

ACTIVITY RECORD FOR BILLING

AM

Name : _____

Baby SANSKRITI MADHAV KADAM
12-11-2013 12 Y 6 M 3 D (F)
Dr. ANUPAMA Y

UHID No. : _____ Consultant: _____ Dept : _____



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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
15/5/26	7:10 AM	ER	OPICU	Abhishek
15/5/26	8:30 PM	ICU	1st floor	Swish

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	Dr. Nabeel	16/5	9611767	
2	Dr. Archib. Venang	18/5/26	9621635	
3				
4				
5				
6				
7				
8				
9				
10				

INVESTIGATIONS

Date	Investigations	Order No.	Signature
15/5	CBP, RP2, PCT,		
	Blood c/s, CRP	26049252	J-b-17
	Blood Grouping		
15/5	Open report		
15/5	Gram stain		
	- AFB	26049322	[Signature]
	Analysis		
	fluid for culture		
15/5	chest CT with contrast	24567	Jyothi
15/5	USG abdomen chest	024436	[Signature]
15/5	TBCulture		Sudh
	CRP (1) →	24772	
17/5	CRP, CRP	2502	[Signature]
18/5	USG chest (2)	024933	[Signature]
19/5	* USG chest	025301	[Signature]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
15/5/26	Iv placement	①	9609135	[Signature]
16/5/26	NHA	①	9611257	[Signature]
18/5	2ed placement	①	9611764	[Signature]
	conscious sedation	①		

ANY OTHER INFORMATION

W99 - chest ②
 CT ①
 x-ray ① ① missing

Date: 20/5/26 Time: 10am Prepared By: [Signature]

Staff Nurse [Signature]	Shift / Ward CWO-2	Billing Assistant	Billing Supervisor
----------------------------	-----------------------	-------------------	--------------------

ADMISSION SHEET

Registration Details :



Admission No : IP5-00173852 Admit Date : 15-May-2026 Admit Time : 06:50 AM UHID : BAH-00656323

Patient Details :

Patient Name : Baby SANSKRITI MADHAV KADAM Age : 12 Y 6 M 3 D
Guardian : Mr MADHAV RAO KADAM DOB : 12-11-2013
Gender : Female Religion :
Occupation : Martial Status : Single
Address (H) : # Mudkhed Stn Nanded Maharashtra INDIA Phone No : 8668704127/ 8805379629
431806 E-mail : nomailid@gmail.com

Admission Details :

Bed Type : PICU Bed No : PICU 223 Ward Name : 2F-PICU II
Room No : PICU 223 Admission Type : First Visit

Contact Details :

Name : Mr MADHAV RAO KADAM Relationship : Father
Contact Address : # Mudkhed Stn Nanded Maharashtra INDIA Phone No : 8668704127 / 8805379629
431806

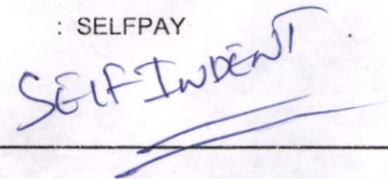

Signature

Doctor Details :

Doctor Name : Dr. ANUPAMA Y Specialisation : PEDIATRIC INTENSIVE CARE
Referral Doctor : Self Phone No :
Co-Consultant : Dr. DINESH KUMAR CHIRLA

Payment Details :

Payment Mode : Cash Deposit Amount : 0.00
Payor Name : SELFPAY



BAH-00656323 IP5-00173852
Baby SANSKRITI MADHAV KADAM
12-11-2013 12 Y 6 M 3 D (F)
Dr. ANUPAMA Y



PEDIATRIC INTENSIVE CARE ADMISSION RECORD

Date: 15/5/26 Time: 2:10 AM

Patient Assessment Form:

Informant: Father Mother Other

Presenting Complaints / Chief Complaints :

12yr/ Female child
complaints of fever since 5 days
high grade, not associated with chills/rash
2-2 spikes/day

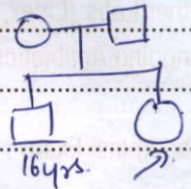
Complaints of fever and cough since 4-5 days.
Severe cough
no post tussive vomiting

No. No vomiting/ loose stools) Complaints of poor oral intake
Burning micturition

↓
Admitted for 3 days on Nanded.
taken IV Antibiotics.

Past History (Including previous treatment and investigations) :

nil



Birth and Developmental History : Term/ 4.2.5kg/ MVP/ GAB/ no No neon stay

Immunization History : vaccinated H.U. date

H / O Allergy : nil

Family History : nil

INITIAL ASSESSMENT

RBS : 10.2 mg/dL Temperature : 101.7 F Weight (kg) : 26 kg

Respiratory System Findings:

Air Way: Open Maintainable Not Maintainable Intubated, If Intubated, size & position of ETT : off O2 - 92%

Respiratory Examination Finding: (Air entry, breath sounds, s/o distress etc.): Respiratory Rate : 42/min Bilateral air entry present. Decreased on left lower zone

SPO2: 99% O by NC / FM / NRB mask / Oxyhood, at on low flow O2 @ 2 L/min

Ventilatory Support: Yes No - Day # of Vent : Respiratory Efforts : Nasal Prongs good

Ventilatory Settings : Leak around ETT : Delivered Vt :

ABG : EtCO2 : P/F ratio : O.I. :

Any Nebs : ICD? Yes No, if Yes, details :

CXR :

Cardio Vascular System Clinical Exam : Heart Rate : 150/min Cardiac Rhytho : Regular (Heart sounds, murmur etc.) : S1,2 (normal)

Quality of Pulses : good cap refill Time : 3 sec Liver Edge : cm below Rt costal margin

Blood Pressures : NIBP : IBP : CVP :

Infusion of any Inotropes? : Yes No - If yes, then details :

Any Other Infusions :

Last 2D Echo Findings :

Size of the heart and lung fields in latest CXR :

Arterial line in Situ : Yes No Place of art, line & its condition :

Central line in Situ : Yes No Place of central line & its condition :

Infection and Antibiotics :

Febrile Afebrile Current Antibiotics Details (antibiotic name and day #) :

Cultures Done outside? Yes No - If yes, details :

Describe c/s Reports :

Other Labs (Latex, Serology, etc) :

Ongoing Antibiotics : taken iv Antibiotics for 2 day

Abdominal Exam : soft

ENT Exam :

Central Nervous System :

Level of Consciousness : AVPU / GCS score : alert

Neurological Findings : pupils - bilateral reactive No Abnormality detected

Relevant data from outside (Neuro imaging any ongoing medications etc) :

Special Needs Screening: (If any of the below are Positive, Please fill "Cross Consultation Form" to Concerned Department)
 (Please select and 'tick mark' [✓] the boxes as applicable)

- a. Nutritional Screening Criteria: Screening is Positive Negative
- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Diabetes Mellitus | <input type="checkbox"/> Needs Therapeutic Diet. | <input type="checkbox"/> Diarrhoea > 4days | <input type="checkbox"/> Food Allergy |
| <input type="checkbox"/> Overweight | <input type="checkbox"/> Psychological Eating Disorder | <input type="checkbox"/> Major Surgery | <input checked="" type="checkbox"/> Patient in ICU |
| <input type="checkbox"/> Under Weight | <input type="checkbox"/> Difficulty swallowing / Chewing | <input type="checkbox"/> Hyperemesis gravidarum | <input type="checkbox"/> Tube Feeding |
| <input type="checkbox"/> Poor Appetite > 3days | <input type="checkbox"/> Unplanned Change in Weight | | |

- b. Psychological Screening Criteria: Screening is Positive Negative
- Non-compliance to offered treatment Over weight Suspected Drug Abuse
- Emotional / Behavioural Problem (Tearful, uncooperative)

- c. Functional Screening Criteria: Screening is Positive Negative
- Patient cannot position himself in bed Change in Muscle Power
- Restricted ROM Impaired Daily Living Activities

- d. Socio-economic Screening Criteria: Screening is Positive Negative
- Living alone Suspected abuse or neglect
- Cultural or religious background that would need to know for the plan of care Unable to assess due to lack of family

e. Need for Interpreter Screening is Yes No If Yes then plan

6. Patient needs additional specialized assessments: Yes No

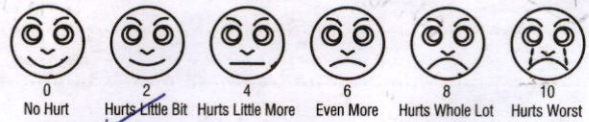
If yes, Please fill Individualized Initial Assessments Form for Special Populations

Others

Pain Screening:

Pain Scale used Wong Baker (Scale 0-10) FLACC (Scale 0-10)

Pain Score "Whenever Applicable"



Location:

Duration: days / weeks / months (Strike Out that is not applicable)

Character: localized diffuse sharp aching referred vague burning / soreness

Frequency: constant intermittent occasional

Pain Management done Yes No

Nutritional Evaluation: fair

Current Medications:

Provisional Diagnosis : Lower Respiratory tract infection
Left sided pneumonia

Prism III score at 24 hrs of admission : Worse SOFA Score :

Referred Patient - Self Referral - Rainbow Patient

Transferring Unit : Ward OT - Transported? Yes No - If yes : Long (> 30 kms) Short (< 30 kms)

Referring Consultant :

Admitting Consultant : as per rota

Indication for PICU referral :

PLAN OF CARE

Preventive aspects of the treatment : Respiratory failure/septic

Desired goals of the treatment : Resolution of symptoms, respiratory distress

PLANNED INVESTIGATIONS

CRP, PCT, Blood Culture
RP₂
UCV chest
N.B venule

PLANNED MANAGEMENT

Ceftriaxone
Azithromycin
Clomeprazole
iv fluids
N.B venule

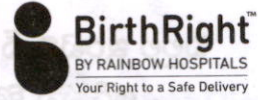
Final Diagnosis : Lower Respiratory tract infection
? left sided pneumonia/effusion

Doctor's Signature : Madhu
Name : Madhu
Date : 15/1/16
Time : 2:26 AM

Consultant's Signature : [Signature]
Name : D. Anupama
Date : 15/1/16
Time : 7:26 AM
DR ANUPAMA
Registration No: 60853



**SSION
SIVE CARE UNIT**



Name: Sanskriti madhav kadam Age: 12yr Gender: Male Female

UHD.No : BAH-00656323 Date:

I S/o, D/o, W/o, hereby
declare that our patient Master/Baby who is related to me as
is getting admitted in the Pediatric Intensive Care Unit of Rainbow Children's Hospital on

The doctors have explained to me in a language understood by me that my child has following health related issues :

.....
Respiratory distress / left sided pneumonia
.....

