

ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____

Date of Admission : _____

Room / Bed No. : _____

BAH-00598157
Baby KHUSHI
12-05-2016
Dr. UJJWALA DESAI
IP5-00176128
11 Y 1 M 27 D (F)

Consultant: _____ Dept : _____

Date of Discharge : _____ Time: _____

Suggested Billable bed type : _____

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
9/12/16	4:30 AM	CR	116	Lachel.

Cross Consultation Visit

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

[illegible]

9/7/26	Blood cl, CRP, CRP	} 8455	} Chorem
	LFT, S/E, RFT		
	5 Viral panel		

9/10/16	coe	moshi	9
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11A	CBP, CRP	06321	Q
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10/1	1000	20069100	100
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[illegible]

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[illegible]

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[illegible]

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	1		
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[illegible]

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MEDICAL EQUIPMENT (WARD & ICU)

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
9/7/26	IV placement	①	7035	Chavan
9/8/26	NHA	①	24052	sc

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date : 12/07/26

Time : 10:00am

Prepared By : shanthi

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
shanthi	Grw - I		

ADMISSION SHEET



Registration Details :

Admission No : IP5-00176128 Admit Date : 09-Jul-2026 Admit Time : 03:38 AM UHID : BAH-00598157

Patient Details :

Patient Name	: Baby KHUSHI	Age	: 11 Y 1 M 27 D
Guardian	: Mr GOPAL SINGH	DOB	: 12-05-2015
Gender	: Female	Religion	:
Occupation	:	Martial Status	: Single
Address (H)	: H NO. 10-1-670/1, AC GUARDS, SAIFABAD SCIENCE COLLEGE Khairatabad Hyderabad Telangana INDIA 500004	Phone No	: 9908528743/ 9866907114
		E-mail	: THAKURGOPALSINGH580@GMAIL.CO

Admission Details :

Bed Type : GENERAL WARD Bed No : GW 116 Ward Name : 1F-GENERAL WARD I
Room No : GW 116 Admission Type : First Visit

Contact Details :

Name : Mr GOPAL SINGH Relationship : Father
Contact Address : H NO. 10-1-670/1, AC GUARDS, SAIFABAD
SCIENCE COLLEGE Khairatabad Hyderabad
Telangana INDIA 500004 Phone No : 9908528743

Gopal Singh

Signature

Doctor Details :

Doctor Name : Dr. UJJWALA DESAI Specialisation : GENERAL PEDIATRICS
Referral Doctor : Self Phone No :
Co-Consultant : Dr. FAISAL B NAHDI

Payment Details :

Payment Mode : Cash Deposit Amount : 0.00
Payor Name : HDFC ERGO GENERAL INSURANCE
CO LTD



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PEDIATRIC IN-PATIENT MEDICAL RECORD

BAH-00598157 IP5-00176128
Baby KHUSHI
12-05-2016 11 Y 1 M 27 D (F)
Dr. UJJWALA DESAI



Patient Name: _____

UHID ID: _____

Department: _____

Consultant: _____

**Pediatric Multiorgan History & Physical Examination**

Name : Khushi Age/Sex 11 / F
Information given by: mother Relationship good

Chief Presenting Complaints & Duration (Chronologically)

Co :- fever x 3 days.
- headache x 3 days
- throat pain x 3 days.
- vomiting 2 episodes x 1 d.

History of present illness :

child premonitory well.

① → fever x 3 days.

→ Temp 101 & 103°F., every 3 hrs.

→ no chills (+), shivering (+).

② → headache, mainly during fever spikes
subsides in between
~~frontal~~, all over cranium.

③ → vomiting 2 episodes, projectile x 1 day,
non bilious.

④ → throat pain - solids > liquids.
during swallowing.

→ Medications: Azee 250mg x 2 doses
Augmentin x 1 doses.

→ No labs.



Pediatric Multiorgan History & Physical Examination

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

Birth & Neonatal History:

② perinatal transition

Birth & Socio Economic History:

About Father :

About Mother :

Any additional Information :

no sick contact

no similar illness in family

Developmental History :

②

Immunization History :

uptodate as per NIS
last at 10 yrs

(P.T.O.)

System :

neck rigidity
Kernig's weak positive
Brodzinski ~~positive~~ negative

Superficials:

Diagnostic:

② Acute febrile - PO



Pediatric Multiorgan History & Physical Examination

Anthropometry :

Head Circum (cms) _____ (Centile _____) Height (cms): 138cm (Centile _____)
Weight (kgs) 26.3kg (Centile _____)

On Examination :

Temperature : 99.5°F Pulse Rate : 86/min B.P. 99/58 SPO2 97%
Resp. rate and type of breathing : 20/min

Rash ⊖
Lymphadenopathy cervical LN ⊕, ⊕ level II 2x2cm
Oedema : ⊖ rest insignificant
Allergies (if any) : ⊖ posterior. lens

Respiratory System :

Inspection (any s/o distress) : _____
Air entry & breath sounds : B.A.E. ⊕
Any adduc sounds : _____
Relevant data : _____

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: septic shock

Desired goals of the treatment : resolution

Planned Labs:

- Blood c/s
- CRP
- CRP
- LFT
- S/E
- urea, creatinine
- extra plain
- R/V CBV serology
- R/V
- viral panel
- R/V EBV serology

Planned Management

- Ceftriaxone
- Paracetamol
- Sucralfate
- Fever management
- I/F 1/2 maintenance
- NPO from Fam
- + R/V LP/Neuro opinion

Signature of the Doctor: Ujjwala
Name of the Doctor: Ujjwala
Date & Time: 9/7/2026

Signature of the Consultant: Dr. Ujjwala
Name of the Consultant: Dr. Ujjwala
Date & Time: 9/7/26

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/12	<u>Cylin Resident</u> 8! Acute febrile illness. did not pass stool for 1 day - Fever - Since Monday - 100°-101° 103° ^F , relieved on medication associated to chills and rigor. - Vomiting - 1 episode yesterday morning No episode after. - Headache intermittent With no other complaints H/o travel to Kid Tirupathi O/E - (C) cervical LN enlargement at - angle of mandible. - Oral cavity - congested. Vitals - Stable. RA - soft, No sign of meningeal irritation.	<u>plan</u> - ct 2x ceftriaxone (D) - ct iv fluids. - Trace 5 viral panel, blood cl. - monitor vitals.
	Febrile illness EURI	Send CUE Trace viral panel Continue ceftriaxone
		DR. UJJWALA DESAI Registration No: 90550

