

ACTIVITY RECORD FOR BILLING

Name : BAH-00654245 IP5-00176629
Master OMAR AHMED YASIN
01-08-2024 1 Y 11 M 19 D (M)
 UHID No. : Dr. NALLA ANURAAG REDDY
 Date of Adm : _____ Time : _____ Date of Discharge : _____ Time : _____
 Room / Bed No : _____ Ward : _____ Suggested Billable bed type : _____

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
20/7/20	9:30 am	ER	ONC0125	[Signature]

Cross Consultation Visit

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

[illegible]

2017

2117

Creative, LFT

CVE

CBP, MTX Level.

72636

730747

260 73777

Temp

Blum

2

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
28/7	Infusion pump	6:30 hr	9:30 hr 10 pm	9713138	[Signature]
28/7	Infusion pump	6:50 hr	9:30 hr 9 pm	9713143	[Signature]

Signature



9713138

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
20/07	iv placement	1	12082	<i>[Signature]</i>
20/7	Lumbar puncture			
	conscious sedation	①	9713144	<i>[Signature]</i>
	& chemotherapy			

Sheldor
21/07/24

ANY OTHER INFORMATION

Don't charge for NHA - Nickithy

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.....

Date : 23/7/24

Time : 11AM

Prepared By : *[Signature]*

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
<i>[Signature]</i>	OM		

BAH-00654245 IP5-00176629
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01-08-2024 1 Y 11 M 19 D (M)
Dr. NALLA ANURAAG REDDY


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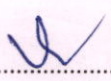
ADMISSION CRITERIA – ONCOLOGY

Admission / Transfer from:

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

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

- ☐ For Chemotherapy-Day Care or IP Admission as per the Type of Chemotherapy
- ☐ Febrile Neutropenias (ANC <500 cells / mm³)
- ☐ Neutropenic Enterocolitis
- ☐ Mucositis Induced Significant Diarrhea or Pain
- ☐ Neurological Complications (like Seizures, Bleeding, Thrombosis) that can arise while on Chemotherapy Treatment or at the Time of Presentation and also for other Systemic Problems like Pancreatitis during Chemotherapy
- ☐ Management of Oncological Emergencies
- ☐ Bleeding Problems (where it is indicated)
- ☐ Evaluation and Management of Severe Anemias
- ☐ Day Care Admissions for PRBC Transfusions
- ☐ Evaluation and Management of Sick Children who come with Hematological Problems like Severe Anemia like Autoimmune Hemolytic Anemia/ Bleeding/ Others
- ☐ Primary Immunodeficiency Disorders with Infections that Warrants Hospitalisation
- ☐ Management and Evaluation of Hemophagocytic Lymphohistiocytosis
- ☐ Any Systemic Disorders with Significant Hematological issues like JRA / SLE with Secondary HLH

Signature of the Doctor: 

Name of the Doctor: Nalla Anuraag Reddy

Date & Time: 20/7/26 @ 9:40 AM

BAH-00654245 IP5-00176629
Master OMAR AHMED YASIN
01-08-2024 1 Y 11 M 19 D (M)
Dr. NALLA ANURAAG REDDY



DISCHARGE CRITERIA – ONCOLOGY

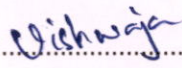
Discharge to:

☐ HDU / Step down ICU ☒ Ward ☐ Outside Facility ☐ Others:

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

- ☐ Completion of chemotherapy, with no debilitating side effects.
- ☐ Resolution of febrile episode, with no fever > 24hrs and Absolute Neutrophil count (ANC) > 500cells/mm³.
- ☐ Admitted patients - Once the admitting problem gets resolved or made a plan to manage further on out-patient basis.

Signature of the Doctor: 

Name of the Doctor : 

Date & Time: 23/7/26 at 10.15 AM

ADMISSION SHEET
Registration Details :


Admission No : IP5-00176629 Admit Date : 20-Jul-2026 Admit Time : 08:29 AM UHID : BAH-00654245

Patient Details :

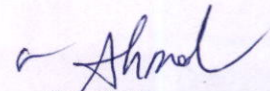
Patient Name	: Master OMAR AHMED YASIN	Age	: 1 Y 11 M 19 D
Guardian	: Mr SALAD AHMED YASIN	DOB	: 01-08-2024 10:03 PM
Gender	: Male	Religion	:
Occupation	:	Marital Status	: Single
Address (H)	: PARAMOUNT COLONY Tolichowki Hyderabad Telangana INDIA 500008	Phone No	: 9392377972
		E-mail	: NA@GMAIL.COM

Admission Details :

Bed Type : FOUR SHARING Bed No : FSW 125 Ward Name : 1F-HEMATO-ONCOLOGY
 Room No : FSW 125 Admission Type : First Visit

Contact Details :

Name : Mr SALAD AHMED YASIN Relationship : Father
 Contact Address : PARAMOUNT COLONY Tolichowki Hyderabad Phone No : 9392377972
 Telangana INDIA 500008


 Signature

Doctor Details :

Doctor Name : Dr. NALLA ANURAAG REDDY Specialisation : HEMATO ONCOLOGY
 Referral Doctor : Self Phone No :
 Co-Consultant :

Payment Details :

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



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PEDIATRIC IN-PATIENT MEDICAL RECORD

①

Patient Name:

OMAR AHMED YASIN

UHID ID:

BAH-00654245

IP5-00176629

Master OMAR AHMED YASIN

01-08-2024

1 Y 11 M 19 D

(M)

Dr. NALLA ANURAAG REDDY



Department:

Consultant:



Pediatric Multiorgan History & Physical Examination

Name : OMAR AHMED YASIN Age/Sex 1y1
Information given by: AHMED Relationship Father

Chief Presenting Complaints & Duration (Chronologically)

Kid - BALL / CALLA NEG / mll +ve / ent -ve /
GPR ON BFM protocol
Came for 1p chemotherapy

History of present illness :

cto cough since 3 days
no H/O fever
cold

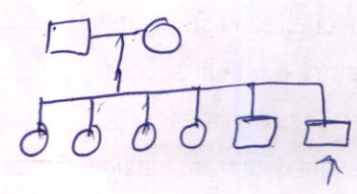
Pediatric Multiorgan History & Physical Examination

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

not significant

Birth & Neonatal History:

S/I/T/NVD/ Birth wt-
NO NICU Admission



Birth & Socio Economic History:

About Father : _____

About Mother : _____

Any additional Information : _____

Developmental History :

appropriate for age

Immunization History :

completed as per schedule



Pediatric Multiorgan History & Physical Examination

Anthropometry :

Head Circum (cms) _____ (Centile _____) Height (cms): 85cm (Centile) _____

Weight (kgs)) 11.80kg (Centile _____)

On Examination :

Temperature : 98.6°F Pulse Rate : 106bpm B.P. 94/52 ⁽⁶⁷⁾ SP02 97%

Resp.rate and type of breathing : _____

Rash NO

Lymphadenopathy NO

Oedema : NO

Allergies (if any): NO

Respiratory System :

Inspection (any s/o distress) : _____

Air entry & breath sounds : _____

Any addes sounds : _____

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

Cardiovascular System :

Inspection of procordium : _____

Heart Sounds : S1, S2 + rnt

Any murmur : _____

Relevant data from outside (Chest X-Ray, ECG, ECHO, etc.,) : _____

Per Abdomen :

Inspection _____

Palpation : soft non tender

Ausculation : _____

Spine : _____ External Genitalia : _____

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

Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : conscious 15/15

Cranial Nerves : 2

Motor System:

Nutriton : 2

Tone: 2

Power 2

Co-ordinator : 2

Posture : 2

Involuntary Movements : 2

Reflexes :

DTR

Superficials:

Plantars 2

Sensory System :

Bladder / Bowel : 2

Clinical Summary & Diagnostic:

Kido - BAK / CAU -ve / mlt+ve / CNS -ve /

GPR on BFM protocol

Came for chemotherapy



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: pre Infection control

Desired goals of the treatment : haemodynamic stability

Planned Labs:

creatinine
LFT

N/A
Temp

Planned Management

LP & chemotherapy

w/ondarsehan

Syp septran

Syp calcimax

Syp zincovit

MIB

sepan

20/7/26

at 9:15 AM

Signature of the Doctor: Dr. Ram

Signature of the Consultant:

Name of the Doctor: Dr. SAMRITA RANBYA

Name of the Consultant: Dr Nalla Anurag

Date & Time: 20/7/26 9:10am

Date & Time:

Dr. SANDHYA VADDADI
Reg. No: 71664



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Date & Time	Progress Notes	Doctor's Order
	Morning Round Procedure Note	
01/07/26 12:30 PM	↓ Strict Aseptic precautions ↓ Short Sedation Lumbar procedure done Intra thecal chemo given. Procedure as successful	
		<i>[Signature]</i> T Parani
		NIB Eluvam 1/2 20/7/26
2		

