

ACTIVITY RECORD FOR BILLING

Name : _____

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

Date of Admission: _____ Time : _____ Date of Discharge: 8/24/16 Time: _____

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
6/17/26	2:20 Am	GE	138	Azm

Cross Consultation Visit

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

[illegible]

Date	Investigations	Order No.	Signature
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Date	Investigations	Order No.	Signature
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Date	Investigations	Order No.	Signature
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Date	Investigations	Order No.	Signature
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6/9	car, car	060219090	JB
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6/9	car, car	060219090	JB
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6/9	car, car	060219090	JB
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6/9	car, car	060219090	JB
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67790	06229	06229	67790
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67790	06229	06229	67790
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67790	06229	06229	67790
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67790	06229	06229	67790
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#1	Veine c/s	26067472	10/24
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#1	Veine c/s	26067472	10/24
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#1	Veine c/s	26067472	10/24
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#1	Veine c/s	26067472	10/24
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[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature

ANY OTHER INFORMATION

Don't Charge for NHA.

— *manlio*

Date :

Time :

Prepared By :

Staff Nurse

Shift / Ward

Billing Assistant

Billing Supervisor

**Rainbow Children's Hospital - Banjara Hills**

8-2-120/103/1,2,3,4 and 5, Road No: 2, Banjara Hills, Telangana, Hyderabad, INDIA Banjara Hills, Hyderabad, Telangana, India, 500034.
TEL NO : +91-40-4466 5555
WEB : <https://rainbowhospitals.in>

ADMISSION SHEET**Registration Details :**

Admission No : IP5-00176000 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

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

Patient Sticker
 Syman Alitkacem Danae
 138

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	1			
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				
		4			
		54			
	Total No. of Pages				

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-00852018 IP5-00176000
Master AYMAN ABDIKARIM OMAR
15-06-2018 8 Y 0 M 21 D (M)
Dr. SIRISHA RANI




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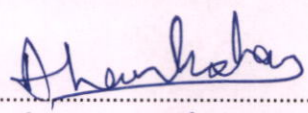
ADMISSION CRITERIA – ONCOLOGY

Admission / Transfer from:

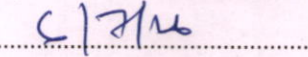
☐ Emergency ☐ Outpatient (OPD) ☒ Ward ☐ Operation Theater ☐ Others:

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: 

Name of the Doctor: 

Date & Time: 

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




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DISCHARGE CRITERIA – ONCOLOGY

Discharge to:

☐ HDU / Step down ICU

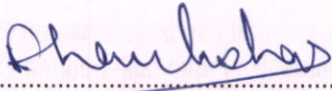
☒ Ward

☐ Outside Facility

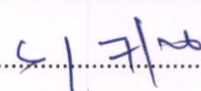
☐ Others:

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: 

Name of the Doctor : 

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 :

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

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

all
Sankh

Signature of the Doctor: [Signature]

Name of the Doctor: Sankh

Date & Time: 6/7/26 2AM

Signature of the Consultant: [Signature]

Name of the Consultant: Sirisha Rani

Date & Time:

Pediatric Multiorgan History & Physical Examination

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

Birth & Neonatal History:

① perinatal transition

Birth & Socio Economic History:

About Father : _____

About Mother : _____

Any additional Information : _____

Developmental History :

Developed as per age

Immunization History :



Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs)) 25 kg (Centile _____)

On Examination :

Temperature : 98°F Pulse Rate : 102/min B.P. 98/62 mmHg SPO2 98% RA

Resp. rate and type of breathing : 25/min

Rash _____

Lymphadenopathy _____

Oedema : _____

Allergies (if any): _____

Respiratory System :

Inspection (any s/o distress) : _____

Air entry & breath sounds : BAC ⊕

Any addles sounds : ⊖

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

Cardiovascular System :

Inspection of precordium : _____

Heart Sounds : S1 S2 ⊕

Any murmur : _____

Relevant data from outside (Chest X-Ray, ECG, ECHO, etc.,) : /

Per Abdomen :

Inspection _____

Palpation : Soft, NT

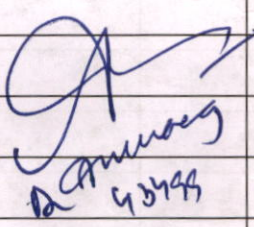
Auscultation : BS ⊕

Spine : _____ External Genitalia : /

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



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/7/26 8:45 AM	Morning round Bulbitt's lymphoma / D17 of CYVE cycle - 2. now with febrile illness / ? sepsis. fever ⊕ 100.8°F No other issues. feeding fair U/O Adequate S/E → P/W FLOTTA C/S R/S ⊕ P/S brown. Ceftriaxone D₁ - 2 Ripitor D ₁  Dr. Amrutha 4/5/26	<u>Adm</u> 1) left drugs as per chart 2) monitor vitals 3) if supportive care 4) send ^{send} blood cl. (OPV) 5) send urine cl. <u>Ahmadshah</u> Noted by nurse 6/7/26 c 14 PM

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
7/7/26 9AM	<u>Morning rounds</u> Burkitt lymphoma / D. & CYVE ydx-8 / febrile "Unu" Ongoing fever 2AM. No other issues. Vitals (N) Stechle S/E → PWF, CFT 3.5 C/S P/S oral ulcers @	1. Base Urine dx 2. cont rest. 3. monitor vitals 4. w/f fever 5. Sympt S/S. Shaukhan If further high grade fever → 100.5°F → Inj Dexa 2.5mg iv stat 6. stop w/f. [Signature] 2/20 10AM. N.B Subhannan @ 7:17 @ 9:30AM



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



(5)

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/7/18 am	Burkitt's Leukemia / D+19 post CYVE (2)	
	No fever	
	vital stable	Plan
	pipraz - P3	1. Trace urine ds
	linzolid - D2/5	2. plan dlc today.
	vor.	
		Dear
	→ stop Vancomazole	
	→ linzolid x3d	
	→ dlc today	
	→ Saturday Administer	
	Dr. Anurag Goverdhan	

7. SIRISHA RANI



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[illegible]



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PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name:

~~AA~~ Ayman Ablikarim 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 :

K/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 /
crashes / 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: 06/07/2026 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 July</u>	Start Date <u>6/7</u>	<u>6/7 6H</u> <u>9AM 6:30PM</u> <u>10:30</u>
Doctor's Signature <u>Phanish</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 July</u>	Start Date <u>6/7</u>	<u>10PM</u> <u>10:30</u> <u>11PM</u>
Doctor's Signature <u>Phanish</u>		Valid Period	Pharm.	
Additional Instructions: <u>T>100°F</u>				



REGULAR PRESCRIPTIONS

Weight. 25 kg Ward. 002

DRUG : <u>INV. 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>Blank</u>
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
DRUG : <u>INV. PANTOPRAZOLE</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				

Weight. Ward.

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]

VERIFICATION: Name



I.V. FLUIDS CHART

Weight. Ward.

6/7/26

9AM

DNS
 + 5ml mVI

IV

40 d

New
 Divya

Dr. Sirisha Rani
 Dr. Sirisha Rani

Dr. Sirisha Rani
 Dr. Sirisha Rani

Signature

VERIFIED BY : Name

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



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Sheet No:

REGULAR PRESCRIPTIONS

Weight 25kg Ward ONCD

DRUG : TAB. VORICONAZOLE				Date Time	6/7/17															
Dose	Route	Frequency	Start Dt.																	
200mg	PO	OD	06/07																	
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Nandan</u>				2pm 16/07/17 Dr. Nandan																
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign				d d																
DRUG : TAB. SHEZCAL 250				Date Time	6/7/17															
Dose	Route	Frequency	Start Dt.																	
1 tablet	PO	OD	06/07																	
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Nandan</u>				8pm 16/07/17 Dr. Nandan																
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign				d d																
DRUG : Syf. MORTEL				Date Time	6/7/17															
Dose	Route	Frequency	Start Dt.																	
5ml	PO	OD	06/07																	
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Nandan</u>				8pm 16/07/17 Dr. Nandan																
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign				d d																
DRUG : Inj PIPERACILIN TAZOBACTAM				Date Time	6/7/17															
Dose	Route	Frequency	Start Dt.																	
2.25gr IV	TID		6/7																	
Name & Signature of the Doctor Starting the Drugs: <u>Ashwini</u>				2pm 16/07/17 Dr. Ashwini																
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign				d d																

Signature
 VERIFIED BY : Name



Sheet No:

REGULAR PRESCRIPTIONS

Weight ... 25kg

Ward ... 020

DRUG : T. LINEZOLID				Date Time																
Dose	Route	Frequency	Start Dt.																	
1/2 tab	PO	BD	6/7																	
Name & Signature of the Doctor Starting the Drugs:																				
<u>Ahmed Hassan</u>																				
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. MORTEL	5ml	PO	OD	05/07/26	☒ C ☐ DC
5	TAB. SHELICAL-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: Sankh

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:

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:

1. None	3. Reassurance & Support	5. Respect values & beliefs	7. Other, Specify
2. Obtain translator	4. Teach Family / Others	6. Respect Cultural / Religion Preference	

Understanding: 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	Rt D.A.	[Signature]	☐ Nursing ☒ Others:
6/7 @ 2pm	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	DB-Cu Au	Haemodynamic stability	Rv fluids Rv antibiotics	[Signature]	☒ Medical ☐ Others:
6/7/26 10am	☐ Medical ☐ Nursing ☒ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	AFI C Buell Au	Normal Hgb protein diet	RDA E: 1550kcal/d L: 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



SCHOOL AGE (5-12 years)
Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 8/7/20 Time: 7 AM

Doctor / Nurse / Family Concern?

