

ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____

Date of Admission: _____

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

FDH-00042898 IP5-00175869
Master MASUM SEKH
21-04-2023 3 Y 2 M 11 D (M)
Dr. SIRISHA RANI



ultant: _____ Dept : _____

of Discharge : _____ Time: _____

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
02/07/20	11:35A	ER	141	dy

Cross Consultation Visit

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

INVESTIGATIONS

[illegible]

[illegible]

Name of Equipment

Connecting Time

Disconnecting Time

Order No.

Signature

2/04

Infusion pump.

12pm

~~5/9/26~~
Stop

9607696

gleep

[illegible]

parents Don't need HELP. Don't charge for NHA.

Prepared By : 

Billing Supervisor

Shariya.

Ans. (11)

FDH-00042898 IP5-00175869

Master MASUM SEKH

21-04-2023

3 Y 2 M 13 D

(M)

Dr. SIRISHA RANI



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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

EFFICIENCY CHECK LIST OF CASE SHEET

Sl.No.	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission sheet	1			
2	Discharge Summary	3			
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	5			
8	Consultation sheet				
9	General consent for treatment	1			
10	Consent for Surgery				
11	Consent for blood transfusion				
12	Consent for chemotherapy	1			
13	Consent for high risk				
14	Consent for Restraint				
15	LAMA consent				
16	Consent for special procedure / Sedation	4			
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	4			
30	Intake and Out take chart (fluid chart)	2			
31	Drug chart (Regular Prescription)	1+3			
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				
	Extra	6			
	Total No. of Pages	42			

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

ADMISSION SHEET

Registration Details :



Admission No : IP5-00175869 Admit Date : 02-Jul-2026 Admit Time : 11:01 AM UHID : FDH-00042898

Patient Details :

Patient Name	: Master MASUM SEKH	Age	: 3 Y 2 M 11 D
Guardian	: Mr MASREK SEKH	DOB	: 21-04-2023
Gender	: Male	Religion	:
Occupation	:	Martial Status	: Single
Address (H)	: PEERAMCHERU,BANDLAGUDA, NEAR KALIMANDIR BANDLAGUDA JAGIR Hyderabad Telangana INDIA 500086	Phone No	: 9647757308/ 6304250656
		E-mail	: NOMAIL@GMAIL.COM

Admission Details :

Bed Type : GENERAL WARD Bed No : GW 141 Ward Name : 1F-GENERAL WARD II
 Room No : GW 141 Admission Type : First Visit

Contact Details :

Name : Mr MASREK SEKH Relationship : Father
 Contact Address : PEERAMCHERU,BANDLAGUDA, NEAR
 KALIMANDIR BANDLAGUDA JAGIR Hyderabad
 Telangana INDIA 500086 Phone No : 9647757308 / 6304250656



Signature

Doctor Details :

Doctor Name : Dr. SIRISHA RANI Specialisation : HEMATO ONCOLOGY
 Referral Doctor : Self Phone No :
 Co-Consultant : Dr. SANDHYA VADDADI

Payment Details :

Deposit Amount : 0.00
 Payment Mode : Cash Payor Name : SELFPAY

CONSENT FOR CHEMOTHERAPY

Patient Name : Masum Sheikh. Age : 3yr Gender: Male ☒ Female ☐
UHID No : Department : Date : 2/7
Type of Chemotherapy : intravenous

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

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

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

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

Patient Attendant :

Signature : Mariyakhatun
Name : Mariyakhatun
Relationship with Patient: Mother
Date & Time : 3pm 2/7/26

Witness :

Signature : Merlin
Name : Merlin
Date & Time : 3pm 2/7/26

Doctor (who is taking the consent):

Signature : [Signature]
Name : Dr. Samelhya V
Date & Time : 2/7/26



It takes a lot to treat the little.

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name:

FDH-00042898 IP5-00175869
Master MASUM SEKH
21-04-2023 3 Y 2 M 11 D (M)
Dr. SIRISHA RANI

UHID ID:



Department:

Consultant:



Pediatric Multiorgan History & Physical Examination

Name : Masum Sekh Age/Sex 3y / M

Information given by: Relationship Mother

Chief Presenting Complaints & Duration (Chronologically)

K/C/O B-cell ALL
↓
Now for LP & chemotherapy

History of present illness :

No fresh issues

K/C/O B-cell ALL / CAHA - Positive
CNS - Negative

↓
Now admitted for LP & chemotherapy



Pediatric Multiorgan History & Physical Examination

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

K/C/O B-cell ALL

Birth & Neonatal History:

Not significant

Birth & Socio Economic History:

About Father : _____

About Mother : _____

Any additional Information : _____

} lower middle class

Developmental History :

Achieved as per age.

Immunization History :

As per schedule.



Pediatric Multiorgan History & Physical Examination

Anthropometry :

Head Circum (cms) _____ (Centile _____) Height (cms): _____ (Centile _____)
Weight (kgs)) 14.97 kg (Centile _____)

On Examination :

Temperature : 98.4°f Pulse Rate : 94 bpm B.P. 96/60 mmHg SPO2 100% RA
Resp. rate and type of breathing : 24 br / min

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

Respiratory System :

Inspection (any s/o distress) : _____
Air entry & breath sounds : 3 L ABB, clear
Any addes sounds : _____
Relevant data from outside (Chest X-Ray, ABG, etc.,) _____

Cardiovascular System :

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

Per Abdomen :

Inspection _____
Palpation : _____
Ausculation : Soft, nondistended
Spine : _____ External Genitalia : _____
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 : 2

Motor System:

Nutriton : 2

Tone : 2 Power : 2

Co-ordinator : 2

Posture : 2

Involuntary Movements : 2

Reflexes :

DTR

Superficials:

Plantars

Sensory System :

Bladder / Bowel :

Clinical Summary & Diagnostic:

KPC10 B-cell ALL now for chemotherapy



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: _____

Sepsis
complications of ALL

Desired goals of the treatment: _____

Remission

Planned Labs:

Planned Management

Syp. calinease pty
Syp. Montel
Syp. Lupizyme pty
Syp. MV-out
Tab. Langel-SR 15mg
Ino. ondansetron.

Signature of the Doctor: Nalal

Name of the Doctor: Dr. Nandan

Date & Time: 02/07/2020, 10:45AM

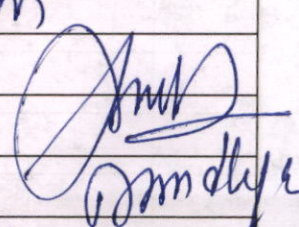
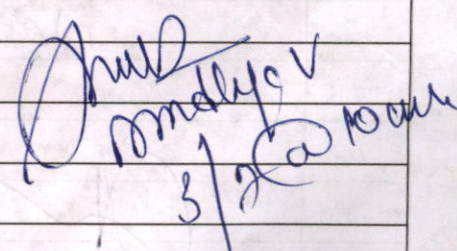
Signature of the Consultant: Sandhya Vaddadi

Name of the Consultant: Dr. Sandhya Vaddadi

Date & Time: _____

Dr. SIRISHA RANI
Reg. No: 40525

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/7/26 11:45 am	Sib Sandhya A B cell ALL /	admitted for chemotherapy
	Doing well	(P)
		→ LPE intrathecal chemotherapy today
	C/S R/S D/A	→ Send CBL, creat, SALT and chemotherapy CFT/M
		
3/7/26 6:10 AM	Morning rounds Still well / now for chemotherapy /	Dr. SANDHYA VADDADI Reg. No: 71664
	At home No fresh vom Vitals (N) S/E → PRW FLUIDS	1) bare wt 2) Start folic acid 3) wnt rest 4) Inform SOS
	WS R/S P/R	
	Not passed stool - 2 days	Dr. Sandhya Vaddadi 3/7/26

Dr. SIRISHA RANI
Reg. No: 40525

Dr. SANDHYA VADDADI
Reg. No: 71664



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/7/26	Evening rounds	
4pm	No fever No vomiting vitals stable	Plan 1. ct chemotherapy 2. Trace w/e.
		Dr. Sirisha Rani Reg. No: 40525
4/7/26	Morning rounds	
8:40 AM	seen sup physical M W / for chemotherapy.	
	do exam do frequent stools. Vitals @ feeding fine S/T SPPOV UTLS	1) Start folinic rescue @ 11 AM 2) USP MTX level / thru by pink. 3) monitor vitals 4) if sympt case 5) vitals @
WE PM 7	W/S P/S / @ P/S / @	Ahankya
	Dr. Anurag 43251 @ 8:30 AM Dr. Anurag Reddy	

Date & Time	Progress Notes	Doctor's Order
4/17/16 2:15 PM	imms: stomach abdomen pain - 1 contraction noted	<u>sbh</u> - Continue Mvor powder. - Continue hydration as per chems chart.
	 Anurag Reddy Dr. Anurag Reddy	
5/2/16 9 AM	B-ALL/Protocol-M 1st dose No fever No complaints	<u>Plan</u> 1- ct supportive care 2- d/c today Plu 10/7 ECAI. <u>han</u>

F. SIRISHA RANI

FDH-00042898

FDH-00042800
Master MASUM SEKH

21.04.2023

3 Y 2 M 13 D

(M)

[illegible]

FDH-00042898 IP5-00175869
Master MASUM SEKH
21-04-2023 3 Y 2 M 11 D (M)
Dr. SIRISHA RANI



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BirthRight[™]
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

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 :

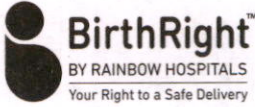
 CT :

 MRI :

 Others (ECG, Contrast Studies etc.,) :



Masum Sekh



MEDICATION RECONCILIATION FORM

Drug Allergies: ☒ Not known any Drug Allergies

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

Shifting From: ER Shifted to: Hemat-oncology

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	Syp-Calimax	5ml	PO	OD	01/07/26 10AM	☒ C ☐ DC
2	Syp-MORIZEL	5ml	PO	OD	01/07/26 10AM	☒ C ☐ DC
3	Syp-LOPIGYME-PLUS	5ml	PO	BD	01/07/26 9 PM	☒ C ☐ DC
4	Syp-MO-OUT	5ml	PO	OD	01/07/26 9 PM	☒ C ☐ DC
5	TAB-LANSOPRAZOLE	15mg	PO	OD	01/07/26 8 AM	☒ 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: Dr. Nandan

Date & Time: 02/07/26, 11 AM

Nurse Name & Signature: Kethan

Date & Time: 02/07/26 @ 11:30 AM



un sekh

DRUG CHART

Date of Admission: 02/07/26 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:																			

VERIFIED BY : Name

Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward

DRUG : TAB ANSOPRAZOLE				Date	Time
Dose	Route	Frequency	Start Dt.		
15mg	PO	OD	02/07		
Name & Signature of the Doctor Starting the Drugs:					
Dr. Nandan					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					
DRUG : INT. ONDANSETRON				Date	Time
Dose	Route	Frequency	Start Dt.		
3mg	IV	BD	02/07		
Name & Signature of the Doctor Starting the Drugs:					
Dr. Nandan					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					
DRUG : Syr DOMPERIDONE				Date	Time
Dose	Route	Frequency	Start Dt.		
4ml	PO	BD	2/7/26		
Name & Signature of the Doctor Starting the Drugs:					
Dr. Nandan					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					
DRUG : INT DEXAMETHASONE				Date	Time
Dose	Route	Frequency	Start Dt.		
1.5mg	IV	OD	2/7/26		
Name & Signature of the Doctor Starting the Drugs:					
Dr. Nandan					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					

Sheet NO:

REGULAR PRESCRIPTIONS

Weight

Ward

DRUG : <u>SYP SUCRAL</u>				Date Time																
Dose <u>7.5ml</u>	Route <u>P/O</u>	Frequency <u>BD</u>	Start Dt. <u>2/2</u>	<u>6 AM</u>	<u>X</u>	<u>1 PM</u>	<u>X</u>	<u>4 PM</u>	<u>X</u>	<u>7 PM</u>	<u>X</u>									
Name & Signature of the Doctor Starting the Drugs: <u>[Signature]</u>																				
Additional Instructions: <u>6pm</u>																				
Daily Doctor's Endorsement by a Sign																				
DRUG : <u>INJ FOLINIC ACID</u>				Date Time																
Dose <u>13mg</u>	Route <u>IV</u>	Frequency <u>TID</u>	Start Dt. <u>2/2</u>	<u>6 AM</u>	<u>X</u>	<u>12 PM</u>	<u>X</u>	<u>5 PM</u>	<u>X</u>											
Name & Signature of the Doctor Starting the Drugs: <u>[Signature]</u>																				
Additional Instructions: <u>shot @ 11 AM</u>																				
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 :

DRUG :

STAT / ONCE ONLY DRUGSDate _____

Weight. Ward.

[illegible]



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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 05/07/22 Time: 9 am 6 am		
Doctor / Nurse / Family Concern?		
Temperature (°F)	104	
	103	
	102	
	101	
	100	
	99	
	98	
	97	
	96	
	95	
94		
Heart Rate (bpm)	190	
	180	
	170	
	160	
	150	
	140	
	130	
	120	
	110	
	100	
Blood Pressure (mmHg) *	90	
	80	
	70	
	60	
	50	
	Note: BP does not score in early warning scoring	
	Heart Rate (Number)	
	Resp. Rate (bpm) (Over 1 Minute) *	70
		60
		50
40		
30		
20		
10		
Resp Rate (Number)		
Resp		Mod/ Severe
Distress		None / Mild
Receiving O ₂ (l/min)		
O ₂ Saturations (%)		
Conscious	Normal	
Level	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.

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)



PRESCHOOL (1-5 years)

Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 04/07/23	Time: 2am	6am	10am	2pm	6pm	10pm	
Doctor / Nurse / Family Concern?							
Temperature (F)	104						
	103						
	102						
	101						
	100						
	99						
	98						
	97						
	96						
	95						
94							
Heart Rate (bpm)	190						
	180						
	170						
	160						
	150						
	140						
	130						
	120						
	110						
	100						
Blood Pressure (mmHg) *	90						
	80						
	70						
	60						
	50						
	40						
	30						
	20						
	10						
	0						
Note:	BP does not score in early warning scoring						
Heart Rate (Number)	80bpm	78bpm	120bpm	110bpm	124bpm	110bpm	
Resp. Rate (bpm) (Over 1 Minute) *	70						
	60						
	50						
	40						
	30						
	20						
	10						
	0						
	Resp Rate (Number)	28bpm	26bpm	29bpm	28bpm	28bpm	20bpm
	Resp Distress	None	None	None	None	None	None
Receiving O ₂ (l/min)	100%	100%	100%	99%	100%	100%	
O ₂ Saturations (%)	100%	100%	100%	99%	100%	100%	
Conscious Level	Normal	Normal	Normal	Normal	Normal	Normal	
GCS *	15/15	15/15	15/15	15/15	15/15	15/15	
TOTAL SCORE	1	1	1	1	0	1	
Number of shaded boxes	0	0	0	0	0	0	
Pain Score	0	0	0	0	0	0	
Observer's Initials							

ACTIONS

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- 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)



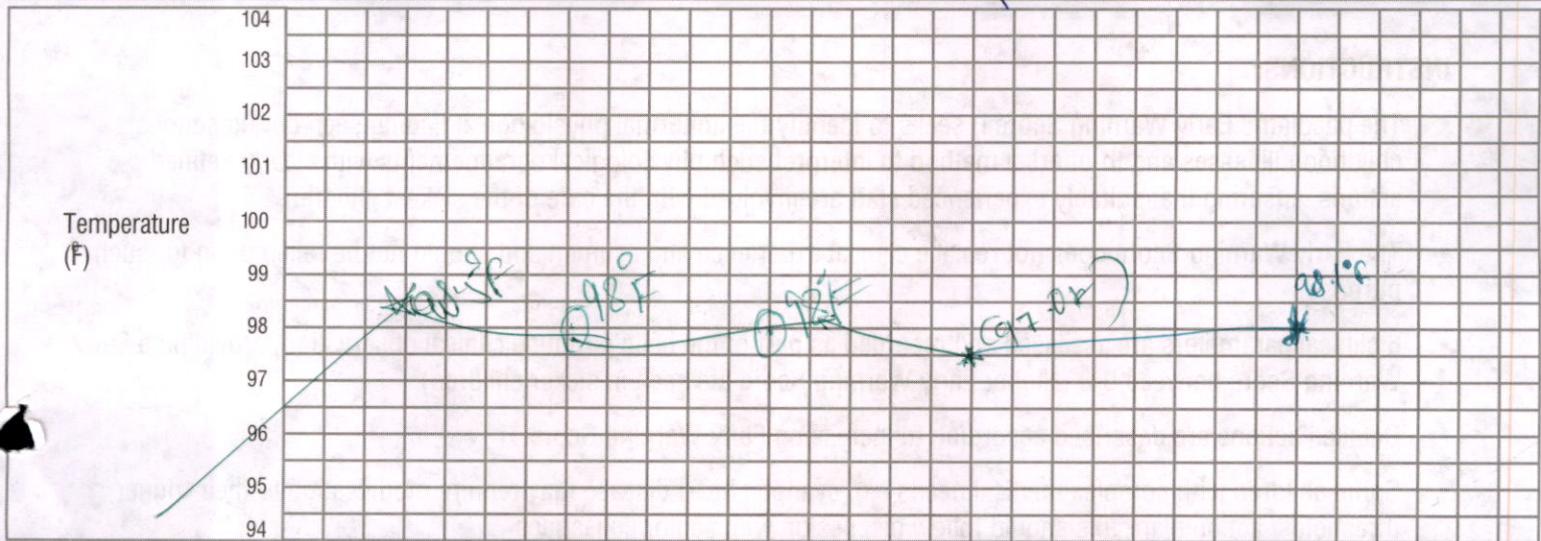
PRESCHOOL (1-5 years)

Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 3/07/23 Time: 6 am 10 am 1 pm 6 pm 10 pm

Doctor / Nurse / Family Concern?



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

Note: BP does not score in early warning scoring

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 ₂ Saturations (%)	

Conscious Level	Normal
	Altered

GCS *

TOTAL SCORE	
Number of shaded boxes	
Pain Score	
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.
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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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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 (6-12 years)

Children's Observation &
Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date :	Time: 6pm	10pm	2am	
Doctor / Nurse / Family Concern?				
Temperature (F)	104			
	103			
	102			
	101			
	100			
	99			
	98	97.8	97.8	97.8
	97			
	96			
	95			
94				
Heart Rate (bpm)	190			
	180			
	170			
	160			
	150			
	140			
	130			
	120			
	110	97	100	100
	100			
Blood Pressure (mmHg) *	90			
	80			
	70			
	60			
	50			
	40			
	30			
	20			
	10			
	0			
Note: BP does not score in early warning scoring				
Heart Rate (Number)	101bpm	100bpm	100bpm	
Resp. Rate (bpm) Over 1 Minute) *	70			
	60			
	50			
	40			
	30			
	20			
	10			
	0			
	0			
	0			
Resp Rate (Number)	20bpm	20bpm	20bpm	
Resp Distress	Mod/ Severe	None / Mild		
Receiving O ₂ (l/min)				
O ₂ Saturations (%)	97%	97%	97%	
Conscious Level	Normal	Altered		
GCS *	15/15	15/15	15/15	
TOTAL SCORE	1	1	1	
Number of shaded boxes	1	1	1	
Pain Score	0	0	0	
Observer's Initials				

ACTIONS

NB: Scores 3 should be
recorded overleaf

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

- The paediatric Early Warning Score i) seeks to identify the abnormal physiological finding seen during serious childhood illnesses and ii) offers a method to interpret such physiological derangements with clearly defined actions, ensuring that suitably experienced staff are involved with the care of the sickest children.
- The Early Warning Score does not replace clinical experience and acumen and should not be relied upon for such purpose.
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- 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

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Date	Time	Early Warning Score	Date	Time	Name

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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)

FDH-00042898 IP5-00175869
 Master MASUM SEKH
 21-04-2023 3 Y 2 M 11 D (M)
 Dr. SIRISHA RANI



Patient Stic

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

FLUID CHART

Sheet No. :

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

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G								
	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
	Total Intake :						Total Output :						
21/4	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
	Total Intake :						Total Output :						
02/07	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
	Total Intake :						Total Output :						
03/07	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.

		Intake			Output						IV Site Thrombophlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G								
2/4	08:00 am	Chemo		25+50		/			/		0	} need	
	09:00 am			25+50				0					
	10:00 am			25+50				0					
	11:00 am			25+50				0					
	12:00 pm			25+50				0					
	01:00 pm			25+50				0					
Total Intake :					Total Output :								
3/04	02:00 pm	↑				/			/		↑	} 200	
	03:00 pm	↑								↑			
	04:00 pm	Chemo therapy								↓			
	05:00 pm	↓								↓			
	06:00 pm	↓								↓			
	07:00 pm	↓								↓			
Total Intake :					Total Output :								
03/07	08:00 pm	↑	Receft	50ml		/			/		1	} 300	
	09:00 pm	↑	H ₂ O	50ml						✓	1		
	10:00 pm	Chemo		50ml						✓	1		
	11:00 pm	therapy		50ml						✓	1		
	12:00 am	↓		50ml						✓	1		
	01:00 am	↓		50ml						✓	1		
Total Intake :					Total Output :								
04/07	02:00 am	↑		70ml		/			/		1	} 300	
	03:00 am	↑	H ₂ O	70ml						✓	1		
	04:00 am	Chemo		70ml						✓	1		
	05:00 am	therapy		70ml						✓	1		
	06:00 am	↓		70ml						✓	1		
	07:00 am	↓		70ml						✓	1		
Total Intake :					Total Output :								
Total 24 hrs. Intake					Total 24 hrs. Output								



