

ACTIVITY RECORD FOR BILLING

Name : _____

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

Date of Admission: _____ Time : _____ Date of Discharge: 8/21/16 Time: _____

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
6/17/20	2:20 PM	GE	138	Azm

Cross Consultation Visit

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

[illegible]

Investigations

Order No.

Signature

$$6/7$$

CDP, CRP

06067374

95

7/7

CRP

67790

Ans

7/11

Urine C/S

26067472

Qing

[illegible]

THE UNIVERSITY OF CHICAGO

[illegible]**ANY OTHER INFORMATION**

Don't Charge for NHA

→ members

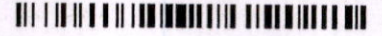
Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

ADMISSION SHEET

Registration Details :

Admission No : IP5-00176000

Admit Date : 06-Jul-2026

Admit Time : 01:15 AM **UHID** : BAH-00652018

Patient Details :
Patient Name : Master AYMAN ABDIKARIM OMAR HASSAN

Age : 8 Y 0 M 21 D

Guardian : Mr ABDIKARIM OMAR HASSAN

DOB : 15-06-2018

Gender : Male

Religion :

Occupation :

Martial Status : Single

Address (H) : FLAT NO 301, ASAAN RESIDENCY,
PARAMOUNT COLONY, GATE NO 03
Tolichowki Hyderabad Telangana INDIA
500008

Phone No : 7416952253

E-mail : NOMAIL@GMAIL.COM

Admission Details :
Bed Type : FOUR SHARING

Bed No : FSW 138

Ward Name : 1F-HEMATO-ONCOLOGY

Room No : FSW 138

Admission Type : First Visit

Contact Details :
Name : Mr ABDIKARIM OMAR HASSAN

Relationship : Father

Contact Address : FLAT NO 301, ASAAN RESIDENCY,
PARAMOUNT COLONY, GATE NO 03
Tolichowki Hyderabad Telangana INDIA 500008

Phone No : 7416952253


Doctor Details :
Doctor Name : Dr. SIRISHA RANI

Specialisation : HEMATO ONCOLOGY

Referral Doctor : Self

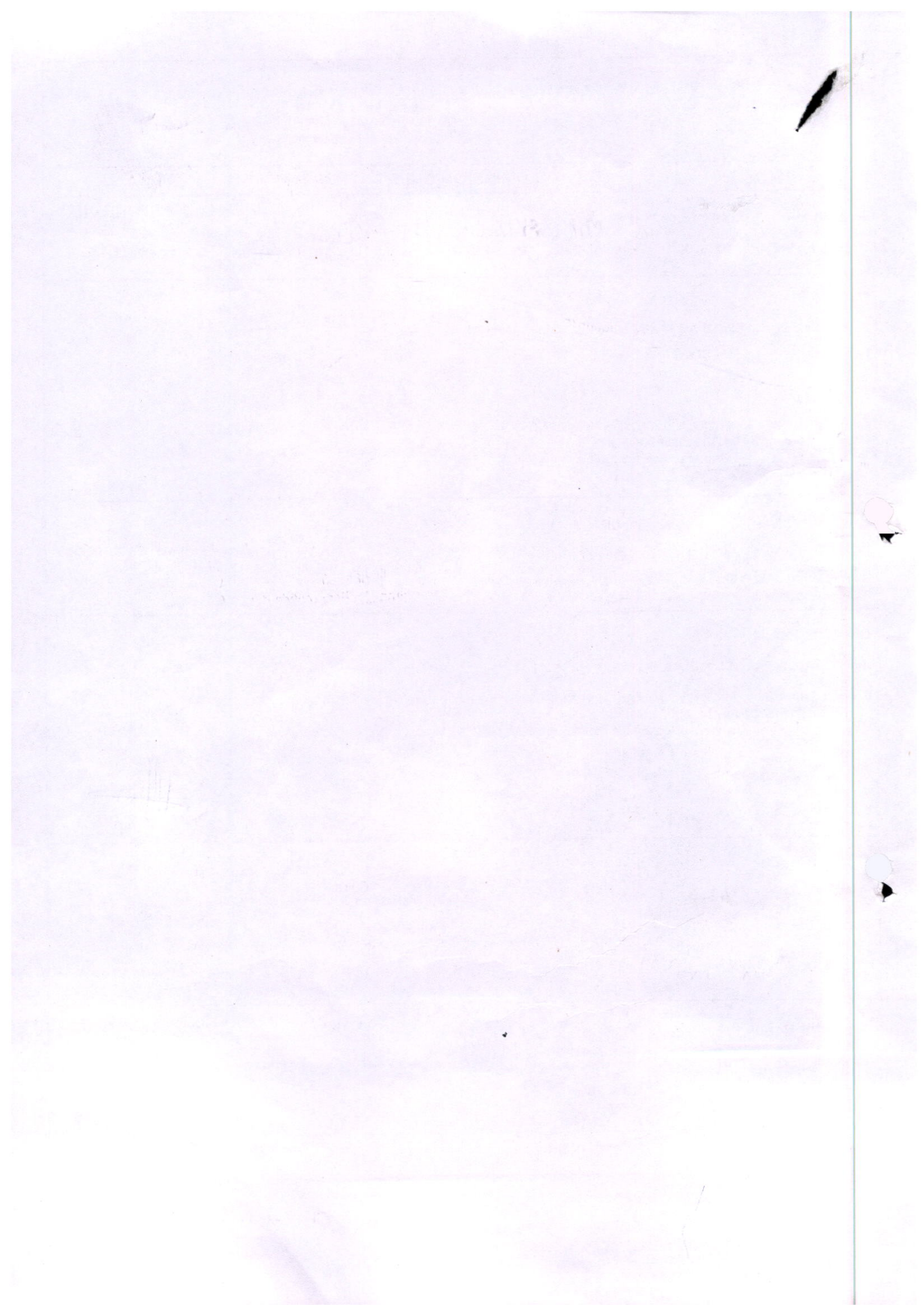
Phone No :

Co-Consultant : Dr. SANDHYA VADDADI

Payment Details :
Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : SELF PAY



