

ADMISSION SHEET



Registration Details :

Admission No : IP5-00176112 Admit Date : 08-Jul-2026 Admit Time : 03:27 PM UHID : BAH-00661048

Patient Details :

Patient Name	: Baby FATIMA ALI MUZAMMIL	Age	: 3 Y 11 M 9 D
Guardian	: Mrs NAIMA SAHER	DOB	: 29-07-2022
Gender	: Female	Religion	:
Occupation	:	Marital Status	: Single
Address (H)	: HS NO 20-4-555 Chowmahalla palace. Charminar Hyderabad Telangana INDIA 500002	Phone No	: 6305434983/ 9849295222
		E-mail	: naima.seher1@gmail.com

Admission Details :

Bed Type	: SUITE	Bed No	: SUITE 1 (311)	Ward Name	: 3F-ZONE A
Room No	: SUITE 1 (311)	Admission Type	: First Visit		

Contact Details :

Name	: Mrs NAIMA SAHER	Relationship	: MOTHER
Contact Address	: HS NO 20-4-555 Chowmahalla palace. Charminar Hyderabad Telangana INDIA 500002	Phone No	: 6305434983

Naima Seher
Signature

Doctor Details :

Doctor Name	: Dr. FAISAL B NAHDI	Specialisation	: GENERAL PEDIATRICS
Referral Doctor	: Dr Milind Bhide	Phone No	: 9394867102
Co-Consultant	: Dr. ANNAPOORNA TADAVARTHY		

Payment Details :

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

ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____ IP No. _____ Dept : _____

Date of Admission: _____ charge : _____ Time: _____

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

BAH-00661048 IP5-00176112
Baby FATIMA ALI MUZAMMIL
29-07-2022 3 Y 11 M 9 D (F)
Dr. FAISAL B NAHDI



WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
8/7/26	4:00pm	EB	311	

Cross Consultation Visit

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

INVESTIGATIONS

[illegible]

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
08/17	Ev placemf	①	93333	af

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor



It takes a lot to treat the little.

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: _____

BAH-00661048 IPS-00176112
Baby FATIMA ALI MUZAMMIL
29-07-2022 3 Y 11 M 9 D (F)
Dr. FAISAL B NAHDI



UHID ID: _____

Department: _____

Consultant: _____

Curative Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

Loose stools since 3 days

Vomitus } since 2 days
Fever }

Poor oral intake }
Dull activity } since 2 days.

History of present illness:

Loose stools - Watery, yellow colour
- 2-3 episodes/day.

Vomitus → 7-8 episodes/day
- non bilious, non projectile vomitus.
- Nil

Fever - Since 2 days
- max. 101°F.
- 2-3 spikes/day.
- Yes - antipyretic medication.

Poor oral intake }
Dull activity } since 2 days.

Oral medication taken yesterday, but not improving hence came for further management

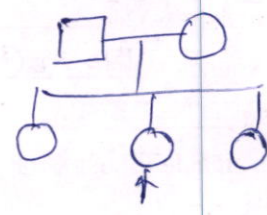
Sticker
 BAH-00661048 IP5-00176112
 Baby FATIMA ALI MUZAMMIL
 29-07-2022 3 Y 11 M 9 D (F)
 Dr. FAISAL B NAHDI

& Physical Examination

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

Birth & Neonatal History:

4.3kg / NVD / @ transition



Birth & Socio Economic History:

About Father : _____
 About Mother : _____
 Any additional Information : _____

} upper middle class.

Developmental History :

(N) development

Immunization History :

vaccinations as per (upto date) (VS schedule)



Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs)) 15 kg (Centile _____)

On Examination :

Temperature : 98.3°F Pulse Rate : 152/min B.P. 91/39(53) SPO2 96% on RA

Resp. rate and type of breathing : RR = 26/min

CRBS = 57mg/dL

Rash _____

Lymphadenopathy _____

Oedema : _____

Allergies (if any): _____

Respiratory System :

Inspection (any s/o distress) : _____

Air entry & breath sounds : BIL AET

Any addes sounds : _____

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

Cardiovascular System :

Inspection of procordium : _____

Heart Sounds : S1S2 (F)

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 Multisystem History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : _____

Cranial Nerves : _____

Motor System:

Nutrition : _____

Tone: _____ Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR

Superficials:

Plantars _____

Sensory System :

Bladder / Bowel : _____

Clinical Summary & Diagnostic:

AGE with some dehydration

BAH-00661048 IPS-00176112
Baby FATIMA ALI MUZAMMIL
29-07-2022 3 Y 11 M 9 D (F)
Dr. FAISAL B NAHDI



History & Physical Examination

Preventive aspects of the treatment: _____

Desired goals of the treatment: _____

Planned Labs:

CBP, CRP, S-Electrolytes,

S-Creatinine, Blood Urea

CVE

CSE, Stool C/S

M/B Anand
8/7/26

Planned Management

IV bolus of Hydration

Inj Ceftriaxone

Inj Paracetamol

Electrolyte solution

Inj Ondansetron

M/B Anand
8/7/26

Signature of the Doctor: Ramya

Name of the Doctor: Dr. Ramya

Date & Time: 8/7/26 2.50pm

Signature of the Consultant: Dr. Ujjwal

Name of the Consultant: Dr. Ujjwal

Date & Time: 8/7/26 5 PM

Dr. UJJWAL DESAI
Reg. No: 90530

BAH-00681048
Baby FATIMA ALI MUZAMMIL
28-07-2022 3 Y 11 M 9 D
Dr. FAISAL B NAHDI (F)

1'S NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/7/26 4:20 pm	C/S/B Dr. Kijwale C/S/B Resident	
	Δ: AGE ± some dehydration	Adv:
	cf: - Sepsis vomiting	1) USG W/A. now
	- 4 epis bilious vomiting	X-ray erect abdomen
	- last passed urine at 9am.	2) NS Bolus 160 ml now
	O/E: child dull.	3) INF DNS. at
	tongue dry.	100% ± x maintenance
	CR7 ~ 3 sec.	= 62ml 52
	peripheral pulses	4) W/f urine output
	- good vol.	5) Gastrodiet.
	Tachycardia (+)	6) Ceftriaxone
	HR - 130/min	Ordem.
	RR - 20/min	Econorm
	Upt RBS - 70mg/dl.	Zinc
	abdomen - soft & non tender	7) Send CSE / Stool C/S.
	chest clear.	CUE.
		Noted by Dr. Kijwale Akhile



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/7 9am	C/S/B Resident Δ : AGE + some dehydration last fever spike yest night 5 loose stools - small no further vomitings orally accepting food passing urine.	Adv. 1) Continue full maintenance fluids
9/7 9am	C/S/B Resident	Pls.
9/7 (8-30)	C/S/B Resident No fever No electrolyte today.	⊖: paracetamol E

Dr. FAISAL B NAHDI
 Reg. No: 66228



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/7/26 8:30am	C/S/B Resident	
	Δ: <u>Age E</u> some dehydration	
	± loose stool yesterday	
	↓ qty	↓ <u>Adm</u>
	↑ consistency	1) Stop IVF
	no vomiting	2) (D) today.
	good oral intake & appetite	
	Up - good activity - good	Akhile
	O/E: active	
	vitals stable	
	no dehydration	Syp 2ipax. ✓
	CRT < 2s.	
	warm peripheries	keonem Sautels. ✓
	chest clear	
	abdomen soft	Syp Zincoma. ✓
	(D) BS.	
	Culdi Acqua.	1 flv. i m mnd Bm d

Dr. FAISAL B NAHDI
 Reg. No: 66228

10/7
 Chd.
 (AKH)
 Bus.

Dr. FAISAL B NAHDI



PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

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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	8/7				
Time	4pm				
Hb	13.2				
PCV	39%				
RBC	5.07				
WBC	7030				
N/L	70/25				
Platelets	2.63L				
CRP	39↑				
ESR					
PCT					
RBS					
Na	128				
K	4.7				
Cl	96				
Ca/Mg					
Phosphate					
Urea					
Creatinine	0.5				
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					

Date	8/7/20					
Time						
CUE - Alb	Trace					
CUE - Sugar	Trace					
CUE - Ketones	+++					
CUE - PUS Cells	2-3					
CUE - RBC Cells	0					
CUE						
No leucocytes & casts.						
Stool Pus Cell	8-10					
OVA / Cyst	NIL					
Occult Blood	-ve.					

Culture and Sensitivities :

Stool C/S. —

Blood C/S. —

Radiology : USG :

X-Ray :

ECHO :

CT :

MRI :

Others (ECG, Contrast Studies etc.) :



Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward

DRUG :				Date Time
Dose	Route	Frequency	Start Dt.	
5ml	PO	OD	8/7	
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				

Patient Sticker

Weight 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				

BAH-00661048 IP5-00176112
 Baby FATIMA ALI MUZAMMIL
 29-07-2022 3 Y 11 M 9 D (F)
 Dr. FAISAL B NAHDI



DRUG CHART

Date of Admission: 8/7/22 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:																			



REGULAR PRESCRIPTIONS

Weight. 15 kg Ward.

DRUG : <u>Inj CEFTRIAXONE</u>				Date Time	<u>8/7</u>	<u>9/7</u>	<u>10/7</u>													
Dose	Route	Frequency	Start Date																	
<u>750mg</u>	<u>IV</u>	<u>BD</u>	<u>8/7/26</u>	<u>6am</u>	<u>4:30pm</u>	<u>6:30pm</u>														
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Rameez</u>																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign				<u>A A</u>																

DRUG : <u>Inj ESOMEPRAZOLE</u>				Date Time	<u>8/7</u>	<u>9/7</u>	<u>10/7</u>													
Dose	Route	Frequency	Start Date																	
<u>15mg</u>	<u>IV</u>	<u>OD</u>	<u>8/7/26</u>	<u>6am</u>	<u>4:30pm</u>	<u>6:30pm</u>														
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Rameez</u>																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign				<u>A A</u>																

DRUG : <u>ECONORM SACHET</u>				Date Time	<u>8/7</u>	<u>9/7</u>														
Dose	Route	Frequency	Start Date																	
<u>1sachet</u>	<u>PO</u>	<u>BD</u>	<u>8/7/26</u>	<u>6am</u>	<u>10am</u>	<u>4pm</u>														
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Rameez</u>																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign				<u>A A</u>																

DRUG : <u>Inj ONDANSETRON</u>				Date Time	<u>8/7</u>	<u>9/7</u>	<u>10/7</u>													
Dose	Route	Frequency	Start Date																	
<u>3mg</u>	<u>IV</u>	<u>TID</u>	<u>8/7/26</u>	<u>6am</u>	<u>4:30pm</u>	<u>10am</u>														
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Rameez</u>																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign				<u>A X</u>																

BAH-00661048 IP5-00176112
 Baby FATIMA ALI MUZAMMIL
 29-07-2022 3 Y 11 M 9 D (F)
 Dr. FAISAL B NAHDI



Weight. 15 kg Ward.

		ate me	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	3:00 pm	IV D10%	35me	IV	B	Geetha
8/7/26	3:10 pm	NS bolus	150me	IV	B	Geetha
8/7/26	5:30 pm	NS Bolus	160ml	IV	A	Arup poorja Sneha

Weight. 154 Ward.

[illegible]

fc

Pat

BAH-00661048 IP5-00176112
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29-07-2022 3 Y 11 M 9 D (F)
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MEDICATION RECONCILIATION FORM

Drug Allergies:

☒ Not known any Drug Allergies

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

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

Shifting From: ICU

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
						☐ 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. Ramya A

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

Nurse Name & Signature: Annab

Date & Time : 8/7/26 3:40pm



8/7/22

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date :	Time: 4:00pm	6:35pm	7:25pm	10:10pm	11:20pm	12:00am	2:00am	6:00am
Doctor / Nurse / Family Concern?								
Temperature (°F)	98.5°F	99.4°F	99.8°F	99.6°F	99.6°F	99.1°F	99.2°F	99.5°F
Heart Rate (bpm)	126bpm	126bpm	126bpm	126bpm	126bpm	126bpm	126bpm	126bpm
Blood Pressure (mmHg) *	104/73	108/50	108/50	108/50	108/50	108/50	108/50	108/50
Note: BP does not score in early warning scoring								
Resp. Rate (bpm) (Over 1 Minute) *	26bpm	26bpm	26bpm	26bpm	26bpm	26bpm	26bpm	26bpm
Resp Rate (Number)	26bpm	26bpm	26bpm	26bpm	26bpm	26bpm	26bpm	26bpm
Resp Mod/ Severe Distress None / Mild								
Receiving O ₂ (l/min)								
O ₂ Saturations (%)	96%	97%	97%	97%	97%	97%	97%	97%
Conscious Level Normal / Altered								
GCS *	15/15	15/15	15/15	15/15	15/15	15/15	15/15	15/15
TOTAL SCORE	0	0	0	0	0	0	0	0
Number of shaded boxes	0	0	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0	0	0
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 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)

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...: RCH/ FRM / CLINICAL / 125