②



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/8/24	<u>procedure notes</u> Under aseptic condition under radiation lumbar puncture done, IT chemotherapy given. procedure successful.	
		<u>Verhugers</u>
20/8/24	<u>Febrile rounds</u> Blood AUC / CALA -ve / CRP -ve / MUERS GFR on RFM protocol Child alert Euthermic Vitals stable CVC } PI } (W) PIA }	
		<u>Plan</u> 1) Continue chemotherapy 2) Continue supportive care 3) Monitor vitals informatics
	N.B GONG DISTU @ Jm	<u>Verhugers</u> Dr. SANDHYA KADDADI Reg. No. 71664 Promethazine (P.T.O)



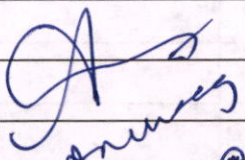
Date & Time	Progress Notes	Doctor's Order
21/07/28	Morning Rounds	
9 AM	B cell ALL / CACIA ve / CNS-ve / MLC +ve Am on BFM Protocol / CPR	Plan → continue chemo → Continue Supportive care - monitor vitals - CRF today
	child Alert & Active Euthermic Vitals stable CVS RS PIF	
		<i>[Signature]</i> D. SANDHYA VADDADI Reg. No: 71664 Noted by Am m 21/7/28 @ 11 AM

3

N. B. Bhusal
21/7/26 @ 8y

24

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/7/26 9:00AM	B one ALL / CALLA  negative / CNS - / MLL  GPR on BMT protocol - M 1 st dose	
	<u>O/C</u> Child active Vitals stable	<u>plan</u> 1) Inf. folinec added from 10AM today. 2) plan CBP; Mtx levels donations - 3) Monitor vitals.
	 Anuraag @ 9:45 AM. Dr. Anuraag Reddy 22/7/26 @ 9:20 AM	Noted by Ann M 22/7/26 @ 11 AM
	Dr. Nalla Anuraag Reddy MBBS, MD, FIAP (PHO), Fellowship in Paediatric BMT Reg. No: TSMC/FMR/44399	

5



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[illegible]

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1

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RESULT SHEET

Date	13/8	20/7/16	23/7/26			
Time			8 AM			
Hb	12.2		11.9			
PCV			36.5			
RBC			3.86			
WBC	6500		2.33			
N/L	44/47		17.6/72.5			
Platelets	3.77 lakh		548			
CRP						
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine		0.2				
ALP		248				
SGPT		47				
SGOT		20				
T.Bill/Conj		0.1				
T.Protein		6.4				
S.Albumin		4.1				
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

Date	21/7/26					
Time						
CUE - Alb						
CUE - Sugar	NIL					
CUE - Ketones	negative					
CUE - PUS Cells	2-3					
CUE - RBC Cells	0					
CUE						
PH	8.0					
Epithelial	1-2.					
Stool Pus Cell						
OVA / Cyst						
Occult Blood						

Culture and Sensitivities :

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.....

.....

Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI

 Others (ECG, Contrast Studies etc.,) :



DRUG CHART

Date of Admission: 20/7/26 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 :				Date Time
Dose	Route	Frequency	Start Date	
Doctor's Signature				Valid Period
Pharm.				
Additional Instructions:				

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

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

VERIFIED BY : Name Signature



REGULAR PRESCRIPTIONS

Weight. 116.80 kg Ward.

VERIFIED

VERIFIED

VERIFIED

VERIFIED

DRUG : <u>INJ ONDANSETRON</u>				Date Time	<u>20/7</u>	<u>21/7</u>	<u>22/7</u>	<u>23/7</u>
Dose <u>2mg</u>	Route <u>IV</u>	Frequency <u>8hrly</u>	Start Date <u>20/7/26</u>					
Name & Signature of the Doctor Starting the Drugs: <u>Ramya</u>								
Additional Instructions:								
Daily Doctor's Endorsement by a Sign								
DRUG : <u>SYP DOMPERIDONE</u>				Date Time	<u>20/7</u>	<u>21/7</u>	<u>22/7</u>	<u>23/7</u>
Dose <u>2ml</u>	Route <u>oral</u>	Frequency <u>twice daily</u>	Start Date <u>20/7/26</u>					
Name & Signature of the Doctor Starting the Drugs: <u>Ramya</u>								
Additional Instructions:								
Daily Doctor's Endorsement by a Sign								
DRUG : <u>INJ DEAMETAXONE</u>				Date Time	<u>20/7</u>	<u>21/7</u>	<u>22/7</u>	<u>23/7</u>
Dose <u>1mg</u>	Route <u>IV</u>	Frequency <u>OD</u>	Start Date <u>20/7</u>					
Name & Signature of the Doctor Starting the Drugs: <u>harani</u>								
Additional Instructions:								
Daily Doctor's Endorsement by a Sign								
DRUG : <u>INJ FOLINIC ACID</u>				Date Time	<u>22/7</u>	<u>23/7</u>		
Dose <u>10mg</u>	Route <u>IV</u>	Frequency <u>TID</u>	Start Date <u>22/7</u>					
Name & Signature of the Doctor Starting the Drugs: <u>Ashwathory</u>								
Additional Instructions:								
Daily Doctor's Endorsement by a Sign								



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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
20/07/24	12:30pm	Inj Ketamine	5mg	IV	[Signature]	[Signature]
20/07/24	12:36pm	Inj MIDAZOLAM	0.5mg	IV	[Signature]	[Signature]

Weight. 81.80 kg Ward.

[illegible]

BAH-00654245
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01-08-2024 1 Y 11 M 19 D (M)
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SIN

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MEDICATION RECONCILIATION FORM

Drug Allergies:

☒ Not known any Drug Allergies

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

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

Shifting From: ER

Shifted to: ONC

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	SYRUP. CALUMAX	3ml	oral	OD	11/8/26	☒ C ☐ DC
2	SYRUP. SEPTRAN	2.5ml	oral (MON. WED) FRI	BD	16/7/26	☐ C ☒ DC
3	SYRUP. ZINCOVIT	2.5ml	oral	OD	19/8/26	☒ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

* C - Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: *P. Srinivas*

Date & Time: 20/8/26 9:10 am

Nurse Name & Signature: *S. Ganesh*

Date & Time: 20/8/26 @ 9:15 am

BAH-00654245

IP5-00176629

Master OMAR AHMED YASIN

01-08-2024

1 Y 11 M 19 D

(M)

Dr. NALLA ANURAAG REDDY



CHEMOTHERAPY PRESCRIPTION

All the chemotherapy medications are high risk / high alert drugs.
While administering chemotherapy drugs watch for nausea, vomiting, rashes,
urine output and any local extravasation of the drug.

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Sheet No. ①	Weight (kg) : 11.84	Body Surface Area:	Diagnosis: ProB-ALL	Protocol: m1st dose.						
DATE	TIME	Composition of Chemotherapy (if infusion, mention ml / hr = Mcg / kg / min. etc.)	DOSE	ROUTE	Flow Rate (ml/hr)	Doctor Sign.	Nurse Sign.	Date of Stopping	Doctor Sign.	Nurse Sign.
20/7	12pm	ly METHOTREXATE 8mg ly CYTARABINE 20mg ly HYDROURICONE 10mg	8mg 20mg 10mg	IT (INTRATHECAL)	STAT.	A	Shreya Pooja	20/7	A	Shreya Pooja
20/7	2:30pm	ly NaHCO ₃ in 100ml NS	10ml	IV	100ml/hr	A	Sonam Anu	20/7	A	Sonam Anu
20/7	3:50pm	ly METHOTREXATE in 100ml NS	100mg	IV	100ml/hr	A	Sonam Anu	20/7	A	Sonam Anu
20/7	5:50pm	ly METHOTREXATE in 500ml NS	900mg	IV	25ml/hr	A	Sonam Anu	21/7	A	Shreya Pooja
20/7	5:58pm	ly NaHCO ₃ in 500ml NS	15ml	IV	35ml/hr	A	Sonam Anu	21/7	A	Anu M Divya
20/7	9:00pm Together	ly NaHCO ₃ in 500ml NS	15ml	IV	35ml/hr	A	Anu M Divya	22/7	A	Anu Subh

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CHEMOTHERAPY PRESCRIPTION

All the chemotherapy medications are high risk / high alert drugs.
 While administering chemotherapy drugs watch for nausea, vomiting, rashes,
 urine output and any local extravasation of the drug.

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Sheet No. ②	Weight (kg): 11.8kg	Body Surface Area: 0.5	Diagnosis: PNB-ALL	Protocol: M ① chdore.
-------------	---------------------	------------------------	--------------------	-----------------------

DATE	TIME	Composition of Chemotherapy (if infusion, mention ml / hr = Mcg / kg / min. etc.)	DOSE	ROUTE	Flow Rate (ml/hr)	Doctor Sign.	Nurse Sign.	Date of Stopping	Doctor Sign.	Nurse Sign.
22/7	1AM	ly Nanco ₃ in 500ml 1/2 DNS	15ml	IV	50ml/hr	d	4) subh	22/7	Zi	Am m Diya
22/7	12pm	ly Nanco ₃ in 500ml 1/2 DNS	15ml	IV	50ml/hr	d	Am m Diya	22/7	Zi	Am m Sushmita

PAIN ASSESSMENT FORM

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

Re-assessment Frequency:

1. Every eight hours for all hospitalized patients.

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

a) At least every 2 hours for the first 24 hours

b) Then every 4 hours.

c) Prior to pain relieving intervention.

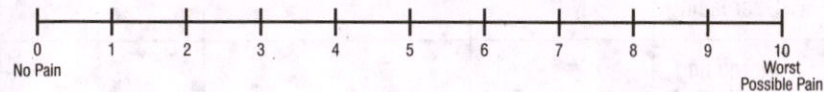
d) Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

Numerical Pain Scale (Obstetric and Gynecology)



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

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR RR, BP, SaO₂	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO ₂ 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

Wong - Baker (Pediatrics) Above 7 Years



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
20/7/26	8:35 am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA NA	Pooja
20/7	4pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Sonam
21/7	12am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Sang
21/7	8am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Sang
21/7	2pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Rey
21/07	10pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	Sumita
22/07	6Am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	Sumita
22/7	2pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	Sumita
22/7	10pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA NA	Sumita
23/7	6am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA NA	Sumita

Re-assessment Frequency:

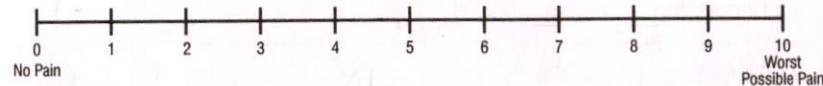
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after in relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

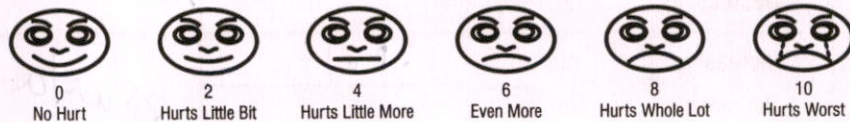
Numerical Pain Scale (Obstetric and Gynecology)



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Assessment Criteria	Sedation		Normal	Pain / Agitation	
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Wong - Baker (Pediatrics) Above 7 Years



EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 23/7/2028 Time: 9Am

Doctor / Nurse / Family Concern?

Temperature
(F)

98.1 F.

Heart Rate
(bpm)

and

Blood Pressure
(mmHg) *

Note:
BP does not score
in early
warning scoring

Heart Rate (Number)

98
(62)
102 bpm

Resp. Rate (bpm)
Over 1 Minute) *

Resp Rate (Number)

125 bpm

Resp Mod/ Severe
Distress None / Mild

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

100

Conscious Level
Normal Altered

15/15

GCS *

15/15

TOTAL SCORE

Number of shaded boxes

0

Pain Score

0

Observer's Initials

0

ACTIONS

NB: Scores 3 should be
recorded overleaf

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

- If at any time additional help is required, call help – regardless of the Early Warning Score!
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The SBAR communication tool (situation, background, assessment, recommendations) is a helpful mnemonic that can be used to describe a child's clinical condition to a colleague.

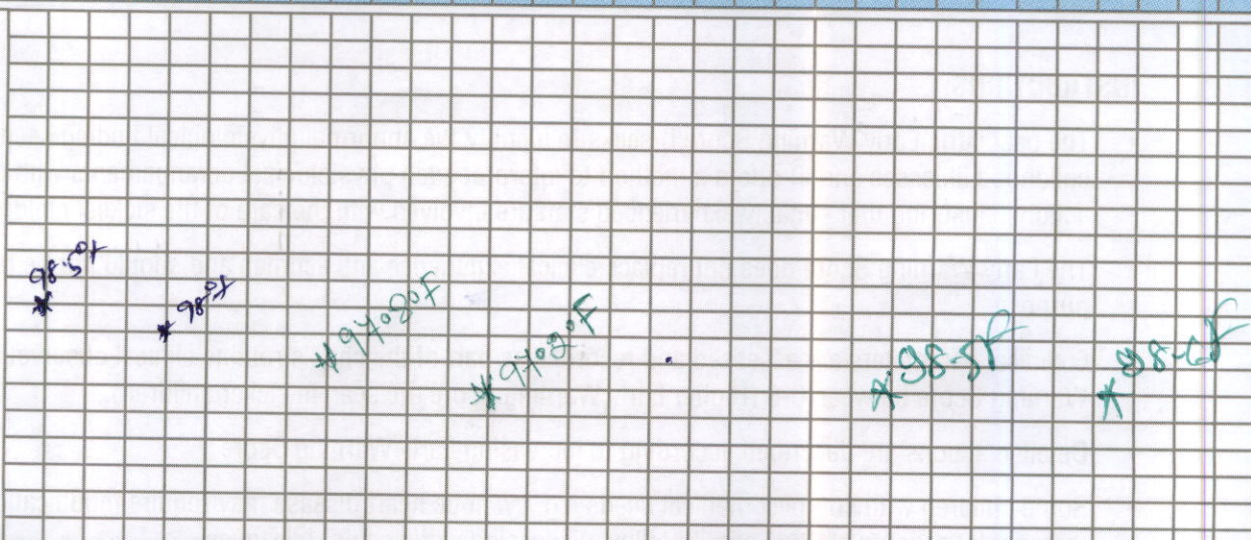
I	IDENTITY: I am (name), a nurse on ward (X). I am calling about (child X)
S	SITUATION : I am calling because I am concerned that ... (e.g. BP is low/high, pulse is XXX, Temperature is XX, Early Warning Score is XX)
B	BACK GROUND : Child (X) was admitted on (XX date) with (e.g. respiratory infection).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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 22/07 Time: 9am 10am 4pm 7pm 10pm 3am 6am
Doctor / Nurse / Family Concern?

Temperature
(F)

104
103
102
101
100
99
98
97
96
95
94



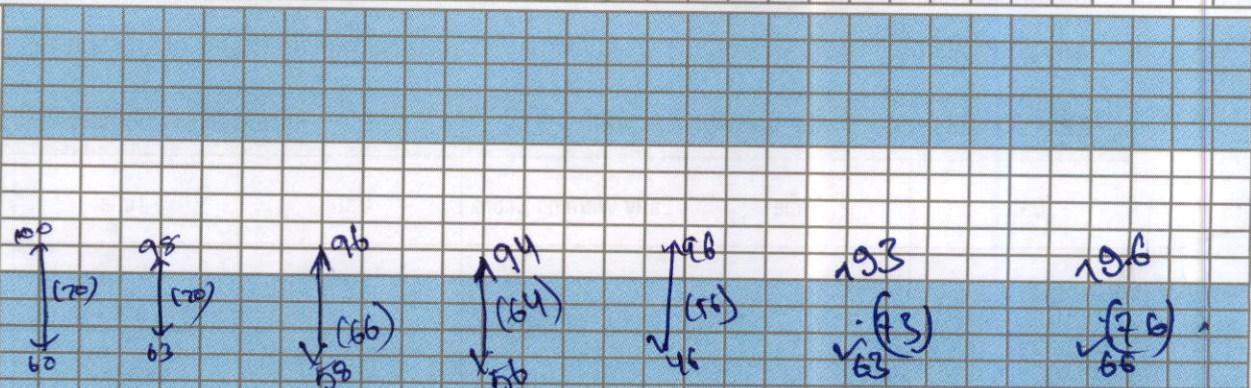
Heart Rate
(bpm)

and

Blood Pressure
(mmHg) *

Note:
BP does not score
in early
warning scoring

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

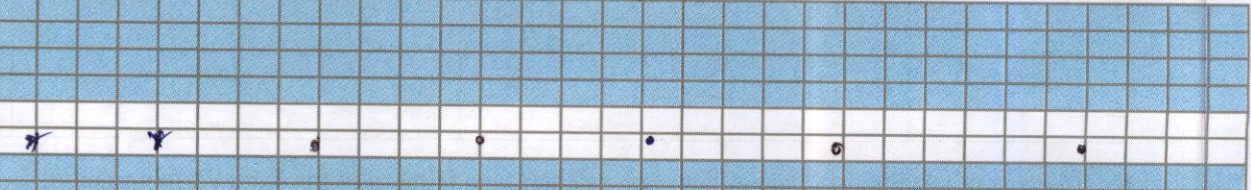


Heart Rate (Number)

185bpm 120bpm 119bpm 118bpm 102bpm 108bpm 112bpm

Resp. Rate (bpm)
(/minute) *

70
60
50
40
30
20
10



Resp Rate (Number)

26bpm 24bpm 26bpm 28bpm 24bpm 24bpm 25bpm

Resp Mod/ Severe
Distress None / Mild

* * * * - 0 0

Receiving O₂(l/min)
O₂Saturations (%)

100% 100% 100% 100% 99% 100% 100%

Conscious Normal
Level Altered

15/15 15/15 c c c c c

GCS *

15/15 15/15 15/15 15/15 15/15 15/15 15/15

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

0 0 0 0 0 0 0
0 0 0 0 0 0 0
[Initials]

ACTIONS

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



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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 21/7/26	Time: 9am	10am	11am	12pm	3pm	6pm
Doctor / Nurse / Family Concern?						
Temperature (F)	104					
	103					
	102					
	101					
	100					
	99	97.9°F	98.2°F	98.2°F	98.2°F	98.2°F
	98					
	97					
	96					
	95					
Heart Rate (bpm)	190					
	180					
	170					
	160					
	150					
	140					
	130					
	120					
	110					
	100					
Blood Pressure (mmHg) *	130					
	120					
	110					
	100					
	90					
	80					
	70					
	60					
	50					
	40					
Heart Rate (Number)	190					
	180					
	170					
	160					
	150					
	140					
	130					
	120					
	110					
	100					
Resp. Rate (bpm) (Over 1 Minute) *	70					
	60					
	50					
	40					
	30					
	20					
	10					
	0					
	0					
	0					
Resp Rate (Number)	70					
	60					
	50					
	40					
	30					
	20					
	10					
	0					
	0					
	0					
Resp Mod/ Severe Distress None / Mild	70					
	60					
	50					
	40					
	30					
	20					
	10					
	0					
	0					
	0					
Receiving O ₂ (l/min) O ₂ Saturations (%)	70					
	60					
	50					
	40					
	30					
	20					
	10					
	0					
	0					
	0					
Conscious Level Normal Altered	70					
	60					
	50					
	40					
	30					
	20					
	10					
	0					
	0					
	0					
GCS *	70					
	60					
	50					
	40					
	30					
	20					
	10					
	0					
	0					
	0					
TOTAL SCORE	70					
	60					
	50					
	40					
	30					
	20					
	10					
	0					
	0					
	0					
Number of shaded boxes	70					
	60					
	50					
	40					
	30					
	20					
	10					
	0					
	0					
	0					
Pain Score	70					
	60					
	50					
	40					
	30					
	20					
	10					
	0					
	0					
	0					
Observer's Initials	70					
	60					
	50					
	40					
	30					
	20					
	10					
	0					
	0					
	0					

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BAH-00654245 IP5-00176629
 Master OMAR AHMED YASIN
 01-08-2024 1 Y 11 M 20 D (M)
 Dr. NALLA ANURAAG REDDY

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

FLUID CHART

Sheet No. : 4

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
23/07	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						Total Output :						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						Total Output :						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						Total Output :						
Total 24 hrs. Intake						Total 24 hrs. Output						



FLUID CHART

Sheet No. : 3

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
22/07	08:00 am			50ml							I	J
	09:00 am	H ₂ O	100ml	50ml					150ml			
	10:00 am			50ml								
	11:00 am			50ml								
	12:00 pm			50ml					200ml			
	01:00 pm			50ml								
Total Intake :			400ml			Total Output :					350ml	
	02:00 pm	rice	1cup	50ml							I	K
	03:00 pm	H ₂ O	150ml	50ml					150ml			
	04:00 pm			50ml								
	05:00 pm			50ml								
	06:00 pm	yogurt		50ml								
	07:00 pm	H ₂ O	100ml	50ml					150ml			
Total Intake :			550ml			Total Output :					300ml	
	08:00 pm			50ml					150ml	6	I	L
	09:00 pm	H ₂ O	100ml	50ml						6		
	10:00 pm	orange		50ml						0		
	11:00 pm			50ml						0		
	12:00 am	H ₂ O	100ml	50ml					150ml	0		
	01:00 am			50ml						0		
Total Intake :			500ml			Total Output :					350ml	
	02:00 am									0	I	M
	03:00 am									0		
	04:00 am								100ml	0		
	05:00 am									0		
	06:00 am	H ₂ O	100ml							0		
	07:00 am								100ml	0		
Total Intake :			100ml			Total Output :					200ml	
Total 24 hrs. Intake		1550ml ÷ 151.3cc/kg										
Total 24 hrs. Output		1150cc ÷ 110cc/kg										



FLUID CHART

Sheet No. : 2

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

		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							
2/12	08:00 am			25+35ml							I	J
	09:00 am			25+35ml						210ml		
	10:00 am			25+35ml								
	11:00 am			25+35ml								
	12:00 pm			25+35ml						150ml		
	01:00 pm	alido		25+35ml								
Total Intake :		370 ml				Total Output : 360ml						
2/17	02:00 pm			25+35							I	J
	03:00 pm	suko		25+35						260ml		
	04:00 pm	100ml		25+35								
	05:00 pm			35ml								
	06:00 pm			35ml						200ml		
	07:00 pm			35ml								
Total Intake :		385ml				Total Output : 460ml						
	08:00 pm	rice		50ml							I	J
	09:00 pm	H2O	100ml	50ml						120ml		
	10:00 pm			50ml								
	11:00 pm	H2O	60ml	50ml								
	12:00 am			50ml								
	01:00 am			50ml						130ml		
Total Intake :		460ml				Total Output : 250						
	02:00 am			50ml							I	J
	03:00 am	100!		50ml						120ml		
	04:00 am			50ml								
	05:00 am			50ml								
	06:00 am	100!		50ml								
	07:00 am			50ml						150ml		
Total Intake :		300ml				Total Output : 270 ml						

Total 24 hrs. Intake	1515; 128cl/kg/day.	Total 24 hrs. Output	1280; 4.5cl/kg
----------------------	---------------------	----------------------	----------------

FLUID CHART

Sheet No. : 1

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

Intake						Output					IV Site Thrombo- phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
	08:00 am			-							0	
	09:00 am			-							0	
	10:00 am			-							0	
	11:00 am			-						150ml	0	
	12:00 pm			-							0	
	01:00 pm			-							0	
Total Intake :						Total Output :						
	02:00 pm										0	
	03:00 pm	Feu		50ml						150ml	0	
	04:00 pm			50ml							0	
	05:00 pm	H2O	100ml	50ml							0	
	06:00 pm			25+35ml							0	
	07:00 pm			25+35ml						150ml	0	
Total Intake :						Total Output :						
	08:00 pm			25+35ml						200ml	0	
	09:00 pm			25+35ml							0	
	10:00 pm	2ice	100ml	25+35ml							0	
	11:00 pm	H2O	100ml	25+35ml							0	
	12:00 am			25+35ml							0	
	01:00 am			25+35ml						100ml	0	
Total Intake :						Total Output :						
	02:00 am			25+35ml							0	
	03:00 am			25+35ml						150ml	0	
	04:00 am			25+35ml							0	
	05:00 am			25+35ml							0	
	06:00 am			25+35ml						150ml	0	
	07:00 am			25+35ml							0	
Total Intake :						Total Output :						

Total 24 hrs. Intake

1280:108cc/Kh

Total 24 hrs. Output

1080:3.8cc/Kh HR



Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 9:40 AM Mode of Arrival: By father Admitting From: ☒ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction: NA Body Weight: Kg

Height: cm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
<u>NA</u>	<u>NA</u>	<u>NA</u>

Family History: Healthy family

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

If yes please list,

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

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

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

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

Temp.: 99.2 F HR: 102 bpm RR: 28 bpm BP: 94/52/62

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

Fall Risk Assessment: ☐ Yes ☐ No Score: 28 (Document in the Humpty Dumpty Sheet)

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

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

Character of Pain: Location: Frequency: Duration:

FUNCTIONAL SCREENING:

- ☐ Mobility Problem
☐ Developmental Delay

- ☒ No Abnormalities Detected
☐ Walking Problem
☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING:

- ☐ Underweight
☐ Feeding Problem

- ☒ No Abnormalities Detected
☐ Overweight
☐ Special diet

- ☐ Special Feeding Method
☐ 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): 20/7/26 @ 9:45 AM

Cultural & Spiritual Needs: ☐ Yes ☐ No if Yes specify Inform consultant for positive criteria.

Social History: Lives With

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

All Information Obtained From ☐ Patient ☒ Mother ☐ Father ☐ Other Family Member

Orientation has been given regarding the following aspects:

Call Bell in Reach: ☒ Yes ☐ No

Waste Disposal Explained: ☒ Yes ☐ No

Infusion Pump: ☒ Yes ☐ No

Hand hygiene Explained: ☒ Yes ☐ No

☐ Others

Patient Rights & Responsibilities: ☒ Yes ☐ No

Information given to No other

Nurse Signature: *G. Goufathen*

Nurse Name: *Goufathen*

Date: 20/7/26

Time: 9:45 AM

10

BAH-00654245
Master OMAR AHMED YASIN
01-08-2024 1 Y 11 M 21 D (M)
Dr. NALLA ANURAAG REDDY



IP5-00176629

[Signature]

NURSING CARE RECORD

Shift: ☐ Morning ☐ Night Date:

Assessment:

- Goals
- ☐ Maintain Airway and Oxygenation

☐ Relieve Pain & Discomfort

☐ Maintain Fluid Balance

☐ Improve Activity Tolerance

☐ Maintain Good Nutritional Status

☐ Maintain Skin Integrity
- ☐ Maintain Personal Hygiene

☐ Prevent Infection

☐ Meet Elimination Needs

☐ Ensure Safety

☐ Early Ambulation Reduce Anxiety

☐ Patient & Family Education
- ☐ Identify Potential Complications

☐ Any Others. Specify.....

Time	Plan of Care	Time	Implementation	Evaluation

Re-Assessment:

Special Notes:

Nurse Signature: Nurse Name: Date & Time:

BAH-00654245 IP5-00176629
Master OMAR AHMED YASIN
01-08-2024 1 Y 11 M 21 D (M)
Dr. NALLA ANURAAG REDDY



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: 23/7/26

Assessment: patient having weakness

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8 AM	Assess the patient general condition	9 AM	Assessed the patient general condition	patient feel better
10 AM	check vitals	10:30	checked vitals	
11 AM	provide sickle guard	11:30	provided sickle guard	
12 AM	Maintain S/O chart	12:30	Maintained S/O chart	
1 PM	Administer medication	2 PM	Administered medication	

Re-Assessment: NA

Special Notes: NA

Nurse Signature: [Signature] Nurse Name: Gayathri Date & Time: 23/7/26 @ 2 PM



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 22/7

Assessment: Baby has poor oral Intake

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	Assess General condition of the baby	8pm	assessed General condition of the baby	Baby has Eating well
8:10pm	Monitor vital signs	8:10pm	monitored vital signs	
10pm	Administer medications as per chart	10pm	Administered medications as per chart	
11am	Ensure safety	12am	provided oral care	
2am	Encourage oral Intake	2am	Baby has taking orally well	
4am	Maintain fluid balance	4am	Administered fluids	
6am	Maintain I/O chart	6am	Maintained I/O chart	

Re-Assessment: Baby has eating well

Special Notes:

Nurse Signature: [Signature] Nurse Name: Jayaram Date & Time: 23/7/2024



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 22/7/2026

Assessment: patient having weakness.

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	→ Assess the patient condition	2:30pm	→ Assessed the patient condition	patient feel better.
3pm	→ maintain personal hygiene.	3:30pm	→ maintained personal hygiene.	
4pm	→ monitor vital signs.	4:30pm	→ monitored vital signs.	
5pm	→ Administer medication.	5:30pm	→ administered medication.	
6pm	→ maintain s/o chart.	6:30pm	→ maintained s/o chart.	
7pm	→ provide Supportive care.	7:30pm	→ provided Supportive care.	

Re-Assessment:

patient feel better.

Special Notes:

at Same.

Nurse Signature:

Karima

Nurse Name:

Karima

Date & Time:

22/7/2026 08pm



8

NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 22/7/26

Assessment: patient is having chemotherapy

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8 AM	*Assess the general Condition	8:30 AM	*Assessed the general Condition	patient is comfortable
9 AM	*Monitor and note vitals	9:30 AM	*Monitored and noted vitals	
10 AM	*Ensure safety	10:30 AM	*Ensured safety	
11 AM	*Provide comfortable position	11:30 AM	*Provided comfortable position	
12 PM	*Provide supportive care	12:30 PM	*Provided supportive care	
1 PM	*Administer medications *Monitor output	1:30 PM	*Administered medications *Monitored output	

Re-Assessment: patient is comfortable

Special Notes:

Nurse Signature: Amm

Nurse Name: Amm m

Date & Time: 22/7/26 @ 2 PM



5

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 21/07/26

Assessment: Patient's having weakness

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	Assess the patient condition.	9pm	Assessed the patient condition	Patient's condition is now improved
10pm	To check vital signs.	11pm	checked vital signs and records	
12Am	To maintain fluid balance	1Am.	Maintained fluid balance	
2Am	To ensure safety.	3Am	Provided side rails.	
4Am	To prevent infection.	5Am	Administered medication as per doctors order.	
6Am	To maintain I/O chart.	7Am	Maintained I/O chart.	

Re-Assessment: Patient is now stable

Special Notes: Nil

Nurse Signature: [Signature]

Nurse Name: Sumita

Date & Time: 22/07/26 @ 8Am



4

NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 21/7/26

Assessment: patient is having chemotherapy

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8:00 AM	* Assess the general condition	8:30 AM	* Assessed the general condition	
9:00 AM	* Monitor & note vitals	9:30 AM	* Monitored and noted vitals	
10:00 AM	* Ensure safety	10:30 AM	* Ensured safety	
11:00 AM	* Provide comfortable position	11:30 AM	* Provided comfortable position	patient is comfortable
12:00 PM	* Provide supportive care	12:30 PM	* Provided supportive care	
5:00 PM	* Administer medications	4:30 PM	* Administered medications	
2:00 PM	* Monitor output	8:00 PM	* Monitored output	

Re-Assessment: patient is comfortable

Special Notes:

Nurse Signature: *Arum*

Nurse Name: Arum

Date & Time: 21/7/26 @ 8 PM

BAH-0054245
Master OMAR AHMED YASIN
1 Y 11 M 19 D
01-08-2024
DR. NALLA ANURAG REDDY
IP5-00176629

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☐ Night

Date: 20/7/26

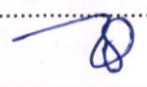
Assessment: Patient Having weakness.

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm. Assess the patient condition.	9pm. monitor vital.	8:30am	Assessed the patient condition.	Patient feel better NOW.
9pm. maintain IV fluids.	10pm. Administer medication.	10pm.	maintained IV fluids.	
10pm. provide personal hygiene.	11pm.	11pm.	Administered medication.	
6am. provide supportive.	7am.	7am.	provided supportive care.	
6am.				

Special Notes:

Patient feel better NOW.

Nurse Signature: 

Nurse Name: Savithri

Date & Time: 21/7/26 8am



NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 20/7/26

Assessment: Patient having weakness

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	→ Assess the general condition of the patient.	2:10pm	→ Assessed the general condition of the patient.	Patient felt better
3pm	→ Monitor vital signs.	3:10pm	→ Monitored vital signs.	
4pm	→ Provided side rails.	4:10pm	→ Provided side rails.	
5pm	→ Maintain hygiene.	5:30pm	→ Maintained hygiene.	
6pm	→ Administer medication.	6:30pm	→ Administered medication.	
7pm	→ Maintain I/O chart.	8pm	→ Maintained I/O chart.	

Re-Assessment: Patient felt better

Special Notes: at home

Nurse Signature:

Nurse Name: Sonam

Date & Time: 20/7 @ 8pm



NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 20/7/26

Assessment: patient came for L-x and chemo.

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
9:45	Assess the patient general condition	10:00 AM	Assessed the patient general condition	patient feels better
10:15	check vitals	10:30	checked vitals	
11 AM	provide side rail	11:30	provided side rails	
12 PM	Maintain D10 chart	12:30	Maintained D10 chart	
1 PM	Administer medication	2 PM	Administered medication	

Re-Assessment: DA

Special Notes:

Nurse Signature: DA

Nurse Name: Gayathri

Date & Time: 20/7/26 @ 2 PM



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Nalla Anurag Department: CC Date of Admission: 20/7/26

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:					
BACKGROUND	Area	Shift Time	<u>CC</u> <u>9:30 AM</u>	<u>CC</u> <u>2 PM</u>	<u>CC</u> <u>8 PM</u>	<u>CC</u> <u>8 AM</u>	<u>CC</u> <u>8 PM - 2 PM</u>	<u>CC</u> <u>8 PM</u>
	Medical Condition (Any special condition to be noted):		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>N/A</u>	<u>NA</u>
ASSESSMENT	Allergy:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Tubes/Drains/Catheter:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:	Temp:	<u>98.1 F</u>	<u>98.1 F</u>	<u>98.6 F</u>	<u>98.6 F</u>	<u>98.0 F</u>	<u>98.4 F</u>
		Res:	<u>28 bpm</u>	<u>28 bpm</u>	<u>27 bpm</u>	<u>28 bpm</u>	<u>26 bpm</u>	<u>28 bpm</u>
		SpO ₂ :	<u>100%</u>	<u>100%</u>	<u>100%</u>	<u>100%</u>	<u>100%</u>	<u>100%</u>
		Pulse:	<u>112 bpm</u>	<u>112 bpm</u>	<u>110 bpm</u>	<u>102 bpm</u>	<u>112 bpm</u>	<u>112 bpm</u>
		BP:	<u>94/52</u>	<u>94/52</u>	<u>100/60</u>	<u>100/60 (72)</u>	<u>98/63 (72)</u>	<u>100/60</u>
		Fall Risk Score:	<u>11</u>	<u>11</u>	<u>11</u>	<u>11</u>	<u>11</u>	<u>11</u>
Pain Score:		<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0</u>	<u>0</u>	<u>0</u>	
Recommendations	Safety Needs:	<u>Yes</u>	<u>Yes</u>	<u>Side rail</u>	<u>Side rail</u>	<u>Side rail</u>	<u>Side rail</u>	
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>N/A</u>	<u>NA</u>	
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Other Special Orders / Medications:	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>N/A</u>	<u>NA</u>	
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>N/A</u>	<u>NA</u>	
Handed Over By Name :		<u>poora</u>	<u>Ganesh</u>	<u>Sargam</u>	<u>Savitri</u>	<u>Anam</u>	<u>Shruti</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>20/7/26</u>	<u>20/7</u>	<u>20/7</u>	<u>21/7</u>	<u>21/7</u>	<u>21/7/26</u>	
Time:		<u>9:30 AM</u>	<u>2 PM</u>	<u>8 PM</u>	<u>8 AM</u>	<u>2 PM</u>	<u>8 PM</u>	
Taken Over By Name :		<u>Shruti</u>	<u>Sargam</u>	<u>Madhu</u>	<u>Anam</u>	<u>[Signature]</u>	<u>Sumita</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>20/7</u>	<u>20/7</u>	<u>20/7</u>	<u>21/7</u>	<u>21/7/26</u>	<u>21/7</u>	
Time:		<u>9:30 AM</u>	<u>2 PM</u>	<u>8 PM</u>	<u>8 AM</u>	<u>2 PM</u>	<u>8 PM</u>	



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Anuraag Department: Neonology Date of Admission: 20/07

SITUATION	Diagnosis: <u>B-cell ALL</u>		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:					
BACKGROUND	Area	<u>Onco 8pm-8am</u>	<u>Onco 8am-2pm</u>	<u>Onco 2pm-8pm</u>	<u>Onco 8pm-2am</u>	<u>Onco 2am-8am</u>		
	Shift Time							
BACKGROUND	Medical Condition (Any special condition to be noted):	<u>NA</u>	<u>N/A</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>		
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Vital Signs:	Temp:	<u>98.2°F</u>	<u>98.0°F</u>	<u>98.0°F</u>	<u>98.8°F</u>	<u>98.1°F</u>	
		Res:	<u>28b/m</u>	<u>26b/m</u>	<u>28b/m</u>	<u>26b/m</u>	<u>26b/m</u>	
		SpO ₂ :	<u>100%</u>	<u>100%</u>	<u>100%</u>	<u>100%</u>	<u>100%</u>	
		Pulse:	<u>118b/m</u>	<u>120b/m</u>	<u>110b/m</u>	<u>116b/m</u>	<u>116b/m</u>	
		BP:	<u>93/53(13)</u>	<u>98/68(20)</u>	<u>98/60(17)</u>	<u>100/61</u>	<u>100/60</u>	
		Fall Risk Score:	<u>11</u>	<u>11</u>	<u>11</u>	<u>11</u>	<u>11</u>	
Pain Score:	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>			
Recommendations	Safety Needs:	<u>Side rails</u>	<u>Side rails</u>	<u>Side rails</u>	<u>Side rails</u>	<u>Side rails</u>		
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:	<u>NA</u>	<u>N/A</u>	<u>NA</u>	<u>N/A</u>	<u>NA</u>		
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Other Special Orders / Medications:	<u>NA</u>	<u>N/A</u>	<u>NA</u>	<u>N/A</u>	<u>NA</u>		
Post Operative Procedure Special Orders:		<u>NA</u>	<u>N/A</u>	<u>NA</u>	<u>N/A</u>	<u>NA</u>		
Handed Over By Name :		<u>Sumita</u>	<u>Anur M</u>	<u>Kavima</u>	<u>Anur M</u>	<u>Gopu</u>		
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>		
Date:		<u>22/7</u>	<u>22/7</u>	<u>22/7/26</u>	<u>23/7</u>	<u>23/7</u>		
Time:		<u>8AM</u>	<u>2PM</u>	<u>8PM</u>	<u>2AM</u>	<u>2PM</u>		
Taken Over By Name :		<u>Anur M</u>	<u>Kavima</u>	<u>Submanu</u>	<u>Anur M</u>	<u>DC</u>		
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>		
Date:		<u>22/7</u>	<u>22/7/26</u>	<u>22/7</u>	<u>23/7</u>	<u>23/7</u>		
Time:		<u>8PM</u>	<u>2PM</u>	<u>8PM</u>	<u>2AM</u>	<u>2PM</u>		

CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0	0									
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1	-									
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	-									
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3	-									
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4	-									
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5	-									
Signature of the Nurse				9									

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

Signature of Shift In Charge :

Signature of Ward In Charge :

Signature : Name :

Signature : Name :



CHECKLIST FOR THROMBOPHLEBITIS

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

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

Signature of Shift In Charge :

Signature of Ward In Charge :

Signature : Name :

Signature : Name :

CHECKLIST FOR THROMBOPHLEBITIS

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

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 : [Signature] Name : Subhannan

Signature of Ward In Charge :

Signature : Sanitha Name : Subhannan

BAH-00654245 IP5-00176629
Master OMAR AHMED YASIN
01-08-2024 1 Y 11 M 21 D (M)
Dr. NALLA ANURAAG REDDY



BRADEN 'Q' SCALE

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

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

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

BAH-00654245
Master OMAR AHMED YASIN
01-08-2024 1 Y 11 M 19 D (M)
Dr. NALLA ANURAG REDDY

BRADEN 'Q' SCALE

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

					Date :	20/7/24	22/7	
					Time :	8:30am	8am	8am
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e.tremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4	4	
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4	4	
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	
FRICITION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 4 Mild Risk : 15-18 Not at Risk: 19-23					TOTAL SCORE	28	28	28
Docu. No. : RCHBH /FRM / CLINICAL / 119					Evaluator's Name	pooja		

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

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Part - I.

Patient's / Learner Language: 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		

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				

TERDISCIPLINARY PATIENT
/ FAMILY EDUCATION RECORD



1

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

2. Treatment and Care Plan

3. Pain Management

4. Informed Consent
5. Medication / Therapy (safety, effects/ side effect, interactions)

6. Discharge Medication

7. Infection Control Measures

8. Diagnostic Test / Procedures
9. Nutrition / Diet

10. Fall Risk Education

11. Safe use of Medical Equipment / Implantable Devices Safety

12. Patient's / Family Rights
13. Risk / Safety

14. Activity / Exercise

15. Social & Rehabilitation Needs

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		
20/7/26	8:35 am	7	infection control measures	F	4	0	1	1	NA	poor
20/7/26	1pm	9	soft high protein diet	F	1	0	1	1	-	Nikitha
22/7/26	8am	7	to maintain personal hygiene	F	1	0	1	1	NA	Adm

Part - III: CODES

Who was taught:

PT: Patient

F: Father

M: Mother

S: Spouse

Sn: Son

D: Daughter

C: Caregiver

O: Other (Specify)

Learning Barriers:

1. No Learning Barriers

2. Physical Impairment

3. Emotional Barriers

4. Language Barrier

5. Educational Level

6. Desire / Motivate to Learn

7. Impaired Thought Process/Cognitive limitations

8. Responsibilities at Home

9. Cultural Differences

10. Financial Difficulties

11. Beliefs and Values

12. Impaired Vision/ or Hearing

13. Cultural/Religion Practice

14. Others (Specify)

Teaching Tools Used:

A: Audio

D: Demonstration

V: Video

O: Oral

P: Printed

Mechanism/s to overcome barrier/s:

1. None

2. Obtain translator

3. Reassurance & Support

4. Teach Family / Others

5. Respect values & beliefs

6. Respect Cultural / Religion Preference

7. Other, Specify

Understanding:

1. Verbalizes Understanding

2. Demonstrates Understanding

3. Needs Review



MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis: B-cell ALL

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
<u>20/7/26</u> <u>9AM</u>	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	<u>B-cell ALL</u>	<u>hemodynamic stability</u>	<u>chemotherapy</u>	<u>[Signature]</u>	☒ Nursing ☐ Others:
<u>20/7/26</u> <u>9AM</u>	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	<u>B-cell ALL</u>	<u>ct - stability</u>	<u>chemotherapy</u>	<u>[Signature]</u>	☒ Medical ☐ Others:
<u>20/7/26</u> <u>1PM</u>	☐ Medical ☐ Nursing ☒ Others: <u>diets</u>	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	<u>ctc/o Bcell ALL</u>	<u>soft high protein diet</u>	<u>ROA!</u> <u>E: 1200 kcal/d</u> <u>P: 20g/d</u>	<u>Nicita</u>	☐ Medical ☐ Nursing ☒ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:



THE HUMPTY DUMPTY SCALE

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

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position							
Call device within reach							
Wheels Locked							
Room free of clutter							
Adequate Lighting							
Wheel Chair Support							
Other Intervention(s) Specify							
Nurse's Name :							
Signature :							
Date :							
Time :							

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Master OMAR AHMED YASIN
01-08-2024 1 Y 11 M 19 D (M)
Dr. NALLA ANURAAG REDDY



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THE HUMPTY DUMPTY SCALE

2017 2/16 22/7 23/7

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

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position	yes	yes	yes	yes	
Call device within reach	yes	yes	yes	yes	
Wheels Locked	yes	yes	yes	yes	
Room free of clutter	yes	yes	yes	yes	
Adequate Lighting	yes	yes	yes	yes	
Wheel Chair Support	no	no	NA	NA	
Other Intervention(s) Specify	no	no	NA	NA	
Nurse's Name :	poofa	soof	Sumita	A	
Signature :	Q	Q	Q	Q	
Date :	2017	21/7	22/7	23/7	
Time :	8:55 am	8 am	8 AM	8 AM	



CONSENT FOR CHEMOTHERAPY

Patient Name : Yasin Age : 2yr Gender : Male ☒ Female ☐
UHID No : BAH-00654245 Department : PED Date : 20/7/26

Type of Chemotherapy : Lithamycin

The type of reactions, nature of the major risks and complications arising from the treatment despite precautions has been explained to me. These can include Bone Marrow depression with subsequent infections, bleeding, nausea, vomiting, diarrhea, mouth ulcers, alopecia, fever, phlebitis, ulceration at the site of injection organ injuries etc.

The doctor have explained to me about the benefits and alternative for this procedure that in N/A

I understand that no promise of cure or freedom from risk can be given. During the course of treatment I will report any symptoms if they become bothersome.

I have read the above and have no further questions about the treatment to be given.

Patient Attendant : Ahmed
Signature : Ahmed Yasin
Name : Ahmed Yasin
Relationship with Patient : Father
Date & Time : 20/7 @ 3PM

Witness : Ahmed
Signature : Ahmed Yasin
Name : Ahmed Yasin
Date & Time : 20/7 @ 3PM

Doctor (who is taking the consent):

Signature : [Signature]
Name : AKHANI
Date & Time : 20/7/26 11am

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CONSENT FOR SPECIAL PROCEDURES

Patient Name : Yasin Gender: ☒ Male ☐ Female
UHID No : 654245 Department : Onco Date : 20/7/26
I Parent of Yasin
S/D/W/O

Here by give consent for procedure of : LP + 1st chemotherapy
For my patient, Named : Yasin

The doctors have clearly explained to me that the procedure has following possible complications:

pain, bleeding, headache

The doctor have explained to me about the alternatives, risks and benefits for this procedure that :

Nil

I have understood the matter mentioned above in language known to me and give consent for the procedure.

Name of the Doctor performing the procedure:

Patient Attendant:

Signature : Amy

Name : Ahmed Yasin Salag

Relationship with Patient: father

Date & Time : 20/7/26 @ 12pm

Witness :

Signature : Shrus

Name : Shrus

Date & Time : 20/7/26 @ 12pm

Doctor (who is taking the consent) :

Signature : Ahanksha

Name : Ahanksha

Date & Time : 20/7/26 @ 12pm

ప్రత్యేక విధానాలకు సమ్మతి



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రోగి పేరు లింగం ☐ పురుషుడు ☐ స్త్రీ

యు.హెచ్.ఐ.డి విభాగం తేదీ

నేను S/D/W/O

ప్రత్యేక విధానాలకు సమ్మతి ఇవ్వడం ద్వారా

నా రోగికి, పేరు :

ఈ ప్రక్రియ కోసం ప్రత్యామ్నాయాలు, నష్టాలు మరియు ప్రయోజనాలు గురించి డాక్టర్ నాకు తెలిసిన భాషలో వివరించా

.....
.....
.....

నాకు తెలిసిన భాషలో పైన పేర్కొన్న విషయాన్ని నేను అర్థం చేసుకున్నాను మరియు ప్రక్రియకు సమ్మతిని తెలియజేస్తున్నాను.

ప్రక్రియ చేస్తున్న వైద్యుని పేరు :

సహాయకుడు (అటెండెంట్)

సంతకము

పేరు

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము

పేరు

సాక్షి

సంతకము

పేరు

తేదీ మరియు సమయము

BAH-00654245 IP5-00176629
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PROCEDURE SAFETY CHECK LIST (TIMEOUT OUTSIDE OT)

Procedure Name: LP + IT hemo Date: 20/7/24 In-Time: 12:30m Out-Time: 1:10m
Doctor Performing Procedure: Dr. Nalla Anuraag Reddy Doctor Giving Sedation: Dr. Sandhya Assisting Nurse: Dr. Anuraag

SIGN IN	Time: <u>12:30pm</u>	Yes	No	NA
Patient is verified using two identifiers (Name & UHID)	☒	☐	☐	
All required documents, images, studies are available	☒	☐	☐	
NPO Status Checked from Patient / Patient Attendant	☒	☐	☐	
Consent is Signed	☒	☐	☐	
Any need for blood products	☐	☒	☐	
If Yes Comment:				
Any Risk of Hemodynamic Compromise	☐	☒	☐	
If Yes Comment:				
Any drug or food allergy	☐	☒	☐	
If Yes Comment:				
Correct Site of Procedure Marked	☒	☐	☐	
All resources required are correct, available and functioning	☒	☐	☐	
Signature of the Doctor: <u>Dr. Nalla Anuraag Reddy</u>				
Name of the Doctor: <u>Dr. Nalla Anuraag Reddy</u>				

TIME OUT	Time: <u>12:40pm</u>	Yes	No	NA
Correct Patient	☒	☐	☐	
Correct Site	☒	☐	☐	
Correct Procedure	☒	☐	☐	
All the team members introduced	☒	☐	☐	
Signature of the Nurse: <u>Dr. Sandhya</u>				
Name of the Nurse: <u>Dr. Sandhya</u>				

SIGN OUT	Time: <u>1:10m</u>	Yes	No	NA
Name of the Surgical / Invasive Procedure is recorded	☒	☐	☐	
Instrument, Sponge and Needle Count Completed	☒	☐	☐	
Specimens are labeled	☒	☐	☐	
Any equipment problems are addressed	☒	☒	☐	
Signature of the Nurse: <u>Dr. Anuraag</u>				
Name of the Nurse: <u>Dr. Anuraag</u>				

Any Adverse / Unexpected Events

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Master OMAR AHMED YASIN
01-08-2024 1 Y 11 M 19 D (M)
Dr. NALLA ANURAG REDDY

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Moderate Sedation Flow-Sheet

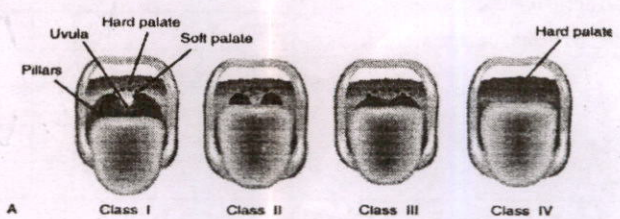
Immediate Pre-Sedation Assessment

B.P	P.R	R.R	Temp	SPO ₂	Pain Score	Weight
96/72	248/1	20/1	98.2/	100%	—	—

Diagnosis: All

Procedure: LP + IT

Comorbidities: _____

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

Monitoring of Patient Intra – Procedure

Procedure Monitoring

Heart Rate (HR), Respiratory Rate (RR), Oxygen Saturation (O₂ 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 ₂ Sat%	O ₂ Supplementation	Comments / Initials
Baseline	98/62	122b/min	24b/min	100%	—	—
1						

DRUG & IV Fluid: (including Nitrous Oxide)	ROUTE	DOSE	TIME GIVEN	SUBSEQUENT DOSES AND TIME
kefauzine	IV	5mg	12:30pm	—
Molavone	IV	0.5mg	12:35pm	✓
				✓

Doctor Notes: Unremarkable

Time of transportation to post sedation care room: 125 LOC: Alert

Doctor Name: Ashwath Signature: Ashwath

[illegible]

Activity :	Consciousness:	Respiration:	Oxygen Saturation:	Circulation:
Four extremities = 2	Fully awake = 2	Breathe Deep= 2	Sat O ₂ >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 ₂ >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: 12:00 PM

Nurse Name: Bhavna

Date: 20/7/26 Time: 2:07

Consultant Name: Dr. Singh

Stamp

Signature: _____

Signature: Shankha

BAH-00654245 IP5-00176629
Master OMAR AHMED YASIN (M)
01-08-2024 1 Y 11 M 19 D
Dr. NALLA ANURAG REDDY

EMERGENCY ROOM TRIAGE FORM

Patient's Name: OMAR AHMED YASIN Age: 1y
Date: 20/08/24 Time of Arrival: 8-15 am
Allergies: ☒ No ☐ Yes ☐ Food ☐ Medications ☐ Other (Specify): NA
Source of Information: ☒ Parents ☐ Others (Specify): NA
Mode of Arrival: ☒ Ambulance ☐ Wheelchair ☐ Stretcher ☐ Ambulance

Gender: ☐ Male ☐ Female
Triage Completion Time: 8:17 am
☐ Not known any drug Allergies

INITIAL PHYSIOLOGICAL CATEGORIZATION

Appearance

☒ Normal
☐ Sick Looking

Circulation / Colour

☒ Normal ☐ Abnormal

Bleeding

☐ Normal ☐ Abnormal

Work of Breathing

☒ Normal ☐ Decreased

☐ Increased ☐ Gasping / Apnea

INITIAL PHYSIOLOGICAL STATUS

☒ Stable ☐ Unstable:

☐ Not - Life - Threatening

☐ Life - Threatening

Initial Vital signs: Temp: 98.6°F

Chief Complaints: Came for Chest pain

Triage Classification

☐ Level 1: Resuscitation

☐ Level 2: EMERGENCY: Life or limb threatening

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

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

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

NOTE: All immunocompromised children and preterm babies to be considered Level 2.
All Children less than 2 years age with high fever to be considered Level 3.

