

ADMISSION SHEET

Registration Details :

Admission No : IP5-00176102

Admit Date : 08-Jul-2026

Admit Time : 12:12 PM **UHID** : BAH-00603934

Patient Details :
Patient Name : Master SHIVANSH RATHAUR

Age : 3 Y 3 M 5 D

Guardian : Mr AMARJEET SINGH RATHAUR

DOB : 03-04-2023

Gender : Male

Religion :

Occupation :

Martial Status : Single

Address (H) : H NO - 8-3-231/B201, 2ND FLOOR , SRI
KRISHNA NAGAR , Yousufguda Hyderabad
Telangana INDIA 500045

Phone No : 7982876007/ 9569350319

E-mail : nomail@gmail.com

Admission Details :
Bed Type : SEMI PRIVATE

Bed No : SPVT 108

Ward Name : 1F-VIBGYOR

Room No : SPVT 108

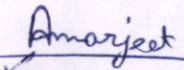
Admission Type : First Visit

Contact Details :
Name : Mr AMARJEET SINGH RATHAUR

Relationship : Father

Contact Address : H NO - 8-3-231/B201, 2ND FLOOR , SRI
KRISHNA NAGAR , Yousufguda Hyderabad
Telangana INDIA 500045

Phone No : 7982876007 / 9569350319


Signature
Doctor Details :
Doctor Name : Dr. ANUPAMA Y

Specialisation : GENERAL PEDIATRICS

Referral Doctor : Self

Phone No :

Co-Consultant :

Payment Details :
Deposit Amount : 0.00

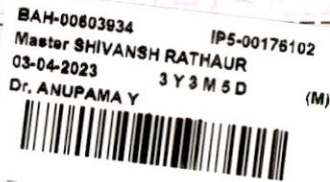
Payment Mode : Cash

Payor Name : NIVA BUPA HEALTH INSURANCE
COMPANY LTD

ACTIVITY RECORD FOR BILLING

Name : _____ UHID No. : _____ Date of Admission : _____ Room / Bed No : _____ Ward : _____ Suggested Billable bed type : _____

Consultant : _____ Dept : _____ Date of Discharge : _____ Time : _____



WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
8/7/26	12:50pm	ER	108	[Signature]
08/07/26	5:13pm	108	317	[Signature]

Cross Consultation Visit

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

[illegible]

08/07	CRP, CRP, c/t, blood clts
-------	---------------------------

26 068 267.
9.698438

Tenaf

[illegible]

[illegible]

Date :

Time :

Prepared By :

Staff Nurse

Shift / Ward

Billing Assistant

Billing Supervisor



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PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name:

Shivansh Rathaur

UHID ID:

BAH-00603934 IP5-00176102
Master SHIVANSH RATHAUR
03-04-2023 3 Y 3 M 5 D (M)
Dr. ANUPAMA Y

Department:



Consultant:



Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

Rash over hands, legs, perianal region since 3 days

Oral ulcers since 3 days

Poor oral intake

Dull activity

} since 3 days.

History of present illness :

Child was apparently normal 3 days ago. Child is having above mentioned complaints since 3 days.

• Rash over hands, legs, perianal region since 3 days.

→ Started suddenly.

→ Observed after travel H/O.

• Oral ulcers since 3 days.

→ associated with poor oral intake

→ Unable to take water also.

• Dull activity since 3 days

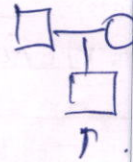


Pediatric Multiorgan History & Physical Examination

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

Birth & Neonatal History:

2y5kg / NVD / @ transition



Birth & Socio Economic History:

About Father : _____
About Mother : _____ } upper middle class
Any additional Information : _____

Developmental History :

@ development

Immunization History :

Vaccination - IAP schedule



Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs)) 11.86 kg (Centile _____)

On Examination :

Temperature : 98.8°F Pulse Rate : 116/min B.P. 93/51 (61) SPO2 100% on RA

Resp. rate and type of breathing : RR = 26/min

Rash _____

Lymphadenopathy } _____

Oedema : nil

Allergies (if any): _____

Respiratory System :

Inspection (any s/o distress) : _____

Air entry & breath sounds : 2/LAE (1)

Any addes sounds : _____

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

Cardiovascular System :

Inspection of procordium : _____

Heart Sounds : S1S2 (1) murmur (1)

Any murmur : _____

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

Per Abdomen :

Inspection _____

Palpation : soft, NT

Ausculation : _____

Spine : _____ External Genitelia : _____

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

Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score _____

Cranial Nerves : _____

Motor System:

Nutriton : _____

Tone: _____

Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR

Superficials:

Plantars _____

Sensory System :

Bladder / Bowel : _____

Clinical Summary & Diagnostic:

Hand Foot mouth disease & dehydration



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: _____

Desired goals of the treatment : _____

Planned Labs:

CSP —
CRP —
S. Electro
Blood Gs
N/A
Ismene

Planned Management

Inj Ceftriaxone
Tab Linnol
Quadrangel for LA.
ZVF DNB

Signature of the Doctor: Ramya

Name of the Doctor: Dr. Ramya

Date & Time: 8/7/26; 12pm

Signature of the Consultant: [Signature]

Name of the Consultant: [Signature]

Date & Time: 8/7/26

Dr. ANUPAMA
Reg. No. 50853



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
08/07/26 5:30pm	C/S/B Resident Δ Hand Foot Mouth disease + some dehydration 1 fever spike after admission at 3pm O/E: child alert Resp - BAE ⊕, clear PIA - soft CVS - S ₁ S ₂ heard. Vital - stable Poor oral Intake	Plan 1) Continue IV ceftriaxone QID 2) Continue IV fluids 3) Quadrigel for local application 4) Trace Blood c/s 5) Monitor Vital Inform SOS
		Dr. Jayasri
		Seema
9/7/26 9am	C/S/B PICU Follow Δ: Acute exanthematous fever Hemodynamically stable on room air. S/E: None. Papules on hands & feet Oral ulcers. + fever spike yesterday 3p-1w.F. Oral intake little.	① Cont antibiotic ② IV fluids ③ Trace Blood c/s ④ Monitor vital ⑤ Decide on ESR
		Jay.

Date & Time	Progress Notes	Doctor's Order
9/7/26 10am	SIB Dr. Anupama Hand foot mouth Disease. low grade fever.	Plan Discharge (tm)
	Dr. ANUPAMA Y Reg. No: 50853	
		noted by satya
9/7/26 5pm	c/s/B Resident Hand Foot Mouth disease No fever spikes Rash - better Oral Intake - Good Resp } PIA } (N) CVS }	Plan 1) Stop IV fluids 2) Continue IV Ceftriaxone (D2) 3) Quadrigel for C/A 4) Trace blood c/s 5) Monitor Vitals 6) Inform SOS
	Vitals - stable	Dr. Jayashree
		NB seems



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7. ANUPAMA Y



PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

BAH-00603934 IP5-00176102
Master SHIVANSH RATHAUR
03-04-2023 3 Y 3 M 5 D (M)
Dr. ANUPAMA Y



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RESULT SHEET

Date	8/7				
Time	100 pm				
Hb	11				
PCV	34.9				
RBC	4.69				
WBC	9950				
N/L	70121				
Platelets	3.24				
CRP	17				
ESR					
PCT					
RBS					
Na	137				
K	4.4				
Cl	107				
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					

BAH-00603934 IP5-00176102
Master SHIVANSH RATHAUR
03-04-2023 3 Y 3 M 5 D (M)
Dr. ANUPAMA Y



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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: ICU

Shifted to: Ward

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1						☐ 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. Ramya

Date & Time : 8/7/26; 12pm.

Nurse Name & Signature: Nr. Sushmita

Date & Time : 8/7/26 @ 8/7/12:30pm



DRUG CHART

Date of Admission: 8/7/26 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 : <u>INJ-PARACETAMOL</u>				Date Time															
Dose <u>180mg</u>	Route <u>IV</u>	Frequency <u>SOS</u>	Start Date <u>08/07</u>																
Doctor's Signature <u>Jayahi</u>		Valid Period	Pharm.																
Additional Instructions:																			

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

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

VERIFIED BY : Name Signature



REGULAR PRESCRIPTIONS

Weight. 11.86kg Ward.

VERIFIED

DRUG : <u>INJ CEFTRIAXONE</u>				Date Time	<u>8/7/26</u>	<u>10H</u>
Dose	Route	Frequency	Start Date			
<u>600mg</u>	<u>IV</u>	<u>BD</u>	<u>8/7/26</u>			
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Anupama</u>						
Additional Instructions:						
Daily Doctor's Endorsement by a Sign						

DRUG : <u>10 Tab LANZOPRAZOLE</u>				Date Time	<u>8/7/26</u>	<u>10H</u>
Dose	Route	Frequency	Start Date			
<u>PO</u>	<u>OD</u>	<u>8/7/26</u>				
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Anupama</u>						
Additional Instructions: <u>1 tab = 15mg + 5ml water give 4ml</u>						
Daily Doctor's Endorsement by a Sign						

DRUG : <u>QUADRYGEL OINTMENT</u>				Date Time	<u>8/7/26</u>	<u>10H</u>
Dose	Route	Frequency	Start Date			
<u>LA</u>	<u>TID</u>	<u>8/7/26</u>				
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Anupama</u>						
Additional Instructions: <u>For mouth ulcers</u>						
Daily Doctor's Endorsement by a Sign						

DRUG : <u>INJ. ESOMEPRAZOLE</u>				Date Time	<u>8/7/26</u>	<u>10H</u>
Dose	Route	Frequency	Start Date			
<u>10mg</u>	<u>IV</u>	<u>OD</u>	<u>8/7</u>			
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Anupama</u>						
Additional Instructions:						
Daily Doctor's Endorsement by a Sign						

VERIFIED

VERIFIED

Weight. 11.86 kg Ward.

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

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

STAT / ONCE ONLY DRUGS[illegible]

3 Y 3 M 5 D

Dr. ANUPAMA Y

(M)



Weight. 11.86 kg Ward.

[illegible]

Signature _____

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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 |

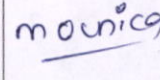
Part - II

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		
8/7/23	2:30 pm	7	Infection control measure	m	4	0	1	1	-	<i>[Signature]</i>
8/7/23	1pm	9	soft diet	m	1	0	1	1	-	<i>monica</i>

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

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
8/7/26 12:30 pu	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Hand food mouth disease	H. Stabel	IVF		☐ Nursing ☒ Others:
8/7/26 12:30 pu	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Hand food mouth disease	H. Stabel	IVF		☒ Medical ☐ Others:
8/7/26 1pm	☐ Medical ☐ Nursing ☒ Others: diet plan	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Hand food mouth disease	soft diet	<u>RDA:-</u> E:- 1300 kcal/d P:- 22g/d		☐ 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:

Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 12:50 pm Mode of Arrival: wheel chair Admitting From: ☒ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction

Body Weight: 11.86 kg 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>NA</u>	<u>NA</u>	<u>NA</u>

Family History:

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: 11.86 kg Length: — Head Circumference (< 2 years): —

Temp.: 99.0 F HR: 98 bpm RR: 27 bpm BP: 91/59

Pain Score: 0/10 Specify Site: — (Follow Pain Assessment Sheet & Document)

Fall Risk Assessment: ☐ Yes ☐ No Score: 11 (Document in the Humpty Dumpty Sheet)

Risk of Pressure Sore (Braden Q Score 22) (Document in the Braden Q Assessment Sheet)

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

Character of Pain NA Location NA Frequency NA Duration NA

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

Inform consultant for positive criteria

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

Inform consultant for positive criteria

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

If Yes Consultant Notified: (Date/Time):

Cultural & Spiritual Needs: ☐ Yes ☐ No if Yes specify Inform consultant for positive criteria.**Social History:** Lives WithSiblings in household ☒ Yes ☐ No (if yes How Many?)All Information Obtained From ☒ Patient ☐ Mother ☐ Father ☐ Other Family Member**Orientation has been given regarding the following aspects:**Call Bell in Reach : ☒ Yes ☐ NoWaste Disposal Explained: ☒ Yes ☐ NoInfusion Pump : ☒ Yes ☐ NoHand hygiene Explained: ☒ Yes ☐ No☐ OthersPatient Rights & Responsibilities: ☒ Yes ☐ NoInformation given to motherNurse Signature: Nurse Name: SeemaDate: 8/11/20Time: 11:30 am



PRESCHOOL (1-5 years)

Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 8/07/2023	Time:	3pm	4:20pm	5:40 PM	6:30 PM	10pm	2am	6am
Doctor / Nurse / Family Concern?								
Temperature (F)	104							
	103							
	102							
	101							
	100							
	99							
	98							
	97							
	96							
	95							
94								
Heart Rate (bpm)	190							
	180							
	170							
	160							
	150							
	140							
	130							
	120							
	110							
	100							
Blood Pressure (mmHg) *	130							
	120							
	110							
	100							
	90							
	80							
	70							
	60							
	50							
	50							
Note: BP does not score in early warning scoring								
Heart Rate (Number)								
Resp. Rate (bpm) (Over 1 Minute) *								
Resp Rate (Number)								
Resp Mod/ Severe Distress None / Mild								
Receiving O ₂ (l/min)								
O ₂ Saturations (%)								
Conscious Level Normal / Altered								
GCS *								
TOTAL SCORE								
Number of shaded boxes								
Pain Score								
Observer's Initials								

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

- The paediatric Early Warning Score i) seeks to identify the abnormal physiological finding seen during serious childhood illnesses and ii) offers a method to interpret such physiological derangements with clearly defined actions, ensuring that suitably experienced staff are involved with the care of the sickest children.
- The Early Warning Score does not replace clinical experience and acumen and should not be relied upon for such purpose.
- 6 clinical parameters are assessed and recorded as part of the child's routine clinical observation, providing a Early Warning Score between 0-6 (Higher Early Warning Score are seen in sicker children)
- Detailed actions are described according to increasing Early Warning Score.
- Some children with complex medical needs e.g. cyanotic heart disease may require modification to their trigger thresholds/ action plan- this should follow discussion with senior colleagues.
- Any Early Warning Score of 3 or above should be recorded below with details of any subsequent action initiated

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

- If at any time additional help is required, call help – regardless of the Early Warning Score!
- Following a Early Warning Score assessment, senior help may be required

The SBAR communication tool (situation, background, assessment, recommendations) is a helpful mnemonic that can be used to describe a child's clinical condition to a colleague.

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



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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 9/19/26 Time: 11 am		6:40	10 pm	2 am	6 am
Doctor / Nurse / Family Concern?					
Temperature (°F)	104				
	103				
	102				
	101				
	100				
	99				
	98	97.9°F	97.6°F	97.7°F	97.6°F
	97				
	96				
	95				
Heart Rate (bpm) and Blood Pressure (mmHg) *	190				
	180				
	170				
	160				
	150				
	140				
	130				
	120				
	110				
	100				
Note: BP does not score in early warning scoring	90				
	80				
	70				
	60				
	50				
	99				
	98				
	97				
	96				
	95				
Heart Rate (Number)	106 bpm	94 bpm	110 bpm	105 bpm	
Resp. Rate (bpm) (Over 1 Minute) *	70				
	60				
	50				
	40				
	30				
	20				
	10				
	Resp Rate (Number)	25 bpm	23 bpm	26 bpm	26 bpm
	Resp Mod/ Severe Distress None / Mild				
Receiving O ₂ (l/min) O ₂ Saturations (%)					
	99%	99%	100%	100%	
Conscious Level Normal Altered					
GCS *	15/15	15/15	15/15	15/15	
TOTAL SCORE					
Number of shaded boxes	0	0	0	0	
Pain Score	0	0	0	0	
Observer's Initials					

ACTIONS

NB: Scores 3 should be recorded overleaf

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

- The paediatric Early Warning Score i) seeks to identify the abnormal physiological finding seen during serious childhood illnesses and ii) offers a method to interpret such physiological derangements with clearly defined actions, ensuring that suitably experienced staff are involved with the care of the sickest children.
- The Early Warning Score does not replace clinical experience and acumen and should not be relied upon for such purpose.
- 6 clinical parameters are assessed and recorded as part of the child's routine clinical observation, providing a Early Warning Score between 0-6 (Higher Early Warning Score are seen in sicker children)
- Detailed actions are described according to increasing Early Warning Score.
- Some children with complex medical needs e.g. cyanotic heart disease may require modification to their trigger thresholds/ action plan- this should follow discussion with senior colleagues.
- Any Early Warning Score of 3 or above should be recorded below with details of any subsequent action initiated

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

- If at any time additional help is required, call help – regardless of the Early Warning Score!
- Following a Early Warning Score assessment, senior help may be required

The SBAR communication tool (situation, background, assessment, recommendations) is a helpful mnemonic that can be used to describe a child's clinical condition to a colleague.

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

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Dr. ANUPAMA Y



Patient

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FLUID CHART

Sheet No. :

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

		Intake			Output					IV Site	Sign. Nurse	
Date	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine	Thrombo-phlebitis Score		
			Mouth	I.V	N.G							
28/04/23	08:00 am											
	09:00 am			ER								
	10:00 am											
	11:00 am											
	12:00 pm			USM								
	01:00 pm	DNS		USM								
Total Intake :					Total Output :							
	02:00 pm											
	03:00 pm	DNS		USM								
	04:00 pm			USM								
	05:00 pm			USM								
	06:00 pm			USM								
	07:00 pm			USM								
Total Intake :					Total Output : m=0, u=1							
	08:00 pm			USM								
	09:00 pm			USM								
	10:00 pm											
	11:00 pm	DNS										
	12:00 am			USM								
	01:00 am			USM								
Total Intake :					Total Output :							
	02:00 am			USM								
	03:00 am			USM								
	04:00 am			USM								
	05:00 am	DNS		USM								
	06:00 am			USM								
	07:00 am			USM								
Total Intake :					Total Output :							
Total 24 hrs. Intake			Total 24 hrs. Output									
			M=0, U=3									

FLUID CHART

Sheet No. :

1. All measurements in ml.
2. Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.
3. 24 hrs. total to be entered in the kardex in RED.

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
9/12			Mouth	I.V	N.G							
	08:00 am			45ml						✓	0	Satya
	09:00 am	P	H2o	45ml							0	
	10:00 am	W	juice	45ml							0	
	11:00 am	S		45ml							0	
	12:00 pm		sho	-			✓			✓	0	
	01:00 pm			-							0	
Total Intake :						Total Output : M-1 U-2						
9/12	02:00 pm			45ml							0	seema
	03:00 pm	D	H2o	-			✓			✓	0	
	04:00 pm	M		-			NP				0	
	05:00 pm	S	H2o	-							0	
	06:00 pm			-						✓	0	
	07:00 pm			✓							0	
	Total Intake :						Total Output : m-0 U-2					
9/12	08:00 pm			-							0	Satya
	09:00 pm			-			✓			✓	0	
	10:00 pm			-							0	
	11:00 pm	no UR		-							0	
	12:00 am			-							0	
	01:00 am			-							0	
	Total Intake :						Total Output :					
10/12	02:00 am			-							0	Satya
	03:00 am			-							0	
	04:00 am	no		-			NP				0	
	05:00 am	UR		-							0	
	06:00 am			-						✓	0	
	07:00 am			-							0	
	Total Intake :						Total Output :					

Total 24 hrs. Intake

Total 24 hrs. Output

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NURSING CARE RECORD

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Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 08/07/2023

Assessment: Baby having pain at mouth side (cancers) and having fever spikes

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
12pm	Assess the baby general condition and monitor the vitals and record.	2:30pm	Assessed the baby general condition and monitored the vitals and recorded	By doing all above procedure baby condition improving well
3pm	Doctor advice. Continue medication as per chart. Inj. Ceftriaxone, Esomeprazole, Quadragel. U/A. Inj. Paracetamol.	3:30pm	Doctor advised Continued the medication as per chart.	
4pm	Continue DMS @ 45mc/hr.		Inj. Ceftriaxone, Esomeprazole, Quadragel. U/A.	
	Provide Comfortable position.	4:30pm	Baby having fever doctor advice Inj PCNM 100mg.	
	Provide nutritional diet, and liquids.	4:50pm	Provided Comfortable position.	
4:50pm	Ensure the safety needs.	5pm	Ensured the safety needs	
8:00pm	Baby is shifted to SLT	8:20pm	Baby was shifted to SLT.	

Re-Assessment: Re assessment done

Special Notes: Watch for fever spikes

Nurse Signature: Sanyal

Nurse Name: K. Sanyal ID 607682

Date & Time: 08/07/2023 @ 8:00pm



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 8/7/26

Assessment: pt having mouth side rose

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8PM	→ Assess the pt condition.	8PM	→ Assessed the baby condition	Baby is stable
11PM	→ vital chart maintain	11PM	→ vital chart maintained	
9AM	→ Doctor round Done	12AM	→ Ensured safety	
8AM	→ continue IV fluid	4AM	→ continue IV antibiotic	
		8AM		

Re-Assessment: Baby is stable and comfortable

Special Notes: -nil-

Nurse Signature: *[Signature]*

Nurse Name: Kdney

Date & Time: 9/7/26 @ 8AM

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NURSING CARE RECORD

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Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 9/6/26

Assessment: patient having mouth ulcer

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	8.10am	→ baby is stable	pt stable
9am	→ monitor vitals	9.10am	→ vitals stable	
10am	→ monitor f/o cholest	10.10am	→ monitored down me - fed	
11am	→ to administer medication	11.10am	→ administered medication	
12pm	→ to encourage orally	12.20pm	→ oral intake good	
1pm	→ to encourage ambulation	1.30pm	→ well ambulatory	

Re-Assessment: Re-assessed after 2 hrs pt stable

Special Notes: IV fluids continue

Nurse Signature: Satya Nurse Name: Satya Date & Time: 9/6/26 @ 2pm

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Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 9/12/26

Assessment: Patient is having mouth ulcer

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 general condition of the patient	2:10pm	Assessed the general condition of the patient	Patient is stable
3pm	plan for vitals	3:10pm	checked vitals	
4pm	Administer medication as per doctor's order	4:10pm	Administered medication as per doctor's order	
5pm	Continue IV fluids	5:15pm	Continued IV fluids	
6pm	Maintain good nutritional status	6:30pm	Maintained good nutritional status	
7pm	Ensure safety	7:15pm	provide side rails	

Re-Assessment: Re-assessment done every 2nd hrly

Special Notes: - NA -

Nurse Signature: Seema

Nurse Name: Seema

Date & Time: 9/12/26 @ 8pm

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Dr. ANUPAMA Y



NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 9/7/24

Assessment: Rashes, Oral Ulcer

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	→ To assess the general condition of the pt	8:10pm	→ Assessed the general condition of the pt	Patient Stable Vitals normal
11pm	→ To monitor vital signs	11:30pm	→ Monitored vitals and recorded	
2am	→ To encourage oral intake	2:10am	→ Encouraged oral intake	
4am	→ To ensure safety	4:40am	→ Provided side rails	
7am	→ To administer medicines -	7:20am	→ Administered medicines.	

Re-Assessment:

After applying of quadrigel ointment, oral ulcer get better (reducing)

Special Notes:

Plan O/c - 7pm

Nurse Signature:

(Signature)

Nurse Name:

Kalyani

Date & Time:

10/7 at 8am

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(M)



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Date:

Assessment:

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation

Re-Assessment: Good

Special Notes:

Nurse Signature: Nurse Name: Date & Time:

Nurse Name:

Date & Time:



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Anupama Y Department: ER Date of Admission: 8/7/26

SITUATION		Diagnosis:		Any Infection: ☐ Yes ☐ No ☒ Not Known		If Yes Specify:		
BACKGROUND	Area	ER	2nd Floor	3rd Floor	3rd Floor	3rd Floor	3rd Floor	
	Shift Time	12:45 PM	8PM	2PM-8PM	2PM	8PM	8AM	
ASSESSMENT	Medical Condition (Any special condition to be noted):	Nil	ATI	NA	NA	ATI	NA	
	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
ASSESSMENT	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Vital Signs:	Temp:	98.8°F	98°F	97.9°F	97.5°F	98°F	98°F
		Res:	26bpm	27bpm	26bpm	26bpm	27bpm	27bpm
		SpO ₂ :	100%	100%	99%	99%	99%	100%
		Pulse:	116bpm	106bpm	106	94bpm	102bpm	102bpm
		BP:	93/51(61)	71/45	99/72	90/70	99/68	102/71
	Fall Risk Score:	11	11	11	11	11	11	
	Pain Score:	0	0/10	0/10	0/10	0/10	0	
Recommendations	Safety Needs:	Yes	Yes	Yes	Yes	Yes	Side rails	
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:	Nil	NA	NA	NA	NA	NA	
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
Other Special Orders / Medications:		Nil	NA	NA	NA	NA	NA	
Post Operative Procedure Special Orders:		Nil	NA	NA	NA	NA	NA	
Handed Over By Name :		Sudhita	Sudhita	Kalneh	Sahya	Sudhita	Kalyani	
Signature :								
Date:		8/7/26	8/7/26	9/7/26	9/7/26	9/7/26	10/7	
Time:		12:45 PM	8 PM	8 AM	2 PM	8 PM	8 AM	
Taken Over By Name :		Anketha	Kalneh	Sahya	Sudhita	Kalyani		
Signature :								
Date:		08/07/26	8/7/26	9/7/26	9/7/26	9/7		
Time:		@ 8:55 PM	8 AM	8 AM	8 PM	8 AM		



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:					
Recommendations	Pain Score:						
	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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THE HUMPTY DUMPTY SCALE

8/7/20 9/7/20 10/7

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		
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	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		
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	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		
	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		
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		
TOTAL			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		
Call device within reach	yes	yes	yes		
Wheels Locked	yes	yes	yes		
Room free of clutter	yes	yes	yes		
Adequate Lighting	yes	yes	yes		
Wheel Chair Support	no	na	no		
Other Intervention(s) Specify	no	na	no		
Nurse's Name :	Susmita	Rajna	Rajana		
Signature :	[Signature]	[Signature]	[Signature]		
Date :	8/7/20	9/7/20	10/7		
Time :	12:30 pm	8A	6am		

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BRADEN 'Q' SCALE

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					Date : 8/11/22	9/17/22	10/9/22	
					Time : 12:38	8:44	6am	
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. extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	7	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	7	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	7	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	7	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	7	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	7	4	
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	7	4	
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23					TOTAL SCORE	28	28	28
Docu. No. : RCHBH /FRM / CLINICAL / 119					Evaluator's Name	AN	AN	Anupama

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



CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0		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		-	-	-	-	-				
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 : Sourav Name : Sourav

Signature of Ward In Charge :

Signature : Neeraja Devi Name : Neeraja Devi

PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
8/1/26	12:30 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	nil nil	[Signature]
8/1/26	8 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Seema
8/2/26	12 AM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA NA	Kelly
9/1/26	8 AM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Latya
9/1/26	2 PM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Seema
9/1/26	8 PM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Seema
9/7	10 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Under observation	Kalyani
10/7	8 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Under observation	Kalyani
				☐ 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:

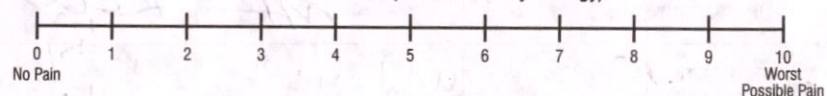
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

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

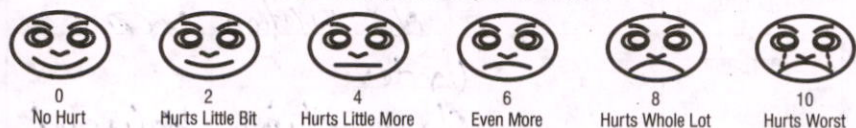
Numerical Pain Scale (Obstetric and Gynecology)



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



PATIENT TRANSFER FORM

BAH-00603934 IP5-00176102
Master SHIVANSH RATHAUR
03-04-2023 3 Y 3 M 5 D (M)
Dr. ANUPAMA Y



Date & Time of Admission 08/07/26 4 12:12pm.		Date & Time of Transfer Order 08/07/26 4 5:13pm
Treating Consultant Name Dr. Anupama N.	Transfer Ordered by Dr. Karthik	Reason for Transfer Need private room
From Unit 108	To Unit 317	Information to Attendant Yes ☒ No ☐
Number of Sheets in Clinical File 25	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☒ If Yes, what?	Patient shifted with ID band: Yes ☒ No ☐ If No:
Number of Imaging Films -		

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	Medications (All)	1
2.		
3.		
4.		
5.		

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

Name & Signature of Person who is Transferring K. Srauthi	Name of Person Ordered Transfer Dr. Karthik
--	--

Patient & Clinical Records Received by :

Date & Time of Patient Received :

Suma
8/7/26 @ 5:20 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

(26)



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 advice

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

Explain to mother and father.

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: Personal Hygiene

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

☐ Patient ☐ Family Member

☐ Others:

Nurse Signature: K. S. Srinanthi

Nurse Name: K. S. Srinanthi

Date and Time: 08/07/26 @ 3:40pm



108 → 317

NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 8/7/26 Time: 1 p.m.

Weight: 11.86 kgs Centile: 45th

Height: 97 cms Centile: 50th

Inference: underweight child

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

Diet Recommendations: soft diet

Re-Assessment: Avoid spicy, chilled & outside foods

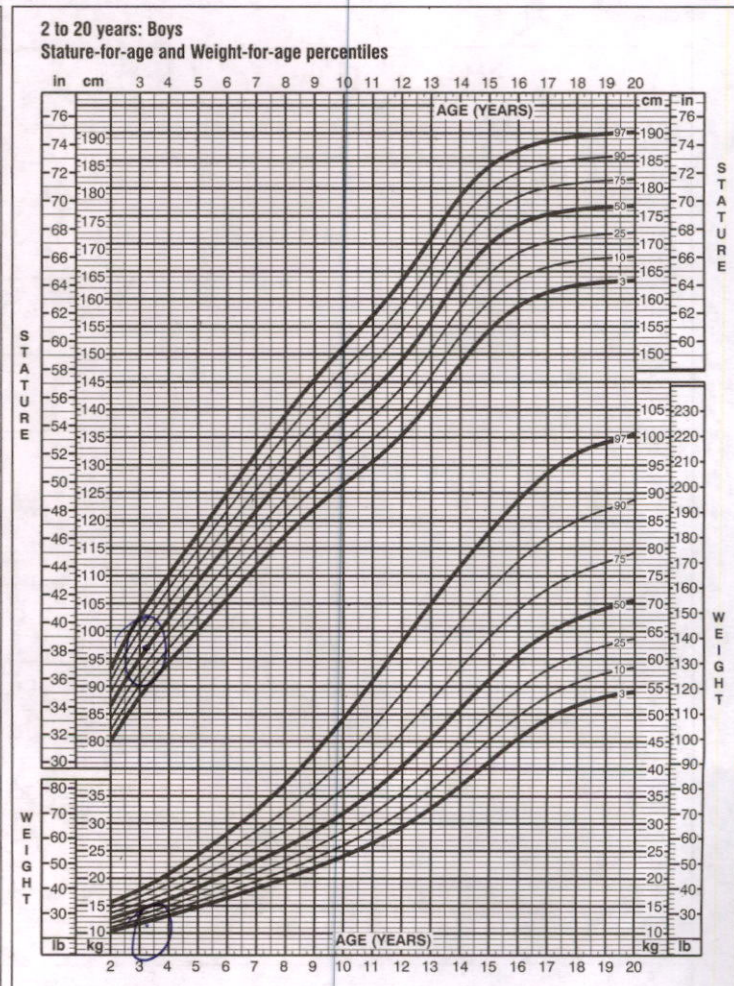
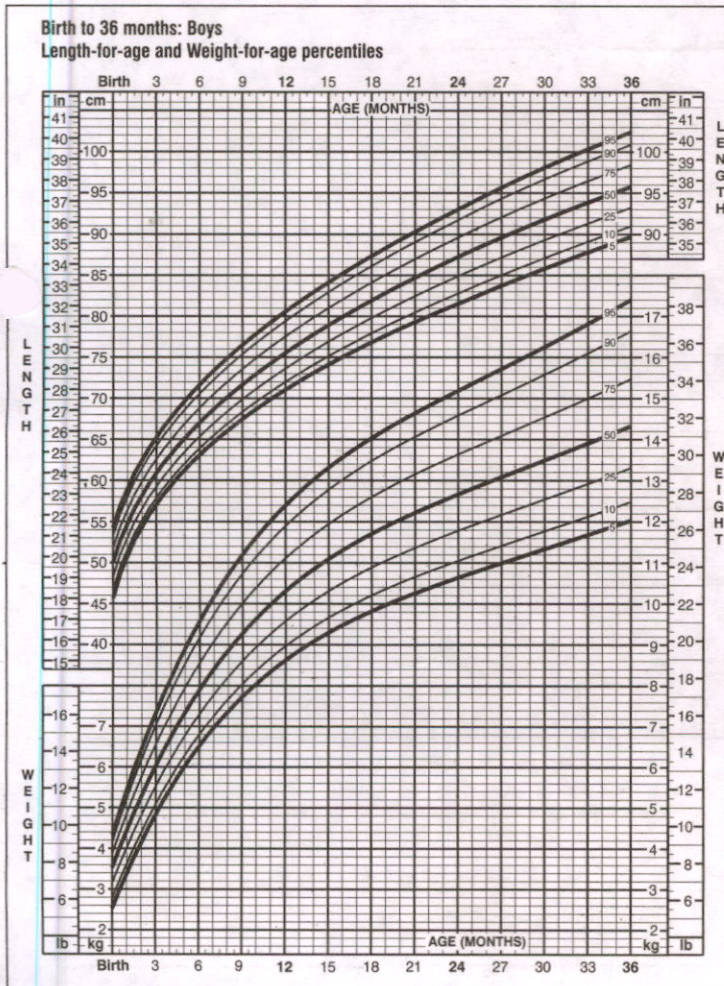
Food Allergies: No Veg/Non-veg: Non-veg

Diagnosis: hand-foot mouth disease & dehydration

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: Aneta

GROWTH CHART (BOYS)



Dietician's Name: monica

Dietician's Signature: monica

Daily Notes:

9/8/26

Child is stable, Intake is fair

8am

ondine

soft diet

same

10/7/26

Child is stable, Intake is fair

9am

ondine

soft diet

same