

ADMISSION SHEET

Registration Details :



Admission No : IP5-00175779

Admit Date : 30-Jun-2026

Admit Time : 03:39 PM UHID : BAH-00659027

Patient Details :

Patient Name : Baby FAIZA SOUMAINE IBED
Guardian : Mrs SOUMAINE IBED
Gender : Female
Occupation :
Address (H) : PARAMOUNT Tolichowki Hyderabad
Telangana INDIA 500008

Age : 12 Y 8 M 20 D

DOB : 10-10-2013

Religion :

Marital Status : Single

Phone No : 7893725455

E-mail : NA@GMAIL.COM

8790067170

Admission Details :

Bed Type : SEMI PRIVATE

Bed No : SPVT 109

Ward Name : 1F-VIBGYOR

Room No : SPVT 109

Admission Type : First Visit

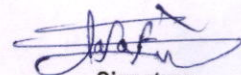
Contact Details :

Name : Mrs SOUMAINE IBED

Relationship : MOTHER

Contact Address : PARAMOUNT Tolichowki Hyderabad
Telangana INDIA 500008

Phone No : 7893725455


Signature

Doctor Details :

Doctor Name : Dr. M N V POUHYA SAI

Specialisation : PEDIATRIC GASTROENTEROLOGY AND
HEPATOLOGY

Referral Doctor : Self

Phone No :

Co-Consultant :

Payment Details :

Payment Mode : Cash

Deposit Amount : 0.00

Payor Name : SELFPAY

Karna form
300mg (1.10 pm)

BAH-00659027 IP5-00175779
 Baby FAIZA SOUMAIN IBED
 10-10-2013 12 Y 8 M 20 D (F)
 Dr. M N V POUISHYA SAI

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

ACTIVITY RECORD FOR BILLIN

Name : _____

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

Date of Admission: _____ Time : _____ Date of Discharge : 7/7/26 Time: _____

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
30/6/26	4:40pm	ER	109	<i>[Signature]</i>

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	Dr. sneha kul	<u>7/7/26</u>	82998	Neel's
2	Dr:- Venkat Ramsir	<u>04/07/26</u>	9687401	Shafiq
3				
4				
5				
6				
7				
8				
9				
10				

INVESTIGATIONS

[illegible]

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
30/06	iv placement	①	81225	T. snare
30/6	RNA	①	961338	Appu

ANY OTHER INFORMATION

CXR : ①
USG : ①

Date : 24/7/26 Time : 2pm Prepared By : Shainy

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
Shainy	11/3402		

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Age : 12 Y 8 M 22 D

Guardian : Mrs SOUMAINE IBED

DOB : 10-10-2013

Gender : Female

Religion :

Occupation :

Martial Status : Single

Address (H) : PARAMOUNT Tolichowki Hyderabad
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Contact Details :

Name : Mrs SOUMAINE IBED

Relationship : MOTHER

Contact Address : PARAMOUNT Tolichowki Hyderabad
Telangana INDIA 500008

Phone No : 7893725455

Signature

Doctor Details :

Doctor Name : Dr. M N V POUSHYA SAI

Specialisation : PEDIATRIC GASTROENTEROLOGY AND
HEPATOLOGY

Referral Doctor : Self

Phone No :

Co-Consultant : Dr. Prashant Bachina

Payment Details :

Payment Mode : DC/CC Card

Deposit Amount : 40000.00

Payor Name : SELF PAY

*Added
Co-consultant
Please add
him in
Case sheet*

Patient Sticker
 Paiza Samir Israel
 Date-00659027
 109

DEFICIENCY CHECK LIST OF CASE SHEET

Sl.No.	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission sheet	1			
2	Discharge Summary	1			
3	Nursing Initial assessment	1			
4	Patient Transfer form	1			
5	In-patient Medical record	1			
6	Doctors progress sheets	5			
7	Nursing plan of care and handover sheets	6			
8	Consultation sheet	2			
9	General consent for treatment	1			
10	Consent for Surgery				
11	Consent for blood transfusion				
12	Consent for chemotherapy				
13	Consent for high risk				
14	Consent for Restraint				
15	LAMA consent				
16	Consent for special procedure / Sedation				
17	Consent for Formula feed				
18	Consent for MTP				
19	Consent for Radiological Investigations				
20	Consent for HIV test				
21	Anaesthesia notes (Pre Anaesthesia& post)				
22	Neonatal Admission/Delivery/Physical Exam				
23	Medication Reconciliation	1			
24	Emergency Triage record	1			
25	Pre operative check list				
26	Surgical safety checklist				
27	Operation Theatre notes				
28	Nurses clinical Presentation				
29	TPR & BP chart	5			
30	Intake and Out take chart (fluid chart)	4			
31	Drug chart (Regular Prescription)	1			
32	Investigation Values (result sheet)	1			
33	Nebulization chart				
34	Nutritional review chart	1			
35	Intensive care unit (ICU Charts)				
36	Consent for Admission in PICU / NICU				
37	The Humpty dumpty scale	1			
38	Braden Q Scale	1			
39	Bed side check list	1			
40	PICU bed formula Dilution feeds				
41	Gastro monitoring chart				
42	Rch ED doctors note				
43	BP Monitoring chart				
44	RBS monitoring chart				
	Extra	4			
	Total No. of Pages	36			

ERROR LOG

LOCATION : OT / Birthing Centre / BirthRight Premium / 3rd Floor (Zone A,B,C) / NICU / PICU /
2nd Floor Ward / Oncology / 1st Floor Wards.

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE



It takes a lot to treat the little.

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name:

Faiza

UHID ID:

BAH-00859027 IP5-00175779
Baby FAIZA SOUMAINE IBED
10-10-2013 12 Y 8 M 20 D (F)
Dr. M N V POUISHYA SAI

Department:



Consultant:

BAH-00659027

IP5-00175779

Baby FAIZA SOUMAIN IBED

10-10-2013

12 Y 8 M 20 D (F)

Dr. M N V POUISHYA SAI



Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

Abdominal pain since 3 months.

vomitings since 9 months.

Pain while passing urine since 2 weeks.

Red coloured urine for 3 days ago.

History of present illness :

Child is a follow up case of Constipation / Gastritis



Now came for further management

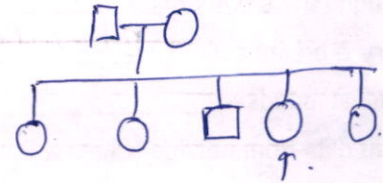


Pediatric Multiorgan History & Physical Examination

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

Birth & Neonatal History:

NVD / Lt Not known / NO H/O NICU stay.



Birth & Socio Economic History:

About Father : _____
About Mother : _____
Any additional Information : _____
} upper middle class.

Developmental History :

② development

Immunization History :

g



Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs)) 29.7kg (Centile _____)

On Examination :

Temperature : 98.2°F Pulse Rate : 106/min B.P. 103/58(73) SpO2 99% on RA

Resp.rate and type of breathing : RR = 22/min

Rash _____

Lymphadenopathy _____

Oedema : nil

Allergies (if any): _____

Respiratory System :

Inspection (any s/o distress) : _____

Air entry & breath sounds : BILAE+

Any addes sounds : _____

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

Cardiovascular System :

Inspection of procordium : _____

Heart Sounds : S1S2+

Any murmur : _____

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

Per Abdomen :

Inspection _____

Palpation : Soft, NT

Ausculation : _____

Spine : _____ External Genitalia : _____

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



Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : 2

Cranial Nerves : N

Motor System:

Nutriton : 2

Tone: N

Power

Co-ordinator :

Posture :

Involuntary Movements :

Reflexes :

DTR

Superficials:

Plantars

Sensory System :

Bladder / Bowel : N

Clinical Summary & Diagnostic:

Constipation & Acute gastritis .



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: _____

Desired goals of the treatment : _____

Planned Labs:

S-Electrolytes _____
CBP _____
ESR _____
CRP _____
Urea, Creatinine, LFT, GGT,
INR _____
Albumin _____
N.B. Israil 30/6/26

Planned Management

Mucot powder
Syp. Smutur
Syp Domstel
Syp Par.

Signature of the Doctor: Ramyx

Name of the Doctor: Dr. Ramya

Date & Time: 30/6/26; 3:50 pm

Signature of the Consultant: Refer

Name of the Consultant: _____

Date & Time: 30/6/26 4PM



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
30/6/26	q/s B has no team	
3pm	AS - constipation	
	Stools -	
	anal hole - S	Plan
	up ✓	
	Abd pain on R of	① cert laxative
	o/s intake nals	② + high fiber diet
	Ampt	③ intake charty
	AS ④	④ 1/2 @ fluids
	no tenderness	⑤ Enema orally.
		⑥ Trace order.
		⑦ R/L adding cyp citel-vel.
repeat	12-15 E/fth cells	repeated
28/6	4-6 pm cells	→ vomite - to be
	RBCs 1-2	recorded.
28/6	upst	
	mild fecal body g	
	when	

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
01/08/26 9AM	C/S/B - Gastro Team.	
	<u>Consultation</u>	<u>Plan</u>
	Stool - Passed stool.	ix Drugs as per chart -
	vomiting. 2 episode ^{today} momy	→ Psychiatrist consultation
	O/E - Hemodynamically stable.	Dr. Nitya for eating disorder
	P/A - soft.	or Dr. Sneha.
	CNC - N/A	3x
	Mild tenderness.	
	Undigested / semi digested food.	
referred	referred	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	O/D	
	1x Eosinophilic esophagitis	Biopsy - Report not available
	2x H. pylori gastritis	
	3x ??? TB	
	4x R/O SMA syndrome	
	C/I/B. Dr. Praharb. B.	
		<u>Plan</u>
	Hemodynamically stable	1x B/C/S & WE now
	Chest clear	2x Talk to parents
	P/A - Soft, BS (+)	↓
		Re-eval To discuss regarding repeat upper GI endoscopy w/ + biopsy
		Starting steroids
		3x Drugs as per chart.
		4x IV fluids - 2/3 mF (+)



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
02/07/20 5PM	45/8 - gastro team.	
	Hemodynamically stable	Plan
	P/A - soft CML - hard.	Drugs as per chart
	No tenderness.	ex monitor vitals
	Patient denying for repeat Endoscopy	3x Plan to start steroids T/M
	40/10 - Dr. Pouishya.	4x Trace - B/ds
	Plan to start steroids T/M	5 COE report
	3 episode Vomiting food particle.	Dr. Kanef
	90 pain in @ thigh. pelvis / knee.	
	limp while walking	
	afternoon.	

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/12/26 11 AM	CKSB has no team No pain 2 of 9 Vom yesterday. Abd pain (e) No pain in Rt U. (thigh) tenderness (e) Response to PPI (+) ① Pain in Rt U. = 1 yr. (thigh) on & off. when pain, has analgic felt. ② Family Hx of B → Neg. ③ Anal Viscer/fume part 1. Overns / Affair BPT Neg Neg history. ④ Not loss history ⑤ Constipation severity → no blood in stool part H/O (+) → hard stools / diff. in during stools. ⑥ Stooling → upling Intermittent constipation ⑦ Abd pain location. → 1 yr. ↑ after eating food, vomiting. also after eating vomits on everyday → immediately after eating.	Plan 1) OSA. of Rt lower limb. (? myositis) ; Xray of Rt thigh, C hip joint 2) CPE to be sent 3) Vit D₂, ca, Poy³ - 25, OH } now 4) Xray of Pelvis (B/L hip joint) B/L thigh & knee joint Stashenrip

[illegible]

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/2/20		
3:50pm	Ys/B Gashes <u>team</u>	
	No fura.	
	Vom - twice (small qty)	Plan
	stools - twice.	1) <u>Went</u> medic ⁿ as per chart
	anal not $\downarrow$.	2) Dr. Sheba to see the child today
	o/E	3) <u>Embrace</u> orally.
	Vitals stable	4) Vitals <u>charting</u>
	Plasop.	
	BS @	
<u>reflex</u>		<u>reflex</u>
		<u>reflex</u>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
02/07/26 9 AM	C/S/B - Gastro Team	
	Issue: ① Vomiting persistent - after food intake, small quantity, NB/NP -	
	② Pain abdomen - intermittent. more morning times	
	③ Appetite - low to fair.	
	④ weight loss - 8.	
29/07/26	UGI Endoscopy - D ₂ Narrowing (scope passed). Nodularity - Du. RUT - Hypyloni Gastritis	
	Colonoscopy - Terminal ileum - Nodularity. Sigmoid colon - ulcer.	
	CT Enterography - Terminal ileum - Mild mucosal enhancement.	
	ESR - 8	A/p constipation ①.
	Albumin - 4.6	Psychosocial -
	fecal calprotectin - ②	↓
	ANCA $\begin{cases} \text{MPO} \\ \text{PR3} \end{cases}$ Negative.	No significant disorder noted.
	ANCA $\begin{cases} \text{IgG} \\ \text{IgA} \end{cases}$ Negative.	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
04/07/26	CLB - Galbro Team.	→ Dairy of wheat diet.
	Recurrent vomiting /	Recurrent ? GGD's
	Pain abdomen & evaluation	2. Re Incomplete treated H. pylori
		Plan Gasmb
	Vomiting - twice.	1. Drugs as per chart
	Stool - 2	
	oral intake - ↑	2. Continue steroids
	pain abdomen - c/o twice	3. Pain killer sol., if c/o.
		leg pain.
	o/c. Hemodynamically stable.	
	Chest clear	4. Dr. Venkat Ramm consultation
	P/A - soft,	L in v/o leg pain
	No tenderness.	5. monitor vitals
	No Distension.	6. (R) Knee - HRUS.
		RTV CPK levels, (L) MRI thigh.
	(R) leg dragging pain.	c Knee/Hip. Dr. K
	(+) pain in hip & knee	
	(R)	
	o/c. (R) Knee & (R) Hip tenderness (+).	
	Tenderness in (R) thigh.	Abduction - Painful.
	ROM - Hip - Painful flexion > 120°; IR/ER (0)	Extension - 2
	Knee - Painful flexion & extension	Mild swelling (+)
	SLRT (R) (L)	Patellar ballotability (+)
	60 90°	

Probably
 2° to
 irritation of
 flexor hip
 m/c &
 knee flexors

[illegible]

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 Dr. M N V POUISHYA SAI



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RESULT SHEET

Date	30/6	37			
Time					
Hb	13.6				
PCV	40.9				
RBC	4.86				
WBC	4.13				
N/L	42/53				
Platelets	293				
CRP	5				
ESR	23				
PCT					
RBS					
Na	138				
K	4.9				
Cl	101				
Ca/Mg		9.6			
Phosphate		3.9			
Urea	12				
Creatinine	0.5				
ALP					
SGPT	16				
SGOT	21				
T.Bill/Conj	0.4/0.1				
T.Protein					
S.Albumin	4.7				
S.Globulin	3.6				
A/G Ratio	1.3				
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein / Sugar					
Cells					
WBC CPK		33			



CROSS CONSULTATION FORM

Doctor Name : Dr. Venkat Ram Dhyally Date : _____ Time : _____

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 :

Dr. J. Raju

Dr. Poudyal

Reaction antihist. 9 @ 10 /
ghated segn.

1/2 hyge - (R) u.
(10) days
month

Admisi
Rempe (10) gm in 100

to be
feverful / earlier hyge
12 ip mount
scab
tu

Consultant :

Name : Dr. Venkat Ram Dhyally Signature : Dr. Venkat Ram Dhyally Date & Time : 12/10/2013

2

(1) T. Chymed fl $\xrightarrow{\quad}$ (4) dym

(2) T. Flexon - one

$\frac{1}{2} - \frac{1}{2} - (3) An$

(3) T. Lincee $\xrightarrow{\quad}$

(10) dym

(4) Jack 0-36r with one /

(6) Recher

✓



CROSS CONSULTATION FORM

Doctor Name : Dr. Srujan Kulkarni Date : 11/7/2026 Time : 4:40 p.m

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 :

history noted. , thanks for referral .
 → child reports → vomiting - 6-7 episodes/day
 after eating .
 - TDI ~ 9 mts
 → no h/o purging
 → feels an urge to vomit.
 → cannot control. Significant
 wt loss ⊕
 → functioning impaired .
 → currently → episodes ↓ 1-2 / day .
 → so the child did not report any stressors .
 → ⊕ family h/o → mother - ? anxiety & lo.
 → child did not report any signs of anxiety
 or depression .
 → no thoughts of negative body image / etc.

