



KOH-00295418 IP2-00056527
 Master VIRAJ SINHA
 09-12-2021 4 Y 6 M 3 D (M)
 Dr. DAVID SUVARNARAJU PARIMI

Patient Name

UHID No.:



NEBULISATION CHART

Date	Time	Drug	Nurse	Parents Signature
12/6/26	10:30 AM	Neb. Hyperneb CO2	945323	Swapnil
	6:00 PM	Neb. Hyperneb CO2	945446	Swapnil
13/6/26	8:30 AM	neb: Hyper CO2	945575	Swapnil
	9:30 AM	Neb Hyper CO2 (1)	945736	Swapnil
	4:00 PM			
19/6	7:30 AM	Neb Hyper CO2	945864	Swapnil
14/6	10:30 AM	Neb Hyper CO2	945899	
	7.00			
	8.00			
	9.00			
	10.00	c/w done by		
	11.00	Total 6		
	12.00	pieces at 12 AM		
	13.00			
	14.00			
	15.00			
	16.00			
	17.00			
	18.00			
	19.00			
	20.00			
	20.00			
	21.00			
	22.00			
	23.00			

12 Am Neb. refused to parents.

Rahul
Sweetie

14/6 - 3:40 Am Neb.
refused

ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____ IP N _____ it: _____ Dept : _____

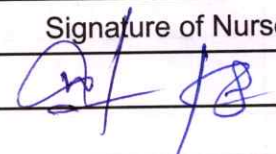
Date of Admission: _____ Discharge : _____ Time: _____

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

KOH-00295418 IP2-00056527
Master VIRAJ SINHA
09-12-2021 4 Y 6 M 2 D (M)
Dr. DAVID SUVARNARAJU PARIMI



WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
11/6/20	12:21 PM	ER	411	

Cross Consultation Visit

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

MEDICAL EQUIPMENT (WARD & ICU)

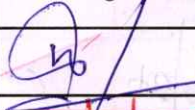
Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
11/6/26	Infusion pump	12:40 PM	13/04/26 5:00	944964	Sandhya
out					
out					
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access Cleared by
Reg. In 11/06/26

INVESTIGATIONS

Date	Investigations	Order No.	Signature
9/6/26	CBP, CRP, Dengue NSI	1572953	[Signature]
9/6/26	CUE	1572954	[Signature]
9/6/26	Bloods	213150	[Signature]
11/6/26	CBP, CRP, S/Cr, LFT	26008054	[Signature]
11/6/26	Urea, Resp Panel	26008054	[Signature]
In ER cross check done by Ujj - 10			11/6/26
11/6/26	Urine ds	26008067	pawes
11/6/26	mp, widal	26008092	Anita
cross checked done by pawes at 12Am			

PROCEDURE

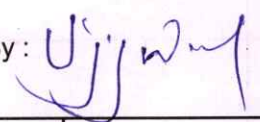
Date	Procedure	Quantity	Order No.	Signature
11/6/26	For Cannulation	1	544921	
<i>In ER cross check done by Ujjwala 11/6/26</i>				
11/6/26	N.H.A	(1)	945021	Sondhya
<i>copy</i>				
12/10/26 For Cannulation (1) 945121 Poojamma				
<hr/>				
<i>cross check done by Poojamma at 12/10/26</i>				

ANY OTHER INFORMATION

*op file given to parents.
 ✓ Rehul Singh*

Date: 11/06/26

Time: 11:50 AM

Prepared By: 

<p>Staff Nurse <i>check by Ujjwala 11/6/26</i></p>	<p>Shift / Ward ER to 44 Sondhya</p>	<p>Billing Assistant</p>	<p>Billing Supervisor</p>
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PEDIATRIC IN-PATIENT MEDICAL RECORD

KOH-00295418 IP2-00056527
Master VIRAJ SINHA (M)
09-12-2021 4 Y 6 M 2 D
Dr. DAVID SUVARNARAJU PARIMI



Patient Name : VIRAJ.

Patient ID# : _____

Consultant : _____

Final Diagnosis : _____

Pediatric Multiorgan History & Physical Examination

Name : Vivaj Age/Sex _____

Informant _____ Reliability _____

Chief Presenting Complaints & Duration (Chronologically):

epo fever x 4 days
mild cold
↓ intake & activity

History of present illness :

→ epo fever - high grade ~103°F
every 3-4 hrs
axs & chills
no rash.

→ sunny nose ⊕
mild cough
↓ intake & activity

No H/o vomiting / ur
no H/o travelling & no H/o
similar epo in family

Pediatric Multiorgan History & Physical Examination

Anthropometry

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

Weight (kgs) 15.4 kg (Centile _____)

On Examination :

Temperature : 102.3°F Pulse Rate: _____ Description _____

B.P. 98/83 SPO2 98% at RA

Resp. rate and type of breathing : 28/3

Rash _____ congestion of

Lymphadenopathy _____ throat (+)

Oedema : _____

Respiratory system :

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

Air entry & breath sounds : _____ BAG (+) clear

Any addes sounds : _____

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

Cardiovasclular System :

Inspection of procordium : _____ (N)

Heart Sounds : _____ S1S2 (+)

Any murmur : _____

Relevant date from outside (Chest X-Ray, ECG, ECHO, Etc.,) _____

Per Abdomen :

Inspection _____ (N)

Palpation : _____ soft

Ausculation : _____

Spine: _____ External Genitelia : _____

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

Pediatric Multiorgan History & Physical Examination

Central Nervous System :

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

Cranial Nerves : _____

Motor System :

Nutrition : _____

Tone : _____ Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR

Superficials :

Plantars _____ (N)

Sensory System :

Bladder / Bowel : _____

Clinical Summary & Diagnostic :

AFI (04)

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment :

complications

Desired goals of the treatment :

H. stability

Planned Labs :

CBP, CRP, CVE
Blood Cfs, dengue NSI } 9/6

urine cfs ~~→ D~~
LFT ✓, CRP ✓, CBP ✓
S. creat ✓, B. urea ✓
Resp panel ✓

Noted by Smith

Planned Management :

- 1) IVF - FM
- 2) Inj. ceftriaxone
- 3) AMIKACIN
- 4) Fever management

Please fill up the following details

1. Name of the Referring Doctor : _____
2. Name of the Referring Hospital : _____
(Including the name of City)
3. Contact number of the Referring Doctor : _____
(Preferring Mobile #)
4. Name of the doctor in Rainbow Team Dr. David on
whose name the patient is being referred

Doctor's Signature Name Dr. Bharg Date 11/06/26 Time _____

KOH-00295418

IP2-00056527

Master VIRAJ SINHA

09-12-2021

4 Y 6 M 2 D

(M)

Dr. DAVID SUVARNARAJU PARIMI



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
12/6/26	SB Dr David	
7:00 AM	AFI	
	3 fetal spikes	
	O/E: clear	
	Vital A/C	
		p/ly
		Continue same
		Hc Report
		Hypermets & GI
		norm
	noted by Sanyas 12/6/26 @ 10/30 AM	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
12/6/26 UP	S/B Reg	
	AFI	
	1 fever (+) OLE: Alert, activity better.	
	CVS: S, S, G RI: BAE (+) PLA: soft	Plan - Cont IV Abx, Nebul
	2 episodes of loose stool.	- Monitor vitals. <i>flow</i>
	9A A send	
12/6 8PM	Rem ↓ con (9A)	Aches under + nasal discharge con
	no	Cough soon
		nasal
	noted by sushma	12/6/26 @ 8pm



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
13/6/26	SIB - Dr. David Register	
4:50pm	Adenoviral I/V	
	No fever spikes	
	child - active	
	playful	
	oral intake - best	Ad. ✓
	vital - stable	-
	C/S - 150	- Continue same
	R1 - clear	
	P/CN - soft	
	2A Dr David	
	no fever	
	intake - slightly ↑	
	skin	
	(9/10) resp	
	resp	Cough seen
		mostly
	Noted by Chandrani @ 6pm	13/6/26

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 Dr. DAVID SUVARNARAJU PARIMI

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
14/6/26	SB. Dr. David	
11am	Adenoidal illness	
	No fever spike	
	oral intake - improved	
	no fresh cough	
	vital - stable	
	C/S	D/S
	R/W	- Cephalos @ 20mg/11l
	PA	Ktota 7.
		- Citizine
		Keb 5 3-1. W - 6hly
		Klasodes
		R/W - after - 3 days (Wed)
		most of

noted by Raju 14/06/26
 11A



OP basis **RESULT SHEET**

Date	05/6/26	11/6/26			
Time	10.57 PM	12.10 PM			
Hb	12.9	13.0			
PCV	38.5	38.3			
RBC	4.68	4.67			
WBC	9.94	9.47			
N/L					
Platelets	264	264			
CRP	46	37.0			
ESR					
PCT					
RBS					
Na					
K					
Cl					
Ca/Mg					
Phosphate					
Urea		18.5			
Creatinine		0.4			
ALP					
SGPT		16			
SGOT		35			
T.Bill/Conj		0.5 < 0.2			
T.Protein		7.6			
S.Albumin		4.1			
S.Globulin		3.5			
A/G Ratio		1.1			
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein / Sugar					
Cells					
N/L					

Ophtis

Date	09/6/26				
Time	6.56 PM				
CUE - Alb protein	Trace				
CUE - Sugar	Nil				
CUE - Ketones	Negative				
CUE - PUS Cells	10-12				
CUE - RBC Cells	Nil				
CUE epithelial leucocytes	4-6 (Present (+))				
Stool Pus Cell					
OVA / Cyst					
Occult Blood					
Dengue NS, IgM	Negative				
Dengue NS, IgG	Negative				
Genex post RSV	Negative				
FluA	Negative				
B	Negative				
RSV	Negative				
Adenovirus	Positive				
mp	→ Negative				
widal	→				
		Widal: 11/06/26 @ 9:45 pm salmonella Typhi O - Agglutination seen in titre 1:120 salmonella Typhi H - Agglutination seen in titre 1:50. Typhi AH - Agglutination not seen. " " " BH - " " "			
		Methodology: Tube Agglutination			

Culture and Sensitivities : 09/6/26 (Ophtis) 11:30 pm (Blood c/s → No growth after 24 hrs.)
11/6/26 @ 2 PM urine c/s → 24 hrs no growth

Radiology :
 USG :
 X-Ray :
 ECHO :
 CT :
 MRI :
 Others (ECG, Contrast Studies etc.) :

us hours

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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: 411

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						<input type="checkbox"/> C <input type="checkbox"/> DC
2						<input type="checkbox"/> C <input type="checkbox"/> DC
3						<input 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: [Signature]

Date & Time: 11/6/26 @ 11:40am

Nurse Name & Signature: [Signature]

Date & Time: 11/6/26 @ 11:40am

Docu. No. : RCH / FRM / GENERAL / 090

1) Dosis: - Ceftriaxone 750 mg = $\frac{750 \text{ mg} \times 10 \text{ ml}}{1000 \text{ mg}} = 7.5 \text{ ml}$

2) Dosis: - Amikacin 225 mg = $\frac{225 \text{ mg} \times 2 \text{ ml}}{250 \text{ mg}} = 1.8 \text{ ml}$

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DRUG CHART

Date of Admission: 11/06/26 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 : SYP. CROCIIN - DS				Date Time	12/6														
Dose	Route	Frequency	Start Date																
5ml	oral	SOS	11/06	10 PM [Signature]															
Doctor's Signature		Valid Period	Pharm.																
[Signature]																			
Additional Instructions:																			
max 6th hly																			

DRUG : SYP. IBUGESIC				Date Time	11/06														
Dose	Route	Frequency	Start Date																
7ml	oral	SOS	11/06	5 PM [Signature]															
Doctor's Signature		Valid Period	Pharm.																
[Signature]																			
Additional Instructions:																			
max 8th hly																			

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

VERIFIED BY : Name Signature

REGULAR PRESCRIPTIONS

Weight. 15.4 Ward.



DRUG : INJ. CEFTRIAZONE				Date/Time	11/6	12/6	13/6	14/6
Dose	Route	Frequency	Start Date					
750mg	IV	BD	11/06	6am	X	Amrita Sunita	Amrita Sunita	Chand Poornam
Name & Signature of the Doctor Starting the Drugs:								
<i>Amrita Sunita</i>								
Additional Instructions:								
				6pm	2pm poornam	11pm Amrita Sunita	Amrita Sunita	
Daily Doctor's Endorsement by a Sign								

DRUG : INJ. AMIKACIN				Date/Time	11/6	12/6	13/6	14/6
Dose	Route	Frequency	Start Date					
225mg	IV	OD	11/06	6am	2pm poornam	Amrita Sunita	Amrita Sunita	Chand Poornam
Name & Signature of the Doctor Starting the Drugs:								
<i>Amrita Sunita</i>								
Additional Instructions:								
15mg/kg/day								
Daily Doctor's Endorsement by a Sign								

DRUG : NASIVION P Nasal				Date/Time	11/6	12/6	13/6	14/6
Dose	Route	Frequency	Start Date					
2°	PN	8th	11/06	6am	2pm poornam	Amrita Sunita	Amrita Sunita	Chand Poornam
Name & Signature of the Doctor Starting the Drugs:								
<i>Amrita Sunita</i>								
Additional Instructions:								
				6pm	2pm poornam	Amrita Sunita	Amrita Sunita	Chand Poornam
Daily Doctor's Endorsement by a Sign								

DRUG : SYP. CETRIXINE				Date/Time	11/6	12/6	13/6	14/6
Dose	Route	Frequency	Start Date					
2.5ml	Oral	HS	11/06	6am	Amrita Sunita	Amrita Sunita	Chand Poornam	
Name & Signature of the Doctor Starting the Drugs:								
<i>Amrita Sunita</i>								
Additional Instructions:								
Daily Doctor's Endorsement by a Sign								

Patient Name :	I.P. No.	Sheet No.	Wards	Weight (kg)
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REGULAR PRESCRIPTIONS

DRUG : 3% NS Nebbs				Date															
				Time															
Dose	Route	Frequency	Start Dt.																
3 ml	PN	6 th M	12/6																
Name & Signature of the Doctor starting the Drugs:				} see the chart															
Additional Instructions:																			
Daily Doctor's Endorsement by a Sign.																			

DRUG : ENTEROCERMINA				Date															
				Time	12/6	13/6	14/6												
Dose	Route	Frequency	Start Dt.																
1ml	PO	OD	12/6																
Name & Signature of the Doctor starting the Drugs:				} see the chart															
Additional Instructions:																			
Daily Doctor's Endorsement by a Sign.																			

DRUG : ORS				Date															
				Time															
Dose	Route	Frequency	Start Dt.																
150ml	PO	BS	12/6																
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.																			

Patient Name :	I.P. No.	Sheet No.	Wards	Weight (kg)
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REGULAR PRESCRIPTIONS

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.																				

Patient's Name: Vijay Shankar
4y6m

NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 11/6/26 Time: 4pm

Weight: 15.4kg Centile: <3rd Centile

Height: Centile:

Inference: Not weished

RDA: Calories: 1500 cal/day Protein: 30 gm/day

Diet Recommendations: soft diet

Re-Assesment:

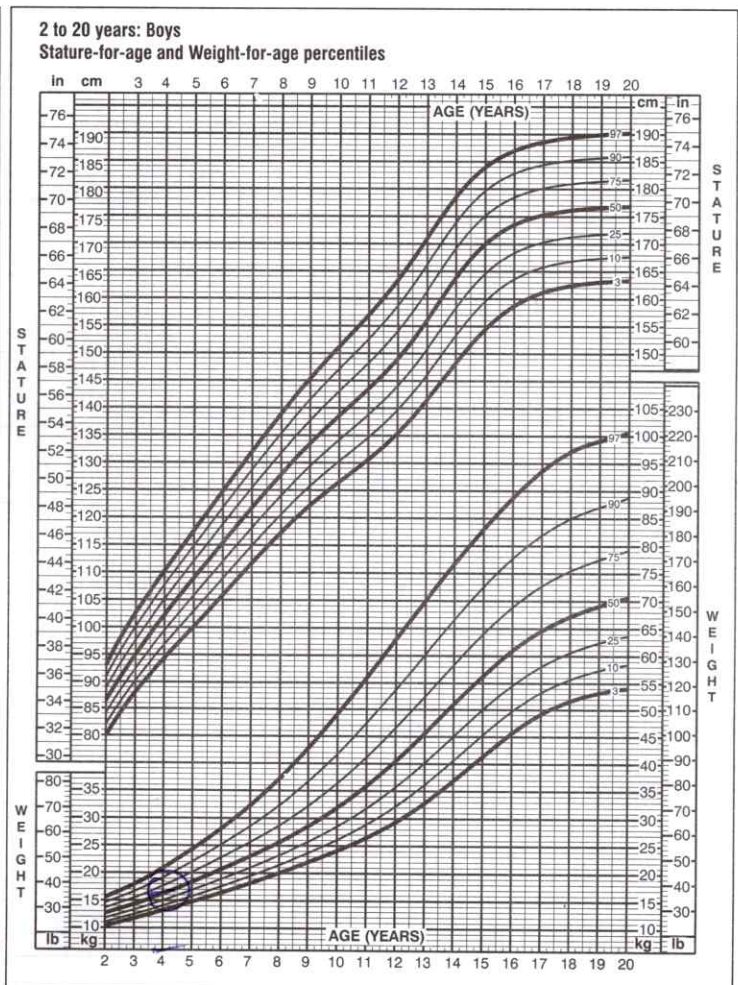
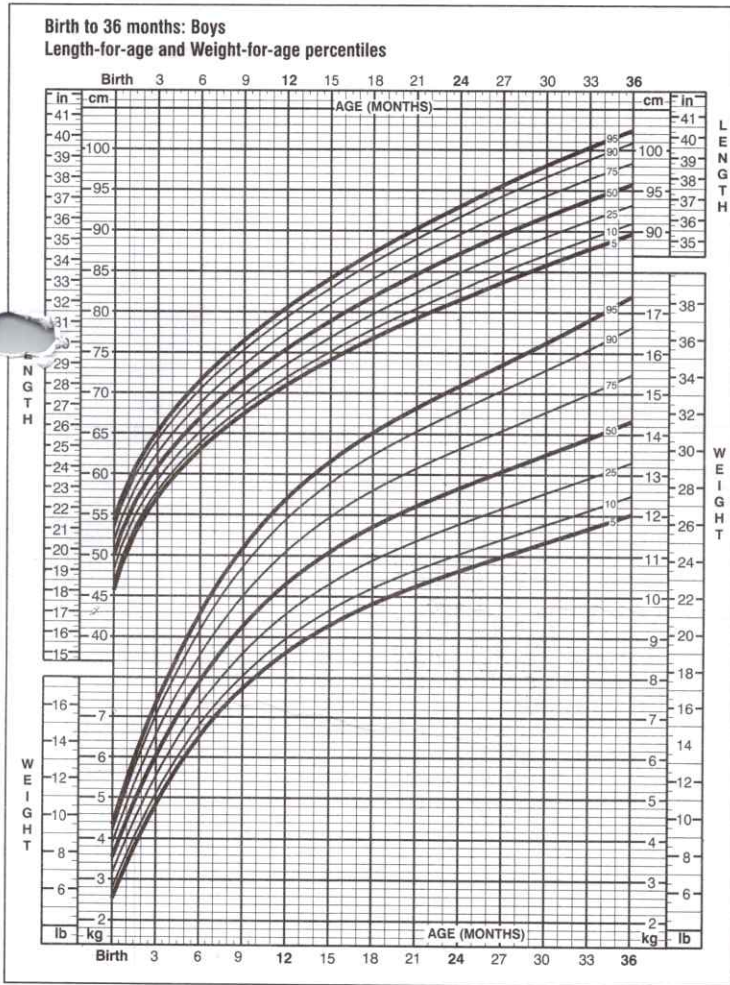
Food Allergies: NO allergies Veg/Non-veg

Diagnosis: AFS DCA

Nutritional Intervention - Oral Enteral Parenteral

Patient's Signature: Swapnil

GROWTH CHART (BOYS)



Dietician's Name: Jayashree

Dietician's Signature: [Signature]



.Pulse Rate : Normal Rate by Age (beats/minute) Reference:PALS Guidelines, 2015

Age	Awake Rate	Sleeping Rate	
Neonate(<28days)	100-205	90-160	
Infant (1 month-1yr)	100-180	90-160	
Toddler (1-2yr)	98-140	80-120	
Preschool (3-5 yr)	80-120	65-100	
School -age (6-11yr)	75-118	58-90	
Adolescent (12-15yr)	60-100	50-90	

Respiratory Rate: Normal Respiratory Rate by Age (breaths/minute) Reference:PALS Guidelines, 2015

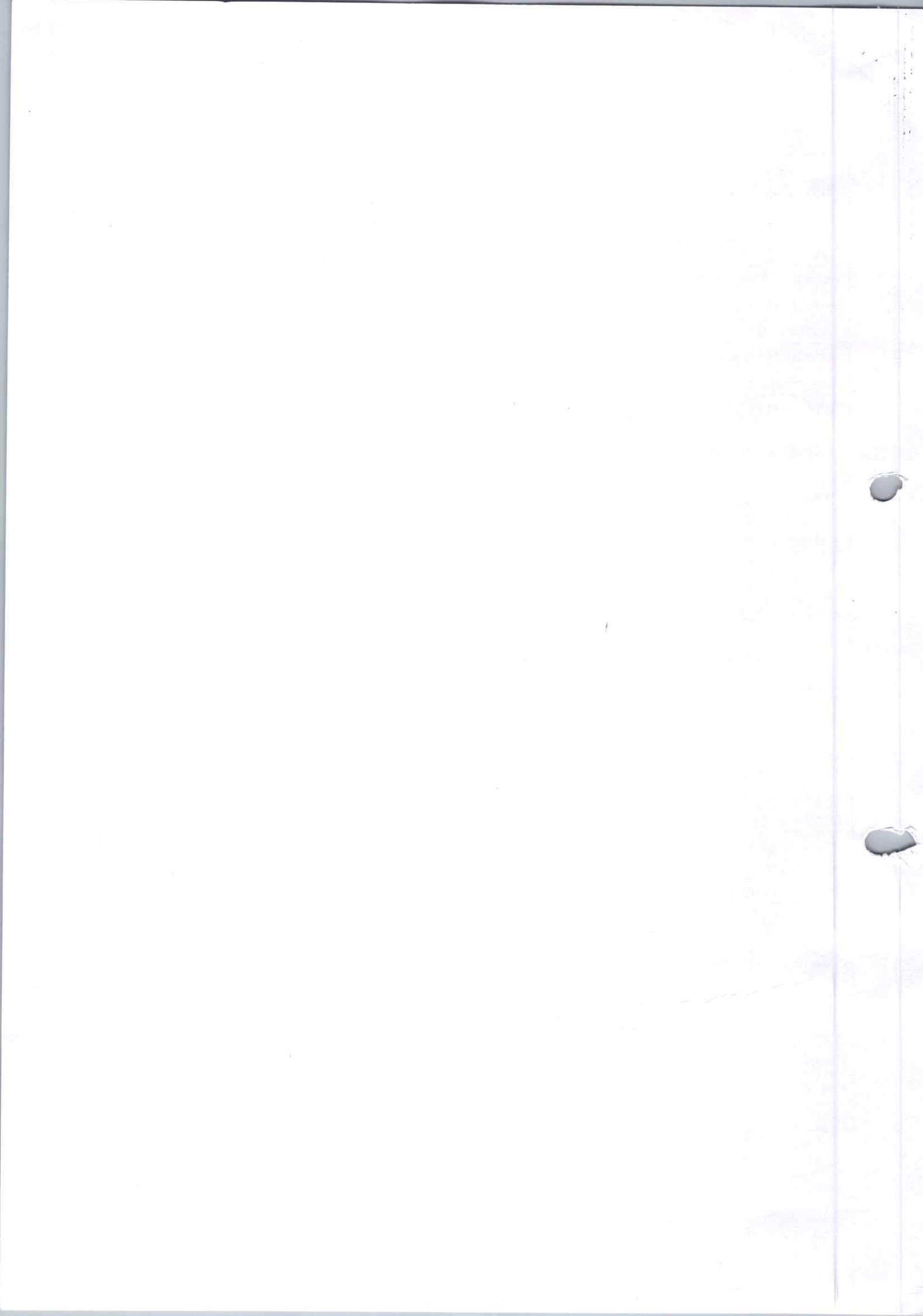
Age	Normal Respiratory Rate		
Infant (1 month-1yr)	30-53		
Toddler (1-2yr)	22-37		
Preschool (3-5 yr)	20-28		
School -age (6-11yr)	18-25		
Adolescent (12-15yr)	12-20		

Blood Pressure:Normal Blood Pressure by Age (mm/hg) Reference:PALS Guidelines, 2015

Age	Systolic Pressure	Diastolic Pressure	Systolic Hypo tension
Birth	39-59	16-76	<40-50
Birth	60-76	31-45	<50
Neonate(<28days)	67-84	35-53	<60
Infant (1 month-1yr)	72-104	37-56	<70
Toddler (1-2yr)	86-106	42-63	<70 + (age in years x 2)
Preschool (3-5 yr)	89-112	46-72	<70 + (age in years x 2)
School -age (6-11yr)	97-115	57-76	<70 + (age in years x 2)
Pre-adolescent (10-11y)	102-120	67-80	<90
Adolescent (12-15yr)	110-132	64-83	<90

Temperature :Normal Temperature Range by Method Reference: CPS Position Statement on Temperature Measurement in Pediatrics, 2015

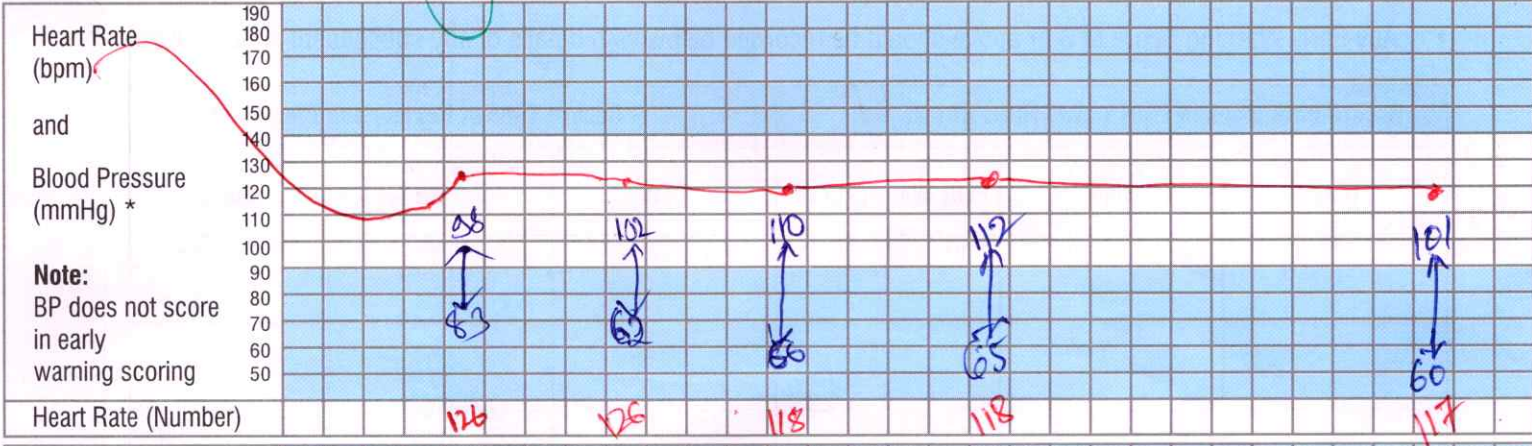
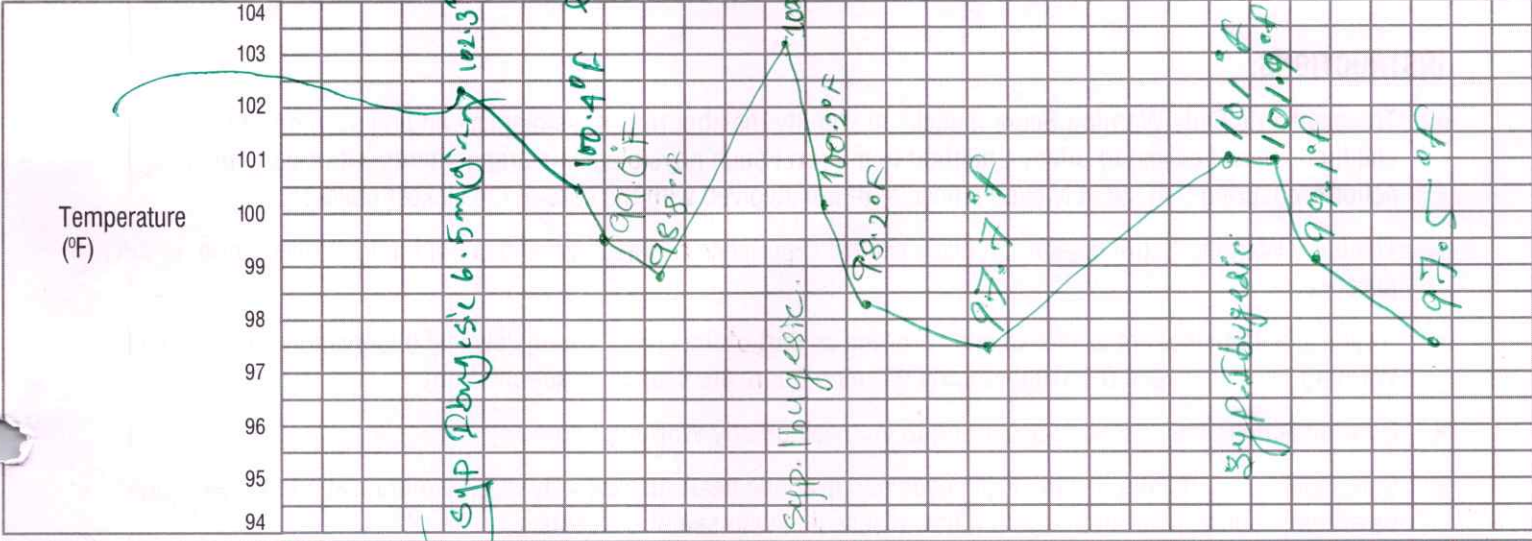
Method	Normal Range (°C)	Normal Range (°F)
Rectal	36.6-38	97.8-100.4 °F
Ear	35.8-38	96.4-100.4 °F
Oral	35.5-37.5	95.9-99.5 °F
Axillary	36.5-37.5	97.7-99.5 °F



EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 11/6/26 Time: 7 8 9 10 11 12 1 2 3 4 5 6 7 8 9 10 11 12 1 2 3 4 5 6 7

Doctor / Nurse / Family Concern?



Resp Distress	Mod/ Severe None / Mild	RA	RA	RA	RA	RA
Receiving O ₂ (l/min)		3l/min	10l	10l	10l	9l/min
O ₂ Saturations (%)		99%	100%	100%	100%	99%
Conscious Level	Normal / Altered	15/15	15/15	15/15	15/15	15/15

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

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

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

Patient Name :

Date of Birth :

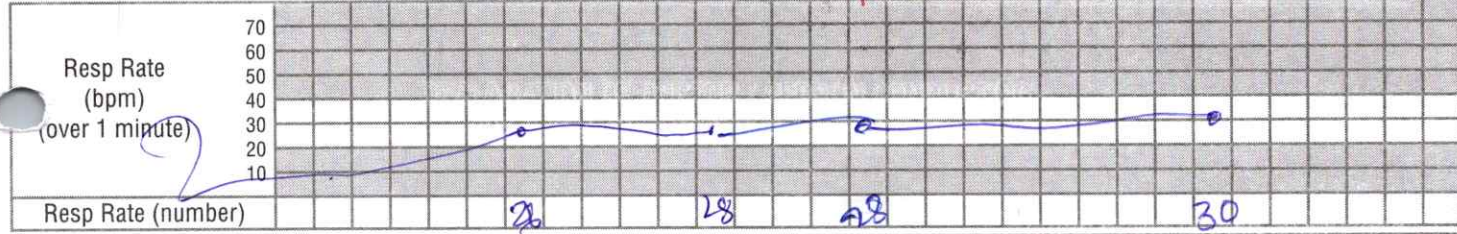
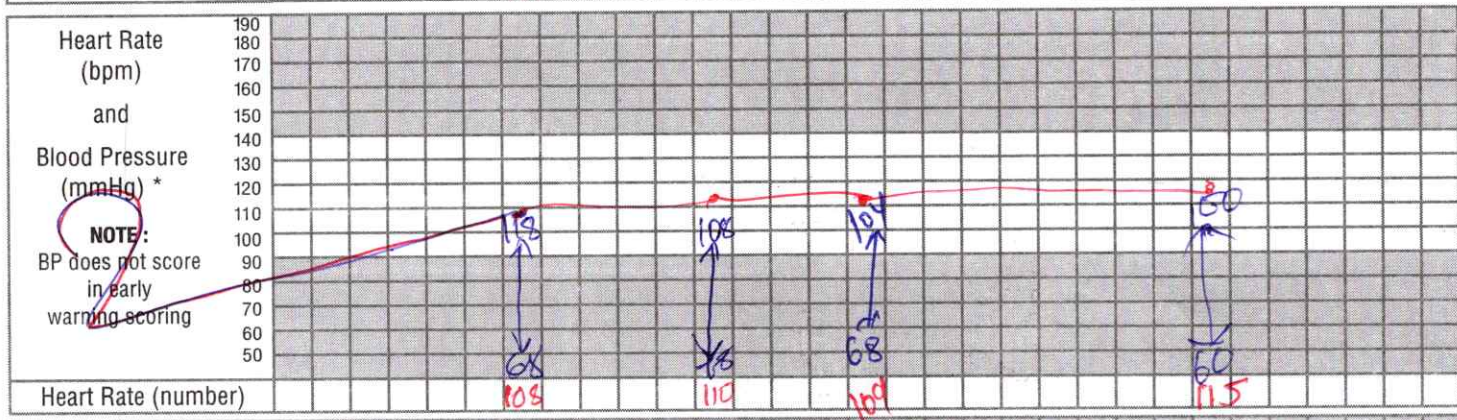
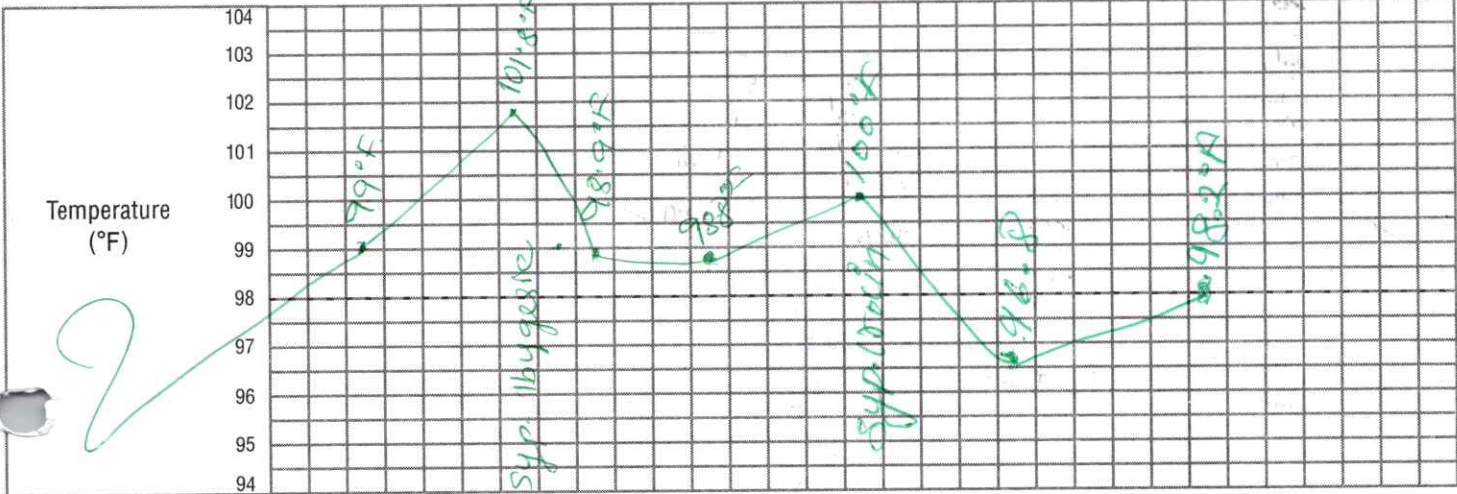
KOH-00295418
Master VIRAJ SINHA
09-12-2021
Dr. DAVID SUVARNARAJU PARIMI (M)

IP2-00058527
4 Y 6 M 2 D

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 12/6 Time: 8 9 10 11 12 1 2 3 4 5 6 7 8 9 10 11 12 1 2 3 4 5 6 7 8 9 10 11

Doctor / Nurse / Family Concern? _____



Resp. Mod/Severe Distress None/Mild	PA	PA	PA	PA
Receiving O2 (L/min)	0	0	0	0
O2 saturations (%)	97%	97%	97%	100%
Conscious Normal Level Decreased				
GCS *	15/15	15/15	15/15	15/15

TOTAL SCORE				
Number of shaded boxes	0	0	0	0
Observer's initials	DP	DP	DP	DP

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.

Handwritten notes at the top of the page, including the number '17' and some illegible scribbles.

Handwritten notes in the upper middle section, featuring several lines of text and some faint diagrams or sketches.

Handwritten notes in the middle section, containing more text and a prominent diagram with lines and arrows.

Handwritten notes in the lower middle section, with text and some faint markings.

Handwritten notes at the bottom of the page, including a horizontal line and some final scribbles.

13/6/26

KOH-00295418 IP2-00056527
 Master VIRAJ SINHA
 09-12-2021 4 Y 6 M 4 D (M)
 Dr. DAVID SUVARNARAJU PARIMI

WS / 02



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

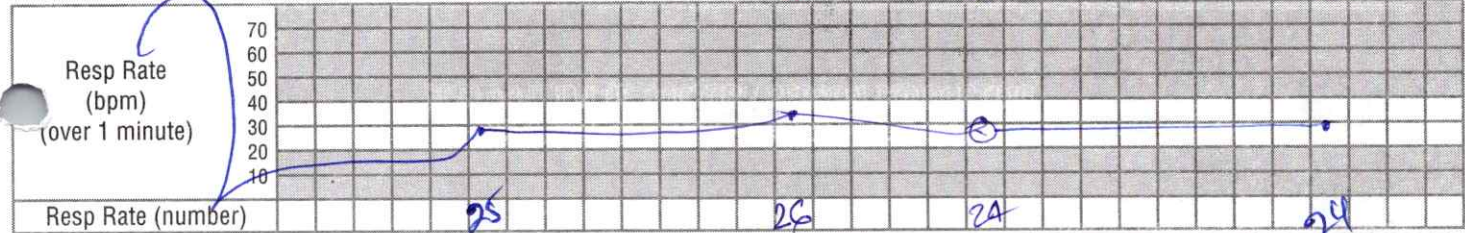
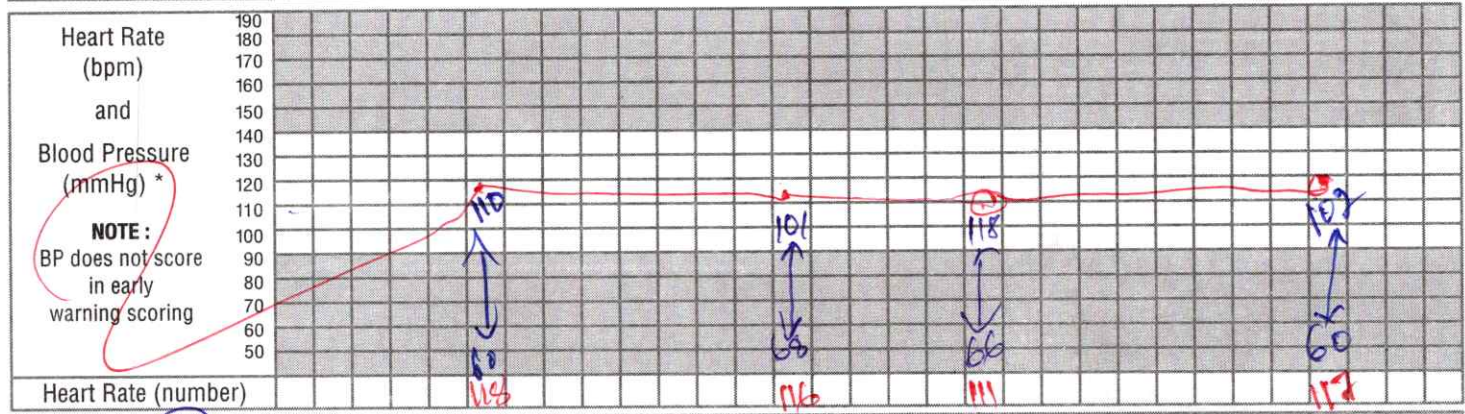
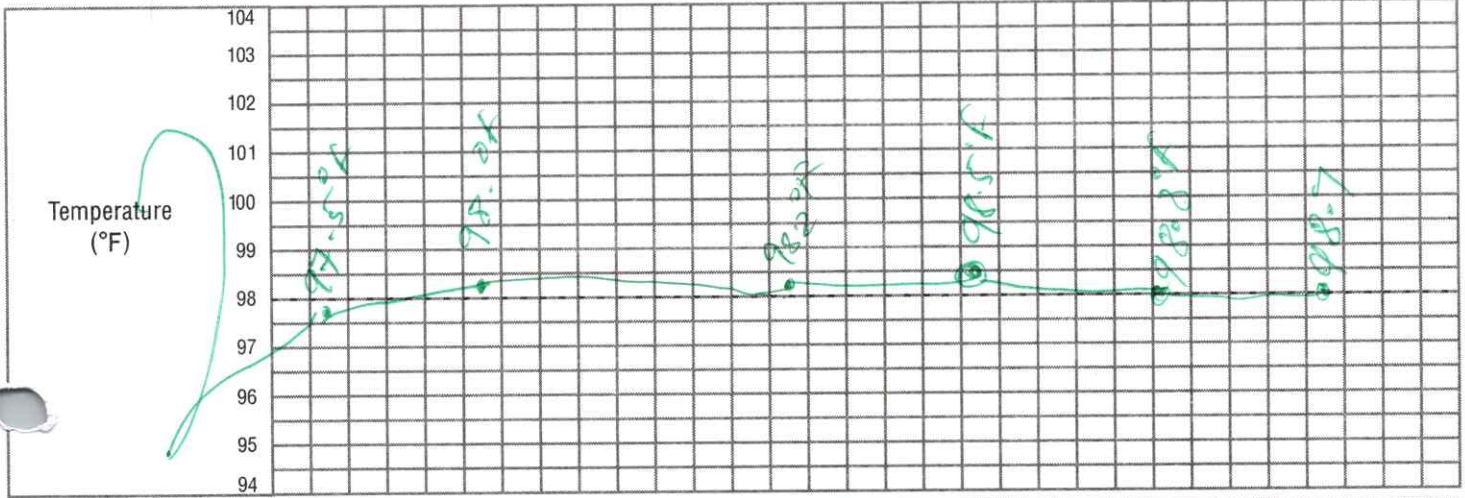
Patient N
 Date of E



EARLY WARNING SCORE: CHILDREN'S UNIT

Date : Time: 7 8 9 10 11 12 1 2 3 4 5 6 7 8 9 10 11 12 1 2 3 4 5 6 7

Doctor / Nurse / Family Concern?



Resp. Mod/Severe Distress	None/Mild
Receiving O2 (L/min)	0
O2 saturations (%)	99%
Conscious Level	Normal
GCS *	15/15
TOTAL SCORE	0
Number of shaded boxes	0
Observer's initials	B

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.

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	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
12/6/20	08:00 am			50ml								
	09:00 am	D		50ml		✓						
	10:00 am	N	puri	50ml								
	11:00 am	S	H ₂ O	—								
	12:00 pm			—								
	01:00 pm				50ml							
Total Intake : DNS + Puri + H ₂ O - 100 ml						Total Output : U-02 M-01						
	02:00 pm			50ml								
	03:00 pm	D	Dal	50ml		✓						
	04:00 pm		T	50ml								
	05:00 pm	N	Rice	50ml		✓						
	06:00 pm	S		—								
	07:00 pm			50ml								
Total Intake : DNS - 250ml Dal + Pr -						Total Output : U-00 M-02						
	08:00 pm	D	chapati	50ml								
	09:00 pm			50ml								
	10:00 pm	N	panir	50ml								
	11:00 pm		+	50ml								
	12:00 am			50ml								
	01:00 am	S	H ₂ O	50ml								
Total Intake : DNS - 300ml + chapati panir						Total Output : U-1 M-0						
	02:00 am			50ml								
	03:00 am		H ₂ O	50ml								
	04:00 am			50ml								
	05:00 am			50ml								
	06:00 am			50ml								
	07:00 am			—								
Total Intake : H ₂ O + DNS - 250ml						Total Output : U-2 M-0						
Total 24 hrs. Intake		Dal Rice + H ₂ O chapati panir DNS - 900 ml				Total 24 hrs. Output		U-5 M-3				

13/6/26



FLUID CH

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			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombophlebitis Score	Sign. Nurse	
		Nature of Fluid	Mouth	I.V								N.G
	08:00 am											
	09:00 am	D	2ddy	-								
	10:00 am	D	water	25ml								
	11:00 am	D	water	25ml								
	12:00 pm	S		-								
	01:00 pm			-								
Total Intake :				2ddy + DNS 50ml			Total Output :				U - 3M - 1	
	02:00 pm			-								
	03:00 pm		Bread	-								
	04:00 pm	D		25ml								
	05:00 pm	N	pan	25ml								
	06:00 pm	S		-								
	07:00 pm		H ₂ O	-								
Total Intake :				Bread pan - 50ml			Total Output :				U = 0, M = 0	
	08:00 pm											
	09:00 pm		Chapati									
	10:00 pm		+ H ₂ O									
	11:00 pm											
	12:00 am		H ₂ O									
	01:00 am											
Total Intake :				Chapati + H ₂ O			Total Output :				U - 1, M - 0	
	02:00 am											
	03:00 am		H ₂ O									
	04:00 am											
	05:00 am											
	06:00 am		H ₂ O									
	07:00 am											
Total Intake :				H ₂ O			Total Output :				U - 0, M - 0	
Total 24 hrs. Intake		2ddy + Bread + Chapati + H ₂ O + DNS - 100ml			Total 24 hrs. Output		U - 7, M - 0					

Patient Sticker



FLUID CHART

Sheet No. :

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			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