

BAH-00660223 IP5-00175750
Master KURUVA BHARGAVA RAM
03-06-2020 6 Y 0 M 26 D (M)
Dr. M N V POUISHYA SAI

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

ACTIVITY RECORD FOR BILLING

Name : _____
UHID No. : _____
Date of Admission : _____
Room / Bed No : _____ Ward : _____
Suggested Billable bed type : _____

BAH-00660223 IP5-00175750
Master KURUVA BHARGAVA RAM
03-06-2020 6 Y 0 M 26 D (M)
Dr. M N V POUISHYA SAI

Consultant: _____ Dept : _____

Date of Discharge : _____ Time: _____

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
29/06/26	6:30pm	ER	117	Kanthi
04/07/26		117	OT	Ch

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	Dr. Harish Jayaram	30/6/26	0682083	pmiyaka
2				
3				
4				
5				
6				
7				
8				
9				
10				

INVESTIGATIONS

[illegible]

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
29/06/26	IV placement	1	80065	Ismael
30/6/26	NHA	1	968082	Anura
9/7/26	PAC	①	9686848	f

ANY OTHER INFORMATION

.....

.....

.....

USU - ⑧

.....

.....

Date : 4/7/26 Time : @ 11am Prepared By : Ankit

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
Ankit	new I		

ADMISSION SHEET
Registration Details :

Admission No : IP5-00175750

Admit Date : 29-Jun-2026

Admit Time : 04:51 PM **UHID** : BAH-00660223

Patient Details :
Patient Name : Master KURUVA BHARGAVA RAM

Age : 6 Y 0 M 29 D

Guardian : Mr KURUVA SRINIVASULU

DOB : 03-06-2020

Gender : Male

Religion :

Occupation :

Martial Status : Single

Address (H) : H NO 7-1-211/A, DK ROAD, NEAR SONA BAI
TEMPLE , AMEERPET Begumpet Hyderabad
Telangana INDIA 500016

Phone No : 9295852310/ 9246118500

E-mail : NOMAIL@GMAIL.COM

Admission Details :
Bed Type : GENERAL WARD

Bed No : GW 117

Ward Name : 1F-GENERAL WARD I

Room No : GW 117

Admission Type : First Visit

Contact Details :
Name : Mr KURUVA SRINIVASULU

Relationship : Father

Contact Address : H NO 7-1-211/A, DK ROAD, NEAR SONA BAI
TEMPLE , AMEERPET Begumpet Hyderabad
Telangana INDIA 500016

Phone No : 9295852310

Signature
Doctor Details :
Doctor Name : Dr. M N V POUHYA SAI

Specialisation : PEDIATRIC GASTROENTEROLOGY AND
HEPATOLOGY

Referral Doctor : SELF

Phone No :

Co-Consultant : Dr. Prashant Bachina

Payment Details :
Payment Mode : DC/CC Card

Deposit Amount : 5000.00

Payor Name : STAR HEALTH AND ALLIED
INSURANCE CO LTD

*Added
Co-consultant
please add
this in
Case sheet*

ADMISSION SHEET

Registration Details :



Admission No : IP5-00175750

Admit Date : 29-Jun-2026

Admit Time : 04:51 PM UHID : BAH-00660223

Patient Details :

Patient Name : Master KURUVA BHARGAVA RAM

Age : 6 Y 0 M 26 D

Guardian : Mr KURUVA SRINIVASULU

DOB : 03-06-2020

Gender : Male

Religion :

Occupation :

Marital Status : Single

Address (H) : H NO 7-1-211/A, DK ROAD, NEAR SONA BAI
TEMPLE , AMEERPET Begumpet Hyderabad
Telangana INDIA 500016

Phone No : 9295852310/ 9246118500

E-mail : NOMAIL@GMAIL.COM

Admission Details :

Bed Type : GENERAL WARD

Bed No : GW 117

Ward Name : 1F-GENERAL WARD I

Room No : GW 117

Admission Type : First Visit

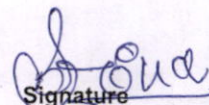
Contact Details :

Name : Mr KURUVA SRINIVASULU

Relationship : Father

Contact Address : H NO 7-1-211/A, DK ROAD, NEAR SONA BAI
TEMPLE , AMEERPET Begumpet Hyderabad
Telangana INDIA 500016

Phone No : 9295852310


Signature

Doctor Details :

Doctor Name : Dr. M N V POUSHYA SAI

Specialisation : PEDIATRIC GASTROENTEROLOGY AND
HEPATOLOGY

Referral Doctor : SELF

Phone No :

Co-Consultant :

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : STAR HEALTH AND ALLIED
INSURANCE CO LTD

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

Name: Kunwva Bhargava Ram Age: 6 Sex: male UHID.No: BAH 00660723

Date: 3/7/2026 Time: 9.30pm Proposed Operation: Laparoscopy + omentectomy

Diagnosis: Omental Torsion

B.P / CRT: H.R: Weight: 12.76Kg ASA Physical Status: ☐ 1 ☒ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:

Hgb: 11.3 Glucose: Protein: HIV: X-Ray:
PCV: 35.5 Urea: Alb: HBS Ag: ECG:
WBC: Creat: 0.3 Total Bill: HCV: 2D Echo:
Plate: 446 Na: 136 Dir. Bill: Blood group: Stress/Angio:
PT: K: 4 LDH: T3 Other:
PTT: Ca++: Alk phos: T4
INR: Mg++: Amylase: TSH
Cl-: SGOT/SGPT:

Allergies: w/

Medical History: CVS: ⊖

RESP: no pain abdomen → 3deg

Diabetes: normal developed

CNS: ⊖ Fever → 2deg

Renal: ⊖

Hepatic / GE: ⊖

Physical Activity: active

Others: ⊖

Past Anaesthetic History: MAC for CEC

Physical Exam:

Airway: MP 1 2 3 4 Mouth Opening: nl Mentohyoid Distance: nl Neck: nl Teeth: nl luc

Lungs: clear

Heart: S1S2

CNS: Good

Pregnant: ☐ Yes ☐ No ☐ NA

Venous Access Site:

Spine Exam for regional:

Anaesthetic Plan: ☐ MAC ☐ REGIONAL ☐ GA-ETT ☐ LMA

Peri-Operative Plan Explained to the Patient: ☐ Yes ☐ No

CURRENT MEDICATIONS	DOSAGE
Fentanyl patch 12.5mcg applied on	3/7/26
CEFTRIAXONE	

Pre-Operative Instructions:

- DVT Prophylaxis:
- NIL ORAL $\leftarrow$ Water / ORS 2 Hours
 $\leftarrow$ Others 6 Hours
- Informed Consent: ☒ Standard ☐ High Risk
- Post Operative Pain Management: ☐ Discussed with Patient
- Other Instructions:

Signature: [Signature] Name: Dr. Shalini

Date & Time:

Patient Sticker

Department of Anaesthesiology
EPIDURAL ANALGESIA RECORD

Date: Time: Procedure done by

CSE /Spinal /Epidural Position : Space : Technique (LOR/LOS)

Depth: Catheter at Skin: Attempts :

Parasthesia : Yes/No if yes details :

Solution Composition :

Any other issues :

a)

b)

[illegible]

Delivery Details : Time : APGAR: SVD / Instrumental / LSCS (if LSCS Details)

Catheter Removed by and Tip Inspected :

Patient Satisfaction :

Discharge /Shifting ordered by

Doctor Signature:

Doctor Name:

Date and Time :

CONSENT FOR ANAESTHESIA

Authorization By: ☐ Patient ☒ Patient Attendant

Operative Procedure: Laparoscopy + Omentectomy

Anaesthesiologist: Dr. Shabna Surgeon: Dr. Harish

Please read this before you consent for Anaesthesia

General anaesthesia involves rendering a patient unconscious before an operation. This ensures the patient is not aware of events and does not feel pain during the operation. Drugs given through a vein and / or inhaled from an anaesthesia machine produce it. Regional anaesthesia involves using a local anaesthetic to numb a specific area of the body for surgery: Prolonged pain relief can be achieved by infusing weak solutions of local anaesthetics and narcotic drugs to particular parts of the body after surgery or injury, using catheters.

Specific High Risk(s): The doctors have explained to me the details of the high risk involved due to the following medical problems and I have sought necessary clarification on all my doubts.

☐ Heart Disease ☐ Hypertension ☐ Diabetes ☐ Renal Failure ☐ Multi Organ Failure ☐ Hepatic Disorders

☐ Shock ☐ Obesity ☐ Chronic Obstructive Pulmonary Disease

☐ Others Dental issues, Bronchospasm, Laryngospasm

Declaration by Patient Attendant

- I authorize and give consent for anaesthesia as considered appropriate by the anaesthesia team
☐ Regional Anaesthesia ☒ General Anaesthesia ☐ Monitored Anaesthesia Care
- I understand that there are some infrequent complications that can occur due to use of anaesthesia, these include pain or some injury at the site of injections, temporary breathing difficulties, allergic reactions, headaches, variations in blood pressure, nausea and vomiting.
- I authorize the anaesthesia team to perform any additional procedures (for example, Central Venous Access, arterial line, use of suppositories and or nerve blocks for pain relief, changing from regional to general anaesthesia etc) which are considered necessary by them during the course of surgery.
- I also authorize and give consent to the team of doctors attending on me to administer blood products during the course of operative period and immediately thereafter if need arises.
- I acknowledge that the anaesthesiologist have informed me about the anaesthetic procedure, risk, benefits and alternative treatments.
- I acknowledge that I fully understand the above information. I have had the opportunity to ask questions, and they have been answered to my satisfaction in a language I understand. I affirm that this consent is given by me in my full senses.

Patient / Patient Attendant:

Signature: Sirisha

Name: Sirisha

Relationship with patient: mother

Date & Time: 3/7/26 9:35pm

Witness:

Signature: Dr. Harish

Name: Dr. Harish

Date & Time: 3/7/26 9:35pm

Doctor (who is taking consent):

Signature: Dr. Shabna Name: Dr. Shabna Date: 3/7/26 Time: 9:35pm

అనస్థీషియా కోసం అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

శస్త్రచికిత్స:

అనస్థీషియా వైద్యుడు: శస్త్రచికిత్స నిపుణుడు:

అనస్థీషియా కోసం మీ అనుమతి ఇవ్వడానికి ముందు దయచేసి ఇది చదవండి

సాధారణ అనస్థీషియా అనేది శస్త్రచికిత్స ముందు రోగిని పూర్తిగా అపస్మారక స్థితిలోకి తీసుకెళ్లే ప్రక్రియ. దీనితో రోగి శస్త్రచికిత్స సమయంలో ఏదీ తెలుసుకోడు, నొప్పి అనుభవించడు. దీనిని శిరస్రావం ద్వారా ఇచ్చే మందులతో లేదా అనస్థీషియా యంత్రం నుండి పీల్చే మందులతో అందిస్తారు.

రిజనల్ అనస్థీషియా అనేది శరీరంలోని ఒక ప్రత్యేక భాగాన్ని లోకల్ అనస్థీషియా నొప్పి రాకుండా చేయడం. శస్త్రచికిత్స లేదా గాయం తరువాత దీర్ఘకాలిక నొప్పి ఉపశమనం కోసం, కాథెటర్లు ఉపయోగించి వీక్ లోకల్ అనస్థీషియా లేదా నార్కోటిక్ మందులను నిరంతరం ఆ భాగానికి అందించవచ్చు.

స్పెసిఫిక్ హై రిస్క్:

క్రింద పేర్కొన్న వైద్య సమస్యల కారణంగా ఉండే అధిక ప్రమాదాల గురించి వైద్యులు నాకు వివరంగా చెప్పారు. నాకు ఉన్న సందేహాలను నేను అడిగాను మరియు అవి నివృత్తి చేయబడ్డాయి.

☐ హృదయ వ్యాధి ☐ రక్తపోటు ☐ మధుమేహం ☐ మూత్రపిండాల వైఫల్యం ☐ బహుళ అవయవ వైఫల్యం

☐ కాలేయ సమస్యలు ☐ షాక్ ☐ ఊబకాయం ☐ దీర్ఘకాల శ్వాసకోశ వ్యాధి (COPD)

☐ ఇతరవి:

రోగి / రోగి అటెండెంట్

- అనస్థీషియా బృందం అవసరమని భావించిన విధంగా నాకు అనస్థీషియా ఇవ్వడానికి నేను అనుమతి ఇస్తున్నాను.
☐ రిజనల్ అనస్థీషియా ☐ జనరల్ అనస్థీషియా ☐ మానిటర్డ్ అనస్థీషియా కేర్
- అనస్థీషియా ఉపయోగంలో అప్పుడప్పుడూ జరిగే కొన్ని అరుదైన సమస్యలు ఉండవచ్చు అని నేను అర్థం చేసుకున్నాను. వీటిలో ఇంజక్షన్ ఇచ్చిన చోట నొప్పి లేదా స్వల్ప గాయం, తాత్కాలిక శ్వాస ఇబ్బందులు, అలెర్జిక్ ప్రతిచర్యలు, తలనొప్పి, రక్తపోటు మార్పులు, వాంతులు మరియు అసహనం వంటి సమస్యలు ఉండవచ్చు.
- శస్త్రచికిత్స సమయంలో అవసరం అనిపిస్తే, అదనపు చర్యలు (ఉదాహరణకు సింట్రిల్ వెనస్ యాక్సెస్, ఆర్థిరియల్ లైన్, సపోజిటరీలు, నొప్పి నివారణ కోసం నర్వ్ బ్లాకులు, రిజనల్ అనస్థీషియా నుండి జనరల్ అనస్థీషియాకు మార్పు మొదలైనవి) చేయడానికి అనస్థీషియా బృందానికి నేను అనుమతి ఇస్తున్నాను.
- శస్త్రచికిత్స సమయంలో మరియు వెంటనే అనంతరం, అవసరమైతే రక్త పదార్థాలు (Blood products) ఇవ్వడానికి నా చికిత్సలో ఉన్న వైద్యుల బృందానికి కూడా నేను అనుమతి ఇస్తున్నాను.
- అనస్థీషియా విధానం, ప్రమాదాలు, ప్రయోజనాలు మరియు ప్రత్యామ్నాయ చికిత్సల గురించి అనస్థీషియా వైద్యులు నాకు వివరించినట్లు నేను అంగీకరిస్తున్నాను.
- పై సమాచారం అంతా నేను పూర్తిగా అర్థం చేసుకున్నాను. నాకు ప్రశ్నలు అడిగే అవకాశం లభించింది, మరియు నాకు అర్థమయ్యే భాషలో వాటికి సమాధానాలు ఇచ్చారు. ఈ అనుమతి నేను పూర్తిగా స్వచ్ఛమైన భావాలతో, స్వయంగా ఇస్తున్నానని ధృవీకరిస్తున్నాను.

రోగి / రోగి అటెండెంట్:

సాక్షి:

సంతకం:

సంతకం:

పేరు:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

తేదీ & సమయం:

డాక్టర్ :

సంతకం: పేరు: తేదీ & సమయం:



PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: _____

UHID ID: _____

Department: _____

Consultant: _____

BAH-00660223 IP5-00175750
Master KURUVA BHARGAVA RAM
03-06-2020 6 Y 0 M 26 D (M)
Dr. M N V POUISHYA SAI





Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

Pain abdomen since 3 days.

Fever since 2 days.

Poor oral intake since 3 days.

History of present illness :

Child is apparently well 3 days ago. Child developed above mentioned complaints.

• Pain abdomen since 3 days.

- Continuous pain

- Not relieved with oral medication.

- Not associated with food intake.

• Fever - ~~not~~ not recorded

- But medication given.

- 2-3 spikes/day

Poor oral intake since 2-3 days because of pain abdomen.

NO H/o loose stools, burning micturition.

H/o dribbling of urine (+).

NO H/o other fresh complaints.

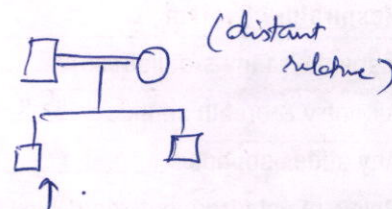


Pediatric Multiorgan History & Physical Examination

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

Birth & Neonatal History:

2-5kg) LSCS / (N) transition



Birth & Socio Economic History:

About Father : _____
About Mother : _____ } upper middle class
Any additional Information : _____

Developmental History :

(N) development

Immunization History :

vaccination NIP schedule #update



Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs)) 12.76 kg (Centile _____)

On Examination :

Temperature : 99.5°F Pulse Rate : 116/min B.P. 91/72(78) mmHg SPO2 100% on RA

Resp. rate and type of breathing : RR = 22/min

Rash _____

Lymphadenopathy _____

Oedema : _____

Allergies (if any): _____

Respiratory System :

Inspection (any s/o distress) : _____

Air entry & breath sounds : B/LAE (+)

Any addes sounds : _____

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

Cardiovascular System :

Inspection of procordium : _____

Heart Sounds : S1S2 (+)

Any murmur : _____

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

Per Abdomen :

Inspection _____

Palpation : Soft, ~~no~~ no organs palpable, tenderness over abdomen (+)

Ausculation : _____

Spine : _____ External Genitalia : _____

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



Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : 7

Cranial Nerves : 2

Motor System:

Nutriton : 2

Tone: 2 Power 2

Co-ordinator : 2

Posture : 2

Involuntary Movements : 2

Reflexes :

DTR

Plantars 2

Superficials:

Sensory System :

Bladder / Bowel : 2

Clinical Summary & Diagnostic:

AF1 c Acute Gastritis with dehydration.

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: _____

Desired goals of the treatment : _____

Planned Labs:

CBP, S. Electro, Lipase,
 ESR, CRP, Albumin,
 Blood Gs.
 USG Abdomen → look for
 pancreas, appendix,
 bowel wall thickening.
 CUE / Urine Gs → Mid stream.

m B Anab
29/6/20

Planned Management

IVF DNS.
 Inj Pantop.
 Supp. Sucral.
 Inj Tramadol } SOS.
 Inj PCM }
 Inj Ceftriaxone (Start after culture sample sent) ^{Urine}
 Betamyl GM continued

m B
Anab
29/6/20

Signature of the Doctor: _____

Name of the Doctor: _____

Date & Time: _____

Signature of the Consultant: _____

Name of the Consultant: _____

Date & Time: _____



PROGRESS NOTES AND DOCTOR'S ORDER

Time	Progress Notes	Doctor's Order
11/6/22 10:00pm	C/S/B hasho team	
	A:- APc/Ac. gaslets D ₃	Plan
	to fever. Abd pain X 3 days. drinking of milk.	1. Send CBP, CRP, ESR S/E
hand stroke	O/E. P/A- tenderness in Periumb area on deep palp.	Lipase S. Alb. AT cfs.
	Pale looking. Phimosis Short scrotum (? diff Anura)	2) Start ceftriaxone after sending cultures.
		3) Start Pan/Enzymal
		4) Use ICM/Traimodal for <i>Keshav</i>
		Use Betam/AM
		5) Use Abd wall → Pancreas.
		Appendix Bowel wall thickening Bladder.
		<i>Keshav</i>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
30/6/20 9:15 AM	S/B Dr. Pouishya	Plan:
	- no fever - Abdominal pain intermittent - no vomiting - passed stool after Enema ↓ oral intake	① Peglax sachet ↓ 1/2 sachet in 1 lit water, to drink over 8 hours.
	O/E: Alert chest: clear P/A: soft.	② Dr. Nabeel consultation. ③ iv fluid - 1/2 maint.
refer	refer	refer
28/6/20 5:15 PM	Q/SB hasho team No fever No Abd pain - after enema No vom. passed 2 stools after Peglax → Pasty, big qty oral diet ↑	Plan 1) Encourage orally 2) High fibre diet 3) Surgical consult for Primaries 4) can stop Nif @ night if toler well. 5) Complete 1L of Peglax
refer	refer	refer
	O/E: Vitals stable Plump	→ Peglax Kenanbump 1/4 sachet + 500ml water 1 time

BAH-00660223 IP5-00175750
Master KURUVA BHARGAVA RAM
03-06-2020 6 Y 0 M 26 D (M)
Dr. M N V POUISHYA SAI



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/26/20 4pm	YSLB back team	
	No fever, wbc	Plan
	No compl of abd pain	1) cont provide until child wakes up then to 2H to 1/2M & then stop
	No Vomitus	
	near NPO	
	O/E	
	Vitals stable	2) Encourage orally
	Resp	3) Vitals clearing
	As P	
	CT → (16) study (Verbal)	
		Respiratory

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
02/07/2026 9AM	C/I/B - Gastro Team	
	no pain abdomen. once @ night.	<u>Plan</u>
	mommy mild pain - reduced on passing stool orally accepting stool - soft/pasty	1 st Drugs as per chart 2 nd Monitor vitals 3 rd for reporting (D) - T/m
	O/C - Hemodynamically stable	(1) Antibiotic x 5 days
	P/A - No tenderness Rt (A)	(2) Rest
	Active.	(3) Oral pain medication x 2 days (Hb sol)
		(4) Mu-onl.
		(5) pantop.
		4 th Continue IV Antibiotics & Drugs as per chart

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
07/126 3:30pm	461B Gastro team	
	No fever No vom eval just 7	Plan
	No pain	1) Cont same drip
	In afternoon gave cyclopan	2) Vitals closely
	No fresh urine	3) Empty orally
	of Vitals stable	4) Keep sunny ready
	Plngt	5) Diet
	no tenderness	6) Give 10 dose of cephixone after morning
		7) Infamox
		8) To give analgesic if > 20min 9 40 Abd pain Else Placebo
		Reshaling
		NIB prameela



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
03/07/26 9 AM	to call Pain abdomen - omental infarct.	
	40 pain abdomen intense since night. c/o severe pain now - Tramadol ongoing	Plan 1x Drug as per chart - 2x USG Abdomen - (urgent) comment on bowel's increase in size of omental infarct
	v/c - Hemodynamically stable Chest - clear P/A - soft, No tenderness. BS (+)	3x monitor vitals
	Poised stool - soft. No vomiting	4x Allow soft diet as tolerated.
		5x Immobilization.
		6x Fentanyl patch - now.
3/7/26	Seen by axon anandam → history noted. Fentanyl patch 12.5mcg	Adv 1) Fentanyl patch 12.5mcg 2) Monitor the vitals & for Gives after application of patch

[Signature]
Dr. KUMAR



PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

3/7/26
2:30 PM

cls/o Dr Harish

Case reviewed i/v/o

persisting pain abdomen.

cf. colicky pain abdomen - intermittent
episodes lastly upto 30-

No a/w vomiting, abd disten. xfer

O/E Child active

Vitals - stable

P/A - soft

USG - Abdomen

CECT Abdomen renewed

Adv

① Laparoscopy
& omentectomy

- PAC

- Financial counselling

Imp:- Omental Infarction
? Meckels diverticulitis.

cls/o Dr Harish

Dr Harish
3/7/26
2:30 PM

4/3/26
9:15 AM

Case reviewed

cf. pain abdomen reduced
today

No cf. vomiting

O/E - R child sleeps

P/A - soft

Adv

① w/h plan for surgery -
Laparoscopy + omentectomy

② USG Abd & pelvis today

③ Review SOS

④ Allow crabs.

Dr Harish
4/7/26
9:15 AM



CROSS CONSULTATION FORM

Doctor Name : Dr. Harish Jayaram Date : 30/6/20 Time :

Diagnosis :

Hospital :

Type of Referral :

- ☐ Emergency
☐ Urgent
☐ Non Urgent

Referred for : ☐ Opinion ☐ Co-Management ☐ Transfer of care

Reason for Referral : If for concurrent care specify the particular need, especially in the absence of a second diagnosis:

? physiological phimosis

Signature:

Findings and Recommendations :

Thank you,

History noted,

6 year male c/o intermittent
pain abdomen 2nd month;
colicky type of pain - not associated
w/ pain. After constipation.
No c/o vomiting or fever episodes.
Not after loss of appetite or weight.
c/o difficulty retracting foreskin.
Not after dribbling of urine.

O/E - Child active
stable

P/A - soft, voluntary guarding

L/E - phimosis (+)
meatus orthotopic

Adv

- BETAMILL-GM 4A
TWICE DAILY for 15 days,
↓
Sib
ONCE DAILY for 15 days

- Review after 1 month
Dr. Harish Jayaram in OPD

Consultant :

Name : Dr. Harish Signature : [Signature] Date & Time : 30/6/20 6 AM

J660223 IP5-00175750
 KURUVA BHARGAVA RAM
 -2020 6 Y 0 M 26 D (M)
 A N V P O U S H Y A S A I



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


BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

RESULT SHEET

	29/6	3				
	11.3					
	35.8					
	5.11					
	14.66					
	57.4/33.6					
	446					
CRP	40					
ESR						
PCT						
RBS						
Na	136					
K	4.0					
Cl	102					
Ca/Mg						
Phosphate						
Urea						
Creatinine	0.3					
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin	4.4					
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase	61					
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

MEDICATION RECONCILIATION FORM

Drug Allergies:

☒ Not known any Drug Allergies

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

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

Shifting From: ER

Shifted to: 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. Ramya

Date & Time: 29/6/2020 : 4:45 pm

Name & Signature: Ravi

Time: 29/06/2020 5 pm

BAH-00660223 IP5-00175750
Master KURUVA BHARGAVA RAM
03-06-2020 6 Y 0 M 27 D (M)
Dr. M N V POUISHYA SAI



Sheet no.

REGULAR PRESCRIPTIONS

Weight

Ward

DRUG : <u>MU-OUT POWDER</u>				Date Time	29/6
Dose	Route	Frequency	Start Dt.		
	PO	OD	29/6/20		
Name & Signature of the Doctor Starting the Drugs:					
Additional Instructions:					
mix 3 loops in 180ml water					
Daily Doctor's Endorsement by a Sign					
DRUG : <u>Syp SMUTH</u>				Date Time	29/6
Dose	Route	Frequency	Start Dt.		
10ml	PO	OD	29/6/20		
Name & Signature of the Doctor Starting the Drugs:					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					
DRUG : <u>MU OUT POWDER</u>				Date Time	2/7/20
Dose	Route	Frequency	Start Dt.		
	PO	OD	2/7/20		
Name & Signature of the Doctor Starting the Drugs:					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					
DRUG : <u>Inf. PARACETAMOL</u>				Date Time	1/7/20 3/7 4/7
Dose	Route	Frequency	Start Dt.		
120mg	IV	TID	1/7 6AM X		
Name & Signature of the Doctor Starting the Drugs:					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					

Patient Sticker

Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward

DRUG : <u>100mg IV. METRONIDAZOLE</u>				Date Time															
Dose	Route	Frequency	Start Dt.																
100mg	IV	QID	3/2																
Name & Signature of the Doctor Starting the Drugs:																			
<u>Heena Charya</u>																			
Additional Instructions:																			
Daily Doctor's Endorsement by a Sign																			

DRUG : <u>100mg IV. METRONIDAZOLE</u>				Date Time															
Dose	Route	Frequency	Start Dt.																
100mg	IV	QID	3/2																
Name & Signature of the Doctor Starting the Drugs:																			
<u>Heena Charya</u>																			
Additional Instructions:																			
Daily Doctor's Endorsement by a Sign																			

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

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

Signature

VERIFIED BY : Name



DRUG CHART

Date of Admission: 29/06/26 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>54P CYCLOPAM</u>				Date Time															
Dose	Route	Frequency	Start Date																
<u>5mg</u>	<u>PO</u>	<u>TID</u> <u>(500)</u>	<u>01/07</u>																
Doctor's Signature				Valid Period	Pharm.														
Additional Instructions:																			
<u>for pain abdomen</u>																			

DRUG : <u>1/2 TRAMADOL</u>				Date Time															
Dose	Route	Frequency	Start Date																
<u>9mg</u>	<u>PO</u>	<u>TID</u> <u>(500)</u>	<u>01/07</u>																
Doctor's Signature				Valid Period	Pharm.														
Additional Instructions:																			
<u>if 1/2 tramadol abdomen if not subsiding</u>																			

DRUG : <u>INT. PARACETAMOL</u>				Date Time															
Dose	Route	Frequency	Start Date																
<u>40mg</u>	<u>IV</u>	<u>TID</u> <u>(500)</u>	<u>01/07</u>																
Doctor's Signature				Valid Period	Pharm.														
Additional Instructions:																			
<u>if 40mg Abdominal pain</u>																			

Weight. 12.76 kg Ward.

Page: 2/4



Weight. Ward.

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
29/6/24	8:30pm	NEOTOMIC ENEMA.	1 unit	PR	\$	098 chander 19:30pm
30/6	11AM	PEG LAC sachet	1/2 sachet in 1 lit water Drink over 8 hrs.	oral	@ H	Pringla
	6AM					
3/7	6AM	Syr. CEFTRIAXONE 1.2g		IV	Kup	Sachin Prasanna
3/7		SYP MEDICAL	6ml	PO	Keshav	
3/7/26	1.08pm	GENTANYL PATCH	12-5mg	SK	SL	Amish



Weight. 12.76 kg Ward.

[illegible]

Signature _____

VERIFIED BY: Name: _____



SCHOOL AGE (5-12 years)

Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 4/7/26 Time:

Doctor / Nurse / Family Concern?

2am

6am

Temperature
(°F)

104
103
102
101
100
99
98
97
96
95
94

97.8°F

96.5°F

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

105
(85)
64

110
(85)
56

Heart Rate (Number)

110bpm

106bpm

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

70
60
50
40
30
20
10

28

26

Resp Rate (Number)

28b/min

26b/min

Resp Mod/ Severe
Distress None / Mild

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

100%

98%

Conscious Level
Normal Altered

GCS *

15/15

15/15

TOTAL SCORE

Number of shaded boxes

1

1

Pain Score

0

0

Observer's Initials

C

C

ACTIONS

NB: Scores 3 should be
recorded overleaf

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

* NB: If GCS is below 12 or the Oxygen requirement is >3 Lit./min. , then irrespective of rest of the score, the Nurse MUST inform the PICU team.

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 3/7/2020	Time :	6 AM	10 AM	1 PM	6 PM	10 PM
Doctor / Nurse / Family Concern?						
Temperature (F)	104	103	102	101	100	99
	98	97	96	95	94	
Heart Rate (bpm)	190	180	170	160	150	140
and	130	120	110	100	90	80
Blood Pressure (mmHg) *	120	110	100	90	80	70
Note:	60	50				
BP does not score in early warning scoring						
Heart Rate (Number)	95 bpm	106 bpm	95 bpm	97 bpm	108 bpm	
Resp. Rate (bpm) (Over 1 Minute) *	27 bpm	25 bpm	23 bpm	25 bpm	26 bpm	
Resp Rate (Number)						
Resp Mod/ Severe Distress None / Mild						
Receiving O ₂ (l/min) O ₂ Saturations (%)	100%	100%	99%	97%	99%	
Conscious Level Normal / Altered						
GCS *	15/15	15/15	15/15	15/15	15/15	
TOTAL SCORE	1	1	1	1	1	
Number of shaded boxes	0	0	0	0	0	
Pain Score	0	0	0	0	0	
Observer's Initials	Dr	D	D	D	D	

ACTIONS

NB: Scores 3 should be recorded overleaf

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

* NB: If GCS is below 12 or the Oxygen requirement is >3 Lit./min. , then irrespective of rest of the score, the Nurse MUST inform the PICU team.

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : <u>27/6</u> Time: <u>10AM</u>	<u>1PM</u>	<u>6P</u>	<u>10PM</u>	<u>3/4</u>	<u>2AM</u>
Doctor / Nurse / Family Concern?					
Temperature (°F)	97.6°F	98.0°F	98.4°F	98.3°F	98.1°F
Heart Rate (bpm)	105	101	104	101	103
Blood Pressure (mmHg) *	65/78	62/75	66/90	60/75	62/79
Heart Rate (Number)	102b1m	110b1m	107b1m	105b1m	115b1m
Resp Rate (bpm) (Over 1 Minute) *	26	26	28	25	23
Resp Rate (Number)	26b1m	26b1m	28b1m	25b1m	23b1m
Resp Mod/ Severe Distress					
Receiving O ₂ (l/min)					
O ₂ Saturations (%)	99%	98%	98%	100%	99%
Conscious Level					
GCS *	15/15	15/15	15/15	15/15	15/15
TOTAL SCORE					
Number of shaded boxes	1	1	1	1	1
Pain Score	0	0	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 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)



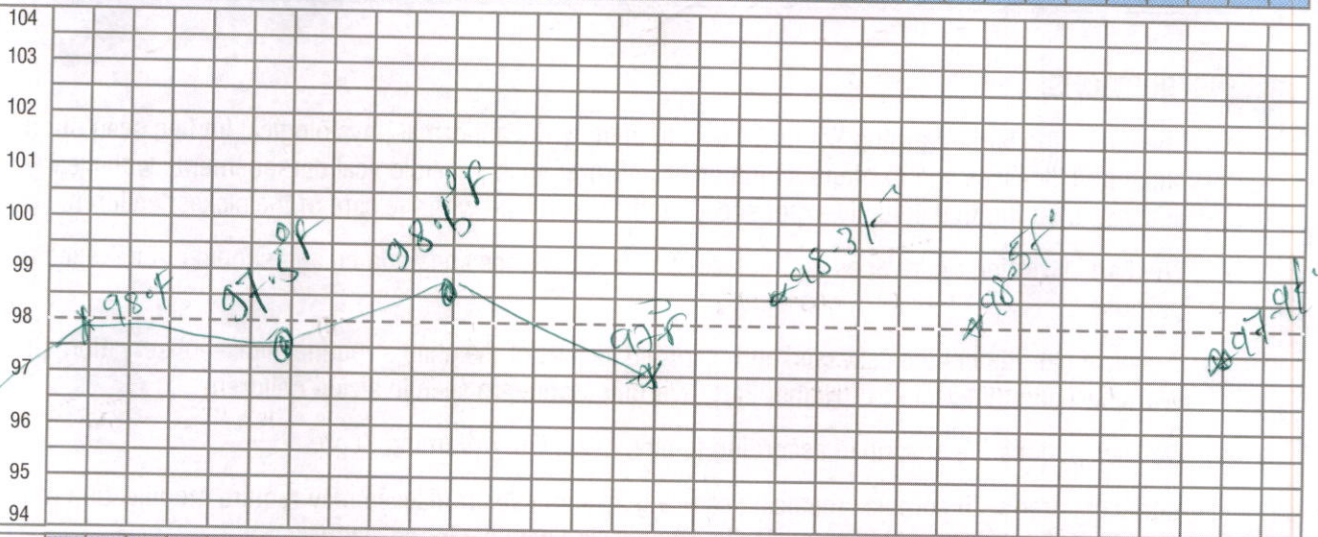
SCHOOL AGE (5-12 years)
Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 16/7/20 Time: 10AM 1PM 6pm 10PM 2AM 6AM

Doctor / Nurse / Family Concern? Cam

Temperature (F)



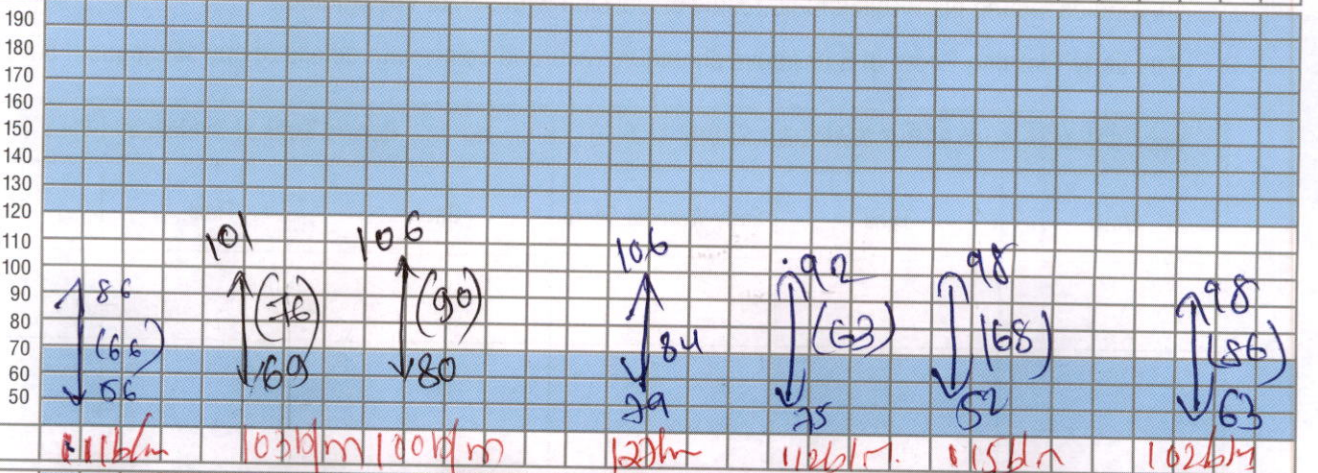
Heart Rate (bpm)

and

Blood Pressure (mmHg) *

Note:

BP does not score in early warning scoring



Heart Rate (Number)

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

Resp Rate (Number)

Resp Mod/ Severe Distress None / Mild

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

Conscious Level Normal Altered

GCS *

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

ACTIONS

NB: Scores 3 should be recorded overleaf

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

* 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.

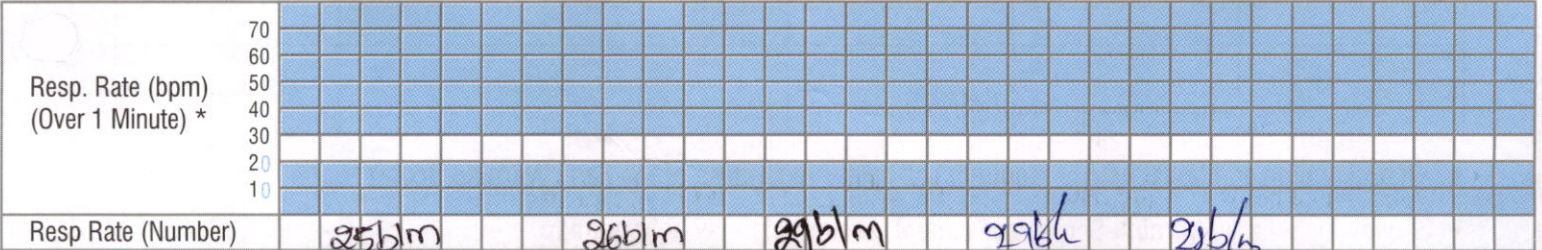
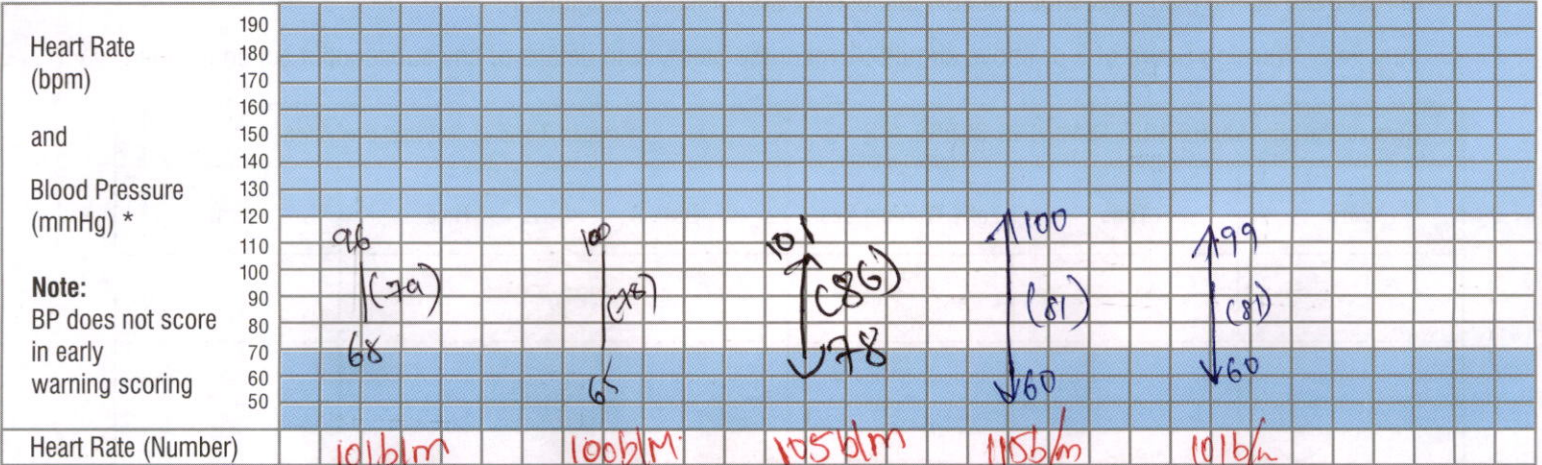
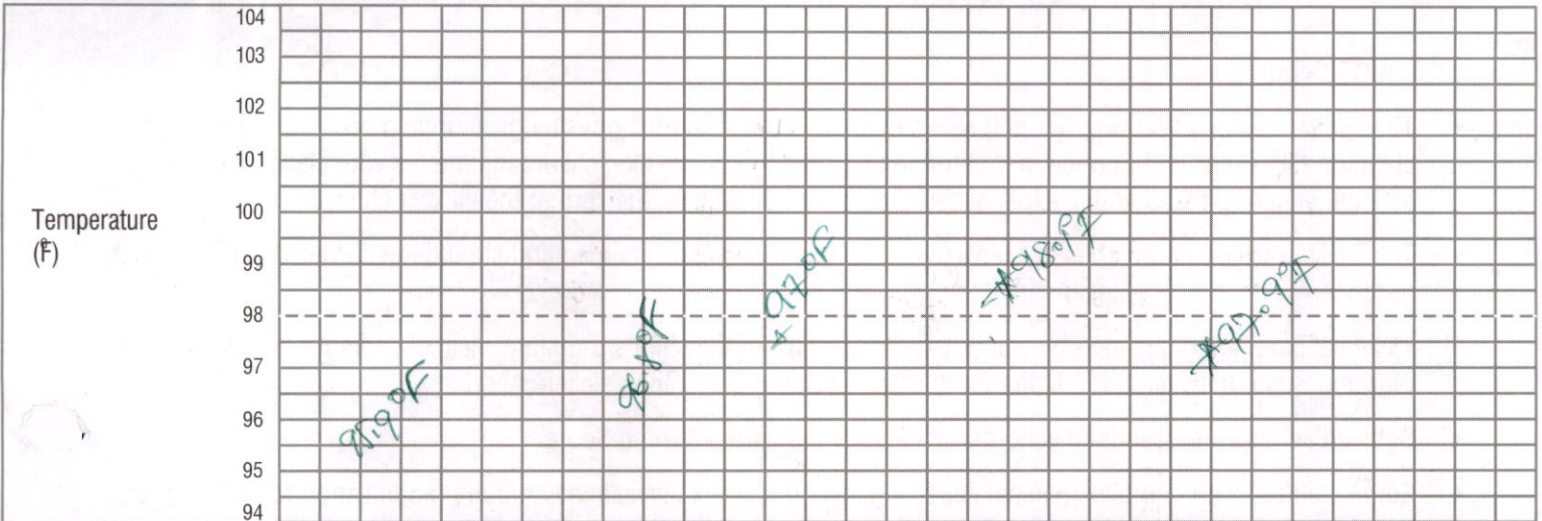
I	IDENTITY: I am (name), a nurse on ward (X). I am calling about (child X)
S	SITUATION : I am calling because I am concerned that ... (e.g. BP is low/high, pulse is XXX, Temperature is XX, Early Warning Score is XX)
B	BACK GROUND : Child (X) was admitted on (XX date) with (e.g. respiratory infection). 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 : 30/6/20	Time: 10AM	1PM	5PM	10PM	2AM
Doctor / Nurse / Family Concern?					



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

Handwritten GCS: 15/15, 15/15, 15/15, 15/15, 15/15

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

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

* 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)

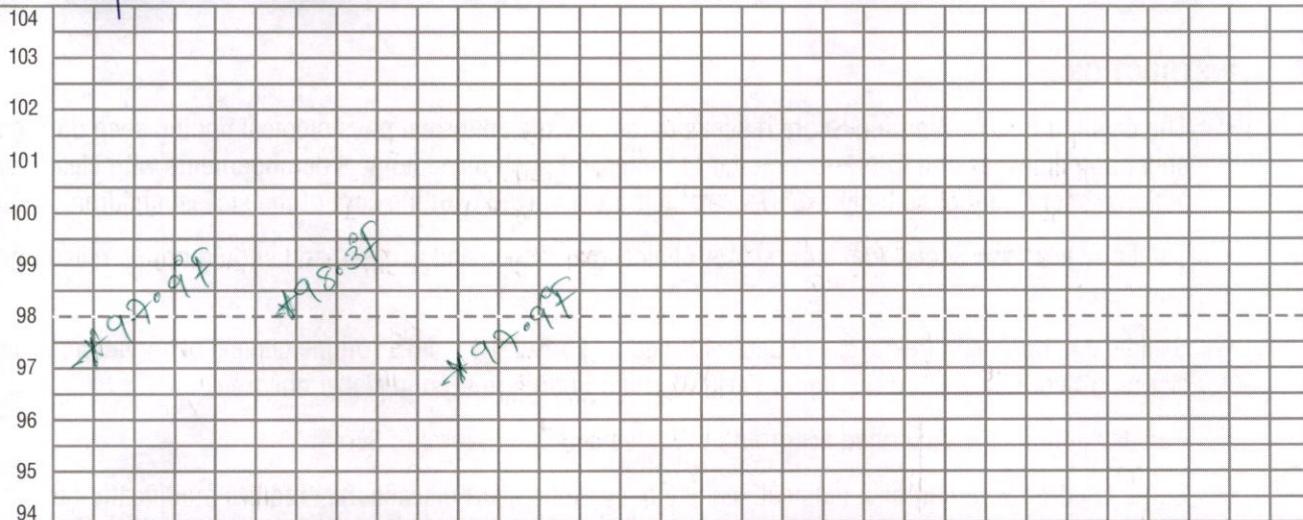
Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 29/6/20 Time: 10pm 2am 6am

Doctor / Nurse / Family Concern? 10pm 2am 6am

Temperature
(F)

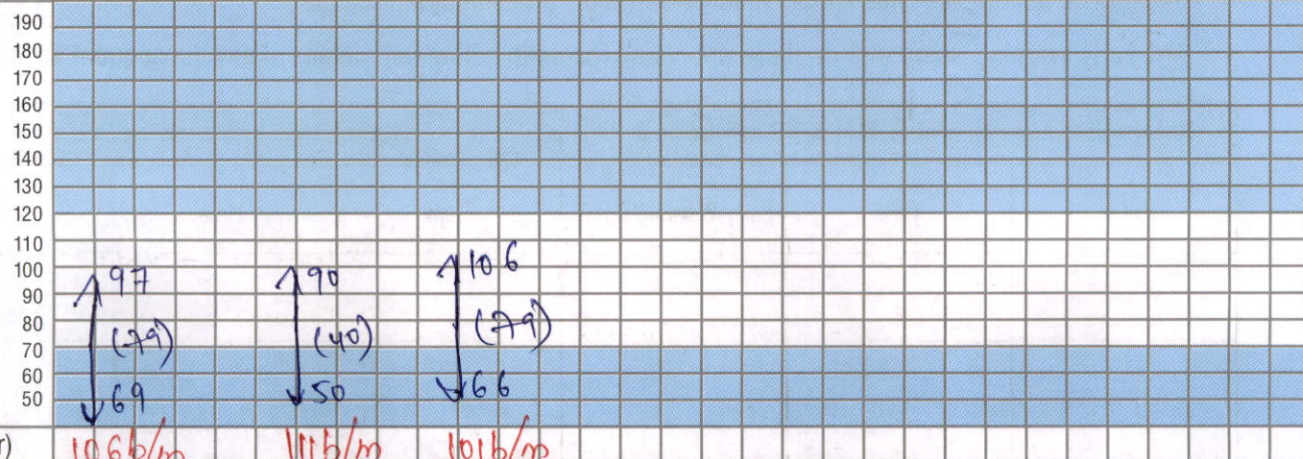


Heart Rate
(bpm)

and

Blood Pressure
(mmHg) *

Note:
BP does not score
in early
warning scoring



Heart Rate (Number)

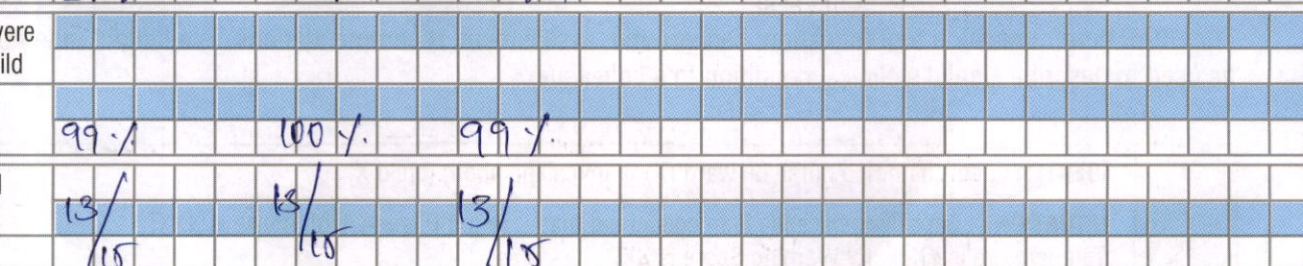
Resp. Rate (bpm)
(Over 1 Minute) *



Resp Rate (Number)

Resp Mod/ Severe
Distress None / Mild

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



TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials



ACTIONS

NB: Scores 3 should be
recorded overleaf

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

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)



Patient Sticker

FLUID CHART

Sheet No. : ①

- 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 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	1		32ml							0	Chand
	09:00 pm			32ml							0	
	10:00 pm	Dr		—			✓		✓		0	Chand
	11:00 pm			—							0	
	12:00 am			—							0	Chand
	01:00 am			32ml							0	
Total Intake :						Total Output :						
	02:00 am			32ml							0	
	03:00 am			32ml							0	Chand
	04:00 am	Dr		32ml					✓		0	
	05:00 am			32ml							0	Chand
	06:00 am			32ml							0	
	07:00 am			32ml					✓		0	Chand
Total Intake :						Total Output :						

Total 24 hrs. Intake

Total 24 hrs. Output

FLUID CHART

Sheet No. : 2

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

		Intake			Output					IV Site	Sign.	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	Thrombo-phlebitis Score	Nurse
			Mouth	I.V	N.G							
30/6	08:00 am	DNS		30ml	NA	/			/		0	Asw
	09:00 am			30ml					/		0	
	10:00 am			30ml			✓	NA			0	Anna
	11:00 am			30ml						✓	0	
	12:00 pm					/			/			
	01:00 pm					/			/			
Total Intake :					Total Output :							
30/6	02:00 pm	DNS		—	NA	/			/		0	Srishta
	03:00 pm			—				✓		✓	0	
	04:00 pm			20ml			✓	NA			0	
	05:00 pm			20ml			✓			✓	0	
	06:00 pm					/			✓		0	
	07:00 pm					/			✓		0	
Total Intake :					Total Output :							
30/6	08:00 pm	No Diet			/	/			/		0	Chand
	09:00 pm							✓		✓	0	
	10:00 pm									✓	0	
	11:00 pm									✓	0	
	12:00 am							✓		✓	0	
	01:00 am									✓	0	
Total Intake :					Total Output :							
1/7	02:00 am	No IVF			/	/			/		0	Chand
	03:00 am							✓		✓	0	
	04:00 am									✓	0	
	05:00 am									✓	0	
	06:00 am									✓	0	
	07:00 am									✓	0	
Total Intake :					Total Output :							
Total 24 hrs. Intake					Total 24 hrs. Output							

BAH-00660223 IP5-00175750
Master KURUVA BHARGAVA RAM
03-06-2020 6 Y 0 M 27 D (M)
Dr. M N V POUISHYA SAI

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

FLUID CHART

Sheet No. : 3

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

		Intake			Output					IV Site	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		Thrombo-phlebitis Score
			Mouth	I.V	N.G							
1/7	08:00 am	↑		-		/			/		0	Pongank
	09:00 am	↑		-		/			/	✓	0	
	10:00 am	↑		-		/			/		0	Pongank
	11:00 am	↑		-		/			/	✓	0	
	12:00 pm	↑		-		/			/		0	Pongank
	01:00 pm	↓		-		/			/		0	
Total Intake :					Total Output :							
1/7	02:00 pm	↑		23ml		/			/	✓	0	Pongank
	03:00 pm	↑		23ml		/			/		0	
	04:00 pm	↑		23ml		/			/		0	Pongank
	05:00 pm	↑		23ml		/			/		0	
	06:00 pm	↓		-		/			/		0	Pongank
	07:00 pm	↓		-		/			/		0	
Total Intake :					Total Output :							
1/7/20	08:00 pm	↑		23ml		/			/		0	Sourabh
	09:00 pm	↑		23ml		/			/		0	
	10:00 pm	↑		-		/			/	✓	0	Sourabh
	11:00 pm	↑		-		/			/		0	
	12:00 am	↑		23ml		/			/		0	Sourabh
	01:00 am	↑		23ml		/			/	✓	0	
Total Intake :					Total Output :							
2/7/20	02:00 am	↑		23ml		/			/		0	Sourabh
	03:00 am	↑		23ml		/			/	✓	0	
	04:00 am	↑		23ml		/			/		0	Sourabh
	05:00 am	↑		23ml		/			/		0	
	06:00 am	↑		-		/			/	✓	0	Sourabh
	07:00 am	↑		-		/			/		0	
Total Intake :					Total Output :							
Total 24 hrs. Intake					Total 24 hrs. Output							



FLUID CHART

Sheet No. : (4)

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

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G								
2/7/20	08:00 am					/	✓		/	✓	0	Aruna	
	09:00 am					/			/	✓	0	Aruna	
	10:00 am	NO			NA	/			NA	✓	0	Aruna	
	11:00 am	IVF		NA	NA	/			/	✓	0	Aruna	
	12:00 pm					/			/	✓	0	Aruna	
	01:00 pm					/			/	✓	0	Aruna	
Total Intake :						Total Output :							
2/7/20	02:00 pm		Rice			/			/	✓	0	Aruna	
	03:00 pm					/			/	✓	0	Aruna	
	04:00 pm	NO		NO	NA	/			NA	✓	0	Aruna	
	05:00 pm	IVF				/			/	✓	0	Aruna	
	06:00 pm					/			/	✓	0	Aruna	
	07:00 pm					/			/	✓	0	Aruna	
Total Intake :						Total Output :							
2/7/20	08:00 pm		Rice			/			/	✓	0	pranvi	
	09:00 pm		H.O			/			/	✓	0	pranvi	
	10:00 pm	NO				/			/	✓	0	pranvi	
	11:00 pm	IVF				/	NP		/	✓	0	pranvi	
	12:00 am					/			/	✓	0	pranvi	
	01:00 am					/			/	✓	0	pranvi	
Total Intake :						Total Output :							
3/7/20	02:00 am					/			/	✓	0	pranvi	
	03:00 am					/			/	✓	0	pranvi	
	04:00 am	NO				/			/	✓	0	pranvi	
	05:00 am	IVF				/	NP		/	✓	0	pranvi	
	06:00 am					/			/	✓	0	pranvi	
	07:00 am					/			/	✓	0	pranvi	
Total Intake :						Total Output :							

Total 24 hrs. Intake

Total 24 hrs. Output

FLUID CHART

Sheet No. : 5

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

		Intake			Output					IV Site Thrombo- phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G						
3/7	08:00 am	1			/	/	/	/	/	0	Srishe
	09:00 am	1								2	
	10:00 am	1								0	
	11:00 am	1								0	
	12:00 pm	1								0	
	01:00 pm	1								0	
Total Intake :					Total Output :						
3/7	02:00 pm	1			/	/	/	/	/	0	L Appu
	03:00 pm	1								0	
	04:00 pm	1								0	
	05:00 pm	1								0	
	06:00 pm	1								0	
	07:00 pm	1								0	
Total Intake :					Total Output :						
3/7	08:00 pm	1			/	/	/	/	/	0	Srishe
	09:00 pm	1								0	
	10:00 pm	1								0	
	11:00 pm	1								0	
	12:00 am	1								0	
	01:00 am	1								0	
Total Intake :					Total Output :						
4/7	02:00 am	1			/	/	/	/	/	0	Srishe
	03:00 am	1								0	
	04:00 am	1								0	
	05:00 am	1								0	
	06:00 am	1								0	
	07:00 am	1								0	
Total Intake :					Total Output :						
Total 24 hrs. Intake					Total 24 hrs. Output						

BAH-00660223 IP5-00175750
Master KURUVA BHARGAVA RAM
03-06-2020 6 Y 1 M 0 D (M)
Dr. M N V POUISHYA SAI

FLUID CHART

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Sheet No. : 5

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

		Intake				Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
4/6/26			Mouth	I.V	N.G						0		
	08:00 am	↓	n	32ml							0		
	09:00 am	↓	p	32ml							0		
	10:00 am	↓	o								0		
	11:00 am										0		
	12:00 pm										0		
	01:00 pm										0		
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							

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 29/6/20

Assessment: pt having dull activity

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	→ Assess the pt General Condition	8:10pm	→ Assessed the pt General Condition	
10pm	→ Check the Vital Signs	10:10pm	→ Checked the Vital Signs	
12am	→ Plan for Administration medication	12:10am	→ Providing medication as per Doctor Order	pt is stable
6am	→ Plan for S/o Chart	6:10am	→ Maintaining S/o Chart	
8am	→ Plan for Comfortable Position	8:10am	→ Providing Comfortable	

Re-Assessment: Re-Assessment Every 4th Hour

Special Notes:

Nurse Signature: [Signature]

Nurse Name: Chandan

Date & Time: 30/6/20 28am

BAH-00660223 IP5-00175750
Master KURUVA BHARGAVA RAM
03-06-2020 6 Y 0 M 26 D (M)
Dr. M N V POUISHYA SAI



NURSING CARE RECORD

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 30/6/26

Assessment:

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8am	Assess the general condition of the baby.	8am	Assessed the general condition of the baby	by done all these to improve baby condition
9am	Dr. poushya nam advis Dr. nabeel sir cons, peglac sacket 1 liter 8 hours.	9am	Dr. poushya nam advis Dr. nabeel sir cons, peglac sacket 1 liter 8 hours. stated	
11am	monitor vital sings and recovered.	11am	monitored vital sings & recovered	
	IVF DNS. 32ml/hr ongoing		IVF DNS 32ml/hr ongoing	
2pm	Administred medication as per doctor orders.	2pm	Administred medication as per doctor orders	

Re-Assessment:

Special Notes: Dr. nabeel sir consult to day

Nurse Signature: Aruna

Nurse Name: Aruna

Date & Time: 30/6/26 @ 2pm



NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Baby having discomfort

Date: 30/6

Assessment:

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8PM	→ Assess the baby	8:10PM	→ Assessed the baby	baby condition is improve
9PM	→ monitor the vitals	9:10PM	→ monitored the vitals	
10PM	→ maintain IV fluids	10:10PM	→ maintained IV fluids	
11PM	→ provide comfortable position	11:10PM	→ Provided comfortable position	
6PM	→ Administer medication as per doctor orders	6:10PM	→ Administered medication as per doctor orders	

Re-Assessment:

Special Notes:

Nurse Signature: _____

Nurse Name: _____

Date & Time: _____

30/6 10 8pm



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 30/6/20

Assessment: Pt having Abdomen Pain

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	→ Assess the Pt General Condition	8:10pm	→ Assessed the Pt General Condition	
10pm	→ Monitor the Vital Signs	10:10pm	→ Checked the Vital Signs	
12am	→ Plan for Administration Medication	12:10am	→ providing medication as per doctor Order	Pt is stable
2am	→ plan for I/O Chart	2:10am	→ maintaining I/O Chart	
6am	→ plan for Comfortable position	6:10am	→ providing Comfortable position	
8am		8:10am		

Re-Assessment: Re-Assessment every 4 hrs

Special Notes:

Nurse Signature: [Signature]

Nurse Name: Chandana

Date & Time: 1/7/20 2pm



NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 01/07/26

Assessment: Baby having pain in abdomen

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8am	=> Assess the baby General condition of vitals stable	8am	=> Assessed the baby General condition vitals stable	By doing the all procedures the baby condition is improved.
9am	=> provide comfort position	9am	=> provided comfort position	
10am	=> Baby having pain in abdomen	10am	=> Abdomen pain was Reduced after Inj:- Tramadol	
11am	=> Doctor come for rounds and	11am		
12pm	Doctor advised to CECT abdomen	12pm	=> CECT abdomen today at 2pm	
1pm	with Sedation	1pm	=> administered the all drugs as per doctor order	
2pm	=> Baby in NPO	2pm		

Re-Assessment:

Done by doing inj:- Tramadol
CECT abdomen T/m

Special Notes:

Nurse Signature: Shailaja

Nurse Name: Shailaja (605567)

Date & Time: 01/07/26 (2pm)



NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 1/6/26

Assessment: baby having discomfort

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
9am	Assess the pt general condition	2:00	Assessed pt general condition	by the above care the pt is comfortable & not in pain
4pm	provide comfortable position	4:10a	Provided comfortable position	
	monitor vitals		monitored vitals	
6pm	maintain I/O chart	6:10a	monitored I/O chart	
	doctor order to do CECT today.		Today done CECT at 3pm	
7pm	Administer medication as per chart	2:30 pm	Administered medication as per chart	
			After CT baby sedation is 100%.	

Re-Assessment: Mark vitals

Special Notes: Today done CECT at 3pm (1/6/26)

Nurse Signature: [Signature]

Nurse Name: Divitha

Date & Time: 1/6/26 (6pm)

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 1/07/26

Assessment: Pt having DM Activity

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8PM	→ Assess the Pt General condition	8PM	→ Assessed Pt General condition.	Pt condition is normal.
10PM	→ monitor vital signs	10PM	→ monitored vital signs	
2AM	→ maintained %o chart	2AM	→ maintained %o chart	
8AM	→ Administered the medications as per doctors orders	8AM	→ Administered the medications as per doctors orders.	

Re-Assessment: 2/1/

Special Notes:

Nurse Signature: [Signature]

Nurse Name: sravanthi

Date & Time: 2/7/26 2AM

BAH-00660223
Master KURUVA BHARGAVA RAM
03-06-2020 6 Y 0 M 28 D (M)
Dr. M N V POUISHYA SAI

NURSING CARE RECORD

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 9/7/26

Assessment: Baby having abdominal pain

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8am	Assess the general condition of the baby	8am	Assessed the general condition of the baby	by done all those to improve baby condition
9am	Doctor advis. contiou medication	9am	Doctor advised contiou medication	
11am	monitor vital sing & recored.	11am	monitored vital sings & recored	
	Provid comfortable position		provided comfortable position	
2pm	Administr medication as per doctor orders.	2pm	Administred medication as per doctor orders	

Re-Assessment: To reduced abdominal pain

Special Notes:

Nurse Signature: Aruna

Nurse Name: Aruna

Date & Time: 9/7/26 @ 2pm

NURSING CARE RECORD

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 21/7/26

Assessment: Baby having stomach pain

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	* Assess the baby general condition. monitor vital signs	2pm	* Assessed the baby general condition. monitored vital signs	Baby condition is improving slowly
3pm	* Baby having stomach pain. give	3pm	* Baby having stomach pain given syp. cyclopam 5ml	
4pm	* provide comfortable position	5pm	* provided comfortable position	
5pm	* Administer medication as per doctor order	6pm	* Administered medication as per doctor order	
6pm	* Ensure safety siderails	7pm	* Ensured safety siderails	

Re-Assessment: Given syp. cyclopam 5ml reduce pain

Special Notes: we will watch for abdominal pain it > 2min to give analgesics.

Nurse Signature: 

Nurse Name: Sneekha

Date & Time: 21/7/26 8pm



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 2/7/26

Assessment: Baby having mild pain at abdominal site

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm.	⇒ Assess the pt general condition.	8:05pm.	⇒ Assessed the pt general condition.	By doing all the procedures the baby condition is improving.
10pm	⇒ provide the comfortable position.	10:05pm	⇒ provided the comfortable position.	
12AM	⇒ Check the vitals. sign.	12:05AM	⇒ Checked the vital signs.	
2AM	⇒ provide side rails.	2:05AM	⇒ provided side rails.	
4AM	⇒ Give the analgesics, when the baby complaining the stomach pain.	4:05AM	⇒ Given the analgesics.	
6AM	⇒ Administer the Medication as per doctors order.	6:05AM	⇒ Administered the Medication as per doctors order.	

Re-Assessment: Giving the analgesics.

Special Notes: NU plan d/c TM.

Nurse Signature: 

Nurse Name: Prameela (015802)

Date & Time: 2/7/26 @ 8AM

BAH-00660223 IP5-00175750
Master KURUVA BHARGAVA RAM
03-06-2020 6 Y 0 M 29 D (M)
Dr. M N V POUISHYA SAI



NURSING CARE RECORD

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 3/7

Assessment: Baby having Abdominal pain

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

Time	Plan of Care	Time	Implementation	Evaluation
9am	→ Assess the baby general condition	9:10am	→ Assessed the baby general condition	Baby condition is normal
10am	→ monitor the vitals	10:10am	→ monitored the vitals	
11am	→ send LAT	11:10am	→ send LAT	
12pm	→ Administer medication as per doctor orders	12:10pm	→ Administered medication as per doctor orders	

Re-Assessment:

Special Notes:

Nurse Signature: [Signature]

Nurse Name: [Signature]

Date & Time: 3/7/26 @ 2pm

BAH-00660223 IP5-00175750
Master KURUVA BHARGAVA RAM
03-06-2020 6 Y 0 M 29 D (M)
Dr. M N V POUISHYA SAI



NURSING CARE RECORD

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 3/7/26

Assessment: Baby Having Pain

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	→ Assess the Baby General condition monitor vitals & record	2:30pm	→ Assessed the Baby General condition monitored vitals & recorded	
4pm	→ plan to do Laparoscopy Appendectomy	4:30pm	→ planned to do Laparoscopy Appendectomy	By All kids down pt condition is improved
5pm	→ Administer medication as per doctor order	6pm	→ Administered medication as per doctor order	
8pm	→ Ensure safety	8pm	→ ensured safety	

Re-Assessment: for Pain fentanyl patch put in Body

Special Notes: plan for Laparoscopy Appendectomy

Nurse Signature:

Nurse Name: Aparanjitha (091966)

Date & Time: 03/7/26 @ 8pm

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Poushya Sai Department: pediatric Date of Admission: 29/06/26

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:					
BACKGROUND	Area	Shift Time	1st floor 8pm-8am	1st floor 8am-8pm	1st floor 8pm-8am	1st floor 8am-8pm	1st floor 8pm-8am	1st floor 8am-8pm
	Medical Condition (Any special condition to be noted):		NA	NA	NA	NA	NA	NA
ASSESSMENT	Allergy:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Tubes/Drains/Catheter:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:	Temp:	98.0°F	98.3°F	98.6°F	97.5°F	98.1°F	98.4°F
		Res:	23b/m	21b/m	26b/m	23b/m	26b/m	26b/m
		SpO ₂ :	100%	99%	98%	99%	100%	100%
		Pulse:	122b/m	111b/m	106	117	111b/m	106b/m
		BP:	92/60	91/62	105/75	113/73	98/60	99/67
	Fall Risk Score:	1/1	1/1	1/1	1/1	0/10	1/1	
Pain Score:	0/10	0/10	0/10	0/10	0/10	1/10		
Recommendations	Safety Needs:		✓	ye	ye	yes	ye	Sid rails
	Physiotherapy		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Others Specify:		NA	NA	NA	NA	NA	NA
	Special Diet:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Other Special Orders / Medications:		NA	NA	NA	NA	NA	NA
Post Operative Procedure Special Orders:			NA	NA	NA	NA	NA	NA
Handed Over By Name :			Keerthi	Chandana	Aruna	Srisheela	Chandana	Priyanka
Signature :			Ke	Ch	Aruna	S	Ch	P
Date:			29/6	30/6	30/6	30/6	1/7/26	1/7
Time:			6:30pm	8am	8pm	8pm	8am	2pm
Taken Over By Name :			Aruna	Srisheela	Chandana	Priyanka	Priyanka	Aruna
Signature :			Aruna	S	Ch	P	P	Ar
Date:			29/6	30/6	30/6	30/6	1/7/26	1/7
Time:			8pm	8am	8pm	8pm	8am	2pm

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: DR - P-S Department: Gastro Date of Admission: 29/6/20

SITUATION		Any Infection: ☐ Yes ☒ No ☐ Not Known If Yes Specify:						
BACKGROUND	Area							
	Shift Time	1st floor 2nd-4	1st floor 5PM-8PM	1st floor 8PM-11PM	1st floor 11PM-2PM	1st floor 2PM-5PM	1st floor 5PM-8PM	
ASSESSMENT	Medical Condition (Any special condition to be noted):	NA	NA	NA	NA	NA	NA	
	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
ASSESSMENT	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Vital Signs:	Temp:	99.1°	98.1°	98.0°	98.1°	97.1°	98.5°
		Res:	26	22	26	28	29	23
		SpO ₂ :	99%	100%	98%	98%	100%	99%
		Pulse:	112	115	110	104	112	102
		BP:	96/80	95/73	101/61	96/69	95/61	99/71
		Fall Risk Score:	1	1	1	1	1	1
	Pain Score:	0/10	0/10	0/10	0/10	0/10	0/10	
Recommendations	Safety Needs:	Yes	Yes	Yes	Yes	side rail	Yes	
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:	NA	NA	NA	NA	NA	NA	
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Other Special Orders / Medications:	NA	NA	NA	NA	NA	NA	
Post Operative Procedure Special Orders:		NA	NA	NA	NA	NA	NA	
Handed Over By Name :		Uthab	Saravathi	Arung	Suneel	Praneel	Srisheela	
Signature :								
Date:		2/7	2/7/20	2/7	2/7/20	3/7/20	3/7	
Time:		8PM	8AM	2PM	8PM	8AM	2PM	
Taken Over By Name :		Saravathi	Arung	Suneel	Praneel	Srisheela	Arpita	
Signature :								
Date:		2/7/20	2/7	2/7/20	2/7/20	3/7	3/7	
Time:		8PM	8AM	2PM	8PM	8AM	2PM	



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. P-S Department: Gastro Date of Admission: 29/6/20

SITUATION	Diagnosis: <u>AGE E</u> <u>Gastroitis</u>		Any Infection: ☐ Yes ☒ No ☐ Not Known If Yes Specify:			
	Area	Shift Time				
BACKGROUND	Medical Condition (Any special condition to be noted):	<u>NA</u>	<u>NA</u>			
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:	Temp: <u>98.8°F</u>	<u>96.7°F</u>			
	Res:	<u>26b/m</u>	<u>24</u>			
	SpO ₂ :	<u>100%</u>	<u>100</u>			
	Pulse:	<u>119b/m</u>	<u>117</u>			
	BP:	<u>98/60</u>	<u>100/54</u>			
	Fall Risk Score:	<u>1</u>	<u>1</u>			
Recommendations	Pain Score:	<u>0/10</u>	<u>0/10</u>			
	Safety Needs:	<u>yes</u>	<u>yes</u>			
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Others Specify:	<u>NA</u>	<u>NA</u>			
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
Other Special Orders / Medications:		<u>NA</u>	<u>NA</u>			
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>			
Handed Over By Name :		<u>Appy</u>	<u>Swarun</u>			
Signature :		<u>[Signature]</u>	<u>[Signature]</u>			
Date:		<u>3/7</u>	<u>4/7</u>			
Time:		<u>8pm</u>	<u>8am</u>			
Taken Over By Name :		<u>Swarun</u>	<u>Ankitha</u>			
Signature :		<u>[Signature]</u>	<u>[Signature]</u>			
Date:		<u>3/7</u>	<u>4/7</u>			
Time:		<u>8pm</u>	<u>8am</u>			

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
	Area							
BACKGROUND	Shift Time							
	Medical Condition (Any special condition to be noted):							
ASSESSMENT	Allergy:		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs:							
	Temp:							
	Res:							
	SpO ₂ :							
	Pulse:							
	BP:							
Fall Risk Score:								
Pain Score:								
Recommendations	Safety Needs:							
	Physiotherapy		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:							
	Special Diet:		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:							
Post Operative Procedure Special Orders:								
Handed Over By Name :								
Signature :								
Date:								
Time:								
Taken Over By Name :								
Signature :								
Date:								
Time:								

BAH-00660223 IP5-00175750
Master KURUVA BHARGAVA RAM
03-06-2020 6 Y 1 M 0 D (M)
Dr. M N V POUHYA SAI

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

BirthRight[™]
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

THE HUMPTY DUMPTY SCALE

4/7

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4					
	3 to less than 7 years old	3	3				
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	2				
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1				
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	1	1				
	History of Falls or Infant - Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2				
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	1				
Medication Usage	Sedatives (excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1				
TOTAL			11				

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position						
Call device within reach						
Wheels Locked						
Room free of clutter						
Adequate Lighting						
Wheel Chair Support						
Other Intervention(s) Specify						
Nurse's Name :						
Signature :						
Date :						
Time :						

Patient

BAH-00680223
Master KURUVA BHARGAVA RAM
03-06-2020 6 Y 0 M 26 D (M)
Dr. M N V POUISHYA SAI



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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

THE HUMPTY DUMPTY SCALE

29/6 30/6 1/7 2/7 3/7

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4					
	3 to less than 7 years old	3	3	3	3	3	3
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	2	2	2	2	2
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1	1	1	1
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	1	1	1	1	1	1
	History of Falls or Infant - Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2	2	2	2	2
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	1	1	1	1	1
Medication Usage	Sedatives (excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1	1	1	1
TOTAL			11	11	11	11	11

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position	✓	Yes	Yes	Yes	Yes
Call device within reach	✓	Yes	Yes	Yes	Yes
Wheels Locked	✓	Yes	Yes	Yes	Yes
Room free of clutter	✓	Yes	Yes	Yes	Yes
Adequate Lighting	✓	Yes	Yes	Yes	Yes
Wheel Chair Support	✓	Yes	No	No	No
Other Intervention(s) Specify	✓	Yes	No	No	No
Nurse's Name :	Kaithu	Chand	Chand	Chand	pranvi
Signature :	Kg	Chand	Chand	Chand	pranvi
Date :	29/6	30/6	1/7	2/7	3/7
Time :	4:35 pm	6am	6am	6am	6am



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
2/7/26	2:30pm	2/10	abdomen	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☐ Dull ☒ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	syp. cycloperm (5ml)	Sudheer.
2/7/26	3pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	N/A	Sudheer
2/7/26	9pm	0/10	NIL	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NIL	prameela
3/7/26	5AM	0/10	NIL	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NIL	prameela
3/7	1pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Appu
3/7	6:40pm	1/10	Body	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	fentanyl patch	Anish
3/7	10pm	1/10	abdomen	☐ Continuous ☒ Intermittent	☐ Acute ☒ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	INJ PCM	Su
3/7	11pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	Su
4/7	7AM	0/10	AI	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	@
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

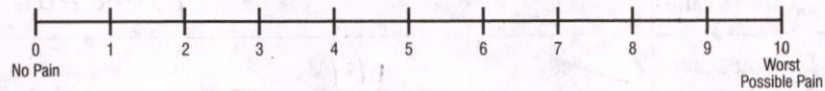
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

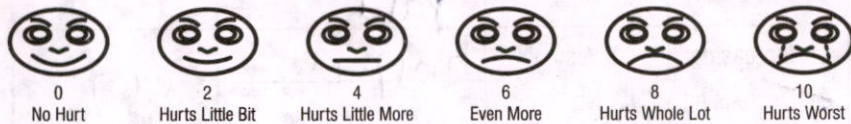
Numerical Pain Scale (Obstetric and Gynecology)



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

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

Wong - Baker (Pediatrics) Above 7 Years





PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
29/5/26	4:30 pm	0/10	Nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	Keethi
29/6/26	11pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Chandani
30/6/26	6am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Chandani
30/6/26	4pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Chandani
1/7/26	6am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Chandani
1/7	2pm 9:30 AM	1/10	abdomen	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Syp. cyclopam	Priyanka
1/7	11AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Priyanka
1/7	2pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Nikitha
2/7	3AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Saranya
2/7	11AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	Aruna

Re-assessment Frequency:

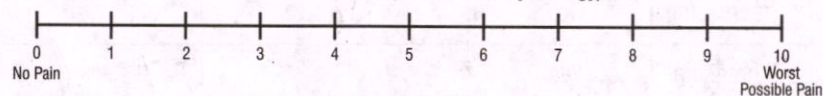
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

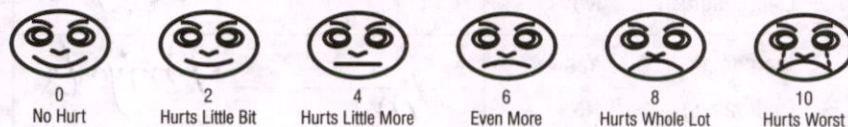
Numerical Pain Scale (Obstetric and Gynecology)



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

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

Wong - Baker (Pediatrics) Above 7 Years





BRADEN 'Q' SCALE

					Date :	5/7	6/7		
					Time :	6AM	6U		
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e:xtremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4			
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4			
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4			
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4			
FRICITION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4			
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4			
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4			
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23					TOTAL SCORE	28	20		
Docu. No. : RCHBH / FRM / CLINICAL / 119					Evaluator's Name	Pranav			

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

BRADEN 'Q' SCALE

					Date:	29/6	30/6	1/7/26	2/7
					Time:	4pm	6am	6am	6:30
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4	4	4	
"Activity The degree of physical activity"	1. Bedfast: Confined to bed	2. Chairfast: Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4	4	4	
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	4	
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	4	
FRICION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	4	
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	4	
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4	
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23					TOTAL SCORE	28	28	28	28
Docu. No. : RCHBH /FRM / CLINICAL / 119					Evaluator's Name	Ked/Li	Cy	Cy	Q

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



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										
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1										
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2										
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3										
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4										
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5										
Signature of the Nurse													

NOTE : Phlebitis greater than grade 2 should be reported to physicians and other appropriate health care personal ongoing observation of the site should continue for 48 hours post removal to detect post infusion phlebitis.

Signature of Shift In Charge :

Signature : [Signature] Name : C. Anish

Signature of Ward In Charge :

Signature : [Signature] Name : Neeraja



CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	01/2 DAY-1			21/5 DAY-2			31/2 DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0	0	0	0	0	0	0	0	0		
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1	-	-	-	-	-	-	-	-		
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	-	-	-	-	-	-	-	-		
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3	-	-	-	-	-	-	-	-		
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4	-	-	-	-	-	-	-	-		
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord pyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5	-	-	-	-	-	-	-	-		
Signature of the Nurse				<i>Ponir</i> <i>subi prami</i> <i>Ly Appo sel</i> 									

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 : *Ponshandly* Name : *Kochinady*

Signature of Ward In Charge :

Signature : *Nesly* Name : *Neesaya*



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	0			0	0	0	
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1			-	1			-	-	-	30/6/26 cannula removed @ 7AM
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2			-	-			-	-	-	
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3			-	-			-	-	-	
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4			-	-			-	-	-	
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord pyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5			-	-			-	-	-	
Signature of the Nurse						Aruna				Aruna	Aruna	Aruna	

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 : Arun Name : Arun

Signature of Ward In Charge :

Signature : Neeraj Name : Neeraj devi



INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Part - I.

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

Identified Education Needs:

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

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
29/6	9pm	2	Treatment & care plan	F	1	1	1	0	—	Beethi
30/6/26	8am	9	Normal diet	F	1	0	1	1	—	monu

Part - III: CODES

Who was taught: PT: Patient F: Father M: Mother S: Spouse Sn: Son D: Daughter C: Caregiver O: Other (Specify)									
Learning Barriers: 1. No Learning Barriers 4. Language Barrier 7. Impaired Thought Process/Cognitive limitations 10. Financial Difficulties 13. Cultural/Religion Practice 2. Physical Impairment 5. Educational Level 8. Responsibilities at Home 11. Beliefs and Values 14. Others (Specify) 3. Emotional Barriers 6. Desire / Motivate to Learn 9. Cultural Differences 12. Impaired Vision/ or Hearing									
Teaching Tools Used: A: Audio D: Demonstration V: Video O: Oral P: Printed									
Mechanism/s to overcome barrier/s: 1. None 3. Reassurance & Support 5. Respect values & beliefs 7. Other, Specify 2. Obtain translator 4. Teach Family / Others 6. Respect Cultural / Religion Preference									
Understanding: 1. Verbalizes Understanding 2. Demonstrates Understanding 3. Needs Review									



MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis:

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
29/06/20 @ 5pm	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Abdomin pain	H. stability	Iv fluids & Antibiotic	Ramya	☐ Nursing ☒ Others:
29/06/20 10pm	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Abdomen pain	H. stability	Iv fluids & Antibiotics	Geetha	☒ Medical ☐ Others:
30/6/20 9am	☐ Medical ☐ Nursing ☒ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	API & Acute Gastritis & Delayed milk	Normal diet	RDA E: 1450kcal/d P: 25g/d	Namitha	☐ Medical ☐ Nursing ☒ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:



CONSENT FOR ANAESTHESIA

Authorization By: ☐ Patient ☒ Patient Attendant

Operative Procedure: LT ABDOMIN

Anaesthesiologist: Dr Adith Surgeon: _____

Please read this before you consent for Anaesthesia

General anaesthesia involves rendering a patient unconscious before an operation. This ensures the patient is not aware of events and does not feel pain during the operation. Drugs given through a vein and / or inhaled from an anaesthesia machine produce it. Regional anaesthesia involves using a local anaesthetic to numb a specific area of the body for surgery. Prolonged pain relief can be achieved by infusing weak solutions of local anaesthetics and narcotic drugs to particular parts of the body after surgery or injury, using catheters.

Specific High Risk(s): The doctors have explained to me the details of the high risk involved due to the following medical problems and I have sought necessary clarification on all my doubts.

- ☐ Heart Disease ☐ Hypertension ☐ Diabetes ☐ Renal Failure ☐ Multi Organ Failure ☐ Hepatic Disorders
☐ Shock ☐ Obesity ☐ Chronic Obstructive Pulmonary Disease
☐ Others DESTRUCTIVE, BRADYCARDIA, LARYNGOSPASM

Declaration by Patient Attendant

- I authorize and give consent for anaesthesia as considered appropriate by the anaesthesia team
☐ Regional Anaesthesia ☐ General Anaesthesia ☒ Monitored Anaesthesia Care
- I understand that there are some infrequent complications that can occur due to use of anaesthesia, these include pain or some injury at the site of injections, temporary breathing difficulties, allergic reactions, headaches, variations in blood pressure, nausea and vomiting.
- I authorize the anaesthesia team to perform any additional procedures (for example, Central Venous Access, arterial line, use of suppositories and or nerve blocks for pain relief, changing from regional to general anaesthesia etc) which are considered necessary by them during the course of surgery.
- I also authorize and give consent to the team of doctors attending on me to administer blood products during the course of operative period and immediately thereafter if need arises.
- I acknowledge that the anaesthesiologist have informed me about the anaesthetic procedure, risk, benefits and alternative treatments.
- I acknowledge that I fully understand the above information. I have had the opportunity to ask questions, and they have been answered to my satisfaction in a language I understand. I affirm that this consent is given by me in my full senses.

Patient / Patient Attendant:

Signature: [Signature]
Name: Srinivasulu
Relationship with patient: brother
Date & Time: 11/7/2021 3.29

Witness:

Signature: [Signature]
Name: Sirisha
Date & Time: 11/7/2021 3.29

Doctor (who is taking consent):

Signature: [Signature] Name: Dr Adith Date: 11/7/2021 Time: 3.29

అనస్థీషియా కోసం అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

శస్త్రచికిత్స:

అనస్థీషియా వైద్యుడు: శస్త్రచికిత్స నిపుణుడు:

అనస్థీషియా కోసం మీ అనుమతి ఇవ్వడానికి ముందు దయచేసి ఇది చదవండి

సాధారణ అనస్థీషియా అనేది శస్త్రచికిత్స ముందు రోగిని పూర్తిగా అపస్మారక స్థితిలోకి తీసుకెళ్లే ప్రక్రియ. దీనితో రోగి శస్త్రచికిత్స సమయంలో ఏదీ తెలుసుకోడు, నొప్పి అనుభవించడు. దీనిని శిరస్రావం ద్వారా ఇచ్చే మందులతో లేదా అనస్థీషియా యంత్రం నుండి పీల్చే మందులతో అందిస్తారు.

రిజనల్ అనస్థీషియా అనేది శరీరంలోని ఒక ప్రత్యేక భాగాన్ని లోకల్ అనస్థీషియా నొప్పి రాకుండా చేయడం. శస్త్రచికిత్స లేదా గాయం తరువాత దీర్ఘకాలిక నొప్పి ఉపశమనం కోసం, కాథెటర్లు ఉపయోగించి వీక్ లోకల్ అనస్థీషియా లేదా నార్మల్ బ్లడ్ మందులను నిరంతరం ఆ భాగానికి అందించవచ్చు.

స్పెసిఫిక్ హై లిస్ట్:

క్రింద పేర్కొన్న వైద్య సమస్యల కారణంగా ఉండే అధిక ప్రమాదాల గురించి వైద్యులు నాకు వివరంగా చెప్పారు. నాకు ఉన్న సందేహాలను నేను అడిగాను మరియు అవి నివృత్తి చేయబడ్డాయి.

☐ హృదయ వ్యాధి ☐ రక్తపోటు ☐ మధుమేహం ☐ మూత్రపిండాల వైఫల్యం ☐ బహుళ అవయవ వైఫల్యం

☐ కాలేయ సమస్యలు ☐ షాక్ ☐ ఊబకాయం ☐ దీర్ఘకాల శ్వాసకోశ వ్యాధి (COPD)

☐ ఇతరవి:

రోగి / రోగి అటెండెంట్

- అనస్థీషియా బృందం అవసరమని భావించిన విధంగా నాకు అనస్థీషియా ఇవ్వడానికి నేను అనుమతి ఇస్తున్నాను.
☐ రిజనల్ అనస్థీషియా ☐ జనరల్ అనస్థీషియా ☐ మానిటర్డ్ అనస్థీషియా కేర్
- అనస్థీషియా ఉపయోగంలో అప్పుడప్పుడూ జరిగే కొన్ని అరుదైన సమస్యలు ఉండవచ్చు అని నేను అర్థం చేసుకున్నాను. వీటిలో ఇంజక్షన్ ఇచ్చిన చోట నొప్పి లేదా స్వల్ప గాయం, తాత్కాలిక శ్వాస ఇబ్బందులు, అలెర్జిక్ ప్రతిచర్యలు, తలనొప్పి, రక్తపోటు మార్పులు, వాంతులు మరియు అసహనం వంటి సమస్యలు ఉండవచ్చు.
- శస్త్రచికిత్స సమయంలో అవసరం అనిపిస్తే, అదనపు చర్యలు (ఉదాహరణకు సెంట్రల్ వెన్స్ యాక్సెస్, ఆర్థిరియల్ లైన్, సపోజిటరీలు, నొప్పి నివారణ కోసం నర్వ్ బ్లాకులు, రిజనల్ అనస్థీషియా నుండి జనరల్ అనస్థీషియాకు మార్పు మొదలైనవి) చేయడానికి అనస్థీషియా బృందానికి నేను అనుమతి ఇస్తున్నాను.
- శస్త్రచికిత్స సమయంలో మరియు వెంటనే అనంతరం, అవసరమైతే రక్త పదార్థాలు (Blood products) ఇవ్వడానికి నా చికిత్సలో ఉన్న వైద్యుల బృందానికి కూడా నేను అనుమతి ఇస్తున్నాను.
- అనస్థీషియా విధానం, ప్రమాదాలు, ప్రయోజనాలు మరియు ప్రత్యామ్నాయ చికిత్సల గురించి అనస్థీషియా వైద్యులు నాకు వివరించినట్లు నేను అంగీకరిస్తున్నాను.
- పై సమాచారం అంతా నేను పూర్తిగా అర్థం చేసుకున్నాను. నాకు ప్రశ్నలు అడిగే అవకాశం లభించింది, మరియు నాకు అర్థమయ్యే భాషలో వాటికి సమాధానాలు ఇచ్చారు. ఈ అనుమతి నేను పూర్తిగా స్వచ్ఛమైన భావాలతో, స్వయంగా ఇస్తున్నానని ధృవీకరిస్తున్నాను.

రోగి / రోగి అటెండెంట్:

సంతకం:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

సాక్షి:

సంతకం:

పేరు:

తేదీ & సమయం:

డాక్టర్ :

సంతకం: పేరు: తేదీ & సమయం:

Moderate Sedation Flow-Sheet

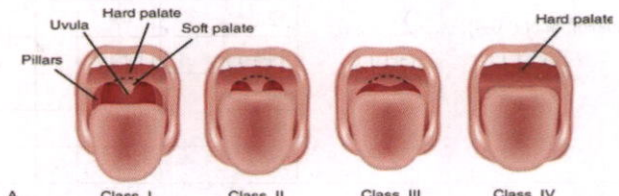
Immediate Pre-Sedation Assessment

B.P	PR	R.R	Temp	SPO ₂	Pain Score	Weight
	100	26		100%	0/10	13 kg

Diagnosis: Abdomen pain & evaluation

Procedure: CECT Abdomen

Comorbidities: nil

☒ Risk, benefits & alternatives discussed; ☐ Patient understand & elects to proceed ☒ Consents for procedure and sedation signed and dated ASA Physical Status ☒ ASA PS 1: Healthy Patient ☒ ASA PS 2: Mild Systemic Disease, no functional limitations ☐ ASA PS 3: Severe Systemic Disease, functional limitations ☐ ASA PS 4: Severe Systemic Disease, constant threat to life ☐ ASA PS 5: Moribund Patient unlikely to survive 24 hrs. ☐ ASA PS 6: A declared braindead patient whose organs are being removed for donor purposes ☐ E: Emergency procedure GCS: E M V ☒ IV Site: Gauge: 26 Sedation Plan: Monitored Anesthetic care Allergies: nil	AIRWAY EVALUATION Mouth: ☒ Normal ☐ Loose Teeth ☐ Small Mouth ☐ Protruding Incisors ☐ Receding Lower Jaw ☐ Dentures Neck: ☒ Normal ☐ Decreased ROM ☐ Thyromental Distance Less Than 6 cm ☐ Short Neck  Mallampati Class: ☒ I ☐ II ☐ III ☐ IV
--	--

Monitoring of Patient Intra – Procedure

Procedure Monitoring

Heart Rate (HR), Respiratory Rate (RR), Oxygen Saturation (O₂ Sat) continuously monitored, and Level of Consciousness (LoC) to be monitored and recorded minimally every 15 minutes until 15 minutes after the last administration of any sedation, then every 30 minutes, then every 1 hour until stable. Respiratory status to be monitored continuously.

Level of Consciousness (LOC):

- ☒ A - Alert
☐ V - Verbally Responsive
☐ P - Painfully Responsive
☐ U - Unresponsive

Observation to be documented every 15 mins

TIME	BP	PR	RR	O ₂ Sat%	O ₂ Supplementation	Comments / Initials
Baseline		100/mnt	26	100%	—	—
03:40 PM		102/mnt	26	100%	4L O ₂	→
03:50 PM		100/mnt	24/mnt	100%	4L O ₂	→

DRUG & IV Fluid: (including Nitrous Oxide)	ROUTE	DOSE	TIME GIVEN	SUBSEQUENT DOSES AND TIME
B. GLYCOPYROLATE	IV	0.1mg	3:40pm	—
B. MIDAZOLAM	IV	0.5mg	3:50pm	—
B. PROPOFOL	IV	30mg	3:40pm	—

Doctor Notes: Unremarkable

Time of transportation to post sedation care room: LOC:

Doctor Name: Dr. Ameen Signature: [Signature]

Post Sedation Care Room

Time																			
Monitoring ECG NBP Oximeter Pain Score (0-10) 0 Sedation Score (0-4) 2	180																		
	160																		
	140																		
	120																		
	100																		
	80																		
	60																		
	40																		

TOTAL ALDRETTE SCORE AT DISCHARGE =
(If 9 and more patient can discharge from post Sedation care unit)

Activity :	Consciousness:	Respiration:	Oxygen Saturation:	Circulation:
Four extremities = 2	Fully awake = 2	Breathe Deep = 2	Sat O ₂ > 92 % on room air = 2	BP +/- 20 mm hg of pre-op = 2
Two extremities = 1	Arousal on calling = 1	Dyspnea, limited breathing = 1	Needs oxygen to maintain Sat O ₂ > 90% = 1	BP +/- 20-50 mm hg of pre-op = 1
No extremities = 0	Unresponsive = 0	Apnea = 0	Saturation < 90% with oxygen = 0	Bp +/- 50 mm hg of Pre-Op = 0

Patient Discharge Time:

Nurse Name:

Signature:

Date: Time:

Consultant Name: Dr. Ameen

Signature: [Signature]

Stamp

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

BAH-00660223 IP5-00175750
Master KURUVA BHARGAVA RAM
03-06-2020 6 Y 0 M 29 D (M)
Dr. M N V POUISHYA SAI

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Name: MASTER KURUVA BHARGAVA Age: 6Y Sex: M UHID.No: BAH 00660223
Date: 1/7/2022 Time: Proposed Operation: CT ABDOMEN
Diagnosis: CT ABDOMEN & SEDATION
B.P / CRT: H.R: Weight: 12.76 ASA Physical Status: ☒ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:

Hgb: 11.3 Glucose: Protein: HIV: X-Ray:
PCV: 35 Urea: Alb: HBS Ag: ECG:
WBC: 13.66 Creat: 0.3 Total Bill: HCV: 2D Echo:
Plate: Na: 136 Dir. Bill: Blood group: Stress/Angio:
PT: K: 4.0 LDH: T3: Other:
PTT: Ca++: Alk phos: T4:
INR: Mg++: Amylase: TSH:
Cl-: 102 SGOT/SGPT:

Allergies: No known drug allergy

Medical History: CVS: — or spm Diabetes:
RESP: no cough with
CNS:
Renal: stomach pain & fever
Hepatic / GE: — no vomiting Physical Activity:
Others:

Past Anaesthetic History: —

Physical Exam:

Airway: MP 1 2 3 4 Mouth Opening: Mento-hyoid Distance: Neck: Teeth:
Lungs:
Heart:
CNS:

Pregnant: ☐ Yes ☐ No ☒ NA Venous Access Site: RUL 226 Spine Exam for regional:

Anaesthetic Plan: ☒ MAC ☐ REGIONAL ☐ GA-ETT ☐ LMA

Peri-Operative Plan Explained to the Patient: ☒ Yes ☐ No

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions:

- DVT Prophylaxis:
- NIL ORAL
 Water / ORS 2 Hours
 Others 6 Hours
- Informed Consent: ☒ Standard ☐ High Risk
- Post Operative Pain Management: ☐ Discussed with Patient
- Other Instructions:

Signature: [Signature] Name: [Signature]

Change in Patient Condition:		☐ Yes ☒ No		Fasting Status: >6hr	
Physical Status:		☐ Patient Identified		☒ Consent Present	
				☐ Chart Reviewed	
H.R: 92/min		B.P / CRT: 90/60mm		SpO ₂ : 100%	
R.R: 21/min		Last Feed: >6hr			
Pre-OP Diagnosis: Abdomen pain & evaluation		Operation: CECT-Abdomen		Date:	
Surgeon:		Anaesthesiologist: Dr. Ameen		Technician: Shivteela	
TIME 03:30 - 04:00					
N ₂ O / AIR / O ₂ LPM				Antibiotic	
HALO / SO / SEVO				Suppository	
Drugs:				Blood Loss	
HYCOPHYLOCATE 0.1mg					
MIDAZOLAM 0.1mg					
PRONOFOL 30mg + 20mg					
FIO ₂ / SaO ₂		100 100 100			
ETCO ₂		CR - SR - SR			
ECG					
Temperature				NOTES	
Urine Output					
Fluids					
Blood					
B.P		240			
V Systolic		220			
A Diastolic		200			
X Mean		180			
Heart Rate		160			
Tourniquet on Time		140			
Tourniquet off Time		120			
Throat Pack In		100			
Throat Pack Out		80			
		60			
		40			
		20			
		10			
		0			
LAB Values		ABG			
		GRBS			
		Others			
☒ Equipment Checked and Functional		Temp:		Regional:	
☐ BP		☐ HME ☐ Fluid Warmer		Extremity Specify:	
☐ Cuff Site:		☐ Cling Film ☐ OH Warmer		☐ Spinal ☐ Epidural ☐ Caudal	
☐ Art Site:		☐ Hugger's ☐ Cotton Wool		Others:	
☒ EKG Lead		☒ Other		Position:	
☐ Temp Site		Times:		Site:	
☐ FIO ₂ Monitor		Anaes Start: 03:30		Needle Size: Depth:	
☐ Agent Monitor		OP Start: ↓		Parasthesia ☐ Yes ☐ No	
☒ Pulse Oximeter		OP End: ↓		Catheter at skin cm	
☐ Capnograph		Leave OR: 03:50 PM		Drug Name & Conc:	
☐ Ventilator		Anaesthesia:		Bolus:	
☐ Nerve Stimulator		☐ GA		Infusion:	
Position: Supine		☒ Monitored Anaesthesia Care		Block Level:	
☒ Pressure Points Checked		☐ Regional		Comments:	
Eye Care:		Line (Size & Location)		Transportation to	
☐ Oint		☐ CVP:		☐ PACU ☐ ICU ☐ Other	
☒ Tape		☐ ART:		Relaxant Reversed ☐ Yes ☐ No ☐ NA	
☐ Padding		☒ IV: D 22g		Name of the Doctor: Dr. Ameen	
☐ Awake		☐ IV:		Signature of the Doctor: [Signature]	
		☐ IV:			
		☐ IV:			
		Induction			
		☐ IV ☐ Inhal			
		☐ Pre O ₂ ☐ RSI			
		☐ Others			
		☒ Mask ☐ SGA			
		☐ Airway ☐ Oral ☐ Nasal			
		ETT# at cm			
		☐ Oral ☐ Nasal ☐ Cuff			
		☐ Tracheostomy ☐ Topical			
		☐ Drug:			
		☐ Awake ☐ Direct Vision			
		☐ Video Laryngoscopy ☐ Stylette / Bougie			
		☐ Fiberoptic			
		Blade# Attempts:			
		Difficulty Why?			
		☐ Bilat = BS			
		☐ Semi-Closed Circle			
		☐ Closed Circle			
		☐ Other			

POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Time Received : Time Discharged :

250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0 SPO ₂	250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0	250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0	IV Cannula Site : ☐ O ₂ Mask ☐ Nasal Prongs ☐ Tracheostomy ☐ T-Piece ☐ Oral Airway ☐ Nasal Airway Vomiting : ☐ Yes ☐ No Drug: NG Tube : ☐ Yes ☐ No Drain: ☐ Yes ☐ No Urinary Catheter: ☐ Yes ☐ No Chest Tube: ☐ Yes ☐ No Nil Oral ☐ Yes ☐ No IV Fluids: Oral Feeds:
---	---	---	--

POST ANAESTHESIA SCORE (Modified Aldrete Score)		IN	MINUTES			OUT	SCORING INTERPRETATION
			30	60	90		
Able to move 4 extremities voluntary or on command	= 2	ACTIVITY				A Minimum Total Score of 8 is Required for Discharge Exceptions to this, are to be explained in the space below by the Discharging Physician:	
Able to move 2 extremities voluntary or on command	= 1						
Able to move 0 extremities voluntary or on command	= 0						
Able to deep breathe & cough freely	= 2	RESPIRATION					
Dyspnea or limited breathing	= 1						
Apneic	= 0						
BP ± 20 of Pre Anaesthetic level	= 2	CIRCULATION					
BP ± 20-50 of Pre Anaesthetic level	= 1						
BP ± 50 of Pre Anaesthetic level	= 0						
Fully awake	= 2	CONSCIOUSNESS					
Arousable on calling	= 1						
Not responding	= 0						
Pink	= 2	COLOR					
Pale, dusky, blotchy, jaundiced, other	= 1						
Cyanotic	= 0						
TOTAL							

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature

Pain Tool Used: ☐ N PASS ☐ FLACC ☐ Wong Baker ☐ NPS

Anaesthesiologist Name : Dr. Ameen

Anaesthesiologist Signature: [Signature]

Date & Time:

PACU Nurse Name :

PACU Nurse Signature:

Date & Time:

Reassessment Frequency:

1. Every eight hours for all hospitalized patients.
2. For post surgical patient, patient with chronic pain, patient with severe pain
 - a. Every 2 hours for first 24 hours
 - b. After 24 hours every 4 hours
 - c. Prior to pain relieving intervention
 - d. Within 30-60 minutes after pain relief intervention

Transferred to Unit by (PACU):

Date & Time:

Patient Sticker

Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

Date: Time: Procedure done by

CSE /Spinal /Epidural Position : Space : Technique (LOR/LOS)

Depth: Catheter at Skin: Attempts :

Parasthesia : Yes/No if yes details :

Solution Composition :

Any other issues :

a)

b)

Time	Infusion Rate (ml/hr)	Bolus (ml)	Level		Maternal		FHR	Comments
			Left	Right	BP	Pulse		

Delivery Details : Time : APGAR: SVD / Instrumental / LSCS (if LSCS Details)

Catheter Removed by and Tip Inspected :

Patient Satisfaction :

Discharge /Shifting ordered by

Doctor Signature:

Doctor Name:

Date and Time :

117 NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 30/6/26 Time: 8 AM

Weight: 12.76 kgs Centile: <5th

Height: 112cm Centile: 25th

Inference: Underweight child

RDA: — Calories: 1450 kcal/d Protein: 25g/d

Diet Recommendations: Normal diet

Re-Assessment: Avoid spicy, chilled and outside foods.

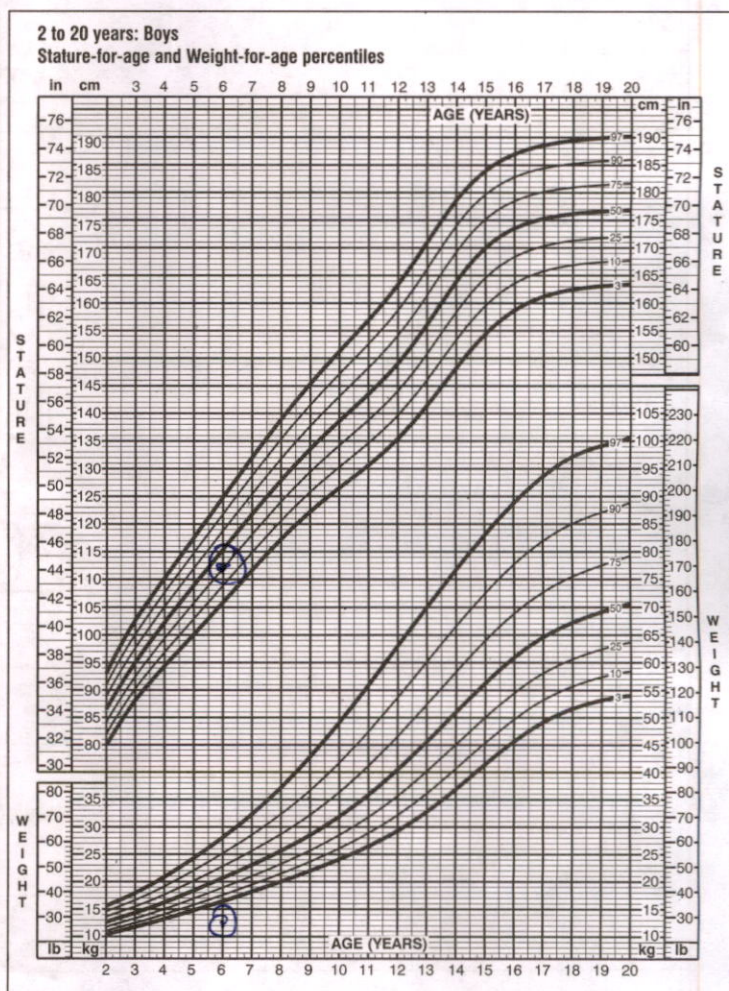
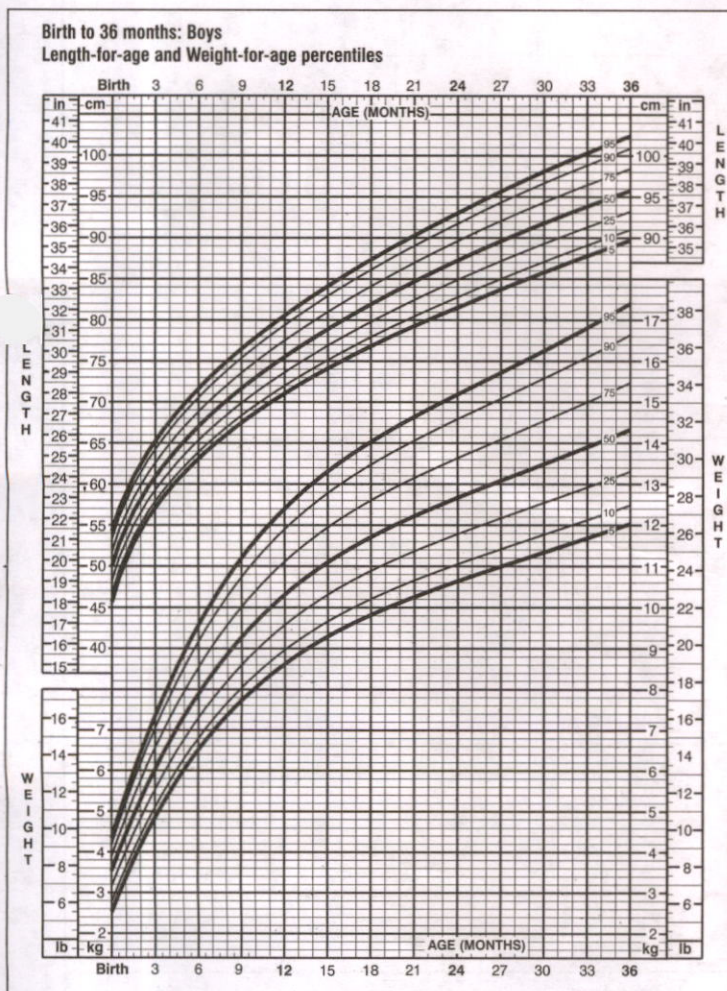
Food Allergies: No Veg/Non-veg: neg

Diagnosis: AFI ± Acute Gastritis ± dehydration

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: Sridha

GROWTH CHART (BOYS)



Dietician's Name: Mounica

Dietician's Signature: Mounica

Daily Notes:

1/7/26
10am child is stable. oral intake is Good.
continue τ Normal diet — Nikitha.

2/7/26
10:30am child is stable Oral Intake is Better.
Continue τ Normal diet. — Mouli

3/7/26
11Am child is Stable Oral Intake is Better
Continue τ Normal diet. — Mouli