Consultant :

Signature : Date & Time :

Adult

→ child needs detailed psychological evaluation



difficult to establish the rapport due to language barrier

→ Currently no psychopathology noted.

→ No acute psychological/psychiatric intervention required.

→ Review SOS.

Shely.

Dr. Sucha Kulkarni

BAH-00659027

IP5-00175779

Baby FAIZA SOUMAINÉ IBED

10-10-2013 12 Y 8 M 20 D (F)

Dr. M N V POUISHYA SAI

Patil



MEDICATION RECONCILIATION FORM

Drug Allergies:

☐ Not known any Drug Allergies

Medication Reconciliation will be done at the time of admission and also whenever there is change in the treating team or shifting from one unit to another unit.
 (Example: at the time of admission shifting from ICU to Ward, or Ward to ICUs)

Shifting From: ER

Shifted to: Ward

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1						☐ 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. Ramya

Date & Time: 30/6/26 3:30pm

Nurse Name & Signature: Submita

Date & Time: 30/6/26 @ 4:30pm



DRUG CHART

Date of Admission: 30/6/26 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 : <u>CROUN DS SUPRIN</u>				Date Time															
Dose <u>9mc</u>	Route <u>PO</u>	Frequency <u>6thly</u>	Start Date <u>30/6</u>																
Doctor's Signature <u>[Signature]</u>		Valid Period <u>✓</u>	Pharm. <u>✓</u>																
Additional Instructions: <u>5:40pm mediv</u>																			

DRUG : <u>SYP IBOA ESIC</u>				Date Time															
Dose <u>12ml</u>	Route <u>PO</u>	Frequency <u>q8h</u>	Start Date <u>3/7</u>																
Doctor's Signature <u>[Signature]</u>		Valid Period	Pharm.																
Additional Instructions:																			

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

Weight. 29.7kg Ward.

VERIFIED

Daily Doctor's Endorsement by a Sign

Daily Doctor's Endorsement by a Sign

Daily Doctor's Endorsement by a Sign

Daily Doctor's Endorsement by a Sign

VERIFIED

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 Dr. M N V POUHYA SAI



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

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 BY RAINBOW HOSPITALS
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Sheet No:

REGULAR PRESCRIPTIONS

Weight Ward

DRUG: <u>ly Ondansetron</u>				Date/Time	1/7															
Dose	Route	Frequency	Start Dt.																	
4mg	IV	BD	01/07																	
Name & Signature of the Doctor Starting the Drugs:				Dr. Kumar Dr. Kumar 01/07/20 change dose																
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG: <u>LYP. SUCRALFATE</u>				Date/Time	1/7	2/7	3/7	4/7												
Dose	Route	Frequency	Start Dt.																	
7ml	PO	TID	01/07																	
Name & Signature of the Doctor Starting the Drugs:				Kumar 20mg 100mg 100mg 100mg																
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG: <u>LYP. EMUTH</u>				Date/Time	1/7	2/7	3/7													
Dose	Route	Frequency	Start Dt.																	
15ml	PO	OD H/S	30/1/7																	
Name & Signature of the Doctor Starting the Drugs:				Dr. Pouchya Sai 100mg 100mg 100mg 100mg																
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG: <u>LYP. DOMSTAL</u>				Date/Time	1/7	2/7	3/7	4/7												
Dose	Route	Frequency	Start Dt.																	
6ml	PO	TID	30/1/7																	
Name & Signature of the Doctor Starting the Drugs:				Dr. Pouchya Sai 20mg 100mg 100mg 100mg																
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

Sheet No:

REGULAR PRESCRIPTIONS

Weight Ward

DRUG : ORAL T. METRONIDAZOLE Date 3/7 Time 4/7

Dose	Route	Frequency	Start Dt.
	<u>PO</u>	<u>TID</u>	<u>01/06</u>

Name & Signature of the Doctor Starting the Drugs:
Dr. Kunal

Additional Instructions:
400mg - 200mg - 400mg
1 tab - 400mg

Daily Doctor's Endorsement by a Sign

DRUG : INJ. ONDANSETRON Date 3/7 Time 4/7

Dose	Route	Frequency	Start Dt.
<u>4mg</u>	<u>IV</u>	<u>TID</u>	<u>02/06</u>

Name & Signature of the Doctor Starting the Drugs:
Dr. Kunal

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG : 1mg METHYLPREDNISOLONE Date 3/7 Time 4/7

Dose	Route	Frequency	Start Dt.
<u>1mg</u>	<u>PO</u>	<u>BD</u>	<u>3/7</u>

Name & Signature of the Doctor Starting the Drugs:
Dr. Kunal

Additional Instructions:
15mg

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



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
21.2	1.30 PM	3mg. PARACETAMOL	300mg	PO	[Signature]	Neelish Pillay
		Tab. 100mg				



Weight. 29.7kg Ward.

[illegible]

Signature

VERIFIED BY: Name



TEENAGE (12 + years)

Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 4/1/20 Time:

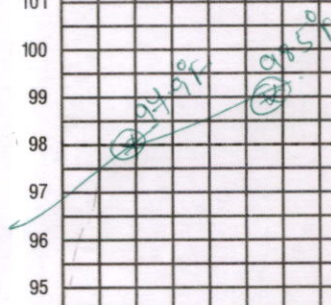
Doctor / Nurse / Family Concern?

2 AM

6 AM

Temperature
 (°F)

104
103
102
101
100
99
98
97
96
95
94



Heart Rate
 (bpm)

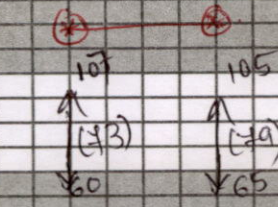
and

Blood Pressure
 (mmHg) *

Note:

BP does not score
 in early
 warning scoring

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



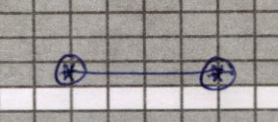
Heart Rate (Number)

109bpm

111bpm

Resp. Rate (bpm)
 (Over 1 Minute)

70
60
50
40
30
20
10



Resp Rate (Number)

21bpm

26bpm

Resp Mod/ Severe
 Distress None / Mild

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

100%

100%

Conscious Normal
 Level Altered

GCS *

15/5

15/15

TOTAL SCORE

Number of shaded boxes

1

1

Pain Score

6

6

Observer's Initials

8

10

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 in charge AND PICU fellow or PICU consultant to be informed.

BAH-00659027 IP5-00175779
Baby FAIZA SOUMAIN IBED
10-10-2013 12 Y 8 M 22 D (F)
Dr. M N V POUHYA SAI



No. : RCHBH/ FRM / CLINICAL / 127

TEENAGE (12 + years) Children's Observation & Early Warning Scoring Chart

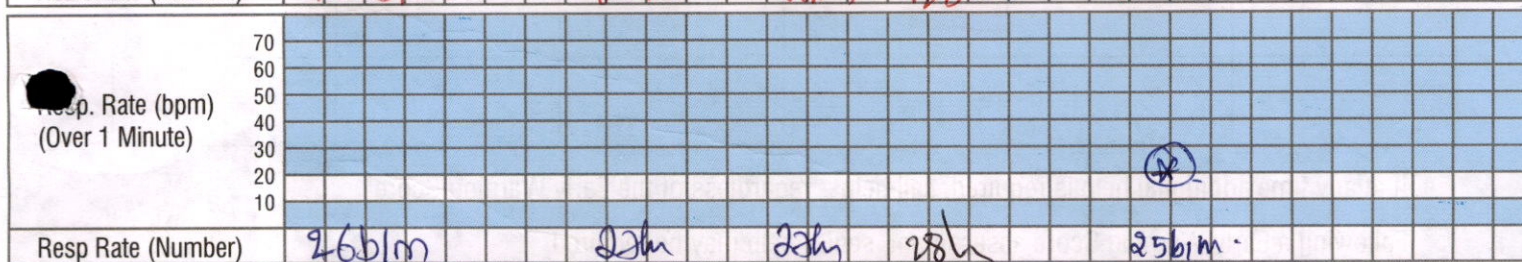
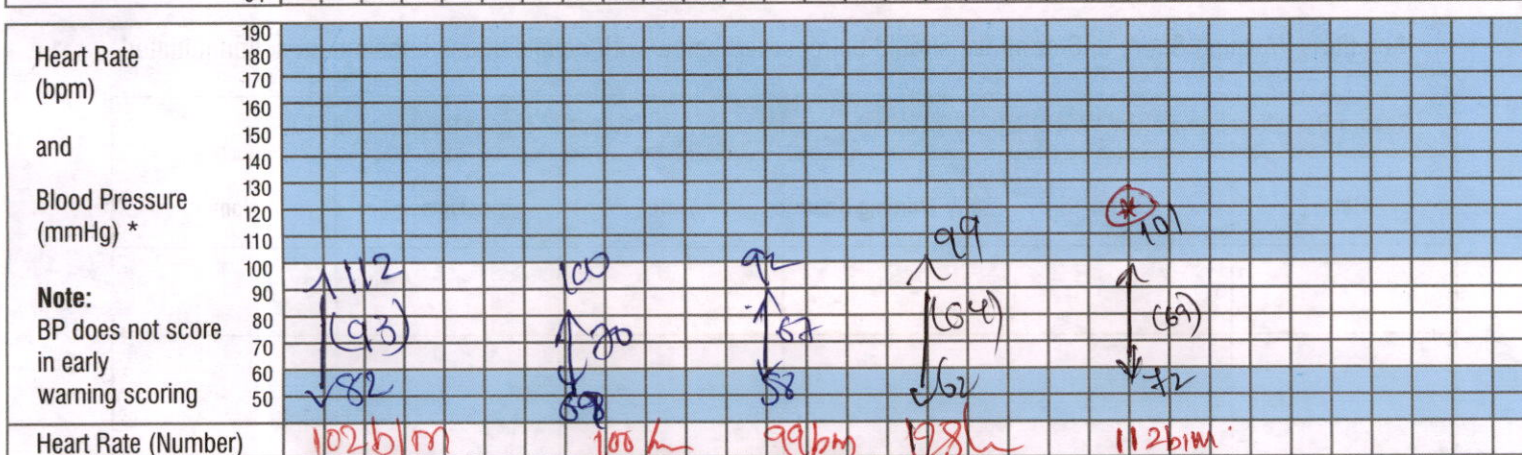
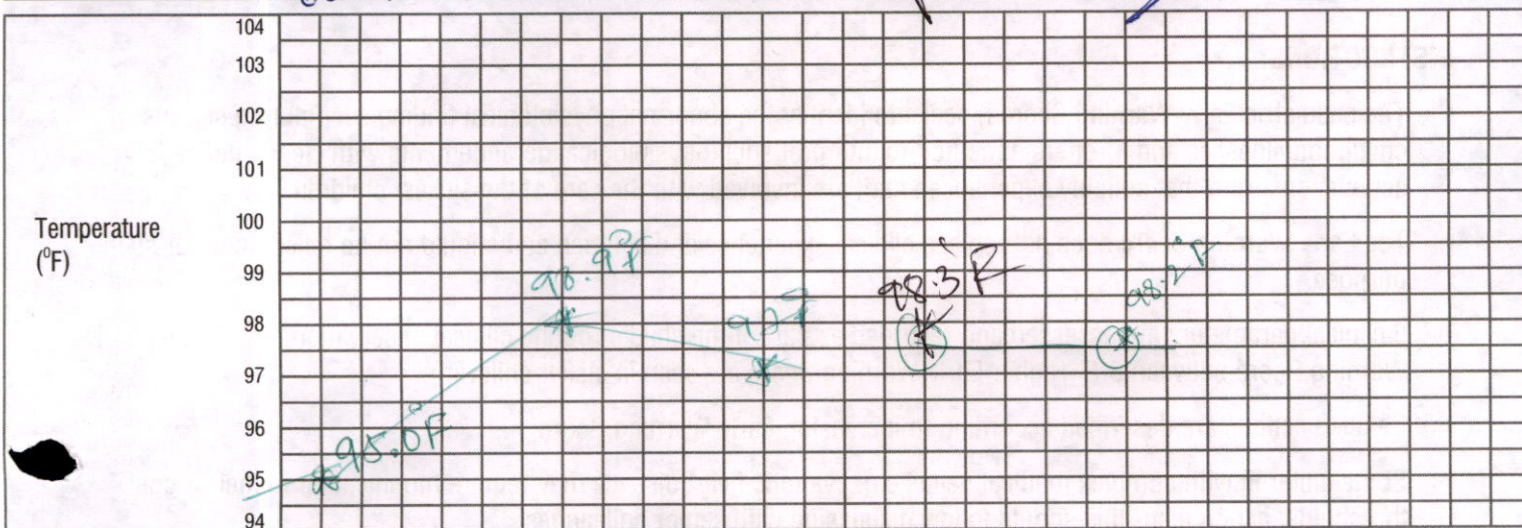
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Children's
Hospital
It takes a lot to treat the little.

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 12/10/2013 Time: 10am 2pm 6pm 10pm

Doctor / Nurse / Family Concern? 6am 10am 2pm 6pm 10pm



Resp Distress	Mod/ Severe	
	None / Mild	
Receiving O ₂ (l/min)		
O ₂ Saturations (%)		
	99%	99%
	100%	99%
	100%	100%

Conscious Level	Normal	
	Altered	
GCS *	15/15	15/15
	15/15	15/15
	15/15	15/15

TOTAL SCORE					
Number of shaded boxes	1	1	1	1	1
Pain Score	0	0	0	0	0
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.
- 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)

BAH-00659027 IP5-00175779
 Baby FAIZA SOUMAIN IBED
 10-10-2013 12 Y 8 M 21 D (F)
 Dr. M N V POUHYA SAI



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

SCHOOL AGE (5-12 years)

Children's Observation &
 Early Warning Scoring Chart

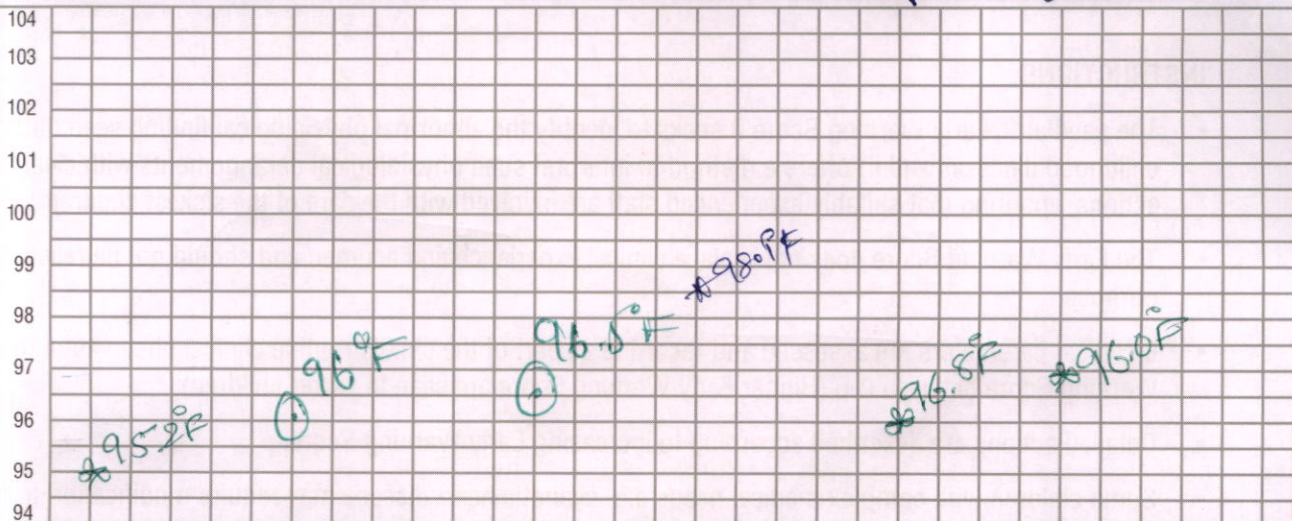
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EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 2/10/13 Time: 6am 10am 2pm 6pm 10pm 2am
 Doctor / Nurse / Family Concern?

