

DISCHARGE SUMMARY

Name	Master ABHYAN VAYU	UHID	HNH-00016638
Father/Guardian	Mr AKSHAY RAMINI	Age/Gender	0 Y 1 M 25 D/ Male
Address	3-3-53/7A VS ROAD, Kachiguda, Hyderabad, Telangana, INDIA, 500027		
IP No	IP26-00006872	Admission Date	17-07-2026
Ref Doctor	Self.		
Discharge Date	18-07-2026		

Consultant:

Dr. SANJAY SRIRAMPUR
MBBD,Md(Pead),DCH
HMC9465

Co-Consultant:

Dr. PRITESH NAGAR
MBBS MD
Medical Registration No. 47184

DIAGNOSIS	ICD CODE
ACUTE DYSENTRY WITH DEHYDRATION	

History: Master ABHYAN VAYU, 0 Y 1 M 25 D , old boy presented with history of loose stools since 2 days and blood in stools since 1 day prior to admission. For the above complaints he was admitted at Rainbow Children's Hospital - for

Name	Master ABHYAN VAYU	UHID	HNH-00016638
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further management.

OPD investigation:

USG abdomen on 17.07.2026 showed, no significant sonographic abnormality.

Examination: He was afebrile, maintaining saturations at room air and was hemodynamically stable. His heart rate was 128/min and Respiratory Rate - 35/min. Capillary Refill Time was <2 secs. Peripheries were warm & pulses well felt. On examination dry lips, oral mucosa, sunken eyes, flushing were present. On auscultation, air entry was bilaterally equal were present. Heart sounds were normal and there was no murmur. Abdomen was soft with no organomegaly. On neurological examination, he was conscious and alert. Pupils were bilaterally equal and reacting to light. There were no focal neurological or cranial nerve deficits. There were no signs of raised intracranial pressure.

Weight on admission: 6.1 kilo grams.

Investigations: Enclosed reports.

Initial hemogram showed Hemoglobin of 10.5 gm%, White Blood Cell count of 8670 cells/cumm, platelet count of 5.17 lakhs/cumm and C-Reactive Protein of 5 mg/l. Complete urine examination was normal.

Stool culture & sensitivity sent, report awaited.

Management: He was admitted in the ward and was started on Intra Venous fluids.

In view of loose stools he was treated symptomatically with probiotics and zinc.

He was regularly monitored for further blood in stools, fever spikes,

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hemodynamic status. His loose stools and other symptoms gradually settled. Child maintaining saturations on room air.

He remained hemodynamically stable during the hospital stay. He improved with the above line of management and is being discharged with the following advice.

At the time of discharge : He is active, afebrile and hemodynamically stable.

Medication during hospital stay:

B4 nappy cream

Pro-GG drops

Z & D drops

Advice:

* Diet as advised.

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S.N o	MEDICATION	DOSE	TIMINGS	DURATION
1	B4 nappy cream (Diaper rash cream)	For local application	As per need	For 3 days
2	Pro GG drops	0.5ml	twice daily	For 3 days
3	Z & D drops (1ml/20mg)	0.5 ml	9am (after food)	For 12 days
4	Nasoclear nasal drops, 2 drops in each nostril SOS for nose block.			

Plan: To collect stool culture & sensitivity report after 2 days.

Review consultation with **Dr. SANJAY SRIRAMPUR** on Sunday (19.07.2026) at his OPD clinic.

Food instructions while taking medications:

* By consuming your **probiotic** with food you provide a buffering system for the supplement and ensure its safe passage through the digestive tract. Aside from protection, food also provides the friendly bacteria in your probiotic the proper food and nourishment to ensure it survives, grows and multiplies in your gut. It is recommended to take probiotics at the **END** of a meal. Concurrent administration of antibiotics could kill a large number of the organisms, reducing the efficacy of probiotics. Separate administration of antibiotics from probiotics by **atleast two hours**.

Follow up immediately in Emergency Room if high grade fever, vomiting, breathlessness or refusal to feed occurs.

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The content of the patient discharge summary, medication, food & drug interaction, care to be provided at home, nutrition, immunization and safe parenting, when and how to obtain emergency care etc also have been explained by doctor in a language that I can understand and I acknowledge.

Parent/ Attender

In case of emergency contact 9154865030 emergency pediatrician on duty.

To take appointment for OPD consultation at Rainbow **Banjara Hills** / Rainbow Clinic **Madhapur** / **Kukatpally** / **Vikrampuri** / **LB Nagar** / dial just one toll free number **18002122**.

You can also take appointments at any time by going **online** to our website **www.rainbowhospitals.in**

Sanjay
Registrar/Resident/C.M.O



Dr. SANJAY SRIRAMPUR
MBBD,Md(Pead),DCH
HMC9465



DEFICIENCY CHECK LIST OF CASE SHEET

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

ERROR LOG

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

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE

ADMISSION SHEET

Registration Details :



Admission No : IP26-00006872 Admit Date : 17-Jul-2026 Admit Time : 01:00 PM UHID : HNH-00016638

Patient Details :

Patient Name	: Master ABHYAN VAYU	Age	: 0 Y 1 M 24 D
Guardian	: Mr AKSHAY RAMINI	DOB	: 23-05-2026 01:00 AM
Gender	: Male	Religion	:
Occupation	:	Marital Status	:
Address (H)	: 3-3-53/7A VS ROAD Kachiguda Hyderabad Telangana INDIA 500027	Phone No	: 9059198142/ 8125412129
		E-mail	: NA@GMAIL.COM

Admission Details :

Bed Type : DAY CARE Bed No : ER01 Ward Name : GF -EMERGENCY
Room No : ER01 Admission Type : First Visit

Contact Details :

Name : Mr AKSHAY RAMINI Relationship : Father
Contact Address : 3-3-53/7A VS ROAD Kachiguda Hyderabad
Telangana INDIA 500027 Phone No : 9059198142


Signature

Doctor Details :

Doctor Name : Dr. SANJAY SRIRAMPUR Specialisation : GENERAL PEDIATRICS
Referral Doctor : Self. Phone No :
Co-Consultant : Dr. PRITESH NAGAR

Payment Details :

Deposit Amount : 30000.00
Payment Mode : Cash Payor Name : SELFPAY

ACTIVITY

HNH-00016638 IP26-00006872
Master ABHYAN VAYU
23-05-2026 0 Y 1 M 24 D (M)
Dr. SANJAY SRIRAMPUR

Name: -----

UHID No: ----- Consultant: ----- Dept: -----

Date of Admission: 17/7/26 Time: 1pm Date of Discharge: ----- Time: -----

Room / Bed No: 310 Ward: 3rd floor Suggested Billable bed type: -----

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
17/7/26	1pm	ER2	3rd floor/310	Dr. Manjusha

Cross Consultation Visit

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



Order No.

1949

11967

11970

Cross checked done by
Amrutha

(8) 7/26 e 8 Am

[illegible]

[illegible]



PEDIATRIC IN-PATIENT MEDICAL RECORD

HNH-00016638 IP26-00006872
Master ABHYAN VAYU
23-05-2026 0 Y 1 M 24 D (M)
Dr. SANJAY SRIRAMPUR



Patient Name : ABH

Patient ID# : _____

Consultant : _____

Final Diagnosis : ACUTE DYSENTERY WITH DEHYDRATION.

Pediatric Multiorgan History & Physical Examination

Name: ABHYAN VAYU.

Informant: Mother.

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Master ABHYAN VAYU
23-05-2026 0 Y 1 M 24 D (M)
Dr. SANJAY SRIRAMPUR



Age/Sex: 3m AD.
Reliability: Good.

Chief Presenting Complaints & Duration (Chronologically):

~~Blood in stools x 1~~

Loose stools x 2 days

Bloody stools x yesterday night.

History of present illness:

- Child came with complaints of loose stools, semi-solid, yellowish in color, mucoid, passing one every 2 hrs, small in quantity & since 2 days.

- Also do blood streaks in stools since yesterday night associated with straining while passing stools & perianal redness.

- No vomiting, fever, no straining, excessive crying while passing urine.

- Active - A.

Pediatric Multiorgan History & Physical Examination

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

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Dr. SANJAY SRIRAMPUR



-NIL-

Birth & Neonatal History :

Term / AYAAL ~~Female~~ Male -

Birth & Socio Economic History :

About Father : _____

About Mother : _____

Any additional Information : _____

Developmental History :

Developmentally (N)

Immunization History :

As per NIS -

Pediatric Multiorgan History & Physical Examination

HNH-00016638

IP26-00006872

Master ABHYAN VAYU

23-05-2026

0 Y 1 M 24 D

(M)

Dr. SANJAY SRIRAMPUR



Anthropometry

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

Weight (kgs) 6.1 kgs. (Centile _____)

On Examination :

Temperature : Afebrile Pulse Rate: _____ Description _____

B.P. _____ SPO2 100% at RA.

