

ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____

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

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

BAH-00612760 IP5-00176019
Baby ANAM ALI KHAN (F)
07-10-2017 8 Y 8 M 29 D
Dr. SIRISHA RANI



WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
6/7/26	11:55 AM	ER	onco	[Signature]

Cross Consultation Visit

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

INVESTIGATIONS

[illegible]

MEDICAL EQUIPMENT (WARD & ICU)

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
6/7/26	IV placed done	1	689948	R
6/7/26	Lumbar Puncture	1		
6/7/26	Conscious Sedation	2	9690404	rh

ANY OTHER INFORMATION

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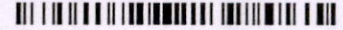
.....

Date : 6/7/26

Time : 4pm

Prepared By : Pooja

Staff Nurse Pooja	Shift / Ward Day shift On cology	Billing Assistant	Billing Supervisor
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ADMISSION SHEET
Registration Details :


Admission No : IP5-00176019

Admit Date : 06-Jul-2026

Admit Time : 11:05 AM UHID : BAH-00612780

Patient Details :

Patient Name : Baby ANAM ALI KHAN

Age : 8 Y 8 M 29 D

Guardian : Mr MIR AMER ALI KHAN

DOB : 07-10-2017

Gender : Female

Religion : Muslim

Occupation :

Martial Status : Single

Address (H) : H NO 13-6-437/1/A/3, KHADER BAGH,
LANGAR HOUSE Golconda Hyderabad
Telangana INDIA 500008

Phone No : 9346102519/ 7416507740

E-mail : yk.adnaan@gmail.com

Admission Details :

Bed Type : DAY CARE

Bed No : HO DC 3

Ward Name : 1F-HEMATO-ONCOLOGY

Room No : HO DC 3

Admission Type : First Visit

Contact Details :

Name : Mr MIR AMER ALI KHAN

Relationship : Father

Contact Address : H NO 13-6-437/1/A/3, KHADER BAGH,
LANGAR HOUSE Golconda Hyderabad
Telangana INDIA 500008

Phone No : 6305365513 / 8374910033


Signature

Doctor Details :

Doctor Name : Dr. SIRISHA RANI

Specialisation : HEMATO ONCOLOGY

Referral Doctor : Self

Phone No :

Co-Consultant :

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : SELFPAY

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07-10-2017 8 Y 8 M 29 D (F)
Dr. SIRISHA RANI




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ADMISSION CRITERIA – ONCOLOGY

Admission / Transfer from:

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

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

- ☐ For Chemotherapy-Day Care or IP Admission as per the Type of Chemotherapy
- ☐ Febrile Neutropenias (ANC <500 cells / mm³)
- ☐ Netropenic Enterocolitis
- ☐ Mucositis Induced Significant Diarrohea or Pain
- ☐ Neurological Complications (like Seizures, Bleeding, Thrombosis) that can arise while on Chemotherapy Treatment or at the Time of Presentation and also for other Systemic Problems like Pancreatitis during Chemotherapy
- ☐ Management of Oncological Emergencies
- ☐ Bleeding Problems (where it is indicated)
- ☐ Evaluation and Management of Severe Anemias
- ☐ Day Care Admissions for PRBC Transfusions
- ☐ Evaluation and Management of Sick Children who come with Hematological Problems like Severe Anemia like Autoimmune Hemolytic Anemia/ Bleeding/ Others
- ☐ Primary Immunodeficiency Disorders with Infections that Warrants Hospitalisation
- ☐ Management and Evaluation of Hemophagocytic LymphoHisticytosis
- ☐ Any Systemic Disorders with Significant Hematological issues like JRA / SLE with Secondary HLH

Signature of the Doctor: Shanksh

Name of the Doctor: Shanksh

Date & Time: 6/7/24 11:05 AM

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07-10-2017 8 Y 8 M 29 D (F)
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DISCHARGE CRITERIA – ONCOLOGY

Discharge to:

☐ HDU / Step down ICU

☐ Ward

☐ Outside Facility

☒ Others: Home

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

- ☐ Completion of chemotherapy, with no debilitating side effects.
- ☐ Resolution of febrile episode, with no fever > 24hrs and Absolute Neutrophil count (ANC) > 500cells/mm3.
- ☐ Admitted patients - Once the admitting problem gets resolved or made a plan to manage further on out-patient basis.

Signature of the Doctor: [Signature]

Name of the Doctor: Shankha

Date & Time: 6/7/25 6pm



Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

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RESULT SHEET

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

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

Culture and Sensitivities :

.....

.....

.....

Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI :

 Others (ECG, Contrast Studies etc.,) :



DRUG CHART

Date of Admission: 6/7/20 Drug Allergies: ☒ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

SOS / PRN (As Required Medication)

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

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

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

VERIFIED BY : Name

Weight. 23.94 kg Ward.

Page: 2/4

Weight. 23.94 kg Ward.



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

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

STAT / ONCE ONLY DRUGS[illegible]



Weight. 23.94kg Ward.

[illegible]

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MEDICATION RECONCILIATION FORM

Drug Allergies:

☐ Not known any Drug Allergies

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

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

Shifting From: ER

Shifted to: Ward

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	Tib GMP	2tib	PO	OD		☒ C ☐ DC
2	Tib Methotrexate	1tib prn 1 1/2 tib	PO	OD weekly once		☒ C ☐ DC
3	Tib MONTELUKAST	1tib	PO	HS	5/7/26	☒ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

* C - Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Ramya

Date & Time : 6/7/26; 11am

Nurse Name & Signature : pooja

Date & Time : 6/7/26 E 11:15 AM

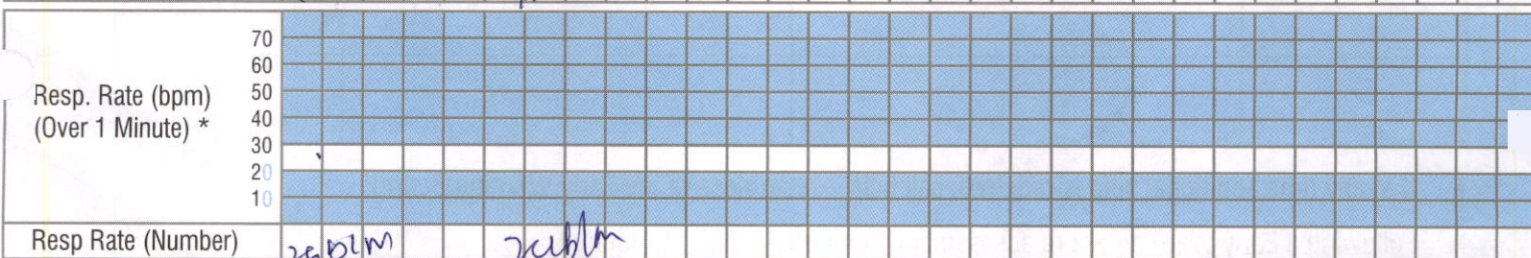
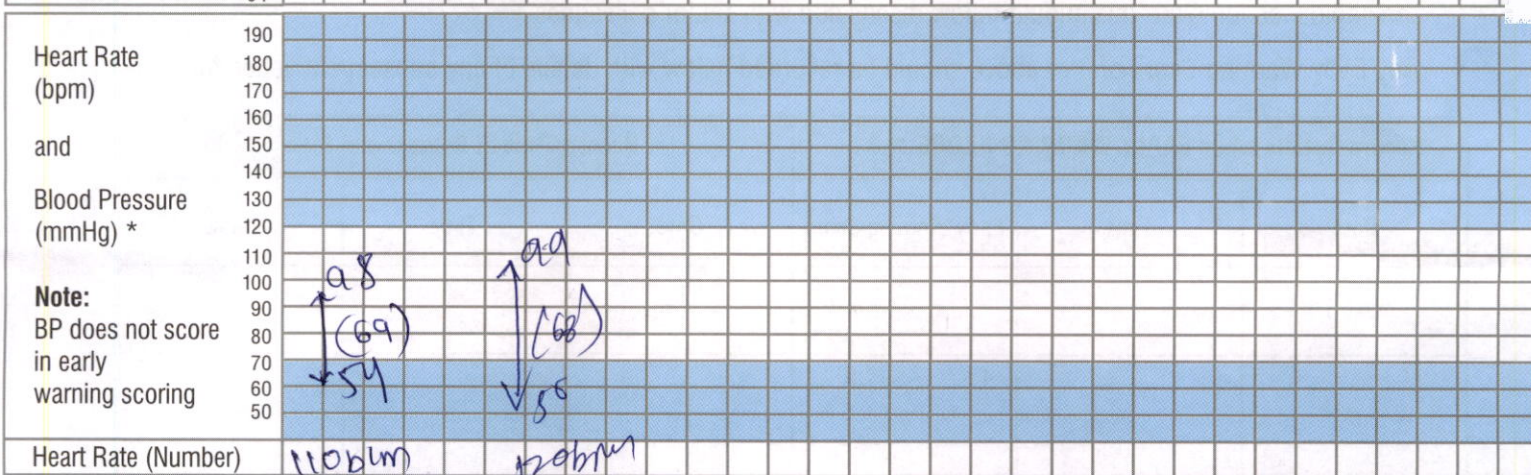
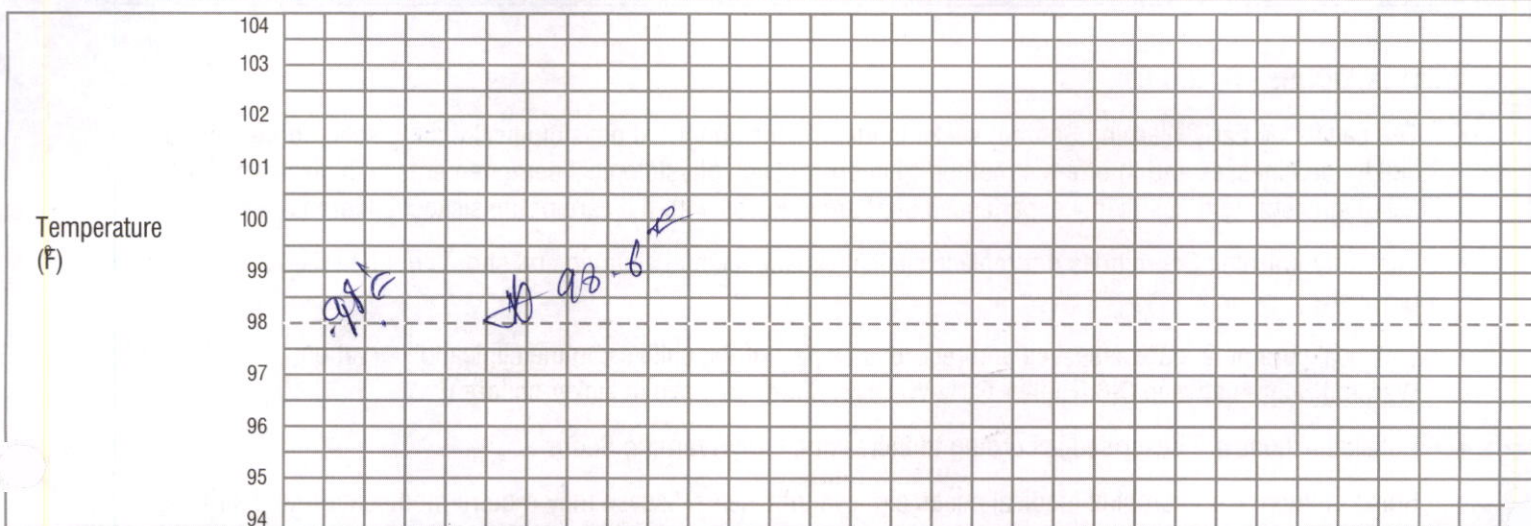
Patient Sticker

Doc. No. : RCHBH/ FRM / CLINICAL / 126

SCHOOL AGE (5-12 years)

Children's Observation &
Early Warning Scoring ChartRainbow®
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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 6/8/20... Time: 9am - 1pm
Doctor / Nurse / Family Concern?

Resp Distress Mod/ Severe
None / Mild

Receiving O₂ (l/min)
O₂ Saturations (%)

100% 100%

Conscious Level Normal
Altered

GCS *

TOTAL SCORE

Number of shaded boxes

0

0

0

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.

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

Sheet No. : ①

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
	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	tho 100ml							150ml		0	
	04:00 pm										0	
	05:00 pm										0	
	06:00 pm	tho 100ml									0	
	07:00 pm										0	
Total Intake : 200ml						Total Output : 150ml						
	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						

Patient Sticker

FLUID CHART

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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							



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
6/7/26	11am	0	nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	nil nil	[Signature]
6/7/26	4pm	0	nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	nil nil	[Signature]
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

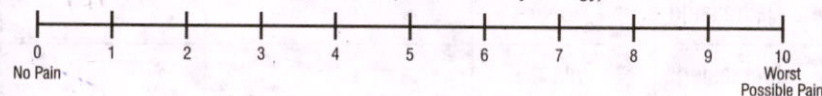
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

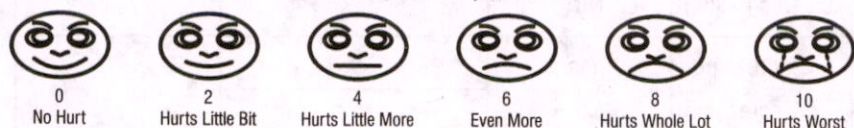
Numerical Pain Scale (Obstetric and Gynecology)



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

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

Wong - Baker (Pediatrics) Above 7 Years



NURSING CARE RECORD

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 6/8/26

Assessment: patient having weakness

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
12pm	Assess general condition & the condition	1pm	Assessed general condition & the pt	Patient is Stable
1pm	monitored vital signs	2pm	monitored vital signs.	
2pm	maintain hygiene.	3pm	maintained hygiene.	
3pm	Administer medications	4pm	Administered medications	
	Ensure safety.		provided safety	
3pm	maintain I/O chart	4pm	maintained I/O chart	

Re-Assessment: patient is stable

Special Notes:

Nurse Signature: Senthil

Nurse Name: Senthil

Date & Time: 6/8/26 @ 4pm

Patient Sticker

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:

BAH-00612780
Baby ANAM ALI KHAN
07-10-2017
Dr. SIRISHA RANI
IP5-00176019
8 Y 8 M 29 D (F)



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. S. R. Department: Onco Date of Admission: 6/7/26

SITUATION	Diagnosis: <u>B-cell ALL</u>		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:				
BACKGROUND	Area	<u>ER</u>	<u>Onco</u>				
	Shift Time	<u>11:55 pm</u>	<u>4 pm</u>				
	Medical Condition (Any special condition to be noted):	<u>nil</u>	<u>nil</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>98.1°F</u>				
	Res:	<u>28 bpm</u>	<u>26 bpm</u>				
	SpO ₂ :	<u>98%</u>	<u>98%</u>				
	Pulse:	<u>160 bpm</u>	<u>122 bpm</u>				
	BP:	<u>106/66</u>	<u>99/68</u>				
	Fall Risk Score:	<u>8</u>	<u>9</u>				
Recommendations	Pain Score:	<u>0</u>	<u>0</u>				
	Safety Needs:	<u>yes</u>	<u>yes</u>				
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:	<u>NOI</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>Susmita</u>	<u>Susmita</u>				
	Signature :	<u>[Signature]</u>	<u>[Signature]</u>				
	Date:	<u>6/7/26</u>	<u>6/7/26</u>				
	Time:	<u>12:00 pm</u>	<u>4 pm</u>				
	Taken Over By Name :	<u>Pooja</u>	<u>[Signature]</u>				
	Signature :	<u>[Signature]</u>	<u>[Signature]</u>				
	Date:	<u>6/7/26</u>	<u>[Signature]</u>				
	Time:	<u>[Signature]</u>	<u>[Signature]</u>				

Treating Doctor: Department: Date of Admission:

BAH-00612780 IP5-00176019
Baby ANAM ALI KHAN
07-10-2017 8 Y 8 M 29 D (F)
Dr. SIRISHA RANI



Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 12pm Mode of Arrival: by parents Admitting From: ☒ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction Body Weight: 23.9 Kg

..... na Height: cm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
<u>na</u>	<u>na</u>	<u>4Fs</u>

Family History:

healthy family

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

If yes please list,

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

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

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

Observations: Weight: 23.9kg Length: Head Circumference (< 2 years):

Temp.: 98.8 HR: 104b/m RR: 26b/m BP: 100/60

Pain Score: 0 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 28) (Document in the Braden Q Assessment Sheet)

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

Character of Pain Location Frequency Duration

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

Inform consultant for positive criteria

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

Inform consultant for positive criteria

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

If Yes Consultant Notified: (Date/Time):

Cultural & Spiritual Needs: ☐ Yes ☒ No if Yes specify Inform consultant for positive criteria.**Social History:** Lives WithSiblings in household ☐ Yes ☒ No (if yes How Many?)All Information Obtained From ☐ Patient ☒ Mother ☐ Father ☐ Other Family Member**Orientation has been given regarding the following aspects:**Call Bell in Reach: ☐ Yes ☐ NoWaste Disposal Explained: ☒ Yes ☐ NoInfusion Pump: ☒ Yes ☐ NoHand hygiene Explained: ☒ Yes ☐ No ☐ OthersPatient Rights & Responsibilities: ☒ Yes ☐ NoInformation given to motherNurse Signature: PiNurse Name: PoojaDate: 8/8/16Time: 12:10 pm

BAH-00612780 IP5-00176019

Baby ANAM ALI KHAN

07-10-2017 8 Y 8 M 29 D (F)

Dr. SIRISHA RANI



CONSENT FOR PROCEDURAL SEDATION

Authorization By: ☐ Patient ☒ Patient Attendant

I, the undersigned do hereby acknowledge the following:

- I have been made aware by the doctors in language known to me the details of sedation planned for the procedure

Short sedation, LP + IT chemo

- I have been made aware of the possible complications from the procedure of sedation as follows:
- Changes in heart rate, blood pressure, need for oxygen supplementation, allergic reactions, upper airway obstruction, laryngospasm, conversion to general anaesthesia

I have been made aware that the sedation is being advised to relieve pain and anxiety during the procedure. It will help me remain calm, comfortable, and cooperative, allowing the procedure to be performed smoothly and safely.

- I have been clearly explained about the benefits, risk, and alternative of the sedation which is General Anaesthesia.
- I authorize Dr. Sirisha Rani and his / her team to perform the procedural sedation upon the patient / myself.
- I acknowledge that I fully understand the above information. I have had the opportunity to ask questions, and they have been answered to my satisfaction in a language I understand. I affirm that this consent is given by me in my full senses.

Patient / Patient Attendant:

Signature: [Signature]
Name: Sauya Yar Khan
Relationship with patient: Mother
Date & Time: 6/2/20

Witness:

Signature: [Signature]
Name: Mir Amer Ali Khan
Date & Time: 6/2/20

Doctor (who is taking consent):

Signature: [Signature] Name: Ashwisha Date: 6/2/20 Time:

ప్రాసీజర్ల సెడేషన్కు అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

నేను, దిగువ సంతకం చేసిన వ్యక్తి, క్రింది విషయాలను అంగీకరిస్తున్నాను:

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

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

రోగి / రోగి అటెండెంట్:

సంతకం:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

సాక్షి:

సంతకం:

పేరు:

తేదీ & సమయం:

డాక్టర్ :

సంతకం: పేరు: తేదీ & సమయం:

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CONSENT FOR SPECIAL PROCEDURES

Patient Name : Anam Gender: ☐ Male ☒ Female

UHID No : 612780 Department : Oncology Date : 6/8/20

I parent of Anam
S/D/W/O

Here by give consent for procedure of : LP + IT chemotherapy

For my patient, Named :

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

pain, bleeding, headache

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

None

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 : [Signature]

Name : Saniya Yar Khan

Relationship with Patient: Mother

Date & Time : 6/8/20

Witness :

Signature : [Signature]

Name : Mir Amer Ali Khan

Date & Time : 6/8/20

Doctor (who is taking the consent) :

Signature : [Signature]

Name : Shanksha

Date & Time : 6/8/20

ప్రత్యేక విధానాలకు సమ్మతి



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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

Moderate Sedation Flow-Sheet

Immediate Pre-Sedation Assessment

B.P	PR	R.R	Temp	SPO ₂	Pain Score	Weight
100/6	104b/m	26b/m	98.8	100%	0	24 kg

Diagnosis: B cell ALL

Procedure: LP, IT chemo, BMA + 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 M V

☒ IV Site: Gauge:

Sedation Plan: short sedation

Allergies:

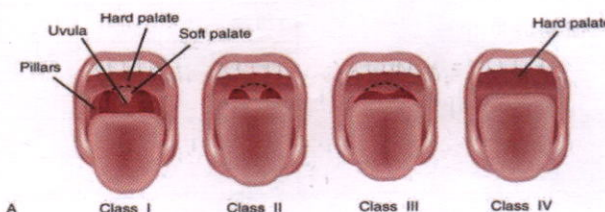
AIRWAY EVALUATION

Mouth:

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

Neck:

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



Mallampati Class: ☐ I ☐ II ☐ III ☐ IV

Monitoring of Patient Intra – Procedure

Procedure Monitoring

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

Level of Consciousness (LoC):

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

TIME	BP	PR	RR	O ₂ Sat%	O ₂ Supplementation	Comments / Initials
Baseline	100/60	104b/min	26b/min	100%	-	✓
	100/60	108b/min	26b/min	100%	-	-

DRUG & IV Fluid: (including Nitrous Oxide)	ROUTE	DOSE	TIME GIVEN	SUBSEQUENT DOSES AND TIME
Ketamine	IV	20 mg	2pm	-
Rudawane	IV	2 mg	2pm	-

Doctor Notes: Uneventful.

Time of transportation to post sedation care room: DC LOC: Alert

Doctor Name: Ashwika Signature: Ashwika

[illegible]

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

Patient Discharge Time: 2:30pm

Nurse Name: Pooja

Signature:

Date: 6/8/26 Time: 2:30 PM

Signature: 

Consultant Name: D. S. Nandhini

Stamp

BAH-00612780
Baby ANAM ALI KHAN
07-10-2017
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IP5-00178019
(F)

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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Patient's / Learner's

di: English

Patient / Learner Literacy: ☐ Read ☒ Write ☐ Speak

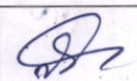
Willingness to Learn: ☒ Yes ☐ No

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		
6/7/26	11am	7.	Infection Control measures	m	4	0	1	1	-	

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 2. Physical Impairment 3. Emotional Barriers 4. Language Barrier 5. Educational Level 6. Desire / Motivate to Learn 7. Impaired Thought Process/Cognitive limitations 8. Responsibilities at Home 9. Cultural Differences 10. Financial Difficulties 11. Beliefs and Values 12. Impaired Vision/ or Hearing 13. Cultural/Religion Practice 14. Others (Specify)							
Teaching Tools Used: A: Audio D: Demonstration V: Video O: Oral P: Printed							
Mechanism/s to overcome barrier/s: 1. None 2. Obtain translator 3. Reassurance & Support 4. Teach Family / Others 5. Respect values & beliefs 6. Respect Cultural / Religion Preference 7. Other, Specify							
Understanding: 1. Verbalizes Understanding 2. Demonstrates Understanding 3. Needs Review							

MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis:

B-cell AU

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
6/7/26 11:15 am	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	B-cell AU	H-dynamic sterility	LP procedure		☒ Nursing ☐ Others:
6/7/26 11am	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	B-cell AU	lt - sterility	LP		☒ 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:

BRADEN 'Q' SCALE

BAH-00612780
Baby ANAM ALI KHAN
07-10-2017
Dr. SIRISHA RANI 8 Y 8 M 29 D
IP5-00176019
(F)

					Date : 6/12/26			
					Time : 11 am			
Mobility	completely immobile: 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			
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23					TOTAL SCORE	28		
Docu. No. : RCHBH /FRM / CLINICAL / 119					Evaluator's Name	Susmita		

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-00612780
Baby ANAM ALI KHAN
07-10-2017 8 Y 8 M 29 D (F)
Dr. SIRISHA RANI



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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

THE HUMPTY DUMPTY SCALE

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					
Gender	Male	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					
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	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					
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	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					
TOTAL			8				

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position							
Call device within reach							
Wheels Locked							
Room free of clutter							
Adequate Lighting							
Wheel Chair Support							
Other Intervention(s) Specify							
Nurse's Name :							
Signature :							
Date :							
Time :							



PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : Dr. Sirisha Rani

Date : 6/7/26

Type of Admission: ☒ OPD ☐ ER ☐ Referral (if referral, Doctor's Name: _____)

Start Time of Assessment: 10:11am

Weight: 23.94 kg.

Allergic History: _____

Chief Complaints:

B cell Ate on maintenance

↓
Now came for IP procedure

H/o Cdd, cough since 2 week (+)

Pediatric Assessment Triangle

A Appearance - TICLS _____



- B Breathing
- ☐ ↑ WOB
 - ☐ ↓ WOB
 - ☒ Normal
 - ☐ Gasping / Apnea
- C Circulation
- ☒ Normal
 - ☐ Abnormal
 - ☐ Pallor
 - ☐ Cyanosis
 - ☐ Mottling
 - ☐ Bleeding

Initial Physiological Status: ☒ Stable ☐ Unstable

- ☐ Life Threatening
- ☐ Non Life Threatening

Any urgent interventions needed: ☐ Yes ☐ No

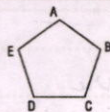
If Yes _____

Significant Past History: 4/7/26: CBP → 12.8 → 3500 → 2.89L

Medication History: 36.8 N44%

Relevant Investigations: _____

Primary Assessment



Airway



- ☒ Open
- ☐ Maintainable
- ☐ Not Maintainable

Any urgent interventions needed: ☐ Yes ☒ No

If Yes _____

Breathing



Rate: 24/min SpO₂ on FiO₂ 100% on RA

Rhythm: Regular

- Retractions: ☐ Suprasternal ☐ ICR ☐ SCR
- ☐ Sternal ☐ Supraclavicular ☐ Nasal Flaring

Respiratory Noises: ☐ Stridor ☐ Wheezing ☐ Grunting

Air Entry: B/L AET (+)

Palpation Findings (If necessary) _____

Any urgent interventions needed: ☐ Yes ☒ No

If Yes _____

**Circulation**HR: 140/minCFT ☐ Central
☐ PeripheralAny urgent interventions needed: ☐ Yes ☒ NoBP: 106/66/95 mmHgPulse Volume: ☐ Central
☐ PeripheralIf in Shock: ☐ Compensated
☐ HypotensiveMuffled Heart Sound: ☐ Yes ☒ NoEngorged Neck Veins: ☐ Yes ☒ NoMurmurs: ☐ Yes ☒ No

Liver Span:

ECG:

Any Signs of
Heart Failure: ☐ Yes ☒ No

If Yes

**Disability**GCS: 15/15 AVPU:Pupils: ☐ Responsive ☒ Non-Responsive ☐Size ☐ Right
☐ LeftActive Seizures: ☐ Yes ☒ No Sugars:

Signs of Neurological compromise

Any urgent interventions needed: ☐ Yes ☒ No

If Yes

ExposureTemp.: 98.3°FAny Rash: ☐ Yes ☒ No,

If yes describe the rash

Active bleed

Lacerations ☐ Abrasions ☐ bruises ☐

Describe:

Any urgent interventions needed: ☐ Yes ☒ No

If Yes

Final Physiological Status: ☐ Respiratory Distress ☐ Respiratory Failure ☐ Respiratory Arrest
☐ Shock - Compensated ☐ Hypotensive ☐
☐ Cardiopulmonary Arrest ☒ Hemodynamically Stable

Secondary Assessment: Head to toe examination with positive findings:

Labs Planned:CAPTPT/PTTN.B. Arterial
6/7/2016
11:38pm**Treatment Planned:**LP procedureNPO to continueAspirinNeed for Oxygen: ☐ Yes ☒ No if yes Low Flow ☐ High Flow ☐ PPV ☐Final Diagnosis with possible Differential Diagnosis (If necessary): B-cell ALL on maintenance

Assessment done by

Name of the Doctor: Dr RamyaSignature: [Signature]Date & Time: 6/7/2016; 11:10am

Sr. Doctor on Duty (If necessary)

Name of the Sr. Doctor:

Signature:

Date & Time:

PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00612780 IP5-00176019 Baby ANAM ALI KHAN 07-10-2017 8 Y 8 M 29 D (F) Dr. SIRISHA RANI 		Date & Time of Admission 6/7/26 @ 11:05 AM	Date & Time of Transfer Order 6/7/26 @ 11:55 AM
		Transfer Ordered by Dr. Ranjya	Reason for Transfer Admission
From Unit ER	To Unit Onc	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 20	Number of Imaging Films Nil	Personal belongings including clinical documents. If any handed over to attendant op file Yes ☒ No ☐ If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring Dr. Seemita		Name of Person Ordered Transfer Dr. Ranjya	
Patient & Clinical Records Received by : Pooja			
Date & Time of Patient Received : 6/7/26 @ 12pm			

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