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Rainbow® Children's Hospital
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Your Right to a Safe Delivery

DISCHARGE SUMMARY

Name	Baby CHANDANA PRIYA	**UHID**	VIH-00205916
Father/Guardian	Mr RAMA KOTESHWARA RAO	**Age/Gender**	10 Y 10 M 4 D/ Female
Address	Nagaram, Nagaram, Hyderabad, Telangana, INDIA, 500083		
IP No	IP26-00006813	**Admission Date**	11-07-2026
Ref Doctor	Self		
Discharge Date	11.07.2026		

Consultant:
Dr. ALLU CHANDANA
MBBS, MS ENT, DNB, Post doctoral fellowship in Paediatric ENT
03408

DIAGNOSIS	ICD CODE
ADENOIDECTOMY + SEPTOPLASTY + FRENULUM CYST EXCISION	
? SURGICAL SITE BLEEDING	

Procedure : ENDOSCOPIC SEPTOPLASTY + ADENOIDECTOMY + FRENULUM CYST EXCISION UNDER GENERAL ANESTHESIA DONE ON 10.07.2026

History: Baby CHANDANA PRIYA, 10 Y 10 M 3 D child presented with history of snoring since 7 years, recurrent upper respiratory and infections form since 2 years prior to admission. For the above complaints child was admitted at Rainbow Children's Hospital for surgical management.

Examination: Child was afebrile, maintaining saturations at room air & hemodynamically stable. Heart rate was 88 /min and Respiratory rate 20 /min. On examination grad IV adenoid hypertrophy deviated nasal septum present. On auscultation of chest air entry was bilaterally equal with normal heart sounds. Abdomen was soft with no organomegaly. Examination of other systems was normal.

Weight on admission: 23.8 kilo grams.

Name	Baby CHANDANA PRIYA	UHID	VIH-00205916
IP No	IP26-00006813	Admission Date	11-07-2026

Investigations: Enclosed reports.

Procedure : ENDOSCOPIC SEPTOPLASTY + ADENOIDECTOMY + FRENULUM CYST EXCISION UNDER GENERAL ANESTHESIA DONE ON 10.07.2026

Surgery Notes:
* Under general anesthesia supine position with head end elevation.
* Under endoscopic guidance spurectomy done on right side of septum.
* Grade 3 adenoids reduced to grad - O with coblation.
* Frenulum cyst excision done with bipolar cautery..

Post-Operative Notes: Immediate Post operative period was uneventful. Child was initiated on oral feeds gradually which child tolerated well.
On POD-1, child had severe pain, post nasal pack removal child had significant bleeding, for which Inj. Tranexamic acid was given and local pressure applied. Post which child's bleeding got controlled. She remained hemodynamically stable during the hospital stay and operated site remained healthy.
Child is being discharged with the following advice.

Advice:
* Diet as advised.
* Syrup. Augmentin DDS - 6ml twice daily after food for 1 week
* Syrup Ibugesic Plus 8ml Thrice daily for 5 days then SOS for pain
* Tab. Junior Lansol 15mg - once daily in morning for 1 week
* Syrup. Relent plus 5ml twice daily for 3 days.
* Zytee gel for local application thrice daily , flour of mouth for 3days.
* Nasivion nasal drops, 2 drops in each nostril, 3 times/day for 5 days.
* Solspre nasal spray, 2 puffs in each nostril every 4 hourly for 2 weeks
* Normal Saline- Nasal Douching with 20 ml NS, as advised, 3 times/day for 1 week.

Fever Management
* Syrup. Crocin DS (Paracetamol - 5ml/240mg) 8 ml after food as and whenever required, if temperature > 100 *F (maximum 4 times a day at 6 hour intervals).
* Tepid sponging if fever > 101 *F.

Review consultation with Dr. ALLU CHANDANA after 1 weeks in OPD at Himayatnagar with prior appointment **(Review consultation will be charged)**.

Food instructions while taking medications:

Name	Baby CHANDANA PRIYA	**UHID**	VIH-00205916
IP No	IP26-00006813	**Admission Date**	11-07-2026

* **Antibiotics** along with food & milk products prevent their absorption of drugs & supplements. Antibiotics can be given 1 hour before food or 2 hours after food based on tolerance of stomach.
* **Anti ulcer drugs** can decrease the absorption of Iron&vit-B12. Anti ulcer drugs can be taken at least 1 hour before food (OR) 2hrs after food. Avoid caffeine that increases stomach acidity.
* Food can decrease the absorption of **antihistamines.** Antihistamines can be taken on an empty stomach /before food to increase their effectiveness.
* **Analgesics** without food/empty stomach can cause gastrointestinal irritation, frequent use of these drugs lowers the absorption of folate and Vit-C. **Analgesics** can be taken with food & recommonded diet to be followed.

Follow up immediately in Emergency Room if high grade fever, vomiting, breathlessness or refusal to feed occurs.

The content of the patient discharge summary, medication, food & drug interaction, care to be provided at home, nutrition, immunization and safe parenting, when and how to obtain emergency care etc also have been explained by doctor ..... in a language that I can understand and I acknowledge.

Parent/ Attender

In case of emergency contact 9154865030 emergency pediatrician on duty.

To take appointment for OPD consultation at Rainbow **Banjara Hills /** Rainbow Clinic **Madhapur / Kukatpally / Vikrampuri / LB Nagar** dial just one toll free number **18002122.**

You can also take appointments at any time by going **online** to our website **www.rainbowhospitals.in**

Name	Baby CHANDANA PRIYA	**UHID**	VIH-00205916
IP No	IP26-00006813	**Admission Date**	11-07-2026

Registrar/Resident/C.M.O

Consultant:
Dr. ALLU CHANDANA
MBBS, MS ENT, DNB, Post doctoral fellowship in Paediatric ENT
03408

Rainbow Childrens Hospital-Himayatnagar

Rainbow Children's Hospital, Door no. 3-6-267, opp. Cafe niloufer, Old MLA quarters road AP State Housing Board Himayatnagar ,Hyderabad ,Telangana, INDIA ,500029.
TEL NO :040-48873000
WEB : https://rainbowhospitals.in

ADMISSION SHEET

Registration Details :

Admission No : IP26-00006813 **Admit Date** : 11-Jul-2026 **Admit Time** : 12:27 PM **UHID** : VIH-00205916

Patient Details :

Patient Name	: Baby CHANDANA PRIYA	**Age**	: 10 Y 10 M 4 D
Guardian	: Mr RAMA KOTESHWARA RAO	**DOB**	: 07-09-2015
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: Nagaram Nagaram Hyderabad Telangana INDIA 500083	**Phone No**	: 9866777122/ 9949630185
		E-mail	: na@gmail.com

Admission Details :

Bed Type : TWIN SHARING **Bed No** : SPVT-315 **Ward Name** : 3F -SEMI PRIVATE

Room No : SPVT-315 **Admission Type** : First Visit

Contact Details :

Name : Mr RAMA KOTESHWARA RAO **Relationship** : Father

Contact Address : Nagaram Nagaram Hyderabad Telangana INDIA 500083 **Phone No** : 8179224334

Signature

Doctor Details :

Doctor Name : Dr. ALLU CHANDANA **Specialisation** : EAR NOSE AND THROAT

Referral Doctor : Self **Phone No** :

Co-Consultant :

Payment Details :

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

Payor Name : NUCLEAR FUEL COMPLEX

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ACTIVITY RECORD FOR BILLING

Name :___ VIH-00205916 IP26-00006813 _____
Baby CHANDANA PRIYA
07-09-2015 10 Y 10 M 4 D (F)
UHID No. : _ Dr. ALLU CHANDANA _____Consultant: _____ Dept : _____

Date of Adm _____ Time : _____Date of Discharge : _____ Time: _____

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

WARD TRANSFERS

D	Time	From	To	Signature of Nurse
11/12/26	1pm.	ward	ward	

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Signature

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
11/7/26	Infusion Pump	1:30pm	5:30pm	2782	

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature

ANY OTHER INFORMATION

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

Ref.No. F/IN/PR/10

Rainbow®
Children's
Hospital

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name : _____ VIH-00205916 IP26-00006813
Baby CHANDANA PRIYA
Patient ID# : _____ 07-09-2015 10 Y 10 M 4 D (F)
Dr. ALLU CHANDANA

Consultant : _____

Final Diagnosis : _____

Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Informant _____ Reliability _____

Chief Presenting Complaints & Duration (Chronologically):

c/o Nasal bleeding - post septoplasty :

History of present illness :

child was operated on 10/7/26 in view of history of recurrent upper respiratory tract infections since last 2 years

on evaluation child had deviated nasal septum & adenoid hypertrophy

For which child underwent - Adenoidectomy + Septoplasty + Frenulum cyst Excision.

Pediatric Multiorgan History & Physical Examination

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

Birth & Neonatal History :

FT / LSCS / AGA

Birth & Socio Economic History :

About Father :

About Mother : ⓟ

Any additional Information :

Developmental History :

Normal

Immunization History :

Upto date

Pediatric Multiorgan History & Physical Examination

Anthropometry

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

Weight (kgs) 23-8 kg (Centile _____)

On Examination :

Temperature : 99.3°F Pulse Rate: 155/m Description _____

B.P. _____ SPO2 96% at _____

Resp. rate and type of breathing : 26/m

Rash B/L Nasal pack in situ c bleeding

Lymphadenopathy Throat - congested & blood noted

Oedema : _____

Respiratory system :

Inspection (any s/o distress) : _____

Air entry & breath sounds : B/L AE ⊕

Any addes sounds : _____

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

Cardiovasclular System :

Inspection of procordium : _____

Heart Sounds : S1S2 ⊕

Any murmur : _____

Relevant date from outside (Chest X-Ray, ECG, ECHO, Etc.,) _____

Per Abdomen :

Inspection _____

Palpation : Soft

Ausculation : _____

Spine: _____ External Genitelia : _____

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

Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS Score : 15/15

Cranial Nerves : WNL

Motor System :

Nutrition :

Tone : Power

Co-ordinator : WNL

Posture :

Involuntary Movements :

Reflexes :

DTR **Superficials :**

Plantars

Sensory System :

WNL

Bladder / Bowel :

Clinical Summary & Diagnostic :

Post Septoplasty & Adenoidectomy - bleed

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment :

Desired goals of the treatment :

17. D Stability

Planned Labs :

If Justified Need → Investigation

Planned Management :

Inj Amoxyclav

Inj Tranexamic Acid

Syp Ibugesic

Nasivion - 1

Solspic Nasal Spray

Nasal pack removal & Saline Wash

Please fill up the following details

1. Name of the Referring Doctor : _____
2. Name of the Referring Hospital : _____
   (Including the name of City)
3. Contact number of the Referring Doctor : _____
   (Preferring Mobile #)
4. Name of the doctor in Rainbow Team Dr. Chandan on whose name the patient is being referred

Doctor's Signature Name For Dr. Chandan Date _____ Time _____

VIH-00205916 IP26-00006813
Baby CHANDANA PRIYA
07-09-2015 10 Y 10 M 4 D (F)
Dr. ALLU CHANDANA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/7/26 1 PM	S/B Dr. Sreeja; Post-operated case of Septoplasty + Adenoidectomy + Frenulum cyst excision	
	Re-admitted since child had bout of nasal bleed while removing nasal pack	P/o
	Pressure gauze applied.	Inj. Tranexamic acid 350 mg IV Stat
		C/F CROCIN 6th
	CNS - S1S2 ⊕ RS - BLE-AIF ⊕	Ibugesic Syrup SOS for pain
	P/A Soft Conscious.	w/f bleed through nasal cavity
		C/F IVF DNS @ 50ml
		13-17 NB - Sug... 1pm @ 11/7/26

Docu. No. : RCH /FRM / CLINICAL / 088 (P.T.O)

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/7/20 3pm	c/c/b - Ds. Chandana POD - 1 O/E Afebrile (R) nasal pack removal done Saline wash given throat no post nasal bleed Soakage (1)	- Adenoidectomy + Septoplasty L&A Adv - observe for bleeding 1hour - plan d/s if nil concerns
o/v on saturday/monday		
		n/B Syrup @ 3pm
4:30pm	CB/B Dr PRANAV Pain (R) - Bettle No fresh bleeding child alert Vitals stable	Plan 1) D/C Today & F/Up after 1 week at SOS in OPD

Docu. No. : RCH /FRM / CLINICAL / 088

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DRUG CHART

Date of Admission: ..... Drug Allergies: ..... ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

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

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

SOS / PRN (As Required Medication)

DRUG : Syp. IBUGESIC				Date ▸ Time
Dose	Route	Frequency	Start Date	
7.5ml	oral	SOS/8h	11/7	
Doctor's Signature		Valid Period	Pharm.	
Additional Instructions: Paracetamol (5ml/100mg)				

DRUG : Syp. IBUGESIC				Date ▸ Time 11/7
Dose	Route	Frequency	Start Date	12PM
7.5ml	oral	TDS/8h	11/7	
Doctor's Signature		Valid Period	Pharm.	
Additional Instructions: IBUPROFEN (5ml/100mg)				

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

VERIFIED BY : Name Signature

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Dr. ALLU CHANDANA

REGULAR PRESCRIPTIONS

Weight. 23.8 Ward. .....

DRUG : Inj. AMOXYCLAV

Dose	Route	Frequency	Start Date
900mg	IV	BD	11/7

Name & Signature of the Doctor Starting the Drugs: B. Singh

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date/Time	11/7
	6AM ✓
	6pm

DRUG : Syp. CROCIN-DS

Dose	Route	Frequency	Start Date
7.5ml	oral	6th h	11/7

Name & Signature of the Doctor Starting the Drugs: B. Singh

Additional Instructions: Perfalgan 1 (5ml) 240mg

Date/Time	11/7
	6AM
	10AM
	4pm
	10pm

Daily Doctor's Endorsement by a Sign

DRUG : NASIVION-P NASAL Drop

Dose	Route	Frequency	Start Date
2°	P/N	TID	11/7

Name & Signature of the Doctor Starting the Drugs: Prem

Additional Instructions:

Date/Time	11/7
	7AM X
	2pm
	11pm

Daily Doctor's Endorsement by a Sign

DRUG : SOLSPRE NASAL SPRAY

Dose	Route	Frequency	Start Date
2 Puff	Each Nostril	4th hly	11/7

Name & Signature of the Doctor Starting the Drugs: Prem

Additional Instructions:

Date/Time	11/7
	12AM X
	6AM X
	12pm X
	6pm

Daily Doctor's Endorsement by a Sign

VIH-00205916 IP26-00006813
Baby CHANDANA PRIYA
07-09-2015 10 Y 10 M 4 D (F)
Dr. ALLU CHANDANA

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

DRUG :	Date▸ Time		Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.
		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
11/7/15	4:30 PM	Inj. TRANEXAMIC ACID	350mg	IV		

Signature

VERIFIED BY Name

VIH-00205916 IP26-00006813
Baby CHANDANA PRIYA
07-09-2015 10 Y 10 M 4 D (F)
Dr. ALLU CHANDANA

I.V. FLUIDS CHART

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

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
11/7	1PM	D NS	IV	50 ml	PM		11/8		

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RESULT SHEET

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

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

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

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CH/ 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: 10 12 2

Doctor / Nurse / Family Concern? AM PM PM

Temperature (F)

104 103 102 101 100 99 98 97 96 95 94

100.5 T
99.1
98.4 T

Heart Rate (bpm)

and

Blood Pressure (mmHg) *

Note: BP does not score in early warning scoring

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

Heart Rate (Number)

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

70 60 50 40 30 20 10

Resp Rate (Number)

Resp Distress: Mod/ Severe / None / Mild

Receiving O_2(l/min)

O_2Saturations (%)

Conscious Level: Normal / Altered

GCS *

TOTAL SCORE
Number of shaded boxes

Pain Score

Observer's Initials

ACTIONS

NB: Scores 3 should be recorded overleaf

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

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

Patient Sticker

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

V... 0205916 IP26-00006813
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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.

		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							
11/7/26	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm	DNS		50ml								
Total Intake :						**Total Output :**						
11/7/26	02:00 pm			50ml								
	03:00 pm			50ml								
	04:00 pm	DNS		50ml								
	05:00 pm			50ml								
	06:00 pm			50ml								
	07:00 pm			50ml								
Total Intake :						**Total Output :**						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						**Total Output :**						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						**Total Output :**						

Total 24 hrs. Intake		Total 24 hrs. Output	

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FLUID CHART

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						
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**	

VIH-00205916 IP26-00006813
Baby CHANDANA PRIYA
07-09-2015 10 Y 10 M 4 D (F)
Dr. ALLU CHANDANA

BRADEN 'Q' SCALE

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

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				Date :	11/7			
				Time :	M5			
Mobility	**1. Completely immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	**3. Slightly limited:** Makes frequent through slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.	4			
"Activity The degree of physical activity"	**1. Bedfast :** Confined to bed	**2. Chairfast :** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	**3. Walks occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. All patients too young to ambulate; OR walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	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			
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			
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			
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			
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4			
				TOTAL SCORE	20			
				Evaluator's Name				

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

Docu. No. : RCH /FRM / CLINICAL / 119

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

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NURSING CARE RECORD

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It takes a lot to treat the little.

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Date: 11/7/26

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	Nurse Name & Signature
Morning	4pm						
Afternoon	2pm 8pm	→ Assess the pt condition – monitor vitals & Ob chart → drugs as per chart		→ Assessed the pt condition → monitored vitals & Ob chart → drugs as per chart	pt is stable	rechecked vitals	[illegible]
Night							

Docu. No: RCH /FRM / CLINICAL / 148

Patient Sticker

NURSING CARE RECORD

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Date: .....

Goals

- ☐ Maintain Airway and Oxygenation
- ☐ Relieve Pain & Discomfort
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- ☐ Maintain Good Nutritional Status
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- ☐ 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	Nurse Name & Signature
Morning							
Afternoon							
Night							

Pat VIH-00205916 IP26-00006813
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07-09-2015 10 Y 10 M 4 D (F)
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IFT HAND OVER FORM - WARD

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

SITUATION	Diagnosis: Adenoidectomy			Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:			
BACKGROUND	Area / Shift Time	11/7/26 M6	11/7/26 E2				
	Medical Condition (Any special condition to be noted):						
ASSESSMENT	Allergy:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:	98.6°F	98.2°F				
	Res:	28/m	29/m				
	SpO_2:	99%	99%				
	Pulse:	101	102				
	BP:	100/69	100/69				
	Fall Risk Score:	-	-				
	Pain Score:	"0"	0				
Recommendations	Safety Needs:	Yes	Yes				
	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 :		Supriya					
Signature :							
Date:		11/7/26	11/7/26				
Time:		2PM	3pm				
Taken Over By Name :							
Signature :							
Date:		11/7/26					
Time:		2pm					

Docu. No. : RCH/FRM / CLINICAL / 097

Patient Sticker

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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:							