

BAH-00660974 IP5-00176083
 Master VEERANSH HIRAWAT
 14-03-2019 7 Y 3 M 23 D (M)
 Dr. ANUPAMA Y



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
7/7/26	7:50 pm	ER	232	[Signature]

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	DR. Alisha Bebban	9/7/26	9695050	[Signature]
2				
3				
4				
5				
6				
7				
8				
9				
10				

[illegible]

Signature

Samohy



Beni

Bew

w'ide,

put

Rosen

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
7/7	Implacemnt	①	92269	Samby
8/7	NHA	①	9683818	Haitap

ANY OTHER INFORMATION

.....

Date : 10/7/26 Time : 10:10a Prepared By : duc

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
			

ADMISSION SHEET

Registration Details :


Admission No : IP5-00176083 **Admit Date** : 07-Jul-2026 **Admit Time** : 07:09 PM **UHID** : BAH-00660974

Patient Details :

Patient Name : Master VEERANSH HIRAWAT	Age : 7 Y 3 M 23 D
Guardian : Mr SHREYANSH HIRAWAT	DOB : 14-03-2019
Gender : Male	Religion :
Occupation :	Martial Status : Single
Address (H) : FLAT NO 201, LEGEND LECHALET APARTMENTS, CHIKOTI GARDENS Begumpet Hyderabad Telangana INDIA 500016	Phone No : 9849545545/ 9440894716
	E-mail : NOMAIL@GMAIL.COM

Admission Details :

Bed Type : PRIVATE ROOM **Bed No** : PVT 237 **Ward Name** : 2F-SECOND FLOOR
Room No : PVT 237 **Admission Type** : First Visit

Contact Details :

Name : Mr SHREYANSH HIRAWAT	Relationship : Father
Contact Address : FLAT NO 201, LEGEND LECHALET APARTMENTS, CHIKOTI GARDENS Begumpet Hyderabad Telangana INDIA 500016	Phone No : 9849545545

Shrey
 Signature

Doctor Details :

Doctor Name : Dr. ANUPAMA Y	Specialisation : GENERAL PEDIATRICS
Referral Doctor : Dr Rajesh Khanna	Phone No : 9848034179
Co-Consultant :	

Payment Details :

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



It takes a lot to treat the little.

PEDIATRIC IN-PATIENT MEDICAL RECORD

BAH-00660974 IP5-00176083
Master VEERANSH HIRAWAT
14-03-2019 7 Y 3 M 23 D (M)
Dr. ANUPAMA Y



Patient Name: _____

UHID ID: _____

Department: _____

Consultant: _____



Pediatric Multiorgan History & Physical Examination

Name : Veerush Age/Sex 7Y/male

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

Fever
Headache
Pain abdomen } 5 days

History of present illness :

Apparently asymptomatic 5 days

1. Fever sudden

mod-high grade

Intermittent 2-3 spikes/day

~~Subtle~~ not associated with rash

2. Headache temporal ; R/L ; Intermittent

3. Pain abdomen sudden

umbilical

colicky

intermittent

no aggravating factors

received symptomatic Rx + 1- Cefixime X 1 day



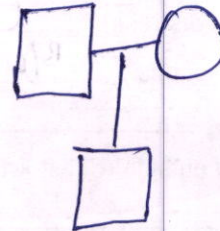
Pediatric Multiorgan History & Physical Examination

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

NOT significant

Birth & Neonatal History:

T.G / AHA



Birth & Socio Economic History:

About Father :

About Mother :

Any additional Information :

Upper middle

Developmental History :

②

Immunization History :

till date as per NIS.



Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs)) 23.18 kg (Centile _____)

On Examination :

Temperature : 100.4 F Pulse Rate : 110/min B.P. 102/56 SPO2 98% ↓ R-A

Resp. rate and type of breathing : _____
20/min CRT < 3 sec

Rash _____

Lymphadenopathy _____

Oedema : _____

Allergies (if any): _____

Respiratory System :

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

Air entry & breath sounds : B/L VBS+

Any adduced sounds : _____

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

Cardiovascular System :

Inspection of precordium : (N)

Heart Sounds : S1 S2 +

Any murmur : _____

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

Per Abdomen :

Inspection (N)

Palpation : NA Hsm; Non Tender

Auscultation : BS+

Spine : (N) External Genitalia : N/E

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



Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : Aw

Cranial Nerves : go

Motor System:

Nutriton : go

Tone: go Power 5/5

Co-ordinator : go

Posture : go

Involuntary Movements : go

Reflexes :

DTR

Plantars ↓

Superficials:

Sensory System :

2

Bladder / Bowel : Regular

Clinical Summary & Diagnostic:

AFI-D5 ?Dayne June



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: _____

Complications

Desired goals of the treatment : _____

Diagnosis; Peritonitis

Planned Labs:

Blood c/s

+ 1 plain

CRP, CRP

ure; LFT; us, sent outside

AB
Alb
7/7/26

Planned Management

IVF - full maintenance

- Inj. ceftriaxone

Pantoprazole

Signature of the Doctor: _____

Name of the Doctor: _____

Date & Time: _____

DR. ANUPAMA Y
Registration No: 50853

Signature of the Consultant: _____

Name of the Consultant: _____

Date & Time: _____

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
08/07/19 8:00am	S/B D <u>PRW</u> fellow D: AFI ↓ Evaluation FS ⊕ (3 spikes: admission) → relud 2 pen but reappe P/A: felt Uret. Ureter No mucus Ceftriaxone, Emuprazole - Oral Intake: food.	<u>PLAN</u> 1) Blood $\leq$ 1, 2) w/f fever
8/7 9:55am	S/B D <u>Dr. Anupama</u> Ante viral screen Ds fever.	<u>Plan</u> 1) Send CRP, CRP, malaria widal 2) 2 plan & 2 EDRA Extra to collect 3) Add Azithromycin. 4) USG abdomen & liver 5) 5 viral panel

Dr. Anupama
08/07/19

Dr. ANUPAMA Y
Registration No: 50853

Docu. No. : RCHBH /FRM / CLINICAL / 088

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 4-03-2019 7 Y 3 M 23 D (M)
 Dr. ANUPAMA Y



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
09/02/20 8:00a	S/R PICU follow	
	<u>AFI ↓ Evaluation</u>	<u>PLAN</u>
	- 5 fet spikes in last 2 hours	1) (T) 5 vital Panel
	last - 2:00am	Blood Cx
		Urine Cx of outside
		wound
	- 2 vomiting, 2 loose stool	2) Stool Rx/stool Cx.
	- Hemodynamically Stable	3) Monitor intake
		4) Watch for dehydration
		5) If oral intake improves, taper IV fluids.
		key:

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/7	CL/B Dr. Anupama	Plan
10:00 AM		
	Acute Viral Illness Acute Gastroenteritis	Plan
		1) Soft diet
	Loose stools (+) Fever spikes (+)	2) Trace Stool Power & culture
		3) Dr. Anupama to see
		4) End stool R+
9/7/20	CL/B Resident	Plan
5 PM	Acute Viral Illness Acute Gastroenteritis (Salmonella typhi positive)	1) Trace Blood & Stool cl
	No further fever spikes Ongoing loose stools o/e child alert	Adeno Report
	Resp PLA (+) CVS	2) Dry ceftriaxone (D3) Oral Azithromycin (D2)
	Vital - stable	3) Monitor Vital w/ dehydration
		4) Inform SOS
		Dr. Jayachandran



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/7/26 8:00am	S/R AF? widal	
	No fever H/dynamik stable On vom an On Intake food	PLAN ① (+) Ablood U E slide further margens
10/7 10am	S/R Dr. Anupama	
	Typhoid fever. Afebrile Loose stool (+)	Plan - Dixerage - Tylenol - 10 x 10 days Azul x 4 days Lampri x 10 days. Beron x 2 wks. E. Wom x 3 days Rw E Dr. Rajan prama after 3-4 days DR ANUPAMA Y Registration No. 50855 10/7/26 10am



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[illegible]



CROSS CONSULTATION FORM

Doctor Name : Dr. Alisha Date : 9/7/26 Time :

Diagnosis :

Hospital : RCH

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:

Gastroenteritis.

Signature:

Findings and Recommendations :

40 fever - 5 days

40 loose stools :: yesterday

10-12 episodes yesterday

watery, small-moderate

no mucus/blood in stool

no abdominal pain

1 episode vomiting (non bilious)

O/B Alert

P/A: spleen 2cm ↓ L ear.

liver 1cm ↓ R cm

Possibility: Enteric fever

Plan:

① no active intervention
for diarrhea

② Antibiotic
duration: 10-14
days.

③ Continue Eosinor
& Zinc

④ Review 8d.

Consultant :

Name : Dr. Alisha Signature : [Signature] Date & Time : 9/7/26

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RESULT SHEET

Date	07/07/24	8/7/26			
Time	3:00pm	11:00am			
Hb	14.1	14.4			
PCV	42.1	43.3			
RBC	5.3	5.43			
WBC	6000	6390			
N/L	47/44	53/38			
Platelets	2.66L	2.74Lakh			
CRP	22.7	33.0			
ESR					
PCT					
RBS					
Na	134				
K	4.6				
Cl	100				
Ca/Mg					
Phosphate					
Urea	20				
Creatinine	0.4				
ALP	225				
SGPT	16				
SGOT	38				
T.Bill/Conj	0.5/0.1				
T.Protein					
S.Albumin					
S.Globulin					
A/G Ratio					
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein / Sugar					
Cells					
N/L					

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MEDICATION RECONCILIATION FORM

Drug Allergies:

☒ Not known any Drug Allergies

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

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

Shifting From: *fr*

Shifted to: *coad*

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
						☐ C ☐ DC
2						☐ C ☐ DC
3						☐ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : *Rahul*

Date & Time : *7/7/26 7:30 PM*

Nurse Name & Signature: *Shavani*

Date & Time : *7/7/26 @ 7:50 PM*



Sheet No:

REGULAR PRESCRIPTIONS

Weight 23 kg Ward

DRUG : SUP ZINC				Date/Time	9/7															
Dose	Route	Frequency	Start Dt.																	
5ml	PO	OD	08/02																	
Name & Signature of the Doctor Starting the Drugs:				Dr. Anupama Y																
Additional Instructions:				(5ml = 20mg)																
Daily Doctor's Endorsement by a Sign																				
DRUG : SUP AZITHROMYCIN				Date/Time	9/7	10/7														
Dose	Route	Frequency	Start Dt.																	
55ml	PO	PO	09/02																	
Name & Signature of the Doctor Starting the Drugs:				Dr. Anupama Y																
Additional Instructions:				20mg																
Daily Doctor's Endorsement by a Sign																				
DRUG :				Date/Time																
Dose	Route	Frequency	Start Dt.																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG :				Date/Time																
Dose	Route	Frequency	Start Dt.																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

Sheet No:

REGULAR PRESCRIPTIONS

Weight ...2.5kg Ward

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

Signature
VERIFIED BY : Name

Date of Admission: 7/2/26 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)

[illegible]

DRUG: <u>INS ONDENSE TPN</u>				Date
Dose	Route	Frequency	Start Date	Time
<u>500ml</u>	<u>IV</u>	<u>STAT</u>		
Doctor's Signature	Valid Period	Pharm.		
<u>[Signature]</u>				
Additional Instructions:				
<u>For Nausea/Vomiting</u>				

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



REGULAR PRESCRIPTIONS

Weight. 23kg Ward.

DRUG : <u>2g. CEFTRIAXONE</u>				Date Time	<u>P1</u>	<u>P2</u>	<u>P3</u>	<u>P4</u>
Dose <u>1gm</u>	Route <u>I.V</u>	Frequency <u>B-D</u>	Start Date <u>7/7</u>	<u>7/7</u>	<u>8/7</u>	<u>9/7</u>	<u>10/7</u>	
Name & Signature of the Doctor Starting the Drugs: <u>[Signature]</u>				<u>Cam X</u> <u>8/7</u> <u>9/7</u> <u>10/7</u> <u>6pm</u> <u>8pm</u> <u>10pm</u> <u>12pm</u> <u>9pm</u> <u>11pm</u> <u>1pm</u> <u>3pm</u>				
Additional Instructions:				<u>6pm</u> <u>8pm</u> <u>10pm</u> <u>12pm</u> <u>9pm</u> <u>11pm</u> <u>1pm</u> <u>3pm</u>				
Daily Doctor's Endorsement by a Sign				<u>4</u> <u>9</u> <u>C</u>				
DRUG : <u>20mg. ESOMEPRAZOLE</u>				Date Time	<u>7/7</u>	<u>8/7</u>	<u>9/7</u>	<u>10/7</u>
Dose <u>20mg</u>	Route <u>I.V</u>	Frequency <u>O.D</u>	Start Date <u>7/7</u>	<u>7/7</u>	<u>8/7</u>	<u>9/7</u>	<u>10/7</u>	
Name & Signature of the Doctor Starting the Drugs: <u>[Signature]</u>				<u>Cam X</u> <u>8/7</u> <u>9/7</u> <u>10/7</u> <u>6pm</u> <u>8pm</u> <u>10pm</u> <u>12pm</u> <u>9pm</u> <u>11pm</u> <u>1pm</u> <u>3pm</u>				
Additional Instructions:				<u>6pm</u> <u>8pm</u> <u>10pm</u> <u>12pm</u> <u>9pm</u> <u>11pm</u> <u>1pm</u> <u>3pm</u>				
Daily Doctor's Endorsement by a Sign				<u>1</u> <u>0</u> <u>5</u>				
DRUG : <u>500mg. CLARITHROMYCIN</u>				Date Time	<u>8/7</u>	<u>9/7</u>		
Dose <u>500mg</u>	Route <u>PO</u>	Frequency <u>OD</u>	Start Date <u>08/07</u>	<u>8/7</u>	<u>9/7</u>			
Name & Signature of the Doctor Starting the Drugs: <u>Dr. VAMSII</u>				<u>Cam X</u> <u>8/7</u> <u>9/7</u> <u>6pm</u> <u>8pm</u> <u>10pm</u> <u>12pm</u> <u>9pm</u> <u>11pm</u> <u>1pm</u> <u>3pm</u>				
Additional Instructions: <u>(5ml = 200mg)</u>				<u>Stop</u> <u>11/7</u> <u>12pm</u> <u>01/8</u>				
Daily Doctor's Endorsement by a Sign				<u>10</u>				
DRUG : <u>ECONDOLY</u>				Date Time	<u>8/7</u>	<u>9/7</u>	<u>10/7</u>	
Dose <u>150mg</u>	Route <u>PO</u>	Frequency <u>BD</u>	Start Date <u>08/07</u>	<u>8/7</u>	<u>9/7</u>	<u>10/7</u>		
Name & Signature of the Doctor Starting the Drugs: <u>Dr. VAMSII</u>				<u>Cam X</u> <u>8/7</u> <u>9/7</u> <u>10/7</u> <u>6pm</u> <u>8pm</u> <u>10pm</u> <u>12pm</u> <u>9pm</u> <u>11pm</u> <u>1pm</u> <u>3pm</u>				
Additional Instructions:				<u>10pm</u> <u>12pm</u> <u>2pm</u> <u>4pm</u> <u>6pm</u> <u>8pm</u> <u>10pm</u> <u>12pm</u> <u>9pm</u> <u>11pm</u> <u>1pm</u> <u>3pm</u>				
Daily Doctor's Endorsement by a Sign				<u>4</u>				

[illegible]



Weight. 23kg Ward.

[illegible]

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Dr. ANUPAMA Y



INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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.....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		
14/3	8pm	7	Infection control measures	M	1	0	1	2	-	Shravat
8/1/26	8am	9	Normal diet	F	1	0	1	1	-	Mouice

Part - III: CODES

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

MULTI-DISCIPLINARY PLAN OF CARE FORM

BAH-00660974
Master VEERANSH HIRAWAT
14-03-2019 7 Y 3 M 23 D (M)
Diag Dr. ANUPAMA Y



Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
7/7/26 8pm	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	fever x 4 day Headache x 4 day	# stability	IV fluids	prabhu	☐ Nursing ☒ Others:
7/7/26 8pm	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	fever x 4 days Headache x 4 day	# stability	IV fluids	Blomas	☐ Medical ☒ Others:
8/7/26 9am	☐ Medical ☐ Nursing ☒ Others: Dietitian	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	AFI	Normal diet	<u>RDA</u> E- 1500 kcal/d P- 26 g/d	Mounica	☐ Medical ☐ Nursing ☒ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:



Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 7:45 am Mode of Arrival: By walk Admitting From: ☒ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction

Body Weight: 23 kg Kg

Height: NA cm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
<u>NA</u>	<u>NA</u>	<u>NA</u>

Family History: Healthy family

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: 23 kg Length: 108 cm Head Circumference (< 2 years): 25 cm

Temp.: 98.9 F HR: 108 bpm RR: 25 bpm BP: 102/64 mmHg

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

Fall Risk Assessment: ☐ Yes ☒ No Score: 1 (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: 0/10 Pain Tool Used: ☐ N Pass ☒ FLACC ☐ Wong Baker

Character of Pain: NA Location: NA Frequency: NA Duration: NA

FUNCTIONAL SCREENING:

☒ No Abnormalities Detected

☐ Mobility Problem

☐ Walking Problem

☐ Developmental Delay

☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING:

☒ No Abnormalities Detected

☐ Underweight

☐ Overweight

☐ Special Feeding Method

☐ Feeding Problem

☐ Special diet

☐ No Abnormality Detected

Inform consultant for positive criteria

Psychological Screening: ☒ No Significant Findings

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

If Yes Consultant Notified: (Date/Time):

Social History: Lives With Family

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

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: Suata Date: 7/7/20 Time: 8:10pm

[Signature]
Signature

Children's Observation & Early Warning Scoring Chart

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

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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)



9/7/26.

PRESCHOOL (1-5 years)

Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : Time: 6am 10Am 2pm 6pm 10pm 2Am 6Am
 Doctor / Nurse / Family Concern?

Temperature (F)	104							
	103							
	102							
	101							
	100							
	99							
	98							
	97							
Heart Rate (bpm)	190							
	180							
	170							
	160							
	150							
	140							
	130							
	120							
Blood Pressure (mmHg) *	110							
	100							
	90							
	80							
	70							
	60							
	50							
	40							
Note: BP does not score in early warning scoring	102							
	100							
	98							
	105							
	109							
	102							
	104							
	100							
Heart Rate (Number)	112b/m							
	89b/m							
	112b/m							
	124b/m							
	120b/m							
	115b/m							
	112b/m							
	112b/m							
Resp. Rate (bpm) (Over 1 Minute) *	70							
	60							
	50							
	40							
	30							
	20							
	10							
	0							
Resp Rate (Number)	24b/m							
	26b/m							
	28b/m							
	24b/m							
	24b/m							
	23b/m							
	24b/m							
	24b/m							
Resp Mod/ Severe Distress None / Mild								
Receiving O ₂ (l/min) O ₂ Saturations (%)	RIA							
	RA							
	RA							
	RA							
	RIA							
	RIA							
	RIA							
	RIA							
Conscious Level Normal Altered								
GCS *	15/15							
	15/15							
	15/15							
	15/15							
	15/15							
	15/15							
	15/15							
	15/15							
TOTAL SCORE	0							
	0							
	0							
	0							
	0							
	0							
	0							
	0							
Pain Score	0							
	0							
	0							
	0							
	0							
	0							
	0							
	0							
Observer's Initials	Hy							
	Hy							
	Hy							
	Hy							
	Hy							
	Hy							
	Hy							
	Hy							

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

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

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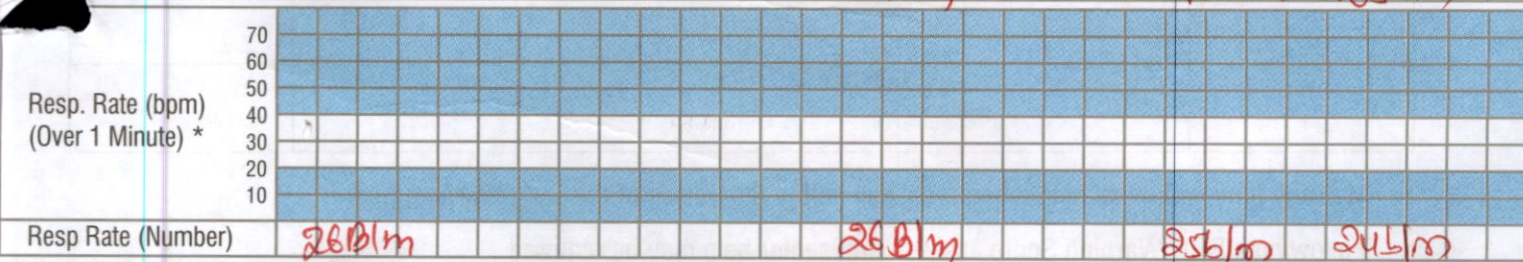
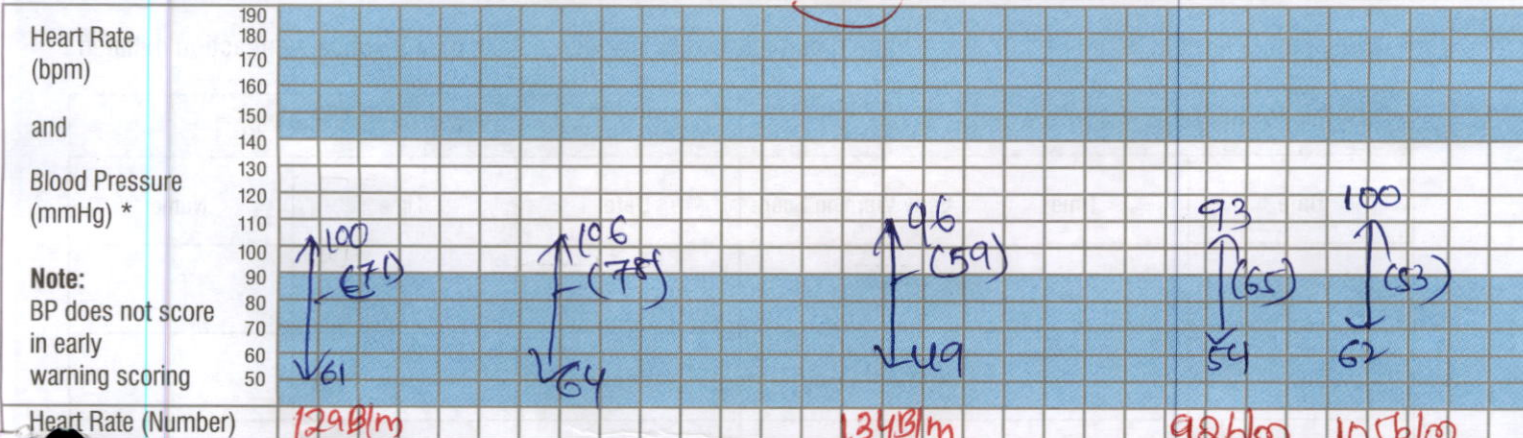
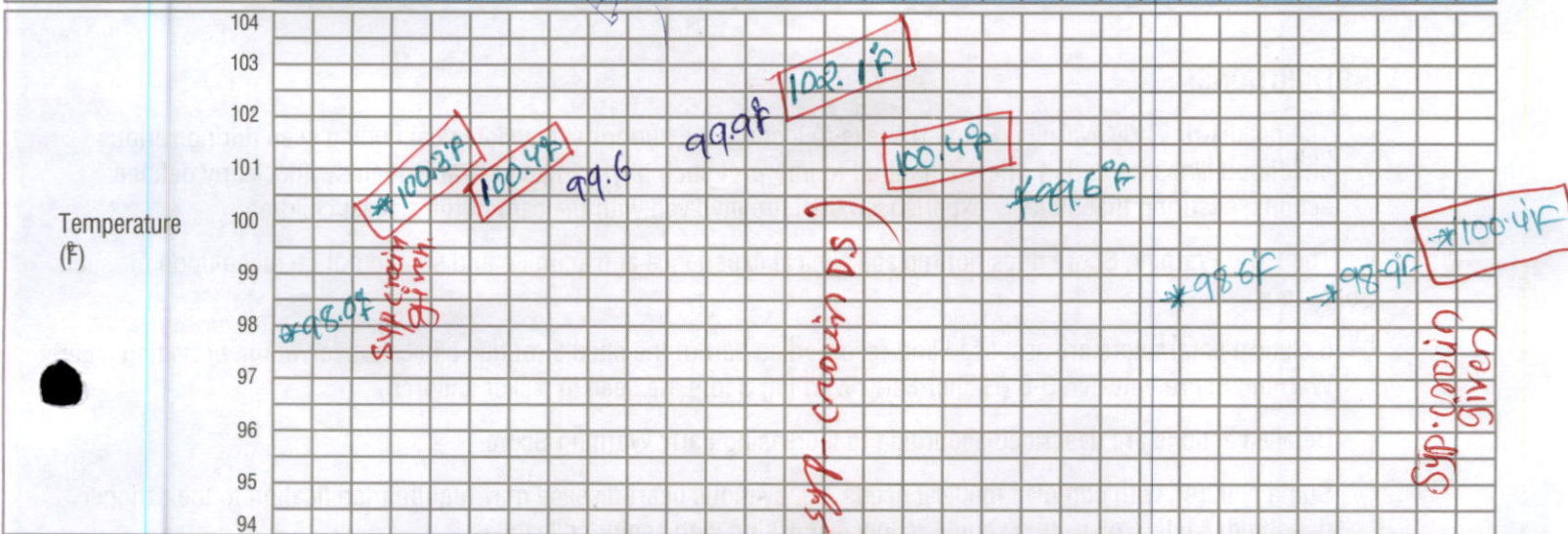
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PRE-SCHOOL (1-5 years)
Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : Time: 10Am 11Am 12pm 2pm 4pm 5pm 6pm 7pm 10pm 2am 3am
 Doctor / Nurse / Family Concern?



Resp Distress	Mod/ Severe	None / Mild
Receiving O ₂ (l/min)	RA	RA
O ₂ Saturations (%)	99%	100%
Conscious Level	Normal	Altered
GCS *	15/15	15/15

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

ACTIONS	Score 1 : Continue normal observation by staff nurse
	Score 2 : Shift in charge nurse to be informed and continue hourly observations
	Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.
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* NB: If GCS is below 12 or the Oxygen requirement is >3 Lit./min. , then irrespective of rest of the score, the Nurse MUST inform the PICU team.

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

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

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date :	Time:	10pm	12:30am	1:30am	2pm	6:30 AM	7:30
Doctor / Nurse / Family Concern?							
Temperature (F)	104						
	103						
	102						
	101						
	100						
	99						
	98						
	97						
	96						
	95						
Heart Rate (bpm)	190						
and	150						
Blood Pressure (mmHg) *	130						
Note: BP does not score in early warning scoring	120						
	110						
	100						
	90						
	80						
	70						
	60						
	50						
	Heart Rate (Number)		120		120	120	
	Resp. Rate (bpm) (Over 1 Minute) *	70					
Resp Rate (Number)	60						
	50						
	40						
	30						
	20						
	10						
	Resp						
	Mod/ Severe						
	Distress						
	Receiving O ₂ (l/min)						
O ₂ Saturations (%)		99%		99%	98%		
Conscious Level		C		C	C		
GCS *		15/15		15/15	15/15		
TOTAL SCORE							
Number of shaded boxes		0		0	0		
Pain Score		0		0	0		
Observer's Initials							

ACTIONS

NB: Scores 3 should be added overleaf

- Score 1 : Continue normal observation by staff nurse
- Score 2 : Shift in charge nurse to be informed and continue hourly observations
- Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.
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BAH-00660974 IP5-00176083
Master VEERANSH HIRAWAT (M)
14-03-2019 7 Y 3 M 23 D
Dr. ANUPAMA Y

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

FLUID CHART

Sheet No. :

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						Total Output :						
	08:00 pm	1ml	60ml							0	0	0
	09:00 pm	1ml	60ml							✓	0	0
	10:00 pm	1ml	60ml								0	0
	11:00 pm	1ml	60ml								0	0
	12:00 am	1ml	60ml							✓	0	0
	01:00 am	1ml	60ml							✓	0	0
Total Intake :			300ml			Total Output :					M-0 U-3	
	02:00 am	1ml	60ml								0	0
	03:00 am	1ml	60ml							✓	0	0
	04:00 am	1ml	60ml								0	0
	05:00 am	1ml	60ml							✓	0	0
	06:00 am	1ml	60ml								0	0
	07:00 am	1ml	60ml							✓	0	0
Total Intake :			120ml			Total Output :					M-0 U-6	
Total 24 hrs. Intake			420ml			Total 24 hrs. Output			M-0 U-6			



FLUID CHART

Sheet No. :

8/7

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 Thrombo-phlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
8/7	08:00 am	↑		60ml						✓	0	Rosny	
	09:00 am	ONS	weats	60ml							0	Rosny	
	10:00 am			60ml			✓	✓		✓	0	Rosny	
	11:00 am			-			✓				0	Rosny	
	12:00 pm			60ml			✓				0	Rosny	
	01:00 pm			60ml						✓	0	Rosny	
Total Intake :			200ml			Total Output : M-3 U-3							
8/7	02:00 pm	↑	Rice	60ml							0	Rosny	
	03:00 pm	ONS		60ml						✓	0	Rosny	
	04:00 pm			-							0	Rosny	
	05:00 pm			60ml			✓				0	Rosny	
	06:00 pm			-						✓	0	Rosny	
	07:00 pm			60ml							0	Rosny	
Total Intake :			240ml			Total Output : M-1 U-2							
8/7	08:00 pm	↓	Rice	-						✓	0	Haily	
	09:00 pm	↓	water	-							0	Haily	
	10:00 pm	ONS		-			NP				0	Haily	
	11:00 pm	↑		60ml							0	Haily	
	12:00 am			60ml							0	Haily	
	01:00 am			60ml						✓	0	Haily	
Total Intake :			180ml			Total Output : m-0 U-2							
9/7	02:00 am	↓		60ml							0	Haily	
	03:00 am			60ml						✓	0	Haily	
	04:00 am	ONS		60ml			NP				0	Haily	
	05:00 am	↑		60ml							0	Haily	
	06:00 am			-							0	Haily	
	07:00 am			-						✓	0	Haily	
Total Intake :			240ml			Total Output : m-0 U-2							
Total 24 hrs. Intake			960ml			Total 24 hrs. Output			m-4 U-8				



FLUID CHART

Sheet No. :

09/11/26.

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

Date	Time	Nature of Fluid	Intake			Output						IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
9/12/26	08:00 am	↑		60ml			✓			✓	0	Rosny	
	09:00 am	DNS soup		60ml			✓			✓	0	Rosny	
	10:00 am			-							0	Rosny	
	11:00 am	↓		60ml					✓	0	Rosny		
	12:00 pm	Bottle milk		60ml			✓			0	Rosny		
	01:00 pm	↓		60ml						0	Rosny		
Total Intake :			300ml			Total Output : M-3 U-3							
09/12	02:00 pm	↑		60ml			✓			0	Rosny		
	03:00 pm	DNS Rice por		60ml			✓		✓	0	Rosny		
	04:00 pm	↓		60ml			✓			0	Rosny		
	05:00 pm	↓		-			✓		✓	0	Rosny		
	06:00 pm	↓		60ml					✓	0	Rosny		
	07:00 pm			-					✓	0	Rosny		
Total Intake :			240ml			Total Output : M-5 U-3							
9/12	08:00 pm	↓	Idly	60ml						0	Hanks		
	09:00 pm	↓	water	60ml					✓	0	Hanks		
	10:00 pm	DNS		60ml			NP			0	Hanks		
	11:00 pm	↑		-						0	Hanks		
	12:00 am	↑		-						0	Hanks		
	01:00 am			60ml					✓	0	Hanks		
Total Intake :			240ml			Total Output : m-0 u-2							
10/12	02:00 am	↓		60ml						0	Hanks		
	03:00 am	↓		60ml						0	Hanks		
	04:00 am	DNS		60ml			NP			0	Hanks		
	05:00 am	↑		60ml						0	Hanks		
	06:00 am	↑		-					✓	0	Hanks		
	07:00 am			-						0	Hanks		
Total Intake :			240ml			Total Output : m-0 u-1							
Total 24 hrs. Intake			1020ml			Total 24 hrs. Output			m-8 u-9				



FLUID CHART

Sheet No. :

10/7/26.

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

		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								
10/7/26	08:00 am			60ml								0	Rashu
	09:00 am			60ml								0	Rashu
	10:00 am											0	Rashu
	11:00 am												
	12:00 pm												
	01:00 pm												
Total Intake :						Total Output :							
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :							
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
Total Intake :						Total Output :							
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
Total Intake :						Total Output :							
Total 24 hrs. Intake						Total 24 hrs. Output							



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Anupama Y Department: ER Date of Admission: 7/7/26

SITUATION	Diagnosis: <u>APR</u>		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:					
	Area	Shift Time	<u>ER</u> 7:30pm-11:30pm	<u>HD unit</u> 2pm-8pm	<u>HD unit</u> 2pm-8am	<u>HD unit</u> 8am-8pm	<u>HD unit</u> 8pm-8am	
BACKGROUND	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>98.2°F</u>	<u>97.4°F</u>	<u>98.9°F</u>	<u>98.6°F</u>	<u>98.3°F</u>	<u>98.6°F</u>
	Res:		<u>24b/m</u>	<u>25b/m</u>	<u>28b/m</u>	<u>24b/m</u>	<u>28b/m</u>	<u>24b/m</u>
	SpO ₂ :		<u>100%</u>	<u>99%</u>	<u>100%</u>	<u>100%</u>	<u>99%</u>	<u>100%</u>
	Pulse:		<u>132b/m</u>	<u>125b/m</u>	<u>129b/m</u>	<u>124b/m</u>	<u>126b/m</u>	<u>124b/m</u>
	BP:		<u>98/62</u>	<u>100/62</u>	<u>100/64</u>	<u>96/55</u>	<u>100/60</u>	<u>102/62</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:		<u>yes</u>	<u>yes</u>	<u>Siderals</u>	<u>Siderals</u>	<u>Siderals</u>	<u>Siderals</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>Shavani</u>	<u>Swathi</u>	<u>Rosmary</u>	<u>Hanika</u>	<u>Rosmary</u>	<u>Hanika</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>7/7/26</u>	<u>8/7/26</u>	<u>8/7/26</u>	<u>9/7/26</u>	<u>9/7/26</u>	<u>10/7/26</u>	
Time:		<u>7:50pm</u>	<u>@ 8pm</u>	<u>at 8pm</u>	<u>@ 8am</u>	<u>@ 8pm</u>	<u>@ 8am</u>	
Taken Over By Name :		<u>Shavani</u>	<u>Rosmary</u>	<u>Hanika</u>	<u>Rosmary</u>	<u>Hanika</u>	<u>Rosmary</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>7/7/26</u>	<u>8/7/26</u>	<u>8/7/26</u>	<u>9/7/26</u>	<u>9/7/26</u>	<u>10/7/26</u>	
Time:		<u>@ 8pm</u>	<u>at 8:10am</u>	<u>@ 8pm</u>	<u>at 8am</u>	<u>@ 8pm</u>	<u>@ 8am</u>	

NURSING SHIFT HAND OVER CARD

Treating Doctor: Department:

Date of Admission:

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



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 7/7/26

Assessment:

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8PM	* Assess The pt General condition	7:10AM	* Assessed The pt General condition	pt is comfortable
12AM	* Monitor vital signs	12:10AM	* Monitoring vital signs	
4AM	* ensure safety	4:10AM	* provided side rails	
6AM	* Maintain fluid balance	6:10AM	* Maintained fluid balance	
8AM	* Administer medication as per doctor order	8:10AM	* Administer medication as per doctor order	

Re-Assessment: Re assessed was done

Special Notes: wlf fever spikes

Nurse Signature:

Nurse Name: Swathi

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



NURSING CARE RECORD

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 8/2/26

Assessment: Baby having Fever.

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8Am	Assess the baby General condition	8:15Am	Assessed the baby General condition	Monitor vital Baby vital Stable.
10Am	Monitor vital signs.	10:15Am	Monitor vital and Recorded	
2pm	Maintain Fluid Balance.	2:30pm	Maintained Fluid Balance DMS 60ml /hourly	
4pm	Maintain personal Hygiene	4:30pm	Explained about Hand Hygiene.	
7pm	Administered Medication as per doctor Advice.	7:30pm	Administered Medication as drug chart.	

Re-Assessment: Reduced the Body temperature.

Special Notes: stool culture stool Routine.

Nurse Signature: Rosna

Nurse Name: Rosna

Date & Time: 8/2/26 at 8pm



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 09/11/26

Assessment: patient having fever spikes

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 ↓ 10pm ↓ 2am ↓ 8am	Assess the patient general Condition. Monitor the vital signs. Maintain Ilo chart. Administer the medication as per doctor order. Maintain fluid balance. provide comfortable position	8:10pm ↓ 10:20pm ↓ 2:30am ↓ 8:15am	Assessed the patient general condition. monitored the vital signs. maintained Ilo chart. administered the medication as per doctor order. maintained fluid balance. provided comfortable position.	All plans are Implemented as per doctor order.

Re-Assessment: Re-assessment was done.

Special Notes: WLF fever spikes

Nurse Signature: (Signature)

Nurse Name: Hemika

Date & Time: 09/11/26 @ 8am



NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 9/7/20

Assessment: Baby having loose stool.

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	7 Assess the baby's general condition	8:10AM	7 Assessed the baby's general condition	→ All plan are Implemented followed by Doctor order.
10AM	7 Monitor vital signs.	10:15AM	7 Monitored vital and Recorded.	
12PM	7 Maintain Fluid Balance	12:15PM	7 Maintained Fluid Balance.	
3PM	7 Maintain personal Hygiene.	3:30PM	7 Maintained Hand Hygiene.	
6PM	7 Administer Medication as per doctor Advice.	6:30PM	7 Administered Medication as per drug chart.	

Re-Assessment: Baby is Active.

Special Notes: w/r lower Spikes.

Nurse Signature: Rosvora

Nurse Name: Rosvora

Date & Time: 9/2/20 at 3pm



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 10/7/26.

Assessment: patient having good 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 ↓ 10pm ↓ 2am ↓ 8am	Assess the patient general condition. Monitor the vital signs. Maintain Ilo chart. Administer the medication as per doctor order. Maintain fluid balance provide comfortable position.	8:10pm ↓ 10:10pm ↓ 2:30am ↓ 8:10am	Assessed the patient general condition. Monitored the vital signs. Maintained Ilo chart. Administered the medication as per doctor order. Maintained fluid balance. provided comfortable position.	All plans are Implemented as per doctor order.

Re-Assessment: Re-assessment was done.

Special Notes: w/f loose stools, w/f fever spikes.

Nurse Signature: Nurse Name: Hanka Date & Time: 10/7/26 @ 8am

BAH-00660974 IP5-00176083
Master VEERANSH HIRAWAT
14-03-2019 7 Y 3 M 25 D (M)
Dr. ANUPAMA Y



NURSING CARE RECORD


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


BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Shift: ☐ Morning ☐ Afternoon ☐ Night

Date:

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:

Patient Sticker

NURSING CARE RECORD

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:

Patient Sticker

NURSING CARE RECORD


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


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

Shift: ☐ Morning ☐ Afternoon ☐ Night

Date:

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:



CHECKLIST FOR THROMBOPHLEBITIS

10/7/22

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0										
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1										
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2										
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3										
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4										
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord pyrexia	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 : Kala Name : Kalarathi

Signature of Ward In Charge :

Signature : _____ Name : _____



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-00660974 IPS-00176083
Master VEERANSH HIRAWAT
14-03-2019 7 Y 3 M 23 D (M)
Dr. ANUPAMA Y



PAIN ASSESSMENT FORM

Date	Time	Re (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
2/7/26	8pm	0/10	←	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	Sharan
8/7/26	4AM	0/10	✓	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA NA	Swetha
8/7/26	12pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA NA	Rosny
8/7/26	8pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA NA	Rosny
8/7/26	4am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA NA	Hanika
9/7/26	12pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA NA	Rosny
9/7	8pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA NA	Rosny
10/7	4am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA NA	Hanika
				☐ 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:

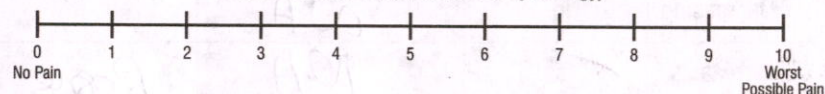
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

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 or sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

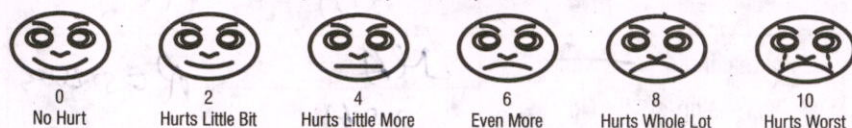
Numerical Pain Scale (Obstetric and Gynecology)



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 :				
					Time :				
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.					
"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.					
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.					
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.					
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."					
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.					
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.					
					TOTAL SCORE				
					Evaluator's Name				

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

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-00660974 IP5-00176083
Master VEERANSH HIRAWAT
14-03-2019 7 Y 3 M 23 D (M)
Dr. ANUPAMA Y



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 :	7/2	8/2	9/2	10/2
					Time :	8pm	6AM	6AM	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	4	4	4
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.		4	4	4	4
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.		4	4	4	4
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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."		4	4	4	4
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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	28	28	28
Docu. No. : RCHBH / FRM / CLINICAL / 119					Evaluator's Name	Blawu, Shant, Haridap, Hentep			

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)
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THE HUMPTY DUMPTY SCALE

2/2 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					
	7 to less than 13 years old	2	2	2	2	2	
	13 years old and above	1					
Gender	Male	2	2	2	2	2	
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1	1	1	
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	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	
	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	
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	
TOTAL			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		✓	✓	✓	✓	
Call device within reach		✓	✓	✓	✓	
Wheels Locked		✓	✓	✓	✓	
Room free of clutter		✓	✓	✓	✓	
Adequate Lighting		✓	✓	✓	✓	
Wheel Chair Support		No	No	Yes	Yes	
Other Intervention(s) Specify		No	No	No	No	
Nurse's Name :		Shweta	Shweta	Haila	Haila	
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	
Date :		2/7	2/7	9/7	10/7	
Time :		8pm	8am	6am	6am	

PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00660974 IP5-00176083 Master VEERANSH HIRAWAT 14-03-2019 7 Y 3 M 23 D (M) Dr. ANUPAMA Y 		Date & Time of Admission 7/7/26 @ 7:09 pm	Date & Time of Transfer Order 7/7/26 @ 7:50 pm
		Transfer Ordered by Dr. prathiba	Reason for Transfer Admission
From Unit ER	To Unit 237	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 21	Number of Imaging Films NO	Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ If yes, what? <i>Shoes</i>	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	ONS	①	
2.	Intrafix	①	
3.	op file	①	
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring NR. Bhavani		Name of Person Ordered Transfer Dr. prathiba	
Patient & Clinical Records Received by : Y. Sathi 7/7/26 @ 8 pm.			
Date & Time of Patient Received :			

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



DISCHARGE PLANNING FORM

Nationality: 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

Need Assistance

☐ Bathing ☒ Yes ☐ No

✓

☐ Eating ☒ Yes ☐ No

✓

☐ Walking ☒ Yes ☐ No

✓

☐ Dressing ☒ Yes ☐ No

✓

☐ Toileting ☒ Yes ☐ No

✓

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: maintain personal Hyge

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

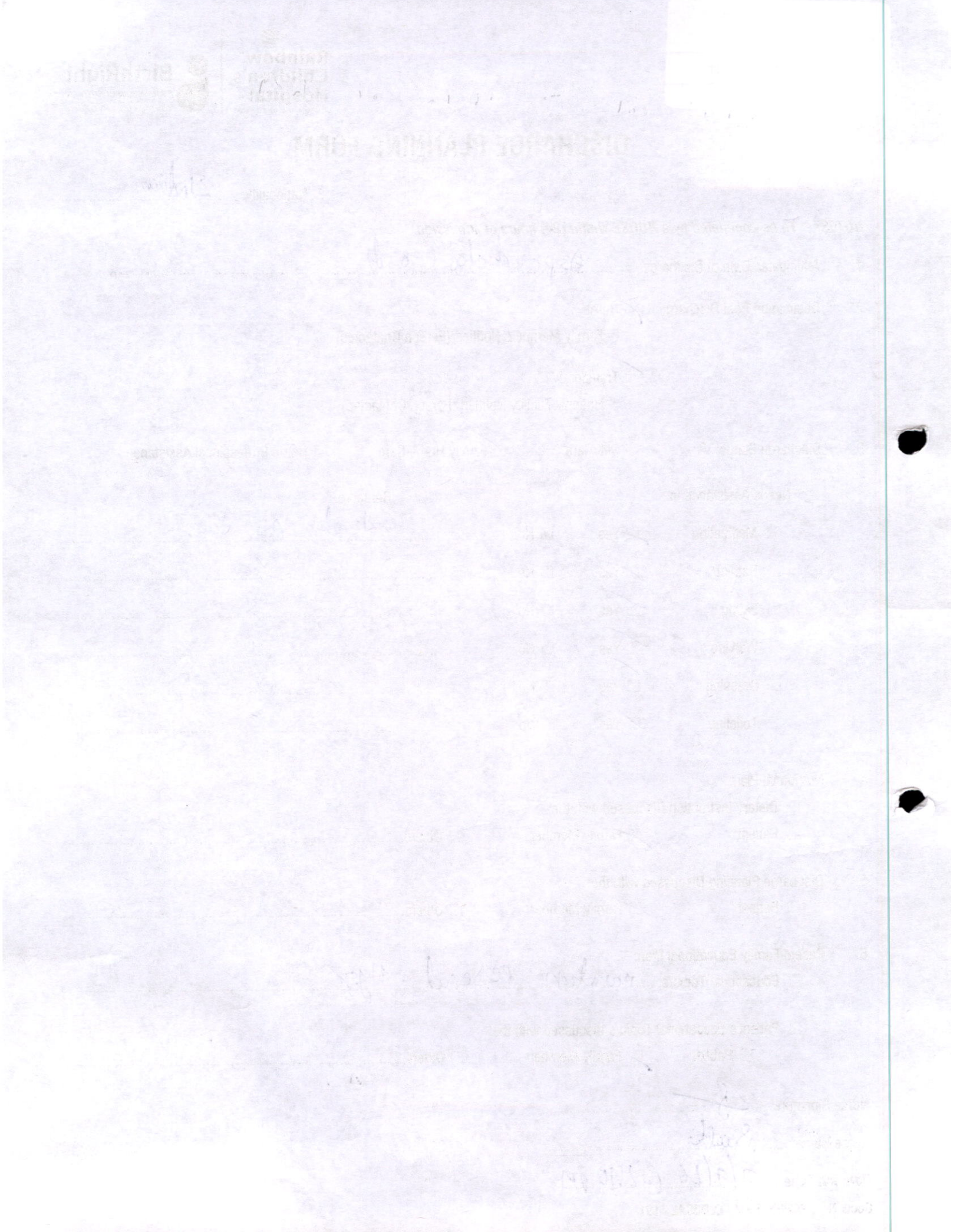
☐ Patient ☒ Family Member

☐ Others:

Nurse Signature: [Signature]

Nurse Name: Suetha

Date and Time: 7/7/16 02:10 PM





NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 8/7/26 Time: 8:40am

Weight: 23 kg Centile: 50th

Height: 135 cm Centile: 95th

Inference: Well Child

RDA: - Calories: 1500 kcal/d Protein: 26 g/d

Diet Recommendations: Normal diet

Re-Assessment: Avoid spicy, chilled, outside foods

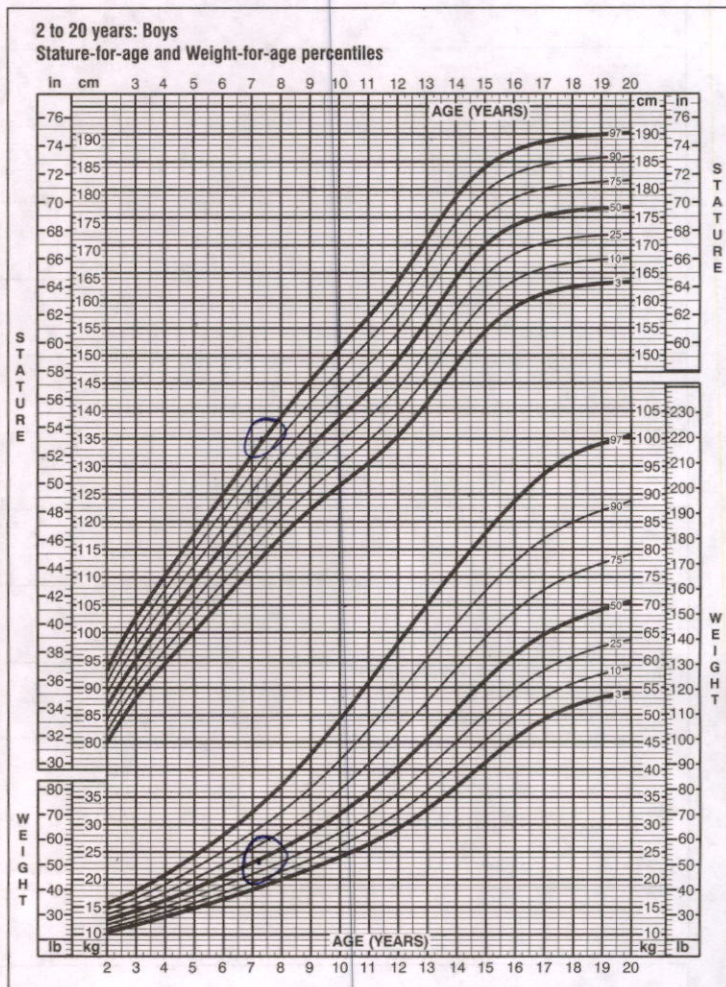
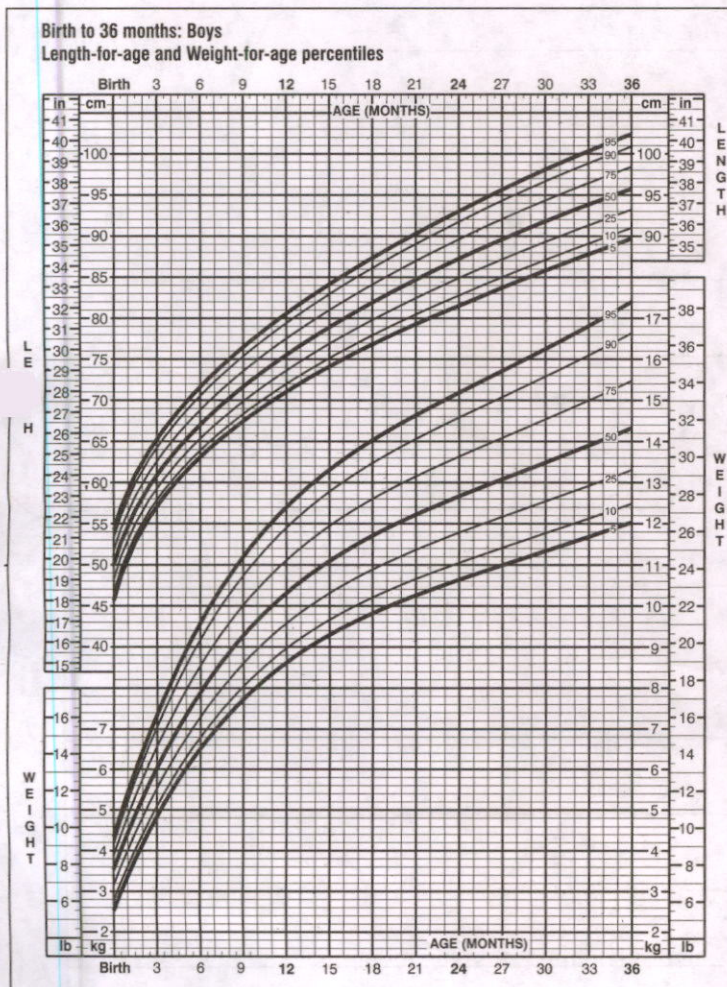
Food Allergies: No Veg/Non-veg Veg.

Diagnosis: AFI ↓ Evaluation

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: Sheey.

GROWTH CHART (BOYS)



Dietician's Name: Monica

Dietician's Signature: Monica

Daily Notes:

9/7/26
9am

Child is stable. Intake is better.

Continue normal diet

Hanna

10/7/26
8am

Child is stable. Intake is good

continue in normal diet

Nikita