CONSENT FOR ADMISSION IN PEDIATRIC INTENSIVE CARE UNIT

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Name: ..... HNH-00016559 IP26-00006839 Baby HANA PARVEZ BAIG 14-09-2025 0 Y 9 M 29 D (F) Dr. PRITESH NAGAR ..... Age: 9m Gender: Male ☐ Female ☑

UHID.No : .... Date: 13/7/26

I ..... S/o, D/o, W/o, ... hereby declare that our patient Master/Baby ..... who is related to me as .....

is getting admitted in the Pediatric Intensive Care Unit of Rainbow Children's Hospital on .....

The doctors have explained to me in a language understood by me that my child has following health related issues :

..... Paracetamol overdose - risk of liver injury .....

.....

.....

The doctors have clearly explained to me that my patient Master / Baby ..... during his / her stay in the Pediatric Intensive Care Unit may undergo various medical and surgical procedures like airway management, mechanical ventilation, Central Line Insertion, Peripherally Inserted Central Catheter Line and arterial line placements, chest drain, or peritoneal drain insertion etc.

I have been told by the doctors that while performing such procedures I will be informed and a separate consent for this procedure shall be taken. However, in case of any life threatening emergency if the time is not available for taking informed consent it is implied that I give consent for various invasive procedure to save the life of my child.

I understand that a sick child in Pediatric Intensive Care Unit has life threatening medical conditions.

I understand that when a child is sick in the Pediatric Intensive Care Unit with multiple medical and surgical procedures performed upon him/her, there are inherent risks due to these high risk procedures, and high risk medications, in the form of infections, bleeding, air leaks, skin and other tissue damage etc.

I give my consent to the team of doctors to go ahead and admit the child Master / Baby : .... in the Pediatric Intensive Care Unit fully understanding the associated risk, benefits and alternatives involved from various procedures, high risk medications and infections in the Pediatric Intensive Care Unit and treat him/her with all necessary means.

The doctors have explained to me in the language best understood to me.

Patient Attendant :

Signature: .....

Name: .....

Relationship with Patient: .....

Date & Time: .....

Witness :

Signature: .....

Name: .....

Date & Time: .....

Doctor (who is taking the consent) :

Signature: .....

Name: Dr. Praveen

Date & Time: 13/7/26

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RESULT SHEET

Date	13/7/26					
Time	9°.12Pm					
Hb	11.4					
PCV	33.2					
RBC	4.63					
WBC	21.52					
N/L	56.9/36.5					
Platelets	512					
CRP	38					
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP	224					
SGPT	20					
SGOT	39					
T.Bill/Conj	0.7/0.3					
T.Protein	7.9					
S.Albumin	4.7					
S.Globulin	3.1					
A/G Ratio	3.1					
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

(P.T.O)

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones	Present					
CUE - PUS Cells	4-6					
CUE - RBC Cells	NILL					
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

Rainbow Children's Hospital

BirthRight by Rainbow

Rainbow Childrens Hospital-Himayatnagar

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

ADMISSION SHEET

Registration Details :

Admission No : IP26-00006839 **Admit Date** : 13-Jul-2026 **Admit Time** : 08:06 PM **UHID** : HNH-00016559

Patient Details :

Patient Name	: Baby HANA PARVEZ BAIG	**Age**	: 0 Y 9 M 29 D
Guardian	: Mr MIRZA PARVEZ BAIG	**DOB**	: 14-09-2025 01:00 AM
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: 5-4-85/f/10/3, tayyab nagar Mahabubnagar Mahabubnagar Telangana INDIA 509001	**Phone No**	: 9100776228
		E-mail	: zohakhan572@gmail.com

Admission Details :

Bed Type : DAY CARE **Bed No** : ER04 **Ward Name** : GF -EMERGENCY

Room No : ER04 **Admission Type** : First Visit

Contact Details :

Name : Mr MIRZA PARVEZ BAIG **Relationship** : Father

Contact Address : 5-4-85/f/10/3, tayyab nagar Mahabubnagar Mahabubnagar Telangana INDIA 509001 **Phone No** : 9100776228

Signature

Doctor Details :

Doctor Name : Dr. PRITESH NAGAR **Specialisation** : PEDIATRIC INTENSIVE CARE

Referral Doctor : Self. **Phone No** :