DEFICIENCY CHECK LIST OF CASE SHEET

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

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

BAH-00652018 IP5-00176000
Master AYMAN ABDIKARIM OMAR
15-06-2018 8 Y 0 M 21 D (M)
Dr. SIRISHA RANI



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ADMISSION CRITERIA – ONCOLOGY

Admission / Transfer from:

☐ Emergency ☐ Outpatient (OPD) ☒ Ward ☐ Operation Theater ☐ Others:

Tick (✓) any of the following criteria requiring admission / transfer to ONCOLOGY

- ☐ For Chemotherapy-Day Care or IP Admission as per the Type of Chemotherapy
- ☒ Febrile Neutropenias (ANC <500 cells / mm³)
- ☐ Netropenic Enterocolitis
- ☐ Mucositis Induced Significant Diarrohea or Pain
- ☐ Neurological Complications (like Seizures, Bleeding, Thrombosis) that can arise while on Chemotherapy Treatment or at the Time of Presentation and also for other Systemic Problems like Pancreatitis during Chemotherapy
- ☐ Management of Oncological Emergencies
- ☐ Bleeding Problems (where it is indicated)
- ☐ Evaluation and Management of Severe Anemias
- ☐ Day Care Admissions for PRBC Transfusions
- ☐ Evaluation and Management of Sick Children who come with Hematological Problems like Severe Anemia like Autoimmune Hemolytic Anemia/ Bleeding/ Others
- ☐ Primary Immunodeficiency Disorders with Infections that Warrants Hospitalisation
- ☐ Management and Evaluation of Hemophagocytic LymphoHisticytosis
- ☐ Any Systemic Disorders with Significant Hematological issues like JRA / SLE with Secondary HLH

Signature of the Doctor: Ahankah

Name of the Doctor: Ahankah

Date & Time: 2/7/16

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DISCHARGE CRITERIA – ONCOLOGY

Discharge to:

☐ HDU / Step down ICU

☒ Ward

☐ Outside Facility

☐ Others:

Tick (✓) any of the following criteria requiring discharge / transfer from ONCOLOGY

- ☐ Completion of chemotherapy, with no debilitating side effects.
- ☐ Resolution of febrile episode, with no fever > 24hrs and Absolute Neutrophil count (ANC) > 500cells/mm³.
- ☐ Admitted patients - Once the admitting problem gets resolved or made a plan to manage further on out-patient basis.

Signature of the Doctor: *Sirisha Rani*

Name of the Doctor : *Sirisha Rani*

Date & Time: *5/7/20*



Pediatric Multiorgan History & Physical Examination

Central Nervous System :

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

Cranial Nerves : NAD

Motor System:

Nutriton : _____

Tone: _____ Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR

Superficials:

Plantars _____

Sensory System :

Intact

Bladder / Bowel : Regular

Clinical Summary & Diagnostic:

Acute febrile illness.

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: Sepsis

Desired goals of the treatment : hemodynamic stability.

Planned Labs:

CBP
CRP
Blood cfs → now
Extra plain

Planned Management

- Inj. Ceftriaxone
- Inj. Pantoprazole
- Tab. vancomycin
- Syf. Baltrim
- Syf. Montel
- Tab. Tranex
- Tab. Shelcal-250

new
Jambh

Signature of the Doctor: [Signature]

Name of the Doctor: Satish

Date & Time: 6/7/26 2AM.

Signature of the Consultant: [Signature]

Name of the Consultant: Dr. Sirisha Rani

Date & Time:

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
17/6	Morning round	

Patient Sticker

Pediatric Multiorgan History & Physical Examination

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

Birth & Neonatal History:

perinatal transition

Birth & Socio Economic History:

About Father : _____

About Mother : _____

Any additional Information : _____

Developmental History :

Developed as per age

Immunization History :

PROGRESS NOTES AND DOCTOR'S ORDER	
Date & Time	Progress Notes
6/7/20 6:30pm	Evening rounds Leishitt lymphoma / D17 WVE ydc-2 / febrile illness. Ongoing fever @ 12pm No other issues V. file @ S/E → PLWH CFT 4500 CWS MS / @ PLA / @
	Doctor's Order Adv 1) Bone marrow, urine cs. 2) Drugs as per chart 3) monitor vitals 4) Inform SOS. 5) CSF t/m. <u>Shankar</u> Noted by nandini 6/7/20 6pm

Inspection: _____
 Palpation: Soft, NT
 Auscultation: BS (+)
 Spine: _____ External Genitalia: /
 Relevant data from outside (CT, USG etc.,) _____

3

(P.T.O)

Date & Time	Progress Notes	Doctor's Order
10/16 11:20 AM	Evening rounds Duchenne lymphoma / D18 / CR-VE - cycle 8 / febrile illness	
	No fever - 15 hours No other issues. Feeding fine. Vitals (12).	Adm 1) Have urine ls. 2) monitor vitals 3) <u>Plan D/L</u>
	Slews / No / No /	n/b post 9 10/16 spu. <u>Amankhan</u>



Date & Time	Progress Notes	Doctor's Order
8/7/10 9am	Burkitt's Leukaemia	D+19 post CYVE (2)
	No fever	
	vitals stable	Plan
	pipraz - P3	1. Trace urine ds
	linzolid - D2/S	2. plan d/c today.
	vor.	
		leave
	→ stop Vancomycin	
	→ linzolid x3d	
	→ d/c today	
	→ Saturday Admins	
	Admins Graham 8:50 AM	

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PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]



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PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: ~~AH~~ Ayman Abdikarim Omar.

UHID ID: _____

Department: _____

Consultant: _____

Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

C/O fever :: 3 days.

History of present illness :

R/C/O Burkitt leukemia (CNS -ve /
MRD -ve
post CYVE - 2 cycle.

C/O fever :: 3 days - mod to high grade,
no chills, more at night
subsiding with medication.
no cough / cold / vomiting / loose stools /
rashes / burning micturition / conjunctivitis.

Oral intake fair
Activity good.
Urine output adequate.

