm

Nurse Name & Signature : Peruka

Date & Time : 10/7/26 1 5:30pm

Sheet No:

REGULAR PRESCRIPTIONS

Weight 43.52kg. Ward

DRUG : Syrup. CACIMAX RUS				Date Time	11/7/26															
Dose	Route	Frequency	Start Dt.																	
5ml	PO	OD	11/7/26																	
Name & Signature of the Doctor Starting the Drugs: <i>Medline</i>																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG :				Date Time																
Dose	Route	Frequency	Start Dt.																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG :				Date Time																
Dose	Route	Frequency	Start Dt.																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG :				Date Time																
Dose	Route	Frequency	Start Dt.																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

Patient Sticker

Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward

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



DRUG CHART

Date of Admission: 10/7/26 Drug Allergies: ☒ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

- GENERAL** - Ensure that all patient details are entered above. ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.
- DOCTOR** - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
- Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
 - Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
 - Discontinue a drug by drawing a line **I** through it and a similar line through subsequent recording panels.
 - The date and time of stopping the drug along with the doctors name and sign must be mentioned.
 - Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.
- NURSES** - Nurses must follow strictly the FIVE RIGHTS before administration of medication.
- 1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time
- AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

SOS / PRN (As Required Medication)

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

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

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

Weight. 43.52 kg Ward.

Page: 2/4



Weight..... Ward.....

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
10/2/26	9:30pm	20% ALBUMIN	100ml over 4 hours	IV	N. Pm	Miffy Olundw.
10/2/26	11:30p.	1mg CASIX	30mg midway and 30mg at end	IV	N. Pm	Miffy Olundw.
11/2/26	5pm	20% ALBUMIN	100ml over 4 hours	IV	CH	Sora
11/2/26	7pm	1mg CASIX	30mg - midway	IV	CH	Sora
	9pm		30mg - midway	IV	CH	Sora

Signature

VERIFIED BY Name



I.V. FLUIDS CHART

Weight. Ward.

[illegible]



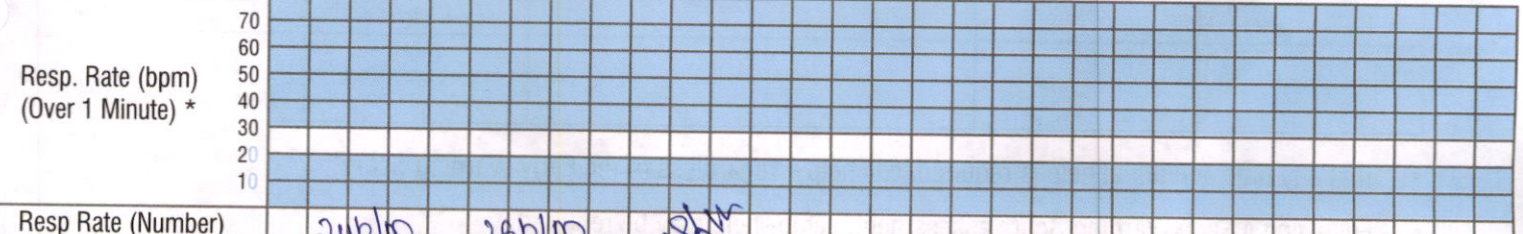
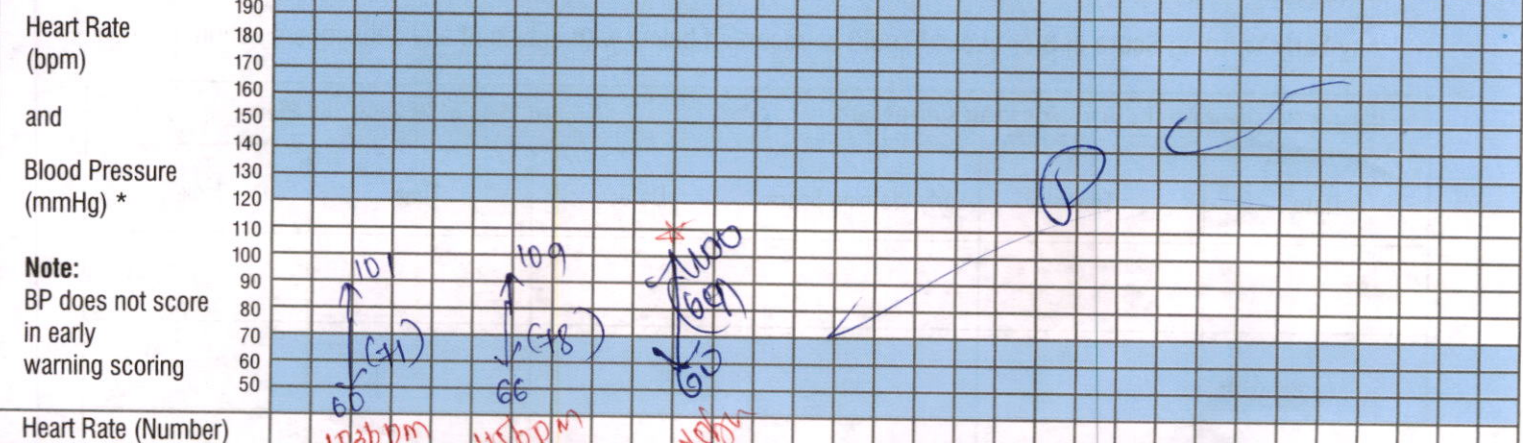
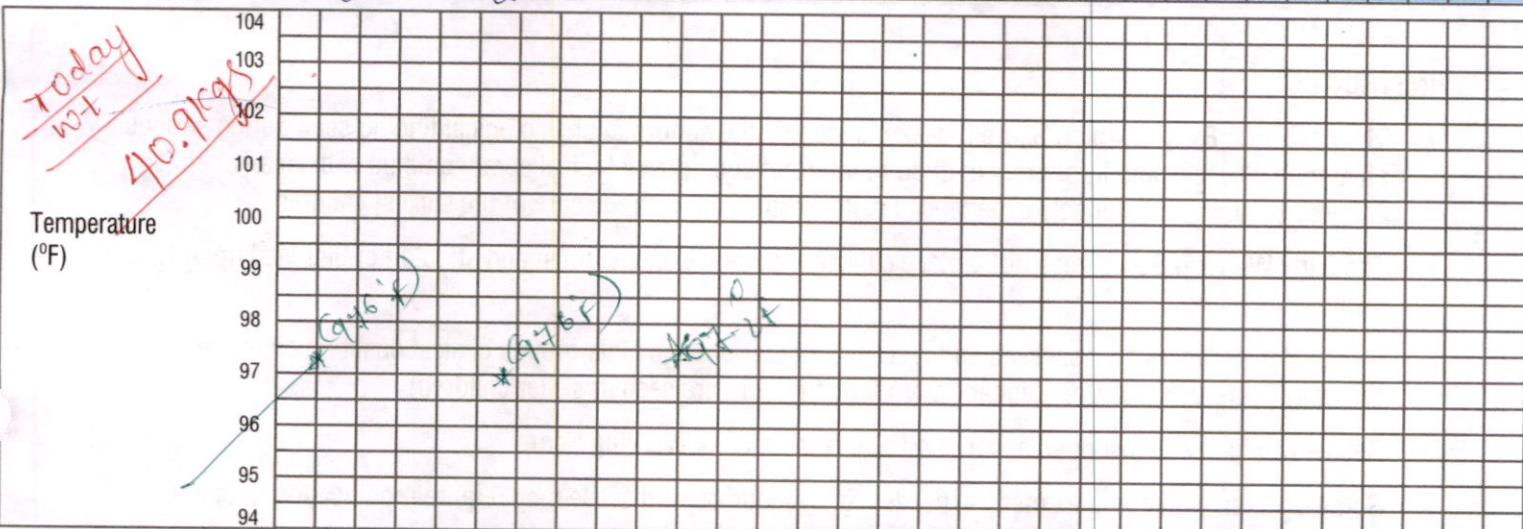
SCHOOL AGE (5-12 years)

Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 12/2/18 Time: 2 6 10

Doctor / Nurse / Family Concern? am am am



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

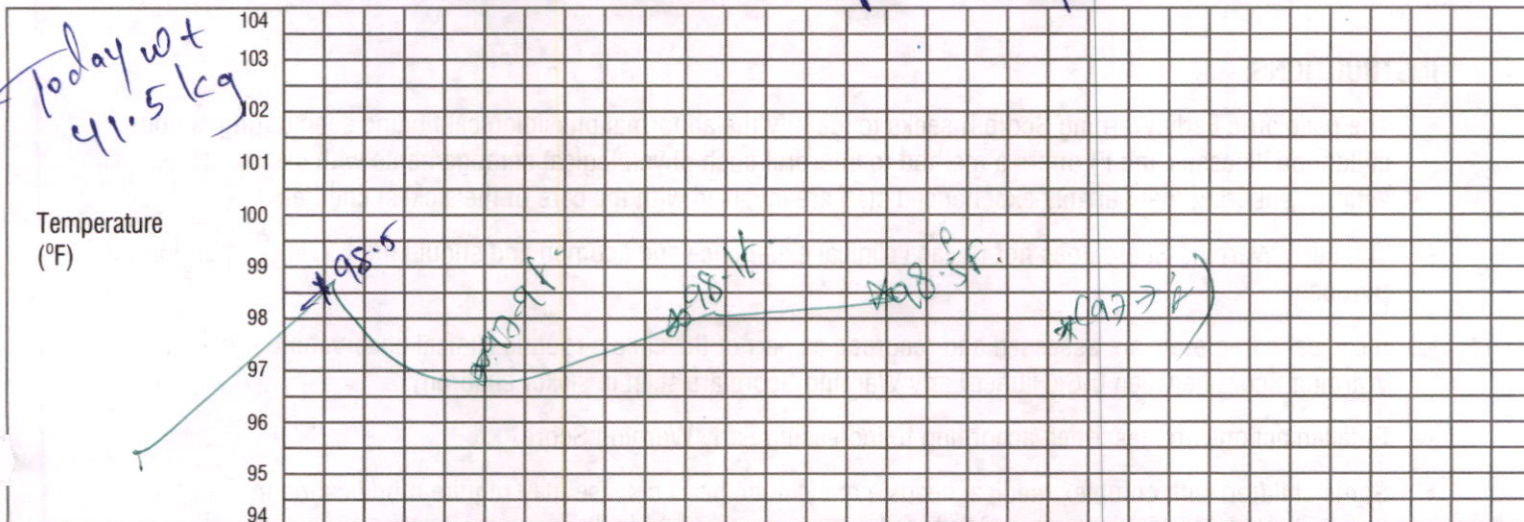


SCHOOL AGE (5-12 years)

Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 11/2/20 Time: 6am 10am 12m 6pm 10pm
Doctor / Nurse / Family Concern?



Heart Rate (bpm)	190	180	170	160	150	140	130	120	110	100	90	80	70	60	50
and															
Blood Pressure (mmHg) *															
Note: BP does not score in early warning scoring															
Heart Rate (Number)	111b/m	101b/m	105b/m	110b/m	115b/m										

Resp. Rate (bpm) (Over 1 Minute) *	70	60	50	40	30	20	10
Resp Rate (Number)	28b/m	28b/m	28b/m	28b/m	28b/m		

Resp Distress	Mod/ Severe None / Mild																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																	
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TOTAL SCORE					
Number of shaded boxes	0	1	1	1	1
Pain Score	0	0	0	1	1
Observer's Initials	Q				

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

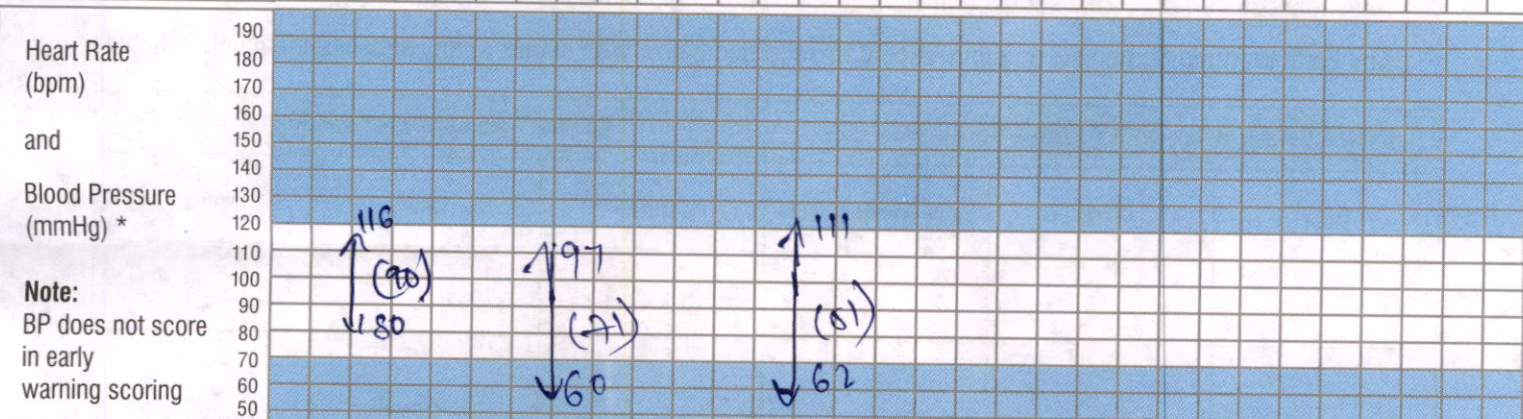
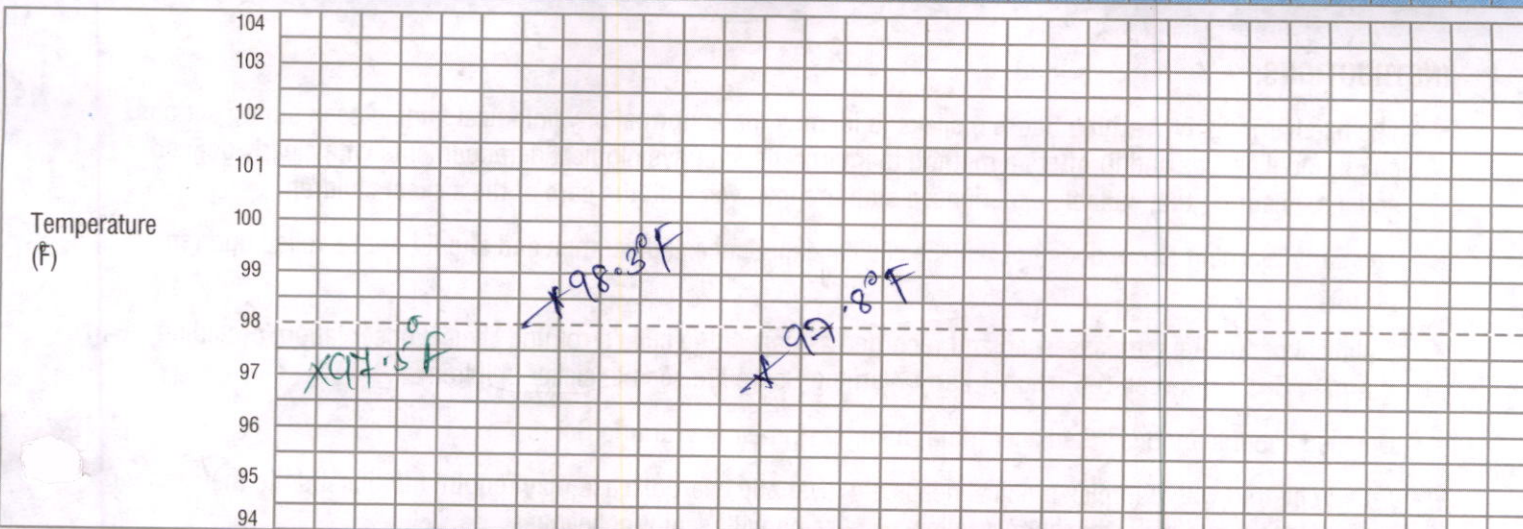


SCHOOL AGE (5-12 years)

Children's Observation & Early Warning Scoring Chart

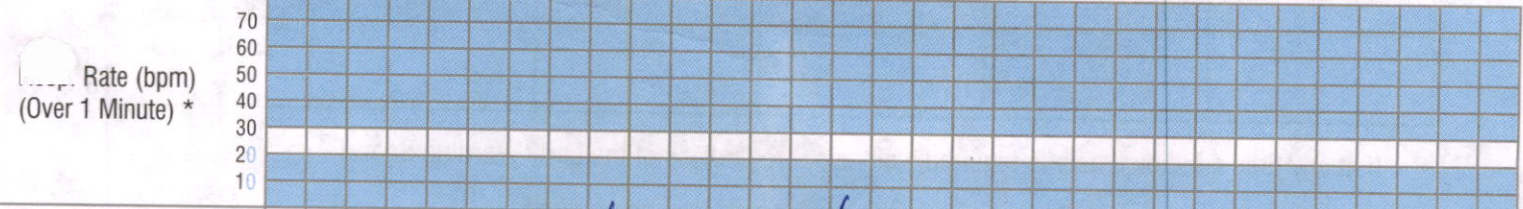
EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 10/03/2017 Time: 6:45pm 10PM 2am
Doctor / Nurse / Family Concern?



Heart Rate (Number)

116 bpm 97 bpm 111 bpm



Resp Rate (Number)

26 bpm 26 bpm 26 bpm

Resp Mod/ Severe Distress None / Mild

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

100% 100% 99%

Conscious Level Normal / Altered

GCS *

15/15 15/15 15/15

TOTAL SCORE

Number of shaded boxes

1 0 0

Pain Score

0 0 0

Observer's Initials

15/15 15/15 15/15

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.

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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)

Patient Sticker

BAH-00417599 IP5-00176225
 Master BASANI RIYAN RAYAPU
 20-03-2017 9 Y 3 M 20 D (M)
 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

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.

		Intake				Output				IV Site	Sign. Nurse
Date	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine	Thrombo-phlebitis Score	
			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	Oral							250ml	0	Chand
	07:00 pm										
Total Intake :						Total Output :					
	08:00 pm								350ml	0	Chand
	09:00 pm	Albumin 25ml								0	Chand
	10:00 pm									0	Chand
	11:00 pm								370ml	0	Chand
	12:00 am									0	Chand
	01:00 am	Oral							415ml	0	Chand
Total Intake :						Total Output :					
	02:00 am									0	Chand
	03:00 am									0	Chand
	04:00 am									0	Chand
	05:00 am	Oral							450ml	0	Chand
	06:00 am									0	Chand
	07:00 am								500ml	0	Chand
Total Intake :						Total Output :					
Total 24 hrs. Intake						Total 24 hrs. Output					
						4-2,335					



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

		Intake			Output						IV Site	Sign. Nurse
Date	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine	Thrombo-phlebitis Score		
11/7/26			Mouth	I.V	N.G					300ml	0	
	08:00 am			25ml							0	
	09:00 am			25ml							0	
	10:00 am	DPS		25ml							0	
	11:00 am			25ml							0	
	12:00 pm			40ml					100ml		0	
01:00 pm			40ml							0		
Total Intake :					Total Output :							
11/07/26	02:00 pm		Rice								0	
	03:00 pm			40ml							0	
	04:00 pm			40ml							0	
	05:00 pm			40ml							0	
	06:00 pm			40ml					50ml		0	
	07:00 pm								50ml		0	
Total Intake :					Total Output : 350ml							
11/04	08:00 pm										0	
	09:00 pm		Rice						200ml		0	
	10:00 pm	DNS		40ml					400ml		0	
	11:00 pm			40ml					370ml		0	
	12:00 am			40ml							0	
	01:00 am			40ml							0	
Total Intake :					Total Output :							
12/7	02:00 am			40ml							0	
	03:00 am			40ml							0	
	04:00 am	DNS		40ml							0	
	05:00 am			40ml							0	
	06:00 am								500ml		0	
	07:00 am								400ml		0	
Total Intake :					Total Output : 2820							
Total 24 hrs. Intake					Total 24 hrs. Output					2820		
										2.87-20kg		



