

B9

ACTIVITY RECORD FOR BILLING

Name : _____

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

Date of Admission: _____ Discharge : _____ Time: _____

Room / Bed No : _____ Wara : _____ Estimated Billable bed type : _____

BAH-00662020
Master SAMPETA SRI ADITYA GOUD
20-09-2023 2 Y 9 M 28 D
Dr. DR. V. V. R. SATYA PRASAD (M)

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
18/7/26	6:34pm	ER	PICU	Abhishek
18/7/26	11 PM	PICU	IU2	Boris

Cross Consultation Visit

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

[illegible]

Signature

Israel

7

Q

Handwritten cursive letters 'e' and 'c' on lined paper. The letter 'e' is formed with a single stroke, indicated by a curved arrow labeled '1'. The letter 'c' is formed with a single stroke, indicated by a curved arrow labeled '1'.

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
18/07	iv placement	1	709899	Ismael
18/7	Albumin Transfusion	(1)	810001	Ismael
19/7	albumin transfusion	(1)	2405832	Ismael
20/7	NHA	(1)	260352	Ismael

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date : 21/7/20

Time :

Prepared By : Ismael

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
Anurupa	Geo-II (142)		

ADMISSION SHEET

Registration Details :

Admission No : IP5-00176584

Admit Date : 18-Jul-2026

Admit Time : 05:48 PM **UHID** : BAH-00662020

Patient Details :
Patient Name : Master SAMPETA SRI ADITYA GOUD

Age : 2 Y 9 M 28 D

Guardian : Mr SAMPETA BHAGAVAN

DOB : 20-09-2023

Gender : Male

Religion :

Occupation :

Martial Status : Single

Address (H) : FLAT -401, ROAD.NO 17, PARIMALA CLASSIC, MARUTHI NAGAR, KOTHAPET Kothapet Hyderabad Telangana INDIA 500035

Phone No : 8686765316/ 9381938232

E-mail : SAMPETABHAGAVAN@GMAIL.COM

Admission Details :
Bed Type : GENERAL WARD

Bed No : GW 142

Ward Name : 1F-GENERAL WARD II

Room No : GW 142

Admission Type : First Visit

Contact Details :
Name : Mr SAMPETA BHAGAVAN

Relationship : Father

Contact Address : FLAT -401, ROAD.NO 17, PARIMALA CLASSIC, MARUTHI NAGAR, KOTHAPET Kothapet Hyderabad Telangana INDIA 500035

Phone No : 8686765316


Signature
Doctor Details :
Doctor Name : Dr. DR.V.V.R.SATYA PRASAD

Specialisation : PEDIATRIC NEPHROLOGY

Referral Doctor : Self

Phone No :

Co-Consultant : Dr. SRUTHI BALLA

Payment Details :
Payment Mode : Cash

Deposit Amount : 0.00

Payor Name : ICICI LOMBARD GENERAL INSURANCE CO LTD



DEFICIENCY CHECK LIST OF CASE SHEET

Sl.No.	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission sheet	1			
2	Discharge Summary	2			
3	Nursing Initial assessment	1			
4	Patient Transfer form	1 + 1			
5	In-patient Medical record	1			
6	Doctors progress sheets	3			
7	Nursing plan of care and handover sheets	4			
8	Consultation sheet				
9	General consent for treatment	1			
10	Consent for Surgery				
11	Consent for blood transfusion	1 + 1 + 1			
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	2			
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	3			
30	Intake and Out take chart (fluid chart)	2			
31	Drug chart (Regular Prescription)	2			
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				
40	PICU bed formula Dilution feeds				
41	Gastro monitoring chart				
42	Rch ED doctors note				
43	BP Monitoring chart				
44	RBS monitoring chart				
	<i>Other:-</i>	1			
	<i>Signature:-</i>	2			
	Total No. of Pages				

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



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PEDIATRIC IN-PATIENT MEDICAL RECORD

BAH-00662020 IP5-00178584
Master SAMPETA SRI ADITYA GOUD
20-09-2023 2 Y 9 M 28 D (M)
Dr. DR.V.V.R.SATYA PRASAD



Patient Name:

SRI ADITYA

UHID ID:

Department:

Consultant:



Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: Mother Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

yo New onset nephrotic syndrome
brrought to OPD
1

History of present illness :

yo Periorbital puffiness : 2 weeks

No H/o fever

No H/o Hematuria

No H/o joint pains

18/7/26 - Albumin 1.9

Creatinine 0.3

Bicarbonate 24.

Na/K/Cr 132/3.9/0.7

ESR - 65

Spot protein/creatinine ratio - 3.59.

CBP - 13.1/12.37/488

N/L - 27.5/6513.

ESR - 30.



Pediatric Multiorgan History & Physical Examination

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

Birth & Neonatal History:

normal neonatal transition

Birth & Socio Economic History:

About Father :

About Mother :

Any additional Information :

Developmental History :

normal for age

Immunization History :

immunized till age



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: 2nd observation

Desired goals of the treatment : Resolution of Symptoms

Planned Labs:

CRP
HbS Ag N/R
Q level
1 sample
18/07/26

Planned Management

uj- Ceftriaxone 80
uj- Mefenylprednisolone - 25mg OD
uj- Lasix 12 mg IV BD
Abtelabs →
HCRP ⊖
IV Albumin 50ml over 4 hours
uj- Lasix 12mg midway
12mg End.
- WF DUE 20ml/hr.

Signature of the Doctor: N. Pradeep

Name of the Doctor: N. Pradeep

Date & Time: 18/07/26
5:15 PM

DR. V V R SATYA PRASAD
Registration No: 43599

Signature of the Consultant: [Signature]

Name of the Consultant: Dr. Satya Prasad

Date & Time: 18/7/26 10:00 AM

PHYSICIAN'S NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/7/26 10 AM	Seen by Resident. Ais- Neurosensory Nephrotic Syndrome T. wt- 12.5 kg (13.1 kg) U/O- 1.6 1.630 cc @ 24 hrs @ 5.4 cc/kg/m. No fever issues. O/E child alert, afebrile hemodynamically stable. Edema reduced chest clear abdomen soft.	Plan 1. CEFTRIAXONE (D3) METHYLPRED (D2) 2. IV fluids @ 50% maint R/V to make it 70%. 3. Daily wt check Monitor vitals input output charting
20/7/26 11 AM	Seen by Dr Satyaprasad, Dr Suthar B.	Sahithi Continue same Plan PIC tomorrow.
		DR. VVR SATYAPRASAD Registration No. 4359



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/9/2023 1:15pm	SB Dr. Sankar Case Reviewed	As
	Passing urine well Hemodynamically stable	- Continue same - Strict I/O charting
	Hydration fair	- Daily wt charting - vitals weekly - No Labs 1/M
	seen by Resident	As
20/9/2023 5pm	ASis - New onset nephrotic syndrome. passing adequate urine hemodynamically stable. edema resolved chest clear, abd soft.	Plan 1. Continue medications as charted 2. R/V Plan DIC to monitor 3. Daily wt check I/O monitoring or vitals monitoring
		As Sankar

BAH-00662020 IP5-00176584
Master SAMPETA SRI ADITYA GOUD
20-09-2023 2 Y 10 M 0 D (M)
Dr. DR.V.V.R.SATYA PRASAD



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
21/7/23 10 AM.	Seen by Resident DS is New onset nephrotic Syndrome. t.wt - 12.6 kg (12.5 kg). U/O - 1260 cc @ 24 hrs 4.165 cc/kg/hr.	Plan 1. Plan D/C today.
	Oral intake fair No fresh issues O/E child alert, afebrile hemodynamically stable Edema decreased Chest clear abdomen soft.	\$ Satinth:
	Seen by Dr. Satya Prasad.	D/C today. Syp. DMNACORTIL FORTE 4.5 ml BD x 6 weeks 5 weeks
		T. lanxol 15mg OD Calcimax Plus 5ml OD Furosed drops - 1.2 ml BD x 3d 2d Syp Ziprax (5/100) 3ml BD x 3d
		R/v after 1 wk = CUE & SUPCR.

DR. VVR SATYA PRASAD
Registration No: 43599

[



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PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

BAH-00662020 IP5-00176584
Master SAMPETA SRI ADITYA GOUD
20-09-2023 2 Y 9 M 28 D (M)
Dr. DR.V.V.R.SATYA PRASAD



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RESULT SHEET

Date	18/7	20/7			
Time	.				
Hb	13.4				
PCV	38.3				
RBC	5.44				
WBC	10,100				
N/L	54/42				
Platelets	4,91,000				
CRP	5				
ESR	65				
PCT					
RBS					
Na	132	134			
K	3.9	4.2			
Cl	107	99			
Ca/Mg					
Phosphate					
Urea	30	27.4			
Creatinine	0.3	0.3			
ALP					
SGPT					
SGOT					
T.Bill/Conj					
T.Protein					
S.Albumin	1.9				
S.Globulin					
A/G Ratio					
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein / Sugar					
Cells					
N/L	Biasmate	24	27		



MEDICATION RECONCILIATION FORM

Drug Allergies:

☐ Not known any Drug Allergies

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

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

Shifting From:

Shifted to:

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	INJ CEFTRIAZONE	600mg	IV	BD	18/2	☒ C ☐ DC
2	INJ ESMO PROZOLE	14mg	IV	OD	18/2	☒ C ☐ DC
3	INJ LASIX	12mg	IV	BD	18/2	☒ C ☐ DC
4	SYP CALCIMAX PLUS	5ml	PO	OD	18/2	☒ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature :

Date & Time :

Nurse Name & Signature:

Date & Time :

BAH-00662020 IP5-00176584
Master SAMPETA SRI ADITYA GOUD
20-09-2023 2 Y 9 M 28 D (M)
Dr. DR.V.V.R.SATYA PRASAD

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MEDICATION RECONCILIATION FORM

Drug Allergies:

☐ Not known any Drug Allergies

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

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

Shifting From: ICU

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 : 18/7/26 ; 5:30pm

Nurse Name & Signature: Abhishek

Date & Time : 18/7/26 5:30pm



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

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

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

VERIFIED BY : Name Signature



REGULAR PRESCRIPTIONS

Weight. 13.62 kg Ward.

VERIFIED

DRUG : <u>Ijy CEFTRIAXONE</u>				Date Time	<u>18/7/19/7/20/7</u>
Dose <u>600mg</u>	Route <u>IV</u>	Frequency <u>BD</u>	Start Date <u>18/7/20</u>		
Name & Signature of the Doctor Starting the Drugs: <u>Dr Ramya</u>				<u>10pm X 208</u>	
Additional Instructions:				<u>10pm Ray pram</u> <u>10pm Ray pram</u> <u>10pm Ray pram</u>	
Daily Doctor's Endorsement by a Sign				<u>8 8 8</u>	

VERIFIED

DRUG : <u>Ijy ESOMEPRAZOLE</u>				Date Time	<u>18/7/19/7/20/7/21/7</u>
Dose <u>14mg</u>	Route <u>IV</u>	Frequency <u>OD</u>	Start Date <u>18/7/20</u>		
Name & Signature of the Doctor Starting the Drugs: <u>Ramya</u>				<u>6pm 9.1m pram</u> <u>6pm 9.1m pram</u> <u>6pm 9.1m pram</u>	
Additional Instructions:				<u>10pm Ray pram</u> <u>10pm Ray pram</u> <u>10pm Ray pram</u>	
Daily Doctor's Endorsement by a Sign				<u>8 8 8</u>	

VERIFIED

DRUG : <u>Ijy LASIX</u>				Date Time	<u>18/7/19/7/20/7</u>
Dose <u>12mg</u>	Route <u>IV</u>	Frequency <u>BD</u>	Start Date <u>18/7/20</u>		
Name & Signature of the Doctor Starting the Drugs: <u>Dr Ramya</u>				<u>10pm X 208</u>	
Additional Instructions:				<u>10pm Ray pram</u> <u>10pm Ray pram</u> <u>10pm Ray pram</u>	
Daily Doctor's Endorsement by a Sign				<u>8 8 8</u>	

VERIFIED

DRUG : <u>Syp. CALCIMAX PLUS</u>				Date Time	<u>18/7/19/7/20/7</u>
Dose <u>5ml</u>	Route <u>PO</u>	Frequency <u>OD</u>	Start Date <u>18/7/20</u>		
Name & Signature of the Doctor Starting the Drugs: <u>Dr Ramya</u>				<u>10pm Ray pram</u> <u>10pm Ray pram</u> <u>10pm Ray pram</u>	
Additional Instructions:				<u>10pm Ray pram</u> <u>10pm Ray pram</u> <u>10pm Ray pram</u>	
Daily Doctor's Endorsement by a Sign				<u>8 8 8</u>	

BAH-00662020 IP5-00176584
Master SAMPETA SRI ADITYA GOUD
20-09-2023 2 Y 9 M 28 D (M)
Dr. DR.V.V.R.SATYA PRASAD

Sheet No.

REGULAR PRESCRIPTIONS

Weight

Ward

DRUG :				Date Time
Dose	Route	Frequency	Start Dt.	
25mg	IV	Q24H	19/07	
Name & Signature of the Doctor Starting the Drugs:				
T. Pavani				
Additional Instructions:				
2mg/kg/day				
Daily Doctor's Endorsement by a Sign				
DRUG :				Date Time
Dose	Route	Frequency	Start Dt.	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
DRUG :				Date Time
Dose	Route	Frequency	Start Dt.	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
DRUG :				Date Time
Dose	Route	Frequency	Start Dt.	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
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				

BAH-00662020 IP5-00176564
Master SAMPETA SRI ADITYA GOUD
20-09-2023 2 Y 9 M 28 D (M)
Dr. DR.V.V.R.SATYA PRASAD

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Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward

VERIFIED BY : Name Signature

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



Weight. Ward.

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
18/7/26	6pm	Inj AVIL	0.3ml	IV	h	h
18/7/26	8pm	Inj HYDROCORTISONE	28mg	IV	h	h
18/7/26	6:30pm	Inj ALBUMIN (20%)	some over 4hrs	IV	h	h
18/7/26	8pm	Inj LASIX (midway)	12mg	IV	h	h
18/7/26	10pm	Inj LASIX (midway)	12mg	IV	h	h
19/7/26	3pm	Inj ALBUMIN	some over 4hrs	iv	Pr	Pr
	3pm	Inj LASIX	12mg midway	iv	Pr	Pr
	7pm		midway	iv	Pr	Pr

6:30 pm
6:30 pm
6:30 pm
9:10 pm
10:30 pm

VERIFIED BY : Name

Signature

Weight. 13.96 kg Ward.

Page: 4/4

BAH-00662020 IP5-00176584
Master SAMPETA SRI ADITYA GOUD
20-09-2023 2 Y 10 M 0 D (M)
Dr. DR.V.V.R.SATYA PRASAD

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

PRESCHOOL (1-5 years)

Children's Observation &
Early Warning Scoring Chart

Pratiksha
Rainbow
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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 21/7/26 Time:

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)

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

Resp Rate (Number)

Resp Mod/ Severe
Distress None / Mild

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

Conscious Level
Normal Altered

GCS *

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

ACTIONS

NB: Scores 3 should be
recorded overleaf

Score 1 : Continue normal observation by staff nurse

Score 2 : Shift in charge nurse to be informed and continue hourly observations

Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.

Score 4 : Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see

Score 5 & 6 : Shift 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)



PRESCHOOL (1-5 years)

Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 20/7 Time: 6am		10am	10pm	2pm	6pm	10pm	2am
Doctor / Nurse / Family Concern?							
Temperature (°F)		Today wt = 12.5kg 97.5°F 98 97 96 95 94					
Heart Rate (bpm)		189 (59) 123 (98) 104 (76) 89 bpm 106 bpm					
and Blood Pressure (mmHg) *		123 104 85 67					
Note: BP does not score in early warning scoring							
Heart Rate (Number)		89 bpm 106 bpm					
Resp Rate (bpm) (Over 1 Minute) *		26 bpm 24 bpm					
Resp Distress		Mod/ Severe None / Mild					
Receiving O ₂ (l/min)		100% 92%					
O ₂ Saturations (%)		100% 92%					
Conscious Level		Normal Altered					
GCS *		15/15 15/15					
TOTAL SCORE		1					
Number of shaded boxes		0					
Pain Score		0					
Observer's Initials		o					

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.

* 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

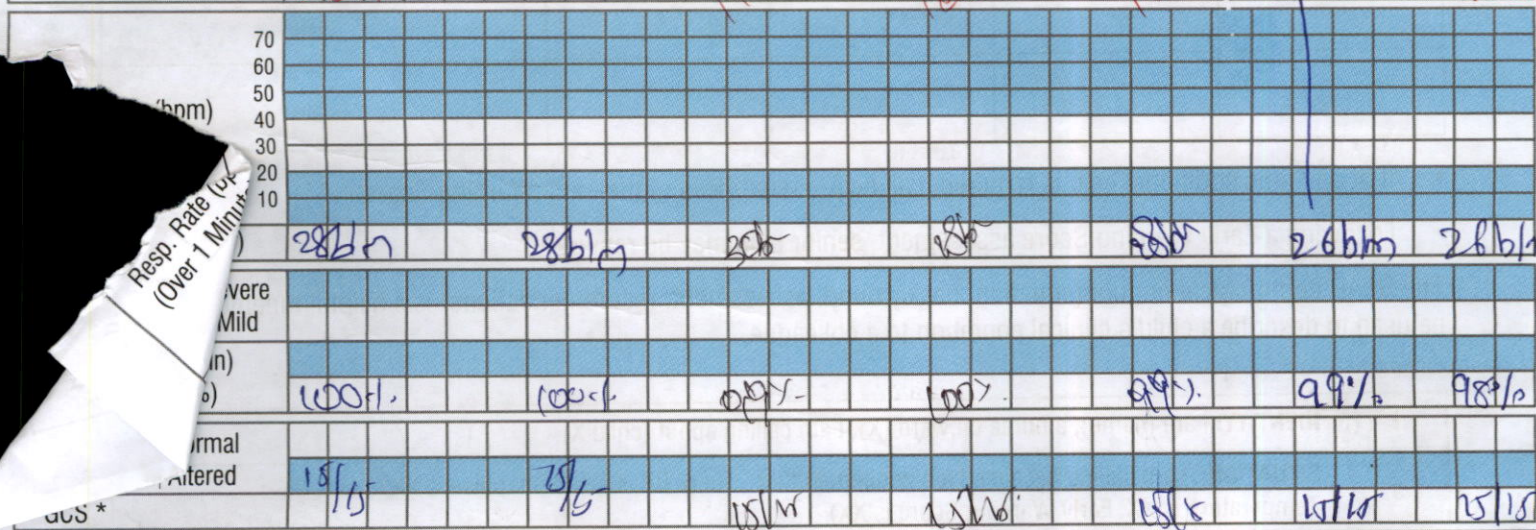
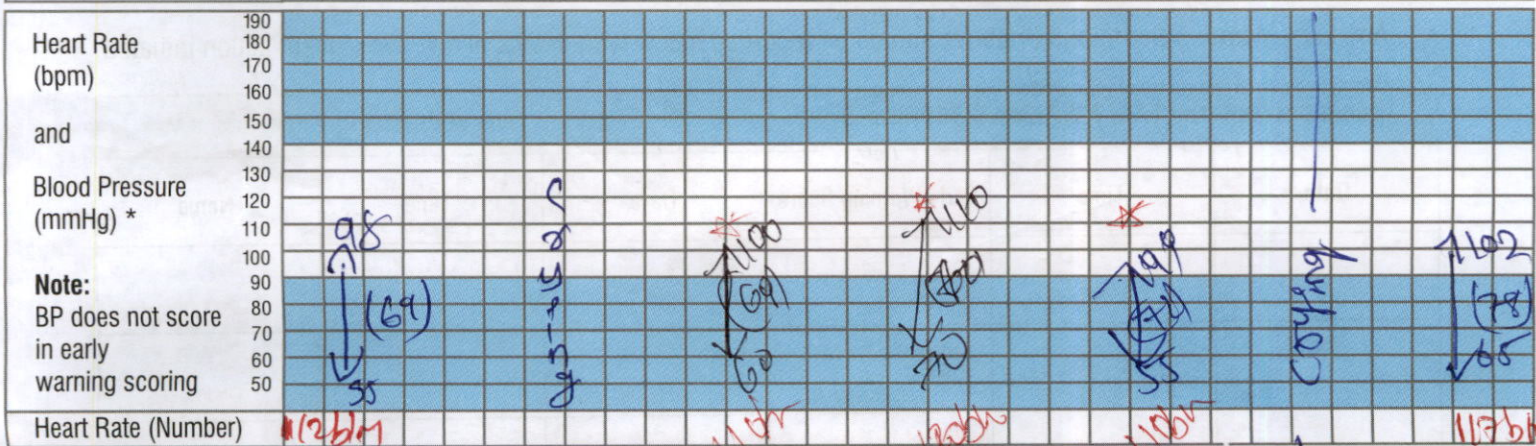
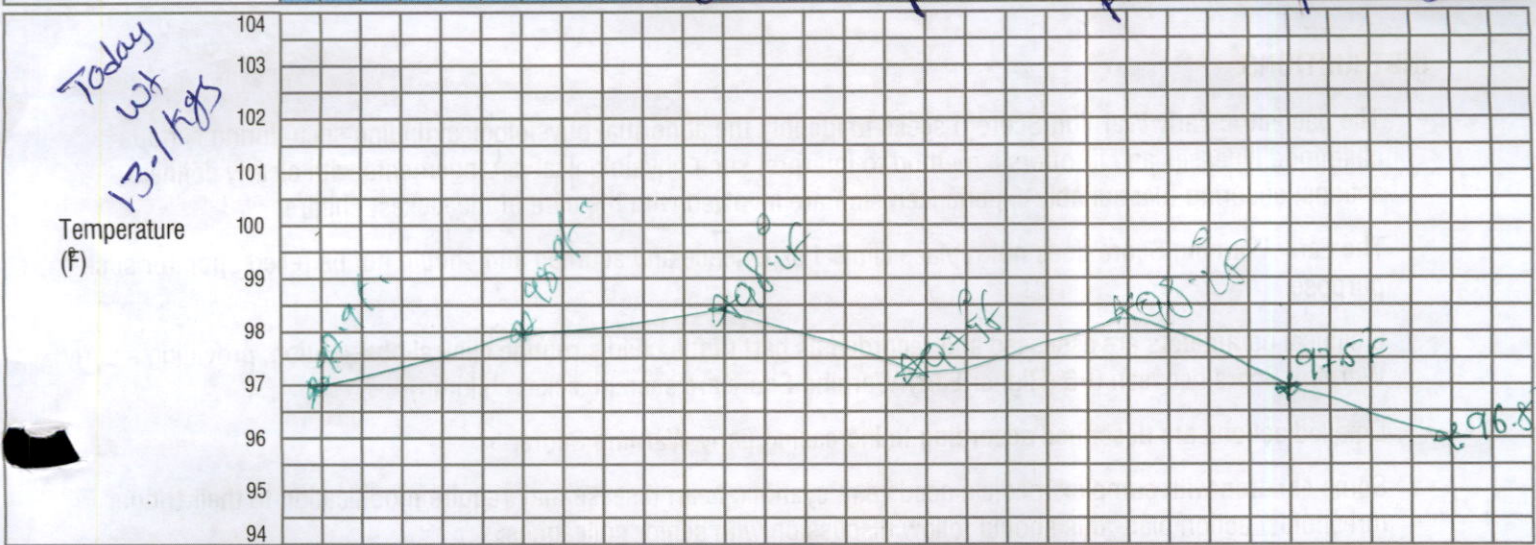
The SBAR communication tool (situation, background, assessment, recommendations) is a helpful mnemonic that can be used to describe a child's clinical condition to a colleague.

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)
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R	RECOMMENDATION : I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)



EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 19/09/23 Time: 8 AM 6 AM 10 AM 2 PM 6 PM 10 PM 2 AM
Doctor / Nurse / Family Concern?



TOTAL SCORE	1	1	1	1	1	1	1
Number of shaded boxes	1	1	1	1	1	1	1
Pain Score	0	0	0	0	0	0	0
Observer's Initials	2	0	0	0	0	0	0

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.
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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)

BAH-00662020 IP5-00176584
Master SAMPETA SRI ADITYA GOUD
20-09-2023 2 Y 9 M 28 D (M)
Dr. DR.V.V.R.SATYA PRASAD



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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

FLUID CHART

Sheet No. :

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
	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 :						
18/7	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm		20ml									
	12:00 am		20ml						200ml			Di
	01:00 am		20ml									
	Total Intake :					Total Output :						
19/7/24	02:00 am		20ml									
	03:00 am		20ml									
	04:00 am		20ml									
	05:00 am		20ml									
	06:00 am								266ml			Di
	07:00 am											
	Total Intake :					Total Output :						
Total 24 hrs. Intake					Total 24 hrs. Output							



FLUID CHART

Sheet No. :

1. All measurements in ml.
2. Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.
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									
19/07/23	08:00 am	DMS	20ml	20ml							0			
	09:00 am		20ml					110ml	0					
	10:00 am		20ml					0						
	11:00 am		20ml				175ml	0						
	12:00 pm		20ml					0						
	01:00 pm		20ml					0						
Total Intake :					Total Output :									
19/07/23	02:00 pm	DMS	20ml							20ml	0			
	03:00 pm		20ml					20ml	0					
	04:00 pm		20ml					20ml	0					
	05:00 pm							20ml	0					
	06:00 pm							20ml	0					
	07:00 pm		20ml					20ml	0					
Total Intake :					Total Output :									
19/7	08:00 pm	DMS	20ml							100ml	0			
	09:00 pm		20ml					80ml	0					
	10:00 pm		Mealy water					50ml	0					
	11:00 pm		20ml				50ml	0						
	12:00 am		20ml					0						
	01:00 am		20ml					0						
Total Intake :					Total Output :									
20/7	02:00 am	DMS	20ml							100ml	0			
	03:00 am		20ml						0					
	04:00 am		20ml						0					
	05:00 am		20ml					100ml	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. :

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
20/9	08:00 am										0	7 Apr	
	09:00 am										0		
	10:00 am								320ml	0	7 Apr		
	11:00 am									0	7 Apr		
	12:00 pm									0	7 Apr		
	01:00 pm									0	7 Apr		
Total Intake :						Total Output :							
20/9	02:00 pm			20ml						86ml	0	7 Apr	
	03:00 pm			20ml						0	7 Apr		
	04:00 pm			20ml						0	7 Apr		
	05:00 pm			20ml						0	7 Apr		
	06:00 pm								168ml	0	7 Apr		
	07:00 pm								155ml	0	7 Apr		
Total Intake :						Total Output :							
21/9	08:00 pm										0	7 Apr	
	09:00 pm									0	7 Apr		
	10:00 pm								185ml	0	7 Apr		
	11:00 pm								141ml	0	7 Apr		
	12:00 am									0	7 Apr		
	01:00 am									0	7 Apr		
Total Intake :						Total Output :							
21/9	02:00 am			20ml							0	7 Apr	
	03:00 am			20ml						0	7 Apr		
	04:00 am			20ml						0	7 Apr		
	05:00 am			20ml						0	7 Apr		
	06:00 am			20ml					205ml	0	7 Apr		
	07:00 am			20ml						0	7 Apr		
Total Intake :						Total Output :							
Total 24 hrs. Intake						Total 24 hrs. Output							



FLUID CHART

Sheet No. :

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

Total 24 hrs. Intake

Total 24 hrs. Output

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 19/7/26

Assessment: Pt having pain.

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
11PM	→ Assess the pt general condition	11PM	→ Assessed pt general condition	Pt condition is normal
12AM	→ monitor vital signs	12AM	→ monitored vital signs	
2AM	→ maintain I/O chart	2AM	→ maintained I/O chart	
8AM	→ Administer the medications as per doctors order.	8AM	→ Administered the medications as per doctors order.	

Re-Assessment: N/A

Special Notes: monitor urine assess out put.

Nurse Signature: [Signature]

Nurse Name: sravathi

Date & Time: 19/7/26



NURSING CARE RECORD

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 19/07/23

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
8am	*Assess The pt General condition	9am	*Assessed The pt General condition	pt is stable
10am	*check The pt activity	11am	*checked The pt activity	
12pm	*maintain I/O chart	1pm	*maintained I/O chart	
2pm	*provide comfortable position	5pm	*provided comfortable position	
6pm	*administer all medication given by doctor order	8pm	*administered all medication given by doctor order	

Re-Assessment:

Special Notes:

Even albumin transfusion done tomorrow Rf

Nurse Signature:

Nurse Name: Chanthi

Date & Time: 19/07/23 8pm

BAH-00662020 IP5-00176584
Master SAMPETA SRI ADITYA GOUD
20-09-2023 2 Y 9 M 29 D (M)
Dr. DR.V.V.R.SATYA PRASAD



NURSING CARE RECORD

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 19/7/26

Assessment: Baby having discomfort & pain

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
☒ Patient & Family Education

Time	Plan of Care	Time	Implementation	Evaluation
10pm	→ Assess the baby general condition & monitor the vital sign.	10:30 PM	→ Assessed the baby general condition & monitored the vital sign.	patient Baby condition is improved.
12am	→ Maintain the IV fluids.	12:30 am	→ Maintained the I/O chart	
2am	→ Administer the medication as per doctor order.	2:30 am	→ Administered the medication as per doctor order.	
4am	→ provide the comfortable position.	4:30 am	→ provided the comfortable position.	
6am	→ Maintain the I/O chart.	7:30 am	→ Maintained the IV fluids	

Re-Assessment: urine output checking

Special Notes: RP2/TM daily wt check

Nurse Signature:

Nurse Name:

Date & Time: 20/7/26 @ 8am



NURSING CARE RECORD

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 20/7/26

Assessment: Baby Having Edema

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
9am	→ Assess the Baby General Condition, monitor vitals & Record	10am	→ Assessed the Baby General Condition, monitored vitals & Recorded	eg Ankle's dose pt conditions improved
11am	→ provide comfortable position	11:30am	→ provided comfortable position	
12pm	→ maintain I/O chart	2pm	→ maintained I/O chart	
4pm	→ continue IV fluid's 20ml/hr	4pm	→ Continued IV fluid's 20ml/hr	
6pm	→ Administer medication as per doctor order	6pm	→ Administered medication as per doctor order	
8pm	→ Check daily weight	8pm	→ Checked daily weight	

Re-Assessment: Done by doing measurement of Urine

Special Notes: Strict I/O charting plan O/C

Nurse Signature:

Nurse Name: Shailaja Gossari

Date & Time: 20/7/26 (8pm)



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 20/7/26

Assessment: Baby having Edema

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 general condition of the patient.	8pm	* assessed the general condition of the patient.	By doing all the procedures the patient can be stable.
10pm	* maintain personal hygiene.	10pm	* maintained personal hygiene.	
2am	* maintain IV fluid.	2am	* maintained IV fluid.	
6am	* monitor vitals.	6am	* monitored vitals.	

Re-Assessment: monitor urine out put.

Special Notes:

Nurse Signature: [Signature] Nurse Name: Riniya Date & Time: 21/7/26 @ 8am



Patient Sticker

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☐ Night

Date:

Assessment:

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation

Re-Assessment:

Special Notes:

Nurse Signature:

Nurse Name:

Date & Time:

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Satya Prasad Department: ER Date of Admission: 18/7

SITUATION		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:						
BACKGROUND	Diagnosis:	<u>Nephrotic Syndrome</u>						
	Area							
BACKGROUND	Shift Time	<u>ER 6:34pm</u>	<u>PICU</u>	<u>1st floor 8:10am</u>	<u>1st floor 8:10am</u>	<u>1st floor 8:10am</u>	<u>1st floor 8:10am</u>	
	Medical Condition (Any special condition to be noted):	<u>NA</u>	<u>NA</u>	<u>NA</u>	<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>98.2°F</u>	<u>98.6°F</u>	<u>98.2°F</u>	<u>98.2°F</u>	<u>98.2°F</u>	<u>98.0°F</u>
		Res:	<u>20b/m</u>	<u>20b/m</u>	<u>26b/m</u>	<u>26b/m</u>	<u>26b/m</u>	<u>26b/m</u>
		SpO ₂ :	<u>98%</u>	<u>100%</u>	<u>99%</u>	<u>99%</u>	<u>100%</u>	<u>99%</u>
		Pulse:	<u>90b/m</u>	<u>101</u>	<u>126b/m</u>	<u>126b/m</u>	<u>126b/m</u>	<u>126b/m</u>
		BP:	<u>109/66</u>	<u>105/67</u>	<u>102/62</u>	<u>100/60</u>	<u>105/68</u>	<u>106/70</u>
	Fall Risk Score:	<u>12</u>	<u>yes</u>	<u>12</u>	<u>12</u>	<u>12</u>	<u>12</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>	<u>yes</u>	
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:	<u>NA</u>	<u>NO</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>Abhishek Rai</u>	<u>Rai</u>	<u>Srinivas</u>	<u>Ravi</u>	<u>Ravi</u>	<u>Shrinivas</u>	
Signature :		<u>Abhishek Rai</u>	<u>Rai</u>	<u>Srinivas</u>	<u>Ravi</u>	<u>Ravi</u>	<u>Shrinivas</u>	
Date:		<u>18/7/26</u>	<u>18/7/26</u>	<u>19/7</u>	<u>19/7</u>	<u>20/7</u>	<u>20/7</u>	
Time:		<u>6:34pm</u>	<u>@ 8pm</u>	<u>@ 8am</u>	<u>8pm</u>	<u>@ 8am</u>	<u>(8am)</u>	
Taken Over By Name :		<u>Rai</u>	<u>Srinivas</u>	<u>Shrinivas</u>	<u>Ravi</u>	<u>Aparna</u>	<u>Wings</u>	
Signature :		<u>Rai</u>	<u>Srinivas</u>	<u>Shrinivas</u>	<u>Ravi</u>	<u>Aparna</u>	<u>Wings</u>	
Date:		<u>18/7/26</u>	<u>18/7</u>	<u>19/107</u>	<u>19/7</u>	<u>20/7</u>	<u>20/7</u>	
Time:		<u>7:40pm</u>	<u>@ 11pm</u>	<u>@ 8am</u>	<u>@ 8pm</u>	<u>@ 8am</u>	<u>8pm</u>	



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
	Area	Shift Time						
BACKGROUND	Medical Condition (Any special condition to be noted):							
ASSESSMENT	Allergy:		☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Tubes/Drains/Catheter:		☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Vital Signs:	Temp:	98.2°					
		Res:	18					
		SpO ₂ :	98%					
		Pulse:	110b					
		BP:	99/62					
		Fall Risk Score:	10					
Pain Score:		0/10						
Recommendations	Safety Needs:		yes					
	Physiotherapy		☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Others Specify:		NA					
	Special Diet:		☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Other Special Orders / Medications:		NA					
Post Operative Procedure Special Orders:		NA						
Handed Over By Name :		Shruti						
Signature :		[Signature]						
Date:		21/7						
Time:		8am						
Taken Over By Name :		Anurag						
Signature :		[Signature]						
Date:		21/7						
Time:		8pm						

THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	18/7	19/7	20/7	21/7	
	3 to less than 7 years old	3	4	4	4	4	
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	2	2	2	2	
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1	1	1	
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	1	2	1	1	1	
	History of Falls or Infant - Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2	2	2	2	
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	1	1	1	1	
Medication Usage	Sedatives (excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1	1	1	
TOTAL			12	12	12	12	

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		✓	yes	yes	yes	
Call device within reach		✓	yes	yes	yes	
Wheels Locked		✓	yes	yes	yes	
Room free of clutter		✓	yes	yes	yes	
Adequate Lighting		✓	yes	yes	yes	
Wheel Chair Support		✓	no	no	no	
Other Intervention(s) Specify		✓	no	no	no	
Nurse's Name :		Abhishek Srivastava				
Signature :		Abhi				
Date :		18/7 19/7 20/7 21/7				
Time :		5pm 6am 6am				



BRADEN 'Q' SCALE

					Date :	18/7	19/7	20/7	21/7
					Time :	5pm	6am	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 extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.		4	4	4	4
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.		4	4	4	4
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.		4	4	4	4
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.		4	4	4	4
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."		4	4	4	4
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings of meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.		4	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.		4	4	4	4
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23					TOTAL SCORE	28	28	28	28
Docu. No. : RCHBH/FRM / CLINICAL / 119					Evaluator's Name	Abhi	San	Rat	

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



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
18/7	5pm	0/10	Nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	Abhishek
18/7	8pm	0/10	Nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	Rg
18/7	11pm	0/10	Nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	ff
19/7	6am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	8
19/07	2pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	SL
19/7	9pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	Pr
20/7	4am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Pu
20/7	12am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	888
20/7	8pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	888
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

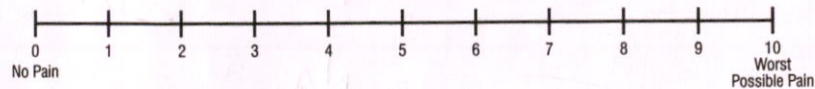
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 - 60 minutes after pain relief intervention.

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

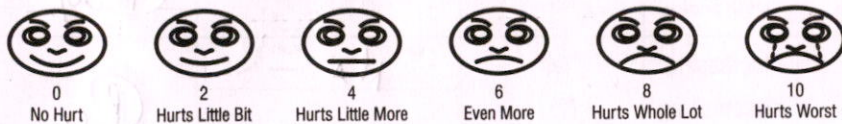
Numerical Pain Scale (Obstetric and Gynecology)



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



BAH-00662020 IP5-00176584
Master SAMPETA SRI ADITYA GOUD
20-09-2023 2 Y 9 M 28 D (M)
Dr. DR.V.V.R.SATYA PRASAD

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

DISCHARGE PLANNING FORM

Nationality: Indian

NOTES: * To be completed by a NURSE within (24) hours of admission.

1. Anticipated Date of Discharge: as per doctors order

2. Destination Post Discharge: ☒ Home

Family Members Notified (Person Contacted)

☐ Transfer

Hospital Facility Notified (Person Contacted)

3. Discharge Status: ☐ Self Care ☒ Family Home Care ☐ Home Professional Assistance

☐ Needs Assistance In:

Remarks

☒ Medication

☐ Yes

☐ No

☐ Bathing

☐ Yes

☐ No

☐ Eating

☐ Yes

☐ No

☐ Walking

☐ Yes

☐ No

☐ Dressing

☐ Yes

☐ No

☐ Toileting

☐ Yes

☐ No

Explain to mother

4. Nutritional Plan:

☐ Dietary Instruction Discussed with the:

☐ Patient

☒ Family Member

☐ Others:

5. Discharge Planning Discussed with the:

☐ Patient

☒ Family Member

☐ Others:

6. Patient/Family Educational Plan:

☐ Educational Topic/s: Personal hygiene

☐ Patient's Educational Topic/s discussed with the:

☐ Patient

☒ Family Member

☐ Others:

Nurse Signature: [Signature]

Nurse Name: S. Srinivas

Date and Time: 18/7/26 11 PM

Docu. No. : RCHBH / FRM / CLINICAL / 191



INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Part

Patient's / Learner Language: English 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		
18/7	5:00pm	7	Infection Control measures	M	1	0	1	1	NA	Abhishek
19/7/2023	9AM	9	Soft low salt diet	M	1	0	1	1		Abhishek

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 2. Physical Impairment 3. Emotional Barriers 4. Language Barrier 5. Educational Level 6. Desire / Motivate to Learn 7. Impaired Thought Process/Cognitive limitations 8. Responsibilities at Home 9. Cultural Differences 10. Financial Difficulties 11. Beliefs and Values 12. Impaired Vision/ or Hearing 13. Cultural/Religion Practice 14. Others (Specify)									
Teaching Tools Used: A: Audio D: Demonstration V: Video O: Oral P: Printed									
Mechanism/s to overcome barrier/s: 1. None 2. Obtain translator 3. Reassurance & Support 4. Teach Family / Others 5. Respect values & beliefs 6. Respect Cultural / Religion Preference 7. Other, Specify									
Understanding: 1. Verbalizes Understanding 2. Demonstrates Understanding 3. Needs Review									

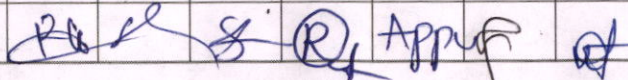
MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis:

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
18/7 6:00pm	☐ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	new onset nephrotic syndrome	hemodynamic stability	W Albumin w antibiotic	N. Prj	☐ Nursing ☐ Others:
18/7 6:00pm	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Nephrotic syndrome	Hemodynamic Stability	Iv Albumin Iv Antibiotic	Abhishek	☐ Medical ☐ Others:
18/7/23 9AM	☐ Medical ☒ Nursing ☐ Others: Dietician	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Nephrotic Syndrome	Soft low salt diet	RDA E: 1250 kcal/d P: 2g/d	Naitan	☐ 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:



CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			20/7 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	
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1			+	-	-	-	-	-	-	
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2			-	-	-	-	-	-	-	
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3			-	-	-	-	-	-	-	
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4			-	-	-	-	-	-	-	
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord pyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5			-	-	-	-	-	-	-	
Signature of the Nurse													

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

Signature of Shift In Charge :

Signature : Sourav Name : Sourav

Signature of Ward In Charge :

Signature : Neeraj Name : Neeraj

Albumin

CONSENT FOR BLOOD TRANSFUSION

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Name: Aditya Goud. Age: 2y 9m. Gender: Male ☒ Female ☐
UHID.No: BAH-00662020 Date: 18/7/26

Type of Blood Product: ☐ Fresh Frozen Plasma ☐ Packed Red Blood Cells ☐ Random Donor Platelets
☐ Cryoprecipitate ☐ Single Donor Platelet ☐ Whole Blood
☒ Albumin ☐ Red Blood Cell ☐ Others

I hereby give my consent for whole blood transfusion or the blood components as part of treatment of myself / my patient while being admitted at Rainbow Hospital. I have been explained all the known risks of transfusion reactions. I have also been explained that the donor blood has been screened for Human Immunodeficiency Virus antibodies, Hepatitis B surface antigen, Hepatitis C antibodies, Malaria and Syphilis. I have also been explained that transfusion transmitted infections occur even with screened blood, especially if it is in. The "window period" and also due to various other infections which have not been screened for. I also understand that any blood components transfusions carries risk of transfusion associated reactions, fluid overload etc. which are generally rare. The same risks apply for multiple transfusions too.

The doctor have explained to me about the alternative for this procedure that ②.....

All the above-mentioned risk, benefits and alternatives have been explained to me by the doctor treating me / my patient in the language that I fully understand and I accept the same and give my consent for all transfusions (the whole blood / or blood components Packed Red Blood Cells, Red Blood Cell, Platelets, Fresh Frozen Plasma, Cryoprecipitate etc.) to me / my Patient during he present hospital stay and treatment.

Patient (Or Patient Relative / Guardian):

Signature: [Signature]
Name: Bhagawan
Date & Time: 18/7/26 6:20 PM

Doctor (Who is talking the consent)

Signature: [Signature]
Name: N. Pratik
Date & Time: 18/7/26, 6pm

Witness

Signature: [Signature]
Name: [Signature]
Date & Time: 18/07/26 6pm



BLOOD PRODUCTS TRANSFUSION MONITORING FORM

Date: 18/7/26 Time: 7 PM

Blood Group of the Patient: Blood Group on the Blood Bag:

Blood Bank Issue No: Date of Collection: Date of Expiry:

Date & Time of Starting Transfusion: 18/7/26 7 PM Planned duration of Transfusion: 4 hours

Check for Correct Unit: ☒ Correct Patient: ☒

Blood products cross checked by: Nurse 1: Raj Nurse 2: Palash

Before starting transfusion vitals: Temp: 98.4°F HR 100 bpm RR: 22 bpm BP: 89/40 SpO₂ 100.1%

PLEASE MONITOR THE FOLLOWING:

Date	Time	HR	Temperature	Blood Pressure	SpO ₂	Any Rash	Any Rigors	Any Breathlessness	Any Other Problem
18/7/26	15 Min	101	98.4°F	101/49	100.1%	-	-	-	-
18/7/26	15 Min	112	98.5°F	80/49	100.1%	-	-	-	-
18/7/26	30 Min	101	98.4°F	90/60	100.1%	-	-	-	-
18/7/26	30 Min	98	98.6°F	40/40	100.1%	-	-	-	-
18/7/26	30 Min	90	98.7°F	89/60	100.1%	-	-	-	-
18/7/26	1 Hr	85	98.4°F	89/40	100.1%	-	-	-	-
18/7/26	1 Hr	95	98.3°F	55/65	100.1%	-	-	-	-

Comments:

Name of the Incharge-Nurse: Jaini

Signature of the Incharge-Nurse: Jaini

Date & Time: 18/7/26 10 PM

Docu. No. : RCHB/FRM / CLINICAL / 078

Name of the Nurse: Raj

Signature of the Nurse: Raj

Date & Time: 18/7/26 11 PM

BAH-00662020 IP5-00176584
Master SAMPETA SRI ADITYA GOUD
20-09-2023 2 Y 9 M 30 D (M)
Dr. DR.V.V.R.SATYA PRASAD



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BLOOD PRODUCTS TRANSFUSION MONITORING FORM

Date: 19/07/26 Time: 19/07/26 3pm

Blood Group of the Patient: Blood Group on the Blood Bag:

Blood Bank Issue No: Date of Collection: 19/7/26 Date of Expiry:

Date & Time of Starting Transfusion: 19/7/26 Planned duration of Transfusion: 4 hours

Check for Correct Unit: ☒ Correct Patient: ☒

Blood products cross checked by: Nurse 1: P. N. N. Nurse 2: S. N. N.

Before starting transfusion vitals: Temp: 98.6° HR: 90b/min RR: 28b/min BP: 100/60 SpO2: 99%

PLEASE MONITOR THE FOLLOWING:

Date	Time	HR	Temperature	Blood Pressure	SpO ₂	Any Rash	Any Rigors	Any Breathlessness	Any Other Problem
19/07/26	15 Min	72b/min	97.4°	110/70	99%	—	—	—	—
19/07/26	15 Min	80b/min	98.3°	100/65	100%	—	—	—	—
19/07/26	30 Min	90b/min	97.4°	100/65	99%	—	—	—	—
19/07/26	30 Min	75b/min	98.2°	100/60	99%	—	—	—	—
19/07/26	30 Min	92b/min	97.2°	100/60	99%	—	—	—	—
19/07/26	1 Hr	80b/min	98.3°	100/60	99%	—	—	—	—
19/07/26	1 Hr	75b/min	97.2°	99/65	100%	—	—	—	—

Comments:

Name of the Incharge-Nurse: Neeraja

Name of the Nurse: Anjali

Signature of the Incharge-Nurse:

Signature of the Nurse:

Date & Time: 19/07/26 @ 3pm

Date & Time: 19/07/26 @ 3pm

CONSENT FOR BLOOD TRANSFUSION



BAH-00662020 IP5-00176584
Master SAMPETA SRI ADITYA GOUD
20-09-2023 2 Y 9 M 30 D (M)
Dr. DR.V.V.R.SATYA PRASAD



Name: Age: Gender: Male ☐ Female ☐

UHID.No : Date:

Type of Blood Product: ☐ Fresh Frozen Plasma ☐ Packed Red Blood Cells ☐ Random Donor Platelets
☐ Cryoprecipitate ☐ Single Donor Platelet ☐ Whole Blood
☒ Albumin ☐ Red Blood Cell ☐ Others

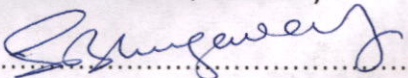
I hereby give my consent for whole blood transfusion or the blood components as part of treatment of myself / my patient while being admitted at Rainbow Hospital. I have been explained all the known risks of transfusion reactions. I have also been explained that the donor blood has been screened for Human Immuno-deficiency Virus antibodies, Hepatitis B surface antigen, Hepatitis C antibodies, Malaria and Syphilis. I have also been explained that transfusion transmitted infections occur even with screened blood, especially if it is in. The "window period" and also due to various other infections which have not been screened for. I also understand that any blood components transfusions carries risk of transfusion associated reactions, fluid overload etc. which are generally rare. The same risks apply for multiple transfusions too.

The doctor have explained to me about the alternative for this procedure that

All the above-mentioned risk, benefits and alternatives have been explained to me by the doctor treating me / my patient in language that I fully understand and I accept the same and give my consent for all transfusions (the whole blood / or blood components Packed Red Blood Cells, Red Blood Cell, Platelets, Fresh Frozen Plasma, Cryoprecipitate etc.) to me / my Patient during he present hospital stay and treatment.

Patient (Or Patient Relative / Guardian):

Doctor (Who is talking the consent)

Signature: 

Signature: 

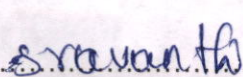
Name: S. BHAGAVAN

Name: T. Pavani

Date & Time 19/07/26 3pm

Date & Time 19/07/26 3pm

Witness

Signature: 

Name: Sravanthi

Date & Time 19/07/26 3pm

రక్త మార్పిడి కొరకు అంగీకార పత్రము

రోగి పేరు: వయస్సు: లింగము ☐ పురుషుడు ☐ స్త్రీ
UHID. సంఖ్య: తేదీ:

రక్త ఉత్పత్తి రకాలు:

- | | | |
|---|---|---|
| ☐ తాజా ఘనీభవించిన ప్లాస్మా | ☐ ప్యాక్ చేయబడిన ఎర్ర రక్త కణాలు | ☐ Random Donor Platelets |
| ☐ క్రయోప్రెసిపిటేట్ | ☐ ఒకే ధాత ఫ్లేటిలెట్స్ | ☐ Whole Blood |
| ☐ మొత్తం రక్తం | ☐ ఎర్ర రక్త కణం | ☐ ఇతరులు..... |

నేను ఇందు మూలముగా రెయిన్ఫో ఆసుపత్రిలో అడ్మిట్ అయి ఉన్నప్పుడు పూర్తి చికిత్సలో భాగంగా నాకు గాని/ నా రోగికి గాని రక్తమార్పిడి/రక్త రక్త ఉత్పత్తుల మార్పిడికి అంగీకారం తెలుపుతున్నాను. ధాత రక్తాన్ని హెచ్ ఐ వి యాంటీ బడీస్, హైపటెటిస్ జి సర్ఫేస్ యాంటిజన్, హైపటెటిస్ యాంటిబడీస్, మలేరియా మరియు సిఫ్లిస్ లక్షణాలు లేవని పరీక్షించి బడినది అని వివరించడమైనది. రక్త పరీక్ష నిర్ణయ కాల పరిమితి లో జరిగినప్పటికీ పరీక్షలో కనబడని అనేక ఇతర ఇన్ఫెక్షన్ ద్వారా అతి అరుదుగా ఇన్ఫెక్షన్లు సోక వచ్చునని కూడా తెలియపరచడమైనది. ఏదైన రక్త ఉత్పత్తుల మార్పిడికి సంబంధించిన ప్రతిచర్యలు సోకే ప్రమాదం వుందని, ప్రసరణ వ్యవస్థలో అదనపు ద్రవం మొదలగు అరుదైనది పర్యవసానాలు తెలెత్తవచ్చు అని నేను అర్థం చేసుకున్నాను.

ఈ ప్రక్రియకు ప్రత్యామ్నాయం గురించి డాక్టర్ నాకు వివరించారు

పైన పేర్కొన్న అన్ని ప్రమాదాలు, ప్రయోజనాలు మరియు ప్రత్యామ్నాయాలు నాకు / నా రోగికి చికిత్స చేస్తున్న డాక్టర్ ద్వారా నాకు వివరించబడ్డాయి. చికిత్స చేస్తున్న సమయంలో అన్ని రకముల రక్తమార్పిడులకు (మొత్తం రక్తం / లేదా రక్త ఉత్పత్తులు ప్యాక్ చేయబడిన ఎర్ర రక్త కణాలు, ఎర్ర రక్త కణాలు, ప్లేట్ లెట్స్, ప్లాస్మా ప్రోథెజిన్ ప్లాస్మా, క్రయోప్రెసిపిటేట్ మొదలైనవి) నా అంగీకారము తెలుపుతున్నాను. నాకు పూర్తిగా అర్థమగు భాషలో నాకు నా రోగికి వివరించారు మరియు నేను దానిని సమ్మతిస్తున్నాను

సహాయకుడు(అటెండెంట్)

సాక్షి

సంతకము

సంతకం

పేరు

పేరు

తేదీ మరియు సమయము

తేదీ మరియు సమయము

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము

పేరు

PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00662020 IP5-00176584 Master SAMPETA SRI ADITYA GOUD 20-09-2023 2 Y 9 M 28 D (M) Dr. DR.V.V.R.SATYA PRASAD 		Date & Time of Admission 18/7/26	Date & Time of Transfer Order
		Transfer Ordered by Dr. Dr. V.V.R. Satya P	Reason for Transfer Stable
From Unit PICU	To Unit 142	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 20	Number of Imaging Films Nil	Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring Raj		Name of Person Ordered Transfer Dr. DR.V.V.R.S.P.	
Patient & Clinical Records Received by : Saurabh			
Date & Time of Patient Received : 18/7/26 11PM			

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

- ☐ Unavailable Bed ☐ Nurse not Available ☐ Available Bed not ready

BAH-00662020 IP5-00176584
Master SAMPETA SRI ADITYA GOUD
20-09-2023 2 Y 9 M 30 D (M)
Dr. DR.V.V.R.SATYA PRASAD

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Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 4:55pm Mode of Arrival: wheel chair Admitting From: ☒ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction

Body Weight: 13.62 Kg

Height: cm

No Allergy Reaction

Past Medical History: Obtained From ☐ Patient ☒ Family Member ☐ Medical Record ☐ Other (specify)

Past Medical History	Past Surgical History	Previous Hospital Admission
<u>N/I</u>	<u>N/I</u>	<u>N/I</u>

Family History:

N/I

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

If yes please list,

Was the child's birth normal? ☒ Yes ☐ No If No, please describe problems:

Are the child's immunization up to date? ☐ Yes ☒ No

Current Medication: ☐ None ☒ Yes, If Yes, fill reconciliation form

Observations: Weight: 13.62kg Length: Head Circumference (< 2 years):

Temp.: 98.2°F HR: 126 b/m RR: 26 b/m BP: 108/68

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

Fall Risk Assessment: ☒ Yes ☐ No Score: 12 (Document in the Humpty Dumpty Sheet)

Risk of Pressure Sore (Braden Q Score 28) (Document in the Braden Q Assessment Sheet)

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

Character of Pain 0 Location 0 Frequency 0 Duration 0

FUNCTIONAL SCREENING:☒ No Abnormalities Detected

- ☐ Mobility Problem
☐ Developmental Delay

- ☐ Walking Problem
☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING:☒ No Abnormalities Detected

- ☐ Underweight
☐ Feeding Problem

- ☐ Overweight
☐ Special diet

- ☐ Special Feeding Method
☐ No Abnormality Detected

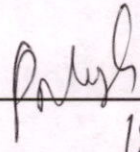
Inform consultant for positive criteria

Psychological Screening:☐ No Significant FindingsUnusual concerns about patient's Psychological Status: ☒ Yes ☐ No

If Yes Consultant Notified: (Date/Time):

Cultural & Spiritual Needs: ☒ Yes ☐ No if Yes specify Inform consultant for positive criteria.**Social History:** Lives WithSiblings in household ☐ Yes ☐ No (if yes How Many?)All Information Obtained From ☐ Patient ☒ Mother ☐ Father ☐ Other Family Member**Orientation has been given regarding the following aspects:**Call Bell in Reach : ☐ Yes ☐ NoWaste Disposal Explained: ☒ Yes ☐ NoInfusion Pump : ☒ Yes ☐ NoHand hygiene Explained: ☒ Yes ☐ No☐ OthersPatient Rights & Responsibilities: ☐ Yes ☐ NoInformation given to MotherNurse Signature: K. SravanthiNurse Name: SDate: 19/7/26Time: @ 5pm

PATIENT TRANSFER FORM

Patient Name & UHID No.		Date & Time of Admission	Date & Time of Transfer Order
BAH-00662020 IPS-00176584 Master SAMPETA SRI ADITYA GOUD 20-09-2023 2 Y 9 M 28 D (M) Dr. DR. V.V.R. SATYA PRASAD 		18/7/26 at 5:48pm	18/7/26 at
		Transfer Ordered by	Reason for Transfer
		Dr. Rameya	Admission
From Unit	To Unit	Information to Attendant	
ER	PICU	Yes ☒ No ☐	
Number of Sheets in Clinical File	Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ If Yes, what? OP File	Patient shifted with ID band:	
Number of Imaging Films		Yes ☒ No ☐ If No:	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring		Name of Person Ordered Transfer	
Mr. Abhishek		Dr. Rameya	
Patient & Clinical Records Received by :			
 Date & Time of Patient Received : 18/07/26 6pm			

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

- ☐ Unavailable Bed
 ☐ Nurse not Available
 ☐ Available Bed not ready



NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 19/7/26 Time: 9 AM

Weight: 13.62 kgs Centile: 25th

Height: 98 cm Centile: 77.5th

Inference: well child

RDA: Calories: 1250 kCal/d Protein: 21 g/d

Diet Recommendations: soft low salt diet

Re-Assessment: Avoid spicy, chilled and outside foods.

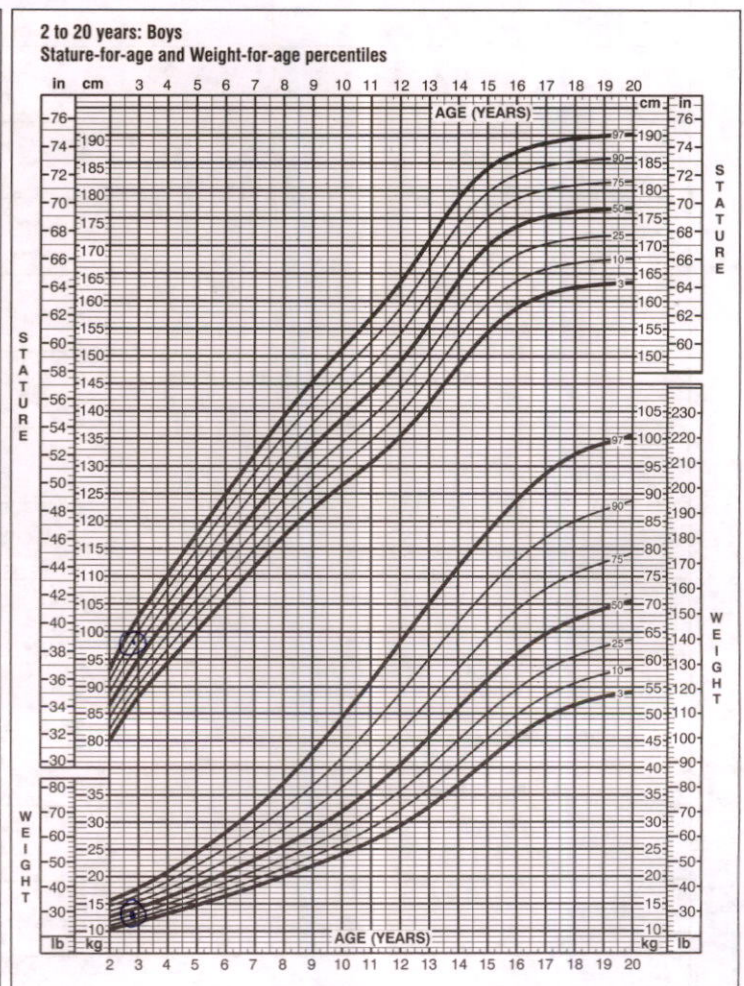
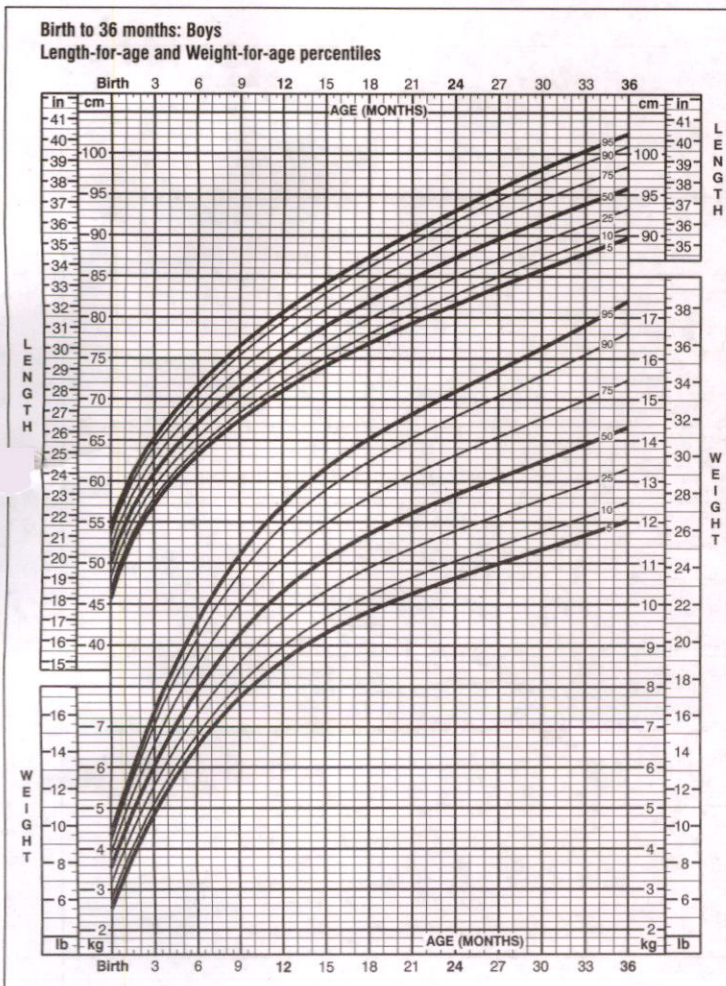
Food Allergies: No Veg/Non-veg: non-veg

Diagnosis: new onset nephrotic syndrome

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: [Signature]

GROWTH CHART (BOYS)



Dietician's Name: NPKRTHA

Dietician's Signature: [Signature]

Daily Notes:

20/2/20
WAM

Child is stable oral intake is better

Continue to soft low salt diet.

- Nkeke