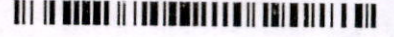


ADMISSION SHEET

Registration Details :



Admission No : IP5-00173847

Admit Date : 15-May-2026

Admit Time : 12:22 AM

UHID : KUH-00184417

Patient Details :

Patient Name : Master ADITYA G

Age : 1 Y 4 M 19 D

Guardian : Mr G V PRAVEEN

DOB : 26-12-2024 06:47 PM

Gender : Male

Religion :

Occupation :

Martial Status : Single

Address (H) : HABSIGUDA 1-57/1 JSN COLONY STREET -8
Habsiguda Hyderabad Telangana INDIA
500007

Phone No : 8686575211 / 9819529036

E-mail : deepthi009@gmail.com

Admission Details :

Bed Type : PRIVATE ROOM

Bed No : PVT 235

Ward Name : 2F-SECOND FLOOR

Room No : PVT 235

Admission Type : First Visit

Contact Details :

Name : Mr G V PRAVEEN

Relationship : Father

Contact Address : HABSIGUDA 1-57/1 JSN COLONY STREET -8
Habsiguda Hyderabad Telangana INDIA
500007

Phone No : 8686575211 / 9819529036

Signature

Doctor Details :

Doctor Name : Dr. FAISAL B NAHDI

Specialisation : GENERAL PEDIATRICS

Referral Doctor : Self

Phone No :

Co-Consultant : Dr. UJJWALA DESAI

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : ICICI LOMBARD GENERAL
INSURANCE CO LTD

ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____ Consultant: _____ Dept : _____

KUH-00184417 IP5-00173847
Master ADITYA G
28-12-2024 1 Y 4 M 19 D (M)
Dr. FAISAL B NAHDI

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



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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
14/5	12:50 AM	ER	235	(B)

Cross Consultation Visit

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

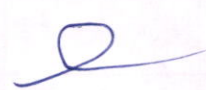


PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
15/5	IV Placement	①	8034	Samsky
15/5	NHA	①	9610097	Wounif

ANY OTHER INFORMATION

.....
 5 vials — ①

Date: 16/5/26 Time: 2:10am Prepared By: *Shithe*

Staff Nurse <i>Shithe</i>	Shift / Ward 	Billing Assistant 	Billing Supervisor 
----------------------------------	---	---	---



Rainbow[®] Children's Hospital

It takes a lot to treat the little.

PEDIATRIC IN-PATIENT MEDICAL RECORD

KUH-00184417 IP5-00173847
Master ADITYA G
28-12-2024 1 Y 4 M 19 D (M)
Dr. FAISAL B NAHDI



Patient Name: _____

UHID ID: _____

Department: _____

Consultant: _____

Pediatric Multiorgan History & Physical Examination

Name : Master Adithya G Age/Sex 1yr 4m / male
Information given by: Mrs Deepthi Relationship Mother

Chief Presenting Complaints & Duration (Chronologically)

Fever x 2 days.

Seizure @ 8:20pm on 14/5/28 (Today)

History of present illness :

Fever x 2 day

high grade, sudden onset, progressing gradually intermittent every 6-7hrs.
on Syb CROCW/Syb calpol 250. Preceded by 4 eps of normal stools on formula + solid (washed).
fb 1 episode of seizures at 8:20pm.

Seizure → Eye rolling.

froth small quantity from mouth.
lasted for 5-7min
hands flexed
not responding to name.

epi ended immediately after recovery.

NO H/O cold, cough, loose stools or rash.

Family history:

1^o cousins H/O febrile seizures

Taken to nearby hospital @ 8:30pm on 14/5

① PCM Rectal suppository

② Tab Paracetamol 5mg 1/2 tab } given.

CBP:

Hb-11.9.

WBC-9560'

Plate-2.41l

CRP

1.5

NIL- 37151



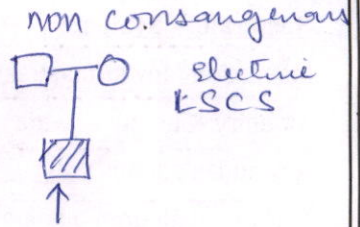
Pediatric Multiorgan History & Physical Examination

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

NO similar complaint in the past.