Co-Consultant :

Payment Details :

Payment Mode : DC/CC Card **Deposit Amount** : 10000.00

Payor Name : CARE HEALTH INSURANCE LIMITED

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ACTIVITY RECORD FOR BILLING

Name: -- HNH-00016559 IP26-00006839
Baby HANA PARVEZ BAIG
UHID No : 14-09-2025 0 Y 9 M 29 D (F)
Dr. PRITESH NAGAR

---------- Consultant : ---------- Dept : ----------

Date of A e : ---------- Date of Discharge : ---------- Time: ----------

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
17/	9 PM	ER	PICU	

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Sign
13/7/26	CBP. CRP	11668	
	VBG VRBS (89) mg	11667	
	(Respiratory Panel)	11668	
	LFT ..	11668	
13/7/26	CUE	11670	

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
13/7	invasive monitor			13586	
	infusion pump	9pm			[illegible]

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
13/7/26	IV placement	1	13511	Ashish
14/7/26	NHA	1	13684	Ravi

ANY OTHER INFORMATION

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

Ref.No. F/IN/PR/10

Rainbow® Children's Hospital

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name : Baby HANA PARVEZ

Patient ID# : HNH-00016559 IP26-00006839
Baby HANA PARVEZ BAIG
14-09-2025 0 Y 9 M 29 D (F)
Dr. PRITESH NAGAR

Consultant : Dr. Pritesh

Final Diagnosis :

Pediatric Multiorgan History & Physical Examination

Name : HAWA PARVEZ Age/Sex Female, 9m

Informant Mother. Reliability Good.

Chief Presenting Complaints & Duration (Chronologically):

c/o - Fever x 2 days
- Cold x 3-4 days.
- Vomiting 1 episode yesterday.
- A/H/O PARACETAMOL OVERDOSE - from yesterday 9pm. at home.

History of present illness :

A 9m old Girl presented with complaints of Fever - high grade
- intermittent
- no L/O travel, w/o outside food.
- no Family H/O

cold a/w running nose, nose block
noisy breathing x 3-4 days.

Vomiting 1 episode content - food/milk
after giving syrup - small quantity

Took PARACETAMOL DROPS (100 mg/ml) 3ml twice, last night
FEPANIL 250mg 1.5ml 2 doses.

↓

120 mg/kg (Toxic dose).

Oral intake fair

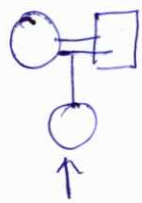
Urine output - Good.

Pediatric Multiorgan History & Physical Examination

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

Birth & Neonatal History :

33 weeks | LSCS | ? TTNB → H/O x 4 days
(leak PV) | NNJ+ NICU admission (On Ventilator)
↓
On PTx



Birth & Socio Economic History :

About Father :

About Mother :

Any additional Information :

Developmental History :

Wave Bye Bye up to date

Immunization History :

last vaccine at 8 months. at Saudi Arabia
↓
Document ?

Pediatric Multiorgan History & Physical Examination

Anthropometry

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

Weight (kgs) 7.62 (Centile _____)

On Examination :

Temperature : Afebrile Pulse Rate: 180/min Description _____

B.P. _____ SPO2 98% on RA at _____

Resp. rate and type of breathing : 43/min

Rash no Signs of dehydration +

Lymphadenopathy no irritable

Oedema : no

Respiratory system :

Inspection (any s/o distress) : (N) shape, stridor occasionally +

Air entry & breath sounds : NVBS+, BILAE+

Any addes sounds : stridor +, conducted sounds +

Relevant data from outside (Chest X-Ray, ABG, etc.,) no.

Cardiovasclular System :

Inspection of procordium : (N) shape

Heart Sounds : $S_1 S_2$ +

Any murmur : no

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

Per Abdomen :

Inspection ~~soft~~ (N) shape

Palpation : soft, Non-tender, no hepatosplenomegaly

Ausculation : BS+

Spine: N External Genitelia : N

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

Pediatric Multiorgan History & Physical Examination

Central Nervous System :

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

Cranial Nerves : WNL

Motor System :

Nutrition :

Tone : Power

Co-ordinator :

Posture : WNL

Involuntary Movements :

Reflexes :

DTR **Superficials :**

Plantars

Sensory System : WNL.

Bladder / Bowel :

Clinical Summary & Diagnostic :

AFI ⊂ dehydration
? VIRAL PYREXIA
PARACETAMOL POISONING

Preventive aspects of the treatment :

Desired goals of the treatment :

Planned Labs :

CBC, CRP, LFT, Respiratory panel, CUE, VBG, GRBS - 89(mg/dl)

NB Jyoti

Planned Management :

NO PARACETAMOL !!

SOS IBUGESIC only

NAC

~~IVfluids~~/DBF

NB Jyoti

Please fill up the following details

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

Doctor's Signature Name Date Time

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
14/7/26	c/s/B - Dr. Prashanti / Dr Pranav.	
12:50 AM	Δ - AFI c̄ dehydration PARACETAMOL OVERDOSE (120 mg/kg)	
		WBC - 22 N - 56.9%
	Fever - No Passing urine Activity - intermittent irritability	Plan - Trace CRP LFT Respiratory panel
	O/E HR - 201 RR - 37/min SpO2 - 100% on RA CFT < 3 sec	- Continue NAC as per chart - Decide about Abs > CRP [signature]
	S/E P/A - Soft, nontender, no hsm, distention+ CNS - WNL CVS - S1S2+, No murmurs RS -	Noted by [signature]

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

(P.T.O)

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
14/7 6 Am	C/S/B Dr- Pranav / Dr Prashanth	
	D - AFI c̄ dehydration	
	Paracetamol overdose	
	1 Episode Vomiting	
		Plan
	Fever - 102°F	
	Urine } Passed	
	Stool	-> Cont NAC
		-> Add Neb c̄ Levolin
	O/E	
		-> Add Inj [illegible]
	HR - 132/min	
	RR - 34/m	-> Cd - Nasal drops
	SpO_2 - 96%	
		-> Monitor Vitals
	S/E : Noisy breathing - Stridor	-> Trace Respiratory Panel
	Mild SCR (+)	
	R.S - B/L AE (+)	Pranav
	occ Wheeze (+)	
	Conducted Sounds (+)	

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

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
14/7 9Am	C/B/B Dr. Pritesh Sir	
	Acute Febrile Illness c Delay starts	
	Fever (+) - 102°F @ 2A	
	Snoring (+)	Plan
		1) Send S Vim Panel
	S Friday	
		2) CT - NAC -
	Vital	3) Inj Amoxyclav
	HR - 152/m	
	SpO_2 - 96 %	4) Nasal drops
	RR - 46/m	
		5) Repeat LFT after 48h
	R.S - B/L AE (+)	
	conducted sound	6) Do not give Paracetamol
	PA - Soft.	
		7) Monitor Vitals
		After NAC - Stop it

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9:30am 13/07/26	Counselled Blood - Infection WBC ↑↑ CRP ↑↑ ↓ antb Start ✓ Adenovirus → Swab test → T/M Sounds → laryngomalacia → chest ok O_2 Sat ok ✓ NAC → evening complete → Room shift ↓ 2 Reaction Risk ✓ MW 1	Umama Ayub

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DRUG CHART

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

FOR THE SAFETY OF THE PATIENT

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

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

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

SOS / PRN (As Required Medication)

DRUG : Syp IBUGESIC				Date ▸ / Time	14/7
Dose	Route	Frequency	Start Date		2AM ✓
2ml	PO	BD	7/6		✓
Doctor's Signature	Valid Period	Pharm.			10AM ✓
Prati					
Additional Instructions: (100mg/5ml)					

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

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

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REGULAR PRESCRIPTIONS

Weight. 7.6 kg. Ward. .....

DRUG : NASIVION mini N/D Baby

Dose	Route	Frequency	Start Date
1	both Nostrils	BD	14/7

Name & Signature of the Doctor Starting the Drugs: Dr. Prashanth

Additional Instructions:

Date → / Time ↓	13/7	14/7
	10AM	✓
	10PM	2AM ✓

Daily Doctor's Endorsement by a Sign

DRUG : Nasoclear N/D

Dose	Route	Frequency	Start Date
1	Both nostrils	QID	14/7

Name & Signature of the Doctor Starting the Drugs: Dr. Prashanth

Additional Instructions:

Date → / Time ↓	13/7	14/7
	6AM	✓
	12PM	✓
	6PM	✓
	12AM	✓

Daily Doctor's Endorsement by a Sign

DRUG : Inj AMOXICILLIN + CLAVULANIC

Dose	Route	Frequency	Start Date
250mg	IV	TID	14/7

Name & Signature of the Doctor Starting the Drugs: Pranav

Additional Instructions: 100mg/kg/day

Date → / Time ↓	14/7
6AM	✓
2PM	
10PM	

Daily Doctor's Endorsement by a Sign

DRUG : NEB ~ LEVOLIN

Dose	Route	Frequency	Start Date
0.3ml	NEB	6th hly	14/7

Name & Signature of the Doctor Starting the Drugs: Pranav

Additional Instructions:

Date → / Time ↓	
	check
	See the

Daily Doctor's Endorsement by a Sign

HNH-00016559 IP26-00008839
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14-09-2025 0 Y 9 M 29 D (F)
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Weight. ..... Ward. .....

	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.	

Signature .....

VERIFIED BY : Nam

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses

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I.V. FLUIDS CHART

Weight. 7.6 kg Ward. ....

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
13/7/26	10.30 pm	Inj. NAC 1.4 g + 100 ml of 5% DNS ↓	IV	25 ml/hr over 4 hrs	Ruth	[signature] [signature]	14/7		[signature] [signature]
14/7/26	3 AM	Inj. NAC 250 5% 750 mg + ml DNS	IV	over next 16 hrs	Ruth	[signature] [signature]			

VERIFIED BY : Name .... Signature ....

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NURSING SHIFT HAND OVER FORM - WARD

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

SITUATION	Diagnosis: AFI c dehydration. Paracitamol over dose	Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
BACKGROUND	Area / Shift Time	13/7 N1	14/7/26 M5				
	Medical Condition (Any special condition to be noted):	Paracetamol poisoining	paracetamol poisoning				
ASSESSMENT	Allergy:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:	98.5°F	99.9°F				
	Res:	40b/m	40b/m				
	SpO_2:	99%	98%b/m				
	Pulse:	112b/m	129b/m				
	BP:	—	—				
	Fall Risk Score:	—	—				
	Pain Score:	—	—				
Recommendations	Safety Needs:	—	—				
	Physiotherapy	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:	—	—				
	Special Diet:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:	NA	NA				
Post Operative Procedure Special Orders:		NA	NA				
Handed Over By Name :		Sunitha	Ramya				
Signature :							
Date:		13/7/26	14/7/26				
Time:		8AM	8pm				
Taken Over By Name :		Ramya					
Signature :							
Date:		14/7/26					
Time:		8 Pm					

Patient Sticker

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NURSING SHIFT HAND OVER FORM - WARD

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

SITUATION	Diagnosis:	Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
BACKGROUND	Area / Shift Time						
	Medical Condition (Any special condition to be noted):						
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:						
	Res:						
	SpO_2:						
	Pulse:						
	BP:						
	Fall Risk Score:						
	Pain Score:						
Recommendations	Safety Needs:						
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:						
	Special Diet:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:						
Post Operative Procedure Special Orders:							
Handed Over By Name :							
Signature :							
Date:							
Time:							
Taken Over By Name :							
Signature :							
Date:							
Time:							

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PAIN ASSESSMENT FORM

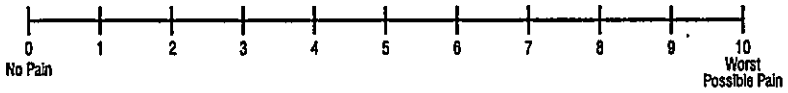
Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
13/7	10Pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	NA	[signature]
13/7	5AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	NA	[signature]
14/7/26	11AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
14/7/26	5pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
				☐ 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		
				☐ 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:

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

PAIN ASSESSMENT TOOLS

Numerical Pain Scale (Obstetric and Gynecology)



Wong - Baker (Pediatrics) Above 7 Years

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
	0	1	2
Face	No Particular expression or smile	Occasional Grimace or Frown, withdraw, Disoriented	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs drawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, 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

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, SaO_2	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

HNH-00016559 IP26-00006839
Baby HANA PARVEZ BAIG
14-09-2025 0 Y 9 M 29 D (F)
Dr. PRITESH NAGAR

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CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1 13/7			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0			0	0	0					
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1			NA	NA	NA					
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2			NA	NA	NA					
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3			NA	NA	NA					
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4			NA	NA	NA					
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5			NA	NA	NA					
			Signature of the Nurse										

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

Signature of Shift In Charge :

Signature : ..... Name : .....

Signature of Ward In Charge :

Signature : ..... Name : .....

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THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE 13/7	DATE 14/7	DATE	DATE	DATE
Age	Less than 3 years old	4	✓	✓			
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2					
	Female	1	✓	✓			
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	✓	✓			
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own ability	1					
	History of Falls or Infant-Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2					
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2	✓	✓			
	More than 48 hours/ None	1					
Medication Usage	Sedatives (Excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	✓	✓			
	Total		9	9			

Intervention: -Fall Risk: Low Humpty Dumpty Score = 7-11, High Risk Humpty Dumpty Score = 12 or above

	Bed in low position		✓	✓			
	Call device within reach		✓	✓			
	Wheels Locked		✓	✓			
	Room free of clutter		✓	✓			
	Adequate lighting		✓	—			
	Wheel chair support		✓	—			
	Other Intervention(s) Specify		✓	—			
	Nurse's Name:		Sumitra	Ranjan			
	Signature:		[signature]	[signature]			
	Date:		14/7	14/7			
	Time:		8AM	8pm			

Docu. No. : RCH /FRM / CLINICAL / 005

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00016559 IP26-00006839 Baby HANA PARVEZ BAIG 14-09-2025 0 Y 9 M 29 D (F) Dr. PRITESH NAGAR	13/7/26 @ 8.06 PM	13/7/26 @ 9 PM
	Transfer Ordered by Dr. Prasanth	Reason for Transfer Admission
From Unit ER	To Unit PICU	Information to Attendant Yes ☐ No ☐
Number of Sheets in Clinical File 95	Number of Imaging Films VB	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.		
2.		
3.		
4.		
5.		

Shifting Summary / Notes Written by Doctor : Yes ☐ No ☐

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Siss Iyer	Dr. Prasanth

Patient & Clinical Records Received by : Suriya

Date & Time of Patient Received : 13/7/26 at 9.30 pm

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

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

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EMERGENCY ROOM TRIAGE FORM

Patient's Name : Baby Hana Parvez Baig Age : 9m Gender: ☐ Male ☑ Female

Date : 13/7/26 Time of Arrival : 7:40pm.

Allergies: ☑ No ☐ Yes ☐ Food ☐ Medications ☐ Blood Transfusion ☐ Other (Specify): .... ☐ Not known

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

Mode of Arrival : ☐ Ambulatory ☐ Wheelchair ☐ Ambulance

Initial Vital Signs: Temp: 98.6 F PR: 1........ BP: .... RR: .... SpO_2: 99%

Chief Complaints: c/o fever since x2 ds, [illegible], vomiting 3 times.

INITIAL PHYSIOLOGICAL CATEGORIZATION	INITIAL PHYSIOLOGICAL STATUS
Appearance: ☑ Normal ☐ Sick Looking Circulation / Colour: ☑ Normal ☐ Abnormal ☐ Bleeding Work of Breathing: ☑ Normal ☐ Increased ☐ Decreased ☐ Gasping / Apnea	☑ Stable ☐ Unstable : ☐ Not – Life - Threatening ☐ Life – Threatening

Triage Classification	CTAS
☐ Level 1 : Resuscitation	☐ Immediate
☐ Level 2 : EMERGENT : Life or limb threatening	☐ < 15 min
☐ Level 3 : URGENT : Significant illness / injury with potential to become life or limb threatening	☑ 30 min
☐ Level 4 : LESS URGENT : Significant illness but not life threatening	☐ 60 min
☐ Level 5 : NON – URGENT : May receive care when convenient	☐ 120 min

NOTE : All immunocompromised children and preterm babies to be considered Level 2.
All Children less than 2 years age with high fever to be considered Level 3.

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian

Triage Completion Time : 7:42pm

Communicable Disease Triage Screening

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

1. Have you had fever (elevated temperature) in the past 2 weeks ☐ Yes ☑ No
2. Have you had cough or a rash in the past 2 weeks ☐ Yes ☑ No
3. Have you had shortness of breath or difficulty breathing in the past 2 weeks ☐ Yes ☑ No

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

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

   If yes, State Location: ....

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

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

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

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

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

Name of Triage Nurse : Atom

Signature of Triage Nurse : [signature]

Date & Time : 13/7/26 @ 7:44pm.

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

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 13/7/25 Time of arrival : 7246 pm

Chief Complaints: C/O fever since x2 days x vomiting 3 times RBS: .....

Height : ..... Weight : 7.6 kg BMI : ..... Head Circumference (<2 years) .....

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

If yes , identify .....

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

☐ Character N/A ☐ Location — ☐ Frequency ..... ☐ Duration .....

RISK FOR FALL:

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

☐ If Patient is > 6 years
Assess the below parameters

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

Ambulatory Aids:

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

Gait/Transferring:

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

Mental Status: Forgets limitations ☐ Yes ☑ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening: ☑ No Abnormalities Detected

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

Inform consultant for positive criteria

.....

.....

Nutritional Screening: ☑ No Abnormalities Detected

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

Inform consultant for positive criteria

Psychological Screening: ☑ No Significant Findings

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

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

Social History: Lives With family

Siblings in household ☐ Yes ☑ No (if yes How Many?) N/A

Time of Initial assessment completed by ER Nurse : 7149 pm

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

Time	Nursing Notes
	-Assess the pt condn
	-monitor vitals
	-IV placement done
	-Sample collection

Samples collected by: } Arun
Samples sent by :

Time: } 9pm
Time:

Medication given in ER:

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

Condition of patient at time of shift - out :	**Details of Shift - out**
HR: 130 b/m BP: .... CFT:	Shift - out from ER to: 9 floor PICU
RR: .... SPO_2 : 100%	Time of Shift - out: 9pm
GCS: 15/15 Temperature : 98°F	Handover given to: ~ (Nurse's Name)
Pain Score: —	
Repeat RBS (if applicable): —	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any): IV placement done

Name of the Nurse : Syeni

Signature of the Nurse : [signature]

Date & Time : 13/7/26 @ 8pm

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MEDICATION RECONCILIATION FORM

Drug Allergies: ..... ☑ Not known any Drug Allergies

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

Shifting From: ER Shifted to: PICU

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						☐ C ☐ DC
2						☐ C ☐ DC
3						☐ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Prasanthi

Date & Time : 13/7/26 @ 8 pm

Nurse Name & Signature: Jyoti / AP

Date & Time : 13/7/26 @ 8 pm

Docu. No. : RCH / FRM / GENERAL / 090

Patient Sticker 9M

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NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 14/7/26 Time: 11 Am

Weight: 7.6 Centile: 40th

Height: 69.5 Cms Centile: —

Inference: underweight Child

RDA: — Calories: 98kcal/kg/d Protein: 1.6gms kg/d

Diet Recommendations: DBF feeding.

Re-Assesment: Stage (2) weaning foods & HCE advised

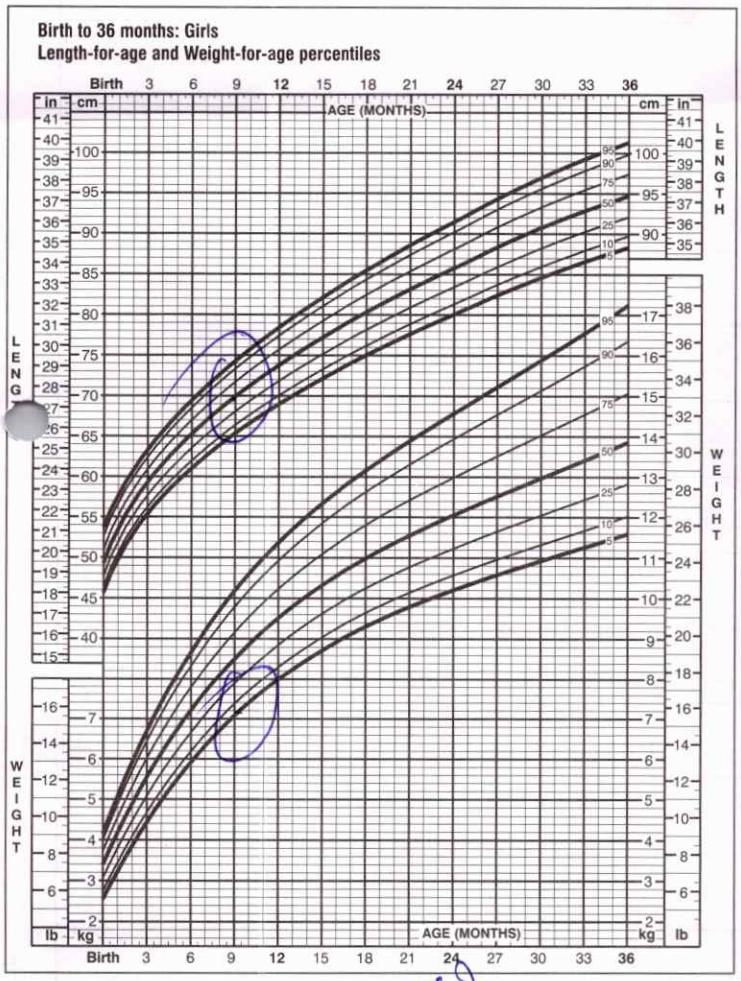
Food Allergies: NO Veg/Non-veg Non Veg

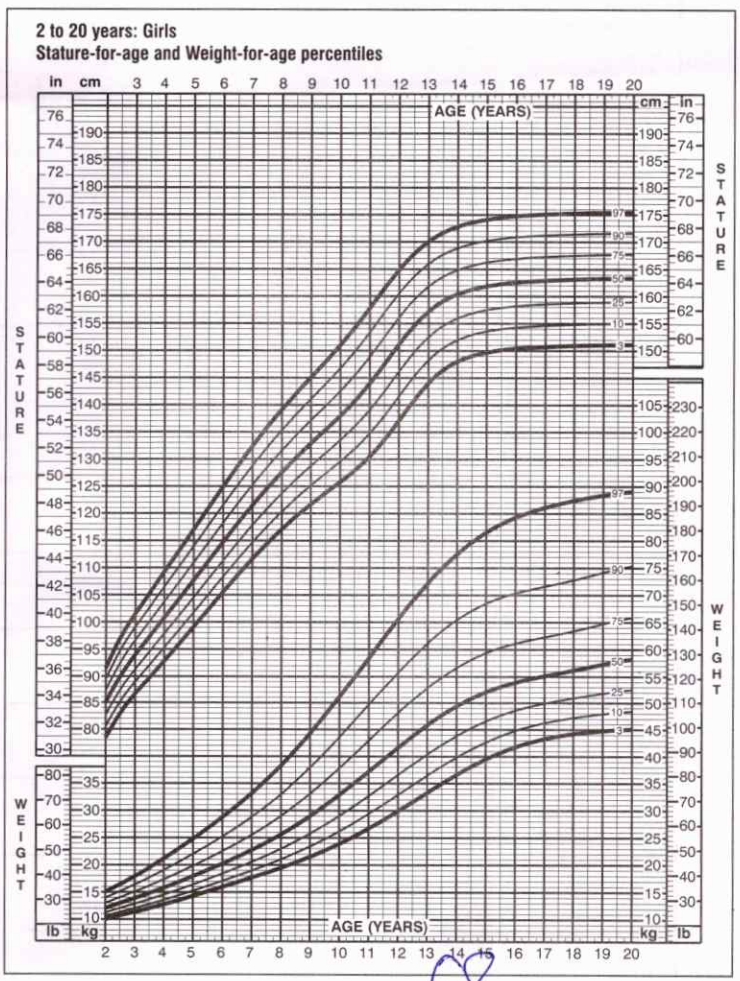
Diagnosis: AFI & Dehydration (paracetamol overdose)

Nutritional Intervention - ☑ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: Unreadable

GROWTH CHART (GIRLS)





Dietician's Name Sathwika-G Dietician's Signature