FLUID CHART

Sheet No. :

- All measurements in ml.
- 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			
20/03/2017		1	Mouth	I.V	N.G								
	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm									200ml			
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							



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.
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			
	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

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 10/2/21

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	→ monitor 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 I/O Chart	2:10am	→ strictly I/O Chart	
8am	→ plan for Comfortable position	8:10am	→ Albumin transfusion	
			→ Rpr plan	
			→ providing Comfortable position	

Re-Assessment: Re-Assessment Every 4th hrly

Special Notes:

Nurse Signature: 

Nurse Name: Chendran

Date & Time: 10/2/21 2:30am



NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 11/7/26

Assessment: Pt having discomfort

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 pt general condition	8AM	→ Assessed pt general condition.	pt condition is normal.
10AM	→ monitor vital signs	10AM	→ monitored vital signs	
12PM	→ maintain I/O chart	12PM	→ maintained I/O chart	
1PM	→ monitor urine output	1PM	→ monitored urine output	
	→ Administer the medications as per doctors order.		→ Administered the medications as per doctors order	

Re-Assessment:

Special Notes: monitor urine output.

Nurse Signature: *Qi*

Nurse Name: srawuthi

Date & Time: 11/7/26 2AM



NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 11/07/16

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 well
3pm	* check the pt all vitals	3:30 pm	* checked the pt all vitals	
4pm	* maintain I/O chart	4:30 pm	* maintained I/O chart	
5pm	* provide comfortable position	6pm	* provided comfortable position	
7pm	* administer all medication	8pm	* administered all medication	
	Given as per doctor order		given as per doctor order	

Re-Assessment:

Special Notes: Blood urine tomorrow

Nurse Signature:

Nurse Name: Shanthi

Date & Time: 11/07/16 8 pm

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 12/04/26

Assessment: Baby having edema in body and decreased urine output

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	8pm	=> Assessed the baby general condition	By doing the all procedures the baby condition is improved slowly.
10pm	=> provide comfort position	10pm	=> provided comfort position	
12am	=> monitor the vitals & Recorded it	12am	=> monitored the vitals & Recorded it	
2am	=> administer the all drugs as per doctor orders	2am	=> administered the all drugs as per	
4am		4am		
6am		6am		
8am	=> ensure the safety.	8am	=> Ensured the safety steadily.	

Re-Assessment: Done by giving albumin.

Special Notes: Blood urea T/m

Nurse Signature:

Nurse Name: Charujyoti Bost

Date & Time: 12/07/26 (8am)

NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 12/07/16

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
8am	*Assess the pt General condition	8:30 am	*Assessed The pt General condition	pt is stable
9am	*check the pt all vitals	9:30 am	*checked the pt all vitals	
10am	*maintain I/O chart	10:30 am	*maintained I/O chart	
11am	*provide comfortable position	12pm	*provided comfortable position	
1pm	*administer all medication given by per doctor order	2pm	*administered all medication given by per doctor order	

Re-Assessment:

Special Notes:

Nurse Signature:

Nurse Name: Shanthi

Date & Time: 12/07/16 @ 2 PM

BAH-00417599 IP5-00176225
 Master BASANI RIYAN RAYAPU
 20-03-2017 9 Y 3 M 21 D (M)
 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:

Assessment:

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

Re-Assessment:

Special Notes:

Nurse Signature:

Nurse Name:

Date & Time:



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Satya Prasad Department: Neonatology Date of Admission: 10/7/20

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☒ Not Known					
	SDNS		If Yes Specify: _____					
BACKGROUND	Area	Shift Time	ER 8:05 AM - 8:30 AM	1st Floor 8:30 AM - 8:45 AM	1st Floor 8 PM - 8 AM	1st Floor 8 PM - 8 AM	2nd Floor 2 PM - 8 PM	2nd Floor 8 AM - 10 AM
	Medical Condition (Any special condition to be noted):		NA	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:	98.6°F	96.1°F	98.3°F	98.1°F	98.0°F	98.0°F
		Res:	24b/m	25	26b/m	28b/m	28b/m	26b/m
		SpO ₂ :	98%	99%	100%	100%	99%	99%
		Pulse:	125b/m	120	121b/m	112b/m	120b/m	122b/m
		BP:	130/70 (84)	101/64	111/63	101/69	100/60	98/60
	Fall Risk Score:	11	11	11	16	10	10	
Pain Score:	0/10	0/10	0/10	0/10	0/10	0/10		
Recommendations	Safety Needs:	Side rail	ye	ye	ye	ye	ye	
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:	NA	NA	NA	NA	NA	NA	
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
Other Special Orders / Medications:		NA	NA	NA	NA	NA	NA	
Post Operative Procedure Special Orders:		NA	NA	NA	NA	NA	NA	
Handed Over By Name :		Renika	Sreeraj	Chandana	Sreeraj	Shankar	Shankar	
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	
Date:		10/7/20	10/7/20	10/7/20	11/7/20	11/7/20	11/7/20	
Time:		6:10 PM	8 PM	8 AM	2 PM	8 PM	8 AM	
Taken Over By Name :		Sreeraj	Chandana	Sreeraj	Shankar	Shankar	Shankar	
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	
Date:		10/7	10/7/20	11/7/20	11/7/20	11/7/20	11/7/20	
Time:		6:30 PM	8 PM	8 AM	2 PM	8 PM	8 AM	



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Satya Prasad Department: Neonatology Date of Admission: 10/3/20

SITUATION	Diagnosis: <u>SDPS</u>		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
BACKGROUND	Area	<u>1st floor to 8am 2m</u>						
	Shift Time							
	Medical Condition (Any special condition to be noted): <u>NA</u>							
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ 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	☐ Yes ☐ No
	Vital Signs:	Temp: <u>38.1</u>						
		Res: <u>28b/m</u>						
		SpO ₂ : <u>99%</u>						
		Pulse: <u>110b/m</u>						
		BP: <u>100/60</u>						
Recommendations	Fall Risk Score:	<u>10</u>						
	Pain Score:	<u>0/10</u>						
	Safety Needs:	<u>NA</u>						
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:	<u>NA</u>						
	Special Diet:	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications: <u>NA</u>							
	Post Operative Procedure Special Orders: <u>NA</u>							
	Handed Over By Name : <u>Charitha</u>							
	Signature : <u>[Signature]</u>							
	Date: <u>12/3/20</u>							
	Time: <u>8am</u>							
	Taken Over By Name :							
	Signature :							
	Date:							
	Time:							

THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4					
	3 to less than 7 years old	3	3	3	3		
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	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	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			1		
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		
	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		
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		
TOTAL			11	11	11		

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

Bed in low position	Yes	Yes	Yes		
Call device within reach	Yes	Yes	Yes		
Wheels Locked	Yes	Yes	Yes		
Room free of clutter	Yes	Yes	Yes		
Adequate Lighting	Yes	Yes	Yes		
Wheel Chair Support	No	No	No		
Other Intervention(s) Specify	No	No	No		
Nurse's Name :		Keneko	Chand	Shah	
Signature :		E	Ch	Sh	
Date :		10/3/24	11/3	12/3	
Time :		5:30	6:00	6:00	

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	6:00 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	Renubho
10/7	11 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Chandam
11/7	6 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Chandam
11/7	2 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Swathi
11/7	10 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Shaily
12/7	6 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Shaily
12/07	2 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Shaily
				☐ 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:

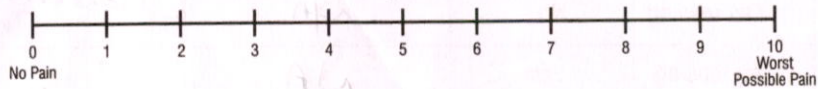
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
	0	1	2
Face	No Particular expression or smile	Occasional Grimace or Frown, withdraw, Disoriented	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs drawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, rigid, or Jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams or 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 - slow recovery - 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





CHECKLIST FOR THROMBOPHLEBITIS

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	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 cordpyrexia	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 personal 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 : [Signature]

Patient Sticker

BAH-00417599 IP5-00176225
 Master BASANI RIYAN RAYAPU
 20-03-2017 9 Y 3 M 20 D
 Dr. DR.V.V.R.SATYA PRASAD (M)

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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

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telugu Patient / Learner Literacy: ☐ Read ☒ Write ☐ Speak Willingness to Learn: ☐ Yes ☒ No Healthcare Literacy: ☐ Yes ☒ No

- | | | | |
|----------------------------|---|--|---|
| 1. Diagnosis | 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		
10/3/20	6:00 PM	7	Infection control measures	F	M	0	1	1	-	pena
11/3/20	9am	9	Normal low salt diet	F	1	0	1	1	-	aribella

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							

BAH-00417599
Master BASANI RIYAN RAYAPU
20-03-2017 9 Y 3 M 20 D
Dr. DR.V.V.R.SATYA PRASAD (M)

MULTI-DISCIPLINARY PLAN OF CARE FORM

Rainbow®
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Diagnosis.

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
10/7/21	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	SDNS	Resolving symptoms	IV fluid Lab Albumin transfusion	NR	☐ Nursing ☐ Others:
10/7/26 8:00 AM	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	SDNS	H- stability	Albumin Transfusion	revel	☒ Medical ☐ Others:
11/7/26 9 AM	☐ Medical ☐ Nursing ☒ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	SDNS c relapse	Normal low salt diet	ROA E - 1600 kcal/d P - 25g/d	NR	☐ 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:

BLOOD PRODUCTS TRANSFUSION MONITORING FORM

Date: 11/07/16 Time: 5:00pm

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: Soma Nurse 2: Shanthi

Before starting transfusion vitals: Temp: 98.4 HR 90b RR: 28b BP: 100/60 SpO₂ 99%

PLEASE MONITOR THE FOLLOWING:

Date	Time	HR	Temperature	Blood Pressure	SpO ₂	Any Rash	Any Rigors	Any Breathlessness	Any Other Problem
11/07/16	15 Min	90b	98.4	100/60	99%	—	—	—	—
	15 Min	73b	98.4	100/60	100%	—	—	—	—
	30 Min	72b	98.4	100/60	99%	—	—	—	—
	30 Min	90b	98.4	100/60	99%	—	—	—	—
	30 Min	90b	98.4	100/60	100%	—	—	—	—
	1 Hr	90b	98.4	100/60	100%	—	—	—	—
	1 Hr	72b	98.4	100/60	100%	—	—	—	—

Comments:

Name of the Incharge-Nurse:

Name of the Nurse:

Signature of the Incharge-Nurse:

Signature of the Nurse:

Date & Time:

Date & Time:

CONSENT FOR BLOOD TRANSFUSION

BAH-00417599 IP5-00176225
Master BASANI RIYAN RAYAPU
20-03-2017 9 Y 3 M 21 D (M)
Dr. DR.V.V.R.SATYA PRASAD
Name: Age: 9x Gender: Male ☒ Female ☐
UHID.No : Date: 11/7/2026

Type of Blood Product: ☐ Fresh Frozen Plasma ☐ Packed Red Blood Cells ☐ Random Donor Platelets
☐ Cryoprecipitate ☐ Single Donor Platelet ☐ Whole Blood
☒ Albumin ☐ Red Blood Cell ☐ Others

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

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

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

Patient (Or Patient Relative / Guardian):

Signature:

Name: Balu Vamsi Reddy

Date & Time 11/07/2026 6:00

Doctor (Who is talking the consent)

Signature:

Name:

Date & Time 11/7/26

Witness

Signature:

Name:

Date & Time 11/7/26

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. దాత రక్తాన్ని హెచ్ ఐ వి యాంటీ బడిస్, హైపటెటిస్ జ సర్వేస్ యాంటిజన్, హైపటెటిస్ యాంటిబడిస్, మలేరియా మరియు సిఫిస్ 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, ఫ్రెష్ ఫ్రాజెన్ 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

CONSENT FOR BLOOD TRANSFUSION



BAH-00417599 IP5-00176225
Master BASANI RIYAN RAYAPU
20-03-2017 9 Y 3 M 20 D (M)
Name: Dr. DR.V.V.R.SATYA PRASAD Age: 9y Gender: Male ☒ Female ☐
UHID.No : Date: 10/7/26

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

..... 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: Signature:
Name: B. Archana Name: Sairam
Date & Time: 10/07/2026 @ 9pm Date & Time: 10/7/26

Witness
Signature:
Name: Chandan
Date & Time: 10/7/26 @ 9pm

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

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సహాయకుడు(అటెండెంట్)

సాక్షి

సంతకము

సంతకం

పేరు

పేరు

తేదీ మరియు సమయము

తేదీ మరియు సమయము

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము

పేరు



BLOOD PRODUCTS TRANSFUSION MONITORING FORM

Date: 10/2/26 Time: 10pm

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: Nurse 2:

Before starting transfusion vitals: Temp: 98.3°F HR 111b/min RR: 26b/min BP: 98/60 SpO₂ 99%

PLEASE MONITOR THE FOLLOWING:

Date	Time	HR	Temperature	Blood Pressure	SpO ₂	Any Rash	Any Rigors	Any Breathlessness	Any Other Problem
<u>10/2</u>	<u>15 Min</u>	<u>113b/min</u>	<u>98.9°F</u>	<u>99/62</u>	<u>100%</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>
	<u>15 Min</u>	<u>111b/min</u>	<u>98.8°F</u>	<u>101/50</u>	<u>100%</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>
	<u>30 Min</u>	<u>108b/min</u>	<u>97.9°F</u>	<u>111/63</u>	<u>100%</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>
	<u>30 Min</u>	<u>116b/min</u>	<u>97.7°F</u>	<u>98/51</u>	<u>100%</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>
	<u>30 Min</u>	<u>98b/min</u>	<u>98.3°F</u>	<u>99/62</u>	<u>100%</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>
	<u>1 Hr</u>	<u>100b/min</u>	<u>98.4°F</u>	<u>97/42</u>	<u>100%</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>
	<u>1 Hr</u>	<u>105b/min</u>	<u>98.6</u>	<u>98/60</u>	<u>100%</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>

Comments:

Name of the Incharge-Nurse: Krishna

Signature of the Incharge-Nurse: Krishna

Date & Time: 10/2/26 2pm

Name of the Nurse: Chandra

Signature of the Nurse: Chandra

Date & Time: 10/2/26 2pm



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NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 11/2/26 Time: 9am

Weight: 43.52kg Centile: >90th

Height: 146cm Centile: >90th

Inference: Overweight child

RDA: - Calories: 1600 kcal/d Protein: 28g/d

Diet Recommendations: Normal low salt diet

Re-Assessment: Avoid spicy, Chilled, outside foods

Food Allergies: No Veg/Non-veg: Non-veg

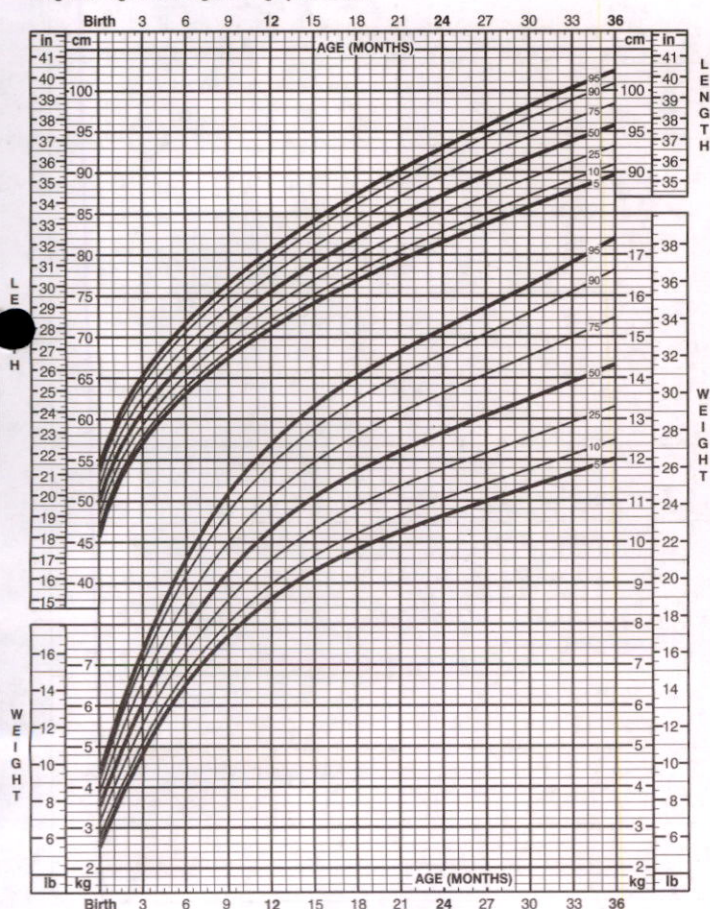
Diagnosis: SDNS & relapse

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

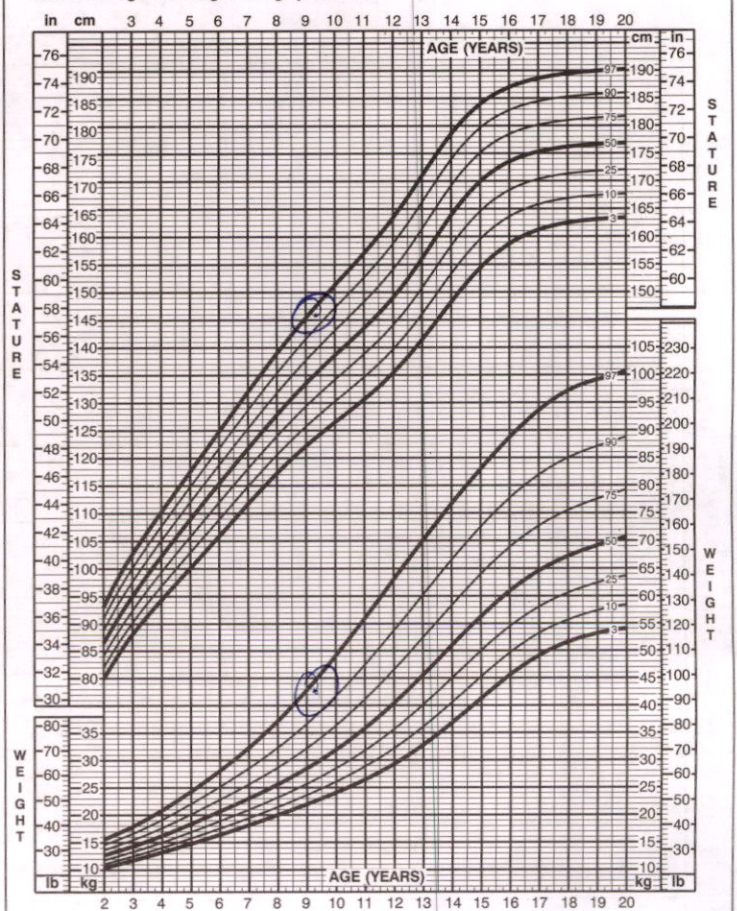
Patient's Signature: [Signature]

GROWTH CHART (BOYS)

Birth to 36 months: Boys
Length-for-age and Weight-for-age percentiles



2 to 20 years: Boys
Stature-for-age and Weight-for-age percentiles



Dietician's Name: Nikitha

Dietician's Signature: [Signature]

Daily Notes:

12/7/26
10 min

Child is stable Oral Intake is fair

Continue Normal low salt diet.

- NPKite