

ADMISSION SHEET



Registration Details :

Admission No : IP5-00176536 Admit Date : 17-Jul-2026 Admit Time : 06:55 PM UHID : BAH-00661975

Patient Details :

PatientName	: Baby YASHIKA TAK	Age	: 8 Y 1 M 17 D
.. dian	: Mr PRADEEP TAK	DOB	: 31-05-2018
Gender	: Female	Religion	:
Occupation	:	Martial Status	: Single
Address (H)	: H NO 20-1-54, DOODH KHANNA , PURANAPUL Bahadurpura Hyderabad Telangana INDIA 500064	Phone No	: 9000002148/ 9509759321
		E-mail	: NOMAIL@GMAIL.COM

Admission Details :

Bed Type : PRIVATE ROOM Bed No : PVT 306 Ward Name : 3F-ZONE B
Room No : PVT 306 Admission Type : First Visit

Contact Details :

Name	: Mr PRADEEP TAK	Relationship	: Father
Contact Address	: H NO 20-1-54, DOODH KHANNA , PURANAPUL Bahadurpura Hyderabad Telangana INDIA 500064	Phone No	: 9000002148

Signature

Doctor Details :

Doctor Name	: Dr. NITASHA BAGGA	Specialisation	: GENERAL PEDIATRICS
Referral Doctor	: Self	Phone No	:
Co-Consultant	:		

Payment Details :

Payment Mode	: Cash	Deposit Amount	: 5000.00
		Payor Name	: HDFC ERGO GENERAL INSURANCE CO LTD

ADMISSION SHEET


Registration Details :
Admission No : IP5-00176536

Admit Date : 17-Jul-2026

Admit Time : 06:55 PM **UHID :** BAH-00661975

Patient Details :
Patient Name : Master YASHIKA TAK

Age : 8 Y 1 M 17 D

Guardian : Mr PRADEEP TAK

DOB : 31-05-2018

Gender : Male

Religion :
Occupation :
Martial Status : Single

Address (H) : H NO 20-1-54, DOODH KHANNA , PURANAPUL
 Bahadurpura Hyderabad Telangana INDIA
 500064

Phone No : 9000002148/ 9509759321

E-mail : NOMAIL@GMAIL.COM

Admission Details :
Bed Type : PRIVATE ROOM

Bed No : PVT 306

Ward Name : 3F-ZONE B

Room No : PVT 306

Admission Type : First Visit

Contact Details :
Name : Mr PRADEEP TAK

Relationship : Father

Contact Address : H NO 20-1-54, DOODH KHANNA ,
 PURANAPUL Bahadurpura Hyderabad
 Telangana INDIA 500064

Phone No : 9000002148

Pradeep Tak
 Signature

Doctor Details :
Doctor Name : Dr. NITASHA BAGGA

Specialisation : GENERAL PEDIATRICS

Referral Doctor : Self

Phone No :
Co-Consultant :
Payment Details :
Payment Mode : Cash

Deposit Amount : 0.00

Payor Name : HDFC ERGO GENERAL INSURANCE
 CO LTD

BAH-00661975 IP5-00176536
Master YASHIKA TAK
31-05-2018 8 Y 1 M 17 D (M)
Dr. NITASHA BAGGA



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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____ 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
18/7/18	9:00 AM	ER	Ward	[Signature]

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	DR. Alisha	18/7/18	9212988	[Signature]
2				
3				
4				
5				
6				
7				
8				
9				
10				

[illegible]

Investigations

Signature

17/07/20 CBP, CRP, ESR, Blood cts.
Mycoplasma Tgm, LFT
5 viral panel ✓
Throat swab cts

71846

Temp

 $C \times R$

35716

17/07	Mantoups (RT) Lead FIS Tpm
-------	----------------------------

71842

Tenue

18/7	Dengan Dorn, EBY tetra pannel widal
------	--

26070 244

[Signature]

1817	CUG.
------	------

26072072

Durga

19/7 AFB stain & CBDAAT

26072403

Durga

[illegible]

Date _____

Name of Equipment

Connecting Time

Disconnecting Time

Order No.

Signature

17/7

Infusion pump

10 PM

2605282

gma

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
17/07	iv placement	1	8295	Temp

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor



Rainbow[®] Children's Hospital

It takes a lot to treat the little.

PEDIATRIC IN-PATIENT MEDICAL RECORD

BAH-00661975 IP5-00176536
Baby YASHIKA TAK
31-05-2018 8 Y 1 M 17 D (F)
Dr. NITASHA BAGGA



Patient Name: Yeshika tak.

UHID ID: _____

Department: _____

Consultant: _____

**Pediatric Multiorgan History & Physical Examination**Name : _____ Age/Sex 8yrs / f

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)fever ($\approx$ 10 days)cough ($\approx$ 10 days)swelling over (L) cervical node**History of present illness :**

- fever intermittent type, relieved on medication, initially ~~not~~ - not documented, since last 4 days

~~has~~ Given Paracetamol ~~for~~ three daily.

Not associated $\bar{c}$ rash, chills.

- cough. ~~there~~ sputum induced, white colored, more in the morning, non blood stained, non foulsmelling

- N/A to vomiting, loose stool, pain abdomen, burning micturition.

- N/A to recent wt loss / anorexia

- N/A to recent travel / recent vaccination

N/A to contact $\bar{c}$ TB patients

N/A to contact $\bar{c}$ animals

Admitted in Hope hospital for 4 days; taken by ~~for~~ ceftriaxone.

BAH-00661975 IP5-00176536
Baby YASHIKA TAK
31-05-2018 8 Y 1 M 17 D (F)
Dr. NITASHA BAGGA



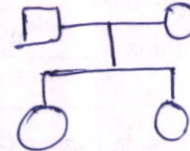
Pediatric multiorgan History & Physical Examination

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

the nil

no recurrent URTI/UTI

Birth & Neonatal History:



Birth & Socio Economic History:

About Father : _____

About Mother : _____

Any additional Information : _____

Developmental History :

According to eye

Immunization History :

Till date



Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs)) 19.5 kg (Centile _____)

On Examination :

Temperature : 98.2°F Pulse Rate : 110/min B.P. 96/56 (Gr) SP02 99% on RA

Resp. rate and type of breathing : 24/min

Rash _____

Lymphadenopathy by (P) cervical lymphadenopathy (.1.5 x 1.5 cm).

Oedema : _____

Allergies (if any): _____

Respiratory System :

Inspection (any s/o distress) : _____

Air entry & breath sounds : BAE (+), wheeze (+)

Any addes sounds : _____

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

Cardiovascular System :

Inspection of precordium : _____

Heart Sounds : SS (+)

Any murmur : _____

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

Per Abdomen :

Inspection _____

Palpation : _____

Ausculation : Bowel sounds (+)

Spine : _____ External Genitalia : _____

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



Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : 15/15

Cranial Nerves : 12

Motor System:

Nutrition : 12

Tone: 12 Power 12

Co-ordinator : 12

Posture : 12

Involuntary Movements : 12

Reflexes :

DTR

Plantars 12

Superficials:

Sensory System :

Bladder / Bowel : 12

Clinical Summary & Diagnostic:

Acute febrile illness (Acute tonsillitis)
Myocard.

BAH-00661975 IP5-00176536
Baby YASHIKA TAK
31-05-2018 8 Y 1 M 17 D (F)
Dr. NITASHA BAGGA



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: _____

Complete

Desired goals of the treatment: _____

Hjkblm

Planned Labs:

- CBC, CRP, ESR.
- Blood cl., myeloperoxidase (MPO).
- LFT
- 5 viral panel.
- Throat swab cl.
- (Extra Plain & EDTA)
- Chest xray PA view
- Mantoux test

N/B

Temp

Planned Management

- Ery melopenem
- Symp Azithromycin
- SWF DNS
- Ery ATOP
- Symp Amoxicillin Plus
- NCB C Flexury
- Budecort
- NIB
- Leucine
- TATK

Signature of the Doctor: _____

Name of the Doctor: Dr. Remedios

Date & Time: 12/12/18

Signature of the Consultant: _____

Name of the Consultant: _____

Date & Time: _____

IP5-00176536

Baby YASHIKA TARI (F)
21.05.2018 8 Y 1 M 21 D

31-05-2018

8 Y 1 M 21 D

(F)

Dr. NITASHA BAGGA



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



BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

DEFICIENCY CHECK LIST OF CASE SHEET

Sl.No.	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission sheet	1			
2	Discharge Summary	1			
3	Nursing Initial assessment	1			
4	Patient Transfer form	1			
5	In-patient Medical record	1			
6	Doctors progress sheets	3			
7	Nursing plan of care and handover sheets	4			
8	Consultation sheet	1			
9	General consent for treatment	1			
10	Consent for Surgery				
11	Consent for blood transfusion				
12	Consent for chemotherapy				
13	Consent for high risk				
14	Consent for Restraint				
15	LAMA consent				
16	Consent for special procedure / Sedation				
17	Consent for Formula feed				
18	Consent for MTP				
19	Consent for Radiological Investigations				
20	Consent for HIV test				
21	Anaesthesia notes (Pre Anaesthesia& post)				
22	Neonatal Admission/Delivery/Physical Exam				
23	Medication Reconciliation	1			
24	Emergency Triage record	1			
25	Pre operative check list				
26	Surgical safety checklist				
27	Operation Theatre notes				
28	Nurses clinical Presentation				
29	TPR & BP chart	5			
30	Intake and Out take chart (fluid chart)	1			
31	Drug chart (Regular Prescription)	2			
32	Investigation Values (result sheet)	1			
33	Nebulization chart	1			
34	Nutritional review chart	1			
35	Intensive care unit (ICU Charts)				
36	Consent for Admission in PICU / NICU	1			
37	The Humpty dumpty scale	1			
38	Braden Q Scale	1			
39	Bed side check list				
40	PICU bed formula Dilution feeds				
41	Gastro monitoring chart	2			
42	Rch ED doctors note				
43	BP Monitoring chart				
44	RBS monitoring chart				
	Total No. of Pages	71			

Doc. No. : RCHBH/ FRM / GENERAL / 126

Signature and Date :

(P.T.O)

ERROR LOG

LOCATION : OT / Birthing Centre / BirthRight Premium / 3rd Floor (Zone A,B,C) / NICU / PICU /
2nd Floor Ward / Oncology / 1st Floor Wards.

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
18/7 8:15am	C/S/B Resident A: PUO (D12) 1 fever spike post admission - 100.6°F	- C/S R/V IgM. - Dengue IgM - Widal. - USG abdomen. - CUE CUE + cervical. sputum AFB/CBS/NAAT, LN, <u>Swab</u> + screening ingrains
	Qo: throat pain dysphagia. neck pain (L) side. nausea. no vomiting	1) Trace mycoplasma IgM Throat swabs C/S 2 adenovirus
	O/E: - alert - vitals stable - CRT < 3s. - throat: B/L tonsils congested cervical LN pl (+) 2cm. axillary (-) inguinal - 1cm (+) chest: clear abdomen soft mild hepatomegaly rounded edge	3.) R/V Meropenam. Continue Azithromycin 4.) R/V Widal. CUE USG abdomen.
	CVS: (+) heart sounds.	Shivile mills

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
18/17 10:30am	Seen by Dr. Nitasha	
		1) Dr. Shishe consultation
		2) Change Meropenam to Pipraz
		3) Trace adeno.
		4) Send : → sputum AFB or AFB & CBNAAT gastric asp + m bar → Dengue NS + IgM → USG abdomen + cervical LN + axillary/inguinal screening. → EBV tetrapanel → Widal → SCLT
		Shikha

BAH-00661975

IP5-00176536

Baby YASHIKA TAK

31-05-2018

8 Y 1 M 18 D

(F)

Dr. NITASHA BAGGA



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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
18/7 5:30pm	C/S/B Dr. Nitasha	
	Δ: AEI PUO (D12)	
18/7 (P)	fever spike at 2pm - low grade	Adv:
	O/E: alert vitals stable S/E: NAD	1) Plan to involve hematology team on Monday
		2) To read Mantoux 4m 6pm
		3) Trace reports: Dengue / mycoplasma IgM EBV tetrapanel / Widal / Throat C/S swab adenovirus
		4) Add Mucant powder ProctoClysis cream now
		5) w/f fever spikes A while



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/4 10am	C/S/B Resident <u>A: EBV illness</u> last fever spike - 6pm doing well O/E: alert stable vitals S/E: NAD	<u>Advs</u> 1.) Continue current Abx plan to deescalate 1 abx after 48h cultures 2.) W/f fever spikes 3.) Cont IVF Encourage orally noted by Deanna 19/4/20 @ 8pm
	<u>mtk</u>	

BAH-00661975 IP5-00176536
 Baby YASHIKA TAK
 31-05-2018 8 Y 1 M 18 D (F)
 Dr. NITASHA BAGGA



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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
24/7/26 8AM	SIB Resident ↓: CBV 9/10/10	Plan. ① cont. same
	last fever spike at 5:30pm - 101.5°F	② cont. medication as per chart ③ trace mycoplasma IgM
	O/E: child active/alert vitals stable.	throat swab q.s. Dengue IgM CBV tetrapanel ATB stain & CBNAAT
	PC BLACED CNS - SIS 2 (12) PIA - soft.	④ monitor vitals ⑤ Infum ac.
		noted by <u>subale</u> 24/7/26 @ 8AM
		Madhvi
		Ints



Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

BAH-00661975
Baby YASHIKA TAK
31-05-2018 8 Y 1 M 17 D (F)
Dr. NITASHA BAGGA



Outside report

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

RESULT SHEET

RCHB

Date	14/7	15/7	16/7	17/7/26		
Time				9AM		
Hb	9.7	8.9		10.4		
PCV				31.4		
RBC	65			3.83		
WBC	12,500	11,300		16.15		
N/L	23/68	23/68		24.7/66		
Platelets	1,50,000	1,70,000		190		
CRP		5.8		7		
ESR		$\frac{12}{20} \frac{1 \text{ hr}}{45}$		32 ↑		
PCT		1.7				
RBS						
Na	140					
K	4.3					
Cl	101					
Ca/Mg						
Phosphate						
Urea	12					
Creatinine	0.9					
ALP	296	283 ↓		239		
SGPT	217 ↑	164 ↓		159 ↑		
SGOT	331 ↑	119 ↓		115 ↑		
T.Bill/Conj	2/1.3	0.8 < 0.5	0.7 < 0.5	0.5 < 0.2		
T.Protein	6.6	6	8.1	8.1		
S.Albumin	4	3.4	3.9	3.9		
S.Globulin	2.6	2.6	4.2	4.2		
A/G Ratio	1.5	1.3	1.2	4.2		
Uric Acid						
S.Amylase		22.5				
Sr.Lipase		14				
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L	GCT	201	147 ↓			



CROSS CONSULTATION FORM

Doctor Name : Dr. Alisha Date : 18/7/26 Time :

Diagnosis :

Hospital :

Type of Referral :

☐ Emergency

☐ Urgent

☐ Non Urgent

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

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

Thansaminitis / Acute febrile illness ⊕ hepatomegaly ⊕
lymphadenopathy ⊕ micturic hepatitis.
EBV Signature:

Findings and Recommendations :

Q fever : last week of June
intermittent, temp - undocumented
∴ 8th July - fever every day ± chills.
no rash
Q mild cold, cough : 8 days.
no vomiting, no loose stools
no abdominal pain

17/7/26

LFT:
SBR/DBR: 0.7/0.5
SGOT: 115
SUPT: 159
ALP: 239
ALB: 3.9

USG: Mild GB wall
edema

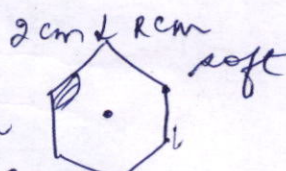
O/E: Alert

chest: clear

P/A: soft

non tender

liver span: 12 cm.



last stool - 15/7/26.

Widal & anailed
EBV
Dengue : negative
HAV Ig m: -ve
S visalband -ve.

Consultant :

Name : Dr. Alisha Signature: [Signature] Date & Time : 18/7/26

Plan:

- ① collect 5 viral panel and EBV
- ② NO active intervention for transaminitis
- ③ Proctoclysis Enema
- ④ Nasal powder 4 scoop + 240 ml water once at night
- ⑤ May need lymph node aspiration for definitive Diagnosis

~~Shira~~

Patient Sticker

BAH-00881975 IP5-00176536
Baby YASHIKA TAK
31-05-2018 8 Y 1 M 17 D (F)
Dr. NITASHA BAGGA

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

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: ICUShifted to: Ward

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

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: [Signature]Date & Time: 12/7/20 & 8:30 pmNurse Name & Signature: [Signature]Date & Time: 12/7/20 & 8:45 pm



DRUG CHART

Date of Admission: 17/7/20 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 : Symp: Cloven DS				Date Time	18/7/20														
Dose 6mg	Route PO	Frequency Sol	Start Date 17/7		6AM	5:10PM													
Doctor's Signature By		Valid Period	Pharm. Per																
Additional Instructions: If temp > 100°F																			

DRUG : Teal Symp MEPTAL				Date Time															
Dose 9mg	Route PO	Frequency Sol	Start Date 17/7																
Doctor's Signature By		Valid Period	Pharm. Per																
Additional Instructions: If temp > 100°F																			

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

VERIFIED BY : Name



REGULAR PRESCRIPTIONS

Weight. 19.56 Ward.

DRUG : <u>Py MEROPENEM</u>				Date Time	17/7	18/7														
Dose	Route	Frequency	Start Date																	
750mg	iv	BD TID	17/7	6AM	X	mor														
Name & Signature of the Doctor Starting the Drugs: <u>Py</u>																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

DRUG : <u>Inj PANTOPRAZOLE</u>				Date Time	17/7	18/7	19/7	20/7	21/7											
Dose	Route	Frequency	Start Date																	
20mg	iv	OD	17/7	6AM	10PM	mor	mor	mor	mor	mor										
Name & Signature of the Doctor Starting the Drugs: <u>Py</u>																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

DRUG : <u>Syrp AZITHROMYCIN</u>				Date Time	17/7	18/7	19/7	20/7												
Dose	Route	Frequency	Start Date																	
5mg	PO	OD	17/7	2PM	mor	mor	mor	mor	mor											
Name & Signature of the Doctor Starting the Drugs: <u>Py</u>																				
Additional Instructions: <u>200mg/5mg</u>																				
Daily Doctor's Endorsement by a Sign																				

DRUG : <u>MES LEVONOR</u>				Date Time	17/7	18/7	19/7													
Dose	Route	Frequency	Start Date																	
1000	NEL	8th day	17/7	6AM	X															
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions: <u>1000 - 0.63mg</u>																				
Daily Doctor's Endorsement by a Sign																				

VERIFIED

VERIFIED



Nurse Sig.

	Dose
--	------

Dr. Sign.

	Dose
--	------

Dr. Sign.

	Dose
--	------

Dr. Sign.

	Dose
--	------

Dr. Sign.

Nurse Sig.

	Dose
--	------

Dr. Sign.

Dose	
------	--

Dr. Sign.

	Dose
--	------

Dr. Sign.

	Dose
--	------

Dr. Sign.

STAT / ONCE ONLY DRUGS[illegible]



I.V. FLUIDS CHART

Weight. 19.5kg Ward.

[illegible]

Signature _____

VERIFIED BY: Name

BAH-00661975
 Baby YASHIKA TAK
 31-05-2018 8 Y 1 M 17 D (F)
 Dr. NITASHA BAGGA



Sheet No:

REGULAR PRESCRIPTIONS

Weight Ward

DRUG : Nck C BUDCOCT				Date Time	17/7	18/7	19/7	20/7	21/7
Dose 12mg	Route PO	Frequency BD	Start Dt. 17/7	11AM	X	5mg	5mg		
Name & Signature of the Doctor Starting the Drugs: Cy									
Additional Instructions:									
Daily Doctor's Endorsement by a Sign									

DRUG : Symp AMRODOL PWS				Date Time	17/7	18/7	19/7	20/7	21/7
Dose 5mg	Route PO	Frequency TDS	Start Dt. 17/7	6AM	X	more	more	more	more
Name & Signature of the Doctor Starting the Drugs: Cy									
Additional Instructions:									
Daily Doctor's Endorsement by a Sign									

DRUG : Trj PIPERACILIN TA20				Date Time	17/7	18/7	19/7	20/7	21/7
Dose 2g	Route IV	Frequency TID	Start Dt. 18/7	6AM	X	more	more	more	more
Name & Signature of the Doctor Starting the Drugs: Shikile									
Additional Instructions: 100mg/1 dose									
Daily Doctor's Endorsement by a Sign									

DRUG : MuonT powder				Date Time	18/7	19/7	20/7
Dose C	Route PO	Frequency As	Start Dt. 18/7				
Name & Signature of the Doctor Starting the Drugs: Shikile							
Additional Instructions: → 4 scoop + 240ml water							
Doctor's Endorsement by a Sign							

BAH-00661975 IP5-00176536
Baby YASHIKA TAK
31-05-2018 8 Y 1 M 17 D (F)
Dr. NITASHA BAGGA




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


BirthRight
BY RAINBOW HOSPI
Your Right to a Safe De

Sheet No:

REGULAR PRESCRIPTIONS

Weight

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																							



NEBULISATION CHART

Date	Time	Drug	Nurse	Parents Signature
17/7/26	00.00	Neb. Levolin 10PM	Suman 9708231	
	01.00	Neb. Budecort 10PM		
18/7/26	02.00	Neb. Levolin 6AM		
18/7/26	03.00	Neb!- Budecort 11:18pm	9709988	Durga
	04.00	Neb!- Levolin 4PM		
	05.00	Neb. Levolin 10PM	9709989	Suman
	06.00	Neb. Budecort 11PM		
19/7/26	07.00	Neb. Levolin 6AM		
	08.00			
19/7/26	09.00	Neb!- Budecort 11:17pm	9711251	Durga
	10.00	Neb!- Levolin 3pm		
	11.00			
19/7/26	12.00	Neb = Budecort - 11pm	9711875	Suehi
	13.00	Neb = Levolin - 10pm		
20/7/26	14.00	Neb = Levolin - 6AM	9712689	Suehi
	15.00	Neb = Budecort - 11AM		
20/7/26	16.00	Neb = Budecort - 11AM	9712689	Syothi
	17.00	Neb = Levolin - 2pm		
	18.00			
20/7/26	19.00	Neb = Levolin - 10 pm	Sangeetha	9713766
	20.00	Neb = Budecort - 11pm		
	21.00	Neb = Levolin - 6AM		
	22.00			
	23.00			

17/7/20

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

SCHOOL AGE (5-12 years)

Children's Observation & Early Warning Scoring Chart

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

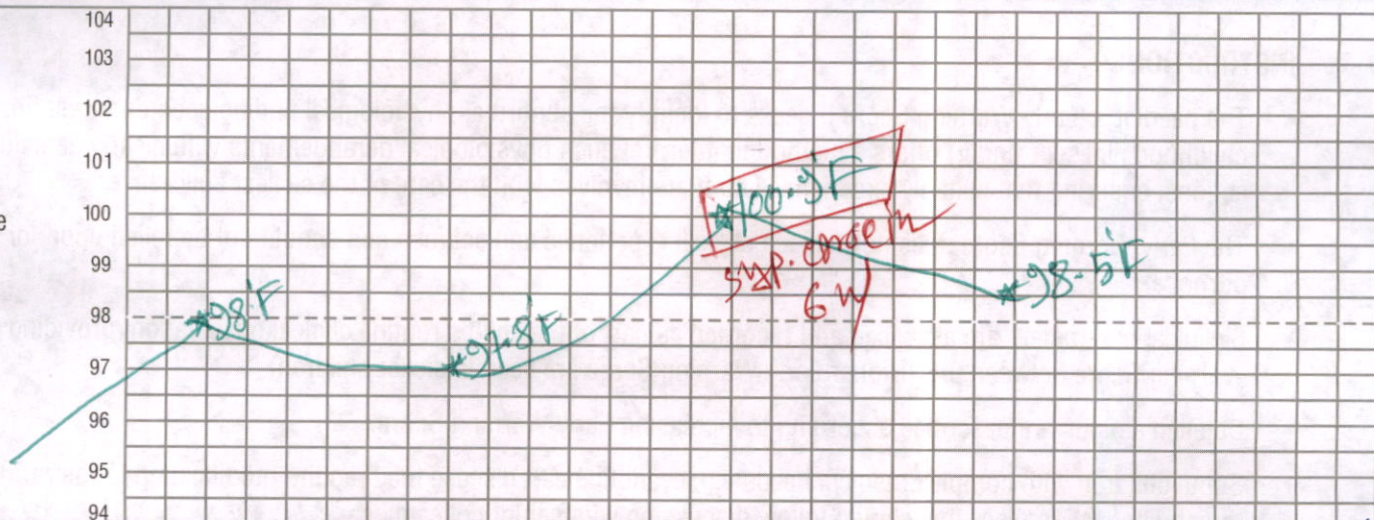
BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : Time: 10PM 3AM 6AM 7AM
Doctor / Nurse / Family Concern?

Temperature
(F)

104
103
102
101
100
99
98
97
96
95
94



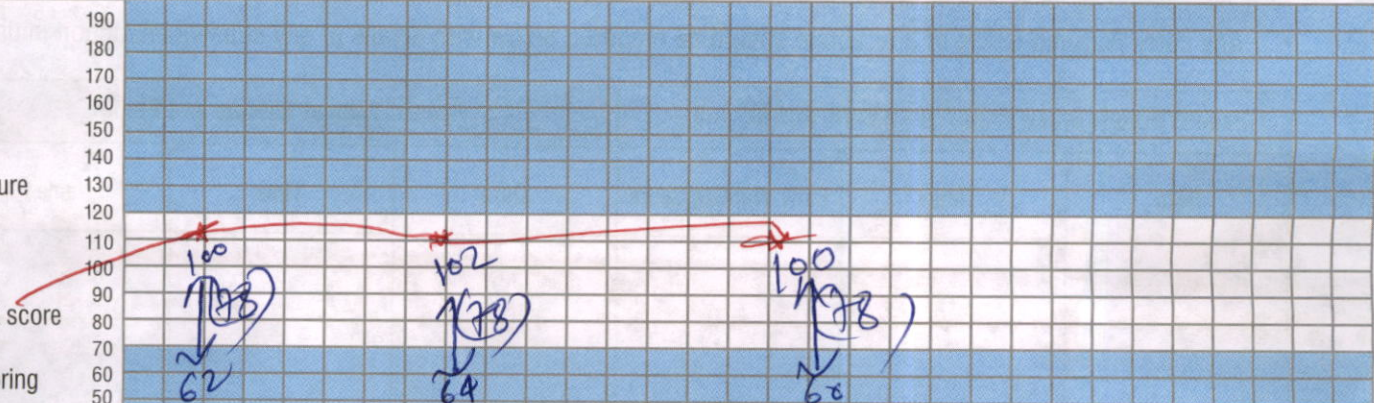
Heart Rate
(bpm)

and

Blood Pressure
(mmHg) *

Note:
BP does not score
in early
warning scoring

190
180
170
160
150
140
130
120
110
100
90
80
70
60
50

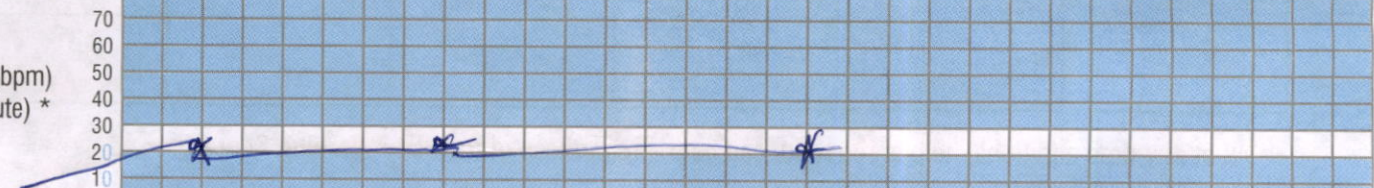


Heart Rate (Number)

110 112 114

Resp. Rate (bpm)
per 1 Minute) *

70
60
50
40
30
20
10



Resp Rate (Number)

26 24 28

Resp Mod/ Severe
Distress None / Mild

Receiving O₂(l/min)
O₂Saturations (%)

99% 99% 99%

Conscious Normal
Level Altered

GCS *

(14/15) (14/15) (14/15)

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

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.

ACTIONS

NB: Scores 3 should be
recorded overleaf

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

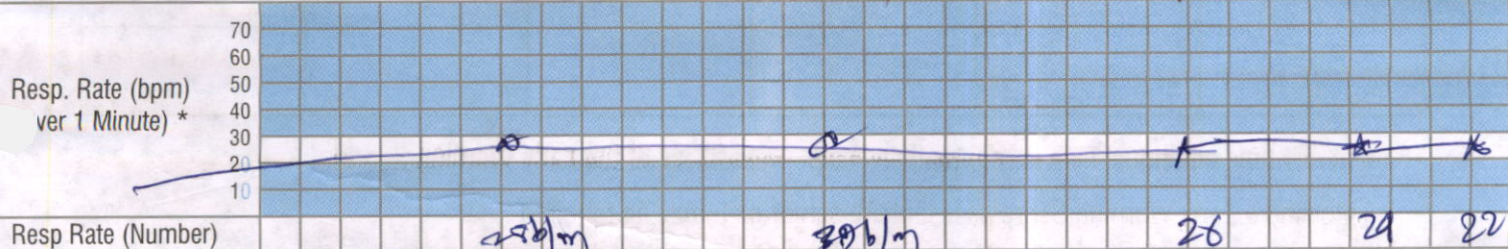
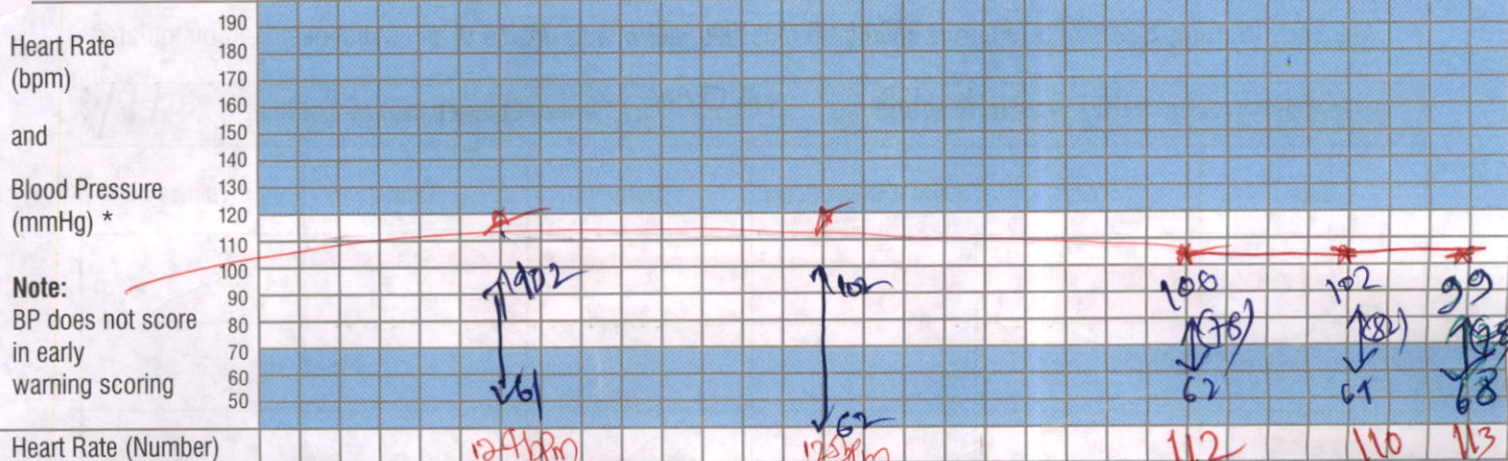
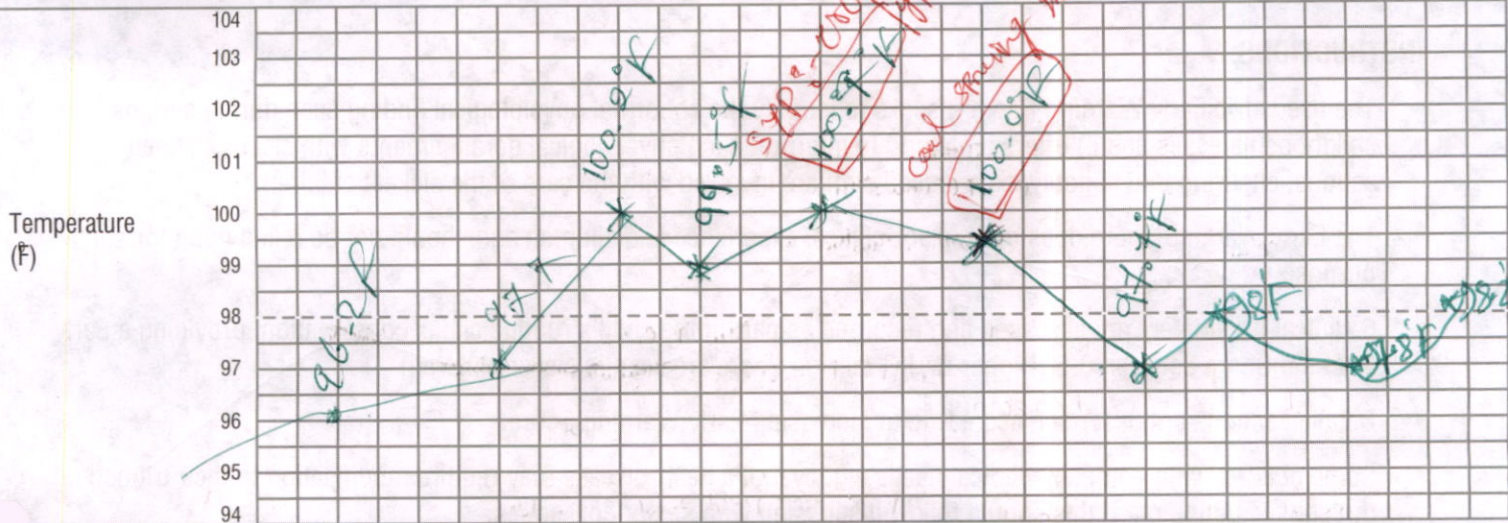
- If at any time additional help is required, call help – regardless of the Early Warning Score!
- Following a Early Warning Score assessment, senior help may be required

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

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : Time: 8:45 AM 10 AM 12 PM 2 PM 5:15 PM 6 PM 8:30 PM 10 PM 12 AM 6 AM
Doctor / Nurse / Family Concern?



Resp Distress	Mod/ Severe	
	None / Mild	
Receiving O ₂ (l/min)		
O ₂ Saturations (%)		
Conscious Level	Normal	
	Altered	
GCS *		
TOTAL SCORE		
Number of shaded boxes		
Pain Score		
Observer's Initials		

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:

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

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

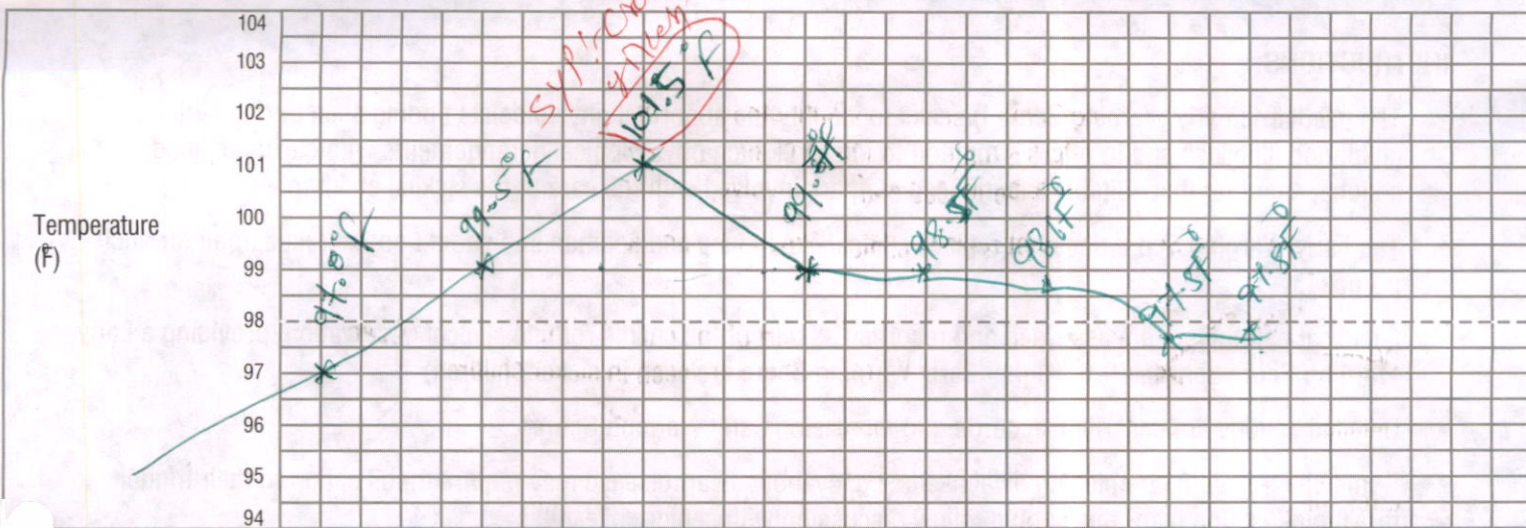
- If at any time additional help is required, call help – regardless of the Early Warning Score!
- Following a Early Warning Score assessment, senior help may be required

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

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 19/7/26 Time : 11AM 1:30 PM 5:30 PM 6:30 PM 8:30 PM 12AM 3AM 6AM
 Doctor / Nurse / Family Concern?



Heart Rate (bpm)	190
and	180
Blood Pressure (mmHg) *	170
	160
	150
	140
	130
	120
	110
	100
	90
	80
	70
	60
	50
Note: BP does not score in early warning scoring	
Heart Rate (Number)	118bpm, 142bpm, 108bpm, 144bpm, 108bpm, 146bpm, 119bpm

Resp. Rate (bpm) ver 1 Minute) *	70
	60
	50
	40
	30
	20
	10
Resp Rate (Number)	28b/m, 28b/m, 26b/m, 32b/m, 24b/m, 22b/m, 24b/m

Resp Distress	Mod/ Severe
	None / Mild
Receiving O ₂ (l/min)	
O ₂ Saturations (%)	99%, 99%, 98%, 99%, 98%, 99%, 97%
Conscious Level	Normal
	Altered
GCS *	(15/10), (10/10), (15/15), (15/15), (15/15), (15/15), (15/15)

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

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:

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

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

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

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

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

- If at any time additional help is required, call help – regardless of the Early Warning Score!
 - Following a Early Warning Score assessment, senior help may be required
- The SBAR communication tool (situation, background, assessment, recommendations) is a helpful mnemonic that can be used to describe a child's clinical condition to a colleague.

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



SCHOOL AGE (5-12 years)

Children's Observation &
Early Warning Scoring Chart

21/7/26

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : Time: 10:00 AM

Doctor / Nurse / Family Concern?

Temperature
(°F)

104
103
102
101
100
99
98
97
96
95
94

97.6
97.6
97.6

Heart Rate
(bpm)

and

Blood Pressure
(mmHg) *

Note:

BP does not score
in early
warning scoring

190
180
170
160
150
140
130
120
110
100
90
80
70
60
50

99
130
65

Heart Rate (Number) 102 bpm

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

70
60
50
40
30
20
10

30

Resp Rate (Number) 28 bpm

Resp Mod/ Severe
Distress None / Mild

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

99%

Conscious Level Normal
Altered

GCS *

15/16

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

ACTIONS

NB: Scores 3 should be
recorded overleaf

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

BAH-00661975 IP5-00176536
 Baby YASHIKA TAK
 31-05-2018 8 Y 1 M 17 D (F)
 Dr. NITASHA BAGGA



FLUID CHART

12/7/20

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	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	Thrombo-phlebitis Score	
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						Total Output :						
	08:00 pm											
	09:00 pm										0	gme
	10:00 pm										0	sm
	11:00 pm										0	sm
	12:00 am										0	sm
	01:00 am										0	sm
Total Intake :						Total Output : U - 1 M - 0						
	02:00 am										0	sm
	03:00 am										0	sm
	04:00 am										0	sm
	05:00 am										0	sm
	06:00 am										0	sm
	07:00 am										0	sm
Total Intake :						Total Output : U - 1 M - 0						
Total 24 hrs. Intake		Total = 270ml										
Total 24 hrs. Output		U - 2 M - 0										

FLUID CHART

Sheet No. : ②

18/1/26

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.

		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							
	08:00 am	1	H ₂ O	30ml			✓				0	Durga
	09:00 am	1	H ₂ O	30ml							0	Durga
	10:00 am	1	H ₂ O	30ml							0	Durga
	11:00 am	1	H ₂ O	30ml							0	Durga
	12:00 pm	1	H ₂ O	30ml						✓	0	Durga
	01:00 pm	1	H ₂ O	30ml							0	Durga
Total Intake :		120ml				Total Output : 0-1 ml						
	02:00 pm	1	H ₂ O				1				0	Durga
	03:00 pm	1	H ₂ O	30ml						✓	0	Durga
	04:00 pm	1	H ₂ O	30ml							0	Durga
	05:00 pm	1	H ₂ O	30ml							0	Durga
	06:00 pm	1	H ₂ O							✓	0	Durga
	07:00 pm	1	H ₂ O								0	Durga
Total Intake :		60ml				Total Output : 0-2 ml						
	08:00 pm	1	H ₂ O				1				0	Suman
	09:00 pm	1	H ₂ O								0	Suman
	10:00 pm	1	H ₂ O	30ml						✓	0	Suman
	11:00 pm	1	H ₂ O	30ml						✓	0	Suman
	12:00 am	1	H ₂ O	30ml							0	Suman
	01:00 am	1	H ₂ O								0	Suman
Total Intake :		30ml				Total Output : 0-2 ml						
	02:00 am	1	H ₂ O	30ml							0	Suman
	03:00 am	1	H ₂ O	30ml							0	Suman
	04:00 am	1	H ₂ O	30ml						✓	0	Suman
	05:00 am	1	H ₂ O	30ml						✓	0	Suman
	06:00 am	1	H ₂ O	30ml							0	Suman
	07:00 am	1	H ₂ O	30ml							0	Suman
Total Intake :		30ml				Total Output : 0-2 ml						

Total 24 hrs. Intake

Total: 480ml

Total 24 hrs. Output

0-7 ml



FLUID CHART

Sheet No. : (3) 191726

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G.	NG	Diarrhoea	Vomit	Drainage	Urine			
	08:00 am		H ₂ O								0	Durga	
	09:00 am									✓	0	Durga	
	10:00 am		H ₂ O	30ml			NP				0	Durga	
	11:00 am			30ml							0	Durga	
	12:00 pm		H ₂ O	30ml					✓		0	Durga	
	01:00 pm			30ml							0	Durga	
Total Intake : 90ml						Total Output : 0-2						m-0	
	02:00 pm		H ₂ O	30ml							0	Durga	
	03:00 pm										0	Durga	
	04:00 pm		H ₂ O	30ml			✓		✓		0	Durga	
	05:00 pm										0	Durga	
	06:00 pm		H ₂ O	30ml					✓		0	Durga	
	07:00 pm										0	Durga	
Total Intake :						Total Output : 0-2						m-1	
	08:00 pm										0	snesh	
	09:00 pm		H ₂ O	30ml					✓		0	snesh	
	10:00 pm						✓				0	snesh	
	11:00 pm		H ₂ O	30ml					✓		0	snesh	
	12:00 am										0	snesh	
	01:00 am		H ₂ O	30ml			✓		✓		0	snesh	
Total Intake :						Total Output : 0-3						M-2	
	02:00 am										0	snesh	
	03:00 am		H ₂ O	30ml					✓		0	snesh	
	04:00 am										0	snesh	
	05:00 am		H ₂ O	30ml					✓		0	snesh	
	06:00 am										0	snesh	
	07:00 am		H ₂ O	30ml					✓		0	snesh	
Total Intake :						Total Output : 0-3						M-0	
Total 24 hrs. Intake			Total 390ml/day										
Total 24 hrs. Output			0-10 M-3										



FLUID CHART

Sheet No. : 20/7/26

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.
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		
	08:00 am	↑	470	30ml			↑		0.5	—	0	Jyoti
	09:00 am	↑		30ml			↑			—	0	Jyoti
	10:00 am	↑	470	30ml			↑		0.5	—	0	Jyoti
	11:00 am	↑		30ml			↑			—	0	Jyoti
	12:00 pm	↑	470	30ml			↑		0.5	—	0	Jyoti
	01:00 pm	↑		30ml			↑			—	0	Jyoti
Total Intake : 180ml			Total Output : 1.5 ml									
	02:00 pm	↑								✓	0	Jessie
	03:00 pm	↑	470				✓			✓	0	Jessie
	04:00 pm	↑								✓	0	Jessie
	05:00 pm	↑	470							✓	0	Jessie
	06:00 pm	↑								✓	0	Jessie
	07:00 pm	↑	470							✓	0	Jessie
Total Intake :			Total Output : 0.4 ml									
	08:00 pm	↑									0	Sam
	09:00 pm	↑	470				✓				0	Sam
	10:00 pm	↑					✓				0	Sam
	11:00 pm	↑	470				✓				0	Sam
	12:00 am	↑					✓				0	Sam
	01:00 am	↑	470				✓				0	Sam
Total Intake :			Total Output : 0 ml									
	02:00 am	↑	470								0	Sam
	03:00 am	↑									0	Sam
	04:00 am	↑	470								0	Sam
	05:00 am	↑									0	Sam
	06:00 am	↑	470								0	Sam
	07:00 am	↑									0	Sam
Total Intake :			Total Output : 0 ml									

Total 24 hrs. Intake : 470 + 180ml

Total 24 hrs. Output : 1.4 ml

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 17/7/26

Assessment: PT having

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 condition.	8PM	→ Assessed the PT condition.	PT is stable
11PM	→ vital chart maintain	11PM	→ vital chart maintain	
12AM	→ ensure safety	12AM	→ ensured safety	
4AM	→ continue IV fluid	4AM	→ continue nebulization	
8AM	→ continue nebulization	8AM		

Re-Assessment: PT is stable

Special Notes: - nil

Nurse Signature: S

Nurse Name: smaneel

Date & Time: 18/7/26 @ 8AM

BAH-00661975 IP5-00176536
 Master YASHIKA TAK
 31-05-2018 8 Y 1 M 17 D (M)
 Dr. NITASHA BAGGA

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: 18/7/20

Assessment: Pt 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
8am	x assess the general condition of the Pt	9pm	x assessed the general condition of the Pt	x now Pt is stable
10pm	x monitor the vitals	11pm	x monitored the vitals	
12pm	x Administer medication as per chart	1pm	x Administered medication as per chart	
2pm	x Relieve pain & discomfort	4pm	x Relieved pain & discomfort	
4pm	x maintain I/O chart	5pm	x maintained I/O chart	
6pm	x ensure safety	7pm	x ensured safety	

Re-Assessment: or - assessment done

Special Notes:

Nurse Signature: [Signature]

Nurse Name: Durga

Date & Time: 18/7/20 @ 8pm

BAH-00661975 IP5-00176536
 Baby YASHIKA TAK
 31-05-2018 8 Y 1 M 18 D (F)
 Dr. NITASHA BAGGA



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

Patient having cough

Date: 18/7/26

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 condition	8PM	→ Assessed the Pt condition	Pt is stable
11PM	→ vital chart maintain	11PM	→ vital chart maintained	
12AM	→ Ensure safety	12AM	→ continue nebulization	
9AM	→ continue nebulization	9AM	→ continue IV fluid	
8AM	→ continue IV fluid	8AM		

Re-Assessment:

Pt is stable
 Sputum AFB & CBNAT sent for FTM

Special Notes:

Nurse Signature:

S

Nurse Name:

Sumana

Date & Time:

19/7/26 8AM

BAH-00661975 IP5-00176536

Baby YASHIKA TAK

31-05-2018 8 Y 1 M 18 D (F)

Dr. NITASHA BAGGA



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: 19/7/26

Assessment: Pt 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
8pm	* Assess the general condition of the Pt	9pm	* Assessed the general condition of the Pt	* Now Pt is stable
10am	* Monitor the vitals	11pm	* monitored the vitals	
12pm	* Administer medications per chart	1pm	* Administer medication as per chart	
2pm	* Relieve Pain & discomfort	3pm	* Relieved Pain & discomfort	
4pm	* maintain I/O chart	5pm	* maintained I/O chart	
6pm	* ensure safety.	7pm	* ensured safety	

Re-Assessment: re-assessment done

Special Notes:

Nurse Signature:

Nurse Name: Durg

Date & Time: 19/7/26 @ 8pm

BAH-00661975 IP5-00176536

Baby YASHIKA TAK

31-05-2018 8 Y 1 M 19 D (F)

Dr. NITASHA BAGGA



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: 10/7/20

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 condition.	8PM	→ Assessed the PT condition	PT is stable
11PM	→ vital chart maintain	11PM	→ vital chart maintain	
12AM	→ Ensure safety	12AM	→ Ensured safety	
4AM	→ continue IV fluid	4AM	→ continue nebulization	
8AM		8AM		

Re-Assessment: PT is stable

Special Notes: -MT-

Nurse Signature: [Signature]

Nurse Name: snehal - 607638

Date & Time: 20/7/20 @ 8AM

NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 20/7/26

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
8AM	→ Assess the pt condition	8:10	→ Assessed the pt condition	now pt is stable
10AM	→ maintain vital signs	10:20	→ maintained vital signs	
11AM	→ maintain IV fluids	11:30	→ maintain IV fluids	
12PM	→ administer medication	12:30	→ administer medication	
1PM	→ provided ensure safety	1:30	→ provided ensure safety	

Re-Assessment: Re-assessment

Special Notes:

Nurse Signature: Ar

Nurse Name: Jyoti (2010533)

Date & Time: 20/7/26 @ 2PM

NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 20/7/20

Assessment: pt 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
2:30 pm	Assess the pt general condition	3pm	Assessed the pt general condition	pt is stable
3:30 pm	Assess the pt vitals	4:30 pm	Assessed the pt vitals	
5pm	Assess the pt in a comfortable position	5:30 pm	Assessed the pt in a comfortable position	
6:30 pm		7pm		
7:30 pm	Provide pt hygiene	8pm	Assessed the pt hygiene provided	

Re-Assessment: pt is stable

Special Notes: NA

Nurse Signature: [Signature]

Nurse Name: Jessie @ 9010577

Date & Time: 20/7/20 @ 8pm

Patient Sticker

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 2017/12/26

Assessment: Patient is 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
8pm	Admin the patient General condition	8:15pm	Admin the patient General condition	Also Patient is Stable
10pm	Administer medication as per chart	10:15pm	Administered medication as per chart	
12am	Maintain fluid balance	12:15am	Maintained fluid balance	
2am	Maintain vital signs	2:15am	Maintained vital signs	
4am	Ensure safety	4:15am	Ensured safety	

Re-Assessment: Re. Assessment done every 2 hours

Special Notes: N/A

Nurse Signature: [Signature]

Nurse Name: Kangotha

Date & Time: 2017/12/26 @ 8am

BAH-00661975 IP5-00178536
Baby YASHIKA TAK
31-05-2018 8 Y 1 M 21 D (F)
Dr. NITASHA BAGGA



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


**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

BAH-00661975 IP5-00176536
 Baby YASHIKA TAK
 31-05-2018 8 Y 1 M 17 D (F)
 Dr. NITASHA BAGGA



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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Nitasha Department: ICU Date of Admission: 17/7/20

SITUATION		Diagnosis:		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:					
BACKGROUND	Area								
	Shift Time	ER 9:00	3rd Floor 8PM-8A	3rd Floor 8PM-8A	3rd Floor 8PM-8A	3rd Floor 8PM-8A	3rd Floor 8PM-8A		
ASSESSMENT	Medical Condition (Any special condition to be noted):	NA	NA	NA	NA	NA	NA		
	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No		
RECOMMENDATIONS	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No		
	Vital Signs:	Temp:	98.6°F	98.1°F	98.1°F	98.1°F	98.1°F	98.1°F	
		Res:	24b/m	26b	26b/m	26b/m	28b/m	26b	
		SpO ₂ :	99%	99%	98%	99%	98%	99%	
		Pulse:	142b/m	136b	138b/m	132b/m	125b/m	124b	
		BP:	111/65/6	110/70	102/71	100/70	102/71	100/70	
		Fall Risk Score:	09	09	09	09	09	09	
	Pain Score:	0/10	0/10	0/10	0/10	0/10	0/10		
Safety Needs:	Side rails	Side rails	Side rails	Side rails	Side rails	Side rails			
Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No			
Others Specify:	NA	NA	NA	NA	NA	NA			
Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No			
Other Special Orders / Medications:	NA	NA	NA	NA	NA	NA			
Post Operative Procedure Special Orders:	NA	NA	NA	NA	NA	NA			
Handed Over By Name :	Renub	Sumang	Durga	Sumang	Durga	Sumang			
Signature :									
Date:	17/7/20	18/7/20	18/7	18/7/20	19/7	20/7			
Time:	9:10pm	8PM	8PM	8AM	8PM	8AM			
Taken Over By Name :	Sumang	Durga	Sumang	Durga	Sumang	Sumang			
Signature :									
Date:	17/7/20	18/7	18/7/20	19/7	19/7/20	20/7			
Time:	9PM	8PM	8PM	8PM	8PM	8AM			



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Nitasha Bagga Department: 3rd floor Date of Admission: 17/7/20

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:					
	<u>APR</u>							
BACKGROUND	Area	Shift Time	<u>2nd floor 8pm-12pm</u>	<u>3rd floor 8pm-8pm</u>	<u>3rd floor 8pm-6pm</u>			
	Medical Condition (Any special condition to be noted):		<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>98.1F</u>	<u>98.2F</u>	<u>98.1F</u>			
		Res:	<u>20b/m</u>	<u>21b/m</u>	<u>21b/m</u>			
		SpO ₂ :	<u>99.1</u>	<u>99.1</u>	<u>100+</u>			
		Pulse:	<u>108</u>	<u>108</u>	<u>117b/m</u>			
		BP:	<u>96/62</u>	<u>95/60</u>	<u>100/71</u>			
		Fall Risk Score:	<u>9</u>	<u>9</u>	<u>0/0</u>			
Pain Score:	<u>0/10</u>	<u>0/10</u>	<u>0/0</u>					
Recommendations	Safety Needs:	<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>				
	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>				
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>	<u>NA</u>				
Handed Over By Name :		<u>Jyoti</u>	<u>Jessie</u>	<u>Sangeetha</u>				
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>				
Date:		<u>20/7</u>	<u>20/7</u>	<u>21/7</u>				
Time:		<u>2pm</u>	<u>8pm</u>	<u>8am</u>				
Taken Over By Name :		<u>Jessie</u>	<u>Sangeetha</u>	<u>Dr. Agg</u>				
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>				
Date:		<u>20/7</u>	<u>20/7</u>	<u>21/7</u>				
Time:		<u>2pm</u>	<u>8pm</u>	<u>8am</u>				



THE HUMPTY DUMPTY SCALE

17/12 18/12 19/12 20/12 21/12

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					
	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					1
	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	✓
	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					1
	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			9	9	9	9	9

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 :		Kanika	Sumit	Sumit	Sumit	Sumit
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date :		17/12	18/12	19/12	20/12	21/12
Time :		8:30	8 AM	8A	8P	8P

BAH-00661075 IP5-00176536
 Baby YASHIKA TAK
 31-05-2018 8 Y 1 M 19 D (F)
 Dr. NITASHA BAQGA



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

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

THE HUMPTY DUMPTY SCALE

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					
	13 years old and above	1					
Gender	Male	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					
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own ability	1					
	History of Falls or Infant-Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2					
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1					
Medication Usage	Sedatives (Excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1					
Total							

Intervention:

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

High Risk Humpty Dumpty Score = 12 or above

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

BAH-00661975

IP5-00176536

Baby YASHIKA TAK

31-05-2018

8 Y 1 M 17 D

(F)

Dr. NITASHA BAGGA



BRADEN 'Q' SCALE

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

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

					Date :	12/7	18/7/20	19/7/20	20/7/20
					Time :	9:00 AM	8 AM	8 AM	8 AM
Mobility	Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4	4	4	
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4	4	4	
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	4	
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	4	
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	
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	4	
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be < 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4	
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23					TOTAL SCORE	28	28	28	28
Docu. No. : RCHBH /FRM / CLINICAL / 119					Evaluator's Name	Neha	Shruti	Shruti	Shruti

Risk Score	Category	Action	Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice
15-18	At Risk	• Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • Advance to a higher level of risk if other major risk factors are present	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	• Use the Same Protocol as for “At Risk” Patients • Position patient at 30 degree lateral incline using foam wedges	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	• Follow the same protocol as for “Moderate Risk” Patients • In addition to regular turning schedule • Make small shifts in their position frequently	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	• Use same protocol as for “High Risk” Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay



BRADEN 'Q' SCALE

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

Risk Score	Category	Action	Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice
15-18	At Risk	• Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • Advance to a higher level of risk if other major risk factors are present	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	• Use the Same Protocol as for “At Risk” Patients • Position patient at 30 degree lateral incline using foam wedges	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	• Follow the same protocol as for “Moderate Risk” Patients • In addition to regular turning schedule • Make small shifts in their position frequently	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	• Use same protocol as for “High Risk” Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay



CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0			6	0	0	0	0	0		
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1			1	1	1	1	1	1		
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2			1	1	1	1	1	1		
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			1	1	1	1	1	1		
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			1	1	1	1	1	1		
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			1	1	1	1	1	1		
Signature of the Nurse						Sc	Sur	Durg	Sur	Durg	Sur		

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 : Lovel

Signature of Ward In Charge :

Signature : Name : Anshu



CHECKLIST FOR THROMBOPHLEBITIS

20/7/24

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	-	-	-							
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				Sythi jessie									

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 : lovely

Signature of Ward In Charge :

Signature : Name : Anitha

BAH-00651975
Baby YASHIKA TAK
31-05-2018 8 Y 1 M 17 D
Dr. NITASHA BAGGA (F)
IP5-00176536

PAIN ASSESSMENT FORM

Date	Time	Score (0)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
17/7/26	2:00 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	Renubha
18/7/26	6 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Durga
18/7	12 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Durga
18/7	6 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Durga
18/7/26	12 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	SN
18/7/26	6 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Sumana
19/7/26	12 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Durga
19/7	6 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Durga
20/7	2 AM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Snoli
20/7	8 AM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	SN

Re-assessment Frequency:

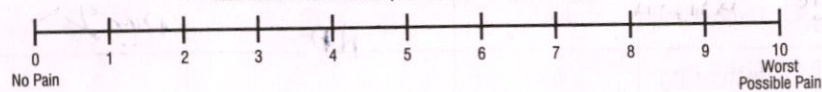
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

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 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

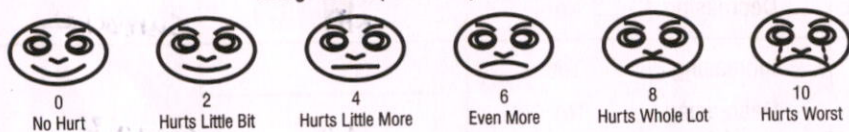
Numerical Pain Scale (Obstetric and Gynecology)



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



PAIN ASSESSMENT FORM

Date	Time	Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
20/7	2pm	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Jessie
20/7	8pm	2/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Jessie
20/7	11pm	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	-	Sangul
20/7	7am	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	-	Sangul
				☐ 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:

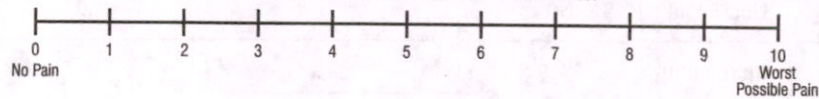
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

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



INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

BAH-00661975
Baby YASHIKA TAK
31-05-2018
Dr. NITASHA BAGGA
8 Y 1 M 17 D (F)
IP5-00176536

Patient / Learner Literacy: ☐ Read ☐ Write ☐ Speak Willingness to Learn: ☒ Yes ☐ No Healthcare Literacy: ☐ Yes ☐ No

1. Treatment
2. Pain Management
3. Informed Consent
4. Education / Therapy (safety, effects/ side effect, interactions)
5. Discharge Medication
6. Infection Control Measures
7. Diagnostic Test / Procedures
8. Nutrition / Diet
9. Fall Risk Education
10. Safe use of Medical Equipment / Implantable Devices Safety
11. Patient's / Family Rights
12. Risk / Safety
13. Activity / Exercise
14. Social & Rehabilitation Needs
15. Special Discharge / Follow-up Education / Coping Skills
16. Others
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		
17/7/16	8-55PM	7	Infection control measures	M	4	0	1	1	-	Rever
18/7/16	9:10 am	9	Normal diet	M	1	0	1	1	-	Sains

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

BAH-00661975
Baby YASHIKA TAK
31-05-2018 8 Y 1 M 17 D (F)
Dr. NITASHA BAGGA

Patient Sticker

IP5-00176536

MULTI-DISCIPLINARY PLAN OF CARE 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	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
17/7/26 8-30pm	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	ATI	H-stability	IV fluids	Dr. Bang KobL	☐ Nursing ☐ Others:
17/7/26 8-42	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Acute febrile illness	H-stability	IV fluids & IV medication	permed	☐ Medical ☐ Others:
18/7/26 9:10 am	☐ Medical ☐ Nursing ☒ Others: dietitian	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	acute febrile illness	Normal diet	RDA E: 1550kcal/d P: 27gm/d	saine	☐ 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:

BAH-00661975 IP5-00176536
Master YASHIKA TAK
31-06-2018 8 Y 1 M 17 D (M)
Dr. NITASHA BAGGA

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: 19/7/26

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

→ Assistance needed

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:

☐ Patient's Educational Topic/s discussed with the:
☐ Patient ☒ Family Member ☐ Others:

Nurse Signature: S

Nurse Name: Samara

Date and Time: 17/7/26

BAH-00661975 IP5-00176536

Master YASHIKA TAK

31-05-2018 8 Y 1 M 17 D (M)

Dr. NITASHA BAGGA



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

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

nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 09:30 Mode of Arrival: Admitting From: ☒ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction Nil Body Weight: Kg

Height: cm

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

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

Family History:

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

as 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: 19.54 Length: Head Circumference (< 2 years):

Temp.: 98.8 F HR: 108 bpm RR: 26 bpm BP: 100/70

Pain Score: 1/2 Specify Site: 4-7 (Follow Pain Assessment Sheet & Document)

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

Risk of Pressure Sore (Braden Q Score) (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:☒ 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 FindingsUnusual concerns about patient's Psychological Status: ☐ Yes ☒ No

If Yes Consultant Notified: (Date/Time):

Cultural & Spiritual Needs: ☐ Yes ☐ No if Yes specify Inform consultant for positive criteria.**Social History:** Lives WithSiblings 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 ☐ NoWaste Disposal Explained: ☒ Yes ☐ NoInfusion Pump : ☒ Yes ☐ NoHand hygiene Explained: ☒ Yes ☐ No☐ OthersPatient Rights & Responsibilities: ☒ Yes ☐ NoInformation given to parentNurse Signature: [Signature]Nurse Name: SumanDate: 17/7/20Time: 09



EMERGENCY ROOM TRIAGE FORM

Patient's Name : Yashika Tak Age : 8 yrs Gender: ☐ Male ☒ Female

Date : 17/1/20 Time of Arrival : 6:20pm Triage Completion Time : 6:22pm

Allergies: ☐ No ☐ Yes ☐ Food ☐ Medications ☐ Other (Specify): ☐ Not known any drug Allergies

Source of Information : ☒ Parents ☐ Others (Specify):

Mode of Arrival : ☐ Ambulatory ☐ Wheelchair ☐ Stretcher ☐ Ambulance

INITIAL PHYSIOLOGICAL CATEGORIZATION		INITIAL PHYSIOLOGICAL STATUS
Appearance	Work of Breathing	☒ Stable
☒ Normal	☒ Normal	☐ Unstable :
☐ Sick Looking	☐ Increased	☐ Not - Life - Threatening
Circulation / Colour	☐ Decreased	☐ Life - Threatening
☒ Normal	☐ Gasping / Apnea	
☐ Abnormal		
☐ Bleeding		

Initial Vital Signs: Temp: 98.2°F PR: 138bpm BP: 96/65 (65) RR: 20bpm SpO₂: 99% RA

Chief Complaints: cold level x 10 days, swelling over neck x 2 days

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

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

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian

Communicable Disease Triage Screening

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

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

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

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

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

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

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

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

Name of Triage Nurse : Mr. Rachel

Signature of Triage Nurse : [Signature]

Date & Time : 17/1/20 @ 6:22pm

BAH-00661975
Master YASHIKA TAK
31-05-2018
Dr. NITASHA BAGGA
8 Y 1 M 17 D
(M)

Patie

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date: 12/2/20 Time of arrival: 6:22 PM
Chief Complaints: fever x 10 days, swelling over neck x 2 days RBS: NA
Height: 128 cm Weight: 19.5 kg BMI: Head Circumference (<2 years) NA
Allergies: ☐ Yes ☒ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other: NA
If yes, identify NA
Pain Screening: ☐ Yes ☒ No If Yes, Pain Score: 0/10 Pain Tool Used: ☐ N Pass ☐ FLACC ☒ Wong Baker
☐ Character NA ☐ Location NA ☐ Frequency NA ☐ Duration NA

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: NA (Date/Time): NA

Social History: Lives With family

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

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

Time of Initial assessment completed by ER Nurse: 6:25 PM

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

Time	Nursing Notes
6:20pm	→ Assess the child condition.
	→ Seeing Dr. Rama Krishna.
	→ vitals are recorded.
	→ IV placement Done
	→ Samples collected and send for lab.
	→ Shifted to ward.

Samples collected by: Shambhu
 Samples sent by: Shambhu

Time: 6:55 pm

Time: 7:00 pm

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: 138 bpm BP: 96/55(65) CFT: 120cc RR: 24 bpm SPO ₂ : 99% GCS: 15/15 Temperature: 98.2°F Pain Score: 0/10 Repeat RBS (if applicable): NA	Shift - out from ER to: 300, Time of Shift - out: 8:50 pm Handover given to: _____ (Nurse's Name)

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any):

IV placement done

Name of the Nurse: Renuka Signature of the Nurse: [Signature]

Date & Time: _____

PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00661975 IP5-00176536 Master YASHIKA TAK 31-06-2018 8 Y 1 M 17 D (M) Dr. NITASHA BAGGA 		Date & Time of Admission 17/7/26 @ 6:55 PM	Date & Time of Transfer Order 17/7/26 @ 9:00 PM
		Transfer Ordered by Dr. Rama Krishna	Reason for Transfer Admission
From Unit C2	To Unit 306	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File - 20 -	Personal belongings including clinical documents. If any handed over to attendant Prodded Yes ☒ No ☐ If Yes, what? 01 files	Patient shifted with ID band: Yes ☒ No ☐ If No:	
Number of Imaging Films Chest x-ray			
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	DNS (500 ml)	①	
2.	Introsin	①	
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring NR - Renuk		Name of Person Ordered Transfer Dr. Rama Krishna	
Patient & Clinical Records Received by : Smahel			
Date & Time of Patient Received : 17/7/26 @ 9:10 PM			

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

☐ Unavailable Bed

☐ Nurse not Available

☐ Available Bed not ready

306



NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 18/7/26 Time: 9am

Weight: 19.5kg's Centile: <5th

Height: 116cm Centile: <5th

Inference: underweight child

RDA: - Calories: 1550kcal/d Protein: 27gm/d

Diet Recommendations: Normal diet

Re-Assesment: avoid spicy, chilled & outside foods

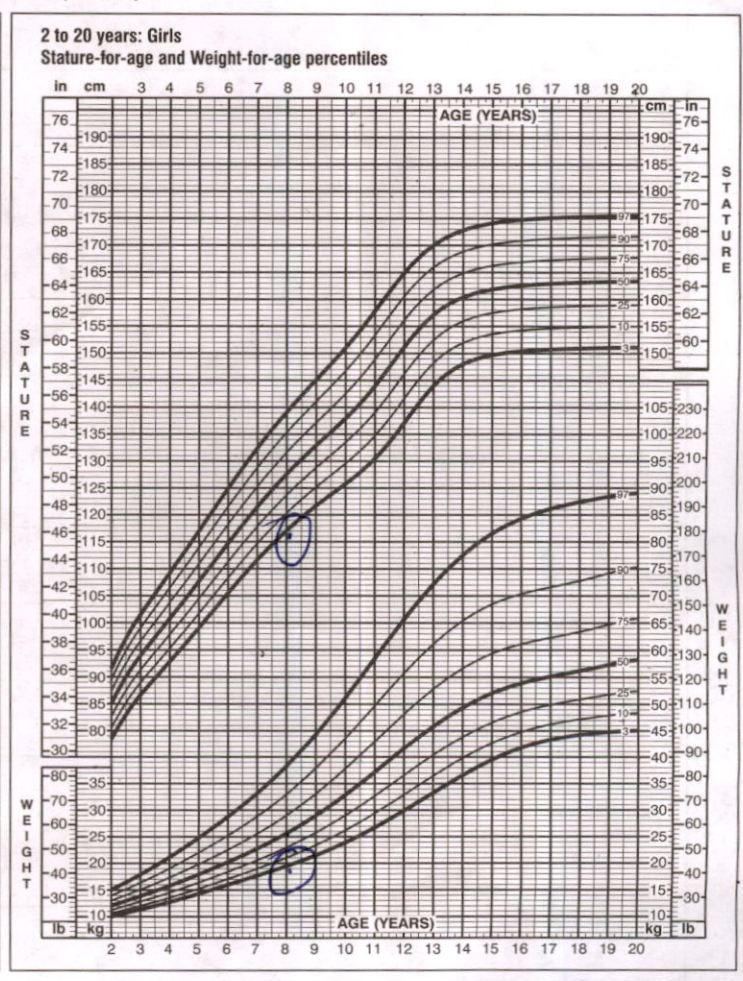
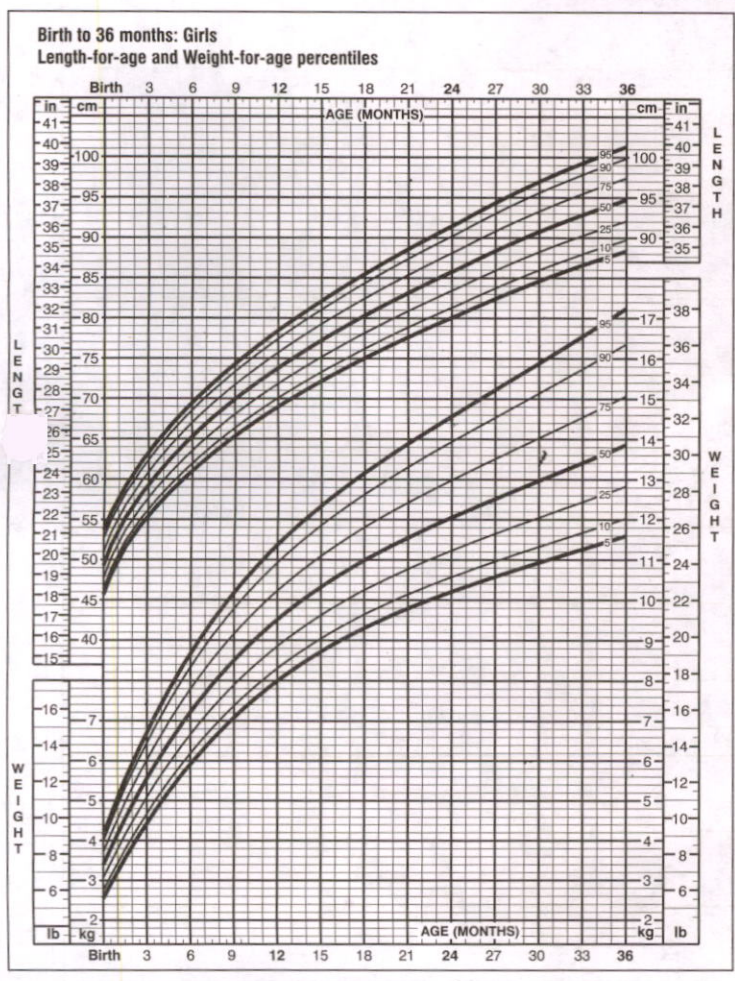
Food Allergies: NO Veg/Non-veg veg

Diagnosis: API, (acute tonsillitis)

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: Pooja

GROWTH CHART (GIRLS)



Dietician's Name Saine

Dietician's Signature Saine

Daily Notes:

19/7/26

child is stable, oral intake is fair

10:50
am

continue Normal diet

Saine

20/7/26

child is stable, oral intake is better.

9:40
am

continue Normal diet

Saima