

By



# ACTIVITY RECORD FOR BILLING

Name : \_\_\_\_\_

BAH-00661071 IP5-00176134  
Master YUVANVEER MOTALLA  
27-03-2019 7 Y 3 M 12 D (M)  
Dr. DINESH KUMAR CHIRLA

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 |
|--------|---------|------|------|--------------------|
| 9/7/26 | 2:20 AM | ER   | PICU | [Signature]        |
|        |         |      |      |                    |
|        |         |      |      |                    |
|        |         |      |      |                    |
|        |         |      |      |                    |

## Cross Consultation Visit

|    | Doctors Name | Date     | Order No. | Signature   |
|----|--------------|----------|-----------|-------------|
| 1  | Dr. Abhishek | 09/07/26 | 9694645   | [Signature] |
| 2  |              |          |           |             |
| 3  |              |          |           |             |
| 4  |              |          |           |             |
| 5  |              |          |           |             |
| 6  |              |          |           |             |
| 7  |              |          |           |             |
| 8  |              |          |           |             |
| 9  |              |          |           |             |
| 10 |              |          |           |             |



[illegible]

Signature

2006 फ़रव

Tarad

Answer



1m



## MEDICAL EQUIPMENT (WARD & ICU)

[illegible]



## PROCEDURE

[illegible]

ANY OTHER INFORMATION *None*

ywf

VBG

$\odot \in CG$

~~1. Decho~~

Date : 10/07/16

Time : 10:00am

Prepared By :

Shanth

| Staff Nurse | Shift / Ward | Billing Assistant | Billing Supervisor |
|-------------|--------------|-------------------|--------------------|
|-------------|--------------|-------------------|--------------------|

| Staff Nurse | Shift / Ward | Billing Assistant | Billing Supervisor |
|-------------|--------------|-------------------|--------------------|
|-------------|--------------|-------------------|--------------------|

| Staff Nurse | Shift / Ward | Billing Assistant | Billing Supervisor |
|-------------|--------------|-------------------|--------------------|
|-------------|--------------|-------------------|--------------------|

| Staff Nurse | Shift / Ward | Billing Assistant | Billing Supervisor |
|-------------|--------------|-------------------|--------------------|
|-------------|--------------|-------------------|--------------------|

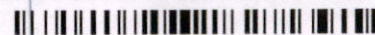
Shanthi

5/2/1



# ADMISSION SHEET

## Registration Details :



Admission No : IP5-00176134      Admit Date : 09-Jul-2026      Admit Time : 08:07 AM      UHID : BAH-00661071

## Patient Details :

Patient Name : Master YUVANVEER MOTALLA      Age : 7 Y 3 M 12 D  
Guardian : Mr DAMODAR MOTALLA      DOB : 27-03-2019  
Gender : Male      Religion :  
Occupation :      Martial Status : Single  
Address (H) : FLAT NO 501, 5TH FLOOR SRI VINAYAGAR      Phone No : 9441968001/ 7036553666  
RESIDENCY A ZONE SUJATHA NAGAR      E-mail : nomaild@gmail.com  
Pendurthi Vishakhapatnam Andhra Pradesh  
INDIA 531173

## Admission Details :

Bed Type : PICU      Bed No : PICU 211      Ward Name : 2F-PICU I  
Room No : PICU 211      Admission Type : First Visit

## Contact Details :

Name : Mr DAMODAR MOTALLA      Relationship : Father  
Contact Address : FLAT NO 501, 5TH FLOOR SRI VINAYAGAR      Phone No : 9441968001 / 7036553666  
RESIDENCY A ZONE SUJATHA NAGAR  
Pendurthi Vishakhapatnam Andhra Pradesh  
INDIA 531173

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 :

Deposit Amount : 20000.00  
Payment Mode : DC/CC Card      Payor Name : MEDI ASSIST INSURANCE TPA PVT LTD



### ADMISSION SHEET

#### Registration Details :



Admission No : IP5-00176134      Admit Date : 09-Jul-2026      Admit Time : 08:07 AM      UHID : BAH-00661071

#### Patient Details :

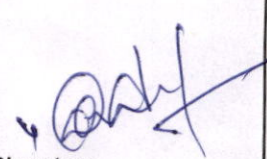
|              |                                                                                                                                     |                |                          |
|--------------|-------------------------------------------------------------------------------------------------------------------------------------|----------------|--------------------------|
| Patient Name | : Master YUVANVEER MOTALLA                                                                                                          | Age            | : 7 Y 3 M 12 D           |
| Guardian     | : Mr DAMODAR MOTALLA                                                                                                                | DOB            | : 27-03-2019             |
| Gender       | : Male                                                                                                                              | Religion       | :                        |
| Occupation   | :                                                                                                                                   | Martial Status | : Single                 |
| Address (H)  | : FLAT NO 501, 5TH FLOOR SRI VINAYAGAR<br>RESIDENCY A ZONE SUJATHA NAGAR<br>Pendurthi Vishakhapatnam Andhra Pradesh<br>INDIA 531173 | Phone No       | : 9441968001/ 7036553666 |
|              |                                                                                                                                     | E-mail         | : nomaild@gmail.com      |

#### Admission Details :

Bed Type : PICU      Bed No : PICU 211      Ward Name : 2F-PICU I  
 Room No : PICU 211      Admission Type : First Visit

#### Contact Details :

Name : Mr DAMODAR MOTALLA      Relationship : Father  
 Contact Address : FLAT NO 501, 5TH FLOOR SRI VINAYAGAR  
RESIDENCY A ZONE SUJATHA NAGAR  
Pendurthi Vishakhapatnam Andhra Pradesh  
INDIA 531173      Phone No : 9441968001 / 7036553666

  
 Signature

#### Doctor Details :

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

#### Payment Details :

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



BAH-00661071  
Master YUVANVEER MOTALLA  
27-03-2019 7 Y 3 M 12 D (M)  
Dr. DINESH KUMAR CHIRLA

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## PEDIATRIC INTENSIVE CARE ADMISSION RECORD

Date: 9/7/26 Time: 7:24 am

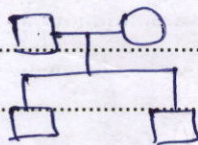
### Patient Assessment Form:

Informant: ☐ Father ☒ Mother ☐ Other

Presenting Complaints / Chief Complaints :  
+/- abnormal walk - yesterday night  
+/- vomiting @ 9pm on 8/7/26.  
No +/- fever  
+/- pain abdomen & headache :- today morning  
+/- cold :- 4-5 days.  
No +/- cough.

Past History (Including previous treatment and investigations) : Not significant

Birth and Developmental History :



HT/ Wt / BW = 3.5 kgs / CIAB

+/- NICU admission for  
14 days in V/O ? MAF /  
? neonatal seizures

Immunization History : as per schedule

H / O Allergy : nil

Family History : not significant



# INITIAL ASSESSMENT

RBS : 106 mg/dl Temperature : 98.4° F Weight (kg) : 32.5 lbs

## Respiratory System Findings:

Air Way: Open Maintainable Not Maintainable Intubated, If Intubated, size & position of ETT :

Respiratory Examination Finding: (Air entry, breath sounds, s/o distress etc.): Respiratory Rate : 24/min

BAE (+) clear

SPO<sub>2</sub> : 100% O by NC / FM / NRB mask / Oxyhood, at room air L / min

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

Ventilatory Settings : Leak around ETT : Delivered Vt :

ABG : EtCO<sub>2</sub> : P/F ratio : O.I. :

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

CXR :

Cardio Vascular System Clinical Exam : Heart Rate : 98/min Cardiac Rhyth : regular

(Heart sounds, murmur etc.) : S1S2 (+)

Quality of Pulses : good vol, regular cap refill Time : 2s Liver Edge : cm below Rt costal margin

Blood Pressures : NIBP : 92/76 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 :

Abdominal Exam : soft

ENT Exam : (N)

Central Nervous System :

Level of Consciousness : AVPU / GCS score : E4 V5 M6

Neurological Findings : No focal neurological deficits

No meningeal signs.

pupils - B/E 3mm, reacting to light

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
- ☐ Diabetes Mellitus ☐ Needs Therapeutic Diet. ☐ Diarrhoea > 4days ☐ Food Allergy
- ☐ Overweight ☐ Psychological Eating Disorder ☐ Major Surgery ☒ Patient in ICU
- ☐ Under Weight ☐ Difficulty swallowing / Chewing ☐ Hyperemesis gravidarum ☐ Tube Feeding
- ☐ Poor Appetite > 3days ☐ 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 Interpretar 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"

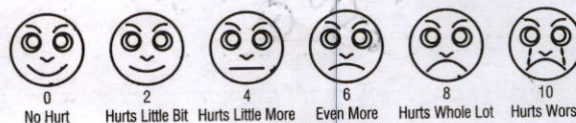
Location: .....

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: ..... well nourished

Current Medications: .....







## PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : PICU as per note

Date : 9/7/26

Type of Admission: ☐ OPD ☒ ER ☐ Referral (if referral, Doctor's Name: \_\_\_\_\_)

Start Time of Assessment: 6:35 am Weight: 32.5 kg

Allergic History: \_\_\_\_\_

### Chief Complaints:

- Altered sensorium since last night
- 1 episode of ? seizure activity today ~ 1 hr ago + headache
- 1 episode of vomiting yesterday

### Pediatric Assessment Triangle

A Appearance - TICLS \_\_\_\_\_

B Breathing \_\_\_\_\_

C Circulation \_\_\_\_\_

☒ Normal  
☐ Abnormal

☐ Pallor ☐  
☐ Cyanosis ☐  
☐ Mottling ☐  
☐ Bleeding ☐

☐ ↑ WOB  
☐ ↓ WOB  
☒ Normal  
☐ Gasping / Apnea

Initial Physiological Status: ☐ Stable ☒ Unstable

☐ Life Threatening  
☒ Non Life Threatening

Any urgent interventions needed: ☐ Yes ☒ No

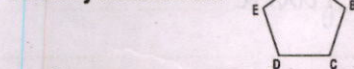
If Yes \_\_\_\_\_

Significant Past History: Preterm / birth asphyxia / HMD / Sepsis

Medication History: \_\_\_\_\_

Relevant Investigations: \_\_\_\_\_

### Primary Assessment



#### Airway



- ☒ Open  
☐ Maintainable  
☐ Not Maintainable

Any urgent interventions needed: ☐ Yes ☒ No

If Yes \_\_\_\_\_



#### Breathing

Rate: 26/min SpO<sub>2</sub> on FiO<sub>2</sub> 98.7 (RA)

Rhythm: (N)

Retractions: ☐ Suprasternal ☐ ICR ☐ SCR  
☒ NO ☐ Sternal ☐ Supraclavicular ☐ Nasal Flaring

Respiratory Noises: ☐ Stridor ☐ Wheezing ☐ Grunting  
☒ NO

Air Entry: B/L equal

Palpation Findings (If necessary) \_\_\_\_\_

Any urgent interventions needed: ☐ Yes ☒ No

If Yes \_\_\_\_\_





### Circulation

HR: 114/min

CFT ☐ Central ☒ Peripheral } 23sAny urgent interventions needed: ☐ Yes ☒ No

If Yes .....

BP: ..... mmHg

Pulse Volume: ☐ Central ☒ Peripheral } goodIf in Shock: ☐ Compensated ☒ HypotensiveMuffled Heart Sound: ☐ Yes ☒ NoEngorged Neck Veins: ☐ Yes ☒ NoMurmurs: ☐ Yes ☒ No

Liver Span: .....

ECG: .....

Any Signs of Heart Failure: ☐ Yes ☒ No

### Disability

GCS: E4 V3 M5 AVPU: .....

Any urgent interventions needed: ☐ Yes ☒ No

If Yes .....

Pupils: ☐ Responsive ☐ Non-ResponsiveSize ☐ Right ☒ Left } equalActive Seizures: ☐ Yes ☐ No Sugars: 106 mg/dl

Signs of Neurological compromise .....

### Exposure



Temp.: 98.4°F

Any Rash: ☐ Yes ☒ No,

If yes describe the rash .....

Active bleed ☒ NOLacerations ☐ Abrasions ☐ bruises ☐

Describe: .....

Any urgent interventions needed: ☐ Yes ☒ No

If Yes .....

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: Altered Sensorium

### Labs Planned:

CBP, CRP, RPR, blood c/s

### Treatment Planned:

iv fluid

iv Ondem

iv Pantop

iv Paracetamol

Neurology consultation

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

Final Diagnosis with possible Differential Diagnosis (If necessary): Acute encephalopathy &amp; evaluation

Assessment done by

Name of the Doctor: DR. SOMASREE

Signature:

Date &amp; Time: 21/7/26

Sr. Doctor on Duty (If necessary)

Name of the Sr. Doctor:

Signature:

Date &amp; Time: 21/7/26





## ADMISSION CRITERIA – PICU

### Admission / Transfer from:

☒ Emergency ☐ Outpatient (OPD) ☐ Ward ☐ Operation Theater ☐ Others: .....

### Tick (✓) any of the following criteria requiring admission / transfer to PICU

- ☐ All patients requiring mechanical ventilation;
- ☐ Patients with impending respiratory failure;
  - ☐ Upper airway obstruction;
  - ☐ Lower airway obstruction;
  - ☐ Alveolar disease; and
  - ☐ Unstable airway;
- ☐ All Paediatric patients after successful resuscitation;
- ☐ **Comatose Patients;**
  - ☒ Meningitis, encephalitis; ☐ Hepatic encephalopathy; ☐ cerebral malaria;
  - ☐ Head injury; ☐ Poisonings; and ☐ Status epilepticus;
- ☐ **All types of shock/hemodynamic instability:**
  - ☐ Septic shock;
  - ☐ Hypovolemic shock; (Bleeding emergencies such as gastrointestinal bleeding, bleeding diathesis, disseminated intravascular coagulation; Cardiogenic shock; myocarditis, cardiomyopathy, congenital heart disease; Neurogenic shock; and Multiple trauma;
- ☐ Cardiac arrhythmias after consulting with the treating consultant
- ☐ Hypertensive Emergencies;
- ☐ Severe acid base disorders;
- ☐ Severe electrolyte abnormalities;
- ☐ Diabetic ketoacidosis (Ph < 7.2, altered sensorium, hyperglycemia)
- ☐ Acute renal failure; Patients requiring acute hemodialysis, hemofiltration and peritoneal dialysis;
- ☐ **Post-Operative Patients;**
  - ☐ Requiring ventilation;
  - ☐ Unstable patients; and
  - ☐ Post-operative patients after open heart surgery, neurosurgery, thoracic surgery and other patients after major general surgery with potential for respiratory/haemodynamic instability;
- ☐ Patients requiring nitric oxide therapy;
- ☐ Malignant hyperpyrexia;
- ☐ Acute hepatic failure
- ☐ Severe dehydration with mental status change;
- ☐ Asthma requiring hourly nebulization/getting tired with increasing oxygen requirement/mental status change.
- "UNSTABLE" PATIENT IS DEFINED AS**
  - ☐ HR < 50 or > 160 per minute or more than upper normal limit according to age. BP < 90 systolic and < 50 diastolic and or requiring inotropic support. Arrhythmia or risk of sudden arrhythmia.
  - ☐ Signs of peripheral poor perfusion or suspicion of any type of shock.
  - ☐ Capillary refill time > 4 seconds.
  - ☐ Children Blood pressure (Syst.) < [70 + (2 × age "Years")].
- Respiratory failure or high risk of failure or airway obstruction:**
  - ☐ Respiration rate < 5 per minute below the normal or > 10-15 per minute above the normal range for age.
  - ☐ O2 Saturation < 90 % or need for O2 > 4 Litres per minute by normal face mask. Abnormal ABG: PH < 7.25, PaO2 < 60 torr, PaCO2 > 50 torr.
  - ☐ Distress and risk of exhaustion
- ☐ **Change of level of consciousness: GCS < 13.**
- ☐ **Persistent oliguria with acidosis.**

Signature of the Doctor: ..... Name of the Doctor: Dr. Vijay ..... Date & Time: 9/7/20.....



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Master YUVANVEER MOTALLA  
27-03-2019 7 Y 3 M 12 D (M)  
Dr. DINESH KUMAR CHIRLA

  
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## 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: .....



## PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time        | Progress Notes                                                                                                                                                                                                                                                               | Doctor's Order                                                                                                                                                                                                                                     |
|--------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 9/7/2026<br>9:50pm | <u>c/s/b Dr Anupama</u><br><u>Di-Ant conjunctival state</u>                                                                                                                                                                                                                  | <u>Plan</u>                                                                                                                                                                                                                                        |
|                    | Had 2 episode of<br>Ante conjunctival state<br>since yesterday Night<br>child on Room air<br>Hemodynamically stable<br>currently oriented<br>GCS - 15/15<br>No focal deficit<br>HR - 98/min<br>SpO <sub>2</sub> - 99%<br>RR - 16/min<br>BP - 96/70 (80)<br>GRBS - 106 mg/dl. | <ol style="list-style-type: none"> <li>① USG Abdomen</li> <li>② Add - Astatid</li> <li>③ stop 3-1 Nacl</li> <li>④ continue ondans<br/>pantop.</li> </ol> <p>1. B. Term<br/>09/07/26<br/>② 10pm</p> <p><u>Dr. Anupama</u><br/>9/7/26<br/>9:50pm</p> |





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## PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]









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## PROGRESS NOTES AND DOCTOR'S ORDER

Bed ④

| Date & Time          | Progress Notes                                                                                                                                                                                                                                                                                                                | Doctor's Order                      |
|----------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|
| 9/7/2026<br>10:58 AM | <u>counselling Notes</u>                                                                                                                                                                                                                                                                                                      | <u>Room 2</u><br><u>Dr. Anupama</u> |
|                      | <p>Parents have been counselled that possibility could be some unknown product infection. one more possibility is seizures. We will get one EEG and MRI Brain. plain. If EEG shows any changes of seizure, we will start medications. Process of MRI has been explained to parents. We will try to get to MRI slot today.</p> |                                     |
|                      | <p><u>Dr. V. K. K.</u></p>                                                                                                                                                                                                                                                                                                    |                                     |
|                      | <p><u>Plan</u><br/>① EEG and MRI Brain<br/>② NPO Now<br/><u>H.B. Taml</u><br/>09/07/26<br/>① 11 AM</p>                                                                                                                                                                                                                        |                                     |



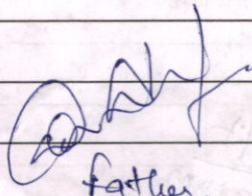


## PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time         | Progress Notes                                                                    | Doctor's Order                                           |
|---------------------|-----------------------------------------------------------------------------------|----------------------------------------------------------|
| 08/07/2018<br>@ 3pm | SIB Rautam                                                                        |                                                          |
|                     | Adm Acute confusional State under evaluation Organic vs Delirium                  | Adm<br>① MRP @ 4pm<br>② continue IV fluids               |
|                     | - On room air<br>- Hemodynamically stable<br>- Cx-15/16<br>- on MD.<br>MRP at 4pm | ③ continue<br>- Pantoprazole &<br>ondansetron.           |
|                     | Chest: BLAD Equal.<br>NRS<br>Mx hgt Bx<br>cm. Cx-15/16<br>No focal deficit        | ④ watch for<br>seizures<br>N.B. Tarnad<br>09/07<br>@ 3pm |
|                     | EEG - Reported to h④                                                              | <br>Dr. Dinesh Kumar Chirla                              |



## PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time         | Progress Notes                                                                                                                                                                                                                                        | Doctor's Order                                                                                   |
|---------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|
| 09/07/2018<br>@ 2pm | Counselling room-2                                                                                                                                                                                                                                    | Dr. Anupama                                                                                      |
|                     | child underwent EEG and it looks normal.<br>today we are planning to get mri today.<br>If needed, we will send toxicology profile<br>for blood and urine. One mri is done,<br>we will plan to shift to ward. We will<br>update once mri reports come. |                                                                                                  |
|                     |                                                                                                                                                                                                                                                       | <br>father. |
| 09/07/18<br>@ 3pm   | Shifting notes<br>SIB Dr. Anupama<br>Acute confusional<br>state against vs<br>Delirium                                                                                                                                                                | Adm<br>① EEG now                                                                                 |
|                     | On room air<br>Hemodynamically stable<br>Chest clear & equal<br>RRs<br>Pa Sat 98%<br>no focal deficit                                                                                                                                                 | ② Shift to room<br>H.B. to room<br>09/07<br>@ 7.10 pm.                                           |



Docu. No. : RCHBH /FRM / CLINICAL / 088





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### PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]





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Docu. No. : RCHBH /FRM / CLINICAL / 088





## CROSS CONSULTATION FORM

Doctor Name: Dr. Abhishek Jain Date: 09/07/2026 Time: 10.30am

Diagnosis: .....

Hospital: .....

**Type of Referral :**

☐ Emergency

☐ Urgent

☐ Non Urgent

Referred for: ☐ Opinion ☐ Co-Management ☐ Transfer of care

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

Signature: .....

**Findings and Recommendations :**

Thanks for Referral!  
Dr. Raji  
D. Vincent

June end → 4 days, gymnastic,

(9/7/26) Cold & mild fever.

(8/7) → went for gymnastic yesterday, → cycling →  
(1 hr) (evening)  
3pm

3/30 pain Abdomen, @

In lift → Stomach,

went out of lift & acid expen → fever, imbalance when walking  
Nausea, 1 ep. of vomiting In response

Slept

after waking up from sleep → Stomach, Nausea, no vomiting  
(fever), Stomach back, unresponsive. (2 more)  
Postictal headache @

**Consultant :**

Name: Dr. Abhishek R. Jain Signature: Dr. Abhishek R. Jain Date & Time: 9/7/26



- Neonatal hypoxia

- lacc is in view of breath

- CABG

- ROB requiring mechanical ventilation

- DO<sub>2</sub> Neonatal requires

CEC done

- Discharged after 15 days

↓  
② discharge

OR

① EEG

② MLT Brain

- Focal non motor impairment

- conscious seizures → partial seizures

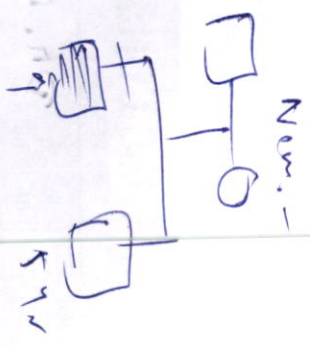
② Neurodevelopment → structural

Adm

- Levopil → Maintenance

- MR Brain (plain)

- EEG before levipil



② Neurodevelopment



BAH-00661071 IP5-00176134  
Master YUVANVEER MOTALLA  
27-03-2019 7 Y 3 M 12 D (M)  
Dr. DINESH KUMAR CHIRLA



**Rainbow<sup>®</sup>  
Children's  
Hospital**  
It takes a lot to treat the little.

**BirthRight<sup>™</sup>**  
BY RAINBOW HOSPITALS  
Your Right to a Safe Delivery

## RESULT SHEET

|                     |         |  |  |  |  |  |
|---------------------|---------|--|--|--|--|--|
| Date                | 9/1/26  |  |  |  |  |  |
| Time                | 8Am     |  |  |  |  |  |
| Hb                  | 12.7    |  |  |  |  |  |
| PCV                 | 40.1    |  |  |  |  |  |
| RBC                 | 5.04    |  |  |  |  |  |
| WBC                 | 8.1K    |  |  |  |  |  |
| N/L                 | 32/60   |  |  |  |  |  |
| Platelets           | 403     |  |  |  |  |  |
| CRP                 | 5       |  |  |  |  |  |
| ESR                 |         |  |  |  |  |  |
| PCT                 |         |  |  |  |  |  |
| RBS                 |         |  |  |  |  |  |
| Na                  | 136     |  |  |  |  |  |
| K                   | 4.4     |  |  |  |  |  |
| Cl                  | 102     |  |  |  |  |  |
| Ca/Mg               | 9.5/    |  |  |  |  |  |
| Phosphate           | 5.9     |  |  |  |  |  |
| Urea                | 24      |  |  |  |  |  |
| Creatinine          | 0.4     |  |  |  |  |  |
| ALP                 | 183     |  |  |  |  |  |
| SGPT                | 20      |  |  |  |  |  |
| SGOT                | 30      |  |  |  |  |  |
| T.Bill/Conj         | 0.4/0.1 |  |  |  |  |  |
| T.Protein           | 7.1     |  |  |  |  |  |
| S.Albumin           | 4.2     |  |  |  |  |  |
| S.Globulin          | 2.9     |  |  |  |  |  |
| A/G Ratio           | 2.9     |  |  |  |  |  |
| Uric Acid           | 2.7     |  |  |  |  |  |
| S.Amylase           | 49      |  |  |  |  |  |
| Sr.Lipase           |         |  |  |  |  |  |
| Blood Lactate       |         |  |  |  |  |  |
| S.Cholesterol       | 127     |  |  |  |  |  |
| PT/INR              |         |  |  |  |  |  |
| APTT                |         |  |  |  |  |  |
| CSF Protein / Sugar |         |  |  |  |  |  |
| Cells               |         |  |  |  |  |  |
| N/L                 |         |  |  |  |  |  |









## REQUEST FOR CREDIT FACILITY

To,  
The Credit Billing,  
Tenet Diagnostics,  
Banjara Hills, Hyderabad.

Patient details:

BAH-00661071 IP5-00176134  
Master YUVANVEER MOTALLA  
27-03-2019 7 Y 3 M 12 D (M)  
Dr. DINESH KUMAR CHIRLA



Dear Sir/Madam,

We are sending the above mentioned patient for the diagnostic test MRI Brain plan  
under sedation in your diagnostic center on credit basis. Request  
you to kindly do the needful. The bill will be settled by Rainbow Hospital, billing department as per the agreement. For  
any further queries, please contact the billing manager.

Order ID: 5-0009694323

Thanking you,  
Department of Inpatient Billing

Coordinator:

Signature: [Signature]

Name: Manoj H.

Date & Time: 09/02/26 @ 11:14am

Manager on Duty (MOD):

Signature: [Signature]

Name: Soujanya

Date & Time: 09/2/26 @ 2:10pm

Mobile: 9676838787

Docu. No: RCH/ FRM/ GENERAL/ 663

Billing Executive:

Signature: [Signature]

Name: [Name]

Date & Time: 9/2/26

Mobile (Billing Manager): 9247505898

**Rainbow Children's Hospital**  
Survey No: 403, Beside Park Hotel  
Road No. 2, Banjara Hills,  
Hyderabad - 500 034, Telangana  
Phone No: 040-44665495



## 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: .....

| S.No | MEDICATION NAME<br>(GENERIC NAME CAPITAL LETTERS) | DOSE<br>(mg, mcg) | ROUTE<br>(PO, NG, SC, IV) | FREQUENCY | LAST DOSE<br>Date / Time | ON<br>ADMISSION<br>/ SHIFTING                                     |
|------|---------------------------------------------------|-------------------|---------------------------|-----------|--------------------------|-------------------------------------------------------------------|
| 1    | INT PANTOPRAZOLE                                  | 30mg              | IV                        | DD        |                          | <input checked="" type="checkbox"/> C <input type="checkbox"/> DC |
| 2    | INT ONDANSETRON                                   | 4mg               | IV                        | TDS       |                          | <input checked="" 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 : Dr. Vamsi

Date & Time : 09/07/26

Nurse Name & Signature: P. 05pm

Date & Time : .....





## MEDICATION RECONCILIATION FORM

Drug Allergies: .....

☒ Not known any Drug Allergies

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

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

Shifting From: .....

Shifted to: .....

| S.No | MEDICATION NAME<br>(GENERIC NAME CAPITAL LETTERS) | DOSE<br>(mg, mcg) | ROUTE<br>(PO, NG, SC, IV) | FREQUENCY | LAST DOSE<br>Date / Time | ON<br>ADMISSION<br>/ 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 |
|      |                                                   |                   |                           |           |                          | <input type="checkbox"/> C <input type="checkbox"/> DC |

\* C- Continue, DC - Discontinue

RECORDED / VERIFIED BY

Doctor Name & Signature : .....

Date & Time : 9/7/26 @ 2 AM

Nurse Name & Signature: Rachel @

Date & Time : 9/2/26 @ 7:10 AM





## DRUG CHART

Date of Admission: 9/7/26 Drug Allergies: ☒ Not known any Drug Allergies

### FOR THE SAFETY OF THE PATIENT

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

### SOS / PRN (As Required Medication)

| DRUG : <u>INJ PARACETAMOL</u>  |           |              |            | Date<br>Time   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|--------------------------------|-----------|--------------|------------|----------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| Dose                           | Route     | Frequency    | Start Date |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| <u>480mg</u>                   | <u>iv</u> | <u>SOS</u>   | <u>9/7</u> | <u>7:12 AM</u> |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Doctor's Signature             |           | Valid Period | Pharm.     |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| <u>Somashree</u>               |           |              |            |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions:       |           |              |            |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| <u>for fever &amp;/or pain</u> |           |              |            |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| DRUG : <u>INJ ONDEM</u>        |           |              |            | Date<br>Time   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose                           | Route     | Frequency    | Start Date |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| <u>4mg</u>                     | <u>iv</u> | <u>SOS</u>   | <u>9/7</u> |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Doctor's Signature             |           | Valid Period | Pharm.     |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| <u>Somashree</u>               |           |              |            |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions:       |           |              |            |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| <u>for vomiting.</u>           |           |              |            |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| DRUG :                         |           |              |            | Date<br>Time   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose                           | Route     | Frequency    | Start Date |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|                                |           |              |            |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Doctor's Signature             |           | Valid Period | Pharm.     |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|                                |           |              |            |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions:       |           |              |            |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|                                |           |              |            |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

VERIFIED BY : Name .....