Resp. rate and type of breathing : _____

Rash _____

Lymphadenopathy _____

Oedema : _____

Sunken eyes.
1st. over sinusoid.
Skinn turgor > 2 sec.

Respiratory system :

Inspection (any s/o distress) : _____

Air entry & breath sounds : _____

Any addles sounds : _____

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

BAC (+), NUB (+).

Cardiovascular System :

Inspection of precordium : _____

Heart Sounds : _____

Any murmur : _____

Relevant date from outside (Chest X-Ray, ECG, ECHO, Etc.,) _____

S₁, S₂ (+), No murmurs.

Per Abdomen :

Inspection _____

Palpation : _____

Ausculation : _____

Spine: _____ External Genitalia : _____

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

SM, NT.

Pediatric Multiorgan History & Physical Examination

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Dr. SANJAY SRIRAMPUR



Central Nervous System :

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

Cranial Nerves : _____

Motor System :

Nutrition : _____

Tone : _____ Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR

Superficials :

Plantars _____

Sensory System :

Bladder / Bowel : _____

Clinical Summary & Diagnostic :

ACUTE DYSENTERY & DEHYDRATION



Preventive aspects of the treatment :

Desired goals of the treatment :

Planned Labs :

CBC

CRP

CWF

Stool C/S:-(PAC)

Notes by *br*

Planned Management :

IVF 2/3rd

~~IV ceftriaxone OD. X~~

~~Change formula to~~

~~Aptamil pepti.~~

2im drops.

Pro C, G drops.

CANDID B CREAM 4A

Notes by *br*

Please fill up the following details

1. Name of the Referring Doctor : _____
2. Name of the Referring Hospital : _____
(Including the name of City)
3. Contact number of the Referring Doctor : _____
(Preferring Mobile #)
4. Name of the doctor in Rainbow Team _____ on
whose name the patient is being referred

Doctor's Signature Name _____ Date _____ Time _____

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
17/08/26 12:30pm	S/B Dr. Srinivas	
	Many thanks for ref	
	Case noted	
	3mth old with blood in stool	
	P/A - soft, No lump felt -	
	No bowels of pain -	
	H/A USG - WNL	
	<u>Adv:</u>	
	- Nil surgical @ present -	
	- Ct medical management - s/s	
	flow	
	for	
	Dr. Srinivas	

NOTES to

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
17/07/26 5 PM	SIB Do-Path	
	Δ Acute Dysentery & dehydration	
	CI - Loose stools 4 episodes	Pln
	CNS - S, S, S	✓ IF ZINC
	RP - DA - ACCO	Pro - 6h
	PLA - 50k	✓ w/ R loose stools / blood dehydration in stools
	⊕ Sleepy	
	CI - diaper rash	✓ IF IV Fluids @ 12 ml/h
		✓ By NAPPI team in 2A in diaper area
		✓ Trace stool / C
		✓ Trace CRP
		✓ CUE
		✓ NB - Mouthwash @ 6 PM.

Dr. Pritesh Nagar
 Consultant Pediatrician & Intensivist
 Reg. No: 47184

(Signature)

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
18/7 7:00 AM	CLSB Dr. Naipanya / Dr. Archana. Acute Diarrhea & dehydration? No loose stools. Vitals - Stable RLS - BIL AEP PLA - soft, NT	Plan Stop IVF Cont zinc PROGA drops Trace stool c/s Monitor vitals @ 7A N/B suppn @ 7A
18/7	SLB Dr. Sanjay G.C. Better Red safe passing stool no Vomiting Vitals @ no Blood in stool o/s @	Discharge 2



PROGRESS NOTES AND DOCTOR'S ORDER

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


BirthRight™
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Your Right to a Safe Delivery

MEDICATION RECONCILIATION FORM

Drug Allergies: Niu

☒ 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: 3rd floor / 310

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

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Varun

Date & Time : 17/7/26 @ 12:40 PM

Nurse Name & Signature : Atom / [Signature]

Date & Time : 17/7/26 @ 2:15 PM

Docu. No. : RCH / FRM / GENERAL / 090

DRUG CHART

Date of Admission: Drug Allergies: ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

SOS / PRN (As Required Medication)

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

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

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

Signature
 VERIFIED BY : Name



REGULAR PRESCRIPTIONS

Weight. 6.15 Ward.