Birth & Neonatal History:

Normal Antenatal and Perinatal transition.



Birth & Socio Economic History:

About Father :

About Mother :

Any additional Information :

} upper middle

Developmental History :

Normal developmental history
all milestones adequate for age.

Immunization History :

Immunized till date @ IAP at RCH.



Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs)) 11.5kg (Centile _____)

On Examination :

Temperature : 100.0°F Pulse Rate : 110/min B.P. _____ SPO2 100% @ Room air

Resp. rate and type of breathing : 24/min , NO ↑ WOB .

Rash Diaper Rash

Lymphadenopathy Nil

Oedema : —

Allergies (if any): —

Respiratory System :

Inspection (any s/o distress) : Normal , Symmetrically moving

Air entry & breath sounds : BAE ⊕ , Airway clear

Any added sounds : No added sounds

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

Cardiovascular System :

Inspection of precordium : Normal

Heart Sounds : S1 S2 ⊕

Any murmur : Nil

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

Per Abdomen :

Inspection Normal , All quadrants moving c respiration

Palpation : Soft , Non tender

Auscultation : Bowel sounds heard

Spine : Normal External Genitalia : Normal

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



Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : 15/15

Cranial Nerves : Intact

Motor System:

Nutrition : Adequate

Tone: Normal Power 4/5

Co-ordinator : Well Coordinated

Posture : Normal

Involuntary Movements : Nil

Reflexes :

DTR +++ Superficials: +++

Plantars Elicited

Sensory System :

Intact

Bladder / Bowel : Urine output & stool output → (+)

Clinical Summary & Diagnostic:

Acute febrile illness with
1st episode of seizure



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: Debris, Seizures, dehydration

Desired goals of the treatment : Resolution

Planned Labs:

- CBP
- CRP
- Bld c/s
- LVE
- Urine c/s
- S viral Panel
- Sr. electrolytes

CRBS - 128 mg/dl
(outside 9:30pm)

MS Shauq
15/5/26

Planned Management

- INS CEFTRIAXONE
- ~~SYP~~ PARACETAMOL
(SYP CROCIN DS)
- IVF DNS @
- TAB FRISIUM 5mg $\frac{1}{2}$ tab
BP

DR. FAISAL B NAHDI
Registra... No: 66228

Signature of the Doctor: Sohel

Name of the Doctor: Dr. Soheli

Date & Time: 11:30pm 14/5/26

Signature of the Consultant: MS Shauq

Name of the Consultant: MS Shauq (Sur)

Date & Time: (MKN)

KUH-00184417 IP5-00173847
 Master ADITYA G
 28-12-2024 1 Y 4 M 19 D (M)
 Dr. FAISAL B NAHDI

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
13/5/26 8 AM	C/S/B Resident	
	A: AFI (D3) - first episode of seizure	
	2 fever spikes no further seizures	Adv:
	O/E: child alert stable vitals S/E: NAP	1) Continue IV Ceftriaxone (D4) 2) Trace CME / adenom Steph
15/5	Culd c' Ad. for ill	Plan:
Culd Culd Culd	E. Colud sym Culd ill	Adenom to have bpl

DR. FAISAL B NAHDI
 Registration No: 66228

KUH-00184417
 Master ADITYA G
 26-12-2024 1 Y 4 M 19 D (M)
 Dr. FAISAL B NAHDI



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
15/5	C/S/B Resident	
5:30 pm	Δ: AFI (P₃) - first episode of seizure	
	- 1 fever spike at 11 am - 102°F	Adv:
D/W	- poor intake	→ Trace adenovirus
MKN	- no further seizures	→ Temperature monitoring
(15/05)	O/E: alert	→ Encourage orally
(6 pm)	vitals stable	→ Decrease IVE
	chest clear	→ Meds as per chart
	abdomen soft	Stipule



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16/12/25	Seen by Resident	
2:30 AM	A1- AFI (D3) ⊖	First episode of seizure
	Fever spikes ⊕	Plan - - Continue medication as per chart
	c/o abdominal discomfort excessive crying	- Temperature monitoring - Syp- Cyclopam sos. 2.5ml
	Adenovirus - Not detected	- Monitor vitals and Inform sos
		Bharath INJ. BUSCOPAN 5mg stat INJ. PANTOPRAZOLE 10mg stat.
16/12/25 8:30 AM	Child c' AFI Day 4 of illness	Plan.
c/w	c' first episode of febrile seizure	⊕ Continue same medication.
(c/w):		⊙ Pmt CBP / CRP / WIDAL.
(c/w):	c/w fever	
	Viral panel negative - seen	

DR. FAISAL B NAHDI
 Registration No: 66228

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16/5 8am	<p>CS/B Resident</p> <p>Δ: AFI (D4) - first episode of seizure</p>	
<p>ME @ 5 viral negative</p>	<p>fever spikes: ongoing last at 2:30am.</p>	<p>Adv:</p>
	<p>oral intake better poor irritability (+) no further seizures O/E: child alert vitals stable chest clear abdomen soft</p>	<p>1) Continue IV Ceftioxone D2 Tab. Frisium D2</p> <p>2) Decrease IVF to 1/2 maintenance - 20ml/h. to cont.</p> <p>3) Trace urine & blood c/s</p>
		<p>Akhila</p>

KUH-00184417 IP5-00173847
 Master ADITYA G
 28-12-2024 1 Y 4 M 19 D (M)
 Dr. FAISAL B NAHDI



RESULT SHEET

Date	15/5				
Time	12:30am				
Hb	11.1				
PCV					
REC					
WBC	8950				
N/L	60/31				
Platelets	2.7/L				
CRP	5				
ESR					
PCT					
RBS					
Na	137				
K	4.5				
Cl	104				
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					

KUH-00184417 IP5-00173847
 Master ADITYA G
 28-12-2024 1 Y 4 M 18 D (M)
 Dr. FAISAL B NAHDI



MEDICATION RECONCILIATION FORM

Drug Allergies: Not known any Drug Allergies

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

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

Shifting From: ER Shifted to: 235

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						<input type="checkbox"/> C <input type="checkbox"/> DC
2						<input type="checkbox"/> C <input type="checkbox"/> DC
3						<input type="checkbox"/> C <input type="checkbox"/> DC
4						<input type="checkbox"/> C <input type="checkbox"/> DC
5						<input type="checkbox"/> C <input type="checkbox"/> DC
6						<input type="checkbox"/> C <input type="checkbox"/> DC
7						<input type="checkbox"/> C <input type="checkbox"/> DC
8						<input type="checkbox"/> C <input type="checkbox"/> DC
9						<input type="checkbox"/> C <input type="checkbox"/> DC
10						<input type="checkbox"/> C <input type="checkbox"/> DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : sahala

Date & Time : 15/5/2020 12 AM

Nurse Name & Signature: sahala Bhavani

Date & Time : 15/5/2020 12 AM

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 : CROCIN DS				Date
				Time
Dose	Route	Frequency	Start Date	
3.5ml	PO	SOS	14/5	15/5 16/5
Doctor's Signature		Valid Period	Pharm.	
Sohel				
Additional Instructions: 5ml - 240mg				
PARACETAMOL				

DRUG : Sup MEFTAL P				Date
				Time
Dose	Route	Frequency	Start Date	
5ml	PO	SOS	16/5	
Doctor's Signature		Valid Period	Pharm.	
[Signature]				
Additional Instructions: (5ml / 100mg)				

DRUG : IV. PARACETAMOL				Date
				Time
Dose	Route	Frequency	Start Date	
160mg	IV	SOS	16/5	
Doctor's Signature		Valid Period	Pharm.	
Bharath		48hrs		
Additional Instructions: If temp > 102°F Max 4 times a day				

VERIFIED BY : Name



REGULAR PRESCRIPTIONS

Weight. 11.5 kg Ward.

DRUG : INJ CEFTRIAXONE				Date Time	14/5	15/5	16/5															
Dose	Route	Frequency	Start Date																			
575mg	I.V	BID	14/5	10am	X	12:30am	16/5															
Name & Signature of the Doctor Starting the Drugs:				<u>Sohub</u>																		
Additional Instructions:				10pm <u>Dipco</u> <u>Rosmar</u>																		
Daily Doctor's Endorsement by a Sign				<u>S</u> <u>S</u>																		
DRUG : TAB FRISIUM				Date Time	14/5	15/5	16/5															
Dose	Route	Frequency	Start Date																			
1/2 tab	PO	BID	14/5	8am	X	12:30am	16/5															
Name & Signature of the Doctor Starting the Drugs:				<u>Sohub</u>																		
Additional Instructions:				8pm outside Mother <u>Dipco</u> <u>Rosmar</u>																		
Daily Doctor's Endorsement by a Sign				<u>S</u> <u>S</u>																		
DRUG : Inj PANTOPRAZOLE				Date Time	15/5	16/5																
Dose	Route	Frequency	Start Date																			
12mg	IV	OD	14/5	6am		12:30am	16/5															
Name & Signature of the Doctor Starting the Drugs:				<u>Sohub</u>																		
Additional Instructions:																						
Daily Doctor's Endorsement by a Sign				<u>S</u> <u>S</u>																		
DRUG :				Date Time																		
Dose	Route	Frequency	Start Date																			
Name & Signature of the Doctor Starting the Drugs:																						
Additional Instructions:																						
Daily Doctor's Endorsement by a Sign																						



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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
16/5	2:20PM	JUSTIN SUPPOSITORY	12.5mg. 1 supp.	P/R	[Signature]	Dipa 2:21 AM Rosnana
16/5	3:00AM	INJ. BUSCOBAN	5mg	IV	Bharath	Dipa 3:30 AM Rosnana
16/5	3:00AM	INJ. PANTOPRAZOLE	10mg	IV	Bharath	Dipa Rosnana 5am
16/5		Inj AVIL	0.5ml.	IV	[Signature]	[Signature]

Signature

VERIFIED BY [Signature]

KUH-00134417 IP5-00173847
 Master A. JIYA G
 26-12-2024 1 Y 4 M 19 D (M)
 Dr. FAISAL B NAHDI

16/5/26

Doc. No. : RCH/FRM/CLINICAL/125

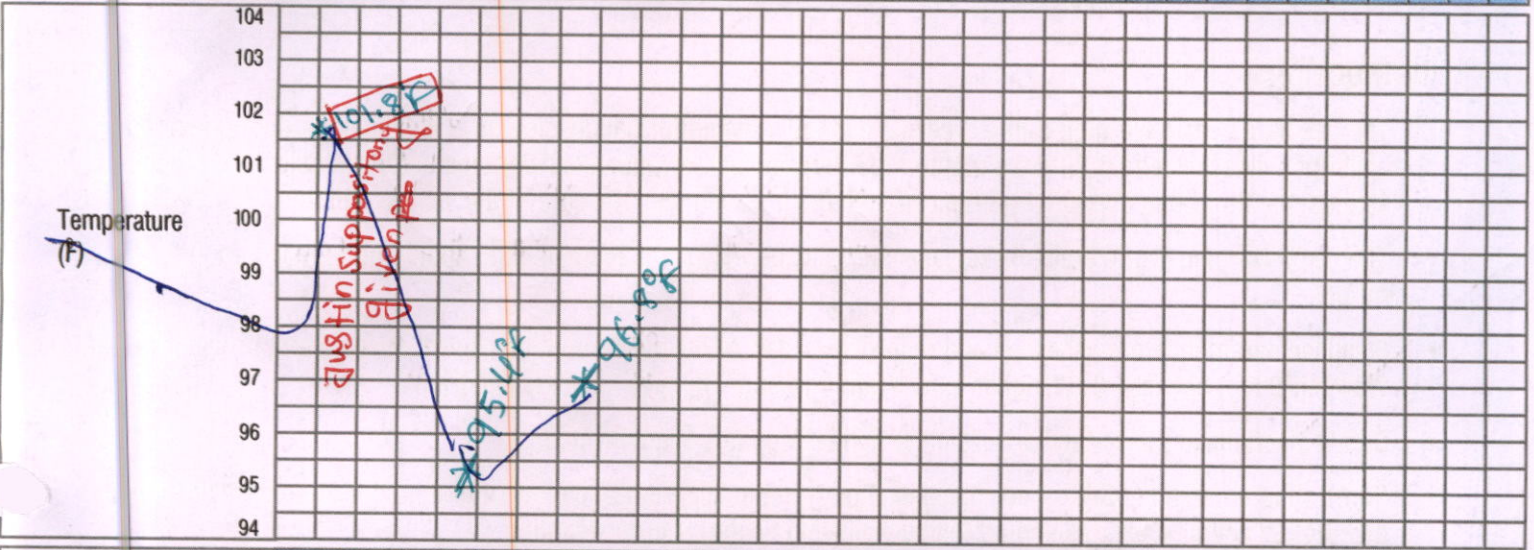
PRESCHOOL (1-5 years)
Children's Observation & Early Warning Scoring Chart



EARLY WARNING SCORE: CHILDREN'S UNIT

Date : Time: 2:20 AM ~~5 AM~~ ~~6 AM~~

Doctor / Nurse / Family Concern? _____



Heart Rate (bpm)	
and Blood Pressure (mmHg) *	
Note: BP does not score in early warning scoring	

Heart Rate (Number) 126 bpm

Resp. Rate (bpm) (Over 1 Minute) *	
Resp Rate (Number)	<u>28 / min</u>

Resp Mod/ Severe Distress None / Mild

Receiving O₂ (l/min) RA

O₂ Saturations (%) 98%

Conscious Level Normal / Altered C

GCS * 15/5

TOTAL SCORE Number of shaded boxes 0

Pain Score 0

Observer's Initials [Signature]

- 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.
- 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)

2 15/5/26

EARLY WARNING SCORE: CHILDREN'S UNIT

Date :	Time:	10Am	11Am	12pm	2pm	4pm	6pm	10pm	10:30pm	11pm	12:50Am	1:40Am
Doctor / Nurse / Family Concern?												
Temperature (F)	104											
	103											
	102											
	101											
	100											
	99	99.5 F	101.4 F	99.2 F	99.7 F	99.7 F	98.7 F	98.9 F	99.9 F	99.2 F	100.8 F	103.9 F
	98											
	97											
	96											
	95											
	94											
Heart Rate (bpm)	190											
and	180											
Blood Pressure (mmHg) *	170											
	160											
	150											
	140											
	130											
	120											
	110											
	100											
	90											
	80											
	70											
	60											
	50											
Note:												
BP does not score in early warning scoring												
Heart Rate (Number)		130b/m	132b/m	135b/m	129b/m							
Resp Rate (bpm) (over 1 Minute) *	70											
	60											
	50											
	40											
	30											
	20											
	10											
Resp Rate (Number)		26b/m	26b/m	23b/m	26b/m							
Resp Mod/ Severe Distress None / Mild												
Receiving O ₂ (l/min)												
O ₂ Saturations (%)		99%	99%	100%	99%							
Conscious Level Normal / Altered		C	C	C	C							
GCS *		15/15	15/15	15/15	15/15							
TOTAL SCORE												
Number of shaded boxes		0	0	0	0							
Pain Score		0	0	0	0							
Observer's Initials		B	B	B	B							

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

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

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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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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)

14/5/26

EARLY WARNING SCORE: CHILDREN'S UNIT

Date :	Time:	<u>2AM</u>	<u>3AM</u>	<u>4AM</u>	<u>6AM</u>
Doctor / Nurse	Family Concern?				
Temperature (F)	104				
	103				
	102				
	101				
	100				
	99				
	98				
	97				
	96				
	95				
	94				
Heart Rate (bpm)	190				
	180				
and Blood Pressure (mmHg) *	150				
	140				
Note: BP does not score in early warning scoring	130				
	120				
	110				
	100				
	90				
	80				
	70				
	60				
	50				
	Heart Rate (Number)		123B/m	120B/m	118B/m
Resp. Rate (bpm) (Over 1 Minute) *	70				
	60				
Resp Rate (Number)	50				
	40				
	30				
	20				
	10				
			28B/m	24B/m	26B/m
	Resp Distress	Mod/ Severe None / Mild			
	Receiving O ₂ (l/min)				
	O ₂ Saturations (%)		99%	100%	100%
	Conscious Level	Normal Altered	c	c	c
GCS *		15/15	15/15	15/15	
TOTAL SCORE		0	0	0	
Number of shaded boxes		0	0	0	
Pain Score		0	0	0	
Observer's Initials		<u>FA</u>	<u>FA</u>	<u>FA</u>	

