

1



ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____ IP _____ Patient: _____ Dept : _____

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

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

BAH-00652018 IP5-00174396
 Master AYMAN ABDIKARIM OMAR
 15-06-2018 7 Y 11 M 12 D (M)
 Dr. BIRISHA RANI




WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
27/05	7:45 PM	CR	136	Tenax

Cross Consultation Visit

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

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
2/8/15	chemotherapy	①	2632516.	

ANY OTHER INFORMATION

Don't charge for NHA — Monica

.....

.....

.....

.....

.....

.....

Date : 2/6/16 Time : 6am Prepared By : Pooja

<p>Staff Nurse</p> <p>Pooja</p>	<p>Shift / Ward</p> <p>Night shift</p> <hr/> <p>Oncology</p>	<p>Billing Assistant</p>	<p>Billing Supervisor</p>
---------------------------------	--	--------------------------	---------------------------

ADMISSION SHEET



Registration Details :

Admission No : IP5-00174396

Admit Date : 27-May-2026

Admit Time : 05:48 PM UHID : BAH-00652018

Patient Details :

Patient Name : Master AYMAN ABDIKARIM OMAR HASSAN

Age : 7 Y 11 M 12 D

Guardian : Mr ABDIKARIM OMAR HASSAN

DOB : 15-06-2018

Gender : Male

Religion :

Occupation :

Martial Status : Single

Address (H) : PARAMOUNT COLONY, GATE NO 3 Tolichowki
Hyderabad Telangana INDIA 500008

Phone No : 7416952253

E-mail : NOMAIL@GMAIL.COM

Admission Details :

Bed Type : FOUR SHARING

Bed No : FSW 136

Ward Name : 1F-HEMATO-ONCOLOGY

Room No : FSW 136

Admission Type : First Visit

Contact Details :

Name : Mr ABDIKARIM OMAR HASSAN

Relationship : Father

Contact Address : PARAMOUNT COLONY, GATE NO 3
Tolichowki Hyderabad Telangana INDIA 500008

Phone No : 7416952253


Signature

Doctor Details :

Doctor Name : Dr. SIRISHA RANI

Specialisation : HEMATO ONCOLOGY

Referral Doctor : Self

Phone No :

Co-Consultant : Dr. SANDHYA VADDADI

Payment Details :

Payment Mode : Cash

Deposit Amount : 0.00

Payor Name : SELFPAY



Rainbow[®] Children's Hospital

It takes a lot to treat the little.

PEDIATRIC IN-PATIENT MEDICAL RECORD

BAH-00652018 IP5-00174396
Master AYMAN ABDIKARIM OMAR
15-06-2018 7 Y 11 M 12 D (M)
Dr. SIRISHA RANI



Patient Name:

Ayman Abdikarim Omar

UHID ID:

Department:

Consultant:

BAH-00652018

IP5-00174396

Master AYMAN ABDIKARIM OMAR

15-06-2018

7 Y 11 M 12 D (M)

Dr. SIRISHA RANI



Perinatal, Multisystem History & Physical Examination

Name : Ayman Abdikarim Omar Age/Sex 7y
Information given by: Mother Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

K1C10 - Burkitt leukemia /
Now admitted for PET CT &
& chemo.

History of present illness :

Child is a K1C10.

- Burkitt leukemia / GUPC /

CNS - Neg / CMYC - Neg / BM - MRN neg

- ON FAB - LMB protocol

- Now plan for

- PET scan.

- Chemotherapy - FAB - LMB

- No. H/O - fever / cough / vomiting



Pediatric Multiorgan History & Physical Examination

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

Birth & Neonatal History:

Normal perinatal
transition



Birth & Socio Economic History:

About Father : _____

About Mother : _____

Any additional Information : upper

Developmental History :

- upt as per age

Immunization History :

as per age

BAH-00652018 IP5-00174396
Master AYMAN ABDIKARIM OMAR
15-06-2018 7 Y 11 M 12 D (M)
Dr. SIRISHA RANI

Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs)) 24.6 kg (Centile _____)

On Examination :

Temperature : 98.6°F Pulse Rate : 130/min B.P. 124/71 (84) SPO2 100%

Resp. rate and type of breathing : 24/min

Rash _____

Lymphadenopathy _____

Oedema : _____

Allergies (if any): _____

Respiratory System :

Inspection (any s/o distress) : _____

Air entry & breath sounds : _____

Any addes sounds : clear

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

Cardiovascular System :

Inspection of procordium : _____

Heart Sounds : _____

Any murmur : S1S2

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

Per Abdomen :

Inspection _____

Palpation : _____

Ausculation : _____

Spine : _____ External Genitalia : Soft, NT

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



Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : Alert

Cranial Nerves : _____

Motor System:

Nutriton : _____

Tone: _____ Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR _____ **(N.)** _____ Superficials: _____
Plantars _____

Sensory System :

Bladder / Bowel : _____

Clinical Summary & Diagnostic:

Kldo - Burkitt's Leukemia
Post RCOPAM-2
Plan for PET CT (chemo)



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: Parental Cl

Desired goals of the treatment: ++ Stability

Planned Labs:

CBP / Creatinine
N/B
Temp

Planned Management

PAC / IUF NS
3 DET CT TIm
3 Chemotherapy to
Start
- cont. Supportive
medication
N/B
Renub
27/5/20

Signature of the Doctor: Pareeni

Name of the Doctor: Pareeni V

Date & Time: 28/5/26 5:37pm

Signature of the Consultant: [Signature]

Name of the Consultant: Dr. SANDHYA V

Date & Time: 28/5/26 5:37pm

Dr. SANDHYA V
Reg. No. 71564

3AH-00652018 IP5-00174396
 Master AYMAN ABDIKARIM OMAR
 15-06-2018 7 Y 11 M 12 D (M)
 Dr. SIRISHA RANI



1

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
29/5/26	Morning Rounds	
8am	C/o Burkitt leukemia / CNS Que (MFD) Bm Que for R-CVVE cycle 1	
	No fever / vomiting oral intake (w) vitals - stable	
		<p>plan</p> <ol style="list-style-type: none"> 1) PBT (R) collect today 2) Continue supportive care 3) monitor vitals 4) Continue chemotherapy as per chart
		<p>Dr. Sandhya Vaddadi 29/5/26 10am Reg. No: 71664</p>

3AH-00652018 IP5-00174396
 Master AYMAN ABDIKARIM OMAR
 15-06-2018 7 Y 11 M 12 D (M)
 Dr. SIRISHA RANI

2



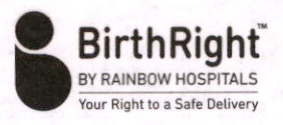
PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
30/5 8AM	<p><u>KLUO Bwkit</u> Lukemia/CNS, MDD (neg) PET good response; R-CYVE ①</p>	<p>R ① I/f lipid CNS @ 30ml/m</p>
	<p>NO temp spikes activity ① ↓ stool intake <u>on EHEXLOT</u> CVS, R2 PIA / ① THS ①</p>	<p>② cont chemotherapy ③ I/f starting ④/4</p>
	<p>(UO = 3.3ml/kg/h)</p>	<p>④ Monitor vitals CRP on 1/6/26 10° B° 37.1 30/5/26 ① 21 (D/K/S)</p>
	<p><i>[Signature]</i> Discharge 4pm @ 5:30 AM</p>	

Ay
Pa

BAH-00652018 IP5-00174396
Master AYMAN ABDIKARIM OMAR
15-06-2018 7 Y 11 M 12 D (M)
Dr. SIRISHA RANI

Omer



RESULT SHEET

Date	27/5.	1/6/26			
Time	10pm.	6:05AM			
Hb	10.8.	9.2			
PCV	33.3	28.4			
RBC	3.87	3.36			
WBC	6.86.	3.60			
N/L	40/28.	90.8/6.9			
Platelets	347	307			
CRP					
ESR					
PCT					
RBS					
Na					
K					
Cl					
Ca/Mg					
Phosphate					
Urea					
Creatinine	0.5				
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					



Ima

DRUG CHART

Date of Admission: 27/5/20 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 :				Date Time																
Dose	Route	Frequency	Start Date																	
Doctor's Signature		Valid Period	Pharm.																	
Additional Instructions:																				

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

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

Signature
VERIFIED BY : Name



Sheet No:

REGULAR PRESCRIPTIONS

Weight ... 23kg ... Ward ... Oncology

DRUG :				Date Time														
PREDNICOLONE ^{eye} drop				28/5														
Dose	Route	Frequency	Start Dt.															
2/2	in each eye	Q8h	28/5	6am														
Name & Signature of the Doctor Starting the Drugs:																		
Sirishi																		
Additional Instructions:																		
Daily Doctor's Endorsement by a Sign																		
DRUG : ^{inj} DEXAMETHASONE				29/5														
Dose	Route	Frequency	Start Dt.															
3mg	IV	Q24h	29/5															
Name & Signature of the Doctor Starting the Drugs:																		
Sirishi																		
Additional Instructions:																		
Daily Doctor's Endorsement by a Sign																		
DRUG : ^{inj} ESMOPRAZOLE				29/5														
Dose	Route	Frequency	Start Dt.															
25mg	IV	Q24h	29/5															
Name & Signature of the Doctor Starting the Drugs:																		
Sirishi																		
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																		

VERIFIED

Signature

Name

BAH-0652018 IP5-00174396
 Master AYMAN ABDIKARIM OMAR
 15-06-2018 7 Y 11 M 15 D (M)
 Dr. SIRISHA RANI



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 :				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 BY : Name Signature



Weight. Ward.

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
28/5/26		IV DEXAMETHASONE	50mg			
28/5/26	4pm	IV AVIL (CLORPHEMINOL MALEATE)	0.5ml (12mg)	IV	d	Phy R
28/5/26	4.5pm	IV HYDROCORTISONE	50mg	IV	d	Phy Phy Phy Nareng
29/5/26	6pm	IV FOSAPREPITANT	75mg	IV	d	
30/5/26		IV FOSAPREPITANT	75mg	IV	d	not

VERIFIED BY : Name Signatu.....



2

CHEMOTHERAPY PRESCRIPTION

All the chemotherapy medications are high risk / high alert drugs.
 While administering chemotherapy drugs watch for nausea, vomiting, rashes,
 urine output and any local extravasation of the drug.



Sheet No.: 2 Weight (kg): 23 kg Body Surface Area: 0.87 Diagnosis: Burkitt's leukemia Protocol: LMB-96 / CLLG-R CUNE

DATE	TIME	Composition of Chemotherapy (if infusion, mention ml / hr = Mcg / kg / min. etc.)	DOSE	ROUTE	Flow Rate (ml/hr)	Doctor Sign.	Nurse Sign.	Date of Stopping	Doctor Sign.	Nurse Sign.
30/5	2pm	120 mg CYTARABINE ETOPOSIDE in 300ml NS	120 mg	IV	@ 100ml/hr	Az	Shrey Narasimha	30/5	A	Navee Amur
30/5/26	8pm	150 mg CYTARABINE in 500ml NS	35mg	IV	40ml/h	d	Navee Anurak	31/5/26	d	Navee Subhalax
31/5/26	8am	150 mg CYTARABINE in 200ml NS	2gram	IV	66ml/h	d	Navee Subhalax	31/5/26	d	Navee Diva
31/5/26	2pm	150 mg ETOPOSIDE in 300ml NS	120mg	IV	100ml/h	d	Navee Diva	31/5/26	d	Navee Gayathri
31/5/26	8pm	150 mg CYTARABINE in 500ml NS	35mg	IV	40ml/h	d	Dehith Subhalax	1/6/26		Navee Gayathri
31/5/26 1/6/26	8am	150 mg CYTARABINE in 200ml NS	2gram	IV	66ml/h	d	Gayathri Navee	1/6/26		Navee Gayathri

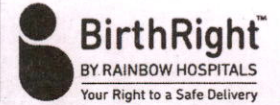
3AH-00652018 IP5-00174396
 Master AYMAN ABDIKARIM OMAR
 15-06-2018 7 Y 11 M 13 D (M)
 Dr. SIRISHA RANI



①

CHEMOTHERAPY PRESCRIPTION

All the chemotherapy medications are high risk / high alert drugs.
 While administering chemotherapy drugs watch for nausea, vomiting, rashes,
 urine output and any local extravasation of the drug.



Sheet No. : ①	Weight (kg) : 23kg	Body Surface Area: 0.87	Diagnosis: Burkitt's Leukemia	Protocol: LMB-96/CCG - R-CHV6
---------------	--------------------	-------------------------	-------------------------------	-------------------------------

DATE	TIME	Composition of Chemotherapy (if infusion, mention ml / hr = Mcg / kg / min. etc.)	DOSE	ROUTE	Flow Rate (ml/hr)	Doctor Sign.	Nurse Sign.	Date of Stopping	Doctor Sign.	Nurse Sign.
28/5	4:00 PM	INT RITUXIMAB IN 200 ML	250 mg	IV	@ 100 ml/hr	As	Bhucy Nareeny	28/5	d	Bhucy Nareeny
29/5	8 PM	INT CYTARABINE IN 500 ML NS	35 mg	IV	@ 40 ml/hr	As	Bhucy Nareeny	29/5	d	Bhucy Nareeny
29/5	8 AM	INT CYTARABINE IN 200 ML NS	2 GRAMS	IV	@ 66 ml/hr	As	Bhucy Nareeny	29/5	d	Bhucy Nareeny
29/5	2 PM	INT GTOPOSID IN 300 ML NS	120 mg	IV	@ 100 ml/hr	As	Bhucy Nareeny	29/5	Ⓡ	Bhucy Nareeny
29/5	8 PM	INT CYTARABINE IN 500 ML NS	35 mg	IV	@ 40 ml/hr	As	Bhucy Nareeny	30/5	As	Bhucy Nareeny
30/5	8 AM	INT CYTARABINE IN 200 ML NS	2 GRAMS	IV	@ 66 ml/hr	As	Bhucy Nareeny	30/5	As	Bhucy Nareeny

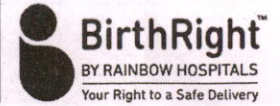
Docu. No. : RCHBH / FRM / CLINICAL / 082

VERIFIED

BAH-00652018
 Master AYMAN ABDIKARIM OMAR
 15-06-2018 IP5-00174396
 Dr. SIRISHA RANI 7 Y 11 M 14 D (M)

CHEMOTHERAPY PRESCRIPTION

All the chemotherapy medications are high risk / high alert drugs.
 While administering chemotherapy drugs watch for nausea, vomiting, rashes,
 urine output and any local extravasation of the drug.



Sheet No. 3 Weight (kg) : 23kg Body Surface Area: 0.87 Diagnosis: Acute leukemia Protocol: R-CVET

DATE	TIME	Composition of Chemotherapy (if infusion, mention ml / hr = Mcg / kg / min. etc.)	DOSE	ROUTE	Flow Rate (ml/hr)	Doctor Sign.	Nurse Sign.	Date of Stopping	Doctor Sign.	Nurse Sign.
1/6/26	2pm	1 μ g ETOPOSIDE in 300ml NS.	120mg	IV	100ml/hr	A	pooja Divya	1/6	A	pooja Divya
1/6/26	8pm	1 μ g CYTARABINE in 500ml NS	35mg	IV	40ml/hr	A	pooja shel	1/6	A	shel pooja
2/6/26	8am	1μg CYTARABINE in 200ml NS	29mg	IV	66ml/hr	A	AS			



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: *Onco*

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	SYP SEPTRAN	5ml	BT PO	Q12H	27/5	<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
				mon/tue/Thu		
2	SYP MORTEL	5ml	PO	OD	27/5	<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
3	SYP CALIMAX PLUS	5ml	PO	OD	27/5	<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
4						<input type="checkbox"/> C <input type="checkbox"/> DC
5						<input type="checkbox"/> C <input type="checkbox"/> DC
6						<input type="checkbox"/> C <input type="checkbox"/> DC
7						<input type="checkbox"/> C <input type="checkbox"/> DC
8						<input type="checkbox"/> C <input type="checkbox"/> DC
9						<input type="checkbox"/> C <input type="checkbox"/> DC
10						<input type="checkbox"/> C <input type="checkbox"/> DC

* C - Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: *Pawanij*

Date & Time: *27/5/2018 @ 6:20pm*

Nurse Name & Signature: *P. S. S. S.*

Date & Time: *27/5/2018 @ 6:30pm*

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)



6

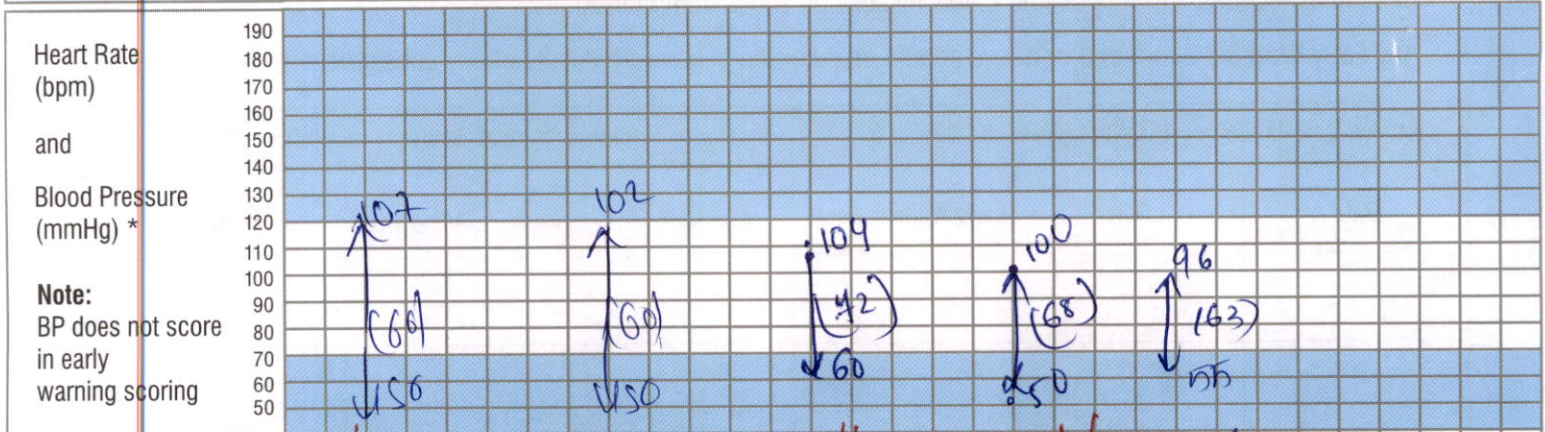
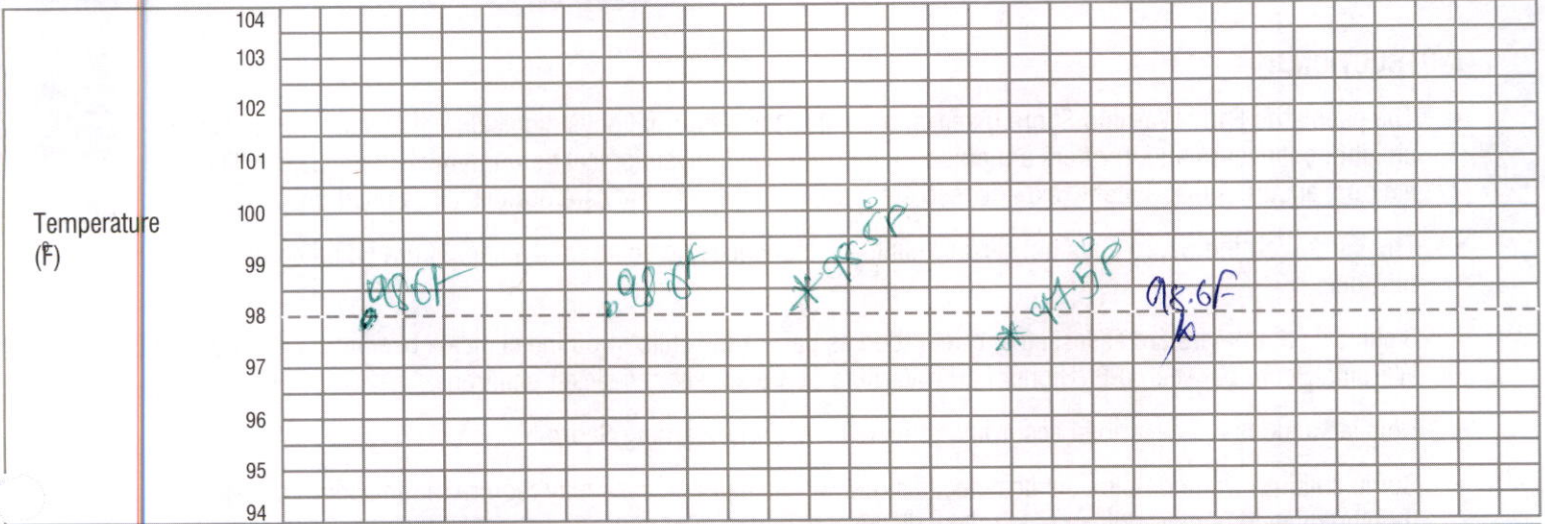
Doc. No. : RCHBH/ FRM / CLINICAL / 126

SCHOOL AGE (5-12 years)
Children's Observation & Early Warning Scoring Chart

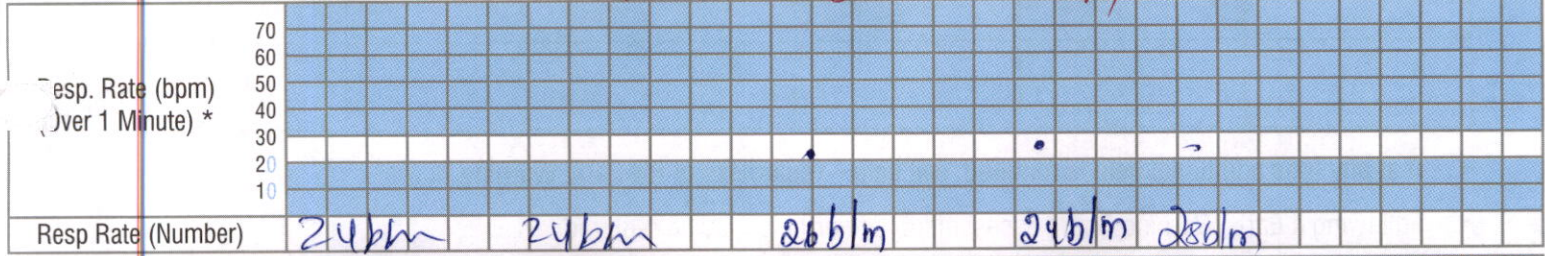


EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 16/20 Time: 9 AM 1 pm 4 pm 7 pm 10 pm
 Doctor / Nurse / Family Concern?



Heart Rate (Number) 110b/m 109b/m 105b/m 102b/m 100b/m



Resp Distress: Mod/ Severe / None / Mild

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

Conscious Level: Normal / Altered

GCS *

Time	Resp Distress	O ₂ Sat (%)	Conscious Level	GCS
9 AM	None	100%	C	15/15
1 PM	None	100%	C	15/15
4 PM	None	99%	C	15/15
7 PM	None	98%	C	15/15
10 PM	None	100%	C	15/15

TOTAL SCORE

Number of shaded boxes: 0 0 0 0 0

Pain Score: 0 0 0 0 0

Observer's Initials: SR SR SR SR SR

- 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: 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

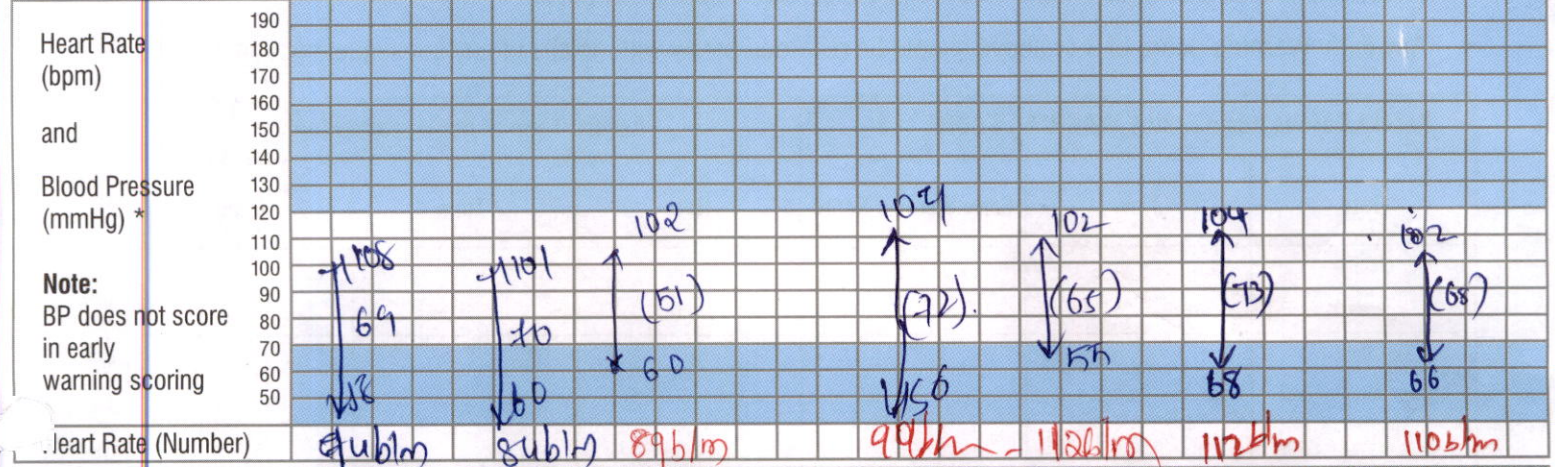
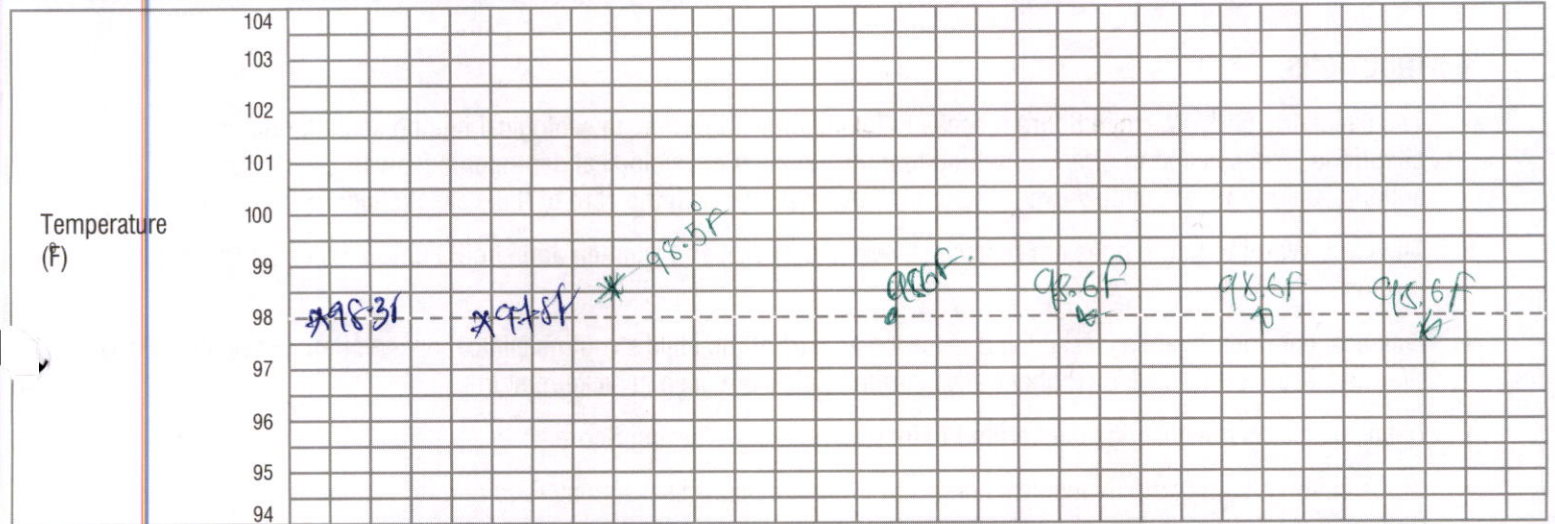
The SBAR communication tool (situation, background, assessment, recommendations) is a helpful mnemonic that can be used to describe a child's clinical condition to a colleague.

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: 5/1/18 Time: 10AM 1pm 4pm 7pm-10pm 3AM 6AM
 Doctor / Nurse / Family Concern?



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

- 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 is there anything I need to do in the meantime? (e.g. stop the fluid/ repeat observation)

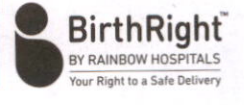
BAH-00652018 IP5-00174396
 Master AYMAN ABDIKARIM OMAR
 15-06-2018 7 Y 11 M 14 D (M)
 Dr. SIRISHA RANI



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

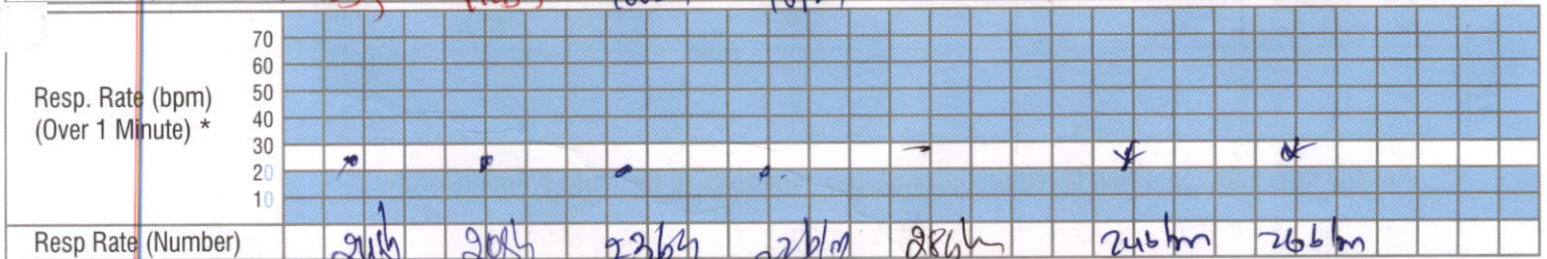
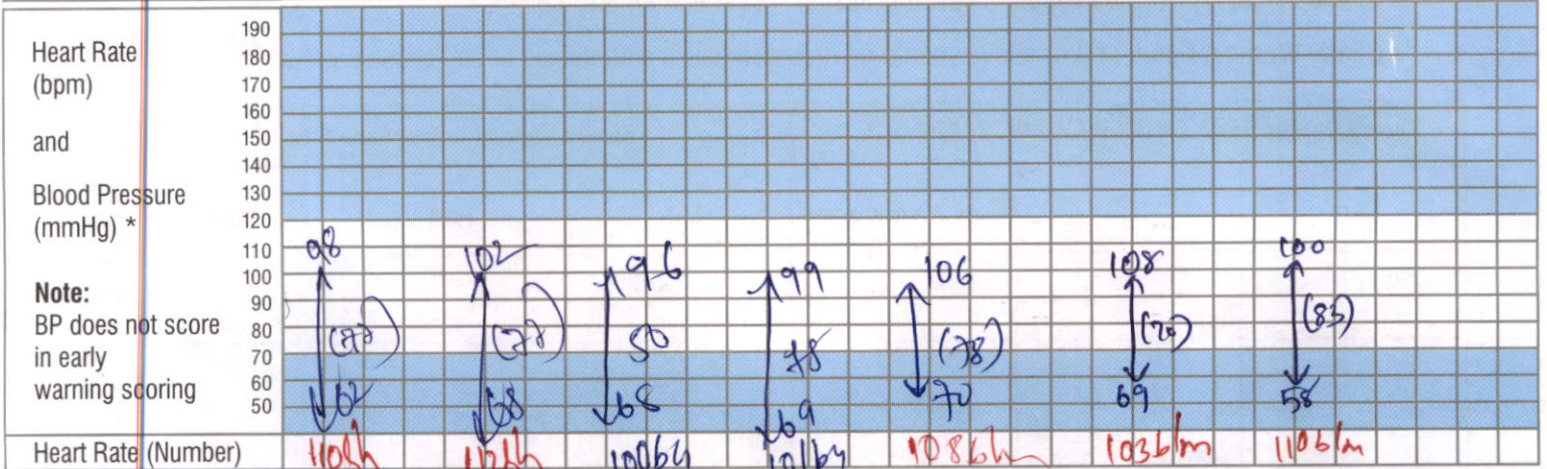
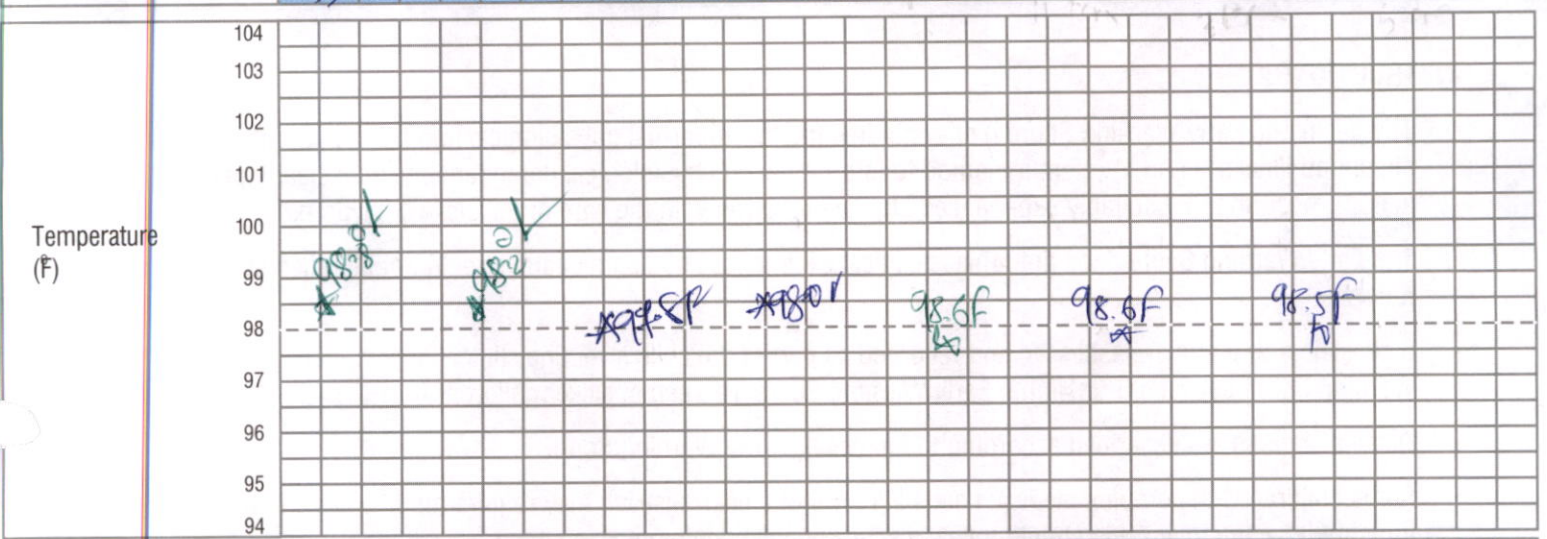
4

SCHOOL AGE (5-12 years)
Children's Observation & Early Warning Scoring Chart



EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 20/5/20 Time: 9 AM 1 PM 4 PM 7 PM 10 PM 3 AM 6 AM
 Doctor / Nurse / Family Concern?



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

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

- 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: 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)



3

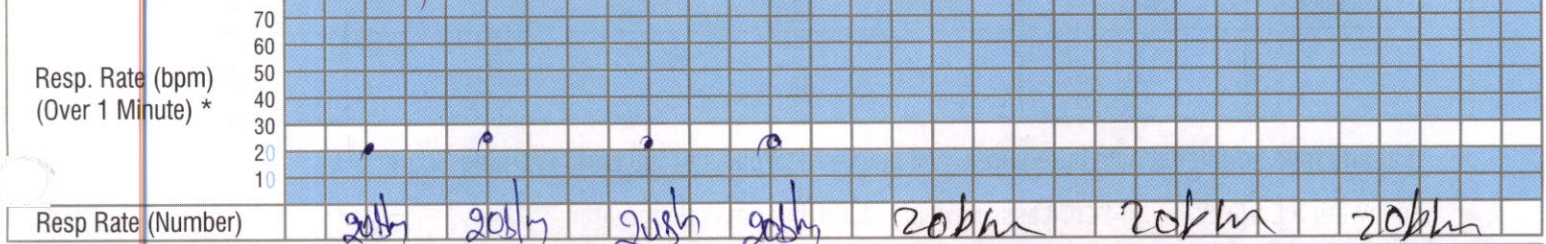
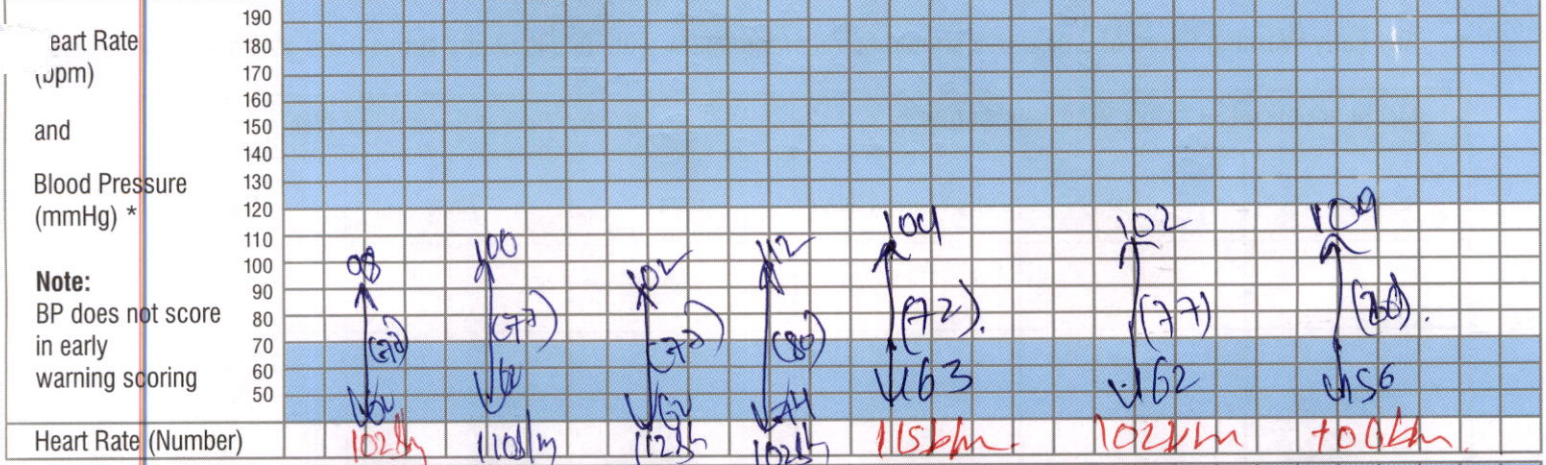
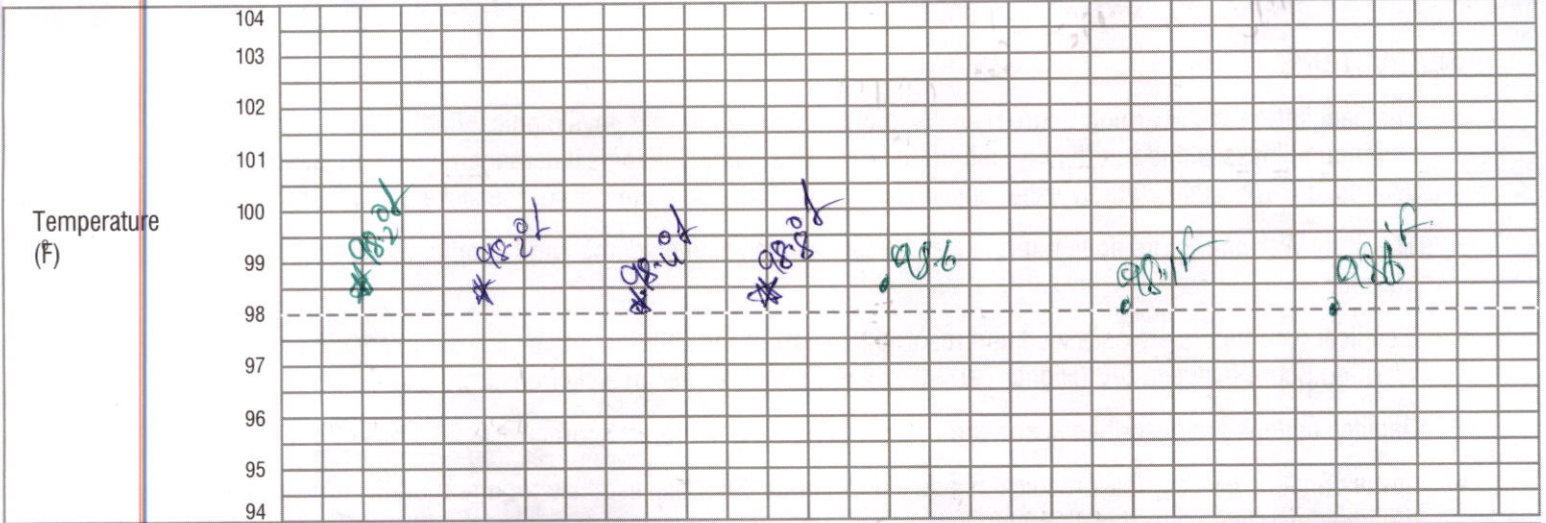
No. : RCHBH/ FRM / CLINICAL / 126

SCHOOL AGE (5-12 years)
Children's Observation & Early Warning Scoring Chart



EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 09/05/2018 Time: 09:00 AM 10:00 AM 11:00 AM 12:00 PM 1:00 PM 3 AM 6 AM
 Doctor / Nurse / Family Concern? *[Handwritten initials]*



Resp Mod/ Severe Distress	None / Mild	•	•	•	•		
Receiving O ₂ (l/min)	O ₂ Saturations (%)	100%	99%	100%	99%	100%	100%
Conscious Level	Normal / Altered	C	C	C	C	C	C
GCS *		15/15	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	<i>[Handwritten]</i>	<i>[Handwritten]</i>	<i>[Handwritten]</i>	<i>[Handwritten]</i>	<i>[Handwritten]</i>	<i>[Handwritten]</i>	<i>[Handwritten]</i>

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 Is there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)



2

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

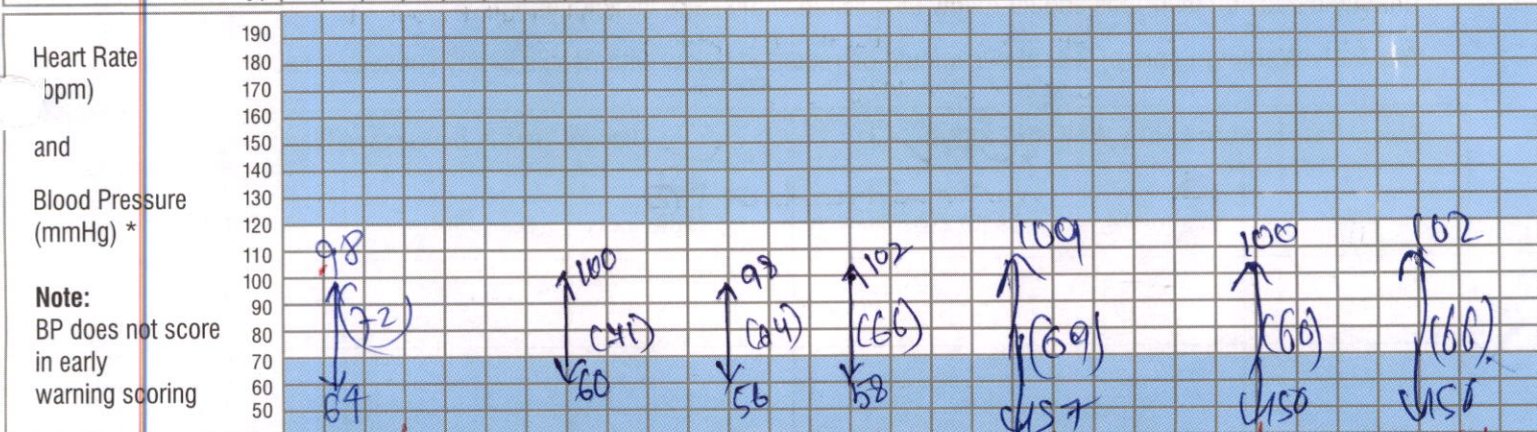
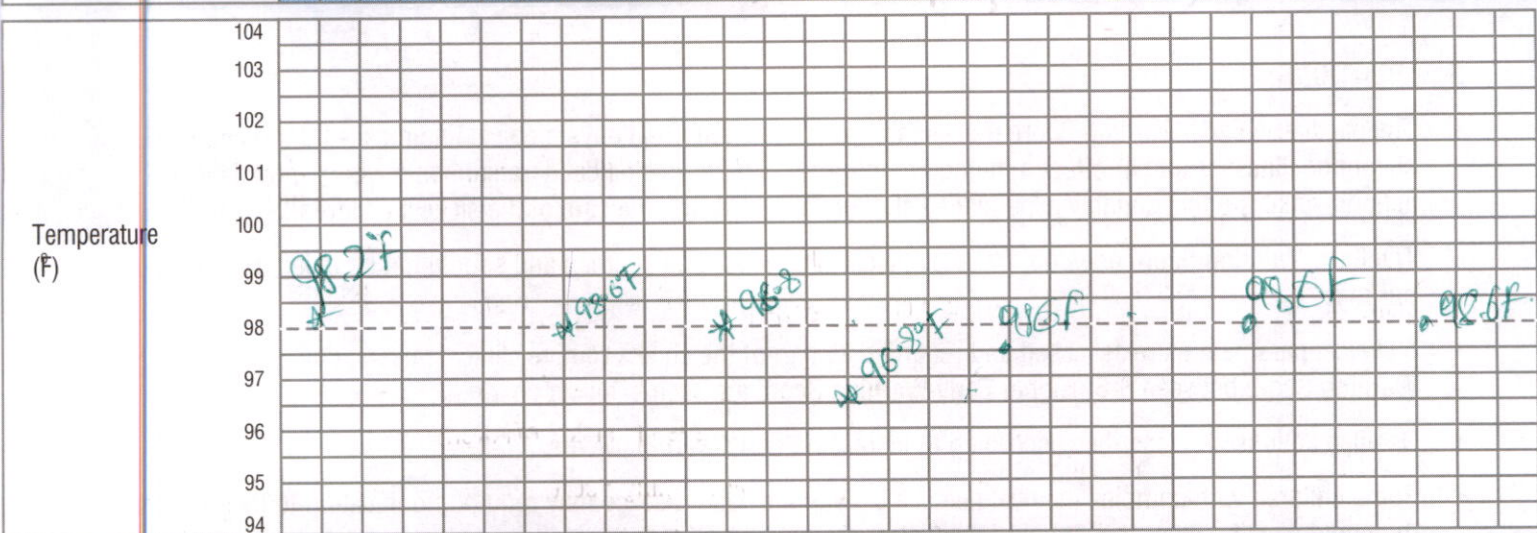
SCHOOL AGE (5-12 years)
Children's Observation & Early Warning Scoring Chart



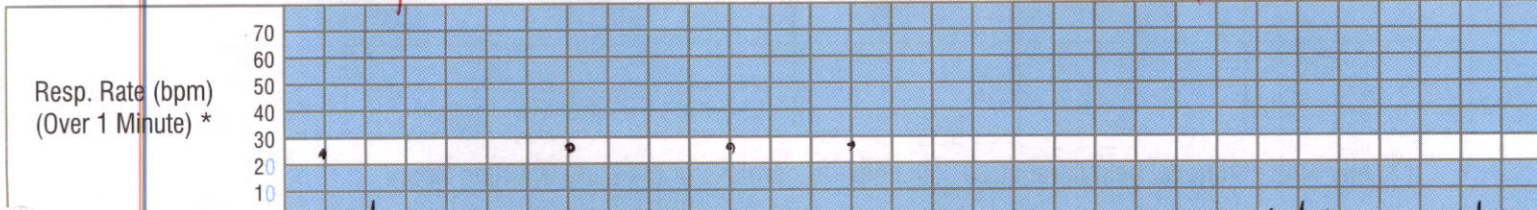
EARLY WARNING SCORE: CHILDREN'S UNIT

Date : Time: 10Am 1pm 4pm 7pm 10pm 3Am 6Am

Doctor / Nurse / Family Concern?



Heart Rate (Number)



Resp Rate (Number)

Resp Mod/ Severe Distress None / Mild

Receiving O₂ (l/min) O₂ 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 is there anything I need to do in the meantime? (e.g. stop the fluid/ repeat observation)

3AH-00652018 IP5-00174396
 Master AYMAN ABDIKARIM OMAR
 15-06-2013 7 Y 11 M 12 D (M)
 Dr. SIRISHA RANI



No. : RCHBH/ FRM / CLINICAL / 126

SCHOOL AGE (5-12 years)
Children's Observation & Early Warning Scoring Chart



EARLY WARNING SCORE: CHILDREN'S UNIT

Date : ... 24/5 ... Time: 10pm 3Am 6Am 10pm

Doctor / Nurse / Family Concern?

Temperature (F)	104			
	103			
	102			
	101			
	100			
	99	98.6F	98.6F	98.7F
	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	100	98	99
	90			
80	(60)	(60)	(61)	
70				
60	150	150	150	
50				

Heart Rate (Number) 100bpm 100bpm 98bpm

Resp. Rate (bpm) (Over 1 Minute) *	70			
	60			
	50			
	40			
	30			
	20			
	10			
	Resp Rate (Number)	25bpm	28bpm	28bpm

Resp Mod/ Severe Distress None / Mild

Receiving O₂ (l/min) O₂ Saturations (%) 100% 100% 100%

Conscious Level Normal Altered C C C

GCS * 15/15 15/15 15/15

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

- 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: 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)



FLUID CHART



Sheet No. : 6

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

Date	Time	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
		Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G							
1/6	08:00 am			60ml					100ml		} payal	
	09:00 am		100ml	40ml								
	10:00 am	milk		40ml								
	11:00 am			40ml					200ml			
	12:00 pm	H ₂ O			40ml							
	01:00 pm				40ml							
Total Intake : 340ml					Total Output : 300ml							
	02:00 pm			100ml					100ml	} pooja		
	03:00 pm			100ml								
	04:00 pm	H ₂ O	100ml	100ml					100ml			
	05:00 pm			20ml								
	06:00 pm			20ml								
	07:00 pm			20ml					200ml			
Total Intake : 460ml					Total Output : 400ml							
	08:00 pm			40ml					200ml	} k		
	09:00 pm	fruits		40ml								
	10:00 pm	H ₂ O	100ml	40ml								
	11:00 pm			40ml								
	12:00 am			40ml								
	01:00 am			40ml					200ml			
Total Intake : 340ml					Total Output : 400ml							
	02:00 am			40ml					150ml	} k		
	03:00 am			40ml								
	04:00 am			40ml								
	05:00 am			40ml								
	06:00 am			40ml								
	07:00 am			40ml					100ml			
Total Intake : 240ml					Total Output : 300ml							
Total 24 hrs. Intake		1,380 :- 600 (kg)			Total 24 hrs. Output		1,400 :- 2,530 (kg)					



FLUID CHART

Sheet No. : 5

- 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		
5/5	08:00 am			30ml						100ml	} Nurse	
	09:00 am	H ₂ O	100ml	66ml								
	10:00 am			66ml								
	11:00 am			66ml								
	12:00 pm			66ml						200ml		
	01:00 pm				30ml							
Total Intake :				424ml		Total Output :					600ml	1ml
	02:00 pm			100ml							} Gayer	
	03:00 pm		100ml	100ml					200ml			
	04:00 pm	H ₂ O		100ml								
	05:00 pm			60ml					300ml			
	06:00 pm			30ml								
	07:00 pm			30ml								
Total Intake :			520ml			Total Output :					500ml	
	08:00 pm			40ml					200ml		} Nurse	
	09:00 pm			40ml								
	10:00 pm	Burd		40ml								
	11:00 pm	H ₂ O	100ml	40ml								
	12:00 am			40ml								
	01:00 am			40ml					200ml			
Total Intake :			340ml			Total Output :					400ml	
	02:00 am			40ml							} Nurse	
	03:00 am			40ml								
	04:00 am			40ml					250ml			
	05:00 am			40ml								
	06:00 am			40ml								
	07:00 am			40ml					100ml			
Total Intake :			240ml			Total Output :					350ml	

Total 24 hrs. Intake 1,524; 66.2 cc/kg

Total 24 hrs. Output 1,850; 3.35 cc/kg/hr

AH-00652018 IP5-00174396
 Master AYMAN ABDIKARIM OMAR
 5-06-2018 7 Y 11 M 14 D (M)
 r. SIRISHA RANI



FLUID CHART



Sheet No. : (4)

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	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
		Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage			Urine
			Mouth	I.V	N.G							
30/5	08:00 am		breast	60ml						300ml		Jah
	09:00 am		Breast	60ml								
	10:00 am	H2O	50ml	60ml								
	11:00 am		100ml	60ml						200ml		
	12:00 pm			50ml								
	01:00 pm		Breast	50ml								
Total Intake : 400ml					Total Output : 500ml					m=1		
30/5	02:00 pm			100ml								Jah
	03:00 pm			100ml						400ml		
	04:00 pm	H2O	50	100ml								
	05:00 pm			50ml								
	06:00 pm			50ml						200ml		
	07:00 pm			50ml								
Total Intake : 500ml					Total Output : 600ml							
	08:00 pm			40ml						200ml		Jah
	09:00 pm	vegg		40ml								
	10:00 pm	Sandwich		40ml								
	11:00 pm	Juice	200ml	40ml								
	12:00 am			40ml								
	01:00 am			40ml								
Total Intake : 460 ml					Total Output : 200							
	02:00 am			40ml						200ml		Jah
	03:00 am			40ml								
	04:00 am			40ml								
	05:00 am			40ml								
	06:00 am			40ml						100ml		
	07:00 am	H2O	100ml	40ml								
Total Intake : 340 ml					Total Output : 300ml							
Total 24 hrs. Intake		1,730 ; 75.2 cc/kg			Total 24 hrs. Output		1600 ; 2.8 cc/kg					

m (1)

FLUID CHART

Sheet No. : 3

- 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			NG	Diarrhoea	Vomit	Output			IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G				Drainage	Urine			
29/5	08:00 am		boiled salt	66ml						200ml		Blue	
	09:00 am	H2O	100ml	66ml									
	10:00 am			66ml									
	11:00 am			66ml						300ml			
	12:00 pm	H2O	20ml	66ml				✓					
	01:00 pm			66ml				✓			200ml		
Total Intake : 550ml						Total Output : 700ml							
29/5	02:00 pm			100ml								Blue	
	03:00 pm		Samosa	100ml						200ml			
	04:00 pm	H2O	50ml	100ml									
	05:00 pm		birds	50ml						300ml			
	06:00 pm	H2O	100ml	50ml									
	07:00 pm			50ml						100ml			
Total Intake : 600ml						Total Output : 600ml							
30/5	08:00 pm			40ml								Gayathri	
	09:00 pm	Fruit	100ml	40ml						200ml			
	10:00 pm			40ml									
	11:00 pm	H2O		40ml									
	12:00 am			40ml						100ml			
	01:00 am			40ml									
Total Intake : 340ml						Total Output : 300ml							
30/5	02:00 am			40ml								Gayathri	
	03:00 am			40ml						150ml			
	04:00 am			40ml									
	05:00 am			40ml						100ml			
	06:00 am			40ml									
	07:00 am			40ml									
Total Intake : 240ml						Total Output : 250ml							

Total 24 hrs. Intake	1,730 :- 75.2 cc/kg/day	Total 24 hrs. Output	1,850 :- 3.3 cc/kg/day
-----------------------------	-------------------------	-----------------------------	------------------------



FLUID CHART

Sheet No. : 2

- 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	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
		Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G							
	08:00 am								100ml			
	09:00 am			60ml								
	10:00 am			60ml								
	11:00 am								120ml			
	12:00 pm	H ₂ O	100ml									
	01:00 pm								20ml			
Total Intake : 280ml					Total Output : 270ml							
	02:00 pm	chicken								0		
	03:00 pm	chicken							220ml	0		
	04:00 pm	H ₂ O	100ml	100ml						0		
	05:00 pm			100ml						0		
	06:00 pm			30ml					200ml	0		
	07:00 pm			30ml						0		
Total Intake : 360ml					Total Output : 470ml							
	08:00 pm			40ml					200ml	0		
	09:00 pm		100ml	40ml						0		
	10:00 pm	egg		40ml						0		
	11:00 pm	sauig		40ml						0		
	12:00 am	H ₂ O		40ml						0		
	01:00 am			40ml					50ml	0		
Total Intake : 340ml					Total Output : 250ml							
	02:00 am			40ml					200ml	0		
	03:00 am			40ml						0		
	04:00 am			40ml						0		
	05:00 am			40ml						0		
	06:00 am			40ml						0		
	07:00 am			40ml					200ml	0		
Total Intake : 240ml					Total Output : 400ml							

Total 24 hrs. Intake	1,060 → 46,080 kg	Total 24 hrs. Output	1,390 → 2,518 kg
-----------------------------	-------------------	-----------------------------	------------------

3AH-00652018
 Master AYMAN ABDIKARIM OMAR
 15-06-2018 7 Y 11 M 12 D (M)
 Dr. SIRISHA RANI

IP5-00174396

FLUID CHART

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Sheet No. : 1

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	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	Bread								200ml			
	11:00 pm	Tea	200ml										
	12:00 am			60ml									
	01:00 am			60ml									
Total Intake : 2200ml						Total Output : 250ml							
	02:00 am			60ml						200ml			
	03:00 am			60ml									
	04:00 am			60ml									
	05:00 am			60ml									
	06:00 am			60ml						200ml			
	07:00 am			60ml									
Total Intake : 360ml						Total Output : 400ml							

Total 24 hrs. Intake 680° - 28.32cc/kg

Total 24 hrs. Output 650° - 2,35cc/kg

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

BAH-00652018 IP5-00174396
 Master AYMAN ABDIKARIM OMAR (M)
 15-06-2018 7 Y 11 M 12 D
 Dr. SIRISHA RANI



Name: MASTER AYMAN AB DIKAR Age: 7Y Sex: M UHID.No: BAH 00652018

Date: 28/5/20 Time: 3:19 Proposed Operation: PET SCAN

Diagnosis: Burkitt leukemia

B.P / CRT: 100/50 H.R: 100 Weight: 23 kg ASA Physical Status: 1 2 3 4 5

Laboratory Data:

Hgb: <u>10.8</u>	Glucose:	Protein:	HIV:	X-Ray:
PCV: <u>33.3</u>	Urea:	Alb:	HBS Ag:	ECG:
WBC: <u>6.85</u>	Creat: <u>0.5</u>	Total Bill:	HCV:	2D Echo:
Plate: <u>347</u>	Na:	Dir. Bill:	Blood group:	Stress/Anglo:
PT:	K:	LDH:	T3	Other:
PTT:	Ca++:	Alk phos:	T4	
INR:	Mg++:	Amylase:	TSH	
	Cl-:	SGOT/SGPT:		

Allergies: No known allergy

Medical History: CVS: —

RESP: No cough, cold fever Diabetes: —

CNS: —

Renal: — Zehuro

Hepatic / GE: — Physical Activity: Prayerful Patient

Others: —

Past Anaesthetic History:

Physical Exam:

Airway: MP 1 2 3 4 Mouth Opening: child sleeping Mentohyoid Distance: — Neck: — Teeth: —

Lungs: AERBE, clear

Heart: S1S2
 CNS: MP 1 2 3 4

Pregnant: Yes No NA Venous Access Site: RU2 Spine Exam for regional: —

Anaesthetic Plan: MAC REGIONAL GA-ETT LMA

Peri-Operative Plan Explained to the Patient: Yes No

CURRENT MEDICATIONS	DOSAGE
<u>Levofloxacin (Mon/wed/Fri)</u>	<u>500 mg PO</u>
<u>Symptomatic</u>	<u>500 mg PO q24h</u>
<u>Zyp calcium</u>	<u>1000 mg OD</u>

Pre-Operative Instructions:

- DVT Prophylaxis:
 - Water / ORS 2 Hours
 - Others 6 Hours
- NIL ORAL: 1 COLON WASH
1 SOLID MEAL
- Informed Consent: Standard High Risk
- Post Operative Pain Management: Discussed with Patient
- Other Instructions:

Signature: Aditi Name: Dr Aditi N



POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Time Received : Time Discharged :

↓ RESP • PULSE > BLOOD PRESSURE	250		250
	240		240
	230		230
	220		220
	210		210
	200		200
	190		190
	180		180
	170		170
	160		160
	150		150
	140		140
	130		130
	120		120
	110		110
	100		100
	90		90
	80		80
	70		70
	60		60
	50		50
	40		40
	30		30
	20		20
	10		10
0		0	

IV Cannula Site :

O₂ Mask Nasal Prongs
 Tracheostomy T-Piece
 Oral Airway Nasal Airway

Vomiting : Yes No Drug:

NG Tube : Yes No

Drain: Yes No

Urinary Catheter: Yes No

Chest Tube: Yes No

Nil Oral Yes No

IV Fluids:

Oral Feeds:

POST ANAESTHESIA SCORE (Modified Aldrete Score)	IN	MINUTES			OUT	SCORING INTERPRETATION
		30	60	90		
Able to move 4 extremities voluntary or on command = 2 Able to move 2 extremities voluntary or on command = 1 Able to move 0 extremities voluntary or on command = 0	ACTIVITY					A Minimum Total Score of 8 is Required for Discharge Exceptions to this, are to be explained in the space below by the Discharging Physician:
Able to deep breathe & cough freely = 2 Dyspnea or limited breathing = 1 Apneic = 0	RESPIRATION					
BP ± 20 of Pre Anaesthetic leve = 2 BP ± 20-50 of Pre Anaesthetic leve = 1 BP ± 50 of Pre Anaesthetic leve = 0	CIRCULATION					
Fully awake = 2 Arousable on calling = 1 Not responding = 0	CONSCIOUSNESS					
Pink = 2 Pale, dusky, blotchy, jaundiced, other = 1 Cyanotic = 0	COLOR					
TOTAL						

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature

Pain Tool Used: N PASS FLACC Wong Baker NPS

Anaesthesiologist Name :

Anaesthesiologist Signature:

Date & Time:

PACU Nurse Name :

PACU Nurse Signature:

Date & Time:

- Reassessment Frequency:**
- Every eight hours for all hospitalized patients.
 - For post surgical patient, patient with chronic pain, patient with severe pain
 - Every 2 hours for first 24 hours
 - After 24 hours every 4 hours
 - Prior to pain relieving intervention
 - With in 30-60 minutes after pain relief intervention
- Transferred to Unit by (PACU):
- Date & Time:

