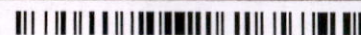


ADMISSION SHEET

Registration Details :

Admission No : IP5-00175826

Admit Date : 01-Jul-2026

Admit Time : 01:36 PM **UHID** : BAH-00647671

Patient Details :
Patient Name : Baby IFRA AYESHA

Age : 5 Y 5 M 6 D

Guardian : Mr MOHAMMED HIMAYATH ALI

DOB : 25-01-2021

Gender : Female

Religion :

Occupation :

Martial Status : Single

Address (H) : H NO 11-21-136, MADEENA STREET
 Warangal Warangal Telangana INDIA 506002

Phone No : 9603649860/ 6300635926

E-mail : MDHALI432@GMAIL.COM

Admission Details :
Bed Type : PRIVATE ROOM

Bed No : PVT 237

Ward Name : 2F-SECOND FLOOR

Room No : PVT 237

Admission Type : First Visit

Contact Details :
Name : Mr MOHAMMED HIMAYATH ALI

Relationship : Father

Contact Address : H NO 11-21-136, MADEENA STREET
 Warangal Warangal Telangana INDIA 506002

Phone No : 9603649860 / 6300635926

Signature
Doctor Details :
Doctor Name : Dr. SHRUTI KOTAPALLI

Specialisation : PULMONOLOGY

Referral Doctor : Self

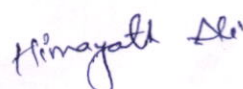
Phone No :

Co-Consultant : Dr. PILLARISETTI NAVEEN SARADHI

Payment Details :
Deposit Amount : 0.40

Payment Mode : Cash

Payor Name : MEDI ASSIST INSURANCE TPA PVT LTD



BAH-00647671 IP5-00175826
Baby IFRA AYESHA
25-01-2021 5 Y 5 M 6 D (F)
Dr. SHRUTI KOTAPALLI



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ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____ IP No. : _____ Consultant: _____ Dept : _____

Date of Admission: _____ T _____ Large : _____ Time: _____

Room / Bed No : _____ W _____ Billable bed type : _____

BAH-00647671 IP5-00175826
Baby IFRA AYESHA
25-01-2021 5 Y 5 M 6 D (F)
Dr. SHRUTI KOTAPALLI



WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
1/7/26	2:20pm	ER	237	Abhishek

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	Dr. Abhishek	2/7/26	9684604	Abhishek
2				
3				
4				
5				
6				
7				
8				
9				
10				

[illegible]

1/07/26 CRP, CRP, CSR, RFT, s/c

65874

Israel

5 viral panel, GRRe (POCT)

01/7/26	<i>Bordetella pertussis</i> PCR
---------	---------------------------------

26065918

Header

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
1/07	IV placement	1	82585	[Signature]
01/2	NHA	(1)	9682899.	Hawley
3/7	Neb 2 Oz	13	9685000	Nig

ANY OTHER INFORMATION

Chr (2)

Date : 04/07/26 Time : 9.20am Prepared By : [Signature]

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
[Signature]	—	—	—



PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : Dr. shruti

Date : 01/07/20

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

Start Time of Assessment: _____

Weight: 20kg

Allergic History: _____

Chief Complaints:

Cough 15 days
cold Breathing difficulty 12 days
Post-tussive vomiting
? uprolling of eyes after poor oral
intake
No H/o fever

Pediatric Assessment Triangle

A Appearance - TICLS (1)
B Breathing
C Circulation ☒ Normal
☐ Abnormal
Pallor ☐
Cyanosis ☐
Mottling ☐
Bleeding ☐
Breathing
☐ ↑ WOB
☐ ↓ WOB
☐ Normal
☒ Gasping / Apnea

Initial Physiological Status: ☒ Stable ☐ Unstable

☐ Life Threatening
☐ Non Life Threatening

Any urgent interventions needed: ☐ Yes ☐ No

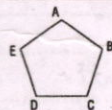
If Yes _____

Significant Past History: Recurrent cough cold used Paracetamol for 8 months seasonal

Medication History: Paracetamol 1.5g

Relevant Investigations: _____

Primary Assessment



Airway



☒ Open
☐ Maintainable
☐ Not Maintainable

Any urgent interventions needed: ☐ Yes ☒ No

If Yes _____

Breathing



Rate: 28/min SpO₂ on FiO₂ 98% on 100% E RA

Rhythm: _____

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

Respiratory Noises: ☐ Stridor ☐ Wheezing ☐ Grunting

Air Entry: 8/c

Palpation Findings (If necessary) _____

Any urgent interventions needed: ☐ Yes ☒ No

If Yes _____

 **Circulation** HR: 111/min CFT ☐ Central 1 case ☐ Peripheral Any urgent interventions needed: ☐ Yes ☒ No

BP: 103/65/72 mmHg

Pulse Volume: ☐ Central ☒ Peripheral 100%

If in Shock: ☐ Compensated ☐ Hypotensive

Murmurs: ☐ Yes ☐ No

Liver Span:

ECG:

Any Signs of Heart Failure: ☐ Yes ☐ No

Muffled Heart Sound: ☐ Yes ☐ No

Engorged Neck Veins: ☐ Yes ☐ No

 **Disability** GCS: AVPU: Any urgent interventions needed: ☐ Yes ☒ No

Pupils: ☐ Responsive ☐ Non-Responsive ☐

Size: ☐ Right ☐ Left

Active Seizures: ☐ Yes ☐ No Sugars:

Signs of Neurological compromise

 **Exposure** Temp.: 98°F Any urgent interventions needed: ☐ Yes ☒ No

Any Rash: ☐ Yes ☐ No, If yes describe the rash

Active bleed

Lacerations ☐ Abrasions ☐ bruises ☐

Describe:

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: <u>88 wbc</u> <u>9255</u> <u>CBP, up, ESR, PFT, SE</u> <u>Singpanel</u> <u>Perth PCR</u>	Treatment Planned: <u>iv augmentin</u> <u>500 mg 2x</u> <u>up. pamp. inj. onlar</u> <u>web - testin, 800mg, 2x</u> <u>from 1st 9 nasospung</u>
---	--

Need for Oxygen: ☐ Yes ☒ No if yes Low Flow ☐ High Flow ☐ PPV ☐

Final Diagnosis with possible Differential Diagnosis (If necessary): LEI

Assessment done by N. Pearson

Name of the Doctor:

Signature: N. P.

Date & Time: 01/12/16, 1pm

Sr. Doctor on Duty (If necessary)

Name of the Sr. Doctor:

Signature:

Date & Time:

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Baby IFRA AYESHA
25-01-2021 5 Y 5 M 6 D (F)
Dr. SHRUTI KOTAPALLI



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PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: _____

UHID ID: _____

Department: _____

Consultant: _____



Pediatric Multiorgan History & Physical Examination

Name : Ifra Age/Sex 5/F

Information given by: mother Relationship good

Chief Presenting Complaints & Duration (Chronologically)

do : difficulty breathing x 15d
do cough/cold

do paroxysmal events of
WOB & after cough &

History of present illness :

↓
child was evaluated

found to have respiratory
distress

↓
Chest Xray B/L hyperinflated

↓
needs IV antibiotics

**Pediatric Multiorgan History & Physical Examination****Past History :** (Including details of any previous investigation or treatment)

[Handwritten: /]

Birth & Neonatal History:

[Handwritten: (N) perinatal transition]

Birth & Socio Economic History:About Father : *[Handwritten: 1]*About Mother : *[Handwritten: (N)]*Any additional Information : *[Handwritten: (N)]***Developmental History :**

[Handwritten: (N)]

Immunization History :

[Handwritten: immunised]



Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs)) 20 kg (Centile _____)

On Examination :

Temperature : 98.2°F Pulse Rate : 111 B.P. 103/65 SP02 100%

Resp. rate and type of breathing : 22/min

Rash _____

Lymphadenopathy _____

Oedema : _____

Allergies (if any): _____

Respiratory System :

Inspection (any s/o distress) : _____

Air entry & breath sounds : BAT ⊕

Any addes sounds : occ. rhonchi ⊕ / clear

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

Cardiovascular System :

Inspection of procordium : _____

Heart Sounds : _____

Any murmur : _____

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

Per Abdomen :

Inspection _____

Palpation : _____

Ausculation : _____

Spine : _____ External Genitalia : _____

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

**Pediatric Multiorgan History & Physical Examination****Central Nervous System :**

Level of Consciousness : AVPU/GCS score : _____

*Alert*Cranial Nerves : _____

_____**Motor System:**

Nutrition : _____

Tone: _____ Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :**DTR****Superficials:**

Plantars _____

Sensory System :

Bladder / Bowel : _____

**Clinical Summary & Diagnostic:***UR 71*



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

RD

Desired goals of the treatment :

Resolution

Planned Labs:

CBP

CRP

ESR

S/E

urea/creat

pertussis PCR

Planned Management

1.) Augmentin

2.) Azithromycin

3.) Levocetirizine

4. Pantop

5 Ondans

6 Levoflo

7 Budesonid

8 Hypernat

9 Flomust

Signature of the Doctor:

Name of the Doctor:

Dr. Shubh

Date & Time:

1/7/26

Signature of the Consultant:

Shruti

Name of the Consultant:

Dr. Shruti Kotapalli

Date & Time:

1/7/26



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	<u>History :-</u> - 5½ yrs old, and by birth order - Term / Cesarean / NICU stay for 4 days. — Required CPAP on day 1 and nasal prongs on day 2. ↓ apparently alright till 2 years of age. ↓ No cough & cold on & off since 2 years, every year usually during winter months. No day care admissions & receiving Nebulisations - Started on Budecort Inhaler (2 puffs BD) from July 2025 - March 2026. — no symptoms when on inhalers. - Restarted on Foracort Inhaler (2 puffs BD) from May 2026. Now - Cough } x 15 days ; No fever. - Cold } - ? breathing difficulty & uprolling of eyes after continuous cough. - Snoring while sleeping - No nasal symptoms. Hb - 10.1 TLC - 10.17 (71% - N, 1-20%, E - 1.9%) CRP - 5	NCM

3AM-00647671

IP5-00175826

3rdy IFRA AYESHA

15-01-2021

6 Y 5 M 6 D

(F)

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
21/1/21 9:00am	CLSB Dr. Naresh Saradhi Dr. Shruti Kotapalli CLD CRTI. No fever. No RD SpO₂ :- 100% R.A. Chest : clear.	Adv :- 1) Continue Augmentin/ Azithromycin / Hydrocortisone / Nebulisation 2) Trace 5 viral panel & pertussis PCR. 3) PFT (pre & post BD) 4) Send na nasopharyngeal + oropharyngeal biofire panel (Hold) <i>[Signature]</i>
21/1/21 5pm	CLSB Pulmo team CLD CRTI (Pertussis). No fever No RD SpO₂ : 99% Chest - clear	Adv :- 1) Continue Augmentin/ Azithromycin / Hydrocortisone. 2) Cl-Nebulisation <i>[Signature]</i>

IP5-00175826

25-01-2021

5Y5M8D

(F)

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PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]



CROSS CONSULTATION FORM

Doctor Name : Dr. Abhishek Jain Date : 21/2/26 Time : 9 am

Diagnosis :

Hospital :

Type of Referral :

☐ Emergency

☐ Urgent

☐ Non Urgent

Referred for : ☐ Opinion ☐ Co-Management ☐ Transfer of care

Reason for Referral : If for concurrent care specify the particular need, especially in the absence of a second diagnosis:

Signature: _____

Findings and Recommendations : Thanks for referral

After coughing - holding breath - UROER, breathing difficulty
multiple episodes post (2d) in awake state,
mouth opening, sometimes c/falls c/preserved sensation

old child conscious
EOM full, pup's UBL awake
none power/12

DDR 20/2/26
Mentor flexor
no meningeal signs

Consultant :

DR. ABHISHEK R. JAIN
Registration No: 2757

Name : Dr. Abhishek Jain Signature : Dr. Abhishek Jain Date & Time : 21/2/26

parent and over - Post fusion
1) ~~parent and over~~ fusion (Non-epilepsy)

1

① A. dequene

② C. 1. 1

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RESULT SHEET

Date	01/7/26				
Time	@ 1:55pm				
Hb	12.1				
PCV	39.3				
RBC	5.06				
WBC	10.14				
N/L	75/22				
Platelets	282				
CRP	5.0				
ESR	22				
PCT					
RBS	88				
Na	136				
K	4.3				
Cl	103				
Ca/Mg					
Phosphate					
Urea	25				
Creatinine	0.4				
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..) :

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Baby IFRA AYESHA
25-01-2021 5 Y 5 M 6 D (F)
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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:

Shifted to:

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	1000					☐ 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 : N. Ravi Kumar, N.P.M.

Date & Time : 21/07/26, 1PM

Nurse Name & Signature: Apurva

Date & Time : 2/7/26 @ 1PM

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 Baby IFRA AYESHA
 25-01-2021 6 Y 6 M 6 D (F)
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Sheet No:

REGULAR PRESCRIPTIONS

Weight 20 kg

Ward HAD

DRUG: BEST BODESAL				Date/Time	1/7 2/7															
Dose	Route	Frequency	Start Dt.	10am	10am	10am	10am	10am	10am	10am	10am	10am	10am	10am	10am	10am	10am	10am	10am	10am
0.5 mg	NEB	12H	01/07																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG: BEST 31 HYPERNEB				Date/Time	1/7 2/7															
Dose	Route	Frequency	Start Dt.	2pm	2pm	2pm	2pm	2pm	2pm	2pm	2pm	2pm	2pm	2pm	2pm	2pm	2pm	2pm	2pm	2pm
	NEB	24H	01/7																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG: INT. ONDEM				Date/Time																
Dose	Route	Frequency	Start Dt.																	
2mg	iv	B.D.																		
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG: INT. ONDANSETRON				Date/Time	1/7 2/7															
Dose	Route	Frequency	Start Dt.	10am	10am	10am	10am	10am	10am	10am	10am	10am	10am	10am	10am	10am	10am	10am	10am	10am
2mg	iv	B.D.	1/7/26																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

Signature
 VERIFIED BY : Name



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Weight 20 kg Ward 102



Sheet No:

REGULAR PRESCRIPTIONS

Weight Ward

DRUG: MDI BUDEKORT (200 ^{mcg})				Date	Time
Dose	Route	Frequency	Start Dt.		
1 puff	MDI	BD	3/7		
Name & Signature of the Doctor Starting the Drugs:					
<i>Somashree</i>					
Additional Instructions:					
with transpacer VM					
Daily Doctor's Endorsement by a Sign					
DRUG: MDI FORMORT (200 ^{mcg})				Date	Time
Dose	Route	Frequency	Start Dt.		
1 puff	MDI	BD	3/7	10:00 AM	3/7
Name & Signature of the Doctor Starting the Drugs:					
<i>Somashree</i>					
Additional Instructions:					
with transpacer VM.					
Daily Doctor's Endorsement by a Sign					
DRUG: SYR ASCORIL - LD				Date	Time
Dose	Route	Frequency	Start Dt.		
3ml	PO	BD	3/7	10:00 AM	3/7
Name & Signature of the Doctor Starting the Drugs:					
<i>Somashree</i>					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					
DRUG: SYR RESWAS				Date	Time
Dose	Route	Frequency	Start Dt.		
3ml	PO	BD	3/7	6:00 AM	3/7
Name & Signature of the Doctor Starting the Drugs:					
<i>Somashree</i>					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					

Patient Sticker

Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward

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

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

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

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

VERIFIED BY : Name Signature

DRUG CHART

Date of Admission: 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 : <i>INJ ONDEM</i>				Date Time
Dose <i>4mg</i>	Route <i>iv</i>	Frequency <i>SOS</i>	Start Date <i>3/7</i>	
Doctor's Signature <i>Somashree</i>		Valid Period	Pharm.	
Additional Instructions: <i>for vomiting & hourly.</i>				

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
 VERIFIED BY : Name



REGULAR PRESCRIPTIONS

Weight ^{20kg} Ward ^{HDU}

DRUG : <u>Amoxicillin-clavulanate</u>				Date Time	1/7	2/7	3/7	4/7												
Dose	Route	Frequency	Start Date	6am	X	Nilai	Nilai	Dipa												
600mg	IV	8H	01/07			Rosa	Rosa	Rosa												
Name & Signature of the Doctor Starting the Drugs: <u>N. Prathishu</u>				2pm Haily 12pm Kala 10pm Nilai Rosa 12pm Nilai 12pm Dipa Rosa																
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG : <u>Amoxicillin-clavulanate</u>				Date Time	1/7	2/7	3/7	4/7												
Dose	Route	Frequency	Start Date	6am	X	Nilai	Nilai	Dipa												
20mg	IV	24H	01/07			Rosa	Rosa	Rosa												
Name & Signature of the Doctor Starting the Drugs: <u>N. Prathishu</u>				2pm Haily 12pm Kala 10pm Nilai Rosa 12pm Nilai 12pm Dipa Rosa																
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG : <u>Syr. Azithromycin</u>				Date Time	01/7	2/7	3/7													
Dose	Route	Frequency	Start Date																	
5ml	PO	24H	01/7																	
Name & Signature of the Doctor Starting the Drugs: <u>N. Prathishu</u>				2pm Haily 12pm Kala 10pm Nilai Rosa																
Additional Instructions: (5ml) 200mg																				
Daily Doctor's Endorsement by a Sign																				
DRUG : <u>NEB LEVUN</u>				Date Time	01/7	2/7	3/7	4/7												
Dose	Route	Frequency	Start Date	2am	X	Nilai	Nilai	Dipa												
0.63	NEB	6H	01/7			Rosa	Rosa	Rosa												
Name & Signature of the Doctor Starting the Drugs: <u>N. Prathishu</u>				2pm Haily 12pm Kala 10pm Nilai Rosa 12pm Nilai 12pm Dipa Rosa																
Additional Instructions:				12pm Haily 12pm Kala 12pm Nilai 12pm Dipa 12pm Rosa 12pm Rosa																
Daily Doctor's Endorsement by a Sign																				



Date Time								
		Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.
	Dose		Dose		Dose		Dose	
	Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
	Dose		Dose		Dose		Dose	
	Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
	Dose		Dose		Dose		Dose	
	Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
	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]

Dr. SHRUTI KOTAPALLI



Weight. 20 kg Ward. 100

Weight

Ward.

[illegible]

BAH-00547671 IP5-00175826
 Baby IFRA AYESHA
 25-01-2021 5 Y 5 M 6 D (F)

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

f.indi

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		
1/7/26	2pm	7	Infection Control measures	M	1	0	1	1	NA	Abhishek
1/7/26	2pm	9	soft high protein diet	F	1	0	1	1	-	Nichlas

Part - III: CODES

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



MULTI-DISCIPLINARY PLAN OF CARE FORM

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
01/12/20	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	LEP	Resolving symptoms	Wp. W anticholinergics	W. Priz	☐ Nursing ☐ Others:
1/7/21 2pm	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	LRTI	H. stability	f v fluids Iv medication Neb	Abhidh	☐ Medical ☐ Others:
11/2/26 2pm	☐ Medical ☐ Nursing ☒ Others: Dietician	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	LRTI	soft high protein diet	ROA E! - 1400 kcal/d P! - 24 g/d	Niritha	☐ 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:



Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 2:20pm Mode of Arrival: By walk Admitting From: ☒ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction

Body Weight: 20 Kg

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>NA</u>

Family History:

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

If yes please list, NA

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: 20kg Length: Head Circumference (< 2 years):

Temp.: 98.6°F HR: 126b/m RR: 104b/m BP: 104/65B/m

Pain Score: 0/10 Specify Site: 12 (Follow Pain Assessment Sheet & Document)

Fall Risk Assessment: ☒ Yes ☐ No Score: 16 (Document in the Humpty Dumpty Sheet)

Risk of Pressure Sore (Braden Q Score 23) (Document in the Braden Q Assessment Sheet)

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

Character of Pain Location Frequency Duration

FUNCTIONAL SCREENING: ☒ No Abnormalities Detected

☐ Mobility Problem

☐ Walking Problem

☐ Developmental Delay

☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING: ☒ No Abnormalities Detected

☐ Underweight

☐ Overweight

☐ Special Feeding Method

☐ Feeding Problem

☐ Special diet

☐ No Abnormality Detected

Inform consultant for positive criteria

Psychological Screening: ☒ No Significant Findings

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

If Yes Consultant Notified: (Date/Time):

Social History: Lives With

Siblings 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 ☐ No

Waste Disposal Explained: ☒ Yes ☐ No

Infusion Pump : ☒ Yes ☐ No

Hand hygiene Explained: ☒ Yes ☐ No ☐ Others

Patient Rights & Responsibilities: ☒ Yes ☐ No

Information given to father

Nurse's Name: Hanika Date: 01/7/26 Time: @6pm

By
Signature

Children's Observation & Early Warning Scoring Chart



BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

* 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)

3AH-00647671
Baby IFRA AYESHA
15-01-2021 5 Y 5 M 6 D
Dr. SHRUTI KOTAPALLI (F)
IP5-00175826

3/7/26

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

SCHOOL AGE (5-12 years)

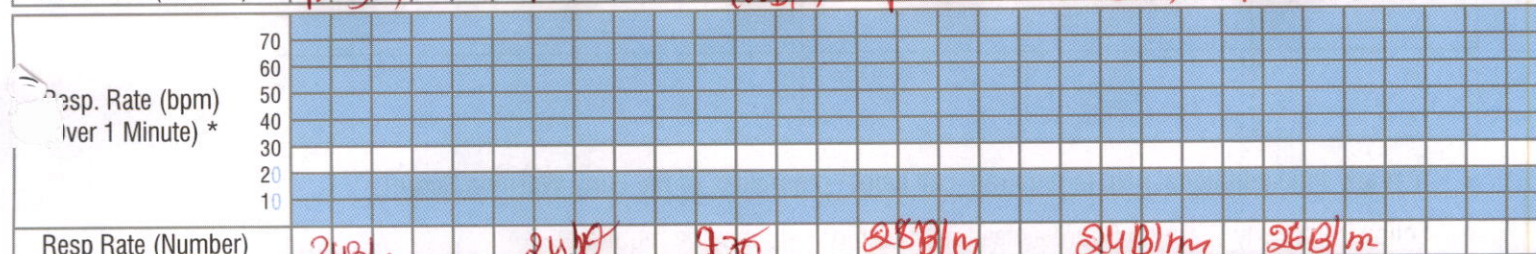
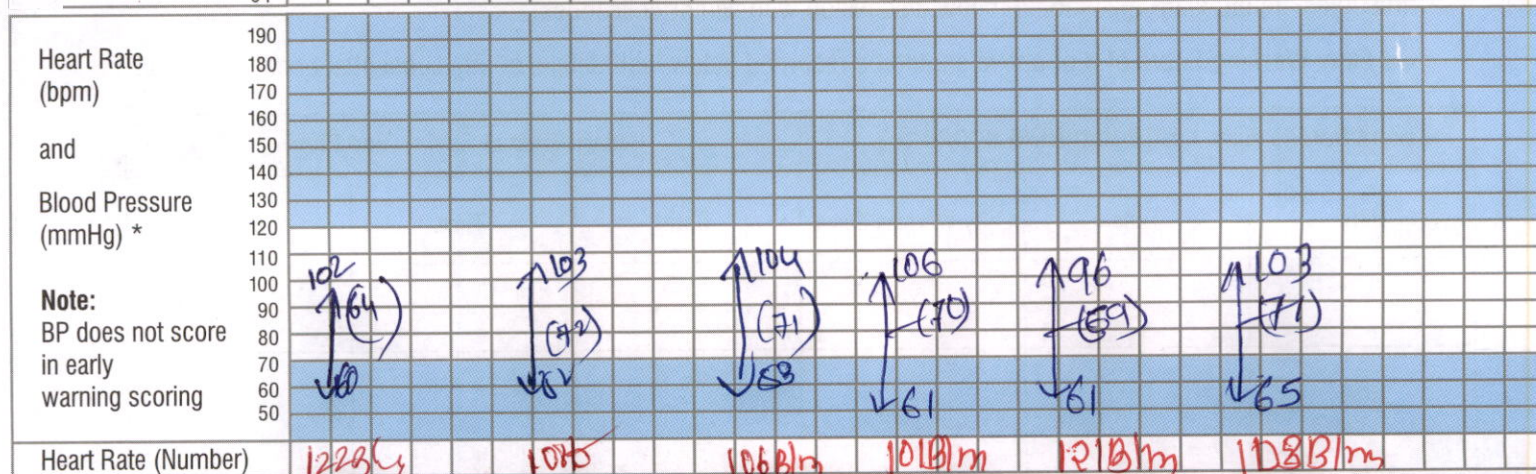
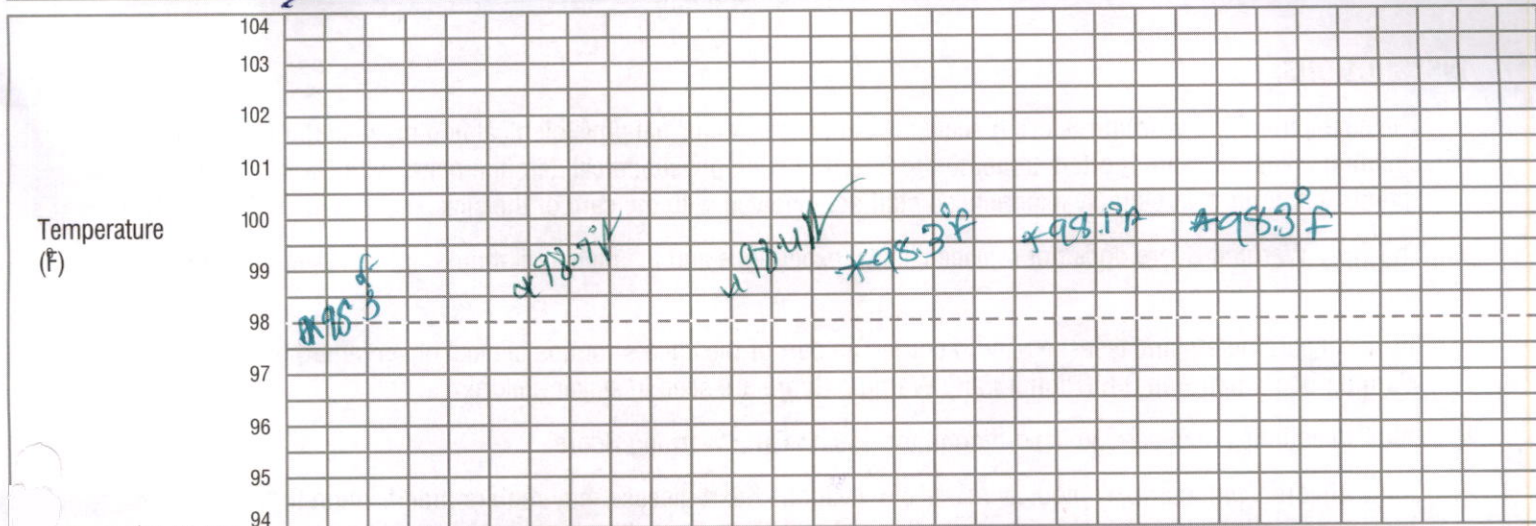
Children's Observation &
Early Warning Scoring Chart

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

BY R
Your R

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : Time: 10 AM 2 PM 6 PM 10 PM 2 AM 6 AM
Doctor / Nurse / Family Concern? 10 AM



Heart Rate (Number)	122 bpm	108 bpm	106 bpm	101 bpm	121 bpm	108 bpm
Resp Rate (Number)	24 bpm	24 bpm	23 bpm	28 bpm	24 bpm	26 bpm
Resp Distress	Mod/ Severe	Mod/ Severe	Mod/ Severe	Mod/ Severe	Mod/ Severe	Mod/ Severe
Receiving O ₂ (l/min)	RA	RA	RA	RA	RA	RA
O ₂ Saturations (%)	100%	98%	98%	99%	100%	99%
Conscious Level	Normal	Normal	Normal	Normal	Normal	Normal
GCS *	15/15	15/15	15/15	15/15	15/15	15/15
TOTAL SCORE	0	0	0	0	0	0
Number of shaded boxes	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0
Observer's Initials	<u>SW</u>	<u>SW</u>	<u>SW</u>	<u>SW</u>	<u>SW</u>	<u>SW</u>

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.
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EARLY WARNING SCORE: CHILDREN'S UNIT

Date :	Time: <u>10Am</u> <u>2pm</u> <u>6pm</u> <u>10pm</u> <u>2Am</u> <u>6Am</u>																																																																																										
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Resp. Rate (bpm) (per 1 Minute) *	<table border="1"> <tr><td>70</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>60</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>50</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>40</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>30</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>20</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>10</td><td></td><td></td><td></td><td></td><td></td></tr> </table>	70						60						50						40						30						20						10																																																					
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Score 1	: Continue normal observation by staff nurse																																																																																										
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Score 3	: Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.																																																																																										
Score 4	: Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see																																																																																										
Score 5 & 6	: Shift in charge AND PICU fellow or PICU consultant to be informed.																																																																																										
NB: Scores 3 should be recorded overleaf																																																																																											

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)

EARLY WARNING SCORE: CHILDREN'S UNIT

Date :	Time: 4pm 6pm 10pm 2Am 6Am
Doctor / Nurse / Family Concern?	
Temperature (F)	104 103 102 101 100 99 98 97 96 95 94 *98.6F *98.0F *98.3F *98.6F *98.4F
Heart Rate (bpm)	190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 126b/m 124b/m 118b/m 121b/m 129b/m
Blood Pressure (mmHg) *	104 (53) 106 (67) 100 (71) 99 (71) 96 (56) 69 53 60 61 44
Heart Rate (Number)	
Resp. Rate (bpm) (Over 1 Minute) *	70 60 50 40 30 20 10 24b/m 25b/m 26b/m 28b/m 26b/m
Resp Rate (Number)	
Resp Distress	Mod/ Severe None / Mild
Receiving O ₂ (l/min)	RA 99% RA 98% RA 99% RA 99% RA 100%
O ₂ Saturations (%)	
Conscious Level	Normal Altered
GCS *	15/15 15/15 15/15 15/15 15/15
TOTAL SCORE	Number of shaded boxes Pain Score Observer's Initials
ACTIONS	Score 1 : Continue normal observation by staff nurse Score 2 : Shift in charge nurse to be informed and continue hourly observations Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue. Score 4 : Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see Score 5 & 6 : Shift in charge AND PICU fellow or PICU consultant to be informed.

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

- The paediatric Early Warning Score i) seeks to identify the abnormal physiological finding seen during serious childhood illnesses and ii) offers a method to interpret such physiological derangements with clearly defined actions, ensuring that suitably experienced staff are involved with the care of the sickest children.
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- 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.
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Record Details when EARLY WARNING SCORE > 3			Record Time of Review and Plan		
Date	Time	Early Warning Score	Date	Time	Name

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

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



FLUID CHART

Sheet No. :

01/11/26

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
01/11	02:00 pm	↓									0	Harika
	03:00 pm	↓									0	Harika
	04:00 pm	DNS Fedly	30ml					✓			0	Harika
	05:00 pm	↑	30ml				NP		✓		0	Harika
	06:00 pm		30ml								0	Harika
	07:00 pm		30ml								0	Harika
Total Intake : 120ml						Total Output : M-0 U-1 V-1						
11/11/26	08:00 pm	↓	30ml								0	Rosny
	09:00 pm	DNS							✓		0	Rosny
	10:00 pm										0	Rosny
	11:00 pm	✓	30ml				NP				0	Rosny
	12:00 am	✓	30ml						✓		0	Rosny
	01:00 am	✓	30ml								0	Rosny
Total Intake : 120ml						Total Output : M-0 U-1 V-2						
21/11/26	02:00 am	↓									0	Rosny
	03:00 am	↓							✓		0	Rosny
	04:00 am	DNS									0	Rosny
	05:00 am		30ml				NP				0	Rosny
	06:00 am	↓	30ml								0	Rosny
	07:00 am	↓	30ml						✓		0	Rosny
Total Intake : 90ml						Total Output : M-0 U-2						
Total 24 hrs. Intake		Total 24 hrs. Output										



FLUID CHART

Sheet No. :

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
2/7/26	08:00 am	I		30ml							0	Mona
	09:00 am	I	30ml							0	Mona	
	10:00 am	DNS	30ml							0		
	11:00 am		30ml						0			
	12:00 pm		30ml						0			
	01:00 pm								0	Mona		
Total Intake :						Total Output : U-2						
2/7	02:00 pm	I									0	Mona
	03:00 pm	I									0	
	04:00 pm	NO									0	
	05:00 pm	IVF									0	
	06:00 pm	I									0	
	07:00 pm	I									0	
Total Intake :						Total Output : U-2						
2/7	08:00 pm	I									0	Roshy
	09:00 pm	I									0	
	10:00 pm	NO									0	
	11:00 pm	IVF									0	
	12:00 am	I									0	
	01:00 am	I									0	
Total Intake :						Total Output : M-0 U-3						
3/7	02:00 am	I									0	Roshy
	03:00 am	I									0	
	04:00 am	NO									0	
	05:00 am	IVF									0	
	06:00 am	I									0	
	07:00 am	I									0	
Total Intake :						Total Output : M-0 U-2						

Total 24 hrs. Intake —

Total 24 hrs. Output M-0 U-9



3/7/22

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								
3/7/22	08:00 am	↓		-							0	Kaly	
	09:00 am	↓	Oral	-						✓	0	Kaly	
	10:00 am	NO		-			✓				0	Kaly	
	11:00 am	NO		-							0	Kaly	
	12:00 pm	↑		-						✓	0	Kaly	
	01:00 pm	↑		-							0	Kaly	
Total Intake :						Total Output :						M-1	U-2
	02:00 pm	↓	Rice water	-							0	Kaly	
	03:00 pm	↓		-						✓	0	Kaly	
	04:00 pm	NO		-			NP				0	Kaly	
	05:00 pm	↑		-						✓	0	Kaly	
	06:00 pm	↓		-						✓	0	Kaly	
	07:00 pm	↓		-						✓	0	Kaly	
Total Intake :						Total Output :						M-0	U-3
	08:00 pm	↓		-							0	Rosny	
	09:00 pm	NO		-						✓	0	Rosny	
	10:00 pm	NO		-							0	Rosny	
	11:00 pm	NO		-			NP				0	Rosny	
	12:00 am	↓		-						✓	0	Rosny	
	01:00 am	↓		-							0	Rosny	
Total Intake :						Total Output :						M-0	U-2
	02:00 am	NO		-							0	Rosny	
	03:00 am	NO		-						✓	0	Rosny	
	04:00 am	NO		-							0	Rosny	
	05:00 am	NO		-			NP			✓	0	Rosny	
	06:00 am	↓		-						✓	0	Rosny	
	07:00 am	↓		-						✓	0	Rosny	
Total Intake :						Total Output :						M-0	U-3
Total 24 hrs. Intake			→			Total 24 hrs. Output			M-1 U-10				

4/1/28
FLUID CHART

Sheet No. :

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

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

NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 01/7/26

Assessment: patient having Breathing problem

- 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
2pm	Assess the patient general condition.	2pm	Assessed the patient condition.	All plans are implemented as per doctor order.
↓	Monitor the vital signs.	↓	Monitored the vital signs.	
↓	Maintain I/O chart.	↓	Maintained I/O chart.	
6pm	Administer the medication as per doctor order.	6pm	Administered the medication as per doctor order.	
↓	Maintain fluid balance.	↓	Maintained fluid balance.	
8pm		8pm		

Re-Assessment: Re-assessment was done.

Special Notes: w/A distress

Nurse Signature: [Signature] Nurse Name: Hanika

Date & Time: 01/7/26 @ 8pm

BAH-00647671 IP5-00175826
 Baby IFRA AYESHA
 25-01-2021 5 Y 5 M 6 D (F)
 Dr. SHRUTI KOTAPALLI



NURSING CARE RECORD

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 1/7/26

Assessment: Baby is Active

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	→ Assess the baby general condition	8:15pm	→ Assessed the baby general condition.	→ Baby vital stable. → Baby feel comfortable.
10pm	→ Monitor vital signs.	10:15pm	→ Monitored vital and Recorded	
12Am	→ Maintained fluid Balance	12:30n	→ Maintained fluid Balance	
3Am	→ Maintain I/O chart	3:10am	→ Maintained I/O chart.	
7Am	→ Administer All medications as per doctor order.	7:19am	→ Administered All medications as per drug chart.	

Re-Assessment: Baby feel comfortable.

Special Notes: w/r spor

Nurse Signature: Rosma

Nurse Name: Rosma

Date & Time: 2/2/26 at 8am

3AH-00647671
3rdy IFRA AYESHA
15-01-2021
Jr. SHRUTI KOTAPALLI
8 Y 5 M 6 D
IP5-00175826
(F)

NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 2/7/26

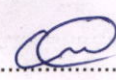
Assessment: Baby having is breathing problem

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

Time	Plan of Care	Time	Implementation	Evaluation
8Am	→ Assess The BABY General condition	8Am	→ Assessed The BABY General condition.	→ BABY vital stable.
10Am	→ Monitor the BABY vitals	10Am	→ monitored the BABY vitals	
12pm	→ maintain I/O chart	12pm	→ maintain I/O chart	
4pm	→ Administer The medication given by doctor order	4pm	→ Administer The medication given by doctor order.	
8pm	→ provide comfortable position	8pm	→ provided comfortable position.	

Re-Assessment: Reduce The pain

Special Notes: W/O for Breathing

Nurse Signature: 

Nurse Name: mounika

Date & Time: 2/7/26 8PM

3AH-00647671 IP5-00175826
 Baby IFRA AYESHA
 15-01-2021 5 Y 5 M 6 D (F)
 Dr. SHRUTI KOTAPALLI



NURSING CARE RECORD

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 21/7/2026

Assessment: Baby having breathing problem

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	Assess the baby	8:10pm	Assessed the baby	
	General condition		General condition.	
10pm	Monitor vital signs.	10:15pm	Monitored vital and Recorded	Baby vital stable.
12Am	Maintain f/o chart	12:12am	Maintained f/o chart.	
3Am	Ensure baby safety	3:10am	Explained about side rails	
5Am	Maintain Airway pressure	5:15Am	Maintained oxygen level in Room Air	
7Am	Administer Medication as per doctor order.	7:30Am	Administered Medication as per prescriber chart.	

Re-Assessment: Baby feel comfortable.

Special Notes: w/r Respiratory distress

Nurse Signature: Rose

Nurse Name: Rosemary

Date & Time: 3/7/26 at 8am



NURSING CARE RECORD

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 31/7/2021

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
11 AM	* Assess The pt General condition	11:00 AM	* Assessed The pt General condition	All plan are implemented pt is stable
12 PM	* Monitor vital signs	12:00 PM	* Monitoring vital signs	
2 PM	* Maintain Personal Hygiene	2:00 PM	* Maintained personal hygiene	
6 PM	* Ensure safety	6:00 PM	* provided side rail	
8 PM	* administer medication as per doctor order	8:00 PM	* administer medication as per doctor order	

Re-Assessment: Re-Assessment was done pt is stable

Special Notes: NA

Nurse Signature: [Signature]

Nurse Name: Shweta

Date & Time: 31/7/2021 8:00 PM

3AH-00647671 IP5-00175826

Baby IFRA AYESHA

15-01-2021 5 Y 5 M 8 D (F)

Dr. SHRUTI KOTAPALLI



NURSING CARE RECORD

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Children's
Hospital**
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BirthRight[™]
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 3/2/26

Assessment: Baby having Breathing problem

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	Assess the baby General condition	8:10pm	Assessed the baby General condition	Baby is stable.
10pm	Monitor vital signs	10:15pm	Monitored vital and Recorded.	
2Am	Provide comfortable position	2:30am	provided comfortable position	
4am	Maintain personal hygiene	4:10am	Maintained Hand Hygiene.	
6am	Administer Medication as per doctor order.	6:30am	Administered Medication as per drug chart.	

Re-Assessment: Baby feel comfortable

Special Notes: w/r Respiratory distress

Nurse Signature: Rosna

Nurse Name: Rosna

Date & Time: 4/2/26 at 8am

BAH-00647671 IP5-00175826
 Baby IFRA AYESHA
 25-01-2021 5 Y 5 M 8 D (F)
 Dr. SHRUTI KOTAPALLI



NURSING CARE RECORD

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Children's
Hospital**
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BirthRight[™]
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

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:

Patient Sticker

NURSING CARE RECORD

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It takes a lot to treat the little.

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

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:

Patie



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Shruti Department: ER Date of Admission: 1/7/26

SITUATION		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:						
BACKGROUND	Diagnosis:	LRTI						
	Area							
BACKGROUND	Shift Time	ER 2:20pm	HD Unit 2pm-8pm	HD Unit 5pm-8am	HD Unit 8am-8pm	HD Unit 2pm-5am	HD Unit 2pm-7pm	
	Medical Condition (Any special condition to be noted):	NA	NA	NA	NA	NA	NA	
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:	98.8	98.2F	98.3F	98.7F	98.3F	98.2F
		Res:	26b/m	26b/m	26b/m	26b/m	26b/m	28b/m
		SpO ₂ :	100%	99%	99%	100%	99%	98%
		Pulse:	110b/m	112b/m	119b/m	112b/m	118b/m	114b/m
		BP:	103/65	102/62	100/60	104/60	106/64	104/63
		Fall Risk Score:	10	10	10	10	10	10
Pain Score:	0/10	0/10	0/10	0/10	0/10	0/10		
Recommendations	Safety Needs:	Yes	Yes	Yes	Yes	Siderals	Siderals	
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:	NA	NA	NA	NA	NA	NA	
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Other Special Orders / Medications:	NA	NA	NA	NA	NA	NA	
Post Operative Procedure Special Orders:		NA	NA	NA	NA	NA	NA	
Handed Over By Name :		Abhishek	Hanks	Rosmary	Mouni	Rosmary	Sweetie	
Signature :		Abhishek	Hanks	Rosmary	Mouni	Rosmary	Sweetie	
Date:		1/7/26	1/7/26	1/7/26	2/7/26	2/7/26	3/7/26	
Time:		2:20pm	2:30pm	at 8am	8pm	at 8am	at 8pm	
Taken Over By Name :		Hanks	Rosmary	Mouni	Rosmary	Sweetie	Rosmary	
Signature :		Hanks	Rosmary	Mouni	Rosmary	Sweetie	Rosmary	
Date:		1/7/26	1/7/26	2/7/26	2/7/26	3/7/26	3/7/26	
Time:		2:20pm	at 8pm	8am	at 8pm	at 8pm	at 8pm	



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Shruti Kotapalli Department: H.D. Omf Date of Admission:

SITUATION	Diagnosis: <u>LRT I</u>		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
BACKGROUND	Area	Shift Time						
	Medical Condition (Any special condition to be noted):	<u>NA</u>						
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Vital Signs:	Temp: <u>98.4°F</u>						
		Res: <u>26B/m</u>						
		SpO ₂ : <u>99%</u>						
		Pulse: <u>106B/m</u>						
		BP: <u>100/60</u>						
		Fall Risk Score: <u>10</u>						
Recommendations	Safety Needs:	<u>gidovaly</u>						
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Others Specify:	<u>NA</u>						
	Special Diet:	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Other Special Orders / Medications:	<u>NA</u>						
Post Operative Procedure Special Orders:		<u>NA</u>						
Handed Over By Name :		<u>Rosmary</u>						
Signature :		<u>[Signature]</u>						
Date:		<u>9/7/26</u>						
Time:		<u>at 8am</u>						
Taken Over By Name :		<u>Haukey</u>						
Signature :		<u>[Signature]</u>						
Date:		<u>9/7/26</u>						
Time:		<u>at 8am</u>						



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
1/7/26	2:05 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	- NA -	Abhe
1/7/26	10 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA NA	Rosny
2/7	8 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA NA	Rosny
2/7	2 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA NA	Mou
2/7/26	10 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA NA	Rosny
3/7/26	8 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA NA	Rosny
3/7/26	2 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA NA	Sach
3/7/26	8 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA NA	Swa
4/7	4 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA NA	Rosny
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

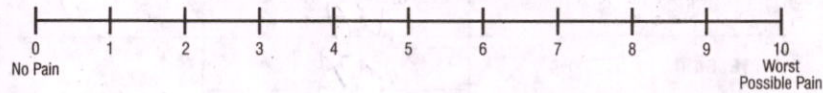
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

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 brawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, right, or Jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams of sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

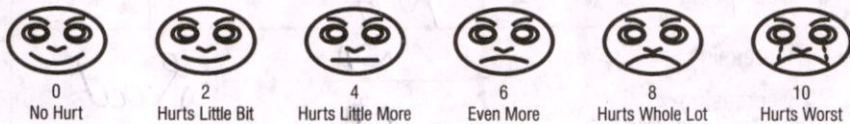
Numerical Pain Scale (Obstetric and Gynecology)



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

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

Wong - Baker (Pediatrics) Above 7 Years



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
				☐ 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:

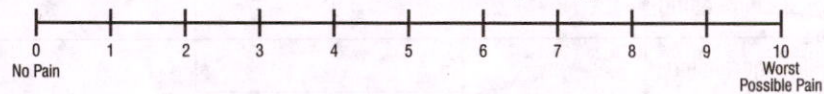
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
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PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
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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

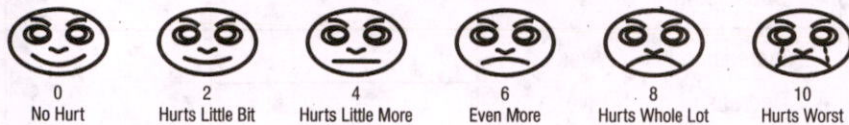
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Wong - Baker (Pediatrics) Above 7 Years





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



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 : (H) Name : Har/Cap

Signature : Aristo Name : Aristo



CHECKLIST FOR THROMBOPHLEBITIS

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

Signature of Ward In Charge :

Signature : Anitha Name : Anitha

BRADEN 'Q' SCALE

BAH-00847671
Baby IFRA AYESHA
25-01-2021
Dr. SHRUTI KOTAPALLI
IPS-00175826
5 Y 6 M 6 D
(F)

		Date :	1/7/20	2/7/20	3/7/20	4/7/20		
		Time :	2:05pm	6am	6am	6am		
Mobility	completely immobile: Cannot make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4	4	4
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4	4	4
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	4
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	4
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	4
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4
TOTAL SCORE					28	28	28	28
Evaluator's Name					Abhy	Rosy	Rosy	Rosy

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

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

Pat



THE HUMPTY DUMPTY SCALE

1/7/26 2/7/26 3/7/26 4/7/26

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4					
	3 to less than 7 years old	3	3	3	3	3	
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2					
	Female	1	1	1	1	1	
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1	1	1	
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	1	1	1	1	1	
	History of Falls or Infant - Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2	2	2	2	
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	1	1	1	1	
Medication Usage	Sedatives (excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1	1	1	
TOTAL			10	10	10	10	

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		✓	✓	✓	✓
Call device within reach		✓	✓	✓	✓
Wheels Locked		✓	✓	✓	✓
Room free of clutter		✓	✓	✓	✓
Adequate Lighting		✓	✓	✓	✓
Wheel Chair Support		✓	✓	✓	✓
Other Intervention(s) Specify		✓	✓	✓	✓
Nurse's Name :		Abhishek	Room	Room	Room
Signature :		Abhishek	Room	Room	Room
Date :		2/7/26	2/7/26	3/7/26	4/7/26
Time :		1:58pm	6am	6am	6am



237

NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 11/7/26 Time: 2 PM

Weight: 20 kgs Centile: >50th

Height: 112 cms Centile: >50

Inference: Well child

RDA: - Calories: 1400 kcal/d Protein: 24 g/d

Diet Recommendations: soft high protein diet

Re-Assessment: Avoid spicy, chilled & outside foods

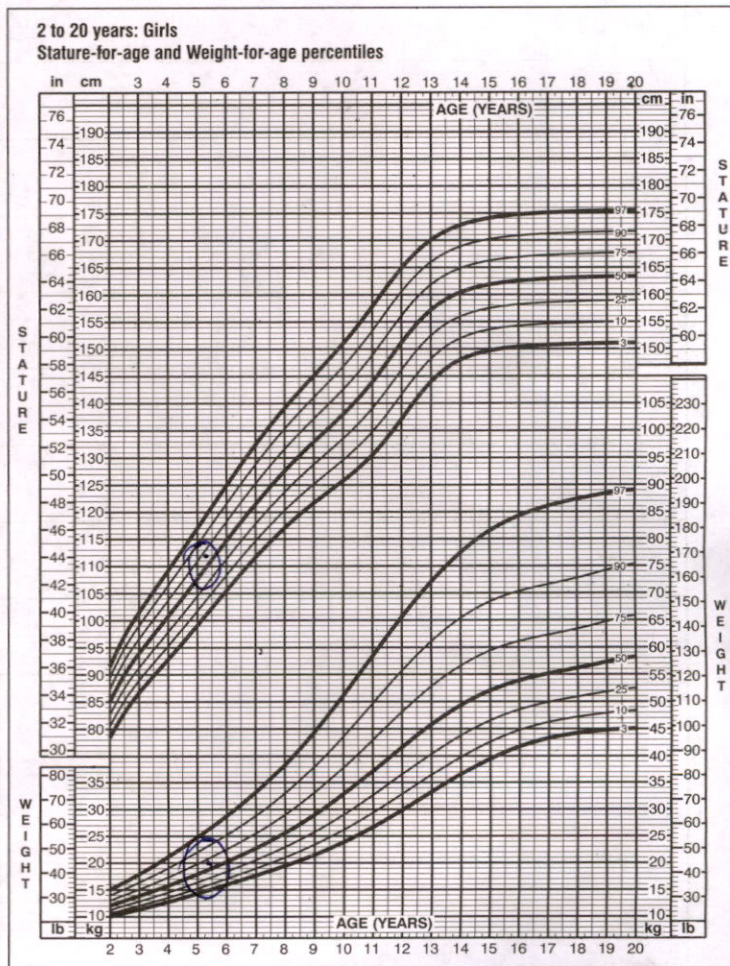
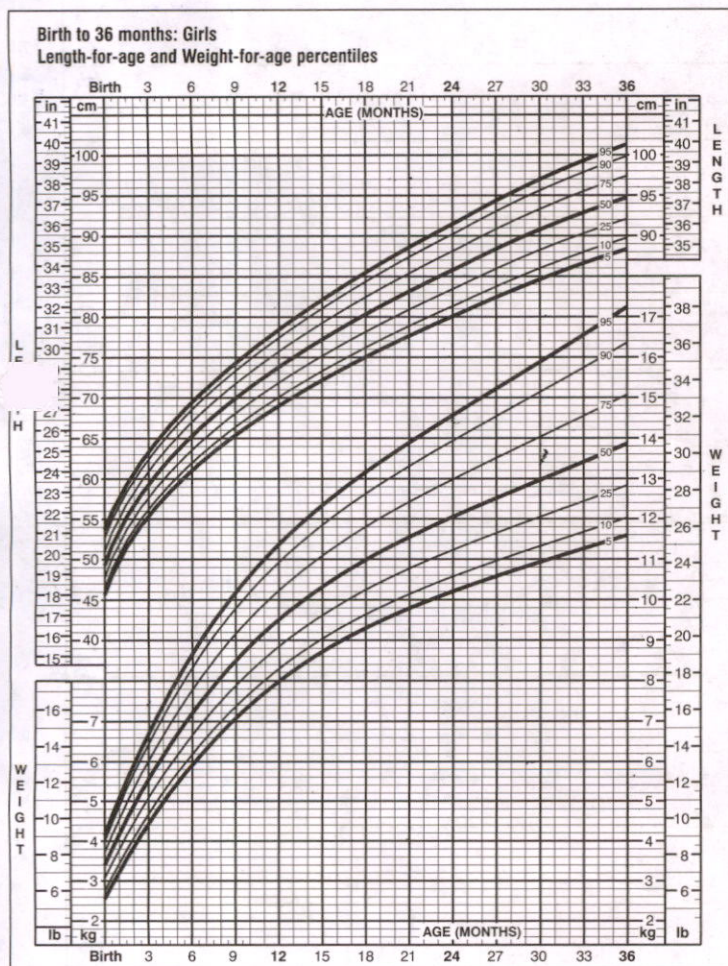
Food Allergies: No Veg/Non-veg Non-veg

Diagnosis: CRTI

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: Himajeth

GROWTH CHART (GIRLS)



Dietician's Name: Nikitha

Dietician's Signature: Nikitha

Daily Notes:

2/2/26
9:50am Child is stable. Intake is better.
Continue soft high protein diet

Mounica

3/2/26
8am child is stable. Intake is improving
continue soft high protein diet

Nebitha

4/2/26
8am child is stable. Intake is better
continue soft high protein diet

Nebitha