Temperature
 (F)

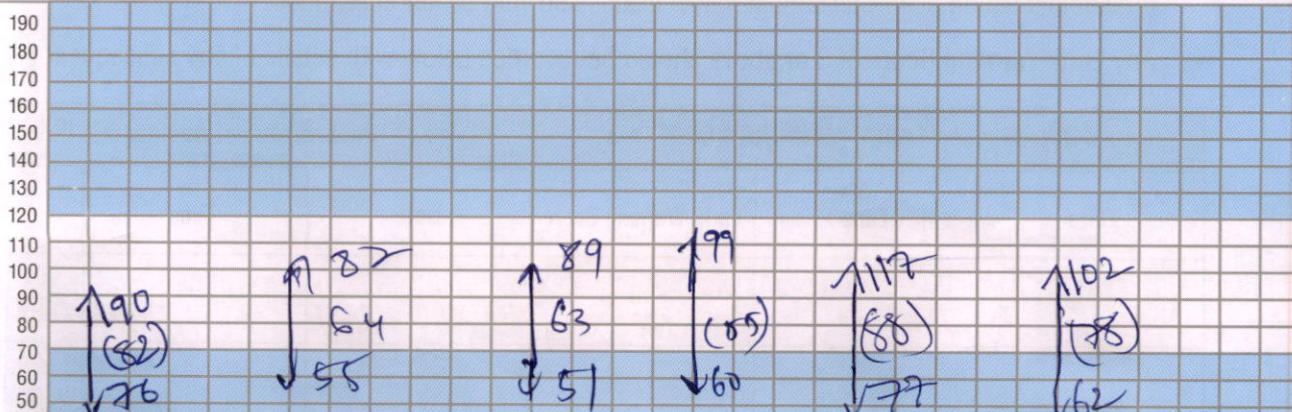


Heart Rate
 (bpm)

and

Blood Pressure
 (mmHg) *

Note:
 BP does not score
 in early
 warning scoring



Heart Rate (Number)

62b/m 61b/m 80b/m 86b 98b/m 111b/m

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



Resp Rate (Number)

26b/m 28b 26b 26b 26b/m 28b/m

Resp Distress Mod/ Severe
 None / Mild

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

100% 100% 100% 100% 100% 99%

Conscious Level Normal
 Altered

GCS *

15/15 15/15 15/15 15/15 15/15 15/15

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

1 1 1 0 1 1
 0 2 0 0 0 0
 0 M M C 0 -

ACTIONS

NB: Scores 3 should be
 recorded overleaf

- Score 1 : Continue normal observation by staff nurse
- Score 2 : Shift in charge nurse to be informed and continue hourly observations
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- 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:

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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)

TEENAGE (12 + years) Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 11/8/26	Time:								
Doctor / Nurse / Family Concern?	2am	6am	10am	1pm	4pm	7pm	10pm	2pm	
Temperature (°F)	97.8	98.8	99.4	99.1		97.5	95.3	97.0	
Heart Rate (bpm)	100b/m	102b/m	101b/m	110b	60b	112b/m	102b/m		
Blood Pressure (mmHg) *	98/64	88/58	99/63	100/55	98/68	113/88	110/62		
Note: BP does not score in early warning scoring									
Resp Rate (Number)	29b/m	28b/m	28b	28b	28b	28b/m	28b/m		
Mod/ Severe Distress									
Receiving O ₂ (l/min)									
O ₂ Saturations (%)	99.1	98.1	97	98x	98%	100%	99%		
Conscious Level									
GCS *	15/15	15/15	14/15	14/15	15/15	15/15	15/15		
TOTAL SCORE	1	1	1	1	1	1	1		
Number of shaded boxes	0	0	0	0	0	0	0		
Pain Score	0	0	0	0	0	0	0		
Observer's Initials	8	0	C	4	CH	3	0		

ACTIONS

NB: Scores 3 should be recorded overleaf

- Score 1 : Continue normal observation by staff nurse
- Score 2 : Shift in charge nurse to be informed and continue hourly observations
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BAH-00659027 IP5-00175779
Baby FAIZA SOUMAIN IBED
10-10-2013 12 Y 8 M 21 D (F)
Dr. M N V POUISHYA SAI



Doc. No. : RCHBH/ FRM / CLINICAL / 127

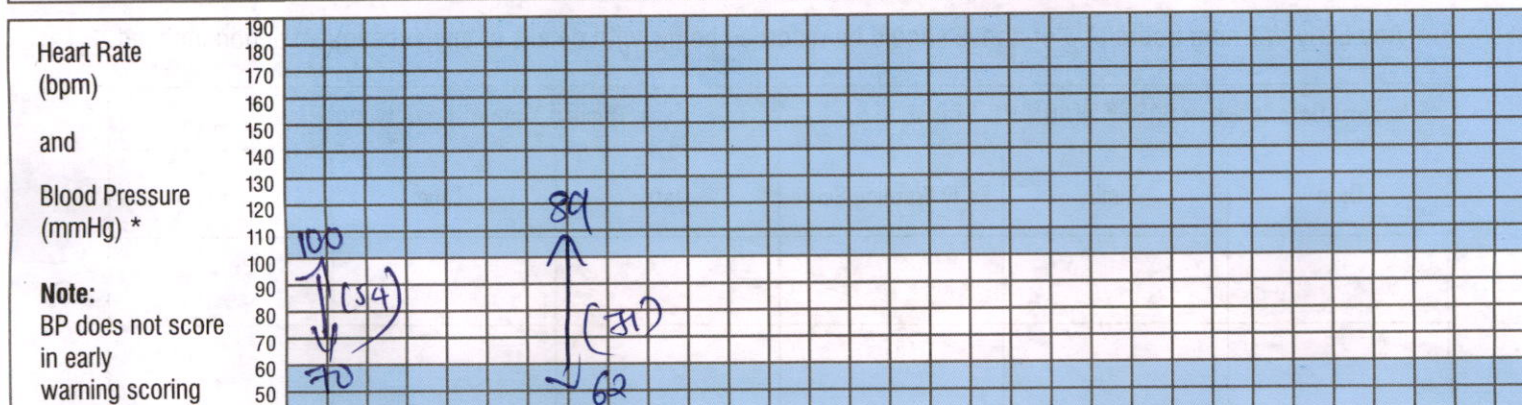
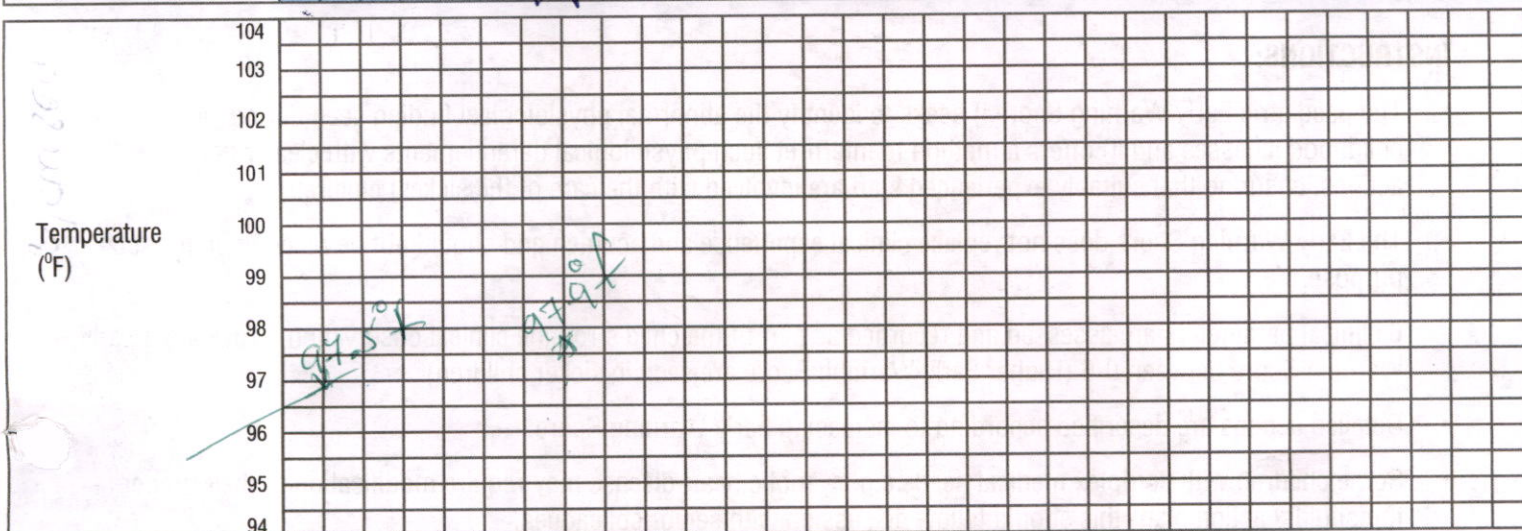
TEENAGE (12 + years) Children's Observation & Early Warning Scoring Chart

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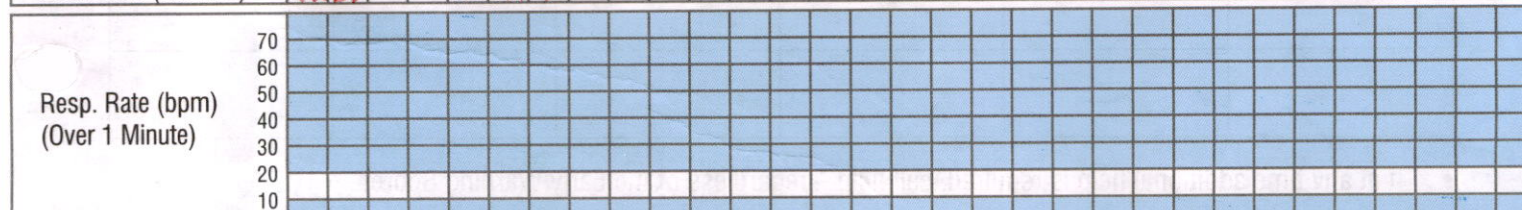
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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 20/10/2013 Time: 6pm
Doctor / Nurse / Family Concern? 6pm 10pm



Heart Rate (Number) 110bpm 100bpm



Resp Rate (Number) 26bpm 29bpm

Resp Mod/ Severe Distress None / Mild

Receiving O₂ (l/min) O₂ Saturations (%) 99% 99-100%

Conscious Level Normal Altered

GCS * 15/15 15/15

TOTAL SCORE
Number of shaded boxes 1 1
Pain Score 0 0
Observer's Initials 1 0

ACTIONS

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How see

BAH-00659027 IP5-00175779
 Baby FAIZA SOUMAINIE IBED
 10-10-2013 12 Y 8 M 20 D (F)
 Dr. M N V POUISHYA SAI

Pati



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 Your Right to a Safe Delivery

FLUID CHART

Sheet No. : ①

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

Date	Time	Nature of Fluid	Intake			Output					IV Site 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 :						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm			35ml							0	
	06:00 pm			35ml							0	
	07:00 pm										0	
Total Intake :						Total Output :						
	08:00 pm			35ml							0	
	09:00 pm			35ml							0	
	10:00 pm										0	
	11:00 pm			35ml							0	
	12:00 am			35ml							0	
	01:00 am			35ml							0	
Total Intake :						Total Output :						
	02:00 am			35ml							0	
	03:00 am			35ml							0	
	04:00 am			35ml							0	
	05:00 am			35ml							0	
	06:00 am										0	
	07:00 am										0	
Total Intake :						Total Output :						

Total 24 hrs. Intake	
-----------------------------	--

Total 24 hrs. Output	
-----------------------------	--



FLUID CHART

Sheet No. : 2

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								
16/7/26	08:00 am			35ml		/							
	09:00 am			35ml		/							
	10:00 am			35ml		/							
	11:00 am	DNS				/							
	12:00 pm			35ml		/							
	01:00 pm			35ml		/							
Total Intake :						Total Output :							
17/7/26	02:00 pm			30ml		/							
	03:00 pm			30ml		/							
	04:00 pm	DNS		30ml		/							
	05:00 pm			30ml		/							
	06:00 pm					/							
	07:00 pm					/							
Total Intake :						Total Output :							
01/08	08:00 pm					/							
	09:00 pm					/							
	10:00 pm	NO IVF				/							
	11:00 pm					/							
	12:00 am					/							
	01:00 am					/							
Total Intake :						Total Output :							
02/08	02:00 am					/							
	03:00 am					/							
	04:00 am	NO IVF				/							
	05:00 am					/							
	06:00 am					/							
	07:00 am					/							
Total Intake :						Total Output :							
Total 24 hrs. Intake						Total 24 hrs. Output							

FLUID CHART

Sheet No. : (3)

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							
2/10	08:00 am	No WF Icky				/	/	/	/	/	0	Mali-
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :					Total Output :							
2/10	02:00 pm	Dry Meeds water				/	/	/	/	/	0	Chand
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :					Total Output :							
2/10	08:00 pm	Dry Bread Jam		50ml		/	/	/	/	/	0	Rave
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :					Total Output :							
3/10	02:00 am	Dys		50ml		/	/	/	/	/	0	R
	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							

FLUID CHART

Sheet No. : 2

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							
3/2	08:00 am	DMS	Poly H ₂ O	SOM	/	/	/	/	/	/	0	prati
	09:00 am			SOM							0	
	10:00 am			SOM							0	
	11:00 am			SOM							0	
	12:00 pm			SOM							0	
	01:00 pm			SOM							0	
Total Intake :					Total Output :							
3/2	02:00 pm	DMS	Poly H ₂ O	SOM	/	/	/	/	/	/	0	prati
	03:00 pm			SOM							0	
	04:00 pm			SOM							0	
	05:00 pm			SOM							0	
	06:00 pm			SOM							0	
	07:00 pm			SOM							0	
Total Intake :					Total Output :							
3/2	08:00 pm	DMS	Poly H ₂ O	SOM	/	/	/	/	/	/	0	prati
	09:00 pm			SOM							0	
	10:00 pm			SOM							0	
	11:00 pm			SOM							0	
	12:00 am			SOM							0	
	01:00 am			SOM							0	
Total Intake :					Total Output :							
4/2	02:00 am	DMS	Poly H ₂ O	SOM	/	/	/	/	/	/	0	prati
	03:00 am			SOM							0	
	04:00 am			SOM							0	
	05:00 am			SOM							0	
	06:00 am			SOM							0	
	07:00 am			SOM							0	
Total Intake :					Total Output :							
Total 24 hrs. Intake			Total 24 hrs. Output									



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☐ Night

Date: 30/6/16

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
5pm	→ Assess the Baby General condition, monitor vitals & record	5:30pm	→ Assessed the Baby General condition, monitored vitals & recorded	By All this done pt condition is improved
6pm	→ provide comfortable position	6:30pm	→ provided comfortable position	
8pm	→ continue IV fluids → administer medication as per doctor order	8pm	→ continued IV fluids → Administered medication as per doctor order	

Re-Assessment:

Special Notes:

Nurse Signature: Ree

Nurse Name: Aparajita (021266)

Date & Time: 30/6/16 09:30

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 30/6/2016

Assessment: Baby having head ache

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
8am	* Assess the baby general condition. monitor vital signs	8am	* Assessed the baby general condition. monitored vital signs	Baby condition is improving slowly
10am	* provide comfortable position	10am	* provided comfortable position	
12am	* maintain Tlo charting	12am	* maintained Tlo charting	
3pm	* Administered medication as per doctor order	3pm	* Administered medication as per doctor order	
8pm	* Ensure safety side rails.	8pm	* Ensured safety side rails	

Re-Assessment: given paracetamol DS for 9ml for headache

Special Notes:

Nurse Signature:

[Signature]

Nurse Name:

Surekha

Date & Time:

1/7/2016 @ 8am



NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 01/07/2016

Assessment: pt having poor intake

- 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
8AM	Assess the pt general condition.	9AM	Assess the pt general condition.	By done all implementation as per order
9AM	monitor vital sign	10AM	monitor vital sign	
10AM	monitor I/O chart	11AM	monitored I/O chart	
11AM	provide comfortable position	12PM	provided comfortable position	
12PM	Administer medication	1PM	Administered medication	

Re-Assessment:

Special Notes:

Dr. Nitika Conk pending

Nurse Signature: Sudha

Nurse Name: Sudha

Date & Time: 1/07/2016 2PM

BAH-00659027

IP5-00175779

Baby FAIZA SOUMAINE IBED

10-10-2013 12 Y 8 M 21 D (F)