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RESULT SHEET

Date	6/7	7/7.				
Time	4AM	8AM.				
Hb	8.0	8.0.				
PCV	23.4	23.6				
RBC	2.90	2.93				
WBC	2.40	4.71.				
N/L	26.9/16.5	34/11				
Platelets	71000	1,65,000				
CRP	127.1					
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	W	a				



DRUG CHART

Date of Admission: 06/07/2020 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: <u>SYP. PARACETAMOL</u>				Date Time
Dose <u>8ml</u>	Route <u>PO</u>	Frequency <u>SOS</u>	Start Date <u>6/7</u>	
Doctor's Signature		Valid Period	Pharm.	
Additional Instructions: <u>240mg/5ml</u>				

DRUG: <u>SYP. METAL</u>				Date Time
Dose <u>10ml</u>	Route <u>PO</u>	Frequency <u>8th hly</u>	Start Date <u>6/7</u>	<u>6/7 6/7</u> <u>9AM 6:30PM</u> <u>AS</u>
Doctor's Signature <u>Ahmed</u>		Valid Period	Pharm.	
Additional Instructions: <u>T>100°F</u>				

DRUG: <u>inj PARACETAMOL</u>				Date Time
Dose <u>350mg</u>	Route <u>IV</u>	Frequency <u>6th hly</u>	Start Date <u>6/7</u>	<u>6/7</u> <u>12PM</u> <u>AS</u> <u>DRW</u>
Doctor's Signature <u>Ahmed</u>		Valid Period	Pharm.	
Additional Instructions: <u>T>100°F</u>				



REGULAR PRESCRIPTIONS

Weight. 25 kg Ward. 0020

DRUG: <u>INJ. CEFTRIAXONE</u>				Date Time
Dose <u>1.25g</u>	Route <u>IV</u>	Frequency <u>BD</u>	Start Date <u>06/07</u>	
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Nandan</u>				<u>stop</u> <u>shambhu</u>
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
DRUG: <u>INJ. PANTOPRAZOL</u>				Date Time
Dose <u>25mg</u>	Route <u>IV</u>	Frequency <u>OD</u>	Start Date <u>06/07</u>	
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Nandan</u>				<u>change</u> <u>for</u> <u>oral</u> <u>MD</u>
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
DRUG: <u>SYP. BACTRIM</u>				Date Time
Dose <u>5ml</u>	Route <u>PO</u>	Frequency <u>BD</u>	Start Date <u>06/07</u>	
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Nandan</u>				<u>on</u> <u>Monday, Wednesday</u> <u>Friday</u>
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
DRUG: <u>TAB. TRANEXAMIC ACID</u>				Date Time
Dose <u>250mg</u>	Route <u>PO</u>	Frequency <u>BD</u>	Start Date <u>06/07</u>	
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Nandan</u>				<u>on</u> <u>Monday, Wednesday</u> <u>Friday</u>
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

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

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

STAT / ONCE ONLY DRUGS[illegible]

Weight. Ward.

[illegible]



Weight 25kg Ward ONC

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15-06-2018 8 Y 0 M 21 D (M)
Dr. SIRISHA RANI



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Sheet No:

REGULAR PRESCRIPTIONS

Weight 25kg

Ward 020

DRUG : T. LINEZOLID				Date Time	6/8/23
Dose 1/2 tab	Route PO	Frequency BD	Start Dt. 6/7		
Name & Signature of the Doctor Starting the Drugs: <i>Ahankumar</i>					
Additional Instructions: 1 tab - 600mg					
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 :				Date Time	
Dose	Route	Frequency	Start Dt.		
Name & Signature of the Doctor Starting the Drugs:					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					



MEDICATION RECONCILIATION FORM

Drug Allergies: ☒ Not known any Drug Allergies

Medication Reconciliation will be done at the time of admission and also whenever there is change in the treating team or shifting from one unit to another unit.

(Example: at the time of admission shifting from ICU to Ward, or Ward to ICUs)

Shifting From: ICU Shifted to: Ward

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	TAB. VORICONAZOLE	200mg	PO	OD	05/07/26	☒ C ☐ DC
2	TAB. TRANEXAMIC ACID	500mg	PO	BD	05/07/26	☒ C ☐ DC
3	SYP. BACTRIM	5ml	PO	BD	05/07/26	☒ C ☐ DC
4	SYP. MOKTEL	5ml	PO	OD	05/07/26	☒ C ☐ DC
5	TAB. SHELCAL-250	1 tab	PO	OD	05/07/26	☒ 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: Nalini, Dr. Nandan

Date & Time: 06/07/2026, 2 AM.

Nurse Name & Signature: Sanjh

Date & Time: 6/7/26 @ 2 AM

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

P2

Patient's / Learner Language: 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		
6/7	2:30 PM	7	To maintain personal hygiene	f	01	ord	01	01	N/A	As
6/7/20	10 AM	9	Normal High protein diet	f	1	0	1	1	-	Monica
7/7	11 AM	7	Personal hygiene	m	1	0	1	1	m	

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	
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																				
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								
1. None	3. Reassurance & Support	5. Respect values & beliefs	7. Other, Specify																				
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Understanding:	<table border="0"> <tr> <td>1. Verbalizes Understanding</td> <td>2. Demonstrates Understanding</td> <td>3. Needs Review</td> </tr> </table>								1. Verbalizes Understanding	2. Demonstrates Understanding	3. Needs Review												
1. Verbalizes Understanding	2. Demonstrates Understanding	3. Needs Review																					



MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis:

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
6/7 @ 2PM	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	BCU Au	Stability	Ref Dr. A	[Signature]	☒ Nursing ☐ Others:
6/7 @ 2PM	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	D B-Cu Au	Haemodynamic stability	Dr fluids Dr antibiotics	[Signature]	☒ Medical ☐ Others:
6/7/26 @ 10AM	☐ Medical ☐ Nursing ☒ Others: Dr. A	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	AFI ± Buell Au	Normal Hgpk protein diet	RDA E: 1550kcal/d P: 27g/d	[Signature]	☐ 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:



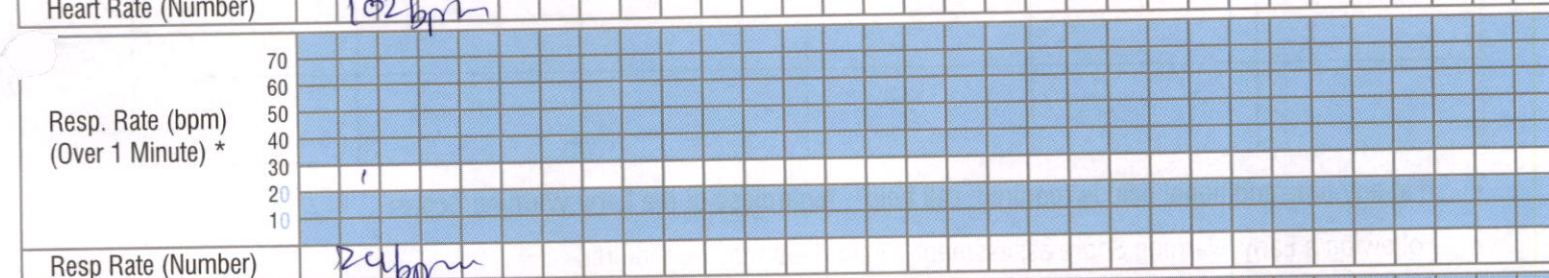
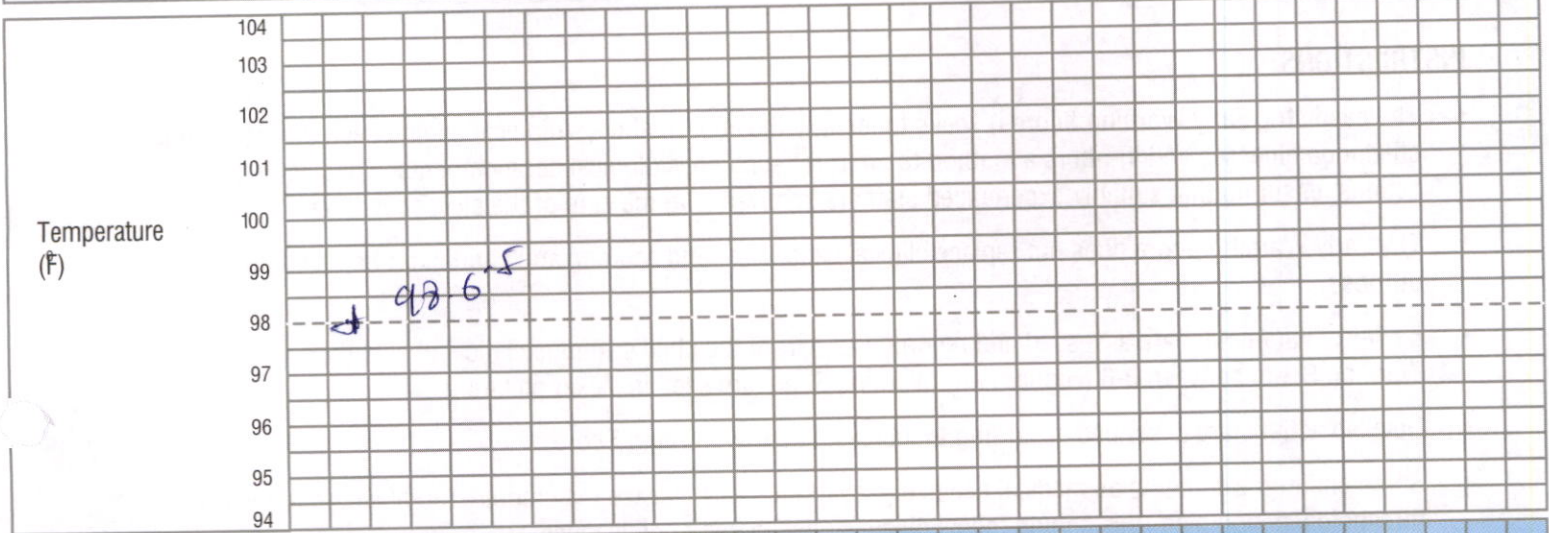
SCHOOL AGE (5-12 years)

Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 15/06/2018 Time: 11AM

Doctor / Nurse / Family Concern?



Resp Distress Mod/ Severe None / Mild

Receiving O₂(l/min) O₂Saturations (%)

Conscious Level Normal Altered

GCS *

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

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

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

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!
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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)
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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)

Date: 7/7/26 Time: 9 AM 10 AM - 4 PM 7 PM 10 PM 3 AM 6 AM

Doctor / Nurse / Family Concern?

Temperature (°F)

Time	Temperature (°F)
0	98.5
1	98.5
2	98.5
3	98.5
4	98.5
5	98.5
6	98.5
7	98.5
8	98.5
9	98.5
10	98.5

[illegible][illegible][illegible][illegible][illegible]

ACTIONS NB: Scores 3 should be recorded overleaf	Score 1 : Continue normal observation by staff nurse
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R	RECOMMENDATION: I need you to ... come to see the child in the next (XX mins) AND Is there anything I need to do in the meantime? (e.g. stop the fluid/ repeat observation)



EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 17/7/20 Time: 6AM

Doctor / Nurse / Family Concern?

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

Heart Rate (bpm) and Blood Pressure (mmHg) * Note: BP does not score in early warning scoring	190	
	180	
	170	
	160	
	150	
	140	
	130	
	120	
	110	
	100	101
	90	(76)
80		
70	67	
60		
50		

Heart Rate (Number) 103b/m

Resp. Rate (bpm) (Over 1 Minute) *	70	
	60	
	50	
	40	
	30	0
	20	
	10	

Resp Rate (Number) 20b/m

Resp Distress	Mod/ Severe	
	None / Mild	.
Receiving O ₂ (l/min)		
O ₂ Saturations (%)		100%

