

HNH-00009752 IP26-00006968
 Master SHANKUR VIRANSH
 04-08-2025 0 Y 11 M 23 D (M)
 Dr. SINDHURA MUNUKUNTALA

310

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

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

RESULT SHEET

Date		27/7/26			
Time					
Hb	9.2	9.2			
PCV	4.1	28.2			
RBC	28.2	4.91			
WBC		14.87			
N/L		30.1/663			
Platelets		273			
CRP		13			
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	27/7					
Time	OPD					
CUE - Alb	-					
CUE - Sugar	-					
CUE - Ketones	-					
CUE - PUS Cells	2-4					
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.,) :



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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 27/7/26	Time: 6 PM	8 PM	10 PM	12:30 PM	2 AM	6 AM
Doctor/Nurse/Family Concern?						
Temperature (°F)						
Heart Rate (bpm)						
Blood Pressure (mmHg) *						
Note: BP does not score in early warning scoring						
Heart Rate (Number)	136b/m	136b/m	136b/m	136b/m	136b/m	136b/m
Resp. Rate (bpm) (Over 1 Minute) *						
Resp Rate (Number)	30b/m	30b/m	30b/m	30b/m	30b/m	30b/m
Resp Mod/ Severe Distress None / Mild						
Receiving O ₂ (l/min) O ₂ Saturations (%)	99%	99%	99%	99%	99%	99%
Conscious Level Normal Altered						
GCS *						
TOTAL SCORE						
Number of shaded boxes	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0
Observer's Initials	MS	MS	MS	MS	MS	MS

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)



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

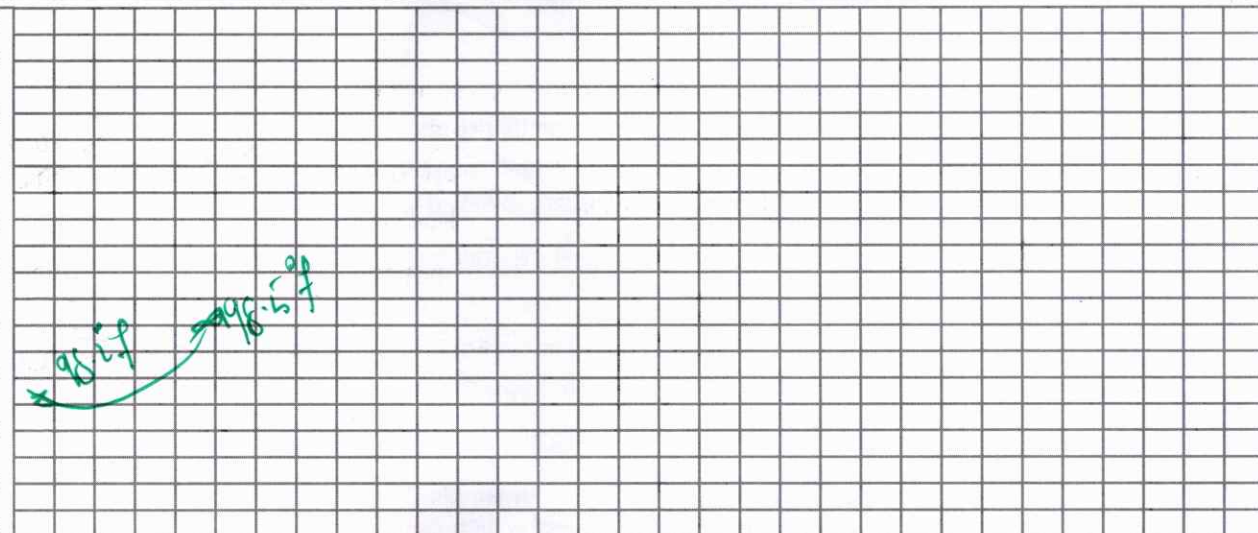
EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 28/7 Time: 10Am 2pm

Doctor/Nurse/Family Concern?