Dr. M N V POUISHYA SAI



NURSING CARE RECORD

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

BirthRight
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Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 11/9/20

Assessment: Baby having headache & stomach pain

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
2pm	Assess the general condition of the baby.	2.30pm	Assessed the general condition of the baby	Implemented all the procedure.
3pm	Continue IV fluids	3.30pm	Continued IV fluids	
4pm	Monitor I/O chart.	4.30pm	Monitored I/O chart.	
5pm	Administer medication as per doctor order.	5.30pm	Administered medication as per doctor order.	
6pm	Monitor vital signs	7pm	Monitored vital signs	

Re-Assessment:

Special Notes: watch for headache

Nurse Signature: Meelin

Nurse Name: Meelin

Date & Time: 11/9/20 2/2

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 2/7/26

Assessment: Baby having headache & stomach pain

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 & monitor the vital sign.	8:10	→ Assessed the baby general condition & monitor vital signs	The baby condition is improving slowly
12AM	→ Maintain the I/O chart	12AM	→ maintained the I/O chart	
4pm	→ provide the comfortable position.	4AM	→ provided comfortable bed and position	
6AM	→ Administer the medication as per doctor order	6AM	→ Administered medication as per doctor order	
8AM	→ Maintain the personal hygiene	8:10 AM	→ maintained personal hygiene	

Re-Assessment: Baby is feeling uncomfortable

Special Notes:

Nurse Signature: Ravina

Nurse Name: Ravina

Date & Time: 2/7/2026 8AM



NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 2/7/26

Assessment: pt having dull activity

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
2pm	→ Assess the pt General Condition	2:10pm	→ Assessed the pt General Condition	pt is stable
4pm	→ Check the Vital signs	4:10pm	→ Checked the Vital Signs	
6pm	→ plan for Administration medication	6:10pm	→ providing medication as per doctor Order	
8pm	→ plan for Ilo Chart	8:10pm	→ maintaining Ilo Chart	
	→ plan for Ensure the Safety		→ providing the Ensuring Safety	

Re-Assessment: Re-Assessment Every 4th hourly

Special Notes: -

Nurse Signature:

Nurse Name: Chandana

Date & Time: 2/7/26 2pm

BAH-00659027 IP5-00175779
 Baby FAIZA SOUMAINE IBED
 10-10-2013 12 Y 8 M 21 D (F)
 Dr. M N V POUHYA SAI



NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 26/07/16

Assessment: pt having well activity

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 pt General condition	9pm	*Assessed the pt General condition	pt is well
10pm	*check the pt all vitals	11pm	*checked the pt all vitals	
12am	*maintain 2nd chart	1am	*maintained 2nd chart	
4am	*provide comfortable position	6am	*provided comfortable position	
7am	*administer all medication given by per doctor order	8am	*administered all medication given by per doctor order	

Re-Assessment: Monitor vital checkin

Special Notes:

Nurse Signature: *[Signature]*

Nurse Name: Ravina

Date & Time: 08/07/16 8am

NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 31/7/2016

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
2pm	* Assess the general condition of the patient.	2pm	* Assessed the general condition of the patient.	By above all the procedure the patient can be stable.
4pm	* maintain personal hygiene.	4pm	* maintained personal hygiene.	
6pm	* maintain the fluid.	6pm	* maintained the fluid.	
7pm	* monitor vitals.	7pm	* monitored vitals.	

Re-Assessment:

monitored vitals.

Special Notes:

Nurse Signature: @f

Nurse Name: Dina

Date & Time: 31/7/2016 @f

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 3/7/20

Assessment: Baby having pain abdomen.

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 pt general condition.	8:05pm	⇒ Assessed the pt general condition.	By done all the procedures the baby condition is Improving
10pm	⇒ provide the comfortable position.	10pm	⇒ provided the comfortable position.	
12AM	⇒ Check the vitals.	12:05AM	⇒ checked the vitals.	
4AM	⇒ Maintain I.V fluids.	4:05AM	⇒ maintained I.V fluids.	
	⇒ provide side rails.		⇒ provided side rails.	
6AM	⇒ Administer the medication as per doctor order.	6:05AM	⇒ Administered the medication as per doctor order.	

Re-Assessment: Re-assessment is done by checking vital signs

Special Notes: Dr. Venkata ram conk Tim.

Nurse Signature: 

Nurse Name: pramela (01500)

Date & Time: 4/7/20 @ 8AM.

BAH-00000027
 Baby FAIZA SOUMAINIE IBED
 10-10-2013 12 Y 8 M 22 D (F)
 Dr. M N V POUISHYA SAI

NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☐ Night

Date:

Assessment:

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation

Re-Assessment:

Special Notes:

Nurse Signature:

Nurse Name:

Date & Time:



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. M N V Poushya Sai Department: Pediatric Date of Admission: 30/6/26

SITUATION		Diagnosis: <u>Gastritis</u> Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:						
BACKGROUND	Area	<u>CR</u> <u>9:40pm - 11:00pm</u>		<u>1st</u> <u>8pm - 9pm</u>		<u>1st</u> <u>8pm - 9pm</u>		
	Shift Time							
BACKGROUND	Medical Condition (Any special condition to be noted):	<u>NA</u>		<u>NA</u>		<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>98.0°F</u>	<u>97.5°F</u>	<u>98.2°F</u>	<u>98.1°F</u>	<u>98.1°F</u>	<u>98.2°F</u>
		Res:	<u>22b/m</u>	<u>26b/m</u>	<u>22b/m</u>	<u>22</u>	<u>22</u>	<u>30b/m</u>
		SpO ₂ :	<u>100%</u>	<u>99%</u>	<u>99%</u>	<u>99</u>	<u>99</u>	<u>100%</u>
		Pulse:	<u>125b/m</u>	<u>112b/m</u>	<u>112b/m</u>	<u>112</u>	<u>111</u>	<u>110b/m</u>
		BP:	<u>110/60</u>	<u>98/60</u>	<u>98/62</u>	<u>99/63</u>	<u>95/61</u>	<u>90/70</u>
		Fall Risk Score:	<u>09</u>	<u>-09</u>	<u>9</u>	<u>9</u>	<u>9</u>	<u>9</u>
Pain Score:	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>		
Recommendations	Safety Needs:	☒	<u>Yes</u>	<u>Yes</u>	<u>Yes</u>	<u>Yes</u>	<u>Yes</u>	
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:	<u>N/A</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Other Special Orders / Medications:	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Handed Over By Name :		<u>Kutti</u>	<u>Aparna</u>	<u>Susha</u>	<u>Susha</u>	<u>Meslin</u>	<u>Ravina</u>	
Signature :		<u>Kutti</u>	<u>Aparna</u>	<u>Susha</u>	<u>Susha</u>	<u>Meslin</u>	<u>Ravina</u>	
Date:		<u>30/6</u>	<u>30/6</u>	<u>01/7/26</u>	<u>11/7/26</u>	<u>1/7</u>	<u>2/7/26</u>	
Time:		<u>11:40pm</u>	<u>8pm</u>	<u>8pm</u>	<u>2pm</u>	<u>8pm</u>	<u>8pm</u>	
Taken Over By Name :		<u>Aparna</u>	<u>Susha</u>	<u>Susha</u>	<u>Meslin</u>	<u>Ravina</u>	<u>Meslin</u>	
Signature :		<u>Aparna</u>	<u>Susha</u>	<u>Susha</u>	<u>Meslin</u>	<u>Ravina</u>	<u>Meslin</u>	
Date:		<u>30/6</u>	<u>30/6/26</u>	<u>1/7</u>	<u>1/7</u>	<u>1/7/26</u>	<u>2/7</u>	
Time:		<u>11:40pm</u>	<u>8pm</u>	<u>8pm</u>	<u>2pm</u>	<u>8pm</u>	<u>8pm</u>	



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. M N V Pouhyasa Department: Cardio Date of Admission: 30/6

SITUATION		Diagnosis:		Any Infection: ☐ Yes ☒ No ☐ Not Known		If Yes Specify:	
BACKGROUND	Area						
	Shift Time	1st floor 8am-2pm	1st floor 2pm-8pm	1st floor 8pm-12am	1st floor 12am-8am	1st floor 8am-12am	1st floor 12am-8am
ASSESSMENT	Medical Condition (Any special condition to be noted):	NA	NA	NA	NA	NA	NA
	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
RECOMMENDATIONS	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:	Temp: 98.5	98.3	98.1	98.0	98.2	98.1
	Res:	25	28	28	28	28	28
	SpO ₂ :	100%	99%	99%	99%	99%	99%
	Pulse:	26	28	28	28	28	28
	BP:	98/61	99/60	100/60	110/70	101/62	101/62
	Fall Risk Score:	0	10	10	10	10	10
	Pain Score:	0/10	0/10	0/10	0/10	0/10	0/10
Other Special Orders / Medications:	Safety Needs:	Yes	Yes	Yes	Yes	Yes	Yes
	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
Post Operative Procedure Special Orders:		NA	NA	NA	NA	NA	NA
Handed Over By Name :		Yellu	Chandana	Pranav	Nikitha	Divya	
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	
Date:		2/7	2/7/26	2/7/26	3/7	3/7	
Time:		2pm	2pm	2pm	2pm	8pm	
Taken Over By Name :		Chandana	Pranav	Nikitha	Divya	Pranav	
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	
Date:		2/7/26	2/7/26	3/7	3/7	3/7/26	
Time:		2pm	2pm	8am	2pm	8pm	



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: DR. P. S. Department: Gastro Date of Admission: 30/6/26

SITUATION	Diagnosis: <u>Gastritis</u>		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:					
	Area	Shift Time						
BACKGROUND	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>98.2</u>						
		Res: <u>25b/m</u>						
		SpO ₂ : <u>100%</u>						
		Pulse: <u>112b/m</u>						
		BP: <u>95/72</u>						
		Fall Risk Score: <u>10</u>						
Recommendations	Safety Needs:	<u>Side rail</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>praveen</u>						
Signature :		<u>[Signature]</u>						
Date:		<u>4/7/26</u>						
Time:		<u>8 AM</u>						
Taken Over By Name :		<u>[Signature]</u>						
Signature :		<u>[Signature]</u>						
Date:		<u>4/7</u>						
Time:		<u>8 am</u>						



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						
BACKGROUND	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:							

BAH-00659027
Baby FAIZA SOUMAINÉ IBED
10-10-2013 12 Y 8 M 20 D
Dr. M N V POUISHYA SAI (F)

Patient

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4					
	3 to less than 7 years old	3					
	7 to less than 13 years old	2	2	2	2	2	2
	13 years old and above	1					
Gender	Male	2					
	Female	1	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	1
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	1	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	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	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	1
TOTAL			9	9	9	9	9

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position	✓	yes	yes	yes	yes
Call device within reach	✓	yes	yes	yes	yes
Wheels Locked	✓	yes	yes	yes	yes
Room free of clutter	✓	yes	yes	yes	yes
Adequate Lighting	✓	yes	yes	yes	yes
Wheel Chair Support	✓	no	no	no	no
Other Intervention(s) Specify	✓	no	no	no	no
Nurse's Name :		Kaithi	Ravina	Ravina	Pravina
Signature :		Kaithi	Ravina	Ravina	Pravina
Date :		20/6/17	20/6/17	20/6/17	20/6/17
Time :		4pm	6pm	6pm	6pm



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
3/7	10am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Nikhil
3/7	6p	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	A
3/7/20	11pm	0/10	NIL	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NIL	praveela
4/7/20	6AM	0/10	NIL	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NIL	praveela
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

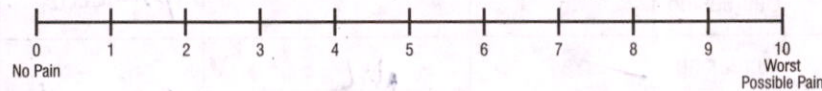
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
	0	1	2
Face	No Particular expression or smile	Occasional Grimace or Frown, withdraw, Disoriented	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs 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

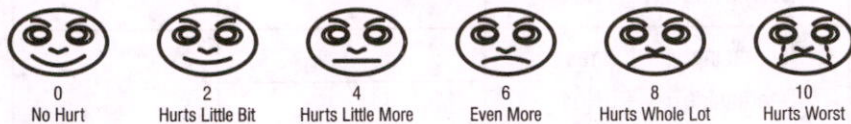
Numerical Pain Scale (Obstetric and Gynecology)



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
30/6/26	4pm	0/10	Nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	Kute
1/7/26	12am	2/10	W'n	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	Nil	Sush
1/7/26	1am	1/10	head weache	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☐ Dull ☒ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Syp. Crocin DS 9ml	Sush
1/7/26	2am	0/10	Nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	Nil	Sush
1/7/26	1pm	0/10	Nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	Sush
1/7/26	5:40pm	1/10	headache	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Syp. Crocin	Melli
1/7/26	7m	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	WA	Melli
2/7/26	3AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Ravina
2/7/26	1:00pm	1/10	stomach pain	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Syp. par	Melli
2/7/26	6pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Chand

Re-assessment Frequency:

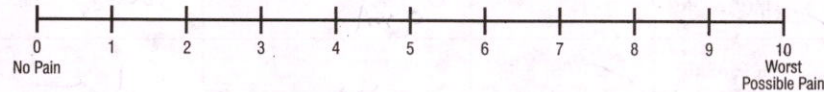
- Every eight hours for all hospitalized patients.
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 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
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FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

Numerical Pain Scale (Obstetric and Gynecology)



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

Assessment Criteria	Sedation		Normal	Pain / Agitation	
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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
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Wong - Baker (Pediatrics) Above 7 Years



BAH-00659027 IP5-00175779
 Baby FAIZA SOUMAIN IBED
 10-10-2013 12 Y 8 M 22 D (F)
 Dr. M N V POUISHYA SAI



BRADEN 'Q' SCALE

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

					Date : 9/11			
					Time : 6AM			
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 e.tremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4			
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4			
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4			
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4			
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4			
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4			
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4			
					TOTAL SCORE	28		
					Evaluator's Name	pranvi		

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

Docu. No. : RCHBH /FRM / CLINICAL / 119

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

BAH-00659027 IP5-00175779
Baby FAIZA SOUMAIN IBED
10-10-2013 12 Y 8 M 20 D (F)
Dr. M N V POUISHYA SAI

BRADEN 'Q' SCALE

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

					Date: 30/10/17	17	27/10/17	17
					Time: 4pm	6m	6AM	6m
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.	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
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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	22	28	28
					Evaluator's Name	10/10/17	10/10/17	10/10/17

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

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CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	3/7 DAY-1			4/2 DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0	0	0	0	0						
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1	—	—	—	—						
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 cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5	—	—	—	—						
Signature of the Nurse				pravi	pravi	pravi							

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

Signature of Shift In Charge :

Signature : [Signature] Name : sourail

Signature of Ward In Charge :

Signature : [Signature] Name : Neeraj

BAH-00659027
Baby FAIZA SOUMAIN IBED
10-10-2013 12 Y 8 M 21 D (F)
Dr. M N V POUISHYA SAI

CHECKLIST FOR THROMBOPHLEBITIS

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

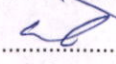
S. NO.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0		0	0	0	0	0	0	0	0	
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1		-	-	-	-	-	-	-	-	
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 cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5		-	-	-	-	-	-	-	-	
Signature of the Nurse				Appo sub			Nelly Davinech						

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

Signature of Shift In Charge :

Signature :  Name : Mitho

Signature of Ward In Charge :

Signature :  Name : Neeraja Devi



INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Part - I.

Patient's / Learner Language: Hindi 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		
30/6	4pm	2	Treatment & care plan	F	1	1	1	0	-	Kulka
30/6/26	4pm	9	Normal high protein diet	F	1	0	1	1	-	Nikites

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

Gastritis.

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
30/6/26	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Constipation / Gastritis	Hemodynamic stability -	IV medication		☒ Nursing ☐ Others:
30/6/26 3:01 pm	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	vomiting x 9 months (once off)	H. Stability	IV fluids.		☒ Medical ☐ Others:
30/6/26 4:40pm	☐ Medical ☐ Nursing ☒ Others: Dietitian	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	constipation & Gastritis	Normal high fiber diet	ROOJ E: 1750 kcal/d P: 34 g/d	Nicitha	☐ 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: