

**ACTIVITY RECORD FOR BILLING**

Name : \_\_\_\_\_  
 UHID No. : \_\_\_\_\_ IP No : \_\_\_\_\_ Dept : \_\_\_\_\_

KOH-00296269 IP2-00056540  
 Baby Of NEHA SINGH  
 04-03-2022 4 Y 3 M 8 D (M)  
 Dr. SWETHA RAVI



Date of Admission: \_\_\_\_\_ Time : \_\_\_\_\_ Date of Discharge : \_\_\_\_\_ Time: \_\_\_\_\_

Room / Bed No : \_\_\_\_\_ Ward : \_\_\_\_\_ Suggested Billable bed type : \_\_\_\_\_

**WARD TRANSFERS**

Date	Time	From	To	Signature of Nurse
12/6/26	12:52 pm	ER	506	[Signature]

**Cross Consultation Visit**

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









## PEDIATRIC IN-PATIENT MEDICAL RECORD

KOH-00296269 IP2-00056540  
Baby Of NEHA SINGH  
04-03-2022 4 Y 3 M 8 D (M)  
Dr. SWETHA RAVI



Patient Name : HETANSH SHARMA .

Patient ID# : \_\_\_\_\_

Consultant : DR. SWETHA RAVI .

Final Diagnosis : AFI .

Pediatric Multiorgan History & Physical Examination

Name : HITANSH Age/Sex 4yr.

Informant Mother Reliability fair

Chief Presenting Complaints & Duration (Chronologically):

FEVER ∴ 7 days.

History of present illness :

It was apparently normal 7 days back. Clo of  
FEVER ∴ 7 days, initially low-grade. (100.1°F).  
∴ 4-5 hrs gap, subsiding ∴ crocin medication &  
again recurring.

child-active interfebrile  
period.

Now <sup>1-2</sup> ~~1-2~~ days high grade fever, reaching upto  
103.1°F, continuous. - Even after using crocin  
medication.

oral intake - decreased.

oral mucosa - dry.

peripheral pulses - well  
felt.

No H/O of cold, cough, vomiting,  
loose-stools.

Abdominal pain present in Epigastric region. (on & off).

clo of pain at site of urination. (on & off).



**Pediatric Multiorgan History & Physical Examination**

**Anthropometry**

Head Circum (cms) \_\_\_\_\_ (Centile \_\_\_\_\_) Height (cm) : \_\_\_\_\_ (Centile \_\_\_\_\_)

Weight (kgs) 16.3 kg (Centile \_\_\_\_\_)

**On Examination :**

Temperature : 102.2°F <sup>(Rectal)</sup> Pulse Rate: 135 b/m Description \_\_\_\_\_

B.P. 105/69 SPO2 98% at \_\_\_\_\_

Resp. rate and type of breathing : regular, @ for age.

Rash \_\_\_\_\_

Lymphadenopathy } NO.

Oedema : \_\_\_\_\_

**Respiratory system :**

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

Air entry & breath sounds : (N) CLEAR  
no added sounds

Any addes sounds : \_\_\_\_\_

Relevant data from outside (Chest X-Ray, ABG, etc.,) throat - Congested Reddened  
tadils - Enlarged.

**Cardiovasclular System :**

Inspection of procordium : (N)

Heart Sounds : S1S2 A1

Any murmur : \_\_\_\_\_

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

**Per Abdomen :**

Inspection (N)

Palpation : soft, non tender.

Ausculation : no organomegaly

Spine: \_\_\_\_\_ External Genitalia : \_\_\_\_\_

Relevant data from outside (CT, USG etc.,) \_\_\_\_\_

**Pediatric Multiorgan History & Physical Examination**

**Central Nervous System :**

Level of Consciousness : AVPU/GCS Score : \_\_\_\_\_

Cranial Nerves : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Motor System :**

Nutrition : \_\_\_\_\_

Tone : \_\_\_\_\_ Power \_\_\_\_\_

Co-ordinator : \_\_\_\_\_

Posture : \_\_\_\_\_

Involuntary Movements : \_\_\_\_\_

**Reflexes :**

①

No signs of  
meningeal irritation.

**DTR**

**Superficials :**

Plantars \_\_\_\_\_

**Sensory System :**

Bladder / Bowel : \_\_\_\_\_

**Clinical Summary & Diagnostic :**

Acute febrile illness.

**Pediatric Multiorgan History & Physical Examination**

Preventive aspects of the treatment :

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Desired goals of the treatment :

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**Planned Labs :**

**Planned Management :**

sr. Electrolytes ✓  
 LFT ✓  
 Blood ← urea ✓  
                     (creatinine) ✓  
 Resp-panel (5) ✓  
~~CBC~~

- 1) IVF DNS.
- 2) INT CFTREAX ONG
- 3) INT PANTOP.
- 4) FEVER management.
- 5) Monitor vitals.

CSP, CPT, PLASD etc, ⇒ done on  
 CUE                      op brain  
 CSP - HB - 12              CSP - 33.  
 WBC - 12.71  
 PLF - 286.

noted by *[Signature]* 12/6/26

**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 \_\_\_\_\_ on  
 whose name the patient is being referred

Doctor's Signature Name *[Signature]* Date 12/6. Time 11:00 am

KOH-00296269 IP2-00056540  
 Baby Of NEHA SINGH  
 04-03-2022 4 Y 3 M 8 D (M)  
 Dr. SWETHA RAVI



## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
12/6/26	S/B Dr. Swetha	
1:15pm	7 Fever	
	Temp 103.1	
	hemodynamic stable	
	S/E: N/A	
		CST
		Trace reports

~~Noted by Draxmi 12/6/26 @ 2pm~~

*[Signature]*  
 Dr. Swetha



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
12/6 4:30pm	<p>clsb reg</p> <p>Fever spikes Present (continuous)</p> <p>cls of ABDominal pain in Epigastric region (an 2 off)</p> <p>O/E</p> <p>RTS - BLA E (H) NO abd sore</p> <p>WT - S1S2 (H)</p> <p>PIA - soft, non tender</p> <p><del>RTS - BLA E (H)</del></p>	<p>Advice</p> <ol style="list-style-type: none"> <li>1) CSF</li> <li>2) trace W&amp;E, KIP panel, repeat</li> <li>3) monitor vitals</li> </ol>
12/6 6pm	<p>fever spikes ⊕</p> <p>NO other issues</p> <p>Vitals - stable</p>	<p>Plan</p> <p>ct. same</p> <p><del>any</del> 12/6</p>



**PROGRESS NOTES AND DOCTOR'S ORDER**

Date & Time	Progress Notes	Doctor's Order
13/6/26 10am		S/R Dr. Swetha
	AFP	
	last level 6hrs	
	hemodynamically stable	
	S/E: NAD	Plan
		- if no level till 12pm
		D/c @ request
		- CST
		Dr. Swetha
	Noted By - Sushma 13/6/26 @ 10 AM	
		S/R Dr. Swetha
13/6/26 2pm	level spike 8hrs	
	- otherwise well	CST P40
		Dr. Swetha

KOH-00296269 IP2-00056540

Baby Of NEHA SINGH  
04-03-2022 4 Y 3 M 8 D (M)

Dr. SWETHA RAVI



# GROSS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2pm	<u>Plan</u>	
	D/c	
	flu monday 15/6/26	
	D/c advise stop all antibiotics	
	some medication	
		Dr. Swetha Ravi
	<hr/> <p>Noted by - Sushma 13/6/26 @ 2pm</p>	

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 Dr. SWETHA RAVI



*Phasis*

# RESULT SHEET

Date	12/6/26				
Time	9:01 AM				
Hb	12.0				
PCV	36.2				
RBC	4.94				
WBC	12.31				
N/L					
Platelets	286				
CRP	33				
ESR					
PCT					
RBS					
Na	139				
K	3.8				
Cl	102				
Ca/Mg					
Phosphate					
Urea	17.2				
Creatinine	0.5				
ALP	170				
SGPT	15				
SGOT	27				
T.Bill/Conj	0.3 < 0.1 0.2				
T.Protein	6.6				
S.Albumin	3.5				
S.Globulin	3.1				
A/G Ratio	1.1				
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein / Sugar					
Cells					
N/L					

OP basis

Date	12/6/26					
Time	10:19am					
CUE - Alb	Nil					
CUE - Sugar	Nil					
CUE - Ketones	160					
CUE - PUS Cells	4-6					
CUE - RBC Cells	Nil					
CUE epithelial Blood	2-3					
leucocytes	Absent					
	(Negative)					
Stool Pus Cell						
OVA / Cyst						
Occult Blood						
<del>Genes panel</del>						
Respiratory panel						
Ehu A	} Negative					
Ehu B						
RSV						
SARS-Cov-2						
Adenovirus	-					

12/06

12/6/26 @ gum (op basis) Blood c/s

Culture and Sensitivities : .....

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

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 04-03-2022 4 Y 3 M 8 D (M)  
 Dr. SWETHA RAVI



## 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 Shifting to: S.O.B.

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: Dr. Anurag

Date & Time: 12/6/26 @ uam

Nurse Name & Signature: [Signature]

Date & Time: 12/6/26 @ uam

$$\text{Inj. pantop} = \frac{16 \text{ mg} \times 4 \text{ ml}}{40 \text{ mg}} = 1.6 \text{ ml}$$

$$\text{Inj. Ceftriaxone} = \frac{800 \text{ mg} \times 10 \text{ ml}}{1000 \text{ mg}} = 8 \text{ ml}$$

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 04-03-2022 4 Y 3 M 8 D  
 Dr. SWETHA RAVI

# DRUG CHART

Date of Admission: 12/6 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
Dose	Route	Frequency	Start Date	Time
Syrup cecorin	oral	SOS	12/6	1 PM
Doctor's Signature: <u>AS</u>				10 AM
Additional Instructions: (5ml/1240mg) (min 4 hourly intake) if T>100.1 F				
DRUG :				Date
Dose	Route	Frequency	Start Date	Time
Syrup IBUG-PRC	oral	SOS	12/6	10 AM
Doctor's Signature: <u>AS</u>				13/6
Additional Instructions: (5ml/1100mg) (min 4 hourly intake) if T>102.1 F				4 AM
DRUG :				Date
Dose	Route	Frequency	Start Date	Time
Doctor's Signature:				
Additional Instructions:				

Dr. SWETHA RAVI

REGULAR PRESCRIPTIONS

Weight: 16.3kg Ward: 5M



**DRUG :** INT PAMAPRA 2016

Dose	Route	Frequency	Start Date	Date/Time
16mg	IV	OD	12/6	12/6 1:30pm Laxmi
				13/6

Name & Signature of the Doctor Starting the Drugs: *Dr. Swetha Ravi*

Additional Instructions: *Cam Chand Manisha*

Daily Doctor's Endorsement by a Sign

**DRUG :** INT CEFTREAXONE

Dose	Route	Frequency	Start Date	Date/Time
800mg	IV	BD	12/6	12/6 1:30pm Laxmi
				13/6

Name & Signature of the Doctor Starting the Drugs: *Dr. Swetha Ravi*

Additional Instructions: *100mg 11/1 day. Cam Manisha*

Daily Doctor's Endorsement by a Sign

**DRUG :**

Dose	Route	Frequency	Start Date	Date/Time

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

**DRUG :**

Dose	Route	Frequency	Start Date	Date/Time

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign





506

Patient's Name: B10-Nehar Singh  
493m

# NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 13/4/26 Time: 10:20am

Weight: 16.31kg Centile: <3rd centile

Height: ..... Centile: .....

Inference: Malnourished

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

Diet Recommendations: soft diet

Re-Assessment: .....

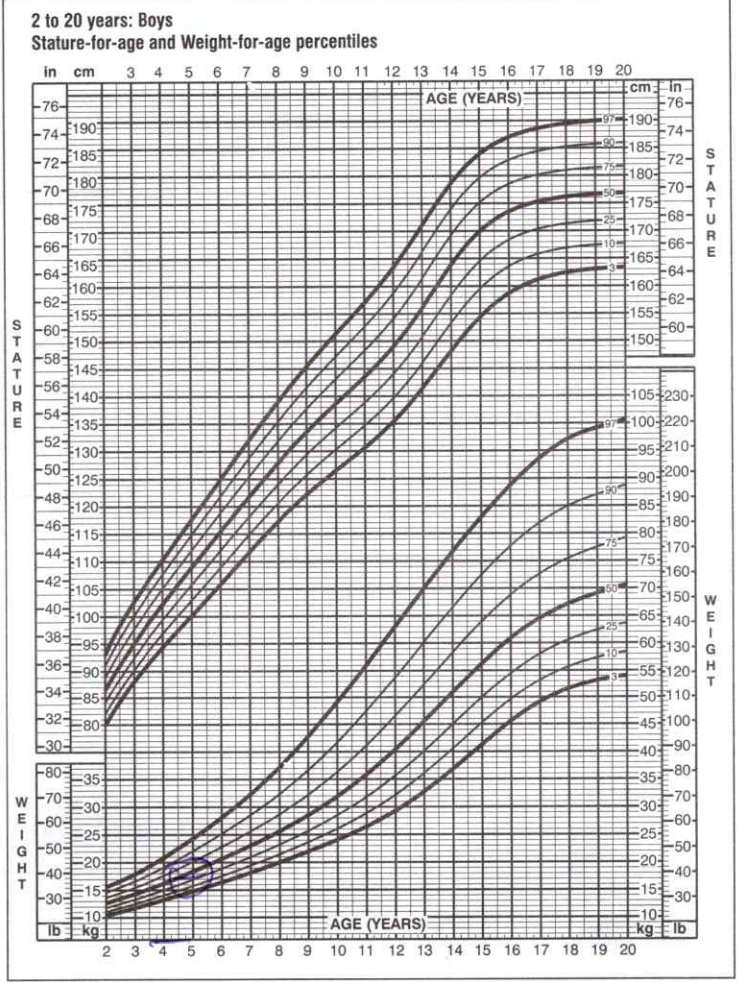
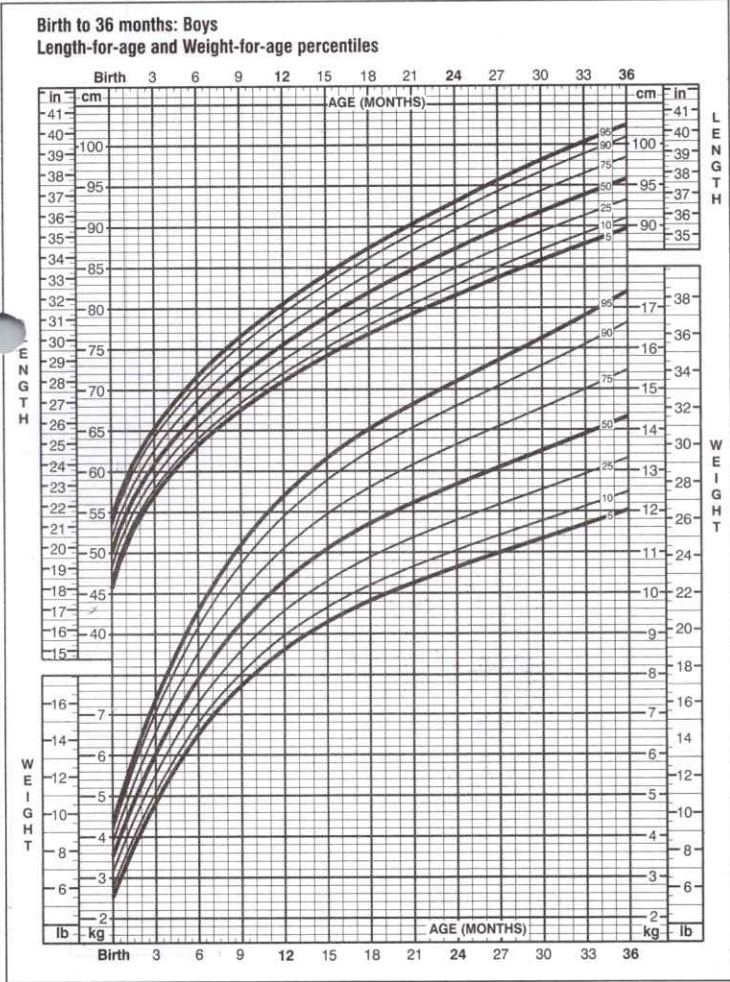
Food Allergies: NO allergies Veg/Non-veg: .....

Diagnosis: AFS

Nutritional Intervention -  Oral  Enteral  Parenteral

Patient's Signature: Neh

## GROWTH CHART (BOYS)



Dietician's Name: anilini

Dietician's Signature: [Signature]



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**.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**

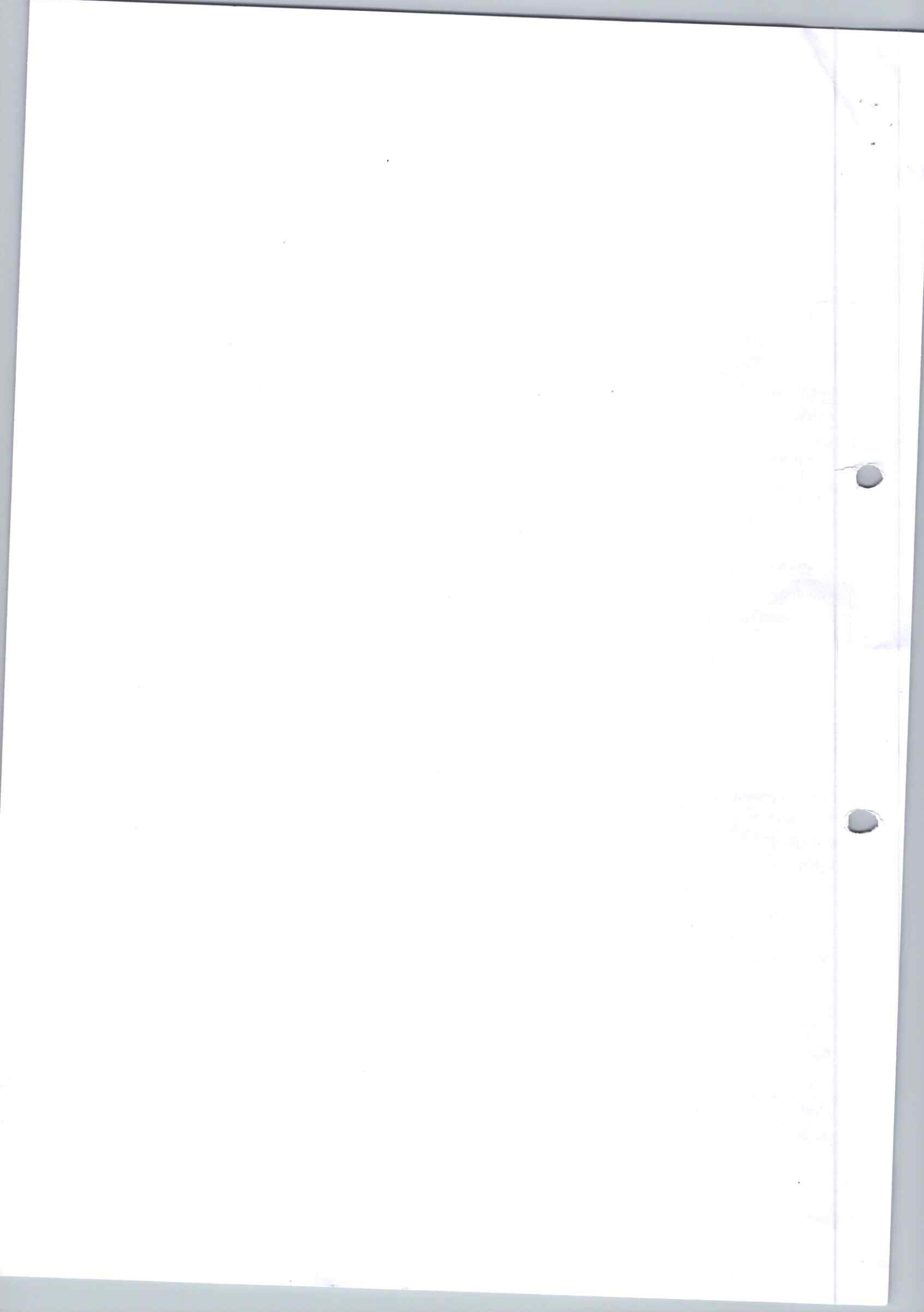
Age	Normal Respiratory Rate
Infant (1 month-1yr)	30-53
Toddler (1-2yr)	22-37
Preschool (3-5 yr)	20-28
School -age (6-11yr)	18-25
Adolescent (12-15yr)	12-20

**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



Patient's

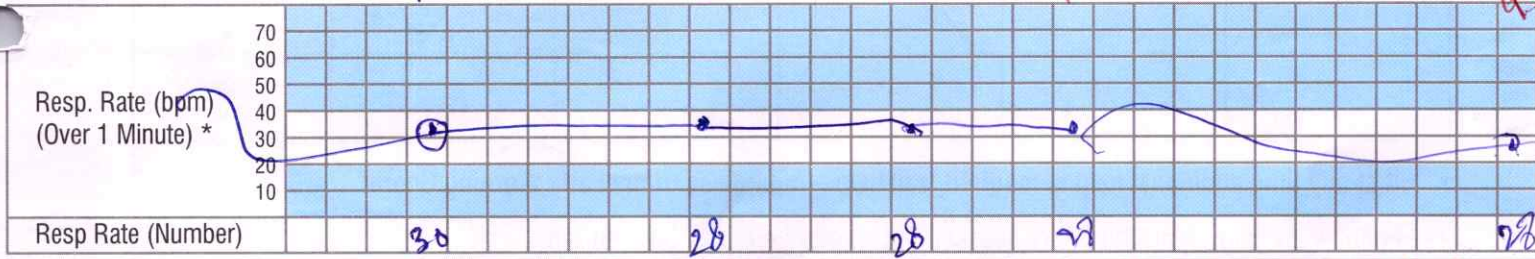
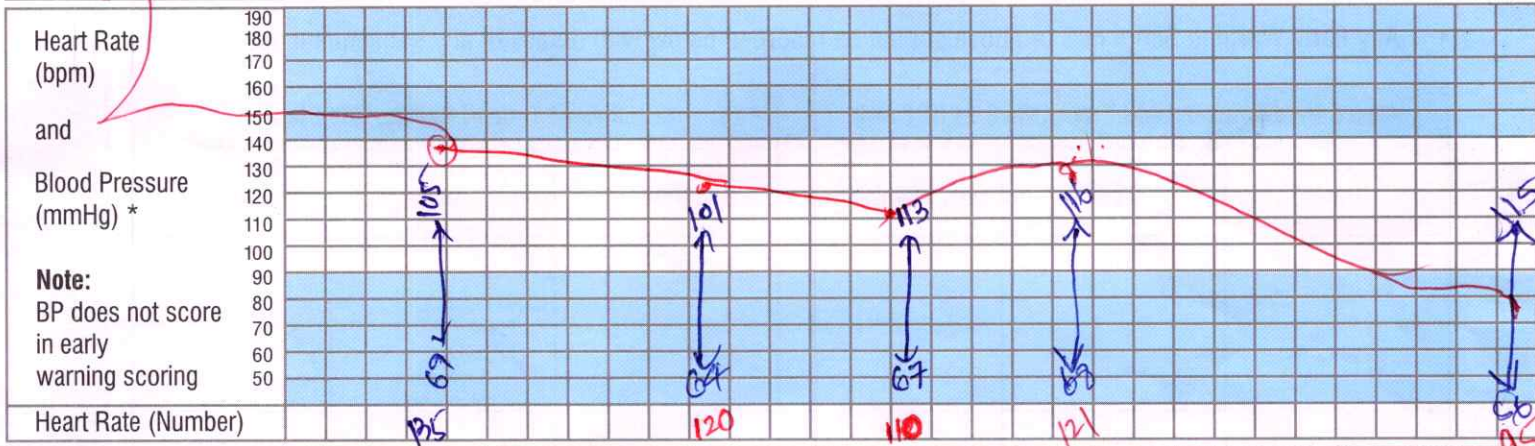
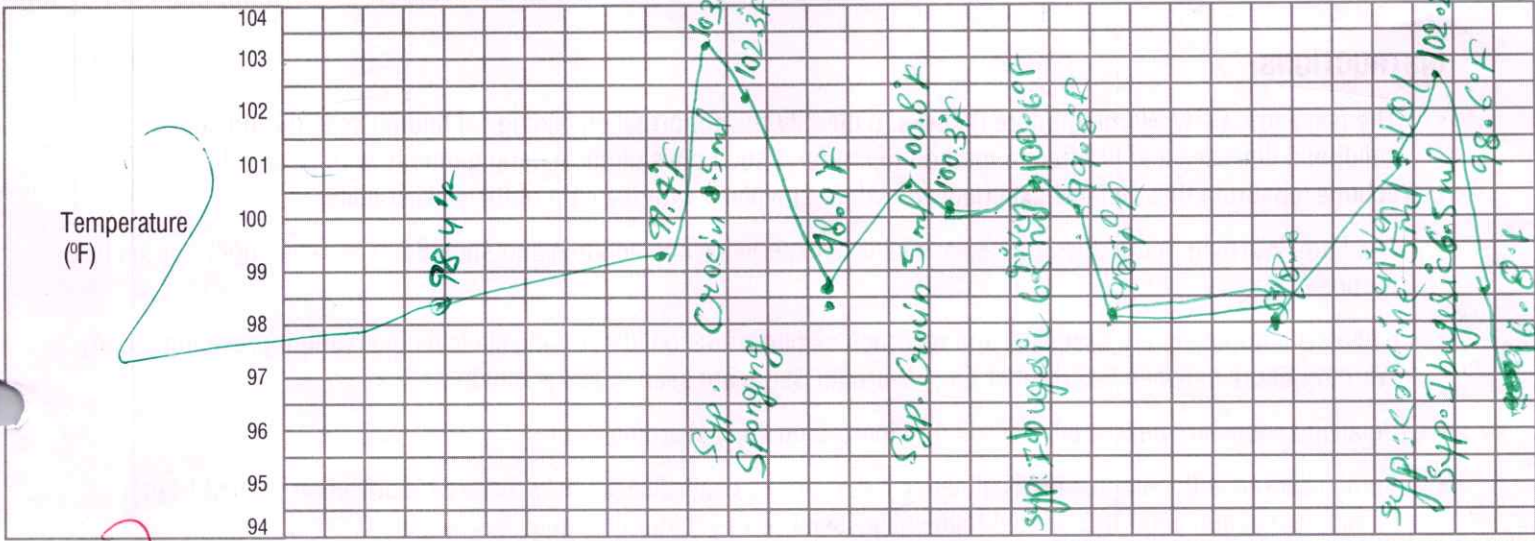


CLINICAL / 125

**EARLY WARNING SCORE: CHILDREN'S UNIT**

Date: 12/11/26 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)

Doctor / Nurse / Family Concern?



Resp Distress	Mod/ Severe None / Mild		RA	RA	RA	RA	
Receiving O <sub>2</sub> (l/min)	O <sub>2</sub> Saturations (%)		0%	99%	98%	99%	94%
Conscious Level	Normal Altered						
GCS *			15/5	15/5	15/5	15/5	15/5

<b>TOTAL SCORE</b>						
Number of shaded boxes			0	0	0	0
Pain Score		0	0	0	0	0
Observer's Initials		Smk	S	S	S	S

- 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.

<b>I</b>	<b>IDENTITY:</b> I am (name), a nurse on ward (X). I am calling about (child X)
<b>S</b>	<b>SITUATION :</b> 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>B</b>	<b>BACK GROUND :</b> 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)
<b>A</b>	<b>ASSESSMENT :</b> 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.
<b>R</b>	<b>RECOMMENDATION :</b> 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

KOH-00296269 IP2-00056540  
Baby Of NEHA SINGH  
04-03-2022 4 Y 3 M 8 D (M)  
Dr. SWETHA RAM

No. : F / HW / EWS / 02

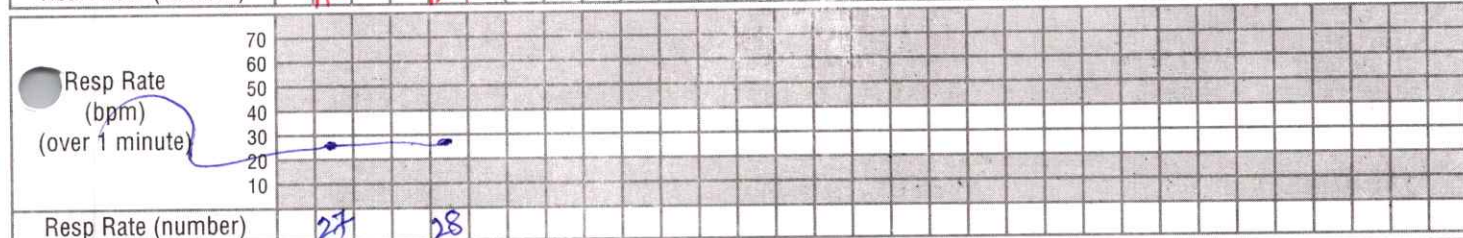
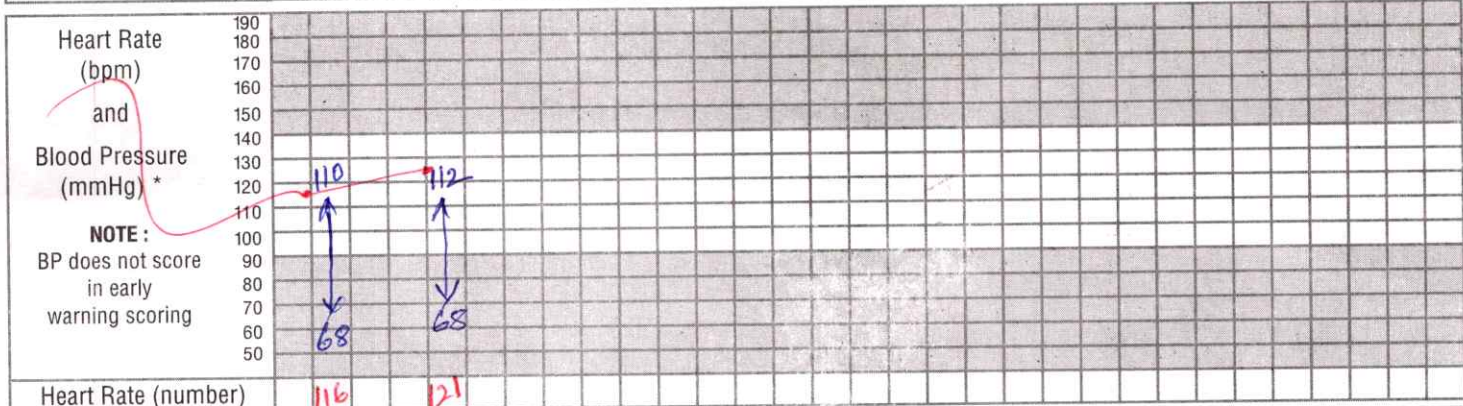
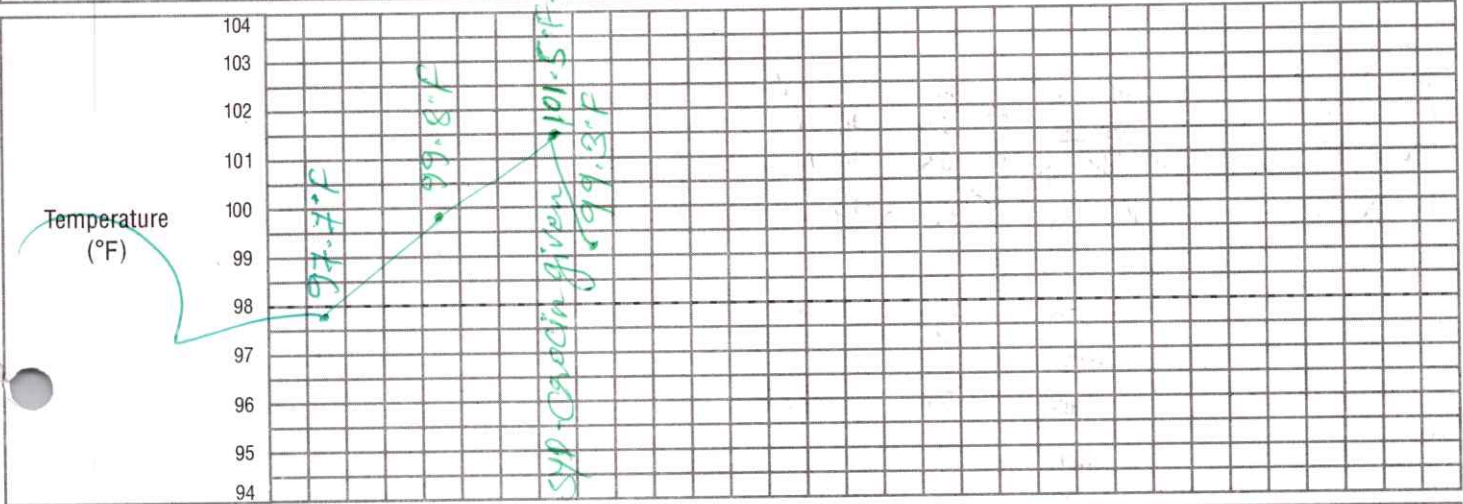


P. No. : .....

**EARLY WARNING SCORE: CHILDREN'S UNIT**

Date : 13/06/20 Time: 8:09 AM 11:12 AM 1:11 PM 2:01 PM 3:04 PM 4:06 PM 7:08 PM 9:10 AM 11:12 AM 1:02 PM 2:03 PM 4:05 PM 7:08 PM

Doctor / Nurse / Family Concern? .....



Resp. Mod/Severe Distress None/Mild	RA	RA
Receiving O2 (L/min)		
O2 saturations (%)	98%	99%
Conscious Normal Level Decreased		
GCS *	15/15	15/15
<b>TOTAL SCORE</b>		
Number of shaded boxes	0	0
Observer's initials	AS	AS

<b>ACTIONS</b>	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.

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Patient :

KOH-00296269

IP2-00056540

Baby Of NEHA SINGH

04-03-2022

4 Y 3 M 8 D

(M)

Dr. SWETHA RAVI



# 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 Thrombophlebitis Score	Sign. Nurse	
		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	DNS H <sub>2</sub> O		36ml								
<b>Total Intake :</b> H <sub>2</sub> O + DNS 36ml					<b>Total Output :</b> U - 0 M - 0							
	02:00 pm			36ml								
	03:00 pm	D rice		36ml								
	04:00 pm	D dal		36ml								
	05:00 pm	H <sub>2</sub> O		36ml								
	06:00 pm											
	07:00 pm	S juice		36ml								
<b>Total Intake :</b> Rice dal + H <sub>2</sub> O + juice + DNS - 180ml					<b>Total Output :</b> U - 0 M - 0							
	08:00 pm											
	09:00 pm	D dhal										
	10:00 pm	N rice										
	11:00 pm	H <sub>2</sub> O										
	12:00 am			36ml								
	01:00 am			36ml								
<b>Total Intake :</b> Dhal Rice H <sub>2</sub> O 72ml					<b>Total Output :</b> U 22 M 20							
	02:00 am											
	03:00 am	D										
	04:00 am											
	05:00 am	N										
	06:00 am	S		36ml								
	07:00 am			36ml								
<b>Total Intake :</b> H <sub>2</sub> O DNS - 72ml -					<b>Total Output :</b> U 24 M 20							

**Total 24 hrs. Intake**  
rice, dal, juice  
H<sub>2</sub>O 36ml  
DNS

**Total 24 hrs. Output**  
U 24 M 20

180  
220  
72  
960



13/06/26

**FLUID CHART**

Sheet No. :     

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse				
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine						
	08:00 am	D		36ml							0	}				
	09:00 am		Uttapam	36ml					✓	0	}					
	10:00 am	N	H2O	36ml						0			}			
	11:00 am		SOUP	<del>36ml</del>						0				}		
	12:00 pm	S							✓	0					}	
	01:00 pm									0						}
<b>Total Intake :</b>			Uttapam, H2O, soup, DNS - 108 ml			<b>Total Output :</b>						U - 2 ml - 0				
	02:00 pm															
	03:00 pm															
	04:00 pm															
	05:00 pm															
	06:00 pm															
	07:00 pm															
<b>Total Intake :</b>						<b>Total Output :</b>										
	08:00 pm															
	09:00 pm															
	10:00 pm															
	11:00 pm															
	12:00 am															
	01:00 am															
<b>Total Intake :</b>						<b>Total Output :</b>										
	02:00 am															
	03:00 am															
	04:00 am															
	05:00 am															
	06:00 am															
	07:00 am															
<b>Total Intake :</b>						<b>Total Output :</b>										

**Total 24 hrs. Intake**

**Total 24 hrs. Output**