

ADMISSION SHEET

Registration Details :

Admission No : IP5-00175888

Admit Date : 02-Jul-2026

Admit Time : 07:11 PM **UHID** : BAH-00659217

Patient Details :
Patient Name : Master SUHAIB MAHMOUD
 MOHAMMEDSAEED HAMED

Age : 12 Y 11 M 16 D

Guardian : Mr ABDELFAH MOHAMEDSAEED HAMID
 IBRAHIM

DOB : 16-07-2013

Gender : Male

Religion :

Occupation :

Martial Status : Single

Address (H) : PARAMOUNT COLONY, GATE NO 03
 Tolichowki Hyderabad Telangana INDIA
 500008

Phone No : 7207830273

E-mail : NOMAIL@GMAIL.COM

Admission Details :
Bed Type : SEMI PRIVATE

Bed No : SPVT 106

Ward Name : 1F-VIBGYOR

Room No : SPVT ~~106~~ 204

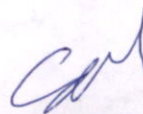
Admission Type : First Visit

Contact Details :
Name : Mr ABDELFAH MOHAMEDSAEED

Relationship : Uncle

Contact Address : PARAMOUNT COLONY, GATE NO 03
 Tolichowki Hyderabad Telangana INDIA 500008

Phone No : 7207830273


Signature
Doctor Details :
Doctor Name : Dr. KOKKULA PRANEETH

Specialisation : PEDIATRIC NEURO SURGERY

Referral Doctor : Self

Phone No :

Co-Consultant : Dr. SRIPARTHA KRISHNA YERRAMILLI

Payment Details :
Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : SELFPAY

B5

ACTIVITY RECORD FOR BILLING

Name : _____
UHID No. _____ Consultant: _____ Dept : _____
Date of Adm. _____ Time : _____ Date of Discharge : _____ Time: _____
Room / Bed No : _____ Ward : _____ Suggested Billable bed type : _____

BAH-00659217 IP5-00175888
Master SUHAIB MAHMOUD 12 Y 11 M 16 D (M)
16-07-2013
Dr. KOKKULA PRANEETH

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
2/7/26	7:51 pm	6R	ward	poorja
3/7/26	7:33 AM	106	OT	sooranthi
3/7/26	2:50 pm	OT	Picu-2	thejas
4/7/26	5 pm	106	204	neelam

Cross Consultation Visit

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

152

[illegible]

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
2/2	inv 2 Monitor inf 2 pump surv 2 pump	(1)		9686122	[Signature]
4/7/26	Inv. monitor Inf. pump Surv. pump			9686121 9686121 9686121	[Signature]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
2/7	iv placement	①	4532	
2/7	PAC	①		
3/7	Arterial line	①	9685595	Thijas
3/7	Central line	①		
3/7	Catheterisation	①		
4/7	NHA	(1)	9688569	Merlin

ANY OTHER INFORMATION

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Date : 06/7/26

Time : 09AM

Prepared By : 

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
Hawla	2nd floor		



ADMISSION CRITERIA – PICU

Admission / Transfer from:

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

Tick (✓) any of the following criteria requiring admission / transfer to PICU

- ☐ All patients requiring mechanical ventilation;
 - ☐ Patients with impending respiratory failure;
 - ☐ Upper airway obstruction;
 - ☐ Lower airway obstruction;
 - ☐ Alveolar disease; and
 - ☐ Unstable airway;
 - ☐ All Paediatric patients after successful resuscitation;
 - ☐ **Comatose Patients;**
 - ☐ Meningitis, encephalitis; ☐ Hepatic encephalopathy; ☐ cerebral malaria;
 - ☐ Head injury; ☐ Poisonings; and ☐ Status epilepticus;
 - ☐ **All types of shock/hemodynamic instability:**
 - ☐ Septic shock;
 - ☐ Hypovolemic shock; (Bleeding emergencies such as gastrointestinal bleeding, bleeding diathesis, disseminated intravascular coagulation; Cardiogenic shock; myocarditis, cardiomyopathy, congenital heart disease; Neurogenic shock; and Multiple trauma;
 - ☐ Cardiac arrhythmias after consulting with the treating consultant
 - ☐ Hypertensive Emergencies;
 - ☐ Severe acid base disorders;
 - ☐ Severe electrolyte abnormalities;
 - ☐ Diabetic ketoacidosis (Ph < 7.2, altered sensorium, hyperglycemia)
 - ☐ Acute renal failure; Patients requiring acute hemodialysis, hemofiltration and peritoneal dialysis;
 - ☐ **Post-Operative Patients;**
 - ☐ Requiring ventilation;
 - ☐ Unstable patients; and
 - ☒ Post-operative patients after open heart surgery, neurosurgery, thoracic surgery and other patients after major general surgery with potential for respiratory/haemodynamic instability;
 - ☐ Patients requiring nitric oxide therapy;
 - ☐ Malignant hyperpyrexia;
 - ☐ Acute hepatic failure
 - ☐ Severe dehydration with mental status change;
 - ☐ Asthma requiring hourly nebulization/getting tired with increasing oxygen requirement/mental status change.
- "UNSTABLE" PATIENT IS DEFINED AS**
- ☐ HR < 50 or > 160 per minute or more than upper normal limit according to age. BP < 90 systolic and < 50 diastolic an or requiring inotropic support. Arrhythmia or risk of sudden arrhythmia.
 - ☐ Signs of peripheral poor perfusion or suspicion of any type of shock.
 - ☐ Capillary refill time > 4seconds.
 - ☐ Children Blood pressure (Syst.) < [70 + (2× age "Years")].
- Respiratory failure or high risk of failure or airway obstruction:**
- ☐ Respiration rate < 5 per minute below the normal or > 10-15 per minute above the normal range for age.
 - ☐ O2 Saturation < 90 % or need for O2 > 4 Litres per minute by normal face mask. Abnormal ABG: PH < 7.25, PaO2 < 60 torr, PaCO2 > 50 torr.
 - ☐ Distress and risk of exhaustion
 - ☐ **Change of level of consciousness: GCS < 13.**
 - ☐ **Persistent oliguria with acidosis.**

Signature of the Doctor:  Name of the Doctor: JAYASRI Date & Time: 3/7/26 @ 3pm

Patient Sticker

DISCHARGE CRITERIA – PICU

Discharge to:

- ☐ HDU / Step down ICU ☐ Ward ☐ Outside Facility ☐ Others:

Tick (✓) any of the following criteria requiring discharge / transfer from PICU

- ☐ Stable hemodynamic parameters.
- ☐ Stable respiratory status (patient extubated with stable arterial blood gases) and airway patency at least for 24 hours with no respiratory distress needing continuous monitoring.
- ☐ Minimal oxygen requirements that do not exceed patient care unit guidelines.
- ☐ Intravenous inotropic support, vasodilators, and antiarrhythmic drugs are no longer required or, when applicable, low doses of these medications can be administered safely in otherwise stable patients in a designated patient care unit.
- ☐ Cardiac dysrhythmias are controlled.
- ☐ Neurologic stability with control of seizures.
- ☐ Removal of all hemodynamic monitoring catheters.
- ☐ Routine peritoneal or hemodialysis with resolution of critical illness not exceeding general patient care unit guidelines.
- ☐ Patients with mature artificial airways (tracheostomies) who no longer require excessive suctioning.

Signature of the Doctor:

Dr. KOKKULA PRANEETH
Reg. No: APMC/FMR/92741

Name of the Doctor :

Dr. Kokkula. praneeth

Date & Time:

3 / 7 / 26



Rainbow[®] Children's Hospital

It takes a lot to treat the little.

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: _____

UHID ID: _____

Department: _____

Consultant: _____

BAH-00659217 IP5-00175888
Master SUHAIB MAHMOUD
16-07-2013 12 Y 11 M 16 D (M)
Dr. KOKKULA PRANEETH





Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

Craniopharyngioma (Sella-suprasellar tumor)

Right Eye optic atrophy



Now came for debulking of tumor

History of present illness :

No H/o fever, cold, cough, vomiting, loose stools,

No Focal neurological deficits.

Rt Eye blindness (+)

A:

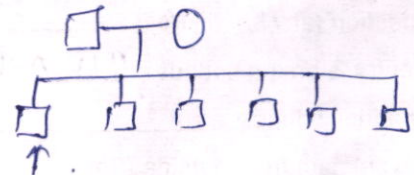


Systemic Multiorgan History & Physical Examination

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

Birth & Neonatal History:

NVD / NO H/O NICU stay



Birth & Socio Economic History:

About Father : _____

About Mother : _____ } upper middle class

Any additional Information : _____

Developmental History :

② development

Immunization History :

immunization as per date



Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs)) 28.1 kg (Centile _____)

On Examination :

Temperature : 98.4°F Pulse Rate : 94/min B.P. 101/60(70) SPO2 98% on RA

Resp. rate and type of breathing : RR = 20/min

Rash _____

Lymphadenopathy _____

Oedema : nil

Allergies (if any): _____

Respiratory System :

Inspection (any s/o distress) : _____

Air entry & breath sounds : B/L AE (1)

Any added sounds : _____

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

Cardiovascular System :

Inspection of precordium : _____

Heart Sounds : S1S2 (1)

Any murmur : _____

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

Per Abdomen :

Inspection _____

Palpation : Soft, NT

Auscultation : _____

Spine : _____ External Genitalia : _____

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



Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : 2 Rt Eye blindness ⊕

Cranial Nerves : N

Motor System:

Nutrition : 2

Tone: N Power

Co-ordinator :

Posture :

Involuntary Movements :

Reflexes :

DTR

Superficials:

Plantars 2

Sensory System :

N

Bladder / Bowel :

Clinical Summary & Diagnostic:

Leucisphaeromon



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: _____

Desired goals of the treatment : _____

Planned Labs:

CRP

Blood grouping & cross matching

Planned Management

NPO tomorrow

Debulking of tumor T/M

Thyroid medication to continue T/M

Stress dose steroids to give on
day of Sp.

Signature of the Doctor: _____

Name of the Doctor: Dr. Ranjith

Date & Time: 2/7/26; 7:30pm

Signature of the Consultant: _____

Name of the Consultant: Dr. Kokkula Praneeth

Date & Time: 2/7/26





OPERATION THEATER NOTES

Patient's Name : SUHAIB MAHMOUD Age : 12 Y Gender : ☒ Male ☐ Female

UHID No. : BAH-00659217 Weight : 28 kg Height :

Surgeon : <u>Dr. Praneeth / Dr. Sri Partha</u>		Asst. Surgeon : <u>-</u>
Anesthetist : <u>DR. ADITI</u>	OT Nurse : <u>JYOTHI, ALAM</u>	OT Technician : <u>BAPU.</u>
Pre-Operative Diagnosis : <u>Cranio-pharyngioma s/p Ommaya placement</u>		
Surgical Procedure : <u>(PP) pterional craniotomy and subtotal excision of tumour</u>		
Indications for Surgery : <u>+ Replacement of Ommaya</u>		
Date : <u>3/7/2026</u>	Start Time : <u>9.55 AM.</u>	End Time : <u>2:40pm</u>
Pre Operative Preparations :		
<u>Betacervub → Chlorhexidine → Betadine</u>		
Post Operative Diagnosis : <u>Same</u>		
Peri-Operative Complications : <u>Nil</u>		
Operation Notes : <u>(1) Previous skin incision opened</u>		
<u>(2) Frontal craniotomy with Ommaya reservoir noted</u>		
<u>(3) Right pterional craniotomy done and skull base nibbled</u>		
<u>(4) Dura opened based on sphenoid wing</u>		
<u>(5) Frontal lobe adhered to skull base</u>		
<u>(6) Sylvian fissure opened and cyst noted in the Sylvian fissure</u>		
<u>(7) Solid tumour → soft, firm with areas of calcification</u>		
<u>(8) Subtotal excision of tumour done.</u>		

- (9) Tumour adhered to hypothalamus, ICA, ACA and pituitary stalk left behind
- (10) ~~Left~~ Ommaya catheter ~~rept~~ repositioned in the Cella after checking the patency
- (11) Hemostasis secured
- (12) Dura closed. Bone flap replaced and Ommaya secured
- (13) wound closed in

Amount of Blood Loss: 150ml

Blood Transfused (in ML) -

Name and Number of Surgical Specimen sent for examination:

Tumour

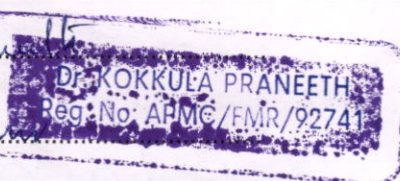
I/O - 1300 / 700

Peri-Operative Complications:

Nil

Name of the Surgeon: Dr. Praneeth

Signature of the Surgeon: Dr. Praneeth



Date & Time: 29.06.2026 3.7.2026

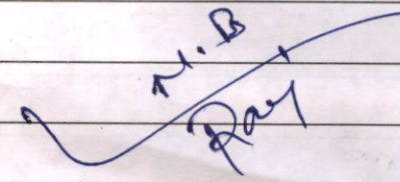
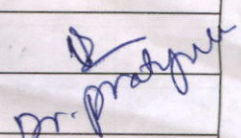
Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/7/26 3pm	ds/b PICU team	Plan
	As:- Suprasellar tumor Cystic) / s/p omaya + VP shunt / s/p debulking of tumor.	1) Send CBP, s. electrolytes now
	Intra-operative issues:- 1) urine output > 10 ml/kg/hr for 3 hrs. $\downarrow$ started on vasopressin @ 0.01 μ g/kg/hr.	2) Monitor urine output 3) Inform if urine output > 10 ¹²⁰ ml/hr.
	2) no hypotension/bradycardia hypoxic events.	4) s. electrolytes / Q6H 5) DNS @ 45 ml/hr. 6) Allow orally after 2 hrs.
	Input:- 1300 ml output = 1000 ml. + 450 ml. last Na ⁺ - 143 mEq/L in ABG.	7) 24. pcm 24. tramadol.
		 

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
03/07/2026 09:15 pm	clerk picu fellow & clerk mr. praneeth	
	I/O informed	<u>Plan</u>
	U/O informed	1) Indent MININ & keep be drink
	Balance @ 7am	2) Iuj. Ordern ASH
	lost 2 hours uo	3) serum sodium to send
	80 ml/hr	4) Inform IF >120 ml/hr
	130 ml/hr	for 2 hours
		5) Inform SOS
		6) Give oral fluids
		certify.
		noted by Sinala
		3/7/26
		9:20 pm

DAILY ASSESSMENT AND HANDOVER SHEET OF PICU

Date of Admission : 02/07/26 Day of Admission : 03 Today's Date & Time : 04/07/26
PRISM - III Score in first 24hrs. of Admission : Today's SOFA Score :

OVERVIEW	Diagnosis : <u>suprasellar tumor (cystic)</u> <u>s/p craniotomy + ventriculostomy</u> <u>s/p debulking of tumor</u> <u>Optic chiasm (R+)</u>	Current Issues : <u>vomiting (yesterday)</u>
	VITAL SIGNS : Today's Wt. (kg) : Temp.: Blood sugar issues :	
RESPIRATORY SYSTEM	Respiratory System Findings : (Air entry, breath sounds, s/o distress etc.) : <u>BIL AE (+) chest clear</u>	
	CXR : _____	
	SPO ₂ : <u>100% on Room Air</u> O ₂ by NC / FM / NRB mask / Oxyhood, at _____ L / min	
	Ventilatory Support : ☐ Yes ☒ No - Day # of Vent : _____ Nitric Oxide : ☐ Yes ☒ No - If Yes, details : _____	
	Ventilatory Settings : Leak around ETT : _____ Delivered Vt : _____ ABG : _____ EtCO ₂ : _____ P/F ratio : _____ O.I. : _____ Chest Physiotherapy Plan : _____ Suctioning Needs : <u>NO</u> Any Nebbs : <u>NO</u> ICD ? ☐ Yes ☐ No, if Yes, details : _____ Plan of care : _____	
CARDIO VASCULAR SYSTEM	Cardio Vascular System Clinical Exam. (Heart sounds, murmur etc.) : <u>S1S2 (+) NO MURMUR</u>	
	Quality of Pulses : <u>Good</u> cap refill Time : <u><3 seconds</u> Liver Edge : _____ cm below Rt costal margin	
	Blood Pressures : NIBP : <u>90/60 mmHg</u> IBP : _____ CVP : _____	
	Infusion of : ☐ Dopamine _____ mcg / kg / min - ☐ Dobutamine _____ mcg / kg / min ☐ Epinephrine _____ mcg / kg / min - ☐ Nor Epinephrine _____ mcg / kg / min ☐ Milrinone _____ mcg / kg / min	
	Any Other Infusions : _____	
	Last 2D Echo Findings : _____	
	Size of the heart and lung fields in latest CXR : _____	
	Arterial line in situ : ☒ Yes ☐ No Place of art, line & its condition : <u>Left Radial</u> Central line in situ : ☒ Yes ☐ No Place of central line & its condition : <u>RT IJV</u> Day of arterial line : <u>02</u> Day of Central line : <u>02</u> Plan of Care : _____	
CNS	Neuro Exam : <u>E4 V5 M6</u>	
	Pupils : <u>3mm equal & React to light</u> Sedation Used ? ☐ Yes ☒ No Any paralysis ? ☐ Yes ☒ No	
	Types of Sedation : _____ Types of Paralysis : _____	
	Relevant CT Scan, MRI EEG, Neurosonogram etc. : _____ Plan of Care : _____ Ramsay Sedation Score : _____	

FLUIDS STATUS NUTRITION AND G.I.	☐ NPO ☒ PO feeds ☐ NG Feeds ☐ NJ Feeds ☐ GT Feeds	
	I / O / Balance : <u>-424</u> / (+/-) Input : ml/k/d UO : <u>3.4</u> ml/kg/hr Stools <u>not passed</u>	
	NG output : PO intake :	
	Feed Formula : Feed Schedule :	
	IV Fluids - Type of IVF : <u>DNS</u> @ <u>45</u> ml / hr (<u>65%</u> times maintenance)	
	TPN : ☐ Yes ☒ No - If yes, details :	
	 % of Dext, Glu Inf Rate (mg/kg/min) Amino Acids (gm/kg/day) Lipids (gm/kg/day)	
	 Cal/kg/d Nitrogen Trace elements & MVI	
	Labs : Na <u>136</u> K <u>3.2</u> Cl <u>105</u> Ca Mg P HCO3 Sr. Amylase : Sr. Lipase :	
	Latest LFT : Abd Exam : <u>soft, nondistended</u> Any organomegaly ? ☐ Yes ☒ No - If yes, describe : Plan (G.I. & Liver) :	
INFECTION	☐ Febrile ☒ Afebrile Current Antibiotics Details (antibiotic name and day #) :	
	Cultures Sent ? ☐ Yes ☒ No - If yes, details :	
	Describe c/s Reports :	
	Other Labs (Latex, Serology, etc) : Ongoing Antibiotics :	
NEPHROLOGY ISSUES	Sr. Creat : Bld. Urea : Other Relevant Labs :	
	P.D. ☐ Yes ☒ No - If yes, details :	
	Diuretics : ☐ Yes ☒ No - If yes, details :	
	Catheterized : ☒ Yes ☐ No - If yes, then day of Catheter : <u>day of catheterisation</u>	
	Relevant Radiology (USC, MCUG radioisotope scan etc) : Plan of Care :	
HEMATOLOGY	Relevant Labs (CBP etc) :	
	Any Coagulopathy :	
	Relevant Transfusion History :	
	Plan of Care :	
CARE PROTOCOLS	VAP Bundle Used ? : ☐ Yes ☒ No ☐ NA	
	CRBSI Bundle Used ? : ☐ Yes ☒ No ☐ NA	
	CA - UTI Bundle Used ? : ☐ Yes ☒ No ☐ NA	
	Patient Managed as per Relevant Protocols : ☐ Yes ☐ No ☐ NA	
	If yes, then details :	
FINAL COMMENTS	Pending Lab Results : ☐ Yes ☒ No If yes, then details :	
	Pending Consultations : ☐ Yes ☐ No If yes, then details :	
		
		
		

Doctor's Name (Handover given) : Dr. Tyoti
 Signature : Dr. Tyoti
 Date & Time : 04/07/26 8:20 AM

Doctor's Name (Handover taken) : Dr. Tyoti
 Signature : Dr. Tyoti
 Date & Time : 04/07/26

Date & Time	Progress Notes	Doctor's Order
4/7/26	C/S/A Neurology	
D.	Cranio pharyngoma (suprasellar tumor) S/P craniotomy / Craniectomy ① Preoperative Craniotomy & Subtotal Excision of tumor Replacement of ossicle (POD-1)	Lead Stylus
	<u>plan</u>	
②	① eye progression vision loss - post 6 months (NO PL before Sx)	① Shift to shifting work (shiftwork) ② Stop IV fluids
Hemodach - frontal (only)	vomiting → 4 episodes - (uneventful)	③ full oral fluids & feeds ④ Strict Input/output monitoring (inform if 2120ml/hr (hourly)) ⑤ Remove Arterial line ⑥ Keep Foley's & Central line intact ⑦ Flush to continue central line ⑧ 4 steroids (same) ⑨ Endocrine plan for monitor
apneustic heart		

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
04/07/26 6:30pm	C/S/B Neuroteam	
	Suprasellar tumor - (cystic) craniopharyngioma S/p anaya reservoir on 07/04/2026. S/p (R) pterional craniotomy & subtotal excision of tumor & replacement of anaya.	
	POD - 1 S.Nat - 137 [04/07/26 5pm]	
	Issues: No fever / spikes / vomiting / seizures	
	O/E: child conscious, alert Afebrile vitals - stable EOM - full Tone, power - Normal	Adv ① Hourly Input - Output charting ② Inform if U. Output > 120 ml/hr for 2 consecutive hrs. ③ Repeat S.Nat @ 11pm (after 6 hrs) ④ vitals monitoring
		



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/7/20	ck/s <u>Neurotrans</u>	
POD 2	K/Ho Craniocephalogram of omaya placement (4/1/20), now with headath & progressive vision loss - 1/2 (R) craniothorax with replacement of omaya reservoir with hypopituitarism.	
	No new ixerel - taking liquids well orally.	
	of - vitals - stable	U-O (Gly) :- 3.1ml/kg/hr.
	- Hox - 2(N)	
	- CN :- (D) eye exam full pupile equal & reactive.	
	- (N) tone, power & reflexes	
	- No meningeal or cerebellar signs.	
	- Input & output monitoring.	Adv. - If U-O > 100ml/hr to inform
	- Si Na+ @ 8pm.	- Remove Foley
	G. infam.	- Stone (only 10)
		- Seal cuff
	Dr. K. Praneeth	Abhishek

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/2/20	ch 13 neuro logs	
	Supra sellar tumor → Cranio-pharyngioma with peritumoral edema Sp 0maga 4 (LH) VP shunt (H/LH) Sp (R) Stereotaxic craniotomy & subtotal excision of tumor [100-3]	
	① No fever spikes No headache/vomiting Accepting orally	Plan ① D/L today
	no vomiting	② I/O monitoring
	U/O — (3ml/4hr)	③ decide on central line
	no polyuria.	④ S/E — Daily on 2nd day
	S/E — (136-138)	⑤ R/V
	⑥ eye-bright light percept from 1m distance	⑥ decide on VEP on 4th day
	⑦ eye RAPD	⑦ Trace Biopsy
	EDM full, Peritumoral edema no cr defect	⑧ H/Done type (mg/100) graded.
	Done / ⑨ para / ⑩ no sign of tumor def	Sys. pathol 5th day 705 RIA 2day c S.E Tayroxin I/O monitoring
	VO	
	Smith x 2days cracin 240 SOS Tosin 2days usual 2days	

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Master SUHAIB MAHMOUD
16-07-2013 12 Y 11 M 18 D (M)
Dr. KOKKULA PRANEETH




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

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

RESULT SHEET

Date	5/7/26	5/7/26	6/7/26			
Time	8am	9:44pm	6:18am			
Hb						
PCV						
RBC						
WBC						
N/L						
Platelets						
CRP						
ESR						
PCT						
RBS						
Na	137	136	138			
K			3.0			
Cl			103			
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

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

Culture and Sensitivities :

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Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI :

 Others (ECG, Contrast Studies etc.) :

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16-07-2013 12 Y 11 M 16 D (M)
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Rainbow®
Children's
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It takes a lot to treat the little.

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

RESULT SHEET

Date	2/7/26	3/7/26	3/7/26	04/07/26	04/07/26	4/7/26
Time		3 PM	9:00 pm		5 pm	11:20 pm
Hb	11.3	9.4				
PCV	34.8	29.1				
RBC	4.22	3.48				
WBC	7800	12,440				
N/L	61.2/31.7	62.2/31.3				
Platelets	4.68	4.71				
CRP						
ESR						
PCT						
RBS						
Na		138	136	138	137	139
K		3.9	3.7			
Cl		111	105			
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

BAH-00659217 IP5-00175888
Master SUHAIB MAHMOUD
16-07-2013 12 Y 11 M 16 D (M)
Dr. KOKKULA PRANEETH

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

MEDICATION RECONCILIATION FORM

Drug Allergies:

☒ Not known any Drug Allergies

Medication Reconciliation will be done at the time of admission and also whenever there is change in the treating team or shifting from one unit to another unit.

(Example: at the time of admission shifting from ICU to Ward, or Ward to ICUs)

Shifting From: ER

Shifted to: Ward

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
						☐ C ☐ DC
2						☐ C ☐ DC
3						☐ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: Dr. Ranjy

Date & Time: 27/6/26 @ 7:30pm

Nurse Name & Signature: pooja

Date & Time: 27/6/26 @ 7:45 pm

BAH-00659217
Master SUHAIB MAHMOUD
16-07-2013 12 Y 11 M 18 D (M)
Dr. KOKKULA PRANEETH

MEDICATION RECONCILIATION FORM

Drug Allergies:

☒ Not known any Drug Allergies

Medication Reconciliation will be done at the time of admission and also whenever there is change in the treating team or shifting from one unit to another unit.

(Example: at the time of admission shifting from ICU to Ward, or Ward to ICUs)

Shifting From: ICU

Shifted to: ward

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	Tab- THYROXINE	25mcg	PO	OD	4/7/26	☒ C ☐ DC
2	Inj- HYDROCORTISONE	25mg	IV	Q6H	4/7/26	☒ C ☐ DC
3	Inj- CEFOTAXIME	1g	IV	Q12H	4/7/26	☒ C ☐ DC
4	Inj Pantoprazole	20mg	IV	OD	4/7/26 6am	☒ C ☐ DC
5	Inj ONDANSETRON	4mg	IV	Q8H	4/7/26 8am	☒ 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: Jayash

Date & Time: 4/7/26 12pm

Nurse Name & Signature: Banani

Date & Time: 4/7/26 06pm



Sheet No:

REGULAR PRESCRIPTIONS

Weight 28kg Ward

DRUG : Inj PARACETAMOL				Date Time	3/7 4/7
Dose 400mg	Route IV	Frequency Q8H	Start Dt. 3/7	6 AM	X <i>Small Dose</i>
Name & Signature of the Doctor Starting the Drugs: <i>Dr. Jayash</i>				2 PM	X <i>Small Dose</i>
Additional Instructions:				10 PM	<i>Pay 8h</i>
Daily Doctor's Endorsement by a Sign					<i>ny m</i>
DRUG : Inj TRAMADOL				Date Time	3/7 4/7
Dose 25mg	Route IV	Frequency Q8H	Start Dt. 3/7	12 AM	X <i>Small Dose</i>
Name & Signature of the Doctor Starting the Drugs: <i>Dr. Jayash</i>				8 AM	X <i>Small Dose</i>
Additional Instructions:				4 PM	<i>Pay 8h</i>
Daily Doctor's Endorsement by a Sign					
DRUG : INJ. ONDANSETRON				Date Time	3/7 4/7
Dose 4mg	Route IV	Frequency TID	Start Dt. 03/7	6 AM	X <i>Small Dose</i>
Name & Signature of the Doctor Starting the Drugs: <i>Dr. Keshav</i>				10 PM	X
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					<i>ny m</i>
DRUG : SYR. SMUTH				Date Time	4/7 5/7 6/7
Dose 10ml	Route PO	Frequency HLS	Start Dt. 4/7		
Name & Signature of the Doctor Starting the Drugs: <i>Dr. Praneeth</i>				10 PM	<i>Pay 8h</i>
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					

Signature

VERIFIED BY - Name

VERIFIED



Sheet No: **REGULAR PRESCRIPTIONS** Weight Ward

DRUG : T. Pantop				Date Time	4/7	5/7	6/7													
Dose	Route	Frequency	Start Dt.																	
20mg	PO	OD	4/7																	
Name & Signature of the Doctor Starting the Drugs: Dr. Praneeth				6am — <i>Tab Pantop</i> <i>500mg</i> <i>500mg</i>																
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG : SyR CROCCIN 240				Date Time	4/7	5/7	6/7													
Dose	Route	Frequency	Start Dt.																	
8ml	PO	TDS	4/7																	
Name & Signature of the Doctor Starting the Drugs: Dr. Praneeth				6am X <i>Diplo</i> <i>500mg</i> <i>500mg</i> 2pm X <i>Kalg</i> <i>Bonal</i>																
Additional Instructions:				10pm <i>Diplo</i> <i>500mg</i> <i>500mg</i>																
Daily Doctor's Endorsement by a Sign																				
DRUG : Tab. HICONE				Date Time	4/7	5/7	6/7													
Dose	Route	Frequency	Start Dt.																	
10mg	PO	TID	5/7																	
Name & Signature of the Doctor Starting the Drugs: Dr. Praneeth				6am X <i>Diplo</i> <i>500mg</i> <i>500mg</i> 9am <i>Kalg</i> <i>Bonal</i> 10pm <i>Diplo</i> <i>500mg</i> <i>500mg</i>																
Additional Instructions:				2pm																
Daily Doctor's Endorsement by a Sign																				
DRUG : Tab. PAX 10				Date Time	4/7	5/7	6/7													
Dose	Route	Frequency	Start Dt.																	
200mg	PO	BD	5/7																	
Name & Signature of the Doctor Starting the Drugs: Dr. Praneeth				6am <i>Diplo</i> <i>500mg</i> <i>500mg</i> 9am <i>Kalg</i> <i>Bonal</i> 10pm <i>Diplo</i> <i>500mg</i> <i>500mg</i>																
Additional Instructions:				200mg Tab																
Daily Doctor's Endorsement by a Sign																				

DRUG CHART

Date of Admission: 21/7/2016 Drug Allergies: ☒ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

SOS / PRN (As Required Medication)

VERIFIED BY : Name Signature

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

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

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

REGULAR PRESCRIPTIONS

Weight. 28.1 kg Ward.



T. THYROXINE

Date 3/7 Time 11:57 AM

Dose 25mcg Route PO Frequency OD Start Date 3/7

Name & Signature of the Doctor
Starting the Drugs:

Dr. Praneeth

Signature of the Doctor

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Signature

DRUG: Inj. HYDROCORTISONE

Date 3/7 Time 4:17 PM

Dose 25mg Route IV Frequency q 6th hrs Start Date 3/7

Name & Signature of the Doctor
Starting the Drugs:

Dr. Praneeth

Signature of the Doctor

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Signature

DRUG: Inj. CEFOTAXIME

Date 3/7 Time 4:17 PM

Dose 1gm Route IV Frequency BD Start Date 3/7

Name & Signature of the Doctor
Starting the Drugs:

Dr. Praneeth

Signature of the Doctor

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Signature

DRUG: Inj. Pantop

Date 3/7 Time 11:57 AM

Dose 20mg Route IV Frequency OD Start Date 3/7

Name & Signature of the Doctor
Starting the Drugs:

Dr. Praneeth

Signature of the Doctor

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Signature



Weight. 28.1 kg Ward.

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
3/7/26	6 AM	Inj HYDROCORTISONE	14mg	IV	R	Pavla Suen
		(2 hrs before surgery) - stress dose				
3/7/26	8:45 AM	2g CEFOTAXIME	1gm	IV	BS	Thy's Bapu
3/7/26	10.00	INJ PARACETAMOL	400 mg	IV	Adel	Bapu Thy
3/8/2024	10.00	INTRANEXAMETAL ALCP	400mg	IV	Adel	Bapu Thy
3/7/2026	5:50 PM	INJ ONDANSETRON	3mg	IV	ssoti	Pavla Suen



Weight. 28.14 Ward.

[illegible]

Signature

VERIFIED BY : Name

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

BAH-00659:17
Master SUHAIB MAHMOUD
16-07-2013 12 Y 11 M 17 D
Dr. KOKILA PRANEETH

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Part - I,

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

Identified Education Needs :

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

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barries	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
4/8/16	9am	9	Child is on NPO	M	1	0	1	1	-	Alwina

Part - III : CODES

Who was taught :	PT : Patient	F : Father	M : Mother	S : Spouse	Sn : Son	D : Daughter	C : Caregiver	O : Other (Specify).....															
Learning Barriers :	<table border="0"> <tr> <td>1. No Learning Barries</td> <td>4. Language Barrier</td> <td>7. Impaired Thought Process / Cognitive limitations</td> <td>10. Financial Difficulties</td> <td>13. Cultural / Religion Practice</td> </tr> <tr> <td>2. Physical Impairment</td> <td>5. Educational Level</td> <td>8. Responsibilities at Home</td> <td>11. Beliefs and Values</td> <td>14. Others (Specify)</td> </tr> <tr> <td>3. Emotional Barries</td> <td>6. Desire / Motivate to Learn</td> <td>9. Cultural Difference</td> <td>12. Impaired Vision / or Hearing</td> <td></td> </tr> </table>								1. No Learning Barries	4. Language Barrier	7. Impaired Thought Process / Cognitive limitations	10. Financial Difficulties	13. Cultural / Religion Practice	2. Physical Impairment	5. Educational Level	8. Responsibilities at Home	11. Beliefs and Values	14. Others (Specify)	3. Emotional Barries	6. Desire / Motivate to Learn	9. Cultural Difference	12. Impaired Vision / or Hearing	
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2. Physical Impairment	5. Educational Level	8. Responsibilities at Home	11. Beliefs and Values	14. Others (Specify)																			
3. Emotional Barries	6. Desire / Motivate to Learn	9. Cultural Difference	12. Impaired Vision / or Hearing																				
Teaching Tools Used :	A : Audio	D : Demonstration	V : Video	O : Oral	P : Printed																		
Mechanism/s to overcome barrier/s :	<table border="0"> <tr> <td>1. None</td> <td>3. Reassurance & Support</td> <td>5. Respect values & beliefs</td> <td>7. Other, Specify.....</td> </tr> <tr> <td>2. Obtain translator</td> <td>4. Teach Family / others</td> <td>6. Respect Cultural / Religion Preference</td> <td></td> </tr> </table>								1. None	3. Reassurance & Support	5. Respect values & beliefs	7. Other, Specify.....	2. Obtain translator	4. Teach Family / others	6. Respect Cultural / Religion Preference								
1. None	3. Reassurance & Support	5. Respect values & beliefs	7. Other, Specify.....																				
2. Obtain translator	4. Teach Family / others	6. Respect Cultural / Religion Preference																					
Understanding :	<table border="0"> <tr> <td>1. Verbalizes Understanding</td> <td>2. Demonstrates Understanding</td> <td>3. Needs Review</td> </tr> </table>								1. Verbalizes Understanding	2. Demonstrates Understanding	3. Needs Review												
1. Verbalizes Understanding	2. Demonstrates Understanding	3. Needs Review																					

BAH-00659217 IP5-00175888
Master SUHAIB MAHMUD
16-07-2013 12 Y 11 M 17 D (P)
Dr. KOKKULA PRANEETH



MULTI-DISCIPLINARY PLAN OF CARE FORM

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Diagnosis: _____

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Others:
4/7/26 8am	☐ Medical ☐ Nursing ☒ Others: Dietitian	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Syprocellar Tumor	Child is on NPO	NPO till further advise	Mounica	☐ Medical ☐ Nursing ☒ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:

Patient Sticker

MULTI-DISCIPLINARY PLAN OF CARE FORM



Diagnosis: _____

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:

BAH-00859217
Master SUHAIB MAHMOUD
16-07-2013 12 Y 11 M 16 D (M)
Dr. KOKKULA PRANEETH



EMERGENCY ROOM TRIAGE FORM

Patient's Name: Mr. Subaib Hamed Age: 12y Gender: ☒ Male ☐ Female
Date: 2/7/26 Time of Arrival: 6:50pm Triage Completion Time: 6:52pm
Allergy Information: ☐ Yes ☐ Food ☐ Medications ☐ Other (Specify): NA
☐ Parents ☐ Others (Specify): NA
Mode of Arrival: ☐ Ambulatory ☐ Wheelchair ☐ Stretcher ☐ Ambulance

INITIAL PHYSIOLOGICAL CATEGORIZATION

Appearance: ☐ Normal ☐ Sick Looking
Circulation / Colour: ☒ Normal ☐ Abnormal ☐ Bleeding
Work of Breathing: ☒ Normal ☐ Increased ☐ Decreased ☐ Gasping / Apnea

INITIAL PHYSIOLOGICAL STATUS

☒ Stable
☐ Unstable:
☐ Not - Life - Threatening
☐ Life - Threatening

Vital Signs: Temp: 98.4°F PR: 94b/m BP: 101/60 RR: 20b/m SpO₂: 98%
Chief Complaints: came for surgery but debulking of tumour + 1m

Triage Classification

- ☐ Level 1: Resuscitation
- ☐ Level 2: EMERGENT: Life or limb threatening
- ☐ Level 3: URGENT: Significant illness / injury with potential to become life or limb threatening
- ☐ Level 4: LESS URGENT: Significant illness but not life threatening
- ☐ Level 5: NON - URGENT: May receive care when convenient

CTAS
☐ Immediate
☐ < 15 min
☐ 30 min
☐ 60 min
☒ 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

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 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).

Signature of Triage Nurse: NR Subaib

Name of Triage Nurse: NR Subaib

Date & Time: 2/7/26 at 6:52pm

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

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

Time	Nursing Notes
6:53pm	Assess the child condition
	- monitored vitals & recorded
	- seen Dr. Ramya
	- shifted to ward

Samples collected by: NR. peannoy

Time: 7:00 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: 98 bpm BP: 101/60 CFT: <2 sec	Shift - out from ER to: ward
RR: 24 bpm SPO ₂ : 100%	Time of Shift - out: 7:15 pm
GCS: 4.1.6 Temperature: 97.8°F	Handover given to: scow bhaty
Pain Score: 0	(Nurse's Name)
Repeat RBS (if applicable): NA	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

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

Name of the Nurse : pooja Signature of the Nurse : [Signature]

Date & Time : 21/12/26 e 7:20 pm

MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis: laminio pharyngoma

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
2/8/26 9:30 pm	☐ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	<u>laminio pharyngoma</u>	<u>supra gl</u> Respiratory symptom	<u>Debulking of tumor</u>	<u>W.R.</u>	☒ Nursing ☐ Others:
2/8/26 7:30 pm	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	<u>laminio pharyngoma</u>	<u>lt - stability</u>	<u>Debulking of tumor</u>	<u>R</u>	☒ Medical ☐ Others:
3/7/26 8 pm	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	<u>polyuria</u>	<u>to reduce the urine output</u>	<u>plan to reduce the urine</u>	<u>gudh</u>	☐ Medical ☒ Nursing ☐ Others:
4/3/26 2:40 pm	☐ Medical ☐ Nursing ☒ Others: <u>diekhan</u>	☐ Initial ☐ Modified ☐ Per-Op ☒ Post Op	<u>suprasellar tumor (cystic) sp excision & mayy screw</u>	<u>Normal diet</u>	<u>ROA</u> <u>E:-1450 kcal/d</u> <u>P:-25 g/d</u>	<u>mounica</u>	☐ Medical ☐ Nursing ☒ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:



INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Part - I.
Patient's / Learner Language: English Patient / Learner Literacy: ☒ Read ☒ Write ☒ Speak Willingness to Learn: ☒ Yes ☐ No Healthcare Literacy: ☒ Yes ☐ No

Identified Education Needs:

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

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
2/8/26	7:15 pm	7	infection control measures	F	1	0	1	1	NA	poofa
3/7/26	8:59 pm	9	nutrition diet	F	2	0	1	1	NA	poofa

Part - III: CODES

Who was taught: PT: Patient F: Father M: Mother S: Spouse Sn: Son D: Daughter C: Caregiver O: Other (Specify)

Learning Barriers:

1. No Learning Barriers	4. Language Barrier	7. Impaired Thought Process/Cognitive limitations	10. Financial Difficulties	13. Cultural/Religion Practice
2. Physical Impairment	5. Educational Level	8. Responsibilities at Home	11. Beliefs and Values	14. Others (Specify)
3. Emotional Barriers	6. Desire / Motivate to Learn	9. Cultural Differences	12. Impaired Vision/ or Hearing	

Teaching Tools Used: A: Audio D: Demonstration V: Video O: Oral P: Printed

Mechanism/s to overcome barrier/s:

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

Understanding: 1. Verbalizes Understanding 2. Demonstrates Understanding 3. Needs Review



NURSING INITIAL ASSESSMENT FOR PICU

Date of Admission: 03/07/26 3:00pm
Source of Admission: ☐ OPD ☐ Ward ☐ Other: OT
Reason for Admission: observation
Admission Diagnosis: Carcinopharyngeal (Selle-suprasellen) tumor.
Accompanied By: ☒ Parent ☐ Guardian ☐ Other Name: _____
Primary Language: ☐ Telugu ☒ English ☐ Hindi ☐ Other Specify _____
Do you require an interpreter? ☐ Yes ☐ No
Allergies: ☐ Yes ☐ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other: _____
If yes, identify _____

Source of Information: ☒ Family ☐ Patient ☐ Others, Specify _____			
SIGNIFICANT HISTORY	Past Medical History	Past Surgical History	Last Hospital Admission
	nim	Carriu	nim
	Family History:		
	Has the child or close family member had recent contact with a communicable disease? ☐ Yes ☐ No If yes please list, _____		
	Was the child's birth normal? ☐ Yes ☐ No If No, please describe problems: _____ Are the child's immunization up to date? ☐ Yes ☐ No		
CURRENT MEDICATIONS	Taking Medications? ☒ Yes ☐ No If yes, Fill the reconciliation form Medicine brought to the hospital? ☒ Yes ☐ No		
Observations: Weight: 28 kg Length: _____ Head Circumference (< 2 years): _____ Temp.: 98.9°F HR: 107 bpm RR: 18 BP: 90/51 Pain Score: 03/10 Specify Site: upper head (Follow Pain Assessment Sheet & Document) Fall Risk Assessment: ☒ Yes ☐ No Score: 10 (Document in the Humpty Dumpty Sheet) Risk of Pressure Sore (Braden Q Score 28) (Document in the Braden Q Assessment Sheet)			

BAH-00659217

IP5-0017588

Master SUHAIB MAHMOUD

16-07-2013 12 Y 11 M 17 D

Dr. KOKKULA PRANEETH



Behavioural Status on Admission :

☐ Sleeping
 ☐ Crying
 ☐ Calm
 ☐ Distressed/Console
 ☒ Drowsy

FUNCTIONAL SCREENING: If a patient needs assistance with any of the following inform consultant

☐ Mobility problem
 ☐ Walking Problem
 ☒ No Abnormality Detected
☐ Developmental Delay
 ☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING:

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

Inform consultant for positive criteria

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

If Yes Consultant Notified: (Date/Time):

Social History: Lives WithSiblings in household ☐ Yes ☐ No (if yes How Many?)

Orientation has been given regarding the following aspects:

- ☒ ID Band in situ
☒ Bedside safety explained
☒ PICU Routine: Doctor's rounds/Medication time
☒ Visiting policy explained

Orientation given to: ☒ Family ☐ Others specifyName of Person Orientation was given to: mother

Orientation not given Reason:

Nurse Name: RajNurse Signature: [Signature]Date & Time: 3/8/26 3:10 PM**DISCHARGE PLAN**Source of Information: ☒ Family ☐ FriendWill patient require transportation arrangements to go home: ☐ Yes ☒ NoWill Physiotherapy require at home: ☐ Yes ☒ NoIs home medical equipment anticipated: ☐ Yes ☒ NoIs home oxygen therapy anticipated: ☐ Yes ☒ NoAre dressing needs at home anticipated: ☒ Yes ☒ NoAny other needs anticipated: ☐ Yes ☒ No If Yes SpecifyDischarge Medications: ☐ Yes ☐ No

Details:

Final Diagnosis:

Nurse Name: RajNurse Signature: [Signature]Date & Time: 3/8/26 3:10 PM

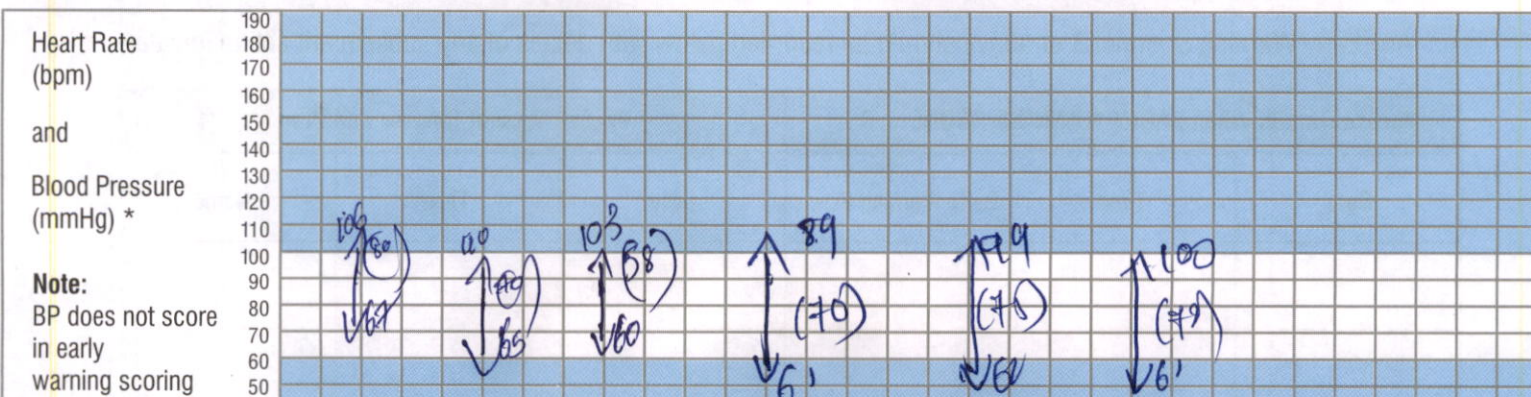
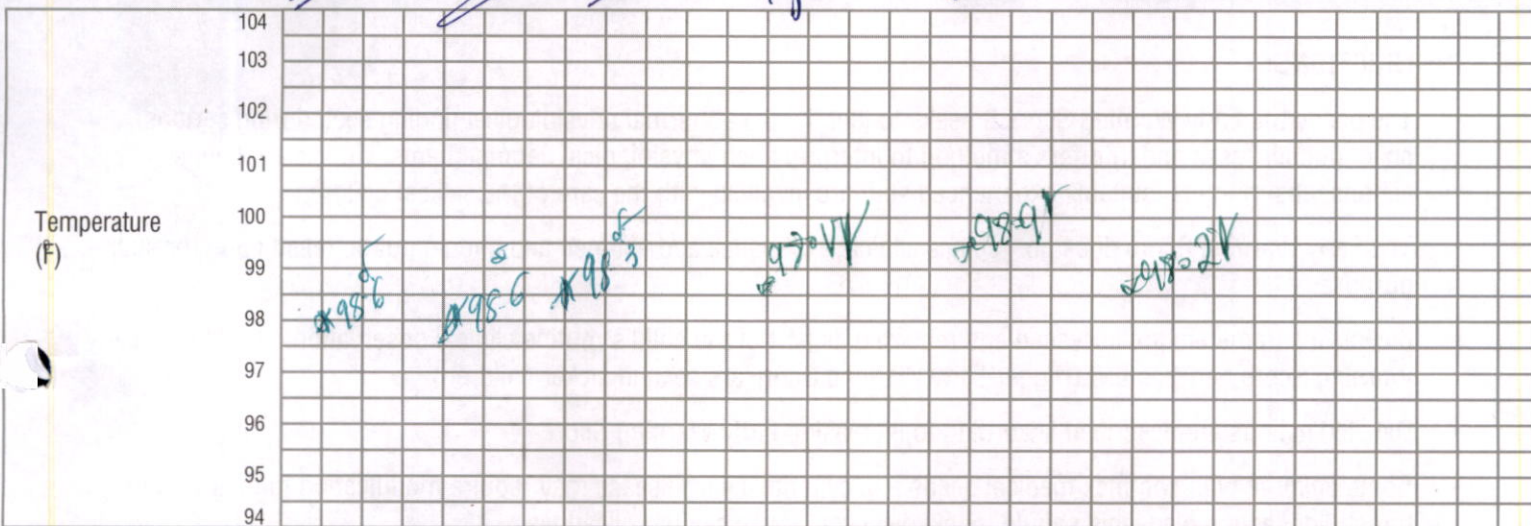
5/7/26

TEENAGE (12 + years)
Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : Time: 10 AM 2 PM 6 PM 10 PM 2 AM 6 AM

Doctor / Nurse / Family Concern? 10 AM 2 PM 6 PM 10 PM 2 AM 6 AM



Heart Rate (Number) 118 bpm 102 bpm 92 bpm 97 bpm 100 bpm 111 bpm



Resp Rate (Number) 24 bpm 22 bpm 24 bpm 24 bpm 23 bpm 22 bpm

Resp Distress Mod/ Severe None / Mild

Receiving O₂ (l/min) O₂ Saturations (%) RA 100% RA 100% RA 99% RA 99% RA 99% RA 99%

Conscious Level Normal Altered

GCS * 15/15 15/15 15/15 15/15 15/15 15/15

TOTAL SCORE Number of shaded boxes 0 0 0 0 0 0

Pain Score 0 0 0 0 0 0

Observer's Initials [Signature] [Signature] [Signature] [Signature] [Signature] [Signature]

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

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

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

- If at any time additional help is required, call help – regardless of the Early Warning Score!
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The SBAR communication tool (situation, background, assessment, recommendations) is a helpful mnemonic that can be used to describe a child's clinical condition to a colleague.

I	IDENTITY: I am (name), a nurse on ward (X). I am calling about (child X)
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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)

TEENAGE (12 + years)

Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date :	Time: 6pm	10pm	8pm	6Am
Doctor / Nurse / Family Concern?				
Temperature (°F)	98.5°F	98.7°F	98.2°F	98.1°F
Heart Rate (bpm)	105b/m	108b/m	102b/m	106b/m
Blood Pressure (mmHg) *	110/65 (71)	108/62 (68)	102/60 (71)	103/62 (71)
Respiratory Rate (Number)	22b/m	22b/m	24b/m	26b/m
Receiving O ₂ (l/min)	2lA	2lA	2lA	2lA
O ₂ Saturations (%)	100%	99%	100%	100%
Conscious Level	15/15	15/15	15/15	15/15
GCS *	15/15	15/15	15/15	15/15
TOTAL SCORE	0	0	0	0
Number of shaded boxes	0	0	0	0
Pain Score	0	0	0	0
Observer's Initials				

ACTIONS

NB: Scores 3 should be recorded overleaf

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

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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.
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BAH-00659217 IP5-00175888
Master SUHAIB MAHMOUD
16-07-2013 12 Y 11 M 16 D (M)
Dr. KOKKULA PRANEETH



RCBH/ FRM / CLINICAL / 127

TEENAGE (12 + years) Children's Observation & Early Warning Scoring Chart

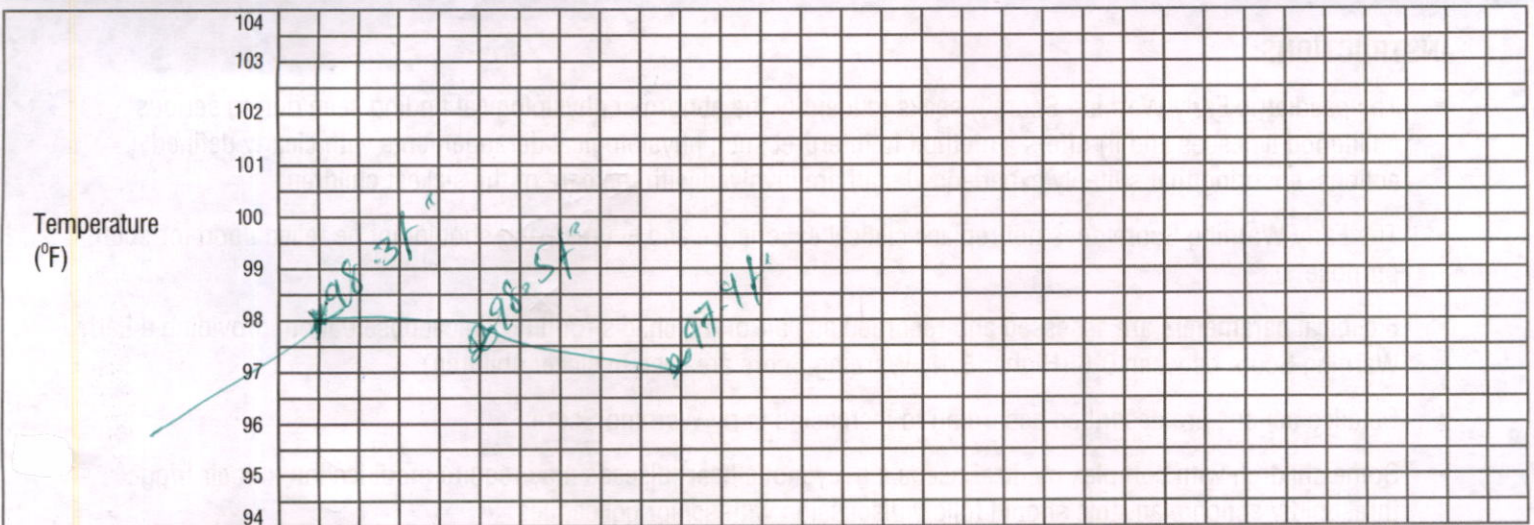
Rainbow
Children's
Hospital
It takes a lot to treat the little.

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 17/7/2013 Time : 10 AM 2 PM 6 PM

Doctor / Nurse / Family Concern?



Heart Rate (bpm)	190	180	170	160	150	140	130	120	110	100	90	80	70	60	50
and															
Blood Pressure (mmHg) *															
Note: BP does not score in early warning scoring															
Heart Rate (Number)	96	98	99												
	128	130	135												
	93	59	55												
	236/m	986/m	1006/m												

Resp. Rate (bpm) (Over 1 Minute)	70	60	50	40	30	20	10
Resp Rate (Number)	28/m	28/m	28/m				

Resp Distress	Mod/ Severe None / Mild																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																</
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TOTAL SCORE			
Number of shaded boxes	1	1	1
Pain Score	0	0	0
Observer's Initials	R	C	O

ACTIONS	Score 1 : Continue normal observation by staff nurse
	Score 2 : Shift in charge nurse to be informed and continue hourly observations
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FLUID CHART

Sheet No. :

4/7/26

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.
3. 24 hrs. total to be entered in the kardex in RED.

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	Route	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
				Central line I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											

Total Intake :

Total Output : 400 ml

	02:00 pm	↑		1ml								
	03:00 pm	↑	360ml water	1ml						70ml	0	Baul
	04:00 pm	NO	Chicken Rice	1ml						60ml	0	Baul
	05:00 pm	IVP	Lemon Juice	1ml						120ml	0	Baul
	06:00 pm		180ml	1ml						115ml	0	Baul
	07:00 pm	↓	180ml water	1ml						180ml	0	Baul

Total Intake :

720 ml

Total Output :

M - 0 U - 545ml

	08:00 pm	↑	180ml water	1ml						300ml	0	Dipa
	09:00 pm	↑	180ml water	1ml						250ml	0	Dipa
	10:00 pm	NO	Milk	1ml						230ml	0	Dipa
	11:00 pm	IVF	180ml water	1ml						170ml	0	Dipa
	12:00 am			1ml						135ml	0	Dipa
	01:00 am	↓		1ml						70ml	0	Dipa

Total Intake :

640 ml

Total Output :

M - 0 U - 1155ml

	02:00 am	↑	180ml water	1ml						40ml	0	Dipa
	03:00 am	↑	180ml water	1ml						50ml	0	Dipa
	04:00 am	NO		1ml						100ml	0	Dipa
	05:00 am	IVF		1ml						80ml	0	Dipa
	06:00 am		180ml water	1ml						50ml	0	Dipa
	07:00 am	↓		1ml						80ml	0	Dipa

Total Intake :

360 ml

Total Output :

M - 0 U - 400ml

Total 24 hrs. Intake	1720 ml
----------------------	---------

Total 24 hrs. Output	M - 0 U - 2100
----------------------	----------------



FLUID CHART

Sheet No. :

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	Route I.V. N.G.	NG	Diarrhoea	Vomit	Drainage	Urine			
5/7/26	08:00 am	↓		1ml					70ml	0		
	09:00 am	↓		1ml					50ml	0		
	10:00 am	NO IVP		1ml					100ml	0		
	11:00 am	180ml		1ml					15ml	0		
	12:00 pm	300ml		1ml						0		
	01:00 pm	300ml		1ml					200ml	0		
Total Intake :			780ml			Total Output :					M - 495ml	
5/7	02:00 pm	↓	180ml	1ml						0		
	03:00 pm	↓	180ml	1ml						0		
	04:00 pm	↓	180ml	1ml					300ml	0		
	05:00 pm	NO IVP		1ml					200ml	0		
	06:00 pm	180ml		1ml						0		
	07:00 pm	↓		1ml					280ml	0		
Total Intake :			720ml			Total Output : M - 0					U - 780	
5/7	08:00 pm	↑	180ml	1ml					50ml	0		Dipa
	09:00 pm	↑	Water	1ml						0		Dipa
	10:00 pm	NO IVP	180ml	1ml					220ml	0		Dipa
	11:00 pm	180ml		1ml						0		Dipa
	12:00 am	Water		1ml						0		Dipa
	01:00 am	30ml Milk		1ml						0		Dipa
Total Intake :			660ml			Total Output :					M - 0 U - 270ml	
6/7	02:00 am	↓		1ml						0		Dipa
	03:00 am	↓		1ml						0		Dipa
	04:00 am	↓		1ml						0		Dipa
	05:00 am	180ml		1ml					600ml	0		Dipa
	06:00 am	180ml		1ml						0		Dipa
	07:00 am	↓		1ml						0		Dipa
Total Intake :			360			Total Output : M - 0 U - 600ml						

Total 24 hrs. Intake

2520ml

Total 24 hrs. Output

M - U - 2145ml

FLUID CHART

Sheet No. :

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

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	water 180ml										
	09:00 am	water 180ml								310ml		
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						Total Output :						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						Total Output :						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						Total Output :						
Total 24 hrs. Intake			Total 24 hrs. Output									

FLUID CHART

Sheet No. :

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

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

BAH-00659217
Master SUHAIB MAHMOUD
16-07-2013
Dr. KOKKULA PRANEETH
12 Y 11 M 16 D
IP5-00175888
(M)

NURSING CARE RECORD

Rainbow Children's Hospital
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BirthRight
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Shift: ☐ Morning

oon

☒ Night

Date:

2/7/26

Assessment:

Pt having discomfort

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	→ Assess the pt general condition	8pm	→ Assessed pt general condition	pt condition is normal
10pm	→ monitor vital signs	10pm	→ monitor vital signs	
2am	→ maintain 1/0 chart	2am	→ maintained 1/0 chart	
6am	→ Administered the medications as per doctors orders.	6am	→ Administered the medications as per doctors order	

Re-Assessment:

Special Notes:

shift to OT on 7:30 AM

Nurse Signature:

[Signature]

Nurse Name:

Sraavanthi

Date & Time:

3/7/26

8AM

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16-07-2013 12 Y 11 M 16 D (M)
Dr. KOKKULA PRANEETH.



NURSING CARE RECORD

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Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 31/7/26

Assessment: to the baby general condition.

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
3 pm	→ Assess to the baby general Condition.	3.30 pm	→ Assess to the baby general Condition.	
4 pm	→ monitor vital on 2/0 chart.	4.30 pm	→ monitor vital on 2/0 chart.	
5 pm	→ Administer medication given as per drug chart.	5.30 pm	→ Administer medication given as per chart.	
6 pm	→ monitor urine output.	6.30 pm	→ monitor urine output.	
7 pm	→ w/f size re.	7.30 pm	→ w/f size re.	
	→ w/f fever spike		→ w/f fever spike.	
	→ monitor 1st urine to inform		→ w/f pain management.	
			→ w/f brady Cardia	
			→ NPO 2nd hour then give food.	

Re-Assessment: Re-Assessment done.

Special Notes: w/f fever spike w/f fever spike

Nurse Signature:

Nurse Name: Raj

Date & Time: 31/7/26 6 pm

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 3/7/26

Assessment: child having poly urica

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
8 AM	Assess the baby general condition	9 AM	Assessed the baby general condition	All points are Implemented
10 AM	monitored the vitals	11 AM	monitored the vitals	
12 AM	Provide comfortable position	1 PM	provided comfortable position	
2 AM	child orally allowed	3 AM	child orally allowed	
4 AM	6th hourly Sr-electrolytes	5 AM	6th hourly need to send Sr. electrolytes	
6 AM	120ml/hr urine output inform Dr.	7 AM	w/f urine output if 120ml more urine output inform	
	Administer medication as per chart		Administer medication as per chart	

Re-Assessment: Encourage oral fluids

Special Notes: w/f urine output

Nurse Signature: Sindhuja

Nurse Name: Sindhuja

Date & Time: 4/7/26 8 AM

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Master SUHAIB MAHMOUD
16-07-2013 12 Y 11 M 17 D (M)
Dr. KOKKULA PRANEETH



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Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 4/2/26

Assessment: Assessed the baby condition.

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
8AM	Assess the baby condition	9AM	Assessed the baby condition	Assessed
10AM	monitor the vital signs	11AM	monitored the vital signs.	All plan's
12PM	maintained I/O chart	1PM	maintained I/O chart	are implemented,
2PM	plan for stop IV fluids	3PM	stopped I/V fluids	
8 PM	orally allowed		orally allowed	

Re-Assessment:

Special Notes: ~~done~~ hourly check urine output.

Nurse Signature:

Nurse Name: premalika

Date & Time: 4/2/26 8PM

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Master SUHAIB MAHMOUD
16-07-2013 IP5-00175888
Dr. KOKKULA PRANEETH 12 Y 11 M 18 D (M)

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 4/7/20

Assessment: Patient having weakness

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	* Assess The baby General condition	8:10pm	* Assessed The baby General conditions	All Plan are Implemented
12AM	* Monitor vital signs	12:10AM	* Monitoring vital signs	
2AM	* Ensure safety	2:10AM	* provided side rails	
6AM	* Maintain personal hygiene	4:10AM	* Maintained personal hygiene	
8AM	* Maintain I/O chart	6:10AM	* Maintained I/O chart	
8AM	* Administer medication as per doctor order	7:10AM	* Administered medication as per doctor order	

Re-Assessment:

Special Notes:

Monitor the strictly urine output

Nurse Signature: [Signature]

Nurse Name: Sivalth

Date & Time: 5/7/20 08AM

NURSING CARE RECORD

Shift: ☒ Morning ☒ Afternoon ☒ Night

Date: 5/7/26

Assessment: Assess the baby condition

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8am	Assess the baby General condition	8am	Assessed the baby General condition	Provide comfortable position
10am	monitor vital & signs	10am	monitored vital signs	
12pm	Encourage orally	12pm	Encouraging orally	
2pm	maintain warm monitor	2pm	maintained warm monitor	
4pm	Ensure Safety	4pm	Provided comfortable position	
8pm	Administer medication as per doctor order	8pm	Administered medication as per doctor order	

Re-Assessment:

Special Notes: w/f fever & vomit out put:

Nurse Signature: [Signature]

Nurse Name: K. Laxmi

Date & Time: 5/7/26 @ 8pm

UH-00659217 IP5-00175888

Master SUHAIB MAHMOUD

-07-2013 12 Y 11 M 19 D (M)

KOKKULA PRANEETH



NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 5/7/26

Assessment: Patient having weakness

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8 PM	* Assess The baby General condition	8:10 PM	* Assessed The baby General condition	All plan Implemented pt is Good
12 AM	* Monitor vital signs	12:10 AM	* Monitor vital signs	
2 AM	* Ensure safety	2:10 AM	* provided side rails	
6 AM	* Maintain personal Hygiene	6:10 AM	* Maintained personal Hygiene	
8 AM	* Administer medication as per doctor order	8:10 AM	* Administer medication as per doctor order	

Re-Assessment: Re-assessment was done

Special Notes: w/o fever spikes, w/o Monitor Measure the urine output

Nurse Signature: [Signature] Nurse Name: [Signature] Date & Time: 6/7/26 @ 8 AM

AH-00659217 IP5-00175888
Nurse SUHAIB MAHMOUD
-07-2013 12 Y 11 M 19 D (M)
KOKKULA PRANEETH



NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☐ Night

Date:

Assessment:

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation

Re-Assessment:

Special Notes:

Nurse Signature:

Nurse Name:

Date & Time:

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: DR. KOKKULA PRANEETH Department: ER Date of Admission: 2/7/26

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:						
	<u>Chaniopharyngimo.</u>								
BACKGROUND	Area	Shift Time	<u>ER</u> <u>7:51 pm</u>	<u>2nd floor</u> <u>8:51 pm</u>		<u>1st floor</u> <u>3:05 pm</u>	<u>ADUOD</u> <u>9pm-8pm</u>	<u>HD unit</u> <u>8am-8pm</u>	
	Medical Condition (Any special condition to be noted):		<u>NA</u>	<u>NA</u>		<u>NA</u>	<u>NA</u>	<u>NA</u>	
ASSESSMENT	Allergy:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☒ No	
	Tubes/Drains/Catheter:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Vital Signs:		Temp:	<u>99.8°F</u>	<u>99.8°F</u>		<u>99.8°F</u>	<u>98.2°F</u>	<u>98.6</u>
	Res:		<u>26bpm</u>	<u>28bpm</u>		<u>28L</u>	<u>27bpm</u>	<u>22bpm</u>	
	SpO ₂ :		<u>100%</u>	<u>100%</u>		<u>100%</u>	<u>99%</u>	<u>100%</u>	
	Pulse:		<u>98bpm</u>	<u>98bpm</u>		<u>98%</u>	<u>100%</u>	<u>98bpm</u>	
	BP:		<u>104/69</u>	<u>105/70</u>		<u>108/70</u>	<u>107/60</u>	<u>106/60</u>	
	Fall Risk Score:		<u>10</u>	<u>10</u>		<u>10</u>	<u>10</u>	<u>10</u>	
Pain Score:		<u>0/10</u>	<u>0/10</u>		<u>0/10</u>	<u>0/10</u>	<u>0/10</u>		
Recommendations	Safety Needs:		<u>yes</u>	<u>yes</u>	<u>yes</u>	<u>yes</u>	<u>yes</u>	<u>yes</u>	
	Physiotherapy		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☒ No	☐ Yes ☐ No	
	Others Specify:		<u>NA</u>	<u>NO</u>		<u>NA</u>	<u>NA</u>	<u>NA</u>	
	Special Diet:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	
	Other Special Orders / Medications:		<u>NA</u>	<u>NA</u>		<u>NA</u>	<u>NA</u>	<u>NA</u>	
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>		<u>NA</u>	<u>NA</u>	<u>NA</u>		
Handed Over By Name :		<u>Poon</u>	<u>Saundhi</u>		<u>Melina</u>	<u>Dipa</u>	<u>Kabir</u>		
Signature :		<u>R</u>	<u>S</u>		<u>Mali</u>	<u>Dipa</u>	<u>Kabir</u>		
Date:		<u>2/7/26</u>	<u>3/7/26</u>		<u>4/7</u>	<u>5/7/26</u>	<u>5/7/26</u>		
Time:		<u>7:05 pm</u>	<u>8AM</u>		<u>8pm</u>	<u>2PM</u>	<u>8pm</u>		
Taken Over By Name :		<u>Saundhi</u>	<u>R</u>		<u>Dipa</u>	<u>Kabir</u>	<u>Saundhi</u>		
Signature :		<u>S</u>	<u>R</u>		<u>D</u>	<u>K</u>	<u>S</u>		
Date:		<u>3/7/26</u>	<u>3/7/26</u>		<u>4/7/26</u>	<u>5/7/26</u>	<u>6/7/26</u>		
Time:		<u>9:05 PM</u>	<u>7:57 AM</u>		<u>8 PM</u>	<u>8 AM</u>	<u>8 PM</u>		

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Kokkula Praneeth Department: 2nd Floor Date of Admission:

SITUATION	Diagnosis: <u>cosmo pharyngoma</u>		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
BACKGROUND	Area	Shift Time						
	Medical Condition (Any special condition to be noted):	<u>ADU 0000 8pm-7AM</u> <u>PA</u>						
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Vital Signs:	Temp:	<u>98.4</u>					
		Res:	<u>25</u>					
		SpO ₂ :	<u>98%</u>					
		Pulse:	<u>108</u>					
		BP:	<u>90/60</u>					
	Fall Risk Score:	<u>0</u>						
Pain Score:	<u>1/10</u>							
Recommendations	Safety Needs:	<u>yes</u>						
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:	<u>PA</u>						
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Other Special Orders / Medications:	<u>PA</u>						
Post Operative Procedure Special Orders:		<u>PA</u>						
Handed Over By Name :		<u>Sugato</u>						
Signature :		<u>[Signature]</u>						
Date:		<u>17/12</u>						
Time:		<u>2:40 PM</u>						
Taken Over By Name :		<u>Nijau</u>						
Signature :		<u>[Signature]</u>						
Date:		<u>17/12</u>						
Time:		<u>8 AM</u>						



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
4/7	8pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	SAD NP	Sweat
4/7	10pm	1/10	Surgical site	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Syp. Crocin given	about
4/7	11pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	Re-assessment done on rel	Sweat
5/7	6AM	0/10	Surgical site	☒ Continuous ☐ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☒ Increasing ☐ Decreasing	☒ Yes ☐ No	Syp. Crocin given	Dipn
5/7	7am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Re-assessment was done pain relief	Dipn
5/7	2pm	0/10	Surgical site	☒ Continuous ☐ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	Syp. Crocin given	DO
5/7/26	3pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	Re-assessment was done	bulky
5/7/26	10pm	1/10	Surgical site	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Syp. Crocin- given	Sweat
5/7/26	11pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	Re-assessment done on rel	Sweat
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

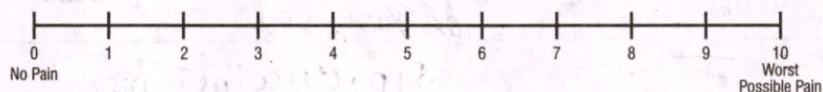
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours.
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
	0	1	2
Face	No Particular expression or smile	Occasional Grimace or Frown, withdraw, Disoriented	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs brawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, right, or Jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams of sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

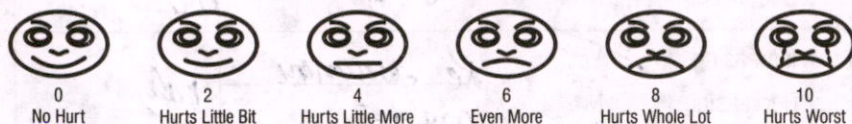
Numerical Pain Scale (Obstetric and Gynecology)



Neonatal Pain, Agitation and Sedation Scale (upto 1 Month)

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR, RR, BP, SaO₂	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO ₂ 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

Wong - Baker (Pediatrics) Above 7 Years





PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
2/7/26	7:15 pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA NA	poor
3/7/26	08:00	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	poor
3/7/26	3 pm	03/10	upper head	☒ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Inf PCM	poor
3/7/26	3:30 pm	02/10	surgical side	☒ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	poor
3/7/26	4:30 pm	01/10	surgical side	☐ Continuous ☒ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Inf-Transadol	poor
3/7/26	5:30 pm	02/10	surgical side	☐ Continuous ☒ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	poor
3/7/26	7 pm	01/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Inf PCM	poor
3/7/26	8 pm	1/10	surgical site	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☐ Dull ☒ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Inf PCM	Sindh
4/7/26	12 Am	1/10	surgical site	☐ Continuous ☒ Intermittent	☒ Acute ☒ Chronic	☐ Sharp ☐ Dull ☒ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Transadol	Sindh
4/7/26	8 pm	1/10	surgical site	☐ Continuous ☒ Intermittent	☒ Acute ☒ Chronic	☐ Sharp ☐ Dull ☒ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	PCM	Sindh

Re-assessment Frequency:

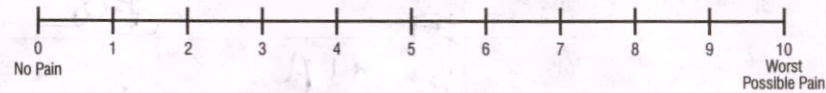
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

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 or sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

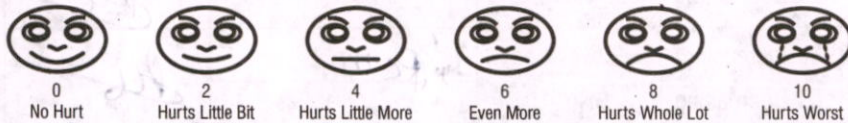
Numerical Pain Scale (Obstetric and Gynecology)



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





BRADEN 'Q' SCALE

					Date : 6/7			
					Time : 6:1			
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			
"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			
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			
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			
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			
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			
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			
					TOTAL SCORE	28		
					Evaluator's Name	Seal		

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 :	2/7	3/7	4/7	5/7
					Time :	9:15pm	GR	6:45	6:00
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 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	
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23					TOTAL SCORE				
Docu. No. : RCHBH /FRM / CLINICAL / 119					Evaluator's Name				

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poofa P Sualli

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
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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



CHECKLIST FOR THROMBOPHLEBITIS

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

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 : Bu Name : Baomala

Signature of Ward In Charge :

Signature : Anita Name : Anita

Patient Sticker

BAH-00659217 IP5-00175888
Master SUHAIB MAHMOUD
16-07-2013 12 Y 11 M 17 D (M)
Dr. KOKKULA PRANEETH



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

ON	STAGE / ACTION	SCORE	2/2 DAY-1			08/7 DAY-2			4/7 DAY-3			Remarks
			M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	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	1			-		-	-		-	-	
3	Two of the following Signs are evident: Pain at IV site Redness	2			-		0	-		-	-	
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	3		R	-		-	-		-	-	
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	4			-		-	-		-	-	
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	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 :

Signature of Ward In Charge :

Signature : Name :



THE HUMPTY DUMPTY SCALE

2/7 3/7 4/7 5/7 6/7

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4					
	3 to less than 7 years old	3					
	7 to less than 13 years old	2	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		yes	yes	yes	yes	yes
Call device within reach		yes	yes	no	yes	yes
Wheels Locked		yes	yes	yes	yes	yes
Room free of clutter		yes	yes	yes	yes	yes
Adequate Lighting		yes	yes	yes	yes	yes
Wheel Chair Support		no	no	no	no	no
Other Intervention(s) Specify		no	no	no	no	no
Nurse's Name :		poor	poor	poor	poor	poor
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date :		2/7	2/7	4/7	5/7	6/7
Time :		7:15 pm	8:15 pm	6:15 am	6:15 am	6:15 am

BAH-00659217 IP5-0017588:
Master SUHAIB MAHMOUD
16-07-2013 12 Y 11 M 17 D
Dr. KOKKULA PRANEETH



CENTRAL LINE MAINTENANCE CARE BUNDLE CHECK LIST

Type of Line: ☐ PICC Line ☐ UAC ☐ UVC ☐ Other Date of Initial Line Insertion: Duration of Central Line:

- Always perform hand hygiene before accessing central line
- Use Sterile gloves for handling central line
- Clean the hub with antiseptic solution every time before & after it is accessed
- Consider – antibiotic via central line before removal of the line
- Inspect Central line in each shift for the following

Parameters	Date	Shift Time	3/7 Day	3/7 Night	4/7 Day	4/7 Night	5/7 Day	5/7 Night
Can we remove Central Line today (Discuss in the clinical round)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No
Evidence of any inflammation at insertion site (Redness / Swelling (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No
Blood at insertion site (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No
Any peeling of dressing? (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No
Is dressing clean and dry? (If no inform the doctor)			☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No
Any leakage at insertion site? (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No
Is there any obstruction to the infusion flow? (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No
Dressing intact and labelled properly			☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No
Central line changed on			NA	NA	NA	NA	NA	
Name of the Nurse			Poj	Swidh	prang	Swidh	Swidh	
Signature of the Nurse			[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	

URINARY CATHETER BUNDLE CHECK LIST

Date of Insertion: 3/7/26

Date of Removal:

Parameters	Date	Shift Time	3/7/26 Pre	3/7 night	4/7 day	4/7 day	5/7 night		
Need for the Catheter	☒ Yes ☐ No		☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Hand Hygiene	☒ Yes ☐ No		☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Usage of Sterile Equipment	☒ Yes ☐ No		☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is the Collection bag below the level of bladder	☒ Yes ☐ No		☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Check the Tube for Obstruction (Free of Kinking)	☒ Yes ☐ No		☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is Catheter dated as policy	☒ Yes ☐ No		☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Collecting bag is been emptied regularly?	☒ Yes ☐ No		☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Maintenance of closed system for the catheter	☒ Yes ☐ No		☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dressing clean and dry?	☒ Yes ☐ No		☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is the line removed as Policy?	☐ Yes ☒ No		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No
Performance of Perineal Care	☒ Yes ☐ No		☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Onset of New Fever	☐ Yes ☒ No		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No
Asses for the leakage at the site of insertion	☒ Yes ☐ No		☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Name of the Nurse			Raj	Sindh	Prang	Sant	Sant		
Signature of the Nurse									



NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 5/7/26 Time: 10am

Weight: 28.1kg Centile: 55th

Height: 95cm Centile: 55th

Inference: underweight child

RDA: - Calories: 1750kcal/d Protein: 30g/d

Diet Recommendations: soft diet

Re-Assessment: Avoid spic, chilled & outside foods

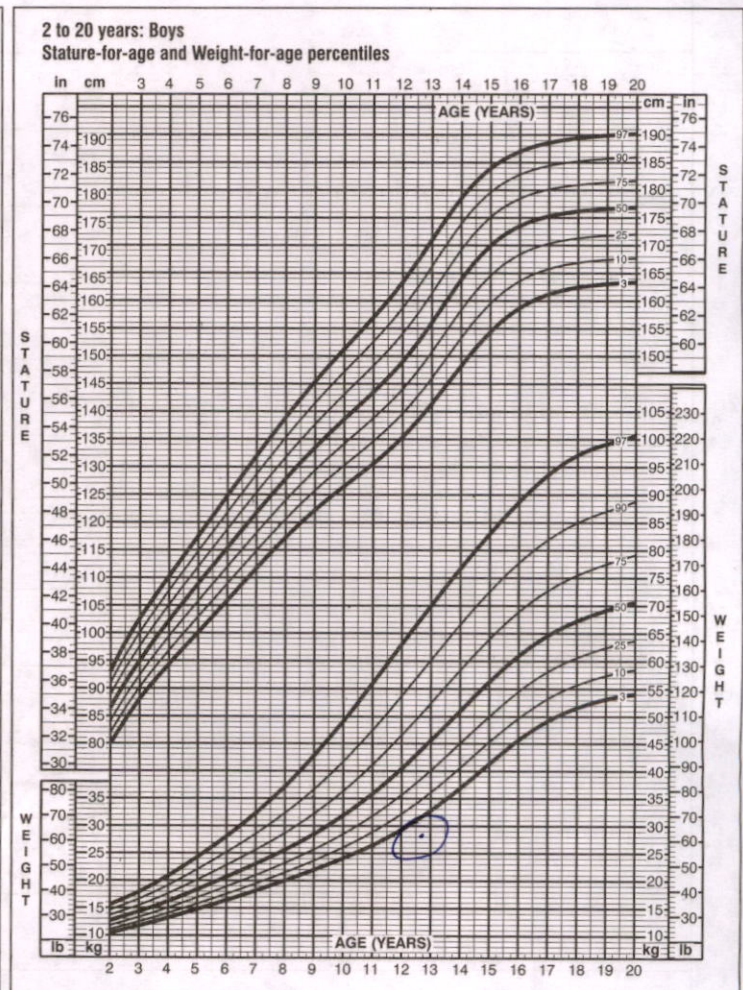
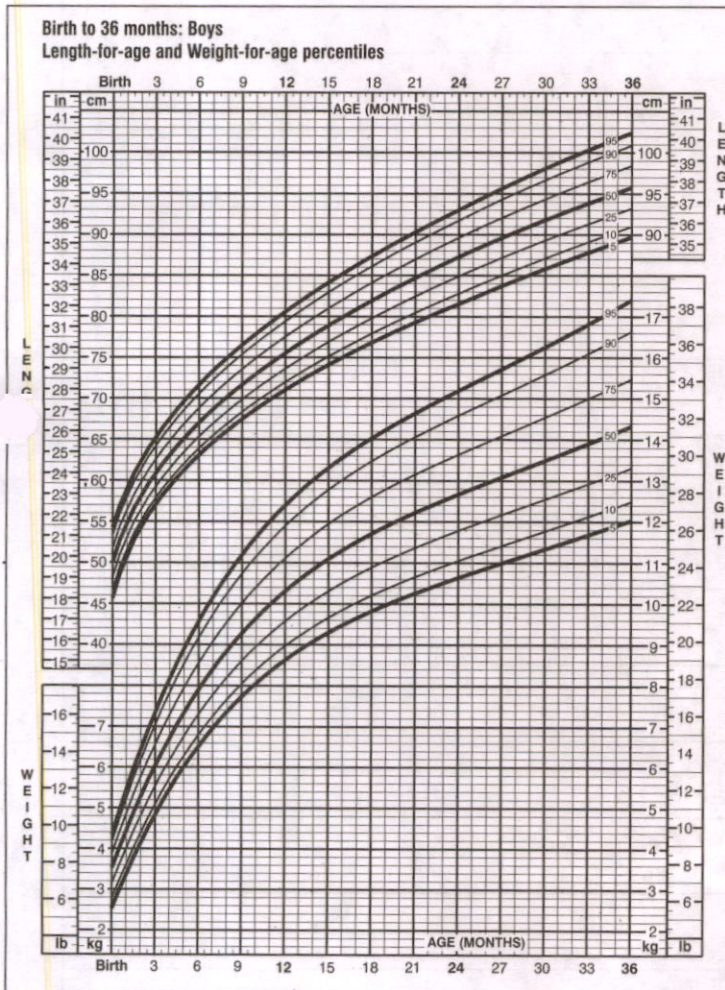
Food Allergies: NO Veg/Non-veg: NON-veg

Diagnosis: supra sellar tumor [cystic] Sp & excision & omaya reservoir

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: [Signature]

GROWTH CHART (BOYS)



Dietician's Name: [Signature]

Dietician's Signature: [Signature]

Daily Notes:

6/7/26
9:40 am

Child is stable. Intake is fair.

Continue soft diet

Maurice

NURSE HAND OFF COMMUNICATION - ICU

SITUATION & BACKGROUND		DOA : 3/8/26		Diagnosis :		Surgery / Procedures :	
		Allergies : NA		Post OP Day :			
SITUATION & BACKGROUND	Date :	3/8	3/8	4/8			
	Area	PICU	PICU	PICU			
	Shift Time	Day	Night	Day			
	Diet :	NPO	Orally	Orally			
Ventilation (RA, NP, NIV, VENTI)		RA	RA	RA			
INVASIVE LINES	1.	Cannula	Cannula	Cannula			
	2.		Arterial line	Arterial line			
	3.	Arterial line	Central line	Central line			
	4.	Central line	Central line	Central line			
Infusions / Transfusions		DNS ABP flush	DNS ABP flush	NA			
PU Prophylaxis		NA	NA	NA			
DVT Prophylaxis							
ASSESSMENT	Vitals	BP	90/74	91/58	95/68		
		PR	80	70	83		
		RR	10	20	20		
		SpO ₂	100%	100%	100%		
		Temp	98.4°F	98.6°F	98.6°F		
	Pain Score		02/10	1/10	1/10		
	LOC (Alert, Conscious, Confusion, Unconscious)		Alert	Alert	Alert		
	Skin Integrity (Intact / Bedsore / Any other condition)		Intact	Intact	Intact		
	Restraints If any		NA	NA	NA		
	Fall Risk (Vulnerable (Y/N) if yes score)		yes	yes	yes		
(Ambulation, walking, moving with assistance, bed ridden)		Ambulation	Ambulation	moving			
ADL (Dependent / Non-Dependent)		Dependent	Dependent	Dependent			
Critical Lab Test / Values (if any)		Nil	Nil	Nil			

Note : RA (Room Air, NP Nasal Prongs, NIV Non-Invasive Ventilation, VENTI Ventilator)

RECOMMENDATIONS	Investigations Procedures	Date :	3/7/26	3/7/26	4/7/26			
		Area						
		Shift Time	Pre Day	Pre Night	Pre Day			
		Ordered / Planned	Followed doctor order	Followed doctor order	Followed doctor order			
		Due	NO due	NO due	NO due			
		Reports Pending	NO Report Pending	NO report pending	NO Report pending			
Referrals (If any)	NO Referrals	NO referrals	NO Referrals					
	Remarks (Special Interventions like, Drainage Tube flushing etc.)	NO Remarks	NO remarks	NO Remarks				
Handed Over By Name :		Raj	Sindhuja	Pravali				
Signature :		[Signature]	[Signature]	[Signature]				
Date :		3/7/26	4/7/26	4/7/26				
Time :		8pm	8pm	3pm				
Taken Over By Name :		Sindhuja	Pravali	Neeli				
Signature :		[Signature]	[Signature]	[Signature]				
Date :		3/7/26	4/7/26	4/7				
Time :		8pm	8pm	@ 3:00pm				

PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-03614217 P5-03 14888 Master SUHAIB MAHMOUD 16-07-2013 12 Y 11 M 18 D (M) Dr. KOKKULA PRANEETH 		Date & Time of Admission 21/7/26 @ 7.11 PM	Date & Time of Transfer Order 4/7/26 @
		Transfer Ordered by Dr. Praneeth	Reason for Transfer Shifting.
From Unit 106	To Unit 209	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 28	Number of Imaging Films MRI	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.	MRI	1	
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☐ No ☐			
Name & Signature of Person who is Transferring Mehin		Name of Person Ordered Transfer	
Patient & Clinical Records Received by : Barmali 4/7/26 at 6 PM			
Date & Time of Patient Received :			

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

Date & Time : 4/7/26 8A.m.



INFORMED CONSENT FOR HIGH RISK PROCEDURE / SURGERY

Name: SUHAIB HAMED Age: 12y 11m Gender: ☒ Male ☐ Female

UHID.No: BAH-00659217 Date: 29.06.2026

I / We have been explained by Dr. Praneeth
about the medical condition and the proposed procedure.

I / We have been told that our patient SUHAIB HAMED has
the following Medical Conditions / Diagnosis:

Cranio pharyngioma S/P Ommaya in-situ

Proposed Treatment / Procedure / Operation:

Redo craniotomy and excision of tumour

I / legal guardian, have been explained in the language understood by me / us, about the medical condition mentioned
above and that our patient has following risks involved during the hospital stay

Bleeding, Blood transfusion, Hormonal disturbance, Redo surgery
Need for hormone replacement, Need for radiotherapy, residual tumour

I / We have been explained risk, benefits and alternatives of the procedure. tumour, need for redo surgery

I / We have been informed that the ongoing treatment in the Intensive Care Unit involves the risk of unsuccessful results,
complications, temporary or permanent injury or disability and even fatality from known or unforeseen causes and no
guarantee or promises have been made to me / us concerning the results of the procedure or treatment.

I / We have understood the consequences of not undergoing the proposed treatment.

I / We hereby give (my / our) full consent for the above - mentioned treatment.

We also indemnify the hospital, the concerned Doctors and the hospital staff in case of any adverse consequences
arising from the treatment.

Patient (Or Patient Relative / Guardian):

Signature: Salih

Name: Salih Mohamed

Date & Time: 29.6.2026

Doctor (Who is talking the consent)

Signature: Praneeth

Name: Dr. Praneeth

Date & Time: 29.6.2026

Witness

Signature: A

Name: KHALID

Relative / Legal Guardian: (Relationship with Patient) Uncle

Address: Toluwechahu

Date & Time: 29.6.2026

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Praneeth
Asst. Surgeon : Dr. Aditi
Anaesthetist : Dr. Aditi
Scrub Nurse : Jyoti, Nam

BAH-00659217 IP5-00175888
Master SUHAIB MAHMOUD
16-07-2013 12 Y 11 M 17 D (M)
Dr. KOKKULA PRANEETH



Age : 12.11m Gender : m
Surgery Name : Pedocraniotomy & Excision of tumour
Date : 3/7/26 In-time : 8.20am Out-time : 3pm



Before Induction of Anaesthesia ➤ ➤

Before Skin Incision ➤ ➤

Before Patient Leaves Operating Room

SIGN IN		Time: <u>8.10 Am</u>
Patient Has Confirmed		
Identity	☒ Yes ☐ No	
Site	☒ Yes ☐ No	
Procedure	☒ Yes ☐ No	
Consent	☒ Yes ☐ No	
Site Marked	☐ Yes ☐ No ☒ NA	
Anaesthesia Safety Check Completed	☐ Yes ☐ No	
Pulse Oximeter on Patient & Functioning	☐ Yes ☐ No	
Does Patient have a:		
Known Allergy?	☐ Yes ☒ No	
Difficult Airway / Aspiration Risk?		
Yes, & Equipment / Assistance Available	☐ Yes ☒ No	
Risk of > 500ml Blood Loss (7ml/kg In Children)?		
Yes, and Adequate Intravenous Access and Fluids Planned	☒ Yes ☐ No ☐ NA	
Blood Units Reserved	☒ Yes ☐ No ☐ NA	
Has Antibiotic Prophylaxis been given within the last 60 minutes?		
	☐ Yes ☒ No ☐ NA	
Signature : <u>Aditi</u>		
Name : <u>Dr Aditi</u>		

TIME OUT		Time: <u>9.54 Am</u>
Confirm all team members have introduced themselves by Name and Role ☒ Yes ☐ No		
Surgeon, Anaesthesia Professional and Nurse Verbally Confirm		
Correct Patient (Check ID Band)	☒ Yes ☐ No	
Correct Site	☒ Yes ☐ No	
Correct Procedure	☒ Yes ☐ No	
Anticipated Critical Events		
Surgeon Reviews:		
What are the Critical or Unexpected Steps, Operative Duration, <u>4 hours</u> , Anticipated Blood Loss? <u>some</u> ☒ Yes ☐ No ☐ NA		
Anaesthesia Team Reviews:		
Are There Any Patient-specific Concerns? ☐ Yes ☒ No ☐ NA		
Nursing Team Reviews: <u>Blood transfusion</u>		
Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns? ☒ Yes ☐ No ☐ NA		
Is Essential Imaging Displayed? ☒ Yes ☐ No ☐ NA		
Power Supply, Earthing, Power Backup and functioning of equipment checked. ☒ Yes ☐ No		
Signature : <u>Thejas</u>		
Name : <u>Thejas</u>		

SIGN OUT		Time: <u>2.40pm</u>
Nurse Verbally Confirms with the Team:		
The Name of the Procedure Recorded	☒ Yes ☐ No	
That Instrument, Sponge and Needle Counts are Correct (or Not Applicable)	☒ Yes ☐ No ☐ NA	
The Specimen is Labelled (including patient name)	☒ Yes ☐ No ☐ NA	
Whether there are any Equipment Problems to be addressed	☐ Yes ☒ No ☐ NA	
To Surgeon, Anaesthetist and Nurse:		
What are the key concerns for recovery and management of this patient? ☒ Yes ☐ No		
DI		
Signature : <u>Praneeth</u>		
Name : <u>Dr. Praneeth</u>		