

HNH-00015967 IP26-00006578  
 Master SAMUEL SATHWIK (M)  
 20-08-2024 1 Y 9 M 25 D  
 Dr. PRITESH NAGAR



## DEFICIENCY CHECK LIST OF CASE SHEET

Sl.No.	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission sheet	1			
2	Discharge Summary	1			
3	Nursing Initial assessment	1			
4	Patient Transfer form	1			
5	In-patient Medical record	1			
6	Doctors progress sheets	4			
7	Nursing plan of care and handover sheets	2			
8	Consultation sheet				
9	General consent for treatment	1			
10	Consent for Surgery				
11	Consent for blood transfusion				
12	Consent for chemotherapy				
13	Consent for high risk				
14	Consent for Restraint				
15	LAMA consent				
16	Consent for special procedure / Sedation				
17	Consent for Formula feed				
18	Consent for MTP				
19	Consent for Radiological Investigations				
20	Consent for HIV test				
21	Anaesthesia notes (Pre Anaesthesia & post)				
22	Neonatal Admission/Delivery/Physical Exam				
23	Medication Reconciliation	1			
24	Emergency Triage record	1			
25	Pre operative check list				
26	Surgical safety checklist				
27	Operation Theatre notes				
28	Nurses clinical Presentation				
29	TPR & BP chart				
30	Intake and Out take chart (fluid chart)	1			
31	Drug chart (Regular Prescription)	1			
32	Investigation Values (result sheet)	1			
33	Nebulization chart				
34	Nutritional review chart	1			
35	Intensive care unit (ICU Charts)				
36	Consent for Admission in PICU / NICU	2			
37	The Humpty dumpty scale	1			
38	Braden Q Scale	1			
39	Bed side check list				
40	PICU bed formula Dilution feeds				
41	Gastro monitoring chart				
42	Rch ED doctors note				
43	BP Monitoring chart				
44	RBS monitoring chart				
	<i>Billing</i>	1			
	<i>Other</i>	5			
	<b>Total No. of Pages</b>	<b>28</b>			

Signature and Date : 18/06/26  
*Jyotsna (P.T.O.)*

<b>Name</b>	Mrs MANYA SHAH	<b>UHID</b>	HNH-00001525
<b>IP No</b>	IP26-00006508	<b>Admission Date</b>	05-06-2026

- (8am-2pm-10pm) after food.
3. Tab. Voveran (Diclofenac-50mg) 1 tablet thrice daily till 09.06.2026 (9am-3pm-11pm) after food.
  4. Tab. Pantodac (Pantoprazole - 40mg) 1 tablet twice daily till 11.06.2026 (7am-7pm) before food.
  5. Tab. Livogen (Elemental Iron - 50mg, folic acid 1.5mg) once daily (7am) for three months before breakfast.
  6. Tab. Shelcal (Elemental Calcium 500mg, vitamin D3 250 IU) once daily (2pm) till breast feeding after food.
  7. Contratubex gel for local application twice daily for 2 weeks.
  8. Nebasulf Powder for local application.

Home Blood pressure monitoring to be done **twice daily** for **two weeks**. Report to emergency if **BP >140/90mmHg**, presence of headache, vomitings, blurred vision, reduced urine output, epigastric pain, seizures.

\* Suggest **PAP smear** and **HPV Vaccine** after **6 weeks**; Please discuss with your treating doctor regarding **HPV vaccination**.

Review with **Dr. SWAPNA SAMUDRALA**, after **2 weeks** on **23.06.2026** at Rainbow Children's Hospital with prior appointment (**Review consultation will be charged**).

**For Women Who Have Had a Caesarean Section**  
**Care of the wound:**

1. You can bath and shower.
2. The wound can get wet during a bath or shower. Dry it thoroughly and gently

218  
FC

### DISCHARGE SUMMARY

<b>Name</b>	Master SAMUEL SATHWIK	<b>UHID</b>	HNH-00015967
<b>Father/Guardian</b>	Mr SABBU JASHVA	<b>Age/Gender</b>	1 Y 9 M 25 D/ Male
<b>Address</b>	FLAT NO G4,1-1-782/B/5 ALEKHYA APARTMENTS,NEAR CANARA BANK, Gandhi Nagar, Hyderabad, Telangana, INDIA, 500080		
<b>IP No</b>	IP26-00006578	<b>Admission Date</b>	14-06-2026
<b>Ref Doctor</b>	Self.		
<b>Discharge Date</b>	15.06.2026		

**Consultant:**

**Dr. PRITESH NAGAR**  
MBBS MD

Medical Registration No. 47184

**Dr. PRITESH NAGAR**  
**MBBS, MD**  
CONSULTANT PEDIATRICIAN &  
PEDIATRIC INTENSIVIST  
Reg No. 47184

**Dr. ANIKET ANIL PARASHAR**  
MBBS- MD  
CONSULTANT PEDIATRICIAN  
TSMC/FMR/08568

<b>Name</b>	Master SAMUEL SATHWIK	<b>UHID</b>	HNH-00015967
<b>IP No</b>	IP26-00006578	<b>Admission Date</b>	14-06-2026

<b>DIAGNOSIS</b>	<b>ICD CODE</b>
SIMPLE FEBRILE SEIZURE 1 <sup>ST</sup> EPISODE	

**History:** Master SAMUEL SATHWIK, 1 Y 9 M 25 D old boy presented with history of cough since 3 days, fever since 1 day, 1 episode of vomiting and abnormal seizure like activity in the form of uprolling of eye balls, posturing of the upper limbs and neck lasting for 2 mins in the ER subsided on midazolam nasal spray. For the above complaints he was admitted at Rainbow Children's Hospital for further management.

**Examination:** He was febrile(100.6°F). Heart rate was 146 /min and Respiratory Rate - 36/min. Peripheries were warm, pulses well felt. On examination, He was drowsy during post ictal state. On auscultation of chest, air entry was bilaterally equal. Heart sounds were normal and there was no murmur. Abdomen was soft with no organomegaly.

On neurological examination, child was drowsy. Pupils were bilaterally equal and reacting to light. There were no focal neurological deficits, no meningeal signs and no signs of raised intracranial pressure.

Weight on admission: 10.5 kgs.

**Investigations: Enclosed reports.**

VBG showed pH - 7.36, pCO<sub>2</sub>- 39.8 mmhg, pO<sub>2</sub> - 49 mmhg, HCO<sub>3</sub> - 21.6 mmol/l, BE: -3.4 mmol/l.

Adenovirus PCR test was sent, which was negative.

<b>Name</b>	Master SAMUEL SATHWIK	<b>UHID</b>	HNH-00015967
<b>IP No</b>	IP26-00006578	<b>Admission Date</b>	14-06-2026

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

<b>Date</b>	<b>On</b>
	<b>14.06.2026</b>
<b>TEST</b>	<b>Result</b>
<b>CBP: Hemoglobin</b>	11.2 g/dl
<b>While blood cell</b>	13850 cell/cmm
<b>Platelets</b>	2.56 lakh/cmm
<b>CRP</b>	5 mg/L
<b>MAGNESIUM</b>	1.7 mg/dl
<b>CALCIUM</b>	9.2 mg/dl
<b>Complete urine examination</b>	4-6 pus cells, 1-2 epithelial cells.

**Management:** He was admitted in PICU in view of febrile seizure in post ictal drowsiness state and was started on low flow oxygen and IV fluids. He was started on Syp Clobazam for febrile seizure prophylaxis. Once child was hemodynamically stable and neurologically active, was shifted to ward.

In view of loose stools, he was administered probiotics and advised gastrodiet.

Name	Master SAMUEL SATHWIK	UHID	HNH-00015967
IP No	IP26-00006570	Admission Date	14-06-2026

He was regularly monitored for fever spikes, hemodynamic & neurological status. His fever spikes gradually settled and there were no further seizure episodes during hospital stay.

He remained hemodynamically stable and is being discharged with the following advice.

Parents were counselled regarding the nature of febrile seizures and measures to reduce fever during future febrile episodes. They were also educated regarding use of intranasal Midazolam spray for termination of future seizure episodes, if any.

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

**Medication during hospital stay:**

Injection. Ondansetron  
Syrup. Cloba  
Pro GG sachet  
Syrup, Zinconla

**Advice:**

\* Diet as advised.

<b>Name</b>	Master SAMUEL SATHWIK	<b>UHID</b>	HNH-00015967
<b>IP No</b>	IP26-00006578	<b>Admission Date</b>	14-06-2026

S.No	MEDICATION	DOSE	TIMINGS	DURATION
1	Syrup. Clobium (Clobazam - 1ml/2.5mg)	0.5 ml	8am - 8pm (after food)	Till 16.06.2026 morning dose
2	Syrup. ZINCONIA (5ml=20mg)	5 ml	10am (after food)	For 13 days
3	PRO GG SACHET	1 SACHET	9am-9pm (after food)	For 3 days
4	Nasoclear nasal drops, 2 drops in each nostril <b>SOS</b> for nose block			

#### Febrile Seizure Prophylaxis:

\* Syrup. Crocin DS (Paracetamol = 5ml/240mg) 3 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.

\* Syrup. Clobium (Clobazam - 1ml/2.5mg) 0.5 ml twice daily for 3 days every time with fever.

\* Medistat - nasal spray (Midazolam = 1.25mg/puff), 1 puff intranasal (into each nostril) for future seizures.

Review consultation with Dr. PRITESH NAGAR **on Thursday(18.06.2026)** at Himayatnagar in OPD with prior appointment (**Review consultation will be charged**).

#### Food instructions while taking medications:

<b>Name</b>	Master SAMUEL SATHWIK	<b>UHID</b>	HNH-00015967
<b>IP No</b>	IP26-00006578	<b>Admission Date</b>	14-06-2026

\* By consuming your **probiotic** with food you provide a buffering system for the supplement and ensure its safe passage through the digestive tract. Aside from protection, food also provides the friendly bacteria in your probiotic the proper food and nourishment to ensure it survives, grows and multiplies in your gut. It is recommended to take probiotics at the END of a meal. Concurrent administration of antibiotics could kill a large number of the organisms, reducing the efficacy of probiotics. Separate administration of antibiotics from probiotics by at least two hours.

Follow up immediately in Emergency Room in case of any emergency like high grade fever, vomiting, breathlessness, refusal to feed occurs or any abnormal movements.

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 **Himayatnagar / 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

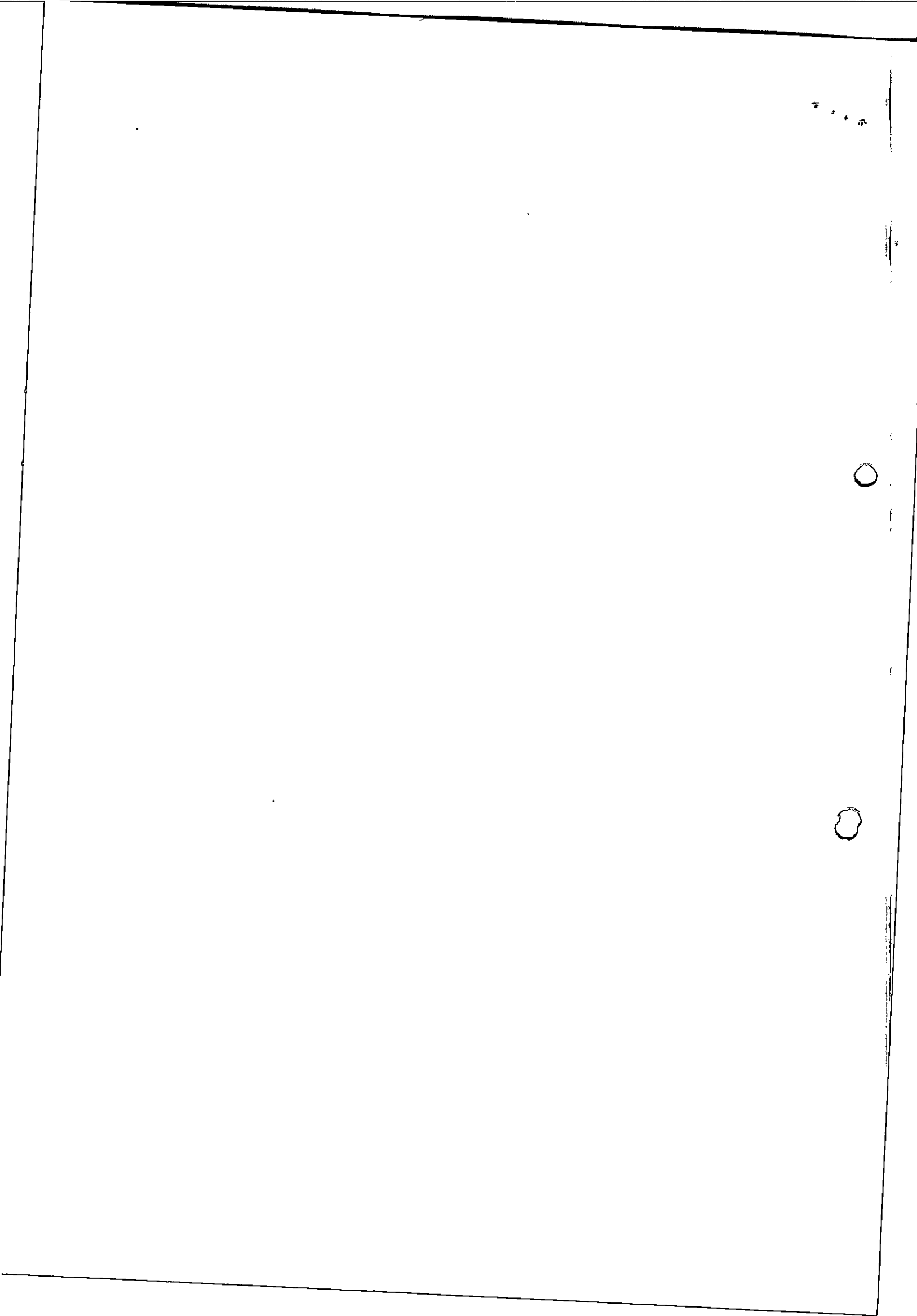
<b>Name</b>	Master SAMUEL SATHWIK	<b>UHID</b>	HNH-00015967
<b>IP No</b>	IP26-00006578	<b>Admission Date</b>	14-06-2026

[www.rainbowhospitals.in](http://www.rainbowhospitals.in)

  
Registrar/Resident/C.M.O



**Dr. PRITESH NAGAR**  
MBBS MD  
Medical Registration No. 47184



**ADMISSION SHEET**



**Registration Details :**

Admission No : IP26-00006578      Admit Date : 14-Jun-2026      Admit Time : 12:36 AM      UHID : HNH-00015967

**Patient Details :**

Patient Name : Master SAMUEL SATHWIK      Age : 1 Y 9 M 25 D  
Guardian : Mr SABBU JASHVA      DOB : 20-08-2024 01:00 AM  
Gender : Male      Religion :  
Occupation :      Martial Status :  
Address (H) : FLAT NO G4,1-1-782/B/5 ALEKHYA      Phone No : 9985267134  
APARTMENTS,NEAR CANARA BANK Gandhi      E-mail : jashvabw@gmail.com  
Nagar Hyderabad Telangana INDIA 500080

**Admission Details :**

Bed Type : DAY CARE      Bed No : ER01      Ward Name : GF -EMERGENCY  
Room No : ER01      Admission Type : First Visit

**Contact Details :**

Name : Mr SABBU JASHVA      Relationship : Father  
Contact Address : FLAT NO G4,1-1-782/B/5 ALEKHYA      Phone No : 9985267134  
APARTMENTS,NEAR CANARA BANK Gandhi  
Nagar Hyderabad Telangana INDIA 500080

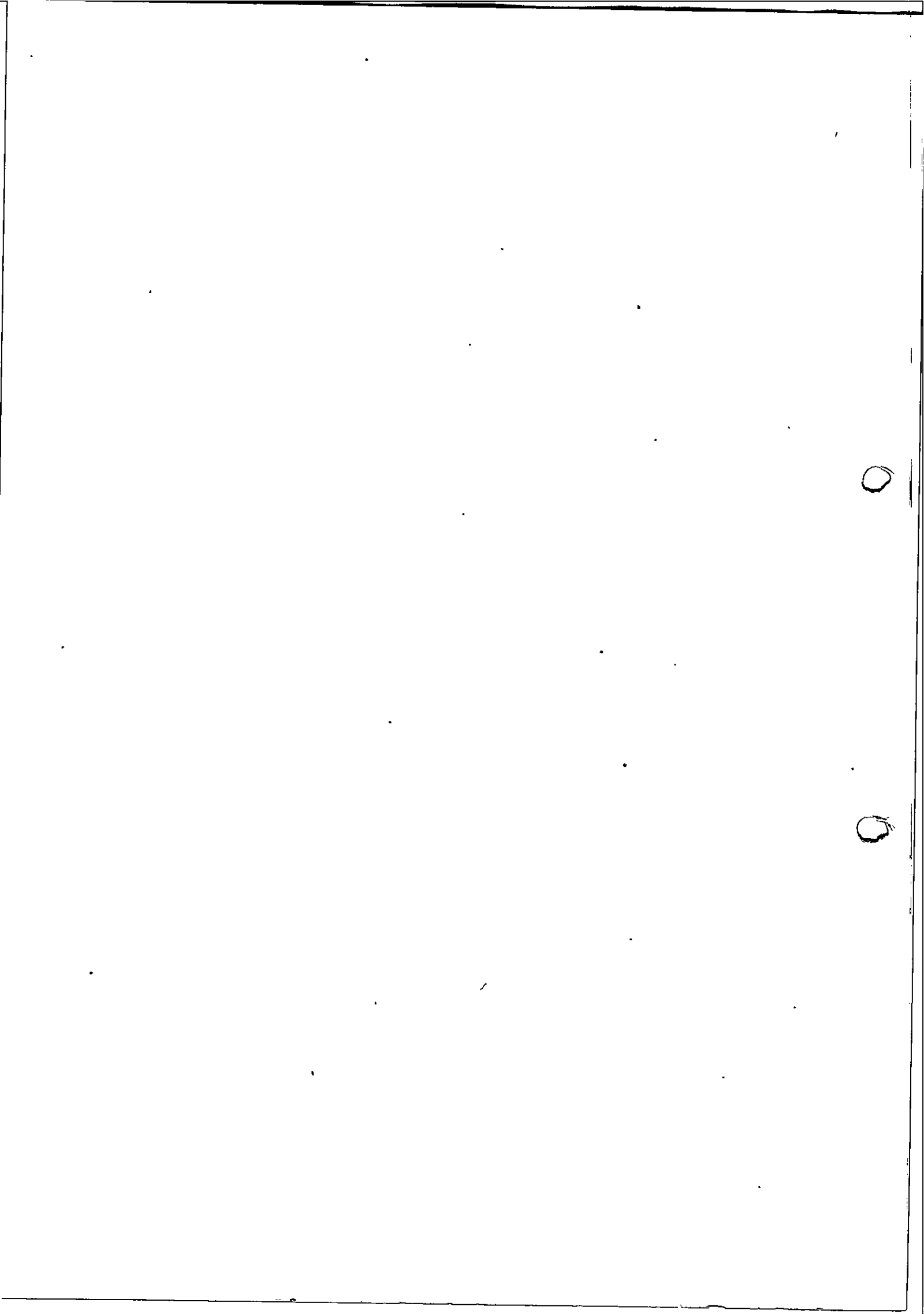
*S. Jashva*  
Signature

**Doctor Details :**

Doctor Name : Dr. PRITESH NAGAR      Specialisation : GENERAL PEDIATRICS  
Referral Doctor : Self.      Phone No :  
Co-Consultant :

**Payment Details :**

Payment Mode : DC/CC Card      Deposit Amount : 40000.00  
Payor Name : SELFPAY



**ACTIVITY**

HNH-00015967 IP26-00006578  
Master **SAMUEL SATHWIK**  
20-08-2024 1 Y 9 M 25 D (M)  
Dr. **PRITESH NAQAR**

Name: -----  
UHID No:  ----- Consultant: ----- Dept: *pediatrics*

Date of Admission: *14/6/26* Time: ----- Date of Discharge: ----- Time: -----

Room / Bed No: ----- Ward: *PIU* Suggested Billable bed type: -----

**WARD TRANSFERS**

Date	Time	From	To	Signature of Nurse
<i>14/6/26</i>	<i>1:05AM</i>	<i>ER</i>	<i>PIU</i>	<i>[Signature]</i>
<i>14/6/26</i>	<i>2:40pm</i>	<i>PIU</i>	<i>208</i>	<i>[Signature]</i>

**Cross Consultation Visit**

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



Sign

INVESTIGATIONS

Date	Investigations		
14/6/24	CKP } CKP } VBG	9789 ✓ 9788 ✓	
	calcium } m. magnesium }	9789 ✓	truffy
	GRBS (130mg/dl)	9788 ✓	truffy
	Responium panel	9790 ✓	truffy
14/6/24	CUE	9793 ✓	Be
	cross checked by swithe 14/6/26 at 1pm		
	Cross checked done		





Ref.No. F/IN/PR/10



**PEDIATRIC IN-PATIENT  
MEDICAL RECORD**

HNH-00015967      IP26-00006578  
Master SAMUEL SATHWIK  
20-08-2024      1 Y 9 M 25 D      (M)  
Dr. PRITESH NAGAR



Patient Name : \_\_\_\_\_

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

Consultant : \_\_\_\_\_

Final Diagnosis : \_\_\_\_\_

Name : \_\_\_\_\_

Age/Sex \_\_\_\_\_

Informant \_\_\_\_\_

Reliability \_\_\_\_\_

**Chief Presenting Complaints & Duration (Chronologically):**

c/o Cough :: 3 days  
 H/o Fever since ~~last~~ 1 day, Vomiting 1 episode  
 H/o Abnormal activity in the ER lasting for 2 mins

**History of present illness :**

A 22 month old boy is  
 c/o Cough since 3 days  
 associated with  
 Fever since 1 day,  
 mod - High grade,  
 no Rash; no chills.

associated with -

\* history of vomiting (1 episode) since evening.  
 non bilious, non projectile, not mixed with blood  
 and is

Abnormal seizure like activity in the form of uprolling  
 of eyeballs and posturing of the upper limbs & neck  
 lasting for 2 mins subsided on midazolam  
 nasal spray.

Pediatric Multiorgan History & Physical Examination

HNH-00015967 IP26-00006578  
Master SAMUEL SATHWIK  
20-08-2024 1 Y 9 M 25 D (M)  
Dr. PRITESH NAGAR



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

Blank lined area for Past History.

Birth & Neonatal History :

No neonatal complications



Birth & Socio Economic History :

About Father : \_\_\_\_\_

About Mother : \_\_\_\_\_

Any additional Information : \_\_\_\_\_

Developmental History :

as per age

Immunization History :

as per schedule

Pediatric Multiorgan History & Physical Examination

MNH-00015967 IP26-00006578  
Master SAMUEL SATHWIK  
20-08-2024 1 Y 9 M 25 D (M)  
Dr. PRITESH NAGAR



Anthropometry

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

Weight (kgs) 10.5 kg (Centile \_\_\_\_\_)

**On Examination :**

Temperature : 100.6° F Pulse Rate: 146/w Description \_\_\_\_\_

B.P. \_\_\_\_\_ SPO2 95% at RA

Resp. rate and type of breathing : \_\_\_\_\_

Roamy, post-dital state

Rash \_\_\_\_\_

Lymphadenopathy \_\_\_\_\_

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

**Respiratory system :**

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

Air entry & breath sounds : NRVS (+)

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

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

**Cardiovasclular System :**

Inspection of procordium : (N)

Heart Sounds : hst (+)

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

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

**Per Abdomen :**

Inspection (N)

Palpation : hyst

Ausculation : RS (+)

Spine: (N) External Genitelia : \_\_\_\_\_

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

Pediatric Multiorgan History & Physical Examination

HNH-00015967 IP26-00006578  
Master SAMUEL SATHWIK  
20-08-2024 1 Y 9 M 25 D (M)  
Dr. PRITESH NAGAR



Central Nervous System :

Level of Consciousness : AVPU/GCS Score : ⊕ Drowsy, postictal

Cranial Nerves : no facial asymmetry.

AF @ level

Motor System :

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

Tone : \_\_\_\_\_ Power ⊕

Co-ordinator : ⊕

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

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

Reflexes : ⊕

DTR

Superficials :

Plantars \_\_\_\_\_

Sensory System :

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

Clinical Summary & Diagnostic :

AFI ⊕ ⊕. Pediatric seizures (1st episode)



Preventive aspects of the treatment :

prevent congestions

Desired goals of the treatment :

Hemodynamic stability

**Planned Labs :**

**Planned Management :**

GRBS - 130 mg/dl

VBS

CBP, CRP

Ca<sup>2+</sup>, Mg<sup>2+</sup>

Resp. panel (5-nims)

CVE → JUE

NIB stetho

→ IVF

→ O<sub>2</sub> E nasal prong

→ Syp CLOBA (1ml/2-smg)  
● -sml /SD

→ Syp Cocin (3-sml / 6<sup>th</sup> hly)

Ibuprofen - 2-sml / 8<sup>th</sup> hly } for

→ SOS → midazolam spray

NIB stetho

**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

Date

14/6

Time

2 AM

Dr. Pritesh Nagar  
Consultant Pediatrician & Intensivist  
Reg. No. 718






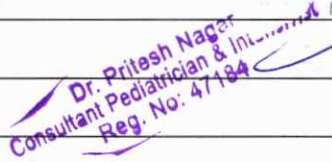
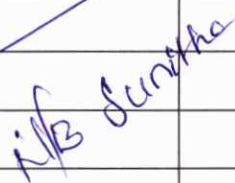
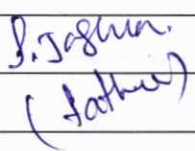


## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
14/2 8:45 AM	<p>CBIR Dr Pritesh S</p>	
	<p>1st Episode Focal Seizure</p>	
	<p>- Fever (102°F)            - Occ Cough            - No further seizure</p>	<p>Ph            1) CT - Claba            2) IVF - stop - 10 ml/kg            3) Sol - Crocin            Ibuprofen</p>
	<p>child asleep            vital            HR - 140/min            SpO<sub>2</sub> - 96%            RR - 30/min</p>	<p>4) Trace Adren            5) Reassess &amp; shift out            by 12 pm            6) Monitor Vitals</p>
	<p>child asleep            RS - B/LABE            MA - soft            CNS - No focal deficits</p>	<p><i>(Large diagonal scribble)</i></p>
		<p>Dr. Pritesh S            Consultant Pediatrician &amp; Neonatologist            Reg. No: 47184</p> <p><i>(Signature)</i></p> <p>NIB Sunil</p>



## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9 AM 14/06/26	<u>Counselled</u>	
	No fits / Feeding ✓ vitals stable ✓	
	Basic test (N) ✓ LWE (N) Flu (N)	
	Fever related fits ↳ wait & watch ✓	
	Fever, viral } 24-48h } Decide }	
	Afternoon - of ole - Room Shift	
 		



## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<del>11:30</del>	<u>CS/B - Dr. Pashank</u>	
14/6/26		
11:30		
Am	3episodes <u>loose stools</u>	
	Greenish	
	Watery	
	Blood tinged	plan:
	Non foul smelling	add. Pro G-G probiotic
	No further fecal spikes	Put
	o/e	
	vitals - stable.	
		N/B Sunitha
	s/e	
	P/A - soft, NT	
	no hem BS+	





**PROGRESS NOTES AND DOCTOR'S ORDER**

Date & Time	Progress Notes	Doctor's Order
15/6	<u>CLSB Dr. Naipunya / Dr. Parashakti</u>	
7:00 AM	Simple febrile seizure. 1st episode.	
	No fever.	<u>Plan</u>
	No further seizure.	Stop IVF
	Vitals - stable.	Cont clobazam.
	RIS - BILAE (+) PIA BIL NURS	Cont PROCA Zincnea.
	L soft, NT	Monitor vitals
		Plan Discharge today after rounds
		P.B Amrutha 28 AM



**PROGRESS NOTES AND DOCTOR'S ORDER**

Date & Time	Progress Notes	Doctor's Order
15/6	<u>CL/B Dr. Pritesh Sa</u>	
9:15 AM		
	<u>Simple Febrile Seizure - 1st Episode</u>	
	Last fever - 3:50 pm (yest) Loose stools -	Plan - D/C Today 1) clobazam till 16/6 (1%) 2) Paracetamol x 3 times
	child activity - better Vitals stable	Zincom - total 16 days
	afebrile	3) Encourage orally
	R-S - B/LHE@	-> Febrile Seizure Prophylaxis
	PIA - soft	-> Flup on Thursday

Dr. Pritesh Nagar  
 Consultant Pediatrician  
 Reg. No: 47184

*(Signature)*

noted by Sr. Sandhya  
 15/6/26  
 9:30 a.m.

# DRUG CHART

Date of Admission: 14/6/26 Drug Allergies: nil  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 must follow strictly the FIVE RIGHTS before administration of medication.
    - 1) Right Patient
    - 2) Right Drug
    - 3) Right Dosage
    - 4) Right Route
    - 5) Right Time
  - AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

## SOS / PRN (As Required Medication)

DRUG : <u>Syp CROCIN-DS</u>				Date/Time	<u>14/6</u>																
Dose	Route	Frequency	Start Date		<u>6AM</u>	<u>14/6</u>															
<u>3 ml</u>	<u>PO</u>	<u>SOS</u> <u>6th July</u>	<u>14/6</u>		<u>Sonam</u>	<u>30/6/26</u>															
Doctor's Signature		Valid Period	Pharm.																		
<u>Pram</u>																					
Additional Instructions: <u>If T &gt; 100°F</u>																					

DRUG : <u>Syp IBUGESIC</u>				Date/Time	<u>14/6</u>																
Dose	Route	Frequency	Start Date		<u>9:30 AM</u>	<u>14/6</u>															
<u>2-5ml</u>	<u>PO</u>	<u>SOS</u> <u>8th July</u>	<u>14/6</u>		<u>Pram</u>																
Doctor's Signature		Valid Period	Pharm.																		
<u>Pram</u>																					
Additional Instructions: <u>If T &gt; 102°F</u>																					

DRUG : <u>MIDACIP NASAL SPRAY</u>				Date/Time																		
Dose	Route	Frequency	Start Date																			
<u>1 Puff - P/N</u> <u>each 4th Hour</u>		<u>SOS</u>	<u>14/6</u>																			
Doctor's Signature		Valid Period	Pharm.																			
<u>Pram</u>																						
Additional Instructions: <u>1 Puff = 1-2.5mg</u>																						

VERIFIED BY : Name Sonam



REGULAR PRESCRIPTIONS

Weight. 10.5kg Ward. ....

<b>DRUG :</b> <u>Syp CLOBA</u>				Date Time																	
Dose	Route	Frequency	Start Date																		
<u>1ml</u>	<u>PO</u>	<u>BD</u>	<u>14/6</u>																		
Name & Signature of the Doctor Starting the Drugs:																					
<u>Pranav</u>																					
Additional Instructions:																					
<u>CLOBA 2AM Sml = 5mg</u>																					
<b>Daily Doctor's Endorsement by a Sign</b>																					
<b>DRUG :</b> <u>Syp ONDANSETRON</u>				Date Time																	
Dose	Route	Frequency	Start Date																		
<u>2mg</u>	<u>IV</u>	<u>TID</u>	<u>14/6</u>	<u>12:30AM</u>	<u>14/6</u>	<u>15/6</u>															
Name & Signature of the Doctor Starting the Drugs:																					
<u>Pranav</u>																					
Additional Instructions:																					
<u>2PM</u>																					
<u>10PM</u>																					
<b>Daily Doctor's Endorsement by a Sign</b>																					
<b>DRUG :</b> <u>Syp CLOBA</u>				Date Time																	
Dose	Route	Frequency	Start Date																		
<u>0.5ml</u>	<u>PO</u>	<u>BD</u>	<u>14/6</u>	<u>10AM</u>	<u>14/6</u>	<u>14/6</u>															
Name & Signature of the Doctor Starting the Drugs:																					
<u>Pranav</u>																					
Additional Instructions:																					
<u>CLOBA 2AM 1ml = 2.5mg 0.1mg/kg</u>																					
<u>10PM</u>																					
<b>Daily Doctor's Endorsement by a Sign</b>																					
<b>DRUG :</b> <u>PRO GG Sachet</u>				Date Time																	
Dose	Route	Frequency	Start Date																		
<u>1sachet</u>	<u>PO</u>	<u>1-0-1</u>	<u>14/6</u>	<u>12PM</u>	<u>14/6</u>	<u>14/6</u>															
Name & Signature of the Doctor Starting the Drugs:																					
<u>Dr. Prashanti</u>																					
Additional Instructions:																					
<u>Probiotic Lactobacillus</u>																					
<b>Daily Doctor's Endorsement by a Sign</b>																					

HNH-00015967 IP26-00006578  
 Master SAMUEL SATHWIK  
 20-08-2024 1 Y 9 M 25 D (M)  
 Dr. PRITESH NAGAR



Sheet No: .....

### REGULAR PRESCRIPTIONS

Weight ..... Ward .....

<b>DRUG :</b> Syp. Zincnea				Date Time	4/6															
Dose	Route	Frequency	Start Dt.																	
Sml	PO	OD	14/6																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Sml = 2ong																				
<b>Daily Doctor's Endorsement by a Sign</b>																				

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

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

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

VERIFIED BY: Name Signature

Sheet No: .....

### REGULAR PRESCRIPTIONS

Weight ..... Ward .....

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

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

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

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

REF: D r No. 1





MNH-00015967 IP26-00006578  
Master SAMUEL SATHWIK  
20-09-2024 1 Y 9 M 25 D (M)  
Dr. PRITESH NAGAR



218



# RESULT SHEET

Date	14/6/26				
Time					
Hb	11.2				
PCV	31.3				
RBC	4.81				
WBC	13.85				
N/L	67.4/26.6				
Platelets	256				
CRP	5.0				
ESR					
PCT					
RBS					
Na					
K					
Cl					
Ca/Mg	9.2/1.7				
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					