Temperature (°F)

104
103
102
101
100
99
98
97
96
95
94

98.5

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

103
102

Heart Rate (Number)

102 bpm

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

70
60
50
40
30
20
10

24 bpm

Resp Distress Mod/ Severe None / Mild

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

98.5

Conscious Level Normal / Altered

GCS *

15/14/5

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

0

15

ACTIONS

NB: Scores 3 should be recorded overleaf

Score 1 : Continue normal observation by staff nurse

Score 2 : Shift in charge nurse to be informed and continue hourly observations

Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.

Score 4 : Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see

Score 5 & 6 : Shift in charge AND PICU fellow or PICU consultant to be informed.

* 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

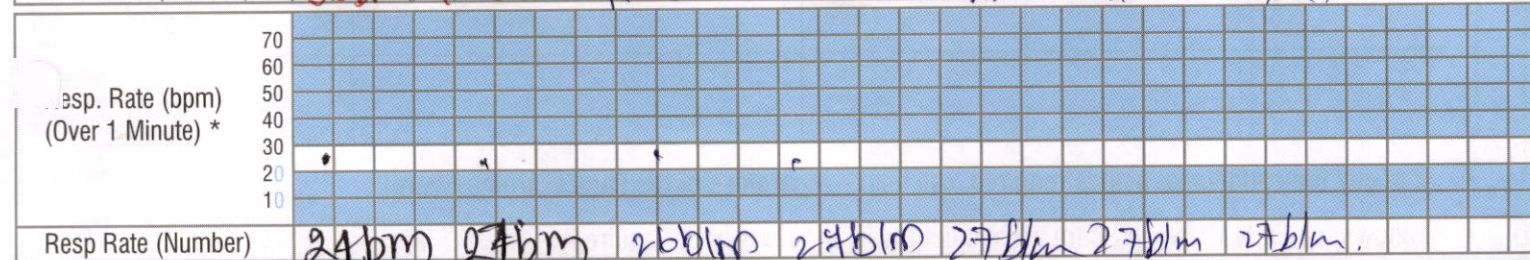
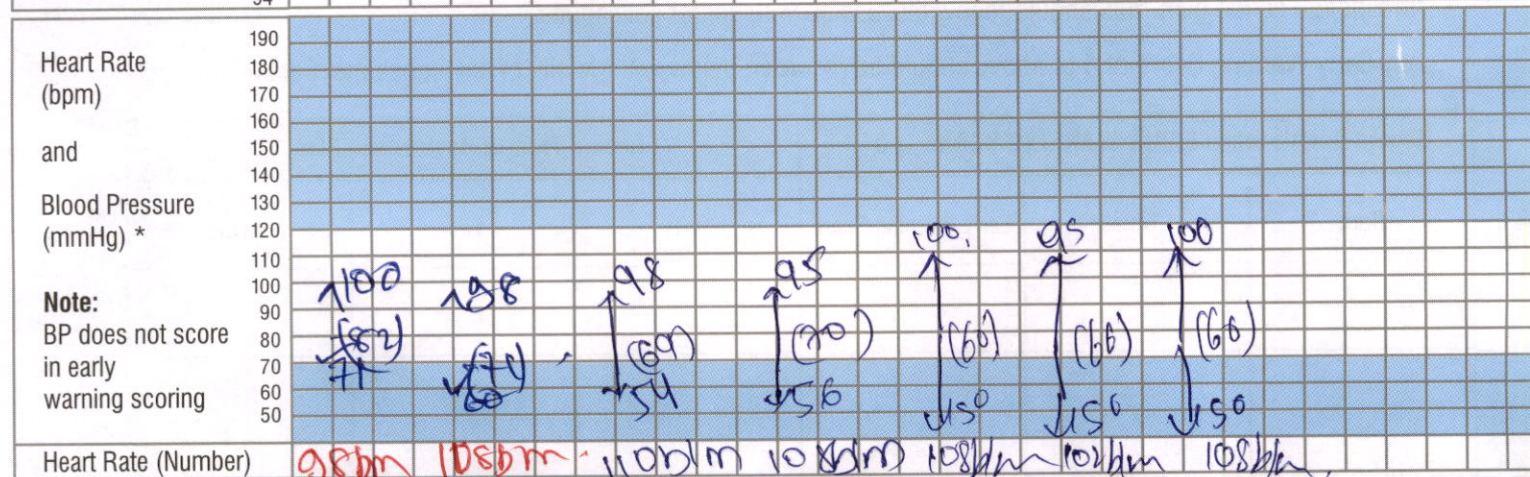
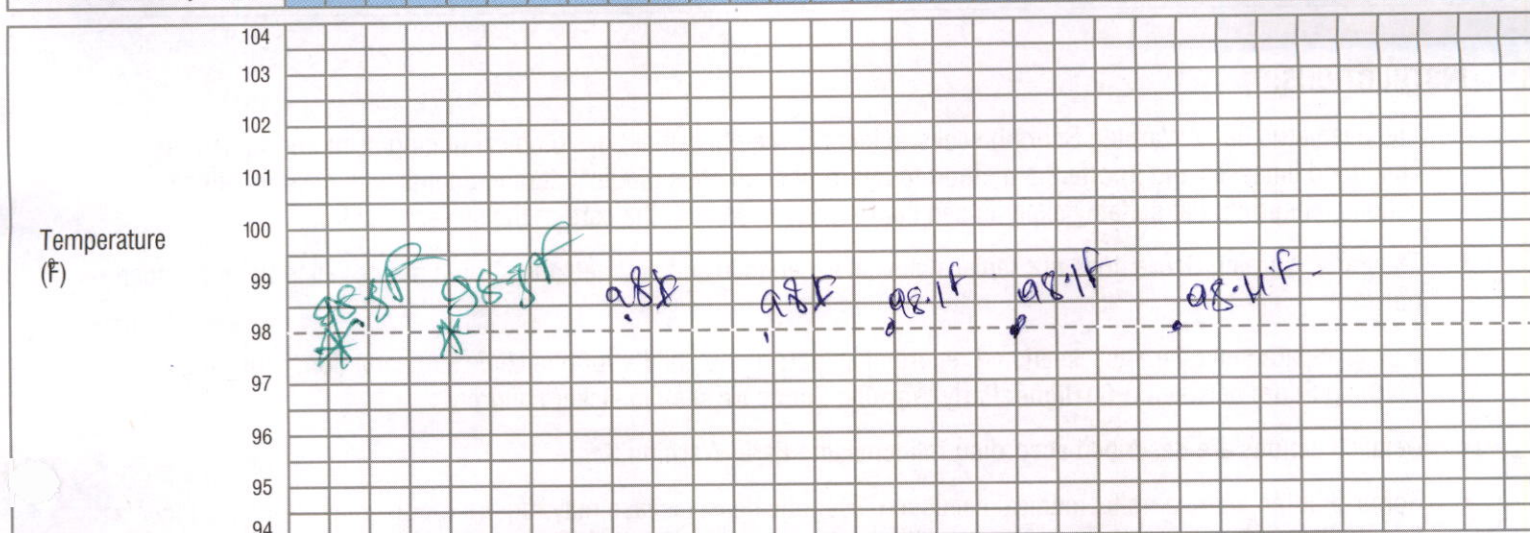
Record Details when EARLY WARNING SCORE > 3			Record Time of Review and Plan		
Date	Time	Early Warning Score	Date	Time	Name

- 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)

Date: 7/7/26	Time: 9AM - 12pm - 4pm - 7pm (off) 3AM - 6AM
Doctor / Nurse / Family Concern?	



Resp Distress	Mod/ Severe None / Mild	0	0	0	0	0	0
Receiving O ₂ (l/min)							
O ₂ Saturations (%)		100%	100%	100%	100%	100%	100%
Conscious Level	Normal Altered	C	C	C	C	C	C
GCS *		15/15	15/15	15/15	15/15	15/15	15/15
TOTAL SCORE		9	0	0	0	0	0
Number of shaded boxes		2	2	2	2	2	2
Pain Score		2	2	2	2	2	2
Observer's Initials		22	22	22	22	22	22

NB: Scores 3 should be recorded overleaf

- | | |
|-------------|---|
| Score 1 | : Continue normal observation by staff nurse |
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GAM

104
103
102
101
100
99
98
97
96
95
94

* 98.5%

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

101
(76)
67

10361m

70
60
50
40
30
20
10

sublim

100%

	c
--	---

15 | 15

1

0

[Signature]

Score 5 & 6 : Shift in charge AND PICU fellow or PICU consultant to be informed.

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BAH-00652018 IP5-00176000
 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

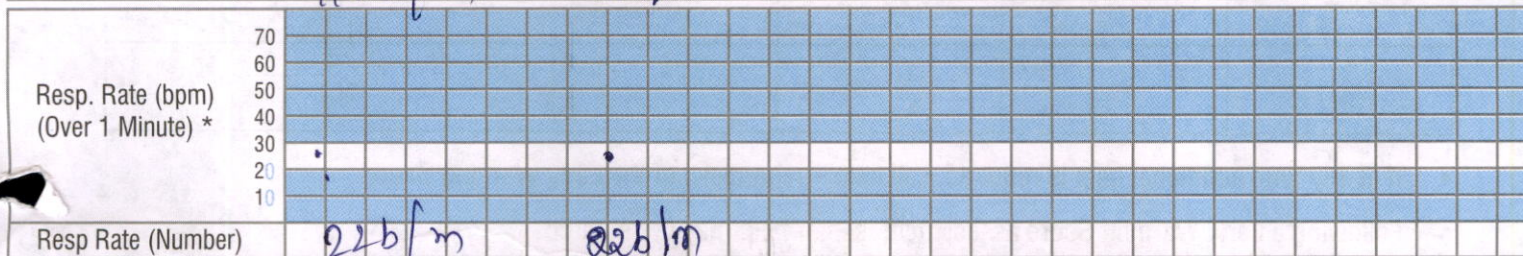
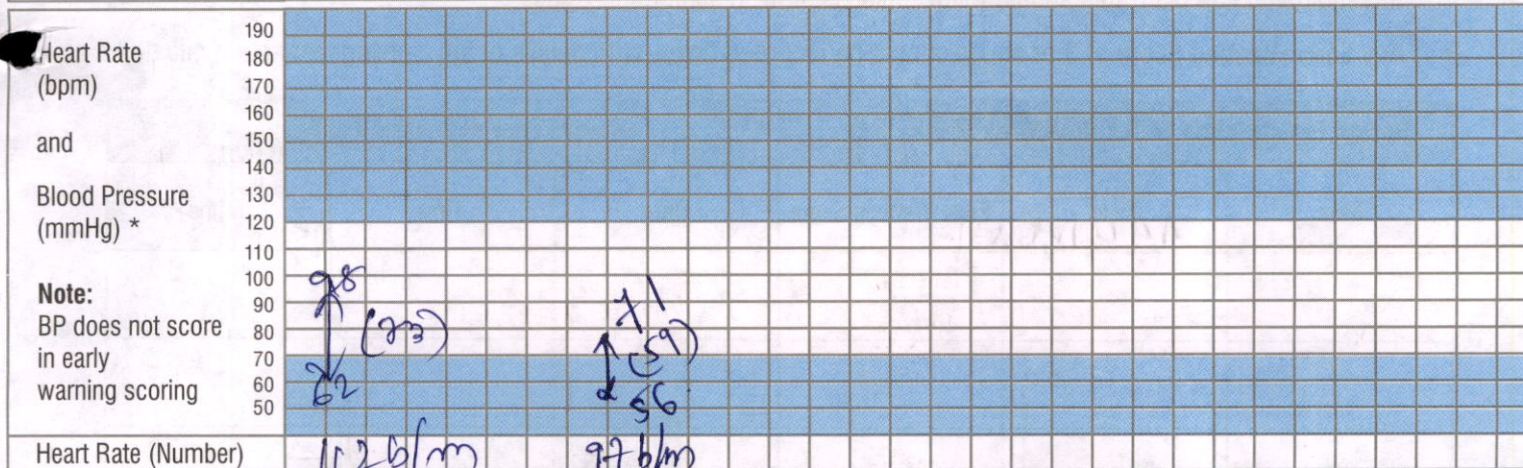
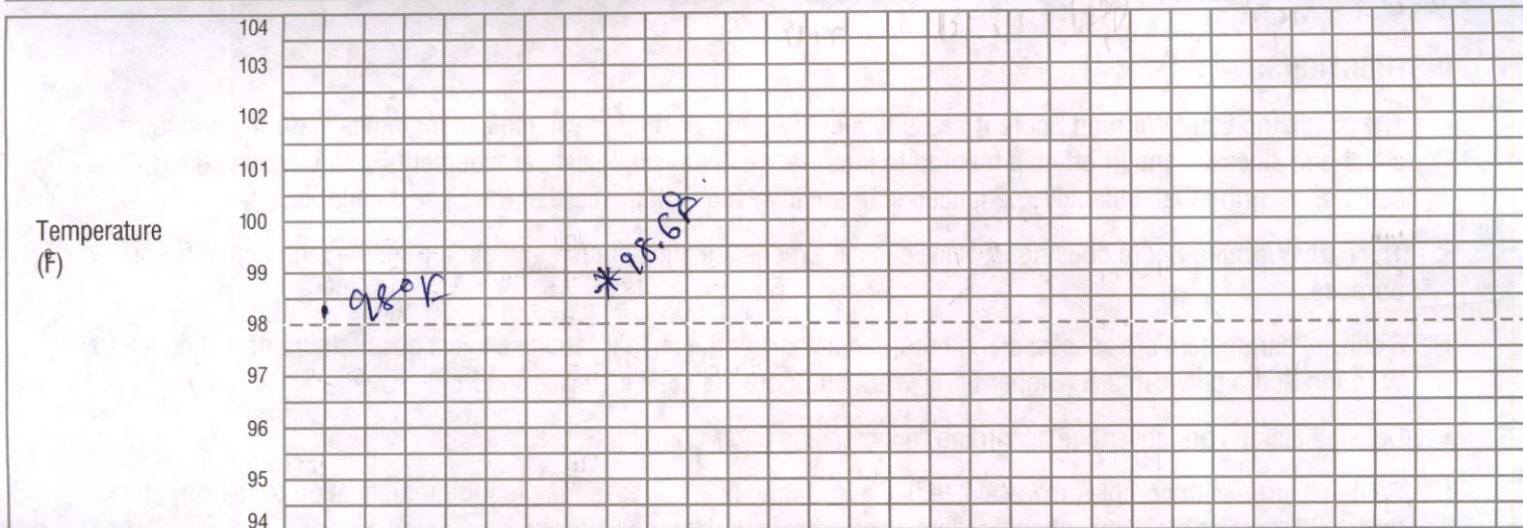
Rainbow Children's Hospital
 It takes a lot to treat the little.

