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ACTIV VIH-00064237 IP-00060161 **ING**
Master RYAN RANVEER
21-11-2014 11 Y 6 M 7 D (M)
Dr. SURENDER RAO DUSA

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

UHID N ---------- Consultant : ---------- Dept : ENT

Date of Admission : 28/05/26 Time : 2:41 PM Date of Discharge : ---------- Time: ----------

Room / Bed No : 112 Ward : 1st floor Suggested Billable bed type : ----------

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
28/5/26	9.15 PM	E.R.	112	

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Sign
28/5/26	CBR CRP electrolytes	26018680	DL.
	Cross checked by [illegible] 29/5/26		

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
28/5	Infusion pump	9.25pm	11Am	3084905	[signature]
	Cross	checked	by [signature]	29/5/26	

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
28/5/26	IV Placement	1	3084906	
	Cross Clubbed by dr		29/5/26	

ANY OTHER INFORMATION

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
	Gayathri 29/5/26		

Rainbow Children's Hospital

BirthRight by Rainbow

Rainbow Children's Hospital - Secunderabad

H.No.3-7-222/223,Sy.No.51 to 54,Opp.Karkhana P S,Karkhana Main Road,Kakaguda, Karkhana ,Hyderabad ,Telangana, INDIA ,500009.
TEL NO :040-42462200, Ext 2000,2001,2002
WEB : https://rainbowhospitals.in

ADMISSION SHEET

Registration Details :

Admission No : IP-00060161 **Admit Date** : 28-May-2026 **Admit Time** : 07:41 PM **UHID** : VIH-00064237

Patient Details :

Patient Name	: Master RYAN RANVEER	**Age**	: 11 Y 6 M 7 D
Guardian	: Mr EDWARD DHANRAJ	**DOB**	: 21-11-2014
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	: Single
Address (H)	: PLOT NO-86,RBI COLONY,BHOODVINAGAR Venkatapuram Hyderabad Telangana INDIA 500015	**Phone No**	: 9849232974
		E-mail	: dhanraj26e@gmali.com

Admission Details :

Bed Type : SHARED WARD **Bed No** : ER 101 **Ward Name** : N 0 GF-EMERGENCY

Room No : ER 101 **Admission Type** : First Visit

Contact Details :

Name : Mr EDWARD DHANRAJ **Relationship** : S/O

Contact Address : PLOT NO-86,RBI COLONY,BHOODVINAGAR Venkatapuram Hyderabad Telangana INDIA 500015 **Phone No** : 9849232974

Rizvi Stella

Signature

Doctor Details :

Doctor Name	: Dr. SURENDER RAO DUSA	**Specialisation**	: GENERAL PEDIATRICS
Referral Doctor	: Self	**Phone No**	:
Co-Consultant	:		

Payment Details :

Payment Mode	: Cash	**Deposit Amount**	: 0.00
		Payor Name	: BAJAJ ALLIANZ GENERAL INSURANCE CO LTD

Patient Name : Mast. RYAN RANVEER UHID : 2134 IPD : 4356 Gender : Male Age : 11

VIH-00064237 IP-00060161
Master RYAN RANVEER
21-11-2014 11 Y 6 M 7 D (M)
Dr. SURENDER RAO DUSA

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EMERGENCY ROOM TRIAGE FORM

wt : 27.40 kg

Patient's Name : Mast Ryan Ranveer Age : 11 yrs Gender: ☑ Male ☐ Female

Date : 28/5/26 Time of Arrival : 7 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: 102.2°F PR: 106 b/m BP: 102/66 (77) RR: 28 b/m SpO$_2$: 100%

Chief Complaints: C/o fever, vomiting x today morning 1 episode

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 : 7:4 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 : Kiran

Signature of Triage Nurse : .....

Date & Time : 28/5/26 at 7:4 PM

Docu. No. : RCH /FRM / CLINICAL / 085

Patient Name : Mast. RYAN RANVEER UHID : 2134 IPD : 4356 Gender : Male Age : 11

VIH-00064237 IP-00060161
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21-11-2014 11 Y 6 M 7 D (M)
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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 28/5/26 Time of arrival : 7:5 PM

Chief Complaints: C/O fever, vomiting x today morning 1 Episode RBS: .....

Height : — Weight : 27.40 kg BMI : — Head Circumference (<2 years) .....

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

If yes , identify .....

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

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

RISK FOR FALL:

☐ If patient is < 6 years
tick below fall risk intervention directly

☑ If Patient is > 6 years
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?) 1 sister

Time of Initial assessment completed by ER Nurse : 28/5/26 @ 7:10 PM

Patient Name : Mast. RYAN RANVEER UHID : 2134 IPD : 4356 Gender : Male Age : 11

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

Time	Nursing Notes
7:00PM	Patient come to the ER.
7:5PM	Vitals checked and Recorded.
7.7 PM	Dr Nikesh has been to the Pt.
7:30 PM	Admission process Done.
8:10 PM	Pt IV Placement Done and Sample sent to Lab.
9.15PM	Pt shift ER TO 112

Samples collected by: Sr Raji
Samples sent by : Sr Kiran

Time: 8:10PM
Time:

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1
8 PM	NS Bolus	IV	500 ml	BN	Sr
8:05 PM	Syp. Ibugesic	P/O	14 ml	ER	Sr

Condition of patient at time of shift - out :

HR: 100b/m BP: 100/60 (76) CFT: <2sec
RR: 23 b/m SPO$_2$: 100%
GCS: 15 Temperature : 100.6°F
Pain Score: 0
Repeat RBS (if applicable): —

Details of Shift - out

Shift - out from ER to: 112
Time of Shift - out: 28/5/26 @ 9.15 PM
Handover given to: Sr. Subham
(Nurse's Name) by Br. Sanjay

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any): IV Cannulization

Name of the Nurse : Bro. Sanjay Signature of the Nurse : Sanjay.

Date & Time : 28/5/26 @

VIH-00064237 IP-00060161
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Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 9:15 PM Mode of Arrival: walking Admitting From: ☐ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction: NO allergy

Body Weight: 27.400 Kg

Height: ..... cm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
NIL	NIL	NIL

Family History: 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: EL-LSCS

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

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

Observations: Weight: 27.400kg Length: ..... Head Circumference (< 2 years): .....

Temp.: 98.6°F HR: 100 b/mt RR: 24 b/mt BP: 102/58 (72)

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

Fall Risk Assessment: ☑ Yes ☐ No Score: 10 (Document in the Humpty Dumpty Sheet)

Risk of Pressure Sore (Braden Q Score 22) (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 — Location — Frequency ..... Duration .....

FUNCTIONAL SCREENING: ☑ No Abnormalities Detected

- ☐ Mobility Problem
- ☐ Walking Problem
- ☐ Developmental Delay
- ☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING: ☑ No Abnormalities Detected

- ☐ Underweight
- ☐ Overweight
- ☐ Special Feeding Method
- ☐ Feeding Problem
- ☐ Special diet
- ☐ No Abnormality Detected

Inform consultant for positive criteria

Psychological Screening: ☐ No Significant Findings

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

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

Social History: Lives With ..... Family .....

Siblings in household ☑ Yes ☐ No (if yes How Many?) ..... 1 .....

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

Orientation has been given regarding the following aspects:

Call Bell in Reach : ☑ Yes ☐ No Waste Disposal Explained: ☑ Yes ☐ No

Infusion Pump : ☑ Yes ☐ No Hand hygiene Explained: ☑ Yes ☐ No ☐ Others

Patient Rights & Responsibilities: ☑ Yes ☐ No

Information given to ..... Mother .....

Nurse's Name: ..... Subham ..... Date: ..... 28/5/26 ..... Time: ..... 9:35PM ..... Signature

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
VIH-00064237 IP-00060161 Master RYAN RANVEER 21-11-2014 11 Y 6 M 7 D (M) Dr. SURENDER RAO DUSA	28/05/26@ 2.41PM	28/05/26@ 9.15PM
	Transfer Ordered by Dr Ramesh.	Reason for Transfer Admission
From Unit ER	To Unit 112	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File (21)	Number of Imaging Films —	Personal belongings including clinical documents. If any handed over to attendant Yes ☑ No ☐ If yes, what ? Clothing

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
Srikanth MG	Dr Ramesh

Patient & Clinical Records Received by : Subham

Date & Time of Patient Received : 28/5/26 @ 9:15 PM

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

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PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: _____ VIH-00064237 IP-00060161 Master RYAN RANVEER 21-11-2014 11 Y 6 M 7 D (M) Dr. SURENDER RAO DUSA _____

UHID ID: _____ _____

Department: _____

Consultant: _____

VIH-00064237 IP-00060161
Master RYAN RANVEER
21-11-2014 11 Y 6 M 7 D (M)
Dr. SURENDER RAO DUSA

Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: Mother Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

- Lethargy / Headache x 1 day
- Vomiting.

History of present illness :

H/O Playing excessively under sun from 11AM (Yesterday) ↑ to 4:30AM
↓ followed by.
H/O headache, lethargic
2 EPS of NB, ND vomiting & ∴ today.

NO H/O outside food/water consumption

VIH-00064237 IP-00060161
Master RYAN RANVEER
21-11-2014 11 Y 6 M 7 D (M)
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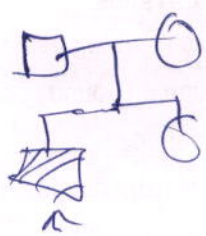
Pediatric Multiorgan History & Physical Examination

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

1st time.

Birth & Neonatal History:

Term/ 2.8kg/ EL-LSCS
NO perinatal
insult.



Birth & Socio Economic History:

About Father :

About Mother :

Any additional Information : Class III

Developmental History :

(N) in all 4 domains

Immunization History :

upto date

(P.T.O.)

VIH-00064237 IP-00060161
Master RYAN RANVEER
21-11-2014 11 Y 6 M 7 D (M)
Dr. SURENDER RAO DUSA

Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs))__27Kg__(Centile _____)

On Examination :

Temperature : 101.°F Pulse Rate :106 B.P. 102/66(77) SPO2 100%

Resp.rate and type of breathing : 24/min.

Rash

Lymphadenopathy

Oedema :

Allergies (if any):

Respiratory System :

Inspection (any s/o distress) :

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

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, NAD.

Ausculation :

Spine : External Genitelia :

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

VIH-00064237 IP-00060161
Master RYAN RANVEER
21-11-2014 11 Y 6 M 7 D (M)
Dr. SURENDER RAO DUSA

Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score :

Cranial Nerves : Intact

Motor System:

Nutriton :

Tone: Power

Co-ordinator :

Posture :

Involuntary Movements :

Reflexes :

DTR **Superficials:**

Plantars

Sensory System :

Bladder / Bowel :

Clinical Summary & Diagnostic:

? Heat Stroke

(P.T.O.)

VIH-00064237 IP-00060161
Master RYAN RANVEER
21-11-2014 11 Y 6 M 7 D (M)
Dr. SURENDER RAO DUSA

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

Desired goals of the treatment :

Planned Labs:

CBP, CRP, SE

Noted by sr. Citon
28/5/26 @ 8:5pm

Planned Management

C/S/B Dr. Surendra @OPD.

- NS Bolus (20ml/kg) over 45min
- Iv ondem (SOS)
- Antipyretic (SOS).
- Antibiotics (after CRP)

Signature of the Doctor: ....

Name of the Doctor: CH. GANESH

Date & Time: 28/5/2026.

Signature of the Consultant: ....

Name of the Consultant: Dr. Surender

Date & Time: ....

VIH-00064237 IP-00060161
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21-11-2014 11 Y 6 M 7 D (M)
Dr. SURENDER RAO DUSA

(1)

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
29/5/26 10:30 AM	C/o/B Resident	
	Dx: ? Heat Stroke.	
	No new issues.	
	Oral Intake - Better.	
	U/O - Adequate.	
	O/E	
	Child is Alert & Active.	
	Vitals Stable	
	CVS: S1S2 (+)	Plan
	RS: BL AE (+)	
Improved.	P/A: Soft	- Continue IVF.
	CNS: NAD.	

Dr. Surender Rao
29/5/26
11:45 AM

Noted by Anitha
29/5
@12pm

Patient Sticker

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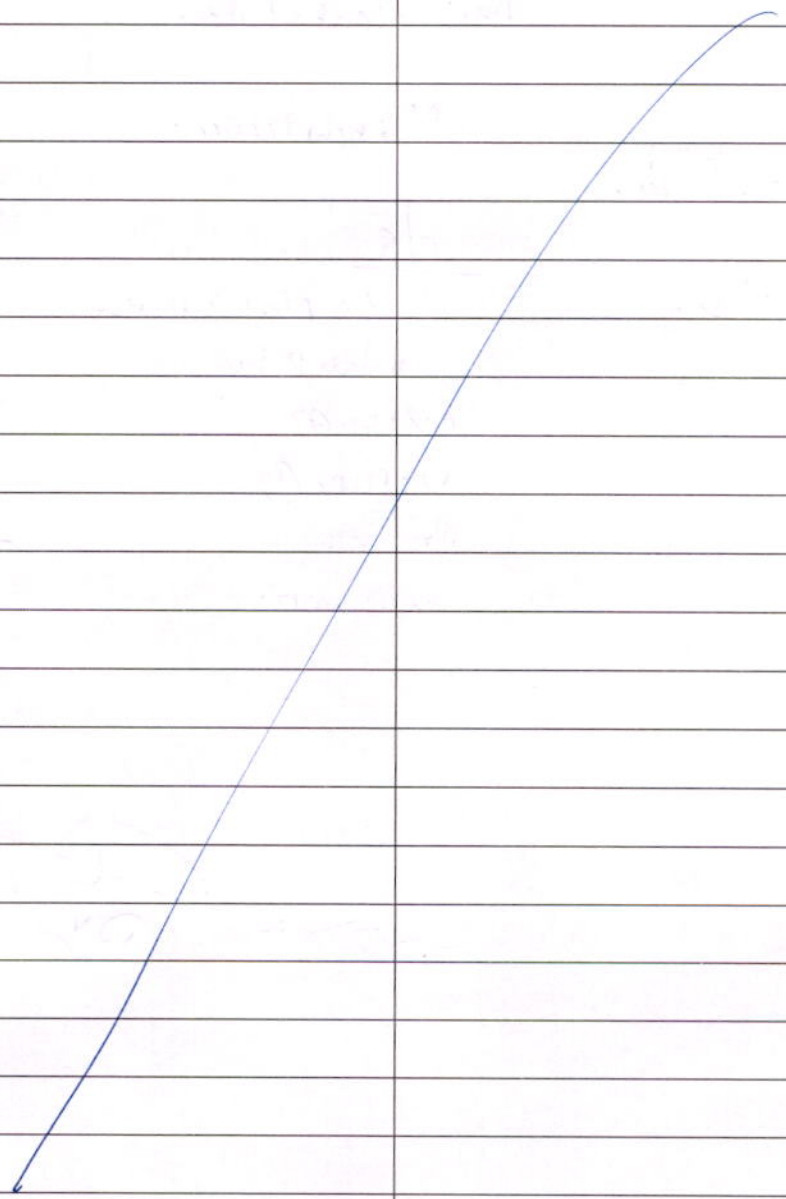
PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order



VIH-00064237 IP-00060161
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WELL'S CRITERIA FOR ASSESSING DVT

NOTE: Assign a **score of 1** if **'YES'** in **parameter 1 to 9** and **Assign a score of -2** if **'YES'** in **parameter No 10**

S.No	Assessment Criteria	Score	Date: 29/5 Time: 5AM	Date: Time:	Date: Time:	Date: Time:	Date: Time:	Date: Time:
1	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)	1	0					
2	Bedridden recently >3 days or major surgery within four weeks	1	0					
3	Calf swelling >3cm compared with asymptomatic side, measured at 10 cm below tibial tubercle (Assess for both legs)	1	0					
4	Collateral (non varicose) superficial veins present (Assess for both legs)	1	0					
5	Entire leg swollen (Assess for both legs)	1	0					
6	Localized tenderness along the deep venous system (Assess for both legs)	1	0					
7	Pitting edema, greater in the symptomatic leg (Assess for both legs)	1	0					
8	Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs)	1	0					
9	Previously documented DVT (Assess for both legs)	1	0					
10	Alternative diagnosis to DVT as likely or more likely (Assess for both legs)/ Co-morbidity like ESLD /Renal disease, Renal failure, CCF Cellulitis (commonly mistaken as DVT), Dependent (stasis) oedema, Lymphatic obstruction.	-2	0					
	Total Score		0					
	Signature of the Nurse							

Intervention: _____

_____

_____

High Risk = >2 Score

Moderate Risk = 1-2 Score

Low Risk = <1 Score

Note : Daily assessment shall be carried out once every 24 hours and documented

VIH-0006297
Master RYAN RANVEER
21-11-2014 11 Y 6 M 7 D (M)
Dr. SURENDER RAO DUSA

FRM / CLINICAL / 126

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

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 28/5/26 Time:	10	1	4	6:45
Doctor / Nurse / Family Concern?	PM	AM	AM	AM

Temperature (°F) — 104 / 103 / 102 / 101 / 100 / 99 / 98 / 97 / 96 / 95 / 94

98.4 · 98.6 · 98.6 · 101 °F · Tab SIDUPRENE

Heart Rate (bpm) and Blood Pressure (mmHg) * — 190 / 180 / 170 / 160 / 150 / 140 / 130 / 120 / 110 / 100 / 90 / 80 / 70 / 60 / 50

Note: BP does not score in early warning scoring

102 (72) 58 · 107 (72) 62

Heart Rate (Number)	92	104	116	104

Resp. Rate (bpm) (Over 1 Minute) * — 70 / 60 / 50 / 40 / 30 / 20 / 10

Resp Rate (Number)	22		28	

Resp Distress: Mod/ Severe / None / Mild				
Receiving O_2 (l/min) O_2 Saturations (%)	99	100	95	99
Conscious Level: Normal / Altered	N	N	N	N
GCS *	15	15	15	15
TOTAL SCORE Number of shaded boxes	0	0	0	0
Pain Score	0	0	0	0
Observer's Initials	SK	SK	SK	SK

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.

Patient Sticker

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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)

VIH-00064237 IP-00060161
Master RYAN RANVEER
21-11-2014 11 Y 6 M 7 D (M)
Dr. SURENDER RAO DUSA

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

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

Rainbow® Children's Hospital — It takes a lot to treat the little.
BirthRight BY RAINBOW HOSPITALS — Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : .... Time:	9	11
Doctor / Nurse / Family Concern?	AM	AM
Temperature (°F) (104–94)	98.6 F	98.6 F
Heart Rate (bpm) and Blood Pressure (mmHg) * (190–50)	98 / (72) / 68	
Heart Rate (Number)	110	108
Resp. Rate (bpm) over 1 Minute) * (70–10)		
Resp Rate (Number)	24	26
Resp Distress — Mod/ Severe		
Resp Distress — None / Mild	N	N
Receiving O_2 (l/min)		
O_2 Saturations (%)	98	99
Conscious Level — Normal	N	N
Conscious Level — Altered		
GCS *	15	15
TOTAL SCORE Number of shaded boxes	0	0
Pain Score	0	0
Observer's Initials	[illegible]	[illegible]

Note: BP does not score in early warning scoring

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.

Noted by Amitha 29/5/25 @12pm

Patient Sticker

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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!
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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.

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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)

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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			DNS								
	10:00 pm											
	11:00 pm			44ml								
	12:00 am		water	44ml								
	01:00 am			44ml								
Total Intake :	132 ml					**Total Output :**						
29/5	02:00 am			44ml						—		Subh
	03:00 am			44ml								29/5
	04:00 am			44ml								@7a
	05:00 am			44ml								
	06:00 am			44ml								
	07:00 am									—		
Total Intake :	220 ml					**Total Output :**						

Total 24 hrs. Intake	352 ml	Total 24 hrs. Output	2 times

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Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
29/5	08:00 am											
	09:00 am		Jelly water							-		
	10:00 am											
	11:00 am			100ml								
	12:00 pm			100ml								
	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 :**						

Noted by Anitha 29/5/26 @12PM

Total 24 hrs. Intake		**Total 24 hrs. Output**	

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DRUG CHART

Date of Admission: 28/5/26 Drug Allergies: Nil ☐ ~~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 / 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: SYP. PARACETAMOL

Dose	Route	Frequency	Start Date
9ml	PO	Q6H	28/5

Doctor's Signature	Valid Period	Pharm.
[signature]		

Additional Instructions: (5ml-240mg) 15mg/kg/dose

Date / Time: (no entries)

DRUG: T. IBUPROFEN

Dose	Route	Frequency	Start Date
1tab	PO	Q6H	28/5

Doctor's Signature	Valid Period	Pharm.
[signature]		

Additional Instructions: 5-10mg/kg/dose. 1tab=200mg

Date	29/5
Time	6:45 AM [signature]

DRUG: INJ. ONDANSETRON

Dose	Route	Frequency	Start Date
4mg	IV	8th hrly	28/5

Doctor's Signature	Valid Period	Pharm.
[signature]		

Additional Instructions: 0.2mg/kg/dose.

Date / Time: (no entries)

VERIFIED BY Name .... Signature ....
Neeraja 28/5/26
Neeraja 28/5
Neeraja

VIH-00064237 IP-00060161
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21-11-2014 11 Y 6 M 7 D (M)
Dr. SURENDER RAO DUSA

REGULAR PRESCRIPTIONS

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

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

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

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

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

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21-11-2014 11 Y 6 M 7 D (M)
Dr. SURENDER RAO DUSA

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.	

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
28/5	8PM	NS BOLUS.	500 ml	IV		Liron Raji
			over 45 min			
28/5	8.05 PM	Syp. IBUPROFEN	14 ml	PO		Sayay Linda

Nee 28/5

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21-11-2014 11 Y 6 M 7 D (M)
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I.V. FLUIDS CHART

Weight. 27kg. Ward. .....

Maggi 28/5

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
28/5	9.25pm.	IV DNS (2/3rd)	IV	44			29/5		

Signature .....

VERIFIED BY : Name .....