Rainbow Children's Hospital

BirthRight by Rainbow

Rainbow Childrens Hospital-Himayatnagar

Rainbow Children's Hospital, Door no. 3-6-267, opp. Cafe niloufer, Old MLA quarters road AP State Housing Board Himayatnagar ,Hyderabad ,Telangana, INDIA ,500029.
TEL NO :040-48873000
WEB : https://rainbowhospitals.in

ADMISSION SHEET

Registration Details :

Admission No : IP26-00006770 **Admit Date** : 06-Jul-2026 **Admit Time** : 10:36 PM **UHID** : HNH-00011978

Patient Details :

Patient Name	: Baby Of G. POOJA SRI	**Age**	: 0 Y 7 M 21 D
Guardian	: Mr B SHARATH	**DOB**	: 15-11-2025 10:35 AM
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	: Single
Address (H)	: 75 LIG BATHKAMMA KUNTA NANDANA VANAM COLONY Amberpet Hyderabad Telangana INDIA 500013	**Phone No**	: 9848338690/ 9908820666
		E-mail	: G.POOJA24ANGEL@gmail.com

Admission Details :

Bed Type : DAY CARE **Bed No** : ER01 **Ward Name** : GF -EMERGENCY

Room No : ER01 **Admission Type** : First Visit

Contact Details :

Name	: Mr B SHARATH	**Relationship**	: Father
Contact Address	: 75 LIG BATHKAMMA KUNTA NANDANA VANAM COLONY Amberpet Hyderabad Telangana INDIA 500013	**Phone No**	: 9908820666

Signature

Doctor Details :

Doctor Name	: Dr. SPANDANA PASUPULETI	**Specialisation**	: GENERAL PEDIATRICS
Referral Doctor	: Self.	**Phone No**	:
Co-Consultant	:		

Payment Details :

Payment Mode	: DC/CC Card	**Deposit Amount**	: 10000.00
		Payor Name	: VOLO HEALTH INSURANCE TPA PVT LTD

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ACTIVIT

HNH-00011978 IP26-00006770
Baby Of G. POOJA SRI
15-11-2025 0 Y 7 M 21 D (F)
Dr. SPANDANA PASUPULETI

Name: ----------

UHID No : ---------- Consultant : ---------- Dept : pediatric

Date of Admission : 6/7/26 ---------- Time : ---------- Date of Discharge : ---------- Time: ----------

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
6/7/26	11:30pm	ER	ward	BJ

Cross Consultation Visit

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

HNH-00011978 IP26-00006770
Baby Of G. POOJA SRI
15-11-2025 0 Y 7 M 21 D (F)
Dr. SPANDANA PASUPULETI

INVESTIGATIONS

Date	Investigations	Order No.	Sign
6/7/26	CBP, CRP ✓		
	Blood CLS ✓		
	Urine CLS ✓	11134	RPT
	Respiratory panel ✓		
	VBG ✓	11135	
	Cross checked by Balarew.		
8/7	LVE	11155	

MEDICAL EQUIPMENT (WARD & ICU)

HNH-00011978 IP26-00006770
Baby Of G. POOJA SRI
15-11-2025 0 Y 7 M 21 D (F)
Dr. SPANDANA PASUPULETI

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
6/7/26	Infusion Pump.	6/7/26 @ 11:40p.	7/7/26 @10:am	11363	

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Baby Of G. POOJA SRI
15-11-2025 0 Y 7 M 21 D (F)
Dr. SPANDANA PASUPULETI

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
6/7/26	IV Placement	1	11311	
7/7/26	NHA	1	11429	
	cross checked by Bala			

ANY OTHER INFORMATION

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

Ref.No. F/IN/PR/10

Rainbow®
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Hospital

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name : HNH-00011978 IP26-00006770
Baby Of G. POOJA SRI
15-11-2025 0 Y 7 M 21 D (F)
Dr. SPANDANA PASUPULETI

Patient ID# :

Consultant :

Final Diagnosis :

Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex

Informant _____ Reliability _____

Chief Presenting Complaints & Duration (Chronologically):

C/o fever X 3 days
C/o vomiting (multiple episodes) X 1 day
C/o decreased oral intake X 1 day.
C/o. decreased urine output X 1 day

History of present illness : Pt was apparently alright 2 days before then had fever of moderate to high degree, on & off type

C/o vomiting (multiple episodes), contains food particles, non-projectile.

C/o decreased oral intake since 1 day.

C/o decreased urine output since 1 day

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

Nothing Significant

Birth & Neonatal History :

T/AGA/. NAD

Birth & Socio Economic History :

About Father :

About Mother :

Any additional Information :

Developmental History :

Developmentally normal

Immunization History :

Upto date till. 6m of life.

Pediatric Multiorgan History & Physical Examination

Anthropometry

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

Weight (kgs) 7.03kg. (Centile _____)

On Examination :

Temperature : 98.7 F Pulse Rate: 112. Description _____

B.P. _____ SPO2 97 % at _____

Resp. rate and type of breathing : 24

- dry lips
- dry oral mucosa
- sunken eyes
- irritable.

Rash (-)

Lymphadenopathy (-)

Oedema : (-)

Respiratory system :

Inspection (any s/o distress) : _____

Air entry & breath sounds : B/L AE (+)

Any addes sounds : B/L NVBS (+)

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

Cardiovasclular System :

Inspection of procordium : _____

Heart Sounds : $S_1 S_2$ heard

Any murmur : _____

Relevant date from outside (Chest X-Ray, ECG, ECHO, Etc.,) _____

Per Abdomen :

Inspection _____

Palpation : Soft, NT

Ausculation : _____

Spine: _____ External Genitelia : _____

Relevant data from outside (CT, USG etc.,) _____

Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS Score : _____

Cranial Nerves : _____

_____

_____

Motor System :

Nutrition : _____

Tone : _____ Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR **Superficials :**

Plantars _____

Sensory System :

_____

_____

_____

Bladder / Bowel : _____

Clinical Summary & Diagnostic :

_____

Acute Gastroenteritis c dehydration.

AFT.

_____

_____

Pediatric Multiorgan History & Physical Examination

HNH-00011978 IP26-00006770
Baby Of G. POOJA SRI
15-11-2025 0 Y 7 M 21 D (F)
Dr. SPANDANA PASUPULETI

Preventive aspects of the treatment :

Desired goals of the treatment :

Planned Labs :

VBG, CBP, CRP.
CUE (due)
Blood C/s.
Urine C/s
Respiratory panel (5 virus)

Planned Management :

- Inj. ondansetron 2mg TID
- Inj esmoprazole 8mg OD
- Inj ceftriaxone 750mg OD.
- IVF DNS 2/3M

P.B Bhargavi

Please fill up the following details

1. Name of the Referring Doctor : _____
2. Name of the Referring Hospital : _____
   (Including the name of City)
3. Contact number of the Referring Doctor : _____
   (Preferring Mobile #)
4. Name of the doctor in Rainbow Team _____ on whose name the patient is being referred

Doctor's Signature Name _____ Date _____ Time _____

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
7/7 7:30 AM	C/W/B Dr Pranav / Dr. Nayjinay	
	AFI	
	Acute Gastroenteritis c̄ Dehydration	
	No Fever ther admission	Ph
	Vomiting - last in ER	1) Inj Ceftriaxone
	LM - 3 Betts -	2) IVF
	Oral intake - on DBF	3) Inj ondem
		Esomeprazole
	child asleep	4) CVE to send
	Vitals stable	5) Team Labs
	Afebrile	6) Monitor Vitals
	R-S - B/L NVBS @	
	P/A - soft	
		W.B Amoxith @ 7AM (signature)

Docu. No. : RCH /FRM / CLINICAL / 088

(P.T.O)

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
7/7/26 10 AM	c/o Dr. Tejaswini COVID (+)	
	- no fever spikes	
	- no vomitings	
	- oral intake : good	
	O/E	Plan
	vitals : stable	1) trace Blood cls, WE. urine cls. adenovirus.
	SLE - normal.	
	P/A : soft.	2) neb c 3% NS 6th hr x 3days
		3) discharge today
		4) mucolite drops on discharge
		5) Review on thursday
		6) STOP cefotaxime
		Dr Tejas
		noted by Sr. sandhya 7/7/26 10:00

Dr. S. TEJASWI REDDY
Registration No: 94068

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	C/S/b Dr. Varun/Dr. Thanvi.	
7/7/26 2:30PM	COVID +ve	
	- No fever spikes.	Plan
	- Cough (+).	- Trace CUE, Blood C/S and urine C/S.
	O/E - vitals stable.	- Ct. Rx.
	S/E - WNL.	- start 3% NS + Mucolite drops
		7/7/26 2:30 pm.
7/7/26 3PM	S/B Dr. Spandan	
	Δ SARI COV-2 positive	
		Plan
	CVS - S1 S2 (+)	- Trace Blood C/S
	RS - B/L - AE (+)	Urine C/S
	P/A - soft	cf Neb c 3% NS 6th hourly
	conscious	
		- Monitor vitals
		N/B Supt @ 3pm

Docu. No. : RCH /FRM / CLINICAL / 088

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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DRUG CHART

Date of Admission: 6/7/26 Drug Allergies: NAD ☐ 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 : CROCIN - DROPS				Date / Time
Dose	Route	Frequency	Start Date	
1ml	PO	SOS 6th hly	6/7	
Doctor's Signature		Valid Period	Pharm.	
Pharm				
Additional Instructions: 1ml = 100 mg				

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

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

VERIFIED BY : Name ..... Signature .....

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Dr. SPANDANA PASUPULETI

REGULAR PRESCRIPTIONS

Weight. 7.3 kg Ward. .....

DRUG : Inj ONDANSETRON

Dose	Route	Frequency	Start Date
1.5mg	IV	TID	6/7

Name & Signature of the Doctor Starting the Drugs: Pranav

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date	6/7	7/7
Time		
6AM	X	
2PM	X	
	12AM	
10PM		

DRUG : Inj ESOMEPRAZOLE

Dose	Route	Frequency	Start Date
7.5mg	IV	once Daily	6/7

Name & Signature of the Doctor Starting the Drugs: Pranav

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date	~~6/7~~
Time	
	12AM
6AM	

DRUG : Inj CEFTRIAXONE

Dose	Route	Frequency	Start Date
750mg	IV	once Daily	6/7

Name & Signature of the Doctor Starting the Drugs: Pranav

Additional Instructions: IV over 1 hour

Daily Doctor's Endorsement by a Sign

Date	6/7
Time	
	12pm
6pm	

STOP

DRUG : 3% NS

Dose	Route	Frequency	Start Date
1 capful	Neb.	Q6H	7/7

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Stop

HNH-00011978 IP26-0000577o
Baby Of G. POOJA SRI
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Dr. SPANDANA PASUPULETI

Weight. ..... Ward. .....

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.	

Signature .....

VERIFIED BY : Name .....

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses

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Baby Of G. POOJA SRI
15-11-2025 0 Y 7 M 21 D (F)
Dr. SPANDANA PASUPULETI

I.V. FLUIDS CHART

Weight. 7.34 Ward. .....

Date		tion of I.V. Fluid n ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
6/7	11pm	IVF - DNS (2/3 M M)	IV	20					

VERIFIED BY : Name ..... Signature .....

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MEDICATION RECONCILIATION FORM

Drug Allergies: ..... N911 ..... ☐ Not known any Drug Allergies

Medication Reconciliation will be done at the time of admission and also whenever there is change in the treating team or shifting from one unit to another unit.
(Example: at the time of admission shifting from ICU to Ward, or Ward to ICUs)

Shifting From: ..... ER ..... Shifted to: ..... Ward .....

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

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : ..... Dr. Nagpunya .....

Date & Time : ..... 6/7/26 @ 11:10pm .....

Nurse Name & Signature: ..... Bhargavi .....

Date & Time : ..... 6/7/26 @ 11:15pm .....

Docu. No. : RCH / FRM / GENERAL / 090

HNH-00011978 IP26-00006770
Baby Of G. POOJA SRI
15-11-2025 0 Y 7 M 21 D (F)
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RESULT SHEET

Date	6/7					
Time						
Hb	11.5					
PCV	32					
RBC	4.45					
WBC	6030					
N/L	51/43					
Platelets	4.25					
CRP						
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						

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

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

Others (ECG, Contrast Studies etc.,) : .....

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: RCH / FRM / CLINICAL / 124

INFANT (<1 year)
Children's Observation & Early Warning Scoring Chart

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 6/7 Time:	11:40pm	2 AM	6 AM
Doctor/Nurse/Family Concern?			
Temperature (°F)	97.3	98.2	99.2
Heart Rate (bpm) and Blood Pressure (mmHg) *			
Note: BP does not score in early warning scoring			
Heart Rate (Number)	145 b/m	140 b/m	139 b/m
Resp. Rate (bpm) (Over 1 Minute) *			
Resp Rate (Number)	38 b/m	35 b/m	30 b/m
Resp Distress: Mod/ Severe / None / Mild			
Receiving O_2(l/min) O_2Saturations (%)	100 %	98 %	100 %
Conscious Level: Normal / Altered			
GCS *			
TOTAL SCORE Number of shaded boxes	0	0	0
Pain Score	0	0	0
Observer's Initials			

ACTIONS	
NB: Scores 3 should be recorded overleaf	Score 1 : Continue normal observation by staff nurse
	Score 2 : Shift in charge nurse to be informed and continue hourly observations
	Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly 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 incharge and PICU /NICU fellow or PICU/NICU 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.

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

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FLUID CHART

Sheet No. : 7

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						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			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 :**					
6/7	08:00 pm										0	
	09:00 pm										0	
	10:00 pm										0	
	11:00 pm	ORS		20ml			0			~	0	A
	12:00 am		Milk	20ml							0	
	01:00 am			20ml							0	
Total Intake : Taken							**Total Output :**			M-0	V-1	
7/7	02:00 am			20ml							0	
	03:00 am	ORS	Milk	20ml							0	
	04:00 am			20ml			0			~	0	A
	05:00 am			20ml							0	
	06:00 am	ORS	Milk	20ml							0	
	07:00 am			20ml							0	
Total Intake : Taken							**Total Output :**			M-0	V-1	

Total 24 hrs. Intake		Total 24 hrs. Output	

HNH-00011978 IP26-00006770
Baby Of G. POOJA SRI
15-11-2025 0 Y 7 M 21 D (F)
Dr. SPANDANA PASUPULETI

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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.

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			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											
	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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NURSING CARE RECORD

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Date: 6/7/26

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	Re-Assessment	Nurse Name & Signature
Morning				N A			
Afternoon							
Night	8pm | 8Am	→ Assess the pt condition → monitoring vitals checked and recorded → I/O chart maintained	8pm | 8Am	→ Assessed the pt condition → Administration & medication given as per doctor orders	→ pt is stable	→ Re-checked vitals	A

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NURSING CARE RECORD

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Date: .....

Goals

- ☐ Maintain Airway and Oxygenation
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	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
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Afternoon							
Night							

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CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0			0							
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			NA							
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2			NA							
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			NA							
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			NA							
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5			NA							
		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 : Amrutha Name :

Signature of Ward In Charge :

Signature : Balaoani Name :

Patient Sticker

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CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
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Signature of Shift In Charge :

Signature : ..... Name : .....

Signature of Ward In Charge :

Signature : ..... Name : .....

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BRADEN 'Q' SCALE

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				Date :	6/7			
				Time :	2			
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			
"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			
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			
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			
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			
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 mean and dairy products. Occasionally eats between meals. Does not require supplementation.	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			
				TOTAL SCORE	23			
				Evaluator's Name	D			

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

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

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NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 7/7/25 Time: 10:10am

Weight: 7.3kg Centile: 25th

Height: — Centile: —

Inference: Underweight child

RDA: — Calories: 98Kcal/kg/day Protein: 1.6gms/kg/day

Diet Recommendations: Gastrodiet :- ORS (WHO), Sago Water, Coconut Water, Rice based fo

Re-Assesment: Avoid:- Ragi, Wheat, Milk, Oat, Egg, Sugar

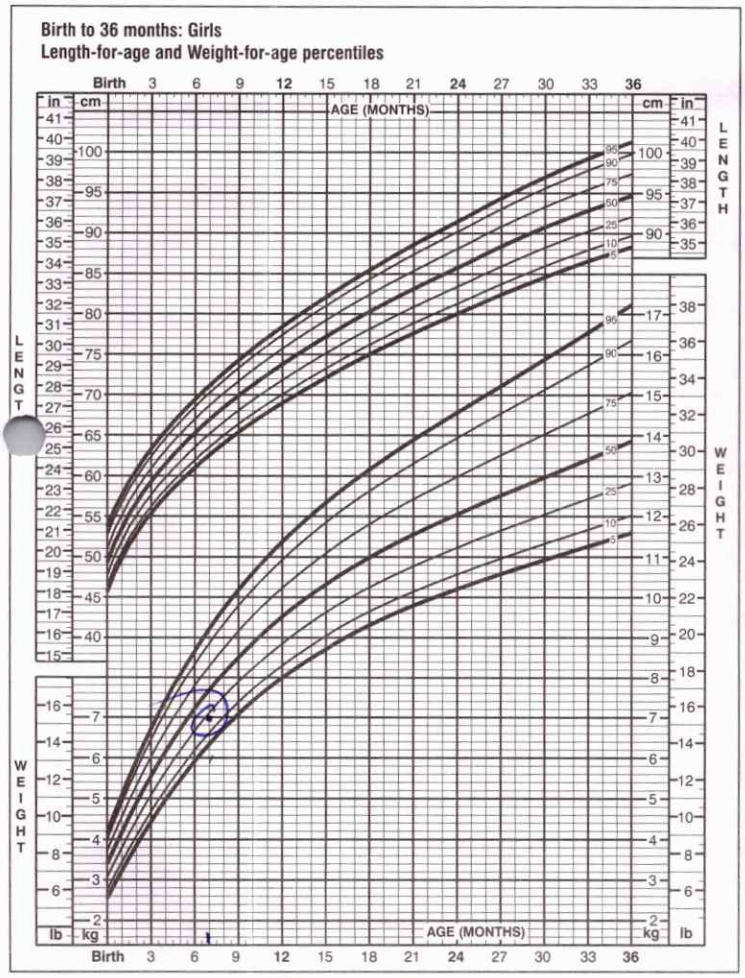
Food Allergies: NO Veg/Non-veg NOG

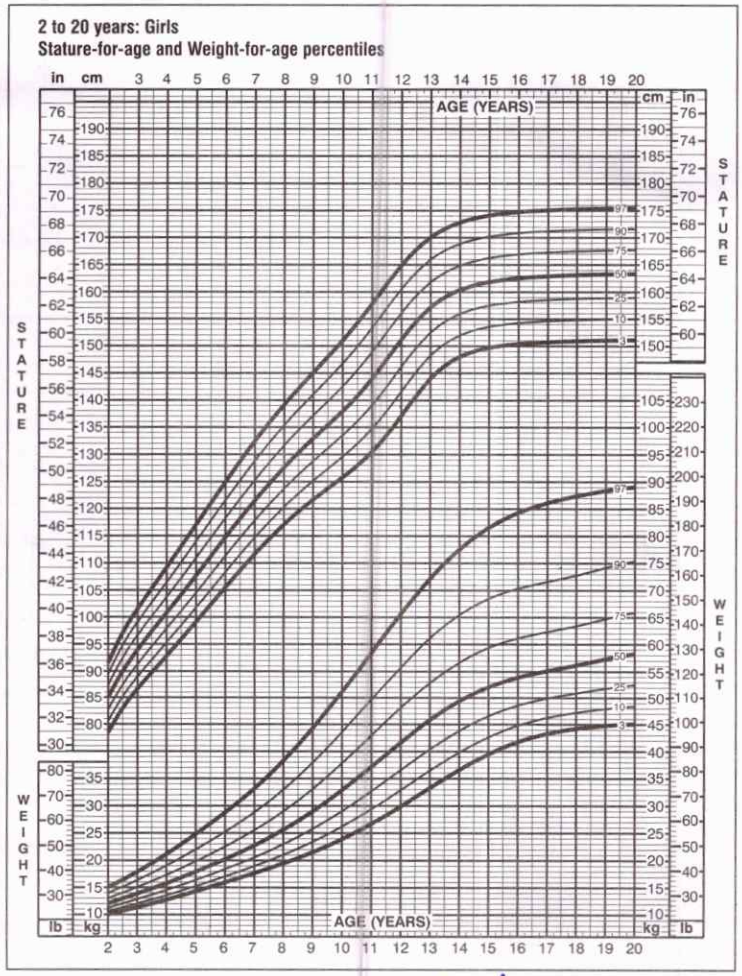
Diagnosis: AFI with Acute gastro enteritis & dehydration

Nutritional Intervention - ☑ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: G. Poojasri

GROWTH CHART (GIRLS)





Dietician's Name Syeda Sobiya Zaheer Dietician's Signature Sobiya

Daily Notes:

HNH-00011978 IP26-00006770
Baby Of G. POOJA SRI
15-11-2025 0 Y 7 M 21 D (F)
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Wt: 7.3kg

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EMERGENCY ROOM TRIAGE FORM

Patient's Name : B/o Gr Pooja sri Age : 7month **Gender:** ☐ Male ☑ Female

Date : 06/07/26 Time of Arrival : 9:40 PM

Allergies: ☐ No ☐ Yes ☐ Food ☐ Medications ☐ Blood Transfusion ☐ Other (Specify): ..... ☐ Not known

Source of Information : ☑ Parents ☐ Others (Specify) .....

Mode of Arrival : ☑ Ambulatory ☐ Wheelchair ☐ Ambulance

Initial Vital Signs: Temp: 98.2°F, PR: 112b/m BP: ..... RR: ..... SpO_2: 97%

Chief Complaints: c/o Vomiting since evening 3 epi, with 3days Fever

INITIAL PHYSIOLOGICAL CATEGORIZATION

Appearance
☑ Normal
☐ Sick Looking

Circulation / Colour
☐ Normal ☐ Abnormal ☐ Bleeding

Work of Breathing
☑ Normal ☐ Increased
☐ Decreased ☐ Gasping / Apnea

INITIAL PHYSIOLOGICAL STATUS
☑ Stable
☐ Unstable :
- ☐ Not – Life - Threatening
- ☐ Life – Threatening

Triage Classification	CTAS
☐ Level 1 : Resuscitation	☐ Immediate
☐ Level 2 : EMERGENT : Life or limb threatening	☐ < 15 min
☐ Level 3 : URGENT : Significant illness / injury with potential to become life or limb threatening	☐ 30 min
☐ Level 4 : LESS URGENT : Significant illness but not life threatening	☑ 60 min
☐ Level 5 : NON – URGENT : May receive care when convenient	☐ 120 min

NOTE : All immunocompromised children and preterm babies to be considered Level 2.
All Children less than 2 years age with high fever to be considered Level 3.

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian

Triage Completion Time : 9:42 PM

Communicable Disease Triage Screening

PART A. The following questions should be asked to all patients at the initial screening:

1. Have you had fever (elevated temperature) in the past 2 weeks ☐ Yes ☑ No
2. Have you had cough or a rash in the past 2 weeks ☐ Yes ☑ No
3. Have you had shortness of breath or difficulty breathing in the past 2 weeks ☐ Yes ☑ No

PART B. For patients reporting fever and respiratory/rash symptoms: ☐ Not applicable

1. Have you travelled outside the INDIA? or had close contact with someone who has recently travelled outside the INDIA, in the past two weeks? ☐ Yes ☑ No
   If yes, State Location: .....
2. Are your parents / close contacts at home is/a healthcare worker? {please encircle the choices} (e.g., nurse, physician, ancillary services personnel, allied health services personnel, hospital volunteer, or laboratory worker, others) who has had a recent exposure to an individual with a highly communicable disease or unexplained, severe febrile respiratory or rash disease? ☐ Yes ☑ No

PART C. A positive communicable disease triage screening is considered for any patient who meets one of the two following criteria:

- ☐ Any patient with Fever / Rash / Vesicles / Discharge from Eyes and Cough
- ☐ Any patient with fever and respiratory symptoms who answered "YES" to any of the questions on epidemiologic risk factors in "PART B" of the triage screening above.

PART D. ACTION / INTERVENTION: (for positive suspected communicable disease triage screening)

- ☐ Patients should be immediately isolated in a negative pressure room or a single room (as appropriate) for pending evaluation.
- ☐ The patient should be given a surgical mask immediately, if not already wearing one.
- ☐ Both patient and triage staff should perform hand hygiene.
- ☐ The staff should use PPE (as appropriate).

Name of Triage Nurse : Prabin

Signature of Triage Nurse : .....

Date & Time : 06/07/26 @ 9:42 PM

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 06/09/26 Time of arrival : 9:40 pm

Chief Complaints: C/o Fever since 3days/ vomiting since today evening

Height : ..... Weight : ..... Head Circumference (<2 years) .....

Allergies: ☐ Yes ☑ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other: .....

If yes , identify .....

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

☐ Character — ☐ Location — ☐ Frequency — ☐ Duration —

RISK FOR FALL:

If patient is < 6 years ☐ Yes ☑ No

If **'Yes'** tick below fall risk intervention directly

If Patient is > 6 years

If **'Yes'** Assess the below parameters

History of Falling: within past 3 months ☐ Yes ☑ No

Ambulatory Aids:

- Wheelchair ☐ Yes ☑ No
- Uses furniture for support ☐ Yes ☑ No

Gait/Transferring:

- Bedrest / immobile ☐ Yes ☑ No
- Weak ☐ Yes ☑ No
- Impaired ☐ Yes ☑ No

Mental Status: Forgets limitations ☐ Yes ☑ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

- ☐ Escort while ambulating
- ☑ Assist Patient
- ☑ Educate patient and family on fall precautions/prevention

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
- ☐ Feeding Problem
- ☐ Special diet
- ☐ Special feeding method

Inform consultant for positive criteria

Psychological Screening: ☑ No Significant Findings

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

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

Social History: Lives With Family

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

Time of Initial assessment completed by ER Nurse : 9:42 pm

Nursing Care Plan (Including Labs / Medications / Other Care):

Time	Nursing Notes
	→ Assessed the pt condition
	→ Checked the pt vitals

Samples collected by: Jyothi Time:

Samples sent by : Time: 11 pm

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1

Condition of patient at time of shift - out :	**Details of Shift - out**
HR: 112 b/m BP: ..... CFT:	Shift - out from ER to: ward
RR: ..... SPO2 at FiO2: 97%	Time of Shift - out: 11.30pm
GCS: ..... Temperature : 98.2°F	Handover given to: Amrutha (Nurse's Name)
Pain Score:	
Repeat RBS (if applicable):	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any): ..... IV placement Done .....

Name of the Nurse : Babin Signature of the Nurse : .....

Date & Time : 06/07/26 @ 9:42 pm

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
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	Transfer Ordered by Dr. Naipunya	Reason for Transfer Admission
From Unit ER	To Unit Ward	Information to Attendant Yes ☐ No ☐
Number of Sheets in Clinical File 25	Number of Imaging Films	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.		
2.		
3.		
4.		
5.		

Shifting Summary / Notes Written by Doctor : Yes ☐ No ☐

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Bhargavi	Dr. Naipunya.

Patient & Clinical Records Received by : Amrutha. 6/7/26 @ 11:30pm.

Date & Time of Patient Received :

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