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 6/7 Time: 2 AM 6 AM

Doctor / Nurse / Family Concern?



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		
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Dr. SIRISHA RANI



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BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

FLUID CHART

Sheet No. : 4

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								
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	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 kcal/kg

Total 24 hrs. Output

1650 ÷ 275 kcal/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 :			335ml			Total Output :			350ml			
6/7	02:00 pm			40ml								
	03:00 pm	pre h2o	100ml	40ml						180ml		
	04:00 pm			40ml								
	05:00 pm			40ml								
	06:00 pm			40ml						250ml		
	07:00 pm			40ml								
Total Intake :			340ml			Total Output :			400ml			
	08:00 pm	fruits		40ml								
	09:00 pm			40ml						200ml		
	10:00 pm	h2o	100ml	40ml								
	11:00 pm			40ml								
	12:00 am			40ml						150ml		
	01:00 am			40ml								
Total Intake :			340ml			Total Output :			350ml			
	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 :			240ml			Total Output :			400ml			

Total 24 hrs. Intake 1255 ÷ 50.2 cckg/hr.

Total 24 hrs. Output 1500 ÷ 2.5 cckg/hr.



FLUID CHART

Sheet No. : 1

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	420	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 sibling 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: 28kg Length: Head Circumference (< 2 years):

Temp.: 37.5 HR: 100bpm RR: 20bpm 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 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 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: Amelia

Date: 6/7/26

Time: 12:00

⑦

NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 8/8/20

Assessment: patient is having weak reflex

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 & 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: *Saritha*

Nurse Name: Saritha

Date & Time: 8/8/20 @ 12:30pm

BAH-00652018
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:

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
- ☒ 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	* Monitored and noted 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 siderals & pillows	
6Am	* Monitor output.	6:30Am	* Monitored output	
7Am	* Administer medications.	7:30Am	* Administered medications.	

Re-Assessment: patient is comfortable.

Special Notes:

Nurse Signature: Aym m Nurse Name: Aym m Date & Time: 8/7/26 @ 8Am



NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 7/7/26

Assessment: The Patient having wheezes

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	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
8AM	Assess the Patient condition.	8:30pm	Assessed the Patient condition.	Patient feel better now.
9AM	monitor vital.	9:30AM	monitored vital.	
10AM	maintain iv fluids	10:30AM	maintained iv fluids.	
11AM	Administer medication.	11:30AM	Administered medication.	
12PM	provide personal hygiene	1pm.	provided personal hygiene.	
1pm.	provide supportive care.	1:30pm	provide & supportive care.	

Re-Assessment: Patient feel better now

Special Notes: next fever give 2.5ml dexu

Nurse Signature: SPS. Nurse Name: SUBHANKAR Date & Time: 7/7/26 9:20pm

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: Ann

Nurse Name: Ann

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



NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 6/1/20

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

Re-Assessment:

patient was stable

Special Notes:

watch for fever spike

Nurse Signature:

Almer

Nurse Name:

Almer

Date & Time:

6/1/20 @ 8 PM

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: AS

Nurse Name: Gargi

Date & Time: 6/7 8AM



NURSING SHIFT HAND OVER FORM - WARD

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

SITUATION		Diagnosis:		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:						
BACKGROUND	Area									
	Shift Time	0700-8pm	0700-8pm	0700-8pm	0700-8pm	0700-8pm	0700-8pm	0700-8pm	0700-8pm	
BACKGROUND	Medical Condition (Any special condition to be noted):	N/A	NA	NA	N/A	NA	NA	NA	NA	
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Vital Signs:	Temp:	98.8	98.8	98.3	98.8	98.8	98.8	98.8	98.8
		Res:	24b/m	22b/m	23b/m	24b/m	24b/m	24b/m	24b/m	24b/m
		SpO ₂ :	100%	100%	99%	99%	98%	98%	100%	100%
		Pulse:	112b/m	114b/m	108b/m	103b/m	105b/m	105b/m	108b/m	108b/m
		BP:	97/65/20	94/60	99/63	99/63	96/66/76	96/66/76	96/60/60	96/60/60
		Fall Risk Score:	9	9	9	9	9	9	9	9
Pain Score:	0	0	0	0	0	0	0	0		
Recommendations	Safety Needs:	Side rail	Side rail	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	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:	N/A	NA	NA	N/A	NA	NA	NA	NA	
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Other Special Orders / Medications:	N/A	NA	NA	N/A	NA	NA	NA	NA	
Post Operative Procedure Special Orders:		N/A	NA	NA	N/A	NA	NA	NA	NA	
Handed Over By Name :		Sandh	Ganesh	Naveen	Arjun	SUBHANKAR	Pooja			
Signature :		Sandh	Ganesh	Naveen	Arjun	SUBHANKAR	Pooja			
Date:		6/7	6/7	6/7	7/7	7/7	7/7			
Time:		2:30pm	8pm	8pm	8pm	2pm	8pm			
Taken Over By Name :		Arjun	Naveen	Arjun	SUBHANKAR	Pooja	Arjun			
Signature :		Arjun	Naveen	Arjun	SUBHANKAR	Pooja	Arjun			
Date:		6/7/26	6/7	6/7	7/7	7/7	7/7			
Time:		2:30pm	8pm	8pm	8pm	2pm	8pm			



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>onco</u>	<u>onco</u>			
	Shift Time	<u>8pm-8am</u>	<u>8am-8am</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>98.5</u>	<u>98.5</u>			
	Res:	<u>24/2/m</u>	<u>26/2/m</u>			
	SpO ₂ :	<u>100%</u>	<u>100%</u>			
	Pulse:	<u>118b/m</u>	<u>102b/m</u>			
	BP:	<u>93/68/70</u>	<u>93/62</u>			
	Fall Risk Score:	<u>9</u>	<u>9</u>			
Recommendations	Pain Score:	<u>0</u>	<u>1</u>			
	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>Sudhan</u>			
	Signature :	<u>Amm</u>				
	Date:	<u>8/7</u>				
	Time:	<u>8am</u>				
	Taken Over By Name :	<u>Sudhan</u>				
	Signature :	<u>Sudhan</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:

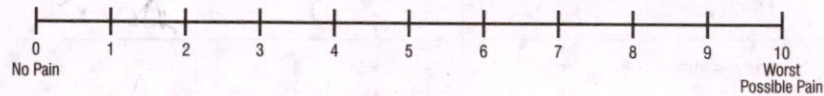
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

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

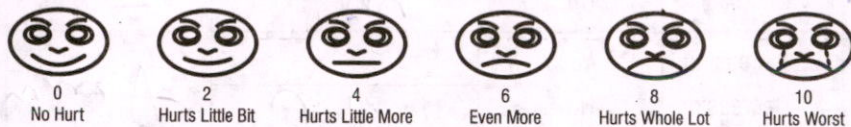
Numerical Pain Scale (Obstetric and Gynecology)



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: 124 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.

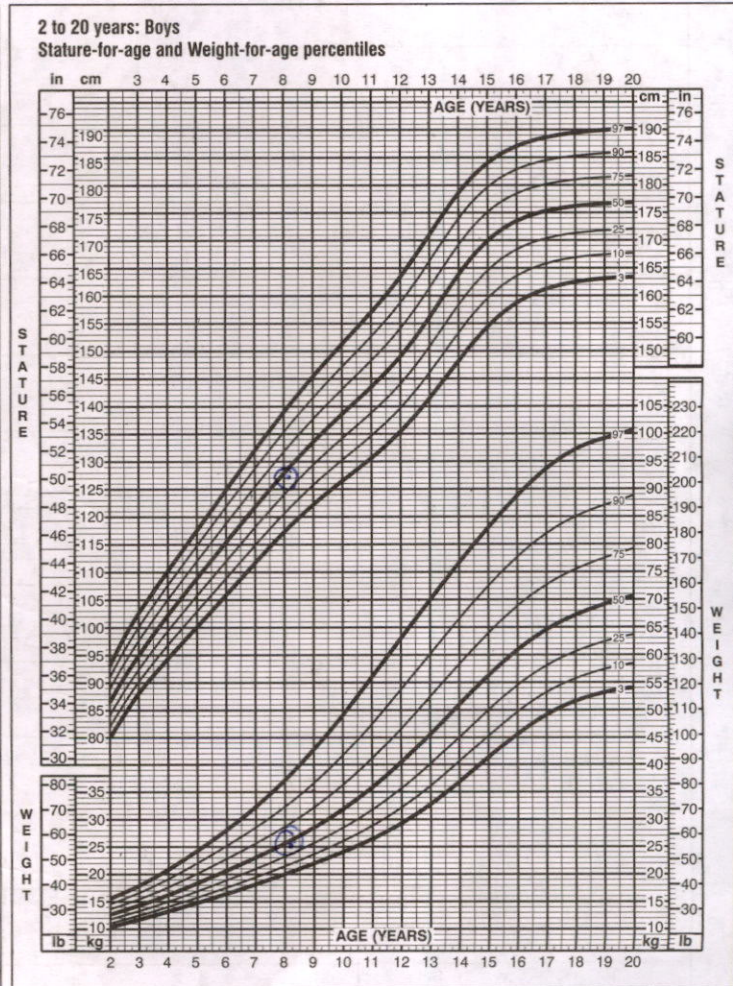
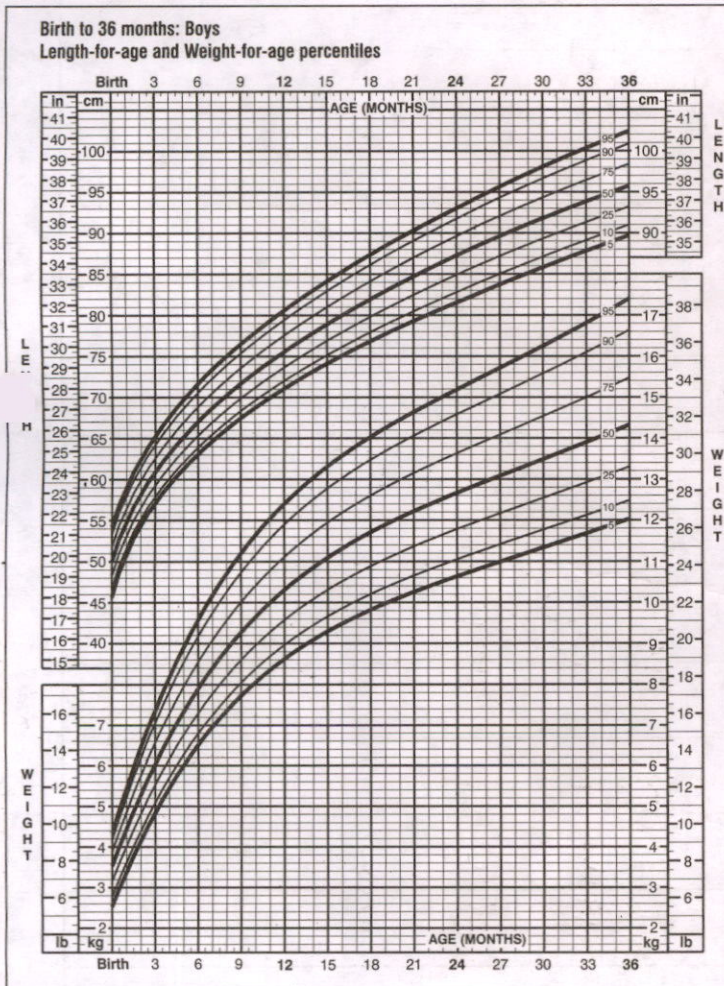
Food Allergies: No Veg/Non-veg non-veg

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

[illegible]