

ADMISSION SHEET

Registration Details :



Admission No : IP5-00176669

Admit Date : 20-Jul-2026

Admit Time : 05:56 PM UHID : BAH-00511526

Patient Details :

Patient Name : Master ABUBAKR RASHID

Age : 4 Y 4 M 9 D

Guardian : Mr RASHID ABDUL RAHMAN

DOB : 11-03-2022

Gender : Male

Religion : Muslim

Occupation :

Martial Status : Single

Address (H) : H.NO 22-3-625, ZEHRA NAGAR, MIR ALAM
MANDI, Charminar Hyderabad Telangana
INDIA 500002

Phone No : 7406822428/ 8008635083

E-mail :
RASHIDABDULRAHMAN6@GMAIL.CO

Admission Details :

Bed Type : DELUXE ROOM

Bed No : DLX 308

Ward Name : 3F-ZONE A

Room No : DLX 308

Admission Type : First Visit

Contact Details :

Name : Mr RASHID ABDUL RAHMAN

Relationship : Father

Contact Address : H.NO 22-3-625, ZEHRA NAGAR, MIR ALAM
MANDI, Charminar Hyderabad Telangana INDIA
500002

Phone No :

Rashid
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 : MEDI ASSIST INSURANCE TPA PVT
LTD

ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____

Date of Admission : _____

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

Ultant : _____ Dept : _____

Time of Discharge : _____ Time : _____

BAH-00511526 IP5-00176669
Master ABUBAKR RASHID
11-03-2022 4 Y 4 M 9 D (M)
Dr. DR. V. V. R. SATYA PRASAD



WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
20/3/20	6:50 PM	ER	308(A)	Annul

Cross Consultation Visit

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

INVESTIGATIONS

[illegible]

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
20/07	iv placement	1	713020	T. Saif

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor



It takes a lot to treat the little.

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: _____

UHID ID: _____

Department: _____

Consultant: _____

BAH-00511526 IP5-00176569
Master ABUBAKR RASHID
11-03-2022 4 Y 4 M 9 D (M)
Dr. DR.V.V.R.SATYA PRASAD



4 yr / 1 mch

BAH-00511526 IP5-00176669
Master ABUBAKR RASHID
11-03-2022 4 Y 4 M 9 D (M)
Dr. DR.V.V.R.SATYA PRASAD



History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

40 pain during micturition | since 2 days
crying during micturition
terminal Hematuria (+)

History of present illness :

40 pain during micturition | since 2 days
crying during micturition

terminal Hematuria (+)

2-4 times

decreased urine output (+)

loose stool (+) since 1 week.

1-2 episodes/day
watery

No 40 fever/cold/cough/vomitings

ATPb
urinalysis → ure 70-75 pus cells
2+ Albumin

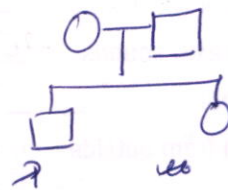
Pediatric Multiorgan System & Physical Examination

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

nil

Birth & Neonatal History:

term / no perinatal complications
Normal transition



Birth & Socio Economic History:

About Father :

About Mother :

Any additional Information :

middle

Developmental History :

appropriate for age

Immunization History :

vaccinated till date

(P.T.O.)

Sensory System :

Bladder / Bowel :

Clinical Summary & Diagnostic:

? UTI

Pediatric Multiorgan History & Physical Examination

Anthropometry :

Head Circum (cms) _____ (Centile _____) Height (cms): _____ (Centile _____)
Weight (kgs)) 13.8 kgs (Centile _____)

On Examination :

Temperature : 97.5°F Pulse Rate : 109/min B.P. 92/57(68) SP02 96% L RA
Resp.rate and type of breathing : 24/min

Rash _____

Lymphadenopathy _____

Oedema : _____

Allergies : _____

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: complications

Desired goals of the treatment : Resolution of symptoms

Planned Labs:

CRP, CRP, Blood C/S

RP2

C/S, urine C/S

S. Albumin

USG Abdomen

S. Calcium / S. uric acid

N/R
Terry
20/07/20

Planned Management

- (1) Png. Eomeprazole
- (2) Png. ceftriaxone
- (3) IVF - DNS 3/4th maintenance
- (4) SOS catheterisation based on USG Abdomen

M/S
Anail
20/07/20

Signature of the Doctor: Madhu

Name of the Doctor: Madhu

Date & Time: 20/07/2026

Signature of the Consultant: [Signature]

Name of the Consultant: _____

Date & Time: _____



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
21/7 10:30am	C/S/B Dr. Satyaprasad	
	<u>Δ. UTI / hematuria</u>	<u>Adv.</u>
	-afebrile post admission	- Xray erect abdomen now
	- no further blood in urine	- spot urine calcium
	- stools - constipated	uric. acid
	no fltys renal calculi	creatinine now
	O/E: alert	- IVF 32ml/h.
	vitals stable	- Cont Ceftriaxone
	chest clear	- ① urine c/s.
	abdomen soft	- No labs t/m.
	gintalia - ②	

DR. V.V.R. SATYAPRASAD
Registration No: 4388

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/7 9:30am	C/S/B Resident Δ: UTI (culture ⊕) ± hypercalciuria / hyperuricosuria ± constipation afebrile stools - O/E : alert stable vitals chest clear no dehydration	Adv. - Trace urine c/s - Continue Ceftriaxone P3 - Monitor vitals Afebrile - Neotomic enema today - No labs T/M. - of fundus Anti . CBP CBP (S+) A/B germs Trace c/s report Rest to continue Same
22/7/mb 2pm	C/S - Klebsiella S/B Dr. Sankar S/B Ceftriaxone	Noted by

Master ABUBAKR RASHID
11-03-2022 4 Y 4 M 10 D (M)
Dr. DR.V.V.R.SATYA PRASAD



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11-03-2022 4 Y 4 M 9 D (M)
Dr. DR.V.V.R.SATYA PRASAD



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

RESULT SHEET

Date	20/7/26				
Time	6:17pm				
Hb	13.2				
PCV	37.3				
RBC	4.63				
WBC	8.49				
N/L	37.3/54.8				
Platelets	315				
CRP	12.0				
ESR					
PCT					
RBS					
Na	137				
K	4.0				
Cl	104				
Ca/Mg	10.3/				
Phosphate					
Urea	18				
Creatinine	0.3				
ALP					
SGPT					
SGOT					
T.Bill/Conj					
T.Protein					
S.Albumin	4.6				
S.Globulin					
A/G Ratio					
Uric Acid	3.1				
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein / Sugar					
Cells					
N/L					

Bicarbonate - 20.

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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: 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: Madhu

Date & Time: 20/2/26

Name & Signature: Anneeb

20/7/26 6 pm

BAH-00511526 IP5-00176669

Master ABUBAKR RASHID

11-03-2022 4 Y 4 M 10 D (M)

Dr. DR.V.V.R.SATYA PRASAD



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Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward

DRUG :- Symp POTRAFE MGB				Date Time	21/7	22/7	23/7													
Dose	Route	Frequency	Start Dt.																	
Sml	PO	BD	21/7																	
Name & Signature of the Doctor Starting the Drugs: <i>Pug</i>																				
Additional Instructions: → to dilute in 1/4 th glass of water.																				
Daily Doctor's Endorsement by a Sign																				
DRUG : MUCIT powder				Date Time	22/7															
Dose	Route	Frequency	Start Dt.																	
2 1/2	PO	HS	22/7																	
Name & Signature of the Doctor Starting the Drugs: <i>Anhile</i>																				
Additional Instructions: → 2 1/2 scoops in 150ml water R																				
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																				

Signature

VERIFIED BY : Name

Patient Sticker

Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward

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

BAH-00511526 IP5-00176669
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11-03-2022 4 Y 4 M 9 D (M)
Dr. DR.V.V.R.SATYA PRASAD

DRUG CHART

Date of Admission: 20/11/2022 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:																			



REGULAR PRESCRIPTIONS

Weight. 13.8 kgs Ward.

DRUG : INJ - CEFTRIAXONE				Date Time	20/7/21	21/7	22													
Dose 700mg	Route IV	Frequency BD	Start Date 20/7/26		10am	10am	10am													
Name & Signature of the Doctor Starting the Drugs: <u>Madhu</u>																				
Additional Instructions:				10pm 10pm 10pm 10pm																
Daily Doctor's Endorsement by a Sign				A A A																

DRUG : INJ - GOMEPRAZOLE				Date Time	20/7	20/7	20/7	20/7												
Dose 14mg	Route IV	Frequency OD	Start Date 20/7/26		6am 10pm	6am 10pm	6am 10pm	6am 10pm												
Name & Signature of the Doctor Starting the Drugs: <u>Madhu</u>																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign				A A A R																

DRUG : ECONORM SACHET				Date Time	20/7															
Dose 15 SACHET	Route PO	Frequency TSD	Start Date 20/7/26		10am	10am	10am	10am												
Name & Signature of the Doctor Starting the Drugs: <u>Madhu</u>																				
Additional Instructions:				10pm 10pm 10pm 10pm 10pm 10pm 10pm 10pm 10pm 10pm 10pm 10pm 10pm 10pm 10pm 10pm 10pm 10pm 10pm 10pm 10pm 10pm 10pm 10pm 10pm 10pm 10pm 10pm 10pm 10pm 10pm 10pm 10pm 10pm 10pm 10pm 10pm 10pm 10pm 10pm																
Daily Doctor's Endorsement by a Sign				A A A R																

DRUG : MUOUT POWDER				Date Time	21/7															
Dose Po	Route Po	Frequency Night	Start Date 21/7		9pm	9pm	9pm	9pm												
Name & Signature of the Doctor Starting the Drugs: <u>Paul</u>																				
Additional Instructions: 2 scoops (+) some water				510P 510P 510P 510P 510P 510P 510P 510P 510P 510P 510P 510P 510P 510P 510P 510P 510P 510P 510P 510P																
Daily Doctor's Endorsement by a Sign				A A A																



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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
21/7/16	6:10 PM	NEOTOMIC ENEMA	1unit	PR	Paul	Surge Durge
22/7		NEOTOMIC enema	1unit	PR	Surge	
22/7	4 pm	DULCOLAX suppository	10 mg	PR	Surge	Jessie Mounitha
22/7	12:30 pm					Jessie Mounitha
22/7		NEOTOMIC enema	1unit	PR	Surge	
23/7	11 AM	PROCTOCYCLIS ENEMA	66ml	P.R	Paul	

Weight. 13.8 kg Ward.

Position of I.V. Fluid (Infusion ml/hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
--	-------	--------------------	----------------	---------------	---------------------	----------------	---------------

[illegible]

EARLY WARNING SCORE: CHILDREN'S UNIT

Date :	Time: 7:10pm	10pm	2pm	6pm
Doctor / Nurse / Family Concern?				
Temperature (F)	98.1 F	98.2 F	98.3 F	98.2 F
Heart Rate (bpm)	101 bpm	101 bpm	102 bpm	103 bpm
Blood Pressure (mmHg) *	88/61	88/62	99/62	100/70
Resp. Rate (bpm) (Over 1 Minute) *	27 bpm	27 bpm	27 bpm	28 bpm
Resp Rate (Number)	27 bpm	27 bpm	27 bpm	28 bpm
Resp Mod/ Severe Distress	None	None	None	None
Receiving O ₂ (l/min)	0.8 l/min	0.8 l/min	0.8 l/min	0.8 l/min
O ₂ Saturations (%)	98%	98%	98%	98%
Conscious Level	Normal	Normal	Normal	Normal
GCS *	(15/15)	(15/15)	(15/15)	(15/15)
TOTAL SCORE	0	0	0	0
Number of shaded boxes	0	0	0	0
Pain Score	0	0	0	0
Observer's Initials	h	h	h	h

ACTIONS

NB: Scores 3 should be recorded overleaf

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

* 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.

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Date	Time	Early Warning Score	Date	Time	Name

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BAH-00511526 IP5-00176669
Master ABUBAKR RASHID
11-03-2022 4 Y 4 M 10 D (M)
Dr. DR.V.V.R.SATYA PRASAD



22/3
RCH/ FRM / CLINICAL / 125

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

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

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date :	Time:	10am	12pm	3pm	6pm	10 pm	12:30 am	6 am
Doctor / Nurse / Family Concern?								
Temperature (°F)		97.5°F	98.1°F	97.6°F	98.1°F	98.1°F		97.9°F
Heart Rate (bpm)		120bpm	124bpm	122bpm	128bpm	122bpm		126bpm
Blood Pressure (mmHg) *		120	125	125	125	125		125
Note: BP does not score in early warning scoring								
Heart Rate (Number)		120bpm	124bpm	122bpm	128bpm	122bpm		126bpm
Resp. Rate (bpm) (Over 1 Minute) *		32bpm	34bpm	34bpm	32bpm	32bpm		32bpm
Resp Rate (Number)		32bpm	34bpm	34bpm	32bpm	32bpm		32bpm
Resp Distress	Mod/ Severe							
Receiving O ₂ (l/min)	None / Mild							
O ₂ Saturations (%)		99%	99%	99%	98%	99%		99%
Conscious Level	Normal							
GCS *	Altered	15/15	15/15	15/15	15/15	15/15		15/15
TOTAL SCORE								
Number of shaded boxes		0	0	0	0	0		0
Pain Score		0	0	0	0	0		0
Observer's Initials		AB	AB	AB	AB	AB		AB

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)

Patient

BAH-00511526 IP5-00176669
 Master ABUBAKR RASHID (M)
 11-03-2022 4 Y 4 M 9 D
 Dr. DR.V.V.R.SATYA PRASAD



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FLUID CHART

Sheet No. : (1)

20/7/26

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					Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine	
	08:00 am										
	09:00 am										
	10:00 am										
	11:00 am										
	12:00 pm										
	01:00 pm										

Total Intake :

Total Output :

	02:00 pm										
	03:00 pm										
	04:00 pm										
	05:00 pm										
	06:00 pm										
	07:00 pm										

Total Intake :

Total Output :

	08:00 pm		32ml	32ml							
	09:00 pm		H2O								
	10:00 pm		32ml	32ml							
	11:00 pm		H2O								
	12:00 am		32ml	32ml							
	01:00 am		H2O								

Total Intake :

Total Output :

	02:00 am		32ml								
	03:00 am		H2O								
	04:00 am		32ml								
	05:00 am		H2O								
	06:00 am		32ml								
	07:00 am		H2O								

Total Intake :

Total Output :

Total 24 hrs. Intake	192 ml	Total 24 hrs. Output	U - P m - O
----------------------	--------	----------------------	-------------



FLUID CHART

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Sheet No. : 21/1/26

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
											0	Durga
	08:00 am	1		32ml						✓	0	Durga
	09:00 am	1		32ml							0	Durga
	10:00 am	1		32ml							0	Durga
	11:00 am	2mls		32ml							0	Durga
	12:00 pm	1		32ml			✓			✓	0	Durga
	01:00 pm										0	Durga
Total Intake :						Total Output : 2 m-1						
	02:00 pm	1		32ml							0	Durga
	03:00 pm	1		32ml						✓	0	Durga
	04:00 pm	2mls		32ml							0	Durga
	05:00 pm	1		32ml							0	Durga
	06:00 pm						✓			✓	0	Durga
	07:00 pm										0	Durga
Total Intake :						Total Output : 3 m-1						
	08:00 pm	1		32ml							0	Sange
	09:00 pm	1									0	Sange
	10:00 pm	2mls		32ml						✓	0	Sange
	11:00 pm	1					✓			✓	0	Sange
	12:00 am	1		32ml						✓	0	Sange
	01:00 am										0	Sange
Total Intake :						Total Output : 3 m-1						
	02:00 am	1		32ml							0	Sange
	03:00 am	1									0	Sange
	04:00 am	2mls		32ml						✓	0	Sange
	05:00 am	1					✓			✓	0	Sange
	06:00 am	1		32ml						✓	0	Sange
	07:00 am										0	Sange
Total Intake :						Total Output : 3 m-1						

Total 24 hrs. Intake

total - 364ml

Total 24 hrs. Output

U-10 m-4

22/7/20

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.
3. 24 hrs. total to be entered in the kardex in RED.

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	1		32ml			1				0	Jessie
	09:00 am	1	H ₂ O	32ml						✓	0	Jessie
	10:00 am	0		32ml							0	Jessie
	11:00 am	1	H ₂ O	32ml			✓				0	Jessie
	12:00 pm	1		32ml			✓			✓	0	Jessie
	01:00 pm	1	H ₂ O	32ml							0	Jessie
Total Intake :			IV = 128 ml			Total Output :			U - 2 M - 1			
	02:00 pm	1		32ml							0	Jessie
	03:00 pm	1	H ₂ O	32ml						✓	0	Jessie
	04:00 pm	0		32ml							0	Jessie
	05:00 pm	1	H ₂ O	32ml			✓			✓	0	Jessie
	06:00 pm	1		32ml							0	Jessie
	07:00 pm		H ₂ O	32ml							0	Jessie
Total Intake :			IV = 128 ml			Total Output :			M - 1 U - 2			
	08:00 pm	1		32ml							0	Swape
	09:00 pm	1	H ₂ O	32ml			✓				0	Swape
	10:00 pm	0		-						✓	0	Swape
	11:00 pm	1	H ₂ O	-							0	Swape
	12:00 am	1		32ml							0	Swape
	01:00 am	1	H ₂ O	32ml							0	Swape
Total Intake :			IV = 128 ml			Total Output :			U - 1 M - 1			
	02:00 am	1		32ml							0	Swape
	03:00 am	1	H ₂ O	-							0	Swape
	04:00 am	0		-							0	Swape
	05:00 am	1	H ₂ O	-			NP				0	Swape
	06:00 am	1		32ml							0	Swape
	07:00 am	1								✓	0	Swape
Total Intake :			IV = 64 ml			Total Output :			U - 1 M - 0			
Total 24 hrs. Intake			TOTAL 448 ml			Total 24 hrs. Output			U - 6 M - 3			



23/7/26

FLUID CHART

Sheet No. : 17

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								
	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							

BAH-00511526 IP5-00176669
Master ABUBAKR RASHID
11-03-2022 4 Y 4 M 9 D (M)
Dr. DR.V.V.R.SATYA PRASAD



NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 20/4/2021

Assessment: Patient is having discomfort

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 patient General condition	8:30pm	→ Assessed the patient General condition	Now patient is stable
10pm	→ Administer medication as per Chart	10:30pm	→ Administered medication as per Chart	
12am	→ Maintain fluid Balance	12:30am	→ Maintained fluid Balance	
3am	→ Monitor vital sign	3:30am	→ Monitored vital sign & document on file	
4pm	→ Ensure safety	4:30am	→ Ensured safety	

Re-Assessment: Re-Assessment done every 3rd hourly

Special Notes: Bp monitoring, strict I/O chart

Nurse Signature: [Signature]

Nurse Name: Bongetha

Date & Time: 21/4/21 @ 8am

BAH-00511526
Master ABUBAKR RASHID
11-03-2022 4 Y 4 M 10 D (M)
Dr. DR.V.V.R.SATYA PRASAD

IP5-00176669

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NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 21/7/20

Assessment: pt is having Discomfort

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 patient's current condition.	8:30pm	Assess the patient's current condition.	pt is stable
10pm	monitor vitals	10:30pm	monitored vitals	
12Am	Administer medication as per chart	12:30Am	Administered medication as per chart	
3Am	Do chart maintenance	3:30Am	Do chart maintenance	
6Am	ensure safety	6:30Am	Ensured safety	

Re-Assessment: pt is stable now

Special Notes: Will

Nurse Signature: [Signature]

Nurse Name: Sangeetha @ 607728

Date & Time: 22/7/20 @ 8Am

NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 22/7/26

Assessment: pt having discomfort

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	8:30 am	Assessed the pt general condition	Pt is stable
10:30 am	Assess the pt vitals	11am	Assessed the pt vitals	
12pm	Assess the pt in a comfortable position	12:30 pm	Assessed the pt in a comfortable position	
1pm		1:30 pm		
1:40 pm	Assess the pt hygiene	2pm	Provided the pt hygiene	

Re-Assessment: pt is stable

Special Notes: NA

Nurse Signature: [Signature]

Nurse Name: Jesnie @ 9010577

Date & Time: 22/7/26 @ 9pm



NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 22/7/26

Assessment: patient is having discomfort

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 condition and vitals check	8:30 pm	* Assessed the baby condition and vitals check	* now patient is condition is stable
10pm	* monitor the Pb chart	10:30 pm	* monitored the Pb chart	
12pm	* Check the Fever spikes	12:30 pm	* checked the Fever spikes	
3pm	* provide Comfortable position to the patient	3:30 pm	* provided Comfortable position to the patient	
6pm	* Administer medicine as per chart	6:30 pm	* Administered medicine as per chart	
7pm	* Ensure Safety	7:30 pm	* Ensured Safety	

Re-Assessment: Assess the patient condition now it is stable

Special Notes: Nil

Nurse Signature: Sneh

Nurse Name: Sneh - 607635

Date & Time: 22/7/26 @ 8pm

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 22/7/26

Assessment: Patient is having discomfort

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	9pm	Assessed the general condition of the patient	Patient is stable & comfortable
10pm	plan for vitals	11pm	checked vitals	
12am	plan for I/O chart	1am	Maintain I/O chart	
2am	Administer medication as per doctor's order	3am	Administered medication as per doctor's order	
4am	continue IV fluids	5am	Continued IV fluids	
6am	Ensure safety	7am	provide sick call	

Re-Assessment: Re-assessment done every 2nd hly

Special Notes: continue same treatment

Nurse Signature: Swapna

Nurse Name: Swapna / 017692

Date & Time: 23/7/26 @ 8am



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: Nephro Date of Admission: 20/7/20

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
BACKGROUND	Area	Shift Time	TR 6:00 7:00	3rd shift 8 PM - 8 AM	3rd shift 8 AM - 12 PM	3rd shift 12 PM - 2 PM	3rd shift 2 PM - 8 PM	3rd shift 8 PM - 8 AM
	Medical Condition (Any special condition to be noted):		UTI	NA	NA	NA	NA	NA
ASSESSMENT	Allergy:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Tubes/Drains/Catheter:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:	Temp:	98.1°	98.2°	98.2°	98.1°	97.6°	98.4°
		Res:	24b/m	24b/m	24b/m	24b/m	26b/m	28b/m
		SpO ₂ :	98%	98%	98%	98%	99%	98%
		Pulse:	116b/m	116b/m	116b/m	112b/m	116b/m	118b/m
		BP:	92/66	92/66	95/62	95/69	92/65	93/64
		Fall Risk Score:	10	10	10	10	10	10
Pain Score:	0/10	0/10	0/10	0/10	0/10	0/10		
Recommendations	Safety Needs:	Yes	Yes	Yes	Yes	Yes	Yes	
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:	NO	NA	NA	NA	NA	NA	
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Other Special Orders / Medications:	NO	NA	NA	NA	NA	NA	
Post Operative Procedure Special Orders:		NO	NA	NA	NA	NA	NA	
Handed Over By Name :		A. nand	Surya	Durga	Surya	Surya	Surya	
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	
Date:		20/7	21/7	21/7	21/7	22/7	22/7	
Time:		6:00	8 AM	8 AM	8 AM	2 PM	8 PM	
Taken Over By Name :		Surya	Durga	Surya	Dessie	Surya	Surya	
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	
Date:		20/7	21/7	21/7	22/7	22/7	22/7	
Time:		8 PM	8 PM	8 PM	8 AM	2 PM	8 PM	

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. S.P. Department: 3rd floor Date of Admission:

SITUATION	Diagnosis: <u>UTI</u>		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:				
BACKGROUND	Area	Shift Time					
	Medical Condition (Any special condition to be noted):	<u>NA</u>					
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs:	Temp: <u>98°F</u>					
		Res: <u>32b/min</u>					
		SpO ₂ : <u>99%</u>					
		Pulse: <u>118b/min</u>					
		BP: <u>99/68</u>					
		Fall Risk Score: <u>-</u>					
Recommendations	Pain Score: <u>0/10</u>						
	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>Swamy</u>							
Signature: <u>[Signature]</u>							
Date: <u>23/7</u>							
Time: <u>8am</u>							
Taken Over By Name: <u>Wikeh</u>							
Signature: <u>[Signature]</u>							
Date: <u>23/7</u>							
Time: <u>8AM</u>							

Patie

BAH-00511526 IP5-00176669
Master ABUBAKR RASHID (M)
11-03-2022 4 Y 4 M 9 D
Dr. DR.V.V.R.SATYA PRASAD

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THE HUMPTY DUMPTY SCALE

2012 21/2 23/2

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4					
	3 to less than 7 years old	3	3	3	3	3	
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	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					
	History of Falls or Infant - Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2	2	2	2	
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	1	1	1	1	
Medication Usage	Sedatives (excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1	1	1	
TOTAL			10	10	10	10	

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position	yes	✓	✓	✓	✓
Call device within reach	yes	✓	✓	✓	✓
Wheels Locked	yes	✓	✓	✓	✓
Room free of clutter	yes	✓	✓	✓	✓
Adequate Lighting	yes	✓	✓	✓	✓
Wheel Chair Support	no	✓	✓	✓	✓
Other Intervention(s) Specify	no	✓	✓	✓	✓
Nurse's Name :		Anil	Shree	Shree	Shree
Signature :		[Signature]	[Signature]	[Signature]	[Signature]
Date :		2012	21/2	23/2	23/2
Time :		6:30 AM	8 AM	8 AM	8 AM

BRADEN 'Q' SCALE

					Date :	20/3	21/3	22/3	23/3
					Time :	8:45	8:45	8:45	8:45
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	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
FRICION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."		4	4	4	4
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.		4	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.		4	4	4	4
					TOTAL SCORE	16	16	16	16
					Evaluator's Name	ABUBAKR RASHID	ABUBAKR RASHID	ABUBAKR RASHID	ABUBAKR RASHID

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

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



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
20/7	5:00 pm	0/0	NO	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NO NO	Annex
20/7	12pm	0/0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Buy
21/7	6AM	0/0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	ewyeth
21/7/20	8pm	0/0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Surge
21/7/20	6pm	0/0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Surge
21/7	12pm	0/0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Surge
21/7	6AM	0/0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Surge
22/7	12pm	0/0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	gessie
22/7/20	3pm	0/0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Jeyathya
22/7/20	6pm	0/0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Jeyathya

Re-assessment Frequency:

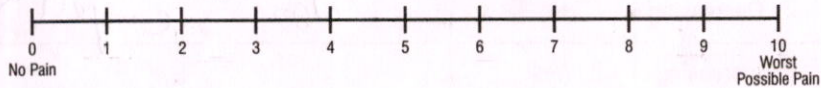
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

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 drawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, rigid, or Jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams 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-00511526 IP5-00176669
Master ABUBAKR RASHID
11-03-2022 4 Y 4 M 9 D (M)
Dr. DR.V.V.R.SATYA PRASAD



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		
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				Sujatha Sridhar Sridhar Sridhar									

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 : Sujatha Name : Sujatha

Signature of Ward In Charge :

Signature : Amita Name : Amita

CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0										
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1										
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2										
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3										
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4										
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	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 of Ward In Charge :

Signature : Name :

Signature : Name :

PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00511526 IP5-00176669 Master ABUBAKR RASHID 11-03-2022 4 Y 4 M 9 D (M) Dr. DR.V.V.R.SATYA PRASAD		Date & Time of Admission 20/11/20 5:50 pm	Date & Time of Transfer Order 20/11/20 6:55 pm
Transfer Ordered by Dr. Madhu		Reason for Transfer Admission	
From Unit ER	To Unit 308 A	Information to Attendant Yes ☐ No ☒	
Number of Sheets in Clinical File 2	Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ If Yes, what? (OP FILE)	Patient shifted with ID band: Yes ☐ No ☒ If No:	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	1 plwz	1	
2.	100 USG Report + Film	1	
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring Anneel		Name of Person Ordered Transfer Dr. Madhu	
Patient & Clinical Records Received by : hiccuden			
Date & Time of Patient Received : 7:15 AM			

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

DISCHARGE PLANNING FORM

Nationality: Indian

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

1. Anticipated Date of Discharge:

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

Yes
Needs
Assistance

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: Hand hygiene

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

☐ Patient

☒ Family Member

☐ Others:

Nurse Signature: Leketha

Name: Leketha

20/7/26 @



308-B

NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 21/2/26 Time: 9:30am

Weight: 13.8 kgs Centile: < 5th

Height: 95 cm Centile: < 5th

Inference: underweight child

RDA: — Calories: 1900 kcal/d Protein: 23 gm/d

Diet Recommendations: soft diet (include plenty of oral liquids)

Re-Assessment: avoid spicy, chilled & outside foods

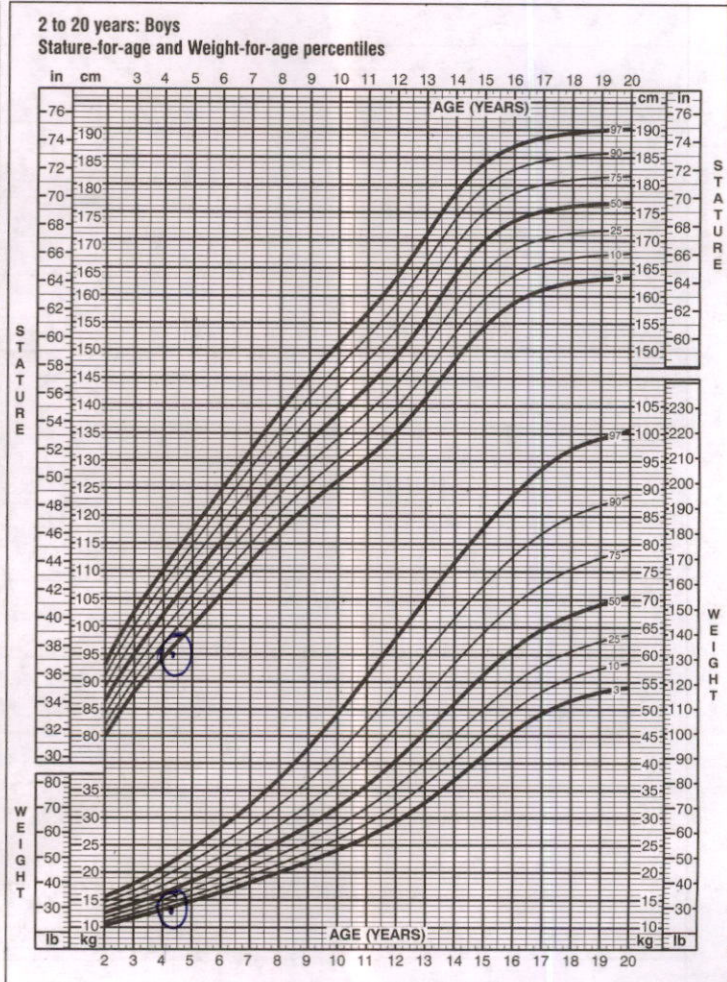
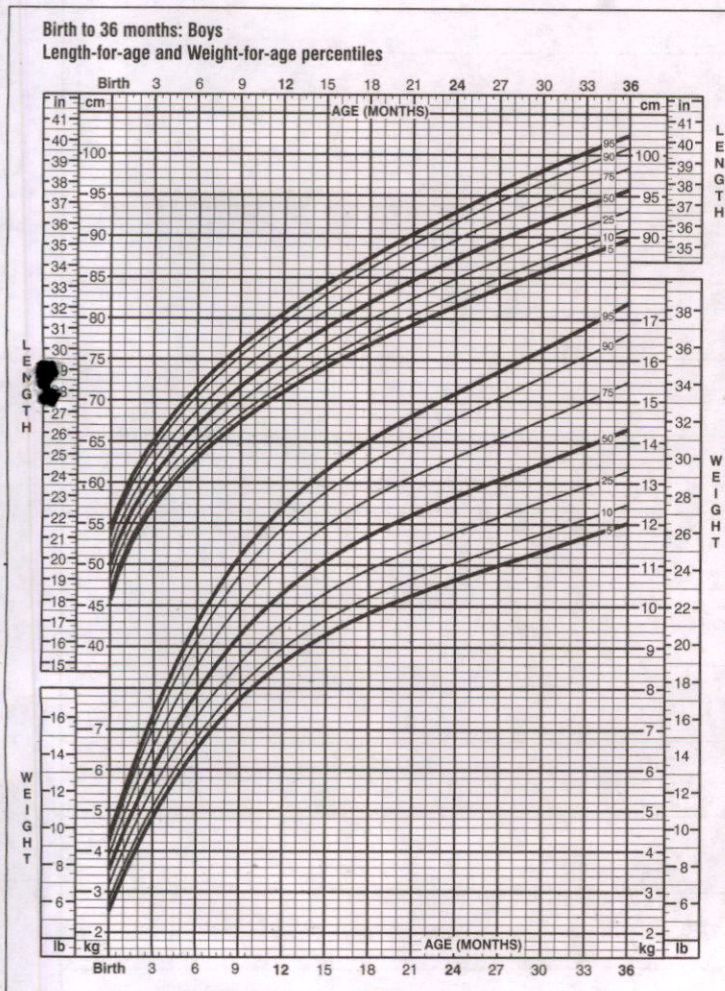
Food Allergies: NO Veg/Non-veg NON-veg

Diagnosis: UTI

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: Rashid

GROWTH CHART (BOYS)



Dietician's Name: Saima

Dietician's Signature: Saima

Daily Notes:

22/7/26

child is stable, oral intake is fair

11:10
am

continue soft diet

Sains