

DISCHARGE SUMMARY

Name	Master MOHAMMED ARHAM	UHID	HNH-00003369
Father/Guardian	Mr MOHAMMED ABDUL FAHEEM	Age/Gender	4 Y 6 M 2 D/ Male
Address	CHIRAG ALI NAGAR, Kishan Bagh, Hyderabad, Telangana, INDIA, 500064		
IP No	IP26-00006657	Admission Date	26-06-2026
Ref Doctor	DR. SAI PRASAD P V		
Discharge Date	28.06.2026		

Consultant:

Dr. PAVULURI VENKATA SAIPRASADA RAO
GENERAL PEADIATRICS
02414

Co-Consultant:

Dr. PRITESH NAGAR
MBBS MD
Medical Registration No. 47184

DIAGNOSIS	ICD CODE
WHEEZE ASSOCIATED LOWER RESPIRATORY TRACT INFECTION WITH MILD RESPIRATORY DISTRESS	

History: Master MOHAMMED ARHAM, 4 Y 6 M 2 D , old boy presented with history of cough and cold since 10 days, high grade fever since 3 days and fast breathing prior to admission. For the above complaints he was admitted at Rainbow Children's Hospital - for further management.

Examination: He was (102°F) febrile. His heart rate was 98/min, Blood pressure - 102/62 mmHg and Respiratory Rate -mild tachypnea with no retractions . Capillary Refill Time was <2 secs. Peripheries were warm & pulses well felt. On auscultation, air entry was bilaterally equal reduced with bilateral

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diffuse wheeze were present. Heart sounds were normal and there was no murmur. Abdomen was soft with no organomegaly. On neurological examination, he was conscious and alert. Pupils were bilaterally equal and reacting to light. There were no focal neurological or cranial nerve deficits. There were no signs of raised intracranial pressure. Bilateral cervical lymphadenopathy present left > right.

Weight on admission: 18.3 kilo grams.

Investigations: Enclosed reports.

GeneXpert FluA+FluB+RSV, SARS-CoV-2 were sent, which was negative.

Initial hemogram showed Hemoglobin of 11.6 gm%, White Blood Cell count of 13050 cells/cumm, platelet count of 3.99 lakhs/cumm and C-Reactive Protein of 5 mg/l.

Chest X-ray was normal.

X-RAY NASOPHARYNX LATERAL VIEW

Lobulated soft tissue along posterior nasopharyngeal wall causing mild narrowing of nasopharyngeal air way - Likely mildly enlarged adenoid.

Management: He was admitted in the ward and was started on Intra Venous fluids . He was treated symptomatically with antacids and antipyretics. In view of chest signs, he was frequently nebulised with Levolin .

He was regularly monitored for fever spikes, hemodynamic status and signs of respiratory distress . His fever spikes and other symptoms gradually settled. Child maintaining saturations on room air with no distress , frequency of nebulizations were tapered accordingly.

In view of noisy breathing XRAY nasopharynx was done, showed mildly enlarged adenoid.

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He remained hemodynamically stable during the hospital stay. He improved with the above line of management and is being discharged with the following advice.

At the time of discharge : He is active, afebrile and hemodynamically stable.

Medication during hospital stay:

Injection. Pantoprazole
Nebulisation Levolin
Otrivin P nasal drops

Advice:

- * Diet as advised.
- * Avoid junk food.

S.N	MEDICATION	DOSE	TIMINGS	DURATION
1	NEBULISATION with Levolin (0.31 mg)	1 respule	8th hourly	For 2 days
2	OTRIVIN-P DROPS	2 drops each nostril	12th hourly	For 2 days
3	Nasoclear nasal drops, 2 drops in each nostril SOS for nose block			

Fever Management

- * Syrup. Crocin DS (Paracetamol - 5ml/240mg) 6 ml after food as and whenever required, if temperature > 100 *F (maximum 4 times a day at 6 hour intervals).
- * Tepid sponging if fever > 101 *F.

Review consultation with Dr. PAVULURI VENKATA SAIPRASADA RAO on 01.07.2026 (Wednesday) at his OPD.

Food instructions while taking medications:

- * **Antibiotics** along with food & milk products prevent their absorption of drugs & supplements. Antibiotics can be given 1 hour before food or 2 hours after food based on tolerance of stomach.

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Follow up immediately in Emergency Room if high grade fever, vomiting, breathlessness or refusal to feed occurs.

The content of the patient discharge summary, medication, food & drug interaction, care to be provided at home, nutrition, immunization and safe parenting, when and how to obtain emergency care etc also have been explained by doctor in a language that I can understand and I acknowledge.

Parent/ Attender

In case of emergency contact 9154865030 emergency pediatrician on duty.

To take appointment for OPD consultation at Rainbow **Banjara Hills** / Rainbow Clinic **Madhapur / Kukatpally / Vikrampuri / LB Nagar** / dial just one toll free number **18002122**.

You can also take appointments at any time by going **online** to our website **www.rainbowhospitals.in**



Signature

Registrar/Resident/C.M.O

Dr. PAVULURI VENKATA SAIPRASADA RAO
GENERAL PEADIATRICS
02414

MASTEE MOHAMMAD AFHAM 43 M HNF 00003369 CHEST PA 26 JUN 20 5 44 PM
RAINBOW CHILDREN'S HOSPITAL HIMAYATH NAGAR

wabii

215



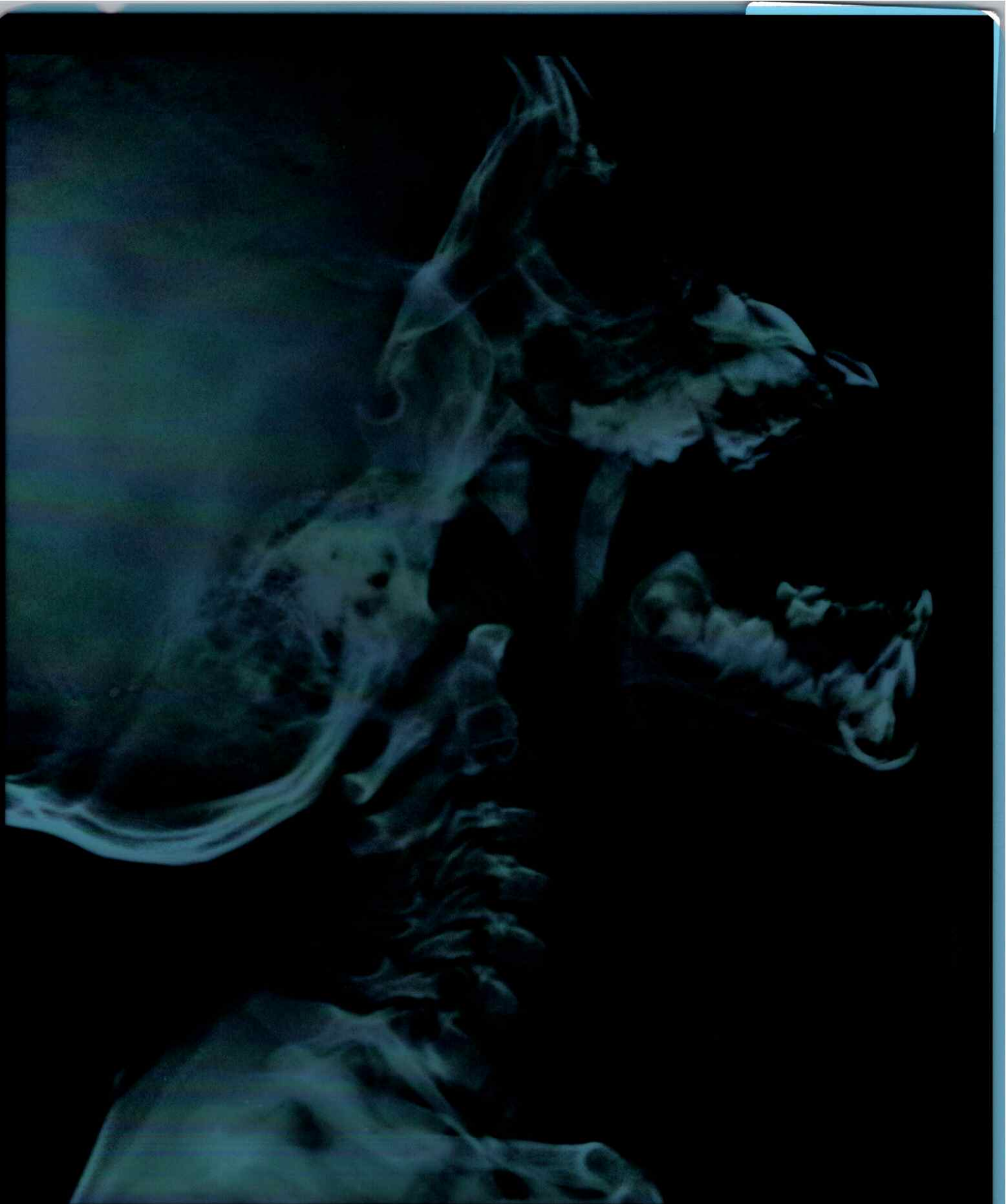


FIGURE 1. Lateral view of the skull of a patient with a fracture of the zygomatic arch. The fracture is clearly visible as a discontinuity in the bony structure of the zygomatic arch. The nasal cavity and maxilla are also visible.

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 Master: MOHAMMED ARHAM
 25-12-2021 4 Y 6 M 1 D (M)
 Dr. PAVULURI VENKATA



4th July



NEBULISATION CHART

Date	Time	Drug	Nurse	Parents Signature
28/6	00.00 -			
	01.00 -			
	02.00 -			
	03.00	levolin	[Signature]	
	04.00			
	05.00			
	06.00			
	07.00	levolin	[Signature]	
	08.00			
	09.00	levolin - ① 8868	[Signature]	
	10.00			
	11.00	Total - ⑩		
	12.00	Cross checked done.		
	13.00			
	14.00			
	15.00			
	16.00			
	17.00			
	18.00			
	19.00			
	20.00			
	21.00			
	22.00			
	23.00			

20 8829 = TOTAL NEB 3



4th baby

NEBULISATION CHART

Date	Time	Drug	Nurse	Parents Signature
27/16	00.00			
	01.00			
	02.00	Levolin Nebulization (0.3l)	MLK	Mahar
	03.00			
	04.00			
	05.00			
	06.00	Levolin Nebulization (0.3l)	MS	Mahar
	07.00		208540 = 3 TOTAL	
	08.00			
	09.00			
	10.00	Levolin nebulization (0.3l)	A	Mahar Banu
	11.00		1	
	12.00		8663	
	13.00			
	14.00	Levolin nebulization (2)		A
	15.00			
	16.00			
	17.00			
	18.00	Levolin	8	Mahar Banu
	19.00			
	20.00			
	21.00			
	22.00			
	23.00	Levolin	oh	

11

12

13

14



15

16

17



18

19

20



HNH-00003389 IP26-00006657
 Master MOHAMMED ARHAM
 25-12-2021 4 Y 6 M 1 D (M)
 Dr. PAVULURI VENKATA



NEBULISATION CHART

Date	Time	Drug	Nurse	Parents Signature
<u>26/6</u>	00.00			
	01.00			
	02.00			
	03.00			
	04.00			
	05.00			
	06.00			
	07.00			
	08.00			
	09.00			
	10.00			
	11.00			
	12.00			
	13.00			
	14.00			
	15.00			
	16.00			
	17.00			
18.00	Levolin	84671	Sri Maima Banerji	
19.00				
20.00				
21.00				
22.00	Levolin		Dr. Meenu	
23.00				

10/11/21


10/11/21

10

10

10/11/21

ACTIVITY RECORD FOR BILLING

Name: ----- HNH-00003369 IP26-00006657 -----
 Master MOHAMMED ARHAM
 UHID No : -- 25-12-2021 4 Y 6 M 1 D (M) ----- Consultant : ----- Dept : -----
 Dr. PAVULURI VENKATA
 Date of Adm  ----- Date of Discharge : ----- Time: -----
 Room / Bed No : ----- Ward : ----- Suggested Billable bed type : -----

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
26/12/26	6pm	ER	ward	<i>[Signature]</i>

Cross Consultation Visit

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

Ref.No. F/IN/PR/10



**Rainbow[®]
Children's
Hospital**

**PEDIATRIC IN-PATIENT
MEDICAL RECORD**

HNH-00003369 IP26-00006657
Master MOHAMMED ARHAM
25-12-2021 4 Y 6 M 1 D (M)
Dr. PAVULURI VENKATA



Patient Name : Mohammed Arham

Patient ID# : _____

Consultant : Dr. Sai Prasad / Dr. Pritesh

Final Diagnosis : _____

Pediatric Multiorgan History & Physical Examination

Name : Ma. Arham Age/Sex 5y/MCH

Informant mother Reliability _____

Chief Presenting Complaints & Duration (Chronologically):

cb cough x 10 days
H/o high-grade fever spikes x 3 days

History of present illness :

Patient was apparently asymptomatic 10 days since ^{he} developed cough, dry in nature (± breathlessness), spasmodic, continuous, associated with snoring at night.

History of ^{moderate} high grade fever for 3 days, (5 days ago) 101-102°F, not ± chills (rigors), 2-3 times per day, not ± rashes.

Pediatric Multiorgan History & Physical Examination

Anthropometry

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

Weight (kgs) 18.3 kgs (Centile _____)

On Examination :

Temperature : 97.6 F Pulse Rate: 98 bpm Description _____

B.P. 102/62 mmHg SPO2 98% at RA

Resp. rate and type of breathing : 22/min, not on retractions

Rash (-)

Lymphadenopathy B/c cervical lymphadenopathy (+) (L&R)

Oedema : (-)

Respiratory system :

Inspection (any s/o distress) : _____

Air entry & breath sounds : Air entry bilaterally reduced, wheeze (+) b/l

Any addes sounds : _____

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

outside CXR s/o ↑ bronchovascular markings,

Cardiovasclular System :

Inspection of procordium : _____

Heart Sounds : (+)

Any murmur : _____

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

Per Abdomen :

Inspection (+)

Palpation : (+)

Ausculation : _____

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 : _____

(N)

Motor System :

Nutrition : _____

Tone : _____ Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR

Superficials :

Plantars _____

Sensory System :

Bladder / Bowel : _____

Clinical Summary & Diagnostic :

where associated LRTI .c distress .

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment :

Desired goals of the treatment :

Planned Labs :

CBP
CRP
CXR - PA view
X-ray nasopharynx
Respiratory panel (5-viruses)

~~NB (Jan)~~

Planned Management :

- Nebulisations e levofloxacin
(0.25 mg respule)
4 hourly
- IVF with plasmalyte
@ 20 cel/hour

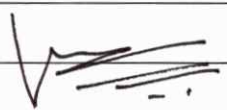
~~NB open~~

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 Swipapud Date _____ Time _____


PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
27/12/26 8 AM.	<p>U ALBI C RD.</p> <hr/> <p>- fever spikes - None (Afebrile since admission).</p> <p>- cough (+).</p>	<p>Uslb Dr. Vasu</p>
	<p>PE - vitals stable. RR - 22/min. SpO2 97% @ NA.</p>	<p>Plan</p> <p>- C. Neb. Zovelin Q4H.</p>
	<p>PE - R/S - BAE (+), occ. crackles (+) over R side.</p>	<p>- C. IVF.</p> <p>- N/Bak</p>
		<p></p>

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
27/1/26	cls/b Dr. Pritesh	
9:30 AM	A - WBLR1	
	- Alebrile.	
	- oral intake good.	Plan
	- Cough ↓.	- Ct. 2nd line Q4H.
	SE vitals stable.	
	SE - WNL.	
	 Dr. Pritesh Nagar Consultant Pediatrician & Intensivist Reg. No: 47184	



18.3 kgs

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
27/6/26 10:10 AM	c/s/hy. Dr Sai prasad. A- WAIARI	
	Afebrile oral intake - fair cough (+) pain per abdomen (+) (epigastric pain) vital stable	Adv Add Pantoprazole 20mg. Stat Otrivin - P drops Plan: Discharge tomorrow after re-assessment - ct rest same Signatures
		P.B Amouth 2:11 AM
27/6/26 2pm	c/s/hy Dr Anusha. WAIARI.	
	Child afebrile. oral intake - good vital stable S/E NIAD, BkAE (+) no distre when I/d	Plan - ct rest same. - A/s Tm plan. - Inform son RR, spo2 Signatures



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
27/6/26	S/B Dr: Pritesh	
4:45pm	Δ: WALK	Advice
on Room Air	cough (P)	ct nebulisations
oral intake - fair		ct symptomatic support
ok	vitaly stable	Discharge (cm)
ste wal		N.B. on C 4:45 PM
		(M)

Dr. Pritesh Nagar
 Consultant Pediatrician & Intensivist
 Lic. No: 47164

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
28/6/26 8:00 AM	<p>CSB - Dr. Prashanti / Dr. Nayunya</p> <hr/> <p>A - WARI.</p>	
	<p>On Room Air cough + fair oral intake.</p>	<p><u>Plan</u> Continue Symptomatic Rx</p>
	<p>o/e vitals stable</p>	<p>- Neb LEVOLIN Q4H - consider - Discharge today</p>
	<p>e/e NUBST BLACT R-base where ↓. Phase CVS - S. Sat Phase CVS - WNL P/A - Soft.</p>	<p>NIB of mouth pink</p>



DRUG CHART

Date of Admission: 26/6/26 Drug Allergies: N/A 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:																				

VERIFIED BY: Name



REGULAR PRESCRIPTIONS

Weight. Ward.

DRUG : Nebulisation - levoflo				Date Time
Dose	Route	Frequency	Start Date	
0.31 mg		4 hourly	26/6/26	
Name & Signature of the Doctor Starting the Drugs:				} see the chart
Additional Instructions:				
LEVOSALBUTAMOL (0.31mg/2.5ml)				
Daily Doctor's Endorsement by a Sign				

DRUG : Inj PANTOPRAZOLE				Date Time
Dose	Route	Frequency	Start Date	
20 mg	IV	OD	27/6/26	
Name & Signature of the Doctor Starting the Drugs:				} 6am 11am
Additional Instructions:				
Dilute in 4ml NS				
Daily Doctor's Endorsement by a Sign				

DRUG : OTR IVIN-P drops				Date Time
Dose	Route	Frequency	Start Date	
2 drop	each nose	BD	27/6/26	
Name & Signature of the Doctor Starting the Drugs:				} 10am 12pm
Additional Instructions:				
10pm				
Daily Doctor's Endorsement by a Sign				

DRUG :				Date Time
Dose	Route	Frequency	Start Date	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

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Master MOHAMMED ARHAM
25-12-2021 4 Y 6 M 1 D (M)
Dr. PAVULURI VENKATA



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RESULT SHEET

Date	26/6/26				
Time					
Hb	11.6				
PCV	33.2				
RBC	4.66				
WBC	18.05				
N/L	529/35:8				
Platelets	399				
CRP	5.0				
ESR					
PCT					
RBS					
Na					
K					
Cl					
Ca/Mg					
Phosphate					
Urea					
Creatinine					
ALP					
SGPT					
SGOT					
T.Bill/Conj					
T.Protein					
S.Albumin					
S.Globulin					
A/G Ratio					
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein / Sugar					
Cells					
N/L					

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V FRM / CLINICAL / 125

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

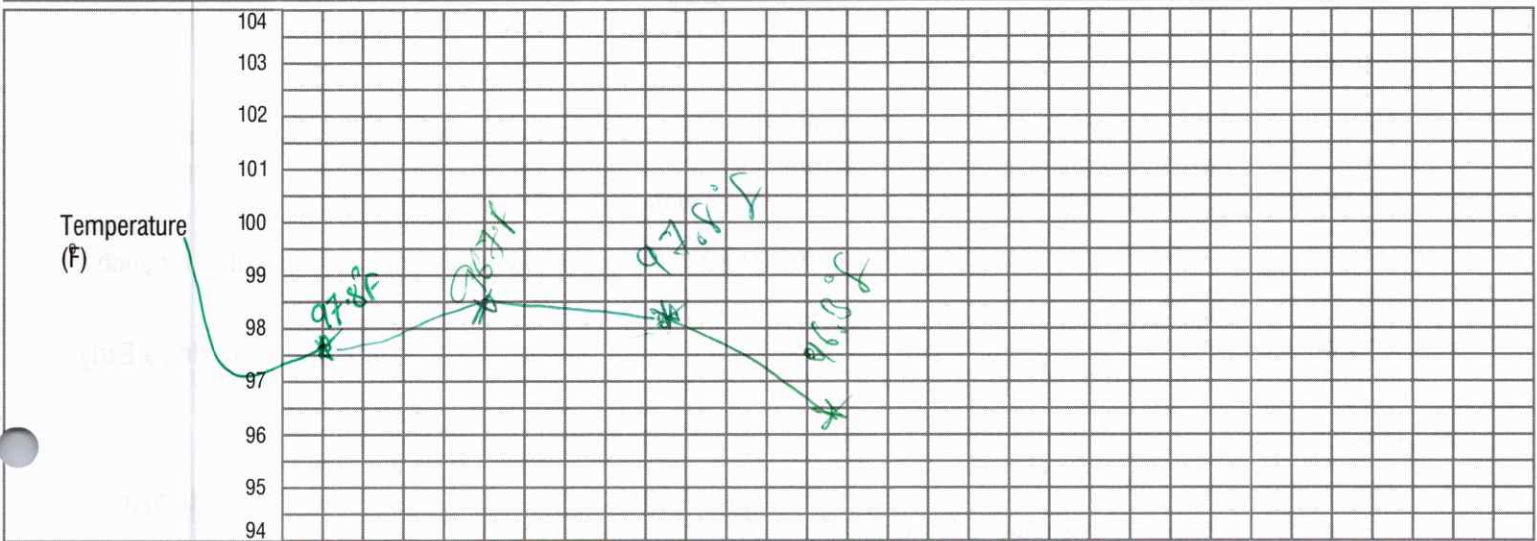
Pratiksha
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EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 26/06/24 Time: 6pm 10pm 2Am 6Am

Doctor / Nurse / Family Concern?



Heart Rate (bpm)				
and				
Blood Pressure (mmHg) *	95/65	94/52	90/68	98/59
Note: BP does not score in early warning scoring				

Heart Rate (Number) 112b/m 80b/m 110b/m 92b/m

Resp. Rate (bpm) (Over 1 Minute) *				
Resp Rate (Number)	<u>20b/m</u>	<u>25b/m</u>	<u>30b/m</u>	<u>30b/m</u>

Resp Mod/ Severe Distress None / Mild

Receiving O₂ (l/min) O₂ Saturations (%) 99% 99% 99% 99%

Conscious Level Normal / Altered
 GCS * 5 6

TOTAL SCORE				
Number of shaded boxes	0	0	0	0
Pain Score	0	0	0	0
Observer's Initials	<u>N</u>	<u>K</u>	<u>N</u>	<u>N</u>

- 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)

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4/ FRM / CLINICAL / 125

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

Pratiksha
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EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 24/6/26	Time: 10 AM	2 PM	6 PM	10 PM	2 AM	6 AM
Doctor / Nurse / Family Concern?						
Temperature (F)	98.5 F	98.5 F	97.6 F	98.5 F	97.5 F	98.1 F
Heart Rate (bpm) and Blood Pressure (mmHg) *	100/60	99/62	94 (21)/62	100/60	100/65	105/60
Note: BP does not score in early warning scoring						
Heart Rate (Number)	110b/m	112b/m	110b/m	94	115b/m	120b/m
Resp. Rate (bpm) (Over 1 Minute) *	20b/m	24b/m	25b/m	22b/m	28b/m	24b/m
Resp Mod/ Severe Distress None / Mild						
Receiving O ₂ (l/min) O ₂ Saturations (%)	100%	99%	100%	100%	100%	99%
Conscious Level Normal / Altered						
GCS *	14/14	14/14		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	P	S	A	P	K	P

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.
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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)

HNH-00003369 IP26-00006657
 Master MOHAMMED ARHAM
 25-12-2021 4 Y 6 M 1 D (M)
 Dr. PAVULURI VENKATA



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
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
26/6/26	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
	Total Intake :						Total Output :					
26/6/26	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm	Plasmaolyte	20ml		NA			NA				
	07:00 pm		20ml									
	Total Intake :						Total Output :					
26/6/26	08:00 pm		20ml									
	09:00 pm		20ml									
	10:00 pm	Plasmaolyte	20ml									
	11:00 pm	Rice + H ₂ O	20ml									
	12:00 am		20ml									
	01:00 am		20ml									
	Total Intake :						Total Output :					
27/6/26	02:00 am		20ml									
	03:00 am		20ml									
	04:00 am		20ml									
	05:00 am	Plasmaolyte	20ml									
	06:00 am		20ml									
	07:00 am		20ml									
	Total Intake :						Total Output :					
Total 24 hrs. Intake						Total 24 hrs. Output						



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			
27/10/20	08:00 am	Milk 20ml		20ml									
	09:00 am		20ml										
	10:00 am		20ml										
	11:00 am		20ml										
	12:00 pm		20ml										
	01:00 pm		20ml										
Total Intake : taken						Total Output : 0 - 0 - 0 - 0 - 0 - 0							
27/10	02:00 pm	Puro 20ml		20ml									
	03:00 pm		20ml										
	04:00 pm		20ml										
	05:00 pm		20ml										
	06:00 pm		20ml										
	07:00 pm		20ml										
Total Intake :						Total Output : 0 - 2 ml -							
28/10	08:00 pm	Milk 20ml											
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
Total Intake :						Total Output :							
28/10	02:00 am	Milk 20ml											
	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

HNH-00003369 IP26-00006657
 Master MOHAMMED ARHAM
 25-12-2021 4 Y 6 M 1 D (M)
 Dr. PAVULURI VENKATA



NURSING CARE RECORD

Date: 26/6/20

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning				NA			
Afternoon	6pm	<ul style="list-style-type: none"> - Assess the pt. condition - Monitor vitals & records - Maintain I/O chart - Cont. IV fluids 	6pm	<ul style="list-style-type: none"> - Assessed the pt. condition - Monitored vitals & records - Maintained I/O chart - cont. IV fluids 	Patient is Stable	Re-checked vitals	
	8pm	<ul style="list-style-type: none"> - Cont. nebulization 	8pm				
Night	8pm	<ul style="list-style-type: none"> → Assess the baby condition → monitor the vitals → maintain I/O chart → drugs give as per drug chart. 	8pm	<ul style="list-style-type: none"> → Assessed the baby condition → Monitored the vitals → maintained I/O chart → drugs given as per drug chart. 	→ pt is stable now	→ Re-assessed the vitals	
	8Am		8Am				

HNH-00003389 IP26-00006657
 Master MOHAMMED ARHAM (M)
 25-12-2021 4 Y 6 M 1 D
 Dr. PAVULURI VENKATA



NURSING CARE RECORD



Date: 27/6/20

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8am	→ assess the pt condition	8am	→ assessed the pt condition	→ pt is stable	→ rechecked vitals	[Signature]
	2pm	→ monitor vitals → maintain IO chart → administer medication as per IO chart → IV cannula present	2pm	→ monitored vitals & recorded → maintained IO chart → medication as per IO chart → pt on soft diet			
Afternoon	2pm	Assess the pt condition	2pm	Assessed the pt condition	→ pt is stable	→ monitor vitals	[Signature]
	4pm	monitor vitals & reu.	4pm	Monitored vitals & reu.			
Night	8pm	Maintain IO clean	8pm	Maintained IO clean	vital's normal	Maintain IO clean	[Signature]
	8pm	provide the comfortable position	8pm	provided the comfortable position			
Night	8pm	medication given as per as doctor ord.	8pm	medication given as per as doctor ord.	Administer Med	Plan A	[Signature]
	8pm	Admission to ICU	8pm	Admission to ICU			



SING SHIFT HAND OVER FORM

SITUATION	Diagnosis: <i>WALRI c disten</i>	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify:					
	Surgery / Procedure:	Post OP Day:					
BACKGROUND	Date	<i>26/6</i>	<i>26/6</i>	<i>27/6/26</i>	<i>27/6</i>	<i>28/6</i>	
	Shift	<i>E2</i>	<i>N1</i>	<i>MG</i>	<i>E2</i>	<i>MG</i>	
	Medical Condition (Any special condition to be noted):	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	
Diet:	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>		
ASSESSMENT	Allergy:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Ventilation (RA, NP, NIV, VENTI):	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Vital Signs:	Temp:	<i>97.8 F</i>	<i>97.1 F</i>	<i>97.2</i>	<i>-</i>	<i>98.1 F</i>
		Res:	<i>20b/m</i>	<i>20b/m</i>	<i>20b/m</i>	<i>20b/m</i>	<i>20b/m</i>
		SpO ₂ :	<i>100%</i>	<i>100%</i>	<i>99%</i>	<i>99%</i>	<i>100%</i>
		Pulse:	<i>118b/m</i>	<i>118b/m</i>	<i>110b/m</i>	<i>99b/m</i>	<i>100%</i>
		BP:	<i>95/65</i>	<i>95/65</i>	<i>100/60</i>	<i>99/62</i>	<i>98/60</i>
		LOC:	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>
	Fall Risk Score:	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	
Pain Score:	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>		
Skin Integrity	<i>-</i>	<i>Good</i>	<i>Good</i>	<i>Good</i>	<i>-</i>		
Recommendations	Safety Needs:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	Physiotherapy:	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	
	Others Specify:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Special Diet:	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	
	Critical Lab Test / Values:	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	
	Other Special Orders / Medications:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	ADL (Dependent / Non Dependent):	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	
Post Operative Procedure Special Orders:	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>		
Handed Over By Name :	<i>Priyanka</i>	<i>Maulika</i>	<i>Aravind</i>	<i>Srujan</i>	<i>Aravind</i>		
Signature / ID :	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>		
Date:	<i>26/6/26</i>	<i>27/6/26</i>	<i>27/6/26</i>	<i>27/6</i>	<i>28/6</i>		
Time:	<i>8pm</i>	<i>8pm</i>	<i>2pm</i>	<i>8pm</i>	<i>8pm</i>		
Taken Over By Name :	<i>maulika</i>	<i>Aravind</i>	<i>Srujan</i>	<i>Aravind</i>	<i>Aravind</i>		
Signature / ID :	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>		
Date:	<i>26/6/26</i>	<i>27/6/26</i>	<i>27/6/26</i>	<i>27/6</i>	<i>28/6</i>		
Time:	<i>8pm</i>	<i>8pm</i>	<i>2pm</i>	<i>8pm</i>	<i>8pm</i>		

Patient Sticker



NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify:						
	Surgery / Procedure:	Post OP Day:						
BACKGROUND	Date	/	/	/	/	/	/	
	Shift							
	Medical Condition (Any special condition to be noted):							
	Diet:							
ASSESSMENT	Allergy:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Ventilation (RA, NP, NIV, VENTI):							
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Vital Signs:	Temp:						
		Res:						
		SpO ₂ :						
		Pulse:						
		BP:						
		LOC:						
		Fall Risk Score:						
Pain Score:								
Skin Integrity								
Recommendations	Safety Needs:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Physiotherapy:							
	Others Specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Special Diet:							
	Critical Lab Test / Values:							
	Other Special Orders / Medications:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	PU Prophylaxis:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
DVT Prophylaxis:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
ADL (Dependent / Non-Dependent):								
Post Operative Procedure Special Orders:								
Handed Over By Name :								
Signature / ID :								
Date:								
Time:								
Taken Over By Name :								
Signature / ID :								
Date:								
Time:								

HNH-00003369 IP26-00006657
 Master MOHAMMED ARHAM
 25-12-2021 4 Y 6 M 1 D (M)
 Dr. PAVULURI VENKATA



IE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
			26/6	27/6/26	28/6		
Age	Less than 3 years old	4					
	3 to less than 7 years old	3	3	3	2		
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	2	2	2		
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1					
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own ability	1	1	1	1		
	History of Falls or Infant-Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2					
	Outpatient Area	1	1	1	1		
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours/ None	1	1	1	1		
Medication Usage	Sedatives (Excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1					
Total			9	9	9		

Intervention:

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		✓	—	✓		
Call device within reach		✓	—	✓		
Wheels Locked		✓	✓	✓		
Room free of clutter		✓	✓	✓		
Adequate lighting		✓	✓	✓		
Wheel chair support		X	X	X		
Other Intervention(s) Specify		X	X	X		
Nurse's Name:		Suresh				
Signature:		[Signature]				
Date:		26/6	27/6/26	28/6		
Time:		8 PM	8 PM	8 PM		



CHECKLIST FOR THROMBOPHLEBITIS

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

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

Signature of Shift In Charge : Sneha
 Signature : Name : Sneha

Signature of Ward In Charge :
 Signature : Balarani Name : Balarani



BRADEN 'Q' SCALE



					Date:	26/12/2021	27/12/2021	28/12/2021	29/12/2021
					Time:	12:00	10:00	10:00	12:00
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.		4	4	4	4
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.		4	4	4	3
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation. OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.		4	4	4	4
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.		4	4	4	4
FRICION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."		4	4	4	4
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.		4	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.		4	3	3	4
					TOTAL SCORE	28	28	28	27
					Evaluator's Name	R	R	R	R

Severe Risk : less than 9 | High Risk : 10-12 | Moderate Risk : 13-14 | Mild Risk : 15-18 | Not at Risk: 19-23

Risk Score	Category	Action	Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice)
15-18	At Risk	<ul style="list-style-type: none"> • Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • Advance to a higher level of risk if other major risk factors are present 	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	<ul style="list-style-type: none"> • Use the Same Protocol as for "At Risk" Patients • Position patient at 30 degree lateral incline using foam wedges 	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	<ul style="list-style-type: none"> • Follow the same protocol as for "Moderate Risk" Patients • In addition to regular turning schedule • Make small shifts in their position frequently 	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	<ul style="list-style-type: none"> • Use same protocol as for "High Risk" Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors. 	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
27/06	6AM	0/10	—	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	NA	SA
27/06/26	10AM	0/10	—	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	NA	SA
27/6	2PM	0	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	NA	SA
27/6	8PM	0	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	NA	SA
28/6	8PM	0	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	NA	SA
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Re-assessment Frequency:

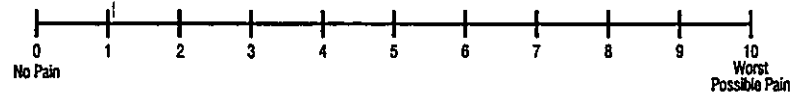
1. Every eight hours for all hospitalized patients.
2. For post-surgical patients, patients with chronic pain, patient with severe pain:
 - a) At least every 2 hours for the first 24 hours
 - b) Then every 4 hours.
 - c) Prior to pain pain-relieving intervention.
 - d) Within 30 – 60 minutes after pain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

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
	0	1	2
Face	No Particular expression or smile	Occasional Grimace or Frown, withdraw, Disoriented	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs drawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, rigid, or Jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams or sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

Numerical Pain Scale (Obstetric and Gynecology)



Neonatal Pain, Agitation and Sedation Scale (upto 1 Month)

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Archling, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR RR, BP, SaO₂	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO ₂ 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

Wong - Baker (Pediatrics) Above 7 Years



0 No Hurt 2 Hurts Little Bit 4 Hurts Little More 6 Even More 8 Hurts Whole Lot 10 Hurts Worst

HNH-00003369 IP26-00006657
 Master MOHAMMED ARHAM
 25-12-2021 4 Y 6 M 1 D (M)
 Dr. PAVULURI VENKATA



MEDICATION RECONCILIATION FORM

Drug Allergies: Not known any Drug Allergies

**Medication Reconciliation will be done at the time of admission and also whenever there is change in the treating team or shifting from one unit to another unit.
 (Example: at the time of admission shifting from ICU to Ward, or Ward to ICUs)**

Shifting From: ER Shifted to: ward

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1						<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

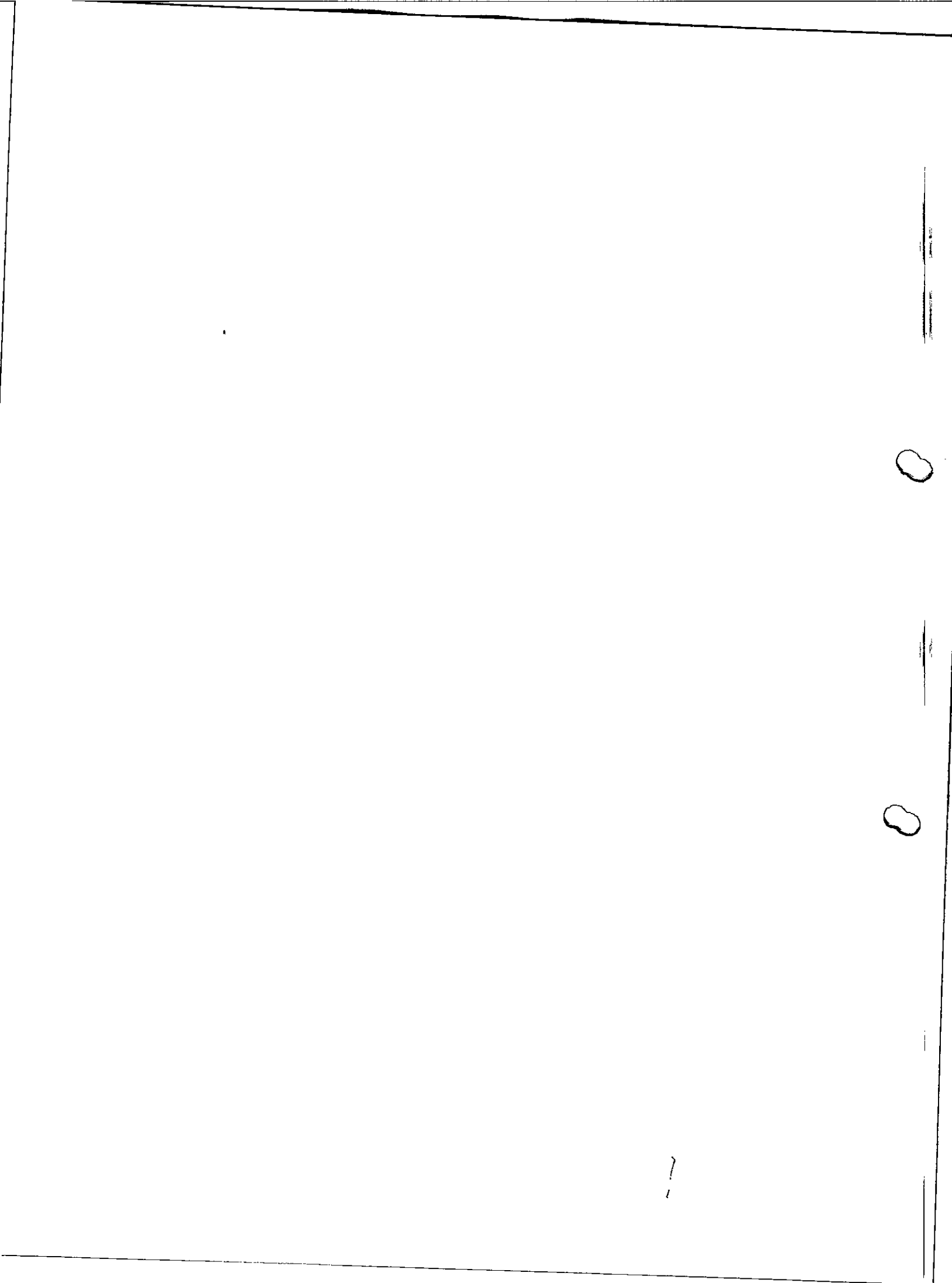
Doctor Name & Signature : Dr. Arachana

Date & Time : 26/6/26 @ 5 PM


Nurse Name & Signature: Jyoti

Date & Time : 26/6/26 @ 5.02 PM

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

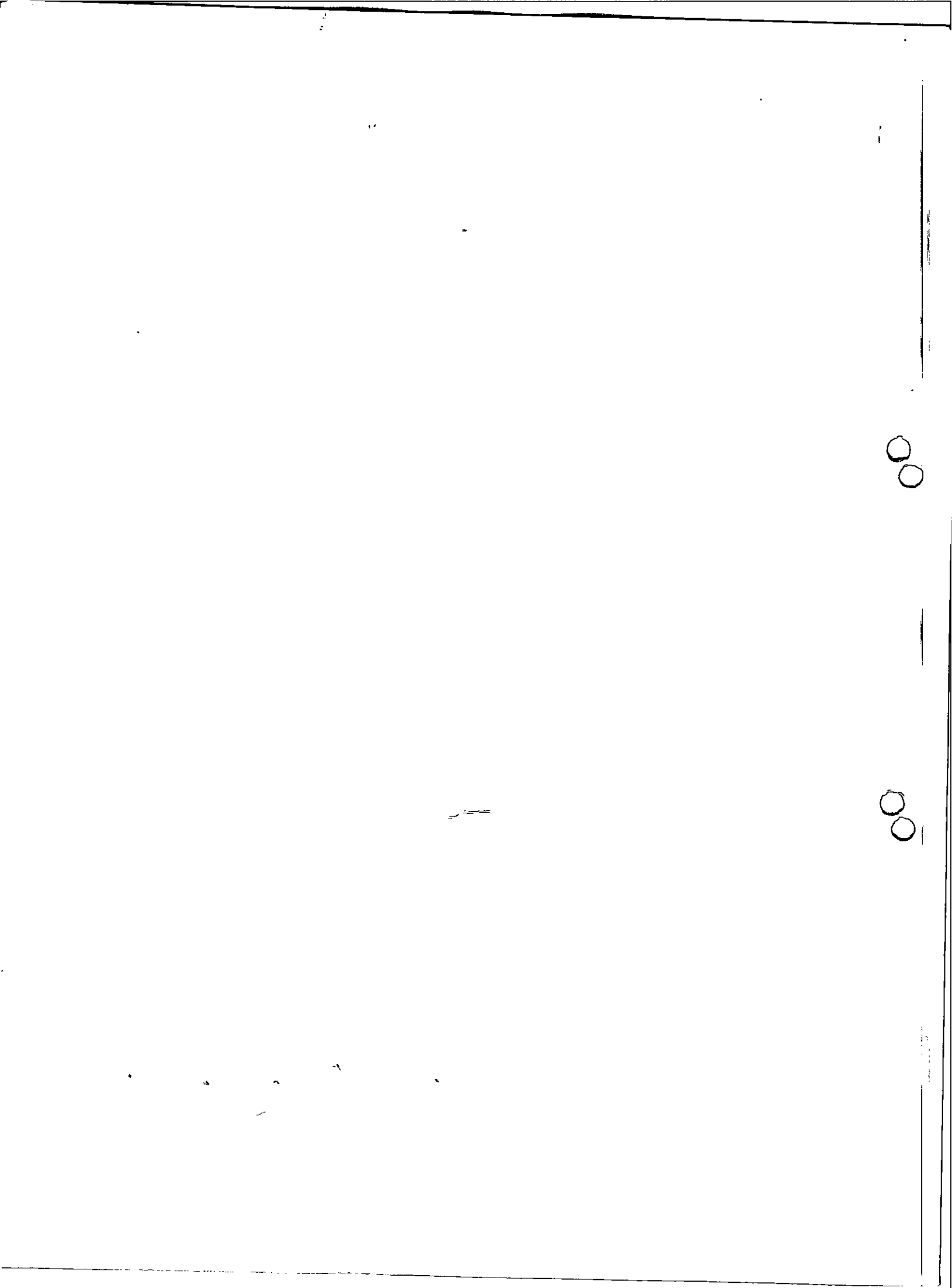


PATIENT TRANSFER FORM

Patient Name & UHID No. HNH-00003369 IP26-00006657 Master MOHAMMED ARHAM 25-12-2021 4 Y 6 M 1 D (M) Dr. PAVULURI VENKATA 		Date & Time of Admission 26/6/26 @ 5:06	Date & Time of Transfer Order 26/6/26 @ 5:40 PM
		Transfer Ordered by Dr. Archana	Reason for Transfer Admission
From Unit ER	To Unit WSD	Information to Attendant Yes <input type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File 25	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes <input type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring Sis Syon / Jyoti		Name of Person Ordered Transfer Dr. Archana	
Patient & Clinical Records Received by : Sneha @ 26/26 @ 6 PM			
Date & Time of Patient Received :			

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

- Unavailable Bed
 Nurse not Available
 Available Bed not ready



Wt - 18.3 kg



EMERGENCY ROOM TRIAGE FORM

Patient's Name : Master Arham Age : 5 Y Gender: Male Female

Date : 26/6/26 Time of Arrival : 4:30pm

Allergies: No Yes Food Medications Blood Transfusion Other (Specify): Not known

Source of Information : Parents Others (Specify)

Mode of Arrival : Ambulatory Wheelchair Ambulance

Initial Vital Signs: Temp: 97.7 F PR: 113b/m BP: 102/63 RR: SpO₂: 99%

Chief Complaints: 10 fever since 6 days x Abdomen pain

INITIAL PHYSIOLOGICAL CATEGORIZATION		INITIAL PHYSIOLOGICAL STATUS
Appearance	Work of Breathing	<input checked="" type="checkbox"/> Stable
<input checked="" type="checkbox"/> Normal	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Unstable:
<input type="checkbox"/> Sick Looking	<input type="checkbox"/> Increased	<input type="checkbox"/> Not - Life - Threatening
<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Life - Threatening
<input type="checkbox"/> Abnormal	<input type="checkbox"/> Gaspng / Apnea	
<input type="checkbox"/> Bleeding		

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

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

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian

Triage Completion Time :

Communicable Disease Triage Screening

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

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

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

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

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

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

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

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

Name of Triage Nurse : Jyoti

Signature of Triage Nurse : Jyoti

Date & Time : 26/6/26 @ 4:32pm



NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 26/6/26 Time of arrival : 4:34 Pm

Chief Complaints : C/O fever since 6 days & Abdominal pain x cough RBS:

Height : Weight : 18.3kg BMI : Head Circumference (<2 years)

Allergies: Yes No Medications Blood Transfusion Food Other:

If yes, identify

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

Character N/A Location Frequency Duration

RISK FOR FALL:

- If patient is < 6 years
tick below fall risk intervention directly
- If Patient is > 6 years
Assess the below parameters

History of Falling: within past 3 months Yes No

Ambulatory Aids:

- Wheelchair Yes No
- Uses furniture for support Yes No

Gait/Transferring:

- Bedrest / immobile Yes No
- Weak Yes No
- Impaired Yes No

Mental Status: Forgets limitations Yes No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

- Escort while ambulating
- Assist Patient
- Educate patient and family on fall precautions/prevention

Functional Screening: No Abnormalities Detected

- Mobility Problem
- Walking Problem
- Developmental Delay
- Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

Nutritional Screening: No Abnormalities Detected

- Underweight
- Overweight
- Feeding Problem
- Special diet
- Special feeding method

Inform consultant for positive criteria

Psychological Screening: No Significant Findings

Unusual concerns about patient's Psychological Status: Yes No

If Yes Consultant Notified: (Date/Time):

Social History: Lives With family

Siblings in household Yes No (if yes How Many?) N/A

Time of Initial assessment completed by ER Nurse : 4:36 p

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

Time	Nursing Notes
	- Assess the pt condition
	- monitor vitals
	- IV placement done
	- Sample collected

Samples collected by: } Apurba
 Samples sent by :

Time: } 6:30pm
 Time: }

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1

Condition of patient at time of shift - out :	Details of Shift - out
HR: 120b/m BP: 103/63 CFT: RR: 20b/m SPO ₂ : 100% GCS: 7/5/15 Temperature: 98.6 P Pain Score: Repeat RBS (if applicable):	Shift - out from ER to: 2nd floor Time of Shift - out: 5:30pm Handover given to: [Signature] (Nurse's Name)

Tick as applicable: MLC LAMA BROUGHT DEAD

Procedures done with details (if any):
 IV placement done

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

Date & Time : 26/6/26 @



215

NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 27/5/25 Time: 9.30 am

Weight: 18.3 Kg Centile: 50th

Height: Centile:

Inference: Well nourished child

RDA: Calories: 1350 Kcal/day Protein: 23gm/day

Diet Recommendations: High protein diet with liquid

Re-Assesment: No Junk, oily, spicy food

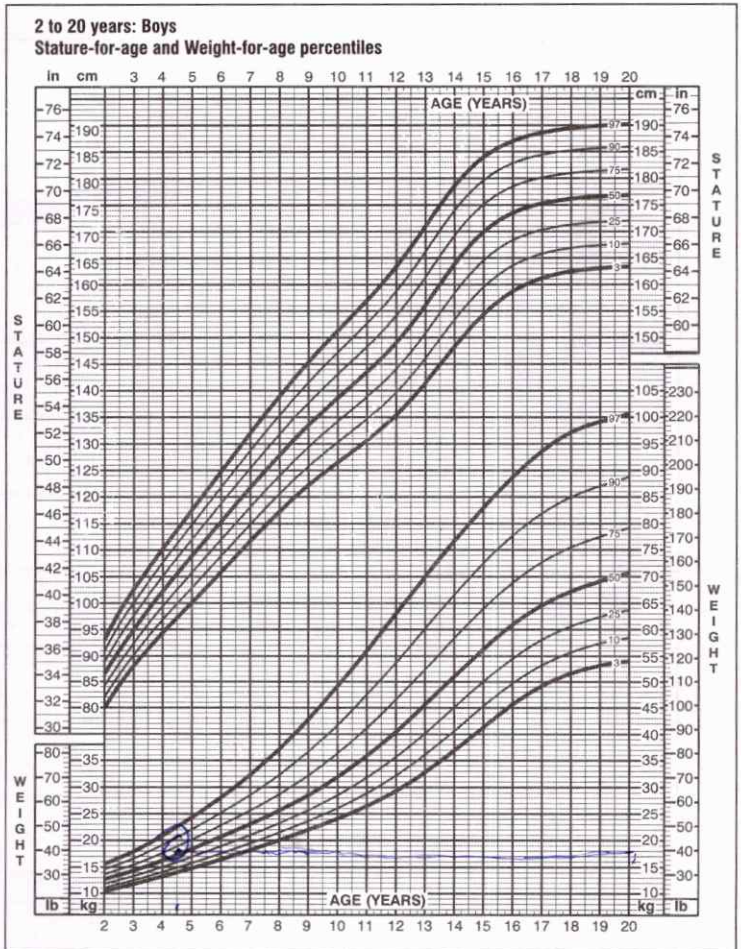
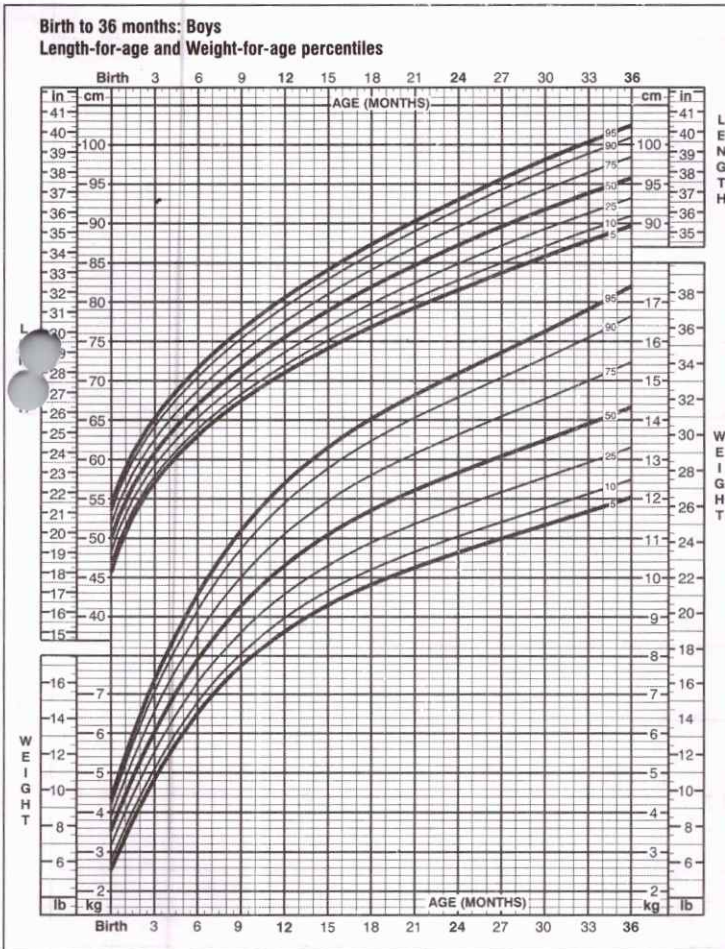
Food Allergies: NO Veg/Non-veg: Non veg

Diagnosis: WALRIERD

Nutritional Intervention - Oral Enteral Parenteral

Patient's Signature: Maimuna B. anis

GROWTH CHART (BOYS)



Dietician's Name: Syeda Sahiya Zakeer

Dietician's Signature: Sahiya