The doctors have clearly explained to me that my patient Master / Baby during his /
her stay in the Pediatric Intensive Care Unit may undergo various medical and surgical procedures like airway management,
mechanical ventilation, Central Line Insertion, Peripherally Inserted Central Catheter Line and arterial line placements, chest drain,
or peritoneal drain insertion etc.

I have been told by the doctors that while performing such procedures I will be informed and a separate consent for this procedure
shall be taken. However, in case of any life threatening emergency if the time is not available for taking informed consent it is implied
that I give consent for various invasive procedure to save the life of my child. I understand that a sick child in Pediatric Intensive Care
Unit has life threatening medical conditions.

I understand that when a child is sick in the Pediatric Intensive Care Unit with multiple medical and surgical procedures performed
upon him/her, there are inherent risks due to these high risk procedures, and high risk medications, in the form of infections,
bleeding, air leaks, skin and other tissue damage etc.

I give my consent to the team of doctors to go ahead and admit the child Master / Baby : Sanskriti
..... in the Pediatric Intensive Care Unit fully understanding the associated risk, benefits and alternatives involved
from various procedures, high risk medications and infections in the Pediatric Intensive Care Unit and treat him/her with all
necessary means.

The doctors have explained to me in the language best understood to me.

Patient Attendant :

Signature: [Signature]

Name: [Signature]

Relationship with Patient: Mother

Date & Time: 15/5/26 @ 7:15AM

Witness :

Signature: [Signature]

Name: [Signature]

Date & Time: 15/5/26 @ 7:15AM

Doctor (who is taking the consent) :

Signature: [Signature]

Name: [Signature]

Date & Time: 15/5/26 7:15AM

BAH-00656323 IP5-00173852
Baby SANSKRITI MADHAV KADAM
12-11-2013 12 Y 6 M 3 D (F)
Dr. ANUPAMA Y



DISCHARGE CRITERIA – PICU

Discharge to:

- HDU / Step down ICU Ward Outside Facility Others:

Tick (✓) any of the following criteria requiring discharge / transfer from PICU

- Stable hemodynamic parameters.
- Stable respiratory status (patient extubated with stable arterial blood gases) and airway patency at least for 24 hours with no respiratory distress needing continuous monitoring.
- Minimal oxygen requirements that do not exceed patient care unit guidelines.
- Intravenous inotropic support, vasodilators, and antiarrhythmic drugs are no longer required or, when applicable, low doses of these medications can be administered safely in otherwise stable patients in a designated patient care unit.
- Cardiac dysrhythmias are controlled.
- Neurologic stability with control of seizures.
- Removal of all hemodynamic monitoring catheters.
- Routine peritoneal or hemodialysis with resolution of critical illness not exceeding general patient care unit guidelines.
- Patients with mature artificial airways (tracheostomies) who no longer require excessive suctioning.

Signature of the Doctor:

Name of the Doctor :

Date & Time:

GENERAL CONSENT FOR TREATMENT

Patient Name: **Baby SANSKRITI MADHAV KADAM** Age : **12 Y 6 M 3 D**
IP No: **IP5-00173852** Sex: **Female**
Consultant: **Dr. ANUPAMA Y** Ward/Bed No: **2F-PICU II/PICU 223**

The undersigned patient and I or responsible relative or person hereby consent to and authorize Rainbow Hospitals doctors and medical personnel to perform medical examinations, conduct routine investigations and administer medical treatments, outpatient procedures, minor dressings, vaccinations and immunizations during the course of the patient's care, as in patient.

Patient, be deemed advisable or necessary.

I understand that the confidentiality of all medical records shall be protected to the full extent of the Law. The undersigned also consent to the use of health related information/ audiovisuals of the patient for research & training purpose or for insurance coverage and while doing so confidentiality of the patient will be maintained at all times and this will not affect the care of the patient.

... giving my general consent to treatment, I understand that I retain the right to refuse any particular examinations, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by treating doctors. I also understand that the practice of medicine is not an exact science and that no guarantee have been made to me as the results of my evaluation and I or treatment.

I understand that I shall not bring valuables to the Hospitals and that the Hospital will not be responsible for the loss, destruction or theft of my personal belongings. I assume full responsibility for all my personal items and release the Hospital from responsibility and liability for such personal items and valuables.

"I am aware that during the patient care it is inevitable that certain re-useable equipment shall be re-used after sterilization and disinfection. I am informed that the hospital assures maximum level of precaution and care in sterilizing and disinfecting the equipment and monitors the whole process as per evidence based guidelines".

Note:
1 We do not allow use of medication brought from outside by the patient.
2 I have received attendant passes as per my room category. I understand that I have to return it back at the time of final bill clearance. In case of failing the submission, I will pay 200/- Rs.
(Receivers Signature:.....*[Signature]*)

Guide book has been given to me and I have been explained about the Hospitals rules and policies.
4 Financial and billing counseling has been done to me.

Signature of Patient/Relative: *[Signature]*

Name: *Madhav Ras Kadam*

Relationship: *Sister*

Date: *12/05/2026*

Witness Name: *[Signature]*

Witness Signature: *[Signature]*

Patient Address:
Mukhed Stn Nanded Maharashtra
INDIA 431806

Time: *06:00 Am*

BAH-00656323 IP5-00173852
Baby SANSKRITI MADHAV KADAM
12-11-2013 12 Y 6 M 3 D (F)
Dr. ANUPAMA Y





PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : As per Rota

Date : 15/5/26

Type of Admission: OPD ER Referral (if referral, Doctor's Name:

Start Time of Assessment: Weight: 26 kg

Allergic History:

Chief Complaints:
c/o fever :- 6 days (9/5/26)
cough - 5 days
asthma (+)
a/w poor oral Intake

Pediatric Assessment Triangle

A Appearance - TICLS Normal

B C Circulation Normal Abnormal

Breathing ↑ WOB ↓ WOB Normal Gasping / Apnea

Pallor Cyanosis Mottling Bleeding

Initial Physiological Status: Stable Unstable
 Life Threatening Non Life Threatening

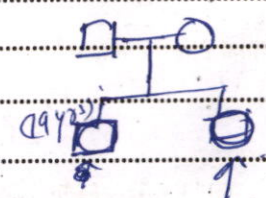
Any urgent interventions needed: Yes No
 If Yes low flow

Significant Past History:

Medication History:

Relevant Investigations: 11/5: CRP - 230

CBP: 12.1 / 81/15 / 2.8



12/5: CRP - 126.9
CBP - 10.3 / 61/15 / 3.08

13/5: CRP - 165


Primary Assessment

Airway Open Maintainable Not Maintainable


Any urgent interventions needed: Yes No
 If Yes

Breathing Rate: 38/min SpO₂ on FiO₂ 92% CRA
 Rhythm: regular
 Retractions: Suprasternal ICR SCR
 Sternal Supraclavicular Nasal Flaring
 Respiratory Noises: Stridor Wheezing Grunting
 Air Entry: BAF (+) ↓ on (L)
 Palpation Findings (if necessary).....


Any urgent interventions needed: Yes No
 If Yes Low flow

Circulation  HR: 140/min CFT Central 2.5 sec Peripheral 2.5 sec Any urgent interventions needed: Yes No
 If Yes*

BP: mmHg Murmurs: Yes No
 Pulse Volume: Central 2.5 sec Peripheral Liver Span:
 If in Shock: Compensated ECG:
 Hypotensive Any Signs of Heart Failure: Yes No
 Muffled Heart Sound: Yes No
 Engorged Neck Veins: Yes No

Disability  GCS: AVPU: A1ext Any urgent interventions needed: Yes No
 If Yes*

Pupils: Responsive Non-Responsive
 Size Right
 Left
 Active Seizures: Yes No Sugars:
 Signs of Neurological compromise

Exposure  Temp.: 101.7°F Any urgent interventions needed: Yes No
 If Yes* Synop mental

Any Rash: Yes No
 If yes describe the rash
 Active bleed
 Lacerations Abrasions bruises
 Describe:

- Final Physiological Status:** Respiratory Distress Respiratory Failure Respiratory Arrest
 Shock - Compensated Hypotensive
 Cardiopulmonary Arrest Hemodynamically Stable

Secondary Assessment: Head to toe examination with positive findings:

Labs Planned:
 CXR
 2 plain
 EDTA
 Blood culture

Treatment Planned: Low flow

Need for Oxygen: Yes No if yes Low Flow High Flow PPV

Final Diagnosis with possible Differential Diagnosis (If necessary): Left pleural effusion

Assessment done by
 Name of the Doctor: Jayabi
 Signature: JM
 Date & Time: 15/5/20

Sr. Doctor on Duty (If necessary)
 Name of the Sr. Doctor: DR. NUPAMA Y
 Registration No: 50000
 Signature: [Signature]
 Date & Time: 15/5/20

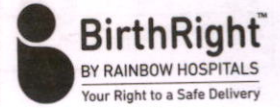


PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
15/5/2021 7:00 AM	CLSB Puro fellow Do likes	<u>Plan</u>
	H/o fever x 6 days Cough x 6 days	① CBP CRP RPa Blood c/s
	Admitted in Loco Hospital in Nanded on 12/4/2026	Blood grouping PT/INR ② Bed side Pours to do
	Chest xray slo Lyt middle and lower zone opacity	③ USG chest by Radiologist
	ole child is Alert/Active HR - 144/min SpO ₂ - 99% on Roomar 98% on 2L O ₂	④ Inj. Ceftriaxone Inj. Azithromycin
	RR - 38/min	⑤ URF DMS ⑥ 40ml/hr
	BP - 104/52 mm Hg Chest - Left sided a/w c/s decreased	⑦ NPO.
	p/A - Soft No organomegaly	⑧ fo depends on Fed Us, UATS
	CNS - Active (Alert)	N.B. - <u>neuro</u>
	C/S - S, S, ⊕ mo.	AA Dr. [Signature]

BAH-00656323 IP5-00173852
 Baby SANSKRITI MADHAV KADAM
 12-11-2013 12 Y 6 M 3 D (F)
 Dr. ANUPAMA Y

Bed (11)



PROGRESS NOTES AND DOCTOR'S ORDER

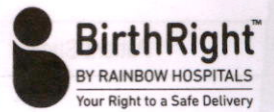
Date & Time	Progress Notes	Doctor's Order
15/5/2016 9:15 AM	<p>counselling notes</p> <p>Relative has been counselled that child has pneumonia of the left lung with effusion. Effusion is lumpy like infarct. Child may need VATS vs ICD insertion. After the use by Peridolant, we will decide on further course. 200ml pleural fluid removed</p>	<p>Room. 2</p> <p>Dr. Anupama</p> <p><Md. T. J. [Signature]</p>
<p>AA</p> <p>Dr. Anupama</p>		

FLUIDS STATUS NUTRITION AND G.I	<input checked="" type="checkbox"/> NPO <input type="checkbox"/> PO feeds <input type="checkbox"/> NG Feeds <input type="checkbox"/> NJ Feeds <input type="checkbox"/> GT Feeds				
	I / O / Balance : / (+/-) Input : ml/k/d UO : ml/kg/hr Stools :				
	NG output : PO intake :				
	Feed Formula : Feed Schedule :				
	IV Fluids - Type of IVF : <u>DNS</u> @ <u>50ml/hr</u> ml / hr (..... times maintenance)				
	TPN : <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No - If yes, details :				
 % of Dext, Glu Inf Rate (mg/kg/min) Amino Acids (gm/kg/day) Lipids (gm/kg/day)				
 Cal/kg/d Nitrogen Trace elements & MVI				
	Labs : Na K Cl Ca Mg P HCO3 Sr. Amylase : Sr. Lipase :				
	Latest LFT : Abd Exam : <u>soft</u> Any organomegaly ? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No - If yes, describe : Plan (G.I. & Liver) :				
INFECTION	<input checked="" type="checkbox"/> Febrile <input type="checkbox"/> Afebrile Current Antibiotics Details (antibiotic name and day #) :				
	Cultures Sent ? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No - If yes, details :				
	Describe c/s Reports :				
	Other Labs (Latex, Serology, etc) : Ongoing Antibiotics :				
NEPHROLOGY ISSUES	Sr. Creat : Bld. Urea : Other Relevant Labs :				
	P.D. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No - If yes, details :				
	Diuretics : <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No - If yes, details :				
	Catheterized : <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No - If yes, then day of Catheter :				
	Relevant Radiology (USC, MCUG radioisotope scan etc) : Plan of Care :				
HEMATOLOGY	Relevant Labs (CBP etc) :				
	Any Coagulopathy :				
	Relevant Transfusion History : Plan of Care :				
CARE PROTOCOLS	VAP Bundle Used ? : <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA CRBSI Bundle Used ? : <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA CA - UTI Bundle Used ? : <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA Patient Managed as per Relevant Protocols : <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA If yes, then details :			Pending Lab Results : <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If yes, then details : Pending Consultations : <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, then details :	
	FINAL COMMENTS <div style="text-align: center;"> <p>- trace labs</p> <p>- USG chest</p> </div>				

Doctor's Name (Handover given) : Madhvi
 Signature : Madhvi
 Date & Time : 15/1/26 at 8AM

Doctor's Name (Handover taken) : Sudhy
 Signature : [Signature]
 Date & Time : 15/1/26 8:10AM

BAH-00656323 IP5-00173852
 Baby SANSKRITI MADHAV KADAM
 12-11-2013 12 Y 6 M 3 D (F)
 Dr. ANUPAMA Y



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
15/5/26 9:20 AM	AB Dr. Anupama	
	Left community Acute	<u>Plan</u>
	Pneumonia	
	ParaPneumonia effusion.	- US chest
	⊙ side air only red.	- SA Surgeon consult.
	HR 108/min	(100/VAZE)
	SpO ₂ 96	N.R Plan.
	Buddhis commelli	

15/5/26
 Dr. Anupama Y
 Registration No: 50853

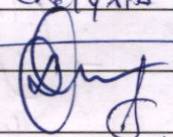
PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
15/5/26 1PM	<p style="text-align: right;">c/s / IB Dr. Sandeep</p> <p>Left pneumonia with para-pneumonic effusion</p> <p>on low flow.</p> <p>Tachypnoea ⊕</p> <p>Hemodynamically stable</p> <p>Alert, active.</p> <p>HR - 110/min</p> <p>RR - 34/min</p> <p>SpO₂ - 100%</p> <p>BP - 110/60 mmHg</p>	<p>Plan</p> <p>- send Gene x pert</p> <p>- Add Inj-Vancomycin after discussing</p> <p>1) send fluid c/s.</p> <p>2) Gram stain AFB.</p> <p>3) Gen Gen Xpert analysis.</p> <p>Noted by JUK</p>
15/5/26 1PM	<p style="text-align: right;">c/d/w Dr Anupama</p> <p>left pleural effusion</p> <p>para-pneumonic effusion.</p>	<p>Plan</p> <p>- Add Inj-Linezolid</p> <p>Noted by Anupama</p> <p>15/5/26 1PM</p> <p>DR. ANUPAMA Y Registration No: 50853</p>

BAH-00656323 IP5-00173852
 Baby SANSKRITI MADHAV KADAM
 12-11-2013 12 Y 6 M 3 D (F)
 Dr. ANUPAMA Y



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	procedure notes	Doctor's Order
15/5/26 1PM	Under strict aseptic condition	pleural tap was done and 20ml pleural fluid tapping done.	
	straw coloured.		Plan.
			send pleural fluid for
			Gram stain
			AFB stain.
			were expect
			pleural fluid analysis
			noted by 
			Dr. Anupama Y.

BAH-00656323 IP5-00173852
 Baby SANSKRITI MADHAV KADAM (F)
 12 Y 6 M 3 D
 Dr. ANUPAMA Y

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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
15/5/26 2pm	<p style="text-align: center;"><u>Counselling room</u> <u>Dr. Sandeep</u></p>	
	<p>Condition of child is explained to parent</p> <ul style="list-style-type: none"> → There is fluid collection around lungs → We will tap fluid & remove send some fluid for testing. → If fluid is thin & not pus-like we will place an ICD tube. → If fluid is thick, we have to go for surgery. → Based on fluid report, we will plan for antibiotics. If report suggests TB, we have to start TB treat. 	
	<p style="text-align: center;"><u>Sandeep</u> <u>(Father)</u></p>	<p style="text-align: center;"><u>Sandeep</u></p>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	<u>Shifting Notes</u>	
15/5/2026		
<u>7:15 PM</u>		<u>Plan</u>
	<p>Di: Left sided pneumonia with left parapneumonic effusion. ? Koch's.</p>	<p>Cont. IV fluids - Cont O₂ by NP @ 2 LPM</p>
	<p>on ^{O₂ by} NP @ 2 LPM Hemodynamically stable No fresh issues</p>	<p>- Cont. Inj. ceftriaxone (D) Inj. Azithromycin (D) Inj. Linezolid (D)</p>
	<p>1 fever spike @ 4 PM - 101°f</p>	<p>- True Pterral fluid - AFB - Gram stain - C/S</p>
	<p>orad HR - 108 bpm SpO₂ - 100% ↓ O₂ by NP @ 2 LPM</p>	<p>- True CECT chest reports - Monitor vitals</p>
	<p>BP - 112/64 mmHg RR - 27 br/min</p>	<p>- W/S RD - If RD present shift to PEU - Inform sos</p>
		<u>Health.</u>

BAH-00656323 IP5-00173852
 Baby SANSKRITI MADHAV KADAM
 12-11-2013 12 Y 6 M 3 D (F)
 Dr. ANUPAMA Y



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
15/5/26 7:15pm	<p style="text-align: center;"><u>Counselling room</u> <u>Dr. Suhanya</u></p>	<p style="text-align: right;">5/2/26</p>
	<p>Child's CT scan showing left pleural effusion with fluid around the lungs. Fluid report suggested tuberculosis. However we need further reports like AFB staining for confirmation. Currently child is stable. We will shift her to ward. In case of any respiratory distress we will shift her back to PICU. We are continuing antibiotics for fluid & pneumonia.</p>	
	<p style="text-align: center;">atd/ri</p>	<p style="text-align: right;">Suby e.</p>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16/5/26. 8 AM	<u>C/S/B p/cu follow.</u>	
	community acquired pneumonia	
	left parapneumonic effusion.	<u>plan,</u>
	on low flow oxygen 2L np	1. continue low flow oxygen 1L np.
	hemodynamically stable.	
	one fever spike at 11pm 100f.	2. Monitor vitals
	Chest - crepitations present	3. Trace CT-Chest Report
	off oxygen - 94%.	4. Trace pleural fluid Gene MTB export cultures.
	Iv ceftriaxone - D2	
	Iv Pseudo - D2	
	Tab Azee - D2	5. continue Iv fluids.

M
as Mathias



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16/5/26	C/S/B Dr Sandeep.	
12 PM		
	Community acquired pneumonia left parapneumonic effusion.	plan.
	on low flow oxygen 1L Np hemodynamically stable.	1. Continue low flow oxygen 1L Np.
	two fever spike at 11pm 100f.	2. monitor vitals.
	8 AM - 100f.	3. Trace CT-Chest Report
	Chest - crepitations present	4. Trace pleural fluid Gene x pest MTB.
		PCR Report
		5. Keep NPO from 1pm.
		6. plan to keep IED of pleural TB PCR Report is negative fluid
		sd Dr Mathan

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	SIB <u>Plan Team</u>	
16/5/26 5:30 pm	<p>dx: Community acquired pneumonia</p> <p>Left parapneumonic effusion</p> <p>fever spike at 8:30 AM - 100.6° F</p> <p>on low flow oxygen</p> <p>no other complaints</p> <p>o/c mild tachypnea (+)</p> <p>Rt - BICAC (+)</p> <p>declared on left lower zones</p> <p>Cvs - S1S2 (+)</p> <p>pr good.</p>	<p>plan -</p> <p>(1) cont</p> <p>ceftriaxone D2</p> <p>Linezolid D2</p> <p>Azithromycin D1</p> <p>(2) Trace culture pleural fluids</p> <p>Cere Xpert</p> <p>(3) monitor vitals</p> <p>(4) cont low flow oxygen</p> <p>(5) wif fevers</p> <p>(6) Inform fac.</p>
		<u>abdino</u>

IPS-00173852
 BAH-00656323
 Baby SANSKRITI MADHAV KADAM (F)
 12-11-2013 12 Y 6 M 5 D
 Dr. ANUPAMA Y

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16/5/2020 7:50 pm	<p style="text-align: center;"><u>Procedure Note</u></p> <p>Under all aseptic precautions after taking consent, ICD was inserted (ICG) in left intercostal space and position of ICD confirmed by chest xray. uneventful</p>	
	<p style="text-align: center;"><u>AA</u> <u>Dr. Anupama</u></p>	
17/5/20 8 AM	<p style="text-align: center;"><u>ICG/B</u> <u>picu follow.</u></p> <p>ΔSIS! - pneumonia with parapneumonic effusion</p> <p>on low flow oxygen - 2L NP hemodynamics stable Chest - clear Temp stable - 56 ml one fever spike 6pm - 103°F</p> <p>inj ceftriaxone - D3 inj Unasyn - D3 Tab Azee - D3 off oxygen - 96% mild tachypnea</p>	<p>1. continue low flow oxygen 2L NP</p> <p>2. w/f fever spikes</p> <p>3. monitor vitals.</p> <p>4. encourage oral intake</p> <p>5. Trace sputum fluid MTB Gene expert.</p> <p style="text-align: right;"><u>My</u> Dr. Mathews</p>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
7/5/26	S/S Dr. Anupama	
11:58 AM		Plan
	Pneumonia & Parapneumonic Effusion.	1) USG abd - 18/5
	Plural fluid	2) True Plural fluid
	Chest - True PCC(+B) -ve	Cl.
	Cl awaited	3) CBP, CRP - Now
	ICD placed y day	4) Add Ipratropium
		DR. ANUPAMA Anupama Registration No: 50855 7/5/26 11:58 AM
		Note by S/S Anupama
	S/S/B PICU team	
17/5/26	bpm 15. Left sided pneumonia with left sided Parapneumonic effusion	Rian USG abdomen T/M
		True Plural fluid cl
	on O ₂ by NP @ 1 LPM Hemodynamically stable	Continue medications as per chart
	ICD - column movement on going fever spike No fresh issues	True pending labs
		Continue low flow
		Monitor vitals

Handwritten signature/initials



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
18/5/26 8 AM	C/S/B PICU follow.	
	DSB: - pneumonia with para-pneumonic effusion.	plan.
	on low-flow oxygen & NP hemodynamically stable.	1. USG abdomen today.
	one fever spike 7:15pm 100f.	2. w/f fever spikes.
	Chest - Clear Fed down - 50ml.	2. monitor vitals.
	off oxygen - 97%.	3. Trace pleural fluid culture.
	inj ceftriaxone - D4 inj Guegard - D4 tab Azee - D4	4. If SpO ₂ < 95% RR > 30 start low flow oxygen & NP or motuex
	CRP - 143 ↓	

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
18/5/26 11a	CS/B Dr Anupama	
	ASIS:- pneumonia with parapneumonic effusion.	
	on low flow oxygen \downarrow Lnp	plan
	hemodynamically stable	Plan
	one fever spike 7:15pm 100°f.	✓ Us on chest
	Icd drain - 50ml.	- Trace H ₂ (Pleural)
	Ivj ceftriaxone - D4	- stop Iv fluids
	Ivj leucoid - D4	- Incentive spirometry.
	tab Azee - D4.	✓ Chest physiotherapy
	CRP - 143 ↓.	D. Anupama
		DR. ANUPAMA Y Registration No: 50053
		Note by S.S. Anur

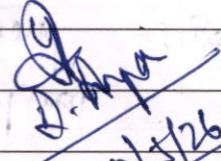
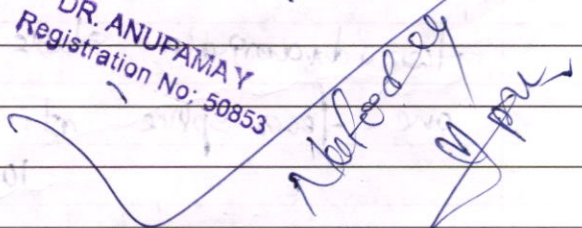


PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<p>18/5/26 5:34 PM</p>	<p style="text-align: center;"><u>C/S/B PICU Resident</u></p> <p>△: Pneumonia with parapneumonic effusion Abscess. Child on room air. SpO₂: 98%. PR: 80/min. RR: 26/min. BP: 102/60 mmHg. Chest: B/L air entry (+). ICD: column movement (+).</p>	<p style="text-align: center;"><u>Plan:</u></p> <ol style="list-style-type: none"> ① Encourage oral feed. ② Cont. antibiotics. ③ Trace culture. ④ Mobilisation. ⑤ Spirometry & chest physiotherapy. <p style="text-align: right;"><i>[Signature]</i></p>
<p>19/5/26. 8 AM</p>	<p style="text-align: center;"><u>C/S/B</u></p> <p>△: pneumonia with parapneumonic effusion on room air hemodynamically stable. one fever spike at 9:30 pm 100.5 F</p> <p>Ig capixone - DS Ig Unegabed - DS tab Azee - DS</p> <p>ICD down - 3 ml.</p>	<p style="text-align: center;"><u>plan.</u></p> <ol style="list-style-type: none"> 1. w/T fever spikes. 2. monitor vitals. 3. Spirometry 4. chest physiotherapy. <p style="text-align: right;"><i>[Signature]</i> Dr. Mathan</p>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/5/26	11/5/13 Dr. Anupama.	
10 AM	pneumonia with para pneumonic effusion	
	on room A76	plan:
	hemodynamic stable	1. Remove ICD
	one fever spike.	2. Tomorrow CBP, CRP (Hold). plan discharge tomorrow
	Fed down - 3ml.	3. spirometry
	Chest - clear.	Chest physiotherapy.
		4. w/F fever spikes.
		5. CXR, CBP at 8 pm.
		 19/5/26 10 AM
		DR. ANUPAMA Y Registration No: 50853 

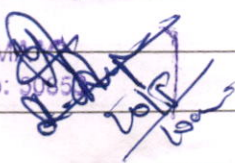


PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
12/1/26 5pm	SIB Resident	
	A: pneumonia with parapneumonic effusion	plan. ① cont. antibiotics as per chart
	no fever	② monitor vitals
	no new issues	③ w/f fever
		④ continue spirometry Chest physiotherapy
	O/E. child alert	⑤ CBP Chest x-ray J at 8pm
	on room air vitals stable	
	PI - RLCAE (+)	
	Cvs - S, L2 (W)	
		washed respirator
		Noted by ANJH



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/5/26 8 AM	C/S/B p/cu fellow.	
	pneumonia with parapneumonic effusion	plan
	on room - A/B	1. w/f fever spikes
	-temperamentally stable.	
	No fever spikes	2. monitor vitals.
	accepting feeds well.	
	inj ceftriaxone - D6	3. Spirometry
	inj Augmentin - D6	Chest physiotherapy.
	Tab Azee - D6.	4. plan discharge today.
		normal -
20/5/26 10 AM	C/S/B by Anupama - pneumonia with parapneumonic effusion.	plan
	Afebrile	1. discharge - for
	air entry equal.	2. Augmentin to do 1 more week SIP recet 5 days.
		3. Budenal BD.
		4. SIP ZAC - B.
		Review on - Tuesday.
		DR. ANUPAMA Y Registration No: 5095 

BAH-00656323 IP5-00173852
Baby SANSKRITI MADHAV KADAM
12-11-2013 12 Y 6 M 6 D (F)
Dr. ANUPAMA Y



CROSS CONSULTATION FORM

Doctor Name : Ashita Venaragi Date : 18-05-26 Time : 1:30pm

Diagnosis : Pneumonia & Parapneumic effusion

Hospital : Res-Bangalore hills

Type of Referral :

- Emergency
- Urgent
- Non Urgent

Referred for : Opinion Co-Management Transfer of care

Reason for Referral : If for concurrent care specify the particular need, especially in the absence of a second diagnosis:

Chest Pt.

Signature:

Findings and Recommendations :

S/B physiotherapist.

Pneumonia & Parapneumic effusion

(L)

ICD (+)

- chest physio
- facilitate expansion
- (L) side up
- ambulation & support

Consultant :

Name : Ashita Venaragi Signature : Ashita Date & Time : 18-05-26 1:30pm



CROSS CONSULTATION FORM

Doctor Name : Dr. Naseel Date : 16/5/26 Time : 7:45pm

Diagnosis : left pleural effusion

Hospital :

Referred for : Opinion Co-Management Transfer of care

Type of Referral :
 Emergency
 Urgent
 Non Urgent

Reason for Referral : If for concurrent care specify the particular need, especially in the absence of a second diagnosis:

ICD placement

[Signature]
Signature:

Findings and Recommendations : Thanks for Referral

HISTORY noted
(L) pleural effusion

- 16 fr ICD placed at 5th ICS
to sedation + strict aseptic
condition

- Straw coloured fluids
noted

- procedure uneventful

Adv
EXR

Consultant :
Name : Dr. Naseel

Signature : [Signature]

Date & Time : 16/5/26
7:45pm

BAH-00656323 IP5-00173852
 Baby SANSKRITI MADHAV KADAM
 12-11-2013 12 Y 6 M 3 D (F)
 Dr. ANUPAMA Y



RESULT SHEET

Date	15/5/26	17/5/26	19/5/26		
Time	9am	10:30PM	9:30PM		
Hb	11.5	11	10.7		
PCV	35.9	33.6	33.0		
RBC	4.54	4.35	4.27		
WBC	4680	6050	6400		
N/L	61/23	69.3/15.5	56/29		
Platelets	3,61,000	4,37,000	525000		
CRP	161	143 ↓			
ESR					
PCT					
RBS					
Na	137				
K	4.5				
Cl	109				
Ca/Mg					
Phosphate					
Urea	14				
Creatinine	0.5				
ALP					
SGPT					
SGOT					
T.Bil/Conj					
T. Protein					
S. Albumin					
S. Globulin					
A/G Ratio					
Uric Acid					
S. Amylase					
Sr. Lipase					
Blood Lactate					
S. Cholesterol					
PT/INR					
APTT					
CSF Protein / Sugar					
Cells					
N/L					

HCO₃ 20

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						

Culture and Sensitivities : Pleural fluid Analysis: (15/05/2026)

APP- Slightly turbid / clot formation (+) / PH-8 / P/tu-4.7 / Sugar-4.9
 cell count - 1600, Polymorphs - 5%, lymphocytes - 95%

pleural fluid AFB - Not detected.

Radiology : USG : pleural fluid - no growth.

X-Ray : pleural fluid gram stain - NO organisms -

ECHO :

CT :

MRI

Others (ECG, Contrast Studies etc.) :

BAH-0056323 IP5-00173852
 Baby SANSKRITI MADHAV KADAM
 12-11-2013 12 Y 6 M 3 D (F)
 Dr. ANUPAMA Y



inside

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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

RESULT SHEET

Date	11/5/26	12/5/26	13/5/26		
Time					
Hb	12.1	10.3			
PCV	35.7	30.5			
RBC	4.72	4.07			
WBC	8800	6100			
N/L	81/15	71/25			
Platelets	2.88 lakh	3.08 lakh			
CRP	7230	176.9	165		
R					
PCT					
RBS					
Na					
K					
Cl					
Ca/Mg					
Phosphate					
Urea					
Creatinine					
ALP					
SGPT					
SGOT					
Bill/Conj					
T.Protein					
S.Albumin					
S.Globulin					
A/G Ratio					
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein / Sugar					
Cells					
N/L					

Date	11/5/26					
Time						
CUE - Alb	+					
CUE - Sugar	nil					
CUE - Ketones						
CUE - PUS Cells	4-5					
CUE - RBC Cells						
CUE	6-7 EC					
Stool Pus Cell						
OVA / Cyst						
Occult Blood						

Culture and Sensitivities :

.....