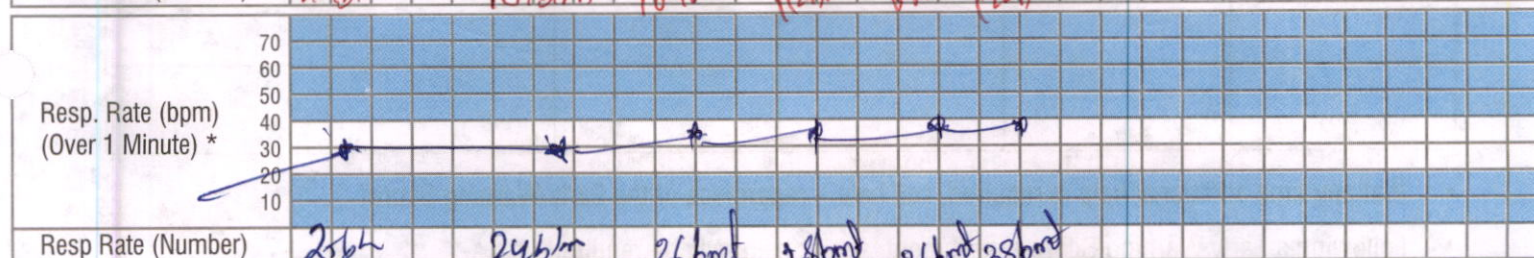
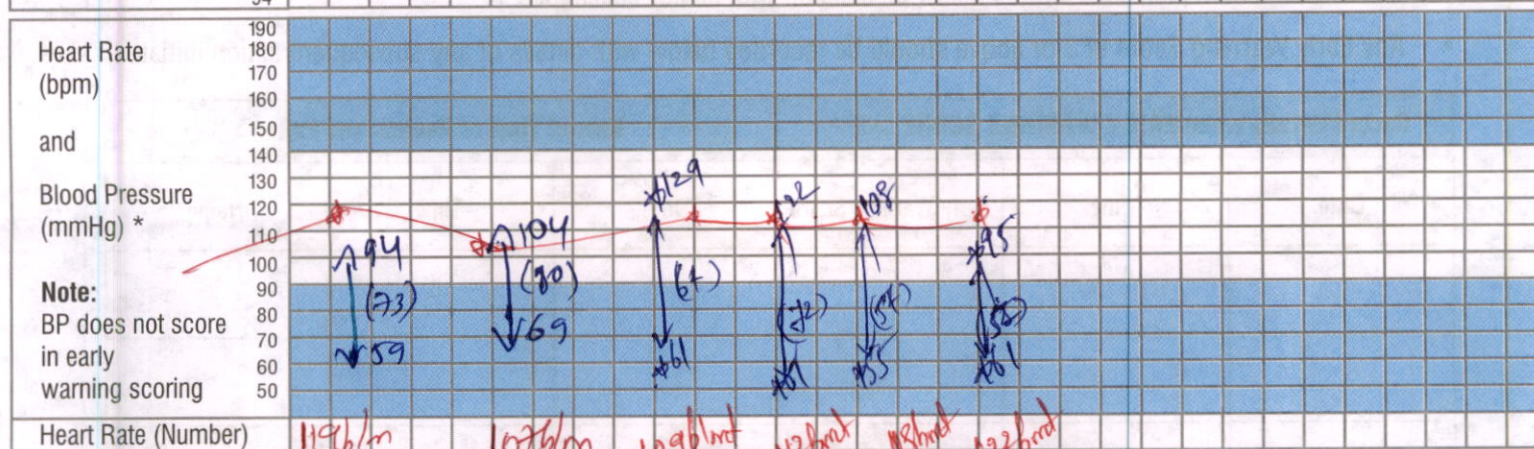
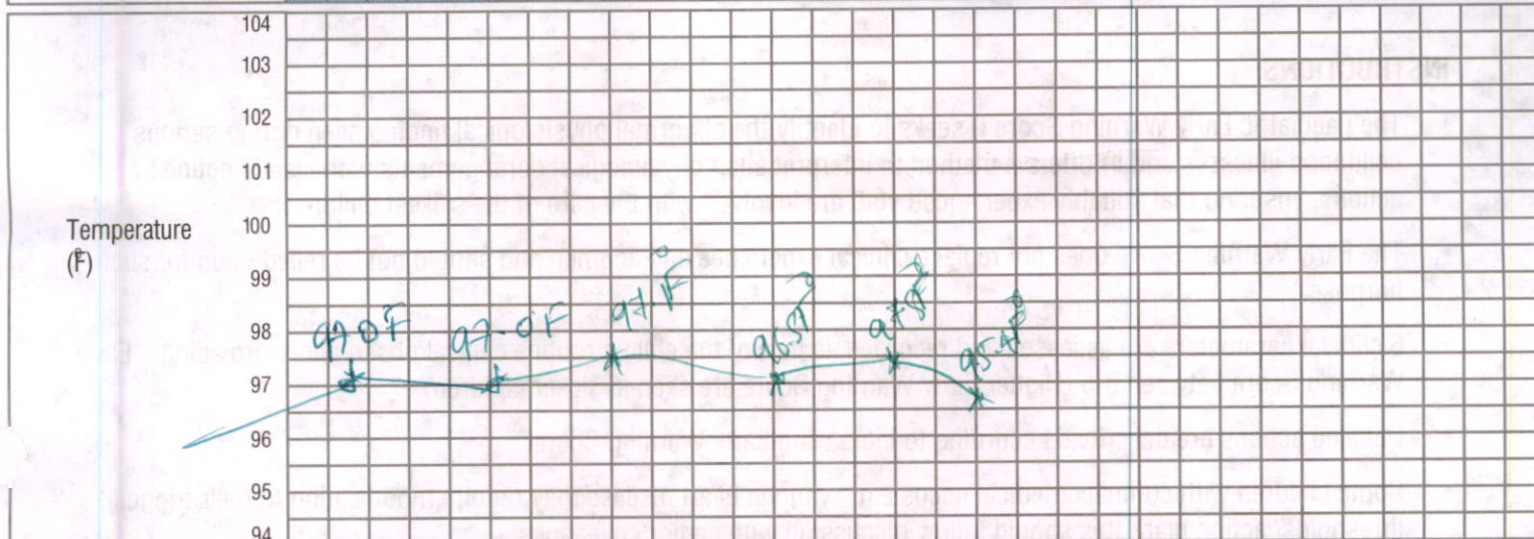
PRESCHOOL (1-5 years)
**Children's Observation &
Early Warning Scoring Chart**

Pratiksha
**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: 29/7/22 Time: 10 AM 6 PM 9 PM 12 AM 3 AM 6 AM
Doctor / Nurse / Family Concern?



Resp Distress	Mod/ Severe	None / Mild
Receiving O ₂ (l/min)	O ₂ Saturations (%)	
Conscious Level	Normal	Altered
GCS *		
TOTAL SCORE		
Number of shaded boxes		
Pain Score		
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)

Patient Sticker

BAH-00661048 IP5-00176112
 Baby FATIMA AU MUZAMMIL
 29-07-2022 3 Y 11 M 9 D (F)
 Dr. FAISAL B NAHDI



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 Hospital
 It takes a lot to treat the little.

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D CHART

Sheet No. : ①

8/7/26

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
	02:00 pm											
	03:00 pm											
	04:00 pm			B2m				✓			0	Pooja
	05:00 pm			B2m							0	Pooja
	06:00 pm			S2m			✓		✓		0	Pooja
	07:00 pm			S2m				✓			0	Pooja
Total Intake : 206ml						Total Output : U-1 m-1						
	08:00 pm			S2m							0	Alekya
	09:00 pm			B2m				✓			0	Alekya
	10:00 pm			S2m					✓		0	Alekya
	11:00 pm			S2m							0	Alekya
	12:00 am			S2m			✓				0	Alekya
	01:00 am			B2m							0	Alekya
Total Intake : 1 1/2 306ml						Total Output : U-1 m-2						
	02:00 am			S2m							0	Alekya
	03:00 am			S2m					✓		0	Alekya
	04:00 am			S2m				✓			0	Alekya
	05:00 am			S2m							0	Alekya
	06:00 am			S2m			✓				0	Alekya
	07:00 am			S2m							0	Alekya
Total Intake : 1 1/2 306ml						Total Output : U-1 m-2						
Total 24 hrs. Intake			818 ml.			Total 24 hrs. Output			U-3 m-5			

FLUID CHART

Sheet No. :

9/7/26

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

		Intake			Output					IV Site	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		Thrombo-phlebitis Score
			Mouth	I.V	N.G							
	08:00 am	1		50ml						0	0	Pooja
	09:00 am	1	tho	52ml						0	0	Pooja
	10:00 am	2	tho	52ml			✓		✓	0	0	Pooja
	11:00 am	3		52ml						0	0	Pooja
	12:00 pm	1	tho	52ml			✓		✓	0	0	Pooja
	01:00 pm	1		52ml						0	0	Pooja
Total Intake :					Total Output : 0-2 m-2							
	02:00 pm	1		-			✓		✓	0	0	Pooja
	03:00 pm	1		52ml					✓	0	0	Pooja
	04:00 pm	2	tho	52ml			✓		✓	0	0	Pooja
	05:00 pm	3		52ml					✓	0	0	Pooja
	06:00 pm	1		-						0	0	Pooja
	07:00 pm	1	tho	-						0	0	Pooja
Total Intake :					Total Output : 0-2 m-2							
	08:00 pm	1								0	0	Sukh
	09:00 pm	1	H ₂ O	40 ml			✓			0	0	Sukh
	10:00 pm	DNB	H ₂ O	40 ml						0	0	Sukh
	11:00 pm	1	H ₂ O	40 ml					✓	0	0	Sukh
	12:00 am	1		40 ml						0	0	Sukh
	01:00 am	1	H ₂ O							0	0	Sukh
Total Intake :					Total Output : 0-2 M-1							
	02:00 am	1		40ml						0	0	Sukh
	03:00 am	1	H ₂ O	40ml					✓	0	0	Sukh
	04:00 am	DNB	H ₂ O	40ml						0	0	Sukh
	05:00 am	1					NP			0	0	Sukh
	06:00 am	1	H ₂ O	40ml					✓	0	0	Sukh
	07:00 am									0	0	Sukh
Total Intake :					Total Output : 0-2 M-1							
Total 24 hrs. Intake		Total - 748 ml/day										
Total 24 hrs. Output		0-8 M-6										



NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 8/7/26

Assessment: Patient is looking dull

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
4pm	Assess the pt condition	4:10pm	Assessed the pt condition	Now the pt is stable
5pm	plan for monitor vitals		monitored vitals	
6pm	plan for maintain I/O chart	5:30pm	maintained I/O chart & recorded.	
7pm	plan for Administer medication	6:30pm	Administered medication	
	plan for check CRBS.		Checked CRBS to	
	plan for give NS bolus.		given bolus	
	plan for USG Abdomen	7:30pm	USG Abdomen done	
9pm	Ensure safety		Ensured safety	

Re-Assessment:

Special Notes:

Re-assessment done
 continue IV fluids, CUE, CSE, stool culture has been sent

Nurse Signature:

poorja

Nurse Name:

poorja (018504)

Date & Time:

8/7/26 @ 8pm

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 8/7/26

Assessment: patient having discomfort

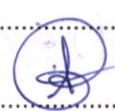
Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8 pm	→ Assess the pt general Condition	8:30 pm	→ Assessed the pt general Condition	pt is stable now
10 pm	→ Assess the pt vitals	11:15 pm	→ Assessed the pt vital	
12:30 AM	→ Assess the pt in a Comfortable position	2 AM	→ Assessed the pt in a Comfortable position	
4:30 AM	→ Assess the pt medication	5:30 am	→ Administered the pt medication	
6:15 am	→ provide person hygiene to the pt	7:30 AM	→ provided personal hygiene	

Re-Assessment: pt is stable now

Special Notes: Continue w fluids

Nurse Signature: 

Nurse Name: Alekya @ 6068920

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

BAH-00661048 IPS-00176112
 Baby FATIMA ALI MUZAMMIL
 29-07-2022 3 Y 11 M 9 D
 Dr. FAISAL B NAHDI (F)

NURSING CARE RECORD

Rainbow®
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Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 9/7/26

Assessment: Patient is irritable

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 pt condition	8:10am	Assessed the pt condition	Now the pt is stable
10am	plan for monitor vitals	11:30am	monitored vitals	
12pm	plan for maintain Ilo chart	1:30pm	maintained Ilo chart & Recorded.	
2pm	plan for Administer medication as per drug chart	4:30pm	Administered medication as per drug chart	
4pm	plan for continue IV fluids	6:30pm	Continuing IV fluids	
8pm	Plan for Ensure safety.	7:50pm	Ensured safety.	

Re-Assessment:

Special Notes: Re-assessment Continue IV fluids

Nurse Signature: Pooja

Nurse Name: Pooja (018504)

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



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 9/7/26

Assessment: patient is having discomfort

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	* Assess the patient Condition and vitals check	8:30 pm	* Assessed the patient Condition and vitals	* now patient Condition is stable.
10pm	* monitor the D/o chart	10:30 pm	* monitored the D/o chart	
12Am	* Assess the patient in a comfortable position	12:30 Am	* Assessed the patient in a comfortable position	
3Am	* check the Fever Spikes	3:30 Am	* checked the Fever Spikes	
6Am	* Administer medicine as per chart	6:30 Am	* Administered medicine as per chart	
7am	* ensure safety	7:30 Am	* ensured safety	

Re-Assessment: Assess the patient Condition now it is stable

Special Notes: Continue IV fluids 40ml/hr

Nurse Signature: Sueh

Nurse Name: Sueh - 607635

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



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Faisal B. Nahdi Department: ER Date of Admission: 8/7/26

SITUATION		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:					
BACKGROUND	Diagnosis:	<u>AER</u>					
	Area	<u>ER</u>	<u>3rd floor</u>	<u>3rd floor</u>	<u>3rd floor</u>	<u>3rd floor</u>	
ASSESSMENT	Shift Time	<u>3W</u>	<u>8am-8pm</u>	<u>8pm-8am</u>	<u>8am-8pm</u>	<u>8pm-8am</u>	
	Medical Condition (Any special condition to be noted):	<u>NOI</u>	<u>AGE</u>	<u>AGE</u>	<u>AGE</u>	<u>AGE</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>98.3C</u>	<u>99.1F</u>	<u>98.4F</u>	<u>98.6F</u>	<u>98.4F</u>
		Res:	<u>20b/m</u>	<u>20b/m</u>	<u>20b/m</u>	<u>24b/m</u>	<u>28b/m</u>
		SpO ₂ :	<u>96%</u>	<u>98%</u>	<u>98%</u>	<u>97%</u>	<u>99%</u>
		Pulse:	<u>152b/m</u>	<u>126b/m</u>	<u>126b/m</u>	<u>119b/m</u>	<u>124b/m</u>
		BP:	<u>91/31</u>	<u>104/83</u>	<u>104/83</u>	<u>93/59</u>	<u>95/61</u>
	Fall Risk Score:	<u>10</u>	<u>10</u>	<u>10</u>	<u>10</u>	<u>10</u>	
Pain Score:	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</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>NOI</u>	<u>NA</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>NOI</u>	<u>NOI</u>	<u>NOI</u>	<u>NOI</u>	<u>NOI</u>	
Post Operative Procedure Special Orders:		<u>NOI</u>	<u>NOI</u>	<u>NOI</u>	<u>NOI</u>	<u>NOI</u>	
Handed Over By Name :		<u>Rusmita</u>	<u>Pooja</u>	<u>Aleka</u>	<u>Pooja</u>	<u>Sushu</u>	
Signature :		<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>9/7/26</u>	<u>9/7/26</u>	<u>9/7/26</u>	
Time:		<u>3PM</u>	<u>8pm</u>	<u>8am</u>	<u>8pm</u>	<u>8am</u>	
Taken Over By Name :		<u>Pooja</u>	<u>Aleka</u>	<u>Pooja</u>	<u>Sushu</u>	<u>Pooja</u>	
Signature :		<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>9/7/26</u>	<u>9/7/26</u>	<u>9/7/26</u>	
Time:		<u>4pm</u>	<u>8pm</u>	<u>8am</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							
	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:						
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:								



THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4					
	3 to less than 7 years old	3	3	3	3		
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2					
	Female	1	1	1	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 sage	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			10	10	10		

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	Susmita		
Signature :		[Signature]	[Signature]		
Date :		8/7/24	9/7/24		
Time :		3:7 pm	8A		

Patient ID

BRADEN 'Q' SCALE

					Date :	8/1/26	9/1/26	10/7/26
					Time :	5:30 P.	8:00 P.	8:45 P.
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4	4	
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4	4	
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	
FRICITION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23					TOTAL SCORE	28	28	28
Docu. No. : RCHBH /FRM / CLINICAL / 119					Evaluator's Name	BA	Pragya	Sushu

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

BAH-00661048 IP5-00176112
 Baby FATIMA ALI MUZAMMIL
 29-07-2022 3 Y 11 M 10 D (F)
 Dr. FAISAL B NAHDI



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
8/7/26	3:10 pm	9/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA NA	poor's
8/7/26	9:10 pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA NA	Alekyan
9/7/26	3 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Alekyan
9/7/26	7 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Alekyan
9/7/26	2 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Pooja
9/7/26	8 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Pooja
9/7/26	10 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Suehi
10/7/26	12 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Suehi
10/7/26	3 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Suehi
10/7/26	6 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Suehi

Re-assessment Frequency:

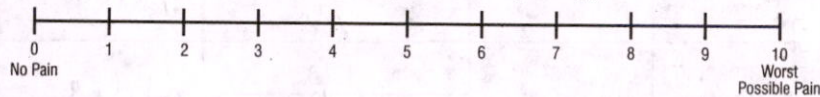
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

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

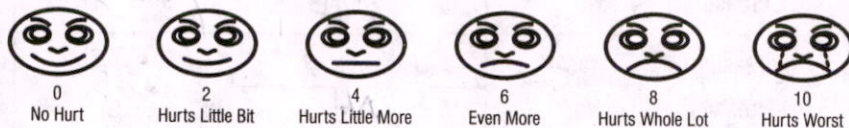
Numerical Pain Scale (Obstetric and Gynecology)



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





CHECKLIST FOR THROMBOPHLEBITIS

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

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 : momitha Name : momitha

Signature of Ward In Charge :

Signature : Aritha Name : Aritha

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 :

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Part - I.

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

Identified Education Needs:

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

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
8/17/26	3:10 pm	7	infection control measures	F	4	0	1	1	NA	Pooja
8/17/26	4:30 pm	9	gastro diet	F	1	0	1	1	-	Saima

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	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op	waiting Rx	A 26	MR IV	[Signature]	☐ Nursing ☐ Others:
8/7/26	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Acute gastroenteritis	U-stability	MR	Am	☐ Medical ☐ Others:
8/7/26 4:30 pm	☐ Medical ☐ Nursing ☒ Others: dietitian	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	acute gastroenteritis	gastro diet	<u>RDA</u> E - 1300 Kcal/d P - 22gm/d	Sainz	☐ 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:



DISCHARGE PLANNING FORM

Nationality: Indian

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

1. Anticipated Date of Discharge: As per doctors order

2. Destination Post Discharge: ☒ Home

Family Members Notified (Person Contacted)

☐ Transfer

Hospital Facility Notified (Person Contacted)

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

no need
Assistance

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 patient condition

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

☐ Patient

☐ Family Member

☐ Others:

Nurse Signature: Pooja

Nurse Name: Pooja

Date and Time: 8/7/26 @ 4pm



Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 4 PM Mode of Arrival: By wheel chair Admitting From: ☒ ER ☐ OPD ☐ Direct
Allergy / Adverse Reaction: NA Body Weight: 15 Kg
Height: NA cm

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

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

Family History:

Has the child or close family member had recent contact with a communicable disease? ☐ Yes ☒ No
If Yes, please list,

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

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

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

Observations: Weight: 15 Kg Length: 126 cm Head Circumference (< 2 years): 25.5 cm
Temp: 99.5 F HR: 126 bpm RR: 25 bpm BP: 104/53

Pain Score: 0/10 Specify Site: (Follow Pain Assessment Sheet & Document)

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

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

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

Character of Pain: Location: Frequency: Duration:

FUNCTIONAL SCREENING: ☒ No Abnormalities Detected

☐ Mobility Problem

☐ Walking Problem

☐ Developmental Delay

☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING: ☒ No Abnormalities Detected

☐ Underweight

☐ Overweight

☐ Special Feeding Method

☐ Feeding Problem

☐ Special diet

☐ No Abnormality Detected

Inform consultant for positive criteria

Psychological Screening: ☒ No Significant Findings

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

If Yes Consultant Notified: (Date/Time):

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

Social History: Lives With

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

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

Orientation has been given regarding the following aspects:

Call Bell in Reach: ☒ Yes ☐ No

Waste Disposal Explained: ☒ Yes ☐ No

Infusion Pump: ☒ Yes ☐ No

Hand hygiene Explained: ☒ Yes ☐ No

☐ Others

Patient Rights & Responsibilities: ☒ Yes ☐ No

Information given to mother

Nurse Signature: 

Nurse Name: Pooja

Date: 8/7/26

Time: 4 pm

PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00661048 IP5-00176112 Baby FATIMA ALI MUZAMMIL 29-07-2022 3 Y 11 M 9 D (F) Dr. FAISAL B NAHDI 		Date & Time of Admission 8/7/26 @ 3:27pm	Date & Time of Transfer Order 8/7/26 @ 3:55m
		Transfer Ordered by Dr. Ramya	Reason for Transfer Admission
From Unit ER	To Unit 311 Suite-(1)	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 20	Number of Imaging Films NIL	Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ If yes, what? <i>Handover</i>	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	Intifix + DWS	(1)	
2.	10% Dextrose	(1)	
3.	10% Dextrose		
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring Dr. Submeta		Name of Person Ordered Transfer Dr. Ramya	
Patient & Clinical Records Received by : pooja			
Date & Time of Patient Received : 8/7/26 @ 4:55pm			

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

☐ Unavailable Bed

☐ Nurse not Available

☐ Available Bed not ready



311

NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 8/7/26 Time: 4:10pm

Weight: 15 kgs Centile: >25th

Height: 94cm Centile: >25th

Inference: well child

RDA: - Calories: 1300 Kcal/D Protein: 22gm/D

Diet Recommendations: gastro diet (avoid wheat, eggs, milk, oats, citrus fruits &

Re-Assessment: fruit Juices, seeds, nuts) can have Rice based foods sage water,

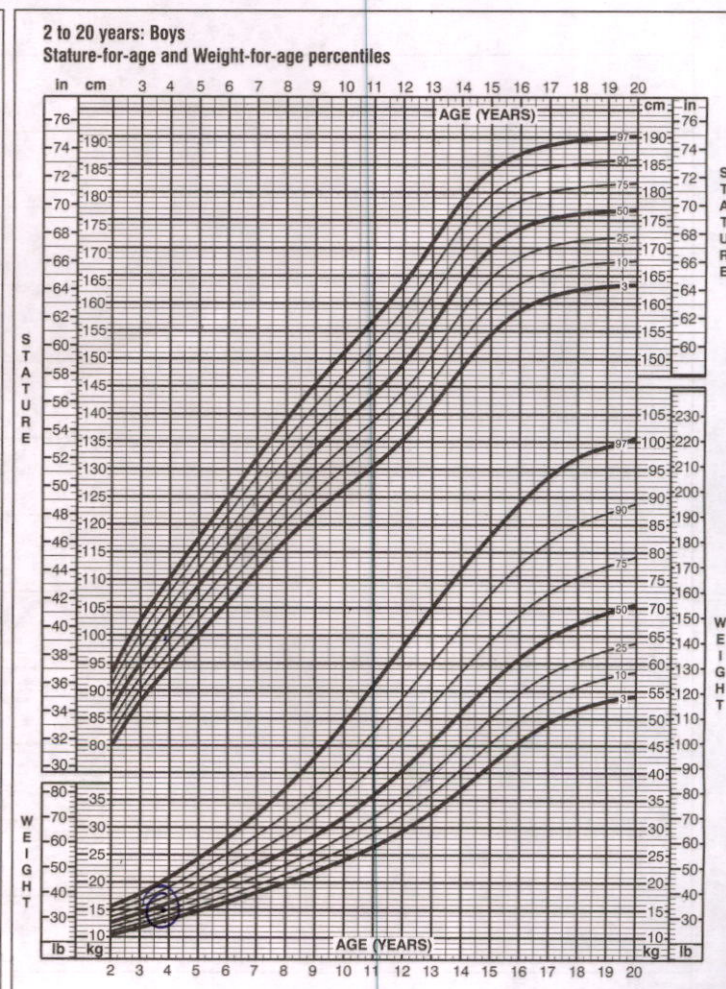
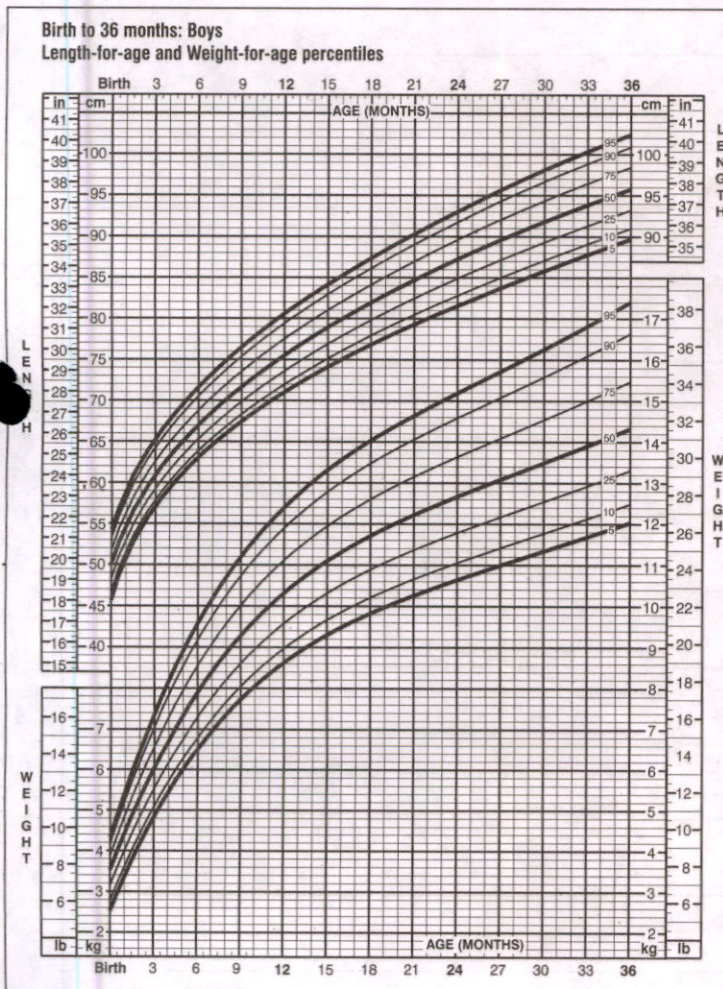
Food Allergies: NO Veg/Non-veg NON-veg

Diagnosis: acute gastro enteritis

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: Name Sehu

GROWTH CHART (BOYS)



Dietician's Name Saima

Dietician's Signature Saima

child is stable, Intake is fair

condite grasso bick

saip