Temperature
(°F)

104
103
102
101
100
99
98
97
96
95
94



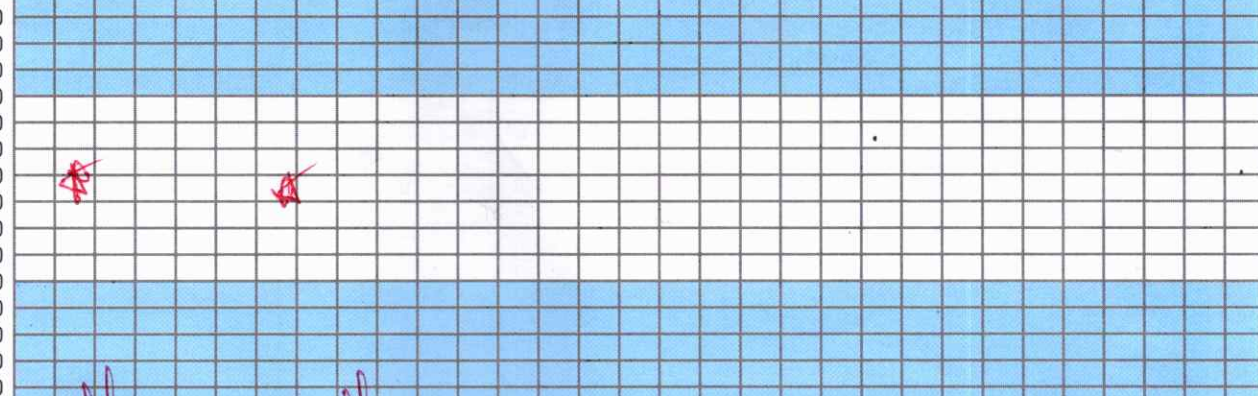
Heart Rate
(bpm)

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

and

Blood Pressure
(mmHg) *

Note:
BP does not score
in early
warning scoring

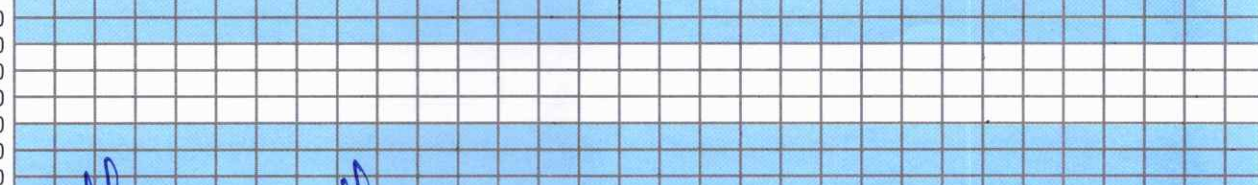


Heart Rate (Number)

138bpm 132bpm

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

70
60
50
40
30
20
10



Resp Rate (Number)

30bpm 32bpm

Resp Distress Mod/ Severe
None / Mild

Receiving O₂(l/min)
O₂Saturations (%)

99% 100%

Conscious Level Normal
Altered

GCS *

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

0 0
0 0
h h

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 is there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date:		Time:	
Doctor/Nurse/Family Concern?			
Temperature (°F)	104		
	103		
	102		
	101		
	100		
	99		
	98		
	97		
	96		
	95		
	94		
Heart Rate (bpm)	190		
	180		
	170		
	160		
	150		
	140		
	130		
	120		
	110		
	100		
	90		
and Blood Pressure (mmHg) *	80		
	70		
	60		
	50		
Note: BP does not score in early warning scoring			
Heart Rate (Number)			
Resp. Rate (bpm) (Over 1 Minute) *	70		
	60		
	50		
	40		
	30		
	20		
	10		
Resp Rate (Number)			
Resp Distress	Mod/ Severe		
	None / Mild		
Receiving O ₂ (l/min)			
O ₂ Saturations (%)			
Conscious Level	Normal		
	Altered		
GCS *			
TOTAL SCORE			
Number of shaded boxes			
Pain Score			
Observer's Initials			

ACTIONS

NB: Scores 3 should be recorded overleaf

- Score 1 : Continue normal observation by staff nurse
- Score 2 : Shift in charge nurse to be informed and continue hourly observations
- Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.
- Score 4 : Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see
- Score 5 & 6 : Shift 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-00009752 IP26-00006968
 Master SHANKUR VIRANSH
 04-08-2025 0 Y 11 M 23 D (M)
 Dr. SINDHURA MUNUKUNTALA

