

ACTIVITY RECORD FOR BILLING

Name : BAH-00861039 IP5-00176110
Master CHILLAMCHARLA KUMAR
23-05-2012 14 Y 1 M 15 D (M)
Dr. KAPIL BHAGWATRAO SACHANE

UHID No. : _____ Consultant: _____ Dept : _____

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
8/7/26	4:30 PM	ER	141	<u>[Signature]</u>

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	Dr. Shrawati Kotapalli	9/7/26	9654416	<u>[Signature]</u>
2	Dr. Nitya . N	9/7/26	965417	<u>[Signature]</u>
3				
4				
5				
6				
7				
8				
9				
10				

[illegible]

817124

CBP, CRP, ESR, Mantoux
procedures

• 8350

Kethief

8/7/26

* say chest

33927

Kethf

97/11/11

TB Grenexpur

33 928

Apr

[illegible]

91746

0-ary — 0

SV 0000

By

Billing Supervisor

ADMISSION SHEET


Registration Details :

Admission No : IP5-00176110 Admit Date : 08-Jul-2026 Admit Time : 02:44 PM UHID : BAH-00661039

Patient Details :

Patient Name	: Master CHILLAMCHARLA KUMAR	Age	: 14 Y 1 M 15 D
Guardian	: Mr CHILLAMCHARLA SARVESHEARAO	DOB	: 23-05-2012
Gender	: Male	Religion	:
Occupation	:	Martial Status	: Single
Address (H)	: H NO - 21-64, V.V. NAGAR , Dilsukhnagar Colony Hyderabad Telangana INDIA 500060	Phone No	: 8187884764/ 7075743118
		E-mail	: NOMAIL@GMAIL.COM

Admission Details :

Bed Type : GENERAL WARD Bed No : GW 141 Ward Name : 1F-GENERAL WARD II
 Room No : GW 141 Admission Type : First Visit

Contact Details :

Name	: Mr CHILLAMCHARLA SARVESHEARAO	Relationship	: Father
Contact Address	: H NO - 21-64, V.V. NAGAR , Dilsukhnagar Colony Hyderabad Telangana INDIA 500060	Phone No	: 8187884764 / 7075743118

CH 23/5/2026
 Signature

Doctor Details :

Doctor Name	: Dr. KAPIL BHAGWATRAO SACHANE	Specialisation	: GENERAL PEDIATRICS
Referral Doctor	: Self	Phone No	:
Co-Consultant	:		

Payment Details :

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

Ch. Kumar
DAH-00661039

121

Patient Sticker

Dr. Jagjit Bheswaha

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

BirthRight[™]
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

DEFICIENCY CHECK LIST OF CASE SHEET

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

ERROR LOG

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

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE



Rainbow[®] Children's Hospital

It takes a lot to treat the little.

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name:

Ch. Kumar

UHID ID:

BAH-00661039 IP5-00176110
Master CHILLAMCHARLA KUMAR
23-05-2012 14 Y 1 M 15 D (M)
Dr. KAPIL BHAGWATRAO SACHANE

Department:



Consultant:



Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

Continuous Cough Since 1 week

Fever for ~~3 days~~ 1 week ago
2 days.

Headache occasional.

History of present illness :

Child is apparently normal 1 week ago. Child developed above mentioned complaints.

→ Continuous Cough during daytime/awake hours

✓ NOT Observed during sleeping

✓ IM dexamphylina, Inj Hydrocort, Nebulizations given on OPD basis
Cep Plurin started.

→ Fever for 1st 2 days, then decreased. 1 week ago.

→ Headache Occasional ⊕.

→ Poor oral intake

→ WT Loss 500gm noted.

6/7/26: CBP - 13.3 / 6300 / 3.83L

RBS = 80.

(Continue)
Lab.

5.2

52 / 39

CVS = Pilsch = 7-9 cells.

ESR = 24.

CRP = 42

Melawel pv = Negative

Widal test = slide test ⇒ 'O' = 1:160

H = 1:80

AH = 1:40

Bit = 1:40

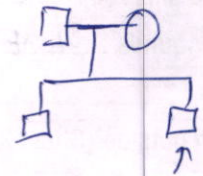


Pediatric Multiorgan History & Physical Examination

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

Birth & Neonatal History:

1.1 Kg / LSC / PT / 34 weeks / NO H/O NICU stay



Birth & Socio Economic History:

About Father : _____

About Mother : _____

Any additional Information : _____

Developmental History :

(N) development

Immunization History :

Vaccination till date (NIP schedule)

Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs)) 51.4 kg (Centile _____)

On Examination :

Temperature : 98 F Pulse Rate : 120/min B.P. 100/86(90) SP02 100% on RA

Resp.rate and type of breathing : RR = 28/min

Rash _____

Lymphadenopathy } NT

Oedema : _____

Allergies (if any): _____

Respiratory System :

Inspection (any s/o distress) : _____

Air entry & breath sounds : B/LAE (+)

Any addes sounds : _____

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

Cardiovascular System :

Inspection of procordium : _____

Heart Sounds : S1S2 (+)

Any murmur : _____

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

Per Abdomen :

Inspection _____

Palpation : Soft, NT.

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 : _____

Cranial Nerves : _____

Motor System:

Nutriton : _____

Tone: _____

Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR

Superficials:

Plantars _____

Sensory System :

Bladder / Bowel : _____

Clinical Summary & Diagnostic:

LR 11.



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: _____

Desired goals of the treatment : _____

Planned Labs:

Blood C/s

CRP

CBP

ESR -

Xray chest

Sputum for TB Gene Expert

Mantoux test

Tamara

Planned Management

Inj Ceftriaxone

Susp 7cb Azee

Inj Hydral

Neb Berodil

SPO₂ monitoring

Tamara

Signature of the Doctor: *Ramya*

Name of the Doctor: *Dr. RAMYA*

Date & Time: *8/7/26 : 3:15pm*

Signature of the Consultant: *[Signature]*

Name of the Consultant: *[Signature]*

Date & Time: *09/07/2024*

BAH-00661039 IP5-00176110
Master CHILLAMCHARLA KUMAR
23-05-2012 14 Y 1 M 16 D (M)
Dr. KAPIL BHAGWATRAO SACHANE



ESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/2/26 6:00 AM	C/S/B Resident Sis - URTI No fever spikes yesterday cough & than before. child on Room air Resp - B/L AE (+) chest clear. No added sounds. HA / WNL CVS / WNL	Plan 1) Continue IV Ceftriaxone & T. Azithromycin 2) w/ any fever spikes. 3) w/ RR, SpO ₂ , vitals 4) Continue Nebulization 5) Trace bloods. -
	Chest Xpert - Neg. Mantoux - Neg.	Typh
	CRP - 42 → 5 ESR - 45 → 14 Bloods - NO growth after 24 hours.	
10/2/26 12:10 PM	C/O/W by Kapil Sir	Plan
	No fever spikes. cough & than before. on Room Air - SpO ₂ - 95-96% Resp - B/L chest clear.	To discharge today on - T. Azithromycin x 3 days - NEB C LEVOLIN 1 respule 96ml - NEB BUDECORT 1 respule 8ml - T. FLUPAC 10mg 1 tab OD x 2 weeks - Review in after 3 days. E Dr. Kapil Sir, Psychiatrist.

Dr. KAPIL BHAGWATRAO SACHIN

[illegible]

BAH-00661039 IP5-00176110
Master CHILLAMCHARLA KUMAR
23-05-2012 14 Y 1 M 16 D (M)
Dr. KAPIL BHAGWATRAO SACHANE

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

REFERRAL FORM

Doctor Name : Dr. Nilesh M. Date : 9/7/26 Time : 11:30 AM

Diagnosis : Functional Disorder

Hospital : RCH

Type of Referral :

☐ Emergency

☐ Urgent

☐ Non Urgent

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

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

Signature:

Findings and Recommendations :

Developed fever followed by cough. since two weeks continuous, except at nights. Able to suppress the cough if required. No head ache due to continuous coughing.

ppt factors? scholastic difficulties &

Avoidance of school.

Reinforcement at home - tv/mobile parental attention.

No sleep disturbances

Consultant :

Name : Dr. Nilesh M. Signature : N. Velth Date & Time : 9/7/26

o/e. Continuous cough
stops while talking & asked to suppress.
Experiences worry about future /
anxiety
almost every day

Imp.
Functional
Disorder.

6
- Cop to UDAc comm
1 — x — x
for 2 weeks

Flu in OPD for review

- Mamatha / Sanyasi
for counselling session

- Parents counselled.

- Plan Educational
assessment

- Mamatha

(Appointment) @

BAH-00661039 IPS-00176110
Master CHILLAMCHARLA KUMAR
23-05-2012 14 Y 1 M 16 D (M)
Dr. KAPIL BHAGWATRAO SACHANE

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

CROSS CONSULTATION FORM

Doctor Name : Dr. Chanti Kotapalli Date : 9/7/26 Time : 10:20am

Diagnosis :

Hospital : RCH Banjara

Type of Referral :

☐ Emergency

☐ Urgent

☒ Non Urgent

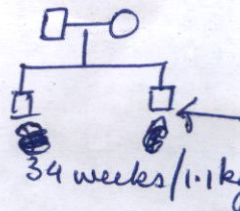
Referred for : ☒ Opinion ☐ Co-Management ☐ Transfer of care

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

Signature: _____

Findings and Recommendations :

14y / M



clo cough since last 1 week

H/o fever for 2 days initially — now afebrile

was treated on OPD basis → cough persisting, almost continuous, ↓ oral intake

H/o pulmonary TB 10 yrs ago
↓
ATT was completed.

↓
Admitted on 8/7/26.

Non-expectorant cough

No sleep disturbance, no exercise intolerance, no snoring

No family H/o asthma.

6/7/26 Hb-13.3 / TLC-6300 / N52 L39 / PU- 3.83 L / CRP-42 / ESR-45

8/7/26 Hb-13.1 / TLC-10000 / N41 L47 / PU-5.83 L / CRP-5 / ESR-14

Consultant :

Name : Dr. Chanti Kotapalli Signature : Chanti Date & Time : 9/7/26

Sputum for GeneXpert TB & Mantoux test reports awaited.

CXR (8/7/26) → B/L perihilar infiltrates, ? no hilar LN enlarged.

Current drugs: Ceftriaxone
Azithromycin
Hydrocort } D2

Levulinic acid q6h

Budecort neb q12h

Ascoril-D.

O/E Vitals stable, SpO₂ - 99% (RA)

Chest - B/L lower zone crepts,

B/L wheeze +, B/L AE +

B/L ITH (+)

Throat - Normal.

Adv

- ① Send Bordetella pertussis PCR
- ② PFT (pre & post bronchodilation)
~~after cough subsides~~
- ③ Suggest Foracort nebulisation
(0.5mg) BD

Review = reports.

BAH-00661039 IP5-00176110
Master CHILLAMCHARLA KUMAR
23-05-2012 14 Y 1 M 15 D (M)
Dr. KAPIL BHAGWATRAO SACHANE




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


BirthRight[™]
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

RESULT SHEET

Outside.

Date	5/3/26	08/07/26				
Time		4 PM				
Hb	13.3	13.1				
PCV		38.5				
RBC	5.2	5.07				
WBC	6300	10,000				
N/L	52/39	41.6/47.8				
Platelets	3.83	5.83				
CRP	42	5.0 ↓				
ESR	45	14				
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

BAH-00661039 IP5-00176110
Master CHILLAMCHARLA KUMAR
23-05-2012 14 Y 1 M 15 D (M)
Dr. KAPIL BHAGWATRAO SACHANE



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



BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

MEDICATION RECONCILIATION FORM

Drug Allergies:

☒ Not known any Drug Allergies

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

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

Shifting From: ER

Shifted to: Ward

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

* C - Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Remya

Date & Time : 8/7/26; 2:40pm

Nurse Name & Signature : Ns. Sushmita

Date & Time : 8/7/26 @ 2:40pm

DRUG CHART

Date of Admission: 8/7/20 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:																			

Weight. 51-48kg Ward.

Page: 2/4

Weight 51-48kg Ward

VERIFIED BY: Signature



Sheet No:

REGULAR PRESCRIPTIONS

Weight 51.48kg Ward

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

Signature
VERIFIED BY : Name



Weight. 51.48 kg Ward.

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
8/7/26	2:40pm	Neb LEVOLIN	1.2mg 2usp	Nebul	h	DeeDee Karthik
8/7/26	2:50pm	Neb BUDECORT 10mg	1usp	Nebul	h	DeeDee Karthik
8/7	9:45pm	Neb C LEVOLIN	1usp	Neb	Pyf	APPU Somy
8/7	10pm	Neb C 3ml 3% NS (+) 3ml Adrenaline	3ml (+) 2ml	Neb	Py	APPU Somy

Weight. 51.48kg Ward.

[illegible]

VERIFIED BY : Name

BAH-00661039 IP5-00176110
 Master CHILLAMCHARLA KUMAR
 23-05-2012 14 Y 1 M 15 D (M)
 Dr. KAPIL BHAGWATRAO SACHANE


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


BirthRight[™]
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

NEBULISATION CHART

Date	Time	Drug	Nurse	Parents Signature
8/7/26	00:00 5:30pm	Levoflo & Budecort	Jamuna	CH. S. S. S. S.
	01:00 7pm	Levoflo	Jamuna	CH. S. S. S. S.
	02:00			
9/7/26	03:00	levoflo - 12am 12am (3)	693700	Appu
	04:00	Budecort - 7am		
	05:00			
	06:00			
	07:00			
	08:00			
	09:00			
	10:00			
	11:00			
	12:00			
	13:00			
	14:00			
	15:00			
	16:00			
	17:00			
	18:00			
	19:00			
	20:00			
	21:00			
	22:00			
	23:00			

Date: 1/12 Time:

[illegible]

Temperature (°F)

94

95

96

97

98

98.7

99

100

101

102

103

104

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

115

75

15

25

[illegible]

esp. Rate (bpm)
(Over 1 Minute)

[illegible][illegible][illegible][illegible][illegible][illegible][illegible][illegible]Observer's Initials Q

Score 1	: Continue normal observation by staff nurse
---------	--

ACTIONS	Score 2 : Shift in charge nurse to be informed and continue hourly observations

NR: Scores 3 should be	Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.
------------------------	---

Score 4	: Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see
---------	--

Score 5 & 6 : Shift in charge AND PICU fellow or PICU consultant to be informed.
--

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

BAH-00661039
Master CHILLAMCHARLA KUMAR
23-05-2012 14 Y 1 M 16 D (M)
Dr. KAPIL BHAGWATRAO SACHANE



ICHBH/ FRM / CLINICAL / 127

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

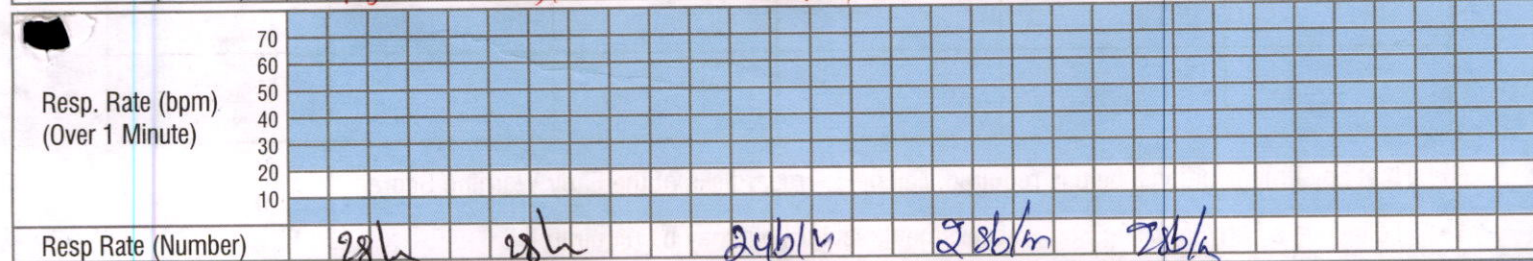
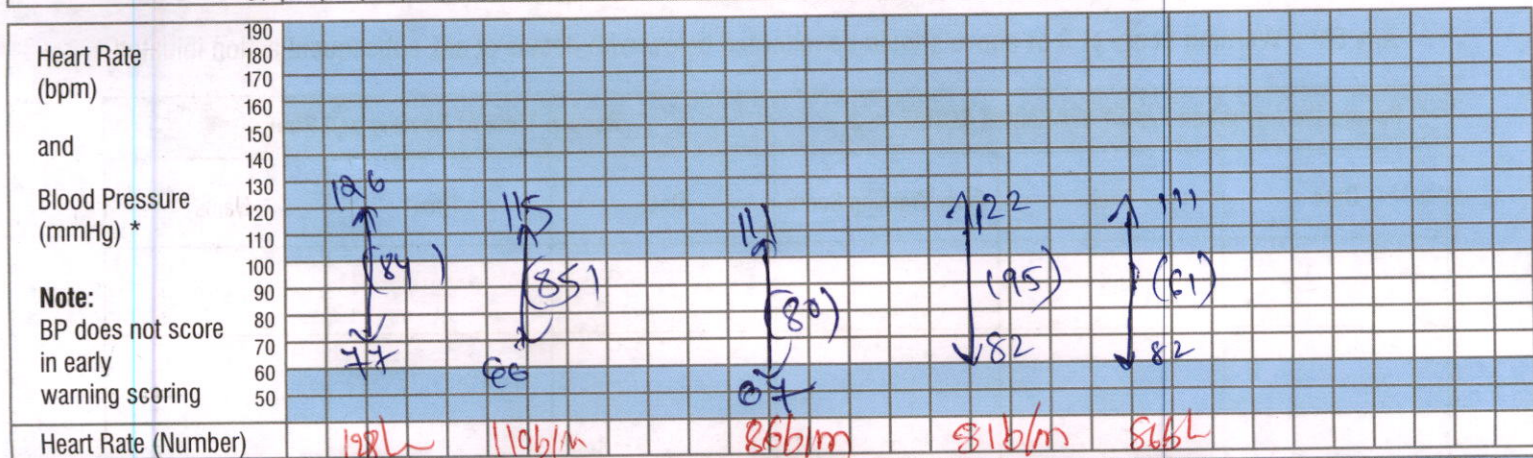
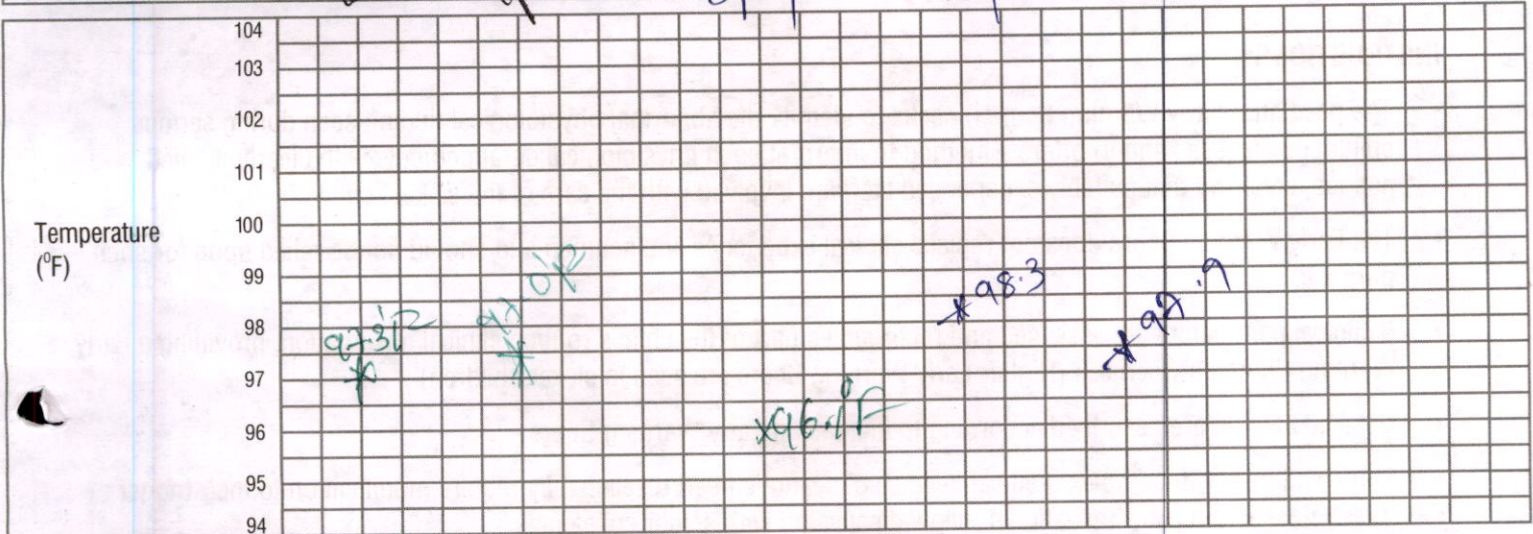
Rainbow
Children's
Hospital
It takes a lot to treat the little.

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 9/7/20 Time: 10:30

Doctor / Nurse / Family Concern? [Signature] 4 5pm 10pm 2am



Resp Mod/ Severe Distress None / Mild

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

Conscious Level Normal / Altered

GCS *

TOTAL SCORE
Number of shaded boxes
Pain Score
Observer's Initials

ACTIONS
NB: Scores 3 should be recorded overleaf

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

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



EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 21/7/2012 Time: 9:30 AM	
Doctor / Nurse / Family Concern? 3pm 1pm 10pm 9:30 AM 6am	
Temperature (°F)	
Heart Rate (bpm) and Blood Pressure (mmHg) *	
Note: BP does not score in early warning scoring	
Heart Rate (Number)	123b/min 114b/min 82b/min
Resp. Rate (bpm) (Over 1 Minute)	
Resp Rate (Number)	28b/min 30b/min 23b/min 22b/min 21b/min
Resp Distress	Mod/ Severe None / Mild
Receiving O ₂ (l/min) O ₂ Saturations (%)	100% 98% 100% 99% 97%
Conscious Level	Normal Altered
GCS *	15/15 15/15 15/15 15/15 15/15
TOTAL SCORE	
Number of shaded boxes	1 1 1 1 1
Pain Score	0 0 0 0 0
Observer's Initials	
ACTIONS	Score 1 : Continue normal observation by staff nurse Score 2 : Shift in charge nurse to be informed and continue hourly observations Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue. Score 4 : Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see Score 5 & 6 : Shift in charge AND PICU fellow or PICU consultant to be informed.

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

FLUID CHART

Sheet No. :

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

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G								
	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
Total Intake :						Total Output :							
	02:00 pm										6	} <i>[Signature]</i>	
	03:00 pm	no feed									0		
	04:00 pm										0		
	05:00 pm										0		
	06:00 pm									✓	0		
	07:00 pm										0		
Total Intake :						Total Output :							
	08:00 pm										0	} <i>[Signature]</i>	
	09:00 pm										0		
	10:00 pm										0		
	11:00 pm										0		
	12:00 am									✓	0		
	01:00 am										0		
Total Intake :						Total Output :							
	02:00 am										0	} <i>[Signature]</i>	
	03:00 am										0		
	04:00 am										0		
	05:00 am										0		
	06:00 am									✓	0		
	07:00 am										0		
Total Intake :						Total Output :							

Total 24 hrs. Intake

Total 24 hrs. Output

FLUID CHART

Sheet No. :

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
9/7	08:00 am	No DUF											
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
Total Intake :						Total Output :							
9/7	02:00 pm	No DUF											
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :							
9/7	08:00 pm	No DUF											
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
Total Intake :						Total Output :							
10/7	02:00 am	No DUF											
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
Total Intake :						Total Output :							

Total 24 hrs. Intake

Total 24 hrs. Output

BAH-00661039 IP5-00176110
 Master CHILLAMCHARLA KUMAR
 23-05-2012 14 Y 1 M 15 D (M)
 Dr. KAPIL BHAGWATRAO SACHANE

NURSING CARE RECORD

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date:

Assessment:

Goals

- | | | | | | |
|---|--|---|--|--|---|
| ☐ 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
9pm	→ Asses the pt general condition	2pm	→ Assesed the pt general condition	well Improving pt condition
3pm	→ monitor vitals	3:30pm	→ monitored vitals	
4pm	→ maintain I/O chart	4:30pm	→ maintained I/O chart	
5pm	→ provide comfortable position	5:30pm	→ provided comfortable position	
6pm	→ given all medication as per doctors order	6pm	→ given all medication as per doctors order	

Re-Assessment:

Special Notes: In taken to surgery Dr. J. S. S. S.

Nurse Signature: *Jamuna*

Nurse Name: *Jamuna*

Date & Time: 8.7.26 8 pm

BAH-00661039 IP5-00176110
Master CHILLAMCHARLA KUMAR
23-06-2012 14 Y 1 M 16 D (M)
Dr. KAPIL BHAGWATRAO SACHANE



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: 8/7/24

Assessment: Baby having dry cough

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
10pm	→ Assess the Baby General Condition, monitor vitals & Record	11pm	→ Assessed the Baby General Condition, monitored vitals & Recorded	By All this done pt condition is improved
12am	→ provide comfortable position	1am	→ provided comfortable position	
2am	→ Give Nebulization	4am	→ Given Nebulization	
6am	→ Administer medication as per doctor order	8am	→ Administered medication as per doctor order	

Re-Assessment: For cough in Hydrocortison & Nebulization's given

Special Notes: monitor spO2

Nurse Signature:

Nurse Name: Aparajita K. Srinivas

Date & Time: 9/7/24 2.50

BAH-00661039 IP5-00176110
 Master CHILLAMCHARLA KUMAR
 23-05-2012 14 Y 1 M 16 D (M)
 Dr. KAPIL BHAGWATRAO SACHANE

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: 9/7/26

Assessment: Baby having dry cough.

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8am	* Assess the general condition of the patient and monitor vitals.	8am	* Assessed the general condition of the patient and monitor vitals.	By doing all the procedure the patient can be Stable
10am	* Encourage orally.	10am	* Encouraged orally.	
12p	* monitor vitals.	12p	* monitored vitals.	
4p	* maintain nebulization	4p	* maintained nebulization	

Re-Assessment: monitor vitals.

Special Notes:

Nurse Signature: [Signature]

Nurse Name: Dhya

Date & Time: 9/7/26

BAH-00881039
Master CHILLAMCHARLA KUMAR
23-05-2012 14 Y 1 M 16 D
Dr. KAPIL BHAGWATRAO SACHANE (M)

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: 9/7/26

Assessment: Baby having cough

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 general condition of the baby	2:10pm	→ Assessed the general condition of the baby	By done. all the procedure baby condition is Improved.
3pm	→ provide comfortable position	4pm	→ provided comfortable position	
5	→ maintain good nutritional → To give nebulization		→ maintained good nutritional → Levulin 1.25mg 6th hourly	
6pm	→ monitor the vital signs	6:30pm	→ monitored the vital signs	
7:30pm	→ Administer medication as per doctor order	8pm	→ Administered medication as per doctor order	

Re-Assessment:

Special Notes:

Nebulization

Nurse Signature: 

Nurse Name: Swarna

Date & Time: 9/7/26 @ 8pm



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 9/7/21

Assessment: pt having Cough

- 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 pt General Condition	8:10pm	→ Assessed the pt General Condition	pt is stable
10pm	→ Check the vital Signs	10:10pm	→ Checked the vital Signs	
12am	→ plan for administration medication	12:10am	→ providing medication as per doctor Order	
2am	→ plan for I/O Chart	2:10am	→ strictly I/O Chart	
8am	→ plan for Comfortable position	8:10am	→ providing Comfortable position	

Re-Assessment: Re-Assessment Every 4th hly

Special Notes: -

Nurse Signature:

Nurse Name: Chandana

Date & Time: 10/7/21 2:00am

BAH-00661039 IP5-00176110
Master CHILLAMCHARLA KUMAR
23-05-2012 14 Y 1 M 16 D (M)
Dr. KAPIL BHAGWATRAO SACHANE



NURSING CARE RECORD


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


BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

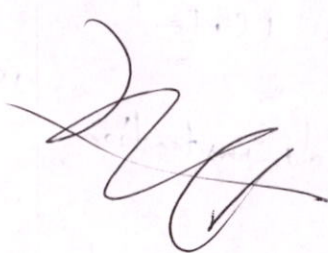
Shift: ☐ Morning ☐ Afternoon ☐ Night

Date:

Assessment:

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
				

Re-Assessment:

Special Notes:

Nurse Signature:

Nurse Name:

Date & Time:

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Kapil Department: ER Date of Admission: 8/7/26

SITUATION	Diagnosis: <u>LRTI</u>		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:					
BACKGROUND	Area	Shift Time	<u>ER</u>	<u>8:00-2:00 PM</u>	<u>1st floor 8pm-8am</u>	<u>2nd floor 8am-4pm</u>	<u>1st floor 2pm-8pm</u>	
	Medical Condition (Any special condition to be noted):		<u>Nil</u>	<u>Nil</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
ASSESSMENT	Allergy:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Tubes/Drains/Catheter:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Vital Signs:	Temp:	<u>98.7 F</u>	<u>97.5 F</u>	<u>98.0 F</u>	<u>98.1 F</u>	<u>96.5 F</u>	<u>98.3 F</u>
		Res:	<u>21/min</u>	<u>28</u>	<u>28/min</u>	<u>19</u>	<u>26</u>	<u>26/min</u>
		SpO ₂ :	<u>98%</u>	<u>95%</u>	<u>99%</u>	<u>99%</u>	<u>99%</u>	<u>100%</u>
		Pulse:	<u>110/min</u>	<u>116/min</u>	<u>81/min</u>	<u>108</u>	<u>108</u>	<u>111/min</u>
		BP:	<u>100/66 (90)</u>	<u>116/78</u>	<u>111/69</u>	<u>99/62</u>	<u>100/77</u>	<u>99/61</u>
Fall Risk Score:	<u>9</u>	<u>9</u>	<u>9</u>	<u>9</u>	<u>9</u>	<u>0/10</u>		
Pain Score:	<u>0</u>	<u>0</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>		
Recommendations	Safety Needs:		<u>yes</u>	<u>yes</u>	<u>yes</u>	<u>yes</u>	<u>yes</u>	
	Physiotherapy		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:		<u>Nil</u>	<u>Nil</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
	Special Diet:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Other Special Orders / Medications:		<u>Nil</u>	<u>Nil</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Post Operative Procedure Special Orders:		<u>Nil</u>	<u>Nil</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>		
Handed Over By Name :		<u>Sushmita</u>	<u>Janeva</u>	<u>Aparanjitha</u>	<u>Ding</u>	<u>Swarany</u>	<u>Chandane</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>8/7/26</u>	<u>8/7/26</u>	<u>9/7</u>	<u>9/7</u>	<u>9/7</u>	<u>10/7/26</u>	
Time:		<u>4:30pm</u>	<u>8pm</u>	<u>8am</u>	<u>2pm</u>	<u>8pm</u>	<u>8am</u>	
Taken Over By Name :		<u>Janeva</u>	<u>Aparanjitha</u>	<u>Ding</u>	<u>Swarany</u>	<u>Chandane</u>	<u>Ding</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>8/7/26</u>	<u>8/7</u>	<u>9/7</u>	<u>9/7/26</u>	<u>9/7/26</u>	<u>10/7</u>	
Time:		<u>4:30pm</u>	<u>8pm</u>	<u>8am</u>	<u>2pm</u>	<u>8pm</u>	<u>8am</u>	

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

SITUATION	Diagnosis:	Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
BACKGROUND	Area						
	Shift Time						
BACKGROUND	Medical Condition (Any special condition to be noted):						
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:					
	Res:						
	SpO ₂ :						
	Pulse:						
	BP:						
	Fall Risk Score:						
	Pain Score:						
Recommendations	Safety Needs:						
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:						
	Special Diet:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:						
Post Operative Procedure Special Orders:							
Handed Over By Name :							
Signature :							
Date:							
Time:							
Taken Over By Name :							
Signature :							
Date:							
Time:							

BAH-00661039 IP5-00176110
Master CHILLAMCHARLA KUMAR
23-06-2012 14 Y 1 M 16 D (M)
Dr. KAPIL BHAGWATRAO SACHANE



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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

THE HUMPTY DUMPTY SCALE

8/8/26 9/17 10/17

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	1	1			
Gender	Male	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		
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	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		
	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		
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		
TOTAL			9	9	9		

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position	yes	yes	yes		
Call device within reach	yes	yes	yes		
Wheels Locked	yes	yes	yes		
Room free of clutter	yes	yes	yes		
Adequate Lighting	yes	yes	yes		
Wheel Chair Support	no	no	no		
Other Intervention(s) Specify	no	no	no		
Nurse's Name :	Susmita	APPO	Manoj		
Signature :	Dr. Ravi	Dr. Ravi	Dr. Ravi		
Date :	8/8/26	9/17	10/17		
Time :	2:48 pm	6am	6am		

CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			9/2 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				
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	1	-	-	-	-	-				
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	1	-	-	-	-	-				
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	1	-	-	-	-	-				
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	1	-	-	-	-	-				
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	1	-	-	-	-	-				
Signature of the Nurse				Devi Appa			S. Choudhary						

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 : Neeraja

Signature of Ward In Charge :

Signature : [Signature] Name : Sowden



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 :

BRADEN 'Q' SCALE

					Date :	8/7/2012	10/2
					Time :	2:50 pm	6 am
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: extremity 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
FRICION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4
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 : 13-14 Mild Risk : 15-18 Not at Risk: 19-23							
Docu. No. : RCHBH /FRM / CLINICAL / 119							
					TOTAL SCORE		
					28		
					Evaluators Name		
					[Signature]		

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



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
8/7/26	2:50 PM	0	NO	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	N/A N/A	[Signature]
9/7/26	10 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Appu
9/7/26	6 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Appu
9/7	2 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[Signature]
9/7	10 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Chend
10/7	6 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Chend
				☐ 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:

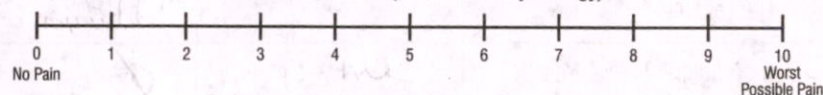
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 - 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

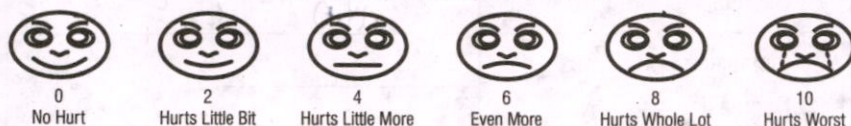
Numerical Pain Scale (Obstetric and Gynecology)



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

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

Wong - Baker (Pediatrics) Above 7 Years



INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

English

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

Identified Education Needs:

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

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
8/7/26	2:50 pm	7.	Infection control measures	M	4	0	1	1	—	<i>[Signature]</i>
8/7/26	4:50 pm	9	Normal high protein diet	M	1	0	1	1	—	<i>[Signature]</i>

Part - III: CODES

Who was taught:		PT: Patient	F: Father	M: Mother	S: Spouse	Sn: Son	D: Daughter	C: Caregiver	O: Other (Specify)
Learning Barriers:									
1. No Learning Barriers	4. Language Barrier	7. Impaired Thought Process/Cognitive limitations		10. Financial Difficulties		13. Cultural/Religion Practice			
2. Physical Impairment	5. Educational Level	8. Responsibilities at Home		11. Beliefs and Values		14. Others (Specify)			
3. Emotional Barriers	6. Desire / Motivate to Learn	9. Cultural Differences		12. Impaired Vision/ or Hearing					
Teaching Tools Used:									
A: Audio	D: Demonstration	V: Video	O: Oral	P: Printed					
Mechanism/s to overcome barrier/s:									
1. None	3. Reassurance & Support	5. Respect values & beliefs		7. Other, Specify					
2. Obtain translator	4. Teach Family / Others	6. Respect Cultural / Religion Preference							
Understanding:									
1. Verbalizes Understanding	2. Demonstrates Understanding	3. Needs Review							



MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis: _____

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
8/7/26 @ 4:16 PM	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	LRTI	Hemodynamic stability	IV medication	[Signature]	☐ Nursing ☐ Others:
8/7/26 @ 4:16 PM	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	LRTI	H - stable	IV medication	[Signature]	☒ Medical ☐ Others:
8/7/26 4:50 PM	☐ Medical ☐ Nursing ☒ Others: Dietitian	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	LRTI	Normal high protein diet	RDA: E:-1850 kcal/d P:-33g/d	[Signature]	☐ 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:

BAH-00661039 IP5-00176110
Master CHILLAMCHARLA KUMAR
23-05-2012 14 Y 1 M 15 D (M)
Dr. KAPIL BHAGWATRAO SACHANE

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

DISCHARGE PLANNING FORM

Nationality: India

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

1. Anticipated Date of Discharge: as per doctor's order

2. Destination Post Discharge: ☒ Home
Family Members Notified (Person Contacted)

☐ Transfer
Hospital Facility Notified (Person Contacted)

3. Discharge Status: ☐ Self Care ☒ Family Home Care ☐ Home Professional Assistance

☐ Needs Assistance In:

Remarks

☒ Medication ☒ Yes ☐ No

☐ Bathing ☐ Yes ☒ No

☐ Eating ☐ Yes ☒ No

☐ Walking ☐ Yes ☒ No

☐ Dressing ☐ Yes ☒ No

☐ Toileting ☐ Yes ☒ No

4. Nutritional Plan:

☐ Dietary Instruction Discussed with the:
☐ Patient ☒ Family Member

☐ Others:

5. Discharge Planning Discussed with the:

☐ Patient ☒ Family Member

☐ Others:

6. Patient/Family Educational Plan:

☐ Educational Topic/s: about nebulisation

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

☐ Patient ☒ Family Member

☐ Others:

Nurse Signature: [Signature]

Nurse Name: [Signature]

Date and Time: 8/2/26 @ 7pm



141

NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 2/8/26 Time: 4:50 PM

Weight: 51.48 kgs Centile: 50th

Height: 152 cms Centile: 75th

Inference: Well child

RDA: — Calories: 1850 kcal/d Protein: 33 g/d

Diet Recommendations: Normal high protein diet

Re-Assessment: Avoid spicy, chilled & outside foods.

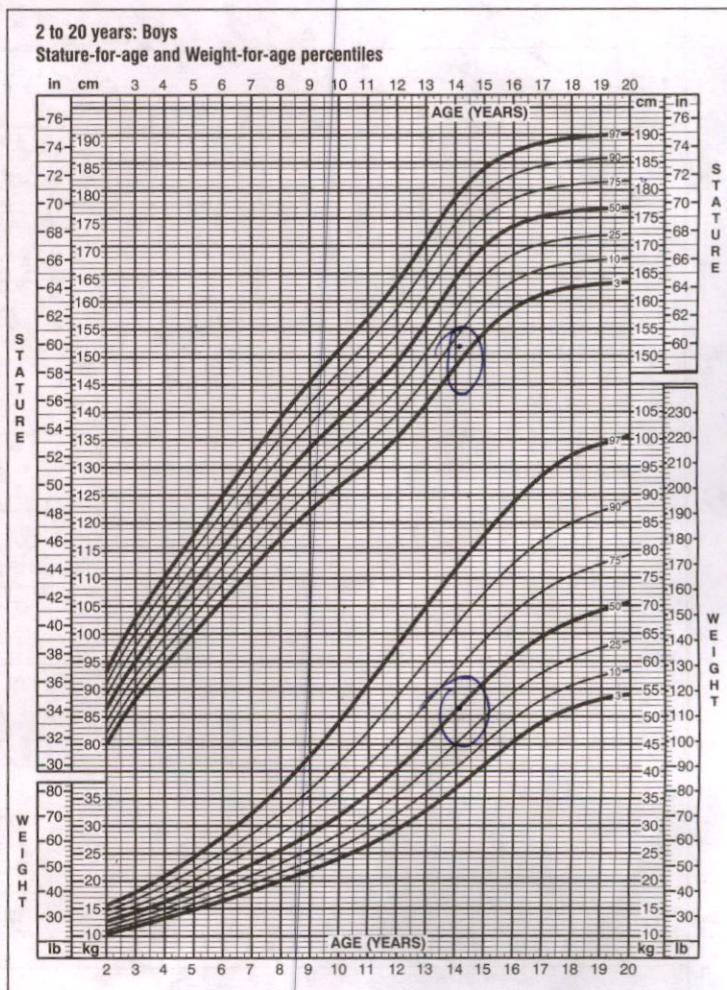
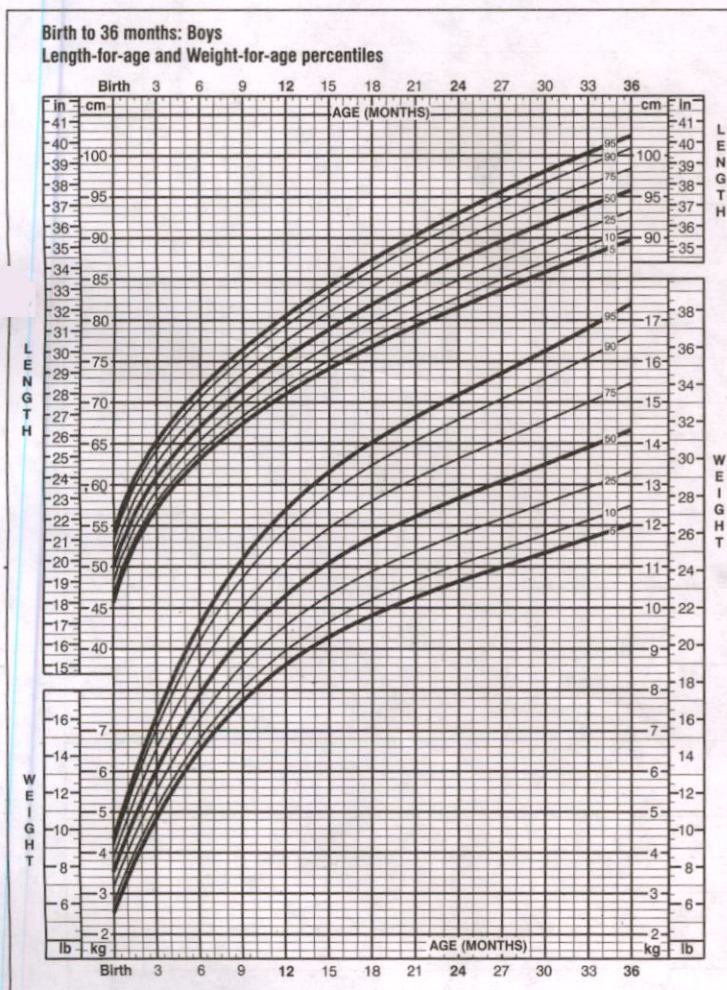
Food Allergies: NO Veg/Non-veg Non-veg (egg)

Diagnosis: LRTI

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: CM. DhanaLaxmi

GROWTH CHART (BOYS)



Dietician's Name: Mounica

Dietician's Signature: Mounica

Daily Notes:

9/8/26
8am

Child is stable Intake is better
continue $\pm$ normal high protein diet while

10/7/26
8:30am

Child is stable Intake is Better
Continue $\pm$ normal High protein diet. - Mander