



MEDICATION RECONCILIATION FORM

Drug Allergies:

☒ Not known any Drug Allergies

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

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

Shifting From: ICU Shifted to: W

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	<u>W Ceftriaxone</u>	<u>1gm</u>	<u>W</u>	<u>24 H</u>		☐ 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 : N. Lakshmi - N. Pr

Date & Time : 6/7/20, 1pm.

Nurse Name & Signature: Keetha K

Date & Time : 06/7/20 @ 1:00pm



DRUG CHART

Date of Admission: 06/07/26 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>SYRUP CROIN DS</u>				Date Time															
Dose <u>5ml</u>	Route <u>PO</u>	Frequency <u>801</u>	Start Date <u>9/7/26</u>																
Doctor's Signature <u>Madhu</u>		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 _____



REGULAR PRESCRIPTIONS

Weight. 14.61 kg Ward.

DRUG: <u>IV. MEROPENEM</u>				Date/Time: <u>6/7 8/2 8/2</u>
Dose: <u>600mg</u>	Route: <u>IV</u>	Frequency: <u>8H</u>	Start Date: <u>6/7</u>	<u>6AM x 5:30pm</u>
Name & Signature of the Doctor Starting the Drugs: <u>N. Prathish</u>				<u>5:30pm</u>
Additional Instructions:				<u>10pm 12am 5:30pm 8:30pm</u>
Daily Doctor's Endorsement by a Sign				
DRUG: <u>IV. METRONIDAZOLE</u>				Date/Time: <u>6/7</u>
Dose: <u>150mg</u>	Route: <u>IV</u>	Frequency: <u>8H</u>	Start Date: <u>6/7</u>	<u>8:30pm</u>
Name & Signature of the Doctor Starting the Drugs: <u>N. Prathish</u>				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
DRUG: <u>IV. AMICACIN</u>				Date/Time: <u>6/7 8/2 8/2 9/7 10/7</u>
Dose: <u>300mg</u>	Route: <u>IV</u>	Frequency: <u>8H</u>	Start Date: <u>6/7</u>	<u>6AM x 5:30pm 8:30pm 11:30pm</u>
Name & Signature of the Doctor Starting the Drugs: <u>N. Prathish</u>				<u>5:30pm 8:30pm 11:30pm</u>
Additional Instructions:				<u>10pm 12am 5:30pm 8:30pm 11:30pm</u>
Daily Doctor's Endorsement by a Sign				
DRUG: <u>T. VORICONAZOLE</u>				Date/Time: <u>6/7 8/2 8/2 9/7</u>
Dose: <u>213mg</u>	Route: <u>PO</u>	Frequency: <u>12H</u>	Start Date: <u>6/7</u>	<u>10AM x 5:30pm 8:30pm 11:30pm</u>
Name & Signature of the Doctor Starting the Drugs: <u>N. Prathish</u>				<u>5:30pm 8:30pm 11:30pm</u>
Additional Instructions:				<u>10pm 12am 5:30pm 8:30pm 11:30pm</u>
Daily Doctor's Endorsement by a Sign				



Ward

Daily Doctor's Endorsement by a Sign

Daily Doctor's Endorsement by a Sign

Daily Doctor's Endorsement by a Sign

's Endorsement by a Sign

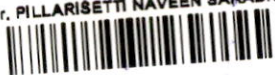
Weight 14.61 Kg Ward

DRUG : 7.1. NS PEB				Date/Time
Dose	Route	Frequency	Start Dt.	
	NEB	12H	6/7	
Name & Signature of the Doctor Starting the Drugs:				
N. Peetwisa.				
Additional Instructions:				
Pulse (2)				
Daily Doctor's Endorsement by a Sign				

DRUG : 7.1. NS NEB				Date/Time
Dose	Route	Frequency	Start Dt.	
100mg NEB		12H	6/7	6/7 7/7 8/7 10/7
Name & Signature of the Doctor Starting the Drugs:				
N. Peetwisa.				
Additional Instructions:				
100mg X 5 times @ 6/7 7/7 8/7 10/7				
Daily Doctor's Endorsement by a Sign				

DRUG : INJ METRONIDAZOLE				Date/Time
Dose	Route	Frequency	Start Dt.	
100mg	IV	TID	6/7/28	6/7 8/7 9/7 10/7
Name & Signature of the Doctor Starting the Drugs:				
[Signature]				
Additional Instructions:				
(100ml = 500mg) 100mg X 3 times @ 6/7 8/7 9/7 10/7				
Daily Doctor's Endorsement by a Sign				

DRUG : INJ PARACETAMOL				Date/Time
Dose	Route	Frequency	Start Dt.	
200mg	IV	TID	6/7/28	6/7 8/7 9/7 10/7
Name & Signature of the Doctor Starting the Drugs:				
[Signature]				
Additional Instructions:				
200mg X 3 times @ 6/7 8/7 9/7 10/7				
Daily Doctor's Endorsement by a Sign				



Sheet No:

REGULAR PRESCRIPTIONS

Weight 14.6 kg Ward

DRUG : ZLD DROPS				Date/Time	7/7/2020 9/6
Dose	Route	Frequency	Start Dt.		
1ml	PO	24h	7/7		
Name & Signature of the Doctor Starting the Drugs:				Somashtree	
Additional Instructions:				1ml = 20mg	
Daily Doctor's Endorsement by a Sign					
DRUG : CANDID MOUTH PAINT				Date/Time	7/7/2020 9/6
Dose	Route	Frequency	Start Dt.		
local application	TID	7/7	6pm		
Name & Signature of the Doctor Starting the Drugs:				Somashtree	
Additional Instructions:				apply locally on tongue	
Daily Doctor's Endorsement by a Sign					
DRUG : ZYTEE - L GEL				Date/Time	7/7/2020 9/6
Dose	Route	Frequency	Start Dt.		
local application	TID	7/7	6pm		
Name & Signature of the Doctor Starting the Drugs:				Somashtree	
Additional Instructions:				apply locally on ulcers	
Daily Doctor's Endorsement by a Sign					
DRUG : TAB. SEPTTRAN DS				Date/Time	7/7/2020 9/6
Dose	Route	Frequency	Start Dt.		
1/2 tab	PO	12 H	8/7		
Name & Signature of the Doctor Starting the Drugs:				Somashtree	
Additional Instructions:				TAP = 80mg per tablet 1 tab = 160 mg/tablet	
Daily Doctor's Endorsement by a Sign					



Weight Ward

VERIFIED BY : Name

Weight. Ward.

VARIABLE DOSE		Date Time							
				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.		Nurse Sig.		
DRUG :			Dose		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

[illegible]



Weight. 14.61 kg Ward.

[illegible]

Signature _____

BAH-00454738 IP5-00176033
 Baby JUVERIYA FATIMA BAQUER
 08-10-2020 5 Y 9 M 1 D (F)
 Dr. PILLARISETTI NAVEEN SARADHI

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

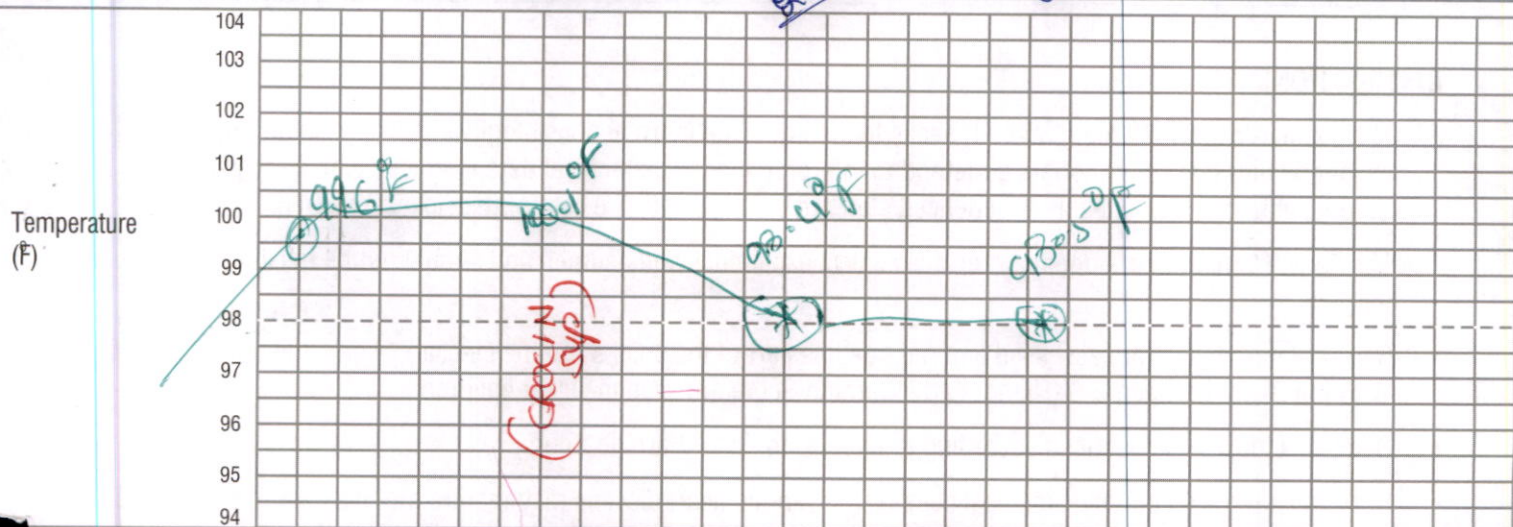
BirthRight[™]
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

NEBULISATION CHART

Date	Time	Drug	Nurse	Parents Signature
10/7/26	00.00	Neb-063-levoflo	(3)	
	01.00	12am, 6am	Appu	
	02.00	14pm Neb 7.1 7am		
	03.00			
	04.00			
	05.00			
	06.00			
	07.00			
	08.00			
	09.00			
	10.00			
	11.00			
	12.00			
	13.00			
	14.00			
	15.00			
	16.00			
	17.00			
	18.00			
	19.00			
	20.00			
	21.00			
	22.00			
	23.00			

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 9/2 Time: 6pm 11pm 10p 6am
 Doctor / Nurse / Family Concern?

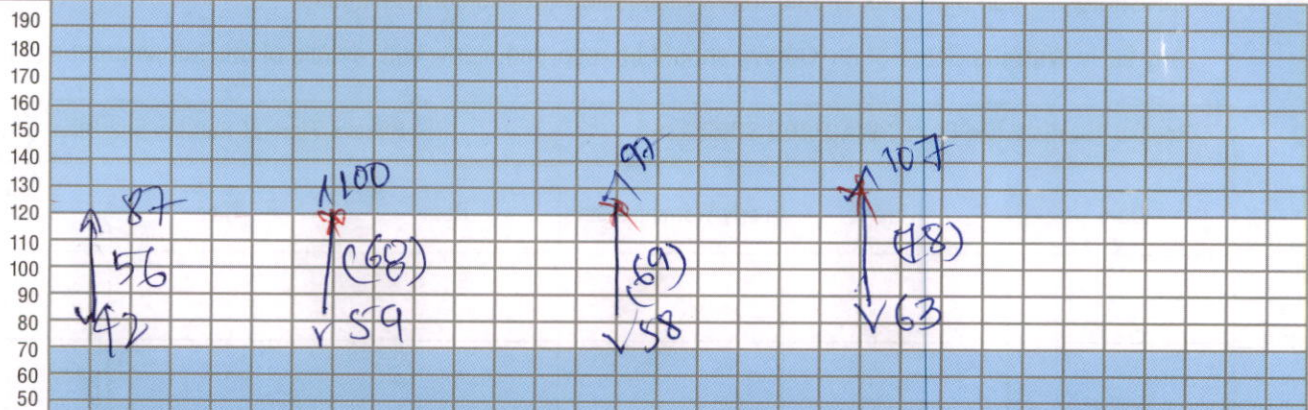


Heart Rate (bpm)

and

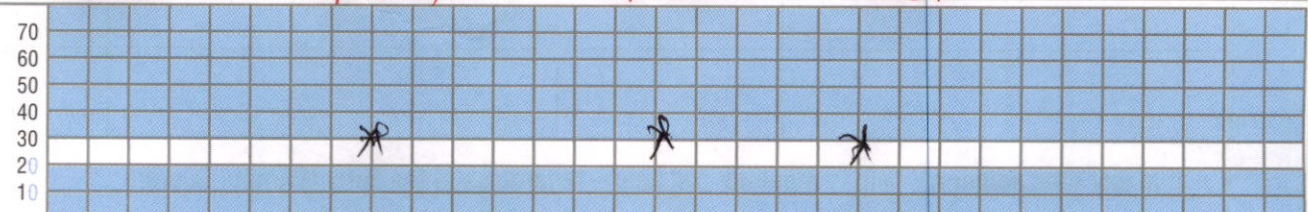
Blood Pressure (mmHg) *

Note:
 BP does not score in early warning scoring



Heart Rate (Number) 118bpm 112bpm 115bpm 116bpm

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



Resp Rate (Number) 25bpm 26bpm 26bpm 27bpm

Resp Mod/ Severe Distress None / Mild

Receiving O₂ (l/min) O₂ Saturations (%) 92% 98% 99% 97%

Conscious Level Normal Altered

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

TOTAL SCORE

Number of shaded boxes 0 1 1 1

Pain Score 0 0 0 0

Observer's Initials 2 2 2 2

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

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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EARLY WARNING SCORE: CHILDREN'S UNIT

Date :	Time: 8:20	10PM	2AM	6AM	10am	4pm	6PM								
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	130	120	110	100	90	80	70	60	50
and															
Blood Pressure (mmHg) *	103	97	95	95	90	87	98								
Note: BP does not score in early warning scoring	103 (99) ↓ 68	97 (92) ↓ 57	95 (90) ↓ 61	95 (90) ↓ 58	90 (85) ↓ 59	87 (82) ↓ 64	98 (93) ↓ 84								
Heart Rate (Number)	120b/m	128b/m		121b/m			102b/m								
Resp. Rate (bpm) (per 1 Minute) *	70	60	50	40	30	20	10								
Resp Rate (Number)	25b/m	26b/m	27b/m	28b/m			28b/m								
Resp Mod/ Severe Distress None / Mild															
Receiving O ₂ (l/min) O ₂ Saturations (%)	100%	100%	99%	100%			100%								
Conscious Level Normal Altered															
GCS *	15/15	15/15	15/15	15/15			15/15								
TOTAL SCORE															
Number of shaded boxes	1	1	1	1			1								
Pain Score	5	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
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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

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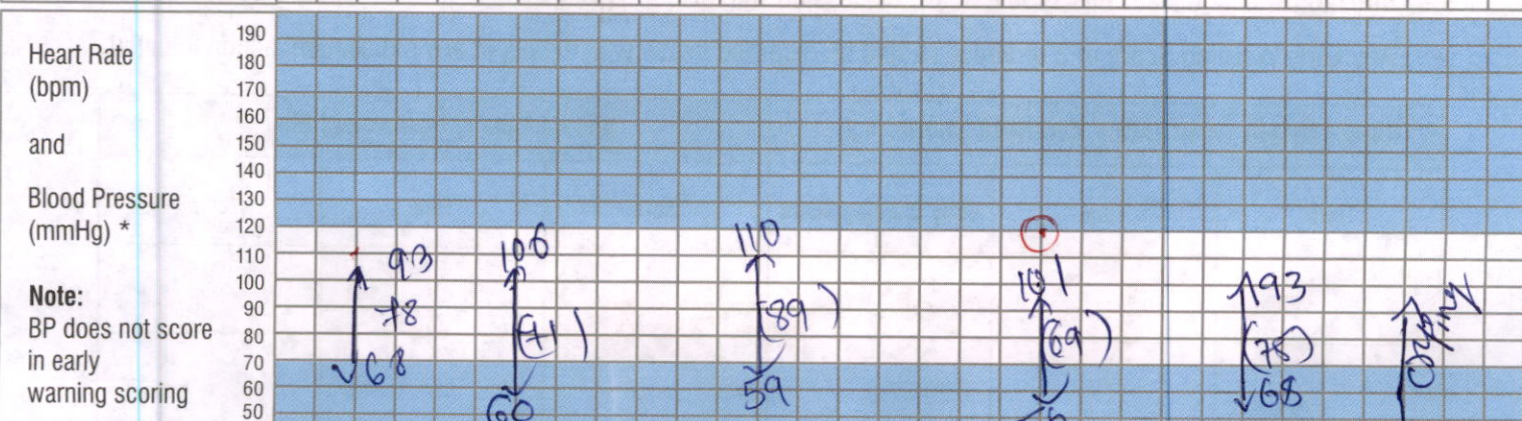
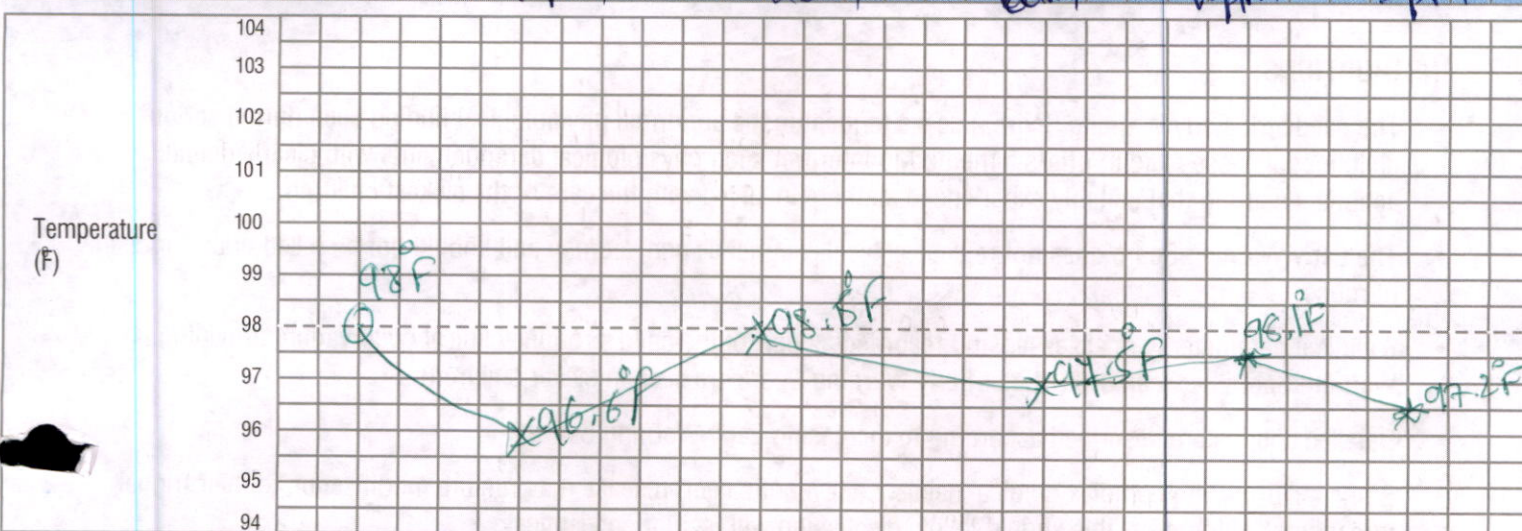
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B	BACK GROUND : Child (X) was admitted on (XX date) with (e.g. respiratory infection). They have had (X operation/ procedure/ investigation). Child (X)'s condition has changed in the last (XX mins). Their last set of observations were (XXX). The child's 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)



EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 6/2 Time: 5pm 7/7/20

Doctor / Nurse / Family Concern? 10pm 2am 6am 10pm 1pm



Heart Rate (Number) 110bpm 115bpm 103bpm 120bpm 111bpm



Resp Rate (Number) 24bpm 28bpm 24bpm 28bpm 26bpm 28bpm

Resp Distress Mod/ Severe None / Mild

Receiving O₂ (l/min) O₂ Saturations (%) 96% 97% 100% 100% 99%

Conscious Level Normal Altered

GCS * 15/15 15/15 15/15 15/15 10/10 15/15

TOTAL SCORE Number of shaded boxes 0 1 1 1 1 1

Pain Score 0 0 0 0 0 0

Observer's Initials

ACTIONS
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 Score 1 : Continue normal observation by staff nurse
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- Any Early Warning Score of 3 or above should be recorded below with details of any subsequent action initiated

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

- If at any time additional help is required, call help – regardless of the Early Warning Score!
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FLUID CHART

Sheet No. :

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

Date	Time	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
		Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :					Total Output :							
	02:00 pm											
	03:00 pm											
	04:00 pm	rice		40ml								
	05:00 pm	rice		40ml								
	06:00 pm	rice		40ml								
	07:00 pm											
Total Intake :					Total Output :							
	08:00 pm			40ml								
	09:00 pm			40ml								
	10:00 pm	rice		40ml								
	11:00 pm	rice		40ml								
	12:00 am			40ml								
	01:00 am			40ml								
Total Intake :					Total Output :							
	02:00 am			40ml								
	03:00 am			40ml								
	04:00 am	rice		40ml								
	05:00 am	rice		40ml								
	06:00 am			40ml								
	07:00 am			40ml								
Total Intake :					Total Output :							
Total 24 hrs. Intake					Total 24 hrs. Output							



FLUID CHART

Sheet No. :

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
7/2	08:00 am			40ml	/						0	R	
	09:00 am	ONS		40ml	/						0		
	10:00 am	+MVT		40ml	/	NP					0		
	11:00 am	2ml			/						0		
	12:00 pm				/						0		
	01:00 pm			40ml	/						0		
Total Intake :						Total Output :							
7/7	02:00 pm				/						0	R	
	03:00 pm				/						0		
	04:00 pm	ONS			/	NP					0		
	05:00 pm	+MVT		20ml	/						0		
	06:00 pm	2ml			/						0		
	07:00 pm				/						0		
Total Intake :						Total Output :							
7/7	08:00 pm			20ml	/						0	R	
	09:00 pm			20ml	/						0		
	10:00 pm	ONS			/						0		
	11:00 pm	+MVT			/						0		
	12:00 am	2ml		20ml	/						0		
	01:00 am			20ml	/						0		
Total Intake :						Total Output :							
8/7	02:00 am			20ml	/						0	R	
	03:00 am			20ml	/						0		
	04:00 am	ONS		20ml	/						0		
	05:00 am	+MVT		20ml	/						0		
	06:00 am	2ml			/						0		
	07:00 am				/						0		
Total Intake :						Total Output :							

Total 24 hrs. Intake

Total 24 hrs. Output



FLUID CHART

Sheet No. :

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

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
8/7			Mouth	I.V	N.G	/			/		0	[Signature]
	08:00 am	↑				/			/	✓	0	
	09:00 am			20ml		/			/		0	
	10:00 am	↓		20ml		/			/		0	
	11:00 am	↓		20ml		/			/		0	
	12:00 pm	↓		-		/			/		0	
Total Intake :						Total Output :						
08/07	02:00 pm			-		/			/	✓	0	[Signature]
	03:00 pm			20ml		/			/		0	
	04:00 pm	↓		20ml		/			/		0	
	05:00 pm	↓		20ml		/			/		0	
	06:00 pm	↓		-		/			/		0	
	07:00 pm			-		/			/		0	
Total Intake :						Total Output :						
8/7	08:00 pm			20ml		/			/		0	[Signature]
	09:00 pm			20ml		/			/		0	
	10:00 pm	↓		-		/			/	✓	0	
	11:00 pm	↓		-		/			/		0	
	12:00 am	↓		20ml		/			/		0	
	01:00 am			20ml		/			/		0	
Total Intake :						Total Output :						
9/7	02:00 am			20ml		/			/		0	[Signature]
	03:00 am	↓		20ml		/			/	✓	0	
	04:00 am	↓		20ml		/			/		0	
	05:00 am	↓		20ml		/			/		0	
	06:00 am			-		/			/		0	
	07:00 am			-		/			/		0	
Total Intake :						Total Output :						
Total 24 hrs. Intake						Total 24 hrs. Output						



FLUID CHART

Sheet No. :

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

		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								
9/7	08:00 am	1	Milk	/	/	/	/	/	/	/	/	/	/
	09:00 am	1											
	10:00 am	1											
	11:00 am	1											
	12:00 pm	1											
	01:00 pm	1											
Total Intake :						Total Output :							
9/7	02:00 pm	1	Rice Panner	/	/	/	/	/	/	/	/	/	/
	03:00 pm	1											
	04:00 pm	1											
	05:00 pm	1											
	06:00 pm	1											
	07:00 pm	1											
Total Intake :						Total Output :							
9/7	08:00 pm	1	/	/	/	/	/	/	/	/	/	/	/
	09:00 pm	1											
	10:00 pm	1											
	11:00 pm	1											
	12:00 am	1											
	01:00 am	1											
Total Intake :						Total Output :							
10/7	02:00 am	1	/	/	/	/	/	/	/	/	/	/	/
	03:00 am	1											
	04:00 am	1											
	05:00 am	1											
	06:00 am	1											
	07:00 am	1											
Total Intake :						Total Output :							

Total 24 hrs. Intake

Total 24 hrs. Output



NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 6/21/20

Assessment: Baby having discomfort due to ulcer.

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 general condition of the baby.	2.30pm	Assessed the general condition of the baby.	Implemented all the procedure.
3pm	Administer medication as per doctor order.	3.30pm	Administered medication as per doctor order.	
4pm	Continue IV fluids	4.30pm	Continued IV fluids	
5pm	Monitor vital signs	5.30pm	Monitored vital signs	
6pm	Give nebulisation	7pm	Given nebulisation.	

Re-Assessment:

Special Notes:

Nurse Signature: Mellin Nurse Name: Merlin Date & Time: 6/21/20 @ 8pm

BAH-00454738 IP5-00176033
 Baby JUVERIYA FATIMA BAQUER
 08-10-2020 5 Y 8 M 28 D (F)
 Dr. PILLARISETTI NAVEEN SARADHI



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 6/7/26

Assessment: Baby 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 general condition of the patient	9pm	Assessed the general condition of the patient	Baby Condition is good
10pm	monitor the vitals signs	11pm	monitored the vitals signs	
12a	maintain I/O chart		maintained I/O chart	
1a	Administer medication as per as chart	2a	Administered medication as per as chart	
4a	maintain fluid balance	5a	maintained fluid balance	
6a	Ensure the patient safety	7a	Ensured the patient safety	

Re-Assessment: Re Assessment

Special Notes:

Nurse Signature: [Signature]

Nurse Name: Swarna

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

NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 7/07/26

Assessment: Baby 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
8am	→ ASSESS the baby general condition & monitor the vital sign.	8:30 am	→ Assessed the baby general condition & monitored the vital sign.	Baby condition is improved
10am	→ Maintain the I/O chart	10:30 am	→ Maintained the I/O chart	
11am	→ Administer the medication as per doctor order	11:30 am	→ Administered the medication as per doctor order	
12pm	→ provide the comfortable position	12:30 pm	→ provided the comfortable position.	
1pm	→ Given Nebulization.	1pm	→ Given Nebulization.	

Re-Assessment:

Special Notes: chest physiotherapy

Nurse Signature: V. Ravina

Nurse Name: V. Ravina (607729)

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

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Baby JUVERIYA FATIMA BAQUER
08-10-2020 5 Y 8 M 28 D (F)
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NURSING CARE RECORD

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Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 7/7/26

Assessment: Baby having dull 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
2pm	Assess pt condition	2:10pm	Assessed pt condition	=> pt condition is normal
4pm	monitor vitals and record	4:30pm	monitored vitals and recorded	
6pm	maintain BLO chart	5:10pm	maintained BLO chart	
8pm	Administer medications as per doctor's order	8:30	Administered IV fluids as per doctor's order	

Re-Assessment:

Special Notes:

Nurse Signature: shirisha

Nurse Name: Shirisha

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

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 Baby JUVERIYA FATIMA BAQUER
 08-10-2020 5 Y 8 M 30 D (F)
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NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 7/7/26

Assessment: Pt having discomfort

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	8PM	→ Assessed Pt General condition	Pt condition is normal
10PM	→ monitor vital signs	10PM	→ monitored vital signs	
2AM	→ maintain I/O chart	2AM	→ maintained I/O chart	
8AM	→ Administer the medications as per doctors order.	8AM	→ Administered the medications as per doctors order.	

Re-Assessment: 12PM

Special Notes:

Nurse Signature: [Signature]

Nurse Name: Sruvanti

Date & Time: 8/7/26 8AM

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 Baby JUVERIYA FATIMA BAQUER
 08-10-2020 5 Y 8 M 30 D (F)
 Dr. PILLARISETTI NAVEEN SARADHI

NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 8/7/26

Assessment:

Baby having some respiratory distress

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 pt general condition.	8:10a	Assessed pt general condition,	By done above all the care pt condition is normal
6am	provide comfortable position.	10:10am	provided comfortable position.	
	monitor vital signs.		monitored vitals & recorded.	
	maintain 1/2 chest		maintained 1/2 chest	
12pm	Ensure safety.	12:10pm	Ensured safety.	
	today doctor's round done		Gave nebulization at 12pm.	
	suggest to do chest physiotherapy		Administered medication	
2pm	& vest therapy.	2:10pm	as per chart	
	Administer medications as per chart			

Re-Assessment:

Monitored vitals & maintained 1/2 chest (Dil + Polysion 2ml)

Special Notes:

today plan (chest physio therapy & vest therapy)

Nurse Signature:

[Signature]

Nurse Name:

Akitha Goleen

Date & Time:

8/7/26 (@ 2pm)



NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 8/7/26

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
2pm	Assess the general condition of the baby.	2:30pm	Assessed the general condition of the baby	Simplified all the procedure
3pm	continue w fluids.	3:20pm	Continued w fluids	
4pm	Give nebulisation	4:30pm	Given nebulisation.	
5pm	Administer medication as per doctor order.	5:30pm	Administered medication as per doctor order.	
6pm	send sputum cts	6:30pm	Sended sputum cts	
7pm	Monitor vital signs	7:30pm	Monitored vital signs.	

Re-Assessment:

Special Notes:

Nurse Signature:

Gravanthi

Nurse Name:

Gravanthi

Date & Time:

8/7/26 @ 8pm

BAH-00454738 IP5-00176033
 Baby JUVERIYA FATIMA BAQUER
 08-10-2020 5 Y 8 M 30 D (F)
 Dr. PILLARISETTI NAVEEN SARADHI



NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 8/7/26

Assessment: pt having full 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.	
9PM	Maintain I/O chart	9PM	Maintained I/O chart	
8PM	Administer the medications as per doctors order.	8PM	Administered the medications as per doctors order.	

Re-Assessment: NIL

Special Notes:

Nurse Signature:

Nurse Name: Swathi

Date & Time: 9/7/26 8PM

BAH-00454738 IP5-00176033
 Baby JUVERIYA FATIMA BAQUER
 08-10-2020 5 Y 9 M 0 D (F)
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NURSING CARE RECORD

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Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 9/17

Assessment: Baby having discom fast

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 baby general condition	9:00am	→ Assessed the baby general condition	baby condition is improve
10am	→ monitor the vital's	10:00am	→ monitored the vital's	
12pm	→ Provide Comfortable Position	12:12pm	→ Provided Comfortable Position	
4pm	→ Administer medication as per doctor order's	4:12pm	→ Administered medication as per doctor order's	

Re-Assessment:

Special Notes:

Nurse Signature: Srishe

Nurse Name: Srishe

Date & Time: 9/17 2pm

BAH-00454738 IP5-00176033
 Baby JUVERIYA FATIMA BAQUER
 08-10-2020 5 Y 9 M 0 D (F)
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Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 9/7/22

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
2pm	Assess the general condition of the baby.	2.30pm	Assessed the general condition of the baby.	Implement all the procedure
3pm	stop IV fluids.	3.30pm	stopped IV fluids	
4pm	provide comfortable position	4.30pm	provided comfortable position	
5pm	Encourage to take orally.	5.20pm	Encouraged to take orally.	
6pm	Administer medication as per doctor order.	6.30pm	Administered medication as per doctor order.	
7pm	Monitor vital signs.	7.30pm	Monitored vital signs.	

Re-Assessment:

Special Notes:

Nurse Signature: Melin

Nurse Name: Melin

Date & Time: 9/7/22 @ 8pm

BAH-00454738 IP5-00176033
 Baby JUVERIYA FATIMA BAQUER
 08-10-2020 5 Y 9 M 0 D (F)
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NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 9/7/26

Assessment: Baby Having Cough

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
10pm	→ Assess the Baby General Condition, monitor vital & record	11pm	→ Assessed the Baby General Condition, monitored vital & recorded	By All the done pt conditions improved
12am	→ provide comfortable position	1am	→ provided comfortable position	
3am	→ plan to do Baidhavan man con's	3am	→ planned to do Baidhavan man con's	
4am	→ Give nebulization	5am	→ Given nebulization	
6am	→ Administer medication as per doctor order	8am	→ Administered medication as per doctor order	

Re-Assessment:

Special Notes:

Nurse Signature: [Signature] Nurse Name: Aparajitha (021265) Date & Time: 10/7/26 02am

BAH-00454738 IP5-00176033
 Baby JUVERIYA FATIMA BAQUER (F)
 08-10-2020 5 Y 9 M 0 D
 Dr. PILLARISETTI NAVEEN SARADHI

NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☐ Night

Date:

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

Re-Assessment:

Special Notes:

Nurse Signature:

Nurse Name:

Date & Time:



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Naveen Department: pediatric Date of Admission: 06/7/20

SITUATION	Diagnosis: <u>HSV stonefiliary</u>		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:				
BACKGROUND	Area	Shift Time	<u>3:05pm</u>	<u>3:20pm</u>	<u>3:30pm</u>	<u>3:40pm</u>	<u>3:50pm</u>
	Medical Condition (Any special condition to be noted):		<u>NA</u>	<u>NA</u>	<u>NA</u>	<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°F</u>	<u>98°F</u>	<u>98°F</u>	<u>98.2°F</u>	<u>98.9°F</u>
	Res:	<u>24b/m</u>	<u>24b/m</u>	<u>22b/m</u>	<u>28b/m</u>	<u>25b/m</u>	<u>28b/m</u>
	SpO ₂ :	<u>100%</u>	<u>100%</u>	<u>99%</u>	<u>100%</u>	<u>99%</u>	<u>100%</u>
	Pulse:	<u>100b/m</u>	<u>100b/m</u>	<u>109b/m</u>	<u>102b/m</u>	<u>105b/m</u>	<u>102b/m</u>
	BP:	<u>102/60</u>	<u>102/60</u>	<u>112/60</u>	<u>99/65</u>	<u>107/60</u>	<u>100/59</u>
Fall Risk Score:	<u>10</u>	<u>10</u>	<u>10</u>	<u>10</u>	<u>10</u>	<u>10</u>	
Pain Score:	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	
Recommendations	Safety Needs:		☒	☒	☒	☒	☒
	Physiotherapy		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Others Specify:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<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>	<u>NA</u>	<u>NA</u>	<u>NA</u>
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Handed Over By Name :	<u>Iceiti</u>	<u>Mpelli</u>	<u>Swarnan</u>	<u>Ravina</u>	<u>Shrinika</u>	<u>Swarnan</u>	
Signature :	<u>KJ</u>	<u>M</u>	<u>S</u>	<u>R</u>	<u>S</u>	<u>S</u>	
Date:	<u>06/7</u>	<u>6/7</u>	<u>7/7</u>	<u>7/7</u>	<u>7/7</u>	<u>7/7</u>	
Time:	<u>3:05pm</u>	<u>3:20pm</u>	<u>3:30pm</u>	<u>3:40pm</u>	<u>3:50pm</u>	<u>3:50pm</u>	
Taken Over By Name :	<u>Mpelli</u>	<u>Swarnan</u>	<u>Ravina</u>	<u>Shrinika</u>	<u>Swarnan</u>	<u>Ankita</u>	
Signature :	<u>M</u>	<u>S</u>	<u>R</u>	<u>S</u>	<u>S</u>	<u>A</u>	
Date:	<u>6/7</u>	<u>6/7</u>	<u>7/7</u>	<u>7/7</u>	<u>7/7</u>	<u>8/7</u>	
Time:	<u>3:30pm</u>	<u>3:40pm</u>	<u>3:50pm</u>	<u>3:50pm</u>	<u>3:50pm</u>	<u>3:50pm</u>	

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. PMS Department: Neonatology Date of Admission: 06/07/26

SITUATION		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:						
BACKGROUND	Diagnosis:	<u>Asp. HSI stomatitis</u>						
	Area	<u>1st floor</u>	<u>1st floor</u>	<u>1st floor</u>	<u>1st floor</u>	<u>1st floor</u>	<u>1st floor</u>	
BACKGROUND	Shift Time	<u>8am-2pm</u>	<u>2pm-8pm</u>	<u>8pm-2am</u>	<u>2am-8am</u>	<u>8am-2pm</u>	<u>2pm-8pm</u>	
	Medical Condition (Any special condition to be noted):	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
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:	<u>97.5°F</u>	<u>99.1°F</u>	<u>98.1°F</u>	<u>98.5°F</u>	<u>98°F</u>	<u>98.5°F</u>
		Res:	<u>26</u>	<u>26</u>	<u>28b/m</u>	<u>25b/m</u>	<u>25</u>	<u>26b/m</u>
		SpO ₂ :	<u>99%</u>	<u>99%</u>	<u>100%</u>	<u>99%</u>	<u>97</u>	<u>99%</u>
		Pulse:	<u>112b/m</u>	<u>120b/m</u>	<u>112b/m</u>	<u>107b/m</u>	<u>118</u>	<u>111b/m</u>
		BP:	<u>96/80</u>	<u>98/51</u>	<u>95/59</u>	<u>101/60</u>	<u>87/42</u>	<u>90/60</u>
		Fall Risk Score:	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>
Pain Score:	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>		
Recommendations	Safety Needs:	<u>Yes</u>	<u>Yes</u>	<u>Yes</u>	<u>Yes</u>	<u>Yes</u>	<u>Yes</u>	
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Other Special Orders / Medications:	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Handed Over By Name :		<u>Anitha</u>	<u>K. Braanthi</u>	<u>Sowathi</u>	<u>Sarsha</u>	<u>Merlin</u>	<u>Aparna</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>8/7</u>	<u>08/07/26</u>	<u>9/7/26</u>	<u>9/7</u>	<u>9/7</u>	<u>10/7</u>	
Time:		<u>2pm</u>	<u>8pm</u>	<u>8am</u>	<u>2pm</u>	<u>8pm</u>	<u>8am</u>	
Taken Over By Name :		<u>K. Braanthi</u>	<u>Sowathi</u>	<u>Sarsha</u>	<u>Merlin</u>	<u>Aparna</u>	<u>Shanthi</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>08/07/26</u>	<u>8/7/26</u>	<u>9/7</u>	<u>9/7</u>	<u>9/7</u>	<u>10/7</u>	
Time:		<u>2pm</u>	<u>8pm</u>	<u>8am</u>	<u>2pm</u>	<u>8pm</u>	<u>8am</u>	

BAH-00454738
 Baby JUVERIYA FATIMA BAQUER
 08-10-2020 5 Y 9 M 0 D
 Dr. PILLARISETTI NAVEEN SARADHI (F)

PAIN ASSESSMENT FORM

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

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

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
10/2	12am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Appu
10/2	8am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Appu
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

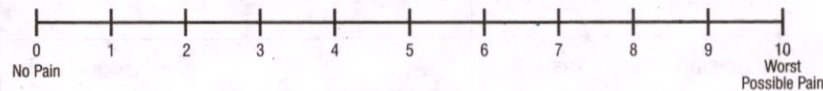
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

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

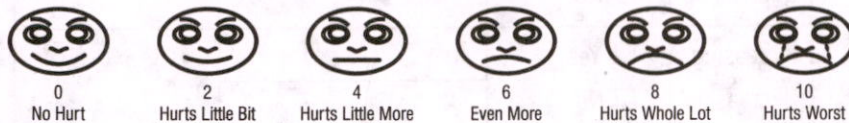
Numerical Pain Scale (Obstetric and Gynecology)



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





PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
06/7	2pm	0/10	Nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	Keethi
6/7	10pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	Nil/12
7/7	8am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Pr
7/7	4pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	smooth
8/7	12AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	smooth
8/7	8am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	Pr
8/7	4pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Graus
9/7	12AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	smooth
9/7	8AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	smooth
9/7	4pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Medi's

Re-assessment Frequency:

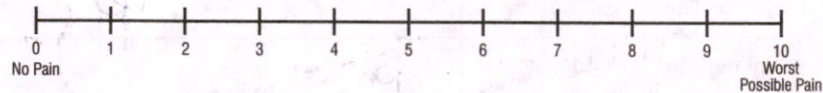
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

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 brawn 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



BRADEN 'Q' SCALE

					Date : 10/12			
					Time : 6am			
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4			
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4			
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4			
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4			
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			
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			
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			
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23					TOTAL SCORE	24		
Docu. No. : RCHBH /FRM / CLINICAL / 119					Evaluator's Name	Appu		

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

BAH-00454738
Baby JUVERIYA FATIMA BAQUER
08-10-2020 5 Y 8 M 28 D
Dr. PILLARISETTI NAVEEN SARADHI (F)

BRADEN 'Q' SCALE

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

				Date:	08/12	2/12	8/27	9/17
				Time:	2pm	8	8:45	6AM
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.tremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	9	4	4	2
"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.	9	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.	9	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.	9	4	4	4
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	9	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.	9	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
TOTAL SCORE					28	28	28	28
Evaluator's Name					Kee...	...	...	...

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

Docu. No. : RCHBH/FRM / CLINICAL / 119

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

Patier



THE HUMPTY DUMPTY SCALE

06/7 2/7 8/7 9/7 10/7

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					
	Female	1	1	1	1	1	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			10	10	10	10	10

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	✓	no	no	no	no
Other Intervention(s) Specify	✓	no	no	no	no
Nurse's Name :	Reed	Nina	Saath	Saath	Appu
Signature :	Reed	Nina	Saath	Saath	Appu
Date :	06/7	2/7	8/7	9/7	10/7
Time :	1pm	6pm	6pm	6pm	6pm



ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____ IP No : _____ Consultant: _____ Dept : _____

Date of Admission: _____ Time : _____ Date of Discharge : _____ Time: _____

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
06/7	3:05pm	ER	115	Kaeth

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	Dr. Khurshaid Shaik	10/7/26	9692629	Souravathi
2	Dr. Brundavan	9/7/26	9694807	Souravathi
3	Dr. Poornima	9/7/26	9694807	Souravathi
4				
5				
6				
7				
8				
9				
10				

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
06/07	iv placement	1	90205	Tenup
7/7	NHA	1	9691561	Q
8/7	VEST THERAPY	1	961520	Socuneth

ANY OTHER INFORMATION

① x-ray

Date : 10/07/16

Time : 10:00am

Prepared By : shanth

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
shanth	SP V5		

ADMISSION SHEET

Registration Details :

Admission No : IP5-00176033

Admit Date : 06-Jul-2026

Admit Time : 01:06 PM **UHID** : BAH-00454738

Patient Details :
Patient Name : Baby JUVERIYA FATIMA BAQUER

Age : 5 Y 8 M 28 D

Guardian : Mr MOHAMMED BAQUER

DOB : 08-10-2020

Gender : Female

Religion : Muslim

Occupation :

Martial Status : Single

Address (H) : H NO 8-3-833/144, PHASE 3, BESIDE UNION
 BANK Kamala Puri Colony Hyderabad
 Telangana INDIA 500073

Phone No : 9052865128/ 9010417786

E-mail : NOMAIL@GMAIL.COM

Admission Details :
Bed Type : SEMI PRIVATE

Bed No : SPVT 115

Ward Name : 1F-VIBGYOR

Room No : SPVT 115

Admission Type : First Visit

Contact Details :
Name : Mr MOHAMMED BAQUER

Relationship : Father

Contact Address : H NO 8-3-833/144, PHASE 3, BESIDE UNION
 BANK Kamala Puri Colony Hyderabad Telangana
 INDIA 500073

Phone No : 9052865128 / 9052865128

B. name
 Signature

Doctor Details :
Doctor Name : Dr. PILLARISETTI NAVEEN SARADHI

Specialisation : PULMONOLOGY

Referral Doctor : SELF

Phone No :

Co-Consultant : Dr. SHRUTI KOTAPALLI

Payment Details :
Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : CARE HEALTH INSURANCE LIMITED



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PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name:

Juveria fatima Baquer

UHID ID:

BAH-00454738 IP5-00176033
Baby JUVERIYA FATIMA BAQUER
08-10-2020 5 Y 8 M 28 D (F)
Dr. PILLARISETTI NAVEEN SARADHI

Department:



Consultant:



Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

40 fever : 2 day

extensive oral ulcers.

poor oral intake.

History of present illness :

40 cough/cold : 2 weeks.

0/E - tongue ulcers

stomatitis @.



Pediatric Multiorgan History & Physical Examination

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

Birth & Neonatal History:

present neonatal trauma

Birth & Socio Economic History:

About Father :

About Mother :

Any additional Information :

Developmental History :

present for age

Immunization History :

Immunized till age 5



Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs)) 14.61 (Centile _____)

On Examination :

Temperature : 98°F Pulse Rate: 130/min B.P. 102/62 (7) 98% SpO2

Resp. rate and type of breathing : 26/min

Rash _____

Lymphadenopathy _____

Oedema : _____

Allergies (if any): _____

Respiratory System :

Inspection (any s/o distress) : _____

Air entry & breath sounds : _____

Any addes sounds : _____

Relevant data from outside (Chest X-Ray, ABG, etc.,) Sp. up to B

wheez B

Cardiovascular System :

Inspection of procordium : _____

Heart Sounds : _____

Any murmur : _____

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

Per Abdomen :

Inspection _____

Palpation : _____

Ausculation : _____

Spine : _____ External Genitelia : Sp. up to B

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



Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : _____

Cranial Nerves : _____

Motor System:

Nutriton : _____

Tone: _____ Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR

Plantars _____

Superficials:

Sensory System :

Bladder / Bowel : _____

Clinical Summary & Diagnostic:

severe HSV Encephalitis + poor oral intake



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: _____

Infection

Desired goals of the treatment: _____

Resolution of symptoms

Planned Labs:

- CRP
- CRP
- RFT, ~~HSV serology~~
- B. U. S.
- 2 Extra plain
- HSV serology
- Swab for ~~Gram stain, KOH~~
 ~~stain~~
 N/B
 Temp
 6/7/26

Planned Management

- fluids
- IV med
- IV metronidazole
- IV acyclovir
- T. verticillium
- dantrolene
- Zytex
- IV paracetamol
- IV insulin
- 7.1. NS med

Signature of the Doctor: _____

Name of the Doctor: _____

Date & Time: _____

Signature of the Consultant: _____

Name of the Consultant: Dr. Naveen Saradhi

Date & Time: _____

DR. PILLARISETTI NAVEEN SARADHI
 Registrar
 3834



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/1/26 5pm	Severe HSV Mucocutaneous HSV Child alert Not eating well SpO₂ - 99 Chest B/L crepts B/L crepts (+)	Adv ① Trace HSV Serology Swab, C&S ② iv Acyclovir ③ iv Meropenem ④ iv Metronidazole ⑤ Varicazazole
7/1/26 9am	ASIB Dr Naveen Saradhi/ Dr Shwanti Kotapalli No severe mucocutaneous HSV Alert, conscious, GCS-15/15 Afebrile for > 12 hrs Vitals stable SpO₂ - 100% (RA) Chest - B/L crepts, B/L AE + CVS - NAD P/A - soft, non-tender Oral intake poor Crusting of lip ulcers Tongue - ulcers (+)	Adv - Trace HSV 1 & 2 IgM + IgG, Swab c/s. - Acyclovir - Meropenem - Metronidazole - Varicazazole - PCM 71D - Candid / Zytex-L gel / Pantop - Neb - Kenolin - 7% NS - Chest physiotherapy - Chest X ray PA view - 2 & D drops

DR. PILLARISETTI NAVEEN SARADHI
Registration No: 38883



PROGRESS NOTES AND DOCTOR'S ORDER

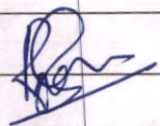
Date & Time	Progress Notes	Doctor's Order
7/7/26 4:30 pm	CL/B Dr. Shreuti Kotapalli Afebrile Vitals stable SpO₂ - 99% (RA) Chest - Rt-sided crepts, B/L AE + Oral ulcers healing Oral intake improved	Adv - Trace swabs c/s - continue same - IV fluid → 1/2 maintenance change IV cannula
8/7/26 9:00 am	CL/B Dr. Naveen Saradhi Dr. Shreuti Kotapalli Assis: Severe mucocutaneous HSV. No fever vitals stable SpO₂ - 100% Chest: B/L crepts (+) Oral ulcers reduced. CVS: S₂ (+) P/A: soft CNS: conscious.	Adv:- Continue • Inj meropenem - D₃ • Inj Acyclovir - D₃ • T. Voriconazole - D₃ • Inj metronidazole - D₃ • Inj Pantop / levofloxi Neb / 7% NS Neb / 2 D drops Candid mouth paint / xylee gel • Chest physiotherapy continue • Trace swabs c/s • Vest therapy today • Add Tab Septtran

BAH-00454738
Baby JUVERIYA FATIMA BAQUER
08-10-2020 5 Y 8 M 28 D (F)
Dr. PILLARISETTI NAVEEN SARADHI

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/7/20	CLSB Pulmo team. 6:00 PM ASIS: Severe mucocutaneous HSV. No fever vitals stable SpO ₂ : 100% R.A. chest: B/L crepts (+). Throat swab c/s - No growth.	Adv: - - Send sputum c/s - Culture same. 
9/7/20	CLSB Dr. Shreeth Kotapalli 8:40 AM Severe mucocutaneous HSV. No fever vitals stable SpO ₂ : 100% chest: B/L crepts (+). eye: S/S (+) P/A: soft CNS: conscious.	Adv: - Dr. Bindarani again consultation Continue • Inj meropenem - D4 • Inj Acyclovir - D4 • Inj metronidazole - D4 • T. Voriconazole - D4 • T. Septran - D4. • Inj Pantop / Levofloxac / Flu Ns Neb / Z Z S drops Candid mouth paint / Zylte gel • Chest physiotherapy in morning • Vest therapy today evening • Trace sputum c/s

[illegible]



CROSS CONSULTATION FORM

Doctor Name : Dr. Padma (PT) Date : 8/11/26 Time : 1: pm

Diagnosis : Sever. mucocutaneous Hc v.

Hospital : RCH, Bangalore

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:

Chest physiotherapy

Signature: _____

Findings and Recommendations :

S/B physiotherapist

clo : Sever mucocutaneous Hc v

o/c : child is alert & stable.

Rx : chest percussions = ACBT

- DBex's

- chest supranar su's

Consultant :

Name : Padma (PT) Signature : gura Date & Time : 8/11/26

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Baby JUVERIYA FATIMA BAQUER
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CROSS CONSULTATION FORM

Doctor Name : Khushid. Shaik Date : 7/7/26 Time : 5pm
Diagnosis : Severe mucocutaneous HSV

Hospital : RCH, Bangalore

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:

chest physiotherapy

Signature:

Findings and Recommendations :

8/B physiotherapist

QOI:- Severe mucocutaneous HSV

O/E:- child is alert & stable

SpO₂ - 99% on room-air

oral ulcers +ve

R:- chest percussions => AcBT

- frequent change of position

- Breathing ex^l

Consultant :

Name : Khushid. Shaik Signature : Khushid. Date & Time : 7/7/26, 5pm
(PT)

BAH-00454738 IP5-00176033
Baby JUVERIYA FATIMA BAQUER
08-10-2020 6 Y 8 M 28 D (F)
Dr. PILLARISETTI NAVEEN SARADHI




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RESULT SHEET

Date	6/7/26.				
Time					
Hb	7.4				
PCV	19.520 N ₆₇ L ₂₈				
RBC					
WBC	19520 N ₆₇ L ₂₈				
N/L					
Platelets	4.78L				
CRP	14				
ESR					
PCT					
RBS					
Na					
K					
Cl					
Ca/Mg					
Phosphate					
Urea	14				
Creatinine	0.3				
ALP					
SGPT					
SGOT					
T.Bill/Conj					
T.Protein					
S.Albumin					
S.Globulin					
A/G Ratio					
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein / Sugar					
Cells					
N/L					

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							
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	0	0	0							
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	0	0	0							
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	0	0	0							
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	0	0	0							
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	0	0	0							
Signature of the Nurse				[Signature]									

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.

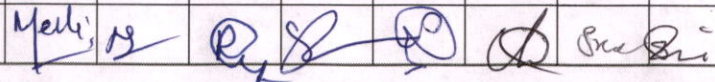
Signature of Shift In Charge :

Signature : [Signature] Name : [Signature]

Signature of Ward In Charge :

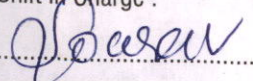
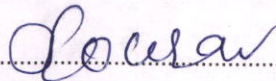
Signature : [Signature] Name : [Signature]

CHECKLIST FOR THROMBOPHLEBITIS

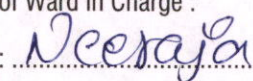
S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0		0	0	0	0	0	0	0		
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first 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													

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 : 

Signature of Ward In Charge :

Signature :  Name : 

BAH-00454738 IP5-00176033
 Baby JUVERIYA FATIMA BAQUER
 08-10-2020 5 Y 8 M 28 D (F)
 Dr. PILLARISETTI NAVEEN SARADHI

DISCHARGE PLANNING FORM

Nationality: as per Indian

NOTES: * To be completed by a NURSE within (24) hours of admission.

1. Anticipated Date of Discharge: as per doctor order.

2. Destination Post Discharge: ☒ Home
 Family Members Notified (Person Contacted)

☐ Transfer
 Hospital Facility Notified (Person Contacted)

3. Discharge Status: ☒ Self Care ☒ Family Home Care ☐ Home Professional Assistance

☒ Needs Assistance In:

Remarks

☒ Medication	☒ Yes	☐ No
☐ Bathing	☐ Yes	☐ No
☐ Eating	☐ Yes	☒ No
☐ Walking	☐ Yes	☒ No
☐ Dressing	☐ Yes	☒ No
☐ Toileting	☐ Yes	☒ No

explains to the

4. Nutritional Plan:

☐ Dietary Instruction Discussed with the:

☐ Patient ☒ Family Member

☐ Others:

5. Discharge Planning Discussed with the:

☐ Patient ☒ Family Member

☐ Others:

6. Patient/Family Educational Plan:

☐ Educational Topic/s: Hand Hygiene

☐ Patient's Educational Topic/s discussed with the:

☐ Patient ☒ Family Member

☐ Others:

Nurse Signature: SL

Nurse Name: Swarany

Date and Time: 7/12/20 @ 3:00pm



NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date: 06/7/26 Time of arrival: 12:00pm Excessive oral clear x 2 weeks
poor oral intake x 1 week

Chief Complaints: Cough & cold 2-3 days fever x 2 days. RBS: Nil

Height: 108 cms Weight: 14.6 kg BMI: Head Circumference (<2 years) Nil

Allergies: ☐ Yes ☒ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other: Nil

If yes, identify

Pain Screening: ☐ Yes ☒ No If Yes, Pain Score: 0/10 Pain Tool Used: ☐ N Pass ☒ FLACC ☐ Wong Baker

☐ Character Nil ☐ Location Nil ☐ Frequency Nil ☐ Duration Nil

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: Nil (Date/Time):

Social History: Lives With parents

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

Cultural & Spiritual Needs: ☐ Yes ☒ No if Yes specify Nil Inform consultant for positive criteria.

Time of Initial assessment completed by ER Nurse: 12:00pm

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

Time	Nursing Notes
12:05 pm	* Assess the child condition.
	* Monitor vital sign's.
	* Seen by Dr. Prathibha.
	* Iv placement Done.

Samples collected by:

Nr. John

Time:

Time:

12pm

Samples sent by :

Medication given in ER:

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

Condition of patient at time of shift - out :	Details of Shift - out
HR: 98b/m BP: 102/60 CFT: 62% RR: 24b/m SPO ₂ : 100% GCS: 15/15 Temperature: 98°F Pain Score: 0/10 Repeat RBS (if applicable):	Shift - out from ER to: 115 Time of Shift - out: 3:30pm Handover given to: Merlin (Nurse's Name)

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any):

Iv placement Done

Name of the Nurse : Keethi Signature of the Nurse : Ky

Date & Time : 06/07/26 @ 2pm



MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis: _____

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
06/17/20 2pm	☐ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Fever x 2 days	H ⁺ stability	Iv fluid & g Antibiotic	[Signature]	☐ Nursing ☒ Others:
06/17 @ 2pm	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Fever	H ⁺ stability	Iv fluid & g Antibiotic	[Signature]	☐ Medical ☐ Others:
6/17/26 3:15pm	☐ Medical ☐ Nursing ☒ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Severe HSV somatitis	soft diet	RDA: E: 1400 kcal/d P: 24 g/d	[Signature]	☐ Medical ☐ Nursing ☒ Others:
7/17/26 5pm	☐ Medical ☐ Nursing ☒ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Severe HSV	Improve lung function	chest physiotherapy	[Signature]	☐ Medical ☐ Nursing ☒ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:



INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Part - I.

Patient's / Learner Language: Hindi 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		
06/7	2pm	2	Treatment & care plan	F	1	1	1	0	-	keel
6/7/26	3:30pm	9	soft diet	F	1	0	1	1	-	manica
27/7/26	5pm	5	chest physiotherapy	M	1	0	1	1	-	Khush

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							



Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 3:30 pm Mode of Arrival: wheelchair Admitting From: ☒ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction

Body Weight: 14.6 kg Kg

Height: cm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
NA	NA	NA

Family History:

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

If yes please list,

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

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

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

Observations: Weight: 14.6 kg Length: Head Circumference (< 2 years):

Temp.: 99.5°F HR: 109 RR: 28 BP: 111/70

Pain Score: 0-10 Specify Site: 6-10 (Follow Pain Assessment Sheet & Document)

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

Risk of Pressure Sore (Braden Q Score 28) (Document in the Braden Q Assessment Sheet)

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

Character of Pain Location Frequency Duration

FUNCTIONAL SCREENING:

☐ Mobility Problem

☐ Developmental Delay

☒ No Abnormalities Detected

☐ Walking Problem

☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING:

☐ Underweight

☐ Feeding Problem

☐ Overweight

☐ Special diet

☒ No Abnormalities Detected

☐ Special Feeding Method

☐ No Abnormality Detected

Inform consultant for positive criteria

Psychological Screening: ☐ No Significant Findings

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

If Yes Consultant Notified: (Date/Time):

Social History: Lives With family

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

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

Orientation has been given regarding the following aspects:

Call Bell in Reach: ☒ Yes ☐ No

Waste Disposal Explained: ☒ Yes ☐ No

Infusion Pump: ☒ Yes ☐ No

Hand hygiene Explained: ☒ Yes ☐ No

☐ Others

Patient Rights & Responsibilities: ☐ Yes ☐ No

Information given to mother

Nurse's Name: Merlin Date: 7/7 Time: 4pm

2
Signature

BAH-00454738 IP5-00176033
Baby JUVERIYA FATIMA BAQUER (F)
08-10-2020 6 Y 8 M 29 D
Dr. PILLARISETTI NAVEEN SARADHI

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

DISCHARGE PLANNING FORM

Nationality: Indian

NOTES: * To be completed by a NURSE within (24) hours of admission.

1. Anticipated Date of Discharge: on per doctor order

2. Destination Post Discharge: ☒ Home
Family Members Notified (Person Contacted)

☐ Transfer
Hospital Facility Notified (Person Contacted)

3. Discharge Status: ☐ Self Care ☒ Family Home Care ☐ Home Professional Assistance

☒ Needs Assistance In:

☒ Medication	☒ Yes	☐ No
☐ Bathing	☐ Yes	☒ No
☐ Eating	☐ Yes	☒ No
☐ Walking	☐ Yes	☒ No
☐ Dressing	☐ Yes	☒ No
☐ Toileting	☐ Yes	☒ No

Remarks

explain to the mother

4. Nutritional Plan:

☐ Dietary Instruction Discussed with the:

☐ Patient ☒ Family Member

☐ Others:

5. Discharge Planning Discussed with the:

☐ Patient ☒ Family Member

☐ Others:

6. Patient/Family Educational Plan:

☐ Educational Topic/s: personal hygiene

☐ Patient's Educational Topic/s discussed with the:

☐ Patient ☒ Family Member

☐ Others:

Nurse Signature: Merlin

Nurse Name: Merlin

Date and Time: 5/7/26 @ 3.30pm

Docu. No. : RCHBH / FRM / CLINICAL / 191

PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00454738 IP5-00176033 Baby JUVERIYA FATIMA BAQUER 08-10-2020 5 Y 8 M 28 D (F) Dr. PILLARISETTI NAVEEN SARADHI 		Date & Time of Admission 06/7/26 at 01:06pm	Date & Time of Transfer Order 06/7/26 @ 3:55pm
		Transfer Ordered by Dr. prathibha.	Reason for Transfer Admission
From Unit ER	To Unit 115	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 20	Number of Imaging Films —	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☐ <i>OP file given.</i> If yes, what? <i>Bangaru</i>	
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 Mr. Kewittu		Name of Person Ordered Transfer Dr. prathibha.	
Patient & Clinical Records Received by : <i>Meelin</i>			
Date & Time of Patient Received : 6/7/26 @ 3:50pm			

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



NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 6/7/26 Time: 3:15 PM

Weight: 14.6 kgs Centile: 25th

Height: 108 cms Centile: >10th

Inference: underweight child

RDA: — Calories: 1400 kcal/d Protein: 24 g/d

Diet Recommendations: soft diet

Re-Assessment: avoid spicy, chilled & outside foods.

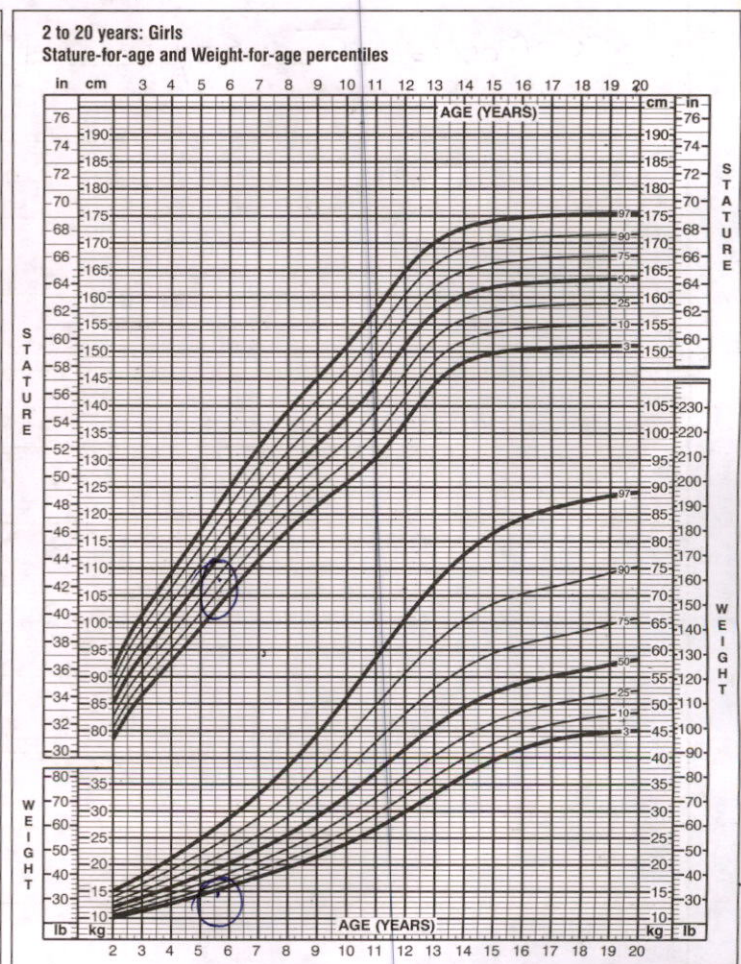
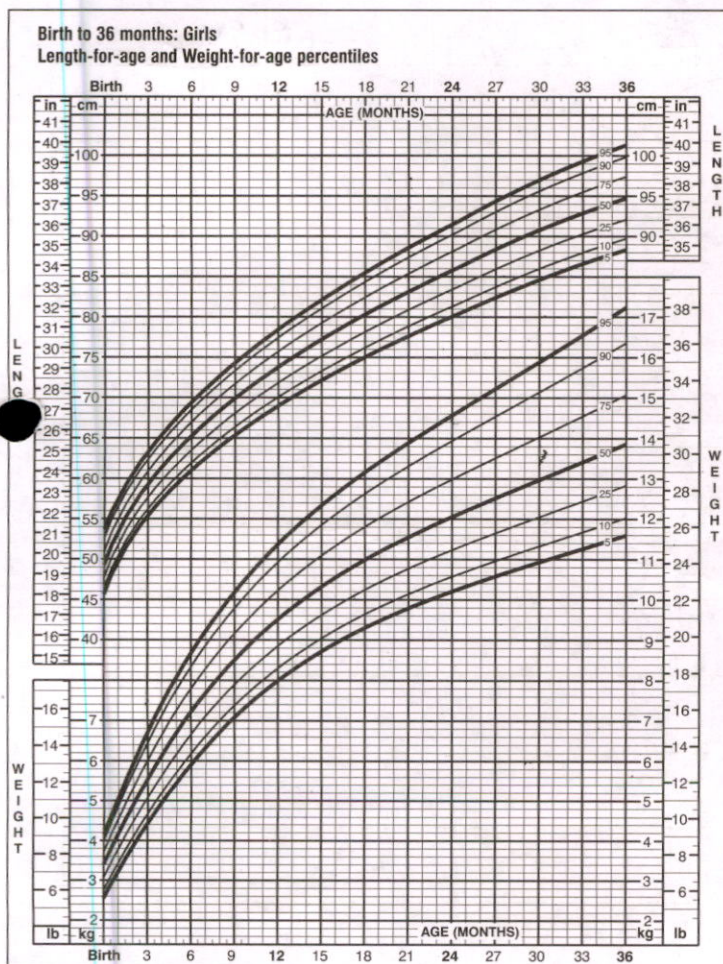
Food Allergies: No Veg/Non-veg Non-veg

Diagnosis: Severe HSV stomatitis

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: Baquer

GROWTH CHART (GIRLS)



Dietician's Name: mounica

Dietician's Signature: mounica

Daily Notes:

1/18/26
10:30am

child is stable. oral intake is good.

continue $\bar{c}$ soft diet

- Nikitha

2/17/26
9:40am

child is stable. oral intake is improved

continue $\bar{c}$ soft diet

- Nikitha

9/2/26
8am

child is stable. Intake is fair

continue $\bar{c}$ soft diet

Nikitha

10/17/26
9am

child is stable. Intake is well

continue $\bar{c}$ soft diet

- Nikitha