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

FLUID CHART

Sheet No. :

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
22/7/22	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
	Total Intake :						Total Output :					
22/7/22	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm	DNS	20ml									
	06:00 pm	DNS	20ml									
	07:00 pm	DNS	20ml									
Total Intake :						Total Output :						
22/7/22	08:00 pm		20ml									
	09:00 pm	↑	20ml									
	10:00 pm		20ml									
	11:00 pm	DNS	20ml									
	12:00 am	↓	20ml									
	01:00 am		20ml									
Total Intake :						Total Output :						
23/7/22	02:00 am		20ml									
	03:00 am	↑	20ml									
	04:00 am		20ml									
	05:00 am	DNS	20ml									
	06:00 am	↓	20ml									
	07:00 am		20ml									
Total Intake :						Total Output :						
24/7/22	02:00 am		20ml									
	03:00 am	↑	20ml									
	04:00 am		20ml									
	05:00 am	DNS	20ml									
	06:00 am	↓	20ml									
	07:00 am		20ml									
Total Intake :						Total Output :						

Total 24 hrs. Intake

Total 24 hrs. Output

FLUID CHART

Sheet No. :

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
28/7/20	08:00 am	DNS		20ml		NA					160ml	P	
	09:00 am			20ml									
	10:00 am			20ml									
	11:00 am			20ml									
	12:00 pm			20ml									
	01:00 pm			20ml									
Total Intake :						Total Output :							
28/7/20	02:00 pm	DNS				NA					0	P	
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output : U - M -							
	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

Date: 27/7/26

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	Nurse Name & Signature
Morning							
Afternoon	5pm	- Assess the Pt Condition - monitor vitals to - monitor I/O chart - Medication Give as per drug chart	8pm	- Assess the Pt Condition - monitor vitals to - monitor I/O chart - Medication Give as per drug chart	It is stable	Re checked vitals	
Night	8pm	- Assess the Pt Condition - monitor vitals to - monitor I/O chart - Medication Give as per drug chart	8pm	- Assess the Pt Condition - monitor vitals to - monitor I/O chart	Patient is stable	Re Assessment vitals	

NURSING CARE RECORD

Date: 28/7.

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	Nurse Name & Signature
Morning	8am	Assess the pt-condition	8am	Assessed the pt-condition	Patient is stable now	Re-checked vitals	P
		- Monitor vitals & records - Maintain I/O chart - Give medication as prescribed by doctor		- monitored vitals & records - Maintained I/O chart - Give medication as prescribed by doctor			
Afternoon	2pm	Assess the patient condition	2pm	Assess the patient condition	Now patient is stable	Rechecked the v/s	Q
	10 am	- Monitor the v/s - Maintain the I/O - Drug as per chart	10 am	- Monitor the v/s - Maintain the I/O - Drug as per chart			
Night							



BRADEN 'Q' SCALE

					Date :	21/22/27/28	28/7/28/2		
					Time :	82	N1	M6	E2
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.	3	3	3	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.	3	3	3	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.	3	3	3	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.	3	3	4	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."	3	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.	3	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.	3	4	4	4	
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23									
Docu. No. : RCH /FRM / CLINICAL / 119									
					TOTAL SCORE				
					21 24 25 28				
					Evaluator's Name				
					[Signatures]				

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



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
29/7/26	6pm	0/10	NA	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☒ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	NA	M
22/7/26	8Am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Q
29/7/26	10pm	0/10	NA	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☒ Sharp ☐ Dull ☐ Aching ☐ Burning	☒ Increasing ☒ Decreasing	☒ Yes ☐ No	NA	J
28/7/26	10Am	0/10	NA	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☒ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	NA	R
28/7/26	2pm	0/10	NA	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☒ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	NA	R
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

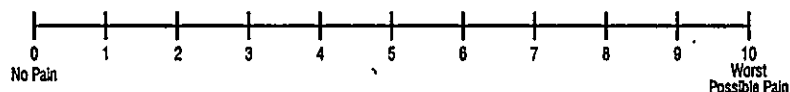
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

Numerical Pain Scale (Obstetric and Gynecology)



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

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

Wong - Baker (Pediatrics) Above 7 Years





NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:			
	AFJ & dehydration					
BACKGROUND	Area	Shift Time	22/7/26 E2	28/7/26 N1	28/7/26 M6	28/7/26 E2
	Medical Condition (Any special condition to be noted):		-	-	-	
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No ☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No ☐ Yes ☐ No
	Vital Signs:	Temp: 98.6°F	98.1°F	97.8°F	98.3°F	
	Res:	36b/m	36b/m	38b/m	32b/m	
	SpO ₂ :	99%	99%	100%	100%	
	Pulse:	132b/m	120b/m	138b/m	132b/m	
	BP:	-	-	-	-	
	Fall Risk Score:	-	-	-	-	
Recommendations	Safety Needs:	-	yes	yes	yes	
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No ☐ Yes ☐ No
	Others Specify:	-	-	-	-	
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No ☐ Yes ☐ No
	Other Special Orders / Medications:	-	-	-	-	
Post Operative Procedure Special Orders:		-	-	-	-	
Handed Over By Name :		Sumanda	Supriya	Priyanka	Sumanda	
Signature :						
Date:		28/7/26	28/7/26	28/7/26	28/7/26	
Time:		8pm	8pm	2pm	8pm	
Taken Over By Name :		Supriya	Priyanka	Sumanda		
Signature :						
Date:		28/7/26	28/7/26	28/7/26		
Time:		8pm	8am	2pm		

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

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

HNH-00009752 IP26-00006968
Master SHANKUR VIRANSH
04-08-2025 0 Y 11 M 23 D (M)
Dr. SINDHURA MUNUKUNTLA



3% NS
6th baby

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			
	12.00	3% NS		
	13.00			
	14.00			
	15.00			
	16.00			
	17.00			
	18.00			
	19.00			
	20.00			
	21.00			
	22.00			
	23.00			

Patient Sticker

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			
	12.00			
	13.00			
	14.00			
	15.00			
	16.00			
	17.00			
	18.00			
	19.00			
	20.00			
	21.00			
	22.00			
	23.00			

ADMISSION SHEET

Registration Details :



Admission No : IP26-00006968 Admit Date : 27-Jul-2026 Admit Time : 03:48 PM UHID : HNH-00009752

Patient Details :

Patient Name	: Master SHANKUR VIRANSH	Age	: 0 Y 11 M 23 D
Guardian	: Mr VINAY KUMAR	DOB	: 04-08-2025 02:57 PM
Gender	: Male	Religion	:
Occupation	:	Marital Status	:
Address (H)	: FLAT NO 401 PARK VIEW RESIDENCY BAGH AMBERPET Amberpet Hyderabad Telangana INDIA 500013	Phone No	: 9030334332/ 8801013656
		E-mail	: SHIVANI.G211998@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 VINAY KUMAR Relationship : Father
Contact Address : FLAT NO 401 PARK VIEW RESIDENCY BAGH
AMBERPET Amberpet Hyderabad Telangana
INDIA 500013 Phone No : 9030334332

Shivan
Signature

Doctor Details :

Doctor Name : Dr. SINDHURA MUNUKUNTLA Specialisation : GENERAL PEDIATRICS
Referral Doctor : Self. Phone No :
Co-Consultant :

Payment Details :

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

PATIENT TRANSFER FORM

Patient Name & UHID No. HNH-00009752 IP26-00006968 Master SHANKUR VIRANSH 0 Y 11 M 23 D (M) 04-08-2025 Dr. SINDHURA MUNUKUNTALA 		Date & Time of Admission 27/7/26 @ 3:48pm	Date & Time of Transfer Order 27/7/26 @ 5:15pm
		Transfer Ordered by Dr. Sreejan	Reason for Transfer Admission
From Unit ER	To Unit Salfroom / 3/10	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 18	Number of Imaging Films 2 X-ray + VBCU	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 Atanul		Name of Person Ordered Transfer Dr. Sreejan	
Patient & Clinical Records Received by : Sunanda @ 5.15 pm			
Date & Time of Patient Received :			

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

☐ Unavailable Bed

☐ Nurse not Available

☐ Available Bed not ready

ACTIVITY RECORD FOR BILLING

Name: ----- HNH-00009752 IP26-00006968 -----
 UHID No : -- 04-08-2025 0 Y 11 M 23 D (M) ----- Consultant : ----- Dept : -----
 Date of Admr  ----- Date of Discharge : ----- Time: -----
 Room / Bed No : 310 Ward : 3rd floor Suggested Billable bed type : -----

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
27/7/26	3:318pm	ER	3rd floor/310	A.P. / SA

Cross Consultation Visit

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

[illegible]

27/7/26

CBP: CRP

Blood cells

Respiratory panel

12731

Dengue NS1

x-ray chest

9215

V B V

12732

2401

MEDICAL EQUIPMENT (WARD & ICU)

[illegible]

PROCEEDURE

Date	Proceeedure	Quantity	Order No.	Signature
27/7/26	IV placemnt	(1)	17522	Me

ANY OTHER INFORMATION

28/7/26

Dont charge for NHA.

Syeda Sobiya Zaher
Dist. Officer

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 : VIRANSH/11 only

Patient ID# : _____

HNH-00009752 IP26-00006968
Master SHANKUR VIRANSH
04-08-2025 0 Y 11 M 23 D (M)
Dr. SINDHURA MUNUKUNTLA

Consultant : _____



Final Diagnosis : _____

Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Informant _____ Reliability _____

Chief Presenting Complaints & Duration (Chronologically):

(1) 1) Fever since 2 days

2) Decreased oral intake :: 2 days

3) Decreased urine output :: yesterday

4) Vomiting since yesterday

History of present illness :

Infant (VIRAMSHI) was apparently asymptomatic 2 days back after which he had fever which was high grade, intermittent associated with chills and not responding to oral paracetamol.

Multiple episodes of non-bilious, non-projectile vomiting
Containing food & mucus

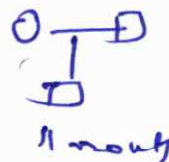
~~Both~~ Baby has decreased oral intake ^{2 days} and decreased urine output since yesterday

Pediatric Multiorgan History & Physical Examination

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

Birth & Neonatal History :

~~Task~~ Late preterm / 2-18kg / 25-35 / C I A B



Birth & Socio Economic History :

About Father :

About Mother :

Any additional Information :

Developmental History :

Нормал.

Immunization History :

4AP Schedule - up to-date

Pediatric Multiorgan History & Physical Examination

Anthropometry

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

Weight (kgs) 7.824 (Centile _____)

On Examination :

Temperature : 104.2°F Pulse Rate: _____ Description _____

B.P. _____ SPO2 _____ at _____

Resp. rate and type of breathing : _____

Rash _____

Lymphadenopathy _____

Oedema : _____

↓ skin turgor
dry oral mucosa
dry lips
dull look

Respiratory system :

Inspection (any s/o distress) : _____

Air entry & breath sounds : BLW ACF

Any added sounds : _____

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

Cardiovascular System :

Inspection of precordium : _____

Heart Sounds : S₁, S₂

Any murmur : _____

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

Per Abdomen :

Inspection _____

Palpation : PLA - 7/24

Auscultation : _____

Spine: _____ External Genitalia : undescended

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

Pediatric Multiorgan History & Physical Examination

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 Febrile Illness = dehydration

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment :

IV fluids

Desired goals of the treatment :

IV Antibiotics

Planned Labs :

CBP

CRP

Blood $\leq$

Resp. panel (CS virus)

Chest X-ray - PA view

Dengue NS 1

VBC

notes on @

Planned Management :

- 1nj. CEFTRIAXONE

750mg IV OD

- IVF DM @ 20ml

- Drop CROCIN 1m 6th L

- Symp. IBUGLIC 2m 12/8th

Monitor vitals

notes on @

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

6 PM



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
27/08/26 6 PM	C/L/B D. Sindhura Fever ⊕ para oral intake Op: All over vital signs stable Sign of dehydration ⊕ Note ⊕ Stable	
	Ref up to grade Patient crossing 10ml/kg/day output	Adm IV fluids Tag Ceftriaxone Suppository can Monitor vitals and Infusion set
		Final N/B Supp @ 6pm



IP26-00006968

04-08-2025

0 Y 11 M 23 D

(M)

Dr. SINDHURA MUNUKUNTLA



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



BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Date & Time	Progress Notes	Doctor's Order
28/7 9:00 AM	<u>CLB/13 Dr. Sindhu</u> SARS-Covid positive illness + dehydration. fever (+) oral intake - fair. Vitals - Stable RLS - B/L AEP B/L NVBS p1A - NAD	<u>Plan</u> - Symplocos SOS - Cont Zyrtec/lorazepam - Trace B/Ls Adenovirap Dengue NS1 - Monitor RR, SpO2 - watch for fever spikes - Neb C 3% NS Q6H
		Dr. Sindhu Antiviral

Date & Time	Progress Notes	Doctor's Order
1/7/26 2 PM	C/S/b Dr. Varun / Dr. Kapur Δ - SARS COV 2 +ve . E dehydration illness	
	fever spikes (+).	
	oral intake - fair.	
	O/E - vitals stable.	
	S/E - <u>WNL</u> .	



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 : Dmp. c Roety				Date Time															
Dose	Route	Frequency	Start Date																
1ml	oral	sos/6h	27/7																
Doctor's Signature		Valid Period	Pharm.																
Dr																			
Additional Instructions:																			
Paracetamol (5ml/2h)																			

DRUG : Syt. 9BUC GIC				Date Time															
Dose	Route	Frequency	Start Date																
2ml	oral	sos/6h	27/7																
Doctor's Signature		Valid Period	Pharm.																
Dr																			
Additional Instructions:																			
9BUPROFEN (5ml/100mg)																			

DRUG : CROCI DROPS				Date Time															
Dose	Route	Frequency	Start Date																
1ml	PO	Soc	28/7																
Doctor's Signature		Valid Period	Pharm.																
Dr																			
Additional Instructions:																			



REGULAR PRESCRIPTIONS

Weight. 7.87kg Ward.

DRUG : 7. j. CEFTRIAXONE				Date Time 27/7
Dose	Route	Frequency	Start Date	
750mg	IV	OD	27/7	
Name & Signature of the Doctor Starting the Drugs: B. Sangeetha				6pm 27/7 27/7
Additional Instructions: dilute in 20ml N give over 2 hours				
Daily Doctor's Endorsement by a Sign				
DRUG : Drop. CROCIN				Date Time 27/7
Dose	Route	Frequency	Start Date	
1ml	oral	6xL	27/7	
Name & Signature of the Doctor Starting the Drugs: B. Sangeetha				12p X 6pm 27/7 12Am X
Additional Instructions: Paracetamol (1mg/100mg)				28/7 STOP
Daily Doctor's Endorsement by a Sign				
DRUG : SYD. XYZAL				Date Time 27/7
Dose	Route	Frequency	Start Date	
2.5ml	PO	HS	27/07	
Name & Signature of the Doctor Starting the Drugs: S. Sangeetha				10pm 27/7
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
DRUG : Neb C 3Y. NS				Date Time
Dose	Route	Frequency	Start Date	
1 resp	Neb	Q6H	28/7	
Name & Signature of the Doctor Starting the Drugs: @				See the chart
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				



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

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

STAT / ONCE ONLY DRUGS[illegible]

Weight. 7-8 kg Ward.

[illegible]

HNH-00009752 IP26-00006968
Master SHANKUR VIRANSH
04-08-2025 0 Y 11 M 23 D (M)
Dr. SINDHURA MUNUKUNTALA




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


BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

MEDICATION RECONCILIATION FORM

Drug Allergies: None ☒ 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: 302 Room / 8/10

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. Sreejan

Date & Time: 27/7/26 @ 3:30 PM

Nurse Name & Signature: Amritha

Date & Time: 27/7/26 @ 3:30 PM

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



wt - 7.8kg

EMERGENCY ROOM TRIAGE FORM

Patient's Name : Vimansh Age : 11m Gender: ☒ Male ☐ Female

Date : 27/7/26 Time of Arrival : 8:40 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: 98.6°F PR: 125/min BP: 101/76(5) RR: 22/min SpO₂: 98%

Chief Complaints: c/o high grade fever since yesterday

INITIAL PHYSIOLOGICAL CATEGORIZATION

Appearance

☒ Normal

☐ Sick Looking

☒ Normal

Circulation / Colour

☐ Abnormal

☐ Bleeding

Work of Breathing

☒ Normal

☐ Decreased

☐ Increased

☐ Gasping / Apnea

INITIAL PHYSIOLOGICAL STATUS

☒ Stable

☐ Unstable:

☐ Not - Life - Threatening

☐ Life -Threatening

Triage Classification

☐ Level 1: Resuscitation

☐ Level 2: EMERGENT: Life or limb threatening

☐ Level 3: URGENT: Significant illness / injury with potential to become life or limb threatening

☐ Level 4: LESS URGENT: Significant illness but not life threatening

☐ Level 5: NON - URGENT: May receive care when convenient

CTAS

☐ Immediate

☐ < 15 min

☐ 30 min

☒ 60 min

☐ 120 min

NOTE: All immunocompromised children and preterm babies to be considered Level 2.

All Children less than 2 years age with high fever to be considered Level 3.

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian

Triage Completion Time : 8:42 PM

Communicable Disease Triage Screening

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

1. Have you had fever (elevated temperature) in the past 2 weeks ☐ Yes ☒ No
2. Have you had cough or a rash in the past 2 weeks ☐ Yes ☒ No
3. 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

1. 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:
2. 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 : Ampam

Signature of Triage Nurse : A.P.

Date & Time : 27/7/26 @ 8:45 PM



NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 27/7/26 Time of arrival : 3:40pm

Chief Complaints : low high fever since yesterday RBS : N/A

Height : Weight : 7.8 kg BMI : Head Circumference (<2 years) :

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

If yes, identify

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

☐ Character ☐ Location ☐ Frequency ☐ Duration

RISK FOR FALL:

- ☐ If patient is < 6 years
tick below fall risk intervention directly

- ☐ If Patient is > 6 years
Assess the below parameters

History of Falling: within past 3 months ☐ Yes ☒ No

Ambulatory Aids:

- Wheelchair ☐ Yes ☒ No
• Uses furniture for support ☐ Yes ☒ No

Gait/Transferring:

- Bedrest / immobile ☐ Yes ☒ No
• Weak ☐ Yes ☒ No
• Impaired ☐ Yes ☒ No

Mental Status: Forgets limitations ☐ Yes ☒ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening: ☒ No Abnormalities Detected

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

Inform consultant for positive criteria

Nutritional Screening: ☒ No Abnormalities Detected

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

Inform consultant for positive criteria

Psychological Screening: ☒ No Significant Findings

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

If Yes Consultant Notified: N/A (Date/Time): N/A

Social History: Lives With Family

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

Time of Initial assessment completed by ER Nurse : 3:45pm

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

Time	Nursing Notes
3:47pm	Assessed the patient condition vital checked.

Samples collected by:

Time:

Samples sent by :

Spoddi

Time:

4:5pm

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: 110b/m BP: 105/39mmHg CFT: - RR: 24/min SPO ₂ : 98% GCS: 15/15 Temperature: 98.3°F Pain Score: 0/1 Repeat RBS (if applicable): N/A	Shift - out from ER to: 310/3rd floor. Time of Shift - out: 5:15pm. Handover given to: Supander (Nurse's Name)

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any):

IV Phacemab 10u

Name of the Nurse : Anurupa

Signature of the Nurse : A.12

Date & Time : 27/7/20 @ 3:45pm

MASTER SHANKU, RAINBOW CHILDREN'S HOSPITAL, HIMAYATHI MARGAR
 RAINBOW CHILDREN'S HOSPITAL, HIMAYATHI MARGAR