DRUG : <u>Drop. 2nd</u>				Date Time																
Dose	Route	Frequency	Start Date																	
<u>1ml</u>	<u>orel</u>	<u>OD</u>	<u>17/7</u>																	
Name & Signature of the Doctor Starting the Drugs: <u>B. Srinivas</u>																				
Additional Instructions: <u>Zinc (1ml/day)</u>																				
Daily Doctor's Endorsement by a Sign																				
DRUG : <u>Pro-GA drop</u>				Date Time	<u>17/7</u>	<u>18/7</u>														
Dose	Route	Frequency	Start Date																	
<u>15</u>	<u>orel</u>	<u>BD</u>	<u>17/7</u>	<u>6AM</u>	<u>X</u>	<u>2</u>														
Name & Signature of the Doctor Starting the Drugs: <u>B. Srinivas</u>																				
Additional Instructions: <u>4PM</u>																				
Daily Doctor's Endorsement by a Sign																				
DRUG : <u>Drop. 2nd</u>				Date Time	<u>17/7</u>	<u>18/7</u>														
Dose	Route	Frequency	Start Date																	
<u>0.5ml</u>	<u>orel</u>	<u>OD</u>	<u>17/7</u>																	
Name & Signature of the Doctor Starting the Drugs: <u>B. Srinivas</u>																				
Additional Instructions: <u>Zinc (2ml/day)</u>																				
Daily Doctor's Endorsement by a Sign																				
DRUG : <u>By NAPPI cream</u>				Date Time	<u>17/7</u>	<u>18/7</u>														
Dose	Route	Frequency	Start Date																	
<u>1</u>	<u>LA</u>	<u>TID</u>	<u>17/7</u>	<u>6AM</u>	<u>X</u>	<u>2</u>														
Name & Signature of the Doctor Starting the Drugs: <u>B. Srinivas</u>																				
Additional Instructions: <u>4PM</u>																				
Daily Doctor's Endorsement by a Sign																				



Weight. Ward.

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses

Weight. Ward.

VERIFIED BY: Name:

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Master ABHYAN VAYU
23-05-2026 0 Y 1 M 24 D (M)
Dr. SANJAY SRIRAMPUR



310

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Children's
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BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

RESULT SHEET

Date	17/7/26				
Time					
Hb	10.5				
PCV	28.9				
RBC	3.69				
WBC	8.67				
N/L	45.6/43.8				
Platelets	517				
CRP	5.0				
ESR					
PCT					
RBS					
Na					
K					
Cl					
Ca/Mg					
Phosphate					
Urea					
Creatinine					
ALP					
SGPT					
SGOT					
T.Bill/Conj					
T.Protein					
S.Albumin					
S.Globulin					
A/G Ratio					
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein / Sugar					
Cells					
N/L					

[illegible]

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.....

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Others (ECG, Contrast Studies etc.) :

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Master ABHYAN VAYU

23-05-2026 0 Y 1 M 24 D (M)

Pa Dr. SANJAY SRIRAMPUR

FRM / CLINICAL / 124



INFANT (<1 year)

Children's Observation &
Early Warning Scoring Chart

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

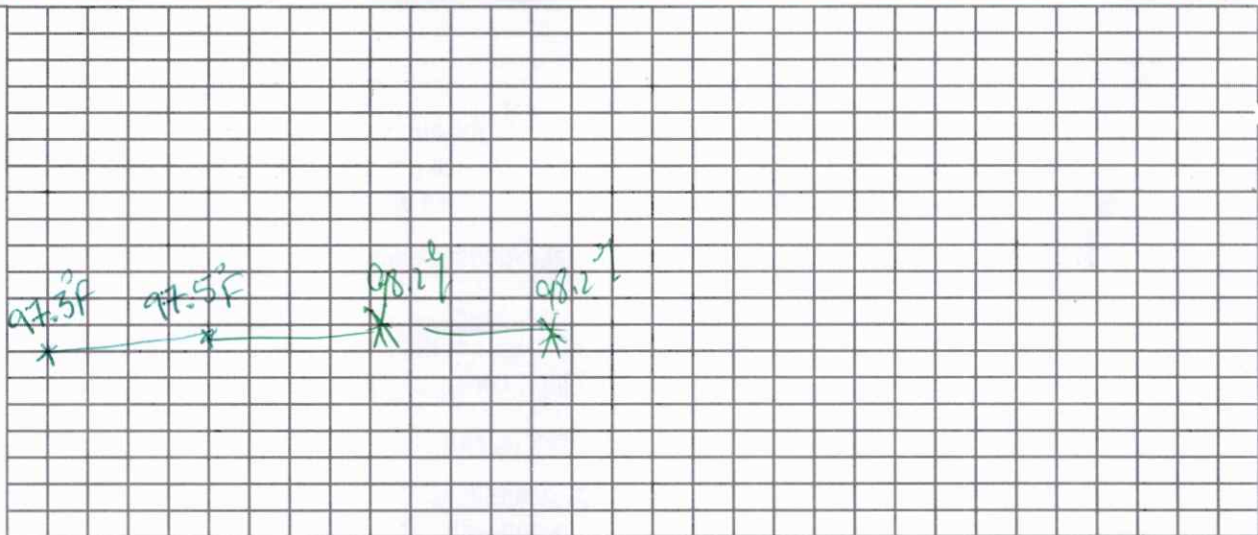
EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 17/7/26 Time: 3pm 6pm 10pm 2A 6A

Doctor/Nurse/Family Concern?

Temperature
(°F)

104
103
102
101
100
99
98
97
96
95
94

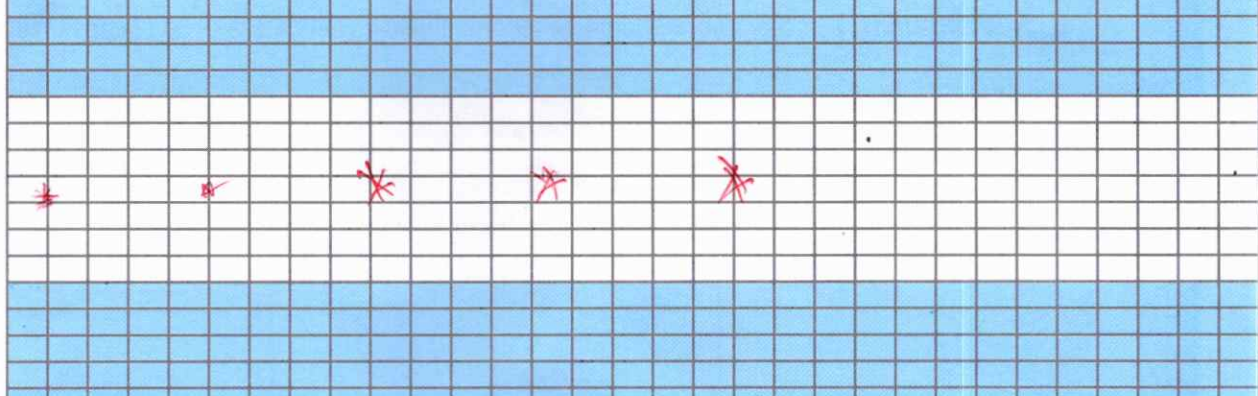


Heart Rate
(bpm)

and

Blood Pressure
(mmHg) *

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



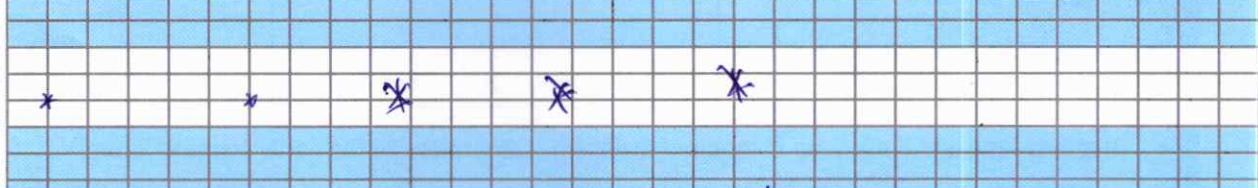
Note:
BP does not score
in early
warning scoring

Heart Rate (Number)

128b/m 125b/m 138b/m 138b/m 126b/m

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

70
60
50
40
30
20
10



Resp Rate (Number)

35b/m 32b/m 33b/m 34b/m 35b/m

Resp Mod/ Severe
Distress None / Mild

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

99% 99% 99% 99% 99%

Conscious Normal
Level Altered

GCS *

15/15 15/15

TOTAL SCORE

Number of shaded boxes

0 0 0 0 0

Pain Score

0 0 0 0 0

Observer's Initials

AS AS AS AS AS

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 incharge and PICU /NICU fellow or PICU/NICU 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)

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FLUID CHART

Sheet No. :

