

DISCHARGE SUMMARY

Name	Baby Of G. POOJA SRI	UHID	HNH-00011978
Father/Guardian	Mr B SHARATH	Age/Gender	0 Y 7 M 22 D/ Female
Address	75 LIG BATHKAMMA KUNTA NANDANA VANAM COLONY, Amberpet, Hyderabad, Telangana, INDIA, 500013		
IP No	IP26-00006770	Admission Date	06-07-2026
Ref Doctor	Self.		
Discharge Date	08.07.2026		

Consultant:

Dr. SPANDANA PASUPULETI
MBBS, MRCPCH
30925

DIAGNOSIS	ICD CODE
ACUTE GASTROENTERITIS WITH DEHYDRATION	
SARS-CoV-2 POSITIVE	

History: Baby Of G. POOJA SRI , 0 Y 7 M 22 D , old girl presented with the history of fever since 3 days, vomiting, loose stools, decreased oral intake and decreased urine output since 1 day prior to admission. For the above complaints she was admitted at Rainbow Children's Hospital - for further management.

Name	Baby Of G. POOJA SRI	UHID	HNH-00011978
IP No	IP26-00006770	Admission Date	06-07-2026

Examination: She was febrile. Her heart rate was 112/min and Respiratory Rate - 24/min. Capillary Refill Time was <2 secs. Peripheries were warm & pulses well felt. On examination signs of dehydration were present such as dry lips, dry oral mucosa, sunken eyes and irritability were present. On auscultation, air entry was bilaterally equal. Heart sounds were normal and there was no murmur. Abdomen was soft with no organomegaly. On neurological examination, she was conscious and alert. Pupils were bilaterally equal and reacting to light. There were no focal neurological or cranial nerve deficits. There were no signs of raised intracranial pressure.

Weight on admission: 7.3 kilo grams.

Investigations: Enclosed reports

GeneXpert FluA+FluB+RSV, SARS-CoV-2 were sent, which was negative.

SARS-CoV-2

POSITIVE

Influenza A

NEGATIVE

Influenza B

NEGATIVE

Respiratory Syncytial Virus (RSV)

NEGATIVE

VBG showed pH of 7.36, pCO₂ of 37.2 mmHg, pO₂ of 43 mmHg, HCO₃ of 20.8 mmol/L and BE of -4.5 mmol/L.

Initial hemogram showed Hemoglobin of 11.5 gm%, White Blood Cell count of 6030 cells/cumm, platelet count of 4.25 lakhs/cumm and C-Reactive Protein of 5 mg/l. Complete urine examination shows 4-6 pus cells, 3-5 epithelial cells. Adenovirus PCR was not detected. Blood culture and sensitivity shows no growth after 24 hours of incubation.

Name	Baby Of G. POOJA SRI	UHID	HNH-00011978
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Management: She was admitted in the ward and started on Intra Venous fluids and Intra Venous antibiotics. She was treated symptomatically with antiemetics, antacids and antipyretics. Respiratory panel was sent which was positive for SARS-CoV-2 and hence IV Antibiotics were stopped.

She was monitored for fever spikes, hemodynamic status. Her fever spikes and other symptoms gradually settled. Child maintaining saturation at room air.

She remained hemodynamically stable during the hospital stay. She improved with the above line of management and is being discharged with the following advice.

At the time of discharge : She is active, afebrile and hemodynamically stable.

Medication during hospital stay:

Injection. Ondansetron
Injection. Esomeprazole
Injection. Ceftriaxone

Advice:

* Diet as advised.

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S.N o	MEDICATION	DOSE	TIMINGS	DURATION
1	VITAMIN D3 DROPS (1ml/800IU)	0.5 ml	9am (after food)	Till 1 year of age
2	Mucolite drops (Ambroxol-7.5mg/1ml)	1ml	twice daily	5 days
3	NEBULISATION with 3 % NS	1 respule	every 6th hourly	3 days
4	Nasoclear nasal drops, 2 drops in each nostril SOS for nose block			

Plan: To collect final blood culture and urine culture report on follow up.

Fever Management

- * Drop. Crocin (Paracetamol - 1ml/100mg) 1ml after food as and whenever required, if temperature > 100 *F (maximum 4 times a day at 6 hour intervals).
- * Tepid sponging if fever > 101 *F.

Review consultation with Dr. SPANDANA PASUPULETI on Friday (10.07.2026) at Himayatnagar in OPD with prior appointment (**Review consultation will be charged**).

Follow up immediately in Emergency Room if high grade fever, vomiting, breathlessness or refusal to feed occurs.

The content of the patient discharge summary, medication, food & drug interaction, care to be provided at home, nutrition, immunization and safe

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parenting, when and how to obtain emergency care etc also have been explained by doctor in a language that I can understand and I acknowledge.

Parent/ Attender

In case of emergency contact 9154865030 emergency pediatrician on duty.
To take appointment for OPD consultation at Rainbow **Himayatnagar / Banjara Hills** / Rainbow Clinic **Madhapur / Kukatpally / Vikrampuri / LB Nagar** / dial just one toll free number **18002122**.

You can also take appointments at any time by going **online** to our website **www.rainbowhospitals.in**


Registrar/Resident/C.M.O



Dr. SPANDANA PASUPULETI
MBBS, MRCPCH
30925

ADMISSION SHEET

Registration Details :



Admission No : IP26-00006770 Admit Date : 06-Jul-2026 Admit Time : 10:36 PM UHID : HNH-00011978

Patient Details :

Patient Name	: Baby Of G. POOJA SRI	Age	: 0 Y 7 M 21 D
Guardian	: Mr B SHARATH	DOB	: 15-11-2025 10:35 AM
Gender	: Female	Religion	:
Occupation	:	Martial Status	: Single
Address (H)	: 75 LIG BATHKAMMA KUNTA NANDANA VANAM COLONY Amberpet Hyderabad Telangana INDIA 500013	Phone No	: 9848338690/ 9908820666
		E-mail	: G.POOJA24ANGEL@gmail.com

Admission Details :

Bed Type : DAY CARE Bed No : ER01 Ward Name : GF -EMERGENCY
Room No : ER01 Admission Type : First Visit

Contact Details :

Name	: Mr B SHARATH	Relationship	: Father
Contact Address	: 75 LIG BATHKAMMA KUNTA NANDANA VANAM COLONY Amberpet Hyderabad Telangana INDIA 500013	Phone No	: 9908820666


Signature

Doctor Details :

Doctor Name	: Dr. SPANDANA PASUPULETI	Specialisation	: GENERAL PEDIATRICS
Referral Doctor	: Self.	Phone No	:
Co-Consultant	:		

Payment Details :

Payment Mode	: DC/CC Card	Deposit Amount	: 10000.00
		Payor Name	: VOLO HEALTH INSURANCE TPA PVT LTD

40

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HNH-00011978

IP26-00006770

Baby Of G. POOJA SRI

15-11-2025

0 Y 7 M 22 D

(F)

Dr. SPANDANA PASUPULETI



37.25 gmbh

Rainbow
Children's
Hospital

It takes a lot to treat the little.



BirthRight™

BY RAINBOW HOSPITALS

Your Right to a Safe Delivery

NEBULISATION CHART

Date	Time	Drug	Nurse	Parents Signature
	00.00			
	01.00			
	02.00			
	03.00			
	04.00			
	05.00			
	06.00			
	07.00			
	08.00			
	09.00			
	10.00			
	11.00			
2/7/26	12.00			
	13.00			
	14.00			
	15.00		self	
	16.00	37.25 NS	A	
	17.00			
	18.00			
	19.00			
	20.00			
	21.00			
	22.00	37.25 NS	A self	
	23.00			



HNH-00011978 IP26-00006770

Baby Of G. POOJA SRI

15-11-2025 0 Y 7 M 22 D (F)

Dr. SPANDANA PASUPULETI



3.1. NS 6th hour



NEBULISATION CHART

Date	Time	Drug	Nurse	Parents Signature
	00.00			
	01.00			
	02.00			
	03.00			
	04.00			
8/12/26	05.00	3.1. NS	A self	
	06.00			
	07.00			
	08.00			
	09.00			
	10.00			
	11.00	3.1. NS	A self	
	12.00			
	13.00			
	14.00			
	15.00			
	16.00			
	17.00			
	18.00			
	19.00			
	20.00			
	21.00			
	22.00			
	23.00			

ACTIVITY HNH-00011978 IP26-00006770

Baby Of G. POOJA SRI
15-11-2025 0 Y 7 M 21 D (F)
Dr. SPANDANA PASUPULETI

Name: -----
UHID No: ----- Consultant: ----- Dept: *pediatric*

Date of Admission: *6/2/26* Time: ----- Date of Discharge: ----- Time: -----

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
<i>6/2/26</i>	<i>11:30pm</i>	<i>ER</i>	<i>ward</i>	<i>B1/Q</i>

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)

IP26-00006770

15-11-2025 9 Y 7 M 21 D

Dr. SPANDANA PASUPULETI



Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
6/7/26	Infusion Pump.	6/7/26 @ 11:40p.	7/7/26 @ 10:am	11363	
Completed					



PROCEEDURE

Date	Procedure	Quantity	Order No.	Signature
6/7/26	DV placement	①	11311 ✓	[Signature]
7/1/26	NHA	i	11429 ✓	[Signature]
	cross checked by Nite			

ANY OTHER INFORMATION

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

Ref.No. F/IN/PR/10



PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name : HNH-00011978 IP25-00006770
Baby Of G. POOJA SRI
15-11-2025 0 Y 7 M 21 D (F)
Dr. SPANDANA PASUPULETI

Patient ID# : 

Consultant : _____

Final Diagnosis : _____

Pediatric Multiorgan History & Physical Examination

HNH-00011978 IP26-00006770
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Dr. SPANDANA PASUPULETI



Name : _____ Age/Se _____

Informant _____ Reliability _____

Chief Presenting Complaints & Duration (Chronologically):

C/o fever X 3 days

C/o Vomitory (multiple episodes) X 1 day

C/o decreased oral intake X 1 day

History of present illness : C/o decreased urine output X 1 day

Pt was apparently alright 2 days before then had fever moderate to high degree, on & off type.

C/o vomitory (multiple episodes), contains food particles, non-projectile

C/o decreased oral intake since 1 day.

C/o decreased urine output since 1 day.

Pediatric Multiorgan History & Physical Examination

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

Nothing Significant

Birth & Neonatal History :

T L A C A / N A I D

Birth & Socio Economic History :

About Father : _____

About Mother : _____

Any additional Information : _____

Developmental History :

Developmentally normal

Immunization History :

Upto date till 6m of life.

Pediatric Multiorgan History & Physical Examination

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 Dr. SPANDANA PASUPULETI



Anthropometry

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

Weight (kgs) 7.3 kg (Centile _____)

On Examination :

Temperature : 98.7 F Pulse Rate: 112 Description _____

B.P. _____ SPO2 97 % at _____

Resp. rate and type of breathing : 24

Rash _____

Lymphadenopathy _____

Oedema : _____

- dry lips
 - dry oral mucosa
 - sunken eyes
 - irritable.

Respiratory system :

Inspection (any s/o distress) : _____

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

Any addes sounds : B/L NUBS (+)

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

Cardiovasclular System :

Inspection of procordium : _____

Heart Sounds : S₁ S₂ heard

Any murmur : _____

Relevant date from outside (Chest X-Ray, ECG, ECHO, Etc.,) _____

Per Abdomen :

Inspection _____

Palpation : Soft, NT

Ausculation : _____

Spine: _____ External Genitalia : _____

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

Pediatric Multiorgan History & Physical Examination

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Central Nervous System :

Level of Consciousness : AVPU/GCS Score : _____

Cranial Nerves : _____

Motor System :

Nutrition : _____

Tone : _____ Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR

Superficials :

Plantars _____

Sensory System :

Bladder / Bowel : _____

Clinical Summary & Diagnostic :

Acute Gastroenteritis + dehydration
AFB.

Pediatric Multiorgan History & Physical Examination

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Preventive aspects of the treatment :

Desired goals of the treatment :

Planned Labs :

Planned Management :

VBG, CBP, CRP.
CUE (true)
Blood C/s.
urine C/s
Respiratory panel
(5 viruses)

- Znj. Ondansetron 2mg
TID
- Zj Esmoprazole 8mg OD
- Zj ceftriaxone 750mg
OD.
- IVF DNS 2/3M

P.B Bhargava

Please fill up the following details

1. Name of the Referring Doctor : _____
2. Name of the Referring Hospital : _____
(Including the name of City)
3. Contact number of the Referring Doctor : _____
(Preferring Mobile #)
4. Name of the doctor in Rainbow Team _____ on
whose name the patient is being referred

Doctor's Signature Name _____ Date _____ Time _____

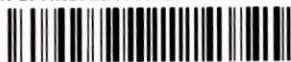
Date & Time	Progress Notes	Doctor's Order
7/7 2:30 PM	<u>CH/B A Baran / Dr. Maymang</u> AFI <u>Acute Gastroenteritis = Dehydration</u> No Feces to admission Vomiting - last in ER 2 M - Better - oral intake - on DBF child asleep Vital stable Afebrile R-S - B/w/m @ P/A - safe	PH 1) <u>2g Ceftriaxone</u> 2) <u>IVF</u> 3) <u>Oral order</u> <u>Esomeprazole</u> 4) <u>CVE to send</u> 5) <u>Peri Labs</u> 6) <u>Monitor Vital</u> W.B Amomtu e 8 AM <u>Phm</u>

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



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
7/7/26 10 am	cl/B Dr. Tejaswini WOUND ⊕ - no fever spikes - no vomitings - oral intake : good <u>O/E</u> vitals : stable SE - normal PIA : soft.	<u>Plan</u> 1) trace Blood clts, WE, urine clts. adrenocortics. 2) neb $\bar{c}$ 3% NS ↳ 6th h x 3 days 3) discharge today 4) mucolite drops on discharge 5) Penicillin on Thursday 6) stop ceftriaxone
	Dr. S. TEJASWINI REDDY Registration No. 94066	Dr. Tejaswini
	noted by Sr. Sanchya 7/7/26 10:12	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
7/7/26 2:30 PM	CL/B Dr. Vennu/Dr. Thanvi WV/D +ve - NO fever spikes. - Cough (+). AE - vitals stable. AE - WNL.	Plan - Take WE, Blood c/ and urine c/s. - Ct. Rx. - start 3% NS & Multi drops ✓
7/7/26 3 PM	S/B Dr. Spandana △ SATY COV-L position CNS - Sp/Sec R-Bio-ACTA Plat 20h conscious	7/7/26 2:30 PM Plan - Take Blood c/ and Urine c/s - Cf Neb I 3% NS & Multi - Monitor vitals A/B Synt @ 3pm

Dr. Spandana
 Consultant Neonatologist & Pediatrician
 Reg. No. 30925



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/11/2025	S/B Dr. Nameenu / Dr. Archana	
	SARS-cov 2 illness	
	Fever spikes -	Plan
	oral intake -	① ct IV ondarethon
	loose stools -	② 3/ NS ues
	cough (+)	③ Monitor vitals
	chest -	④ Trace blood c/s
		urine c/s
		④ Plan o/c
8/12	C/s by Dr. Tejan	
10 AM	Baby active - vitals stable	plan ① today
		Dr. S. TEJASWI REDDY Registration No. 94068
		Dr. Tejan



DRUG CHART

Date of Admission: 6/7/26 Drug Allergies: N911 ☒ 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 : CROCIN - DROPS				Date Time															
Dose 1ml	Route PO	Frequency SOS 60kg	Start Date 6/7																
Doctor's Signature <i>Pharm</i>		Valid Period	Pharm.																
Additional Instructions: 1ml = 100mg																			

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:																			

Signature: Dr. Dhakshayani

VERIFIED BY: Name



REGULAR PRESCRIPTIONS

Weight. 7.3 kg Ward.

DRUG : Inj ONDANSETRON				Date Time	6/7	7/7	8/7													
Dose	Route	Frequency	Start Date																	
1.5mg	IV	TID	6/7																	
Name & Signature of the Doctor Starting the Drugs: Praveen				6am X 7am 8am																
Additional Instructions:				2pm X 3pm 12am 10pm 11pm																
Daily Doctor's Endorsement by a Sign				✓ ✓																
DRUG : Inj ESOMEPRAZOLE				Date Time	6/7	8/7														
Dose	Route	Frequency	Start Date																	
7.5mg	IV	once daily	6/7																	
Name & Signature of the Doctor Starting the Drugs: Praveen				6am 7am 8am																
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign				✓																
DRUG : Inj CEFTRIAXONE				Date Time	6/7															
Dose	Route	Frequency	Start Date																	
750mg	IV	once daily	6/7																	
Name & Signature of the Doctor Starting the Drugs: Praveen				6pm 7pm 8pm																
Additional Instructions: IV once / day				STOP																
Daily Doctor's Endorsement by a Sign																				
DRUG : 3% NS				Date Time																
Dose	Route	Frequency	Start Date																	
100ml	NS	Q6H	7/7																	
Name & Signature of the Doctor Starting the Drugs:				See Mr. [Signature]																
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

HNH-00011978 IP26-00006770
 Baby Of G. POOJA SRI
 15-11-2025 0 Y 7 M 21 D (F)
 Dr. SPANDANA PASUPULETI



Weight Ward

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses

Signature

VERIFIED BY : Name

IP26-00006770

15-11-2025

0 Y 7 M 21 D

(F)

Dr. SPANDANA PASUPULETI



Weight. 7-34 Ward.

[illegible]

Signature _____

VERIFIED BY : Name :

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**Rainbow
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It takes a lot to treat the little.


BirthRight™
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Your Right to a Safe Delivery

MEDICATION RECONCILIATION FORM

Drug Allergies: 2911 ☒ 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						☐ 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. Narpunya

Date & Time : 6/7/26 @ 11:10pm

Nurse Name & Signature : Bhargava

Date & Time : 6/7/26 @ 11:15pm

Docu. No. : RCH / FRM / GENERAL / 090

HNH-00011978 IP26-00006770

Baby Of G. POOJA SRI

15-11-2025 0 Y 7 M 21 D (F)

Dr. SPANDANA PASUPULETI



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RESULT SHEET

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

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

Date	6/7				
Time					
Hb	11.5				
PCV	32				
RBC	4.45				
WBC	6030				
N/L	51/43				
Platelets	425				
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 :

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.....

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Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI :

 Others (ECG, Contrast Studies etc.,) :

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Dr. SPANDANA PASUPULETI



: RCH / FRM / CLINICAL / 124

INFANT (<1 year)
**Children's Observation &
Early Warning Scoring Chart**

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

ARLY WARNING SCORE: CHILDREN'S UNIT

Date: 6/7 Time: 11:40pm 2 Am 6 Am

Doctor/Nurse/Family Concern?

Temperature
(°F)

104
103
102
101
100
99
98
97
96
95
94

Heart Rate
(bpm)

and

Blood Pressure
(mmHg) *

190
180
170
160
150
140
130
120
110
100
90
80
70
60
50

Note:
BP does not score
in early
warning scoring

Heart Rate (Number)

145b/m 140b/m 139b/m

Resp. Rate (bpm)
(Over 1 Minute) *

70
60
50
40
30
20
10

Resp Rate (Number)

38b/m 35b/m 30b/m

Resp Mod/ Severe
Distress None / Mild

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

100% 98% 100%

Conscious Level
Normal
Altered

GCS *

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

0 0 0
0 0 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 incharge and PICU /NICU fellow or PICU/NICU 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)

HNH-00011978 IP26-00006770
 Baby Of G. POOJA SRI
 15-11-2025 0 Y 7 M 21 D (F)
 Dr. SPANDANA PASUPULETI



FLUID CHART

Sheet No. : 2

- All measurements in ml.
- 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 :							
6/7	08:00 pm										0	} A	
	09:00 pm										0		
	10:00 pm										0		
	11:00 pm	DNS		20ml							0		
	12:00 am	DNS Milk		20ml	NA						0		
	01:00 am			20ml							0		
Total Intake : Taken						Total Output : m-o						0-1	
7/7	02:00 am			20ml							0	} A	
	03:00 am	DNS		20ml							0		
	04:00 am	DNS Milk		20ml	NA						0		
	05:00 am	DNS		20ml							0		
	06:00 am	DNS Milk		20ml							0		
	07:00 am			20ml							0		
Total Intake : taken						Total Output : m-o						0-1	
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 :							
2/11	02:00 pm	D/W		20ml									
	03:00 pm			20ml									
	04:00 pm			20ml									
	05:00 pm			20ml									
	06:00 pm			20ml									
	07:00 pm			20ml									
Total Intake :						Total Output :							
2/11	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
Total Intake :						Total Output :							
8/11	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							

HNH-00011978 IP26-00006770
 Baby Of G. POOJA SRI
 15-11-2025 0 Y 7 M 21 D (F)
 Dr. SPANDANA PASUPULETI

NURSING CARE RECORD

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Date: 6/7/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon							
Night	8pm 8Am	→ Assess the pt condition → monitoring vitals checked and recorded → I/O chart main	8pm 8Am	→ Assessed the pt condition → Administration of medication given as per doctor's orders	→ pt is stable	→ Re-checked vitals	A

HNH-00011978 IP26-00006770
 Baby Of G. POOJA SRI
 15-11-2025 0 Y 7 M 21 D (F)
 Dr. SPANDANA PASUPULETI

Patient



NURSING CARE RECORD

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Date: 26/11/2025

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon	2pm	Amni kept - monitor vitals 276 → chg as per ch 2pm → provided comfort		Amni kept - monitor vitals 276 → chg as per ch → provided comfort	pt is stable	fed vitals	[Signature]
Night							

CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1 6/7			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0			0							
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1			NA							
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2			NA							
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3			NA							
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4			NA							
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord pyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5			NA							
Signature of the Nurse						NA							

NOTE : Phlebitis greater than grade 2 should be reported to physicians and other appropriate health care personal ongoing observation of the site should continue for 48 hours post removal to detect post infusion phlebitis.

Signature of Shift In Charge :

Signature : Amrutha Name : Amrutha

Signature of Ward In Charge :

Signature : Balaarani Name : Balaarani

Patient Sticker

CHECKLIST FOR THROMBOPHLEBITIS

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

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

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0										
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1										
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2										
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3										
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4										
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord pyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5										
Signature of the Nurse													

NOTE : Phlebitis greater than grade 2 should be reported to physicians and other appropriate health care personnel ongoing observation of the site should continue for 48 hours post removal to detect post infusion phlebitis.

Signature of Shift In Charge :

Signature of Ward In Charge :

Signature : Name :

Signature : Name :

BRADEN 'Q' SCALE

					Date :			
					Time :			
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	6/7	4		
*Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.		4		
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		
FRICION-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 mean 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. : RCH /FRM / CLINICAL / 119					Evaluator's Name	OR		

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

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NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 7/7/25 Time: 10:10am

Weight: 7.3kg Centile: 25th

Height: Centile:

Inference: Underweight child

RDA: Calories: 98Kcal/kg/day Protein: 1.6gms/kg/day

Diet Recommendations: Gastrodiet: -ORS (WHO), Sugar Water, Coconut Water, Rice based food

Re-Assessment: Avoid: Ragi, Wheat, Milk, Oat, Egg, Sugar

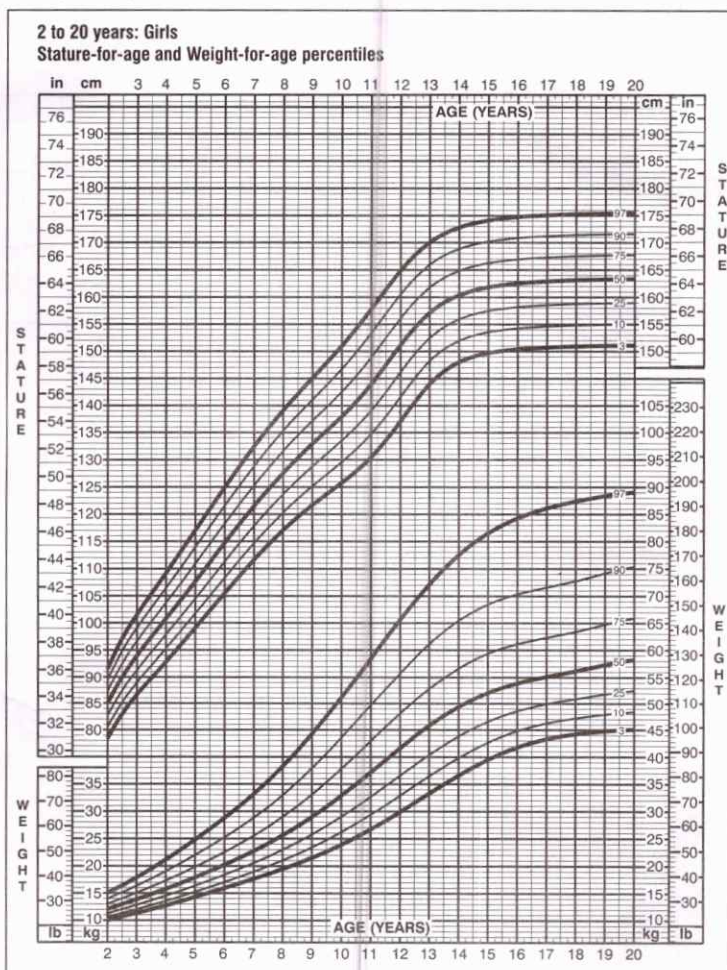
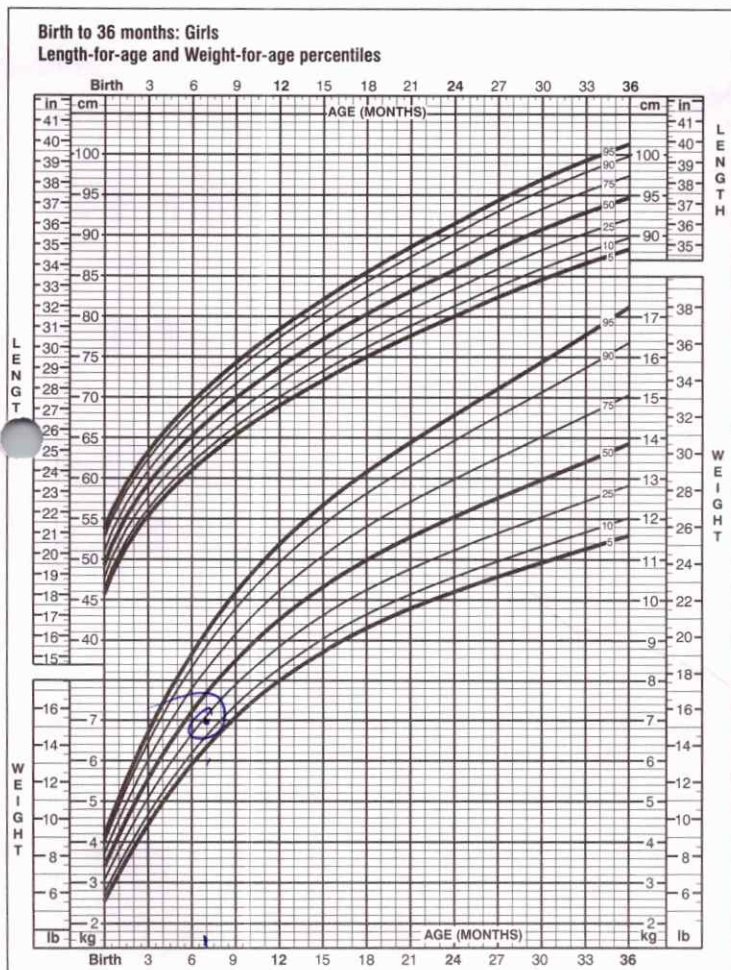
Food Allergies: NO Veg/Non-veg: NO

Diagnosis: AFI with Acute gastro enteritis & dehydration

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: G. Pojasi

GROWTH CHART (GIRLS)



Dietician's Name: Syeda Sobiya Zahedi

Dietician's Signature: Sobiya

[illegible]



wt 7.3kg

EMERGENCY ROOM TRIAGE FORM

Patient's Name : B/o G. Pooja Sri Age : 7 month Gender: ☐ Male ☒ Female

Date : 06/07/26 Time of Arrival : 9:40 PM

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

Source of Information: ☒ Parents ☐ Others (Specify)

Mode of Arrival: ☒ Ambulatory ☐ Wheelchair ☐ Ambulance

Initial Vital Signs: Temp: 98.2° F PR: 112b/m BP: RR: 27 SpO₂: 97%

Chief Complaints: 6 vomiting since evening 3epi, with 3 days Fever

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

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: B. Sri
Triage Completion Time: 9:42 PM

Communicable Disease Triage Screening

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

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

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

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

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

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

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

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

Name of Triage Nurse : Prabin

Signature of Triage Nurse : [Signature]

Date & Time : 06/07/26 @ 9:42 PM



NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date: 06/09/26 Time of arrival: 9:40 pm

Chief Complaints: C/o Fever since 3 days vomiting since today evening

Height: Weight: Head Circumference (<2 years)

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

If yes, identify

Pain Screening: ☐ Yes ☒ No If Yes, Pain Score: 0/10 Pain Tool Used: ☐ N Pass ☐ FLACC ☐ Wong Baker

☐ Character ☐ Location ☐ Frequency ☐ Duration

RISK FOR FALL:

If patient is < 6 years ☒ Yes ☐ No

If 'Yes' tick below fall risk intervention directly

If Patient is > 6 years

If 'Yes' 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: (Date/Time):

Social History: Lives With Family

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

Time of Initial assessment completed by ER Nurse: 9:42 pm

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

Time	Nursing Notes
	→ Assessed the pt condition
	→ checked the pt vitals

Samples collected by:

Samples sent by:

Jyoti

Time:

Time:

11pm

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: <i>112b/m</i> BP: CFT: RR: SPO2 at FiO2: <i>97%</i> GCS: Temperature: <i>98.2°F</i> Pain Score: Repeat RBS (if applicable):	Shift - out from ER to: <i>ward</i> Time of Shift - out: <i>11:30pm</i> Handover given to: <i>Amrita</i> (Nurse's Name)

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any):

IV placement Done

Name of the Nurse:

Prabin

Signature of the Nurse:

[Signature]

Date & Time:

06/07/20 @ 9:42am

PATIENT TRANSFER FORM

Patient Name & UHID No. HHN-00011978 IP26-00006770 Baby Of G. POOJA SRI 15-11-2025 0 Y 7 M 21 D (F) Dr. SPANDANA PASUPULETI 		Date & Time of Admission 6/7/26 @ 10:36pm	Date & Time of Transfer Order 6/7/26 @ 11:30pm
		Transfer Ordered by Dr. Naipunya	Reason for Transfer Admission
From Unit ER	To Unit Ward	Information to Attendant Yes ☐ No ☐	
Number of Sheets in Clinical File 251	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☐ If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☐ No ☐			
Name & Signature of Person who is Transferring Bhargavi		Name of Person Ordered Transfer Dr. Naipunya	
Patient & Clinical Records Received by : Amrutha . 6/7/26 @ 11:30pm			
Date & Time of Patient Received :			

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

☐ Unavailable Bed

☐ Nurse not Available

☐ Available Bed not ready