.....

.....

Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI :

 Others (ECG, Contrast Studies etc.) :



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: PICU

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1						<input type="checkbox"/> C <input type="checkbox"/> DC
2						<input type="checkbox"/> C <input type="checkbox"/> DC
3						<input type="checkbox"/> C <input type="checkbox"/> DC
4						<input type="checkbox"/> C <input type="checkbox"/> DC
5						<input type="checkbox"/> C <input type="checkbox"/> DC
6						<input type="checkbox"/> C <input type="checkbox"/> DC
7						<input type="checkbox"/> C <input type="checkbox"/> DC
8						<input type="checkbox"/> C <input type="checkbox"/> DC
9						<input type="checkbox"/> C <input type="checkbox"/> DC
10						<input type="checkbox"/> C <input type="checkbox"/> DC

* C - Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: Jayalini

Date & Time: 15/5/20 @ 7pm

Nurse Name & Signature: Abhishek

Date & Time: 15/5/20 @ 7pm

BAH-00656323 IP5-00173852
 Baby SANSKRITI MADHAV KADAM
 12-11-2013 12 Y 6 M 3 D (F)
 Dr. ANUPAMA Y



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	INJ. CEFTRIAXONE	1.3g	IV	BD	15/5/26 10 AM	<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
2	INJ. LINEZOLID	250mg	IV	TID	15/5/26 2 PM	<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
3	TAB. AZITHROMYCIN	250mg	PO	OD	15/5/26 10 AM	<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
4	TAB. LANSOPLAZOLE	30mg	PO	OD	15/5/26 8 AM	<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
5						<input type="checkbox"/> C <input type="checkbox"/> DC
6						<input type="checkbox"/> C <input type="checkbox"/> DC
7						<input type="checkbox"/> C <input type="checkbox"/> DC
8						<input type="checkbox"/> C <input type="checkbox"/> DC
9						<input type="checkbox"/> C <input type="checkbox"/> DC
10						<input type="checkbox"/> C <input type="checkbox"/> DC

* C - Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: Nalini, Dr. Nandan

Date & Time: 15/05/2026, 7 PM

Nurse Name & Signature:

Date & Time:



DRUG CHART

Date of Admission: 15/5/26 Drug Allergies: Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

- GENERAL** - Ensure that all patient details are entered above. ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.
- DOCTOR** - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
- Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
 - Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
 - Discontinue a drug by drawing a line **I** through it and a similar line through subsequent recording panels.
 - The date and time of stopping the drug along with the doctors name and sign must be mentioned.
 - Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.
- NURSES** - Nurses must follow strictly the FIVE RIGHTS before administration of medication.
- 1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time
- AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

SOS / PRN (As Required Medication)

DRUG : Inf. PARACETAMOL				Date Time	15/5	10:15														
Dose	Route	Frequency	Start Date																	
400mg	IV	SOS	15/5																	
Doctor's Signature		Valid Period	Pharm.																	
EJPK																				
Additional Instructions:																				
if temp > 101F																				

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



REGULAR PRESCRIPTIONS

Weight. 26kg Ward. Puro

VERIFIED

VERIFIED

VERIFIED

DRUG: INT. CEFTRIAXONE				Date/Time
				15/5
Dose	Route	Frequency	Start Date	
1.3g	IV	BD	15/5/26	
Name & Signature of the Doctor Starting the Drugs:				
Madhu				10 AM 16/5 17/5 18/5 19/5
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
DRUG: INT. AZITHROMYCIN				Date/Time
				15/5
Dose	Route	Frequency	Start Date	
250mg	IV	OD	15/5/26	
Name & Signature of the Doctor Starting the Drugs:				
Madhu				10 AM change to Oral 15/5/26 @ 7 PM Nanda (Dr. Nanda)
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
DRUG: INT. CLONIDINE				Date/Time
				15/5
Dose	Route	Frequency	Start Date	
25mg	IV	OD	15/5/26	
Name & Signature of the Doctor Starting the Drugs:				
Madhu				6 AM change to Oral 15/5/26 7 PM Nanda (Dr. Nanda)
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
DRUG: Inj-VANCOMYCIN				Date/Time
				15/5
Dose	Route	Frequency	Start Date	
500mg	IV	TID	15/5	
Name & Signature of the Doctor Starting the Drugs:				
C. S. D. H. P.				Stop 15/5
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

BAH-00656323 IP5-00173852
 Baby SANSKRITI MADHAV KADAM
 12-11-2013 12 Y 6 M 3 D (F)
 Dr. ANUPAMA Y

Weight. 26kg Ward. Paw



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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
16/5/26	8 PM	INJ PARACETAMOL	400mg	IV	MY	Dal 9:30 PM Sivanthi
17/5	8 PM	SYP. MEFFALIP	10ml	PO	Madh.	Nite Nikit.

Signature
VERIFIED BY: []



I.V. FLUIDS CHART

Weight. 26 kg, Ward. Puw

Date	Time	Position of I.V. Fluid (if infusion, mention ml/hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
15/5	8:30 AM	IVF - DNS (2/3rd)	IV	40	Jaya S.	<i>(Signature)</i> Sudhakar	18/5	H/S	<i>(Signature)</i> Anur

Signature.....
 VERIFIED BY : Name.....



Sheet No: REGULAR PRESCRIPTIONS Weight ...26... Ward

DRUG : Inj-LINEZOLID **Date/Time** 15/5/15 18/5/15 18/5/15 19/5/15 20/5/15

Dose	Route	Frequency	Start Dt.
250mg	IV	TID	15/5

Name & Signature of the Doctor Starting the Drugs:
 K. Sathya

Additional Instructions:
 10mg/ks dose

Daily Doctor's Endorsement by a Sign
 M M M M M

DRUG : TAB. AZITHROMYCIN **Date/Time** 16/5/15 18/5/15 18/5/15

Dose	Route	Frequency	Start Dt.
250mg	PO	OD	15/5

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

Additional Instructions:

Daily Doctor's Endorsement by a Sign
 M M M M

DRUG : TAB. LANSOPRAZOLE **Date/Time** 16/5/15 18/5/15 18/5/15 19/5/15 20/5/15

Dose	Route	Frequency	Start Dt.
30mg	PO	OD	15/5

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

Additional Instructions:

Daily Doctor's Endorsement by a Sign
 M M M M

DRUG : ~~STOP~~ PARACETAMOL **Date/Time** 17/5/15 18/5/15 18/5/15

Dose	Route	Frequency	Start Dt.
260mg	IV	TID	16/5

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

Additional Instructions:
 stop 19/5/26 for nathan

Daily Doctor's Endorsement by a Sign
 M M M

VERIFIED Signature

VERIFIED

BAH-00656323 IP5-00173852
 Baby SANSKRITI MADHAV KADAM
 12-11-2013 12 Y 6 M 6 D (F)
 Dr. ANUPAMA Y



Sheet No: **REGULAR PRESCRIPTIONS** Weight Ward

DRUG : INJ TRAMADOL				Date Time	17/5	18/5	19/5													
Dose	Route	Frequency	Start Dt.																	
26mg	IV	TID	17/5	12AM	12AM	12AM	12AM													
Name & Signature of the Doctor Starting the Drugs: Dr. Matheen				<p>8AM Baam 4PM Nithu Prasad stop 19/5/26 Dr. Matheen</p>																
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign				M. N. D.																

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																				

VERIFIED

Signature

VERIFIED BY : Name



MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis:

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
15/5 9 AM	<input checked="" type="checkbox"/> Medical <input type="checkbox"/> Nursing <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Modified <input type="checkbox"/> Per-Op <input type="checkbox"/> Post Op	Fever cold in cough	For Hemodynamic Stability	IV fluids antibiotics low flow	Jayan	<input checked="" type="checkbox"/> Nursing <input type="checkbox"/> Others:
15/5 7 AM	<input type="checkbox"/> Medical <input checked="" type="checkbox"/> Nursing <input type="checkbox"/> Others:	<input type="checkbox"/> Initial <input type="checkbox"/> Modified <input type="checkbox"/> Per-Op <input type="checkbox"/> Post Op	Fever cold cough	For Hemodynamic Stability	IV fluids Antibiotics Low flow	Abhishek	<input checked="" type="checkbox"/> Medical <input type="checkbox"/> Others:
15/5/13 8 AM	<input type="checkbox"/> Medical <input type="checkbox"/> Nursing <input type="checkbox"/> Others: Dietician	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Modified <input type="checkbox"/> Per-Op <input type="checkbox"/> Post Op	pleural effusion	Child is on NPO	NPO A/Y Further advice	Mounice	<input type="checkbox"/> Medical <input type="checkbox"/> Nursing <input checked="" type="checkbox"/> Others:
	<input type="checkbox"/> Medical <input type="checkbox"/> Nursing <input type="checkbox"/> Others:	<input type="checkbox"/> Initial <input type="checkbox"/> Modified <input type="checkbox"/> Per-Op <input type="checkbox"/> Post Op					<input type="checkbox"/> Medical <input type="checkbox"/> Nursing <input type="checkbox"/> Others:
	<input type="checkbox"/> Medical <input type="checkbox"/> Nursing <input type="checkbox"/> Others:	<input type="checkbox"/> Initial <input type="checkbox"/> Modified <input type="checkbox"/> Per-Op <input type="checkbox"/> Post Op					<input type="checkbox"/> Medical <input type="checkbox"/> Nursing <input type="checkbox"/> Others:



INTERDISCIPLINARY PATIENT / FAMILY EDUCATION

Part - I,

Patient's / Learner Language : Marathi Patient / Learner Literacy : Read Write Speak Willingness to Learn : Yes No Healthcare Literacy : Yes No

Identified Education Needs :

- | | | | |
|----------------------------|--|--|---|
| 1. Diagnosis | 5. Medication / Terapy (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 Barries	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
15/5/15	6:47 AM	7	Infection control measus	M	1	0	1	1	NA	Abhishek
15/5/16	8am	9	Child is on NPO	M	1	0	1	1	-	Mamie

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



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

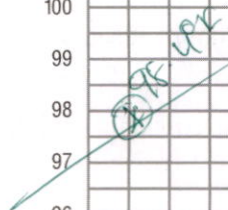
EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 20/5/26 Time: 6:00 PM

Doctor / Nurse / Family Concern?

Temperature (F)

104
103
102
101
100
99
98
97
96
95
94



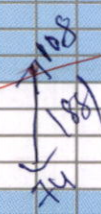
Heart Rate (bpm)

and

Blood Pressure (mmHg) *

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

Note:
 BP does not score in early warning scoring



Heart Rate (Number) 102 bpm

Resp. Rate (bpm) over 1 Minute

70
60
50
40
30
20
10

Resp Rate (Number) 26 bpm

Resp Distress Mod/ Severe None / Mild

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

100%

Conscious Level Normal Altered

GCS * 15/15

TOTAL SCORE

Number of shaded boxes 1

Pain Score 0

Observer's Initials D

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



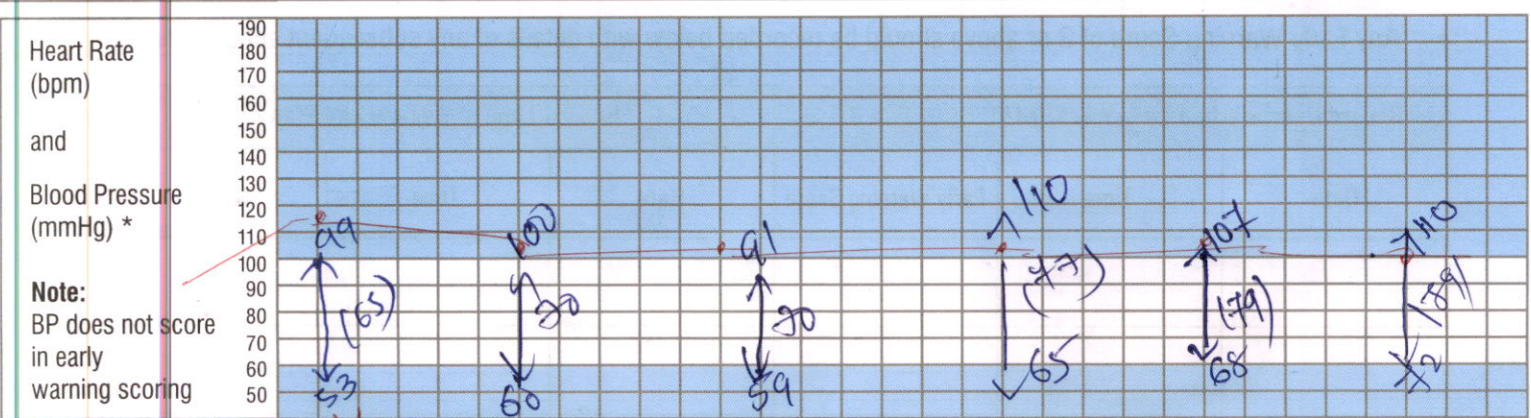
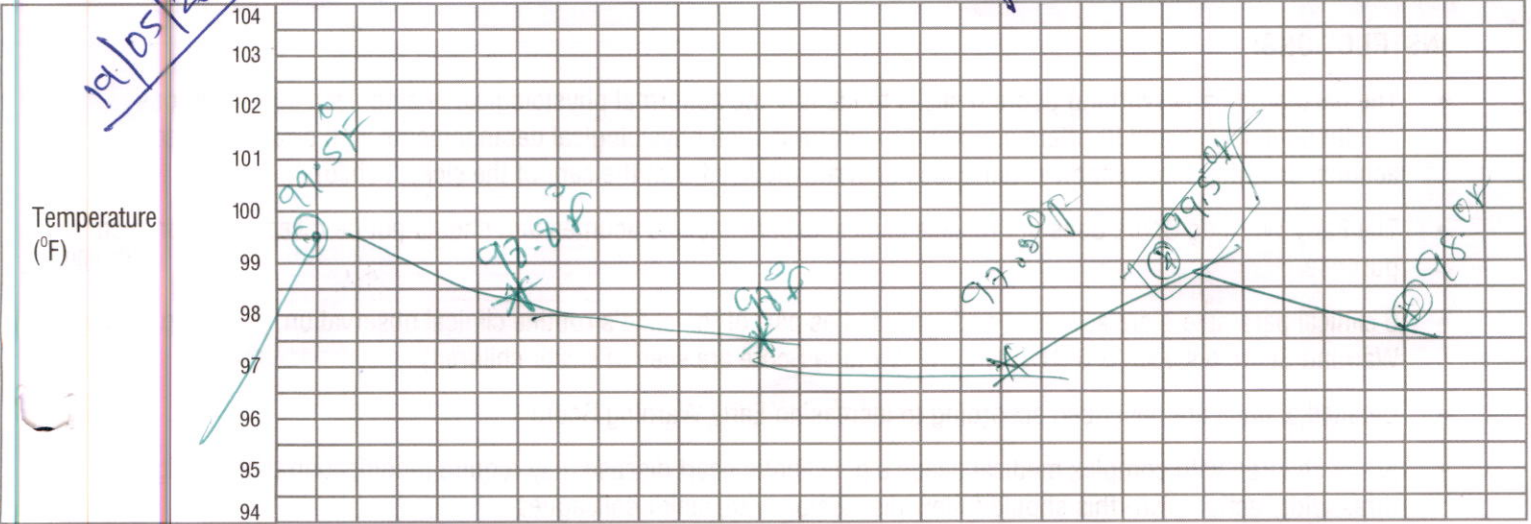
TEENAGE (12 + years)
Children's Observation & Early Warning Scoring Chart



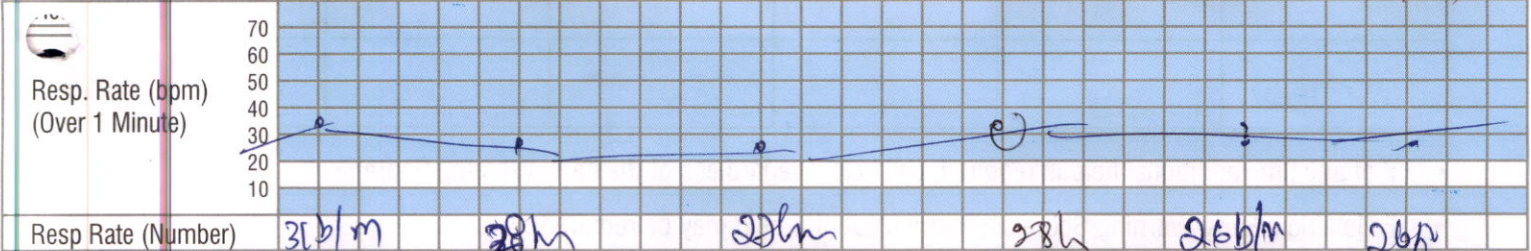
EARLY WARNING SCORE: CHILDREN'S UNIT

Date : Time: 6:30am 10am 1pm 6pm 10pm 2am

Doctor / Nurse / Family Concern? 19/05/26



Heart Rate (Number) 117b/m 109b/m 103b/m 102b/m 108b/m 100b/m



Resp Rate (Number) 31b/m 28b/m 28b/m 28b/m 26b/m 26b/m

Resp Distress: Mod/ Severe None / Mild

Receiving O₂ (l/min) O₂ Saturations (%) 97-1 99x 97% 99+ 94+ 99+

Conscious Level: Normal Altered

GCS * 15/15 15/15 15/15 15/15 15/15 15/15

TOTAL SCORE
 Number of shaded boxes: 1 1 1 1 1 1
 Pain Score: 0 0 0 0 0 0
 Observer's Initials: [Signature] [Signature] [Signature] [Signature] [Signature] [Signature]

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

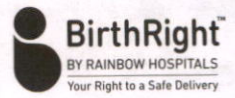
The SBAR communication tool (situation, background, assessment, recommendations) is a helpful mnemonic that can be used to describe a child's clinical condition to a colleague.

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

BAH-00656323 IP5-00173852
 Baby SANSKRITI MADHAV KADAM
 12-11-2013 12 Y 6 M 5 D (F)
 Dr. ANUPAMA Y

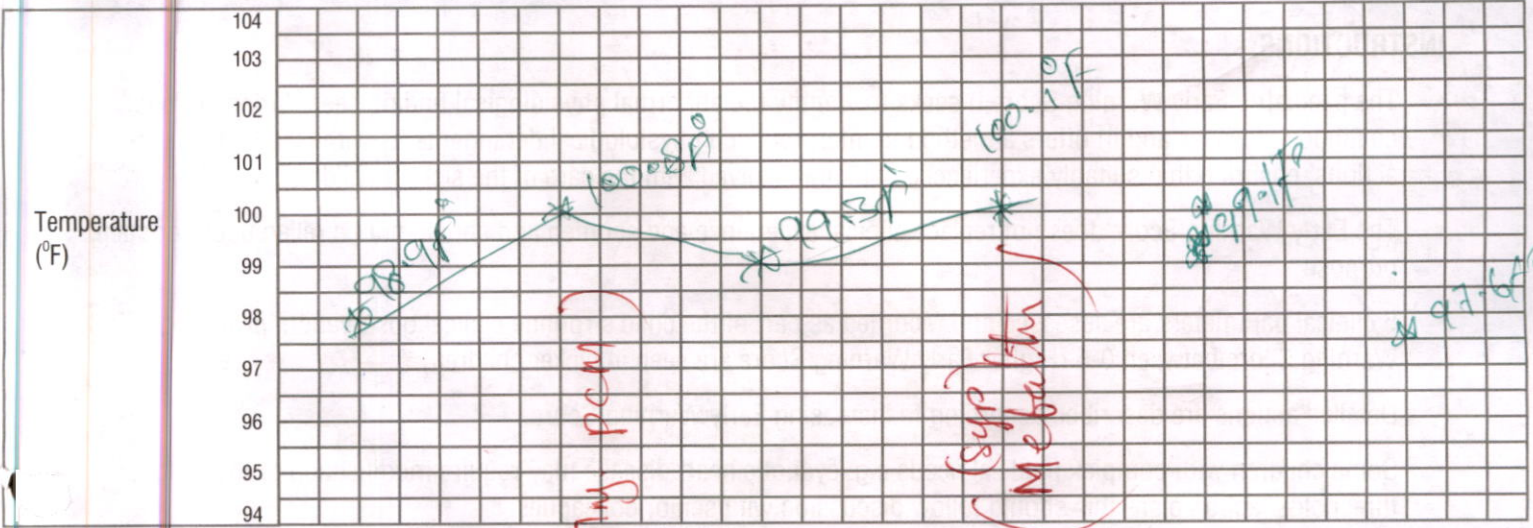
Doc. No. : RCHBH/FRM / CLINICAL / 127

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



EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 19/11/15 Time: 10AM • 11:10AM 1PM 7:55PM 8:15PM 10PM
 Doctor / Nurse / Family Concern?



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

Time	Heart Rate (bpm)	Blood Pressure (mmHg)
10:00 AM	103	105/65
11:10 AM	107	100/62
1:00 PM	100	105/60
7:55 PM	106	100/63

Heart Rate (Number) 103b/m 107b/m 100b/m 106b/m

Resp. Rate (bpm) per 1 Minute

Time	Resp. Rate (bpm)
10:00 AM	26
11:10 AM	26
1:00 PM	27
7:55 PM	28

Resp Rate (Number) 26b/m 26b/m 27b/m 28b/m

Resp Distress Mod/ Severe None / Mild

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

Time	O ₂ (l/min)	O ₂ Sat (%)
10:00 AM	2	100%
11:10 AM	2	99%
1:00 PM	2	99%
7:55 PM	2	100%

Conscious Level Normal / Altered

GCS * 15/15 15/15 15/15 15/15

TOTAL SCORE 1 1 1 1

Number of shaded boxes

Pain Score 0 0 0 0

Observer's initials 2

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

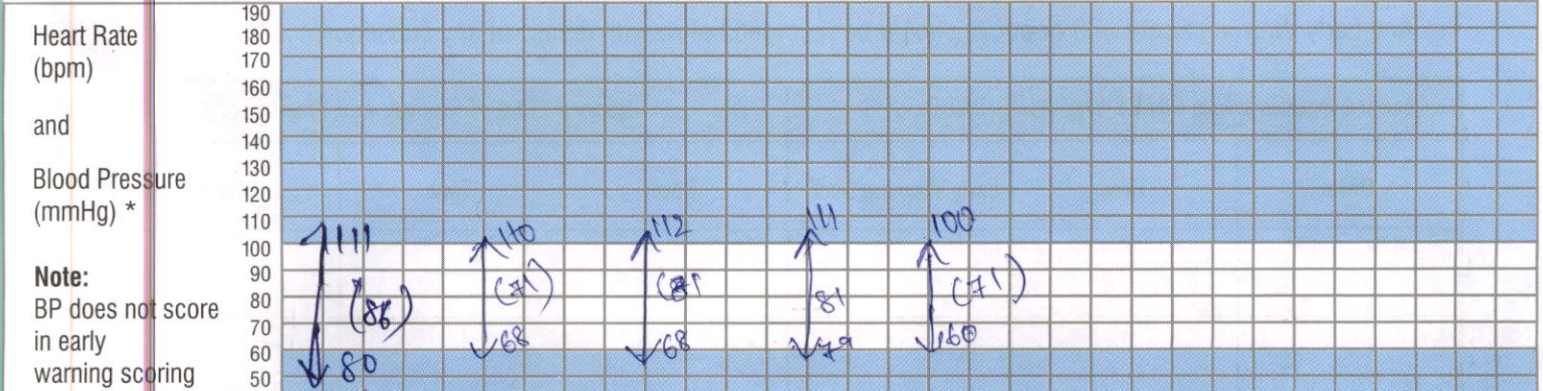
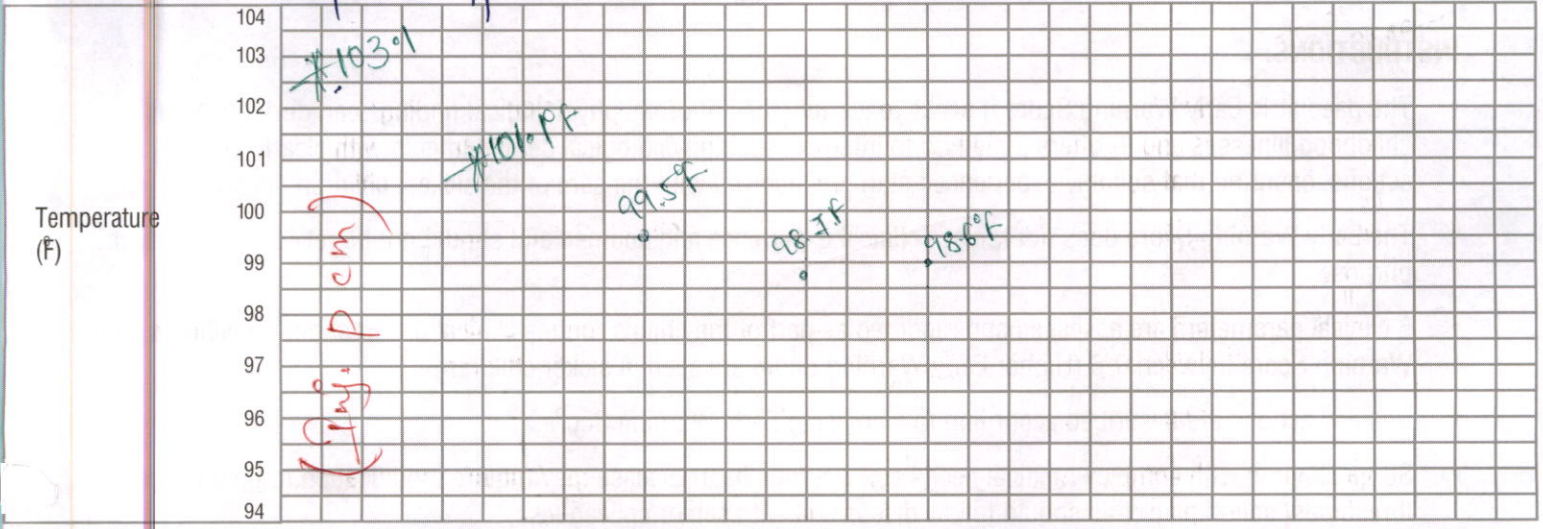


TEENAGE (12 + years) Children's Observation & Early Warning Scoring Chart

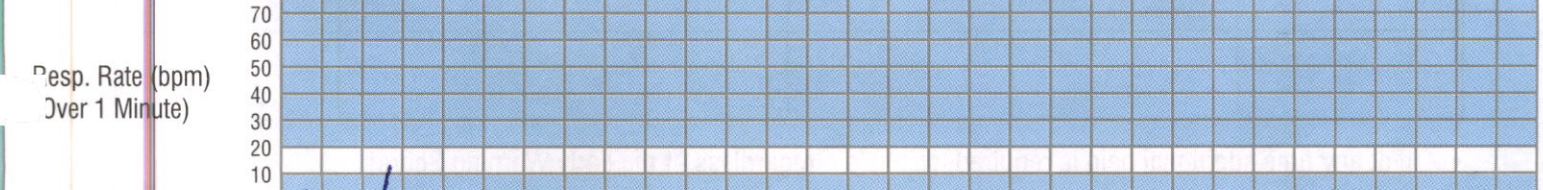
EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 16/11/26 Time: 10pm 2am 6am

Doctor / Nurse / Family Concern? 6pm 7pm



Heart Rate (Number) 116b/min 112b/min 108b/min 106b/min 112b/min



Resp Rate (Number) 26b/min 26b/min 26b/min 26b/min 26b/min

Resp Mod/ Severe Distress None / Mild 2 lit/min 2 lit/min 2 lit/min 2 lit/min 2 lit/min
 Receiving O₂ (l/min) 2 O₂ 2 O₂ 2 O₂ 2 O₂ 2 O₂
 O₂ Saturations (%) 100% 100% 100% 100% 100%

Conscious Level Normal Altered 13/15 15/15 15/15 15/15 15/15
 GCS *

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

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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



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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 15/10/2013	Time: 10:00pm	11:10	12:30am	2am	4am	6am	8:30am	10am	11am
Doctor / Nurse / Family Concern?									

Temperature (F)	104									
	103									
	102									
	101									
	100	99.8°F	100.6°F					100.6°F	99.8°F	
	99			98.5°F	98.7°F		99.5°F			97.8°F
	98									97.8°F
	97									
	96									
	94									

[INI + PARACETMOL] 400mg IV
 (INI + paracetamol) tracing IV

Heart Rate (bpm) and Blood Pressure (mmHg) *	190									
	180									
	170									
	160									
	150									
	140									
	130									
	120									
	110									
	100									

Note: BP does not score in early warning scoring

Heart Rate (Number)	108bpm	110bpm	102bpm	108bpm	112bpm	108bpm	106bpm	116bpm
---------------------	--------	--------	--------	--------	--------	--------	--------	--------

Resp. Rate (bpm) Over 1 Minute	70								
	60								
	50								
	40								
	30								
	20								
	10								
	0								
	0								
	0								

Resp Rate (Number)	38bpm	28bpm	28bpm	26bpm	26bpm	29bpm	29bpm
--------------------	-------	-------	-------	-------	-------	-------	-------

Resp Distress	Mod/ Severe	None / Mild						
Receiving O ₂ (l/min)			2 litres	2 litres	2 litre	2 litre	2 litres	
O ₂ Saturations (%)			100%	100%	100%	100%	100%	99%
Conscious Level	Normal	Altered						
GCS *			15/15	15/15	15/15	15/15	15/15	15/15
TOTAL SCORE			1	1	1	1	1	1
Number of shaded boxes			1	1	1	1	1	1
Pain Score			0	0	0	0	0	0
Observer's Initials			O	O	O	O	O	O

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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



FLUID CHART

Sheet No. : 0

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
Total Intake :						Total Output :							
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :							
	08:00 pm												
	09:00 pm												
	10:00 pm	NPO	40ml										
	11:00 pm	NPO	40ml										
	12:00 am		40ml										
	01:00 am												
Total Intake :						Total Output :							
	02:00 am		40ml										
	03:00 am		40ml										
	04:00 am	NPO											
	05:00 am												
	06:00 am												
	07:00 am												
Total Intake :						Total Output :							
Total 24 hrs. Intake						Total 24 hrs. Output							



FLUID CHART



Sheet No. : 2

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
16/5/26	08:00 am			40ml	/	/		/	✓	0	Sweetani		
	09:00 am			40ml	/	/				0			
	10:00 am	ONS		40ml	/	/				0		Suman	
	11:00 am			40ml	/	/				0			
	12:00 pm			40ml	/	/			✓	0		Jyoti	
	01:00 pm			40ml	/	/				0			
Total Intake :						Total Output :							
16/5	02:00 pm			-	/	/				0	Chand		
	03:00 pm			-	/	/				0			
	04:00 pm	ONS		40ml	/	/			✓	0		Chand	
	05:00 pm			40ml	/	/				0			
	06:00 pm			40ml	/	/			✓	0		Chand	
	07:00 pm			-	/	/				0			
Total Intake :						Total Output :							
16/5	08:00 pm			40ml	/	/				0	A		
	09:00 pm			40ml	/	/				0			
	10:00 pm	ONS MILK		-	/	/			✓	0		A	
	11:00 pm			-	/	/				0			
	12:00 am			40ml	/	/				0		A	
	01:00 am			40ml	/	/				0			
Total Intake :						Total Output :							
17/5	02:00 am			40ml	/	/				0	A		
	03:00 am			40ml	/	/				0			
	04:00 am	ONS		-	/	/			✓	0		A	
	05:00 am			40ml	/	/			✓	0			
	06:00 am			-	/	/				0		A	
	07:00 am			-	/	/				0			
Total Intake :						Total Output :							

Total 24 hrs. Intake

Total 24 hrs. Output

BAH-00656323 IP5-00173852
 Baby SANSKRITI MADHAV KADAM
 2-11-2013 12 Y 6 M 6 D (F)
 Dr. ANUPAMA Y



FLUID CHART

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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Sheet No. : 3

- All measurements in ml.
- Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.
- 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		
17/5	08:00 am			407	/		/			✓	0	Anupam
	09:00 am			407	/		/			✓	0	
	10:00 am	DNS		407	/		/			✓	0	
	11:00 am			407	/		/			✓	0	
	12:00 pm			407	/		/			✓	0	
	01:00 pm	nie				/	/			✓	0	
Total Intake :						Total Output :						
17/5	02:00 pm			400ml	/		/			✓	0	Anupam
	03:00 pm			400ml	/		/			✓	0	
	04:00 pm	DNS		400ml	/	NA	/	NA		✓	0	
	05:00 pm			400ml	/	NA	/	NA		✓	0	
	06:00 pm					/	/			✓	0	
	07:00 pm					/	/			✓	0	
Total Intake :						Total Output :						
18/5	08:00 pm			400ml	/		/			✓	0	Anupam
	09:00 pm			400ml	/		/			✓	0	
	10:00 pm	DNS		-	/	NA	/	NA		✓	0	
	11:00 pm			-	/	NA	/	NA		✓	0	
	12:00 am			400ml	/		/			✓	0	
	01:00 am			400ml	/		/			✓	0	
Total Intake :						Total Output :						
18/5	02:00 am			400ml	/		/			✓	0	Anupam
	03:00 am			400ml	/		/			✓	0	
	04:00 am	DNS		-	/	NA	/	NA		✓	0	
	05:00 am			400ml	/		/			✓	0	
	06:00 am			400ml	/		/			✓	0	
	07:00 am					/	/			✓	0	
Total Intake :						Total Output :						

Total 24 hrs. Intake

Total 24 hrs. Output

ICD Drain 150 - 100 = 50ml

FLUID CHART

Sheet No. : 4

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
18/15	08:00 am			40 ⁺		/							
	09:00 am	DMNS	Baby H ₂ O	40 ⁺		/						Am	
	10:00 am			40 ⁺		/							
	11:00 am	NO		-		/							
	12:00 pm	WF		-		/						Am	
	01:00 pm			-		/							
Total Intake :						Total Output :							
18/15	02:00 pm		Rice	-		/				0		praveen	
	03:00 pm		H ₂ O	-		/				0		praveen	
	04:00 pm	NO		-		/				0		praveen	
	05:00 pm	WF		-		/				0		praveen	
	06:00 pm			-		/				0		praveen	
	07:00 pm			-		/				0		praveen	
Total Intake :						Total Output :							
19/15	08:00 pm		rice			/				0		Sona	
	09:00 pm					/				0		Sona	
	10:00 pm	NO				/				0		Sona	
	11:00 pm	IVF	milk	medicine		NP		NA		0		Sona	
	12:00 am			medicine		/				0		Sona	
	01:00 am					/				0		Sona	
Total Intake :						Total Output :							
19/15	02:00 am					/				0		Sona	
	03:00 am					/				0		Sona	
	04:00 am	NO				/				0		Sona	
	05:00 am	IVF				NP		NA		0		Sona	
	06:00 am		milk	medicine		/				0		Sona	
	07:00 am			medicine		/				0		Sona	
Total Intake :						Total Output :							

Total 24 hrs. Intake

Total 24 hrs. Output

Drain → (103 - 100) 3ml



FLUID CHART

Sheet No. : (5)

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			
12/11	08:00 am												
	09:00 am		Tiffin	medicines									
	10:00 am	NO WF											
	11:00 am												
	12:00 pm												
	01:00 pm												
Total Intake :						Total Output :							
12/11	02:00 pm												
	03:00 pm												
	04:00 pm	NO WF											
	05:00 pm												
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :							
12/11	08:00 pm		Rice water										
	09:00 pm												
	10:00 pm	NO WF											
	11:00 pm												
	12:00 am												
	01:00 am												
Total Intake :						Total Output :							
20/12	02:00 am												
	03:00 am												
	04:00 am	NO WF											
	05:00 am												
	06:00 am												
	07:00 am												
Total Intake :						Total Output :							

Total 24 hrs. Intake []

Total 24 hrs. Output []

BAH-00656323 IP5-00173852
 Baby SANSKRITI MADHAV KADAM
 12-11-2013 12 Y 6 M 5 D (F)
 Dr. ANUPAMA Y



FLUID CHART



Sheet No. :

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

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

117



NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 16/5/26 Time: 9Am

Weight: 26 Kgs Centile: <5th

Height: 137 cms Centile: <5th

Inference: Under weight child

RDA: - Calories: 1750 kcal/d Protein: 31g/d

Diet Recommendations: Child is on NPO

Re-Assessment:

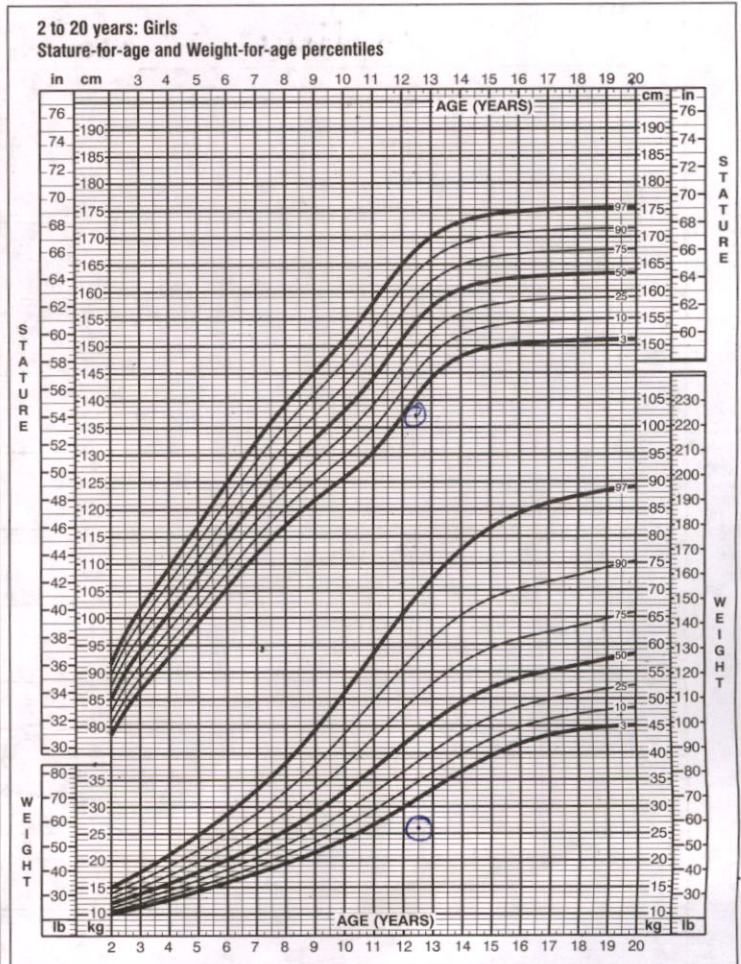
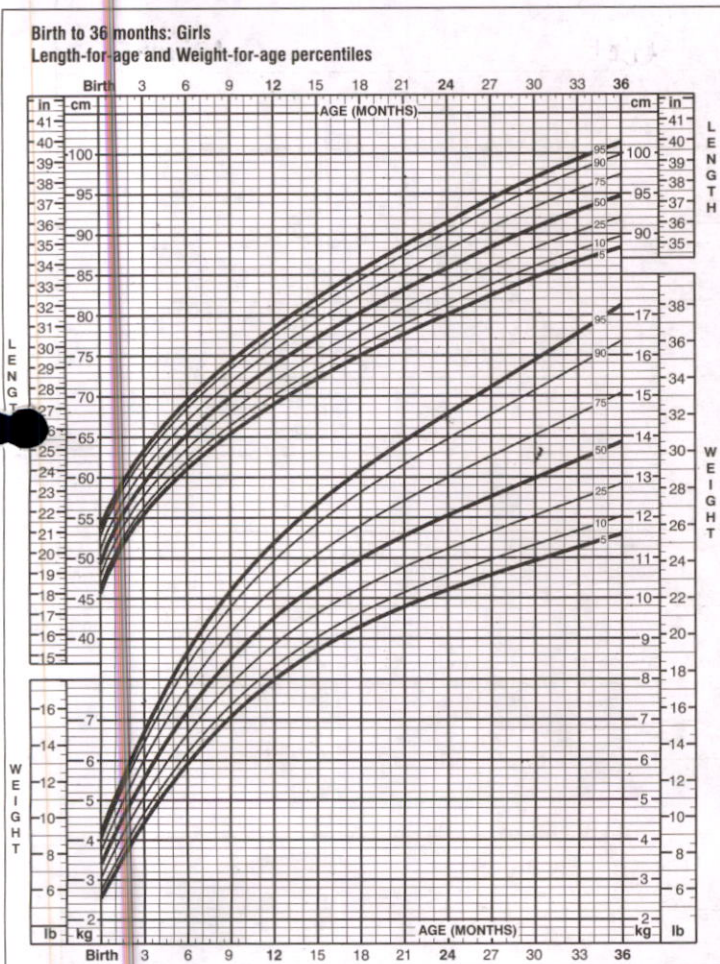
Food Allergies: NO Veg/Non-veg: Neg

Diagnosis: Left pleural Effusion

Nutritional Intervention - Oral Enteral Parenteral

Patient's Signature: *[Signature]*

GROWTH CHART (GIRLS)



Dietician's Name: Mounica

Dietician's Signature: *[Signature]*

Daily Notes:

17/5/26
11:30am

Child is stable Oral Intake is better.

Continue \bar{c} normal diet.

Nepkita

18/5/26
11AM

Child is stable Oral Intake is fair

Continue \bar{c} normal diet.

Nepkita

19/5/26
11AM

Child is stable Oral Intake is better

Continue \bar{c} Normal diet.

Nepkita

20/5/26
8am

Child is stable. Intake is sub-optimal.

continue \bar{c} normal diet

Nepkita