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/5/2015 8 AM	SIB Resident A: AFI	plan. (1) cont. ceftriaxone (2) w/ fever (3) monitor vitals (4) Trace Blood U/s (5) Inform w.o.
	2 fever spikes @ 1h 2 hrs 11 AM - 101.2°F 9 PM - 102.1°F	
verbal Blood c/s no fever growing	no w/o cold/cough paced start - hard OK - fair %C child alert vitals stable RU - BLAC @ 2 days C/S P/A normal	
	AFI with pharyngitis. Resolving fever.	
		Done Drug given 9 AM
		DR. UJJWALA DESAI Registration No: 90550

Date & Time	Progress Notes	Doctor's Order
11/7/25 8 AM	Seen by Resident. ASD - Acute febrile illness.	
	fever spikes - 10 pm - 100.5°F Oral intake fair No fresh issues O/E Child alert, afebrile hemodynamically stable Chest clear, abdomen soft - Well hydrated.	Plan 1. Continue CEFTRIAXONE D3. 2. monitor vitals q uniform 80s.
	Blood vs - NG. CRP - 13 → 11.	Continue IV antibiotic. Adm. Anthony G. Drc Dr. G. J. M. 902
		DR. UJJWALA DESAI Registration No: 90550

BAH-00598157

IP5-00176128

Baby KHUSHI

12-06-2015

11 Y 1 M 28 D

(F)

Dr. UJJWALA DESAI



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/3/26 4:30pm	SIB <u>Resident</u> A: AFI	plan (1) Cont. same (2) plan PIC tomorrow if no fever (3) monitor vitals (4) Inform soc
	1 fever spike - 100.2° F at 10AM no other issues	
	o/c Child alert vitals stable	
	PR C/S PIA	
		DR. UJJWALA DESAI Registration No: 90550
12/3/26 8:30am	o/c/s Resident A: AFI & Pharyngitis. • no fever for 24hrs No vomiting Redness over gums No Accepting orally well o/c vitals - stable Hemodynamically stable Night passed well	plan - Ceftriaxone D4 Syrup Paracetamol (D2) - plan discharge today - monitor vitals
	Discharge	Give Ceftriax 1.3 at 12 noon
	Review.	F/B cefixime x 3d.
	on Wednesday	DR. UJJWALA DESAI Registration No: 90550

BRON 5pp
Zytee gel

BAH-00598157
Baby KHUSHI
12-05-2015
Dr. UJJWALA DESAI

IP5-00176128
11 Y 1 M 27 D (F)

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RESULT SHEET

Date	9/7	11/7.				
Time						
Hb	13.1	13.3.				
PCV	38.7	40				
RBC	4.5	4.6.				
WBC	12,450	6.55k				
N/L	80/12	47/42				
Platelets	2,02,000	2.04L.				
CRP	13	1				
ESR						
PCT						
RBS						
Na	131					
K	4.2					
Cl	101					
Ca/Mg						
Phosphate						
Urea	22					
Creatinine	0.5					
ALP	167					
SGPT	16					
SGOT	21					
T.Bill/Conj	0.5 ^{6-0.1} _{uc-0.4}					
T.Protein	7.2					
S.Albumin	3.7					
S.Globulin	3.5					
A/G Ratio	1					
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						



Ward

BAH-00598157
Baby KHUSHI
12-05-2015
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11 Y 1 M 28 D (F)

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Sheet No:

REGULAR PRESCRIPTIONS

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

Signature

VERIFIED BY : Name



DRUG CHART

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

FOR THE SAFETY OF THE PATIENT

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

26.3 kg

SOS / PRN (As Required Medication)

DRUG : SYP. CROCN DS				Date Time															
Dose	Route	Frequency	Start Date																
8 ML	PO	6 th hly	9/7																
Doctor's Signature		Valid Period	Pharm.																
Additional Instructions:		T > 100° F																	

DRUG : SYP. METAL. P				Date Time															
Dose	Route	Frequency	Start Date																
2 ML	PO	8 th hly	9/7																
Doctor's Signature		Valid Period	Pharm.																
Additional Instructions:		T > 102° F.																	

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

Weight. 26.3 kg Ward.

CONFIRMED

VERIFIED

VERIFIED

VERIFIED

DRUG : <u>1mg CEFTRIAXONE</u>				Date Time	<u>9/7/16</u>	<u>11/7/17</u>
Dose <u>1.3 gram</u>	Route <u>IV</u>	Frequency <u>BD</u>	Start Date <u>9/7</u>			
Name & Signature of the Doctor Starting the Drugs: <u>Ahankush</u>				<u>GAM Arund Som</u> <u>(Signature)</u> <u>Chauhan</u>		
Additional Instructions:				<u>GAM Arund Som</u> <u>(Signature)</u> <u>Chauhan</u>		
Daily Doctor's Endorsement by a Sign				<u>9</u> <u>9</u> <u>9</u>		

DRUG : <u>1mg PANTOPRAZOLE</u>				Date Time	<u>9/7</u>	<u>10/7</u>	<u>11/7</u>	<u>12/7</u>
Dose <u>30 mg.</u>	Route <u>IV</u>	Frequency <u>OD</u>	Start Date <u>9/7</u>					
Name & Signature of the Doctor Starting the Drugs: <u>Ahankush</u>				<u>GAM Arund Som</u> <u>(Signature)</u> <u>Chauhan</u>				
Additional Instructions:								
Daily Doctor's Endorsement by a Sign				<u>9</u> <u>9</u>				

DRUG : <u>SYP. SUCRAL O</u>				Date Time	<u>9/7</u>	<u>10/7</u>	<u>11/7</u>	<u>12/7</u>
Dose <u>8 mL</u>	Route <u>PO</u>	Frequency <u>TID</u>	Start Date <u>9/7</u>					
Name & Signature of the Doctor Starting the Drugs: <u>Ahankush</u>				<u>GAM Arund Som</u> <u>(Signature)</u> <u>Chauhan</u>				
Additional Instructions:				<u>7pm</u> <u>(Signature)</u> <u>Chauhan</u>				
Daily Doctor's Endorsement by a Sign				<u>9</u> <u>9</u>				

DRUG : <u>SYROP. DUPHALAC</u>				Date Time	<u>10/7</u>	<u>11/7</u>
Dose <u>10ml</u>	Route <u>P/O</u>	Frequency <u>OD</u>	Start Date <u>9/7/16</u>			
Name & Signature of the Doctor Starting the Drugs: <u>memor</u>				<u>7pm</u> <u>(Signature)</u> <u>Chauhan</u>		
Additional Instructions:						
Daily Doctor's Endorsement by a Sign				<u>9</u> <u>9</u>		

Weight. 26.3kg Ward.

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

STAT / ONCE ONLY DRUGS[illegible]

(F)



I.V. FLUIDS CHART

Weight. 26.2 kg Ward.

[illegible]

BAH-00598157 IP5-00176128
 Baby KHUSHI 11 Y 1 M 29 D (F)
 12-05-2015
 Dr. UJJWALA DESAI



Doc. No. : RCHBH/ FRM / CLINICAL / 126

SCHOOL AGE (5-12 years)

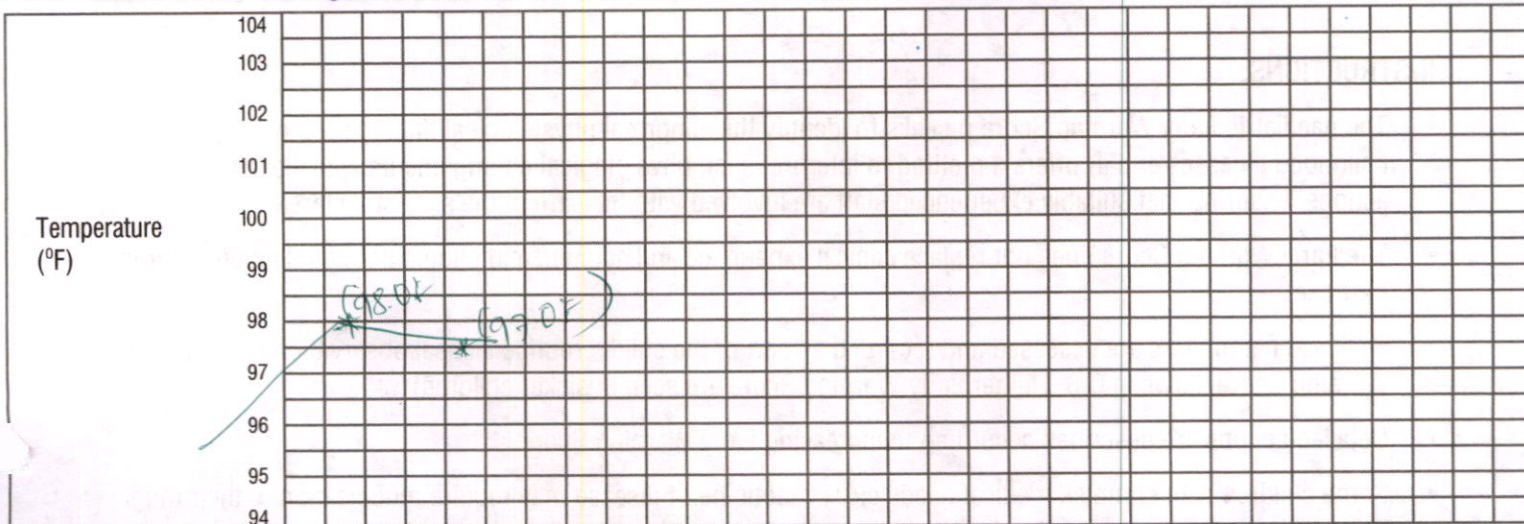
Children's Observation &
 Early Warning Scoring Chart

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 12/07 Time: 2 6
 Doctor / Nurse / Family Concern? am am



Heart Rate (bpm)
 and
 Blood Pressure (mmHg) *

Note:
 BP does not score
 in early
 warning scoring

Heart Rate (Number)

Time	Heart Rate (bpm)	Blood Pressure (mmHg)
2 am	103 bpm	98/60
6 am	101 bpm	94/66

Resp. Rate (bpm)
 (Over 1 Minute) *

Resp Rate (Number)

Time	Resp. Rate (bpm)
2 am	26 bpm
6 am	24 bpm

Resp Distress	Mod/ Severe None / Mild
Receiving O ₂ (l/min)	
O ₂ Saturations (%)	100% 100%
Conscious Level	Normal Altered
GCS *	15.5 15.5

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)

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 11/05/16 Time: 6 PM

Doctor / Nurse / Family Concern?

Temperature
(F)

104
103
102
101
100
99
98
97
96
95
94

Heart Rate
(bpm)

and

Blood Pressure
(mmHg) *

Note:

BP does not score
in early
warning scoring

Heart Rate (Number)

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

Resp. Rate (bpm)
(over 1 Minute) *

Resp Rate (Number)

Resp Mod/ Severe
Distress None / Mild

Receiving O₂(l/min)
O₂Saturations (%)

Conscious Normal
Level Altered

GCS *

TOTAL SCORE

Number of shaded boxes

Pain Score

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oc. No. : RCHBH/ FRM / CLINICAL / 126

SCHOOL AGE (5-12 years)
Children's Observation & Early Warning Scoring Chart

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 10/5/15 Time: 11:30	
Doctor / Nurse / Family Concern? 11pm 11/3 2am 2am 3am 3am 10am 10:40 11:50 12:00 12:00	
Temperature (°F)	99.3 98.3 97.9 98.5 100.2 98.3 98.9
Heart Rate (bpm)	111 (52) 100 (51) 96 (68) 100 (65)
Blood Pressure (mmHg) *	60 40 59 59
Heart Rate (Number)	113b/m 111b/m 102b/m 105b/m
Resp. Rate (bpm) (Over 1 Minute) *	26b/m 26b/m 28b/m 28b/m
Resp Distress	Mod/ Severe None / Mild
Receiving O ₂ (l/min)	99% 100% 100% 100%
O ₂ Saturations (%)	99% 100% 100% 100%
Conscious Level	Normal Altered
GCS *	15/15 15/15 15/15 15/15
TOTAL SCORE	0 0 1 1
Number of shaded boxes	0 0 0 0
Pain Score	0 0 0 0
Observer's Initials	Cy Cy Cy Cy
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 Is there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)



SCHOOL AGE (5-12 years)
Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 10/5/20 Time: 6 AM		10 am	12 PM	4 PM	6 PM	10 PM
Doctor / Nurse / Family Concern?						
Temperature (F)	104					
	103					
	102					
	101					
	100					
	99					
	98					
	97					
	96					
	94					
Heart Rate (bpm)	190					
	180					
	170					
	160					
	150					
	140					
	130					
	120					
	110					
	100					
Blood Pressure (mmHg) *	130					
	120					
	110					
	100					
	90					
	80					
	70					
	60					
	50					
	50					
Note: BP does not score in early warning scoring						
Heart Rate (Number)		98 bpm	100 bpm	100 bpm	101 bpm	96 bpm
Resp. Rate (bpm) (Over 1 Minute) *	70					
	60					
	50					
	40					
	30					
	20					
	10					
	10					
	10					
	10					
Resp Rate (Number)		20 bpm	20 bpm	20 bpm	20 bpm	20 bpm
Resp Distress	Mod/ Severe					
None / Mild						
Receiving O ₂ (l/min)						
O ₂ Saturations (%)		99%	100%	99%	100%	99%
Conscious Level	Normal					
Altered						
GCS *		15/15	15/15	15/15	15/15	15/15
TOTAL SCORE						
Number of shaded boxes		1	1	1	1	0
Pain Score		0	0	0	0	0
Observer's Initials		D	O	D	D	D

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.

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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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)

SCHOOL AGE (5-12 years)
Children's Observation &
Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 11/12/26	Time: 8:45pm	9:15pm	10:15pm	2am
Doctor / Nurse / Family Concern?				
Temperature (°F)	104			
	103			
	102			
	101			
	100			
	99			
	98			
	97			
	96			
	95			
94				
Heart Rate (bpm)	190			
	180			
	170			
	160			
	150			
	140			
	130			
	120			
	110			
	100			
Blood Pressure (mmHg) *	90			
	80			
	70			
	60			
	50			
	Note: BP does not score in early warning scoring			
	Heart Rate (Number)			
	29bpm			
	28bpm			
	Resp. Rate (bpm) Over 1 Minute *	70		
60				
50				
40				
30				
20				
10				
Resp Rate (Number)				
29bpm				
28bpm				
Resp Distress	Mod/ Severe			
	None / Mild			
Receiving O ₂ (l/min)				
O ₂ Saturations (%)		100%		
		99%		
Conscious Level	Normal			
	Altered			
GCS *		15/15		
		15/15		
TOTAL SCORE		1		
Number of shaded boxes		1		
Pain Score		0		
Observer's Initials		0		

ACTIONS

NB: Scores 3 should be recorded overleaf

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

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

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BAH-00598157
Baby KHUSHI
12-05-2015 11 Y 1 M 27 D (F)
Dr. UJJWALA DESAI

IPS-00176128

C. No. : RCHBH/ FRM / CLINICAL / 126

SCHOOL AGE (5-12 years)

Children's Observation &
Early Warning Scoring Chart

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Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 9/7/20	Time: 4:30 AM	6 AM	10 AM	11:10 AM	12 PM	6 PM
Doctor / Nurse / Family Concern?						
Temperature (°F)	104					
	103					
	102					
	101					
	100					
	99					
	98	99.6	99.4	99.8	101.2	99.5
	97					
	96					
	95					
94						
Heart Rate (bpm)	190					
	180					
	170					
	160					
	150					
	140					
	130					
	120					
	110					
	100					
Blood Pressure (mmHg) *	130					
	120					
	110					
	100					
	90					
	80					
	70					
	60					
	50					
	40					
Heart Rate (Number)	116 bpm	110 bpm	110 bpm	110 bpm	120 bpm	110 bpm
Resp. Rate (bpm) (Over 1 Minute) *	70					
	60					
	50					
	40					
	30					
	20					
	10					
Resp Rate (Number)	30 bpm	30 bpm	28 bpm	28 bpm	28 bpm	28 bpm
Resp Mod/ Severe Distress None / Mild						
Receiving O ₂ (l/min) O ₂ Saturations (%)						
Conscious Level Normal Altered						
GCS *	15/5	15/5	15/5	15/5	15/5	15/5
TOTAL SCORE	1	1	1	1	1	1
Pain Score	0	0	0	0	0	0
Observer's Initials	0	0	0	0	0	0

ACTIONS

NB: Scores 3 should be
recorded overleaf

- Score 1 : Continue normal observation by staff nurse
- Score 2 : Shift in charge nurse to be informed and continue hourly observations
- Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.
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R	RECOMMENDATION : I need you to ... come to see the child in the next (XX mins) AND Is there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

BAH-00598157 IP5-00176128
 Baby KHUSHI
 12-05-2015 11 Y 1 M 27 D (F)
 Dr. UJJWALA DESAI



FLUID CHART

Sheet No. :

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

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
	02:00 pm											
	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										0	} Rana
	03:00 am										0	
	04:00 am										0	
	05:00 am										0	
	06:00 am	TDH									0	
	07:00 am	NPO DNS 45ml									0	
Total Intake :						Total Output :						
Total 24 hrs. Intake												
Total 24 hrs. Output												

FLUID CHART

Sheet No. :

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

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
9/07/20			Mouth	I.V	N.G							
	08:00 am			45ml							0	
	09:00 am			45ml							0	
	10:00 am	DNS		45ml							0	
	11:00 am			45ml							0	
	12:00 pm			45ml							0	
	01:00 pm										0	
Total Intake :						Total Output :						
9/7/20	02:00 pm		Rice	45ml							0	
	03:00 pm			45ml							0	
	04:00 pm			45ml							0	
	05:00 pm	DNS		45ml							0	
	06:00 pm			45							0	
	07:00 pm			45							0	
Total Intake :						Total Output :						
9/7/20	08:00 pm										0	
	09:00 pm		Rice								0	
	10:00 pm	DNS	water	45ml							0	
	11:00 pm			45ml							0	
	12:00 am			45ml							0	
	01:00 am			45ml							0	
Total Intake :						Total Output :						
10/7/20	02:00 am			45ml							0	
	03:00 am			45ml							0	
	04:00 am	DNS		45ml							0	
	05:00 am			45ml							0	
	06:00 am										0	
	07:00 am										0	
Total Intake :						Total Output :						

Total 24 hrs. Intake

Total 24 hrs. Output



FLUID CHART

Sheet No. :

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

		Intake				Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G								
10/07/26	08:00 am	DPS	Bk	45ml	/	/	/	/	/	/	0	Shah	
	09:00 am			45ml							0		
	10:00 am			45ml							0		
	11:00 am			45ml							0		
	12:00 pm			45ml							0		
	01:00 pm			45ml							0		
Total Intake :					Total Output :								
10/7/26	02:00 pm	/	/	45ml	/	/	/	/	/	/	0	Shah	
	03:00 pm			45							0		
	04:00 pm			45ml							0		
	05:00 pm			45ml							0		
	06:00 pm			45ml							0		
	07:00 pm			45ml							0		
Total Intake :					Total Output :								
10/7	08:00 pm	/	/	/	/	/	/	/	/	/	0	Chand	
	09:00 pm										45ml		0
	10:00 pm										45ml		0
	11:00 pm										45ml		0
	12:00 am										45ml		0
	01:00 am										45ml		0
Total Intake :					Total Output :								
11/7	02:00 am	/	/	/	/	/	/	/	/	/	0	Chand	
	03:00 am										45ml		0
	04:00 am										45ml		0
	05:00 am										45ml		0
	06:00 am										45ml		0
	07:00 am										45ml		0
Total Intake :					Total Output :								

Total 24 hrs. Intake

Total 24 hrs. Output

BAH-00598157
Baby KHUSHI
12-05-2015
Dr. UJJWALA DESAI

IP5-00176128
11 Y 1 M 28 D (F)

FLUID CHART

Sheet No. :

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
11/7/11	08:00 am	100 100	Rice										Sawathi
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
Total Intake :						Total Output :							
11/7/11	02:00 pm	100 100	Rice										Sawathi
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :							
11/7/11	08:00 pm	100 100	Rice										Sawathi
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
Total Intake :						Total Output :							
12/07/11	02:00 am	100 100	Rice										Sawathi
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
Total Intake :						Total Output :							

Total 24 hrs. Intake

Total 24 hrs. Output

BAH-00598157 IP5-00176128
Baby KHUSHI
12-05-2015 11 Y 1 M 27 D (F)
Dr. UJJWALA DESAI



NURSING CARE RECORD

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Shift: ☐ Morning ☐ Night

Date: 9/7/2026

Assessment: Baby is having dull activity

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8am	⇒ Assess the general condition of the baby	8:30am	⇒ Assessed the general condition of the baby	The baby is condition Improving
9am	⇒ monitor vital signs	9:30am	⇒ monitored vitals	
10am	⇒ provide comfortable bed and position	10:30am	⇒ provided comfortable bed and position	
11am	⇒ administer medication as per doctor order	11pm	⇒ Administered medication as per doctor order	
1pm		2pm		

Re-Assessment:

Baby is feeling discomfortable

Special Notes:

Nurse Signature: Rama

Nurse Name: Rama

Date & Time: 9/7/2026 8pm

NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 9/7/24

Assessment: Baby having dull Activity

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	Assess the general condition of the patient	2:30 pm	Assessed the condition of the patient	Baby Condition is good
3pm	monitor the vitals signs	3:30 pm	monitored the vitals signs	
4pm	maintain I/O chart	4:30 pm	maintained I/O chart	
5pm	Administer medication as per as chart	6pm	Administered medication as per as chart	
6pm	maintain fluid Balance	7:30 pm	maintained fluid Balance	
7pm	maintain personal Hygiene		maintained personal Hygiene	

Re-Assessment: Re Assessment

Special Notes:

Nurse Signature: Al

Nurse Name: Alita

Date & Time: 9/7/24 @ 3pm

BAH-00598157
Baby KHUSHI
12-05-2015 11 Y 1 M 27 D (F)
Dr. UJJWALA DESAI

IP5-00176128



NURSING CARE RECORD

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Your Right to a Safe Delivery

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 9/7/26

Assessment: Baby having fever

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	* Assess the baby general condition. monitor vital signs	8pm	* Assessed the baby general condition. monitored vital signs	Baby condition is improving slowly
10pm	* Provide comfortable position	10pm	* Provided comfortable position	
12 AM	* maintain I/O charting	12pm	* maintained I/O charting	
4 AM	* Encourage take orally well	4 AM	* Encouraged take orally well	
6 AM	* Administered medication as per doctor orders	6 AM	* Administered medication as per doctor orders	
8am	* Ensure safety side rails	8am	* Ensured safety side rails	

Re-Assessment: fever is reduced so given syp nethal (12ml)

Special Notes: watch for fever spike.

Nurse Signature: [Signature]

Nurse Name: Suneeta (021086)

Date & Time: 10/7/26 @ 8am



NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 10/07/26

Assessment: pt having fever

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8am	* Assess the pt General Condition	8:30 am	* Assessed the pt General condition	
9am	* check the pt all vitals	9:30 am	* checked the pt all vitals	
10am	* maintain Flt chart	11am	* maintained Flt chart	
12pm	* provide comfortable position	1pm	* provided comfortable position	pt is
1:30 PM	* administer all medication given as per doctor order	2pm	* administered all medication given as per doctor order	Good

Re-Assessment:

Special Notes:

sup - meftal

Nurse Signature:

Nurse Name:

chanthi

Date & Time:

10/07/26 @ 2pm



NURSING CARE RECORD

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 10/7/26

Assessment: Baby having poor oral Intake

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	Assess the general condition of the children	2:5pm	Assessed the general condition of the children.	By done all procedure baby condition is Improved.
3pm	provide comfortable position	4pm	provided comfortable position	
5pm	Maintain IV fluids	5:30pm	Maintained ONS usual hr	
6pm	Maintain I & O chart	6:30pm	Maintained I & O chart	
7:30pm	Administer medication as per doctor order.	8pm	Administered medication as per doctor order.	

Re-Assessment:

Special Notes:

CP, CRP, t/m

Nurse Signature:

Nurse Name: Swarna

Date & Time: 10/7/26 @ 8pm



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 10/7/26

Assessment: pt having Fever

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 pt General Condition	8:10pm	→ Assessed the pt General Condition	pt is stable
10pm	→ Check the vital signs	10:10pm	→ Checked the vital signs	
12am	→ Plan for Administration medication	12:10am	→ Providing medication as per doctor Order	
2am	→ Plan for Ito Chart	2:10am	→ maintaining Ito Chart	
8am	→ Plan for Comfortable position	8:10am	→ providing Comfortable position	

Re-Assessment: Re-Assessment Every 4th hrly

Special Notes:

Nurse Signature:

[Signature]

Nurse Name:

Chandam

Date & Time:

11/7/26 2:50am



NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 11/7/26

Assessment: Pt having pyrexia

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 general condition.	8AM	→ Assessed Pt general condition.	Pt condition is normal
10AM	→ monitor vital signs	10AM	→ monitored vital signs	
12PM	→ maintain 40 chart	12PM	→ maintained 40 chart	
2PM	→ administer the medications as per doctors order.	2PM	→ Administered the medications as per doctors order.	

Re-Assessment:

Special Notes: watch for fever spike.

Nurse Signature: *Shi*

Nurse Name: sravathi

Date & Time: 11/7/26 2PM

BAH-00598157 IP5-00176128
 Baby KHUSHI
 12-05-2015 11 Y 1 M 29 D (F)
 Dr. UJJWALA DESAI



NURSING CARE RECORD

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Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 11/07/16

Assessment: pt having dull activity

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	*Assess The pt General condition	2:30pm	*Assessed The pt General condition	pt is stable
3pm	*check the pt all vitals	3:30pm	*checked The pt all vitals	
4pm	*maintain s/o chest	4:30pm	*maintained s/o chest	
5pm	*provide comfortable position	6pm	*provided comfortable position	
7pm	*administer all medication given by per doctor order	8pm	*administered all medication given by per doctor order	

Re-Assessment:

Special Notes: continue same treatment

Nurse Signature: [Signature]

Nurse Name: charitha

Date & Time: 11/07/16 8pm

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 11/07/26

Assessment: Baby having pyrexia along stable

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 baby General condition	8pm	→ Assessed the baby General condition	By doing the all the baby condition is improved slowly.
10pm	→ provide comfort position	10pm	→ provided comfortable position	
12am	→ monitor the vitals	12am	→ monitored the vitals & Recorded it	
2am	→ administer the all drugs as per doctor orders	2am	→ administered the all drugs as per doctor orders	
4am		4am		
6am		6am		
8am	→ Ensure the safety	8am	→ Ensured the safety side of all	

Re-Assessment:

Done by doing Rechecking body Temperature

Special Notes:

Plan D/C T/m

Nurse Signature:

[Signature]

Nurse Name:

Shailaja (605563)

Date & Time:

12/07/26 (8am)

BAH-00598157 IP5-00176128
Baby KHUSHI
12-05-2015 11 Y 1 M 29 D (F)
Dr. UJJWALA DESAI



NURSING CARE RECORD


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Shift: ☐ Morning ☐ Afternoon ☐ Night

Date:

Assessment:

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation

Re-Assessment:

Special Notes:

Nurse Signature:

Nurse Name:

Date & Time:

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Baby KHUSHI

12-05-2016

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NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Ujjwala Desai Department: General Paeds Date of Admission: 9/7/26

SITUATION		Any Infection: ☐ Yes ☒ No ☐ Not Known If Yes Specify:						
BACKGROUND	Area	CP	1st Floor	1st Floor	1st Floor	1st Floor	1st Floor	
	Shift Time	4:30A-10:30A	10:30A-2PM	2PM-8PM	8PM-12PM	12PM-4PM	4PM-8PM	
ASSESSMENT	Medical Condition (Any special condition to be noted):	NA	NA	NA	NA	NA	NA	
	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
ASSESSMENT	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Vital Signs:	Temp:	100.2°F	99.0°F	98.2°F	98°F	98°F	98.4°F
		Res:	20b/m	20b/m	20b/m	20	20	20b/m
		SpO ₂ :	98.1%	99%	100%	99%	99%	100%
		Pulse:	128b/m	120b/m	110b/m	110b/m	110b/m	100b/m
		BP:	112/68/70	110/70	100/60	99/69	98/62	100/60
		Fall Risk Score:	9	11	11	11	11	11
	Pain Score:	0	0	0	0/10	0/10	0/10	
Recommendations	Safety Needs:	side rails	yes	yes	yes	yes	yes	
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:	NA	NA	NA	NA	NA	NA	
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Other Special Orders / Medications:	NA	NA	NA	NA	NA	NA	
Post Operative Procedure Special Orders:		NA	NA	NA	NA	NA	NA	
Handed Over By Name :		Dachal	Rana	Shankh	Nikita	Surekha	Shankh	
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	
Date:		9/7/26	9/7/26	9/7/26	9/7/26	10/7/26	10/7/26	
Time:		4AM	8AM	2PM	2PM	8PM	4PM	
Taken Over By Name :		Rana	Shankh	Nikita	Surekha	Shankh	Surekha	
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	
Date:		9/7/26	9/7/26	9/7/26	9/7/26	10/7/26	10/7/26	
Time:		4:30AM	8AM	2PM	8PM	8AM	2PM	



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: DR. V. D. Department: Needs Date of Admission: 9/7/20

SITUATION	Diagnosis: <u>AFI</u>		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:				
BACKGROUND	Area	Shift Time	1st floor 2pm-8pm	1st floor 8pm-8am	1st floor 8am-2pm	1st floor 2pm-8pm	1st floor 8pm-8am
	Medical Condition (Any special condition to be noted):		NA	NA	NA	NA	NA
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:	96.1°	98.3°	98.2°	98.0°	98.0°
	Res:	28	28b/m	28b/m	28b/m	28b/m	
	SpO ₂ :	100%	99%	100%	99%	99%	
	Pulse:	110	111b/m	102b/m	110b/m	110b/m	
	BP:	105/64	98/62	97/59	100/60	106/30	
	Fall Risk Score:	11	11	11	11	11	
Pain Score:	0/10	0/10	0/10	0/10	0/10		
Recommendations	Safety Needs:	Yes	Yes	Yes	Yes	Yes	
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:	NA	NA	NA	NA	NA	
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Other Special Orders / Medications:	NA	NA	NA	NA	NA	
Post Operative Procedure Special Orders:		NA	NA	NA	NA	NA	
Handed Over By Name :		Swaraj	Chandam	Swaraj	Shank	Shailaja	
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	
Date:		10/7/20	11/7/20	11/7/20	11/7/20	12/7/20	
Time:		8pm	8am	2pm	8pm	8am	
Taken Over By Name :		Chandam	Swaraj	Shank	Shailaja	Shank	
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	
Date:		10/7/20	11/7/20	11/7/20	11/7/20	12/7/20	
Time:		8pm	8am	2pm	8pm	8am	

BAH-00598157

IP5-00176128

Baby KHUSHI

11 Y 1 M 27 D

(F)

Patient

12-05-2016

Dr. UJJWALA DESAI



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THE HUMPTY DUMPTY SCALE

9/2 10/7 11/2 12/2

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	9/2				
	3 to less than 7 years old	3					
	7 to less than 13 years old	2	2	2	2	2	
	13 years old and above	1					
Gender	Male	2					
	Female	1	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	1	
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	1	1	1	1	1	
	History of Falls or Infant - Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2	2	2	2	
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	1	1	1	1	
Medication Usage	Sedatives (excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1	1	1	
TOTAL			9	9	9	9	

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position	Yes	Yes	Yes	Yes
Call device within reach	Yes	Yes	Yes	Yes
Wheels Locked	Yes	Yes	Yes	Yes
Room free of clutter	Yes	Yes	Yes	Yes
Adequate Lighting	Yes	Yes	Yes	Yes
Wheel Chair Support	NO	NO	NO	NO
Other Intervention(s) Specify	NO	NO	NO	NO
Nurse's Name :	Dalida	Suh	Chanch	Shahid
Signature :	Dr	Dr	Dr	Dr
Date :	9/2	10/7	11/2	12/2
Time :	4Am	6am	6am	6am



CHECKLIST FOR THROMBOPHLEBITIS

12/07/16

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						
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													

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 : Soumitra Name : Soumitra

Signature : _____ Name : _____

SAH-00598157
Baby KHUSHI
12-05-2015
Dr. UJJWALA DESAI
11 Y 1 M 28 D
IP5-00176128
(F)

CHECKLIST FOR THROMBOPHLEBITIS

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08/07/16 9/07/16

10/07/16

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	
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						Rama	Mike	sw	Boch	Chand			

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 : Sourav Name : Sourav

Signature of Ward In Charge :

Signature : W Name : Weeraja

BAH-00598157

IP5-00176128

Baby KHUSHI

12-05-2015

11 Y 1 M 27 D (F)

Dr. UJJWALA DESAI



BRADEN 'Q' SCALE

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					Date :	10/3/20	10/3/20	11/3/20	12/3/20
					Time :	4 AM	6 AM	6 AM	6 AM
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	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	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	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	4	
FRICTION-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	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	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	4	
TOTAL SCORE					28	28	28	28	
Evaluator's Name					Dr. Ujjwala Desai	Dr. Ujjwala Desai	Dr. Ujjwala Desai	Dr. Ujjwala Desai	

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

Docu. No. : RCHBH / FRM / CLINICAL / 119

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



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
9/2/26	4am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Rachel
9/7/26	12pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	Nikhil
9/7/26	8pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Suek
10/7/26	4am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	Suek
10/7/26	12pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Shr
10/8/26	11pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Chondani
11/8	6am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Chondani
11/8	2pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Suek
11/04	10pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Shafiq
12/04	6am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Shafiq

Re-assessment Frequency:

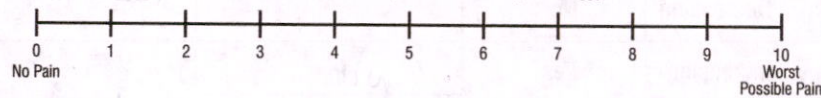
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

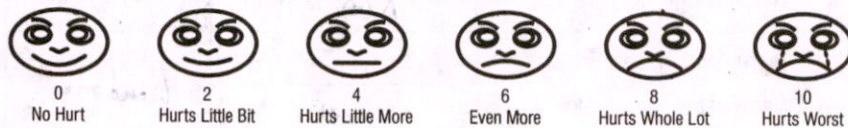
Numerical Pain Scale (Obstetric and Gynecology)



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

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

Wong - Baker (Pediatrics) Above 7 Years





INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Part - I.

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

Identified Education Needs:

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

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
9/12/20	9am	2	Treatment and care plan	M	1	0	1	1	NA	Dr. Ujjwala
9/12/20	8am	9	normal diet	m	1	0	1	1	-	Dr. Ujjwala

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					

BAH-00598157 IP5-00176128
 Baby KHUSHI
 12-05-2015 11 Y 1 M 27 D (F)
 Dr. UJJWALA DESAI



MULTI-DISCIPLINARY PLAN OF CARE FORM

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

BirthRight™
 BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Diagnosis: _____

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
9/7	☒ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op	APR	st. stability	12 f 12 AM	[Signature]	☐ Nursing ☐ Others:
9/7/20	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Acute febrile illness	Hemodynamic stability	fluids	[Signature]	☒ Medical ☐ Others:
9/7/20 sam	☐ Medical ☐ Nursing ☒ Others: Dietician	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	API	normal diet	RNA C- 1700 kcal/d P- 30g/d	[Signature]	☐ Medical ☐ Nursing ☒ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:



DISCHARGE PLANNING FORM

Nationality: Indian

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

1. Anticipated Date of Discharge: AS per doctor order

2. Destination Post Discharge: ☒ Home

Family Members Notified (Person Contacted)

☐ Transfer

Hospital Facility Notified (Person Contacted)

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

☐ Needs Assistance In:

Remarks

☐ Medication	☒ Yes	☐ No
☐ Bathing	☐ Yes	☒ No
☐ Eating	☐ Yes	☒ No
☐ Walking	☐ Yes	☒ No
☐ Dressing	☒ Yes	☐ No
☐ Toileting	☐ Yes	☒ No

Explained
parents

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: hand hygiene

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

☐ Patient ☒ Family Member

☐ Others:

Nurse Signature: Rama

Nurse Name: Rama

Date and Time: 9/7/2026 12:30 AM

PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00598157 IP5-00176128 Baby KHUSHI 12-05-2015 11 Y 1 M 27 D (F) Dr. UJJWALA DESAI 		Date & Time of Admission 9/7/26 @ 3:38AM	Date & Time of Transfer Order 9/7/26 @ 4:30AM
		Transfer Ordered by Dr. Akanksha.	Reason for Transfer Admission
From Unit ER	To Unit 116	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 ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	plain	①	
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring Mr. Lachel 		Name of Person Ordered Transfer Dr. Akanksha.	
Patient & Clinical Records Received by : Rama			
Date & Time of Patient Received : 9/7/2026 4:30AM			

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



NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 9/1/20 Time: 8am

Weight: 26.34 kgs Centile: 5th

Height: 138 cm Centile: 10th

Inference: underweight child

RDA: — Calories: 1700 kcal/d Protein: 30g/d

Diet Recommendations: Child is on NPO → Normal diet

Re-Assessment: avoid spicy, chilled, outside food

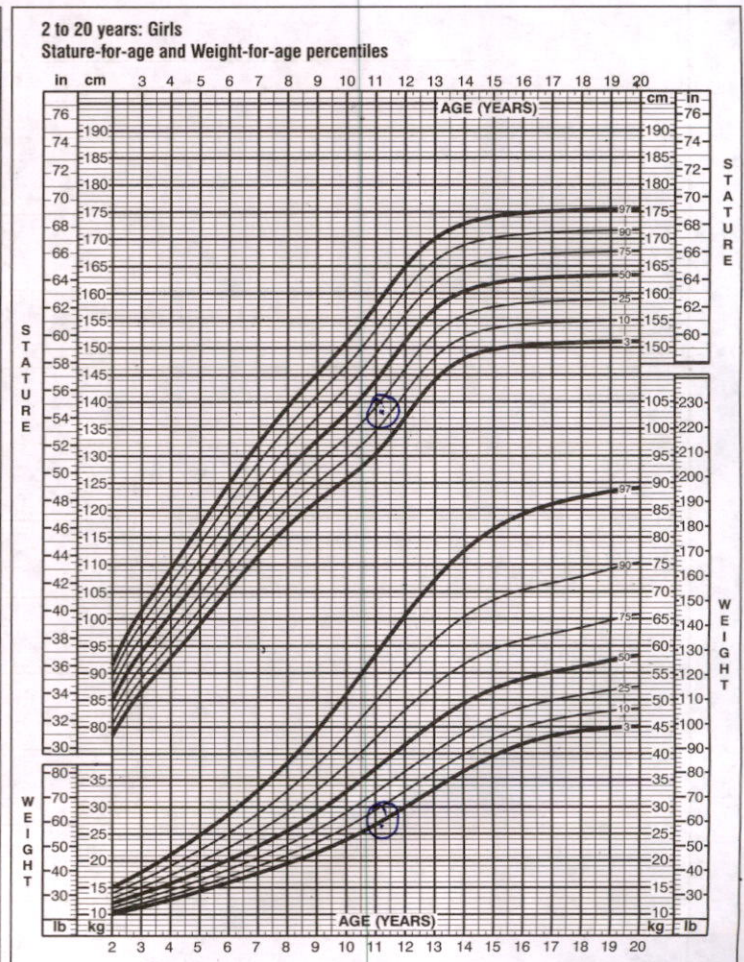
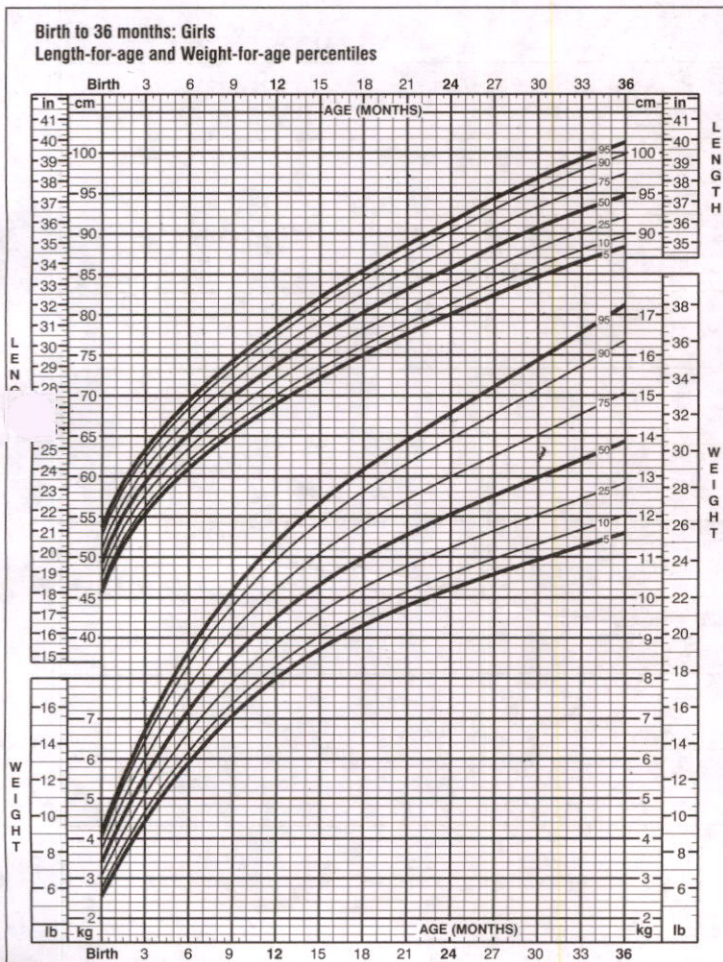
Food Allergies: No Veg/Non-veg: Non-veg

Diagnosis: AFI

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: Gopesh

GROWTH CHART (GIRLS)



Dietician's Name: Nikitha

Dietician's Signature: Nikitha

Daily Notes:

10/7/26
8:30 am

Child is stable Intake is Better

Continue to normal diet.

nowler

11/7/26
10 am

Child is stable. Intake is fair

continue to normal diet

roberts