

ACTIVITY RECORD FOR BILLING

Name : Abi BAH-00660949 IP5-00176630
Master ABDUL AYAAN
19-11-2011 14 Y (M)
UHD No. : Dr. DR.V.V.R.SATYA PRASAD
Date of Admission: Date of Discharge : Time:
Room / Bed No : Ward : Suggested Billable bed type :

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
20/07/26	9:55 AM	ED	PICU	<u> </u>
20/07/26	5:10 PM	PICU	ICG	<u>Sona.</u>

Cross Consultation Visit

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

[illegible]

20/07

Blood grouping

72635

Ismael

20/2

USG guided procedure	36/29
Kidney biopsies	2607

26072741



PROCEDURE

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
20/07	iv placement	1	12078	I. [Signature]
	Conscious Sedation	(1)	2	[Signature]
	Kidney biopsy	(2)	9712416	[Signature]
	N/A	(1)	9713912	[Signature]

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

.....

Date : 21/7/16 Time : 9am Prepared By : [Signature]

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
[Signature]	11/6		

ADMISSION SHEET

Registration Details :



Admission No : IP5-00176630 Admit Date : 20-Jul-2026 Admit Time : 08:37 AM UHID : BAH-00660949

Patient Details :

Patient Name	: Master ABDUL AYAAN	Age	: 14 Y
Guardian	: Mr ABDUL SHOWKATH	DOB	: 19-11-2011
Gender	: Male	Religion	:
Occupation	:	Martial Status	: Single
Address (H)	: Hyderabad Nagarjuna Sagar Road Hyderabad Telangana INDIA 500059	Phone No	: 9912343658/
		E-mail	: 9912343658@gmail.com

Admission Details :

Bed Type : DAY CARE Bed No : PICU - DC 229 Ward Name : 2F-PICU II
Room No : PICU - DC 229 Admission Type : First Visit

Contact Details :

Name : Mr ABDUL SHOWKATH Relationship : Father
Contact Address : Hyderabad Nagarjuna Sagar Road Hyderabad Phone No : / 9912343658
Telangana INDIA 500059


Signature

Doctor Details :

Doctor Name : Dr. DR.V.V.R.SATYA PRASAD Specialisation : PEDIATRIC NEPHROLOGY
Referral Doctor : Self Phone No :
Co-Consultant : Dr. SRUTHI BALLA

Payment Details :

Payment Mode : Cash Deposit Amount : 0.00
Payor Name : SELFPAY



NURSING INITIAL ASSESSMENT FOR PICU

Date of Admission: 20/7/2026
Source of Admission: ☐ OPD ☐ Ward ☐ Other: ER
Reason for Admission: Renal biopsy
Admission Diagnosis: Nephrotic syndrome
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
	<u>NA</u>	<u>NA</u>	<u>NA</u>
	Family History: _____		
	Has the child or close family member had recent contact with a communicable disease? ☐ Yes ☒ No If yes please list, _____ Was the child's birth normal? ☐ Yes ☐ No If No, please describe problems: _____ Are the child's immunization up to date? ☒ Yes ☐ No		
CURRENT MEDICATIONS	Taking Medications? ☒ Yes ☐ No If yes, Fill the reconciliation form Medicine brought to the hospital? ☒ Yes ☐ No		
Observations: Weight: <u>25kg</u> Length: _____ Head Circumference (< 2 years): _____ Temp.: <u>97.4°F</u> HR: <u>97bpm</u> RR: <u>17cpm</u> BP: <u>129/84mmHg</u> Pain Score: _____ Specify Site: _____ (Follow Pain Assessment Sheet & Document) Fall Risk Assessment: ☐ Yes ☐ No Score: _____ (Document in the Humpty Dumpty Sheet) Risk of Pressure Sore (Braden Q Score _____) (Document in the Braden Q Assessment Sheet)			

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 With parentsSiblings in household ☒ Yes ☐ No (if yes How Many?) 2 siblings

Orientation has been given regarding the following aspects:

☒ ID Band in situ☒ Bedside safety explained☒ PICU Routine: Doctor's rounds/Medication time☒ Visiting policy explainedOrientation given to: ☒ Family ☐ Others specifyName of Person Orientation was given to: Abdul Shaukat [Father]

Orientation not given Reason:

Nurse Name: Sona Nurse Signature: SonaDate & Time: 20/7/26 @ 5:00pm**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: Nurse Signature:

Date & Time:



DEFICIENCY CHECK LIST OF CASE SHEET

Sl.No.	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission sheet	1			
2	Discharge Summary	1			
3	Nursing Initial assessment	1			
4	Patient Transfer form	2			
5	In-patient Medical record	1			
6	Doctors progress sheets	2			
7	Nursing plan of care and handover sheets	4			
8	Consultation sheet				
9	General consent for treatment	1			
10	Consent for Surgery				
11	Consent for blood transfusion				
12	Consent for chemotherapy				
13	Consent for high risk				
14	Consent for Restraint				
15	LAMA consent				
16	Consent for special procedure / Sedation	4			
17	Consent for Formula feed				
18	Consent for MTP				
19	Consent for Radiological Investigations				
20	Consent for HIV test				
21	Anaesthesia notes (Pre Anaesthesia& post)				
22	Neonatal Admission/Delivery/Physical Exam				
23	Medication Reconciliation	1			
24	Emergency Triage record	1			
25	Pre operative check list				
26	Surgical safety checklist				
27	Operation Theatre notes				
28	Nurses clinical Presentation				
29	TPR & BP chart	1			
30	Intake and Out take chart (fluid chart)	1			
31	Drug chart (Regular Prescription)	17			
32	Investigation Values (result sheet)	1			
33	Nebulization chart				
34	Nutritional review chart	1			
35	Intensive care unit (ICU Charts)	1			
36	Consent for Admission in PICU / NICU				
37	The Humpty dumpty scale	1			
38	Braden Q Scale	1			
39	Bed side check list				
40	PICU bed formula Dilution feeds				
41	Gastro monitoring chart				
42	Rch ED doctors note				
43	BP Monitoring chart				
44	RBS monitoring chart				
	<i>Extra</i>	6			
	Total No. of Pages	34			

ERROR LOG

LOCATION : OT / Birthing Centre / BirthRight Premium / 3rd Floor (Zone A,B,C) / NICU / PICU /
2nd Floor Ward / Oncology / 1st Floor Wards.

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE

NURSE HAND OFF COMMUNICATION - ICU

SITUATION & BACKGROUND	DOA : 20/7/26		Diagnosis : Nephrotic syndrome		Surgery / Procedures : Renal biopsy		
	Allergies :				Post OP Day :		
	Date : 20/7/26	20/7/26					
	Area	PICU-2					
	Shift Time	Day					
ASSESSMENT	Diet :	Normal					
	Ventilation (RA, NP, NIV, VENTI)	NA					
	INVASIVE	1.					
		2.					
		3.					
		4.					
	INFUSIONS / TRANSFUSIONS	DNLS					
PU Prophylaxis							
DVT Prophylaxis							
Vitals	BP	120/77					
	PR	101 bpm					
	RR	18 bpm					
	SpO ₂	98%					
	Temp	97.4°F					
Pain Score	0/10						
LOC (Alert, Conscious, Confusion, Unconscious)	Alert						
Skin Integrity (Intact / Bedsore / Any other condition)	Intact						
Restrains If any	Physical	NA					
	Chemical	NA					
Fall Risk (Vulnerable (Y/N) if yes score)	No						
(Ambulation, walking, moving with assistance, bed ridden)	walking						
ADL (Dependent / Non-Dependent)	Non-dependent						
Critical Lab Test / Values (if any)							

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

RECOMMENDATIONS	Investigations Procedures	Date :	20/7/26					
		Area	PICU-2					
		Shift Time	Day					
		Ordered / Planned	Ship to Room					
		Due	NO Due					
		Reports Pending	NO Reports Pending					
		Referrals (If any)	NO Referrals					
		Remarks (Special Interventions like, Drainage Tube flushing etc.)	NO Pending					
		Handed Over By Name :	Shanvi					
		Signature :	[Signature]					
Date :	20/7							
Time :	8 PM							
Taken Over By Name :	Arjun							
Signature :	[Signature]							
Date :	20/7							
Time :	8 PM							



Abdul Ayan

14/M

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/07/2026 12:40pm	SfB Dr. Snithi Renal biopsy notes	
	Under Aseptic Precautions, (2) Lower pole kidney biopsy done and sample sent for LM + IF No immediate post procedural complications noted.	
	HR - 102/min RR - 24/min BP - 118/76 mmHg SpO2 - 98% on RA	Adv 1) Strict bed rest till T/M 10Am 2) Strict I/O charting 3) Daily wt charting 4) Watch for Gross Hematuria, Tachycardia, Hypotension 5) Allow orally once Child is fully Conscious 6) Stop IVF if oral intake good 7) Medications as per drug chart.

(Signature)

Date & Time	Progress Notes	Doctor's Order
20/7/2026 1:30pm	S/P Dr. Pritlu Balla	
	Case Reviewed S/P Renal biopsy.	<u>Adv</u>
	Biopsy site clean NO Swelling NO Hematuria currently	1) Allow orally 2) Medications as per drug chart
	Hemodynamically stable	3) vitals 3 hourly 4) I/O charting 5) watch for Hematuria
		Pritlu

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ABDUL AYAAN

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/11/16 9am	Wish ER Resident Dr. N. Peruvu Case of Nephrotic Syndrome. - Admitted for Renal biopsy	Plan
	Wish - Temp 98.6°F PR 96/min BP 127/87 (93) RR 23/min SpO ₂ 100% on RA	Plan - Daycare admission - NPO - Renal biopsy today - Wish morning - Blood group
	12/11/16 - PT-14 INR-1 APTT-31.85	N. Peruvu
	22/11/16 - 128/41/103	
	08/11/16 - USG abdomen ↳ Subtle increase in cortical echotexture in both kidneys	
	N/B Subm. 20/07/2016 at 9AM	

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/11/16 11 AM	Seen by Dr- Satya Prasad. Acute Nephrotic Syndrome Plan for Kidney Biopsy. - shift to ward after biopsy. - on 60mg/day Prednisolone - stop IV fluids after shifting Kidney Biopsy to rule out FSGS. IgM Nephropathy, MCNS, membranous nephropathy	- BP Q 3 hourly - Bed rest for 24 hrs. - T-Lanzol 30mg - Omacortil Am-30mg Pm-20mg - T-Skelcal 250mg
(8/17)	C ₂ 118 C ₄ 24.9 urea 25 crea 0.2 HCO ₃ -25	
20/11/16 6 PM	Seen by Resident No hematuria Vitals stable	- stop IV fluids - medication as charted. I/O monitoring Vitals monitoring

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

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BG-0+ve

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RESULT SHEET

Date	12/7				
Time					
Hb	12.9				
PCV	39				
RBC	4.4				
WBC	12.4 k				
N/L	60/21				
Platelets	3.94 L				
CRP					
ESR					
PCT					
RBS					
Na	128				
K	4.1				
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	14/1				
APTT	30				
CSF Protein / Sugar					
Cells					
N/L					

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

Culture and Sensitivities :

.....

.....

.....

Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI :

 Others (ECG, Contrast Studies etc.,) :



DRUG CHART

Date of Admission: 20/07/20 Drug Allergies: Nil ☒ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

SOS / PRN (As Required Medication)

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

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

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

VERIFIED BY : Name

REGULAR PRESCRIPTIONS

Weight. 29kg Ward.

DRUG : <u>Ins LASIX</u>				Date Time <u>20/7</u>
Dose <u>25mg</u>	Route <u>IV</u>	Frequency <u>BD</u>	Start Date <u>20/7</u>	<u>10 PM</u> <u>10 PM</u> <u>2 PM</u>
Name & Signature of the Doctor Starting the Drugs: <u>Sanku</u>				
Additional Instructions:				<u>11 PM</u> <u>10 PM</u> <u>10 PM</u> <u>10 PM</u>
Daily Doctor's Endorsement by a Sign				
DRUG : <u>Ins CEFTRIAXONE</u>				Date Time <u>20/7</u>
Dose <u>1.2g</u>	Route <u>IV</u>	Frequency <u>BD</u>	Start Date <u>20/7</u>	<u>10 AM</u> <u>10 AM</u> <u>10 AM</u> <u>10 AM</u>
Name & Signature of the Doctor Starting the Drugs: <u>Sanku</u>				
Additional Instructions:				<u>10 PM</u> <u>10 PM</u> <u>10 PM</u> <u>10 PM</u>
Daily Doctor's Endorsement by a Sign				
DRUG : <u>T. OMNACORTIL</u>				Date Time <u>20/7</u>
Dose <u>PO</u>	Route <u>PO</u>	Frequency <u>BD</u>	Start Date <u>20/7</u>	<u>10 AM</u> <u>10 AM</u> <u>10 AM</u> <u>10 AM</u>
Name & Signature of the Doctor Starting the Drugs: <u>Sanku</u>				
Additional Instructions: <u>morning - 30mg</u> <u>night - 20mg</u>				<u>10 PM</u> <u>10 PM</u> <u>10 PM</u> <u>10 PM</u>
Daily Doctor's Endorsement by a Sign				
DRUG : <u>T. LANZOL</u>				Date Time <u>20/7</u>
Dose <u>30mg</u>	Route <u>PO</u>	Frequency <u>OD</u>	Start Date <u>20/7</u>	<u>10 AM</u> <u>10 AM</u> <u>10 AM</u> <u>10 AM</u>
Name & Signature of the Doctor Starting the Drugs: <u>Sanku</u>				
Additional Instructions:				<u>10 PM</u> <u>10 PM</u> <u>10 PM</u> <u>10 PM</u>
Daily Doctor's Endorsement by a Sign				



REGULAR PRESCRIPTIONS

Weight 29 kg Ward

Docu. No. : RCHBH /FRM / CLINICAL / 108

(P.T.O)

Patient Sticker

Sheet No:

REGULAR PRESCRIPTIONS

Weight Ward

DRUG :				Date Time																
Dose	Route	Frequency	Start Dt.																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

DRUG :				Date Time																
Dose	Route	Frequency	Start Dt.																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

DRUG :				Date Time																
Dose	Route	Frequency	Start Dt.																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

DRUG :				Date Time																
Dose	Route	Frequency	Start Dt.																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

Signature
VERIFIED BY : Name

Weight. 29 kg Ward.

[illegible]

Signature _____

VERIFIED BY : Name

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Dr. DR.V.V.R.SATYA PRASAD

CHBH/ FRM / CLINICAL / 127

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

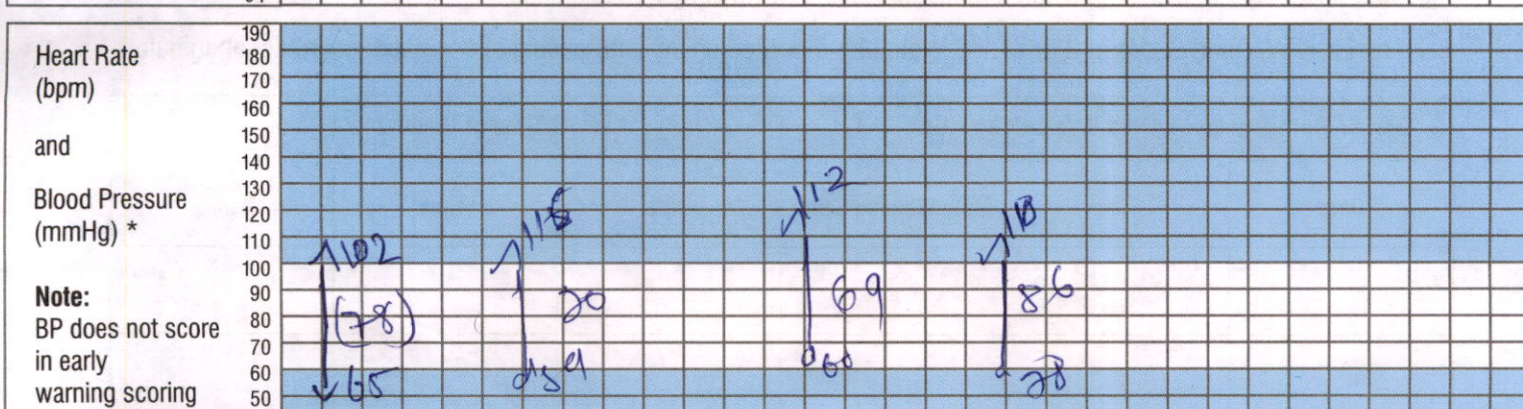
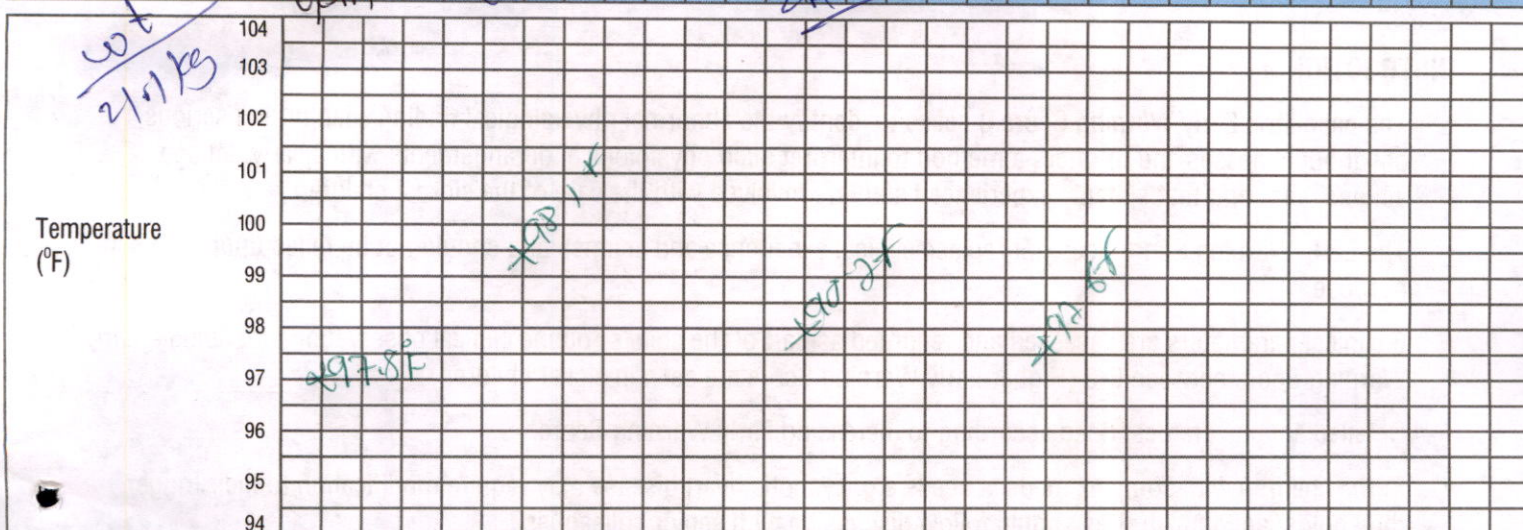
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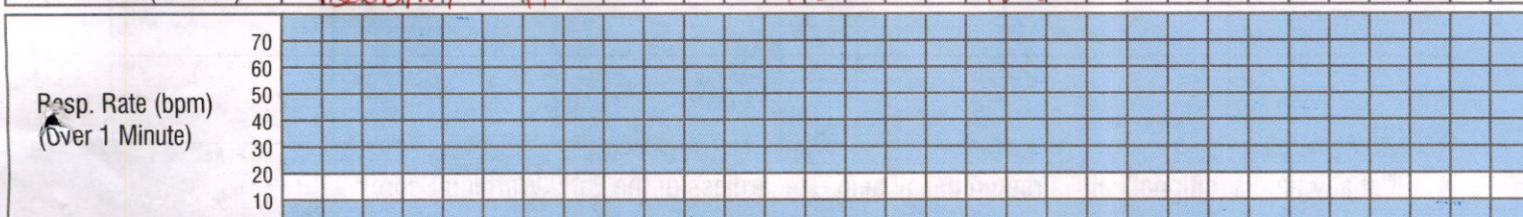
EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 21/12 Time: 21/12/20

Doctor / Nurse / Family Concern? 6pm 10pm 2Am 6Am



Heart Rate (Number) 120b/m 112b/m 112b/m 110b/m



Resp Rate (Number) 26b/m 29b/m 28b/m 29b/m

Resp Distress Mod/ Severe None / Mild

Receiving O₂ (l/min)
O₂ Saturations (%) 100% 97% 99% 97%

Conscious Level Normal Altered

GCS * 15/15 14/15 14/15 14/15

TOTAL SCORE

Number of shaded boxes 1 1 1 1

Pain Score 0 0 0 0

Observer's Initials 0 0 0 0

ACTIONS

NB: Scores 3 should be recorded overleaf

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

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FLUID CHART

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BirthRight™
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 Your Right to a Safe Delivery

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 :						
20/10	08:00 pm											
	09:00 pm											
	10:00 pm	NO										
	11:00 pm	1/2										
	12:00 am											
	01:00 am											
Total Intake :						Total Output :						
21/10	02:00 am											
	03:00 am											
	04:00 am	NO										
	05:00 am	1/2										
	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.

		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												



NURSING CARE RECORD

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 20/7/26

Assessment: Assess for fever and hypertension

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
10:00pm	Assess the child's health condition.	10:00pm	Assessed the child's health condition	The child's health condition is stable.
12:00pm	Assist in renal biopsy procedure.	12:00pm	Assisted in renal biopsy procedure.	
2:00pm	Monitor vital signs and charting.	2:00pm	Monitored vital signs and charting.	
4:00pm	Observe for any vomitings	4:00pm	Observed for vomitings.	

Re-Assessment: Reassessment done.

Special Notes: Look for nausea.

Nurse Signature: Jasmine

Nurse Name: Jasmine.

Date & Time: 20/7/26 @ 4:30pm

BAH-00660949 IP5-00176630
Master ABDUL AYAAN
19-11-2011 14 Y 8 M 1 D (M)
Dr. DR. V. V. R. SATYA PRASAD



NURSING CARE RECORD

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Shift: ☐ Morning ☐ Afternoon ☐ Night

Date: 20/12/28

Assessment: pt having edema

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 pt general condition.	9pm	Assessed pt general condition.	By done all implementation as per order
9pm	monitor vital sign	10pm	monitor vital sign	
10pm	maintain IO chart	11pm	maintained IO chart	
11pm	provide comfortable position	12AM	provided comfortable position	
12AM	Administer medication	6AM	Administered medication as per order	

Re-Assessment:

Special Notes: Kidney Biopsy done
Tim Discharge

Nurse Signature: SM

Nurse Name: Sushma

Date & Time: 21/12/28 @ 8AM



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Satya prasad Department: paed nephro Date of Admission: 2017

SITUATION	Diagnosis: <u>Nephrotic syndrome</u>		Any Infection: ☐ Yes ☒ No ☐ Not Known If Yes Specify:					
BACKGROUND	Area	Shift Time	<u>CP</u> <u>9:55 AM</u>	<u>ISTF</u> <u>8 AM</u>				
	Medical Condition (Any special condition to be noted):		<u>Nil</u>	<u>NA</u>				
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Vital Signs:	Temp:	<u>98.2 F</u>	<u>98.6 F</u>				
		Res:	<u>20b/m</u>	<u>20</u>				
		SpO ₂ :	<u>100%</u>	<u>99</u>				
		Pulse:	<u>90b/m</u>	<u>110</u>				
		BP:	<u>127/87</u>	<u>118/60</u>				
		Fall Risk Score:	<u>9</u>	<u>9</u>				
Pain Score:	<u>0/10</u>	<u>0/10</u>						
Recommendations	Safety Needs:	<u>Nil</u>	<u>Nil</u>					
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:	<u>Nil</u>	<u>Nil</u>					
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Other Special Orders / Medications:	<u>Nil</u>	<u>Nil</u>					
Post Operative Procedure Special Orders:		<u>Nil</u>	<u>Nil</u>					
Handed Over By Name :		<u>NR</u> <u>Pooja</u>	<u>Sushma</u>					
Signature :		<u>[Signature]</u>	<u>[Signature]</u>					
Date:		<u>20/07/20</u>	<u>21/7</u>					
Time:		<u>9:50 AM</u>	<u>8 AM</u>					
Taken Over By Name :		<u>Shruti</u>	<u>Sravanthi</u>					
Signature :		<u>[Signature]</u>	<u>Sravanthi</u>					
Date:		<u>20/7/20</u>	<u>21/7</u>					
Time:		<u>8:10 AM</u>	<u>8 AM</u>					

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:				
BACKGROUND	Area Shift Time						
	Medical Condition (Any special condition to be noted):						
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs:	Temp:					
		Res:					
		SpO ₂ :					
		Pulse:					
		BP:					
	Fall Risk Score:						
	Pain Score:						
Recommendations	Safety Needs:						
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:						
	Special Diet:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:						
	Post Operative Procedure Special Orders:						
	Handed Over By Name :						
	Signature :						
	Date:						
	Time:						
	Taken Over By Name :						
	Signature :						
	Date:						
	Time:						



THE HUMPTY DUMPTY SCALE

20/07/2018

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					
	13 years old and above	1	1	1			
Gender	Male	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			
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	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			
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	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				
TOTAL			9				

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		Yes				
Call device within reach		Yes				
Wheels Locked		Yes				
Room free of clutter		Yes				
Adequate Lighting		Yes				
Wheel Chair Support		Yes				
Other Intervention(s) Specify		NO				
Nurse's Name :		Suban				
Signature :		S				
Date :		20/7				
Time :		8:50 PM				

PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
20/7/26	8:50 AM	0/10	Nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	Nil Nil	2
20/7/26	12:00 PM	1/10	at biopsy site	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Antibiotics	Dr.
20/7/26	11 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Susling
20/7/26	6 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Susling
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

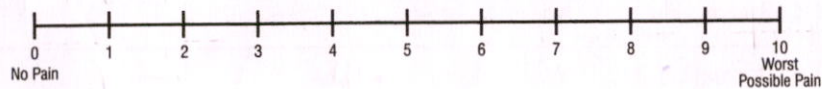
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

Numerical Pain Scale (Obstetric and Gynecology)



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

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

Wong - Baker (Pediatrics) Above 7 Years



BAH-00660949
Master ABDUL AYAAN
19-11-2011 14 Y
Dr. DR.V.V.R.SATYA PRASAD (M)

BRADEN 'Q' SCALE

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BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

					Date : 20/7/21	Time : 9pm		
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e.tremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4		
"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		
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		
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		
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		
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		
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		
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23								
Docu. No. : RCHBH /FRM / CLINICAL / 119								
					TOTAL SCORE			
					Evaluator's Name			

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

BAH-00660949 IP5-00176630
Master ABDUL AYAAN
19-11-2011 14 Y (M)
Dr. DR.V.V.R.SATYA PRASAD

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CONSENT FOR SPECIAL PROCEDURES

Patient Name : Abdul Ayaan Gender: ☒ Male ☐ Female

UHID No : BAH-00660949 Department : Ped Nephrology Date : 20/7/26

I S/D/W/O

Here by give consent for procedure of : Renal Biopsy

For my patient, Named : Abdul Ayaan

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

Pain, Bleeding, hematuria.

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

③

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

Name of the Doctor performing the procedure:

Patient Attendant :

Signature : Sh

Name : Abdul Shoukat

Relationship with Patient : Father

Date & Time : 20/7/26 11AM

Witness :

Signature : Shanty

Name : Shanty

Date & Time : 20/7/26 11AM

Doctor (who is taking the consent) :

Signature : S

Name : Sahini

Date & Time : 20/7/26 11AM

ప్రత్యేక విధానాలకు సమ్మతి



రోగి పేరు లింగం ☐ పురుషుడు ☐ స్త్రీ

యు.హెచ్.ఐ.డి విభాగం తేదీ

నేను S/D/W/O

ప్రత్యేక విధానాలకు సమ్మతి ఇవ్వడం ద్వారా

నా రోగికి, పేరు :

ఈ ప్రక్రియ కోసం ప్రత్యామ్నాయాలు, నష్టాలు మరియు ప్రయోజనాలు గురించి డాక్టర్ నాకు తెలిసిన భాషలో వివరించా

నాకు తెలిసిన భాషలో పైన పేర్కొన్న విషయాన్ని నేను అర్థం చేసుకున్నాను మరియు ప్రక్రియకు సమ్మతిని తెలియజేస్తున్నాను.

ప్రక్రియ చేస్తున్న వైద్యుని పేరు :

సహాయకుడు(అటెండెంట్)

సంతకము

పేరు

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము

పేరు

సాక్షి

సంతకము

పేరు

తేదీ మరియు సమయము



CONSENT FOR SPECIAL SEDATION

Patient Name: Abdul Ayaan Gender: ☒ Male ☐ Female

UHID No: BAH-0060949 Department: Ped Nephro Date: 20/7/26

I S/D/W/O

Here by give consent for procedure for my patient : Renal biopsy under short sedation

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

- Type of Sedation : short IV sedation
- Possible complications from the procedure of sedation:
Bradycardia, hypotension

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

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

Patient Attendant : SA
Signature :

Name : Shame Shoukat

Relationship with Patient: Father

Date & Time : 20/7/26 11AM

Witness :
Signature : Shanty

Name : Shanty

Date & Time : 20/7/26 11AM

Doctor (who is taking the consent) :

Signature : \$

Name : Santhi

Date & Time : 20/7/26 11AM

ప్రత్యేక మత్తు కోసం సమ్మతి

రోగి పేరు : వయస్సు లింగం పు స్త్రీ

యు.హెచ్.ఐ.డి. విభాగము

తేదీ

నేను కుమారుడు / కుమార్తె / భార్య

..... అను విధానంకై పూర్తి అంగీకారం తెలుపుతున్నాను.

వైద్యులు నాకు తెలిసిన భాషలో మత్తుమందు వివరాలను ఈ క్రింది విధంగా వివరించారు:

● సెడేషన్ రకం

● మత్తు ప్రక్రియ నుండి తలెత్తు సమస్యలు:

.....

.....

ప్రక్రియ యొక్క ప్రయోజనాలు, ప్రమాదం, ప్రత్యామ్నాయం గురించి వైద్యులు నాకు వివరించారు.

నేను పైన పేర్కొన్న విషయాన్ని నాకు తెలిసిన భాషలో అర్థం చేసుకున్నాను మరియు మత్తుమందు ఇవ్వడానికి సమ్మతిని ఇచ్చాను.

సహాయకుడు(అటెండెంట్)

సంతకము

పేరు

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము

పేరు

సాక్షి

సంతకము

పేరు

తేదీ మరియు సమయము

NPO: 11:00 pm (Solid)
NPO: 3:00 am (Liquor)

EMERGENCY ROOM TRIAGE FORM

Patient's Name: Abdul Ayaan Age: 14y Gender: ☒ Male ☐ Female
Date: 20/7/2026 Time of Arrival: 8:30 AM Triage Completion Time: 8:35 AM
Allergies: ☒ No ☐ Yes ☐ Food ☐ Medications ☐ Other (Specify): NA ☐ Not known any drug Allergies
Source of Information: ☒ Parents ☐ Others (Specify): NA
Mode of Arrival: ☐ Ambulatory ☐ Wheelchair ☐ Stretcher ☐ Ambulance

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

Initial Vital Signs: Temp: 98.6f PR: 96b/m BP: 127/87/98 RR: 23b/m SpO₂: 100%
Chief Complaints: Came for procedure Renal Biopsy R/O Nephrotic Syndrome

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

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

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian

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).

Name of Triage Nurse: Ram

Signature of Triage Nurse: Ram

Date & Time: 20/07/26 8:35 am

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

NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 20/07/20 Time of arrival : 8:36 AM
Chief Complaints : Came for Renal biopsy RBS : Nil
Height : Nil Weight : 29 kg BMI : Nil Head Circumference (<2 years) : Nil
Allergies : ☐ Yes ☒ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other : Nil
If yes, identify : Nil
Pain Screening : ☐ Yes ☒ No If Yes, Pain Score : 0/10 Pain Tool Used : ☐ N Pass ☐ FLACC ☒ Wong Baker
☐ Character : Nil ☐ Location : Nil ☐ Frequency : Nil ☐ Duration : Nil

RISK FOR FALL:

- ☐ If patient is < 6 years
tick below fall risk intervention directly
☐ If Patient is > 6 years
Assess the below parameters
History of Falling: within past 3 months ☐ Yes ☒ No
Ambulatory Aids:
• Wheelchair ☐ Yes ☒ No
• Uses furniture for support ☐ Yes ☒ No
Gait/Transferring:
• Bedrest / immobile ☐ Yes ☒ No
• Weak ☐ Yes ☒ No
• Impaired ☐ Yes ☒ No
Mental Status: Forgets limitations ☐ Yes ☒ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening: ☒ No Abnormalities Detected

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

Inform consultant for positive criteria

Nutritional Screening: ☒ No Abnormalities Detected

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

Inform consultant for positive criteria

Psychological Screening: ☒ No Significant Findings

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

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

Social History: Lives With family

Siblings in household ☐ Yes ☒ No (if yes How Many?) one brother & sister

Cultural & Spiritual Needs: ☐ Yes ☒ No if Yes specify Nil Inform consultant for positive criteria.

Time of Initial assessment completed by ER Nurse : 8:38 PM

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

Time	Nursing Notes
9 AM	C/SIB. Dr Prativa
	- Iv placement done and sample collected.
	- pt shift to PICU for procedure

Samples collected by: ~~NR Rafikul~~ NR Rafikul.

Time: 8:38 AM

Samples sent by: ~~NR~~

Time:

Medication given in ER:

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

Condition of patient at time of shift - out :	Details of Shift - out
HR: 89b/m BP: 127/82 CFT: 1.5x1	Shift - out from ER to: PICU
RR: 20b/m SPO ₂ : 100% RA	Time of Shift - out: 9:58 AM
GCS: 15/15 Temperature: 38.2°C	Handover given to: Amu
Pain Score: 0/10	(Nurse's Name)
Repeat RBS (if applicable): Nil	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any):

Iv placement done Rt hand (22G)

Name of the Nurse: NR Subnur

Signature of the Nurse: 

Date & Time: 20/07/26 at 9 AM

PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00660949 IP5-00176630 Master ABDUL AYAAN 19-11-2011 14 Y (M) Dr. DR.V.V.R.SATYA PRASAD 		Date & Time of Admission 20/08 at 8:37 AM	Date & Time of Transfer Order 20/08/2019 11:00 AM
		Transfer Ordered by Dr. Prativa	Reason for Transfer Admission
From Unit CC	To Unit PICU	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 19	Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ If Yes, what? op file - ① outside file - ①		Patient shifted with ID band: Yes ☒ No ☐ If No:
Number of Imaging Films nil			
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	Renal biopsy procedure things	①	
2.	mg ketamin	①	
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring NR Subnwa		Name of Person Ordered Transfer Dr. prativa	
Patient & Clinical Records Received by : Shanty			
Date & Time of Patient Received : 20/8/2019 10 AM			

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

☐ Unavailable Bed

☐ Nurse not Available

☐ Available Bed not ready

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: CR

Shifted to: PICU

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	<u>T. amoxicillin</u>	<u>20mg</u>	<u>po</u>	<u>12H</u>	<u>20/7/26</u>	☐ C ☐ DC
2						☐ C ☐ DC
3						☐ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Prakash V. DM

Date & Time : 20/07/26, 8:50 am

Nurse Name & Signature: Subarna

Date & Time : 20/07/26 at 8:50 AM



Moderate Sedation Flow-Sheet

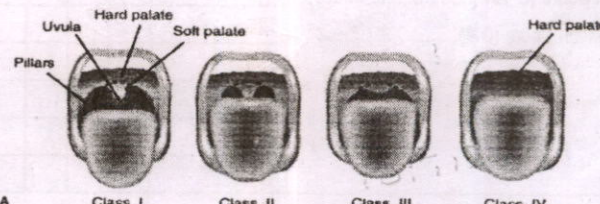
Immediate Pre-Sedation Assessment

B.P	P.R	R.R	Temp	SPO ₂	Pain Score	Weight
	117/m	30/m	98°F	100% NA		

Diagnosis: SENE

Procedure: Kidney Biopsy

Comorbidities: _____

☒ Risk, benefits & alternatives discussed; ☒ Patient understand & elects to proceed ☒ Consents for procedure and sedation signed and dated ASA Physical Status ☒ ASA PS 1: Healthy Patient ☐ ASA PS 2: Mild Systemic Disease, no functional limitations ☐ ASA PS 3: Severe Systemic Disease, functional limitations ☐ ASA PS 4: Severe Systemic Disease, constant threat to life ☐ ASA PS 5: Moribund Patient unlikely to survive 24 hrs. ☐ ASA PS 6: A declared braindead patient whose organs are being removed for donor purposes ☐ E: Emergency procedure GCS: E <u>4</u> M <u>6</u> V <u>5</u> <u>RT hand</u> IV Site: Gauge: <u>22 G</u> Sedation Plan: <u>fentanyl c</u> Allergies: _____	AIRWAY EVALUATION Mouth: ☒ Normal ☐ Loose Teeth ☐ Small Mouth ☐ Protruding Incisors ☐ Receding Lower Jaw ☐ Dentures Neck: ☒ Normal ☐ Decreased ROM ☐ Thyromental Distance Less Than 6 cm ☐ Short Neck  A Class I Class II Class III Class IV Mallampati Class: ☒ I ☐ II ☐ III ☐ IV
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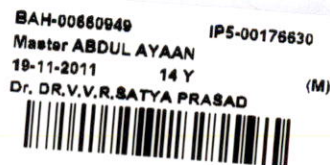
Monitoring of Patient Intra – Procedure

Procedure Monitoring

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

Level of Consciousness (LOC):

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



CHECK LIST (TIMEOUT OUTSIDE OT)

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Patient Name: Abdul Ayaan Gender: ☒ Male ☐ Female UHID. No: BAH- Age:

Date: 20/2/26 In-Time: 12:30 PM Out-Time: 12:30 PM

Doctor Performing Procedure: Dr. Shanti Doctor Giving Sedation: Dr. Mathan Assisting Nurse: Shanti

SIGN IN	Time:
Patient is verified using two identifiers (Name & UHID)	Yes ☒ No ☐ NA ☐
All required documents, images, studies are available	☒ ☐ ☐
NPO Status Checked from Patient / Patient Attendant	☒ ☐ ☐
Consent is Signed	☒ ☐ ☐
Any need for blood products	☒ ☐ ☐
If Yes Comment:	
Any Risk of Hemodynamic Compromise	☐ ☒ ☐
If Yes Comment:	
Any drug or food allergy	☐ ☒ ☐
If Yes Comment:	
Correct Site of Procedure Marked	☒ ☐ ☐
All resources required are correct, available and functioning	☒ ☐ ☐
Signature of the Doctor: <u>Shanti</u>	
Name of the Doctor: <u>Sukanya Ghosh</u>	

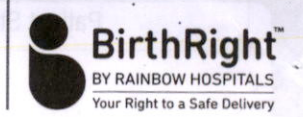
TIME OUT	Time:
Correct Patient	Yes ☒ No ☐ NA ☐
Correct Site	☒ ☐ ☐
Correct Procedure	☒ ☐ ☐
All the team members introduced	☒ ☐ ☐
Signature of the Nurse: <u>Shanti</u>	
Name of the Nurse: <u>Shanti</u>	

SIGN OUT	Time:
Name of the Surgical / Invasive Procedure is recorded	Yes ☒ No ☐ NA ☐
Instrument, Sponge and Needle Count Completed	☒ ☐ ☐
Specimens are labeled	☒ ☐ ☐
Any equipment problems are addressed	☒ ☐ ☐
Signature of the Nurse: <u>Shanti</u>	
Name of the Nurse: <u>Shanti</u>	

Any Adverse / Unexpected Events

Master ABDUL AYAN IP5-00176630
 19-11-2011 14 Y
 Dr. DR.V.V.R.SATYA PRASAD (M)

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		
20/8	8:50 pm	8.	Diagnostic test / Procedure	M/F	1	0	1	1	NT	2
20/8/26	5 pm	9	Normal low salt diet	M	1	0	1	1	-	Mother

Part - III: CODES

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

Learning Barriers:

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

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

Mechanism/s to overcome barrier/s:

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

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



MULTI-DISCIPLINARY PLAN OF CARE FORM

Nephrotic Syndrome

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
20/11/26 8:50 AM	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	<i>Nephrotic Syndrome</i>	<i>Hemodynamic stability</i>	<i>Renal biopsy</i>	<i>N.P.S.</i>	☒ Nursing ☐ Others:
20/07/20 2:50 PM	☐ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	<i>Nephrotic Syndrome</i>	<i>Hemodynamic stability</i>	<i>Renal Biopsy</i>	<i>Z</i>	☐ Medical ☒ Others:
20/7/26 5 PM <i>Delellan</i>	☐ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	<i>Nephrotic Syndrome</i>	<i>Normal low salt diet</i>	<i>RDA Et 1850 kcal/d Pj 33g/d</i>	<i>Monahan</i>	☐ Medical ☐ Nursing ☒ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:



NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 20/7/26 Time: 5pm

Weight: 29 kgs Centile: 5th

Height: 146 cm Centile: 5th

Inference: Underweight child

RDA: — Calories: 1350 Kcal/d Protein: 33g/d

Diet Recommendations: Normal low salt diet

Re-Assesment: Avoid spicy, chilled and outside foods

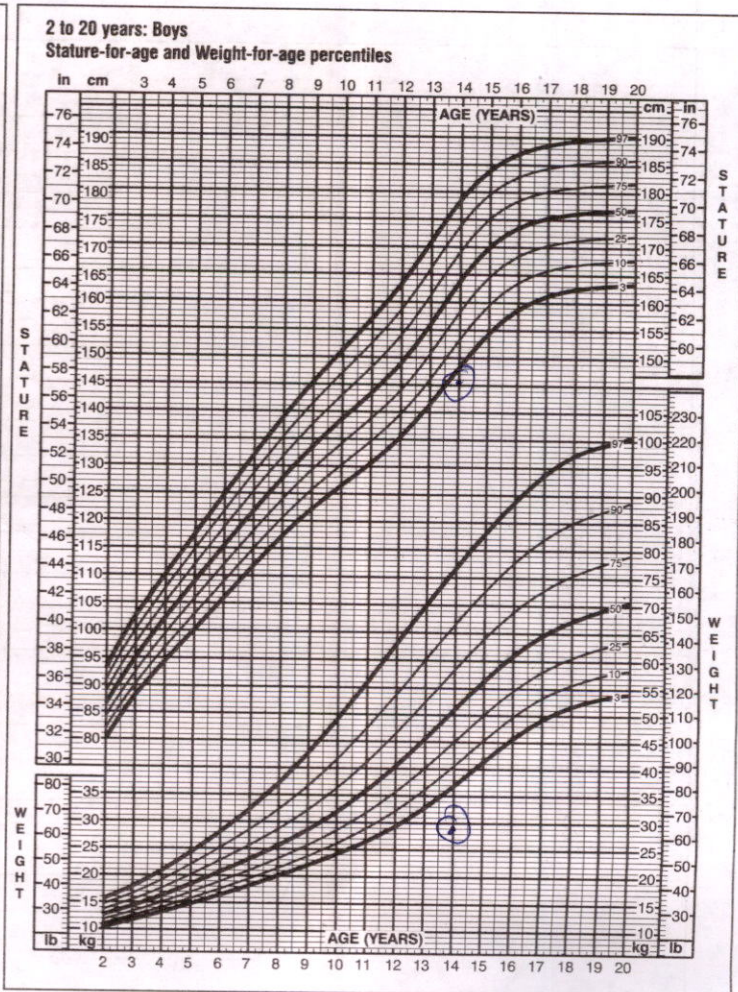
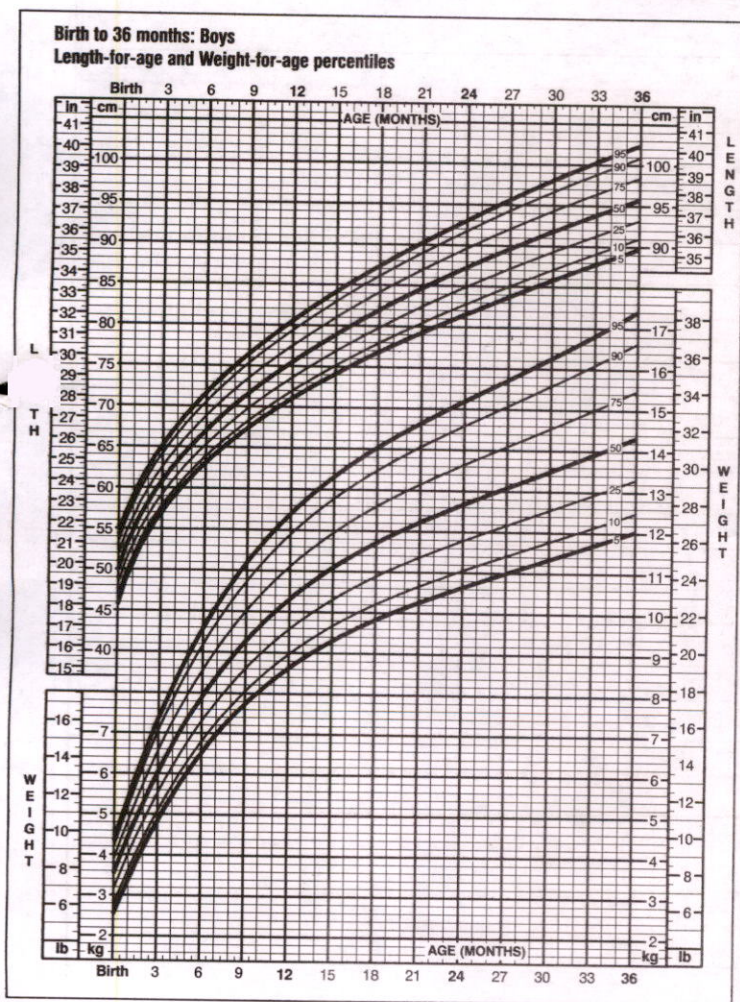
Food Allergies: NO Veg/Non-veg: nonveg

Diagnosis: Nephrotic syndrome for renal biopsy

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: [Signature]

GROWTH CHART (BOYS)



Dietician's Name: Monica

Dietician's Signature: Monica

[illegible]