

ACTIVITY RECORD FOR BILLING

Name : Sanvi

UHID No. : BAH-00610635 IP5-00173796 Consultant: _____ Dept : _____
Baby JENNAPALLY SANVI
11-11-2024 1 Y 6 M 2 D (F)
 Date of Admissi Dr. UJJWALA DESAI Date of Discharge : 16/5/26 Time: _____
 Room / Bed No : _____ Ward : _____ Suggested Billable bed type : _____

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 Baby JENNAPALLY SANVI
 11-11-2024 1 Y 6 M 2 D (F)
 Dr. UJJWALA DESAI



WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
13/5/26	11:45pm	ER	109	Rishi

Cross Consultation Visit

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

ADMISSION SHEET

Registration Details :



Admission No : IP5-00173796 Admit Date : 13-May-2026 Admit Time : 10:52 PM UHID : BAH-00619635

Patient Details :

Patient Name : Baby JENNAPALLY SANVI Age : 1 Y 6 M 2 D
Guardian : Mr JENNAPALLY YADIAIAH DOB : 11-11-2024 01:00 AM
Gender : Female Religion :
Occupation : Martial Status : Single
Address (H) : #10-1-224/1 khairtabad Chintal Basti Phone No : 9912914837/ 6304252060
Hyderabad Telangana INDIA 500004 E-mail : nomailid@gmail.com

Admission Details :

Bed Type : SEMI PRIVATE Bed No : SPVT 109 Ward Name : 1F-VIBGYOR
Room No : SPVT 109 Admission Type : First Visit

Contact Details :

Name : Mr JENNAPALLY YADIAIAH Relationship : Father
Contact Address : #10-1-224/1 khairtabad Chintal Basti Phone No : 9912914837 / 6304252060
Hyderabad Telangana INDIA 500004

G. Yadaviah
Signature

Doctor Details :

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

Payment Details :

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

BA 4-00619635 IP5-00173796
 Baby JENNAPALLY SANVI
 11-1-2024 1 Y 6 M 4 D (F)
 Dr. JJWALA DESAI



DEFICIENCY CHECK LIST OF CASE SHEET

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

ERROR LOG

LOCATION : OT / Birthing Centre / BirthRight Premium / 3rd Floor (Zone A,B,C) / NICU / PICU /
2nd Floor Ward / Oncology / 1st Floor Wards.

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE



Rainbow[®] Children's Hospital

It takes a lot to treat the little.

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: _____

UHID ID: _____

Department: _____

Consultant: _____

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Dr. UJJWALA DESAI





Pediatric Multiorgan History & Physical Examination

Name : Sanvi Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

40 fever since yesterday night
Seizure activity today

History of present illness :

premorbidly well child.
developed fever yesterday night - mod. grade (highest 101.8)
subsiding with medical
not also chills / rashes / cough / cold / loose stools
today @ 4 PM
developed paroxysmal seizure like activity
semiology - sudden loss of consciousness
gurgling sound from mouth
frothing from mouth
uprolling of eyes and head tilt.
loss of tone of all 4 limbs
episode lasted ~ 2 minutes. subsided on
giving inj. MIDAZOLAM at local hospital.
no child regained consciousness, contacted
with parents.
no H/o similar complaints in family / sibling.
also decreased oral intake :: 1 day
dull activity since today
case discussed E Dr. Kamya



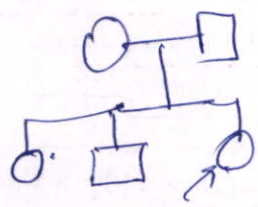
Pediatric Multiorgan History & Physical Examination

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

⊖

Birth & Neonatal History:

FT / ⊕ perinatal transition



Birth & Socio Economic History:

About Father : _____
About Mother : _____
Any additional information : _____

Developmental History :

Developed acc. to age.

Immunization History :

Immunized as per age



Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs)) 10kg (Centile _____)

On Examination :

Temperature : 101.9°F Pulse Rate : 180/min B.P. 83/07 SPO2 (64) mtg 96% RA

Resp. rate and type of breathing : 28/min

Rash _____ } child alert, febrile, interacting with parents after episode.

Lymphadenopathy _____ } now asleep.

Oedema : _____

Allergies (if any): _____

Respiratory System :

Inspection (any s/o distress) : _____

Air entry & breath sounds : BAE ⊕, clear

Any addes sounds : ⊖

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

Cardiovascular System :

Inspection of procordium : _____

Heart Sounds : S₁ S₂ ⊕

Any murmur : ⊕ ⊖

Relevant data from outside (Chest X-Ray, ECG, ECHO, etc.,) /

Per Abdomen :

Inspection _____

Palpation : Soft, NT

Ausculation : Bowel sounds ⊕

Spine : _____ External Genitalia : _____

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



Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : Aleert

Cranial Nerves : (1)

Motor System:

Nutrition : well nourished

Tone : (1) in all 4 limbs Power 2/5

Co-ordinator : (1)

Posture : (1)

Involuntary Movements : (1)

Reflexes :

DTR

Superficials:

Plantars _____

Sensory System :

Bladder / Bowel : Regular

Clinical Summary & Diagnostic:

AFL = seizure activity
? febrile seizure
? fever triggered seizure

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11-11-2024 1 Y 6 M 2 D
Dr. UJJWALA DESAI

pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: prevent complications

Desired goals of the treatment: hemodynamically stability

Planned Labs:

- CBP
- CRP
- Blood c/s
- S. Electrolytes
- Ca, Mg
- RBS.
- CVE.

Planned Management

- IV fluids
- Inj CEFTRIAXONE
- Inj PARANTOPRAZOLE
- Inj PARACETAMOL
- Syp CLOBAZAM.

Signature of the Doctor: [Signature]

Name of the Doctor: Sahithi

Date & Time: 13/5/20 10 PM.

Signature of the Consultant: [Signature]

Name of the Consultant: [Signature]

Date & Time: 14/05 (9h)

[Faint handwritten notes at the bottom of the page]



PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor: As per Rota Date: 13/5/26

Type of Admission: OPD ER Referral (if referral, Doctor's Name:

Start Time of Assessment: Weight: 10kg

Allergic History:

Chief Complaints: clo fever: yesterday night
also paroxysmal activity:

Pediatric Assessment Triangle

A Appearance - TICLS (N)

B Breathing

C Circulation

Normal
 Abnormal

↑ WOB
 ↓ WOB
 Normal
 Gasping / Apnea

Pallor
 Cyanosis
 Mottling
 Bleeding

Initial Physiological Status: Stable Unstable
 Life Threatening
 Non Life Threatening

Any urgent interventions needed: Yes No
 If Yes

Significant Past History: (e)

Medication History:

Relevant Investigations:

Primary Assessment

Airway

Open
 Maintainable
 Not Maintainable

Breathing

Rate: 28/min SpO₂ on FiO₂ 96% RA
 Rhythm: regular

Retractions: Suprasternal ICR SCR
 Sternal Supraclavicular Nasal Flaring

Respiratory Noises: Stridor Wheezing Grunting

Air Entry: BAE ⊕

Palpation Findings (if necessary)

Any urgent interventions needed: Yes No
 If Yes

Circulation

HR: 170/min CFT Central ^{< 2 sec} Peripheral

BP: 83/57 (64) mmHg

Pulse Volume: Central Peripheral ^{good}

If in Shock: Compensated Hypotensive

Muffled Heart Sound: Yes No

Engorged Neck Veins: Yes No

Murmurs: Yes No

Liver Span:

ECG:

Any Signs of Heart Failure: Yes No

Any urgent interventions needed: Yes No

If Yes:

Disability

GCS: AVPU: Alert

Pupils: Responsive Non-Responsive

Size: Right Left ^{equal}

Active Seizures: Yes No

Sugars: 112 mg/dl

Signs of Neurological compromise:

Any urgent interventions needed: Yes No

If Yes:

Exposure

Temp.: 101.9°F

Any Rash: Yes No

If yes describe the rash:

Active bleed:

Lacerations Abrasions bruises

Describe:

Any urgent interventions needed: Yes No

If Yes:

Final Physiological Status: Respiratory Distress Respiratory Failure Respiratory Arrest

Shock - Compensated Hypotensive

Cardiopulmonary Arrest Hemodynamically Stable

Secondary Assessment: Head to toe examination with positive findings: (C)

Labs Planned: CBP
CRP
Blood c/s.
S. electrolytes, Ca, Mg
ABS.
EUF.

Treatment Planned: IV fluids.
Sij Ceftriaxone
Syp Clobaxam
Fever management

Need for Oxygen: Yes No if yes Low Flow High Flow PPV

Final Diagnosis with possible Differential Diagnosis (if necessary):

Assessment done by
Name of the Doctor: Sanithi
Signature: [Signature]
Date & Time: 13/5/20

Sr. Doctor on Duty (if necessary)
Name of the Sr. Doctor:
Signature:
Date & Time:

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 Baby JENNAPALLY SANVI (F)
 11-11-2024 1Y6M3D
 Dr. UJJWALA DESAI

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	Seen by Resident	
14/3/26		
12:30 AM	AFIC, 1st ep. of febrile seizure.	
	No further febrile seizure episodes	Plan
	Child asleep, afebrile	1. Continue medication
	hemodynamically stable	as charted
	Chest clear	2. Trau blood c/s, CVB
	abdomen soft	3. Monitor vitals
		Santini

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
14/5/26 8:30am	C/S/B Resident	
	Δ: AFI with 1 st episode of febrile seizures	
	Fever: 2 days started 12/5/26	Plan
	high grade & chills no loose stools cough, cold followed by 1 st episode of seizure on 13/5/26 for which she was taken to nearby hospital.	① Ory CEFTRIAXONE ② SYP CLOBAZAM BD ③ SYP PARACETAMOL QD ④ IVF DNS @ 40ml/h
	given Midazolam spray, + Inj stat	TO do s/vinal Pand now. <u>Sohela</u>
	OE: vitals stable	
14/5	Culd c AFI & fever	Plan
Cul (M/F)		- Continue same medical
9u Dr. Faisal B Nahdi Reg. No: 66228		- Share the panel
		<u>Dr.</u>

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 Baby JENNAPALLY SANVI (F)
 11-11-2024 1 Y 6 M 3 D
 Dr. UJJWALA DESAI

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
15/5/26 7:50am	CSIB Resident	
	Δ: AFI + 1 st episode of seizure + Influenza B (+)	
		<u>Plan</u>
	Afebrile since yesterday NO fresh complaint child doing well taking good oral feeds.	<ol style="list-style-type: none"> ① Syj ceftriaxone (D₃) ② Syj Pantoprazole ③ Syj. oseltamivir (D₂) ④ Syj. Azithromycin (D₂) ⑤ Syj clobazam. ⑥ Syj paracetamol ⑦ IVF DNS combi/ku
	<p><u>OLE</u>:- vitals stable WS: S₁ S₂ (+) RS: BAET (+), airway clear ENT: clear P/A: soft RR: 30/min</p>	<p><u>Soheh</u> Grace Bldcls</p>
	Afebrile	stop Syj paracetamol
		Da
		Dr. Ujjwal Desai 9am 15/5/26
		DR. UJJWALA DESAI Registration No: 55...

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 11-11-2024 1 Y 6 M 3 D (F)
 Dr. UJJWALA DESAI



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<p>15/5/26 <u>Y. Desai</u></p>	<p><u>C/S/B Resident</u> <u>Dr. Ayushman</u></p>	
	<p><u>AFI + 1st of seizure,</u> <u>+ Influenza B</u></p>	
	<p><u>Afebrile</u></p>	<p><u>Plan</u></p>
	<p>Oral intake - Good No new rime Oral intake - Good</p>	<p>Cont to same + 1 + a cont IV fluids - ok for D/C 7/15</p>
	<p>hemodynamically stable</p>	<p>Ayushman</p>
		<p>Low prijm s/m.</p>
		<p>DR. UJJWALA DESAI Registration No: 90550</p>

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Baby JENNAPALLY SANVI

11-11-2024 1 Y 6 M 2 D (F)

Dr. UJJWALA DESAI



RESULT SHEET

Date	13/5/26				
Time	11:15 AM				
Hb	10.9				
PCV	33.5				
RBC	4.4				
WBC	11.4k				
N/L	60/36				
Platelets	2.7L				
CRP	12				
ESR					
PCT					
RBS	112				
Na	137				
K	4.5				
Cl	103				
Ca/Mg	9.1/2.1				
Phosphate					
Urea					
Creatinine					
ALP					
SGPT					
SGOT					
T.Bil/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					

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MEDICATION RECONCILIATION FORM

Drug Allergies: Not known any Drug Allergies

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

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

Shifting From: ICU Shifted to: Ward

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

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: Dr. Santhi

Date & Time: 13/5/20 11:45

Nurse Name & Signature: Ujjwala

Date & Time: 13/5/20 11:45 PM

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 Dr. UJJWALA DESAI



DRUG CHART

Date of Admission: 13/5/26 Drug Allergies: Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

SOS / PRN (As Required Medication)

DRUG: <u>Syp PARACETAMOL (5ml/100mg)</u>				Date Time															
Dose	Route	Frequency	Start Date	<div style="border: 1px solid black; padding: 5px; width: fit-content;"> <p><i>Made regular Salivati</i></p> </div>															
<u>3.5ml</u>	<u>PO</u>	<u>SOS</u>	<u>13/5</u>																
Doctor's Signature <u>Salivati</u>		Valid Period <u>48hrs</u>	Pharm. <u>[Signature]</u>																
Additional Instructions: <u>if temp > 100f maximum 6hrly.</u>																			

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:																			

Signature
Name



REGULAR PRESCRIPTIONS

Weight. 10kg Ward.

VERIFIED

VERIFIED

VERIFIED

VERIFIED

DRUG: <u>Syr CEFTRIAXONE</u>				Date	13/5	14/5	15/5			
Dose	Route	Frequency	Start Date	Time						
<u>500mg</u>	<u>IV</u>	<u>BD</u>	<u>13/5</u>							
Name & Signature of the Doctor Starting the Drugs:				 Sahithi (Amritha, Anurag, Anurag, Anurag)						
Additional Instructions:				@ 50 mg/kg dose. (Amritha, Anurag, Anurag, Anurag)						
Daily Doctor's Endorsement by a Sign										
DRUG: <u>Syr PANTOPRAZOLE</u>				Date	13/5	14/5	15/5	16/5		
Dose	Route	Frequency	Start Date	Time						
<u>10mg</u>	<u>IV</u>	<u>OD</u>	<u>13/5</u>							
Name & Signature of the Doctor Starting the Drugs:				 Sahithi (Amritha, Anurag, Anurag, Anurag)						
Additional Instructions:				~ 1 mg/kg dose (Amritha, Anurag, Anurag, Anurag)						
Daily Doctor's Endorsement by a Sign										
DRUG: <u>Syr CLOBAZAM</u>				Date	13/5	14/5	15/5			
Dose	Route	Frequency	Start Date	Time						
<u>1ml</u>	<u>PO</u>	<u>BD</u>	<u>13/5</u>							
Name & Signature of the Doctor Starting the Drugs:				 Sahithi (Amritha, Anurag, Anurag, Anurag)						
Additional Instructions:				@ 0.5mg/kg/day. (1ml/2.5mg) (Amritha, Anurag, Anurag, Anurag)						
Daily Doctor's Endorsement by a Sign										
DRUG: <u>Syr PARACETAMOL</u>				Date	14/5	15/5				
Dose	Route	Frequency	Start Date	Time						
<u>3ml</u>	<u>PO</u>	<u>QID</u>	<u>13/5</u>							
Name & Signature of the Doctor Starting the Drugs:				 Sahithi (Amritha, Anurag, Anurag, Anurag)						
Additional Instructions:				(3ml/250mg) Stop 15/5/20. (Amritha, Anurag, Anurag, Anurag)						
Daily Doctor's Endorsement by a Sign										

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Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward

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

VERIFIED BY : Name Signature

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.

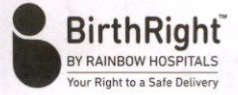
I	IDENTITY: I am (name), a nurse on ward (X). I am calling about (child X)
S	SITUATION : I am calling because I am concerned that ... (e.g. BP is low/high, pulse is XXX, Temperature is XX, Early Warning Score is XX)
B	BACK GROUND : Child (X) was admitted on (XX date) with (e.g. respiratory infection).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



No. : RCHBH/ FRM / CLINICAL / 126

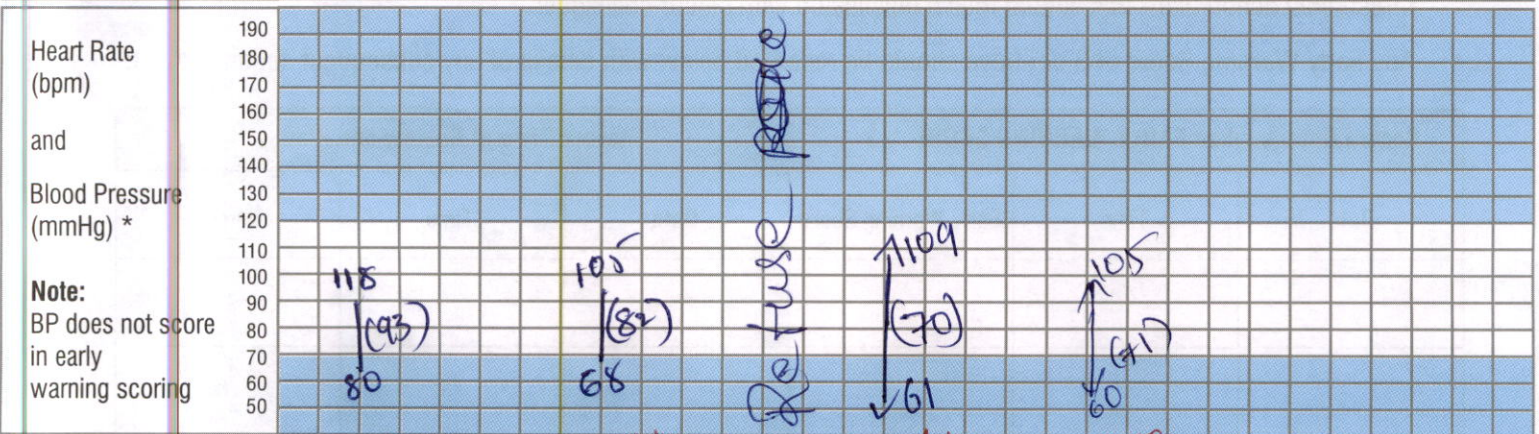
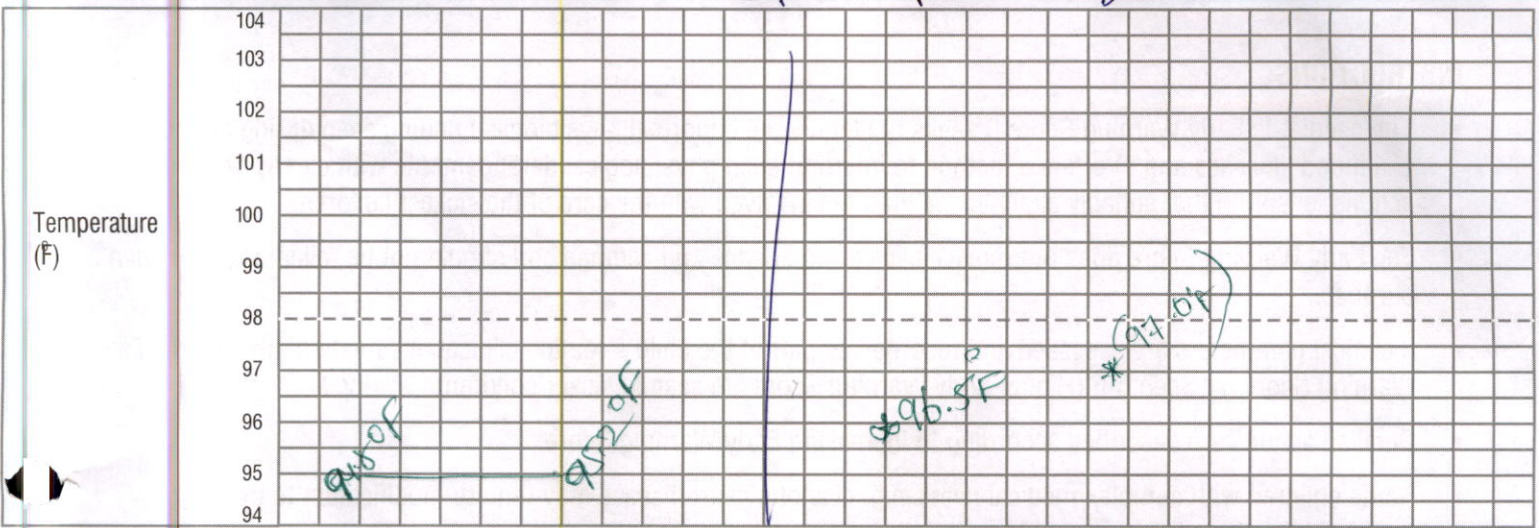
SCHOOL AGE (5-12 years)
Children's Observation & Early Warning Scoring Chart



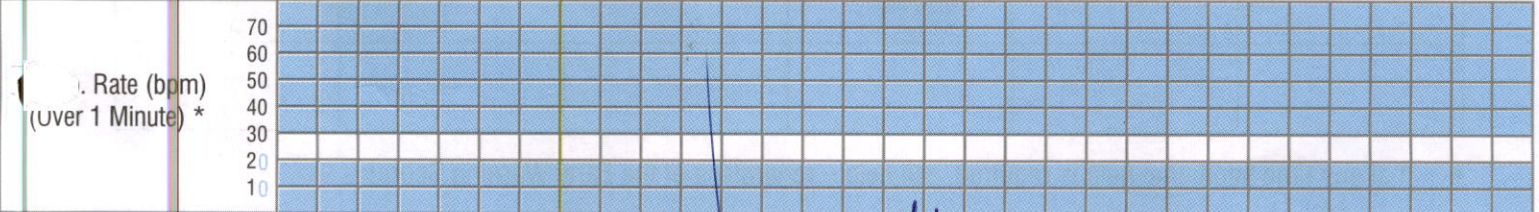
EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 11/11/24 Time: _____

Doctor / Nurse / Family Concern? 10AM 1PM 4PM 10PM 2am



Heart Rate (Number) 132b/m 172b/m 130b/m 131b/m



Resp Rate (Number) 29b/m 26b/m 26b/m 24b/m

Resp Mod/ Severe Distress None / Mild

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

Conscious Level Normal Altered

GCS * 15/15 15/15 15/15 15/15

TOTAL SCORE Number of shaded boxes 1 1 1 1

Pain Score 0 0 0 0

Observer's Initials 0 0 0 0

ACTIONS

NB: Scores 3 should be recorded over leaf

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)

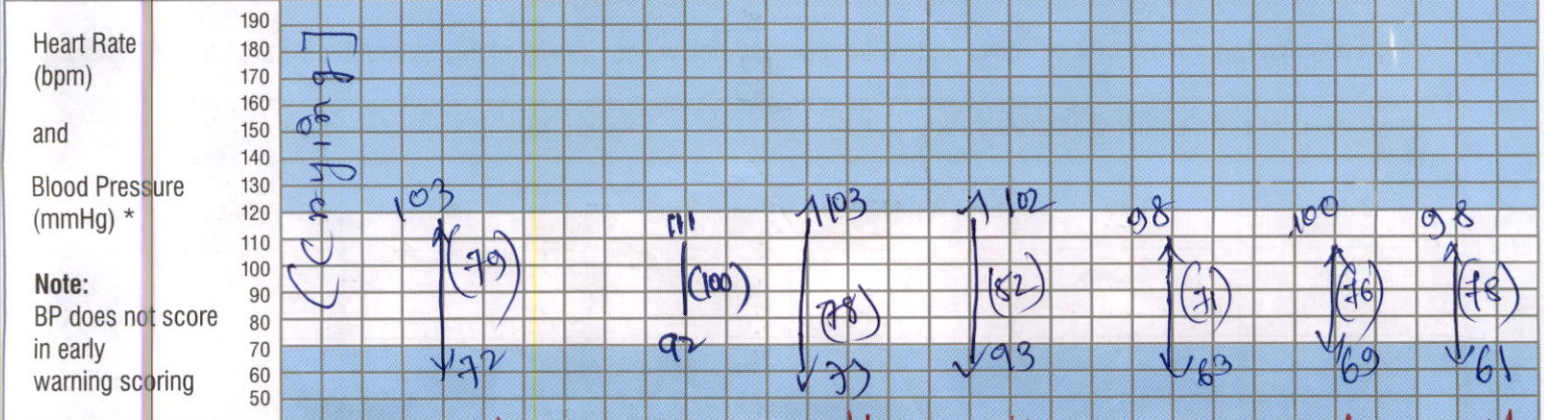
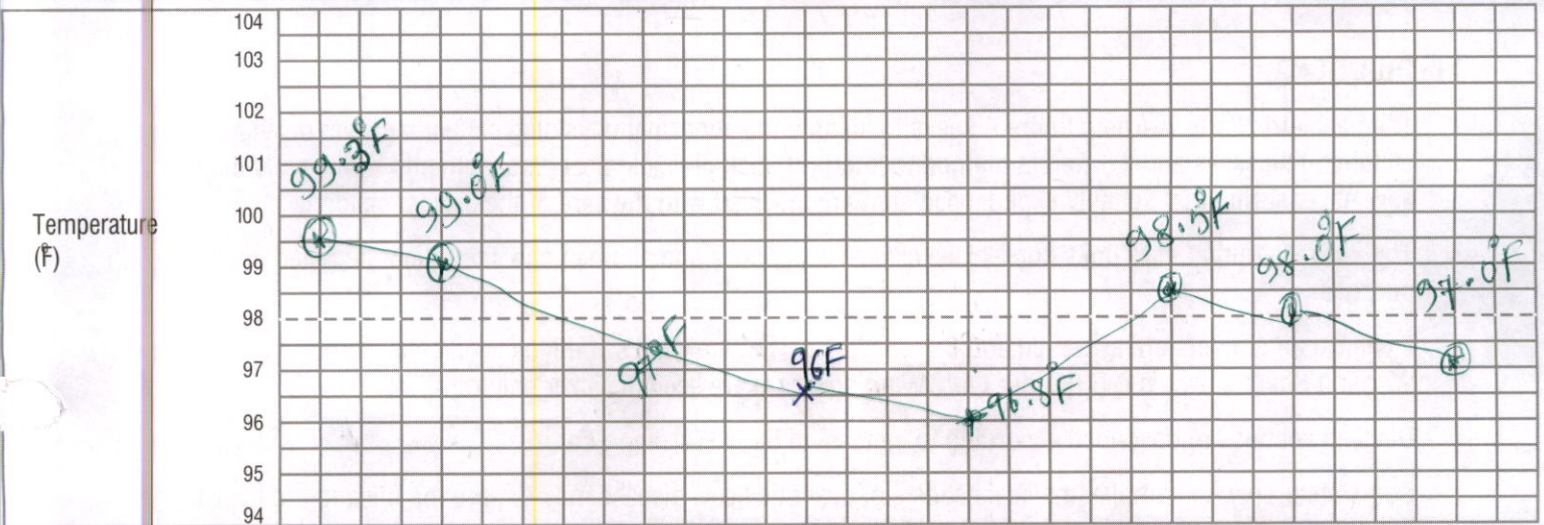


SCHOOL AGE (5-12 years)
Children's Observation & Early Warning Scoring Chart



EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 11/11/24 Time: 12:30 AM 6AM 10AM 2PM 6PM 10PM 2AM 6AM
 Doctor / Nurse / Family Concern? _____



Heart Rate (Number) 132b/m 150b/m 117b/m 132b/m 118b/m 116b/m 110b/m

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

Resp Rate (Number) 28b/m 27b/m 26b/m 26b/m 21b/m 23b/m 24b/m

Resp Mod/ Severe Distress None / Mild

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

Conscious Level Normal / Altered

GCS * 15/15 15/15 15/15 15/15 15/15 15/15 15/15

TOTAL SCORE	Number of shaded boxes	Pain Score	Observer's Initials
1	1	0	a
1	1	0	o
1	1	0	o
1	1	0	o
1	1	0	a
1	1	0	a

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

BAH-00619635 IP5-00173796
 Baby JENNAPALLY SANVI
 11-11-2024 1 Y 6 M 2 D (F)
 Dr. UJJWALA DESAI



FLUID CHART

Sheet No. :

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis 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	DNS		40ml						✓	0	0	P.B	
Total Intake :						Total Output :								
	02:00 am	↑		40ml							0	0	P.B	
	03:00 am			40ml							0	0	P.B	
	04:00 am	DNS		40ml							0	0	P.B	
	05:00 am			40ml							0	0	P.B	
	06:00 am			=							0	0	P.B	
	07:00 am	↓		=						✓	0	0	P.B	
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.

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
11/5	08:00 am				/			/		0	Arung		
	09:00 am		R	P	/		✓	/		0	Arung		
	10:00 am	DNS	R	P	MA			MA		0	Arung		
	11:00 am		R	P	/			/		0	Arung		
	12:00 pm		R	P	/			/		0	Arung		
	01:00 pm		R	P	/			/		0	Arung		
Total Intake :						Total Output :							
12/5	02:00 pm		R	MILK	/			/		0	Arung		
	03:00 pm		R	P	/		✓	/		0	Arung		
	04:00 pm	DNS	R	P	MA			MA		0	Arung		
	05:00 pm		R	P	/		NP	/		0	Arung		
	06:00 pm		R	P	/		✓	/		0	Arung		
	07:00 pm		R	P	/			/		0	Arung		
Total Intake :						Total Output :							
14/5	08:00 pm	↑		-	/			/		0	P.B		
	09:00 pm			-	/			/	✓	0	P.B		
	10:00 pm	DNS		-	/			/		0	P.B		
	11:00 pm			uomL	/			/		0	P.B		
	12:00 am			uomL	/			/		0	P.B		
	01:00 am	↓		uomL	/			/	✓	0	P.B		
Total Intake :						Total Output :							
15/5	02:00 am	↑		uomL	/			/		0	P.B		
	03:00 am			uomL	/			/		0	P.B		
	04:00 am	DNS		uomL	/			/		0	P.B		
	05:00 am			uomL	/			/		0	P.B		
	06:00 am			uomL	/			/		0	P.B		
	07:00 am	↓		uomL	/			/	✓	0	P.B		
Total Intake :						Total Output :							

Total 24 hrs. Intake	
-----------------------------	--

Total 24 hrs. Output	
-----------------------------	--

BAH-00619635 IP5-00173796
 Baby JENNAPALLY SANVI
 11-11-2024 1 Y 6 M 3 D (F)
 Dr. UJJWALA DESAI



FLUID CHART

Sheet No. :

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
15/11	08:00 am			40ml	/	/					0	Aruna	
	09:00 am			40ml	/	/					0	Aruna	
	10:00 am	DNS		-	NA	/					0	Aruna	
	11:00 am			-	/	/					0	Aruna	
	12:00 pm			-	/	/					0	Aruna	
	01:00 pm			-	/	/					0	Aruna	
Total Intake :						Total Output :							
15/11	02:00 pm		RICE		/	/					0	Aruna	
	03:00 pm		RICE	40ml	/	/					0		
	04:00 pm	DNS	RICE	40ml	/	/					0		
	05:00 pm		RICE	40ml	/	/					0		
	06:00 pm		RICE	40ml	/	/					0		
	07:00 pm		RICE	40ml	/	/					0		
Total Intake :						Total Output :							
15/11	08:00 pm			40ml	/	/					0	(Pl)	
	09:00 pm			40ml	/	/					0	(Pl)	
	10:00 pm	DNS	Water	-	NA	/					0	(Pl)	
	11:00 pm			-	NA	/					0	(Pl)	
	12:00 am		RICE	40ml	/	/					0	(Pl)	
	01:00 am			40ml	/	/					0	(Pl)	
Total Intake :						Total Output :							
16/11	02:00 am			40ml	/	/					0	(Pl)	
	03:00 am			40ml	/	/					0	(Pl)	
	04:00 am			40ml	/	/					0	(Pl)	
	05:00 am	DNS		-	NA	/					0	(Pl)	
	06:00 am			-	NA	/					0	(Pl)	
	07:00 am			40ml	/	/					0	(Pl)	
Total Intake :						Total Output :							
Total 24 hrs. Intake						Total 24 hrs. Output							

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FLUID CHART



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Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse		
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine				
	08:00 am													
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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

109

NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 14/5/26 Time: 9am

Weight: 6 kgs Centile: >10th

Height: 77 cms Centile: >10th

Inference: Underweight child

RDA: Calories: 1200 kcal/d Protein: 20g/d

Diet Recommendations: Soft diet

Re-Assessment: Avoid spicy, chilled, outside foods

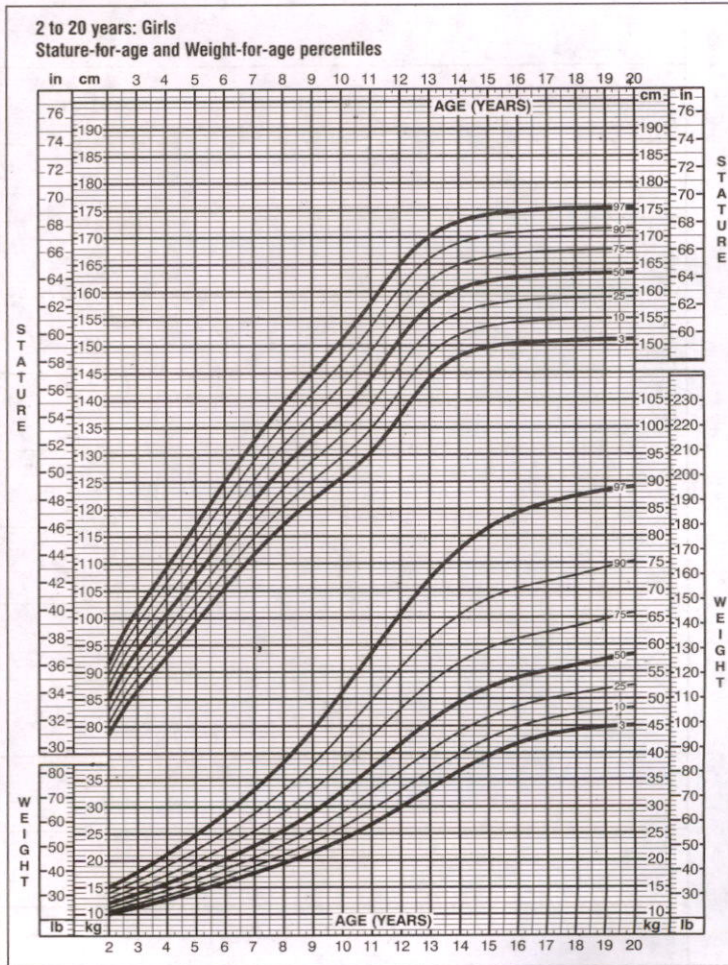
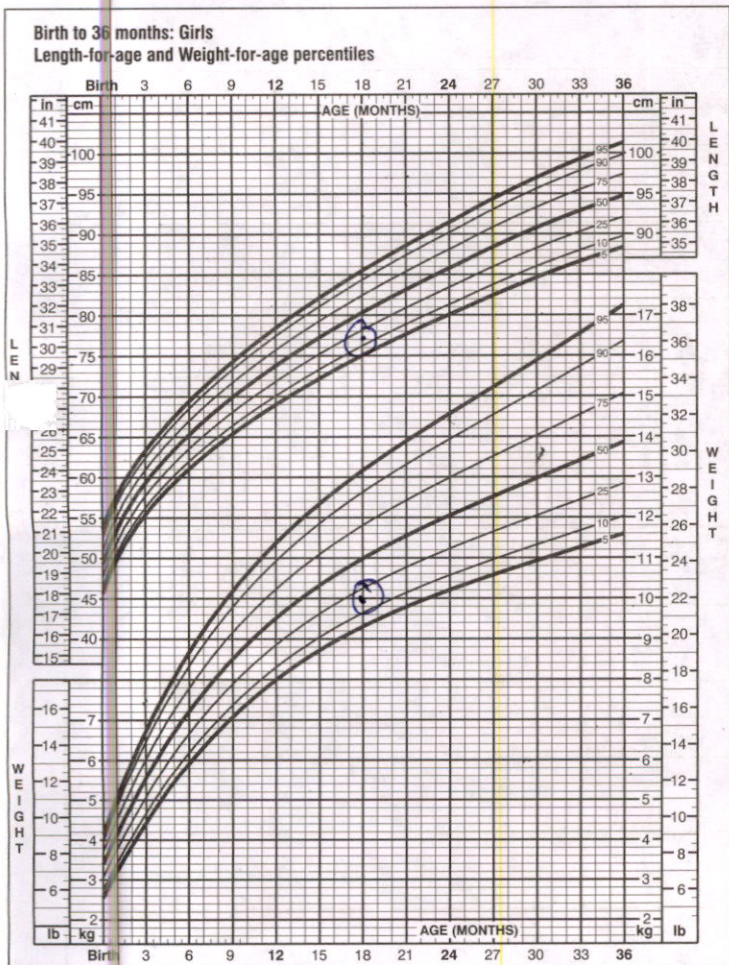
Food Allergies: NO Veg/Non-veg: Non-veg

Diagnosis: APL is 1st episode of febrile seizure

Nutritional Intervention - Oral Enteral Parenteral

Patient's Signature: *[Signature]*

GROWTH CHART (GIRLS)



Dietician's Name: Nikitha

Dietician's Signature: *Nikitha*

Daily Notes:

5/5/26
10AM

child is stable, oral intake is good.

continue \bar{c} soft diet — Xikitha,