

ACTIVITY RECORD FOR BILLING

Name : _____ (2020 90) 780 1/80

UHID No. : _____ 210 60018 5/20

Date of Admission : _____

Room / Bed No : _____

Consultant : _____ Dept : _____

Date of Discharge : _____ Time : _____

Suggested Billable bed type : _____

LBH-00132654 IP5-00176735
Master BOMMU RUSHIKESH
07-08-2023 2 Y 11 M 14 D (M)
Dr. SANDHYA VADDADI

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
20/7/20	10:15 PM	ER	127 PM	[Signature]

Cross Consultation Visit

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

[illegible]

Signature

D

2

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
21/07	Blood transfusion. (ROP)	①	9715676	Sumita
22/7	Blood transfusion (FFP)	①	9716434	Pink

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date : 23/7/2020 Time : 11:00 AM

Prepared By : Sumita

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
Sumita	OPD		

ADMISSION SHEET

Registration Details :


Admission No : IP5-00176735 Admit Date : 21-Jul-2026 Admit Time : 09:40 PM UHID : LBH-00132654

Patient Details :

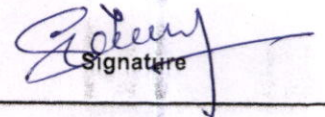
Patient Name	: Master BOMMU RUSHIKESH	Age	: 2 Y 11 M 14 D
Guardian	: Mr BOMMU ABHISHEK	DOB	: 07-08-2023
Gender	: Male	Religion	:
Occupation	:	Martial Status	: Single
Address (H)	: H NO - 12-182/3/A/1, VIKAS EXLIENT SCHOOL , VIDYA NAGAR , Kalwa Kurthy Nagar Kurnool Telangana INDIA 509324	Phone No	: 7718312345/ 9393949500
		E-mail	: an@gmail.com

Admission Details :

Bed Type : FOUR SHARING Bed No : FSW 127 Ward Name : 1F-HEMATO-ONCOLOGY
 Room No : FSW 127 Admission Type : First Visit

Contact Details :

Name	: Mr BOMMU ABHISHEK	Relationship	: Father
Contact Address	: H NO - 12-182/3/A/1, VIKAS EXLIENT SCHOOL , VIDYA NAGAR , Kalwa Kurthy Nagar Kurnool Telangana INDIA 509324	Phone No	: 7718312345 / 9393949500


Doctor Details :

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

Payment Details :

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

LBH-00132654 IP5-00176735
Master BOMMU RUSHIKESH
07-08-2023 2 Y 11 M 15 D (M)
Dr. SANDHYA VADDADI




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ADMISSION CRITERIA – ONCOLOGY

Admission / Transfer from:

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

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

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

Signature of the Doctor:

Name of the Doctor:

Date & Time: 21/07/26 @ 10:30 Am

LBH-00132654 IP5-00176735
Master BOMMU RUSHIKESH
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DISCHARGE CRITERIA – ONCOLOGY

Discharge to:

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

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

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

Signature of the Doctor:

Name of the Doctor :

Date & Time: 21/07/26 @ 10:30pm.



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PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: _____

UHID ID: _____

Department: _____

Consultant: _____

LBH-00132654 IP6-00176735
Master BOMMU RUSHIKESH
07-08-2023 2 Y 11 M 14 D (M)
Dr. SANDHYA VADDADI





Pediatric Multisystem History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

1/0 Fever since morning.
1/0 cold & cough since morning.

History of present illness :

child is 6/10 AM

On AM - 15 Day - 13 of HIDA

1/0 Fever since morning moderate to
high grade & not associated with
chills & Rigors

1/0 cold & cough since morning

cold with running nose.

cough is of dry cough not associated
with sleep disturbance.

No H/O Vomiting & Loose stools.



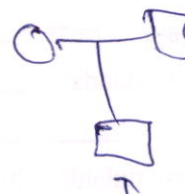
Pediatric Multiorgan History & Physical Examination

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

AML - Under going chemo here.

Birth & Neonatal History:

FT / LSCS / CIAB / 3kg



Birth & Socio Economic History:

About Father :

About Mother :

Any additional Information :

} upper middle class

Developmental History :

As per Age

Immunization History :

As per Age.



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: _____

Prevent Complications

Desired goals of the treatment: _____

dynamic stability

Planned Labs:

*Blood culture cu
sensitivity*

Planned Management

*Inj Meropenam
T. Vori conazole
T. Tranexa
Syp Fluvir
Syp. Relent plus.*

Noted by Shashmita

Signature of the Doctor: _____

Name of the Doctor: _____

Date & Time: _____

Trani

Trani

21/07/26

Signature of the Consultant: _____

Name of the Consultant: _____

Date & Time: _____

[Signature]
Shashmita



[illegible]

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PROGRESS NOTES AND DOCTOR'S ORDER

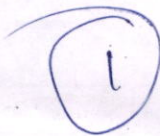
Date & Time	Progress Notes	Doctor's Order
23/7/26 9 AM	AML-M5 FLT3- Post HIDAC 1 day (+14) febrile neutropenia	
	No fever vitals stable	Plan 1. Trace blood c/c 2. d IV antibiotics plan c/c today e IV antibiotics
	Meropenem - P3 ✓ fumaric viii ✓	trans
		ptly Xare
		→ c/c today do 1 st meropenem 80
		→ Valinday CBP & review
		→ Vancomycin to continue
	Dr. Nalla Anuraag Reddy MBBS, MD, FIAP (PHO) Fellowship in Paediatric Infectious Diseases Reg. No: TSMC/FMR/244	Ref by 01/5/26 et al
		1.5 inj mptaz 200mg BID till Vancomycin



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[illegible]

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RESULT SHEET

Date	21/04/26	23/7			
Time	10Am	8Am			
Hb	7.4	10.8			
PCV	21.6	30.7			
RBC	2.54	3.75			
WBC	0.46	1.00			
N/L	5/82	2.0/95.0			
Platelets	15,000	32,000			
CRP	38				
ESR					
PCT					
RBS					
Na					
K					
Cl					
Ca/Mg					
Phosphate					
Urea					
Creatinine					
ALP					
SGPT					
SGOT					
T.Bill/Conj					
T.Protein					
S.Albumin					
S.Globulin					
A/G Ratio					
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein / Sugar					
Cells					
N/L					

Sheet No:

REGULAR PRESCRIPTIONS

Weight 12 kg Ward

DRUG : <u>SYP FLUVIR</u>				Date Time	<u>21/7/2023</u>															
Dose	Route	Frequency	Start Dt.																	
<u>3ml</u>	<u>ora</u>	<u>Q12H</u>	<u>21/07</u>																	
Name & Signature of the Doctor Starting the Drugs:																				
<u>T Parani</u>																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG : <u>SYP Relent Plus</u>				Date Time	<u>21/7/2023</u>															
Dose	Route	Frequency	Start Dt.																	
<u>1ml</u>	<u>ora</u>	<u>Q12H</u>	<u>21/07</u>																	
Name & Signature of the Doctor Starting the Drugs:																				
<u>T Parani</u>																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG : <u>Otrivin P Nasal Drops</u>				Date Time	<u>21/7/2023</u>															
Dose	Route	Frequency	Start Dt.																	
<u>20</u>	<u>Pin</u>	<u>Q8H</u>	<u>21/07</u>																	
Name & Signature of the Doctor Starting the Drugs:																				
<u>T Parani</u>																				
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																				



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.													
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																

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DRUG CHART

Date of Admission: 21/7/20 Drug Allergies: ☒ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

SOS / PRN (As Required Medication)

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



REGULAR PRESCRIPTIONS

Weight. 12 kg Ward.

DRUG : <u>Imi MEROPENAM</u>				Date Time	<u>21/7</u>	<u>22/7</u>	<u>23/7</u>
Dose	Route	Frequency	Start Date				
<u>500mg</u>	<u>IV</u>	<u>Q12H</u>	<u>21/07</u>	<u>6am</u>	<u>8am</u>	<u>8am</u>	
Name & Signature of the Doctor Starting the Drugs: <u>T. Pavani</u>							
Additional Instructions:				<u>6pm-11:00pm</u> <u>Subcutaneous</u>			
Daily Doctor's Endorsement by a Sign				<u>d d d</u>			
DRUG : <u>Imi ENDENSETRON</u>				Date Time	<u>21/7</u>	<u>22/7</u>	<u>23/7</u>
Dose	Route	Frequency	Start Date				
<u>2mg</u>	<u>IV</u>	<u>Q8H</u>	<u>21/07</u>	<u>6am</u>	<u>8am</u>	<u>8am</u>	
Name & Signature of the Doctor Starting the Drugs: <u>T. Pavani</u>							
Additional Instructions:				<u>2pm</u> <u>8pm</u> <u>Subcutaneous</u>			
Daily Doctor's Endorsement by a Sign				<u>d d d</u>			
DRUG : <u>T. VORICONAZOLE</u>				Date Time	<u>21/7</u>	<u>22/7</u>	<u>23/7</u>
Dose	Route	Frequency	Start Date				
<u>1 tab</u>	<u>ora</u>	<u>Q12H</u>	<u>21/07</u>	<u>8am</u>	<u>8am</u>	<u>8am</u>	
Name & Signature of the Doctor Starting the Drugs: <u>T. Pavani</u>							
Additional Instructions:				<u>8pm</u> <u>Home</u> <u>Subcutaneous</u>			
Daily Doctor's Endorsement by a Sign				<u>d d</u>			
DRUG : <u>T. TRANEKA</u>				Date Time	<u>21/7</u>	<u>22/7</u>	<u>23/7</u>
Dose	Route	Frequency	Start Date				
<u>1 tab</u>	<u>ora</u>	<u>Q12H</u>	<u>21/07</u>	<u>8am</u>	<u>8am</u>	<u>8am</u>	
Name & Signature of the Doctor Starting the Drugs: <u>T. Pavani</u>							
Additional Instructions:				<u>8pm</u> <u>Home</u> <u>Subcutaneous</u>			
Daily Doctor's Endorsement by a Sign				<u>d d</u>			



Weight. 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.	

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

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
21/07/24	11:10pm	1 unit RDP	1 unit	Tr over 20min	Li.	Sumita Subhankar
21/07/24	11:10pm	Iri Avil	0.1 ml	IV	Li.	Sumita Subhankar
22/7	12:00pm	PRBC	180ml	IV	d.	Sumita Subhankar 12:15 pm
22/7	12:00pm	Iri Avil	0.3 ml	IV	d.	Sumita Subhankar 12:15 pm

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MEDICATION RECONCILIATION FORM

Drug Allergies:

☒ Not known any Drug Allergies

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

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

Shifting From: ER

Shifted to: ICU

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

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: Dr. Ravani

Date & Time: 21/07/2023

Nurse Name & Signature: Susmita

Date & Time: 21/7/2023 @ 9:55 PM

PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
21/7/26	9:30 PM	0	Nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	Dr
22/7	6 AM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	Dr
22/7	7 PM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	Dr
22/7	10 PM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	Dr
23/7	6 AM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Dr
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

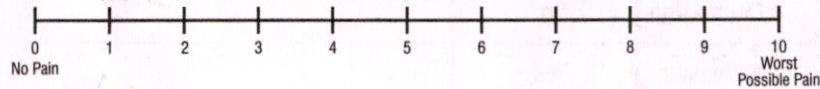
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

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 brawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, right, or Jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams of sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

Numerical Pain Scale (Obstetric and Gynecology)



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

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

Wong - Baker (Pediatrics) Above 7 Years



Date: 23/0 Time: 9 Am

[illegible]

Temperature
(°F)

98.1 F

[illegible][illegible][illegible][illegible][illegible]

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.

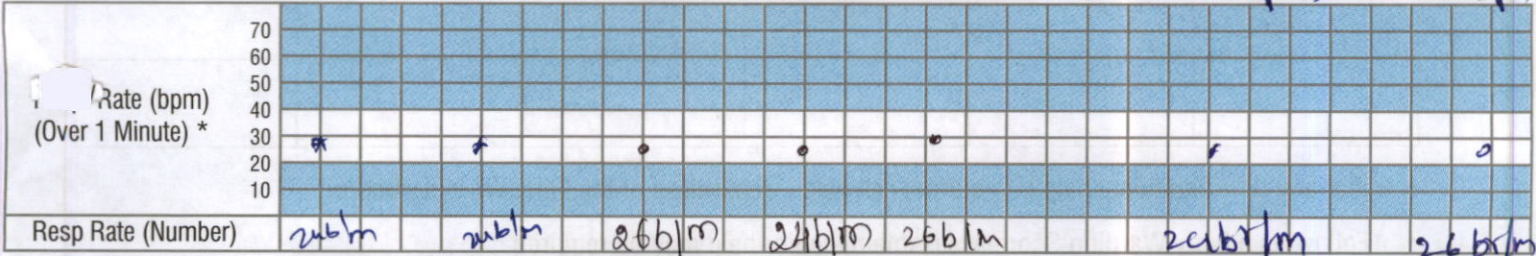
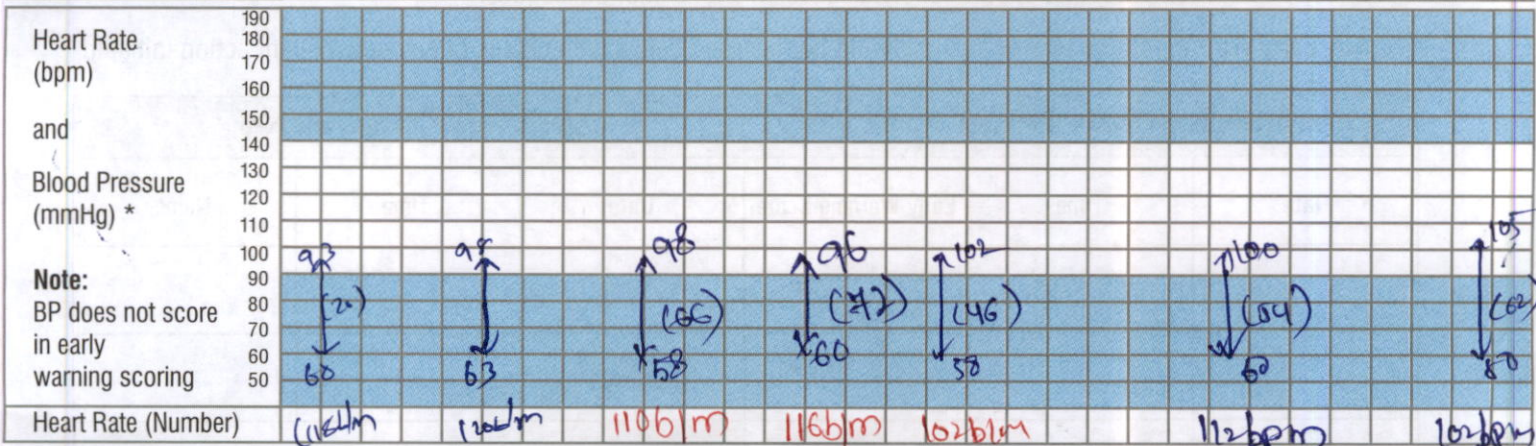
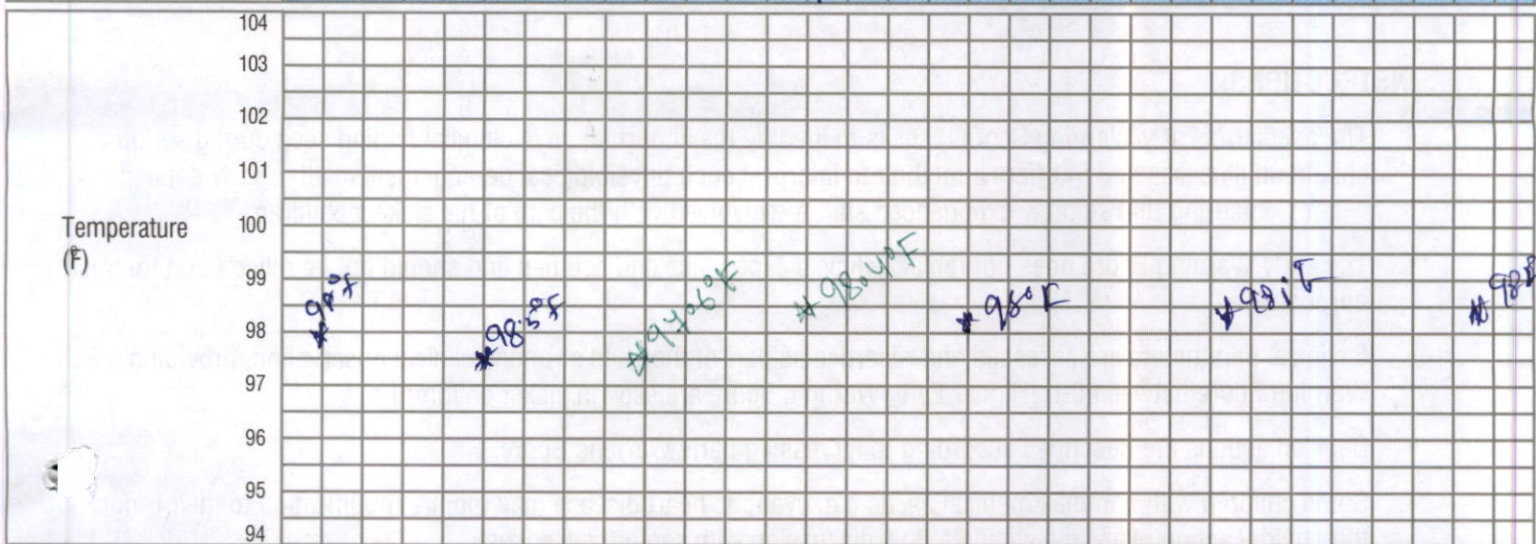
I	IDENTITY: I am (name), a nurse on ward (X). I am calling about (child X)
S	SITUATION : I am calling because I am concerned that ... (e.g. BP is low/high, pulse is XXX, Temperature is XX, Early Warning Score is XX)
B	BACK GROUND : Child (X) was admitted on (XX date) with (e.g. respiratory infection). 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)



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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 22/07 Time: 7am 10am 4pm 7pm 10pm 3am 6am
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	
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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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)



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

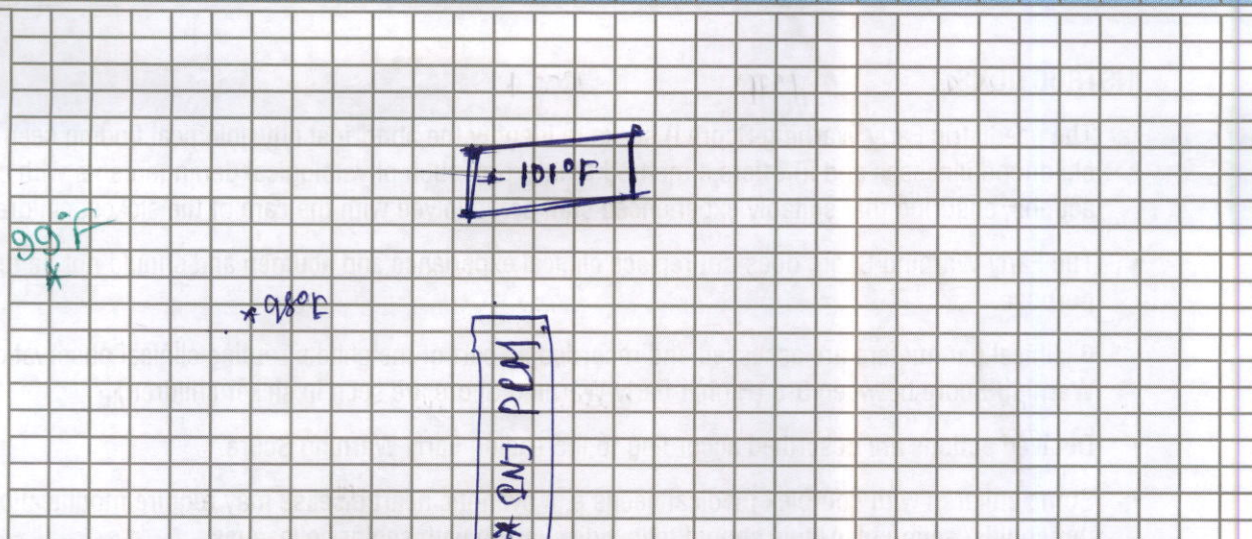
EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 2/10/23 Time: 11pm 3pm 6am

Doctor / Nurse / Family Concern?

Temperature (°F)

104
103
102
101
100
99
98
97
96
95
94



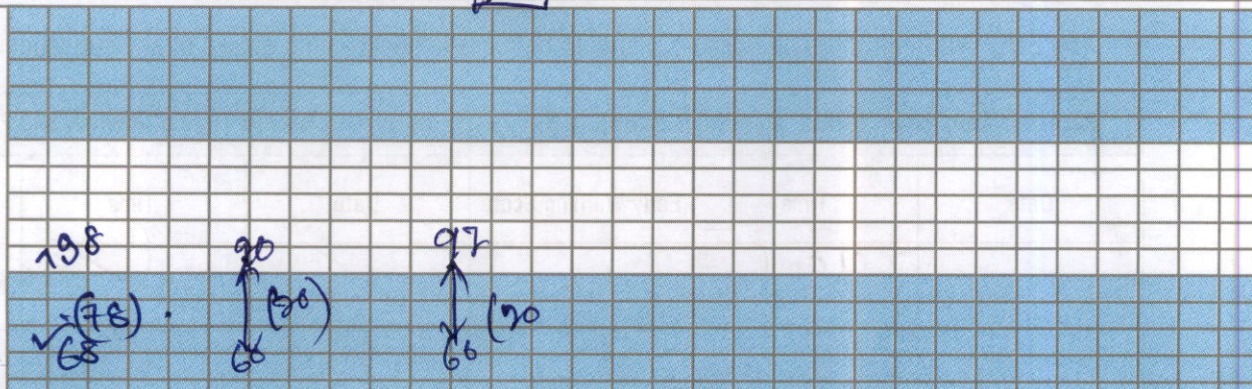
Heart Rate

and

Blood Pressure (mmHg) *

Note:
BP does not score in early warning scoring

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



Heart Rate (Number)

108 bpm 112 bpm 120 bpm

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

70
60
50
40
30
20
10



Resp Rate (Number)

26 bpm 28 bpm 28 bpm

Resp Mod/ Severe Distress None / Mild

0 0 0

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

100% 100% 99.1%

Conscious Level Normal Altered

C C C

GCS *

15/15 15/15 15/15

TOTAL SCORE

Number of shaded boxes

0 0 0

Pain Score

2 2 2

Observer's Initials

2 8 2

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
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LBH-00132654 IP5-00176735
Master BOMMU RUSHIKESH
07-08-2023 2 Y 11 M 15 D (M)
Dr. SANDHYA VADDADI



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

Total 24 hrs. Intake

Total 24 hrs. Output



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							
07/8	08:00 am	Edly		30ml								120ml Aash
	09:00 am			30ml								
	10:00 am			30ml								
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :		90ml				Total Output :					120ml	
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						Total Output :						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						Total Output :						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						Total Output :						

Total 24 hrs. Intake

Total 24 hrs. Output

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Patient S



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FLUID CHART

Sheet No. : 2

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

		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							
22/07	08:00 am	H ₂ O	100ml	30ml						100ml	I	}
	09:00 am			30ml								
	10:00 am			30ml								
	11:00 am			30ml								
	12:00 pm			40ml					150ml			
	01:00 pm			40ml								
Total Intake :			300 ml			Total Output :			250 ml			
	02:00 pm			40ml							I	}
	03:00 pm	H ₂ O	150ml	40ml					200ml			
	04:00 pm	fruits		40ml								
	05:00 pm			40ml					100ml			
	06:00 pm	H ₂ O	100ml	40ml		✓						
	07:00 pm			40ml					50ml			
Total Intake :			490ml			Total Output :			350ml			
	08:00 pm			30ml		✓				100ml	I	}
	09:00 pm	H ₂ O	150ml	30ml								
	10:00 pm			30ml								
	11:00 pm			30ml								
	12:00 am			30ml					200ml			
	01:00 am			30ml								
Total Intake :			280ml			Total Output :			300ml			
	02:00 am			30ml							I	}
	03:00 am			30ml								
	04:00 am			30ml					150ml			
	05:00 am			30ml								
	06:00 am			30ml								
	07:00 am			30ml					100ml			
Total Intake :			180ml			Total Output :			250ml			

Total 24 hrs. Intake

1250ml ÷ 104.1 cal/kg

Total 24 hrs. Output

1150ml ÷ 30.9 cal/kg

FLUID CHART

Sheet No. : 1

1. All measurements in ml.
2. Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.
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							
22/07	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
	Total Intake :					Total Output :						
02:00 pm												
03:00 pm												
04:00 pm												
05:00 pm												
06:00 pm												
07:00 pm												
Total Intake :					Total Output :							
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm	rice	60ml									
	12:00 am	water	100ml	30ml								
	01:00 am		30ml						200ml			
	Total Intake : 220 ml					Total Output : 200ml						
	02:00 am		30ml									
	03:00 am		30ml							130ml		
	04:00 am		30ml									
	05:00 am		30ml									
	06:00 am		30ml									
	07:00 am		30ml							180ml		
	Total Intake : 180ml					Total Output : 310 ml						
Total 24 hrs. Intake		400 ÷ 33.33 cc/kg/day										
Total 24 hrs. Output		570 ÷ 47.2 cc/kg/day										



Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 10:30 pm Mode of Arrival: By wheel chair Admitting From: ☒ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction Nil Body Weight: 12 Kg
Height: cm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
No significant	No significant	No significant.

Family History: No Nil

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: 12 kg Length: Head Circumference (< 2 years):

Temp.: 99.8°F HR: 132 b/m RR: 28 b/m BP: 109/67(78)

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

Fall Risk Assessment: ☒ Yes ☐ No Score: 11 (Document in the Humpty Dumpty Sheet)

Risk of Pressure Sore (Braden Q Score 28) (Document in the Braden Q Assessment Sheet)

Pain Screening: ☒ Yes ☐ No If Yes, Pain Score: 0 Pain Tool Used: ☐ N Pass ☒ FLACC ☐ Wong Baker

Character of Pain Nil Location Nil Frequency Nil Duration Nil

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

If Yes Consultant Notified: Nil (Date/Time): Nil

Cultural & Spiritual Needs: ☐ Yes ☒ No if Yes specify Inform consultant for positive criteria.**Social History:** Lives With FamilySiblings in household ☐ Yes ☒ No (if yes How Many?)All Information Obtained From ☐ Patient ☒ Mother ☐ Father ☐ Other Family Member**Orientation has been given regarding the following aspects:**Call Bell in Reach : ☒ Yes ☐ NoWaste Disposal Explained: ☒ Yes ☐ NoInfusion Pump : ☒ Yes ☐ NoHand hygiene Explained: ☒ Yes ☐ No☐ OthersPatient Rights & Responsibilities: ☒ Yes ☐ No

Information given to mother

Nurse Signature:
Sumita

Nurse Name:

Date: 21/07

Time: 10:40 pm

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6

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:



NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 23/7/26

Assessment: patient having weakness

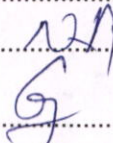
Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8Am	Assess the patient general condition	9Am	Assessed the patient general condition	patient feels better
10Am	check vitals	10:30	checked vitals	
11Am	provide side rails	11:30	provided side rails	
12m	Maintain I/O chart	12:30	Maintained I/O chart	
1m	Administer medication	2m	Administered medication	

Re-Assessment: N/A

Special Notes:

Nurse Signature: 

Nurse Name: Gouyathri

Date & Time: 23/7/26 @ 2m

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 22/7/26

Assessment: patient has weakness.

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	Assess general condition of the patient	8pm	Assessed general condition of the patient	Patient is stable
upn	monitor vital signs	upn	monitored vital signs.	
1AM	maintain hygiene.	2AM	maintained hygiene	
3AM	Administer medications AS per order	4AM	Administered medications AS per order	
5AM	Ensure safety	6AM	provided side rails	
7AM	maintain I/O chart	8AM	maintained I/O chart	

Re-Assessment: patient is stable.

Special Notes:

Nurse Signature: Gayathri

Nurse Name: Gayathri

Date & Time: 23/7/26 @ 8am

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NURSING CARE RECORD

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Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 22/7/26

Assessment: patient having weakness.

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	Assess the patient condition	2:30 pm	Assessed the patient condition.	patient feel better.
3pm	maintain personal hygiene.	3:30 pm	maintained personal hygiene. explaining mouth wash.	
4pm	monitor vital signs.	4:30 pm	monitored vital signs checking all parameters.	
5pm	Administer medication.	5:30 pm	Administered medication as per doctor advice.	
6pm	maintain I/O Chart.	6:30 pm	maintained I/O Chart.	
7pm	provide Supportive care.	2pm	provided Supportive care.	

Re-Assessment: patient feel better.

Special Notes: Today PRBC given.

Nurse Signature: Kavima

Nurse Name: Kavima parvin

Date & Time: 22/7/26 @ 8pm

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NURSING CARE RECORD

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Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 22/7/26

Assessment: patient is having weak knee

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	8:30am	Assessed the general condition	
9am	* Monitor & note vitals	9:30am	* Monitored & noted vitals	
10am	* Provide comfortable position	10:30am	* Provided comfortable position	patient is comfortable
11am	* Provide supportive care	11:30am	Provided supportive care	
12pm	* Ensure safety	12:30pm	Ensured safety	
1pm	* Administer medications	1:30pm	Administered medications	

Re-Assessment: patient is comfortable

Special Notes:

Nurse Signature: Ann m

Nurse Name: Ann m

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

LBH-00132654
Master BOMMU RUSHIKESH
07-08-2023 2 Y 11 M 15 D (M)
Dr. SANDHYA VADDADI

NURSING CARE RECORD

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Shift: ☐ Morning ☐ Afternoon ☒ Night

Assessment: Patient's having weakness. Date: 21/07/26

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
10:31pm	Assess the patient condition.	11:4pm	Assessed the patient condition.	Patient is now improved.
11:05pm	To transfuse ROP.	11:10pm	ROP transfusion started.	
12 AM	To maintain fluid balance.	12:05AM	Maintained fluid balance.	
1 AM	To ensure safety.	2 AM	provided side rails.	
3 AM	To prevent infection.	5 AM	Administered medication as per doctors order.	
6 AM	To maintain I/O chart.	7 AM	Maintained I/O chart.	

Re-Assessment: Patient is now stable.

Special Notes:

Nurse Signature: @

Nurse Name: Susmita

Date & Time: 21/07/26 @ 8 AM



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Sandhya Vaddadi Department: ER Date of Admission: 21/7/26

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:					
	Area		ER 10:00 pm - 11:00 pm	oneo 8pm - 8am	oneo 8am - 2pm	oneo 2pm - 8pm	oneo 8pm - 8am	oneo 8pm - 8am
BACKGROUND	Shift Time							
	Medical Condition (Any special condition to be noted):		Nil	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: 101.6°F	98.9°F	98.5°F	98.6°F	98.1°F	98°F
	Res:		28b/m	28b/m	26b/m	26b/m	27b/m	28b/m
	SpO ₂ :		97%	98%	98%	100%	99%	99%
	Pulse:		156b/m	130b/m	116b/m	108b/m	106b/m	108
	BP:		117/49	112/61	120/62	98/60	99/60	90/60
	Fall Risk Score:		11	11	11	11	11	10
Recommendations	Safety Needs:		yes	side rails	side rails	side rails	yes	yes
	Physiotherapy		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Others Specify:		Nil	Nil	NA	NA	NA	NA
	Special Diet:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Other Special Orders / Medications:		nil	Nil	NA	NA	NA	NA
Post Operative Procedure Special Orders:		Nil	Nil	NA	NA	NA	NA	
Handed Over By Name :		Seemika	Sumita	Arum	Karima	Gayathri	Garni	
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	
Date:		21/7/26	22/7	22/7	22/7/26	22/7	23/7	
Time:		10:20 pm	8 Am	2pm	8pm	8am	8pm	
Taken Over By Name :		Sumita	Arum	Karima	Gayathri	Garni	Arun	
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	
Date:		21/07	21/7	22/7	22/7	22/7	25/7	
Time:		10:30pm	8am	2pm	8pm	8pm	8am	

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	0800 8 AM				
	Medical Condition (Any special condition to be noted):		NA				
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:	98.6				
		Res:	22 bpm				
		SpO ₂ :	99%				
		Pulse:	108				
		BP:	90/60				
		Fall Risk Score:	10				
Pain Score:		0					
Recommendations	Safety Needs:		YES				
	Physiotherapy		☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:		NA				
	Special Diet:		☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:		NA				
Post Operative Procedure Special Orders:		NA					
Handed Over By Name :		Gaya 3					
Signature :		G					
Date:		23/11					
Time:		2 PM					
Taken Over By Name :		OK					
Signature :							
Date:							
Time:							

GENERAL CONSENT FOR TREATMENT

Patient Name: Master BOMMU RUSHIKESH

Age : 2 Y 11 M 14 D

IP No: IP5-00176735

Sex: Male

Consultant: Dr. SANDHYA VADDADI

Ward/Bed No: 1F-HEMATO-ONCOLOGY/FSW 127

The undersigned patient and I or responsible relative or person hereby consent to and authorize Rainbow Hospitals doctors and medical personnel to perform medical examinations, conduct routine investigations and administer medical treatments, outpatient procedures, minor dressings, vaccinations and immunizations during the course of the patient's care, as in patient.

Patient, be deemed advisable or necessary.

I understand that the confidentiality of all medical records shall be protected to the full extent of the Law. The undersigned also consent to the use of health related information/ audiovisuals of the patient for research & training purpose or for insurance coverage and while doing so confidentiality of the patient will be maintained at all times and this will not affect the care of the patient.

In giving my general consent to treatment, I understand that I retain the right to refuse any particular examinations, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by treating doctors. I also understand that the practice of medicine is not an exact science and that no guarantee have been made to me as the results of my evaluation and I or treatment.

I understand that I shall not bring valuables to the Hospitals and that the Hospital will not be responsible for the loss, destruction or theft of my personal belongings. I assume full responsibility for all my personal items and release the Hospital from responsibility and liability for such personal items and valuables.

"I am aware that during the patient care it is inevitable that certain re-useable equipment shall be re-used after sterilization and disinfection. I am informed that the hospital assures maximum level of precaution and care in sterilizing and disinfecting the equipment and monitors the whole process as per evidence based guidelines".

Note:

1 We do not allow use of medication brought from outside by the patient.

2 I have received attendant passes as per my room category. I understand that I have to return it back at the time of final bill clearance. In case of failing the submission, I will pay 200/- Rs.

(Receivers Signature: *[Signature]*)

3 IP Guide book has been given to me and I have been explained about the Hospitals rules and policies.

4 Financial and billing counseling has been done to me.

Signature of Patient/Relative: *[Signature]*

Name: *Bommu Abhinav*

Relationship: *Father*

Date: *21/07/2024*

Witness Name: *Rahul*

Witness Signature: *[Signature]*

Time: *9:40pm*

Patient Address:

H NO - 12-182/3/A/1, VIKAS EXLIENT SCHOOL, VIDYA NAGAR, Kalwa Kurthy Nagar Kurnool Telangana INDIA 509324

CONSENT FOR BLOOD TRANSFUSION

LBH-00132654 IP5-00176735
Master BOMMU RUSHIKESH
07-08-2023 2 Y 11 M 15 D (M)
Dr. SANDHYA VADDADI



Name: Bommu Rushikesh. Age: 2 years Gender: Male ☒ Female ☐
UHID.No: LBH-132654 Date: 22/7/26

Type of Blood Product: ☐ Fresh Frozen Plasma ☒ Packed Red Blood Cells ☐ Random Donor Platelets
☐ Cryoprecipitate ☐ Single Donor Platelet ☐ Whole Blood
☐ Albumin ☐ Red Blood Cell ☐ Others

I B. Rani hereby give my consent for whole blood transfusion or the blood components as part of treatment of myself / my patient while being admitted at Rainbow Hospital. I have been explained all the known risks of transfusion reactions. I have also been explained that the donor blood has been screened for Human Immunodeficiency Virus antibodies, Hepatitis B surface antigen, Hepatitis C antibodies, Malaria and Syphilis. I have also been explained that transfusion transmitted infections occur even with screened blood, especially if it is in the "window period" and also due to various other infections which have not been screened for. I also understand that any blood components transfusions carries risk of transfusion associated reactions, fluid overload etc. which are generally rare. The same risks apply for multiple transfusions too.

The doctor have explained to me about the alternative for this procedure that NA

All the above-mentioned risk, benefits and alternatives have been explained to me by the doctor treating me / my patient in the language that I fully understand and I accept the same and give my consent for all transfusions (the whole blood / or blood components Packed Red Blood Cells, Red Blood Cell, Platelets, Fresh Frozen Plasma, Cryoprecipitate etc.) to me / my Patient during he present hospital stay and treatment.

Patient (Or Patient Relative / Guardian):

Doctor (Who is talking the consent)

Signature: B. Rani Signature: [Signature]

Name: B. Rani Name: Dr. Sravani

Date & Time: 22/7/26 @ 12:00 pm Date & Time: 22/7/26 @ 12:00 pm

Witness

Signature: Arun M

Name: Arun M

Date & Time: 22/7/26 @ 12:00 pm



BLOOD PRODUCTS TRANSFUSION MONITORING FORM

Date: 22/7/26 Time: 12:15 pm
Blood Group of the Patient: Ave Blood Group on the Blood Bag: Ave
Blood Bank Issue No: B4H28-01677 Date of Collection: 12/2/26 Date of Expiry: 23/8/26
Date & Time of Starting Transfusion: 22/7/26 @ 12:30 pm Planned duration of Transfusion: 6 hrs
Check for Correct Unit: ☒ Correct Patient: ☒
Blood products cross checked by: Nurse 1: Nr. Arun 19 Nurse 2: Nr. Veena
Before starting transfusion vitals: Temp: 98°F HR 118b/m RR: 26b/m BP: 93/68(20) SpO₂ 100%

PLEASE MONITOR THE FOLLOWING:

Date	Time	HR	Temperature	Blood Pressure	SpO ₂	Any Rash	Any Rigors	Any Breathlessness	Any Other Problem
22/7	12:15 pm	118b/m	98°F	93/68(20)	100%	N.A	N.A	N.A	N.A
	1:00 pm	120b/m	98.3°F	93/70(60)	100%	N.A	N.A	N.A	N.A
	1:30 pm	118b/m	98.6°F	98/70(60)	100%	N.A	N.A	N.A	N.A
	2:00 pm	120b/m	98°F	93/60(20)	99%	N.A	N.A	N.A	N.A
	30 Min	110b/m	98.6°F	98/56(40)	100%	NA	NA	NA	NA
	1 Hr	108b/m	98°F	98/60(40)	100%	NA	NA	NA	NA
	1 Hr	118b/m	98.4°F	98/52(60)	100%	NA	NA	NA	NA
						NA			

Comments: NO complains.

Name of the Incharge-Nurse: Nasheena Name of the Nurse: Karima
Signature of the Incharge-Nurse: Nasheena Signature of the Nurse: Karima
Date & Time: 22/7/26 Date & Time: 22/7/26

Rainbow Hospital Blood Centre, Rainbow Childrens Hospital,
D.No.8-2-120/103/1,2,3,4 & 5, 1st floor, Sy.No.129/11, 403/P, Road No.2,
Banjara Hills, Hyderabad, Telangana State
Lic.No. 46/HD/TS/2018/BB/G

LEUCO REDUCED BLOOD CELLS I.P

Qty. 262 ml. Prepared from Whole human blood collected in 63 ml. of C.P.D.A. Solution.

A

Rh Positive

HIV I & II/ HBsAG/ HCV - Non
reactive

/DRL - Non reactive

AP - Negative

SAT(HIV I & II/ HBsAG/ HCV)- Non
reactive

Unit No.: **BAH26-01677**

Blood Group: **A Rh Positive**

Collection Date: **12/Jul/2026**

Expiry Date: **23/Aug/2026**

1) Administer Without Warming. 2) Shake Gently Before Use.
Add Any Medication. 4) Check Blood Group on Label & Re-
Group and Name Before Administration. 5) Use Sterile Tray
With Filter. 6) Do Not Dispense Without Prescription. 7) Do
Not Use if There is Any Visible Evidence. 8.) Store Between 2° C to 6° C.
Appropriate Compatible Cross Matched Blood Without Atypical
Antibodies in Recipient Should Be Used.

Issue Label / Cross Matching Report

Patient : **Master RUSHIKESH BOMMU .**

Patient's Blood Group : **A Rh Positive**

Hosp/Dr : **Rainbow Childrens Hospital, dr sandhya**

UHID No.: **LBH-00132654** Wd-Bed No.:

Product : **LR-PRBC**

Blood Group : **A Rh Positive**

Unit No.: **BAH26-01677**

XMatching Report: **Compatible**

X-matched by: **Nachiket**

Issue Dt : **22/Jul/2026**

Colln. Dt : **12/Jul/2026**

Exp. Dt : **23/Aug/2026**

Issued By : **Nachiket**

**Rainbow Hospital Blood Centre, Rainbow Childrens
Hospital**

D.No.8-2-120/103/1,2,3,4 & 5, 1st floor, Sy.No.129/11, 403/P, Road
No.2, Banjara Hills, Hyderabad, Telangana State
Lic.No. 46/HD/TS/2018/BB/G

[Handwritten signature]

LBH-00132654 IP5-00176735
Master BOMMU RUSHIKESH
07-08-2023 2 Y 11 M 14 D (M)
Dr. SANDHYA VADDADI



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

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BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

BLOOD PRODUCTS TRANSFUSION MONITORING FORM

Date: 21/07/26 Time: 11:10 pm
Blood Group of the Patient: A (+ve) Blood Group on the Blood Bag: A (+ve)
Blood Bank Issue No: BAH 26-01740 Date of Collection: 19/07/26 Date of Expiry: 24/07/26
Date & Time of Starting Transfusion: 21/07 @ 11:10 pm Planned duration of Transfusion: 30 min.
Check for Correct Unit: ☐ Correct Patient: ☐
Blood products cross checked by: Nurse 1: Susmita Nurse 2: Subhankar
Before starting transfusion vitals: Temp: 98.8°F HR 127b/m RR: 26b/m BP: 112/61 (78) SpO₂ 98%

PLEASE MONITOR THE FOLLOWING:

Date	Time	HR	Temperature	Blood Pressure	SpO ₂	Any Rash	Any Rigors	Any Breathlessness	Any Other Problem
<u>21/07</u>	<u>15 Min</u>	<u>128</u>	<u>99°F</u>	<u>111/64</u>	<u>98%</u>	<u>Nil</u>	<u>Nil</u>	<u>Nil</u>	<u>Nil</u>
	<u>15 Min</u>	<u>124</u>	<u>98.8°F</u>	<u>110/62</u>	<u>99%</u>	<u>Nil</u>	<u>Nil</u>	<u>Nil</u>	<u>Nil</u>
	<u>30 Min</u>								
	<u>30 Min</u>								
	<u>30 Min</u>								
	<u>1 Hr</u>								
	<u>1 Hr</u>								

Comments: No fast breathing, No Rashes, No complaints.

Name of the Incharge-Nurse: Subhankar

Name of the Nurse: Susmita

Signature of the Incharge-Nurse: [Signature]

Signature of the Nurse: [Signature]

Date & Time: 21/07/26 @ 11:50 pm

Date & Time: 21/07/26 @ 11:50 pm

BAH26-01740



Rainbow Hospital Blood Centre, Rainbow Childrens Hospital
D.No.8-2-120/103/1,2,3,4 & 5, 1st floor, Sy.No.129/11, 403/P, Road No.2,
Banjara Hills, Hyderabad, Telangana State
Lic.No. 46/HD/TS/2018/BB/G

PLATELET CONCENTRATE I.P.

Qty. 60 ml. Prepared from Whole human blood collected in 63 ml. of C.P.D./
SAGM Solution.

A

HIV I & II/ HBsAG/ HCV - Non
reactive
VDRL - Non reactive
MP - Negative
NAT(HIV I & II/ HBsAG/ HCV)- Non
reactive

Unit No.: BAH26-01740
Blood Group: A Rh Positive
Collection Date: 19/Jul/2026
Expiry Date: 24/Jul/2026

1. Do Not Dispense Without Prescription. 2. Check Blood Group On
Label & Recipient's Group And Name Before Administration. 3. Shake
Gently Before Use. 4. Do Not Add Any Medication. 5. Use Immediately
After Issuc. 6. Use Sterile Transfusion Set With Filter. 7. Do Not Use If
There Is Any Visible Evidence Of Deterioration Like Haemolysis

Clottin
Gentle
9. Adr

Issue Label / Cross Matching Report

Patient : Master RUSHIKESH BOMMU .

Patient's Blood Group : A Rh Positive

Hosp/Dr : Rainbow Childrens Hospital, dr sandhya

UHID No.: LBH-00132654

Wd-Bed No.:

Product : RDP

Blood Group : A Rh Positive

Unit No.: BAH26-01740

X Matching Report: Group Specific

X-matched by: B. Abhishek

Issue Dt : 21/Jul/2026

Colln. Dt : 19/Jul/2026

Exp. Dt : 24/Jul/2026

Issued By : B. Abhishek

Rainbow Hospital Blood Centre, Rainbow Childrens
Hospital

D.No.8-2-120/103/1,2,3,4 & 5, 1st floor, Sy.No.129/11, 403/P, Road
No.2, Banjara Hills, Hyderabad, Telangana State
Lic No. 46/HD/TS/2018/BB/G



CONSENT FOR BLOOD TRANSFUSION

Name: BOMMU RUSHIKESH Age: 2 Y 11 M Gender: Male ☒ Female ☐
UHID.No: LBH-00132654 Date: 21/07/26

Type of Blood Product: ☐ Fresh Frozen Plasma ☐ Packed Red Blood Cells ☒ Random Donor Platelets
☐ Cryoprecipitate ☐ Single Donor Platelet ☐ Whole Blood
☐ Albumin ☐ Red Blood Cell ☐ Others

I B. Rai hereby give my consent for whole blood transfusion or the blood components as part of treatment of myself / my patient while being admitted at Rainbow Hospital. I have been explained all the known risks of transfusion reactions. I have also been explained that the donor blood has been screened for Human Immunodeficiency Virus antibodies, Hepatitis B surface antigen, Hepatitis C antibodies, Malaria and Syphilis. I have also been explained that transfusion transmitted infections occur even with screened blood, especially if it is in. The "window period" and also due to various other infections which have not been screened for. I also understand that any blood components transfusions carries risk of transfusion associated reactions, fluid overload etc. which are generally rare. The same risks apply for multiple transfusions too.

The doctor have explained to me about the alternative for this procedure that

All the above-mentioned risk, benefits and alternatives have been explained to me by the doctor treating me / my patient in the language that I fully understand and I accept the same and give my consent for all transfusions (the whole blood / or blood components Packed Red Blood Cells, Red Blood Cell, Platelets, Fresh Frozen Plasma, Cryoprecipitate etc.) to me / my Patient during he present hospital stay and treatment.

Patient (Or Patient Relative / Guardian):

Signature: B. Rai
Name: B. Rai
Date & Time: 21/07/26 @ 10:45pm.

Doctor (Who is talking the consent)

Signature: d
Name: Shavani
Date & Time: 21/7/26 10:45pm

Witness

Signature: B. Rai
Name: B. Rai
Date & Time: 21/07/26 @ 10:45pm.

Patient

LBH-00132654 IP5-00176735
Master BOMMU RUSHIKESH
07-08-2023 2 Y 11 M 14 D (M)
Dr. SANDHYA VADDADI



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HUMPTY DUMPTY SCALE 21/7/26 22/7 23/7 2'

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	2	2	2		
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1	1		
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	1	1	1	1		
	History of Falls or Infant - Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2	2	2		
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	1	1	1		
Medication Usage	Sedatives (excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1	1		
TOTAL			11	11	11		

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	NA	NA		
Other Intervention(s) Specify		NO	NA	NA		
Nurse's Name :		Sushila	Sumita	Gayatri		
Signature :		SR	R	GS		
Date :		20/7/26	22/7	23/7		
Time :		9:30 pm	8 AM	9 pm		



BRADEN 'Q' SCALE

					Date :	21/7/26	22/7	23/7	
					Time :	9:30 PM	8 AM	8 PM	
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e.tremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4	4		
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4	4		
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation. OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4		
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4		
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		
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 of 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	
					Evaluator's Name	GA	GA	GA	

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

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Part -

Patient's / Learner Language: Telugu 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		
21/7/26	9:30 PM	7	Infection control measures	M	4	0	1	1	-	<i>[Signature]</i>
22/7	8 AM	1	To maintain personal hygiene	M	4	0	1	1	-	<i>[Signature]</i>
22/7/26	2 PM	9	soft High protein diet	M	1	0	1	1	-	<i>[Signature]</i>
23/7	12 PM	7	Infection control measure	M	4	0	1	1	-	<i>[Signature]</i>

Part - III: CODES

Who was taught:	PT: Patient	F: Father	M: Mother	S: Spouse	Sn: Son	D: Daughter	C: Caregiver	O: Other (Specify)															
Learning Barriers: <table border="0"> <tr> <td>1. No Learning Barriers</td> <td>4. Language Barrier</td> <td>7. Impaired Thought Process/Cognitive limitations</td> <td>10. Financial Difficulties</td> <td>13. Cultural/Religion Practice</td> </tr> <tr> <td>2. Physical Impairment</td> <td>5. Educational Level</td> <td>8. Responsibilities at Home</td> <td>11. Beliefs and Values</td> <td>14. Others (Specify)</td> </tr> <tr> <td>3. Emotional Barriers</td> <td>6. Desire / Motivate to Learn</td> <td>9. Cultural Differences</td> <td>12. Impaired Vision/ or Hearing</td> <td></td> </tr> </table>									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	
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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: <table border="0"> <tr> <td>1. None</td> <td>3. Reassurance & Support</td> <td>5. Respect values & beliefs</td> <td>7. Other, Specify</td> </tr> <tr> <td>2. Obtain translator</td> <td>4. Teach Family / Others</td> <td>6. Respect Cultural / Religion Preference</td> <td></td> </tr> </table>									1. None	3. Reassurance & Support	5. Respect values & beliefs	7. Other, Specify	2. Obtain translator	4. Teach Family / Others	6. Respect Cultural / Religion Preference								
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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
2/8/16 @ 9:56 PM	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	cold, cough fever x 1 day	H. Stability	Pr fluid		☒ Nursing ☐ Others:
21/7/26 @ 9:56 PM	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	cold, cough fever x 1 day	H - Stable	IV medication		☒ Medical ☐ Others:
22/7/26 2 PM	☐ Medical ☐ Nursing ☒ Others: Debbie	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Amel	Soft High protein diet.	RDA E: 1250 kcal/d P: 2 g/d		☐ 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:

CENTRAL LINE MAINTENANCE CARE BUNDLE CHECK LIST

Type of Line: ☐ PICC Line ☐ UAC ☐ UVC ☐ Other Date of Initial Line Insertion: Duration of Central Line:

- Always perform hand hygiene before accessing central line
- Use Sterile gloves for handling central line
- Clean the hub with antiseptic solution every time before & after it is accessed
- Consider – antibiotic via central line before removal of the line
- Inspect Central line in each shift for the following

Parameters	Date	Shift Time	22/7 8 AM	22/7 8 AM - 2 PM	22/7/26 8 PM	22/7/26 2 PM - 8 AM	23/7 2 PM		
Can we remove Central Line today (Discuss in the clinical round)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No
Evidence of any inflammation at insertion site (Redness / Swelling (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No
Blood at insertion site (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No
Any peeling of dressing? (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No
Is dressing clean and dry? (If no inform the doctor)			☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Any leakage at insertion site? (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No
Is there any obstruction to the infusion flow? (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☒ Yes ☐ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No
Dressing intact and labelled properly			☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☒ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Central line changed on									
Name of the Nurse			Samita	Am	Karima	Gayatri.s	Gaya 3		
Signature of the Nurse									

Deeshkesh 2y11m

Patient Sticker

NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 22/7/26 Time: 2pm

Weight: 12kg Centile: 5th

Height: 86cm Centile: 5th

Inference: underweight child

RDA: - Calories: 1200kcal/d Protein: 21g/d

Diet Recommendations: soft high protein diet

Re-Assessment: Avoid spicy, chilled and outside foods

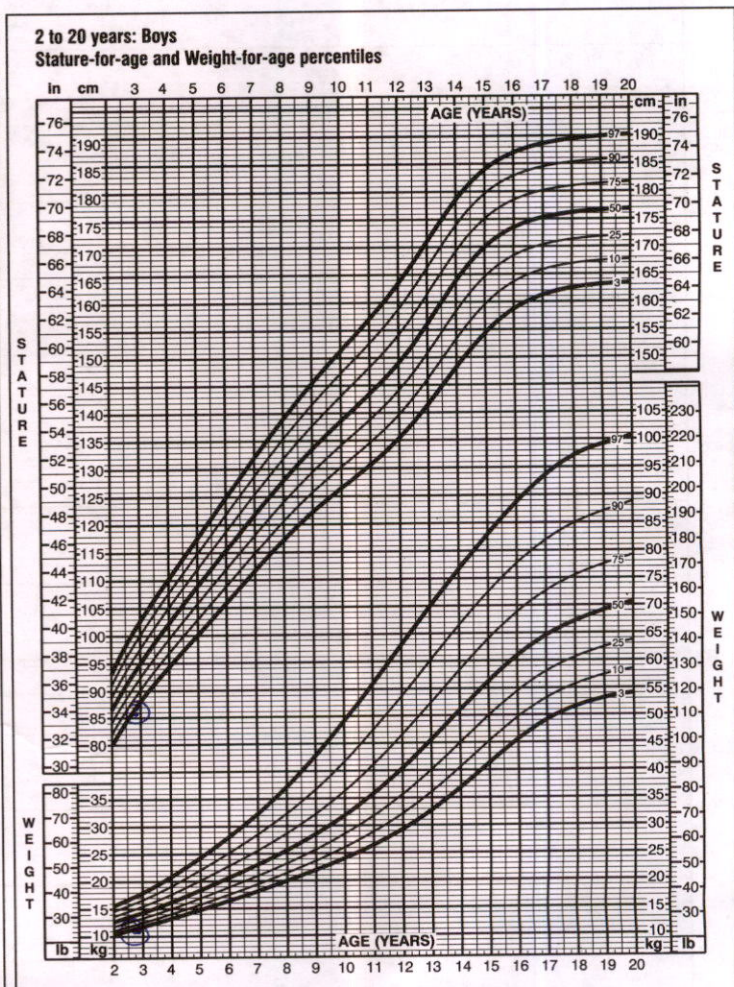
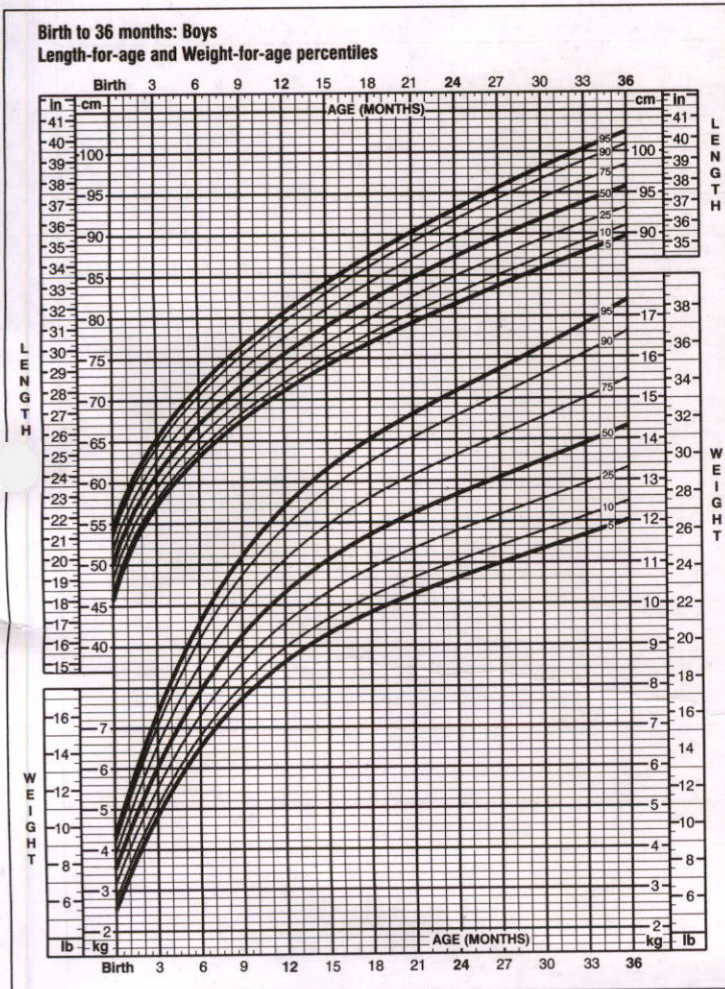
Food Allergies: NO Veg/Non-veg: non-veg

Diagnosis: K/Lb AMI on Post HPAE -

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: Parents Don't need dietitian. Don't change for NHA.

GROWTH CHART (BOYS)



Dietician's Name: Nisha

Dietician's Signature: Nisha

[illegible]