* CTAS - Canadian Triage and Acuity Scale

CTAS

☐ Immediate

☐ < 15 min

☒ 30 min

☐ 60 min

☐ 120 min

Signature of Parent / Guardian

Communicable Disease Triage Screening

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

1. Have you had fever (elevated temperature) in the past 2 weeks ☐ Yes ☒ No

2. Have you had cough or a rash in the past 2 weeks ☐ Yes ☒ No

3. Have you had shortness of breath or difficulty breathing in the past 2 weeks ☐ Yes ☒ No

PART B. For patients reporting fever and respiratory/rash symptoms:

☒ Not applicable

1. Have you travelled outside the INDIA? or had close contact with someone who has recently travelled outside the INDIA, in the past two weeks? ☐ Yes ☒ No

If yes, State Location: India ☐ Yes ☒ No

2. Are your parents / close contacts at home healthcare worker? {please encircle the choices} (e.g., nurse, physician, ancillary services personnel, allied health services personnel, hospital volunteer, or laboratory worker, others) who has had a recent exposure to an individual with a highly communicable disease or unexplained, severe febrile respiratory or rash disease? ☐ Yes ☒ No

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

☐ Any patient with Fever / Rash / Vesicles / Discharge and Cough

☐ Any patient with fever and respiratory symptoms v "YES" to any of the questions on epidemiologic ri "PART B" of the triage screening above.

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

☐ Patients should be immediately isolated in a negative room or a single room (as appropriate) for pending test results.

☐ The patient should be given a surgical mask immediately already wearing one.

☐ Both patient and triage staff should perform hand hygiene.

☐ The staff should use PPE (as appropriate).

Signature of Triage Nurse: [Signature]

Name of Triage Nurse: [Signature]

Date & Time: 20/08/24 @ 8:17 AM

Docu. No.: RCHBH / FRM / CLINICAL / 085

Inform consultant for positive criteria.

(P.T.O.)

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

Time	Nursing Notes
8:30am	Assess the child condition
	monitored vitals & recorded
	seen Dr. pathi
	shifted to ward

Samples collected by: MR. Ratikul

Samples sent by:

Time: 8:45 am

Medication given in ER:

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

Condition of patient at time of shift - out:

HR: 112 bpm BP: 94/52 CFT: 4 sec
RR: 22 bpm SPO₂: 100%
GCS: 4/5/6 Temperature: 97.8°F
Pain Score: 0
Repeat RBS (if applicable): NA

Details of Shift - out

Shift - out from ER to: 6:00 125
Time of Shift - out: 9:30 am
Handover given to: Shullana
(Nurse's Name)

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any):

2x placement done

Name of the Nurse: poola

Date & Time: 20/2/2020 9 am

Signature of the Nurse:

[Signature]

PATIENT TRANSFER FORM

Patient Name & UHID No. IP5-00176629 BAH-00654245 Master OMAR AHMED YASIN (M) 01-08-2024 1 Y 11 M 19 D Dr. NALLA ANURAG REDDY 		Date & Time of Admission 20/7/26 8:29 AM		Date & Time of Transfer Order 20/7/26 9:30 AM	
		Transfer Ordered by DR. Prathiba		Reason for Transfer Admission	
From Unit ER		To Unit ONCO 125		Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 19		Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ If Yes, what? ...sp. files		Patient shifted with ID band: Yes ☒ No ☐	
Number of Imaging Films NA				If No:	
Medications / Consumables / Surgicals / Hand over					
Sl.No.	Item Name			Quantity	
1.					
2.					
3.					
4.					
5.					
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐					
Name & Signature of Person who is Transferring NR - Prathiba			Name of Person Ordered Transfer DR. Prathiba		
Patient & Clinical Records Received by : Shweta					
Date & Time of Patient Received : 20/7/26 9:40 AM					

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

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

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Master OMAR AHMED YASIN
01-08-2024 1 Y 11 M 19 D (M)
Dr. NALLA ANURAAG REDDY



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n)

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NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 20/7/26 Time: 1 PM

Weight: 11.80kg Centile: <25th

Height: 85cms Centile: >25th

Inference: well child

RDA: — Calories: 1200kcal/d Protein: 20g/d

Diet Recommendations: soft + high protein diet

Re-Assessment: Avoid spicy, chilled & outside foods

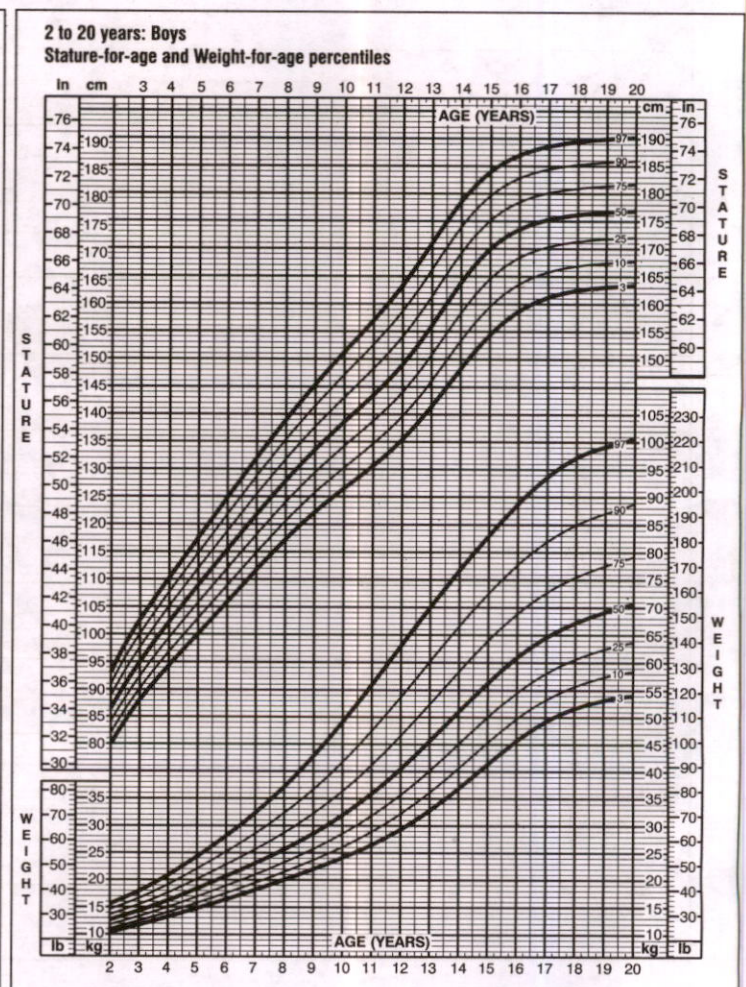
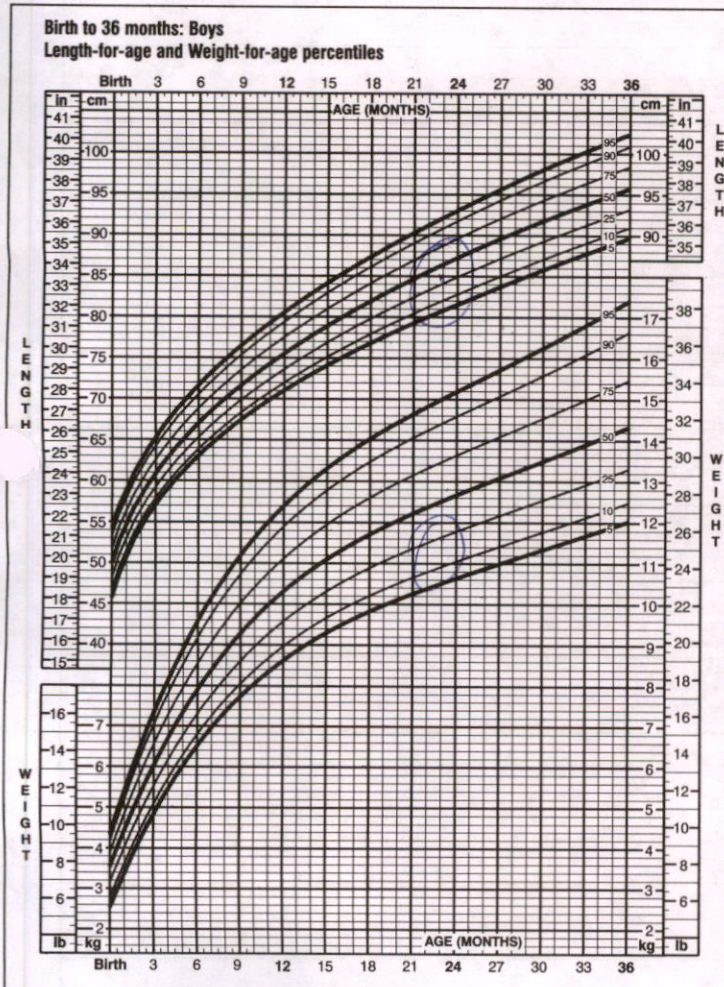
Food Allergies: NO Veg/Non-veg: Non-veg

Diagnosis: keto BAC/ cause

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: parent's don't need dietitian. don't charge for NHA.

GROWTH CHART (BOYS)



Dietician's Name: Nikitha

Dietician's Signature: Nikitha

Daily Notes:

[illegible]