Conscious Level	Normal	
	Altered	C
GCS *		15/15

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

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.
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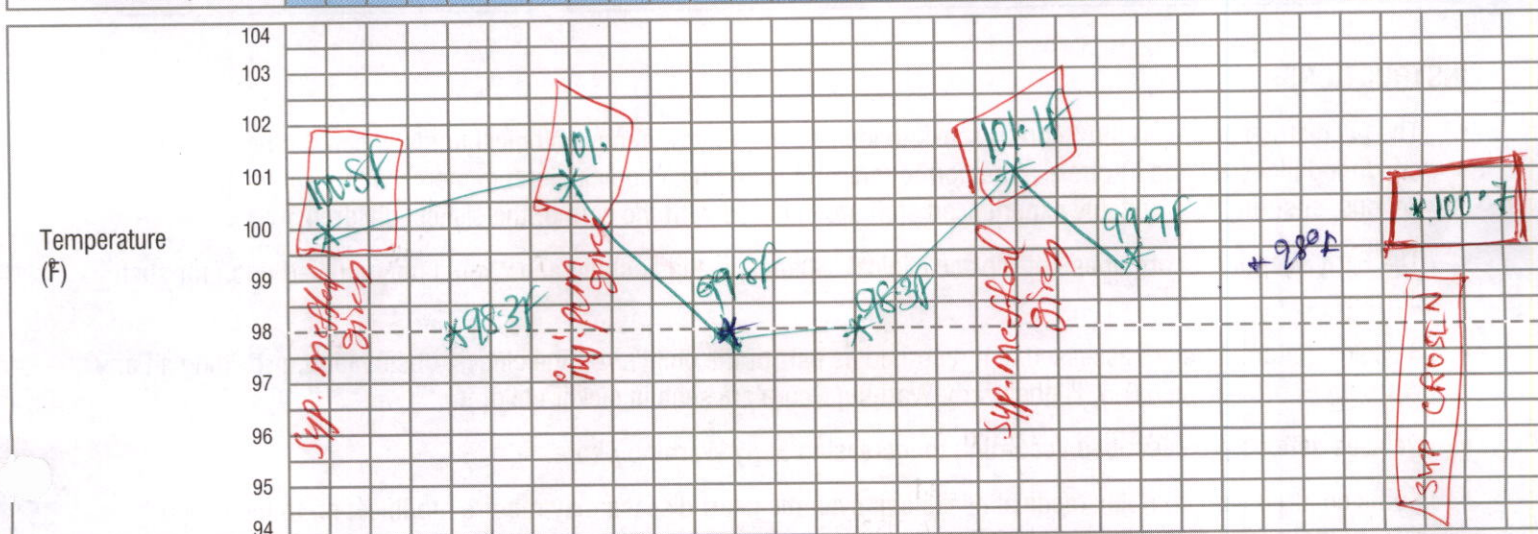
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Date : 6/7	Time: 8:00 AM	10 AM	12 PM	2 PM	4 PM	6:30 PM	8:00 PM	10 PM	1:30 AM
Doctor / Nurse / Family Concern?									



and

Note:
BP does not score
in early
warning scoring

Heart Rate (Number)

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

Resp Rate (Number)

Resp	Mod/ Severe
Distress	None / Mild

Receiving O ₂ (l/min)	O ₂ Saturations (%)
0	95.0
1	95.0
2	95.0
3	95.0
4	95.0
5	95.0
6	95.0
7	95.0
8	95.0
9	95.0
10	95.0
11	95.0
12	95.0
13	95.0
14	95.0
15	95.0
16	95.0
17	95.0
18	95.0
19	95.0
20	95.0
21	95.0
22	95.0
23	95.0
24	95.0
25	95.0
26	95.0
27	95.0
28	95.0
29	95.0
30	95.0
31	95.0
32	95.0
33	95.0
34	95.0
35	95.0
36	95.0
37	95.0
38	95.0
39	95.0
40	95.0
41	95.0
42	95.0
43	95.0
44	95.0
45	95.0
46	95.0
47	95.0
48	95.0
49	95.0
50	95.0
51	95.0
52	95.0
53	95.0
54	95.0
55	95.0
56	95.0
57	95.0
58	95.0
59	95.0
60	95.0
61	95.0
62	95.0
63	95.0
64	95.0
65	95.0
66	95.0
67	95.0
68	95.0
69	95.0
70	95.0
71	95.0
72	95.0
73	95.0
74	95.0
75	95.0
76	95.0
77	95.0
78	95.0
79	95.0
80	95.0
81	95.0
82	95.0
83	95.0
84	95.0
85	95.0
86	95.0
87	95.0
88	95.0
89	95.0
90	95.0
91	95.0
92	95.0
93	95.0
94	95.0
95	95.0
96	95.0
97	95.0
98	95.0
99	95.0
100	95.0

Conscious Level	Normal Altered
-----------------	-------------------

GCS *

TOTAL SCORE

Number of shaded boxes

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BAH-00652018 IP5-00175000
Master AYMAN ABDIKARIM OMAR
15-06-2018 8 Y 0 M 21 D (M)
Dr. SIRISHA RANI



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

SCHOOL AGE (5-12 years)

Children's Observation &
Early Warning Scoring Chart

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 6/7 Time: 20m 6am

Doctor / Nurse / Family Concern?

Temperature
(°F)

104
103
102
101
100
99
98
97
96
95
94

98.0
98.6

Heart Rate
(bpm)

and

Blood Pressure
(mmHg) *

Note:

BP does not score
in early
warning scoring

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

98
92
91
96

Heart Rate (Number)

112b/m 97b/m

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

70
60
50
40
30
20
10

22b/m 22b/m

Resp Rate (Number)

Resp Mod/ Severe
Distress None / Mild

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

99% 99%

Conscious Level
Normal Altered

GCS *

15/15 15/15

TOTAL SCORE

Number of shaded boxes

Pain Score

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FLUID CHART

Sheet No. : 4

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

		Intake				Output					IV Site	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	Thrombo-phlebitis Score	
			Mouth	I.V	N.G							
8/7	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						



FLUID CHART

Sheet No. : ③

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 Thrombo- phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G						
7/7	08:00 am	Porage	W/D	40ml					250ml	T	
	09:00 am	H ₂ O	200ml	40ml							
	10:00 am			40ml							
	11:00 am			40ml							
	12:00 pm			40ml				200ml			
	01:00 pm			40ml							
	Total Intake : 440ml					Total Output : 450ml					
7/7	02:00 pm			40ml						T	
	03:00 pm			40ml				250ml			
	04:00 pm			40ml							
	05:00 pm	H ₂ O	200ml	40ml							
	06:00 pm										
	07:00 pm							200ml			
	Total Intake : 360ml					Total Output : 450ml					
7/7	08:00 pm									T	
	09:00 pm	Milk	100ml								
	10:00 pm	Milk	200ml								
	11:00 pm										
	12:00 am										
	01:00 am							350ml			
	Total Intake : 300ml					Total Output : 350ml					
8/7	02:00 am									T	
	03:00 am										
	04:00 am										
	05:00 am										
	06:00 am	H ₂ O	200ml								
	07:00 am							400ml			
	Total Intake : 200ml					Total Output : 400ml					
Total 24 hrs. Intake		1300ml ÷ 54.1cc/kg									
Total 24 hrs. Output		1650 ÷ 275cc/kg									

FLUID CHART

Sheet No. : (2)

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 Thrombo- phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
6/7	08:00 am	milk	50ml	50ml						150ml		
	09:00 am			50ml								
	10:00 am			50ml								
	11:00 am			50ml								
	12:00 pm			35ml						250ml		
	01:00 pm			50ml								
Total Intake :				235 ml		Total Output :				350 ml		
6/7	02:00 pm			40ml								
	03:00 pm	rice	100ml	40ml						180ml		
	04:00 pm			40ml								
	05:00 pm			40ml								
	06:00 pm			40ml						250ml		
	07:00 pm			40ml								
Total Intake :				340 ml		Total Output :				400 ml		
	08:00 pm			40ml								
	09:00 pm	fruits		40ml						200ml		
	10:00 pm	400	100ml	40ml								
	11:00 pm			40ml								
	12:00 am			40ml						150ml		
	01:00 am			40ml								
Total Intake :				340 ml		Total Output :				350 ml		
	02:00 am			40ml								
	03:00 am			40ml						250ml		
	04:00 am			40ml								
	05:00 am			40ml								
	06:00 am			40ml						150ml		
	07:00 am			40ml								
Total Intake :				240 ml		Total Output :				400 ml		

Total 24 hrs. Intake

1255 ÷ 50.2 cckg/hr.

Total 24 hrs. Output

1500 ÷ 2.5 cckg/hr



FLUID CHART

Sheet No. : 2

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		
	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			50ml						200ml		
	04:00 am			50ml								
	05:00 am			50ml								
	06:00 am	H2O	100ml	50ml								
	07:00 am			50ml						350ml		
Total Intake : 350ml						Total Output : 650ml						

Total 24 hrs. Intake

350 : 14 cckg

Total 24 hrs. Output

650 : 5.2 cckg



Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 3pm Mode of Arrival: with caregiver Admitting From: ☒ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction allergy Body Weight: 25 Kg

Height: cm

Past Medical History: Obtained From ☐ Patient ☒ Family Member ☐ Medical Record ☐ Other (specify)

Past Medical History	Past Surgical History	Previous Hospital Admission
<u>not applicable</u>	<u>not applicable</u>	<u>not applicable</u>

Family History: healthy family

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: 25kg Length: Head Circumference (< 2 years):

Temp.: av 100°F HR: 100/min RR: 24/min BP: 102/61/71

Pain Score: 0 Specify Site: side of rib (Follow Pain Assessment Sheet & Document)

Fall Risk Assessment: ☒ Yes ☐ No Score: 41 (Document in the Humpty Dumpty Sheet)

Risk of Pressure Sore (Braden Q Score 25) (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 Findings

Unusual 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 With Parents

Siblings 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 ☐ No Waste Disposal Explained: ☒ Yes ☐ No
- Infusion Pump : ☒ Yes ☐ No Hand hygiene Explained: ☒ Yes ☐ No ☐ Others
- Patient Rights & Responsibilities: ☒ Yes ☐ No
- Information given to nurses

Nurse Signature: [Signature]

Nurse Name: Shweta

Date: 6/12/20

Time: 12:00

BAH-00652018 IP5-00176000
Master AYMAN ABDIKARIM OMAR
15-06-2018 8 Y 0 M 22 D (M)
Dr. SIRISHA RANI



NURSING CARE RECORD

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 8/12/26

Assessment: patient is having weak pers

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
7am	Assess general condition of the patient	8:30	Assessed general condition of the pt	Patient is stable
9am	monitor vital signs	9:30	monitored vital signs	
10am	Maintain hygiene	10:30	maintained hygiene	
11am	Ensure safety	11:30am	provided side rails	
12pm	maintain I/O chart	12:30pm	maintained I/O chart	

Re-Assessment: patient is stable

Special Notes:

Nurse Signature:

Nurse Name: Saurdhevi

Date & Time: 8/12/26 @ 12:30pm



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☐ Night

Date:

Assessment:

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation

Re-Assessment:

Special Notes:

Nurse Signature:

Nurse Name:

Date & Time:



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 7/7/26

Assessment: patient is having weakness

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 general condition.	8:30pm	* Assessed the general condition	patient is comfortable
10pm	* Monitor and note vitals	10:30pm	* Monitored and noted vitals	
12Am	* Provide comfortable position	12:30pm	* Provided comfortable position	
2Am	* Provide supportive care.	2:30pm	* Provided supportive care.	
4Am	* Ensure Safety.	4:30pm	* Provided siderails & pillows	
6Am	* Monitor output.	6:30pm	* Monitored output	
7Am	* Administer medications.	7:30pm	* Administered medications.	

Re-Assessment:

patient is comfortable.

Special Notes:

Nurse Signature: *Ayman*

Nurse Name: Ayman

Date & Time: 8/7/26 @ 8Am



5

NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 7/7/26

Assessment: The Patient having wheezes

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
☒ Patient & Family Education

Time	Plan of Care	Time	Implementation	Evaluation
2pm	Monitor Vitals	3pm	Monitored Vitals	
3pm	Administer medication as per doctor advice	4pm	Administered medication as per doctor advice.	Pt felt better
4pm	Provide Hydration	5pm	Provided Hydration	
5pm	Provide Supportive Care	6pm	Provided Supportive Care	

Re-Assessment: Pt felt better

Special Notes:

Nurse Signature: [Signature]

Nurse Name: Pooja

Date & Time: 7/7/26 8pm.



NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 7/7

Assessment: patient Having weakness.

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
8 AM	Assess the Patient Condition.	8:30 AM	Assessed the Patient Condition.	Patient feel better. Now.
9 AM	monitor vital.	9:30 AM	monitored vital.	
10 AM	maintain iv fluids	10:30 AM	maintained iv fluids.	
11 AM	Administer medication.	11:30 AM	Administered medication.	
12 PM	provide Personal hygiene	1 PM	provided Personal hygiene.	
1 PM	provide Supportive care	1:30 PM	provide & Supportive care.	

Re-Assessment: Patient feel better now

Special Notes: next fever 41.5° 2.5m Jexu

Nurse Signature: SPS. Nurse Name: SUBHANKAR Date & Time: 7/7/26 5:20 PM

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 6/7/26

Assessment: patient is having weakness

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	* Assess the general condition	8:30pm	* Assessed the general condition	patient is comfortable
10pm	* Monitor and note vitals	10:30pm	* Monitor and note vitals	
12Am	* Provide comfortable position	12:30am	* Provided comfortable position	
2Am	* Provide supportive care	2:30Am	* Provided supportive care	
4Am	* Ensure safety.	4:30Am	* Provided pillows & side rails	
6Am	* Provide education.	6:30Am	* Provided health education seg. personal hygiene	
7Am	* Administer medications as per order.	7:30Am	* Administered medications as per order	

Re-Assessment: patient is comfortable

Special Notes:

Nurse Signature: Am

Nurse Name: Am

Date & Time: 7/7/26 @ 8pm



NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 6/7/20

Assessment: Patient having fever

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
9:30am	Assess the patient's condition	9:45am	Assess the patient's condition	pt was stable
10:40am	Monitor the vital and record	11am	monitored the vital and record	
12:38pm	maintained fluid balance	1:40pm	maintained fluid balance only vomit	
3pm	provide nurse safety	4pm	provided side rail	
3:45pm	provide personal hygiene	5:45pm	provided personal hygiene	
6pm	provide patient & family education	7:45pm	provided patient & family education	

Re-Assessment: Patient was stable

Special Notes: Watch for fever spike

Nurse Signature: *[Signature]*

Nurse Name: *[Signature]*

Date & Time: 6/7/20 @ 8pm

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☐ Night

Date: 6/7

Assessment: Pt having fever.

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
3am	Assess the pt general condition.	3am	Assessed the patient general condition.	Pt felt better.
5am	Monitor vitals.	5am	Checked vitals.	
7am	Maintain I/O chart.	7am	Continue IV fluid.	
8am	Ensure safety.	8am	Giving side rails.	

Re-Assessment: Patient felt better.

Special Notes:

Nurse Signature: [Signature]

Nurse Name: Gargi

Date & Time: 6/7 8am



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. S.R. Department: Emergency Date of Admission: 6/7/24

SITUATION		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:						
BACKGROUND	Area							
	Shift Time	07:00-8:00 AM	08:00-9:00 AM	09:00-10:00 AM	10:00-11:00 AM	11:00-12:00 PM	12:00-1:00 PM	
ASSESSMENT	Medical Condition (Any special condition to be noted):	N/A	N/A	N/A	N/A	N/A	N/A	
	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
RECOMMENDATIONS	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Vital Signs:	Temp:	98.8	98.9	98.3	98.8	98.5	98.6
		Res:	24b/m	22b/m	23b/m	24b/m	24b/m	26b/m
		SpO ₂ :	100%	100%	99%	99%	98%	100%
		Pulse:	112b/m	114b/m	108b/m	103b/m	105b/m	106b/m
		BP:	97/65/20	94/60	99/63	99/63/20	96/66/70	96/60/20
	Fall Risk Score:	9	9	9	9	9	9	
	Pain Score:	0	0	0	0	0	0	
Safety Needs:	Side rail	Side rail	Side rail	Side rail	Side rail	Side rail		
Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No		
Others Specify:	N/A	N/A	N/A	N/A	N/A	N/A		
Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No		
Other Special Orders / Medications:	N/A	N/A	N/A	N/A	N/A	N/A		
Post Operative Procedure Special Orders:		N/A	N/A	N/A	N/A	N/A	N/A	
Handed Over By Name :		Sandh	Ganesh	Naveen	Arjun	SUBHANKAR	Pooja	
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	
Date:		6/7	6/7	6/7	7/7	7/7	7/7	
Time:		2:30 PM	8 PM	8 PM	8 AM	2 PM	8 PM	
Taken Over By Name :		Arjun	Naveen	Arjun	SUBHANKAR	Pooja	Arjun	
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	
Date:		6/7/24	6/7	6/7	7/7	7/7	7/7	
Time:		2:30 PM	8 PM	8 PM	8 AM	2 PM	8 PM	



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. S.R. Department: Oncology Date of Admission: 6/7/26

SITUATION	Diagnosis: <u>B-cell - AN</u>		Any Infection: ☐ Yes ☒ No ☐ Not Known If Yes Specify: <u>NA</u>				
BACKGROUND	Area	<u>oncology</u>	<u>oncology</u>				
	Shift Time	<u>8PM-8AM</u>	<u>8AM-2AM</u>				
	Medical Condition (Any special condition to be noted):	<u>N/A</u>	<u>NA</u>				
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Vital Signs:	Temp:	<u>98.0°</u>	<u>98.0°</u>			
		Res:	<u>242/m</u>	<u>266/m</u>			
		SpO ₂ :	<u>100%</u>	<u>100%</u>			
		Pulse:	<u>118b/m</u>	<u>102b/m</u>			
		BP:	<u>93/65/102</u>	<u>92/62</u>			
		Fall Risk Score:	<u>9</u>	<u>9</u>			
Pain Score:	<u>0</u>	<u>1</u>					
Recommendations	Safety Needs:	<u>side rails</u>	<u>yes</u>				
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Others Specify:	<u>N/A</u>	<u>NA</u>				
	Special Diet:	☐ Yes ☐ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Other Special Orders / Medications:	<u>N/A</u>	<u>NA</u>				
Post Operative Procedure Special Orders:		<u>N/A</u>	<u>NA</u>				
Handed Over By Name :		<u>Amm</u>	<u>Sushie</u>				
Signature :		<u>Amm</u>					
Date:		<u>8/7</u>					
Time:		<u>8AM</u>					
Taken Over By Name :		<u>Sushie</u>					
Signature :		<u>Sushie</u>					
Date:		<u>8/7</u>					
Time:		<u>8AM</u>					



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
6/7	2PM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Am
6/7	10AM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Am
6/7	6PM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Am
7/7	2PM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Am
7/7	10AM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	2
7/7	6PM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA NA	Am
8/7	2PM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Am
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

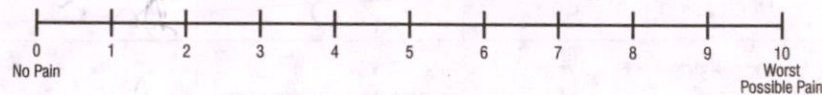
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

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 brawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, right, or Jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams of sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

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





2d

138

NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 6/7/26 Time: 10 AM

Weight: 25 kgs Centile: 75th

Height: 127 cm Centile: 75th

Inference: well child

RDA: — Calories: 1550 kcal/d Protein: 27 g/d

Diet Recommendations: Normal High protein diet

Re-Assessment: Avoid spicy, chilled and outside foods.

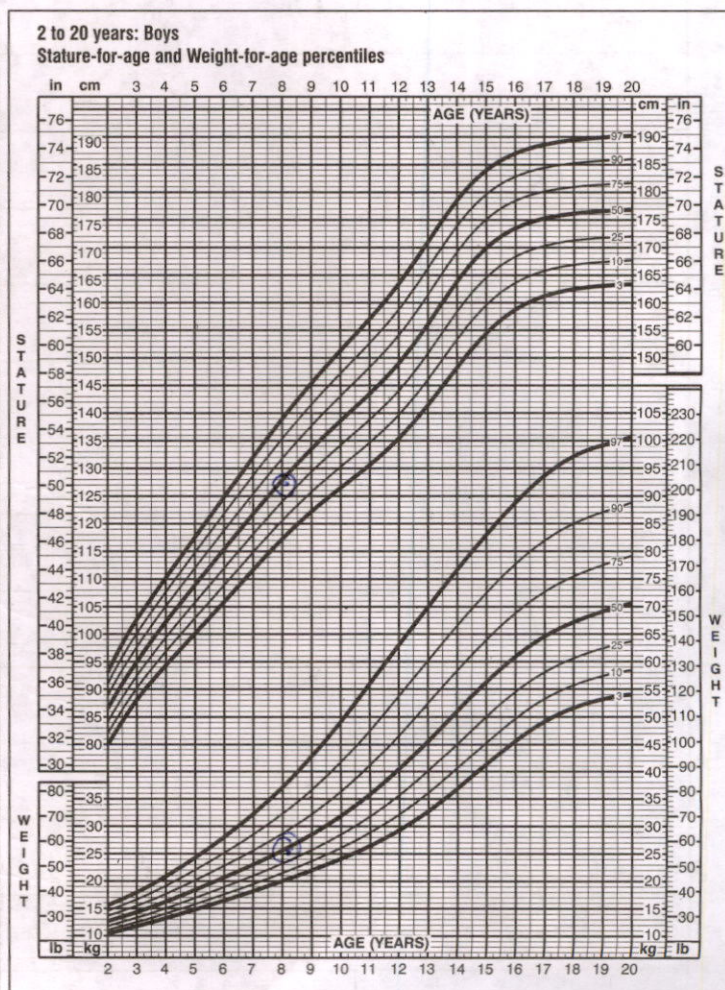
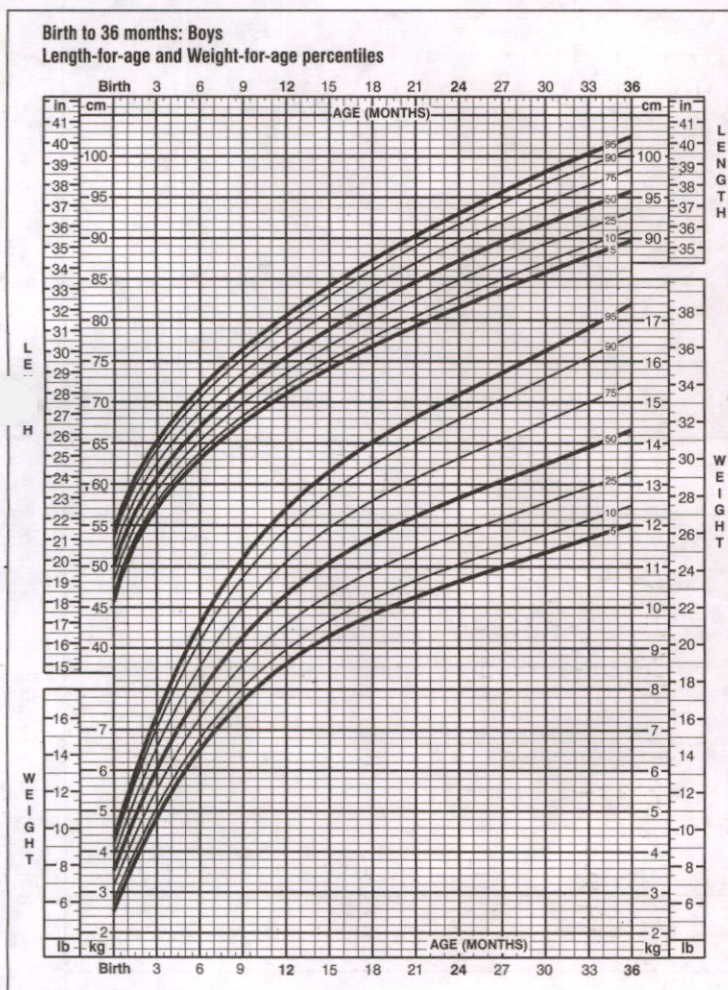
Food Allergies: No Veg/Non-veg non-veg

Diagnosis: Acute febrile illness

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: Parent's Don't need Dietician. Don't charge NHA.

GROWTH CHART (BOYS)



Dietician's Name: Mounica

Dietician's Signature: Mounica

Daily Notes: