

BAH-00662196 IP5-00176668
Master AHAD SHRIF PATHAN
09-02-2022 4 Y 6 M 11 D (M)
Dr. RAMESH KONANKI

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

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ACTIVITY RECORD FOR BILLING

Name : _____

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

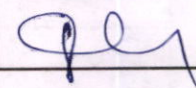
Date of Admission: _____ Time : _____ Date of Discharge : _____ Time: _____

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
20/7/26	7pm	ER	104	

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	Dr. Maian K deb	22/7/26	21716841	
2	Dr. Anwaraj reddy	23/7/26	21717121	
3				
4				
5				
6				
7				
8				
9				
10				

INVESTIGATIONS

[illegible]

MEDICAL EQUIPMENT (WARD & ICU)

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
22/07	iv placement	1	13033	Tenaf
22/7	NH+H	(1)	9716489	(MD)

ANY OTHER INFORMATION

Date : 23/07/16

Time : 12:00pm

Prepared By :

shantli

Staff Nurse

shantli

Shift / Ward

SPU T

Billing Assistant

Billing Supervisor

ADMISSION SHEET

Registration Details :



Admission No : IP5-00176668

Admit Date : 20-Jul-2026

Admit Time : 05:40 PM UHID : BAH-00662196

Patient Details :

Patient Name : Master AHAD SHARIF PATHAN

Age : 4 Y 5 M 11 D

Guardian : Mr SHRIF SHABBIR PATHAN

DOB : 09-02-2022

Gender : Male

Religion :

Occupation :

Marital Status : Single

Address (H) : AT POST ANSAR NAGAR Latur H O Latur
Maharashtra INDIA 413512

Phone No : 9923582100/ 9923902691

E-mail : NOMAIL@GMAIL.COM

Admission Details :

Bed Type : SEMI PRIVATE

Bed No : SPVT 104

Ward Name : 1F-VIBGYOR

Room No : SPVT 104

Admission Type : First Visit

Contact Details :

Name : Mr SHRIF SHABBIR PATHAN

Relationship : Father

Contact Address : AT POST ANSAR NAGAR Latur H O Latur
Maharashtra INDIA 413512

Phone No : 9923582100


Signature

Doctor Details :

Doctor Name : Dr. RAMESH KONANKI

Specialisation : PEDIATRIC NEUROLOGY

Referral Doctor : Self

Phone No :

Co-Consultant : Dr. KAPIL BHAGWATRAO SACHANE

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : SELFPAY



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PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name:

Ahmad

UHID ID:

Department:

Consultant:

BAH-00662196 IP5-00176668
Master AHAD SHRIF PATHAN
09-02-2022 4 Y 5 M 11 D (M)
Dr. RAMESH KONANKI




History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

① H/o Fall on ground (frequently) since 11 days ago.

↓
3-4 times/day.

later - admitted in outside hospital.

For unable to walk properly, unable to stand, fever.

Stuttering of speech since 3-4 days.

History of present illness :

Child was investigated outside MRI Brain → NO significant abn.

NO Evidence of focal pericystic

Child diagnosed as post infectious Acute Cerebellar ataxia /
Cerebellitis & admitted for 5 days.

Given → Inj Ceftriaxone, Inj MPS, Inj Aciclovir, Inj Kel, IV fluids.

Child condition not improved, hence brought to our hospital
for further management

12/7/26

CBP = 12.4 $\times$ 6800 $\times$ 3.12
37.7 46/42

CRP = 12.48

CRP = 53.6

S. Elect → 138 / 8.2 / 1.

S. Cel = 1.26 (1.09 - 1.80 - (N))

8/7

CSF Gluc = 61

Pro = 16

Cells = 60

CRP = 40.15

10/7/26: CRP = 12.56

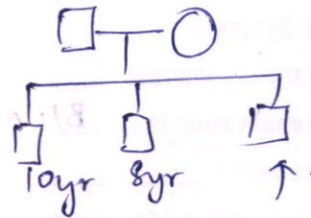
CBP = 12.5 $\times$ 7500 $\times$ 2.971
38.6 44/47

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

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

Birth & Neonatal History:

F7~~10~~ / 3kg / LSCS / NO H/O NICU stay



Birth & Socio Economic History:

About Father : _____
About Mother : _____
Any additional Information : _____

Developmental History :

④ ~~develop~~

Immunization History :

vaccination - ^{Only} Birth vaccine given, later not given

(P.T.O.)

(Opsoclonus - Myoclonus
Ataxic syndrome)

(P.T.O.)



Pediatric Multiorgan History & Physical Examination



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: _____

Desired goals of the treatment : _____

Planned Labs:

1 EDTA

3 plain

12/20/2022

(MRI Brain done on OPD basis.)

Planned Management

- Admit in ward
- Ij Metoprolol
- Ij Esomeprazole

Signature of the Doctor: Ramya

Name of the Doctor: Dr. Ramya

Date & Time: 20/7/26 6pm

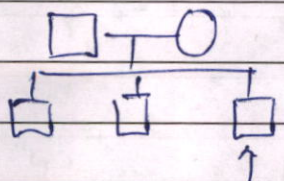
Signature of the Consultant: WA

Name of the Consultant: _____

Date & Time: _____



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
21/7/26 8:30 AM	C/O/B Newsteams Development - (N)  ↓ C/O difficulty in walking @ 11 days ↳ a/w frequent falls - gradually progressive ↳ a/w swaying → Biggi - Unable to stand → a/w scanning speech (+) O/E: Child conscious: No neurocutaneous markers HMF - (N) Ophthal - (L) Convergent squint (+) B/L pupils normal size reacting to light DOM - full Tone - $\frac{N}{N} / \frac{N}{N}$ power - $\frac{4-5}{4-5} / \frac{4-5}{4-5}$ Cerebellar signs: Intentional tremors (+) finger nose test → past pointing (+) truncal ataxia (+) Rombergs (+) Knee heel test (+) ? mild torsional component in nystagmus - to reassess (P.T.O)	H/o Varicella (all family members) → Aug 2025

Date & Time	Progress Notes	Doctor's Order
21/1/26 6:30 pm	<u>C/S/B Neurology:</u> → No fresh complaints <u>O/E:</u> Child conscious Afebrile EOM - full B/L pupils NSRL. Cerebellar signs (+) Vitals - stable	<u>Adv</u> 1) Whole Body PET-CT tomorrow. 2) Continue IVMP. 3) PAC → To decide on IVF. 4) W/f vitals <u>A.B. Nikita.</u>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/4 9am	C/S/B Neuroteam	
	? Post-infectious Acute Onset Cerebellar Syndrome ? post infectious cerebellar ataxia ? Evolving OMAS	
	<u>Issues:</u> No progression of symptoms	
	<u>O/E:</u> HMF-(N) No CN abnormality Tone - hypotonia Power: 4-5 in all 4 limbs <u>Cerebellar Signs:</u>	
	① Gaze evoked nystagmus (+) → towards end gaze. ② Intentional tremors (+) for Dysmetria (+) Truncal ataxia (+) pendular knee jerk (+)	
	PET-CT] Report awaited No Organomegaly	<u>Adl</u> ① continue IVMP - Dz. ② Trace PET-CT



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/7/26 5pm	C/S/B Dr - Kapil 1:- Acute Onset Cerebellar Syndrome ? Post infectious child conscious alert Vital - stable	Plan 1) Trace PET-CT. 2) Continue IVMP - D ₃ .
22/7/26 6pm	C/S/B Neuroteam Metastatic Neuroblastoma c/o OMAS. No progression of symptoms. Issues: HMF - (N) vitals stable Cerebellar signs (+) No progression of symptoms (+)	IVMP - D ₃ M1 ① PAC ② Hematologist Opinion ③ w/f vitals ↳ BP, HR monitoring. ④ financial counselling, plan for Sp.



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RESULT SHEET

Date						
Time						
Hb						
PCV						
RBC						
WBC						
N/L						
Platelets						
CRP						
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

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

Culture and Sensitivities :

.....

.....

.....

Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI

 Others (ECG, Contrast Studies etc..) :



CROSS CONSULTATION FORM

Doctor Name : Dr. Anurag Reddy Date : 23/07/26 Time : 11:00 AM

Diagnosis :

Hospital :

Type of Referral :

- ☐ Emergency
☐ Urgent
☐ Non Urgent

Referred for : ☐ Opinion ☐ Co-Management ☐ Transfer of care

Reason for Referral : If for concurrent care specify the particular need, especially in the absence of a second diagnosis:

Signature:

Findings and Recommendations :

23/7/2026
11 AM

Dr. Anurag Reddy

- Many thanks for reference
- history noted

PBT: suggestive
of supracard
tumours

AOMAS - ? likely neuroblastoma

o/b's vitally stable

ref / was

- Adh
- biopsy / examination
 - family to be counselled.

Consultant :

Name : Dr. Anurag Reddy Signature : [Signature] Date & Time : 23/7/2026 11 AM



CROSS CONSULTATION FORM

Doctor Name : Dr. Mainak Deb Date : 22/7/26 Time : 5:15 pm

Diagnosis :

Hospital :

Type of Referral :

- ☐ Emergency
☐ Urgent
☐ Non Urgent

Referred for : ☐ Opinion ☐ Co-Management ☐ Transfer of care

Reason for Referral : If for concurrent care specify the particular need, especially in the absence of a second diagnosis:

Signature:

Findings and Recommendations :

C/S/B Dr. Mainak Deb

C/O difficulty in walking since 11 days
Intentional tremors (+) on evaluation,

PET CT - s/o
suprarenal
tumor.
→ clinically
s/o opsoclonus myoclonus
syndrome.

P/A - patient not
cooperative.

Adv :

- plan for laparotomy + tumor
excision.
- Reserve 1 @ PRBC
- PAC
- Financial clearance.

Consultant :

Name : Dr. Mainak Deb Signature : [Signature] Date & Time : 22/7/26 5:15 pm

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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: 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						☐ 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. Ramesh

Date & Time: 20/7/26; 6:30pm

Nurse Name & Signature: Susmita

Date & Time: 20/7/26 @ 6:30pm



Moderate Sedation Flow-Sheet

Immediate Pre-Sedation Assessment

B.P	PR	R.R	Temp	SPO ₂	Pain Score	Weight
96/54	112	22	Afebrile	100%		15.8 kgs

Diagnosis: Cerebellar ataxia / Myoclonus ? post infection

Procedure: PET CT whole body

Comorbidities: nil

☒ Risk, benefits & alternatives discussed;
☒ Patient understand & elects to proceed
☒ Consents for procedure and sedation signed and dated

ASA Physical Status

☐ ASA PS 1: Healthy Patient
☒ ASA PS 2: Mild Systemic Disease, no functional limitations
☐ ASA PS 3: Severe Systemic Disease, functional limitations
☐ ASA PS 4: Severe Systemic Disease, constant threat to life
☐ ASA PS 5: Moribund Patient unlikely to survive 24 hrs.
☐ ASA PS 6: A declared braindead patient whose organs are being removed for donor purposes

☐ E: Emergency procedure

GCS: E M V 15/15

☒ IV Site: Gauge: @ UL 22g

Sedation Plan: MAC + drugs

Allergies: nil

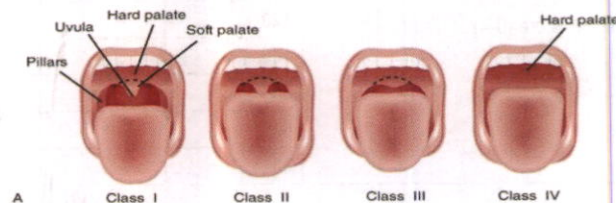
AIRWAY EVALUATION

Mouth:

- ☒ Normal
☐ Loose Teeth
☐ Small Mouth
☐ Protruding Incisors
☐ Receding Lower Jaw
☐ Dentures

Neck:

- ☒ Normal
☐ Decreased ROM
☐ Thyromental Distance Less Than 6 cm
☐ Short Neck



Mallampati Class: ☒ I ☐ II ☐ III ☐ IV

Monitoring of Patient Intra – Procedure

Procedure Monitoring

Heart Rate (HR), Respiratory Rate (RR), Oxygen Saturation (O₂ Sat) continuously monitored, and Level of Consciousness (LoC) to be monitored and recorded minimally every 15 minutes until 15 minutes after the last administration of any sedation, then every 30 minutes, then every 1 hour until stable. Respiratory status to be monitored continuously.

Level of Consciousness (LOC):

- ☐ A - Alert
☐ V - Verbally Responsive
☒ P - Painfully Responsive
☐ U - Unresponsive

Observation to be documented every 15 mins

TIME	BP	PR	RR	O ₂ Sat%	O ₂ Supplementation	Comments / Initials
Baseline	CRT					
9:30AM	<3 sec	56	14	100%	Via facemask	
9:45	<3 sec	62	14	100%	@ 5L/min	
10:00	<3 sec	60	14	100%	"	

DRUG & IV Fluid: (including Nitrous Oxide)	ROUTE	DOSE	TIME GIVEN	SUBSEQUENT DOSES AND TIME
Inj. MIDAZOLAM	0.6mg	IV	9:40AM	/
Inj. PROPOFOL	30mg	IV	9:40AM	/

Doctor Notes: uneventful

Time of transportation to post sedation care room: 10:10AM LOC: _____

Doctor Name: Dr. Arshad K Signature: (Signature)

Post Sedation Care Room 10:10AM 1030 1100 1130

Time																			
Monitoring	180																		
ECG NBP Oximeter	160																		
Pain Score (0-10)	140																		
Sedation Score (0-4)	120																		
	100																		
	80																		
	60																		
	40																		

TOTAL ALDRETTE SCORE AT DISCHARGE = 10/10
(If 9 and more patient can discharge from post Sedation care unit)

Activity :	Consciousness:	Respiration:	Oxygen Saturation:	Circulation:
Four extremities = 2	Fully awake = 2	Breathe Deep = 2	Sat O ₂ > 92 % on room air = 2	BP +/- 20 mm hg of pre-op = 2
Two extremities = 1	Arousal on calling = 1	Dyspnea, limited breathing = 1	Needs oxygen to maintain Sat O ₂ > 90% = 1	BP +/- 20-50 mm hg of pre-op = 1
No extremities = 0	Unresponsive = 0	Apnea = 0	Saturation < 90% with oxygen = 0	Bp +/- 50 mm hg of Pre-Op = 0

Patient Discharge Time: _____

Nurse Name: _____

Signature: _____

Date: 22/1/26 Time: 11:30AM

Consultant Name: Dr. Arshad K

Signature: (Signature)

Stamp



CONSENT FOR PROCEDURAL SEDATION

Authorization By: ☐ Patient ☒ Patient Attendant

I, the undersigned do hereby acknowledge the following:

- I have been made aware by the doctors in language known to me the details of sedation planned for the procedure
PET CT whole body
- I have been made aware of the possible complications from the procedure of sedation as follows:
Changes in heart rate, blood pressure, need for oxygen supplementation, allergic reactions, upper airway obstruction, laryngospasm, conversion to general anaesthesia
- I have been made aware that the sedation is being advised to relieve pain and anxiety during the procedure. It will help me remain calm, comfortable, and cooperative, allowing the procedure to be performed smoothly and safely.
- I have been clearly explained about the benefits, risk, and alternative of the sedation which is General Anaesthesia.
- I authorize Dr. Akhil-K. and his / her team to perform the procedural sedation upon the patient / myself.
- I acknowledge that I fully understand the above information. I have had the opportunity to ask questions, and they have been answered to my satisfaction in a language I understand. I affirm that this consent is given by me in my full senses.

Patient / Patient Attendant:

Signature: [Signature]
Name: Shrif Pathan
Relationship with patient: Father
Date & Time: 22/2/26 8AM

Witness:

Signature: [Signature]
Name: Saima Pathan
Date & Time: 22/2/26 8AM

Doctor (who is taking consent):

Signature: [Signature] Name: Dr. Akhil-K. Date 22/2/26 Time: 8:00 AM

ప్రాసీజర్ సెడేషన్ కు అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

నేను, దిగువ సంతకం చేసిన వ్యక్తి, క్రింది విషయాలను అంగీకరిస్తున్నాను:

నాకు తెలిసిన భాషలో, వైద్యులు ఈ క్రింది ప్రాసీజర్ కు ఇచ్చే సెడేషన్ గురించి పూర్తి వివరాలు నాకు తెలిపారు:

- సెడేషన్ వల్ల సంభవించగల సాధ్యమైన క్రింది సమస్యలు/ప్రమాదాలు గురించి నాకు తెలిపారు: గుండె వేగం మారడం, రక్తపోటు మారడం, ఆక్సిజన్ అవసరం, అలర్జిక్ ప్రతిచర్యలు, ఎగువ శ్వాసనాళ అడ్డంకి, లాలింజోస్పాసమ్, జనరల్ అనస్థీషియాగా మారాల్సిన అవకాశం.
- ప్రాసీజర్ సమయంలో నొప్పి, భయం, ఆందోళన తగ్గించేందుకు సెడేషన్ ఇవ్వడం అవసరం అని నాకు వివరించారు. ఇది ప్రాసీజర్ సజావుగా, సురక్షితంగా జరగడానికి సహాయపడుతుంది.
- సెడేషన్ గురించి సంబంధించిన ప్రయోజనాలు, ప్రమాదాలు, ప్రత్యామ్నాయం (జనరల్ అనస్థీషియా) గురించి నాకు స్పష్టంగా వివరించారు.
- డాక్టర్ _____ గారిని మరియు వారి బృందాన్ని, రోగి/నాపై ఈ ప్రాసీజర్ సెడేషన్ చేయడానికి నేను అనుమతిస్తున్నాను.
- పై సమాచారాన్ని నేను పూర్తిగా అర్థం చేసుకున్నాను. నాకు ఉన్న ప్రశ్నలన్నీ, నాకు అర్థమయ్యే భాషలో సమాధానమిచ్చారు. ఈ అనుమతిని నేను పూర్తి జ్ఞానస్థితిలో స్వచ్ఛందంగా ఇస్తున్నానని ధృవీకరిస్తున్నాను.

రోగి / రోగి అటెండెంట్:

సాక్షి:

సంతకం:

సంతకం:

పేరు:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

తేదీ & సమయం:

డాక్టర్ :

సంతకం: పేరు: తేదీ & సమయం:



REQUEST FOR CREDIT FACILITY

To,
The Credit Billing,
Tenet Diagnostics,
Banjara Hills, Hyderabad.

Patient details:

BAH-00662196 IP5-00176668
Master AHAD SHRIF PATHAN
09-02-2022 4 Y 5 M 12 D (M)
Dr. RAMESH KONANKI



Dear Sir/Madam,

We are sending the above mentioned patient for the diagnostic test PET Scan Whole body
C Sedation in your diagnostic center on credit basis. Request
you to kindly do the needful. The bill will be settled by Rainbow Hospital, billing department as per the agreement. For
any further queries, please contact the billing manager.

Order ID: 5-0009714765

Thanking you,
Department of Inpatient Billing

Coordinator:

Signature: Sara

Name: Sara Bogan

Date & Time: 21/2/26 @ 5pm

Billing Executive:

Signature: A. Eddy

Name: A. Eddy

Date & Time: 21/2/26 @ 5pm

Mobile (Billing Manager): 9247505898

Manager on Duty (MOD): [Signature]

Signature: [Signature]

Name: M. Ramesh

Date & Time: 21/02/26 - 9:00 AM

Mobile: 9676838787

Docu. No: RCH/ FRM/ GENERAL/ 663

BAH-00662196 IP5-00176668
Master AHAD SHRIF PATHAN
09-02-2022 4 Y 5 M 13 D (M)
Dr. RAMESH KONANKI



BAH-00662196
Master AHAD SHRIF PATHAN
09-02-2022 4 Y 5 M 11 D
Dr. RAMESH KONANKI (M)

DRUG CHART

Date of Admission: 20/7/26. Drug Allergies: ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

- GENERAL** - Ensure that all patient details are entered above. ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.
- DOCTOR** - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
- Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
- Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
- Discontinue a drug by drawing a line **I** through it and a similar line through subsequent recording panels.
- The date and time of stopping the drug along with the doctors name and sign must be mentioned.
- Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.
- NURSES** - Nurses must follow strictly the FIVE RIGHTS before administration of medication.
1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time
- AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

SOS / PRN (As Required Medication)

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

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

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



REGULAR PRESCRIPTIONS

Weight. 15.9 kg Ward.

VERIFIED

DRUG : <u>Inj METHYL PREDNISOLONE</u>				Date Time
Dose <u>80mg</u>	Route <u>IV</u>	Frequency <u>OD</u>	Start Date <u>20/7/26</u>	
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Ramesh</u>				
Additional Instructions: <u>30mg/kg/dose IV 5 days.</u>				
Daily Doctor's Endorsement by a Sign				

DRUG : <u>Inj ESOMEPRAZOLE</u>				Date Time
Dose <u>16mg</u>	Route <u>IV</u>	Frequency <u>OD</u>	Start Date <u>20/7/26</u>	<u>21/7 22/7 23/7</u>
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Ramesh</u>				<u>21/7 22/7 23/7</u>
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

DRUG : <u>Inj METHYL PREDNISOLONE</u>				Date Time
Dose <u>480mg</u>	Route <u>IV</u>	Frequency <u>OD</u>	Start Date <u>20/7/26</u>	<u>21/7 22/7 23/7</u>
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Ramesh</u>				<u>21/7 22/7 23/7</u>
Additional Instructions: <u>30mg/kg/dose IV 5 days.</u>				
Daily Doctor's Endorsement by a Sign				

DRUG : <u>Inj METHYL PREDNISOLONE</u>				Date Time
Dose <u>500mg</u>	Route <u>IV</u>	Frequency <u>OD</u>	Start Date <u>21/7/26</u>	<u>21/7 22/7 23/7</u>
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Ramesh</u>				<u>21/7 22/7 23/7</u>
Additional Instructions: <u>20 mg/kg/dose</u>				
Daily Doctor's Endorsement by a Sign				

VERIFIED

Weight. 15.9 kg Ward.

Signature

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.	

VERIFIED BY: Name _____

[illegible]



I.V. FLUIDS CHART

Weight. 15.9 kg Ward.

[illegible]

* 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.
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- Detailed actions are described according to increasing Early Warning Score.
- Some children with complex medical needs e.g. cyanotic heart disease may require modification to their trigger thresholds/ action plan- this should follow discussion with senior colleagues.
- Any Early Warning Score of 3 or above should be recorded below with details of any subsequent action initiated

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

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B	BACK GROUND : Child (X) was admitted on (XX date) with (e.g. respiratory infection). They have had (X operation/ procedure/ investigation). Child (X)'s condition has changed in the last (XX mins). Their last set of observations were (XXX). The child's normal condition is ... (e.g. alert/ drowsy/ confused, pain free)
A	ASSESSMENT : I think the problem is (XXX) and I have ... (e.g. given O2/ analgesia, stopped the infusion), OR I am not sure what the problem is but child (X) is deteriorating, OR I don't know what's wrong but I am really worried.
R	RECOMMENDATION : I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 02/2	Time: 6:07	10 am	4 PM	6 PM	10 PM	2 PM
Doctor / Nurse / Family Concern?						
Temperature (F)	104					
	103					
	102					
	101					
	100					
	99					
Heart Rate (bpm)	190					
	180					
	170					
	160					
	150					
	140					
Blood Pressure (mmHg) *	130					
	120					
	110					
	100					
	90					
	80					
Note: BP does not score in early warning scoring	70					
	60					
	50					
	40					
	30					
	20					
Heart Rate (Number)	190					
	180					
	170					
	160					
	150					
	140					
Resp. Rate (bpm) (Over 1 Minute) *	70					
	60					
	50					
	40					
	30					
	20					
Resp Rate (Number)	70					
	60					
	50					
	40					
	30					
	20					
Resp Mod/ Severe Distress None / Mild	70					
	60					
	50					
	40					
	30					
	20					
Receiving O ₂ (l/min) O ₂ Saturations (%)	70					
	60					
	50					
	40					
	30					
	20					
Conscious Level Normal / Altered	70					
	60					
	50					
	40					
	30					
	20					
GCS *	70					
	60					
	50					
	40					
	30					
	20					
TOTAL SCORE	70					
	60					
	50					
	40					
	30					
	20					
Number of shaded boxes	70					
	60					
	50					
	40					
	30					
	20					
Pain Score	70					
	60					
	50					
	40					
	30					
	20					
Observer's Initials	70					
	60					
	50					
	40					
	30					
	20					

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.

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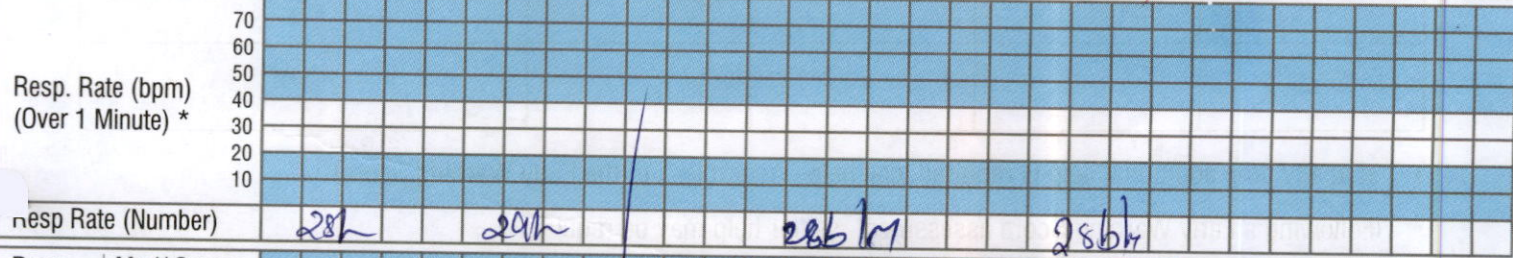
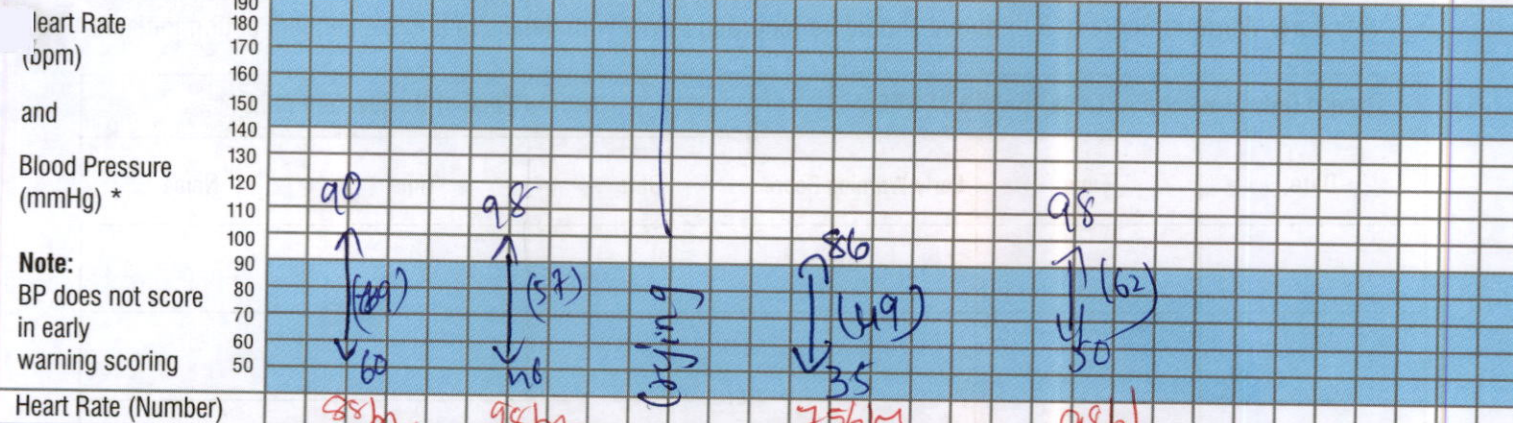
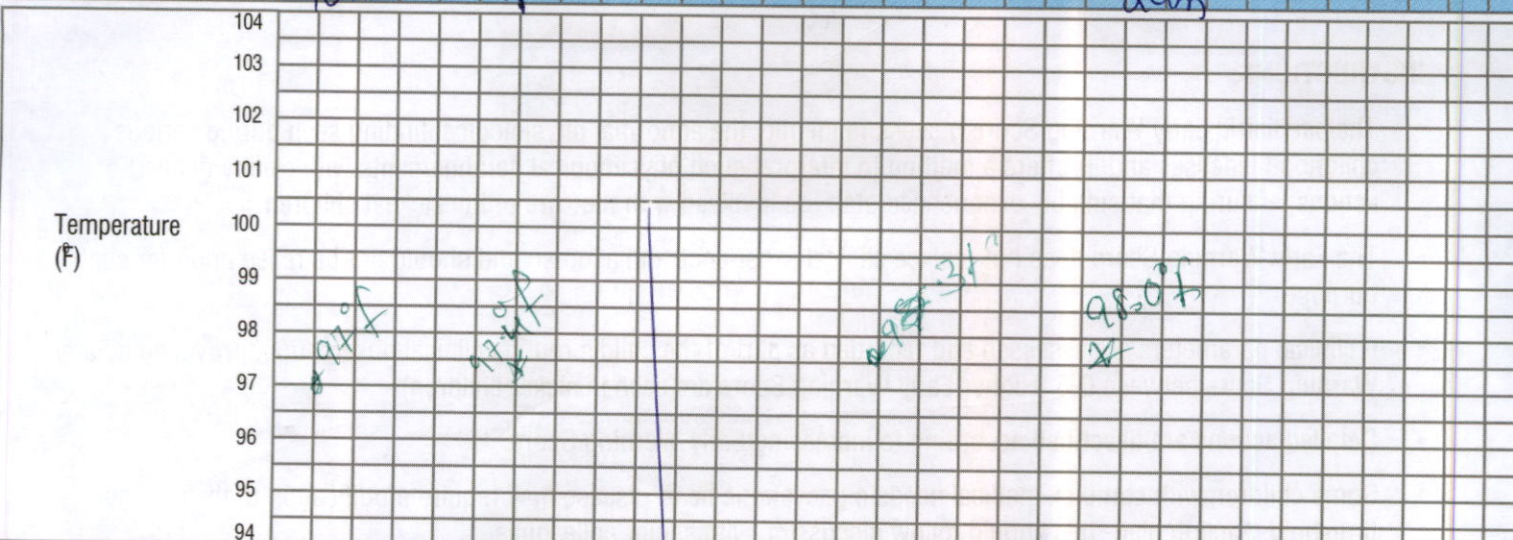
PRESCHOOL (1-5 years)

Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 21/3/22 Time:

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	
Pain Score	
Observer's Initials	

ACTIONS	Score 1 : Continue normal observation by staff nurse
	Score 2 : Shift in charge nurse to be informed and continue hourly observations
	Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.
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BAH-00662196 IP5-00176668
Master AHAD SHRIF PATHAN
09-02-2022 4 Y 5 M 11 D (M)
Dr. RAMESH KONANKI



No. : RCH/ FRM / CLINICAL / 125

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

Pratiksha
**Rainbow
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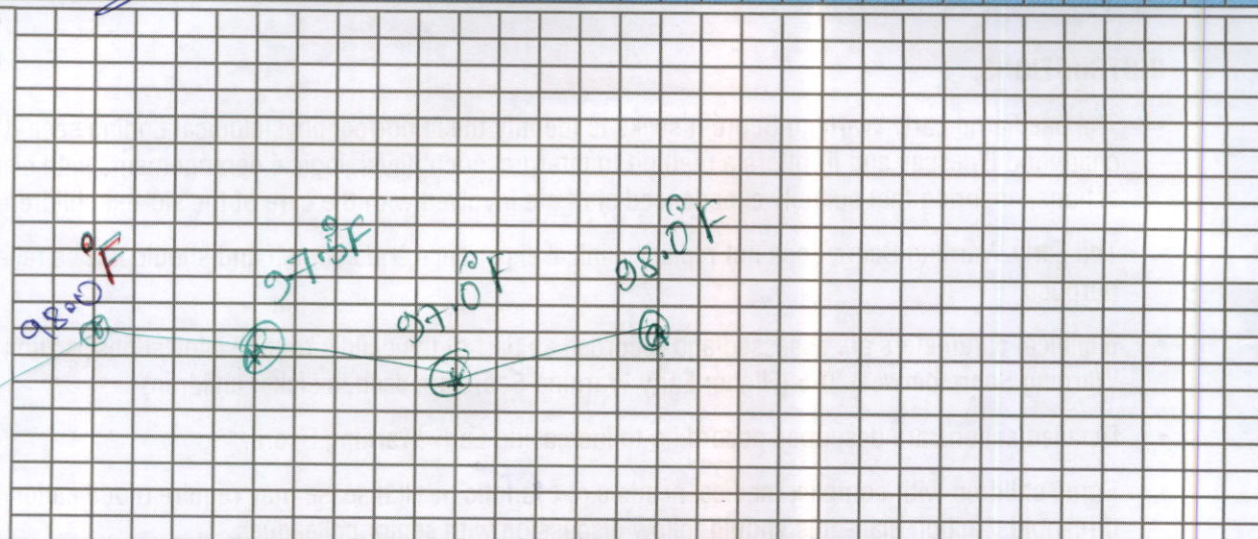
EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 10/2/25 Time: 7:20 PM 10 PM 2 AM 6 AM

Doctor / Nurse / Family Concern?

Temperature
(F)

104
103
102
101
100
99
98
97
96
95
94



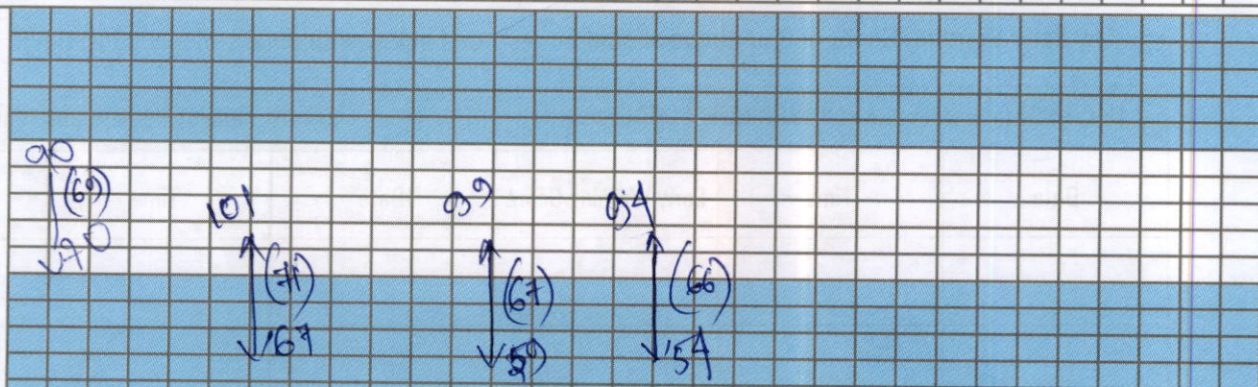
Heart Rate
(bpm)

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

and

Blood Pressure
(mmHg) *

Note:
BP does not score
in early
warning scoring



Heart Rate (Number)

120b/m 110b/m 90b/m 82b/m

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

70
60
50
40
30
20
10



Resp Rate (Number)

28b/m 26b/m 27b/m 26b/m

Resp Mod/ Severe
Distress None / Mild

Receiving O₂(l/min)
O₂Saturations (%)

99% 100% 100% 99%

Conscious Level
Normal Altered

GCS *

15/15 15/15 15/15 15/15

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

1 1 1 1
0 0 0 0
R R R R

ACTIONS

NB: Scores 3 should be
recorded overleaf

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BAH-00662196
Master AHAD SHRIF PATHAN
09-02-2022 4 Y 6 M 11 D
Dr. RAMESH KONANKI (M)

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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			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						Total Output :						
20/7	08:00 pm	↑		—							0	Prinyanka
	09:00 pm			—							0	
	10:00 pm	DNS		27 ml							0	Prinyanka
	11:00 pm			27 ml							0	
	12:00 am			27 ml							0	Prinyanka
	01:00 am	↓		27 ml							0	
Total Intake :						Total Output :						
21/7	02:00 am	↑		27 ml							0	Prinyanka
	03:00 am			27 ml							0	
	04:00 am	DNS		27 ml							0	Prinyanka
	05:00 am			27 ml							0	
	06:00 am			—							0	Prinyanka
	07:00 am	↓		—							0	
Total Intake :						Total Output :						

Total 24 hrs. Intake

Total 24 hrs. Output

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.

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
21/7/25	08:00 am	NS	27ml	/	/	/	/	/	/	0	Sund	
	09:00 am		27ml							✓		6
	10:00 am	-	0							Sund		
	11:00 am	27ml	✓									0
	12:00 pm	27ml	✓									0
	01:00 pm	-	✓									0
Total Intake :						Total Output :						
21/7/25	02:00 pm	Rice	27ml	/	/	/	/	/	/	0	Miki	
	03:00 pm	27ml	✓							0		
	04:00 pm	27ml	0							Miki		
	05:00 pm	27ml	0									
	06:00 pm	27ml	✓									0
	07:00 pm	27ml	0									
Total Intake :						Total Output :						
21/7/26	08:00 pm	Rice	27ml	/	/	/	/	/	/	0	Sund	
	09:00 pm	27ml	✓							0		
	10:00 pm	27ml	✓							0		
	11:00 pm	27ml	0							Sund		
	12:00 am	-	0									
	01:00 am	✓	0									
Total Intake :						Total Output :						
22/7/26	02:00 am	NPO	27ml	/	/	/	/	/	/	0	Sund	
	03:00 am	27ml	✓							0		
	04:00 am	27ml	0							Sund		
	05:00 am	27ml	0									
	06:00 am	✓	0									
	07:00 am	✓	0									
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.

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
22/07/20	08:00 am	DNS	MPO	35ml	NA	NA	NA	NA	NA	0	0	dhg
	09:00 am			35ml						0		
	10:00 am			35ml						0		
	11:00 am	-	0	dhg								
	12:00 pm	-	0									
	01:00 pm	-	0									
Total Intake :			105ml			Total Output :						
22/7/20	02:00 pm	DNS	Rice water	40ml	NA	NA	NA	NA	NA	0	0	mrfh
	03:00 pm			-						0		
	04:00 pm			40ml						0		
	05:00 pm	40ml	0	mrfh								
	06:00 pm	-	0									
	07:00 pm	40ml	0									
Total Intake :			160ml			Total Output :						
22/7	08:00 pm	DNS	Rice	40ml	NA	NA	NA	NA	NA	0	0	South
	09:00 pm			40ml						0		
	10:00 pm			-						0		
	11:00 pm	-	0	South								
	12:00 am	40ml	0									
	01:00 am	40ml	0									
Total Intake :			160ml			Total Output :						
23/7	02:00 am	DNS	Rice	40ml	NA	NA	NA	NA	NA	0	0	South
	03:00 am			40ml						0		
	04:00 am			40ml						0		
	05:00 am	40ml	0	South								
	06:00 am	-	0									
	07:00 am	-	0									
Total Intake :			160ml			Total Output :						

Total 24 hrs. Intake 585 ml

Total 24 hrs. Output U-84mls.

BAH-00662196 IP5-00176668
Master AHAD SHRIF PATHAN (M)
08-02-2022 4 Y 5 M 13 D
Dr. RAMESH KONANKI

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		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G								
23/07/24	08:00 am	1											
	09:00 am												
	10:00 am	ONS											
	11:00 am												
	12:00 pm												
	01:00 pm												
Total Intake :						Total Output :							
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :							
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
Total Intake :						Total Output :							
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
Total Intake :						Total Output :							
Total 24 hrs. Intake													
Total 24 hrs. Output													



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 20/7/26

Assessment: Dull activity

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	Assess general condition of the patient.	8:10 pm	Assessed general condition of the patient.	By done all implementation, as per doctor's order.
10pm	Monitor vital signs.	10:20 pm	Monitored vital signs.	
12AM	Administer I.V fluids 27ml/hr.	12pm	Administered I.V fluids.	
5AM	Maintain Ho chart.	5AM	Maintained Ho Chart.	
6PM	Administer medication as per doctor's order.	6:10 PM	Administered medication as per doctor's order.	

Re-Assessment: Re-Assessment done at by checking vitals.

Special Notes: 1 EDTA, 3 plain [kept in fridge]

Nurse Signature: PB Nurse Name: Pmjanika Date & Time: 21/7/26 8 AM



NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 21/1/26

Assessment: Baby having difficulty

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8am	* Assess the baby general condition. monitor vital signs	8am	* Assessed the baby general condition. monitored vital signs	Baby condition is improving slowly
10am	* provide comfortable position	10am	* provided comfortable position	
12pm	* doctor advice to do tomorrow whole body PET-CT scan	12pm	* doctor advised to do tomorrow whole body PET-CT	
2pm	* Administered medications as per doctor orders	2pm	* Administered medications as per doctor orders	

Re-Assessment:

Special Notes: whole body PET-CT scan.

Nurse Signature:

Nurse Name: Suresha (021088)

Date & Time: 21/1/26 2 pm

NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 21/2/26

Assessment: Baby having dull activity

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2m	Assess the general condition of the patient	2:30 m	Assessed the general condition of the patient	Baby condition is good
3m	monitor the vitals signs	3:30 pm	monitored the vitals signs	
	maintain I/O chart		maintained I/O chart	
4m	Administer medication	4:30 pm	Administered medication	
5m	as per as chart	5:30 pm	as per as chart	
6m	maintain fluid Balance	7m	maintained fluid Balance.	

Re-Assessment: Re-assessment

Special Notes: pet-ei TIm Npo as per pac.

Nurse Signature: [Signature] Nurse Name: Nitya Date & Time: 21/2/26 @ 8pm

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Master AHAD SHRIF PATHAN
09-02-2022 4 Y 5 M 12 D (M)
Dr. RAMESH KONANKI



NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 21/2/26

Assessment: pt having Discomfort.

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	→ ASSESS the pt General condition	8pm	→ Assessed pt General condition	pt condition is normal
10pm	→ monitor vital signs	10pm	→ monitored vital signs	
2am	→ maintain I/O chart	2am	→ maintained I/O chart	
8am	→ Administer the medications as per doctors order.	8am	→ Administered the medications as per doctors order	

Re-Assessment:

Special Notes: pt scan tomorrow 10am

Nurse Signature: S. Li

Nurse Name: Sravathi

Date & Time: 22/2/26 8am

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Master AHAD SHRIF PATHAN
08-02-2022 4 Y 6 M 12 D (M)
Dr. RAMESH KONANKI



NURSING CARE RECORD

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Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 22/07/26

Assessment: pt having well activity

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8am	*Assess The pt General condition	8:30 am	*Assessed The pt General condition.	pt is stable
9am	*check the pt well vitay	9:30 am	*checked the pt well vitay	
10am	*maintain 2eo chart	11am	*maintained 2eo chart	
11:30am	*provide comfortable position	12pm	*provided comfortable position	
2pm	*administer all medication given by per doctor order	2pm	*administered all medication given by per doctor order	

Re-Assessment:

Special Notes: PET scan done by nursing.

Nurse Signature:  Nurse Name: Shanthi

Date & Time: 22/07/26 @ 2pm



NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 22/7/26

Assessment: patient having poor intake.

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	→ Assess the patient general condition.	2pm	→ assessed the patient general condition.	→ pt condition is stable
4pm	→ check the vital	4pm	→ checked the vital sign.	
	→ provide comfortable position.		→ provided comfortable position.	
6pm	→ maintain I/O count	6pm	→ maintained I/O count	
7pm	→ maintain I.V fluid balance		→ maintained I.V fluid balance	
	→ Administer medication as per doctor order.	8pm	→ Administer medication as per doctor order.	

Re-Assessment:

Special Notes: tomorrow hemato operation.

Nurse Signature: (MR)

Nurse Name: Mr. Arjun

Date & Time: 22/7/26 @ 8pm



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 22/7/26

Assessment: Pt having discomfort

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 | | | | | |

Time	Plan of Care	Time	Implementation	Evaluation
8PM	→ Assess the pt General Condition	8PM	→ Assessed pt General Condition	pt condition is normal
10PM	→ monitor vital signs	10PM	→ monitored vital signs	
2AM	→ maintain I/O chart	2AM	→ maintained I/O chart	
8AM	→ Administer the medications as per doctors order	8AM	→ Administered the medications as per doctors order	

Re-Assessment:

Special Notes: hemato operation

Nurse Signature: [Signature] Nurse Name: Sravathi Date & Time: 23/7/26 8AM

Nurse Signature: _____ Nurse Name: _____ Date & Time: _____



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Ramesh Konanki Department: ER Date of Admission: 20/7/22

SITUATION	Diagnosis: <u>Post Infectious Cerebelitis</u>		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:					
BACKGROUND	Area	Shift Time	<u>ER</u> <u>7pm</u>	<u>1st Floor</u> <u>8pm - 8AM</u>	<u>1st Floor</u> <u>8AM - 2pm</u>	<u>1st Floor</u> <u>2pm - 8pm</u>	<u>1st Floor</u> <u>8pm - 8AM</u>	<u>1st Floor</u> <u>8AM - 8pm</u>
	Medical Condition (Any special condition to be noted):		<u>Ni/</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
ASSESSMENT	Allergy:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Tubes/Drains/Catheter:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:		Temp: <u>98.4 F</u>	<u>98.1 F</u>	<u>98.0 F</u>	<u>98.0 F</u>	<u>98.3 F</u>	<u>98.1 F</u>
	Res:		<u>22b/m</u>	<u>26b/m</u>	<u>28b/m</u>	<u>22b/m</u>	<u>28b/m</u>	<u>18b/m</u>
	SpO ₂ :		<u>100%</u>	<u>100%</u>	<u>100%</u>	<u>100%</u>	<u>100%</u>	<u>100%</u>
	Pulse:		<u>94b/m</u>	<u>101b/m</u>	<u>98b/m</u>	<u>114b/m</u>	<u>116b/m</u>	<u>110b/m</u>
	BP:		<u>91/64/70</u>	<u>99/61</u>	<u>98/56</u>	<u>-</u>	<u>-</u>	<u>90/60</u>
	Fall Risk Score:		<u>11</u>	<u>11</u>	<u>11</u>	<u>11</u>	<u>11</u>	<u>11</u>
Pain Score:		<u>0</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	
Recommendations	Safety Needs:		<u>Yes</u>	<u>Side rails</u>	<u>Side rails</u>	<u>Yes</u>	<u>Yes</u>	<u>Yes</u>
	Physiotherapy		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Others Specify:		<u>Ni/</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
	Special Diet:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Other Special Orders / Medications:		<u>Ni/</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
Post Operative Procedure Special Orders:		<u>Ni/</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Handed Over By Name :		<u>Susmita</u>	<u>Priyanka</u>	<u>Susmita</u>	<u>Nikita</u>	<u>Susmita</u>	<u>Chanthi</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>20/7/22</u>	<u>21/7</u>	<u>21/7/22</u>	<u>21/7</u>	<u>22/7/22</u>	<u>22/7/22</u>	
Time:		<u>7pm</u>	<u>8AM</u>	<u>2pm</u>	<u>8pm</u>	<u>8AM</u>	<u>2pm</u>	
Taken Over By Name :		<u>Priyanka</u>	<u>Susmita</u>	<u>Nikita</u>	<u>Susmita</u>	<u>Chanthi</u>	<u>Nikita</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>20/7</u>	<u>21/7/22</u>	<u>21/7</u>	<u>21/7/22</u>	<u>22/7/22</u>	<u>22/7</u>	
Time:		<u>8pm</u>	<u>8AM</u>	<u>2pm</u>	<u>8PM</u>	<u>8AM</u>	<u>2pm</u>	

BAH-00662196 IP5-00176668
Master AHAD SHRIF PATHAN
09-02-2022 4 Y 5 M 11 D (M)
Dr. RAMESH KONANKI



ING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. R. K. Department: Neuro Date of Admission: 20/1/24

SITUATION	Diagnosis: <u>post infectious Coarctation</u>		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
	Area							
BACKGROUND	Shift Time	<u>1st Shift 8 AM - 4 PM</u>	<u>2nd Shift 4 PM - 8 PM</u>					
	Medical Condition (Any special condition to be noted):	<u>NA</u>	<u>NA</u>					
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Vital Signs:	Temp: <u>98.6°</u>	<u>98.3°</u>					
	Res:	<u>22</u>	<u>20</u>					
	SpO ₂ :	<u>98%</u>	<u>99.1%</u>					
	Pulse:	<u>112</u>	<u>105b/m</u>					
	BP:	<u>93/62</u>	<u>98/59</u>					
	Fall Risk Score:	<u>1/10</u>	<u>1/10</u>					
	Pain Score:	<u>0/10</u>	<u>0/10</u>					
	Recommendations	Safety Needs:	<u>yes</u>	<u>yes</u>				
Physiotherapy		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
Others Specify:		<u>NA</u>	<u>NA</u>					
Special Diet:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
Other Special Orders / Medications:		<u>NA</u>	<u>NA</u>					
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>					
Handed Over By Name :		<u>Milly</u>	<u>Swathi</u>					
Signature :		<u>[Signature]</u>	<u>[Signature]</u>					
Date:		<u>22/1</u>	<u>23/1</u>					
Time:		<u>9 AM</u>	<u>8 AM</u>					
Taken Over By Name :		<u>Swathi</u>	<u>Shanthi</u>					
Signature :		<u>[Signature]</u>	<u>[Signature]</u>					
Date:		<u>22/1/24</u>	<u>23/1/24</u>					
Time:		<u>8 PM</u>	<u>8 AM</u>					



THE HUMPTY DUMPTY SCALE

20/7/22 21/7/22 23/7/22

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4					
	3 to less than 7 years old	3	3	3	3	3	
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	2	2	2	2	
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1	1	1	
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	1	1	1	1	1	
	History of Falls or Infant - Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2	2	2	2	
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	1	1	1	1	
Medication Usage	Sedatives (excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1	1	1	
TOTAL			11	11	11	11	

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position	yes	yes	yes	yes
Call device within reach	yes	yes	yes	yes
Wheels Locked	yes	yes	yes	yes
Room free of clutter	yes	yes	yes	yes
Adequate Lighting	yes	yes	yes	yes
Wheel Chair Support	no	no	no	no
Other Intervention(s) Specify	no	no	no	no
Nurse's Name :	Susana	Priyanka	Susana	Susana
Signature :	[Signature]	[Signature]	[Signature]	[Signature]
Date :	20/7/22	21/7	22/7	23/7
Time :	7pm	6am	5am	6am

BAH-00662196
Master AHAD SHRIF PATHAN
09-02-2022 4 Y 5 M 13 D
Dr. RAMESH KONANKI (M)

CHECKLIST FOR THROMBOPHLEBITIS

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S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	23/2 DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0										
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1										
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2										
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3										
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4										
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5										
Signature of the Nurse													

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

Signature of Shift In Charge :

Signature of Ward In Charge :

Signature : Name :

Signature : Name :



CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1 ^{20/7}			DAY-2 ^{21/7}			DAY-3 ^{22/07}			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	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		-	-	-	-	-	-	-		
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	1	-	-	-	-	-	-	-		
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3	ER	-	-	-	-	-	-	-		
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4		-	-	-	-	-	-	-		
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord pyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5		-	-	-	-	-	-	-		
Signature of the Nurse				 Nurse Priya Sush Nurse 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 : K. Srinendu

Signature of Ward In Charge :

Signature : Name : N. Srinendu

BAH-00662196
Master AHAD SHRIF PATHAN
09-02-2022 4 Y 5 M 11 D (M)
Dr. RAMESH KONANKI



BRADEN 'Q' SCALE

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					Date :	20/02/2022	21/02/2022	22/02/2022	23/02/2022
					Time :	10:00 AM	11:00 AM	12:00 PM	1:00 PM
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e.tremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4	4	4	4
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4	4	4	4
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	4	4
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	4	4
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	4	4
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	3	3	3	3
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4	4
Severe Risk : less than 9 High Risk : 10-12 Moderate F 13-14 Mild Risk : 15-18 Not at Risk: 19-23									
					TOTAL SCORE				
					Evaluator's Name				

Risk Score	Category	Action	Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice)
15-18	At Risk	• Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • Advance to a higher level of risk if other major risk factors are present	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	• Use the Same Protocol as for “At Risk” Patients • Position patient at 30 degree lateral incline using foam wedges	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	• Follow the same protocol as for “Moderate Risk” Patients • In addition to regular turning schedule • Make small shifts in their position frequently	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	• Use same protocol as for “High Risk” Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

BAH-00662196 IP5-00176668
Master AHAD SHRIF PATHAN
09-02-2022 4 Y 5 M 13 D (M)
Dr. RAMESH KONANKI



BRADEN 'Q' SCALE

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

					Date :				
					Time :				
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e.tremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.					
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					TOTAL SCORE				
					Evaluator's Name				

Severe Risk : less than 9 | High Risk : 10-12 | Moderate Risk : 13-14 | Mild Risk : 15-18 | Not at Risk: 19-23

Risk Score	Category	Action	Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice)
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Less than 9	Severe Risk	• Use same protocol as for “High Risk” Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay



PAIN ASSESSMENT FORM

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

Re-assessment Frequency:

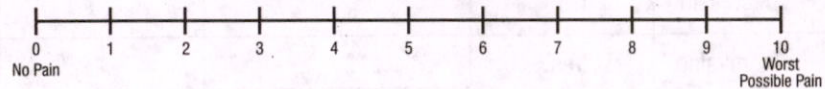
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

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



BAH-00662196 IPS-00176668
Master AHAD SHRIF PATHAN
09-02-2022 4 Y 8 M 11 D (M)
Dr. RAMESH KONANKI



PAIN ASSESSMENT FORM

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
20/7/22	7PM	0	N.I	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	[Signature]
21/7	6AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Poojanka
21/7	2M	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	swetha
21/7	1PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	swetha
22/7	6AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	swetha
22/7	2PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	swetha
22/7	10PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	swetha
23/7	6AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	swetha
				☐ 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:

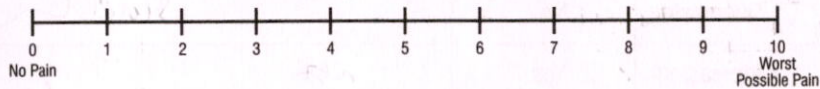
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

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	
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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
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Wong - Baker (Pediatrics) Above 7 Years



PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00662196 IP5-00176668 Master AHAD SHRIF PATHAN 09-02-2022 4 Y 5 M 11 D (M) Dr. RAMESH KONANKI 		Date & Time of Admission 20/7/26 @ 5:40pm	Date & Time of Transfer Order 20/7/26 @ 7pm
		Transfer Ordered by Dr. Ramya	Reason for Transfer Admission
From Unit ER	To Unit 104	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 20	Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ If Yes, what? ... OP file	Patient shifted with ID band: Yes ☒ No ☐ If No:	
Number of Imaging Films nil			
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 Mr. Seemita		Name of Person Ordered Transfer Dr. Ramya	
Patient & Clinical Records Received by : Ramu			
Date & Time of Patient Received : 7:30 pm 20/7/26			

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



Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 7:30 PM Mode of Arrival: wheel chair Admitting From: ☒ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction Nil Body Weight: 15.9 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>Nil</u>	<u>Nil</u>	<u>Nil</u>

Family History: Nil

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: 15.9 Length: Head Circumference (< 2 years):

Temp.: 98.6°F HR: 120b/min RR: 28b/min BP: 110/70 (65)

Pain Score: 10 Specify Site: (Follow Pain Assessment Sheet & Document)

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

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

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

Character of Pain Location Frequency Duration

FUNCTIONAL SCREENING:☒ No Abnormalities Detected

- ☐ Mobility Problem
☐ Developmental Delay

- ☐ Walking Problem
☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING:☒ No Abnormalities Detected

- ☐ Underweight
☐ Feeding Problem

- ☐ Overweight
☐ Special diet

- ☐ Special Feeding Method
☐ No Abnormality Detected

Inform consultant for positive criteria

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

If Yes Consultant Notified: (Date/Time):

Cultural & Spiritual Needs: ☐ Yes ☒ No if Yes specify Inform consultant for positive criteria.Social History: Lives With *family*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 ☐ NoWaste Disposal Explained: ☒ Yes ☐ NoInfusion Pump : ☒ Yes ☐ NoHand hygiene Explained: ☒ Yes ☐ No ☐ OthersPatient Rights & Responsibilities: ☒ Yes ☐ NoInformation given to *mother*Nurse Signature: *Rama*Nurse Name: *Rama*Date: *20/7/26*Time: *7:30pm*



DISCHARGE PLANNING FORM

Nationality: indian

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

1. Anticipated Date of Discharge: as per doctor order

2. Destination Post Discharge: ☐ Home

Family Members Notified (Person Contacted)

☐ Transfer

Hospital Facility Notified (Person Contacted)

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

☐ Needs Assistance In:

Remarks

☐ Medication	☐ Yes	☐ No
☐ Bathing	☐ Yes	☐ No
☐ Eating	☐ Yes	☐ No
☐ Walking	☐ Yes	☐ No
☐ Dressing	☐ Yes	☐ No
☐ Toileting	☐ Yes	☐ No

explained
family
member

4. Nutritional Plan:

☐ Dietary Instruction Discussed with the:

☐ Patient

☒ Family Member

☐ Others:

5. Discharge Planning Discussed with the:

☐ Patient

☒ Family Member

☐ Others:

6. Patient/Family Educational Plan:

☐ Educational Topic/s: hand hygiene

☐ Patient's Educational Topic/s discussed with the:

☐ Patient

☒ Family Member

☐ Others:

Nurse Signature: Rama

Nurse Name: Rama

Date and Time: 7:30 PM 20/7/26



INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Part - I.

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

Identified Education Needs:

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

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
20/12/26	7pm	7	Infection control measures	M	4	0	1	1	—	
21/12/26	8am	9	soft diet	m	1	0	1	1	—	Nitish

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
20/1/26 @ 6:30 PM	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Post infectious cerebellitis	H. Stabel	W antibiotics	<i>[Signature]</i>	☐ Nursing ☐ Others:
20/1/26 @ 6:30 PM	☐ Medical ☒ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Post infectious cerebellitis	H. Stabel	In medication	<i>[Signature]</i>	☐ Medical ☐ Others:
21/1/26 8am	☐ Medical ☐ Nursing ☒ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Post infectious cerebellitis / demyelination	soft gait	ROA! E1-1350 kcal/d P1-23 g/d	<i>[Signature]</i>	☐ Medical ☐ Nursing ☒ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:



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NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 21/7/20 Time: 8am

Weight: 15.93kg Centile: >10th

Height: 103.5cm Centile: >25th

Inference: underweight child

RDA: - Calories: 1350 Kcal/d Protein: 23g/d

Diet Recommendations: soft diet

Re-Assessment: Avoid spicy, chilled, outside foods

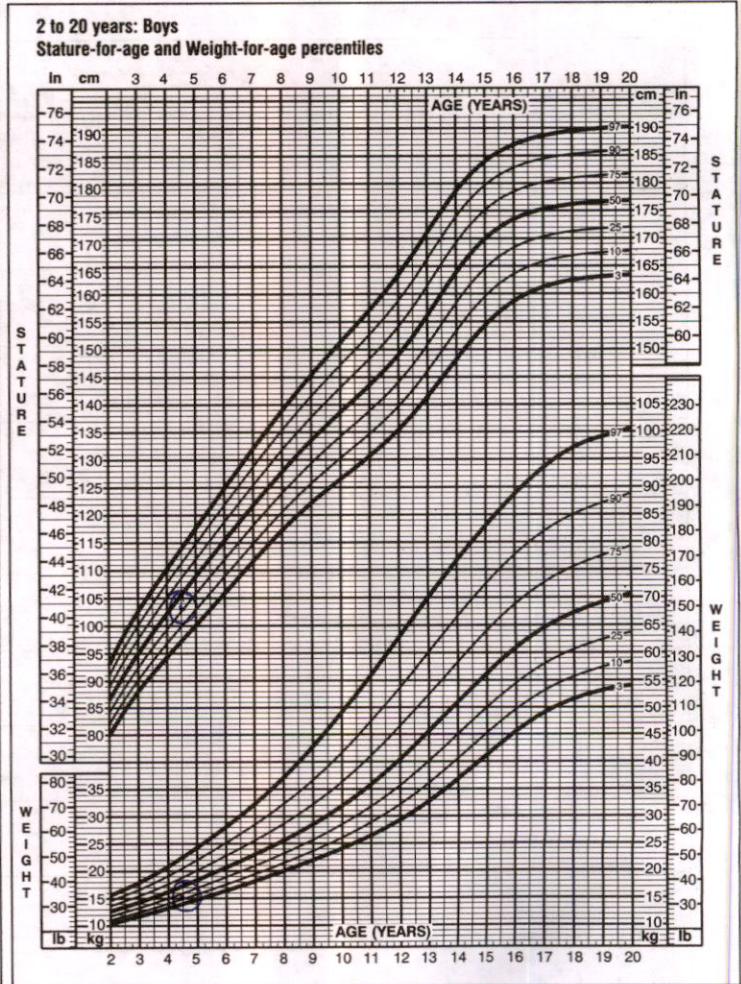
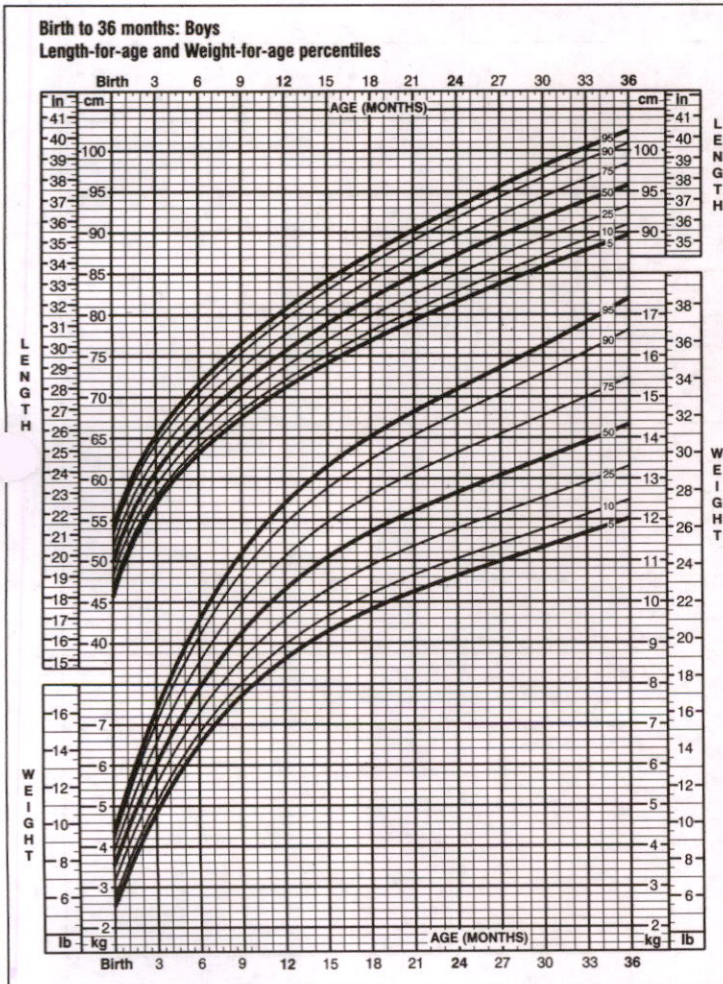
Food Allergies: No Veg/Non-veg: Non-veg

Diagnosis: Post infectious cerebellitis / Demyelination

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: *Saimy*

GROWTH CHART (BOYS)



Dietician's Name: Nikitha

Dietician's Signature: *Nikitha*

Daily Notes:

23/4/26

child is stable. Entake is fair

continue on soft diet

19/10/26