100.7

102.2

99.7

98.3

SYP. COBIPROX given

ER

106 (71)
59

96 (81)
65

109 (75)
58

ACTIONS

NB: Scores 3 should be recorded over leaf

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

KUH-00184417 IP5-00173847
 Master ADITYA G
 28-12-2024 1 Y 4 M 19 D (M)
 Dr. FAISAL B NAHDI

FLUID CHART

Sheet No. :

- 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 Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
	02:00 pm											
	03:00 pm											
	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			30ml						0	Rosny	
	03:00 am			30ml					✓	0	Rosny	
	04:00 am			30ml			✓			0	Rosny	
	05:00 am			30ml					✓	0	Rosny	
	06:00 am			-					✓	0	Rosny	
	07:00 am			30ml					✓	0	Rosny	
Total Intake :			150ml			Total Output :					M1-U-3	
Total 24 hrs. Intake		150ml		Total 24 hrs. Output		M1-U-3						

15/5/20

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		
	08:00 am	↓		30ml					✓	0	Sudathir	
	09:00 am	↓	Idly	30ml			✓	⊗		0	Sudathir	
	10:00 am	DNS	Idly	30ml						0	Sudathir	
	11:00 am	↓		-						0	Sudathir	
	12:00 pm	↓		-				✓	✓	0	Sudathir	
	01:00 pm	↓		30ml						0	Sudathir	
Total Intake :				120ml		Total Output : M1 - U-2						
	02:00 pm	↓		30ml						0	monika	
	03:00 pm	↓	Rice	30ml					✓	0	monika	
	04:00 pm	DNS	Idly	30ml						0	monika	
	05:00 pm	↓		30ml			✓			0	monika	
	06:00 pm	↓		-					✓	0	monika	
	07:00 pm	↓		-						0	monika	
Total Intake :				120ml		Total Output : M1 - U-2						
	08:00 pm	↓	1 full	20ml						0	Rosny	
	09:00 pm	↓	Refrang	30ml			✓		✓	0	Rosny	
	10:00 pm	DNS		-						0	Rosny	
	11:00 pm	↓		-						0	Rosny	
	12:00 am	↓		-					✓	0	Rosny	
	01:00 am	↓		-						0	Rosny	
Total Intake :				40ml		Total Output : M1 - U-2						
	02:00 am	↓		-						0	Rosny	
	03:00 am	↓		-			✓		✓	0	Rosny	
	04:00 am	DNS		-			✓			0	Rosny	
	05:00 am	↓		-				✓		0	Rosny	
	06:00 am	↓		-						0	Rosny	
	07:00 am	↓		-					✓	0	Rosny	
Total Intake :						Total Output : M1 - U-3						

Total 24 hrs. Intake : 280ml

Total 24 hrs. Output : M1 - U - 9

KUH-00184417 IP5-00173847
 Master ADITYA G
 26-12-2024 1 Y 4 M 19 D (M)
 Dr. FAISAL B NAHDI



16/5/24



FLUID CHART

Sheet No. :

- 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 Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
	02:00 pm											
	03:00 pm											
	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 :						

[Handwritten signature]

Total 24 hrs. Intake

Total 24 hrs. Output

Patient Sticker

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			
	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

235

NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 15/5/26 Time: 10:00 am

Weight: 11.5 kg Centile: 72.5th

Height: 83 cm Centile: 77.5th

Inference: Well child

RDA: - Calories: 1200 kcal/d Protein: 2.0 g/d

Diet Recommendations: Soft Diet

Re-Assessment: Avoid spicy, chilled, outside foods

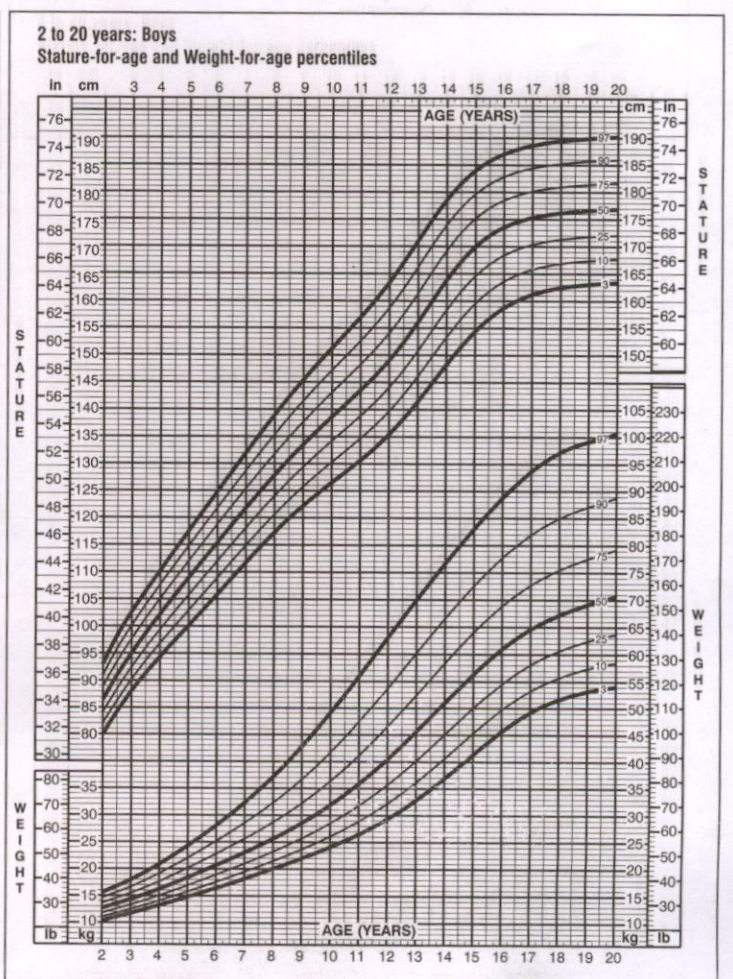
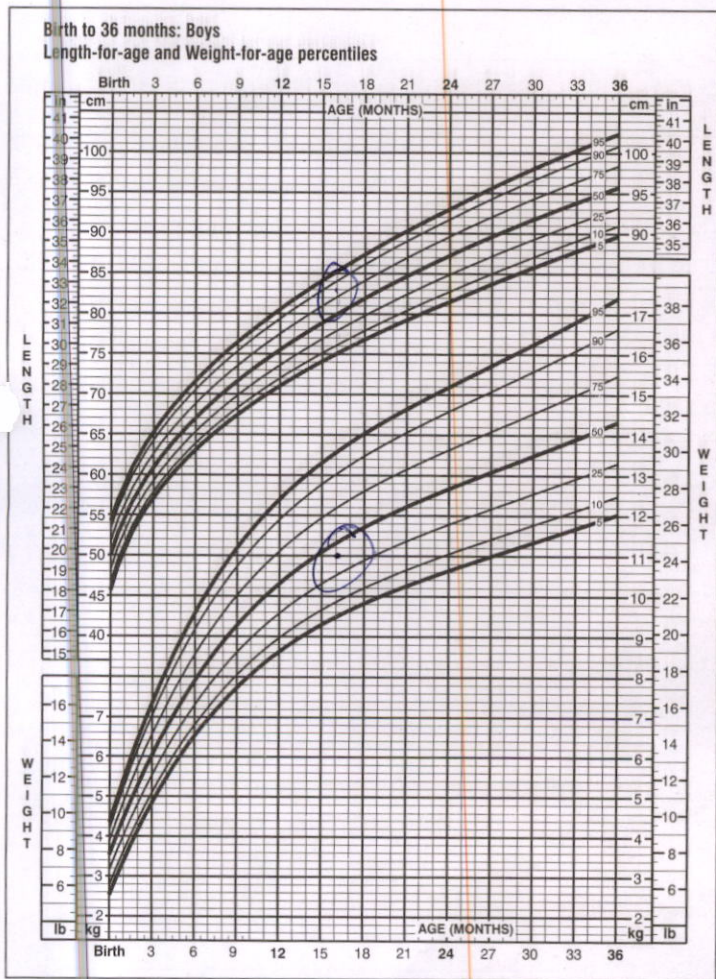
Food Allergies: No Veg/Non-veg Non-veg.

Diagnosis: API e 1st episode febrile seizures

Nutritional Intervention - Oral Enteral Parenteral

Patient's Signature: Deeptha

GROWTH CHART (BOYS)



Dietician's Name: Moulica

Dietician's Signature: Moulica