# REGULAR PRESCRIPTIONS

Weight. 32.5kg Ward. ....

|                                                                              |           |            |            |              |              |             |             |  |  |  |  |  |  |  |  |  |  |  |  |  |
|------------------------------------------------------------------------------|-----------|------------|------------|--------------|--------------|-------------|-------------|--|--|--|--|--|--|--|--|--|--|--|--|--|
| <b>DRUG :</b> <u>INJ PANTOPRAZOLE</u>                                        |           |            |            | Date<br>Time | <u>9/7</u>   | <u>10/8</u> |             |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose                                                                         | Route     | Frequency  | Start Date |              |              |             |             |  |  |  |  |  |  |  |  |  |  |  |  |  |
| <u>30mg</u>                                                                  | <u>IV</u> | <u>OD</u>  | <u>9/7</u> |              |              |             |             |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Name & Signature of the Doctor<br>Starting the Drugs:<br><u>houshree</u>     |           |            |            |              | <u>6 AM</u>  | <u>10/8</u> | <u>some</u> |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions:                                                     |           |            |            |              |              |             |             |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Daily Doctor's Endorsement by a Sign                                         |           |            |            |              |              |             |             |  |  |  |  |  |  |  |  |  |  |  |  |  |
| <b>DRUG :</b> <u>24. ONDANSETRON</u>                                         |           |            |            | Date<br>Time | <u>9/7</u>   | <u>10/8</u> |             |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose                                                                         | Route     | Frequency  | Start Date |              |              |             |             |  |  |  |  |  |  |  |  |  |  |  |  |  |
| <u>4mg</u>                                                                   | <u>IV</u> | <u>TID</u> | <u>9/7</u> |              | <u>6 AM</u>  | <u>10/8</u> | <u>some</u> |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Name & Signature of the Doctor<br>Starting the Drugs:<br><u>Dr. pratyuse</u> |           |            |            |              | <u>2 PM</u>  | <u>10/8</u> | <u>some</u> |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions:                                                     |           |            |            |              |              |             |             |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Daily Doctor's Endorsement by a Sign                                         |           |            |            |              |              |             |             |  |  |  |  |  |  |  |  |  |  |  |  |  |
| <b>DRUG :</b> <u>24. CEFTRIAXONE</u>                                         |           |            |            | Date<br>Time | <u>9/7</u>   |             |             |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose                                                                         | Route     | Frequency  | Start Date |              |              |             |             |  |  |  |  |  |  |  |  |  |  |  |  |  |
| <u>1.6gm</u>                                                                 | <u>IV</u> | <u>BD</u>  | <u>9/7</u> |              | <u>10 AM</u> |             |             |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Name & Signature of the Doctor<br>Starting the Drugs:<br><u>Dr. pratyuse</u> |           |            |            |              |              |             |             |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions:                                                     |           |            |            |              |              |             |             |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Daily Doctor's Endorsement by a Sign                                         |           |            |            |              |              |             |             |  |  |  |  |  |  |  |  |  |  |  |  |  |
| <b>DRUG :</b>                                                                |           |            |            | Date<br>Time |              |             |             |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose                                                                         | Route     | Frequency  | Start Date |              |              |             |             |  |  |  |  |  |  |  |  |  |  |  |  |  |
|                                                                              |           |            |            |              |              |             |             |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Name & Signature of the Doctor<br>Starting the Drugs:                        |           |            |            |              |              |             |             |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions:                                                     |           |            |            |              |              |             |             |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Daily Doctor's Endorsement by a Sign                                         |           |            |            |              |              |             |             |  |  |  |  |  |  |  |  |  |  |  |  |  |





Weight. 32.5kg Ward. ....

|                                |            | Date<br>Time | Nurse Sig. | Nurse Sig. | Nurse Sig. | Nurse Sig. |
|--------------------------------|------------|--------------|------------|------------|------------|------------|
| <b>DRUG :</b>                  |            | 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.  |

| <b>VARIABLE DOSE</b>           |            | Date<br>Time | Nurse Sig. | Nurse Sig. | Nurse Sig. | Nurse Sig. |
|--------------------------------|------------|--------------|------------|------------|------------|------------|
| <b>DRUG :</b>                  |            | 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          |
|--------|---------|------------------|-----------------------------|-------|-----------|-----------------|
| 9/7/26 | 7:30 am | 2ij. PARACETAMOL | 500mg                       | IV    | praty...  | Subha 7.30 am   |
| 9/7/26 | 8am     | 2ij. TRAMADOL    | 30 mg                       | IV    | praty...  | Subha 8 am      |
| 9/7/26 | 9AM     | Trj. AVIL.       | 16mg                        | IV    | ly        | Praveen 9:00 am |
| 9/7/26 | 9AM     | Syp. PEDICLORYL  | 15ml                        | PO    | ly        | Somnath 9:00 am |
|        |         |                  |                             |       |           |                 |
|        |         |                  |                             |       |           |                 |
|        |         |                  |                             |       |           |                 |
|        |         |                  |                             |       |           |                 |
|        |         |                  |                             |       |           |                 |
|        |         |                  |                             |       |           |                 |
|        |         |                  |                             |       |           |                 |
|        |         |                  |                             |       |           |                 |



Weight. 32.5 kg Ward. ....

[illegible]

Signature



BAH-00661071 IP5-00176134  
Master YUVANVEER MOTALLA  
27-03-2019 7 Y 3 M 12 D (M)  
Dr. DINESH KUMAR CHIRLA



## NURSING INITIAL ASSESSMENT FOR PICU

Date of Admission: 9/7/26 @ 7:25 AM.

Source of Admission: ☐ OPD ☒ Ward ☐ Other:

Reason for Admission: seizures

Admission Diagnosis:

Accompanied By: ☒ Parent ☐ Guardian ☐ Other Name:

Primary Language: ☒ Telugu ☒ English ☐ Hindi ☐ Other Specify

Do you require an interpreter? ☒ Yes ☐ No

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

If yes, identify

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                    |                          |                         |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|-------------------------|
| Source of Information : <input type="checkbox"/> Family <input type="checkbox"/> Patient <input type="checkbox"/> Others, Specify                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                    |                          |                         |
| SIGNIFICANT HISTORY                                                                                                                                                                                                                                                                                                                                                                                                                                                | Past Medical History                                                                                                                                                                                                                                                                                                                                                                                                               | Past Surgical History    | Last Hospital Admission |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | no past medical history                                                                                                                                                                                                                                                                                                                                                                                                            | no past surgical history | -                       |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Family History:                                                                                                                                                                                                                                                                                                                                                                                                                    |                          |                         |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <p>Has the child or close family member had recent contact with a communicable disease? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes please list,</p> <p>Was the child's birth normal? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If No, please describe problems:</p> <p>Are the child's immunization up to date? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> |                          |                         |
| CURRENT MEDICATIONS                                                                                                                                                                                                                                                                                                                                                                                                                                                | <p>Taking Medications? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, Fill the reconciliation form</p> <p>Medicine brought to the hospital? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p>                                                                                                                                                                            |                          |                         |
| <p>Observations: Weight: 3.5 kg Length: ~ Head Circumference (&lt; 2 years):</p> <p>Temp.: 98.6 F HR: 101 RR: 20 BP: 118/59</p> <p>Pain Score: 0/10 Specify Site: ~ (Follow Pain Assessment Sheet &amp; Document)</p> <p>Fall Risk Assessment: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Score: 11 (Document in the Humpty Dumpty Sheet)</p> <p>Risk of Pressure Sore (Braden Q Score 4) (Document in the Braden Q Assessment Sheet)</p> |                                                                                                                                                                                                                                                                                                                                                                                                                                    |                          |                         |





Behavioural Status on Admission :

☒ Sleeping ☒ Crying ☐ Calm ☐ Distressed/Console ☐ Drowsy

**FUNCTIONAL SCREENING:** If a patient needs assistance with any of the following inform consultant

☐ Mobility problem ☒ Walking Problem ☐ No Abnormality Detected  
☐ Developmental Delay ☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

**NUTRITIONAL SCREENING:**

☐ Underweight ☐ Overweight ☐ Special Feeding Method  
☐ Feeding Problem ☐ Special diet ☒ No Abnormality Detected

Inform consultant for positive criteria

**Psychological Screening:** ☒ No Significant Findings

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

If Yes Consultant Notified: ..... (Date/Time): .....

**Social History:** Lives With .....

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

Orientation has been given regarding the following aspects:

☒ ID Band in situ  
☒ Bedside safety explained  
☒ PICU Routine: Doctor's rounds/Medication time  
☒ Visiting policy explained

Orientation given to: ☒ Family ☐ Others specify .....

Name of Person Orientation was given to: .....

Orientation not given Reason: .....

Nurse Name: ..... pravalilega Nurse Signature: .....

Date & Time: ..... 9/7/26 @ 7:45AM

**DISCHARGE PLAN**

Source of Information: ☒ Family ☐ Friend

Will patient require transportation arrangements to go home: ☒ Yes ☐ No

Will Physiotherapy require at home: ☐ Yes ☐ No

Is home medical equipment anticipated: ☒ Yes ☐ No

Is home oxygen therapy anticipated: ☒ Yes ☐ No

Are dressing needs at home anticipated: ☐ Yes ☒ No

Any other needs anticipated: ☐ Yes ☒ No If Yes Specify .....

Discharge Medications: ☒ Yes ☐ No

Details: .....

Final Diagnosis: .....

Nurse Name: ..... pravalilega Nurse Signature: .....

Date & Time: ..... 9/7/26 @ 7:45AM



BAH-00661071  
Master YUVANVEER MOTALLA  
27-03-2019 7 Y 3 M 12 D  
Dr. DINESH KUMAR CHIRLA (M)

CHBH/ FRM / CLINICAL / 126

**SCHOOL AGE (5-12 years)**  
**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 : 27/3/19                                   | Time: 10:30                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| Doctor / Nurse / Family Concern? 10pm 2am 6am    |                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| Temperature (°F)                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| Heart Rate (bpm) and Blood Pressure (mmHg) *     |                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| Note: BP does not score in early warning scoring |                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| Heart Rate (Number)                              | 101, 98, 90                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| Resp. Rate (bpm) (Over 1 Minute) *               |                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| Resp Rate (Number)                               | 26, 28, 24                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| Resp Distress                                    | Mod/ Severe<br>None / Mild                                                                                                                                                                                                                                                                                                                                                                                                                               |
| Receiving O <sub>2</sub> (l/min)                 | 0.2, 1.0, 0.2                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| O <sub>2</sub> Saturations (%)                   | 92, 100, 93                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| Conscious Level                                  | Normal<br>Altered                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| GCS *                                            | 15/15, 15/14, 15/15                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| TOTAL SCORE                                      | 1, 1, 1                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| Number of shaded boxes                           | 0, 0, 0                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| Pain Score                                       | 0, 0, 0                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| Observer's Initials                              | D, D, D                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| ACTIONS                                          | Score 1 : Continue normal observation by staff nurse<br>Score 2 : Shift in charge nurse to be informed and continue hourly observations<br>Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.<br>Score 4 : Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see<br>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.

|          |                                                                                                                                                                                                                                                                                                                                      |
|----------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>I</b> | <b>IDENTITY:</b> I am (name), a nurse on ward (X). I am calling about (child X)                                                                                                                                                                                                                                                      |
| <b>S</b> | <b>SITUATION :</b> 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>B</b> | <b>BACK GROUND :</b> 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) |
| <b>A</b> | <b>ASSESSMENT :</b> 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.                                                                                          |
| <b>R</b> | <b>RECOMMENDATION :</b> 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. : .....

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

| Date                        | Time                  | Nature of Fluid | Intake |     |     | Output                      |                       |       |          |       | IV Site Thrombo-phlebitis Score | Sign. Nurse |  |
|-----------------------------|-----------------------|-----------------|--------|-----|-----|-----------------------------|-----------------------|-------|----------|-------|---------------------------------|-------------|--|
|                             |                       |                 | Mouth  | I.V | N.G | NG                          | Diarrhoea             | Vomit | Drainage | Urine |                                 |             |  |
|                             |                       |                 |        |     |     |                             |                       |       |          |       |                                 |             |  |
|                             | 08:00 am              |                 |        |     |     |                             |                       |       |          |       |                                 |             |  |
|                             | 09:00 am              |                 |        |     |     |                             |                       |       |          |       |                                 |             |  |
|                             | 10:00 am              |                 |        |     |     |                             |                       |       |          |       |                                 |             |  |
|                             | 11:00 am              |                 |        |     |     |                             |                       |       |          |       |                                 |             |  |
|                             | 12:00 pm              |                 |        |     |     |                             |                       |       |          |       |                                 |             |  |
|                             | 01:00 pm              |                 |        |     |     |                             |                       |       |          |       |                                 |             |  |
| <b>Total Intake :</b>       |                       |                 |        |     |     | <b>Total Output :</b>       |                       |       |          |       |                                 |             |  |
|                             | 02:00 pm              |                 |        |     |     |                             |                       |       |          |       |                                 |             |  |
|                             | 03:00 pm              |                 |        |     |     |                             |                       |       |          |       |                                 |             |  |
|                             | 04:00 pm              |                 |        |     |     |                             |                       |       |          |       |                                 |             |  |
|                             | 05:00 pm              |                 |        |     |     |                             |                       |       |          |       |                                 |             |  |
|                             | 06:00 pm              |                 |        |     |     |                             |                       |       |          |       |                                 |             |  |
|                             | 07:00 pm              |                 |        |     |     |                             |                       |       |          |       |                                 |             |  |
|                             | <b>Total Intake :</b> |                 |        |     |     |                             | <b>Total Output :</b> |       |          |       |                                 |             |  |
| 9/7                         | 08:00 pm              |                 |        |     |     |                             |                       |       |          |       |                                 |             |  |
|                             | 09:00 pm              |                 |        |     |     |                             |                       |       |          |       | 0                               | Aruna       |  |
|                             | 10:00 pm              |                 |        |     |     |                             |                       |       |          |       | 0                               | Aruna       |  |
|                             | 11:00 pm              | NO IVF          |        |     |     |                             |                       |       |          |       | 0                               | Aruna       |  |
|                             | 12:00 am              |                 |        |     |     |                             |                       |       |          |       | 0                               |             |  |
|                             | 01:00 am              |                 |        |     |     |                             |                       |       |          |       | 0                               | Aruna       |  |
|                             | <b>Total Intake :</b> |                 |        |     |     |                             | <b>Total Output :</b> |       |          |       |                                 |             |  |
| 10/7                        | 02:00 am              |                 |        |     |     |                             |                       |       |          |       | 0                               | Aruna       |  |
|                             | 03:00 am              |                 |        |     |     |                             |                       |       |          |       | 0                               | Aruna       |  |
|                             | 04:00 am              | NO IVF          |        |     |     |                             |                       |       |          |       | 0                               | Aruna       |  |
|                             | 05:00 am              |                 |        |     |     |                             |                       |       |          |       | 0                               | Aruna       |  |
|                             | 06:00 am              |                 |        |     |     |                             |                       |       |          |       | 0                               | Aruna       |  |
|                             | 07:00 am              |                 |        |     |     |                             |                       |       |          |       | 0                               | Aruna       |  |
|                             | <b>Total Intake :</b> |                 |        |     |     |                             | <b>Total Output :</b> |       |          |       |                                 |             |  |
| <b>Total 24 hrs. Intake</b> |                       |                 |        |     |     | <b>Total 24 hrs. Output</b> |                       |       |          |       |                                 |             |  |





# FLUID CHART

Sheet No. : .....

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

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

|                             |  |
|-----------------------------|--|
| <b>Total 24 hrs. Intake</b> |  |
|-----------------------------|--|

|                             |  |
|-----------------------------|--|
| <b>Total 24 hrs. Output</b> |  |
|-----------------------------|--|



BAH-00661071 IP5-00176134  
Master YUVANVEER MOTALLA  
27-03-2019 7 Y 3 M 12 D (M)  
Dr. DINESH KUMAR CHIRLA

## NURSING CARE RECORD

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 09/07/26

Assessment: .....

Baby is crying

Goals

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

| Time  | Plan of Care                            | Time    | Implementation                          | Evaluation            |
|-------|-----------------------------------------|---------|-----------------------------------------|-----------------------|
| 8 Am  | - Monitor vitals.                       | 8.30 am | - Monitored vitals.                     | All plan implemented. |
| 9 Am  | - Maintain I/O chart.                   | 9.30 am | - Maintained I/O chart.                 |                       |
| 10 am | - Stop 3% NS & keep NPO.                | 12 pm   | - 3% NS stopped & baby is NPO.          |                       |
| 12 pm | - Plan to EEG                           | 2 pm    | - EEG Done.                             |                       |
| 2 pm  | - Plan to MRI                           | 4 pm    | - MRI Done.                             |                       |
| 5 pm  | - Administered medication as per order. | 7 pm    | - Administered medication as per order. |                       |

Re-Assessment: .....

Special Notes: .....

Nurse Signature: 

Nurse Name: Pamela

Date & Time: 09/07/26 @ 8 pm





## NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 9/7/26

Assessment: Baby having dis comfort

**Goals**

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

| Time | Plan of Care                                                                                                                                                                                 | Time | Implementation                                                                                                                                                                                     | Evaluation                                          |
|------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|
|      | <p>Assess the general condition of the baby</p> <p>10pm Monitor vital signs &amp; record</p> <p>12AM provide comfortable position</p> <p>6AM Administer medication as per doctor orders.</p> |      | <p>Assessed the general condition of the baby</p> <p>10pm Monitored vital signs &amp; record</p> <p>12AM provided comfortable position</p> <p>6AM Administred medication as per doctor orders.</p> | <p>by done all these to improve baby condition.</p> |

Re-Assessment: .....

Special Notes: N/A

Nurse Signature: Aruna

Nurse Name: Aruna

Date & Time: 10/7/26



BAH-00661071 IP5-00176134  
Master YUVANVEER MOTALLA  
27-03-2019 7 Y 3 M 12 D (M)  
Dr. DINESH KUMAR CHIRLA



## NURSING CARE RECORD

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

  
**BirthRight™**  
BY RAINBOW HOSPITALS  
Your Right to a Safe Delivery

Shift: ☐ Morning ☐ Afternoon ☐ Night

Date: .....

Assessment: .....

**Goals**

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

| Time | Plan of Care | Time | Implementation | Evaluation |
|------|--------------|------|----------------|------------|
|      |              |      |                |            |
|      |              |      |                |            |
|      |              |      |                |            |
|      |              |      |                |            |
|      |              |      |                |            |
|      |              |      |                |            |
|      |              |      |                |            |
|      |              |      |                |            |
|      |              |      |                |            |

Re-Assessment: .....

Special Notes: .....

Nurse Signature: .....

Nurse Name: .....

Date & Time: .....



Patient Sticker

## NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☐ Night

Date: .....

Assessment: .....

**Goals**

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

| Time | Plan of Care | Time | Implementation | Evaluation |
|------|--------------|------|----------------|------------|
|      |              |      |                |            |

Re-Assessment: .....

Special Notes: .....

Nurse Signature: ..... Nurse Name: ..... Date & Time: .....





## NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: ..... Department: ..... Date of Admission: 9/7/26

| SITUATION                                | Diagnosis:                                                |                                                                     | Any Infection: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Not Known<br>If Yes Specify: ..... |                                                                     |                                                          |                                                          |
|------------------------------------------|-----------------------------------------------------------|---------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------|
|                                          |                                                           |                                                                     |                                                                                                                                                |                                                                     |                                                          |                                                          |
| BACKGROUND                               | Area                                                      | Shift Time                                                          | <u>9<sup>th</sup> Floor</u><br><u>7AM</u>                                                                                                      | <u>10<sup>th</sup> Floor</u><br><u>8AM</u>                          |                                                          |                                                          |
|                                          | Medical Condition<br>(Any special condition to be noted): |                                                                     | <u>NA</u>                                                                                                                                      | <u>NA</u>                                                           |                                                          |                                                          |
| ASSESSMENT                               | Allergy:                                                  |                                                                     | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                            | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|                                          | Tubes/Drains/Catheter:                                    |                                                                     | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                            | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|                                          | Vital Signs:                                              | Temp:                                                               | <u>98.5°F</u>                                                                                                                                  | <u>97.0°F</u>                                                       |                                                          |                                                          |
|                                          |                                                           | Res:                                                                | <u>28b/m</u>                                                                                                                                   | <u>24b/m</u>                                                        |                                                          |                                                          |
|                                          |                                                           | SpO <sub>2</sub> :                                                  | <u>97%</u>                                                                                                                                     | <u>98%</u>                                                          |                                                          |                                                          |
|                                          |                                                           | Pulse:                                                              | <u>115b/m</u>                                                                                                                                  | <u>108</u>                                                          |                                                          |                                                          |
|                                          |                                                           | BP:                                                                 | <u>108/61 (73)</u>                                                                                                                             | <u>101/59</u>                                                       |                                                          |                                                          |
|                                          |                                                           | Fall Risk Score:                                                    | <u>11</u>                                                                                                                                      | <u>11</u>                                                           |                                                          |                                                          |
|                                          | Pain Score:                                               |                                                                     | <u>0/10</u>                                                                                                                                    | <u>0/10</u>                                                         |                                                          |                                                          |
|                                          | Recommendations                                           | Safety Needs:                                                       |                                                                                                                                                | <u>side rails</u>                                                   | <u>yes</u>                                               |                                                          |
| Physiotherapy                            |                                                           | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                            | <input type="checkbox"/> Yes <input type="checkbox"/> No            | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                          |
| Others Specify:                          |                                                           | <u>NA</u>                                                           | <u>NA</u>                                                                                                                                      |                                                                     |                                                          |                                                          |
| Special Diet:                            |                                                           | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                            | <input type="checkbox"/> Yes <input type="checkbox"/> No            | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                          |
| Other Special Orders / Medications:      |                                                           | <u>NA</u>                                                           | <u>NA</u>                                                                                                                                      |                                                                     |                                                          |                                                          |
| Post Operative Procedure Special Orders: |                                                           | <u>NA</u>                                                           | <u>NA</u>                                                                                                                                      |                                                                     |                                                          |                                                          |
| Handed Over By Name :                    |                                                           | <u>Lachel</u>                                                       | <u>Arung</u>                                                                                                                                   |                                                                     |                                                          |                                                          |
| Signature :                              |                                                           | <u>[Signature]</u>                                                  | <u>[Signature]</u>                                                                                                                             |                                                                     |                                                          |                                                          |
| Date:                                    |                                                           | <u>9/7/26</u>                                                       | <u>10/7</u>                                                                                                                                    |                                                                     |                                                          |                                                          |
| Time:                                    |                                                           | <u>7:20AM</u>                                                       | <u>8AM</u>                                                                                                                                     |                                                                     |                                                          |                                                          |
| Taken Over By Name :                     |                                                           | <u>praveen</u>                                                      | <u>Shanth</u>                                                                                                                                  |                                                                     |                                                          |                                                          |
| Signature :                              |                                                           | <u>[Signature]</u>                                                  | <u>[Signature]</u>                                                                                                                             |                                                                     |                                                          |                                                          |
| Date:                                    |                                                           | <u>9/7/26</u>                                                       | <u>10/7</u>                                                                                                                                    |                                                                     |                                                          |                                                          |
| Time:                                    |                                                           | <u>7:30AM</u>                                                       | <u>8AM</u>                                                                                                                                     |                                                                     |                                                          |                                                          |



## NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: ..... Department: ..... Date of Admission: .....

|                                          |                                                           |                                                          |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |  |
|------------------------------------------|-----------------------------------------------------------|----------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------|--|
| <b>SITUATION</b>                         | Diagnosis:                                                |                                                          | Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known<br>If Yes Specify: ..... |                                                          |                                                          |                                                          |                                                          |  |
|                                          |                                                           |                                                          |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |  |
| <b>BACKGROUND</b>                        | Area                                                      |                                                          |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |  |
|                                          | Shift Time                                                |                                                          |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |  |
|                                          | Medical Condition<br>(Any special condition to be noted): |                                                          |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |  |
| <b>ASSESSMENT</b>                        | Allergy:                                                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                            | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
|                                          | Tubes/Drains/Catheter:                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                            | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
|                                          | Vital Signs:                                              | Temp:                                                    |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |  |
|                                          |                                                           | Res:                                                     |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |  |
|                                          |                                                           | SpO <sub>2</sub> :                                       |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |  |
|                                          |                                                           | Pulse:                                                   |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |  |
|                                          |                                                           | BP:                                                      |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |  |
|                                          |                                                           | Fall Risk Score:                                         |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |  |
|                                          | Pain Score:                                               |                                                          |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |  |
| <b>Recommendations</b>                   | Safety Needs:                                             |                                                          |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |  |
|                                          | Physiotherapy                                             | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                            | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
|                                          | Others Specify:                                           |                                                          |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |  |
|                                          | Special Diet:                                             | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                            | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
|                                          | Other Special Orders / Medications:                       |                                                          |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |  |
| Post Operative Procedure Special Orders: |                                                           |                                                          |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |  |
| Handed Over By Name :                    |                                                           |                                                          |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |  |
| Signature :                              |                                                           |                                                          |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |  |
| Date:                                    |                                                           |                                                          |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |  |
| Time:                                    |                                                           |                                                          |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |  |
| Taken Over By Name :                     |                                                           |                                                          |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |  |
| Signature :                              |                                                           |                                                          |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |  |
| Date:                                    |                                                           |                                                          |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |  |
| Time:                                    |                                                           |                                                          |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |  |



## NURSE HAND OFF COMMUNICATION - ICU

|                                                           |                                                         |                  |             |  |                        |  |
|-----------------------------------------------------------|---------------------------------------------------------|------------------|-------------|--|------------------------|--|
| SITUATION & BACKGROUND                                    | DOA : 09/07/26                                          |                  | Diagnosis : |  | Surgery / Procedures : |  |
|                                                           | Allergies :                                             |                  |             |  | Post OP Day :          |  |
|                                                           | Date :                                                  | 09/07            |             |  |                        |  |
|                                                           | Area                                                    | PIV              |             |  |                        |  |
|                                                           | Shift Time                                              | DAY              |             |  |                        |  |
| INVASIVE LINES                                            | Diet :                                                  | ONCLY            |             |  |                        |  |
|                                                           | Ventilation (RA, NP, NIV, VENTI)                        | RA               |             |  |                        |  |
|                                                           | 1.                                                      | cannula          |             |  |                        |  |
|                                                           | 2.                                                      | (2)              |             |  |                        |  |
| ASSESSMENT                                                | Infusions / Transfusions                                | DMS              |             |  |                        |  |
|                                                           |                                                         |                  |             |  |                        |  |
|                                                           |                                                         |                  |             |  |                        |  |
|                                                           |                                                         |                  |             |  |                        |  |
|                                                           |                                                         |                  |             |  |                        |  |
|                                                           | PU Prophylaxis                                          | 2                |             |  |                        |  |
|                                                           | DVT Prophylaxis                                         | RA               |             |  |                        |  |
|                                                           | Vitals                                                  | BP               | 99/60       |  |                        |  |
|                                                           |                                                         | PR               | 80          |  |                        |  |
|                                                           |                                                         | RR               | 29          |  |                        |  |
|                                                           |                                                         | SpO <sub>2</sub> | 99%         |  |                        |  |
|                                                           |                                                         | Temp             | 98.6°f      |  |                        |  |
|                                                           | Pain Score                                              | 0                |             |  |                        |  |
|                                                           | LOC (Alert, Conscious, Confusion, Unconscious)          | Alert            |             |  |                        |  |
|                                                           | Skin Integrity (Intact / Bedsore / Any other condition) | Intact           |             |  |                        |  |
| Restraints If any                                         | Physical                                                | RA               |             |  |                        |  |
|                                                           | Chemical                                                |                  |             |  |                        |  |
| Fall Risk (Vulnerable (Y/N) if yes score)                 | yes                                                     |                  |             |  |                        |  |
| (Ambulation, walking, moving with assistance, bed ridden) | moving                                                  |                  |             |  |                        |  |
| ADL (Dependent / Non-Dependent)                           | Dependent                                               |                  |             |  |                        |  |
| Critical Lab Test / Values (if any)                       | RA                                                      |                  |             |  |                        |  |

Note : RA (Room Air, NP Nasal Prongs, NIV Non-Invasive Ventilation, VENTI Ventilator)



|                       |                                                                         |                   |          |  |  |  |  |  |  |
|-----------------------|-------------------------------------------------------------------------|-------------------|----------|--|--|--|--|--|--|
| RECOMMENDATIONS       | Investigations Procedures                                               | Date :            | 09/07    |  |  |  |  |  |  |
|                       |                                                                         | Area              | PTU      |  |  |  |  |  |  |
|                       |                                                                         | Shift Time        | DAY      |  |  |  |  |  |  |
|                       |                                                                         | Ordered / Planned | Followed |  |  |  |  |  |  |
|                       |                                                                         |                   | doctor   |  |  |  |  |  |  |
|                       |                                                                         |                   | order.   |  |  |  |  |  |  |
|                       |                                                                         | Due               | NO       |  |  |  |  |  |  |
|                       |                                                                         |                   | Done.    |  |  |  |  |  |  |
|                       |                                                                         |                   |          |  |  |  |  |  |  |
|                       |                                                                         | Reports Pending   | Blood    |  |  |  |  |  |  |
| C/S                   |                                                                         |                   |          |  |  |  |  |  |  |
|                       |                                                                         |                   |          |  |  |  |  |  |  |
| Referrals (If any)    | NO                                                                      |                   |          |  |  |  |  |  |  |
|                       | referred                                                                |                   |          |  |  |  |  |  |  |
|                       |                                                                         |                   |          |  |  |  |  |  |  |
|                       | Remarks<br>(Special Interventions like, Drainage<br>Tube flushing etc.) | NO<br>remark      |          |  |  |  |  |  |  |
| Handed Over By Name : |                                                                         | Parul             |          |  |  |  |  |  |  |
| Signature :           |                                                                         | (M)               |          |  |  |  |  |  |  |
| Date :                |                                                                         | 09/07             |          |  |  |  |  |  |  |
| Time :                |                                                                         | 8pm               |          |  |  |  |  |  |  |
| Taken Over By Name :  |                                                                         |                   |          |  |  |  |  |  |  |
| Signature :           |                                                                         |                   |          |  |  |  |  |  |  |
| Date :                |                                                                         |                   |          |  |  |  |  |  |  |
| Time :                |                                                                         |                   |          |  |  |  |  |  |  |



## PAIN ASSESSMENT FORM

| Date  | Time  | Pain Score (0/10) | Location | Duration                                                                     | Acuity                                                             | Character                                                                                                                        | Modifying Factors                                                          | Patient / Family Educated                                   | Intervention | Sign   |
|-------|-------|-------------------|----------|------------------------------------------------------------------------------|--------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|-------------------------------------------------------------|--------------|--------|
| 9/7   | 7AM   | 0/10              | NA       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | NA           | @      |
| 09/07 | 10 am | 0                 | NA       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | NA           | (B)    |
| 09/07 | 2pm   | 0                 | NA       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | NA           | (h)    |
| 09/07 | 10pm  | 0                 | NA       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | NA           | (h)    |
| 10/7  | 6AM   | 0                 | NA       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | NA           | Arana. |
|       |       |                   |          | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |              |        |
|       |       |                   |          | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |              |        |
|       |       |                   |          | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |              |        |
|       |       |                   |          | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |              |        |
|       |       |                   |          | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |              |        |

### Re-assessment Frequency:

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

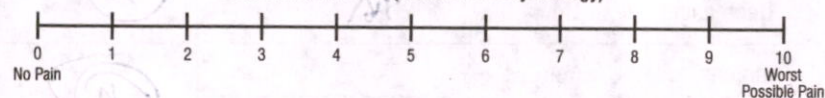


# PAIN ASSESSMENT TOOLS

**FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)**

| CATEGORY      | SCORING                                      |                                                                             |                                                          |
|---------------|----------------------------------------------|-----------------------------------------------------------------------------|----------------------------------------------------------|
|               | 0                                            | 1                                                                           | 2                                                        |
| Face          | No Particular expression or smile            | Occasional Grimace or Frown, withdraw, Disoriented                          | Frequent to constant frown, quivering chin, clenched jaw |
| Legs          | Normal Position or Relaxed                   | Uneasy, restless, tense                                                     | Kicking, or legs drawn up                                |
| Activity      | Laying quietly normal position, moves easily | Squirming shifting back and forth, tense                                    | Arched, right, or Jerking                                |
| Cry           | No Cry (Awake or asleep)                     | Moans or whimpers occasional complaint                                      | Crying steadily, screams of sobs, frequent complaints    |
| Consolability | Content, relaxed                             | Reassured by occasional touching, hugging, or being talked to, distractible | Difficult to console or comfort                          |

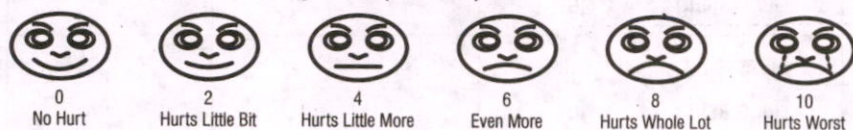
**Numerical Pain Scale (Obstetric and Gynecology)**



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

| Assessment Criteria                            | Sedation                                                |                                                             | Normal                                        | Pain / Agitation                                                                           |                                                                                                                                                         |
|------------------------------------------------|---------------------------------------------------------|-------------------------------------------------------------|-----------------------------------------------|--------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                | -2                                                      | -1                                                          | 0                                             | 1                                                                                          | 2                                                                                                                                                       |
| <b>Crying Irritability</b>                     | 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                                                                                                      |
| <b>Behavior State</b>                          | No arousal to any stimuli<br>No spontaneous movement    | Arouses minimally to stimuli<br>Little spontaneous movement | Appropriate for gestational age               | Restless, squirming<br>Awakens frequently                                                  | Arching, kicking constantly awake or<br>Arouses minimally / no movement (not sedated)                                                                   |
| <b>Facial Expression</b>                       | Mouth is lax<br>No expression                           | Minimal expression with stimuli                             | Relaxed Appropriate                           | Any pain expression intermittent                                                           | Any pain expression continual                                                                                                                           |
| <b>Extremities Tone</b>                        | No grasp reflex<br>Flaccid tone                         | Weak grasp reflex<br>decreased muscle tone                  | Relaxed hands and feet<br>Normal Tone         | Intermittent clenched toes, fists or finger splay<br>Body is not tense                     | Continual clenched toes, fists, or finger splay<br>Body is tense                                                                                        |
| <b>Vital Signs HR, RR, BP, SaO<sub>2</sub></b> | No variability with stimuli<br>Hypoventilation or apnea | Less than 10% variability from baseline with stimuli        | Within baseline or normal for gestational age | Increase 10-20% from baseline<br>SaO <sub>2</sub> 76-85% with stimulation - quick recovery | Increase greater than 20% from baseline, SaO <sub>2</sub> less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator |

**Wong - Baker (Pediatrics) Above 7 Years**







## THE HUMPTY DUMPTY SCALE *9/2 10/7*

| PARAMETER                                        | CRITERIA                                                                                                   | SCORE | DATE      | DATE      | DATE | DATE | DATE |
|--------------------------------------------------|------------------------------------------------------------------------------------------------------------|-------|-----------|-----------|------|------|------|
| <b>Age</b>                                       | Less than 3 years old                                                                                      | 4     |           |           |      |      |      |
|                                                  | 3 to less than 7 years old                                                                                 | 3     |           |           |      |      |      |
|                                                  | 7 to less than 13 years old                                                                                | 2     | <i>2</i>  | <i>2</i>  |      |      |      |
|                                                  | 13 years old and above                                                                                     | 1     |           |           |      |      |      |
| <b>Gender</b>                                    | Male                                                                                                       | 2     | <i>2</i>  | <i>2</i>  |      |      |      |
|                                                  | Female                                                                                                     | 1     |           |           |      |      |      |
| <b>Diagnosis</b>                                 | Neurological Diagnosis                                                                                     | 4     |           |           |      |      |      |
|                                                  | Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc. | 3     |           |           |      |      |      |
|                                                  | Psych / Behavioral Disorders                                                                               | 2     |           |           |      |      |      |
|                                                  | Other Diagnosis                                                                                            | 1     | <i>1</i>  | <i>1</i>  |      |      |      |
| <b>Cognitive Impairments</b>                     | Not Aware of Limitations                                                                                   | 3     |           |           |      |      |      |
|                                                  | Forget Limitations                                                                                         | 2     | <i>2</i>  | <i>2</i>  |      |      |      |
|                                                  | Oriented to own Ability                                                                                    | 1     |           |           |      |      |      |
|                                                  | History of Falls or Infant - Toddler Placed in Bed                                                         | 4     |           |           |      |      |      |
| <b>Environmental Factors</b>                     | Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)            | 3     |           |           |      |      |      |
|                                                  | Patient Placed in Bed                                                                                      | 2     | <i>2</i>  | <i>2</i>  |      |      |      |
|                                                  | Outpatient Area                                                                                            | 1     |           |           |      |      |      |
| <b>Response to Surgery / Sedation Anesthesia</b> | Within 24 hours                                                                                            | 3     |           |           |      |      |      |
|                                                  | Within 48 hours                                                                                            | 2     |           |           |      |      |      |
|                                                  | More than 48 hours / None                                                                                  | 1     | <i>1</i>  | <i>1</i>  |      |      |      |
| <b>Medication Usage</b>                          | Sedatives (excluding ICU patients sedated and paralyzed)                                                   | 3     |           |           |      |      |      |
|                                                  | Hypnotics                                                                                                  | 3     |           |           |      |      |      |
|                                                  | Barbiturates                                                                                               | 3     |           |           |      |      |      |
|                                                  | Phenothiazines                                                                                             | 3     |           |           |      |      |      |
|                                                  | Antidepressants                                                                                            | 3     |           |           |      |      |      |
|                                                  | Laxatives / Diuretics                                                                                      | 3     |           |           |      |      |      |
|                                                  | Narcotics                                                                                                  | 3     |           |           |      |      |      |
|                                                  | One of the Meds listed above                                                                               | 2     |           |           |      |      |      |
|                                                  | Other Medications / None                                                                                   | 1     | <i>1</i>  | <i>1</i>  |      |      |      |
| <b>TOTAL</b>                                     |                                                                                                            |       | <i>11</i> | <i>11</i> |      |      |      |

**Intervention :**

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

High Risk Humpty Dumpty Score = 12 or above

|                               |                    |                    |  |  |  |
|-------------------------------|--------------------|--------------------|--|--|--|
| Bed in low position           | <i>yes</i>         | <i>yes</i>         |  |  |  |
| Call device within reach      | <i>yes</i>         | <i>yes</i>         |  |  |  |
| Wheels Locked                 | <i>yes</i>         | <i>yes</i>         |  |  |  |
| Room free of clutter          | <i>yes</i>         | <i>yes</i>         |  |  |  |
| Adequate Lighting             | <i>yes</i>         | <i>yes</i>         |  |  |  |
| Wheel Chair Support           | <i>no</i>          | <i>no</i>          |  |  |  |
| Other Intervention(s) Specify | <i>no</i>          | <i>no</i>          |  |  |  |
| Nurse's Name :                | <i>Rachar</i>      | <i>Arung</i>       |  |  |  |
| Signature :                   | <i>[Signature]</i> | <i>[Signature]</i> |  |  |  |
| Date :                        | <i>9/2</i>         | <i>10/7</i>        |  |  |  |
| Time :                        | <i>7A</i>          | <i>6PM</i>         |  |  |  |





## BRADEN 'Q' SCALE

|                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                        | Date :                  | 9/7/20 | 10/7 |      |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|--------|------|------|--|
|                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                        | Time :                  | 7 AM   | 6 PM |      |  |
| Mobility                                                                                                                                                                      | <b>1. Completely immobile:</b><br>Does not make even slight changes in body or extremity position without assistance.                                                                                                                                                                                                                    | <b>2. Very limited:</b><br>Makes occasional slight changes in body or extremity position but unable to completely turn self independently.                                                                                                                                                                                                                   | <b>3. Slightly limited:</b><br>Makes frequent through slight changes in body or e:treimity position independently.                                                                                                                                                                              | <b>4. No limitations:</b><br>Makes major and frequent changes in position without assistance.                                                                                                                                                                                          | 4                       | 4      |      |      |  |
| "Activity The degree of physical activity"                                                                                                                                    | <b>1. Bedfast :</b><br>Confined to bed                                                                                                                                                                                                                                                                                                   | <b>2. Chairfast :</b><br>Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."                                                                                                                                                                                                         | <b>3. Walks occasionally:</b><br>Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.                                                                                                                        | <b>4. All patients too young to ambulate; OR walks frequently:</b><br>Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.                                                                                                    | 4                       | 4      |      |      |  |
| Sensory Perception                                                                                                                                                            | <b>1. Completely limited:</b><br>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.                                                                                                                  | <b>2. Very limited:</b><br>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.                                                                                                                               | <b>3. Slightly limited:</b><br>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.                                                           | <b>4. No impairment:</b><br>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                                                                                                                          | <b>1. Constantly moist:</b><br>Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.                                                                                                                                                                   | <b>2. Very moist:</b><br>Skin is often, but not always, moist. Linen must be changed at least every 8 hours.                                                                                                                                                                                                                                                 | <b>3. Occasionally moist:</b><br>Skin is occasionally moist, requiring linen change every 12 hours.                                                                                                                                                                                             | <b>4. Rarely moist:</b><br>Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.                                                                                                                                                                   | 4                       | 4      |      |      |  |
| <b>FRICITION-SHEAR</b><br><b>Friction</b> Occurs when Skin moves against support surfaces<br><b>Shear</b> Occurs when skin and adjacent bony surface slide across one another | <b>1. Significant problem:</b><br>Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.                                                                                                                                                                                                        | <b>2. Problem:</b><br>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.                                                                                                                    | <b>3. Potential problem:</b><br>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.            | <b>4. No apparent problem:</b><br>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                                                                                                                                         | <b>1. Very Poor:</b><br>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. | <b>2. Inadequate:</b><br>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. | <b>3. Adequate:</b><br>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. | <b>4. Excellent:</b><br>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                                                                                                                                                | <b>1. Extremely compromised:</b><br>Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.                                                                                                                                                                                   | <b>2. Compromised:</b><br>Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.                                                                                                                                                                                                | <b>3. Adequate:</b><br>Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.                                                                                                                                        | <b>4. Excellent:</b><br>Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.                                                                                                                                                                               | 4                       | 4      |      |      |  |
| <b>Severe Risk : less than 9   High Risk : 10-12   Moderate Risk : 13-14   Mild Risk : 15-18   Not at Risk: 19-23</b>                                                         |                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                        |                         |        |      |      |  |
| <b>Docu. No. : RCHBH /FRM / CLINICAL / 119</b>                                                                                                                                |                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                        |                         |        |      |      |  |
|                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                        | <b>TOTAL SCORE</b>      |        | 28   | 28   |  |
|                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                        | <b>Evaluator's Name</b> |        | Ch   | Arum |  |



| Risk Score  | Category      | Action                                                                                                                                                                                                                                                                                                                                       | <b>Support Surfaces</b><br>(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       | <ul style="list-style-type: none"> <li>• Regular Turning Schedule</li> <li>• Enable as much activity as possible</li> <li>• Protect the heels</li> <li>• Use pressure redistribution surfaces</li> <li>• Manage moisture, friction and shear</li> <li>• Advance to a higher level of risk if other major risk factors are present</li> </ul> | High density foam mattress<br>Gel pads for high-risk areas<br>Alternating pressure mattress overlay                                                                  |
| 13-14       | Moderate Risk | <ul style="list-style-type: none"> <li>• Use the Same Protocol as for “<b>At Risk</b>” Patients</li> <li>• Position patient at 30 degree lateral incline using foam wedges</li> </ul>                                                                                                                                                        | High density foam mattress<br>Gel pads for high-risk areas<br>Alternating pressure mattress overlay                                                                  |
| 10-12       | High Risk     | <ul style="list-style-type: none"> <li>• Follow the same protocol as for “<b>Moderate Risk</b>” Patients</li> <li>• In addition to regular turning schedule</li> <li>• Make small shifts in their position frequently</li> </ul>                                                                                                             | High density foam mattress<br>Gel pads for high-risk areas<br>Alternating pressure mattress overlay                                                                  |
| Less than 9 | Severe Risk   | <ul style="list-style-type: none"> <li>• Use same protocol as for “<b>High Risk</b>” Patients</li> <li>• Add a pressure redistribution surface for patients with severe pain or with additional risk factors.</li> </ul>                                                                                                                     | High density foam mattress<br>Gel pads for high-risk areas<br>Alternating pressure mattress overlay                                                                  |



# INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

## Part - I.

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

## Identified Education Needs:

- |                            |                                                                      |                                                                |                                                             |
|----------------------------|----------------------------------------------------------------------|----------------------------------------------------------------|-------------------------------------------------------------|
| 1. Diagnosis               | 5. Medication / Therapy (safety, effects/ side effect, interactions) | 9. Nutrition / Diet                                            | 13. Risk / Safety                                           |
| 2. Treatment and Care Plan | 6. Discharge Medication                                              | 10. Fall Risk Education                                        | 14. Activity / Exercise                                     |
| 3. Pain Management         | 7. Infection Control Measures                                        | 11. Safe use of Medical Equipment / Implantable Devices Safety | 15. Social & Rehabilitation Needs                           |
| 4. Informed Consent        | 8. Diagnostic Test / Procedures                                      | 12. Patient's / Family Rights                                  | 16. Special Discharge / Follow-up Education / Coping Skills |
|                            |                                                                      |                                                                | 17. Others .....                                            |

## Part - II

| Date   | Time | Need Identified | Information Taught      | Use codes from the list in part III |                   |                |                                   |               | Comments | Designation / Signature |
|--------|------|-----------------|-------------------------|-------------------------------------|-------------------|----------------|-----------------------------------|---------------|----------|-------------------------|
|        |      |                 |                         | Person Taught                       | Learning Barriers | Teaching Tools | Mechanism/s to overcome barrier/s | Understanding |          |                         |
| 9/7    | 7 AM | 2               | Treatment and care plan | M                                   | 1                 | 0              | 1                                 | 1             | NA       | Rahul                   |
| 9/7/20 | 8 AM | 9               | Child is on NPO         | M                                   | 1                 | 0              | 1                                 | 1             | -        | Mounica                 |
|        |      |                 |                         |                                     |                   |                |                                   |               |          |                         |
|        |      |                 |                         |                                     |                   |                |                                   |               |          |                         |

## Part - III: CODES

Who was taught: PT: Patient F: Father M: Mother S: Spouse Sn: Son D: Daughter C: Caregiver O: Other (Specify) .....

**Learning Barriers:**

|                         |                               |                                                   |                                 |                                |
|-------------------------|-------------------------------|---------------------------------------------------|---------------------------------|--------------------------------|
| 1. No Learning Barriers | 4. Language Barrier           | 7. Impaired Thought Process/Cognitive limitations | 10. Financial Difficulties      | 13. Cultural/Religion Practice |
| 2. Physical Impairment  | 5. Educational Level          | 8. Responsibilities at Home                       | 11. Beliefs and Values          | 14. Others (Specify) .....     |
| 3. Emotional Barriers   | 6. Desire / Motivate to Learn | 9. Cultural Differences                           | 12. Impaired Vision/ or Hearing |                                |

**Teaching Tools Used:** A: Audio D: Demonstration V: Video O: Oral P: Printed

**Mechanism/s to overcome barrier/s:**

|                      |                          |                                           |                         |
|----------------------|--------------------------|-------------------------------------------|-------------------------|
| 1. None              | 3. Reassurance & Support | 5. Respect values & beliefs               | 7. Other, Specify ..... |
| 2. Obtain translator | 4. Teach Family / Others | 6. Respect Cultural / Religion Preference |                         |

**Understanding:** 1. Verbalizes Understanding 2. Demonstrates Understanding 3. Needs Review



# MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis: \_\_\_\_\_

| Date Time     | Discipline                                                                                                                       | Type                                                                                                                                                    | Patient Needs / Problem List         | Goal              | Plan / Intervention       | Signature          | Team Verification                                                                                                   |
|---------------|----------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|-------------------|---------------------------|--------------------|---------------------------------------------------------------------------------------------------------------------|
| 9/7           | <input checked="" type="checkbox"/> Medical<br><input type="checkbox"/> Nursing<br><input type="checkbox"/> Others:              | <input checked="" type="checkbox"/> Initial<br><input type="checkbox"/> Modified<br><input type="checkbox"/> Per-Op<br><input type="checkbox"/> Post Op | Acute ENCEPHALOPATHY<br>↓ EVALUATION | TO KNOW THE CAUSE | IVF                       | <i>[Signature]</i> | <input checked="" type="checkbox"/> Nursing<br><input type="checkbox"/> Others:                                     |
| 9/7           | <input type="checkbox"/> Medical<br><input checked="" type="checkbox"/> Nursing<br><input type="checkbox"/> Others:              | <input checked="" type="checkbox"/> Initial<br><input type="checkbox"/> Modified<br><input type="checkbox"/> Per-Op<br><input type="checkbox"/> Post Op | Seizure Activity                     | Stability         | IVF<br>Medication         | <i>[Signature]</i> | <input checked="" type="checkbox"/> Medical<br><input type="checkbox"/> Others:                                     |
| 9/7/26<br>8am | <input type="checkbox"/> Medical<br><input type="checkbox"/> Nursing<br><input checked="" type="checkbox"/> Others:<br>Dietitian | <input checked="" type="checkbox"/> Initial<br><input type="checkbox"/> Modified<br><input type="checkbox"/> Per-Op<br><input type="checkbox"/> Post Op | Ac. Encephalopathy                   | Child is on NPO   | NPO TTY<br>Further advise | <i>[Signature]</i> | <input type="checkbox"/> Medical<br><input type="checkbox"/> Nursing<br><input checked="" type="checkbox"/> Others: |
|               | <input type="checkbox"/> Medical<br><input type="checkbox"/> Nursing<br><input type="checkbox"/> Others:                         | <input type="checkbox"/> Initial<br><input type="checkbox"/> Modified<br><input type="checkbox"/> Per-Op<br><input type="checkbox"/> Post Op            |                                      |                   |                           |                    | <input type="checkbox"/> Medical<br><input type="checkbox"/> Nursing<br><input type="checkbox"/> Others:            |
|               | <input type="checkbox"/> Medical<br><input type="checkbox"/> Nursing<br><input type="checkbox"/> Others:                         | <input type="checkbox"/> Initial<br><input type="checkbox"/> Modified<br><input type="checkbox"/> Per-Op<br><input type="checkbox"/> Post Op            |                                      |                   |                           |                    | <input type="checkbox"/> Medical<br><input type="checkbox"/> Nursing<br><input type="checkbox"/> Others:            |





## CHECKLIST FOR THROMBOPHLEBITIS

09/09/26

10/10/26

| 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 /<br>Observe cannula                                                              | 0     | 0     | 0   | 0     | 0     |   |   |       |   |   |         |
| 2                      | One of the following signs is evident:<br>* Slight pain near the IV Site /<br>* Slight redness near IV Site                                          | Possibly first signs of phlebitis /<br>Observe cannula                                                  | 1     | -     | -   | -     | -     |   |   |       |   |   |         |
| 3                      | Two of the following Signs are evident:<br>Pain at IV site Redness                                                                                   | Early stage of phlebitis /<br>Resite Cannula                                                            | 2     | -     | -   | -     | -     |   |   |       |   |   |         |
| 4                      | All of the following Signs are evident :<br>Pain along Path of cannula<br>Redness around Site Swelling                                               | Medium stage of phlebitis /<br>Resite Cannula Consider Treatment                                        | 3     | -     | -   | -     | -     |   |   |       |   |   |         |
| 5                      | All of the following Signs are evident and Extensive :<br>Pain along Path of cannula<br>Redness around Site<br>Swelling palpable Venous cord         | Advanced stage of phlebitis or<br>the start of thrombophlebitis /<br>Re site Cannula Consider Treatment | 4     | -     | -   | -     | -     |   |   |       |   |   |         |
| 6                      | All of the following Signs are evident and Extensive : Pain<br>along Path of cannula Redness<br>around Site Swelling palpable<br>Venous cord pyrexia | Advanced stage of<br>thrombophlebitis /<br>Initiate treatment Re site<br>Cannula                        | 5     | -     | -   | -     | -     |   |   |       |   |   |         |
| Signature of the Nurse |                                                                                                                                                      |                                                                                                         |       | (w)   | (w) | Anura |       |   |   |       |   |   |         |

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

Signature of Shift In Charge :

Signature : Name :

Signature of Ward In Charge :

Signature : ..... Name : .....





## CONSENT FOR ADMISSION IN PEDIATRIC INTENSIVE CARE UNIT

Name: Yuvanveer Motalla Age: 7y 3m 12d Gender: Male ☒ Female ☐

UHID.No : \_\_\_\_\_ Date: 9/3/20

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 :

Ant coagulants stat.

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 : \_\_\_\_\_  
\_\_\_\_\_ 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: DARODAR

Relationship with Patient: Father

Date & Time: 9/3/26

### Witness :

Signature: [Signature]

Name: [Signature]

Date & Time: 09/09/26 @ 9:30 AM

### Doctor (who is taking the consent) :

Signature: [Signature]

Name: [Signature]

Date & Time: 9/3/2020



..... వయస్సు.....

.....  
యూ.పా.బి.డి

..... s/o, d/o, w/o .

.....అనుబాండు / బాంక యొక్క చిక్కు మేరకు రెయిన్ఫీల్లల అనుపత్తిలోని పిల్లల ఇంటర్నెస్ కేర్ యూనిట్  
వేది ..... నాడు పూర్తి సమ్మతితో చేర్చితిని.

మూబాలుడి / బాలికలో ఈ కింద తెలిపిన ఆరోగ్య సమస్యల గురించి విద్య సిఫ్టుబుడు నాకు ఆర్థమగు భాషలో వివరించితిరి.

రెయిన్ బో బిల్డిన్స్ హాస్పిటల్ లోని పీడియాట్రిక్ ఇంటెన్సివ్ కేర్ విభాగం లో చేరించి జడ్డుకు ఆరోగ్య సంబంధిత సమస్యలు ఉన్నాయని వైద్యులు నాకు అర్థమయ్యే భాషలో వివరించారు. రోగి \_\_\_\_\_ పీడియాట్రిక్ ఇంటెన్సివ్ కేర్ విభాగం లో ఉన్న సమయంలో ఆతను వివిధ వైద్య మరియు శస్త్ర చికిత్సలకు లోనుతారని వైద్యులు నాకు స్పష్టంగా వివరించారు. ఎయిర్ వే మేనేజ్ మెంట్, మెకానికల్ వెంటిలేషన్, బొడ్డు సిర మరియు ధమనుల కాథెటర్ వంటి . పెరిఫెరల్ ఇన్ఫర్డ్ చేయబడిన సెంట్రల్ కాథెటర్ లైన్ మరియు ఆర్థో లైన్ ప్లేస్ మెంట్స్, చాతీ డ్రైయిన్ లేదా పెరిటోనియల్ డ్రైయిన్ ఇన్ఫర్డ్ మొదలైనవి.

అటువంటి ప్రక్రియలు చేస్తున్నప్పుడు నాకు సమాచారం ఇవ్వబడుతుందని మరియు దీనికి ప్రత్యేక సమ్మతి ఉంటుందని వైద్యులు నాకు చెప్పారు. ఏదేమైనప్పటికీ, ఏదైనా ప్రాణాంతక అత్యుపసర పరిస్థితుల్లో సమాచారం తీసుకోవడానికి సమయం లేకపోతే నా జడ్డ ప్రాణాన్ని కాపాడేందుకు ఇతర వైద్య ప్రక్రియలకు నేను సమ్మతి ఇస్తున్నాను.

పీడియాట్రిక్ ఇంజనీర్స్ కేర్ టిభాగం లో అనారోగ్యంతో ఉన్న పిల్లవాడికి ప్రాణాంతకమైన వైద్య పరిస్థితులు ఉన్నాయని ఆర్థం చేసుకోవడమైనది.

ఒక జుడ్డ అనారోగ్యంతో పీడియాట్రిక్ ఇంటెన్సివ్ కేర్ విభాగంలో ఉన్నప్పుడు అతని/ఆమెపై నిర్వహించబడు అనేక వైద్య మరియు శస్త్రచికిత్సా విధానాలతో ఈ అధిక ప్రమాదకరమైన విధానాల వల్ల సంబంధించు నష్టాలు మరియు అధిక ప్రమాదకరమైన మందుల రూపంలో అంటువ్యాధులు, రక్తస్రావం, శ్వాసపరమైన, చర్మం మరియు ఇతర కణజాల నష్టం మొదలైనవి కలగవచ్చు. డాక్టర్లు నాకు బాగా అర్థమయ్యే భాషలో వివరించారు.

మా బాలుడు / బాలిక ..... ను ఇంటర్నల్ కేర్ యూనిట్ (పి.ఐ.సి.యు) తో చేర్చుకొని  
అవసరమయ్యే వైద్యం చేయుటకు నేను వైద్య బృందానికి నా సమ్మతి ధృవపరుస్తున్నాను.

సహాయకుడు (అటెండెంట్)

సంతకము .....

.....

వెద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము .....

.....

DOCU.No.: RCHBH/FRM/CLINICAL/013

ಶ್ರೀ

సంక్షేమము .....

.....

శ్రీరీ మలయు సమయము .....



# PATIENT TRANSFER FORM

|                                                                                                                                                                                                      |                                |                                                                                                                                                                            |                                                  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|
| BAH-00661071 IP5-00176134<br>Master YUVANVEER MOTALLA<br>27-03-2019 7 Y 3 M 12 D (M)<br>Dr. DINESH KUMAR CHIRLA<br> |                                | Date & Time of Admission<br>9/7/26 @                                                                                                                                       | Date & Time of Transfer Order<br>9/7/26 @ 7:20Am |
| Treating Consultant Name                                                                                                                                                                             |                                | Transfer Ordered by<br>Dr. Somashree .                                                                                                                                     | Reason for Transfer<br>Admission                 |
| From Unit<br>CR                                                                                                                                                                                      | To Unit<br>PICU                | Information to Attendant<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                                                            |                                                  |
| Number of Sheets in Clinical File<br>20                                                                                                                                                              | Number of Imaging Films<br>nil | Personal belongings including clinical documents. If any handed over to attendant<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/><br>If yes, what ? |                                                  |
| Medications / Consumables / Surgicals / Hand over                                                                                                                                                    |                                |                                                                                                                                                                            |                                                  |
| Sl.No.                                                                                                                                                                                               | Item Name                      | Quantity                                                                                                                                                                   |                                                  |
| 1.                                                                                                                                                                                                   | samples                        |                                                                                                                                                                            |                                                  |
| 2.                                                                                                                                                                                                   |                                |                                                                                                                                                                            |                                                  |
| 3.                                                                                                                                                                                                   |                                |                                                                                                                                                                            |                                                  |
| 4.                                                                                                                                                                                                   |                                |                                                                                                                                                                            |                                                  |
| 5.                                                                                                                                                                                                   |                                |                                                                                                                                                                            |                                                  |
| Shifting Summary / Notes Written by Doctor : Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                                                                     |                                |                                                                                                                                                                            |                                                  |
| Name & Signature of Person who is Transferring<br>Dr. Lachel                                                                                                                                         |                                | Name of Person Ordered Transfer<br>Dr. Somashree                                                                                                                           |                                                  |
| Patient & Clinical Records Received by :<br>9/7/26<br>praveen<br>7:25AM.                                                                                                                             |                                |                                                                                                                                                                            |                                                  |
| Date & Time of Patient Received :                                                                                                                                                                    |                                |                                                                                                                                                                            |                                                  |

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



# **CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE**

Patient Name : Yuvanveer makhalla Age : 7 yr Gender : Male ☒ - Female ☐

UHID NO: \_\_\_\_\_ Surgeon Name: \_\_\_\_\_

Anaesthesiologist : DR. K. SRI RAMYA.

Operative procedure planned : MRI BRAIN.

## **PLEASE READ THIS BEFORE YOU CONSENT FOR ANAESTHESIA**

General anaesthesia involves rendering a patient unconscious before an operation. This ensures the patient is not aware of events and does not feel pain during the operation. Drugs given through a vein and / or inhaled from an anaesthesia machine produce it. Regional anaesthesia involves using a local anaesthetic to numb a specific area of the body for surgery: Prolonged pain relief without numbness can be achieved by infusing weak solutions of local anesthetics and narcotic drugs to particular parts of the body after surgery or injury, using catheters.

**Specific High Risk (s) :** The doctors have explained to me the details of the high risk involved due to the following medical problems and I have sought necessary clarification on all my doubts.

- |                                                                               |                                       |                                                 |                                                              |
|-------------------------------------------------------------------------------|---------------------------------------|-------------------------------------------------|--------------------------------------------------------------|
| <input type="checkbox"/> Heart disease                                        | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Diabetes mellitus      | <input type="checkbox"/> Renal failure                       |
| <input type="checkbox"/> Hepatic disorders                                    | <input type="checkbox"/> Shock        | <input type="checkbox"/> Multiple organ failure | <input type="checkbox"/> Polytrauma / Renal Tubular Acidosis |
| <input type="checkbox"/> Incapacitating Chronic Obstructive Pulmonary Disease |                                       |                                                 |                                                              |
| <input type="checkbox"/> Others : <u>DESATURATION.</u>                        |                                       |                                                 |                                                              |

Comments : \_\_\_\_\_

- Doctor to document in medical record also if necessary (Cross-out if not applicable)

## **DECLARATION BY PATIENT / GUARDIAN / PROXY**

I hereby authorize Rainbow Hospital & its authorized doctors to perform upon me / my patient Yuvanveer the above mentioned operation / Diagnostic / Therapeutic procedures

I authorize and give consent for anaesthesia ( ☐ Regional / ☐ General Anesthesia / ☐ Monitored Anesthesia Care as considered appropriate by the anaesthetic team.

I acknowledge that the anaesthetists have informed me about the anaesthetic procedure, risk, benefits and alternative treatments and answered my specific queries and concerns about this matter. I have read and understood the information provided in this form I acknowledge that I have discussed with the anaesthetists any significant risk and Complications specific to my individual circumstances, and I have considered them before Consenting for anesthesia.



I understand that there are some infrequent complications that can occur due to use of anaesthesia, these include pain or some injury at the site of injections, temporary breathing difficulties, asthmatic reactions, headaches.

I authorize the anaesthetic team to perform any additional procedures (for example, Central Venous Pressure line, arterial line, use of nerve blocks for pain relief, changing from regional to general anaesthesia etc), which are considered necessary by them during the course of surgery.

That I authorize and give consent to the team of doctors attending on me to administer blood products during the course of operative period and immediately thereafter in need arises.

I understand that the above mentioned consultant anesthesiologist or occasionally a colleague deputed by him / her will administer the Anaesthesia.

- Pregnant: ☐ Yes ☐ No

#### DECLARATION BY THE ANAESTHETISTS PROVIDING INFORMATION FOR THIS CONSENT

I declare that I have explained the nature of General Anaesthesia / Regional Anaesthesia / Monitored Anesthesia Care to be given and discussed the risks that particularly concern this patient.

I have given the patient an opportunity to ask questions and I have answered these.

**Patient / Patient Attendant :**

Signature : Anusha

Name : Anusha (mother)

Relationship with Patient: .....

Date & Time : 9/7/2018

**Witness :**

Signature : .....

Name : .....

Date & Time : .....

**Doctor (who is taking the consent) :**

Signature : [Signature]

Name : DR. K. S. RAMA

Date & Time : 9/7/2018 3:20 PM



Department of Anaesthesiology  
PRE-ANAESTHETIC EVALUATION

BAH-00661071 IP5-00176134  
Master YUVANVEER MOTALLA  
27-03-2019 7 Y 3 M 12 D (M)  
Dr. DINESH KUMAR CHIRLA

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Idren's  
hospital  
It takes a lot to treat the little.

BirthRight®  
BY RAINBOW HOSPITALS  
Your Right to a Safe Delivery

Name: Yuvanveer motalla Age: 7 Sex: M UHID.No: .....

Date: 9/3/2016 Time: ..... Proposed Operation: .....

Diagnosis: Ant. Encephalopathy & Evaluation.

B.P / CRT: 105/62 H.R: 64 Weight: 33 kg ASA Physical Status: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:

Hgb: 11.7 Glucose: ..... Protein: ..... HIV: ..... X-Ray: .....  
PCV: ..... Urea: 24 Alb: ..... HBS Ag: ..... ECG: .....  
WBC: 8.1/L Creat: 6.4 Total Bill: ..... HCV: ..... 2D Echo: .....  
Plate: 403 Na: ..... Dir. Bill: ..... Blood group: ..... Stress/Angio: .....  
PT: ..... K: ..... LDH: ..... T3 ..... Other: .....  
PTT: ..... Ca++: ..... Alk phos: ..... T4 .....  
INR: ..... Mg++: ..... Amylase: ..... TSH .....  
Cl -: ..... SGOT/SGPT: .....

Allergies: - -

Medical History: CVS: NS

RESP: Yesterday felt unbalanced. Diabetes: FT / Ins / BW-34 kg

CNS: Ho abnormal walks from yesterday H/O ALLU admission under sedation ventilator 11/10/16

Renal: 11/10 Vomiting

Hepatic / GE: NS today morning 6 o'clock Physical Activity: 2 day seizure, a trace

Others: wade up fixed bond eyes abnormal walks till no other symptoms

Past Anaesthetic History: → Up to date vaccines

Physical Exam: not H/O cold cough, fever. 6 yr prodigious till 4 yr.

Airway: MP 1 2 3 4 Mouth Opening: ..... Mentohyoid Distance: ..... Neck: ..... Teeth: - No delay in mastication

Lungs: RAE (P) clear

Heart: S1 S2 (E)

CNS: .....

Pregnant: ☐ Yes ☐ No ☒ NA Venous Access Site: (P) only Spine Exam for regional: -

Anaesthetic Plan: ☐ MAC ☐ REGIONAL ☐ GA-ETT ☐ LMA

Peri-Operative Plan Explained to the Patient: ☐ Yes ☐ No

| CURRENT MEDICATIONS | DOSAGE |
|---------------------|--------|
|                     |        |
|                     |        |
|                     |        |
|                     |        |

Pre-Operative Instructions:

- DVT Prophylaxis:
  - Water / ORS 2 Hours
  - Others 6 Hours
- NIL ORAL
- Informed Consent: ☐ Standard ☐ High Risk
- Post Operative Pain Management: ☐ Discussed with Patient
- Other Instructions:

Signature: [Signature] Name: DR. B. SRI RAMYA

Docu. No. : RCHBH / FRM / CLINICAL / 044

BAH-00661071 IP5-00176134  
Master YUVANVEER MOTALLA  
27-03-2019 7 Y 3 M 12 D (M)  
Dr. DINESH KUMAR CHIRLA



IP5-00176134

BAH-00661071  
Master YUVANVEER MOTALLA  
27-03-2019 7 Y 3 M 12 D (M)  
Dr. DINESH KUMAR CHIRLA

27-03-2019

7 Y 3 M 12 D

(M)

Dr. DINESH KUMAR CHIRLA



## ANAESTHESIA CHART



**Rainbow<sup>®</sup>  
Children's  
Hospital**  
It takes a lot to treat the little.



**BirthRight™**  
BY RAINBOW HOSPITALS  
Your Right to a Safe Delivery

[illegible]





## POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : ..... Time Received : ..... Time Discharged : .....

| <p style="text-align: center;"><b>POST ANAESTHESIA SCORE</b><br/>(Modified Aldrete Score)</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th rowspan="2"></th> <th rowspan="2">IN</th> <th colspan="3">MINUTES</th> <th rowspan="2">OUT</th> </tr> <tr> <th>30</th> <th>60</th> <th>90</th> </tr> </thead> <tbody> <tr> <td>Able to move 4 extremities voluntary or on command = 2<br/>Able to move 2 extremities voluntary or on command = 1<br/>Able to move 0 extremities voluntary or on command = 0</td> <td style="text-align: center;">ACTIVITY</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Able to deep breathe &amp; cough freely = 2<br/>Dyspnea or limited breathing = 1<br/>Apneic = 0</td> <td style="text-align: center;">RESPIRATION</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>BP <math>\pm</math> 20 of Pre Anaesthetic level = 2<br/>BP <math>\pm</math> 20-50 of Pre Anaesthetic level = 1<br/>BP <math>\pm</math> 50 of Pre Anaesthetic level = 0</td> <td style="text-align: center;">CIRCULATION</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Fully awake = 2<br/>Arousable on calling = 1<br/>Not responding = 0</td> <td style="text-align: center;">CONSCIOUSNESS</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Pink = 2<br/>Pale, dusky, blotchy, jaundiced, other = 1<br/>Cyanotic = 0</td> <td style="text-align: center;">COLOR</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td style="text-align: right;">TOTAL</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table> |               | IN | MINUTES |         |  | OUT | 30  | 60 | 90 | Able to move 4 extremities voluntary or on command = 2<br>Able to move 2 extremities voluntary or on command = 1<br>Able to move 0 extremities voluntary or on command = 0 | ACTIVITY |  |  |  |  | Able to deep breathe & cough freely = 2<br>Dyspnea or limited breathing = 1<br>Apneic = 0 | RESPIRATION |  |  |  |  | BP $\pm$ 20 of Pre Anaesthetic level = 2<br>BP $\pm$ 20-50 of Pre Anaesthetic level = 1<br>BP $\pm$ 50 of Pre Anaesthetic level = 0 | CIRCULATION |  |  |  |  | Fully awake = 2<br>Arousable on calling = 1<br>Not responding = 0 | CONSCIOUSNESS |  |  |  |  | Pink = 2<br>Pale, dusky, blotchy, jaundiced, other = 1<br>Cyanotic = 0 | COLOR |  |  |  |  | TOTAL |  |  |  |  |  | <p>IV Cannula Site : .....</p> <p> <input type="checkbox"/> O<sub>2</sub> Mask      <input type="checkbox"/> Nasal Prongs<br/> <input type="checkbox"/> Tracheostomy      <input type="checkbox"/> T-Piece<br/> <input type="checkbox"/> Oral Airway      <input type="checkbox"/> Nasal Airway         </p> <p>Vomiting : <input type="checkbox"/> Yes <input type="checkbox"/> No      Drug: .....</p> <p>NG Tube : <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Drain: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Urinary Catheter: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Chest Tube: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Nil Oral <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>IV Fluids: .....</p> <p>Oral Feeds: .....</p> |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|----|---------|---------|--|-----|-----|----|----|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|--|--|--|--|-------------------------------------------------------------------------------------------|-------------|--|--|--|--|-------------------------------------------------------------------------------------------------------------------------------------|-------------|--|--|--|--|-------------------------------------------------------------------|---------------|--|--|--|--|------------------------------------------------------------------------|-------|--|--|--|--|-------|--|--|--|--|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |               |    | IN      | MINUTES |  |     | OUT |    |    |                                                                                                                                                                            |          |  |  |  |  |                                                                                           |             |  |  |  |  |                                                                                                                                     |             |  |  |  |  |                                                                   |               |  |  |  |  |                                                                        |       |  |  |  |  |       |  |  |  |  |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 30            | 60 |         | 90      |  |     |     |    |    |                                                                                                                                                                            |          |  |  |  |  |                                                                                           |             |  |  |  |  |                                                                                                                                     |             |  |  |  |  |                                                                   |               |  |  |  |  |                                                                        |       |  |  |  |  |       |  |  |  |  |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
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| TOTAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |               |    |         |         |  |     |     |    |    |                                                                                                                                                                            |          |  |  |  |  |                                                                                           |             |  |  |  |  |                                                                                                                                     |             |  |  |  |  |                                                                   |               |  |  |  |  |                                                                        |       |  |  |  |  |       |  |  |  |  |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |

## PAIN ASSESSMENT AND MANAGEMENT FORM

| Date | Time | Pain Score | Intervention | Signature |
|------|------|------------|--------------|-----------|
|      |      |            |              |           |
|      |      |            |              |           |
|      |      |            |              |           |
|      |      |            |              |           |

Pain Tool Used: ☐ N PASS ☐ FLACC ☐ Wong Baker ☐ NPS

Anaesthesiologist Name : .....

Anaesthesiologist Signature: .....

Date & Time: .....

PACU Nurse Name : .....

PACU Nurse Signature: .....

Date & Time: .....

### Reassessment Frequency:

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

Transferred to Unit by (PACU): .....

Date & Time: .....



Patient Sticker

Department of Anaesthesiology

## EPIDURAL ANALGESIA RECORD

Date: ..... Time: ..... Procedure done by .....

CSE /Spinal /Epidural Position : ..... Space : ..... Technique (LOR/LOS) .....

Depth: ..... Catheter at Skin: ..... Attempts : .....

Parasthesia : Yes/No if yes details : .....

Solution Composition : .....

Any other issues :

a) .....

b) .....

| Time | Infusion Rate<br>(ml/hr) | Bolus (ml) | Level<br>Left Right |  | Maternal |       | FHR | Comments |
|------|--------------------------|------------|---------------------|--|----------|-------|-----|----------|
|      |                          |            |                     |  | BP       | Pulse |     |          |
|      |                          |            |                     |  |          |       |     |          |
|      |                          |            |                     |  |          |       |     |          |
|      |                          |            |                     |  |          |       |     |          |
|      |                          |            |                     |  |          |       |     |          |
|      |                          |            |                     |  |          |       |     |          |
|      |                          |            |                     |  |          |       |     |          |
|      |                          |            |                     |  |          |       |     |          |
|      |                          |            |                     |  |          |       |     |          |
|      |                          |            |                     |  |          |       |     |          |
|      |                          |            |                     |  |          |       |     |          |
|      |                          |            |                     |  |          |       |     |          |

Delivery Details : Time : ..... APGAR: ..... SVD / Instrumental / LSCS (if LSCS Details)

Catheter Removed by and Tip Inspected : .....

Patient Satisfaction : .....

Discharge /Shifting ordered by

Doctor Signature: .....

Doctor Name: .....

Date and Time : .....





*mahila*

## Moderate Sedation Flow-Sheet

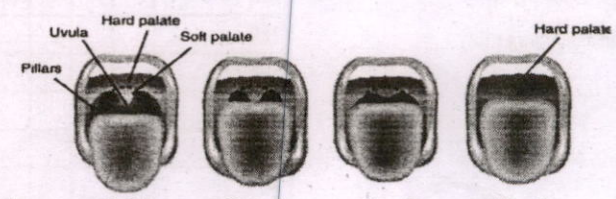
### Immediate Pre-Sedation Assessment

| B.P    | PR | R.R | Temp | SPO <sub>2</sub> | Pain Score | Weight |
|--------|----|-----|------|------------------|------------|--------|
| 105/72 | 69 | 20  |      | 99%              |            | 32kg   |

**Diagnosis:** *Arch Encephalo. pathology & Evaluation*

**Procedure:** *MRI BRAIN*

**Comorbidities:**

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> Risk, benefits & alternatives discussed;<br><input type="checkbox"/> Patient understand & elects to proceed<br><input checked="" type="checkbox"/> Consents for procedure and sedation signed and dated<br><br><b>ASA Physical Status</b><br><input type="checkbox"/> ASA PS 1: Healthy Patient<br><input type="checkbox"/> ASA PS 2: Mild Systemic Disease, no functional limitations<br><input type="checkbox"/> ASA PS 3: Severe Systemic Disease, functional limitations<br><input type="checkbox"/> ASA PS 4: Severe Systemic Disease, constant threat to life<br><input type="checkbox"/> ASA PS 5: Moribund Patient unlikely to survive 24 hrs.<br><input type="checkbox"/> ASA PS 6: A declared braindead patient whose organs are being removed for donor purposes<br><br><input type="checkbox"/> E: Emergency procedure<br>GCS: E M V<br><br><input checked="" type="checkbox"/> IV Site: <i>Left Fore</i> Gauge:<br>Sedation Plan: <i>MAC</i><br>Allergies: | <b>AIRWAY EVALUATION</b><br><b>Mouth:</b><br><input type="checkbox"/> Normal<br><input type="checkbox"/> Loose Teeth<br><input type="checkbox"/> Small Mouth<br><input type="checkbox"/> Protruding Incisors<br><input type="checkbox"/> Receding Lower Jaw<br><input type="checkbox"/> Dentures<br><br><b>Neck:</b><br><input type="checkbox"/> Normal<br><input type="checkbox"/> Decreased ROM<br><input type="checkbox"/> Thyromental Distance Less Than 6 cm<br><input type="checkbox"/> Short Neck<br><br><br>Mallampati Class: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

### Monitoring of Patient Intra – Procedure

#### Procedure Monitoring

Heart Rate (HR), Respiratory Rate (RR), Oxygen Saturation (O<sub>2</sub> Sat) continuously monitored, and Level of Consciousness (LoC) to be monitored and recorded minimally every 15 minutes until 15 minutes after the last administration of any sedation, then every 30 minutes, then every 1 hour until stable. Respiratory status to be monitored continuously.

#### Level of Consciousness (LOC):

- ☒ A - Alert  
☐ V - Verbally Responsive  
☐ P - Painfully Responsive  
☐ U - Unresponsive



| TIME     | BP     | PR | RR | O <sub>2</sub> Sat% | O <sub>2</sub> Supplementation | Comments / Initials |
|----------|--------|----|----|---------------------|--------------------------------|---------------------|
| Baseline |        |    |    |                     |                                |                     |
| 3:30pm   | 110/78 | 90 | 80 | 98%                 |                                |                     |
|          |        |    |    |                     |                                |                     |
|          |        |    |    |                     |                                |                     |

| DRUG & IV Fluid:<br>(including Nitrous Oxide) | ROUTE | DOSE  | TIME GIVEN | SUBSEQUENT DOSES AND TIME |
|-----------------------------------------------|-------|-------|------------|---------------------------|
| INT. MIDAZOLAM                                | IV    | 1 mg  | 8:30 AM    |                           |
| INT. PROPOFOL                                 | IV    | 40 mg | 3:30 PM    | Long + Long + Long        |
| INT. KETAMINE                                 | IV    | 50 mg | 3:40 PM    |                           |
|                                               |       |       |            |                           |

Doctor Notes: .....

Time of transportation to post sedation care room: Baby Alert and stable LOC: Alert

Doctor Name: DR. K. PRI RAMYA. Signature: 

### Post Sedation Care Room

[illegible]

TOTAL ALDRETTE SCORE AT DISCHARGE =

*(If 9 and more patient can discharge from post Sedation care unit*

| Activity :           | Consciousness:       | Respiration:                   | Oxygen Saturation:                                   | Circulation:                     |
|----------------------|----------------------|--------------------------------|------------------------------------------------------|----------------------------------|
| Four extremities = 2 | Fully awake = 2      | Breathe Deep= 2                | Sat O <sub>2</sub> >92 % on room air = 2             | BP +/- 20 mm hg of pre-op = 2    |
| Two extremities = 1  | Arousal on calling=1 | Dyspnea, limited breathing = 1 | Needs oxygen to maintain Sat O <sub>2</sub> >90% = 1 | BP +/- 20-50 mm hg of pre-op = 1 |
| No extremities = 0   | Unresponsive=0       | Apnea = 0                      | Saturation <90% with oxygen = 0                      | Bp +/-50 mm hg of Pre-Op = 0     |

Patient Discharge Time: .....

Nurse Name: .....

Signature: .....

Date: ..... Time: .....

Signature: .....

Consultant Name: .....

### Stamp



# PATIENT TRANSFER FORM

BAH-00661071 IP5-00176134  
Master YUVANVEER MOTALLA  
27-03-2019 7 Y 3 M 12 D (M)  
Dr. DINESH KUMAR CHIRLA  


|                                                     |                                                                                                                                                                                         |                                                                                                                      |
|-----------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------|
| Date & Time of Admission<br><i>9/7/26 @ 8:17 AM</i> |                                                                                                                                                                                         | Date & Time of Transfer Order<br><i>9/7/26</i>                                                                       |
| Treating Consultant Name<br><i>Dr. Dinesh</i>       | Transfer Ordered by<br><i>Dr. Monesh</i>                                                                                                                                                | Reason for Transfer<br><i>stable</i>                                                                                 |
| From Unit<br><i>PICU</i>                            | To Unit<br><i>ICU</i>                                                                                                                                                                   | Information to Attendant<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                      |
| Number of Sheets in Clinical File<br><i>30</i>      | Personal belongings including clinical documents. If any handed over to attendant<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/><br>If Yes, what? <i>Amulya</i> | Patient shifted with ID band:<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/><br>If No: ..... |
| Number of Imaging Films                             |                                                                                                                                                                                         |                                                                                                                      |

## Medications / Consumables / Surgical / Hand over

| Sl.No. | Item Name | Quantity |
|--------|-----------|----------|
| 1.     | USG — (1) |          |
| 2.     | EEG — (1) |          |
| 3.     | MR — (1)  |          |
| 4.     |           |          |
| 5.     |           |          |

Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐

|                                                                |                                                      |
|----------------------------------------------------------------|------------------------------------------------------|
| Name & Signature of Person who is Transferring<br><i>Ashma</i> | Name of Person Ordered Transfer<br><i>Dr. Monesh</i> |
| Patient & Clinical Records Received by :<br><i>Aruna</i>       |                                                      |
| Date & Time of Patient Received :<br><i>9/7/26 9 AM</i>        |                                                      |

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





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## NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 10/2/26 Time: 2am

Weight: 32.5 kgs Centile: >90th

Height: 131 cms Centile: >90th

Inference: obese child

RDA: — Calories: 1500 kcal/d Protein: 26 g/d

Diet Recommendations: Normal diet

Re-Assessment: Avoid spicy, chilled & outside foods

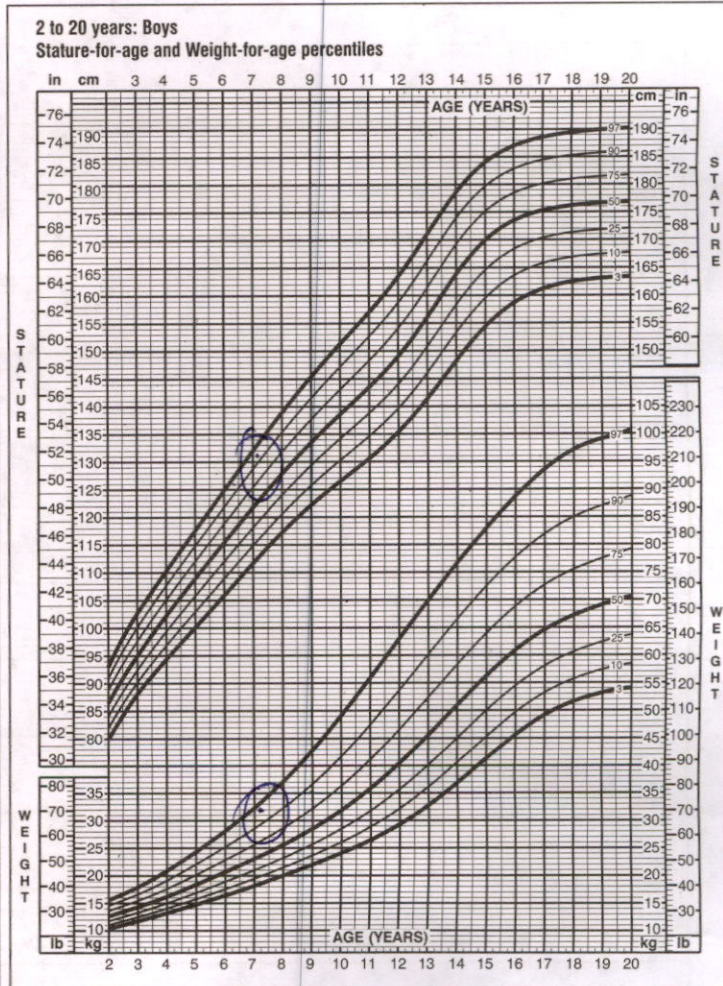
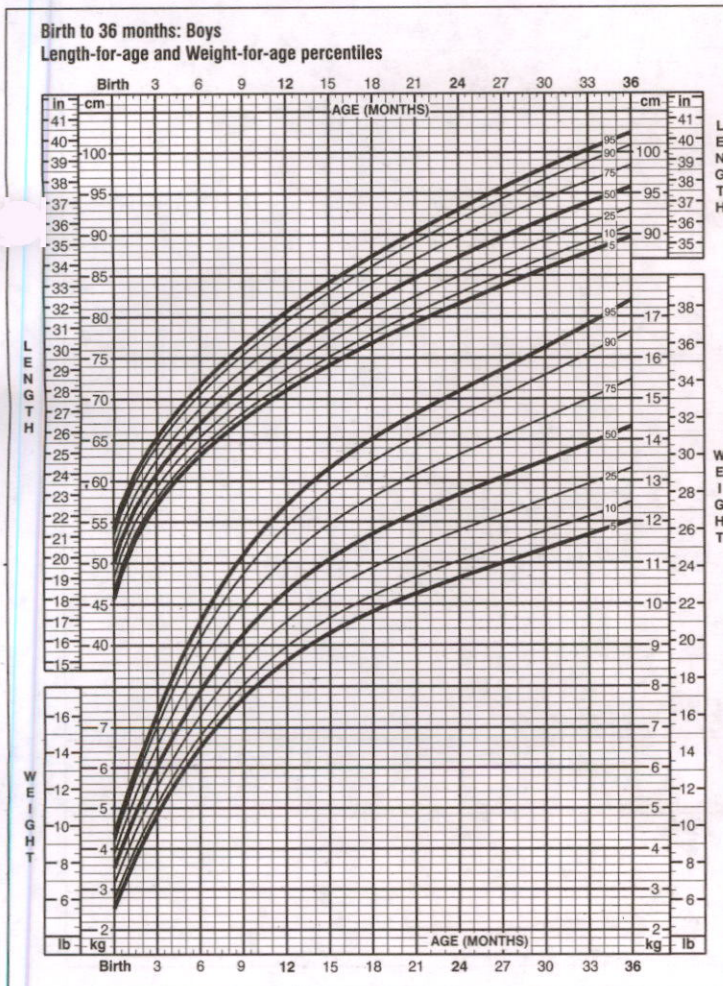
Food Allergies: NO Veg/Non-veg: Non-veg

Diagnosis: Acute encephalopathy & evaluation

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: *[Signature]*

### GROWTH CHART (BOYS)



Dietician's Name: Nikitha

Dietician's Signature: Nikitha



### Daily Notes: