

ACTIVITY RE

VIH-00206749 IP-00060695
Master AARUSH VARMA
09-05-2017 9 Y 2 M 4 D (M)
Dr. PAPPULA SINDHURA

Name: -----



UHID No : -----

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

Date of Admission : 13/7/20 Time : ----- Date of Discharge : ----- Time: -----

Room / Bed No : 136 Ward : 1st C Suggested Billable bed type : -----

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
<u>13/7/20</u>	<u>7:45 PM</u>	<u>EA</u>	<u>136</u>	<u>Jam</u>

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Sign
13/7	CBP. CRP. electrolyte	26023564	nee
	Chest. v. eg. LFT		
	X-Ray Chest	26011305	nee
14/7	GPBS - 30Am - 85mgbl	²³⁶⁸³ 26024098	nee
	Cross checked by nee 12/7/06		
14/7	CSF Analysis	26023648	
14/7	BBP - Cross checked	by nee 18/7/06	
14/7	EEG	26-011316	nee
14/7	EEG	26-011520	
	Cross checked by nee 18/7/06		

[illegible][illegible]

PROCEEDURE

Date	ProceEDURE	Quantity	Order No.	Signature
12/17	IV Placement	1	3101307	Ne
	Cross checked by <i>[Signature]</i> 12/17/26			
14/2	Lumbar. puncture.	1	3101381	<i>[Signature]</i>
	conscious sedation	1	3101440	
15/2	IV placement	1	3101984	<i>[Signature]</i>
	Cross checked by <i>[Signature]</i> 18/2/26			

ANY OTHER INFORMATION

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward <i>[Signature]</i> 18/2/26 @ 8pm	Billing Assistant	Billing Supervisor
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DEFICIENCY CH MEDICAL CASE SHEET

VH-00206749 IP-00060695

Master AARUSH VARMA

09-05-2017 9 Y 2 M 9 D

Dr. PAPPULA SINDHURA

(M)

IP.No:

DOA:

Rainbow
Children's
Hospital

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Patient Name :

Ward:



Sl.No	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission Sheet	01	-	-	
2	Discharge Summary	02	-	-	
3	Nursing Initial assessment form	03	-	-	
4	Patient Transfer Forms	01	-	-	
5	In-patient Medical Record	03	-	-	
6	Doctors Progress Sheets	03	-	-	
7	Nurses Progress notes	05	-	-	
8	Consultation Sheets	-	-	-	
9	General Consent for Treatment	01	-	-	
10	Consent for Surgery	-	-	-	
	Consent for Blood Transfusion	-	-	-	
12	Consent for Chemotherapy	-	-	-	
13	Consent for High Risk	-	-	-	
14	Consent for Restraint	-	-	-	
15	DAMA Consent	-	-	-	
16	Consent for Special Procedure	01	-	-	
17	Consent for Radiological Investigations	-	-	-	
18	Consent for HIV Test	-	-	-	
19	Anaesthesia consent form	01	-	-	
20	Anaesthesia notes (Pre Anaesthesia & Post)	02	-	-	
21	Pre Operative checklist	-	-	-	
22	Surgical safety Checklist	-	-	-	
23	Operation Theatre notes	-	-	-	
24	Nurses Clinical Presentation	-	-	-	
25	TPR & BP chart	05	-	-	
26	Intake and Output chart (fluid Chart)	03	-	-	
	Drug Chart (Regular prescription)	03	-	-	
28	Daily Investigation sheet	-	-	-	
29	Investigation Values (Result Sheet)	01	-	-	
30	Nebulization Chart	-	-	-	
31	Diabetic chart	-	-	-	
32	Nutritional Review chart	01	-	-	
33	MLC form (in case of MLC)	-	-	-	
34	Patient Education Form	-	-	-	
	Humpty Dumpty	03	-	-	
	Thrombophlebitis	02	-	-	
	Pain Assessment	02	-	-	
	Braden Q	04	-	-	
	DVT	01	-	-	
	0-Illness	03	-	-	
	Total No. of Pages	56			

Signature and Date :

Noted by Anitha
18/4/26
@-847

ERROR LOG

LOCATION: - NICU / PICU / HDU / OT / GENERAL WARD

ICD CODE :-

OBSERVATION: -

DATE :

MRD EXECUTIVE

ADMISSION SHEET

Registration Details :


Admission No : IP-00060695 **Admit Date** : 13-Jul-2026 **Admit Time** : 06:11 PM **UHID** : VIH-00206749

Patient Details :

Patient Name :	Master AARUSH VARMA	Age :	9 Y 2 M 4 D
Guardian :	SRINIVAS	DOB :	09-05-2017
Gender :	Male	Religion :	
Occupation :		Martial Status :	
Address (H) :	HNO-5-86 MAMIDIPALLY VILLAGE DANDEPALLY Dandepalli Adilabad Telangana INDIA 504206	Phone No :	9849735343
		E-mail :	na@gmail.com

Admission Details :

Bed Type : SHARED WARD **Bed No** : ER 101 **Ward Name** : N 0 GF-EMERGENCY
Room No : ER 101 **Admission Type** : First Visit

Contact Details :

Name : SRINIVAS **Relationship** : S/O
Contact Address : HNO-5-86 MAMIDIPALLY VILLAGE
 DANDEPALLY Dandepalli Adilabad Telangana
 INDIA 504206 **Phone No** :

Signature

Doctor Details :

Doctor Name : Dr. PAPPULA SINDHURA **Specialisation** : PEDIATRIC NEUROLOGY
Referral Doctor : Dr G Srinivas **Phone No** : 9440469925
Co-Consultant :

Payment Details :

Deposit Amount : 20000.00
Payment Mode : DC/CC Card **Payor Name** : SELFPAY

PATIENT TRANSFER FORM

Patient Name & UHID No. VIH-00206749 IP-00060695 Master AARUSH VARMA 09-05-2017 9 Y 2 M 4 D (M) Dr. PAPPULA SINDHURA 		Date & Time of Admission 13/7/20 @ 6.11 PM	Date & Time of Transfer Order 13/7/20 @ 7.45 PM
Transfer Ordered by Dr. Shrikar		Reason for Transfer Admission	
From Unit ER	To Unit 202	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 28	Number of Imaging Films —	Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring Samuel J. Lora		Name of Person Ordered Transfer Dr. Shrikar	
Patient & Clinical Records Received by : Dr. Anitha			
Date & Time of Patient Received : @ 7.50 AM			

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

Patient: VIH-00206749 AADIISH VARMA UHID: VIH-00206749 IPD: IP-00060695 Gender: Male Age: 9 Y 2

M 4 Master AARUSH VARMA
09-05-2017 9 Y 2 M 4 D
Dr. PAPPULA SINDHURA (M)



Patient ID: _____



EMERGENCY ROOM TRIAGE FORM

Patient's Name: mj. Aarush Age: 9y Gender: ☒ Male ☐ Female

Date: 13/7/26 Time of Arrival: 6.50 PM

Allergies: ☒ No ☐ Yes ☐ Food ☐ Medications ☐ Blood Transfusion ☐ Other (Specify): _____ ☐ Not known

Source of Information: ☒ Parents ☐ Others (Specify): _____

Mode of Arrival: ☒ Ambulatory ☐ Wheelchair ☐ Ambulance

Initial Vital Signs: Temp: 97.36 PR: 100bpm BP: 110/70 RR: 22bpm SpO₂: 98%

Chief Complaints: Seizure

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

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

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

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian: [Signature]
Triage Completion Time: 6.55 PM

Communicable Disease Triage Screening

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

- Have you had fever (elevated temperature) in the past 2 weeks? ☒ Yes ☐ No
- Have you had cough or a rash in the past 2 weeks? ☒ Yes ☐ No
- Have you had shortness of breath or difficulty breathing in the past 2 weeks? ☒ Yes ☐ No

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

- Have you travelled outside the INDIA? or had close contact with someone who has recently travelled outside the INDIA, in the past two weeks? ☒ Yes ☐ No
If yes, State Location: _____
- Are your parents / close contacts at home is/a healthcare worker? (please encircle the choices) (e.g., nurse, physician, ancillary services personnel, allied health services personnel, hospital volunteer, or laboratory worker, others) who has had a recent exposure to an individual with a highly communicable disease or unexplained, severe febrile respiratory or rash disease? ☒ Yes ☐ No

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

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

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

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

Name of Triage Nurse: Bro. Sanyal

Signature of Triage Nurse: [Signature]

Date & Time: 13/7/26 @ 6.55 PM

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

Patient Name : Mast AARUSH VARMA UHID : VIH-00206749 IPD : IP-00060695 Gender : Male Age : 9 Y 2

M 4 VIH-00206749 IP-00060695
Master AARUSH VARMA
09-05-2017 9 Y 2 M 4 D (M)
Dr. PAPPULA SINDHURA



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BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 13/7/26 Time of arrival : 26.56 PM

Chief Complaints : Seizure since today RBS :

Height : Weight : 18kg BMI : Head Circumference (<2 years) :

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

If yes, identify :

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

☐ Character ☐ Location ☐ Frequency ☐ Duration

RISK FOR FALL:

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

☒ If Patient is > 6 years

Assess the below parameters

History of Falling: within past 3 months

☐ Yes ☒ No

Ambulatory Aids:

- Wheelchair
- Uses furniture for support

☐ Yes ☒ No
☐ Yes ☒ No

Gait/Transferring:

- Bedrest / immobile
- Weak
- Impaired

☐ Yes ☒ No
☐ Yes ☒ No
☐ Yes ☒ No

Mental Status: Forgets limitations

☐ Yes ☒ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening: ☒ No Abnormalities Detected

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

Inform consultant for positive criteria

Nutritional Screening: ☒ No Abnormalities Detected

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

Inform consultant for positive criteria

Psychological Screening: ☒ No Significant Findings

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

If Yes Consultant Notified: (Date/Time):

Social History: Lives With family

Siblings in household ☐ Yes ☒ No (if yes How Many?)

Time of Initial assessment completed by ER Nurse : 7 PM

Patient Name : Mast. AARUSH VARMA UHID : VIH-00206749 IPD : IP-00060695 Gender : Male Age : 9 Y 2 M 4 D

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

Time	Nursing Notes
6.50 pm	Pt came to ER.
6.52 pm	Pt vitals checked and Record Done.
7.00 pm	Dr. Shrikar seen the Pt advice Admission.
7.06 pm	Pt admission process Done -
7.20 pm	IV placement Done -
7.45 pm	Pt shift ER to 131

Samples collected by:

Time: - 7.30 pm

Samples sent by:

S sis. mogishna

Time: - 7.35 pm

Medication given in ER:

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

Condition of patient at time of shift - out :	Details of Shift - out
HR: 100bpm BP: 110/70mmHg CFT: Clear	Shift - out from ER to: 131
RR: 22bpm SPO ₂ : 98%	Time of Shift - out: 7.45 pm
GCS: 15 Temperature: 97.3°F	Handover given to: Dr. Anitha
Pain Score: 0	(Nurse's Name)
Repeat RBS (if applicable):	by. Santal

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any):

IV cannulization.

Name of the Nurse: Santal

Signature of the Nurse: 

Date & Time: 13/12/20 @ 7:45 pm



Nursing General Admission Assessment Form For Pediatrics

Diagnosis: Seizures

Arrival Time: 7.45pm Mode of Arrival: Taken by mother Admitting From: ☒ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction - Body Weight: 18 Kg

Height: 7 cm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
<u>-</u>	<u>-</u>	<u>-</u>

Family History: Nil

Has the child or close family member had recent contact with a communicable disease? ☐ Yes ☒ No

If yes please list Nil

Was the child's birth normal? ☒ Yes ☐ No If No, please describe problems: Nil

Are the child's immunization up to date? ☒ Yes ☐ No

Current Medication: ☐ None ☒ Yes, If Yes, fill reconciliation form

Observations: Weight: 18 kg Length: - Head Circumference (< 2 years): Nil

Temp: 98.6 F HR: 100 bpm RR: 22 bpm BP: 96/62/43 mmHg

Pain Score: 0 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 24) (Document in the Braden Q Assessment Sheet)

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

Character of Pain - Location - Frequency - Duration -

FUNCTIONAL SCREENING: ☒ No Abnormalities Detected

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

Inform consultant for positive criteria

NUTRITIONAL SCREENING: ☒ No Abnormalities Detected

- ☐ Underweight ☐ Overweight ☐ Special Feeding Method
☐ Feeding Problem ☐ Special diet ☐ No Abnormality Detected

Inform consultant for positive criteria

Psychological Screening: ☐ No Significant Findings

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

If Yes Consultant Notified: AN1 (Date/Time): —

Social History: Lives With parents

Siblings in household ☒ Yes ☐ No (if yes How Many?) 1

All Information Obtained From ☐ Patient ☒ Mother ☐ Father ☐ Other Family Member

Orientation has been given regarding the following aspects:

Call Bell in Reach: ☒ Yes ☐ No Waste Disposal Explained: ☒ Yes ☐ No

Infusion Pump: ☒ Yes ☐ No Hand hygiene Explained: ☒ Yes ☐ No ☐ Others

Patient Rights & Responsibilities: ☒ Yes ☐ No

Information given to parents

Nurse's Name: Anitha Date: 13/7/26 Time: @ 8pm

Anitha
Signature



It takes a lot to treat the little.

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: _____

VIH-00206749 IP-00060695

Master AARUSH VARMA

09-05-2017 9 Y 2 M 4 D (M)

Dr. PAPPULA SINDHURA

UHID ID: _____



Department: _____

Consultant: _____



Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

- 1st episode of shorlis epilepsy on 9/7
- 4th recurrence of seizure

History of present illness :

- (2) at Birth and Development
Good at studies
- on Monday at night - had stomach ache and
loose stools - at 5am when mother observed
child had face deviation with frothing
and tonic jerking of face. - bringing till he
reach the hospital.
not associated with fever
no behaviour issues before
- today. recurrence at 8am → tonic posturing
of limbs & Headache



Pediatric Multiorgan History & Physical Examination

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

Birth & Neonatal History:

3rd CM (N) Perinatal history

Birth & Socio Economic History:

About Father : _____

About Mother : _____

Any additional Information : _____

Developmental History :

→ (N)

Immunization History :

- uphodelle



Pediatric Multiorgan History & Physical Examination

Anthropometry :

Head Circum (cms) _____ (Centile _____) Height (cms): _____ (Centile) _____
Weight (kgs)) 18 kg (Centile _____)

On Examination :

Temperature : Afebr Pulse Rate : _____ B.P. _____ SP02 _____

Resp. rate and type of breathing : _____
20/min

Rash _____

Lymphadenopathy _____

Oedema : _____

Allergies (if any): _____

Respiratory System :

Inspection (any s/o distress) : _____

Air entry & breath sounds : SM @

Any addles sounds : _____

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

Cardiovascular System :

Inspection of procordium : _____

Heart Sounds : SC 7

Any murmur : _____

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

Per Abdomen :

Inspection _____

Palpation : soft

Ausculation : _____

Spine : _____ External Genitalia : _____

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



Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : _____

Cranial Nerves : ENTIRE

Motor System:

Nutrition : _____

Tone: _____ Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR

Superficials:

Plantars _____

Sensory System :

Bladder / Bowel : _____

Clinical Summary & Diagnostic:

First Episode of Unprovoked focal Seizure (motor)
with impaired awareness.
? SELECTS / ? genetic



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: To prevent complications

Desired goals of the treatment: To treat the underlying cause

Planned Labs:

☒ CBP
☒ CRP
☒ Chest X-ray
☒ U/E
☒ (Ca/Mg/P) hold
☒ Urea & creat
☒ UFT
☒ Bone pain

TIn MRI at CID neuro

Planned Management

2ND MRI 30 up/ly/day
← CSF → protein
leukocyte
Autoimmune Panel.

Not edb &
negative
13/7/26

Signature of the Doctor: 

Name of the Doctor: Dr. Jayaram

Date & Time: 13/7/26

Signature of the Consultant: 

Name of the Consultant: P. Sindhu

Date & Time: _____



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
13/9/26 10:20 PM	Surfing under - This is a case of unprovoked seizure? Genetic etiology - Being shifted to PICU for Limbic Pilex. at 5 AM on 14/9/26.	
14/9/26 4:00 PM	For - send cef for - protein leukocyte Anticholinergic panel.	
14/9/26 8:00 AM	<u>Procedure Notes</u> Procedure done under strict Aseptic precautions. Shortsuction given. Clear CF obtained. Collected samples. No post procedure immediate complications. No Bleeding. Child Alert. vital stable.	Adv - send cef for protein, lactate & Anticholinergic panel.

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	STB Neurology	
14/7	AMI - Repetitive focal status epilepticus 3 episodes in last 1 week with increased hyperactivity & angry issues also - ↑ autoimmune encephalitis No further seizures no fever, vomiting Vitals - (14) pupils - R/L equal, reacting fem - fixed (14) one good anticipatory movements DTR - elicitable	Plan → MRS baclofen TID → CSF analysis → CSF (metab) Hold → CSF autoimmune panel (AIDS Kochs) Hold
		Noted by Manasa 14/7 2:15 PM

Date & Time	Progress Notes	Doctor's Order
10/7	SIR <u>Neurology</u>	
	No further seizures	
10/6	Intake - (R) ADTone Pancu-dfs	<u>Surveillance</u> <u>9:00 pm</u>
		Noted by Manisha 10/7/26 @8pm

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

(P.T.O)



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	SIB <u>neurology</u>	
8/12/6	<u>ADIS</u> - Acute repetitive focal status epilepticus <u>ADIS</u> - 1 ITES ↑ Antiepileptic concentration	(ADIS) Team CSF AE panel
	<u>ADIS</u> - No further seizures	Stop ITES keep
	(ADIS) WJAL - (N) conscious, oriented pupils - equal size	Stop keep 3.6 ml PO BA
		Noted by manisha 15/12/26



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	<u>SIB Necessary</u>	
10/7	<u>ASTI</u> - Acute 'repetitive' focal status	(Plan)
	<u>QNO</u> - ? ITES ! AE	<u>CT scan</u>
	No further seizures Sleep - good	<u>Take CSF AE panel</u>
(OK)	Wtack (10) conscious, oriented	<u>1/1m EEG</u>
	Exam - full	
	(14) tone	
	power - 7/15 in all 4 limbs	
	DR - 12	
	planks - 40s	
		Noted by manisha 16/7/26 @ 2pm



NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: <u>Focal Seizure</u>		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:					
	Surgery / Procedure: <u> </u>		Post OP Day: <u> </u>					
BACKGROUND	Date	<u>13/7/24</u>	<u>13/7</u>	<u>13/7</u>	<u>14/7/26</u>	<u>14/7/26</u>	<u>14/7/26</u>	
	Shift	<u>136</u>	<u>E</u>	<u>N</u>	<u>M</u>	<u>E</u>	<u>N</u>	
	Medical Condition (Any special condition to be noted):	<u> </u>	<u>Nil</u>	<u>Nil</u>	<u>Nil</u>	<u>Nil</u>	<u>Nil</u>	
ASSESSMENT	Diet:	<u>Normal</u>	<u>N. diet</u>	<u>N. diet</u>	<u>S. diet</u>	<u>S. diet</u>	<u>S. diet</u>	
	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Ventilation (RA, NP, NIV, VENTI):	<u>RA</u>	<u>RA</u>	<u>RA</u>	<u>RA</u>	<u>RA</u>	<u>RA</u>	
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Vital Signs:	Temp:	<u>97.3°F</u>	<u>98.2°F</u>	<u>98.6°F</u>	<u>98.4°F</u>	<u>98.6°F</u>	<u>98.1°F</u>
		Res:	<u>22b/m</u>	<u>22b/m</u>	<u>22b/m</u>	<u>26b/m</u>	<u>24b/m</u>	<u>26b/m</u>
		SpO ₂ :	<u>98%</u>	<u>99%</u>	<u>98%</u>	<u>99%</u>	<u>99%</u>	<u>98%</u>
		Pulse:	<u>100b/m</u>	<u>100b/m</u>	<u>100b/m</u>	<u>120b/m</u>	<u>105b/m</u>	<u>109b/m</u>
		BP:	<u>110/70(8)</u>	<u>108/70(7)</u>	<u>105/68(7)</u>	<u>102/66(7)</u>	<u>100/68(6)</u>	<u>94/41(5)</u>
		LOC:	<u>conscious</u>	<u>conscious</u>	<u>conscious</u>	<u>conscious</u>	<u>conscious</u>	<u>conscious</u>
		Fall Risk Score:	<u>12</u>	<u>12</u>	<u>12</u>	<u>12</u>	<u>12</u>	<u>12</u>
	Pain Score:	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	
	Skin Integrity	<u>Intact</u>	<u>Intact</u>	<u>Intact</u>	<u>Intact</u>	<u>Intact</u>	<u>Intact</u>	
	Recommendations	Safety Needs:	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No
		Physiotherapy:	<u> </u>	<u>Nil</u>	<u>Nil</u>	<u>Nil</u>	<u>Nil</u>	<u>Nil</u>
Others Specify:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
Special Diet:		<u>Normal</u>	<u>N. diet</u>	<u>N. diet</u>	<u>S. diet</u>	<u>S. diet</u>	<u>S. diet</u>	
Critical Lab Test / Values:		<u> </u>	<u>Nil</u>	<u>Nil</u>	<u>Nil</u>	<u>Nil</u>	<u>Nil</u>	
Other Special Orders / Medications:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
PU Prophylaxis:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
DVT Prophylaxis:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
ADL (Dependent / Non Dependent):	<u>Dependent</u>	<u>Dependent</u>	<u>Dependent</u>	<u>Dependent</u>	<u>Dependent</u>	<u>Dependent</u>		
Post Operative Procedure Special Orders:		<u> </u>	<u>Nil</u>	<u>Nil</u>	<u>Nil</u>	<u>Nil</u>	<u>Nil</u>	
Handed Over By Name :		<u>BN, Sany</u>	<u>Anitha</u>	<u>Sande</u>	<u>Manasa</u>	<u>Manisha</u>	<u>Vaishnavi</u>	
Signature / ID :		<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>	
Date:		<u>13/7/24</u>	<u>13/7</u>	<u>14/7/26</u>	<u>14/7/26</u>	<u>14/7/26</u>	<u>15/7/26</u>	
Time:		<u>07:45pm</u>	<u>@8pm</u>	<u>@8pm</u>	<u>@2pm</u>	<u>@8pm</u>	<u>@8am</u>	
Taken Over By Name :		<u>Anitha</u>	<u>Sande</u>	<u>Manasa</u>	<u>Manisha</u>	<u>Vaishnavi</u>	<u>Manisha</u>	
Signature / ID :		<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>	
Date:		<u>13/7</u>	<u>13/7/26</u>	<u>14/7</u>	<u>14/7/26</u>	<u>14/7/26</u>	<u>15/7/26</u>	
Time:		<u>@7:50pm</u>	<u>@8pm</u>	<u>@8am</u>	<u>@2pm</u>	<u>@8pm</u>	<u>@8am</u>	



NURSING SHIFT HAND OVER FORM

SITUATION		Diagnosis: <u>Focal seizure</u>					
		Any Infection: ☐ Yes ☒ No ☐ Not Known					
		If Yes Specify:					
		Surgery / Procedure:					
		Post OP Day:					
BACKGROUND	Date	15/7/26	15/7	15/7/26	16/7/26	16/7	16/7
	Shift	M	Evening	Night	M	E	N
	Medical Condition (Any special condition to be noted):	Nil	Nil	Nil	Nil	Nil	Nil
ASSESSMENT	Diet:	S. diet	S. diet	S. diet	S. diet	S. diet	S. diet
	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Ventilation (RA, NP, NIV, VENTI):	RA	RA	RA	RA	RA	RA
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:						
	Temp:	98.4°F	98.6°F	98.6°F	98.6°F	98.6°F	98.12
	Res:	27b/m	28b/m	27b/m	28b/m	28b/m	27b/m
	SpO ₂ :	99.1	96.1	100%	99%	100%	99%
	Pulse:	110b/m	112b/m	112b/m	113b/m	104b/m	112b/m
	BP:	102/77	110/60	101/75	110/79	103/63	102/79
	LOC:	conscious	conscious	conscious	conscious	conscious	conscious
	Fall Risk Score:	12	12	12	12	12	12
	Pain Score:	0	0	0	0	0	0
	Skin Integrity	Intact	Intact	Intact	Intact	Intact	Intact
	Recommendations	Safety Needs:	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No
Physiotherapy:		Nil	Nil	Nil	Nil	Nil	Nil
Others Specify:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
Special Diet:		S. diet	S. diet	S. diet	S. diet	S. diet	S. diet
Critical Lab Test / Values:		Nil	Nil	Nil	Nil	Nil	Nil
Other Special Orders / Medications:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
PU Prophylaxis:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
DVT Prophylaxis:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
ADL (Dependent / Non Dependent):		Dependent	dependent	Dependent	Dependent	dependent	dependent
Post Operative Procedure Special Orders:		Nil	Nil	Nil	Nil	Nil	Nil
Handed Over By Name :	manisha	Subham	manisha	manisha	manisha	Aniltha	
Signature / ID :	manisha	Subham	manisha	manisha	manisha	Aniltha	
Date:	15/7/26	15/7/26	16/7/26	16/7/26	16/7/26	17/7/26	
Time:	@ 2pm	@ 8pm	@ 8pm	2pm	@ 8pm	@ 8am	
Taken Over By Name :	manisha	manisha	manisha	manisha	manisha	manisha	
Signature / ID :	manisha	manisha	manisha	manisha	manisha	manisha	
Date:	15/7/26	15/7/26	16/7/26	16/7/26	16/7/26	17/7/26	
Time:	@ 2pm	@ 8pm	@ 8am	@ 2pm	@ 8pm	@ 8am	

NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: <u>Focal Seizure</u>			Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:			
	Surgery / Procedure:			Post OP Day:			
BACKGROUND	Date	17/7/26 M	17/7 Evening	17/7 N			
	Shift						
	Medical Condition (Any special condition to be noted):	<u>Nil</u>	<u>Nil</u>	<u>Nil</u>			
	Diet:	<u>S. diet</u>	<u>S. diet</u>	<u>S. diet</u>			
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Ventilation (RA, NP, NIV, VENTI):	<u>RA</u>	<u>RA</u>	<u>RA</u>			
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:	Temp: <u>98.6°C</u>	Temp: <u>98.6°F</u>	Temp: <u>98.4°F</u>			
	Res:	<u>28 blm</u>	<u>20 blm</u>	<u>22 blm</u>			
	SpO ₂ :	<u>99%</u>	<u>100%</u>	<u>100%</u>			
	Pulse:	<u>110 blm</u>	<u>92 blm</u>	<u>106 blm</u>			
	BP:	<u>102/72(62)</u>	<u>110/78(81)</u>	<u>94/54(68)</u>			
	LOC:	<u>conscious</u>	<u>conscious</u>	<u>conscious</u>			
	Fall Risk Score:	<u>12</u>	<u>10</u>	<u>10</u>			
	Pain Score:	<u>0</u>	<u>0</u>	<u>0</u>			
	Skin Integrity	<u>Intact</u>	<u>Intact</u>	<u>Intact</u>			
Recommendations	Safety Needs:	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Physiotherapy:	<u>Nil</u>	<u>Nil</u>	<u>Nil</u>			
	Others Specify:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Special Diet:	<u>s. diet</u>	<u>S. diet</u>	<u>S. diet</u>			
	Critical Lab Test / Values:	<u>Nil</u>	<u>Nil</u>	<u>Nil</u>			
	Other Special Orders / Medications:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	PU Prophylaxis:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	DVT Prophylaxis:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
ADL (Dependent / Non Dependent):	<u>Dependent</u>	<u>dependent</u>	<u>Dependent</u>				
Post Operative Procedure Special Orders:		<u>Nil</u>	<u>Nil</u>	<u>nil</u> <u>noted by</u>			
Handed Over By Name :		<u>manisha</u>	<u>Subham</u>	<u>Anitha</u>			
Signature / ID :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>			
Date:		<u>17/7/26</u>	<u>17/7/26</u>	<u>18/7/26</u>			
Time:		<u>@ 2 pm</u>	<u>@ 8 pm</u>	<u>@ 8 pm</u>			
Taken Over By Name :		<u>Subham</u>	<u>Anitha</u>				
Signature / ID :		<u>[Signature]</u>	<u>[Signature]</u>				
Date:		<u>17/7</u>	<u>17/7/26</u>				
Time:		<u>@ 2 pm</u>	<u>@ 8 pm</u>				



NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:				
	Surgery / Procedure:		Post OP Day:				
BACKGROUND	Date						
	Shift						
	Medical Condition (Any special condition to be noted):						
	Diet:						
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Ventilation (RA, NP, NIV, VENTI):						
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Vital Signs:	Temp:					
		Res:					
		SpO ₂ :					
		Pulse:					
		BP:					
		LOC:					
		Fall Risk Score:					
		Pain Score:					
		Skin Integrity					
	Recommendations	Safety Needs:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
		Physiotherapy:					
Others Specify:		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
Special Diet:							
Critical Lab Test / Values:							
Other Special Orders / Medications:		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
PU Prophylaxis:		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
DVT Prophylaxis:		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
ADL (Dependent / Non Dependent):							
Post Operative Procedure Special Orders:							
Handed Over By Name :							
Signature / ID :							
Date:							
Time:							
Taken Over By Name :							
Signature / ID :							
Date:							
Time:							



NURSING CARE RECORD

Date: 13/7/21

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	Nurse Name & Signature
Morning							
Afternoon	7.50pm 8pm	→ Ensure Safety		→ To Side rails kept up	→ To prevent falls risk	→ Patient is Stable	Aneth 13/7 @8pm
Night	11:00 7:00	maintain fluid Balance. maintain aseptic technique	11:30 7:30	maintained fluid Balance. maintained aseptic technique	maintain Hydration prevent from Infection	patient is stable no fresh complaints	Sindu @8pm 13/7

VIH-00206749 IP-00060695
 Master AARUSH VARMA
 09-05-2017 9 Y 2 M 4 D (M)
 Dr. PAPPULA SINDHURA



NURSING CARE RECORD

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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Date: 14/7/26

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	Re-Assessment	Nurse Name & Signature
Morning	9am	Maintain fluid balance		Administered IV fluid DNS 35ml/hr	To prevent from dehydration.	patient is stable.	Manisha 14/7/26 @2pm
Afternoon	3pm	- maintain fluid Balance - Ensure safety		- Administered IV fluid DNS 35ml/hr - side rail kept up	- To maintain hydration - prevent from fall risk	- patient is stable	Manisha 14/7/26 @ 8pm
Night	9pm	Maintain fluid Balance - Ensure safety	9:30 pm	- Maintained input/output chart - provided side rails	- To prevent dehydration - To prevent falls	- patient is stable	Vishu 15/7/26 @ 8am



NURSING CARE RECORD

Date: 16/7/26

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	Nurse Name & Signature
Morning	8pm	Maintain Good nutritional status.		Oral intake is Good.	provided by soft diet	patient is stable	memsha 16/7/26 at: 2 pm
Afternoon	8pm	Ensure safety		Side rails kept up.	To prevent from fall risk	patient is stable	memsha 16/7 @ 8pm
Night	11pm	Maintain Good Nutritional status - Ensure safety	11:10 pm	- Encouraged Oral intake - provided side rails	- To prevent Maintain Nutrition - To prevent falls	- patient is stable	Aniltha 17/7 @ 8pm



NURSING CARE RECORD

Date: 15/9/26

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: <u>nil</u> | | | | |

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	9am	- maintain good nutritional status - ensure safety	9:30 AM	- oral intake is good - side rail kept up	- provided soft diet - prevent from fall risk	- patient is stable	manisha 15/9/26 Rupm
Afternoon	4pm	→ maintain good nutritional status	4pm	→ oral intake is good	Provided by soft diet	→ patient is stable	Subh 15/7 @ 8pm
Night	11 pm	→ maintain good nutritional status	11:10 pm	→ oral intake is good	Provided by soft diet	→ Patient is stable	R 15/7 at 10pm

NURSING CARE RECORD

Date: 17/7/26

Goals

- ☐ Maintain Airway and Oxygenation
- ☒ Maintain Personal Hygiene
- ☐ Identify Potential Complications
- ☐ Relieve Pain & Discomfort
- ☐ Prevent Infection
- ☐ Any Others. Specify: Nil
- ☐ 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	Re-Assessment	Nurse Name & Signature
Morning	8Am	maintain Good nutritional status		- oral intake is Good	Provided by soft diet	Patient is stable	17/7/26 @
Afternoon	4pm	→ Ensure safety	4pm	→ Side rails kept up	→ Prevent from fall risk	→ Patient is stable	Subhram 17/7 @ 8pm
	5pm	→ maintain personal Hygiene		→ Provided Hand washing and hand hygiene	→ To Prevent infection		
Night	9pm	→ Maintain Good Nutritional Status		→ oral intake is Good	→ provided by Soft diet	→ patient is Stable	Amelia 18/7 @ 8Am
	11pm	→ Ensure Safety		→ side rails kept up	→ prevent from fall risk		
	8Am	Discharge note :-		Doctor come for rounds & advice Discharge			

Noted by

VIH-00206749 IP-00060695
 Master AARUSH VARMA
 09-05-2017 9 Y 2 M 7 D (M)
 Dr. PAPPULA SINDHURA



NURSING CARE RECORD



Date:

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	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon							
Night							



THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
			13/7/14	14/7/14	14/7	15/7	15/12
Age	Less than 3 years old	4					
	3 to less than 7 years old	3					
	7 to less than 13 years old	②	2	2	2	2	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	1
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own ability	1	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	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	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	1
Total			10	10	10	10	10

Intervention:

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position	✓	✓	✓	✓	✓	✓
Call device within reach	✓	✓	✓	x	✓	✓
Wheels Locked	✓	✓	✓	✓	✓	✓
Room free of clutter	✓	✓	✓	✓	✓	✓
Adequate lighting	✓	✓	✓	✓	✓	✓
Wheel chair safe	x	x	x	x	x	x
Other Intervention(s) Specify	x	x	x	✓	✓	✓
Nurse's Name:	Bw Saiy	Archi	manisha	manisha	manisha	manisha
Signature:	SK	Archi	manisha	manisha	manisha	manisha
Date:	13/7/14	14/7	14/7	14/7	15/7	15/7
Time:	7:05 PM	8 AM	1 PM	3 PM	12 AM	9 AM



THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
			5/7	15/7	16/7	16/7	16/7
Age	Less than 3 years old	4					
	3 to less than 7 years old	3					
	7 to less than 13 years old	2	2	2	2	2	2
	13 years old and above	1					
Gender	Male	2	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	1
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own ability	1	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	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	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	1
Total			10	10	10	10	10

Intervention:

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		✓	✓	✓	✓	✓
Call device within reach		x	x	x	x	x
Wheels Locked		✓	✓	✓	✓	✓
Room free of clutter		✓	✓	✓	✓	✓
Adequate lighting		✓	✓	✓	✓	✓
Wheel chair up		x	x	x	x	x
Other Intervention(s) Specify		✓	✓	✓	✓	✓
Nurse's Name:		Sukh	Pam	manish	manish	manish
Signature:		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date:		5/7	15/7	16/7	16/7	16/7
Time:		8pm	10pm	2AM	12PM	3pm

VIH-00206749 IP-00060695

Master AARUSH VARMA

09-05-2017

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(M)

Dr. PAPPULA SINDHURA



THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
			16/5	17/5/2017	17/5		
Age	Less than 3 years old	4					
	3 to less than 7 years old	3					
	7 to less than 13 years old	2	2	2	2	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			10	10	10	10	

Intervention:

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		✓	✓	✓	✓	
Call device within reach		✓	✓	✓	✓	
Wheels Locked		✓	✓	✓	✓	
Room free of clutter		✓	✓	✓	✓	
Adequate lighting		✓	✓	✓	✓	
Wheel chair cup		✓	✓	✓	✓	
Other Intervention(s) Specify		✓	✓	✓	✓	
Nurse's Name:		Anil Kumar	Anil Kumar	Anil Kumar	Anil Kumar	
Signature:		Anil Kumar	Anil Kumar	Anil Kumar	Anil Kumar	
Date:		16/5	16/5	17/5	18/5	
Time:		11pm	2pm	8pm	4Am	



CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	13/5 DAY-1			14/7 DAY-2			15/7 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	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 cord pyrexia	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 : Name : Samuel

Signature of Ward In Charge :

Signature : Name : Elizabeth

VH-00206749
Master AARUSH VARMA
09-05-2017
Dr. PAPPULA SINDHURA
IP-00060695
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(M)

CHECKLIST FOR THROMBOPHLEBITIS

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

S. No.	SITE	STAGE / ACTION	SCORE	16/7/26 DAY-1			17/7 DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0	0	0	0	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				[Signature]			[Signature]			[Signature]			

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 : [Signature] Name : Sadya.

Signature of Ward In Charge :

Signature : [Signature] Name : Elizabeth.



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
13/7/26	7 PM	0		☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	— —	Sanyay
13/7/26	11 PM	0	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	Prade
14/7/26	7 AM	0		☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	Prade
14/7/26	1 PM	0	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	Manasa
14/7/26	4 PM	0	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	manisha
15/7/26	12 AM	0	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	— —	Vaishal
15/7/26	9 AM	0	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	manisha
15/7/26	5 PM	0	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	Subh
15/7/26	10 AM	0	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	R
16/7/26	2 PM	0	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	meenisha

Re-assessment Frequency:

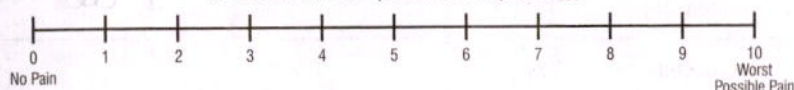
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

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 drawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, rigid, 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

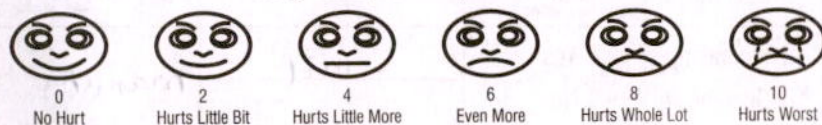
Numerical Pain Scale (Obstetric and Gynecology)



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





PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
16/7	3 PM	0	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	Manava
17/7	12 AM	0	—	☐ Continuous ☒ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	—	Aniltra
17/7	8 AM	0	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	—	manud
17/7	3 PM	0	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	Subher
18/7	12 AM	0	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	Aney
				☐ 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:

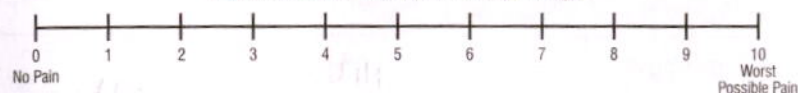
- Every eight hours for all hospitalized patients.
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 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

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 drawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, rigid, 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
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Wong - Baker (Pediatrics) Above 7 Years



VIH-00206749
Master AARUSH VARMA
09-05-2017 9 Y 2 M 4 D
Dr. PAPPULA SINDHURA (M)

BRADEN 'Q' SCALE

		Date :	13/12/13	14/7	14/7			
		Time :	7 PM	4 PM	8 PM			
Mobility	Immobile: 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 extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	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
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
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
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.	1	1	1	1
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 of 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	4	4	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	4	4	4
TOTAL SCORE					25	25	28	28
Evaluator's Name					SM	8	RO	Q

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

Docu. No. : RCH / FRM / CLINICAL / 119

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



BRADEN 'Q' SCALE

				Date :	15/7/2	15/7	15/7	15/7
				Time :	8Am	10Am	5Pm	10Pm
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 extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	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
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
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.	1	1	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 lift up completely during move. Maintains good position in bed or chair at all times."	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	4	4	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	4	4	4
TOTAL SCORE					25	25	28	28
Evaluator's Name					ma	ma	8	2

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)
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



BRADEN 'Q' SCALE

					Date :	16/06/17	16/7	16/7	17/7
					Time :	2 PM	3 PM	12 AM	8 AM
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 extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	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	
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	
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	
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	
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	4	4	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	4	4	4	
TOTAL SCORE					25	28	28	28	
Evaluator's Name					ma	ma	Am	Am	

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)
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

BRADEN 'Q' SCALE

					Date :	17/7/20	17/7	18/7	
					Time :	1 PM	7 PM	3 AM	
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 extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.		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	
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	
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	
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	
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.		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	
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23					TOTAL SCORE	29	27	24	
Docu. No. : RCH / FRM / CLINICAL / 119					Evaluator's Name	[Signature]	[Signature]	[Signature]	

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
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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



WELL'S CRITERIA FOR ASSESSING DVT

NOTE: Assign a score of 1 if 'YES' in parameter 1 to 9 and Assign a score of -2 if 'YES' in parameter No 10

S.No	Assessment Criteria	Score	Date:	Date:	Date:	Date:	Date:	Date:
			13/7	14/7	15/7	16/7	17/7	
			Time:	Time:	Time:	Time:	Time:	Time:
			8pm	2pm	8Am	2Pm	2pm	
1	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)	1	0	0	0	0	0	
2	Bedridden recently >3 days or major surgery within four weeks	1	0	0	0	0	0	
3	Calf swelling >3cm compared with asymptomatic side, measured at 10 cm below tibial tubercle (Assess for both legs)	1	0	0	0	0	0	
4	Collateral (non varicose) superficial veins present (Assess for both legs)	1	0	0	0	0	0	
5	Entire leg swollen (Assess for both legs)	1	0	0	0	0	0	
6	Localized tenderness along the deep venous system (Assess for both legs)	1	0	0	0	0	0	
7	Pitting edema, greater in the symptomatic leg (Assess for both legs)	1	0	0	0	0	0	
8	Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs)	1	0	0	0	0	0	
9	Previously documented DVT (Assess for both legs)	1	0	0	0	0	0	
10	Alternative diagnosis to DVT as likely or more likely (Assess for both legs)/ Co-morbidity like ESLD /Renal disease, Renal failure, CCF Cellulitis (commonly mistaken as DVT), Dependent (stasis) oedema, Lymphatic obstruction.	-2	0	0	0	0	0	
Total Score			0	0	0	0	0	
Signature of the Nurse			Asl	Asl	mea	mea	Subhy	

Intervention: Nil

High Risk = >2 Score

Moderate Risk = 1-2 Score

Low Risk = <1 Score

Note : Daily assessment shall be carried out once every 24 hours and documented

GENERAL CONSENT FOR TREATMENT

Patient Name: Master AARUSH VARMA

Age : 9 Y 2 M 4 D

IP No: IP-00060695

Sex: Male

Consultant: Dr. PAPPULA SINDHURA

Ward/Bed No: N 0 GF-EMERGENCY/ER 101

The undersigned patient and I or responsible relative or person hereby consent to and authorize Rainbow Hospitals doctors and medical personnel to perform medical examinations, conduct routine investigations and administer medical treatments, outpatient procedures, minor dressings, vaccinations and immunizations during the course of the patient's care, as in patient.

Patient, be deemed advisable or necessary.

I understand that the confidentiality of all medical records shall be protected to the full extent of the Law. The undersigned also consent to the use of health related information/ audiovisuals of the patient for research & training purpose or for insurance coverage and while doing so confidentiality of the patient will be maintained at all times and this will not affect the care of the patient.

In giving my general consent to treatment, I understand that I retain the right to refuse any particular examinations, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by treating doctors. I also understand that the practice of medicine is not an exact science and that no guarantee have been made to me as the results of my evaluation and I or treatment.

I understand that I shall not bring valuables to the Hospitals and that the Hospital will not be responsible for the loss, destruction or theft of my personal belongings. I assume full responsibility for all my personal items and release the Hospital from responsibility and liability for such personal items and valuables.

"I am aware that during the patient care it is inevitable that certain re-useable equipment shall be re-used after sterilization and disinfection. I am informed that the hospital assures maximum level of precaution and care in sterilizing and disinfecting the equipment and monitors the whole process as per evidence based guidelines".

Note:

1 We do not allow use of medication brought from outside by the patient.

2 I have received attendant passes as per my room category. I understand that I have to return it back at the time of final bill clearance. In case of failing the submission, I will pay 200/- Rs.

(Receivers Signature:.....)

3 IP Guide book has been given to me and I have been explained about the Hospitals rules and policies.

4 Financial and billing counseling has been done to me.

Signature of Patient/Relative:

Name: SRINIVAS

Relationship: Father

Date: 08/07/20

Witness Name: [Signature]

Witness Signature: [Signature]

Time: 06:11 P.m

Patient Address:

HNO-5-86 MAMIDIPALLY VILLAGE
DANDEPALLY Dandepalli Adilabad
Telangana INDIA 504206

CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MAC

Patient Name : Mast. Anush Varma Age : 9 yrs.
 Gender: M ☐ F ☐ - IP No : Consultant : Dr. Seidhuan
 Ward / Bed No. : Anaesthesiologist : Dr. C.S. Sekhary
 Operative procedure planned : MR Brain

PLEASE READ THIS BEFORE YOU CONSENT FOR ANAESTHESIA

General anaesthesia involves rendering a patient unconscious before an operation. This ensures the patient is not aware of events and does not feel pain during the operation. Drugs given through a vein and / or inhaled from an anaesthesia machine produce it. Regional anaesthesia involves using a local anaesthetic to numb a specific area of the body for surgery. Prolonged pain relief without numbness can be achieved by infusing weak solutions of local anesthetics and narcotic drugs to particular parts of the body after surgery or injury, using catheters.

Specific High Risk (s) : The doctors have explained to me the details of the high risk involved due to the following medical problems and I have sought necessary clarification on all my doubts.

☐ Heart disease ☐ Hypertension ☐ Diabetes mellitus ☐ Renal failure
☐ Hepatic disorders ☐ Shock ☐ Multiple organ failure ☐ Polytrauma / RTA
☐ Incapacitating COPD ☐ Others : hypoxia, ETT / cone placement
 Comments : a ventilation set, seizures

- Doctor to document in medical record also if necessary (Cross-out if not applicable)

DECLARATION BY PATIENT / GUARDIAN / PROXY

I hereby authorize Rainbow Hospital & its authorized doctors to perform upon me / my patient Mast. Anush Varma the above mentioned operation / Diagnostic / Therapeutic procedures MR Brain

I authorize and give consent for anaesthesia (☐ Regional / ☐ General Anesthesia / ☐ Monitored anesthesia care (MAC)) as considered appropriate by the anaesthetic team.

I acknowledge that the anaesthetists have informed me about the anaesthetic procedure, alternative treatments and answered my specific queries and concerns about this matter. I have read and understood the information provided in this form I acknowledge that I have discussed with the anaesthetists any significant risk and Complications specific to my individual circumstances, and I have considered them before Consenting for anesthesia.

I understand that there are some infrequent complications that can occur due to use of anaesthesia, these include pain or some injury at the site of injections, temporary breathing difficulties, asthmatic reactions, headaches.

I authorize the anaesthetic team to perform any additional procedures (for example, CVP line, arterial line, use of nerve blocks for pain relief, changing from regional to general anaesthesia etc), which are considered necessary by them during the course of surgery.

That I authorize and give consent to the team of doctors attending on me to administer blood products during the course of operative period and immediately thereafter in need arises.

I understand that the above mentioned consultant anesthesiologist or occasionally a colleague deputed by him / her will administer the Anaesthesia.

- Pregnant: ☐ Yes ☒ No

DECLARATION BY THE ANAESTHETISTS PROVIDING INFORMATION FOR THIS CONSENT

I declare that I have explained the nature of General Anaesthesia / Regional Anaesthesia / MAC to be given and discussed the risks that particularly concern this patient.

I have given the patient an opportunity to ask questions and I have answered these.

Patient / Patient Attendant :

Signature : E. Srinivas

Name : E. Srinivas

Relationship with Patient: father

Date & Time : 14/7/2026 12:00 am

Witness :

Signature : B. Nagalakshmi

Name : B. Nagalakshmi

Date & Time : 14/7/2026 / 7:00 am

Doctor (who is taking the consent) :

Signature : SAP BARGAVI

Name : SAP BARGAVI

Date & Time : 14/7/26 / 7:00 am

CONSENT FOR SPECIAL SEDATION

Patient Name: Mr. Anurag Verma Gender: ☒ Male ☐ Female
UHID No: 002006909 Department: ICU Date:

I, E. Srivastava S/D/W/O Ranjana

Here by give consent for procedure for my patient:

The doctors have explained to me in language known to me the details of sedation as follows:

- Type of Sedation : MIDAZOLAM / Ketamin
- Possible complications from the procedure of sedation:
↓ HR ↓ BP

The doctors have explained to me about the benefits, risk, alternative of the procedure.

I have understood the matter mentioned above in language known to me and give consent for administering sedation for procedure.

Patient Attendant :

Signature : E. Srivastava

Name : E. Srivastava

Relationship with Patient: father

Date & Time : 13/7/26 / 10:20 PM

Witness :

Signature :

Name :

Date & Time :

Doctor (who is taking the consent) :

Signature : Dr. Anurag

Name : Dr. Anurag

Date & Time : 13/7/26 / 10:20 PM

CONSENT FOR SPECIAL PROCEDURES

Patient Name : Mr. Anush Varma Gender: ☒ Male ☐ Female
UHID No : 00206229 Department : 1st floor Date : _____

I E. Srinivas S/D/W/O laxley
Here by give consent for procedure of : Lumbar puncture.

For my patient, Named : _____

The doctors have clearly explained to me that the procedure has following possible complications:

_____ - Euphoria _____
_____ - Pain _____

The doctor have explained to me about the alternatives, risks and benefits for this procedure that :

I have understood the matter mentioned above in language known to me and give consent for the procedure.

Name of the Doctor performing the procedure: _____

Patient Attendant :

Signature : E. Srinivas
Name : E. Srinivas
Relationship with Patient: Father
Date & Time : 13/7/26 11:02:20 pm

Witness :

Signature : _____
Name : _____
Date & Time : _____

Doctor (who is taking the consent) :

Signature : Dr. Srinivas
Name : Dr. Srinivas
Date & Time : 13/7/26 10:20 pm

**CONSENT FOR ADMISSION
IN PEDIATRIC INTENSIVE CARE UNIT**

Name: Mr. Anurag Sharma Age: 97 Gender: Male ☒ Female ☐

UHID.No : 0020709 Date: 11/12/20

I, E. Srinivas S/o, D/o, W/o, Anurag hereby
declare that our patient Master/Baby who is related to me as
is getting admitted in the Pediatric Intensive Care Unit of Rainbow Children's Hospital on

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

7 SELETS

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

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

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

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

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

Patient Attendant :

Signature: [Signature]

Name: Srinivas

Relationship with Patient: Father

Date & Time: 13/12/20 10.30 PM

Doctor (who is taking the consent) :

Signature: [Signature]

Name: [Signature]

Witness :

Signature:

Name:

Date & Time:

**పిల్లల ఇంటెన్సివ్ కేర్ యూనిట్ లో
అడ్మిషన్ కొరకు సమ్మతి**

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

 **BirthRight[™]**
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

రోగి పేరు వయస్సు లింగం ☐ పు ☐ స్త్రీ

యు.పా.బి.డి శం. d/o. w/o.

నేను అనే బాలుడు / బాలిక యొక్క బికిత్త మేరకు రెయిన్ఫోర్స్ పిల్లల అనుపత్తి లోని పిల్లల ఇంటెన్సివ్ కేర్ యూనిట్

తేదీ నాడు పూర్తి సమ్మతితో వేర్పాడిని.

మా బాలుడి / బాలిక లో ఈ కింద తెలిపిన ఆరోగ్య సమస్యల గురించి విద్య నిపుణుడు నాకు అర్థమగు భాషలో వివరించితిరి.

.....
.....
.....

రెయిన్ బో బిల్డ్ హాస్పిటల్ లోని పీడియాట్రిక్ ఇంటెన్సివ్ కేర్ విభాగం లో చేరించి బిడ్డకు ఆరోగ్య సంబంధిత సమస్యలు ఉన్నాయని వైద్యులు నాకు అర్థమయ్యే భాషలో వివరించారు. రోగి _____ పీడియాట్రిక్ ఇంటెన్సివ్ కేర్ విభాగం లో ఉన్న సమయంలో అతను వివిధ వైద్య మరియు శస్త్ర చికిత్సలకు లోనవుతారని వైద్యులు నాకు స్పష్టంగా వివరించారు. ఎయిర్ వే మేనేజ్ మెంట్, మెకానికల్ నెంటిలేషన్, బొడ్డు ధమని కాథెటర్, బొడ్డు సిర మరియు ధమనుల కాథెటర్ వంటి . పెరిపెరల్ ఇన్ఫర్డ్ వేయబడిన సెంట్రల్ కాథెటర్ లైన్ మరియు ఆర్థో లైన్ ప్లేస్ మెంట్స్, ఛాతీ డ్రైయిన్ లేదా పెరిటోనియల్ డ్రైయిన్ ఇన్సర్షన్ మొదలైనవి.

అటువంటి ప్రక్రియలు చేస్తున్నప్పుడు నాకు సమాచారం ఇవ్వబడుతుందని మరియు దీనికి ప్రత్యేక సమ్మతి ఉంటుందని వైద్యులు నాకు చెప్పారు. ఏదేమైనప్పటికీ, ఏవైనా ప్రాణాంతక అత్యవసర పరిస్థితుల్లో సమాచారం తీసుకోవడానికి సమయం లేకపోతే నా బిడ్డ ప్రాణాన్ని కాపాడేందుకు ఇతర వైద్య ప్రక్రియలకు నేను సమ్మతి ఇస్తున్నాను.

పీడియాట్రిక్ ఇంటెన్సివ్ కేర్ విభాగం లో అనారోగ్యంతో ఉన్న పిల్లవాడికి ప్రాణాంతకమైన వైద్య పరిస్థితులు ఉన్నాయని అర్థం చేసుకోవడమైనది.

ఒక బిడ్డ అనారోగ్యంతో పీడియాట్రిక్ ఇంటెన్సివ్ కేర్ విభాగం లో ఉన్నప్పుడు అతని/ఆమె పై నిర్వహించబడు అనేక వైద్య మరియు శస్త్రచికిత్సా విధానాలతో ఈ అధిక ప్రమాదకరమైన విధానాల వల్ల సంభవించు నష్టాలు మరియు అధిక ప్రమాదకరమైన మందుల రూపంలో అంటువ్యాధులు, రక్తస్రావం, శ్వాసపరమైన, చర్మం మరియు ఇతర కణజాల నష్టం మొదలైనవి కలగవచ్చు డాక్టర్ల నాకు బాగా అర్థమయ్యే భాషలో వివరించారు.

మా బాలుడు / బాలిక ను ఇంటెన్సివ్ కేర్ యూనిట్ (పి.బి.సి.యు) లో చేర్చుకొని అవసరమయ్యే వైద్యం చేయుటకు నేను వైద్య బృందానికి నా సమ్మతి ధృవపరుస్తున్నాను.

సహాయకుడు(అటెండెంట్) సాక్షి

సంతకము సంతకము

పేరు పేరు

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో) తేదీ మరియు సమయము

సంతకము



SCHOOL AGE (5-12 years)

Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 12/7/26	Time: 8 PM	11 PM	1 AM	3 AM	5 AM	7 AM
Doctor / Nurse / Family Concern?						
Temperature (°F)	98.6	98.6	98.6	98.3	98.6	98.3
Heart Rate (bpm)	96	101	103	104	105	101
Blood Pressure (mmHg) *	70/52	70/53	70/53	70/53	70/53	70/53
Resp. Rate (bpm)	22	23	24	25	24	24
Resp Distress	N	N	N	N	N	N
Receiving O ₂ (l/min)	0	0	0	0	0	0
O ₂ Saturations (%)	98	98	97	98	98	98
Conscious Level	N	N	N	N	N	N
GCS *	15	15	15	15	15	15
TOTAL SCORE	0	0	0	0	0	0
Number of shaded boxes	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0
Observer's Initials	Dr. P	Dr. P	Dr. P	Dr. P	Dr. P	Dr. P

ACTIONS

NB: Scores 3 should be recorded overleaf

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

- If at any time additional help is required, call help – regardless of the Early Warning Score!
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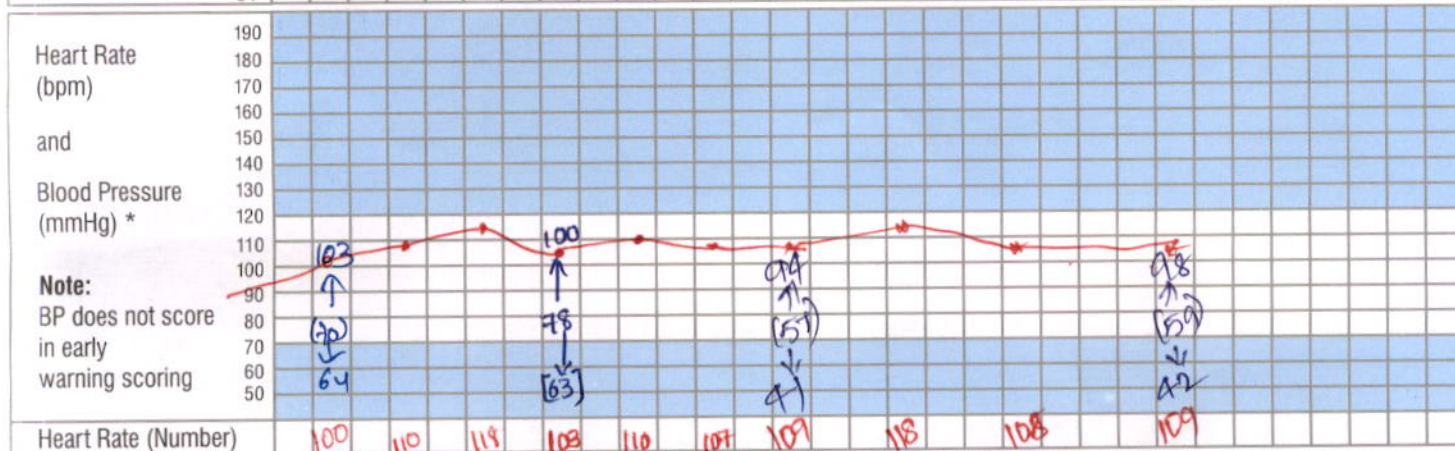
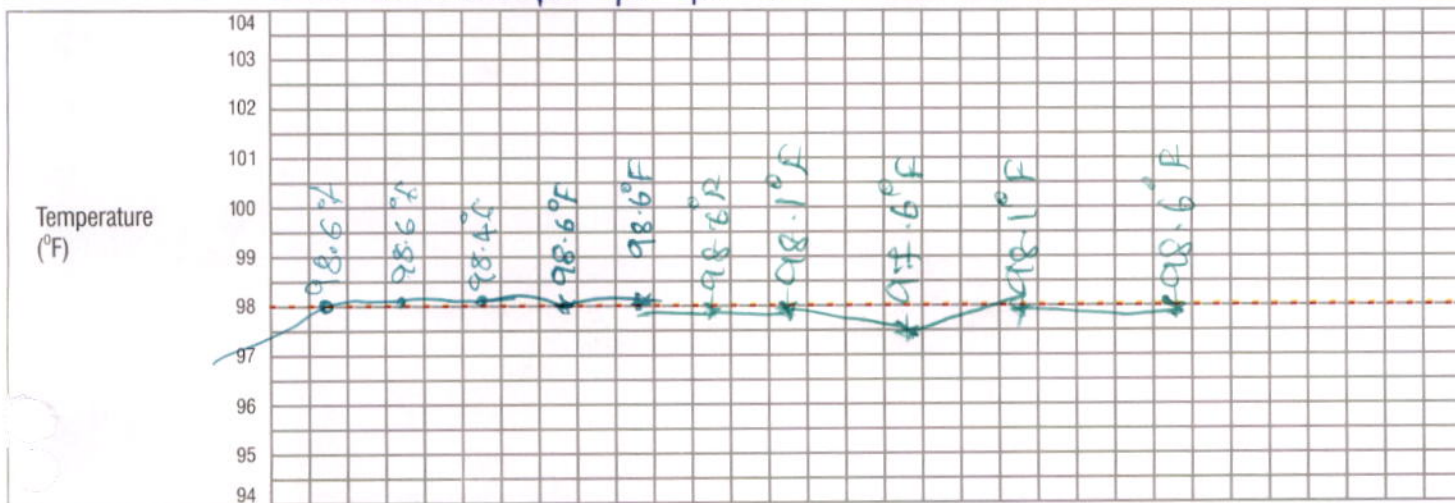
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B	BACK GROUND : Child (X) was admitted on (XX date) with (e.g. respiratory infection). They have had (X operation/ procedure/ investigation). Child (X)'s condition has changed in the last (XX mins). Their last set of observations were (XXX). The child's 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 : 14/7 Time: 9 11 1 3 5 7 9 12 3 5
Doctor / Nurse / Family Concern? AM AM PM PM PM PM PM AM AM AM



Resp Distress	Mod/ Severe None / Mild									
		N	N	N	N	N	N	N	N	N
Receiving O ₂ (l/min)										
O ₂ Saturations (%)		98	99	99	99	100	99	98	99	99
Conscious Level		N	N	N	N	N	N	N	N	N
Normal Altered										
GCS *		15	15	15	15	15	15	15	15	15

TOTAL SCORE										
Number of shaded boxes	0	0	0	0	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0	0	0	0	0
Observer's Initials	me	me	me	M	M	M	V	V	V	V

ACTIONS	Score 1 : Continue normal observation by staff nurse
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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 1/9/7 Time:		9	11	1	4	7	9	11	1	3	5	7
Doctor / Nurse / Family Concern?		Am	Am	pm	pm	pm	pm	pm	Am	Am	Am	Am
Temperature (°F)		98.2	98.6	98.8	98.6	98.3	98.4	98.6	98.6	98.6	98.6	98.6
Heart Rate (bpm) and Blood Pressure (mmHg) *		100/77/64	110/110/64	102/102/64	103/103/64	92/92/64	88/88/64	94/94/64	102/102/64	106/106/64	108/108/64	98/98/64
Note: BP does not score in early warning scoring												
Heart Rate (Number)		100	110	102	103	92	88	94	102	106	108	98
sp. Rate (bpm) per 1 Minute) *		26	25	27	28	22	22	24	26	22	24	26
Resp Rate (Number)		26	25	27	28	22	22	24	26	22	24	26
Resp Distress	Mod/ Severe None / Mild	N	N	N	N	N	N	N	N	N	N	N
Receiving O ₂ (l/min) O ₂ Saturations (%)		99%	99%	99	100	97	98	99	98	97	98	97
Conscious Level	Normal Altered	N	N	N	N	N	N	N	N	N	N	N
GCS *		15	15	15	15	15	15	15	15	15	15	15
TOTAL SCORE		0	0	0	0	0	0	0	0	0	0	0
Number of shaded boxes		0	0	0	0	0	0	0	0	0	0	0
Pain Score		0	0	0	0	0	0	0	0	0	0	0
Observer's Initials		M	M	M	SL	SL	SL	SL	SL	SL	SL	SL

Noted by Anthea 1/8/17 @ 17:00

noted by Antho
18 Feb
@847

ACTIONS

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- | | |
|-------------|---|
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FLUID CHART

Sheet No. :

13/7

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
13/7	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
13/7	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						Total Output :						
13/7	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake : 20ml						Total Output : 2 times						
14/7	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake : 175ml						Total Output : 3 times						
Total 24 hrs. Intake		245ml										
Total 24 hrs. Output		3 times										

VIH-00206749 IP-00060695
Master AARUSH VARMA
09-05-2017 9 Y 2 M 4 D (M)
Dr. PAPPULA SINDHURA



FLUID CHART

Sheet No. : 11

14/7

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
	08:00 am			35ml								
	09:00 am			35ml					✓			
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm	Idly										
Total Intake :						Total Output :						
	02:00 pm	kichidi										
	03:00 pm	water							✓			
	04:00 pm											
	05:00 pm	soup										
	06:00 pm								✓			
	07:00 pm											
Total Intake :						Total Output :						
	08:00 pm	kichidi										
	09:00 pm	water										
	10:00 pm								✓			
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						Total Output :						
	02:00 am											
	03:00 am	water										
	04:00 am								✓			
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						Total Output :						
Total 24 hrs. Intake			Total 24 hrs. Output									



FLUID CHART

Sheet No. : 2

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
15/7/26	08:00 am	Tdy water								✓	1	manisha 15/7/26 @2pm	
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm								✓	1			
	01:00 pm												
Total Intake :						Total Output :							
15/7	02:00 pm	Rice water								✓	1	Sub 15/7 @ 8pm	
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm								✓	1			
	07:00 pm												
Total Intake :						Total Output : 2 times							
15/7	08:00 pm	Rice water								✓	1	Shetty 15/7	
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am								✓	1			
	01:00 am												
Total Intake :						Total Output :							
16/7	02:00 am	water								✓	1	Shetty 16/7	
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am								✓	1			
	07:00 am												
Total Intake :						Total Output :							
Total 24 hrs. Intake						Total 24 hrs. Output			8 times				

Sheet No. : (3)

- | | | Intake | | | | Output | | | | | IV Site | |
|----------------|----------------|-----------------|--------------|-----|-----|----------------|----------------|-------|----------|-------|-------------------------|----------------|
| Date | Time | Nature of Fluid | Route | | | NG | Diarrhoea | Vomit | Drainage | Urine | Thrombo-phlebitis Score | Sign. Nurse |
| 16/7/26 | | | Mouth | I.V | N.G | | | | | | | |
| | 08:00 am | | 200g water | | | | | | | | 1 | } man 16/7 @ 2 |
| | 09:00 am | | | | | | | | | ✓ | 0 | |
| | 10:00 am | | | | | | | | | | 1 | |
| | 11:00 am | | | | | | | | | | | |
| | 12:00 pm | | | | | | | | | | | |
| | 01:00 pm | | | | | | | | | ✓ | | |
| Total Intake : | | | | | | Total Output : | | | | | | |
| | 02:00 pm | | Rice + water | | | | | | | | 1 | } man 16/7 @ 2 |
| | 03:00 pm | | | | | | | | | | 0 | |
| | 04:00 pm | | | | | | | | | ✓ | 1 | |
| | 05:00 pm | | | | | | | | | | | |
| | 06:00 pm | | | | | | | | | | | |
| | 07:00 pm | | | | | | | | | | | |
| | Total Intake : | | | | | | Total Output : | | | | | |
| 16/7 | 08:00 pm | | | | | | | | | | 1 | } man 16/7 @ 2 |
| | 09:00 pm | | Rice | | | | | | | ✓ | 0 | |
| | 10:00 pm | | water | | | | | | | | | |
| | 11:00 pm | | | | | | | | | | | |
| | 12:00 am | | milk | | | | | | | ✓ | 1 | |
| | 01:00 am | | | | | | | | | | | |
| | Total Intake : | | | | | | Total Output : | | | | | |
| 17/7 | 02:00 am | | | | | | | | | | 1 | } man 17/7 @ 2 |
| | 03:00 am | | water | | | | | | | | 0 | |
| | 04:00 am | | | | | | | | | ✓ | | |
| | 05:00 am | | | | | | | | | | | |
| | 06:00 am | | | | | | | | | | | |
| | 07:00 am | | | | | | | | | | | |
| | Total Intake : | | | | | | Total Output : | | | | | |

6 times



FLUID CHART

Sheet No. : 4

12/7/26

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
12/7	08:00 am		idly							-	1	manisha 12/7/26 @ 2pm
	09:00 am		water									
	10:00 am										0	
	11:00 am										1	
	12:00 pm									-		
	01:00 pm											

Total Intake :

Total Output :

12/7	02:00 pm											Subh 12/7 @ 8pm
	03:00 pm		Rice									
	04:00 pm		water							✓		
	05:00 pm											
	06:00 pm											
	07:00 pm											

Total Intake :

Total Output :

12/7	08:00 pm											Anitha 18/7 @ 8Am
	09:00 pm		Rice							✓		
	10:00 pm		water									
	11:00 pm											
	12:00 am									✓		
	01:00 am											

Total Intake :

Total Output :

18/7	02:00 am											Anitha 18/7 @ 8Am
	03:00 am		water									
	04:00 am									✓		
	05:00 am											
	06:00 am											
	07:00 am											

Total Intake :

Total Output :

Total 24 hrs. Intake	
----------------------	--

Total 24 hrs. Output	6 times
----------------------	---------



MEDICATION RECONCILIATION FORM

Drug Allergies: M1 ☒ 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: 136

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. Shrikar

Date & Time: 13/7/26 @ 6:30 pm

Nurse Name & Signature: Sammul Han

Date & Time: 13/7/26 @ 6:30 pm



REGULAR PRESCRIPTIONS

Sheet No:

Weight Ward

DRUG : <u>SyD ENCORATE</u>				Date Time	13/7	14/7	15/7	16/7	17/7						
Dose <u>6ml</u>	Route <u>PO</u>	Frequency <u>(12hrly)</u>	Start Dt. <u>13/7</u>	AM											
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Sankar</u>															
Additional Instructions: <u>(Sof = 200mg)</u>															
Daily Doctor's Endorsement by a Sign															
DRUG : <u>SyD SKETOL</u>				Date Time	14/7	15/7	16/7	17/7	18/7						
Dose <u>3ml</u>	Route <u>PO</u>	Frequency <u>(12hrly)</u>	Start Dt. <u>14/7</u>	AM											
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Nithya</u>															
Additional Instructions: <u>(20mg/kg/day)</u>															
Daily Doctor's Endorsement by a Sign															
DRUG : <u>SyD CEFTRIAXONE</u>				Date Time	14/7	15/7	16/7	17/7	18/7						
Dose <u>900mg</u>	Route <u>IV</u>	Frequency <u>(12hrly)</u>	Start Dt. <u>14/7</u>	AM											
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Nithya</u>															
Additional Instructions: <u>500mg/kg/day</u>															
Daily Doctor's Endorsement by a Sign															
DRUG : <u>SyD LEVITIL</u>				Date Time	15/7	16/7	17/7	18/7							
Dose <u>3-6ml</u>	Route <u>PO</u>	Frequency <u>(12hrly)</u>	Start Dt. <u>15/7</u>	AM											
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Nithya</u>															
Additional Instructions: <u>200mg/kg/day</u>															
Daily Doctor's Endorsement by a Sign															

Verified by Dr. Sindhura
 S. m...
 13/7/2017
 Verified by Dr. Rishika
 Dr. Rishika
 Clinical Pharmacologist
 14/7/2017
 Verified by Dr. Rishika
 Dr. Rishika
 Clinical Pharmacologist

Dr. Rishika
 AGN

Weight Ward

DRUG : T. LANZL JONOR				Date Time	Weight	Ward
Dose 1 tab	Route PO	Frequency one daily	Start Dt. 15/7			
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Lanzi</u>				6 am	Gay	Gay
Additional Instructions: 1 tab - 1 mg						
Daily Doctor's Endorsement by a Sign						
DRUG :				Date Time		
Dose	Route	Frequency	Start Dt.			
Name & Signature of the Doctor Starting the Drugs:						
Additional Instructions:						
Daily Doctor's Endorsement by a Sign						
DRUG :				Date Time		
Dose	Route	Frequency	Start Dt.			
Name & Signature of the Doctor Starting the Drugs:						
Additional Instructions:						
Daily Doctor's Endorsement by a Sign						
DRUG :				Date Time		
Dose	Route	Frequency	Start Dt.			
Name & Signature of the Doctor Starting the Drugs:						
Additional Instructions:						
Daily Doctor's Endorsement by a Sign						

Weight. Ward.

[illegible]



		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.	
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]



REGULAR PRESCRIPTIONS

Weight. 18 kg. Ward.

Naeg. 18 kg (13/7)
Naeg. 18 kg (13/7/26)
Naeg. 18 kg (13/7/26)
Naeg. 18 kg (13/7/26)

DRUG : 2 NJ. METHYL PREDNISOLONE				Date Time 13/7 14/7 15/7 16/7 17/7
Dose 50mg	Route PO	Frequency ONCE daily	Start Date 13/7	
Name & Signature of the Doctor Starting the Drugs: Dr. S. Srinivas				Gr. S. Srinivas Dr. S. Srinivas Dr. S. Srinivas Dr. S. Srinivas
Additional Instructions: 30 mg/kg/day Dilute in 20ml sterile water				
Daily Doctor's Endorsement by a Sign				
DRUG : 400. OXETOL				Date Time 13/7 14/7 15/7
Dose 200	Route PO	Frequency 12th hourly	Start Date 13/7	8am NPO
Name & Signature of the Doctor Starting the Drugs: Dr. S. Srinivas				8pm S. Srinivas
Additional Instructions: (OPCARBAZEPINE) X 3 days, - [8am, 8pm]				
Daily Doctor's Endorsement by a Sign				
DRUG : TAB. VALPARIN				Date Time
Dose 1-1	Route PO	Frequency 12th hourly	Start Date 13/7	
Name & Signature of the Doctor Starting the Drugs: Dr. S. Srinivas				Changed to 200mg
Additional Instructions: 2 TAB = morning 1 TAB = night (1 TAB = 200mg) [9am, 9pm]				Dr. S. Srinivas
Daily Doctor's Endorsement by a Sign				
DRUG : 1 NJ. LEVIRIL				Date Time 13/7 14/7 15/7
Dose 360mg	Route PO	Frequency 12th hourly	Start Date 13/7	7am 7am
Name & Signature of the Doctor Starting the Drugs: Dr. S. Srinivas				7am S. Srinivas
Additional Instructions: 20mg/kg/dose [9am, 7pm]				stop
Daily Doctor's Endorsement by a Sign				