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ACTIVITY RECORD FOR BILLING

VIH-00206873 IP-00060750
Master GUGLAVATH SHREYANS
04-08-2023 2 Y 11 M 14 D (M)
Dr. GEETHA CHANDA

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

UHID No : - --------- Consultant : ---------- Dept : pediatrics

Date of Admission : 18/7/26 Time : ---------- Date of Discharge : ---------- Time: ----------

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
18/7/26	@7:30pM	ER	138	

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Sign

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature

ANY OTHER INFORMATION

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
	19/2/26 @9.40pm		

DEFICIENCY CHECK LIST OF MEDICAL CASE SHEET

VIH-00206873 IP-00060750
Master GUGLAVATH SHREYANS
04-08-2023 2 Y 11 M 15 D (M)
Dr. GEETHA CHANDA

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Patient Name : IP.No:

Ward: DOA:

Sl.No	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission Sheet	01			
2	Discharge Summary	02			
3	Nursing Initial assessment form	03			
4	Patient Trasfer Forms	01			
5	In-patient Medical Record	03			
6	Doctors Progress Sheets	01			
7	Nurses Progress notes	02			
8	Consultation Sheets				
9	General Consent for Treatment	01			
10	Conset for Surgery				
	Consent for Blood Transfusion				
12	Consent forChemotherapy				
13	Consent for High Risk				
14	Consent for Restraint				
15	DAMA Consent				
16	Consent for Special Procedure				
17	Consent for Radiological Investigations				
18	Consent for HIV Test				
19	Anaesthesia consent form				
20	Anaesthesia notes(Pre Anaesthesia & Post)				
21	Pre Operative checklist				
22	Surgical safety Checklist				
23	Operation Theatre notes				
24	Nurses Clinical Presentation				
25	TPR & BP chart	02			
26	Intake and Output chart (fluid Chart)	02			
	Drug Chart (Regular prescription)	02			
28	Daily Investigation sheet	01			
29	Investigation Values (Result Sheet)				
30	Nebulization Chart				
31	Diabetic chart				
32	Nutritional Review chart	-			
33	MLC form (in case of MLC)				
34	Patient Educatlon Form				
	Others Ds	05			
	Billing	04			
	Total No. of Pages	30			

Noted by Dude
CMO
19/8/23

Signature and Date :

ERROR LOG

LOCATION: - NICU / PICU / HDU / OT / GENERAL WARD

ICD CODE :-

OBSERVATION: -

DATE :

MRD EXECUTIVE

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

ADMISSION SHEET

Registration Details :

Admission No : IP-00060750 **Admit Date** : 18-Jul-2026 **Admit Time** : 06:12 PM **UHID** : VIH-00206873

Patient Details :

Patient Name	: Master GUGLAVATH SHREYANS	**Age**	: 2 Y 11 M 14 D
Guardian	: Mrs GUGLAVATH SUMALATHA	**DOB**	: 04-08-2023
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: H NO 2-88 BHILYA THANDA MANDAL KAMMARAPALLY,DAMMANPET(AMEEMAGAR). KONASAMUDRAM,NIZAMABAD. Bhimagal Nizamabad Telangana INDIA 503307	**Phone No**	: 9440232010
		E-mail	: NA@GMAIL.COM

Admission Details :

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

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

Contact Details :

Name : Mrs GUGLAVATH SUMALATHA **Relationship** : MOTHER

Contact Address : H NO 2-88 BHILYA THANDA MANDAL KAMMARAPALLY,DAMMANPET(AMEEMAGAR) .KONASAMUDRAM,NIZAMABAD. Bhimagal Nizamabad Telangana INDIA 503307 **Phone No** : 9440232010

Signature

Doctor Details :

Doctor Name	: Dr. GEETHA CHANDA	**Specialisation**	: PEDIATRIC NEUROLOGY
Referral Doctor	:	**Phone No**	:
Co-Consultant	:		

Payment Details :

Payment Mode : Cash **Deposit Amount** : 0.00

Payor Name : SELFPAY

VIH-00206873 IP-00060750
Master GUGLAVATH SHREYANS
04-08-2023 2 Y 11 M 14 D (M)
Dr. GEETHA CHANDA

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wt 12 kg

EMERGENCY ROOM TRIAGE FORM

Patient's Name : master . Shreyans Age : 2Y Gender: ☑ Male ☐ Female

Date : 18/7/26 Time of Arrival : 2:13 pm

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

Source of Information : ☑ Parents ☐ Others (Specify)

Mode of Arrival : ☑ Ambulatory ☐ Wheelchair ☐ Ambulance

Initial Vital Signs: Temp: 98.6F PR: 106/M BP: 103/53(66) RR: 20b/M SpO$_2$: 100%

Chief Complaints: c/o seizers 2 episodes today

INITIAL PHYSIOLOGICAL CATEGORIZATION

Appearance: ☑ Normal ☐ Sick Looking

Circulation / Colour: ☑ Normal ☐ Abnormal ☐ Bleeding

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

INITIAL PHYSIOLOGICAL STATUS

☑ Stable
☐ Unstable :
- ☐ Not – Life - Threatening
- ☐ Life – Threatening

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

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

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian

Triage Completion Time : 2:17pm

Communicable Disease Triage Screening

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

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

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

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

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

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

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

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

Name of Triage Nurse : Swathi

Signature of Triage Nurse : .....

Date & Time : 18/7/26 @ 2:17pm

Patient Name : Mast. Shreyans UHID : 346788755 IPD : 976445677 Gender : Male Age : 2 Y

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Master GUGLAVATH SHREYANS
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Dr. GEETHA CHANDA

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 18/7/26 Time of arrival : 2:18pm

Chief Complaints: C/O seizers 3 episodes today RBS: 130mg/dl

Height : — Weight : 12kg BMI : — Head Circumference (<2 years) —

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

If yes , identify —

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

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

RISK FOR FALL:

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

☐ If Patient is > 6 years
Assess the below parameters

History of Falling: within past 3 months	☐ Yes	☑ No
Ambulatory Aids:		
• Wheelchair	☐ Yes	☑ No
• Uses furniture for support	☐ Yes	☑ No
Gait/Transferring:		
• Bedrest / immobile	☐ Yes	☑ No
• Weak	☐ Yes	☑ No
• Impaired	☐ Yes	☑ No
Mental Status: Forgets limitations	☐ Yes	☑ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening: ☑ No Abnormalities Detected

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

Inform consultant for positive criteria

.....

.....

Nutritional Screening: ☑ No Abnormalities Detected

☐ Underweight
☐ Overweight
☐ Feeding Problem
☐ Special diet
☐ Special feeding method

Inform consultant for positive criteria

Psychological Screening: ☑ No Significant Findings

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

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

Social History: Lives With family

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

Time of Initial assessment completed by ER Nurse : 2:22pm

Patient Name : Mast. Shreyans UHID : 346788755 IPD : 976445677 Gender : Male Age : 2 Y

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

Time	Nursing Notes
2:13PM	✱ patient Come to ER
2:17PM	✱ vital checked & Recorded
2:21PM	✱ Doctor, seen the patient Adviced Admission
6:30PM	✱ Admission Process done
	✱ patient Shifted to ward [138]

Samples collected by: —— Time: ——

Samples sent by : —— Time: ——

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1
2:39PM	Tab:- clonazepam	oral	0.25mg	Dr. Ramesh	

Condition of patient at time of shift - out :

HR: 100 b/M BP: 105/66 (74) CFT: 3 sec

RR: 20 b/M SPO$_2$: 100 - RA

GCS: 15/15 Temperature : 98.6°F

Pain Score: 0

Repeat RBS (if applicable): —

Details of Shift - out

Shift - out from ER to: 138

Time of Shift - out: 18/7/20 @ 7:30 PM

Handover given to: Sr. Manisha (Nurse's Name) by Architha

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

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

Name of the Nurse : Architha Signature of the Nurse : AB

Date & Time : 18/7/20 @ 7:30PM

PATIENT TRANSFER FORM

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VIH-00206873 IP-00060750 Master GUGLAVATH SHREYANS 04-08-2023 2 Y 11 M 14 D (M) Dr. GEETHA CHANDA	Date & Time of Admission 18/7/26 @ 6:12 PM	Date & Time of Transfer Order 18/7/26 @ 7:30 PM
	Transfer Ordered by Dr. prashanthi	Reason for Transfer Admission
From Unit ER	To Unit 138	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File 21	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant Yes ☑ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.		
2.		
3.		
4.		
5.		

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Architha LAS	Dr. prashanthi

Patient & Clinical Records Received by : Manisha

Date & Time of Patient Received : 18/7/26 @7:30pm

If the transfer order time & Completion time is more than 30 minutes, please tick the reason mentioned below :

☐ Unavailable Bed ☐ Nurse not Available ☐ Available Bed not ready

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Nursing General Admission Assessment Form For Pediatrics

Diagnosis: seizures

Arrival Time: 2:13pm ..... Mode of Arrival: lifted by mother ... Admitting From: ☑ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction ..... Nil ..... Body Weight: 12 ..... Kg

..... Height: — ..... cm

.....

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

Past Medical History	Past Surgical History	Previous Hospital Admission
yes	NO	NO

Family History: Nill

.....

Has the child or close family member had recent contact with a communicable disease? ☐ Yes ☑ No

If yes please list, ... Nil .....

Was the child's birth normal? ☑ Yes ☐ No If No, please describe problems: ..... Nil .....

.....

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

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

Observations: Weight: 12 kg ..... Length: — ..... Head Circumference (< 2 years): — .....

Temp.: 98.4°F ..... HR: 110 b/m ..... RR: 27 b/m ..... BP: 108/78 (64) .....

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

Fall Risk Assessment: ☐ Yes ☑ No Score: 0 ..... (Document in the Humpty Dumpty Sheet)

Risk of Pressure Sore (Braden Q Score ..... 27 .....) (Document in the Braden Q Assessment Sheet)

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

Character of Pain ..... Nil ..... Location ..... Nil ..... Frequency ..... Nil ..... Duration ..... Nil .....

FUNCTIONAL SCREENING: ☑ No Abnormalities Detected

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

Inform consultant for positive criteria

NUTRITIONAL SCREENING: ☑ No Abnormalities Detected

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

Inform consultant for positive criteria

Psychological Screening: ☑ No Significant Findings

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

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

Social History: Lives With ..... parents .....

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

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

Orientation has been given regarding the following aspects:

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

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

Patient Rights & Responsibilities: ☑ Yes ☐ No

Information given to ..... family .....

Nurse's Name: Sr. manisha Date: 18.7.26 Time @ 7:40pm manisha Signature

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PEDIATRIC IN-PATIENT MEDICAL RECORD

VIH-00206873 IP-00060750
Master GUGLAVATH SHREYANS
04-08-2023 2 Y 11 M 14 D (M)
Dr. GEETHA CHANDA

Patient Name: _____ _____

UHID ID: _____ _____

Department: _____

Consultant: _____

VIH-00206873 IP-00060750
Master GUGLAVATH SHREYANS
04-08-2023 2 Y 11 M 14 D (M)
Dr. GEETHA CHANDA

Pediatric Multiorgan History & Physical Examination

Name : Gugulavath Shreyans. Age/Sex 2yr/male.

Information given by: mother Relationship Good

Chief Presenting Complaints & Duration (Chronologically)

c/o left deviation of Angle of mouth.
& Abnormal movements : mvng.

History of present illness :

Child was brought to ER c/o.
deviation of Angle of mouth to (lt) side
: mvng.

c/o Abnormal dystonic movements : mvng.
multiple episodes.
lasting for 1 sec.

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Master GUGLAVATH SHREYANS
04-08-2023 2 Y 11 M 14 D (M)
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Pediatric Multiorgan History & Physical Examination

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

child is a klilo left hemiparesis with left UMN facial weakness after trivial trauma.
c Rt MCA territory cerebral stroke.

Birth & Neonatal History:

N-O.

Birth & Socio Economic History:

About Father : Nil.
About Mother :
Any additional Information :

Developmental History :

Developmt delayed as per Age in all 4 domain.

Immunization History :

Immund as per Age.

(P.T.O.)

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04-08-2023 2 Y 11 M 14 D (M)
Dr. GEETHA CHANDA

Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs)) 12kgs (Centile _____)

On Examination :

Temperature : 98.6f Pulse Rate : 110b/m B.P. 103/53 SPO2 100%.

Resp.rate and type of breathing :

Rash (N)

Lymphadenopathy

Oedema :

Allergies (if any):

Respiratory System :

Inspection (any s/o distress) : (N)

Air entry & breath sounds : BLAEF

Any addes sounds : (N).

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

Cardiovascular System :

Inspection of procordium : (N)

Heart Sounds : S1S2F

Any murmur : (N).

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

Per Abdomen :

Inspection (N)

Palpation : P/A: Soft

Ausculation : (N)

Spine : (N) External Genitelia : (N)

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

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04-08-2023 2 Y 11 M 14 D (M)
Dr. GEETHA CHANDA

Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score :

Cranial Nerves : (N) Pupils - B/L equal reacting to light.

No signs of ICP
& NO meningeal signs.

Motor System:

Nutriton :

Tone: Power (R) (L)

Co-ordinator : >3/5. 1/5

Posture :

Involuntary Movements :

Reflexes :

DTR +2 **Superficials:** +nt.

Plantars Extensor on left side.

Sensory System :

(N)

(N)

Bladder / Bowel :

Clinical Summary & Diagnostic:

K/C/O ~~[illegible]~~ left hemiparesis & left UMN facial weakness.

(RT) MCA denticulostriate stroke.

(P.T.O.)

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Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

Desired goals of the treatment :

Planned Labs:

Planned Management

- Tab. clonazepam (0.25mg) - p/o - 12 hrly.
- monitor vitals
- Inform (SOI)

Noted by ~~Archith~~
18/7/26 @ 6:00 PM

Signature of the Doctor: R
Name of the Doctor: Dr. prashanth.
Date & Time: 18/7/26.

Signature of the Consultant:
Name of the Consultant:
Date & Time:

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
18/7/23. 9:00pm	Parents were counselled regarding the need for cannulation.	
	But parents were not willing for cannulation.	
	Parents refused it.	
	Risks explained.	
	Dr. prahanti	
		Manoj (father).

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/7	S/R Neurology	Acute onset dystonia in r/o left hemiparesis with left UMN facial weakness ?? - mineralising angiopathy (Plan)
	Child better	
	No further dystonic episodes	
		T. Clonazepam (0.25mg) ½ - 0 - ½
		BOS I - 0 - I
		T/D Discharge
	Noted by [illegible] @ 10AM 19/7/25	

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NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: Seizures	Any Infection: ☐ Yes ☐ No ☑ Not Known If Yes Specify: –					
	Surgery / Procedure: Nil	Post OP Day: –					
BACKGROUND	Date / Shift	18/7 ER	18/7/26 E	18/7/26 N	19/7 M		
	Medical Condition (Any special condition to be noted):	Nil	Nil	Nil	nil		
	Diet:		S diet	S.diet	S.diet		
ASSESSMENT	Allergy:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No
	Ventilation (RA, NP, NIV, VENTI):	RA	RA	RA	RA		
	Tubes/Drains/Catheter:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:	98.6°F	98.4°F	98.6°F	98.6°F		
	Res:	20 b/m	22b/m	25 b/m	26b/m		
	SpO_2:	100%.	100%.	99%.	98%		
	Pulse:	110 b/m	105b/m	112b/m	110b/m		
	BP:	103/53 (66)	109/78(63)	105/60(71)	100/66(72)		
	LOC:	Conscious	Conscious	Conscious	Conscious		
	Fall Risk Score:	"0"	0	10	10		
	Pain Score:	"0"	0	0	0		
	Skin Integrity	Intact	Intact	Intact	Intact		
Recommendations	Safety Needs:	☐ Yes ☑ No	☐ Yes ☑ No	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Physiotherapy:	Nil	Nil	Nil	nil		
	Others Specify:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No
	Special Diet:		Nil	Nil	nil		
	Critical Lab Test / Values:	Nil	Nil	Nil	nil		
	Other Special Orders / Medications:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No
	PU Prophylaxis:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No
	DVT Prophylaxis:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No
	ADL (Dependent / Non Dependent):	Dependent	Dependent	dependent	Dependent		
Post Operative Procedure Special Orders:		–	Nil	Nil	nil		
Handed Over By Name :		Achitha	manisha	Benonika	Indu		
Signature / ID :		A/02062	M/9050115	B018727	866668		
Date:		18/7/26	18/7/26	19/7/26	19/7/25		
Time:		@7:30PM	@8pm	@8am	2PM		
Taken Over By Name :		manisha	Benonika	Indu			
Signature / ID :		M/9050115	B018727	866668			
Date:		18/7/26	18/7/26	19/7/26			
Time:		@7:30pm	@8pm	@8Am			

Noted by Indu @10AM 19/8/12

Docu. No. : RCH /FRM / CLINICAL / 097

VIH-00206873 IP-00060750
Master GUGLAVATH SHREYANS
04-08-2023 2 Y 11 M 15 D (M)
Dr. GEETHA CHANDA

Rainbow® Children's Hospital
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NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:					Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:	
	Surgery / Procedure:					Post OP Day:	
BACKGROUND	Date / Shift						
	Medical Condition (Any special condition to be noted):						
	Diet:						
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Ventilation (RA, NP, NIV, VENTI):						
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:						
	Res:						
	SpO_2:						
	Pulse:						
	BP:						
	LOC:						
	Fall Risk Score:						
	Pain Score:						
	Skin Integrity						
Recommendations	Safety Needs:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Physiotherapy:						
	Others Specify:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Special Diet:						
	Critical Lab Test / Values:						
	Other Special Orders / Medications:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	PU Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	DVT Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	ADL (Dependent / Non Dependent):						
Post Operative Procedure Special Orders:							
Handed Over By Name :							
Signature / ID :							
Date:							
Time:							
Taken Over By Name :							
Signature / ID :							
Date:							
Time:							

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NURSING CARE RECORD

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Date: 18/7/26

Goals

- ☐ Maintain Airway and Oxygenation
- ☐ Maintain Personal Hygiene
- ☐ Identify Potential Complications
- ☐ Relieve Pain & Discomfort
- ☐ Prevent Infection
- ☐ Any Others. Specify..... Nil
- ☐ 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	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon	7:00 pm	- Ensure safety		- side rail kept up	- prevent from fall risk	- patient is stable	Manisha 18/7/26 @8pm
Night	9pm → W/f Seizures → Ensure Safety		4pm	→ No seizures activity in night. → Side Rails kept up	→ baby is stable. → Prevent from fall Risk	Patient is Stable	Veronika 19/7 @8am

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NURSING CARE RECORD

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Date: 19/7.

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	Discharge notes :- for advice for discharge.			Gave for round patient is stable.			
Afternoon					Noted by Dr. 10AM 19/7/23		
Night							

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THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE 18/7	DATE 18/7	DATE 19/7	DATE 19/7	DATE 19/7
Age	Less than 3 years old	4	4	4	4	4	4
	3 to less than 7 years old	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	4	4	4	4	4
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1					
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2	2	2	2	2	2
	Oriented to own ability	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	2	2	2	2	2
	More than 48 hours/ None	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		10 17	17	17	17	17

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 seat	X		X	X	X	X
Other Intervention(s) Specify			✓	✓	✓	✓
Nurse's Name:	Archit		manisha	Beneeta	Beneeta	Linda
Signature:	AS		M	Bmita	Bmita	Linda
Date:	18/7		18/7	19/7	19/7	19/7
Time:	6:30 PM		7:00pm	8am	8am	10am

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CHECKLIST FOR THROMBOPHLEBITIS

Ch... Hosp...
It takes a lot to ...

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3		
				M	E	N	M	E	N	M	E	N
1	IV site appears healthy	No signs of phlebitis / Observe cannula	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 cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5		–	–	–					
		Signature of the Nurse			~~Ts~~ Bmij	ϕ						

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.

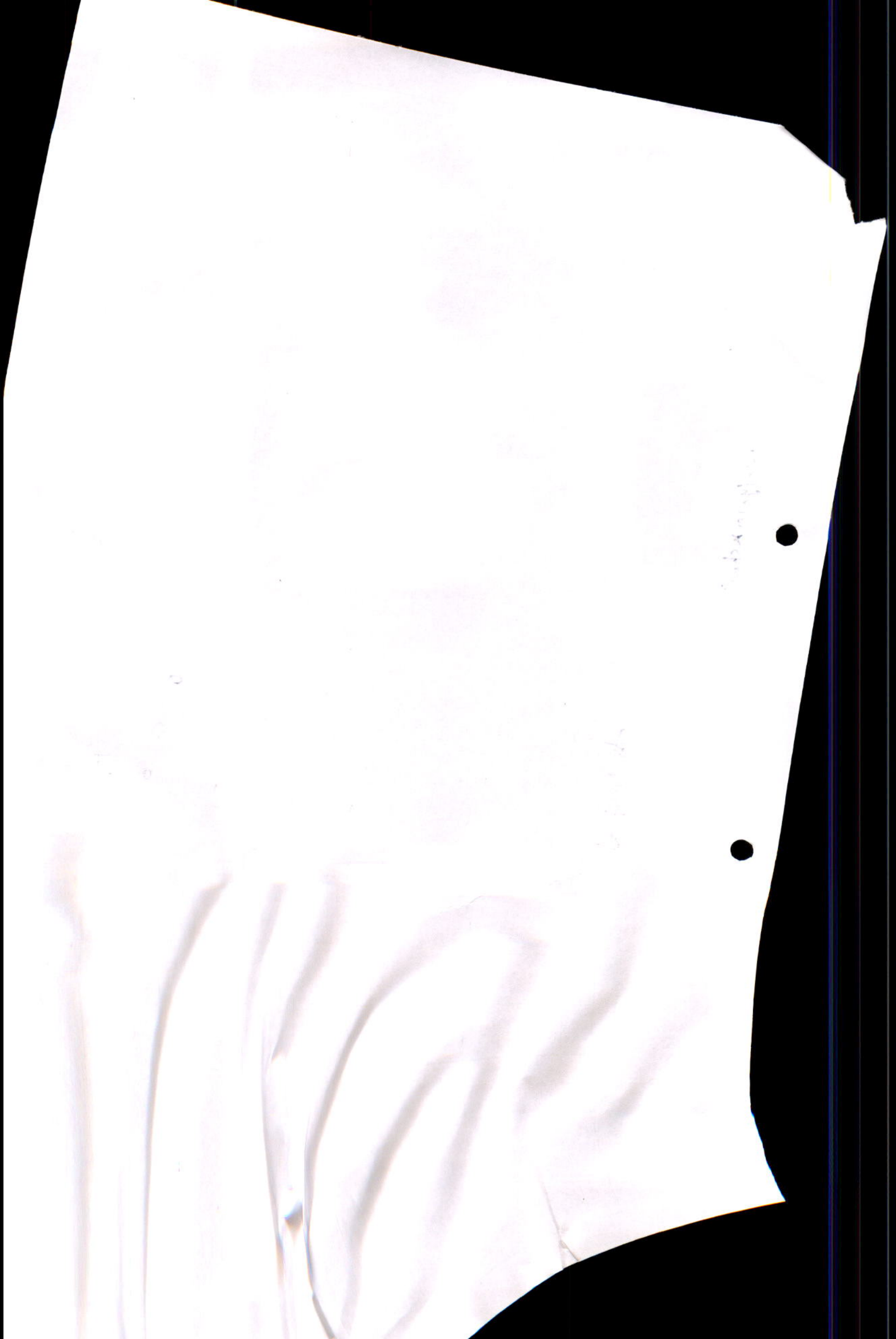
Signature of Shift In Charge :

Signature : ..... Name : Rajyalaxmi

Signature of Ward In Charge :

Signature : eli Name : elizabeth

No. : RCHBH/ FRM / CLINICAL / 137



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Doc. No. : RCH/ FRM / CLINICAL / 125

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

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : ..... Time:	8 pm	10 pm	12 am	2 am	4 am	6 am	8 am
Doctor / Nurse / Family Concern?							
Temperature (°F)	F. 98.6	F. 98.6	F. 98.6	F. 98.6	F. 98.6	F. 98.6	F. 98.6
Heart Rate (bpm) and Blood Pressure (mmHg) *	100/78 (64)	105/(71) 60				100/(77) 63	
Heart Rate (Number)	110	112	108	111	115	110	112
Resp. Rate (bpm) (Over 1 Minute) *							
Resp Rate (Number)	26	30	28	27	29	32	30
Resp Distress: Mod/ Severe / None / Mild	N	N	N	N	N	N	N
Receiving O_2 (l/min) O_2 Saturations (%)	99	98	99	99	15	15	15
Conscious Level: Normal / Altered	N	N	N	N	N	N	N
GCS *	15	15	15	15	15	15	15
TOTAL SCORE Number of shaded boxes	0	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0	0
Observer's Initials	M	B	B	B	B	B	B

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

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

Patient Sticker

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

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PRESCHOOL (1-5 years)

Children's Observation & Early Warning Scoring Chart

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 19/7 Time: 9 AM

Doctor / Nurse / Family Concern?

Temperature (°F): 98.3

Heart Rate (bpm) and Blood Pressure (mmHg) *: 110/70

Note: BP does not score in early warning scoring

Heart Rate (Number): 112

Resp. Rate (bpm) (Over 1 Minute) *: 26

Resp Distress: Mod/ Severe | None / Mild

Receiving O_2 (l/min)

O_2 Saturations (%): 98

Conscious Level: Normal | Altered

GCS *: 15

TOTAL SCORE

Number of shaded boxes: 0

Pain Score: 0

Observer's Initials: Noted by Rudy C 10AM 19/7/24

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

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FLUID CHART

Sheet No. : .....

18/7/26

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

Date	Time	Intake: Nature of Fluid	Intake: Route: Mouth	Intake: Route: I.V	Intake: Route: N.G	Output: NG	Output: Diarrhoea	Output: Vomit	Output: Drainage	Output: Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						**Total Output :**						
18/7/26	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm										1	Manisha 18/7/26 @8pm
Total Intake :						**Total Output :**						
	08:00 pm											
	09:00 pm		rice water									
	10:00 pm									~		
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						**Total Output :**						
19/7/26	02:00 am		water							~	0	Bennika
	03:00 am										1	19/7
	04:00 am											@8am
	05:00 am											
	06:00 am											
	07:00 am									~		
Total Intake :						**Total Output :**						

Total 24 hrs. Intake		Total 24 hrs. Output	

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FLUID CHART

Sheet No. : .....

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

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
19/12	08:00 am		2 Lit water							✓	1	
	09:00 am										0	Rds
	10:00 am											
	11:00 am											19/12
	12:00 pm											
	01:00 pm											
Total Intake :						**Total Output :**						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						**Total Output :**						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						**Total Output :** 19/12						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						**Total Output :**						

Noted by Dr OKAM 19/12

Total 24 hrs. Intake		Total 24 hrs. Output	

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MEDICATION RECONCILIATION FORM

Drug Allergies: ..... ☑ Not known any Drug Allergies

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

Shifting From: ER Shifted to: 138

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. prashanthi

Date & Time : 18/7/26 @ 6:30pM

Nurse Name & Signature: Architha LAs

Date & Time : 18/7/26 @ 6:30 pM

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DRUG CHART

Date of Admission: .... 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 / through it and a similar line through subsequent recording panels.
- The date and time of stopping the drug along with the doctors name and sign must be mentioned.
- Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.

NURSES - Nurses must follow strictly the FIVE RIGHTS before administration of medication.

1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time

- AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

SOS / PRN (As Required Medication)

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

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

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

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

Master GUGLAVATH SHREYANS
04-08-2023 2 Y 11 M 14 D (M)
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IP-00060750 VIH-00206873

I.V. FLUIDS CHART

Weight. 12kgs. Ward. .....

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign

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

04-08-2023 2 Y 11 M 14 D (M)
Dr. GEETHA CHANDA

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

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
18/7	2:39PM	T CLONAZEPAM (0.25 mg)	1 tab	PO		Rajalaxmi / Asha Pillai Rajalaxmi 18/7/23

VIH-00206873 IP-00060750
Master GUGLAVATH SHREYANS
04-08-2023 2 Y 11 M 14 D (M)
Dr. GEETHA CHANDA

REGULAR PRESCRIPTIONS Weight. 12 yr. Ward. ....

DRUG : TAB. CLONAZEPAM				Date ▸ Time ▾	19th
Dose	Route	Frequency	Start Date	6 am	8am Bay Sodidy
0.25 mg	P/O	12 hrly	18/7/26		
Name & Signature of the Doctor Starting the Drugs: Dr. prashanth					
Additional Instructions: 1 tab = 0.25 mg.				6 pm	
Daily Doctor's Endorsement by a Sign					

Rajalaxmi 18/07/26

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

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

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