

ADMISSION SHEET
Registration Details :

Admission No : IP5-00176117

Admit Date : 08-Jul-2026

Admit Time : 05:12 PM **UHID** : HCV-00016584

Patient Details :
Patient Name : Baby MEESALA HANVIKA

Age : 2 Y 10 M 24 D

Guardian : Mr RAM MOHAN RAO

DOB : 14-08-2023

Gender : Female

Religion :

Occupation :

Martial Status : Single

Address (H) : FLAT NO - 201 , SRI LAKSHMI NILAYAM, PLOT
NO-532, SRI RAM NAGAR COLONY ,
PUPPALAGUDA , Manikonda Hyderabad
Telangana INDIA 500089

Phone No : 8074697031/ 7799115352

E-mail : rammohan.560@gmail.com

Admission Details :
Bed Type : PRIVATE ROOM

Bed No : PVT 337

Ward Name : 3F-ZONE B

Room No : PVT 337

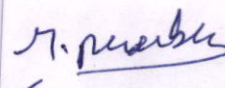
Admission Type : First Visit

Contact Details :
Name : Mr RAM MOHAN RAO

Relationship : Father

Contact Address : FLAT NO - 201 , SRI LAKSHMI NILAYAM,
PLOT NO-532, SRI RAM NAGAR COLONY ,
PUPPALAGUDA , Manikonda Hyderabad
Telangana INDIA 500089

Phone No : 8074697031 / 7799115352


Signature
Doctor Details :
Doctor Name : Dr. VENKATA LAKSHMI A

Specialisation : GENERAL PEDIATRICS

Referral Doctor : Self

Phone No :

Co-Consultant :

Payment Details :
Payment Mode : Cash

Deposit Amount : 0.00

Payor Name : BAJAJ ALLIANZ GENERAL
INSURANCE CO LTD

ACTIVITY RECORD FOR BILLING

Name : _____

HCV-00016584 IP5-00176117

Baby MEESALA HANVIKA

UHID No. : _____ Consultant: _____ Dept : _____

14-08-2023

2 Y 10 M 24 D

(F)

Dr. VENKATA LAKSHMI A

Date of Admi: _____



Date of Discharge : _____

Time: _____

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
8/7/26	6:35 pm	ER	(32) ward	pooja

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	Dr. Braundarami	09/07/26	9694715	Revathi
2	Dr. Abhishek	10/7/26	9696041	Devi
3				
4				
5				
6				
7				
8				
9				
10				

[illegible][illegible]

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
8/11	IV placement	①	693488	Samuel

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor



It takes a lot to treat the little.

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name:

Hanvika

UHID ID:

Department:

Consultant:

HCV-00016584 IP5-00176117
Baby MEESALA HANVIKA
14-08-2023 2 Y 10 M 24 D (F)
Dr. VENKATA LAKSHMI A





Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

Cough since 1 day.

Shortness of breath since 1 day.

Secretions from mouth since 1 day.

History of present illness :

Child is apparently well 1 day ago. Child developed above mentioned complaints.

Cough - Dry cough

- NO Post Tussive vomitings.

- More @ night -

Shortness of breathing since 1 day.

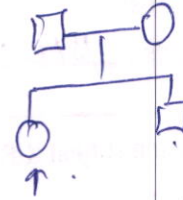
~~Child~~ Child was brought to our hospital for further management.

Pediatric Multiorgan History & Physical Examination

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

Birth & Neonatal History:

Preterm / Em LSCS / Breech / Delayed CMB
Severe activity / No NICU stay



Birth & Socio Economic History:

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

Developmental History :

② development

Immunization History :

vacination as per age till date

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14-08-2023 2 Y 10 M 24 D (F)
Dr. VENKATA LAKSHMI A

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Dr. VENKATA LAKSHMI A

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: _____

Desired goals of the treatment : _____

Planned Labs:

CBP, CRP, → Inform
S-vitd panel reports

SOS send
Blood Gs
& start IV
antibiotics

(Blood Gs sample collected in ER)

Planned Management

- Admit in ward
- Neb Cevolin 6th hly.
- Budecort Neb BD
- Syp - Amoxicil.

nlb pooja
8/7/26
6:30pm

Signature of the Doctor: Ramya

Name of the Doctor: Dr. Ramya

Date & Time: 8/7/26 : 5:30pm

Signature of the Consultant: _____

Name of the Consultant: ee

Date & Time: 9/8

DR VENKATALAKSHMI A
Registration No: 58115



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/2 6:30am	CPB Resident	
	<u>Δ: LRTI</u>	
	cp: cough x 2 days	<u>Actu</u>
	no cold / fever	1) Nebbs as charted
	no sick contact	at exact times
		as charted
	cp ↑ WOB x today	2) Maintain neb chart
	secretions per	with timings -
	oral x today.	keep in pt room
	O/E: vitals:	3) Trache reports
	HR - 126/min	
	BP - 109/83 mmHg	4) Nil by mouth
	SpO ₂ - 98% RA	only gastrostomy
	RR - 32/min	for feeds / water
	B/L chest crepts ⊕	
	(coarse)	5) If any ↑ RR /
	no retractions	↓ SpO ₂ / laboured
	abdomen soft	breathing, put baby in
		Ⓛ lat position &
		do suction
		Inform SOS

Shrile
 N.P. Dine



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/7/26	NUTRITION REVIEW	
	PBW: 11.5kg	
	IBW: 11.5kg	
	~ 1050ml / dy FLOW	
	Per feed = 110-120ml @ 3 HOURS. (8 feeds)	
	COOKED RICH - 15g	
	COOKED DAL = 6g	210ml / feed.
	VEG COOKED - 24g	175ml / feed.
	FROOT. ~ 10g	
	PANIR - 20g.	3 feeds
	OIL - 2.5ml	
	MILK feed - 2 / dy	
	NUTRAMIL-3 - 1 scoop / milk feed	
9/8/26 4:30pm	4th fluid	Brown
	LRTI	Plans:
	- No fever	→
	Q/E	- Drys / Nless as advised.
	distress	- Nutritional as per clinical advice.
	vitals - stable	
	SpO ₂ = 98%	
	RR = 35/min	
	mild rashes	
	Ps = B/L conducted sounds	
		Jahel Ramu.
		Noted by slit

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/8 9:15am	CS/B Resident <u>Δ: LRTI</u> afebrile sleep - better no fast breathing O/E: alert vitals stable chest: BAE ⊕ crepts ↓ abdomen retractions ↓ sed. no tachypnea. frothing ⊕ abdomen soft CS/B Dr. VL	Adv. ⊕ today Stable DR. VENKATALAKSHMI A Registration No: 50115 Dr. Lanya man Review. Ped. Neurology.

HCV-00016584 IPS-00176117
Baby MEESALA HANVIKA
14-08-2023 2 Y 10 M 25 D (F)
Dr. VENKATA LAKSHMI A

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

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CROSS CONSULTATION FORM

Doctor Name: Dr. Abhishek . P. Jai Date: 10/7/26 Time: 10:10 Am

Diagnosis:

Hospital: RCH, BH.

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:

Yo: Paroxysmal activity in the form of fast breathing.

Signature:

Findings and Recommendations :

- History Noted
- Recent video s/o ? ATYPICAL ABSENCE seizure
- Lasting for Brief duration.
- Last seizure

Adv

O/E:

Child conscious

EDM ⊕

partial tracking ⊕

Tone - Flaccidity & Gastrocnemius
spasticity ⊕ B/L

Intermittent Dystonia ⊕

Adv

1) EEG

2) Decide on AED

Based on EEG

Consultant :

Name: Dr. Abhishek . P. Jai Signature: Dr. Abhishek . P. Jai Date & Time:

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mcv: 73.9 ↓
 smear:

RESULT SHEET

Date	8/7				
Time					
Hb	12.5				
PCV	37.9				
RBC	5.13				
WBC	17690				
N/L	68/23				
Platelets	3.55L				
CRP	5				
ESR					
PCT					
RBS					
Na					
K					
Cl					
Ca/Mg					
Phosphate					
Urea					
Creatinine					
ALP					
SGPT					
SGOT					
T.Bill/Conj					
T.Protein					
S.Albumin					
S.Globulin					
A/G Ratio					
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein / Sugar					
Cells					
N/L					

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Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: Mode of Arrival: 6:50 pm Admitting From: ☐ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction Body Weight: Kg

..... Height: cm

..... NA

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

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

Family History:

..... NA

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: 11.5 kg Length: Head Circumference (< 2 years):

Temp.: 98.5°F HR: 142 bpm RR: 28 bpm BP: 90/60

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

Fall Risk Assessment: ☐ Yes ☐ No Score: 16 (Document in the Humpty Dumpty Sheet)

Risk of Pressure Sore (Braden Q Score 2) (Document in the Braden Q Assessment Sheet)

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

Character of Pain 0 Location 0 Frequency 0 Duration 0

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 ☐ No

Information given to mother

Nurse Signature: *[Signature]*Nurse Name: *[Name]*

Date: 8/7/26 @ 6:50pm

Time: 8:50 p.m.



216584

EMERGENCY ROOM TRIAGE FORM

Patient's Name: Hanvika Age: 2 yrs Gender: ☐ Male ☒ Female
Date: 08/12/2023 Time of Arrival: 3:40 pm Triage Completion Time: 3:42 pm
Allergies: ☒ No ☐ Yes ☐ Food ☐ Medications ☐ Other (Specify): NA
Source of Information: ☒ Parents ☐ Others (Specify): NA
Mode of Arrival: ☒ Ambulatory ☐ Wheelchair ☐ Stretcher ☐ Ambulance

INITIAL PHYSIOLOGICAL CATEGORIZATION

Appearance

- ☒ Normal
☐ Sick Looking

Circulation / Colour

- ☒ Normal ☐ Abnormal ☐ Bleeding

Work of Breathing

- ☐ Normal ☒ Increased
☐ Decreased ☐ Gasping / Apnea

INITIAL PHYSIOLOGICAL STATUS

- ☐ Stable
☒ Unstable:
☐ Not - Life - Threatening
☐ Life -Threatening

Initial Vital Signs: Temp: 98.5° PR: 142b/m BP: 109/85 RR: 46b/m SpO₂: 98% in RA

Chief Complaints: Pl. Breathing difficulty

Triage Classification

- ☐ Level 1: Resuscitation
☐ Level 2: EMERGENT: Life or limb threatening
☐ Level 3: URGENT: Significant illness / injury with potential to become life or limb threatening
☐ Level 4: LESS URGENT: Significant illness but not life threatening
☐ Level 5: NON - URGENT: May receive care when convenient

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

CTAS

- ☐ Immediate
☐ < 15 min
☒ 30 min
☐ 60 min
☐ 120 min

Signature of Parent / Guardian

Communicable Disease Triage Screening

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

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

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

1. Have you travelled outside the INDIA? or had close contact with someone who has recently travelled outside the INDIA, in the past two weeks ☐ Yes ☐ No
If yes, State Location: _____
2. Are your parents / close contacts at home 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: T. Ganthu

Date & Time: 8/12/23 3:43 pm

Docu. No.: RCHBH / FRM / CLINICAL / 085

Signature of Triage Nurse: [Signature]

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

Time	Nursing Notes
3:45pm	Assess the child condition
	- monitored vitals & recorded
	- seen Dr. Ramya
	- shifted to ward

Samples collected by:

Samples sent by:

Dr. Ramya

Time: 5:52pm

Time:

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1
8/7/2026 3:45pm	Carbini 0.63mg + 3% NS 2ml	P/N	Inspire		poorhik

Condition of patient at time of shift - out :	Details of Shift - out
HR: 142 bpm BP: - CFT: 2 sec RR: 28 bpm SPO ₂ : 98% GCS: 4/5/6 Temperature: 98.6°F Pain Score: 0 Repeat RBS (if applicable): NA	Shift - out from ER to: ward Time of Shift - out: 6:35 pm Handover given to: _____ (Nurse's Name)

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any):

OR placement done

Name of the Nurse: pooja

Signature of the Nurse: 

Date & Time: 8/7/26 5:52pm

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Part - I.

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

Identified Education Needs:

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

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
8/7/26	5:15 pm	7	Infection control measures	F	4	0	1	1	NA	poofc
10/7/26	9 am	9	child is on breastfeeding feeds	f/m	1	0	1	1	-	same

Part - III: CODES

Who was taught: PT: Patient F: Father M: Mother S: Spouse Sn: Son D: Daughter C: Caregiver O: Other (Specify)

Learning Barriers:

1. No Learning Barriers	4. Language Barrier	7. Impaired Thought Process/Cognitive limitations	10. Financial Difficulties	13. Cultural/Religion Practice
2. Physical Impairment	5. Educational Level	8. Responsibilities at Home	11. Beliefs and Values	14. Others (Specify)
3. Emotional Barriers	6. Desire / Motivate to Learn	9. Cultural Differences	12. Impaired Vision/ or Hearing	

Teaching Tools Used: A: Audio D: Demonstration V: Video O: Oral P: Printed

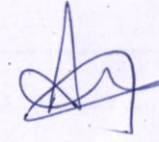
Mechanism/s to overcome barrier/s:

1. None	3. Reassurance & Support	5. Respect values & beliefs	7. Other, Specify
2. Obtain translator	4. Teach Family / Others	6. Respect Cultural / Religion Preference	

Understanding: 1. Verbalizes Understanding 2. Demonstrates Understanding 3. Needs Review

MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis: LRTI

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
8/7/26 6:15 pm	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	fast breathing to RR.		Nebbs		☒ Nursing ☐ Others:
8/7/26 6:15 pm	☐ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Breathing difficulty	st - stability.	nebulization	Pooj's	☒ Medical ☐ Others:
10/7/26 9 AM	☐ Medical ☐ Nursing ☒ Others: <u>breath</u>	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	LRTI	Gastrostomy Jeds 210ml/32mg	RDA e- 1250kcal/d p- 22gml/d	Laina	☐ 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:

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MEDICATION RECONCILIATION FORM

Drug Allergies:

☒ Not known any Drug Allergies

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

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

Shifting From: ER

Shifted to: 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	Tcb Zonerges 100mg	1/4 tab	PO	HS		☒ C ☐ DC
2	Syp. Valparin	5ml	PO	BD	8/7/26	☒ C ☐ DC
3	Tcb Lonzep 0.25mg	1/2 tab	PO	HS		☒ C ☐ DC
4	Tcb Gabapentin 100mg	1/2 tab	PO	HS		☒ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Ramya

Date & Time : 8/7/26 : 6pm

Nurse Name & Signature: pooja

Date & Time : 8/7/26 e 6:05 pm



Sheet No:

REGULAR PRESCRIPTIONS

Weight 11.55kg Ward

DRUG : <u>Syp. SODIUM VAL PROATE</u>				Date Time	<u>8/8/2023</u>														
Dose	Route	Frequency	Start Dt.																
<u>2.5ml</u>	<u>PO</u>	<u>BD</u>	<u>8/7/26</u>																
Name & Signature of the Doctor Starting the Drugs:																			
<u>Dr. Remya</u>																			
Additional Instructions:																			
<u>(200mg / 5ml)</u>																			
Daily Doctor's Endorsement by a Sign				<u>A A A</u>															

DRUG : <u>Teb LONAZEP 0.25mg</u>				Date Time	<u>8/7/26</u>														
Dose	Route	Frequency	Start Dt.																
<u>1/2 teb</u>	<u>PO</u>	<u>HS</u>	<u>8/7/26</u>																
Name & Signature of the Doctor Starting the Drugs:																			
<u>Dr. Remya</u>																			
Additional Instructions:																			
Daily Doctor's Endorsement by a Sign				<u>A A A</u>															

DRUG : <u>Teb GABAPENTIN</u>				Date Time	<u>8/7/26</u>														
Dose	Route	Frequency	Start Dt.																
<u>1/2 teb</u>	<u>PO</u>	<u>P HS</u>	<u>8/7/26</u>																
Name & Signature of the Doctor Starting the Drugs:																			
<u>Dr. Remya</u>																			
Additional Instructions:																			
<u>1 teb = 100mg</u>																			
Daily Doctor's Endorsement by a Sign				<u>A A A</u>															

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																			

VERIFIED
Signature

VERIFIED
Name

Patient Sticker

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																				



DRUG CHART

Date of Admission: 8/7/26 Drug Allergies: Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

- GENERAL** - Ensure that all patient details are entered above. ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.
- DOCTOR** - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
- Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
 - Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
 - Discontinue a drug by drawing a line **I** through it and a similar line through subsequent recording panels.
 - The date and time of stopping the drug along with the doctors name and sign must be mentioned.
 - Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.
- NURSES** - Nurses must follow strictly the FIVE RIGHTS before administration of medication.
- 1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time
- AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

SOS / PRN (As Required Medication)

DRUG : <u>SypCROCINDS</u>				Date Time															
Dose	Route	Frequency	Start Date																
<u>3ml PO</u>		<u>SOS</u>	<u>8/7</u>																
Doctor's Signature		Valid Period	Pharm.																
<u>[Signature]</u>			<u>[Signature]</u>																
Additional Instructions:																			
<u>T>100°F (5/240mg)</u>																			

DRUG : <u>SypMEFALP</u>				Date Time															
Dose	Route	Frequency	Start Date																
<u>5ml</u>		<u>SOS</u>	<u>8/7</u>																
Doctor's Signature		Valid Period	Pharm.																
<u>[Signature]</u>			<u>[Signature]</u>																
Additional Instructions:																			
<u>T>102°F (5/100)</u>																			

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

VERIFIED BY : Name



REGULAR PRESCRIPTIONS

Weight. 11.55kg Ward.

VERIFIED

DRUG : Neb CEVOLINO-63mg				Date Time 8/7/26
Dose	Route	Frequency	Start Date	
1 resp	Nasal	QID	8/7/26	6am slt slt
Name & Signature of the Doctor Starting the Drugs: Dr. Ramey				12pm slt
Additional Instructions:				6pm Rethi 12am slt slt
Daily Doctor's Endorsement by a Sign				A A A

VERIFIED

DRUG : Neb BUDECORT 0.5mg				Date Time 8/7/26
Dose	Route	Frequency	Start Date	
1 resp	Nasal	BD	8/7/26	9am slt slt
Name & Signature of the Doctor Starting the Drugs: Dr. Ramey				9pm slt slt
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				A A A

VERIFIED

DRUG : Syrup AMBRODIL				Date Time 8/7/26
Dose	Route	Frequency	Start Date	
3ml	PO	BD	8/7/26	9am slt slt
Name & Signature of the Doctor Starting the Drugs: Dr. Ramey				9pm slt slt
Additional Instructions:				9pm slt slt
Daily Doctor's Endorsement by a Sign				A A A

VERIFIED

DRUG : Tab ZONEGRAN				Date Time 8/7/26
Dose	Route	Frequency	Start Date	
1/4 tab	PO	TDS	8/7/26	11pm slt slt
Name & Signature of the Doctor Starting the Drugs: Dr. Ramey				11pm slt slt
Additional Instructions:				
1 tab Zonisamide (100mg)				
Daily Doctor's Endorsement by a Sign				A A A

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

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

STAT / ONCE ONLY DRUGS[illegible]

Weight. 11.55kg Ward.

[illegible]

VERIFIED BY: Name

1016584 IP5-00176117
IEESALA HANVIKA
023 2 Y 10 M 25 D (F)
KATA LAKSHMI A



NEBULISATION CHART

Date	Time	Drug	Nurse	Parents Signature
8/7/26	00.00	Budecort . 9pm	9693950	Shinsh
9/7/26	01.00	Levolin 12AM		Shinsh
9/7/26	02.00	Levolin 6AM		Shinsh
9/7/26	03.00	Budecort 10 AM	9694550	Relays
9/7/26	04.00	Levolin 1 pm		
9/7/26	05.00	Levolin 6pm		
9/7/26	06.00	Budecort	9695007	Relays
10/7/26	07.00	Levolin 6AM		
10/7/26	08.00	Levolin 12AM		
10/7/26	09.00	Budecort 9AM	9696024	Relays
10/7/26	10.00	Levolin 12 pm		
	11.00			
	12.00			
	13.00			
	14.00			
	15.00			
	16.00			
	17.00			
	18.00			
	19.00			
	20.00			
	21.00			
	22.00			
	23.00			

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date :	Time:	10p m	12Am	6Am
Doctor / Nurse / Family Concern?				
Temperature (°F)	104			
	103			
	102			
	101			
	100	* 100.3		
	99	* 99.3		
	98			
	97		* 97.3	
	96			
	95			
	94			
Heart Rate (bpm)	190			
	180			
	170			
	160			
	150			
	140			
	130			
	120			
	110			
	100			
	90			
Blood Pressure (mmHg) *	180			
	170			
	160			
	150			
	140			
	130			
	120			
	110			
	100			
	90			
	80			
Note: BP does not score in early warning scoring	70			
	60			
	50			
	40			
	30			
	20			
	10			
	0			
	0			
	0			
	Heart Rate (Number)	135b/m	113b/m	
Resp. Rate (bpm) (Over 1 Minute) *	70			
	60			
	50			
	40			
	30			
	20			
	10			
	0			
	0			
	0			
	Resp Rate (Number)	29b/m	24b/m	
Resp Distress	Mod/ Severe			
None / Mild				
Receiving O ₂ (l/min)				
O ₂ Saturations (%)	100%	100%		
Conscious Level	Normal			
Altered				
GCS *	12/15	13/15		
TOTAL SCORE				
Number of shaded boxes	0	0		
Pain Score	0	0		
Observer's Initials	8	6		

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)

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CV-00016584 IP5-00176117
 Baby MEESALA HANVIKA
 14-08-2023 2 Y 10 M 24 D (F)
 Dr. VENKATA LAKSHMIA



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 Your Right to a Safe Delivery

FLUID CHART

Sheet No. :

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

Date	Time	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
		Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	M. Galya							
	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										0	DR
Total Intake :					Total Output : M-20-0							
	08:00 pm			22ml							0	
	09:00 pm			22ml							0	
	10:00 pm			22ml	400ml						0	
	11:00 pm			22ml							0	
	12:00 am			22ml							0	
	01:00 am			22ml							0	
Total Intake :					Total Output : M-20-1							
	02:00 am			22ml							0	
	03:00 am			22ml							0	
	04:00 am			22ml							0	
	05:00 am			22ml							0	
	06:00 am			22ml							0	
	07:00 am			22ml							0	
Total Intake :					Total Output : M-20-1							
Total 24 hrs. Intake		260										
Total 24 hrs. Output		M-20-2										

FLUID CHART

Sheet No. :

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sgn. Nurse
			Mouth	I.V.	Route	NG	Diarrhoea	Vomit	Drainage	Urine		
9/7					Gastro							
	08:00 am				N.G						0	
	09:00 am										0	
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output : m-0 u-1						
9/7	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
	Total Intake :						Total Output : u-2 m-2					
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
	Total Intake :						Total Output : m-1 u-2					
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
	Total Intake :						Total Output : m-0 u-1					
Total 24 hrs. Intake			Total 24 hrs. Output									

8584 IP5-00176117
SALA HANVIKA
3 2 Y 10 M 25 D (F)
ATA LAKSHMI A



FLUID CHART

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BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Sheet No. :

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

		Intake			Output					IV Site Thrombo- phlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route	NG	Diarrhoea	Vomit	Drainage	Urine				
10/7			Mouth	I.V	Gastro N.G							
	08:00 am									0	} Day	
	09:00 am									0		
	10:00 am				Milk				✓	0		
	11:00 am								✓	0		
	12:00 pm				food					0		
	01:00 pm									0		
Total Intake :					Total Output : m - 0 u - 2							
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :					Total Output :							
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :					Total Output :							
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :					Total Output :							
Total 24 hrs. Intake												
Total 24 hrs. Output												

HCV-00016584 IP5-00176117
 Baby MEESALA HANVIKA
 14-08-2023 2 Y 10 M 25 D (F)
 Dr. VENKATA LAKSHMI A



FLUID CHART

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		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											
	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											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						Total Output :						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						Total Output :						

Total 24 hrs. Intake

Total 24 hrs. Output

8584 IP5-00176117

SALA HANVIKA

2 Y 10 M 25 D (F)

ATA LAKSHMI A



NURSING CARE RECORD

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 Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 3/21/20

Assessment: cough, secretions from mouth

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 patient General condition	8:05pm	Assessed the patient. General condition.	Patient very stable.
10pm	Monitor the vitals	10:05pm	monitored the vitals.	
12AM	Maintain I/O chart.	12:05AM	Maintained I/O chart.	
2AM	provided comfortable position patient.	2:05AM	provided comfortable. position patient very stable.	
4AM	Give to patient nebulizer	4:05AM	nebulization done.	
7AM	To administer medication	7:05AM	Administer medication	

Re-Assessment: after providing comfortable position Patient very stable.

Special Notes: Nebulization done and continue

Nurse Signature: [Signature]

Nurse Name: Shinsl

Date & Time: 9/12/20

HCV-00016584 IP5-00176117
 Baby MEESALA HANVIKA
 14-08-2023 2 Y 10 M 25 D (F)
 Dr. VENKATA LAKSHMI A

NURSING CARE RECORD

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Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 9/7/24

Assessment: patient having cough

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8 AM	=> Assess the patient General condition	8:10 AM	=> Assessed the patient General condition	patient is Stable
10 AM	=> Assess the patient vitals signs	10:20 AM	=> Assessed the patient vitals signs	
12 PM	=> To maintain S/O chart	12:10 PM	=> maintained S/O chart	
1 PM	=> To encourage oral intake	1:20 PM	=> Encouraged oral feeds	
2 PM	=> To provide comfortable position -> plan nebulization	2:10 PM	=> given nebulization	

Re-Assessment: patient is stable

Special Notes: Nebulization continue

Nurse Signature: [Signature]

Nurse Name: Divya

Date & Time: 9/7/24 @ 2:pm

NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 9/7/26

Assessment: patient having lower respiratory tract infection

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	→ Assess the patient general condition	2:30 pm	→ Assessed the patient general condition on the Bed	→ patient was stable now
4pm	→ To monitor vitals	4:30 pm	→ monitored vitals	
5pm	→ To maintain I/O chart	5:50 pm	→ maintained I/O chart	
6pm	→ To give nebulization → To administer the medications	6:	→ nebulization given as per advised → administered the medications as per chart	

Re-Assessment:

Re-assessment has done after 1 hour patient was stable now.

Special Notes: continue - nebulizations

If the patient taking out more saliva suction has to be done.

Nurse Signature: [Signature] Nurse Name: Revathi Date & Time: 9/7/26 @ 8pm

NURSING CARE RECORD

☐ Morning ☐ Afternoon ☒ Night

Date: 9/7/26

Assessment: patient having cough.

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	Assess the patient General condition	8:05pm	Assessed the patient General condition	Patient was stable.
10pm	Monitor the vitals.	10:05pm	Monitored the vitals.	
12AM	Maintain IDO chart.	12:05AM	Maintained IDO chart.	
2AM	provide comfortable position to patient.	2:05AM	provided comfortable position to patient.	
4AM	Plan to give Nebulization.	4:05AM	Nebulization given.	
6AM	Maintain Personal Hygiene.	6:05AM	reinforced Personal Hygiene.	
7AM	To Administer medication	7:05AM	Administer medication.	

Re-Assessment:

after providing comfortable position Patient was stable.

Special Notes: continued nebulization. continued.

Nurse Signature: [Signature]

Nurse Name: Shri's L

Date & Time: 10/7/26 @ 9am



NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date:

Assessment:

very mild difficulty of Breathing
The fo (LRTD)

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	Assist the pt condition.	8:20 AM	Assisted the pt condition	
	Observation of Breathing Pattern.		On bed lying with mother	
9AM	Monitor SpO ₂ . If Output.	9AM	Stable	
	Behavioral Gcs.		V/s checked & recorded	patient is stable
12PM	Medication Administration		By Dr. V. L. Madam	
	As per Order.	10:10	Advised for reassessment	
	Plan for Discharge	10:30 AM	By Abhishek Jain Sir.	
	EEG done		Advised for EEG	
			then Discharge today.	

Re-Assessment:

Special Notes:

Nurse Signature: Raj

Nurse Name: Raj

Date & Time: 10/7/21 02:20pm

V-00016584 IP5-00176117
by MEESALA HANVIKA
08-2023 2 Y 10 M 25 D (F)
VENKATA LAKSHMI A



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:



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: DR. V. L. Department: Neuro Date of Admission: 9/7/2023

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☒ No ☐ Not Known					
	<u>LRTI</u>		If Yes Specify:					
BACKGROUND	Area	Shift Time	ER 6:35 pm	3rd floor 8 AM	3rd floor 2 PM	3rd floor 2 pm 8 pm	3rd floor 8 AM	
	Medical Condition (Any special condition to be noted):		NA	NA	NA	NA	NA	
ASSESSMENT	Allergy:		☒ Yes ☒ No	☒ Yes ☒ No	☒ Yes ☒ No	☒ Yes ☒ No	☒ Yes ☒ No	☒ Yes ☒ No
	Tubes/Drains/Catheter:		☒ Yes ☒ No	☒ Yes ☒ No	☒ Yes ☒ No	☒ Yes ☒ No	☒ Yes ☒ No	☒ Yes ☒ No
	Vital Signs:	Temp:	98.9 F	98.1 F	98.0 F	99.0 F	98.1 F	
		Res:	28 bpm	28 bpm	28 bpm	24 bpm	28 bpm	
		SpO ₂ :	99%	99%	99%	98%	99%	
		Pulse:	121 bpm	120 bpm	170 bpm	140 bpm	130 bpm	
		BP:	109/63	110/60	96/58	120/82	107/80	
	Fall Risk Score:	11	11	11	11	11		
Pain Score:	0/10	0/10	0/10	0/10	0/10			
Safety Needs:	Yes	Yes	Yes	Side rails	Side rails			
Recommendations	Physiotherapy		☒ Yes ☒ No	☒ Yes ☒ No	☒ Yes ☒ No	☒ Yes ☒ No	☒ Yes ☒ No	☒ Yes ☒ No
	Others Specify:	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		
Post Operative Procedure Special Orders:		NA	NA	NA	NA	NA		
Handed Over By Name :		Pooja	Shrisha	Pooja	Pooja	Shrisha		
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]		
Date:		8/7/23	9/7/23	9/7/23	9/7/23	10/7/23		
Time:		6:45 pm	8 AM	2 pm	8 pm	8 AM		
Taken Over By Name :		Pooja	Pooja	Pooja	Shrisha	Pooja		
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]		
Date:		9/7/23	9/7/23	9/7/23	9/7/23	10/7/23		
Time:		8 pm	3 AM	3 pm	8 pm	3 AM		

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

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



THE HUMPTY DUMPTY SCALE 8/2 9/2 10/2

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	4	4	4		
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2					
	Female	1	1	1	1		
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1	1		
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	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		
	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		
Medication Usage	Sedatives (excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1	1		
TOTAL			11	11	11		

Intervention : -Fall Risk : Low Humpty Dumpty Score = 7-11, High Risk Humpty Dumpty Score = 12 or above

Bed in low position	yes	yes	yes		
Call device within reach	yes	yes	yes		
Wheels Locked	yes	yes	yes		
Room free of clutter	yes	yes	yes		
Adequate Lighting	yes	yes	yes		
Wheel Chair Support	NO	NO	NO		
Other Intervention(s) Specify	NO	NO	NO		
Nurse's Name :	poorja	slain	slain		
Signature :					
Date :	8/2	9/2	10/2		
Time :	5:15 pm	6:45	6:45		



CHECKLIST FOR THROMBOPHLEBITIS

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

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 : Subhashini Name : Subhashini

Signature of Ward In Charge :

Signature : R. B. Narayana Name : R. B. Narayana

CHECKLIST FOR THROMBOPHLEBITIS

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

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

Signature of Shift In Charge :

Signature of Ward In Charge :

Signature : Name :

Signature : Name :

PATIENT TRANSFER FORM

Patient Name & UHID No. HCV-00016584 IP5-00176117 Baby MEESALA HANVIKA 14-08-2023 2 Y 10 M 24 D (F) Dr. VENKATA LAKSHMI A 		Date & Time of Admission 8/7/26 5:12 pm	Date & Time of Transfer Order 8/7/26 6:35 pm
		Transfer Ordered by Dr. Nandan	Reason for Transfer Admission
From Unit ER	To Unit ward	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 19	Number of Imaging Films NA	Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ If yes, what ? op files	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	Blood clt	(1)	
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring NR. pooja		Name of Person Ordered Transfer Dr. Nandan	
Patient & Clinical Records Received by :			
Date & Time of Patient Received :			

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

☐ Unavailable Bed

☐ Nurse not Available

☐ Available Bed not ready

HCV-00016584
Baby MEESALA HANVIKA
14-08-2023 2 Y 10 M 24 D (F)
Dr. VENKATA LAKSHMI A



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

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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:

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

yes assistance

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: [Signature]

Nurse Name: [Signature]

Date and Time: 8/7/22 @ 6:57pm

NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 10/7/26 Time: 9am

Weight: 11.5kg Centile: <5th
Height: 85cm Centile: <5th

Inference: underweight child

RDA: - Calories: 1250kcal/d Protein: 22gm/d

Diet Recommendations: child is on gastrostomy feeds

Re-Assessment: 2 time / 3rd hrly

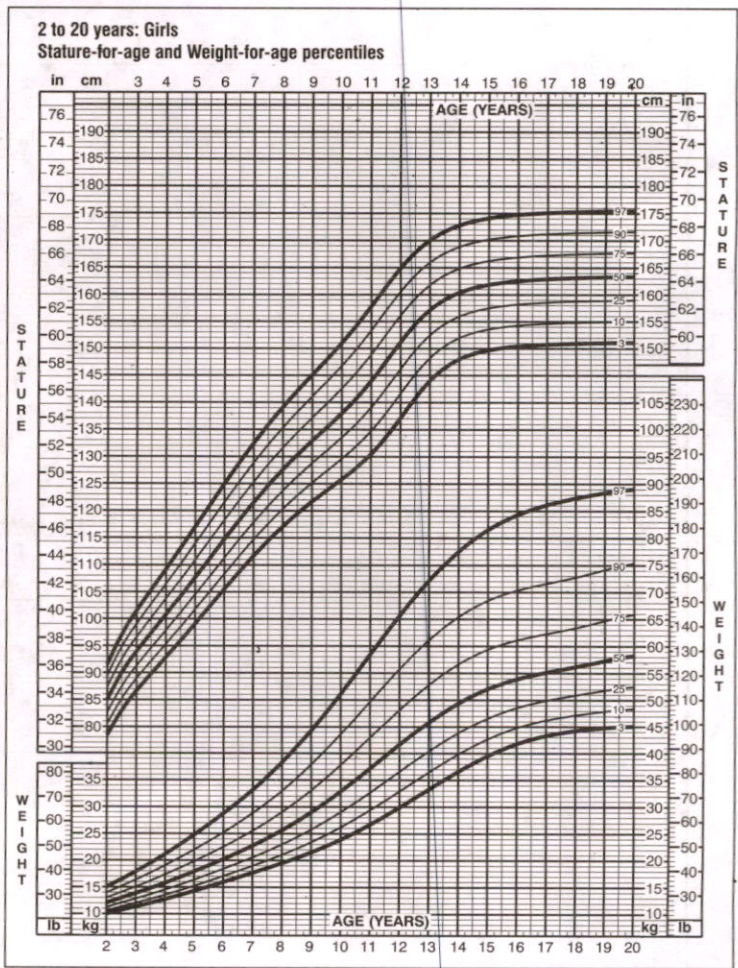
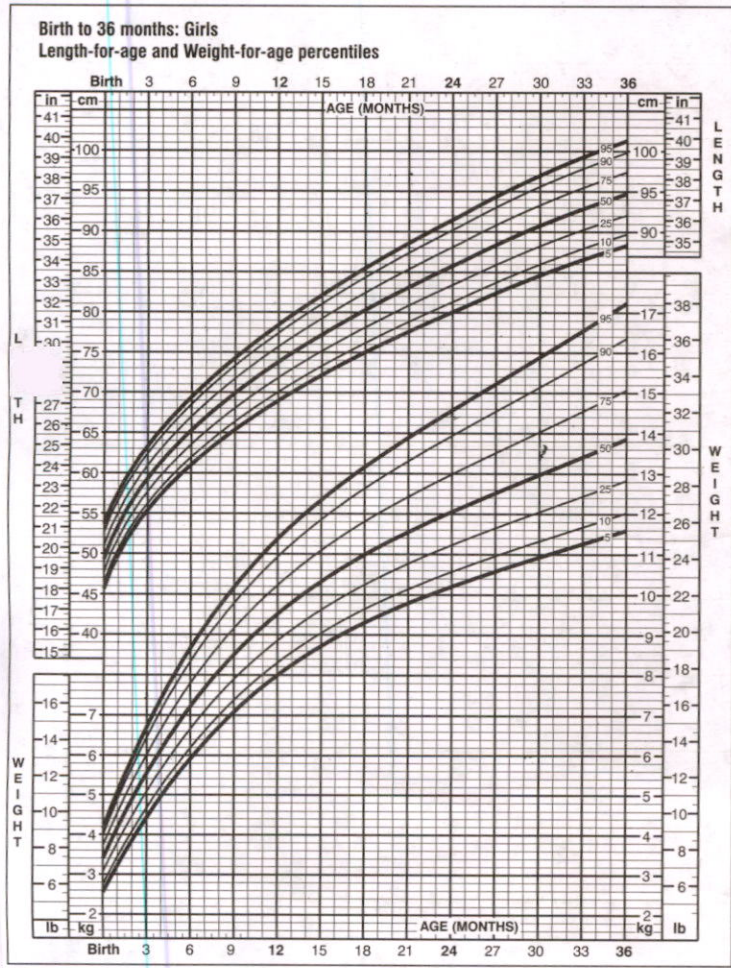
Food Allergies: NO Veg/Non-veg: Non-veg

Diagnosis: developmental delay dystonia & NCV & LPTI

Nutritional Intervention - ☐ Oral ☒ Enteral ☐ Parenteral

Patient's Signature: n. prakash

GROWTH CHART (GIRLS)



Dietician's Name: Lalma

Dietician's Signature: Lalma

Daily Notes: