

ADMISSION SHEET

Registration Details :



Admission No : IP5-00173775

Admit Date : 13-May-2026

Admit Time : 01:17 PM UHID : KUH-00169766

Patient Details :

Patient Name : Master D SIDDHIK SHIVIN

Age : 2 Y 5 M 22 D

Guardian : Mr D SANTOSH NAIDU

DOB : 21-11-2023

Gender : Male

Religion :

Occupation :

Marital Status : Single

Address (H) : FLAT NO 201, VENUS RESIDENCY, BESIDE
POST OFFICE LANE Moti Nagar Hyderabad
Telangana INDIA 500018

Phone No : 8106253156/ 8686866601

E-mail : GOONAHARIKA812@GMAIL.COM

Admission Details :

Bed Type : SEMI PRIVATE

Bed No : SPVT 114

Ward Name : 1F-VIBGYOR

Room No : SPVT 114

Admission Type : First Visit

Contact Details :

Name : Mr D SANTOSH NAIDU

Relationship : Father

Contact Address : FLAT NO 201, VENUS RESIDENCY, BESIDE
POST OFFICE LANE Moti Nagar Hyderabad
Telangana INDIA 500018

Phone No : 8106253156 / 8686866601

G. Harika
Signature

Doctor Details :

Doctor Name : Dr. KAPIL BHAGWATRAO SACHANE

Specialisation : GENERAL PEDIATRICS

Referral Doctor : Self

Phone No :

Co-Consultant :

Payment Details :

Deposit Amount : 0.99

Payment Mode : Cash

Payor Name : NIVA BUPA HEALTH INSURANCE
COMPANY LTD

ACTIVITY RECORD FOR BILLING


Name : _____

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

Date of Admission: _____ Time: _____ Age : _____ Time: _____

Room / Bed No : _____ Ward : _____ Available bed type : _____

KUH-00169766 IP5-00173775
Master D SIDDHIK SHIVIN
21-11-2023 2 Y 5 M 22 D (M)
Dr. KAPIL BHAGWATRAO SACHANE



WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
18/5/26	2:15pm	EL	Ward	Abhishek
18/5/26	3:50pm	114	318	Aruna

Cross Consultation Visit

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

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
12/05	IV placement	1	6208-	<i>[Signature]</i>
13/1	NHA	1	02535	<i>[Signature]</i>

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date : 14/5/26

Time : 12pm

Prepared By : Aruna

<p>Staff Nurse</p> <p><i>Aruna</i></p>	<p>Shift / Ward</p> <p>SPVT</p>	<p>Billing Assistant</p>	<p>Billing Supervisor</p>
----------------------------------------	---------------------------------	--------------------------	---------------------------



PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : Dr. Kapil

Date : 13/5/26

Type of Admission: OPD ER Referral (if referral, Doctor's Name:

Start Time of Assessment: Weight: 9.8kg

Allergic History:

Chief Complaints:
10 fever :- 1 week
high grade spikes at night
not afw chills
mild cough (+)
no vomiting, loose stool
no burning micturition.

Pediatric Assessment Triangle

A Appearance - TICLS Normal

B Breathing

C Circulation

Normal
 Abnormal

Pallor
 Cyanosis
 Mottling
 Bleeding

↑ WOB
 ↓ WOB
 Normal
 Gasping / Apnea

Initial Physiological Status: Stable Unstable
 Life Threatening
 Non Life Threatening

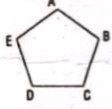
Any urgent interventions needed: Yes No
 If Yes

Significant Past History: admitted in april - For Abdominal pain

Medication History: On MUOut - 2 scoops od.


Relevant Investigations:
(12S) CRP - 9.6 (17.640) (4.57)
CRP - 89 56/36 ; COE 3-upus cells
Flu panel:- Negative. ; uric acid crystals ++

Primary Assessment

Airway 

Open
 Maintainable
 Not Maintainable

Any urgent interventions needed: Yes No
 If Yes

Breathing 

Rate: 26/min SpO₂ on FiO₂ 100% @RA

Rhythm: Reg. tach

Retractions: Suprasternal ICR SCR
 Sternal Supraclavicular Nasal Flaring

Respiratory Noises: Stridor Wheezing Grunting

Air Entry: BAE (+)

Palpation Findings (If necessary).....

Any urgent interventions needed: Yes No
 If Yes



Circulation

HR: 110/min

CFT [Central <3sec
Peripheral

Any urgent interventions needed: Yes No

If Yes:

BP: 108/67 mmHg

Pulse Volume: [Central <3sec
Peripheral

If in Shock: [Compensated

Muffled Heart Sound: Yes No

Engorged Neck Veins: Yes No

Murmurs: Yes No

Liver Span:

ECG:

Any Signs of Heart Failure: Yes No



Disability

GCS: AVPU: alert

Pupils: [Responsive [checked] Non-Responsive []
Size [Right
Left

Active Seizures: Yes No Sugars:

Signs of Neurological compromise

Any urgent interventions needed: Yes No

If Yes:

Exposure



Temp.: 98.4°F

Any Rash: Yes No

If yes describe the rash

Active bleed

Lacerations [] Abrasions [] bruises []

Describe:

Any urgent interventions needed: Yes No

If Yes:

- Final Physiological Status:** Respiratory Distress Respiratory Failure Respiratory Arrest
 Shock - Compensated Hypotensive
 Cardiopulmonary Arrest Hemodynamically Stable

Secondary Assessment: Head to toe examination with positive findings:

Labs Planned:
 Blood/c/s
 widal
 LFT
 USG Abdomen
 (CBP, CRP, CUE, Flu panel, Chest Xray)
 Done in OPD

Treatment Planned:
 - IV ceftriaxone
 - Azithromycin
 - Relentplus
 - IVF

Need for Oxygen: Yes No if yes Low Flow High Flow PPV

Final Diagnosis with possible Differential Diagnosis (If necessary): Acute febrile illness (Dx) - ? UTI

Assessment done by
Name of the Doctor: Jayabin

Signature: JN

Date & Time: 12/5/20 @ 1:00PM

Sr. Doctor on Duty (If necessary)
Name of the Sr. Doctor:

Signature:

Date & Time:

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



**PEDIATRIC IN-PATIENT
MEDICAL RECORD**

Patient Name: _____

UHID ID: _____

Department: _____

Consultant: _____

KUH-00169766 IP5-00173775
Master D SIDDHIK SHIVIN
21-11-2023 2 Y 5 M 22 D (M)
Dr. KAPIL BHAGWATRAO SACHANE



Pediatric Multiorgan History & Physical Examination

Name : Siddhik Shivin Age/Sex _____
Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

40 fever :- 1 week.
also cough.

History of present illness :

40 fever :- 1 week
high grade spikes (max -101)
more at night.
not also chills.

also mild cough, no cold.
no rash, vomiting, loose stools.

Investigated on OPD basis,

also poor oral intake
& dull activity.

12/5 - CBC - 3-4 pus cells
= uric acid crystals ++
flu panel - Negative.
CRP - 89
CBP -
9.6 > 17.6uk. (4.5) L.
56/36



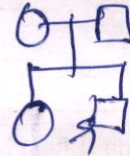
Pediatric Multiorgan History & Physical Examination

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

①

Birth & Neonatal History:

FT/① perinatal trauma



Birth & Socio Economic History:

About Father : _____

About Mother : _____

Any additional Information : _____

Developmental History :

Developed not according to age.

Immunization History :

Immunised as per age



Pediatric Multiorgan History & Physical Examination

Anthropometry :

Head Circum (cms) _____ (Centile _____) Height (cms): _____ (Centile _____)
Weight (kgs) 9.8kg (Centile _____)

On Examination :

Temperature : 98.4°f Pulse Rate : 110/min B.P. 108/67 ^{mmHg} SPO2 100% + RA
Resp. rate and type of breathing : 26/min

Rash _____
Lymphadenopathy _____ ⊖
Oedema : _____
Allergies (if any): _____

Respiratory System :

Inspection (any s/o distress) : _____
Air entry & breath sounds : BAG ⊕
Any addes sounds : ⊖
Relevant data from outside (Chest X-Ray, ABG, etc.,) /

Cardiovascular System :

Inspection of procordium : _____
Heart Sounds : S₁ S₂ ⊕
Any murmur : ⊖
Relevant data from outside (Chest X-Ray, ECG, ECHO, etc.,) : /

Per Abdomen :

Inspection _____
Palpation : soft, slight soft NT
Ausculation : bowel sounds ⊕
Spine : _____ External Genitalia : _____
Relevant data from outside (CT, USG etc.,) /

180704
Munir D BIDDHIK
21-11-2008
IP5-00177
2Y6M22D (M)
KAPIL BHAGWATRAO SACHANE

Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : Best

Cranial Nerves :

Motor System:

Power : 2/5

Reflexes : N/A

Movements :

Superficials:

*Shagwatrao
Sachane
20*

KUH-00169766 IP5-00173775
Master D SHIDHIK SHIVIN
21-11-2023 2 Y 5 M 22 D (M)
Dr. KAPIL BHAGWATRAO SACHANE



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: _____

prevent complication

Desired goals of the treatment: _____

hemodynamic stability

Planned Labs:

*Blood c/s
Widal
LFT
USG Abdomen*

Planned Management

*500mg CEFTRIAXONE
1 ZITHROMYCIN
Syp RELENT PLUS
IV fluids*

Dr. Kapil Bhagwatrao Sachane
Reg. No: TS/2011/12345

Signature of the Doctor: _____

Signature of the Consultant: _____

Name of the Doctor: _____

Name of the Consultant: *Dr. Kapil Sachane*

Date & Time: _____

13/5/23

Date & Time: _____

12/5/26 @ 9:30

KUH-00169766 IP5-00173775
 Master D SIDDHIK SHIVIN 2 Y 5 M 22 D (M)
 21-11-2023
 Dr. KAPIL BHAGWATRAO SACHANE



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/11/23 6pm	SIB Resident	
	dx: AFI	plan. ① trace vital
	No fever since 2 days cough (+) no other complaints.	Blood Ue ② cont: ceftriaxone Azee
	ole child alert Rt - BLCA (+) clear Cvt - S1, 2	③ cont IVF ④ monitor vitals ⑤ wif fever.
USG @ final Abdomen		
14/11/23 8AM	SIB Resident	Madhu
	dx: AFI	plan. ① cont ceftriaxone Azee
	no fever after admission no new signs	② cont IVF ③ monitor vitals ④ wif fever
	ole child alert vitals stable Rt - BLCA (+) clear Cvt - S1, 2 (+) P/w - soft	⑤ Inform fos. ⑥ trace vital Blood Ue
		Madhu

Dr. Kapil Bhagwatrao Sachane
 Reg. No: TSMC/FMR/19525



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
14/5/26 11:40am	SIB Dr. Kapil d: AFI	Plan: (urgent) (1) CBP] new CPP]
	no fever vitals stable BK AG ⊕, clear pr good	(2) plan Discharge today after report (3) Inform sos. (4) monitor vitals.
	Dr. Kapil Bhagwatrao Sachane Reg No: TSMC/FMR/19525	
14/5/26 6:40pm	SIB Dr. Kapil d: Acute febrile illness	Plan: (1) cont. IV ceftriaxone Azee
	no fever vitals stable RI- BLUA ⊕ pr good	(2) monitor vitals (3) w/f fever (4) Inform sos.
	Dr. Kapil Bhagwatrao Sachane Reg. No: TSMC/FMR/19525	

Madhvi

Madhvi
 2 noted by S

IP5-00173775
00169766
Dr D SIDDHIK SHIVIN (M)
2 Y 5 M 23 D
1-2023
KAPIL BHAGWATRAO SACHANE

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's
7/26 6 PM	Acute febrile illness child on room air Hemodynamically stable no fever spikes no fresh rales	c/s/b PICU fellow (Dr. K. Sachin)
	chest - air entry bil @ clear	Plan - CBP, CRP @ consult change or (T/m) - w/ fever spikes - Discharge (T/m) if lab improving H/S/K/S
		noted by sis Kalyani 016344 at 7pm

KUH-00169766 IP5-00173775
 Master: SIDDHIK SHIVIN
 21-11-2023 2 Y 5 M 23 D (M)
 Dr. KAPIL BHAGWATRAO SACHANE



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16/12/26 8 AM	<p>SIB Resident</p> <p>1: Acute febrile illness</p> <p>no fever</p> <p>no new issues</p> <p>OIE</p> <p>child alert</p> <p>vitals stable</p> <p>no PIC AE ⊕</p> <p>Oral intake - good.</p>	<p>Plan.</p> <ol style="list-style-type: none"> 1) continue same 2) monitor vitals 3) medication as per chart 4) wlf fever 5) Review discharge tomorrow.
16/12/26 5:30 PM	<p>Informed</p>	<p>Plan.</p> <ol style="list-style-type: none"> 1) to give today's dose of ceftriaxone 2) discharge today on cefeprox x 5 days.
17/12/26 11:30 PM	<p>S/R Dr. Kapil:</p> <p>no fever</p> <p>no other complaints</p> <p>vitals stable</p>	<p>Plan.</p> <ol style="list-style-type: none"> 1) discharge today <p>Symp. cefeprox x 3 days</p> <p>Review on Tuesday</p>

Madhvi

Madhvi

Dr. Kapil Bhagwatrao Sachane
 Reg. No: TSMC/FMR/19525

KUH-00189766 IPS-00173775

Master D SIDDHIK SHIVIN

21-11-2023

2 Y 6 M 22 D

(M)

Dr. KAPIL BHAGWATRAO SACHANE



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	12/12/23	13/12/23	14/12/23	16/12/23		
Time		4pm	12pm	6:10am		
Hb	9.6					
PCV	29		9.9	10.4		
RBC	4.06		29.17	29.1		
WBC	17,640		4.14	4.17		
N/L	56/36		8500	14,880		
Platelets	4.57 lakh		23/60	16/64.8		
CRP	89 ↑		4.93 lakh	6.25 lakh		
ESR			42 ↓	14 ↓		
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT		126				
SGOT		14				
		28				
T.Bill/Conj		0.2/0.1				
T.Protein		6.7				
S.Albumin		3.8				
S.Globulin		2.9				
A/G Ratio		1.3				
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						

CSP Protein / Sugar

FORM / CLINICAL / 0138

SHIVIN 00173775
 2 Y 5 M 22 D
 DR. KAPIL BHAGWATRAO SACHANE (M)



MEDICATION RECONCILIATION FORM

Drug Allergies:

Not known any Drug

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

Shifting From: ER Shifted to: Ward

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ADMIT / SHIF
1	Syrup CEFURROX	2.5ml	PO	BD	12/5/26	<input type="checkbox"/> C <input type="checkbox"/> DC
2	Syrup RELENT PLUS	2.5ml	PO	BD	13/5/26	<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
3						<input type="checkbox"/> C <input type="checkbox"/> DC
4						<input type="checkbox"/> C <input type="checkbox"/> DC
5						<input type="checkbox"/> C <input type="checkbox"/> DC
6						<input type="checkbox"/> C <input type="checkbox"/> DC
7						<input type="checkbox"/> C <input type="checkbox"/> DC
8						<input type="checkbox"/> C <input type="checkbox"/> DC
9						<input type="checkbox"/> C <input type="checkbox"/> DC
10						<input type="checkbox"/> C <input type="checkbox"/> DC

VERIFIED BY (Jn)

* C- Continue, DC - Discontinue

MEDICATION HISTORY RE

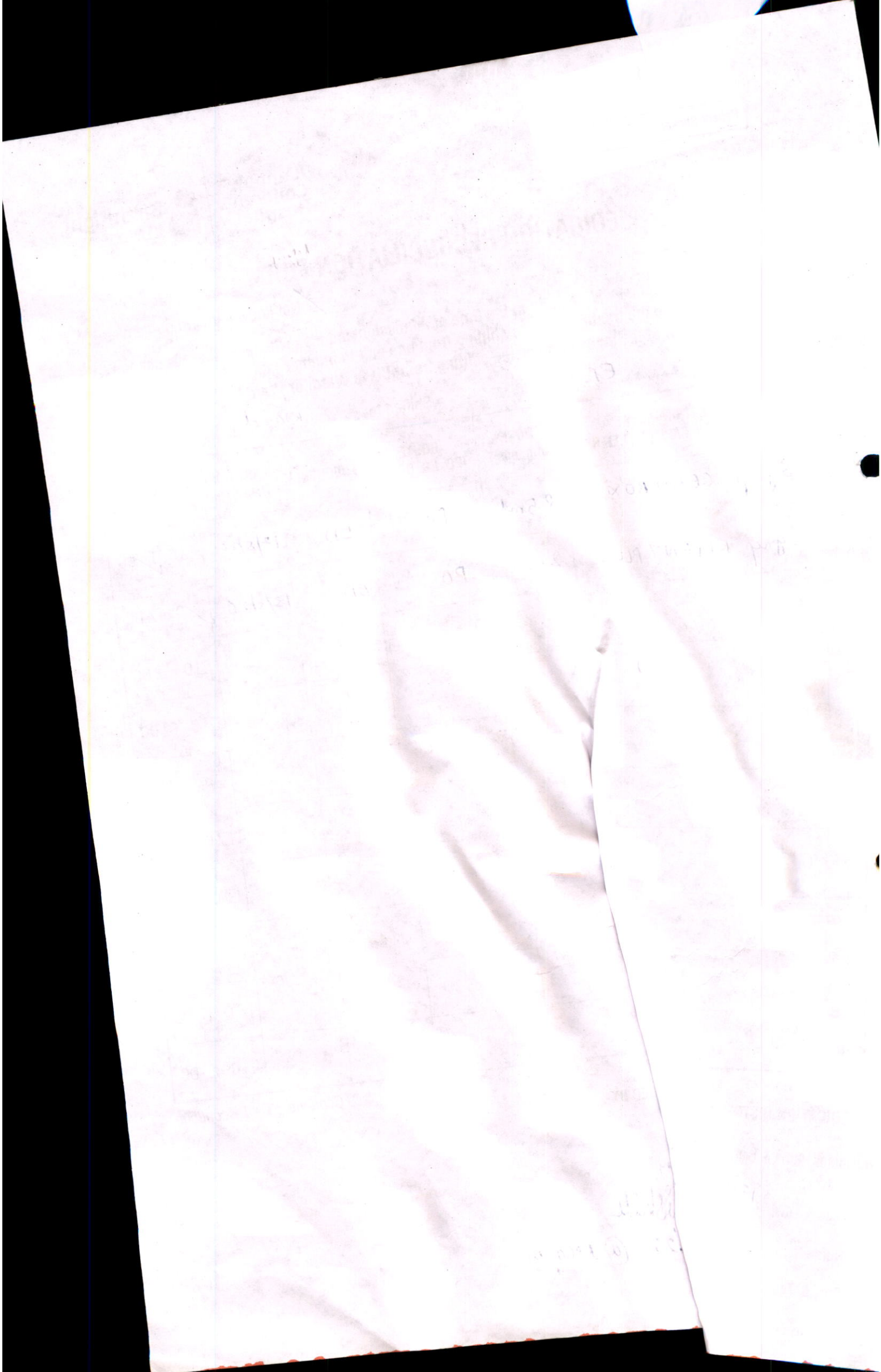
Doctor Name & Signature: Abhishek

Date & Time: 13/5/26 @ 1:00pm

Nurse Name & Signature: Abhishek

Date & Time: 090

Docu. No.: RCHB





DRUG CHART

Date of Admission: 13/5/22 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 : Syrup PARACETAMOL				Date Time															
Dose	Route	Frequency	Start Date																
3ml	PO	6th hrs	13/5																
Doctor's Signature		Valid Period	Pharm.																
Jayashri		2days	[Signature]																
Additional Instructions:																			
(5ml/240mg)																			
DRUG :				Date Time															
Dose	Route	Frequency	Start Date																
Doctor's Signature		Valid Period	Pharm.																
Additional Instructions:																			
DRUG :				Date Time															
Dose	Route	Frequency	Start Date																
Doctor's Signature		Valid Period	Pharm.																
Additional Instructions:																			



REGULAR PRESCRIPTIONS

Weight. 9.8kg Ward.

VERIFIED

DRUG : Inj CEFTRIAXONE				Date/Time	13/5	14/5	15/5	16/5
Dose	Route	Frequency	Start Date					
500mg	IV	BD	13/5					
Name & Signature of the Doctor Starting the Drugs: Jayashri								
Additional Instructions:								
Daily Doctor's Endorsement by a Sign								

VERIFIED

DRUG : Inj EDOMEPRAZOLE				Date/Time	13/5	14/5	15/5	16/5
Dose	Route	Frequency	Start Date					
10mg	IV	OD	13/5					
Name & Signature of the Doctor Starting the Drugs: Jayashri								
Additional Instructions:								
Daily Doctor's Endorsement by a Sign								

VERIFIED

DRUG : Syrup AZITHROMYCIN				Date/Time	13/5	14/5	15/5	
Dose	Route	Frequency	Start Date					
2.5ml	PO	OD	13/5					
Name & Signature of the Doctor Starting the Drugs: Jayashri								
Additional Instructions: (5ml/200mg)								
Daily Doctor's Endorsement by a Sign								

VERIFIED

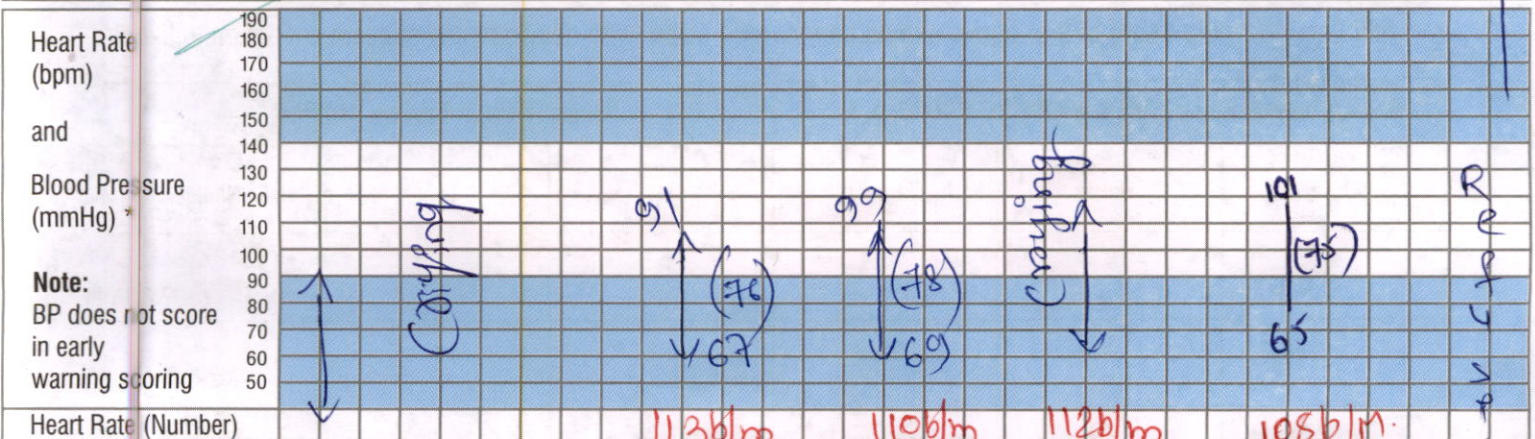
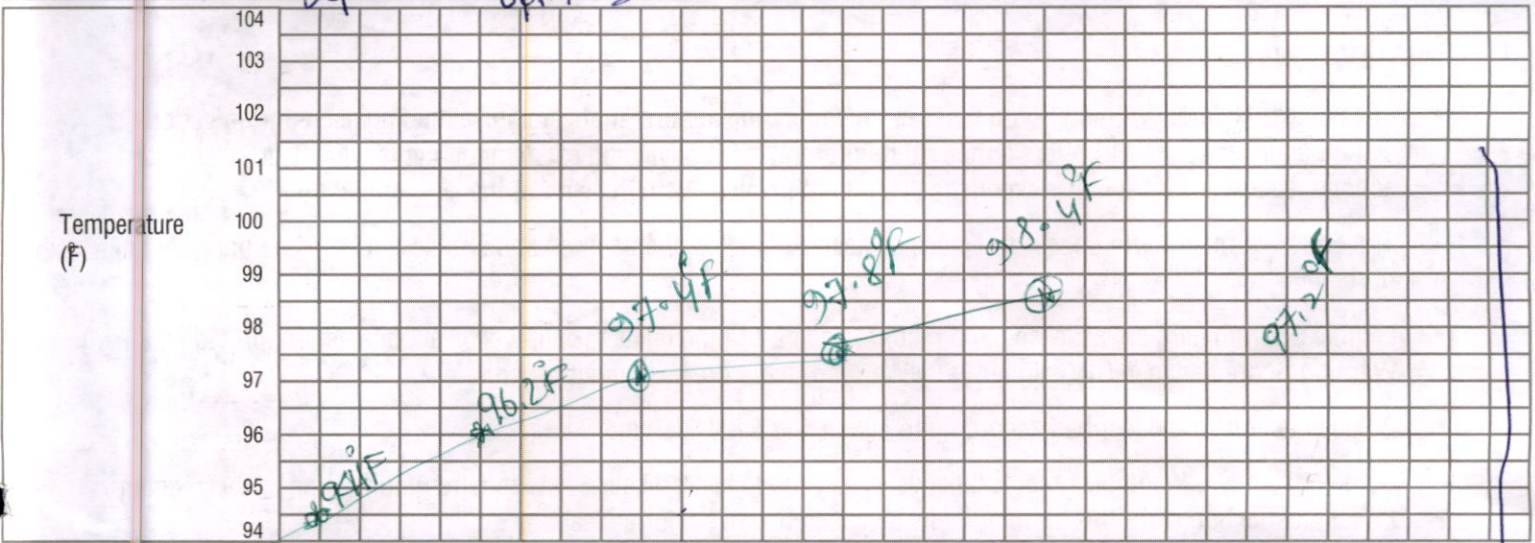
DRUG : Syrup RELENT PLUS				Date/Time	13/5	14/5	15/5	16/5
Dose	Route	Frequency	Start Date					
2.5ml	PO	BD	13/5					
Name & Signature of the Doctor Starting the Drugs: Jayashri								
Additional Instructions:								
Daily Doctor's Endorsement by a Sign								



EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 13/5 Time: 10pm ~~11:15 AM~~ 6AM 10AM 1PM

Doctor / Nurse / Family Concern? 2pm 6pm



Heart Rate (Number)	113	110	112	108
Resp. Rate (bpm) (Over 1 Minute) *				
Resp Rate (Number)	26	21	26	25

Resp Distress	Mod/ Severe	None / Mild				
Receiving O ₂ (l/min)	O ₂ Saturations (%)	99%	100%	100%	100%	99%
Conscious Level	Normal / Altered	15/15	15/15	15/15	15/15	15/15
GCS *		15/15	15/15	15/15	15/15	15/15

TOTAL SCORE						
Number of shaded boxes	0	0	1	1	1	1
Pain Score	0	0	0	0	0	0
Observer's Initials	Q	Q	A	A	V	U

- 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: Scores 3 should be recorded overleaf

* 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)

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 19/11/23 Time: 5 PM 7 PM
 Doctor / Nurse / Family Concern? *10/23* *SPD*

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

Refused *97.6°F* *97.5°F* *Parent Refused Baby Sleeping*

Heart Rate (bpm)	190				
	180				
	170				
	160				
	150				
	140				
	130				
	120				
	110				
	100				
	90				
	80				
	70				
	60				
	50				

Note: BP does not score in early warning scoring

Heart Rate (Number) *99 bpm* *117 bpm*

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

Resp Rate (Number) *26 bpm* *21 bpm*

Resp Distress	Mod/ Severe				
	None / Mild				
Receiving O ₂ Saturations (%)					
		<i>99%</i>	<i>100%</i>		
Conscious Level	Normal				
	Altered				
GCS *		<i>15/1r</i>	<i>14</i>		

TOTAL SCORE					
Number of shaded boxes		<i>0</i>	<i>0</i>		
Pain Score		<i>0</i>	<i>0</i>		
Observer's Initials		<i>V</i>	<i>✓</i>		

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

I	IDENTITY: I am (name), a nurse on ward (X). I am calling about (child X)
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)



15/11/23

PRESCHOOL (1-5 years)
Children's Observation & Early Warning Scoring Chart



EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 15/11/23 Time: 12pm 6pm 10:40pm 11:30pm
 Doctor / Nurse / Family Concern?

Temperature (F)	104				
	103				
	102				
	101				
	100				
	99	98.5°F	97.8°F	97.7°F	97.7°F
	98				
	97				
	96				
	95				
	94				

Heart Rate (bpm) and Blood Pressure (mmHg) *	190				
	180				
	170				
	160				
	150				
	140				
	130				
	120				
	110				
	100				
	90				
80					
70					
60					
50					

Heart Rate (Number) 115b/m 120b/m 122b/m 118b/m

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

Resp Rate (Number) 27b/m 27b/m 20b/m 21b/m

Resp Mod/ Severe Distress None / Mild

Receiving O2 (l/min) O2 Saturations (%) 100% 100% 99% 99%

Conscious Level Normal / Altered

GCS * 15/15 15/15 14 14

TOTAL SCORE Number of shaded boxes 0 0 0 0

Pain Score 0 0 0 1

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.
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* 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

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

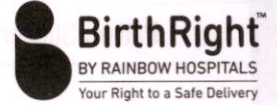
- If at any time additional help is required, call help – regardless of the Early Warning Score!
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R	RECOMMENDATION : I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

Patient

KUH-00169766 IP5-00173775
 Master D SIDDHIK SHIVIN 2 Y 6 M 22 D
 21-11-2023 (M)
 Dr. KAPIL BHAGWATRAO SACHANE



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.

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 :							
13/5	02:00 pm	↓											
	03:00 pm	↓		20ml						✓	0		RB
	04:00 pm	↓		20ml						✓	0		RB
	05:00 pm	↓		-						✓	0		RB
	06:00 pm	↓		-						✓	0		RB
	07:00 pm	↓		20ml						✓	0		RB
Total Intake :						Total Output :							
13/5	08:00 pm	↑		-							0		RB
	09:00 pm			-							0		RB
	10:00 pm	↓		-						✓	0		RB
	11:00 pm			20ml							0		RB
	12:00 am			20ml							0		RB
	01:00 am	↓		20ml						✓	0		RB
Total Intake :						Total Output :							
14/5	02:00 am	↑		20ml							0		RB
	03:00 am			20ml							0		RB
	04:00 am	↓		20ml						✓	0		RB
	05:00 am			20ml							0		RB
	06:00 am			-							0		RB
	07:00 am	↓		-						✓	0		RB
Total Intake :						Total Output :							

Total 24 hrs. Intake

Total 24 hrs. Output

FLUID CHART

Sheet No. : 19.15/26

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
14/11	08:00 am									0	Arung		
	09:00 am								✓	0			
	10:00 am	NO			NA		NA	NA		0	Arung		
	11:00 am	IVF								0			
	12:00 pm								✓	0	Arung		
	01:00 pm								✓	0			
Total Intake :						Total Output :						U-2 N-0	
	02:00 pm	H ₂ O					✓			0	Arune		
	03:00 pm								✓	0			
	04:00 pm	H ₂ O								0	Arune		
	05:00 pm	soup								0			
	06:00 pm	milk							✓	0	Sats		
	07:00 pm								✓	0			
Total Intake :						Total Output :						M-1 U-2	
	08:00 pm									0			
	09:00 pm								✓	0			
	10:00 pm	D	milk				NA			0			
	11:00 pm	N					NA			0	Soma		
	12:00 am	S							✓	0			
	01:00 am		milk							0			
Total Intake :						Total Output :						M-0 U-2	
	02:00 am									0			
	03:00 am									0			
	04:00 am	D					NA			0	Soma		
	05:00 am	N					NA			0			
	06:00 am	S							✓	0			
	07:00 am									0			
Total Intake :						Total Output :						M-0 U-7	

Total 24 hrs. Intake

Total 24 hrs. Output M-1 U-7

KUH-00169766 IP5-00173775
 Master D SIDDHIK SHIVIN
 21-11-2023 2 Y 5 M 23 D (M)
 Dr. KAPIL BHAGWATRAO SACHANE

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	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
		Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage			Urine
			Mouth	I.V	N.G							
08/11/23	08:00 am	1		1						0	Kalyani	
	09:00 am	1							✓	0		
	10:00 am	ORS	H ₂ O	Refused			✓			0		
	11:00 am	ORS		Refused						0		
	12:00 pm	1							✓	0		
	01:00 pm	1	Rice							0		
Total Intake :					Total Output :							
08/11/23	02:00 pm	1		1						0	Kalyani	
	03:00 pm	1	H ₂ O							0		
	04:00 pm	ORS	H ₂ O	Refused			✓			0		
	05:00 pm	ORS	H ₂ O	Refused						0		
	06:00 pm	1	H ₂ O	Refused					✓	0		
	07:00 pm	1	H ₂ O							0		
Total Intake :					Total Output : M=2 U=2							
08/11/23	08:00 pm									0	Seema	
	09:00 pm		H ₂ O				✓		✓	0		
	10:00 pm									0		
	11:00 pm		H ₂ O							0		
	12:00 am								✓	0		
	01:00 am									0		
Total Intake :					Total Output : M=1 U=2							
08/11/23	02:00 am									0	Seema	
	03:00 am		H ₂ O				✓		✓	0		
	04:00 am									0		
	05:00 am						✓			0		
	06:00 am		H ₂ O						✓	0		
	07:00 am									0		
Total Intake :					Total Output : M=0 U=2							
Total 24 hrs. Intake												
Total 24 hrs. Output		M=3 U=8										

KUH-00169766 IP5-00173775
 Master D SIDDHIK SHIVIN
 21-11-2023 2 Y 5 M 23 D (M)
 Dr. KAPIL BHAGWATRAO SACHANE



FLUID CHART

Sheet No. :

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
16/5/2028	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



114 → 318

NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 13/5/26 Time: 2:30PM

Weight: 9.87Kgs Centile: < 5th

Height: 83 cm Centile: > 5th

Inference: under weight child

RDA: - Calories: 1250 Kcal/d Protein: 21g/d

Diet Recommendations: Soft diet

Re-Assessment: Avoid spicy, chilled and outside foods

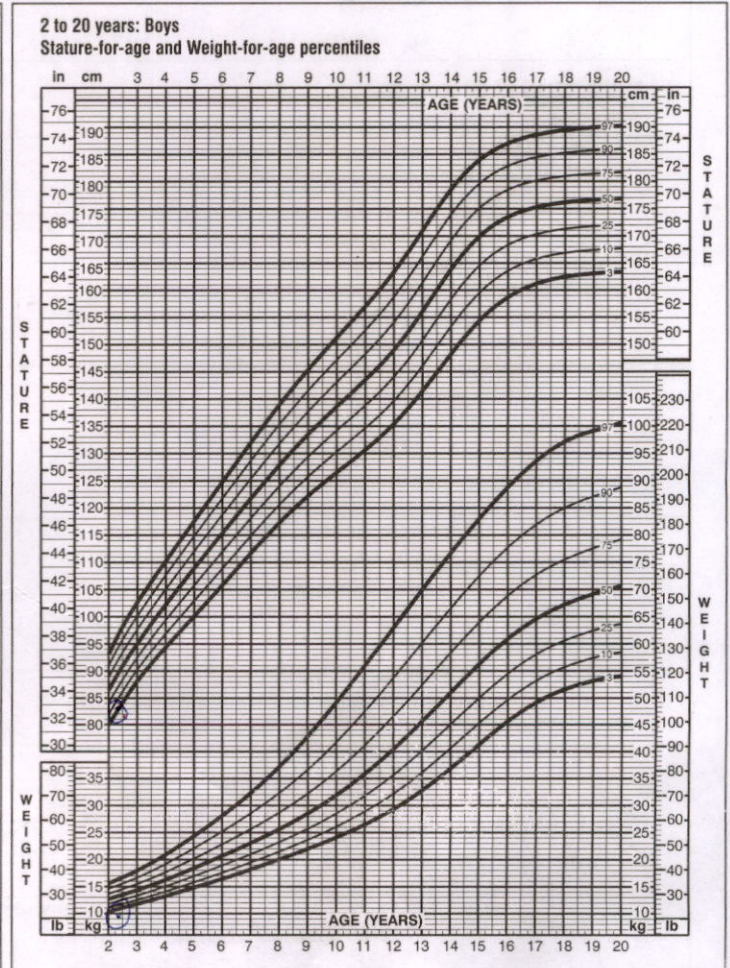
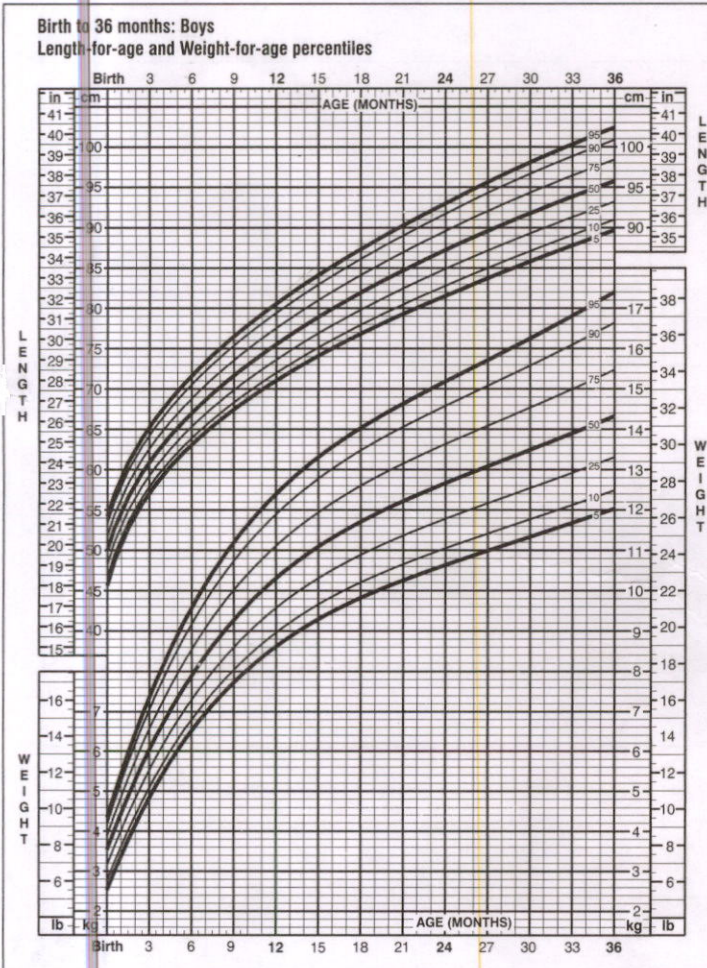
Food Allergies: No Veg/Non-veg: Non-veg

Diagnosis: Fever x 1 week

Nutritional Intervention - Oral Enteral Parenteral

Patient's Signature: *Hanika*

GROWTH CHART (BOYS)



Dietician's Name: *N. P. Kitha*

Dietician's Signature: *N. P. Kitha*

Daily Notes:

15/5/26

child is stable, oral intake is suboptimal

Saima

9:30am

continue, ē soft diet