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
	Total Intake :						Total Output :					
17/7/26	02:00 pm			12ml								
	03:00 pm			12ml								
	04:00 pm	PlasmaLyte		12ml								
	05:00 pm	+ 5% Dextrose		12ml								
	06:00 pm			12ml								
	07:00 pm			12ml								
	Total Intake :						Total Output : U- M-					
17/7/26	08:00 pm			12ml								
	09:00 pm			12ml								
	10:00 pm	PlasmaLyte		12ml								
	11:00 pm	+ 5% Dextrose		12ml								
	12:00 am			12ml								
	01:00 am			12ml								
	Total Intake :						Total Output :					
18/7/26	02:00 am			12ml								
	03:00 am			12ml								
	04:00 am	PlasmaLyte		12ml								
	05:00 am	+ 5% Dextrose		12ml								
	06:00 am			12ml								
	07:00 am			12ml								
	Total Intake :						Total Output :					

Total 24 hrs. Intake

Total 24 hrs. Output

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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.

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

Total 24 hrs. Intake

Total 24 hrs. Output



NURSING CARE RECORD

Date: 17/7/26

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	Nurse Name & Signature
Morning							
Afternoon	2pm / 8pm	→ Assess the general condition of pt. → Monitor vitals → Maintain I/O chart → Administer medication.	2pm / 8pm	→ Assess the general condition of pt. → Monitor vitals → Maintain I/O chart → Administer medication.	pt is stable.	Re-assess vitals.	Moulishi
Night	8pm / 8am	→ Assess the pt condition → Monitor vital & I/O chart → drug as per chart → provide comfortable position.		→ Assess the pt condition → Monitored vitals & I/O chart → drug as per chart. → provided comfortable position.	pt is stable	Rechecked vitals	ye.

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 Dr. SANJAY SRIRAMPUR



NURSING CARE RECORD

Date:

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon							
Night							



BRADEN 'Q' SCALE

					Date : 5/7/26	Time : 12/3/4		
					4	4		
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.				
"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	3		
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		
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		
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4		
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		
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		
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23								
Docu. No. : RCH / FRM / CLINICAL / 119								
					TOTAL SCORE			
					Evaluator's Name			

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

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(M)

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PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
17/7/26	2pm	0/10	PA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	NA
17/7/26	10pm	0/10	NA	☐ Continuous ☒ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☒ No	NA	NA
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

1. Every eight hours for all hospitalized patients.

2. For post-surgical patients, patients with chronic pain, patient with severe pain:

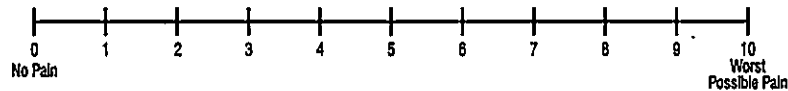
- a) At least every 2 hours for the first 24 hours b) Then every 4 hours.
c) Prior to pain pain-relieving intervention. d) Within 30 – 60 minutes after pain relief intervention.

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



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CHECKLIST FOR THROMBOPHLEBITIS

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17/7/26

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							
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		NA	NA							
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2		NA	NA							
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		NA	NA							
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		NA	NA							
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		NA	NA							
Signature of the Nurse					NA	NA							

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 Sticker

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 cord pyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5										
Signature of the Nurse													

NOTE : Phlebitis greater than grade 2 should be reported to physicians and other appropriate health care personnel 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 :

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NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: <u>Acute Desentary dehydration</u>		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:				
	Surgery / Procedure:		Post OP Day:				
BACKGROUND	Date	<u>17/7</u>	<u>17/7</u>				
	Shift	<u>E2</u>	<u>AM</u>				
	Medical Condition (Any special condition to be noted):	<u>-</u>	<u>-</u>				
	Diet:	<u>-</u>	<u>-</u>				
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Ventilation (RA, NP, NIV, VENTI):	<u>-</u>	<u>-</u>				
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs:	Temp: <u>97.8°F</u>	<u>98.0°F</u>				
	Res:	<u>32b/m</u>	<u>32b/m</u>				
	SpO ₂ :	<u>99%</u>	<u>99%</u>				
	Pulse:	<u>132b/m</u>	<u>130b/m</u>				
	BP:	<u>-</u>	<u>-</u>				
	LOC:	<u>-</u>	<u>-</u>				
	Fall Risk Score:	<u>0</u>	<u>0</u>				
Pain Score:	<u>1</u>	<u>1</u>					
Skin Integrity	<u>Good</u>	<u>Good</u>					
Recommendations	Safety Needs:	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Physiotherapy:	<u>-</u>	<u>-</u>				
	Others Specify:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Special Diet:	<u>-</u>	<u>-</u>				
	Critical Lab Test / Values:	<u>-</u>	<u>-</u>				
	Other Special Orders / Medications:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	PU Prophylaxis:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	DVT Prophylaxis:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
ADL (Dependent / Non Dependent):	<u>-</u>	<u>-</u>					
Post Operative Procedure Special Orders:		<u>-</u>	<u>-</u>				
Handed Over By Name :		<u>Anusha</u>	<u>As</u>				
Signature / ID :		<u>[Signature]</u>	<u>[Signature]</u>				
Date:		<u>17/7/26</u>	<u>18/7/26</u>				
Time:		<u>8pm</u>	<u>8am</u>				
Taken Over By Name :		<u>As</u>					
Signature / ID :		<u>[Signature]</u>					
Date:		<u>17/7/26</u>					
Time:		<u>8pm</u>					

NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:				
	Surgery / Procedure:		Post OP Day:				
BACKGROUND	Date						
	Shift						
	Medical Condition (Any special condition to be noted):						
	Diet:						
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Ventilation (RA, NP, NIV, VENTI):						
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs:	Temp:					
		Res:					
		SpO ₂ :					
		Pulse:					
		BP:					
		LOC:					
		Fall Risk Score:					
	Pain Score:						
	Skin Integrity						
Recommendations	Safety Needs:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Physiotherapy:						
	Others Specify:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Special Diet:						
	Critical Lab Test / Values:						
	Other Special Orders / Medications:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	PU Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	DVT Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
ADL (Dependent / Non Dependent):							
Post Operative Procedure Special Orders:							
Handed Over By Name :							
Signature / ID :							
Date:							
Time:							
Taken Over By Name :							
Signature / ID :							
Date:							
Time:							



wt- 6.17 kg

EMERGENCY ROOM TRIAGE FORM

Patient's Name : MOH. ABHYAN VAYU Age : 3m 25D Gender: ☐ Male ☒ Female

Date : 11:45am Time of Arrival : 11:45am

Allergies: ☒ No ☐ Yes ☐ Food ☐ Medications ☐ Blood Transfusion ☐ Other (Specify): ☐ Not known

Source of Information: ☐ Parents ☐ Others (Specify):

Mode of Arrival: ☐ Ambulatory ☐ Wheelchair ☐ Ambulance

Initial Vital Signs: Temp: 97.8°F PR: 130b/m BP: 98/71(68) RR: 20b/m SpO₂: 100%

Chief Complaints: lt Blood in Stools since 42 days

INITIAL PHYSIOLOGICAL CATEGORIZATION

Appearance

☒ Normal

☐ Sick Looking

☒ Normal

Circulation / Colour

☐ Abnormal

☐ Bleeding

Work of Breathing

☒ Normal

☐ Decreased

☐ Increased

☐ Gasping / Apnea

INITIAL PHYSIOLOGICAL STATUS

☒ Stable

☐ Unstable:

☐ Not - Life - Threatening

☐ Life - Threatening

Triage Classification

☐ Level 1: Resuscitation

☐ Level 2: EMERGENT: Life or limb threatening

☐ Level 3: URGENT: Significant illness / injury with potential to become life or limb threatening

☐ Level 4: LESS URGENT: Significant illness but not life threatening

☐ Level 5: NON - URGENT: May receive care when convenient

CTAS

☐ Immediate

☐ < 15 min

☒ 30 min

☐ 60 min

☐ 120 min

NOTE: All immunocompromised children and preterm babies to be considered Level 2.

All Children less than 2 years age with high fever to be considered Level 3.

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian

Triage Completion Time : 11:47AM

Communicable Disease Triage Screening

PART A. The following questions should be asked to all patients at the initial screening:

- Have you had fever (elevated temperature) in the past 2 weeks ☐ Yes ☒ No
- Have you had cough or a rash in the past 2 weeks ☐ Yes ☒ No
- Have you had shortness of breath or difficulty breathing in the past 2 weeks ☐ Yes ☒ No

PART B. For patients reporting fever and respiratory/rash symptoms: ☐ Not applicable

- Have you travelled outside the INDIA? or had close contact with someone who has recently travelled outside the INDIA, in the past two weeks? ☐ Yes ☒ No
If yes, State Location:
- Are your parents / close contacts at home is/a healthcare worker? {please encircle the choices} (e.g., nurse, physician, ancillary services personnel, allied health services personnel, hospital volunteer, or laboratory worker, others) who has had a recent exposure to an individual with a highly communicable disease or unexplained, severe febrile respiratory or rash disease? ☐ Yes ☒ No

PART C. A positive communicable disease triage screening is considered for any patient who meets one of the two following criteria:

- ☐ Any patient with Fever / Rash / Vesicles / Discharge from Eyes and Cough
- ☐ Any patient with fever and respiratory symptoms who answered "YES" to any of the questions on epidemiologic risk factors in "PART B" of the triage screening above.

PART D. ACTION / INTERVENTION: (for positive suspected communicable disease triage screening)

- ☐ Patients should be immediately isolated in a negative pressure room or a single room (as appropriate) for pending evaluation.
- ☐ The patient should be given a surgical mask immediately, if not already wearing one.
- ☐ Both patient and triage staff should perform hand hygiene.
- ☐ The staff should use PPE (as appropriate).

Name of Triage Nurse : Atanu

Signature of Triage Nurse : [Signature]

Date & Time : 17/7/26 @ 11:47AM



NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 17/7/26 Time of arrival : 11:42 AM

Chief Complaints: elo Blood in Stools since 2 days RBS: N/A

Height : 64cm Weight : 6.7kg BMI : - Head Circumference (<2 years) : -

Allergies: ☐ Yes ☒ No ☐ Medications ☐ Blood Transfusion ☒ Food ☐ Other: -

If yes, identify -

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

☐ Character N/A ☐ Location N/A ☐ Frequency N/A ☐ Duration N/A

RISK FOR FALL:

☐ If patient is < 6 years
tick below fall risk intervention directly

☐ If Patient is > 6 years
Assess the below parameters

History of Falling: within past 3 months ☐ Yes ☒ No

Ambulatory Aids:

• Wheelchair ☐ Yes ☒ No
• Uses furniture for support ☐ Yes ☒ No

Gait/Transferring:

• Bedrest / immobile ☐ Yes ☒ No
• Weak ☐ Yes ☒ No
• Impaired ☐ Yes ☒ No

Mental Status: Forgets limitations ☐ Yes ☒ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

☐ Escort while ambulating
☐ Assist Patient
☐ Educate patient and family on fall precautions/prevention

Functional Screening: ☒ No Abnormalities Detected

☐ Mobility Problem
☐ Walking Problem
☐ Developmental Delay
☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

Nutritional Screening: ☒ No Abnormalities Detected

☐ Underweight
☐ Overweight
☐ Feeding Problem
☐ Special diet
☐ Special feeding method

Inform consultant for positive criteria

Psychological Screening: ☐ No Significant Findings

Unusual concerns about patient's Psychological Status: ☐ Yes ☐ No

If Yes Consultant Notified: N/A (Date/Time): N/A

Social History: Lives With Family

Siblings in household ☐ Yes ☒ No (if yes How Many?) -

Time of Initial assessment completed by ER Nurse : 11:49 AM 



Nursing Notes (Including Labs / Medications / Other Care):

Time	Nursing Notes
11:51 AM	Assessed the patient condition. monitor vitals

Samples collected by:

Sugandha / 17/7/26

Time:

1:20pm

Samples sent by:

Time:

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1

Condition of patient at time of shift - out :	Details of Shift - out
HR: 115b/m BP: 101/75(65) CFT: - RR: 30b/m SPO ₂ : 98% GCS: 15/15 Temperature: 98.3°F Pain Score: 0 Repeat RBS (if applicable): N/A	Shift - out from ER to: 3rd floor Time of Shift - out: 2:15pm Handover given to: M. J. (Nurse's Name)

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any):

IV Placement Done

Name of the Nurse: Atanu

Signature of the Nurse:

Date & Time: 17/7/26 11:53pm

[Signature]

PATIENT TRANSFER FORM

MNH-00016638 IP26-00006872 Master ABHYAN VAYU 23-05-2026 0 Y 1 M 24 D (M) Dr. SANJAY SRIRAMPUR 		Date & Time of Admission 17/7/26 @ 1PM	Date & Time of Transfer Order 17/7/26 @ 2:15 PM
		Transfer Ordered by Dr. Varun	Reason for Transfer Admission
From Unit ER	To Unit 3rd floor / 810	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 20	Number of Imaging Films —	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☒ If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☐ No ☒			
Name & Signature of Person who is Transferring Atanu / Dr.		Name of Person Ordered Transfer Dr. Varun	
Patient & Clinical Records Received by : Moushiki			
Date & Time of Patient Received : @ 2:30 PM, 17/7/26			

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