

ADMISSION SHEET

Registration Details :



Admission No : IP5-00173979 Admit Date : 18-May-2026 Admit Time : 04:38 PM UHID : VIH-00170150

Patient Details :

Patient Name	: Baby MISHTI SAMDARIYA	Age	: 2 Y 9 M 1 D
Guardian	: Mr ARIHANT SAMDARIYA	DOB	: 17-08-2023
Gender	: Female	Religion	:
Occupation	:	Martial Status	: Single
Address (H)	: H NO 1-5-1119, NEAR JAIN MANDIR Chaitanyapuri Colony Hyderabad Telangana INDIA 500060	Phone No	: 8801860008/ 8830814421
		E-mail	: NOMAIL@GMAIL.COM

Admission Details :

Bed Type : DAY CARE Bed No : HO DC 2 Ward Name : 1F-HEMATO-ONCOLOGY
Room No : HO DC 2 Admission Type : First Visit

Contact Details :

Name	: Mr ARIHANT SAMDARIYA	Relationship	: Father
Contact Address	: H NO 1-5-1119, NEAR JAIN MANDIR Chaitanyapuri Colony Hyderabad Telangana INDIA 500060	Phone No	: 8801860008

Suyaje
Signature

Doctor Details :

Doctor Name	: Dr. SIRISHA RANI	Specialisation	: HEMATO ONCOLOGY
Referral Doctor	: Self	Phone No	:
Co-Consultant	:		

Payment Details :

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

ACTIVITY RECORD FOR BILLING


Name : _____

UHID No. : _____ Consultant: _____ Dept : _____

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

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

VIH-00170150 IP5-00173979
Baby MISHTI SANDARIYA
17-08-2023 2 Y 9 M 1 D (F)
Dr. SIRISHA RANI



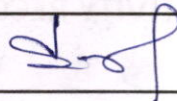
WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
18/5/26	5:30pm	er	oncology	keethi
18/5	8pm	Onco	337	Sarom

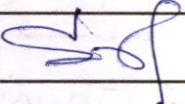
Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Signature
18/05	CBP, CRP, blood clots, s.f.f.	50401	
	CRP, S.E		REVENUE

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
18/05	IR placement	①	14150	

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

.....

Date : _____ Time : _____ Prepared By : _____

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor



**Rainbow[®]
Children's
Hospital**

It takes a lot to treat the little.

**PEDIATRIC IN-PATIENT
MEDICAL RECORD**

VIH-00170150 IP5-00173979
Baby MISHTI SAMDARIYA
17-08-2023 2 Y 9 M 1 D (F)
Dr. SIRISHA RANI



Patient Name: _____

UHID ID: _____

Department: _____

Consultant: _____

VH-00170150

IP5-00173979

Baby MISHI SAMDARIYA

17-08-2023

2 Y 9 M 1 D

(F)

Dr. SIRISHA RANI



Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

ltlo fever :: 4d
cold :: 4d
poor oral intake :: 2d

History of present illness :

Ktlo mucopolysaccharidosis type I .
post HSCT
underwent adenotonsillectomy & coblation
on 13/5/20.

ltlo fever - moderate grade,
not a/w chills
subsiding partially with medications.
not a/w cough/ rashes/ joint pains/ loose stools.

also cold :: 4d.
poor oral intake since 2 days
dull activity :: 2d
No H/o travel.

VH-00170150 IP5-00173979
Baby MISHTI SANDARIYA
17-08-2023 2 Y 9 M 2 D (F)
Dr. SIRISHA RANI



Pediatric Multiorgan History & Physical Examination

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

⊖

Birth & Neonatal History:

⊕ perinatal transition



Birth & Socio Economic History:

About Father : _____

About Mother : _____

Any additional Information : _____

Developmental History :

developed as per age

Immunization History :

⊖

Pediatric Multiorgan History & Physical Examination

Anthropometry :

Head Circum (cms) _____ (Centile _____) Height (cms): _____ (Centile) _____
Weight (kgs)) 11.8kg (Centile _____)

On Examination :

Temperature : 99.7°F Pulse Rate : 120/min B.P. 115/62 ^{ml/h} SPO2 98% RA
Resp. rate and type of breathing : 28/min

_____ Coarse crackles ⊕
Rash _____
Lymphadenopathy ⊖
Oedema : _____
Allergies (if any): _____

Respiratory System :

Inspection (any s/o distress) : _____
Air entry & breath sounds : BAC ⊕, clear.
Any added sounds : ⊖
Relevant data from outside (Chest X-Ray, ABG, etc..) /

Cardiovascular System :

Inspection of precordium : _____
Heart Sounds : S1S2 ⊕
Any murmur : ⊖
Relevant data from outside (Chest X-Ray, ECG, ECHO, etc..) : _____

Per Abdomen :

Inspection _____
Palpation : soft, NT
Auscultation : normal sounds ⊕
Spine : _____ External Genitalia : _____
Relevant data from outside (CT, USG etc..) /

Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : Alert

Cranial Nerves : (N)

Motor System:

Nutriton : _____

Tone: _____ Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR

Superficials:

Plantars _____

Sensory System :

Bladder / Bowel : regular

Clinical Summary & Diagnostic:

Acute febrile illness



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: to prevent complications

Desired goals of the treatment: hemodynamic stability

Planned Labs:
CBP
CRP
Blood U/s
& Electrolytes

Planned Management
IV Piptax
IV Paracetamol
IV fluids - 100%
4mg VORICONAZOLE

Signature of the Doctor: [Signature]
Name of the Doctor: Sarathi
Date & Time: 18/8/26 8PM

Signature of the Consultant: [Signature]
Name of the Consultant: DR. SANDHYA VADDARI
Registration No. 41664

Date & Time:



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

Signature and Date :

[Signature]
 20/8/20

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



①

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/5/23 12 PM	Post MRD H&CT for neurosarcoidosis - Adenoidectomy on 13/5/23 ~ 9 months post - acute febrile illness.	
	No further fever oral intake	(P) → at some antiepileptic at pain relief → caudal with pain
	as s/s R/S BAE (P) amputated sound (T)	→ at Domstal → at IVF - floday
	P/O s/s Enzyme level chimerism	DR. SANDHYA VADDADI Registration No. 71668 March 2023 March → (N)
		K.B. Subhasini 19/5 12 PM 40
19/5 4 PM	NO temp spikes activity (P) vitals stable	Afternoon bandage: R
		1) Cort IV fluids + activity
		2) I/O charting q6h 3) supportive care
		4) monitor vitals M.D. (P)

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/5/23		
9am	<p><u>Morning rounds</u> No M&D HICR past for MPS <u>for AFI</u></p>	
	<p>No fever Cough - better no vomiting / loose stools vitals stable</p>	
	<p><u>Plan</u> ① Dis today</p>	
	<ul style="list-style-type: none"> • Piptoz - total 5 days • Leucopen oral • Orinostat 5ml qd x 10 days • aciclovir • Voriconazole • Gandid mlb + mlb. 	
	<p>- Rev after 5 days cap, cell extra plan</p>	
	<p><i>[Signature]</i></p>	
		<p><i>[Signature]</i> 20/5 @ 10:40 am</p>
	<p>DR. SANDHYA VADDADI Registration No: 71664</p>	

VIH-00170150
 Baby MISHTI SANDARIYA
 17-08-2023 2 Y 9 M 1 D (F)
 Dr. SIRISHA RANI



Patie...



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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

RESULT SHEET

Date	18/5/26			
Time	3:54pm			
Hb	14.0			
PCV	42.2			
RBC	5.10			
WBC	14.01			
N/L	60.3/31.7			
Platelets	288			
CRP	87.0			
ESR	/			
PCT				
RBS				
Na	139			
K	4.6			
Cl	104			
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				
AP T				
CSF Protein / Sugar				
Cells				
N/L				

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

Culture and Sensitivities :

.....

.....

.....

Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI :

 Others (ECG, Contrast Studies etc.,) :

VH-00170150 IP5-00173979
 Baby MISHTI SANDARIYA
 17-08-2023 2 Y 9 M 1 D (F)
 Dr. SIRISHA RANI



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: Onw

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 domstal	3.5ml	PO	TID	13/5/26	<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
2	MDI E BUDELORT 100mcg	2 puffs	NG	BD	13/5/26	<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
3						<input type="checkbox"/> C <input type="checkbox"/> DC
4						<input type="checkbox"/> C <input type="checkbox"/> DC
5						<input type="checkbox"/> C <input type="checkbox"/> DC
6						<input type="checkbox"/> C <input type="checkbox"/> DC
7						<input type="checkbox"/> C <input type="checkbox"/> DC
8						<input type="checkbox"/> C <input type="checkbox"/> DC
9						<input type="checkbox"/> C <input type="checkbox"/> DC
10						<input type="checkbox"/> C <input type="checkbox"/> DC

* C - Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Jayalini (Jr)

Date & Time : 13/5/26 @ 5:00pm

Nurse Name & Signature: Keerthi KC

Date & Time : 13/5/26 @ 5pm



DRUG CHART

Date of Admission: 18/05/26 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. 11.8kg Ward.

VERIFIED

DRUG : Inj PIPERACILLIN TAZOBACTAM				Date Time	18/5	19/5														
Dose	Route	Frequency	Start Date																	
1g	IV	TID	18/5																	
Name & Signature of the Doctor Starting the Drugs: <i>Jayashri</i>				6pm x <i>Kavitha</i>																
Additional Instructions:				2pm x <i>Pratik</i>																
				10pm x <i>Kavitha</i>																
Daily Doctor's Endorsement by a Sign				<i>KA</i> <i>KE</i>																

DRUG : Inj PARACEYAMOL				Date Time	18/5	19/5	20/5													
Dose	Route	Frequency	Start Date																	
170mg	IV	TID	18/5																	
Name & Signature of the Doctor Starting the Drugs: <i>Jayashri</i>				6pm x <i>Kavitha</i>																
Additional Instructions:				2pm x <i>Kavitha</i>																
				10pm x <i>Kavitha</i>																
Daily Doctor's Endorsement by a Sign				<i>UV</i>																

DRUG : Inj VORICONAZOLE				Date Time	18/5	19/5														
Dose	Route	Frequency	Start Date																	
100mg	IV	OD	18/5																	
Name & Signature of the Doctor Starting the Drugs: <i>Jayashri</i>				6pm x <i>Kavitha</i>																
Additional Instructions:				11:00 pm																
Daily Doctor's Endorsement by a Sign				<i>NV</i>																

DRUG : Inj METHYLPREDNISOLONE				Date Time	18/5	19/5														
Dose	Route	Frequency	Start Date																	
10mg	IV	OD	18/5																	
Name & Signature of the Doctor Starting the Drugs: <i>Jayashri</i>				6pm x <i>Kavitha</i>																
Additional Instructions:				11:00 pm																
Daily Doctor's Endorsement by a Sign				<i>NA</i>																

VERIFIED



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
18/5	9:00pm	1mg VITAMIN B12	50mcg	IV	Fajal	Anjali Revathi

Signature
VERIFIED BY : Name



I.V. FLUIDS CHART

Date	Time	Composition of I.V. Fluid <small>(If infusion, mention ml/hr = Mcg/kg/min. etc)</small>	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
18/5	6:30pm	IUF-DWS	IV	40	Jaypr	Sanami Nashera			

Signature
VERIFIED BY : Name



Sheet No:

REGULAR PRESCRIPTIONS

Weight 11.8kg Ward

DRUG: LEVOLIN Nebulization				Date/Time	18/5															
Dose	Route	Frequency	Start Dt.																	
0.3ml	Net	BD	18/5																	
Name & Signature of the Doctor Starting the Drugs: <i>Jayadev</i>					10 AM	X														
Additional Instructions:					10 PM															
Daily Doctor's Endorsement by a Sign																				
DRUG: S-I-NS Nebulization				Date/Time	18/5															
Dose	Route	Frequency	Start Dt.																	
3ml	Net	BD	18/5																	
Name & Signature of the Doctor Starting the Drugs: <i>Jayadev</i>					10 AM	X														
Additional Instructions:					10 PM															
Daily Doctor's Endorsement by a Sign																				
DRUG: 40mg PANTOPRAZOLE				Date/Time	18/5	19/5	20/5													
Dose	Route	Frequency	Start Dt.																	
10mg	IV	Q24h	18/5																	
Name & Signature of the Doctor Starting the Drugs: <i>Sanvi</i>																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG: Symp ACICLOVIR				Date/Time	18/5	19/5														
Dose	Route	Frequency	Start Dt.																	
25ml	PO	Q12H	18/5																	
Name & Signature of the Doctor Starting the Drugs: <i>Sanvi</i>					10 AM	X														
Additional Instructions: (5ml/400mg)					10 PM															
Daily Doctor's Endorsement by a Sign																				

VERIFIED SIGNATURE

VH-00170150 IP5-00173979
 Baby MISHTI SAMDARIYA
 17-08-2023 2 Y 9 M 1 D (F)
 Dr. SIRISHA RANI



Sheet No: **REGULAR PRESCRIPTIONS** Weight Ward

DRUG : luy ONDANSETRON				Date Time	18/5	19/5															
Dose	Route	Frequency	Start Dt.																		
3mg	IV	Q12h	18/5																		
Name & Signature of the Doctor Starting the Drugs:				<p>6pm X 19/5 19/5</p>																	
Additional Instructions:				<p>6pm 19/5 19/5</p>																	
Daily Doctor's Endorsement by a Sign				<p>19/5</p>																	
DRUG : SYR DOMPERIDONE				Date Time	19/5																
Dose	Route	Frequency	Start Dt.																		
2.5ml	PO	BD	19/5																		
Name & Signature of the Doctor Starting the Drugs:				<p>19/5 19/5</p>																	
Additional Instructions:				<p>19/5 19/5</p>																	
Daily Doctor's Endorsement by a Sign				<p>19/5</p>																	
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
Name

VH-00170150 IP5-00173979
 Baby MISHTI SAMDARIYA
 17-08-2023 2 Y 9 M 1 D (F)
 Dr. SIRISHA RANI



Doc. No. : RCH/FRM / CLINICAL / 125

①

PRESCHOOL (1-5 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 : 18/08/2023 Time: 4:30 pm to 7:00 am

Doctor / Nurse / Family Concern?

Temperature (F)	104				
	103				
	102				
	101				
	100				
	99	98.5			
	98				
	97				
	96				
	95				
	94				

Heart Rate (bpm)	190				
	180				
	170				
	160				
	150				
	140				
	130				
Blood Pressure (mmHg) *	120				
	110				
	100				
	90				
	80				
	70				
	60				
	50				

Note:
 BP does not score in early warning scoring

Heart Rate (Number) 117b/m 100b/m 88b/m

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

Resp Rate (Number) 27b/m 28b/m 21b/m

Resp Mod/ Severe Distress None / Mild

Receiving O₂ (l/min) O₂ Saturations (%) 99% 100% 98%

Conscious Level Normal Altered

GCS * 15/15 15/15 15/15

TOTAL SCORE					
Number of shaded boxes	0	0	0		
Pain Score	0	0	0		
Observer's Initials	S	S	S		

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

NB: Scores 3 should be recorded overleaf

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

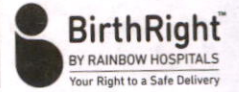
The SBAR communication tool (situation, background, assessment, recommendations) is a helpful mnemonic that can be used to describe a child's clinical condition to a colleague.

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)

VH-00170150 IP5-00173979
 Baby MISHTI SAMDARIYA
 17-08-2023 2 Y 9 M 1 D (F)
 Dr. SRISHA RANI

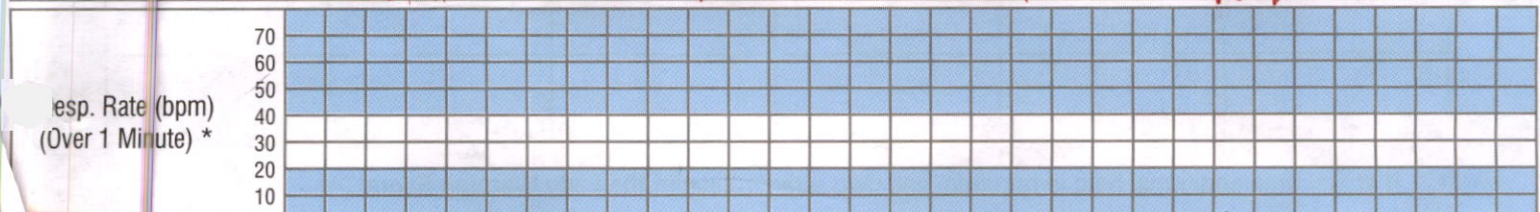
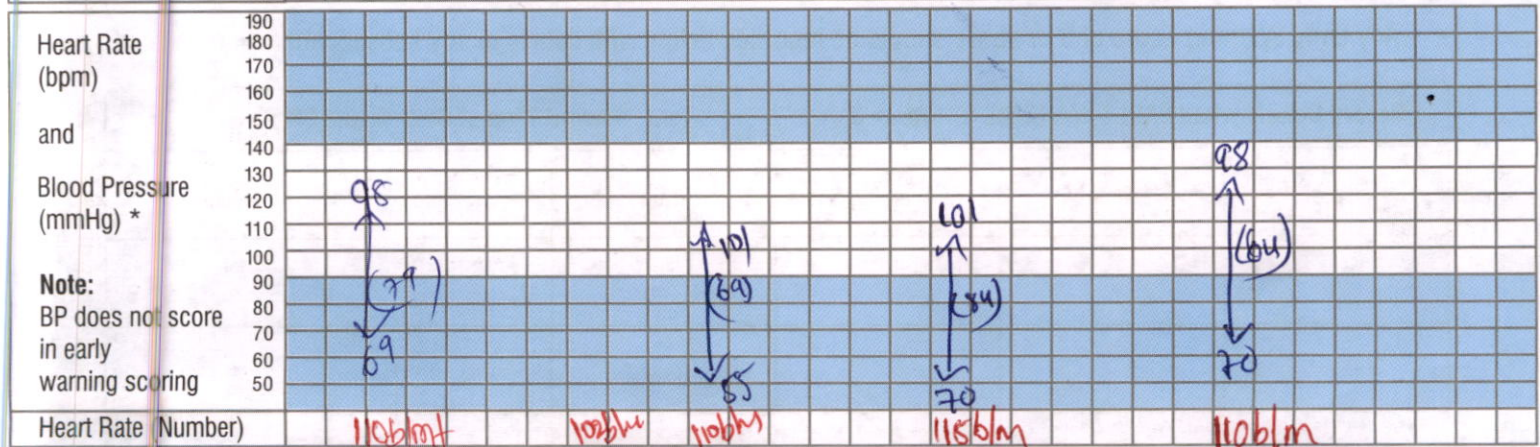
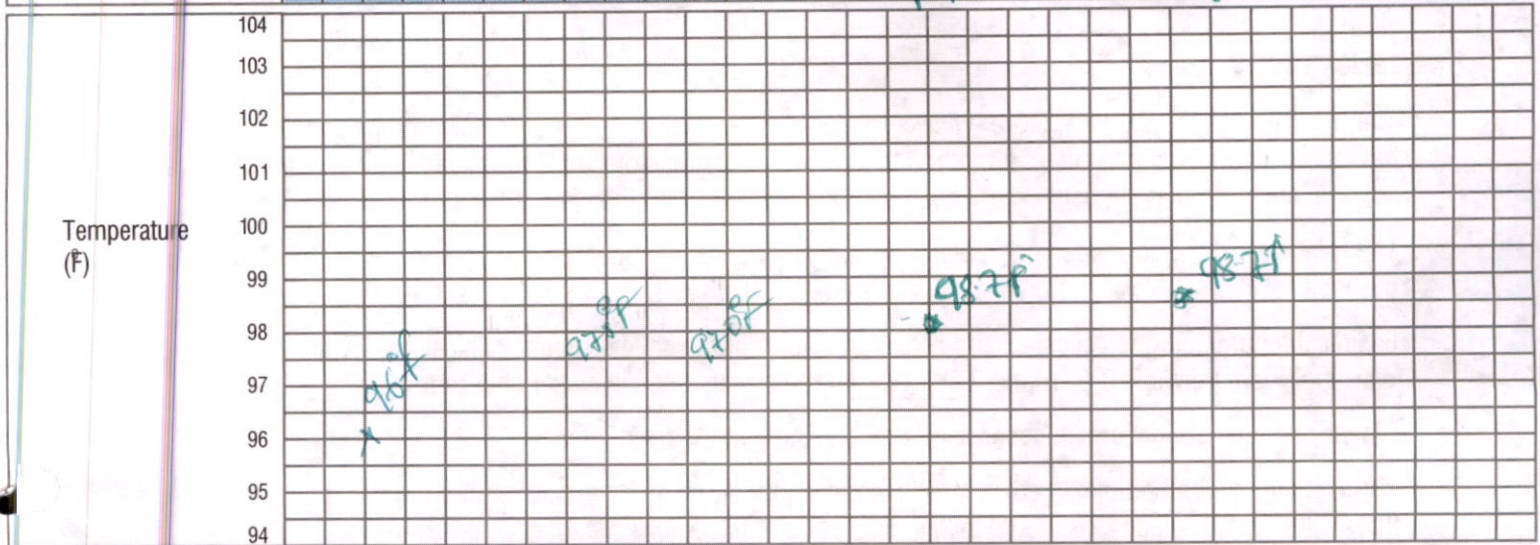
19/5/26
 HBH / FRM / CLINICAL / 125

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



EARLY WARNING SCORE: CHILDREN'S UNIT

Date : Time: 11:00 2:00 6:00 11:00 6:00
 Doctor / Nurse / Family Concern? AM PM AM PM



Resp Mod/ Severe Distress None / Mild

Receiving O₂ (l/min)

Saturations (%)

Conscious level Normal / Altered

Score

Number of shaded boxes

Score

Nurse's Initials

- 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.

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)

VH-00170150
 Baby MISHTI SAMDARIYA
 17-08-2023
 Dr. SIRISHA RANI 2 Y 9 M 2 D
 (F)

oc. No. : RCHBH / FRM / CLINICAL / 125

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



EARLY WARNING SCORE: CHILDREN'S UNIT

Date : Time: 10 am

Doctor / Nurse / Family Concern?

Temperature (F)	104					
	103					
	102					
	101					
	100					
	99					
	98					
	97	* 97.5				
	96					
	95					
94						

Heart Rate (bpm) and Blood Pressure (mmHg) *	190					
	180					
	170					
	160					
	150					
	140					
	130					
	120					
	110					
	100					
	90					
Note: BP does not score in early warning scoring						
80						
70						
60						
50						
Heart Rate (Number)	109					

Resp. Rate (bpm) 'Over 1 Minute) *	70					
	60					
	50					
	40					
	30					
	20					
	10					
Resp Rate (Number)	19					

Resp Distress	Mod/ Severe					
	None / Mild					

Receiving O ₂ (l/min)						
O ₂ Saturations (%)	94.1					

Conscious Level	Normal					
	Altered					
GCS *						

TOTAL SCORE						
Number of shaded boxes	0					
Pain Score	2					
Observer's Initials						

ACTIONS	Score 1 : Continue normal observation by staff nurse
NB: Scores 3 should be recorded overleaf	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)

VH-00170150
 Baby MISHI SAMDARIYA
 17-08-2023 2 Y 9 M 2 D
 Dr. SIRISHA RANI (F)



Doc. No. : RCHBH / FRM / CLINICAL / 125

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



EARLY WARNING SCORE: CHILDREN'S UNIT

Date : Time:

Doctor / Nurse / Family Concern?

Temperature (F): 104, 103, 102, 101, 100, 99, 98, 97, 96, 95, 94

Heart Rate (bpm) and Blood Pressure (mmHg) *
 190, 180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60, 50

Note: BP does not score in early warning scoring

Heart Rate (Number):

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

Resp Rate (Number):

Resp Distress Mod/ Severe / 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)

MH-00170150 IP5-00173979
 Baby MISHTI SAMDARIYA
 17-08-2023 2 Y 9 M 1 D (F)
 Dr. SIRISHA RANI



FLUID CHART

Sheet No. :

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo- phlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	08:00 am	H ₂ O									0		
	09:00 am										0		
	10:00 am	H ₂ O									0		
	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

VIH-00170150 IP5-00173979
 Baby MISHTI SANDARIYA
 17-08-2023 2 Y 9 M 1 D (F)
 Dr. SIRISHA RANI



FLUID CHART



Sheet No. :

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

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

Total 24 hrs. Intake

Total 24 hrs. Output

337

NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 19/5/26 Time: 11:30am

Weight: 11.8 kgs Centile: >5th

Height: 93cm Centile: 250th

Inference: underweight child

RDA: - Calories: 1250 kcal/d Protein: 21g/d

Diet Recommendations: soft diet

Re-Assessment: avoid spicy, chilled and outside foods

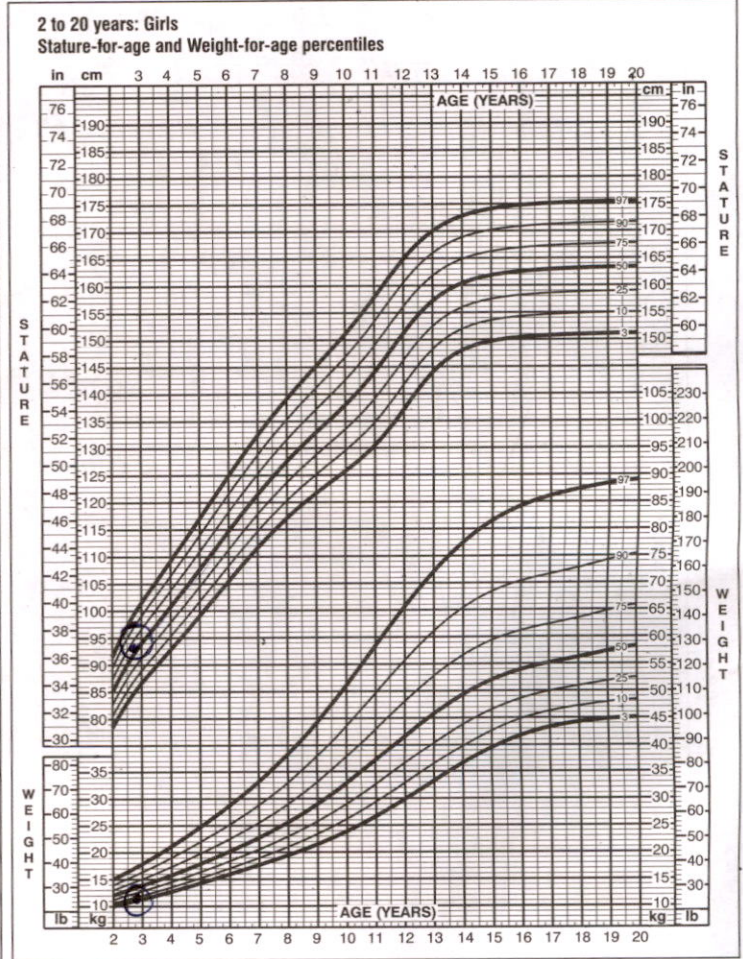
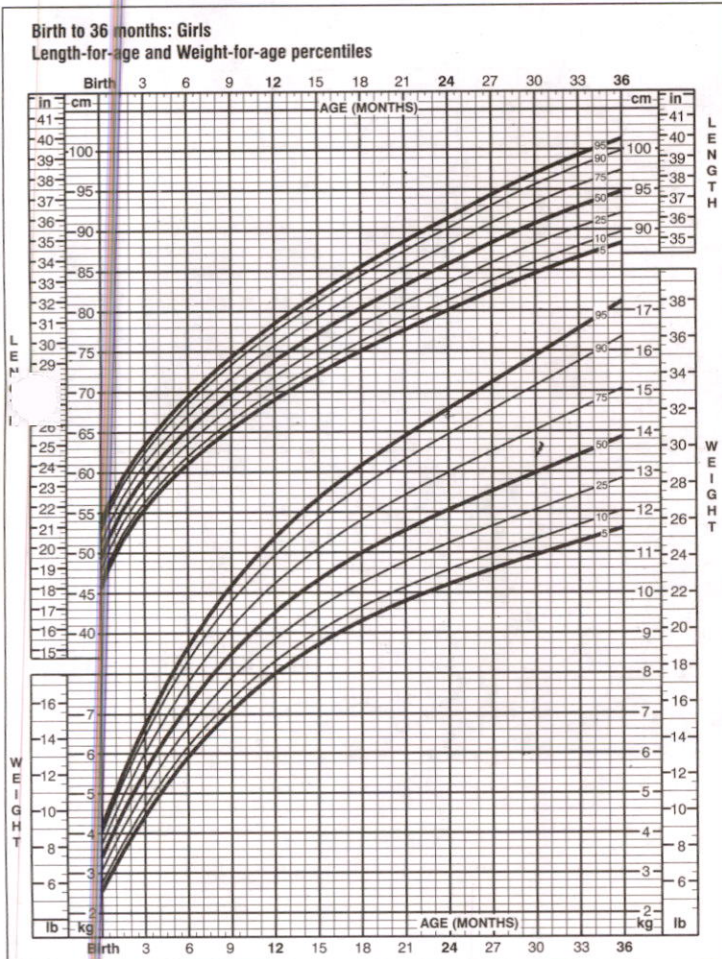
Food Allergies: NO Veg/Non-veg: veg

Diagnosis: Acute Febrile Illness, MPS Type-I

Nutritional Intervention - Oral Enteral Parenteral

Patient's Signature: Supriya

GROWTH CHART (GIRLS)



Dietician's Name: Saima

Dietician's Signature: Saima

Daily Notes:

20/5/26

child is stable, oral intake is good

11am

continue on soft diet

Saima

VH-00170150 IP5-00173979
 Baby MISHTI SAMDARIYA
 17-08-2023 2 Y 9 M 1 D (F)
 Dr. SIRISHA RANI



FLUID CHART

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

Birthright
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Sheet No. :

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			
19/8/23	08:00 am	DMS		40ml								0 0 0 0 0 0	Soubha
	09:00 am			40ml									
	10:00 am			40ml									
	11:00 am			40ml									
	12:00 pm			40ml									
	01:00 pm			40ml									
Total Intake :						Total Output : m-1					u-2		
	02:00 pm	DMS		40ml								0 0 0 0 0 0	Pragna
	03:00 pm			40ml									
	04:00 pm			-									
	05:00 pm			-									
	06:00 pm			40ml									
	07:00 pm			-									
Total Intake :						Total Output : m-1					u-2		
	08:00 pm	DMS	H2O	40ml								0 0 0 0 0 0	Annamma
	09:00 pm			40ml									
	10:00 pm		Milk	40ml									
	11:00 pm			40ml									
	12:00 am		H2O	40ml									
	01:00 am			40ml									
Total Intake :						Total Output :							
	02:00 am	DMS		40ml								0 0 0 0 0 0	Annamma
	03:00 am		H2O	40ml									
	04:00 am		Milk	40ml									
	05:00 am			40ml									
	06:00 am		H2O	-									
	07:00 am			-									
Total Intake :						Total Output :							

Total 24 hrs. Intake Total - 760

Total 24 hrs. Output

m-2 u-10

Patient Sticke



FLUID CHART

Sheet No. : 01

18/8/26

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
18/8	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
	Total Intake :						Total Output :					
18/8	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm				40ml					100ml		
	Total Intake :			40ml			Total Output :					100ml
18/8	08:00 pm			40ml								
	09:00 pm			40ml								
	10:00 pm			uont								
	11:00 pm			uont								
	12:00 am			uont								
	01:00 am			uont								
	Total Intake :			40ml			Total Output :					100ml
19/8	02:00 am			uont								
	03:00 am			uont								
	04:00 am			uont								
	05:00 am			uont								
	06:00 am			injections								
	07:00 am											
	Total Intake :			uont			Total Output :					m-u

Total 24 hrs. Intake ONS 2 uont

Total 24 hrs. Output m-u 3