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			
n/11/20	08:00 am	chemo therapy	Edi's	70ml	/	/	/	/	/	/	/	/	/
	09:00 am			70ml									
	10:00 am			70ml									
	11:00 am			70ml									
	12:00 pm			70ml									
	01:00 pm			70ml									
Total Intake :				Total Output :									
u/b	02:00 pm	chemo	Rice	70ml	/	/	/	/	/	/	/	/	Chand
	03:00 pm			70ml									
	04:00 pm			70ml									
	05:00 pm			70ml									
	06:00 pm			70ml									
	07:00 pm			70ml									
Total Intake :				Total Output :									
u/b	08:00 pm	chemo	Rice	70ml	/	/	/	/	/	/	/	/	/
	09:00 pm			70ml									
	10:00 pm			70ml									
	11:00 pm			70ml									
	12:00 am			70ml									
	01:00 am			70ml									
Total Intake :				Total Output :									
stop	02:00 am	chemo	Rice	70ml	/	/	/	/	/	/	/	/	/
	03:00 am			70ml									
	04:00 am			70ml									
	05:00 am			70ml									
	06:00 am			70ml									
	07:00 am			70ml									
Total Intake :				Total Output :									
Total 24 hrs. Intake				Total 24 hrs. Output									



FLUID CHART

Sheet No. :

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		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						Total Output :						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	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: 21/7/26

Assessment: Baby having dull activity

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	⇒ Asses the pt general condition	2:30pm	⇒ Assessed the pt general condition	
3pm	⇒ monitor vital sign	3:30pm	⇒ monitored vital sign	pt condition
4pm	⇒ maintain I/O chart	5pm	⇒ maintained I/O chart	PS good.
6pm	⇒ Administered medication as per doctors order.	7pm	⇒ Administered medication as per doctor order	

Re-Assessment: Re-Assessment

Special Notes:

Nurse Signature: Nurse Name: Sirisha Date & Time: 21/7/26



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 02/07/26

Assessment: pt having dull activity

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	* Assess The pt General condition	9pm	* Assessed The pt General condition	
10pm	* check the pt vitals.	11pm	* checked the pt vitals	pt is stable.
11am	* maintain I/O chart	12am	* the maintained I/O chart	
12am	* provide comfortable position	6am	* provided comfortable position	
7am	* administer all medication given as per doctor order	8am	* administered all medication given as	

Re-Assessment:

Special Notes:

Chemo medication

Nurse Signature: _____

Nurse Name: shanthi

Date & Time: 03/07/26 8am

NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 3/7/20

Assessment: Baby having chemo

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 general condition of the baby.	8:30am	Assessed the general condition of the baby	Implemented all the procedure
9am	Continue chemo	9:30am	Continued chemo	
10am	Administer medication as per doctor order.	10:30am	Administered medication as per doctor order	
12pm	Monitor vital signs.	12:30pm	Monitored vital signs	
1pm	Ensure safety	1:30pm	Ensured safety	

Re-Assessment:

Special Notes: chemo -

Nurse Signature: Meelin Nurse Name: Meelin Date & Time: 3/7/20 @ 2pm



NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 03/07/26

Assessment: Baby having chemotherapy.

Goals

- ☐ Maintain Airway and Oxygenation
☐ Maintain Personal Hygiene
☐ Identify Potential Complications

- ☐ Relieve Pain & Discomfort
☒ Prevent Infection
☐ Any Others. Specify.....

- ☐ Maintain Fluid Balance
☐ Meet Elimination Needs

- ☒ Improve Activity Tolerance
☐ Ensure Safety

- ☒ Maintain Good Nutritional Status
☐ Early Ambulation Reduce Anxiety

- ☐ Maintain Skin Integrity
☐ Patient & Family Education

Time	Plan of Care	Time	Implementation	Evaluation
2pm	→ Assess the baby General Condition	2pm	→ Assessed the baby General Condition	By doing the all procedures the baby condition is improved.
3pm	→ provide comfort position	3pm	→ provided comfort position	
4pm	→ monitor the vitals & I	4pm	→ monitored the vitals & I	
5pm	→ administer the all drugs as per doctor orders	5pm	→ administered the all drugs as per doctor orders	
6pm	→ ensure the safety	6pm	→ ensured the safety side rails	
7pm		7pm		
8pm		8pm		

Re-Assessment:

Done by giving chemotherapy
Chemo is going

Special Notes:

Nurse Signature:

Nurse Name:

Shariya (60567)

Date & Time:

03/07/26 (8pm)

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 03/07/26

Assessment: Baby having little bit of loose stools and mild pain at the area.

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	Assess the baby general condition and monitor the vitals and record.	8:10 pm	Assessed the baby general condition and monitored the vitals and	By doing all above procedure baby condition improving well.
10pm	After the rounds advice chemotherapy to continue.	10:10 pm	After the rounds advised chemotherapy to continue.	
12am	Trace CUE report	12:10 am	Tracing CUE report	
3am	Provide comfortable position.	3:10 am	Provided comfortable position	
8am	Ensure the safety needs.	8:10 am	Ensured the safety needs.	

Re-Assessment: Re assessment done

Special Notes: Care the procedure

Nurse Signature: Braus K Nurse Name: K. Brauvanthi Date & Time: 04/07/26 @ 8am

NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 4/7/26

Assessment: Baby having chemotherapy

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8am	* Assess the baby general condition. monitor vital signs	8am	* Assessed a baby general condition. monitored vital signs	Baby condition is improving slowly
10am	* provide comfortable position	10am	* provided comfortable position	
12pm	* Administer medication as per doctor order	12pm	* Administered medication as per doctor order	
2pm	* Ensure safety side rails	2pm	* Ensured safety side rails	

Re-Assessment:

Special Notes: CBP, MTX level tomorrow by prick.

Nurse Signature: [Signature] Nurse Name: Sushma (221026) Date & Time: 4/7/26 @ 2pm

NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 4/7/26

Assessment: pt having dull activity

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	→ Assess the pt General Condition	2:10pm	→ Assessed the pt General Condition	pt is stable
4pm	→ Check the vital signs	4:10pm	→ Checked the vital signs	
6pm	→ Plan for Administration medication	6:10pm	→ Providing medication as per doctor Order	
8pm	→ plan for strict I/O Chart	8pm	→ Strictly I/O Chart	
	→ plan for Team Safety		→ Providing Ensuring Safety	

Re-Assessment:

Re-Assessment - Every 4th hrly

Special Notes:

Nurse Signature: _____

Nurse Name: Chandani

Date & Time: 4/7/26 2pm



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 05/07/26

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
8pm	*Assess The pt General condition	9pm	*Assessed The pt General condition	pt is stable
10pm	*check the pt all vitals	11pm	*checked the pt all vitals	
11pm	*maintain I/Os chart	12am	*maintained I/Os chart	
12am	*provide comfortable position	6am	*provided comfortable position	
7am	*administer all medication given as per doctor order	8am	*administered all medication given as per doctor order	

Re-Assessment:

Special Notes:

Nurse Signature:

Nurse Name: Chanthi

Date & Time: 05/07/26 08am

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Sirisha Department: Oncology Date of Admission: 21/4/26

SITUATION	Diagnosis: <u>Bcell ALL</u>		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:			
	Area	Shift Time	<u>11:30A</u>	<u>1st floor 2pm to 8pm</u>	<u>1st floor 8pm to 2pm</u>	<u>1st floor 2pm to 8pm</u>
BACKGROUND	Medical Condition (Any special condition to be noted):		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
ASSESSMENT	Allergy:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Tubes/Drains/Catheter:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:	Temp:	<u>98.1</u>	<u>98.1</u>	<u>98.1</u>	<u>98.1</u>
		Res:	<u>20bpm</u>	<u>20h</u>	<u>20bpm</u>	<u>20bpm</u>
		SpO ₂ :	<u>100%</u>	<u>99%</u>	<u>99%</u>	<u>99%</u>
		Pulse:	<u>112bpm</u>	<u>110h</u>	<u>110bpm</u>	<u>118bpm</u>
		BP:	<u>98/52</u>	<u>100/69</u>	<u>100/60</u>	<u>98/60</u>
	Fall Risk Score:	<u>13</u>	<u>13</u>	<u>13</u>	<u>13</u>	
Pain Score:	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>		
Recommendations	Safety Needs:	<u>NA</u>	<u>Yes</u>	<u>Yes</u>	<u>Yes</u>	
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Other Special Orders / Medications:	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Handed Over By Name :		<u>Katharine</u>	<u>Nikita</u>	<u>Rosh</u>	<u>Merlin</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>21/4</u>	<u>21/4</u>	<u>03/02</u>	<u>31/4</u>	
Time:		<u>11:30A</u>	<u>2pm</u>	<u>@8am</u>	<u>@2pm</u>	
Taken Over By Name :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>21/4</u>	<u>21/4</u>	<u>31/4</u>	<u>03/02</u>	
Time:		<u>12:30pm</u>	<u>@8pm</u>	<u>@8am</u>	<u>@8pm</u>	



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Sirisha Rani Department: oncology Date of Admission: 24/24

SITUATION	Diagnosis: <u>B cell all</u>		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:					
BACKGROUND	Area	<u>1st</u> <u>8am-2pm</u>	<u>1st</u> <u>2pm-8pm</u>	<u>1st</u> <u>8pm-6am</u>				
	Medical Condition (Any special condition to be noted):	<u>NA</u>	<u>NA</u>	<u>NA</u>				
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:	<u>97.2°F</u>	<u>98.3°F</u>	<u>98.5°F</u>			
		Res:	<u>20</u>	<u>20</u>	<u>20</u>			
		SpO ₂ :	<u>99%</u>	<u>100%</u>	<u>99%</u>			
		Pulse:	<u>110b/m</u>	<u>111b/m</u>	<u>110b/m</u>			
		BP:	<u>98/60</u>	<u>99/60</u>	<u>100/60</u>			
	Fall Risk Score:	<u>13</u>	<u>13</u>	<u>13</u>				
	Pain Score:	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>				
	Safety Needs:	<u>yes</u>	<u>yes</u>	<u>yes</u>				
Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No		
Others Specify:	<u>NA</u>	<u>NA</u>	<u>NA</u>					
Recommendations	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Other Special Orders / Medications:	<u>NA</u>	<u>NA</u>	<u>NA</u>				
	Post Operative Procedure Special Orders:	<u>NA</u>	<u>NA</u>	<u>NA</u>				
Handed Over By Name :		<u>Sush</u>	<u>Chandan</u>	<u>Shank</u>				
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>				
Date:		<u>5/7/26</u>	<u>4/7/26</u>	<u>5/7/26</u>				
Time:		<u>2pm</u>	<u>2pm</u>	<u>8am</u>				
Taken Over By Name :		<u>Chandan</u>	<u>Shank</u>	<u>Shank</u>				
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>				
Date:		<u>4/7/26</u>	<u>4/7/26</u>	<u>5/7/26</u>				
Time:		<u>2pm</u>	<u>2pm</u>	<u>8am</u>				

FDH-00042898

IP5-00175869

Master MASUM SEKH

21-04-2023

3 Y 2 M 12 D

(M)

Dr. SIRISHA RANI



CHEMOTHERAPY PRESCRIPTION

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

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Sheet No. : 2		Weight (kg) :	Body Surface Area:	Diagnosis:	Protocol:					
DATE	TIME	Composition of Chemotherapy (if infusion, mention ml / hr = Mcg / kg / min. etc.)	DOSE	ROUTE	Flow Rate (ml/hr)	Doctor Sign.	Nurse Sign.	Date of Stopping	Doctor Sign.	Nurse Sign.
4/7/22	12 AM	INT NaHCO_3 with 500 ml $\frac{1}{2}$ DNS	20ml	iv	70ml/hr	IG	Purell Sauer	4/7/26	d	Durga Saudan
4/07/26	3 PM	INT NaHCO_3 with 500 ml $\frac{1}{2}$ DNS	20ml	iv	70ml/hr	IG	Charan Sushu	4/07/26	d	Charan Sushu
5/07/26	12:30 am	INT NaHCO_3 with 500 ml $\frac{1}{2}$ DNS	10ml	iv	70ml/hr	IG	Shankhi Pouamphen	5/07/26	d	Shankhi Pouamphen

DH-00042898

IP5-00175869

Master MASUM SEKH

21-04-2023

3 Y 2 M 11 D

(M)

Dr. SIRISHA RANI



CHEMOTHERAPY PRESCRIPTION

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

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BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Sheet No. 1		Weight (kg) : 14.9 kg	Body Surface Area: 0.63	Diagnosis: B-ALL	Protocol: Protocol M					
DATE	TIME	Composition of Chemotherapy (if infusion, mention ml / hr = Mcg / kg / min. etc.)	DOSE	ROUTE	Flow Rate (ml/hr)	Doctor Sign.	Nurse Sign.	Date of Stopping	Doctor Sign.	Nurse Sign.
2/7/26	3pm	INT METHOTREXATE INT URAKABINE INT HYDROCORTISONE	12mg 30mg 15mg	INTRATHCAL	Start 12		Pooja Divya	2/7	A	Pooja Divya
2/7/26	3:45 PM	INT NAHCO ₃ with 100 ml NS	10ml	iv	@ 100ml/hr (Q)		Poojanka Nikita	2/7		Poojanka Nikita
2/7/26	5PM	INT METHOTREXATE with 100 ml NS	100mg	iv	@ 100ml/hr (Q)		Poojanka Nikita	2/7		Poojanka Nikita
2/7	6pm	INT METHOTREXATE with 500 ml DNS	1gm	iv	@ 25ml/hr (Q)		Poojanka Nikita	3/7	A	Mithun Meelin
	togeth	INT NAHCO ₃ with 500ml 1/2 DNS	20ml	iv	@ 50ml/hr (Q)		Poojanka Nikita	3/7	A	Mithun Meelin
2/7	12.30pm	INT NAHCO ₃ with 500ml 1/2 DNS	20ml	iv	@ 50ml/hr (Q)		Mithun Meelin	3/7	A	Paul Sana



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
21/7/23	11 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA NA	Jf
02/07/23	7 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	SK
03/07/23	3 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	SK
8/7	11 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	med!
3/07	7 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Shafiq
04/07	3 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Graus
4/7	11 A	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	Swabs
4/7/23	7 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Chondar
5/07/23	3 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	SK
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

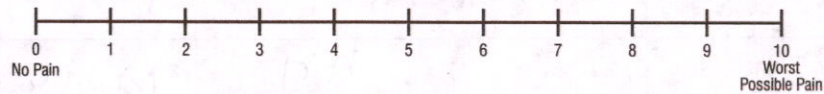
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
	0	1	2
Face	No Particular expression or smile	Occasional Grimace or Frown, withdraw, Disoriented	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs 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 of sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

Numerical Pain Scale (Obstetric and Gynecology)



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

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR, RR, BP, SaO₂	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO ₂ 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

Wong - Baker (Pediatrics) Above 7 Years





BRADEN 'Q' SCALE

					Date :	21/04/23	04/04/23	05/04/23	06/04/23
					Time :	11 PM	6 AM	6 AM	6 AM
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e:xtremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4	4	4	
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4	4	4	
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	4	
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	4	
FRICION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	4	
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	4	
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4	
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23									
Docu. No. : RCHBH /FRM / CLINICAL / 119									
					TOTAL SCORE				
					Evaluator's Name				
					28 28 28 28				
					JP R Praes V				

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

Patient St

FDH-00042898

Master MASUM SEKH

21-04-2023

Dr. BIRISHA RANI

3 Y 2 M 11 D

(M)

IP5-00175859



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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

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

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position	yes	yes	yes	yes
Call device within reach	yes	yes	yes	yes
Wheels Locked	yes	yes	yes	yes
Room free of clutter	yes	yes	yes	yes
Adequate Lighting	yes	yes	yes	yes
Wheel Chair Support	no	no	no	no
Other Intervention(s) Specify	no	no	no	no
Nurse's Name :	Kathee	Shruti	Shruti	Shruti
Signature :	[Signature]	[Signature]	[Signature]	[Signature]
Date :	2/4	03/04	04/04	05/04
Time :	11A	6A	6A	6A



INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Part - I.

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

Identified Education Needs:

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

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
2/7/26	11 AM	7	Infection Control Measures	M	1	0	1	1	NA	H
2/7/26	11:30 AM	9	Child is on NPO	M	1	0	1	1	—	Naresh

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:	<table border="0"> <tr> <td>1. No Learning Barriers</td> <td>4. Language Barrier</td> <td>7. Impaired Thought Process/Cognitive limitations</td> <td>10. Financial Difficulties</td> <td>13. Cultural/Religion Practice</td> </tr> <tr> <td>2. Physical Impairment</td> <td>5. Educational Level</td> <td>8. Responsibilities at Home</td> <td>11. Beliefs and Values</td> <td>14. Others (Specify)</td> </tr> <tr> <td>3. Emotional Barriers</td> <td>6. Desire / Motivate to Learn</td> <td>9. Cultural Differences</td> <td>12. Impaired Vision/ or Hearing</td> <td></td> </tr> </table>								1. No Learning Barriers	4. Language Barrier	7. Impaired Thought Process/Cognitive limitations	10. Financial Difficulties	13. Cultural/Religion Practice	2. Physical Impairment	5. Educational Level	8. Responsibilities at Home	11. Beliefs and Values	14. Others (Specify)	3. Emotional Barriers	6. Desire / Motivate to Learn	9. Cultural Differences	12. Impaired Vision/ or Hearing	
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3. Emotional Barriers	6. Desire / Motivate to Learn	9. Cultural Differences	12. Impaired Vision/ or Hearing																				
Teaching Tools Used:	A: Audio	D: Demonstration	V: Video	O: Oral	P: Printed																		
Mechanism/s to overcome barrier/s:	<table border="0"> <tr> <td>1. None</td> <td>3. Reassurance & Support</td> <td>5. Respect values & beliefs</td> <td>7. Other, Specify</td> </tr> <tr> <td>2. Obtain translator</td> <td>4. Teach Family / Others</td> <td>6. Respect Cultural / Religion Preference</td> <td></td> </tr> </table>								1. None	3. Reassurance & Support	5. Respect values & beliefs	7. Other, Specify	2. Obtain translator	4. Teach Family / Others	6. Respect Cultural / Religion Preference								
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MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis:

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
02/7/26	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	B-All	To Resolve symptoms	LP	N. P. S.	☐ Nursing ☐ Others:
02/10/26 11A	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Bcell All	To resolve symptoms	Lumbar Procedure	dr	☐ Medical ☐ Others:
2/7/26 11:30am	☐ Medical ☐ Nursing ☒ Others: Dr. P. S. Rani	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Bcell All For chemotherapy	Child is on NPO	NPO till further Advised	maam	☐ 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:

CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	21/3 DAY-1			DAY-2			4/7 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	P	P	P	P	P	P	
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	1	1	1	1	1	1	1	1	1	
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	1	1	1	1	1	1	1	1	1	
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	1	1	1	1	1	1	1	1	1	
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	1	1	1	1	1	1	1	1	1	
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	1	1	1	1	1	1	1	1	1	
Signature of the Nurse				11/11	11/11	11/11	11/11	11/11	11/11	11/11	11/11	11/11	

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 of Ward In Charge :

Signature : GOVIND Name : GOVIND

Signature : NEERAJ Name : NEERAJ

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										
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1										
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2										
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3										
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4										
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord pyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5										
Signature of the Nurse													

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

Signature of Shift In Charge :

Signature of Ward In Charge :

Signature : Name :

Signature : Name :

FDH-00042898

IP5-00175869

Master MASUM SEKH

21-04-2023 3 Y 2 M 11 D (M)

Dr. SIRISHA RANI



Rainbow
Children's
Hospital

It takes a lot to treat the little.

BirthRight™

BY RAINBOW HOSPITALS

Your Right to a Safe Delivery

DISCHARGE PLANNING FORM

Nationality: Indian

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

1. Anticipated Date of Discharge:

2. Destination Post Discharge: ☒ Home

Family Members Notified (Person Contacted)

☒ Transfer

Hospital Facility Notified (Person Contacted)

3. Discharge Status: ☐ Self Care ☒ Family Home Care ☐ Home Professional Assistance☐ Needs Assistance In:

Remarks

☐ Medication ☒ Yes ☐ No☐ Bathing ☐ Yes ☒ No☐ Eating ☐ Yes ☒ No☐ Walking ☐ Yes ☒ No☐ Dressing ☐ Yes ☒ No☐ Toileting ☐ Yes ☒ NoExplain to mother

4. Nutritional Plan:

☐ Dietary Instruction Discussed with the:☐ Patient ☒ Family Member ☐ Others:

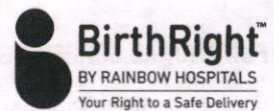
5. Discharge Planning Discussed with the:

☐ Patient ☒ Family Member ☐ Others:

6. Patient/Family Educational Plan:

☐ Educational Topic/s: Hand Hygiene☐ Patient's Educational Topic/s discussed with the:☐ Patient ☒ Family Member ☐ Others:Nurse Signature: ANurse Name: AnikideDate and Time: 21/2/20 @ 11:50pm

Docu. No. : RCHBH / FRM / CLINICAL / 191



Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

B-cell all

Arrival Time:

11:50pm

Mode of Arrival:

with family

Admitting From:

☒ ER

☐ OPD

☐ Direct

Allergy / Adverse Reaction

NA

Body Weight: 14.92 Kg

Height: cm

Past Medical History: Obtained From

☐ Patient

☒ Family Member

☐ Medical Record

☐ Other (specify)

Past Medical History	Past Surgical History	Previous Hospital Admission
NA	NA	NA

Family History:

NA

Has the child or close family member had recent contact with a communicable disease? ☒ Yes ☐ No

If yes please list,

Was the child's birth normal? ☐ Yes ☒ No If No, please describe problems:

Are the child's immunization up to date? ☒ Yes ☐ No

Current Medication: ☐ None ☐ Yes, If Yes, fill reconciliation form

Observations: Weight: 14.92 kg Length: Head Circumference (< 2 years):

Temp.: 99.6 HR: 112 RR: 22h BP: 99/69/70

Pain Score: 0 Specify Site: 0 LLO (Follow Pain Assessment Sheet & Document)

Fall Risk Assessment: ☒ Yes ☐ No Score: 13 (Document in the Humpty Dumpty Sheet)

Risk of Pressure Sore (Braden Q Score 28) (Document in the Braden Q Assessment Sheet)

Pain Screening: ☒ Yes ☐ No If Yes, Pain Score: 0 Pain Tool Used: ☐ N Pass ☒ FLACC ☐ Wong Baker

Character of Pain Location Frequency Duration

FUNCTIONAL SCREENING:☒ No Abnormalities Detected☐ Mobility Problem☐ Walking Problem☐ Developmental Delay☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING:☒ No Abnormalities Detected☐ Underweight☐ Overweight☐ Special Feeding Method☐ Feeding Problem☐ Special diet☐ No Abnormality Detected

Inform consultant for positive criteria

Psychological Screening:☒ No Significant FindingsUnusual concerns about patient's Psychological Status: ☒ Yes ☐ No

If Yes Consultant Notified: (Date/Time):

Cultural & Spiritual Needs: ☐ Yes ☐ No if Yes specify Inform consultant for positive criteria.**Social History:** Lives WithSiblings in household ☐ Yes ☐ No (if yes How Many?)All Information Obtained From ☐ Patient ☒ Mother ☒ Father ☐ Other Family Member**Orientation has been given regarding the following aspects:**Call Bell in Reach : ☒ Yes ☐ NoWaste Disposal Explained: ☒ Yes ☐ NoInfusion Pump : ☒ Yes ☐ NoHand hygiene Explained: ☒ Yes ☐ No☐ OthersPatient Rights & Responsibilities: ☒ Yes ☐ No

Information given to

Nurse Signature: 

Nurse Name: Anil

Date: 21/07/26

Time: 11:50 pm

PATIENT TRANSFER FORM

Patient Name & UHID No. FDH-00042898 IP5-00175869 Master MASUM SEKH 21-04-2023 3 Y 2 M 11 D (M) Dr. SIRISHA RANI 		Date & Time of Admission 22/07 @ 11:01 AM	Date & Time of Transfer Order 22/07/26 @ 11:35 AM
		Transfer Ordered by Dr Nandan	Reason for Transfer Admission
From Unit ER.	To Unit ICU	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File -19-	Number of Imaging Films Nil	Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.	Nil		
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring Kethane		Name of Person Ordered Transfer df.	
Patient & Clinical Records Received by : Ankithe			
Date & Time of Patient Received : 22/07/26 @ 11:35 AM			

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

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



42898

NPO - 8:10 AM

EMERGENCY ROOM TRIAGE FORM

Patient's Name: Masum Sekh Age: 3yr Gender: ☒ Male ☐ Female

Date: 02/07/2023 Time of Arrival: 10:38 AM Triage Completion Time: 10:40 AM

Allergies: ☒ No ☐ Yes ☐ Food ☐ Medications ☐ Other (Specify): ☐ Not known any drug Allergies

Source of Information: ☒ Parents ☐ Others (Specify):

Mode of Arrival: ☒ Ambulatory ☐ Wheelchair ☐ Stretcher ☐ Ambulance

INITIAL PHYSIOLOGICAL CATEGORIZATION

Appearance

☒ Normal

☐ Sick Looking

☒ Normal

Circulation / Colour

☐ Abnormal

☐ Bleeding

Work of Breathing

☒ Normal

☐ Increased

☐ Decreased

☐ Gasping / Apnea

INITIAL PHYSIOLOGICAL STATUS

☒ Stable

☐ Unstable:

☐ Not - Life - Threatening

☐ Life - Threatening

Initial Vital Signs: Temp: 97.3F PR: 105b/m BP: 94/46 RR: 24b/m SpO₂: 98%

Chief Complaints: K/c/o: B - All Now came for dip procedure

Triage Classification

☐ Level 1: Resuscitation

☐ Level 2: EMERGENT: Life or limb threatening

☐ Level 3: URGENT: Significant illness / injury with potential to become life or limb threatening

☐ Level 4: LESS URGENT: Significant illness but not life threatening

☐ Level 5: NON - URGENT: May receive care when convenient

CTAS

☐ Immediate

☒ < 15 min

☐ 30 min

☐ 60 min

☐ 120 min

NOTE: All immunocompromised children and preterm babies to be considered Level 2.

All Children less than 2 years age with high fever to be considered Level 3.

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian

Communicable Disease Triage Screening

PART A. The following questions should be asked to all patients at the initial screening:

1. Have you had fever (elevated temperature) in the past 2 weeks ☐ Yes ☒ No

2. Have you had cough or a rash in the past 2 weeks ☐ Yes ☒ No

3. Have you had shortness of breath or difficulty breathing in the past 2 weeks ☐ Yes ☒ No

PART B. For patients reporting fever and respiratory/rash symptoms: ☒ Not applicable

1. Have you travelled outside the INDIA? or had close contact with someone who has recently travelled outside the INDIA, in the past two weeks? ☐ Yes ☐ No

If yes, State Location:

2. Are your parents / close contacts at home healthcare worker? {please encircle the choices} (e.g., nurse, physician, ancillary services personnel, allied health services personnel, hospital volunteer, or laboratory worker, others) who has had a recent exposure to an individual with a highly communicable disease or unexplained, severe febrile respiratory or rash disease? ☐ Yes ☐ No

PART C. A positive communicable disease triage screening is considered for any patient who meets one of the two following criteria:

- ☐ Any patient with Fever / Rash / Vesicles / Discharge from Eyes and Cough
- ☐ Any patient with fever and respiratory symptoms who answered "YES" to any of the questions on epidemiologic risk factors in "PART B" of the triage screening above.

PART D. ACTION / INTERVENTION: (for positive suspected communicable disease triage screening)

- ☐ Patients should be immediately isolated in a negative pressure room or a single room (as appropriate) for pending evaluation.
- ☐ The patient should be given a surgical mask immediately, if not already wearing one.
- ☐ Both patient and triage staff should perform hand hygiene.
- ☐ The staff should use PPE (as appropriate).

Name of Triage Nurse: Larange

Date & Time: 02/07/2023 @ 10:40 AM

Docu. No.: RCHBH / FRM / CLINICAL / 085

Signature of Triage Nurse: Larange

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



NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 02/04/23 Time of arrival : 10:42 AM

Chief Complaints : lame for LP procedure RBS : NA

Height : 95 cms Weight : 14.9 Kgs BMI : NA Head Circumference (<2 years)

Allergies: ☐ Yes ☒ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other:

If yes, identify

Pain Screening: ☒ Yes ☐ No If Yes, Pain Score: 0/10 Pain Tool Used: ☐ N Pass ☒ FLACC ☐ Wong Baker

☐ Character NA ☐ Location NA ☐ Frequency NA ☐ Duration NA

RISK FOR FALL:

- ☐ If patient is < 6 years
tick below fall risk intervention directly

- ☐ If Patient is > 6 years
Assess the below parameters

History of Falling: within past 3 months ☐ Yes ☐ No

Ambulatory Aids:

- Wheelchair ☐ Yes ☐ No
- Uses furniture for support ☐ Yes ☐ No

Gait/Transferring:

- Bedrest / immobile ☐ Yes ☐ No
- Weak ☐ Yes ☐ No
- Impaired ☐ Yes ☐ No

Mental Status: Forgets limitations ☐ Yes ☐ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

- ☒ Escort while ambulating
- ☒ Assist Patient
- ☒ Educate patient and family on fall precautions/prevention

Functional Screening: ☒ No Abnormalities Detected

- ☐ Mobility Problem
- ☐ Walking Problem
- ☐ Developmental Delay
- ☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

Nutritional Screening: ☒ No Abnormalities Detected

- ☐ Underweight
- ☐ Overweight
- ☐ Feeding Problem
- ☐ Special diet
- ☐ Special feeding method

Inform consultant for positive criteria

Psychological Screening: ☒ No Significant Findings

Unusual concerns about patient's Psychological Status: ☐ Yes ☒ No

If Yes Consultant Notified: NA (Date/Time): NA

Social History: Lives With family NA

Siblings in household ☐ Yes ☒ No (if yes How Many?) NA

Cultural & Spiritual Needs: ☐ Yes ☒ No if Yes specify NA Inform consultant for positive criteria.

Time of Initial assessment completed by ER Nurse : 10:44 AM

Nursing Notes (Including Labs / Medications / Other Care):

Time	Nursing Notes
	Bp - 89/53 (6a)
	admission done
11:35A	shifted to ward for further Management

Samples collected by:

/NA

Time:

Samples sent by:

Time:

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1
		NA			

Condition of patient at time of shift - out :	Details of Shift - out
HR: 112b/min BP: 89/53 CFT: 28cc RR: 22b/min SPO ₂ : 95% GCS: 15/15 Temperature: 98.5 F Pain Score: 0/10 Repeat RBS (if applicable): NA	Shift - out from ER to: 11:35A Time of Shift - out: 11:35A Handover given to: (Nurse's Name)

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any):

NA

Name of the Nurse: Kethure

Signature of the Nurse: [Signature]

Date & Time: 21/07/24 @ 12p



141

NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 2/7/26 Time: 11:30 AM

Weight: 14.97 kgs Centile: >25th

Height: 95 cm Centile: 25th

Inference: well child

RDA: — Calories: 1300 kcal/d Protein: 22g/d

Diet Recommendations: child is on NPO

Re-Assessment:

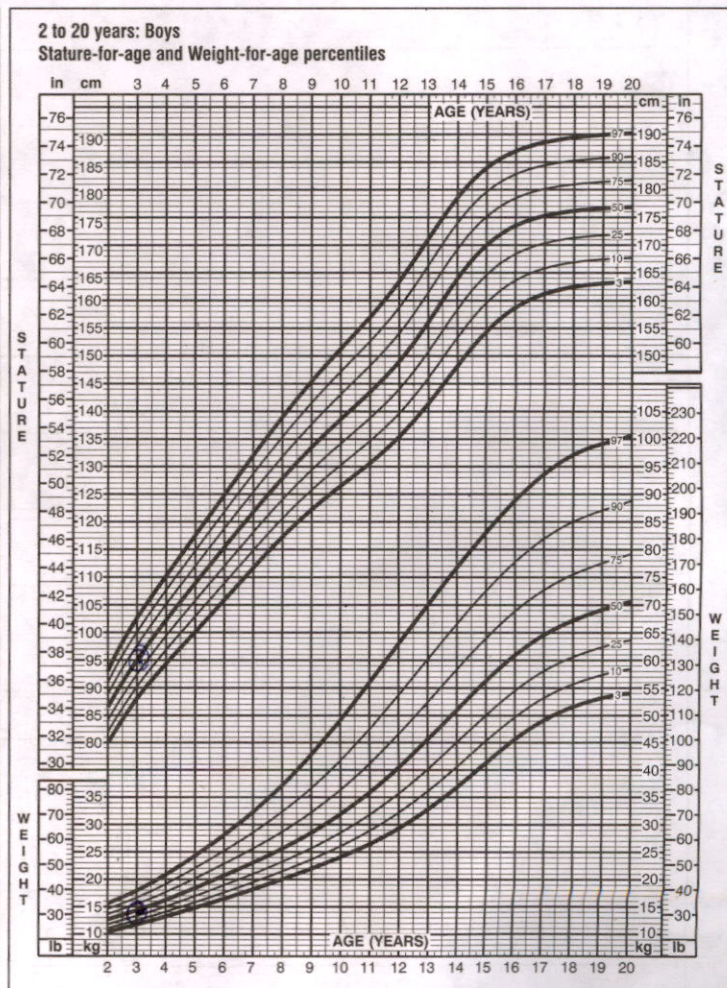
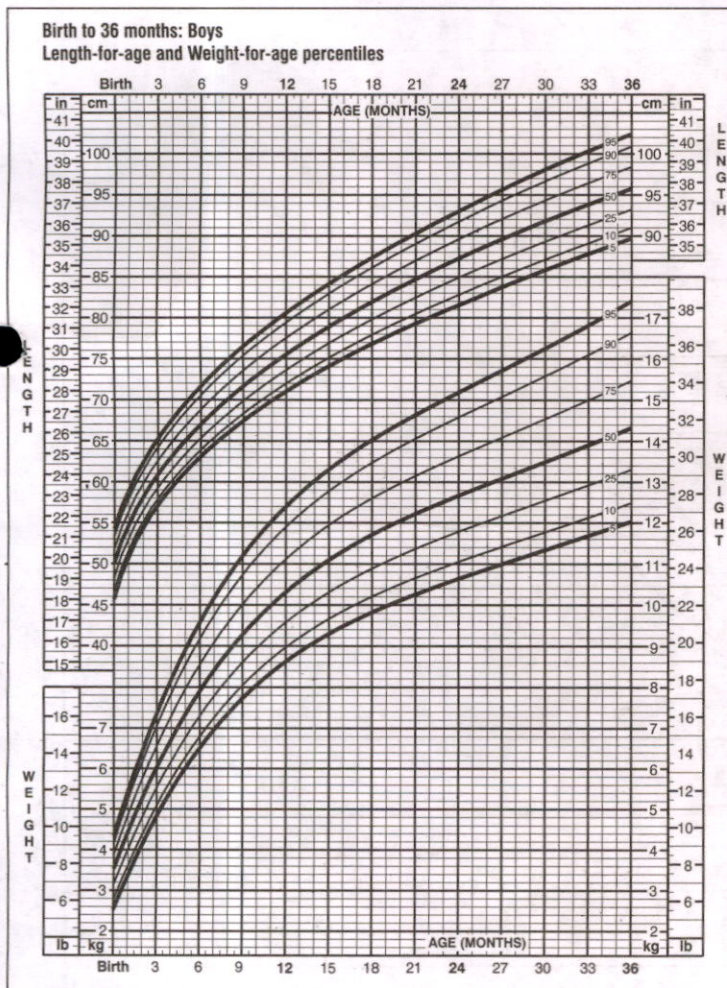
Food Allergies: NO Veg/Non-veg: veg

Diagnosis: K/L/O B-cell ALL now for chemotherapy

Nutritional Intervention - ☐ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: Parents Don't need depletion. Don't change for NHA.

GROWTH CHART (BOYS)



Dietician's Name: Mounica

Dietician's Signature: Mounica

Daily Notes:

stabs
gam

child is stable. Intake is fair
continue c soft high protein diet Walt