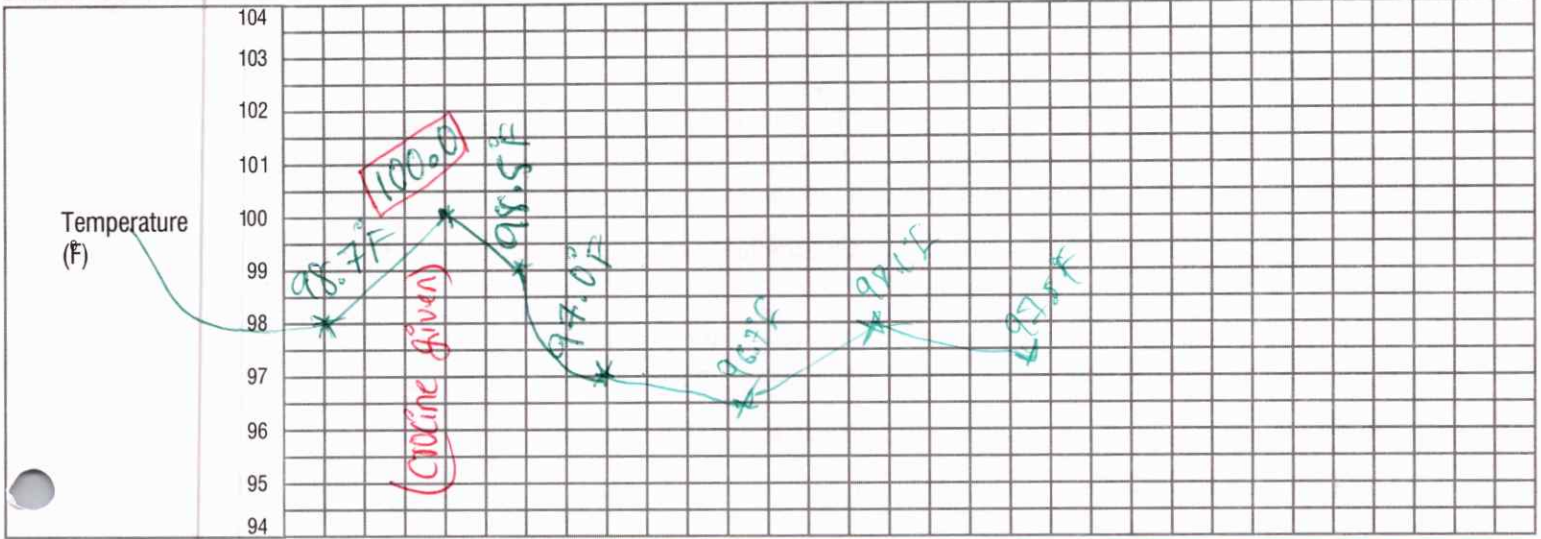
Patient Sticker



**WARNING SCORE: CHILDREN'S UNIT**

Date : 14/10/26 Time: 3pm 3:50 pm 5pm 8:40 pm 10pm 2Am 6Am

Doctor / Nurse / Family Concern?



Heart Rate (bpm) and Blood Pressure (mmHg) *	3pm	3:50 pm	5pm	8:40 pm	10pm	2Am	6Am
Heart Rate (Number)	115 bpm	118 bpm	125 bpm	120 bpm	125 bpm	120 bpm	120 bpm
Blood Pressure (mmHg)	100/71	98/57	98/51	100/51	100/51	100/51	100/51

Resp. Rate (bpm) (Over 1 Minute) *	3pm	3:50 pm	5pm	8:40 pm	10pm	2Am	6Am
Resp Rate (Number)	22 bpm	22 bpm	20 bpm	20 bpm	20 bpm	20 bpm	20 bpm

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

TOTAL SCORE	3pm	3:50 pm	5pm	8:40 pm	10pm	2Am	6Am
Number of shaded boxes	0	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0	0
Observer's Initials	PN	PN	PN	PN	PN	PN	PN

**ACTIONS**

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

NB: Scores 3 should be recorded overleaf

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

# CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

## INSTRUCTIONS:

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

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

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

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

<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)

MNH-00015967 IP26-00006578  
 Patient Master SAMUEL SATHWIK  
 20-08-2024 1 Y 9 M 25 D (M)  
 Dr. PRITESH NAGAR



# 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												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
<b>Total Intake :</b>						<b>Total Output :</b>							
14/6/26	02:00 pm			10ml									
	03:00 pm	Milk		10ml									
	04:00 pm	PlasmaLyte		10ml									
	05:00 pm			10ml									
	06:00 pm			10ml									
	07:00 pm			10ml									
<b>Total Intake :</b>						<b>Total Output :</b>							
14/6	08:00 pm	PlasmaLyte		10ml									
	09:00 pm		H <sub>2</sub> O	10ml									
	10:00 pm		+ 10ml	10ml									
	11:00 pm		10ml	10ml									
	12:00 am		10ml	10ml									
	01:00 am		10ml	10ml									
<b>Total Intake : Taken</b>						<b>Total Output : m- 0-</b>							
14/6	02:00 am			10ml									
	03:00 am			10ml									
	04:00 am	H <sub>2</sub> O		10ml									
	05:00 am	PlasmaLyte		10ml									
	06:00 am			10ml									
	07:00 am			10ml									
<b>Total Intake : Taken</b>						<b>Total Output : m- 0-</b>							

**Total 24 hrs. Intake**

**Total 24 hrs. Output**

MNH-00015967 IP26-00006578  
 Master SAMUEL SATHWIK  
 20-08-2024 1 Y 9 M 28 D (M)  
 Dr. PRITESH NAGAR



# 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 Thrombo- phlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
<b>Total Intake :</b>						<b>Total Output :</b>							
	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>							

<b>Total 24 hrs. Intake</b>	
-----------------------------	--

<b>Total 24 hrs. Output</b>	
-----------------------------	--

HNH-00015967 IP26-00006578  
 Master SAMUEL SATHWIK  
 20-08-2024 1 Y 9 M 25 D (M)  
 Dr. PRITESH NAGAR

# NURSING CARE RECORD



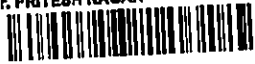
Date: 14/6/26

- 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	8pm to 8pm	→ Assess pt condition → Monitor the vitals →		P I C U			
	2pm to 8pm	→ Assess pt condition → monitor the vitals → maintain I/O chart → Administer medication as per drug chart	2pm to 8pm	→ Assessed pt condition → monitored vitals → maintained I/O chart → Administered medication as per drug chart	Patient is stable	Re-checked vitals	Amulya
Night	8pm to 8Am	→ Assess the pt condition → monitoring vitals checked and recorded → I/O chart maintain	8pm to 8Am	→ Assessed the pt condition → Administration of medication given as per doctor's orders → I/O chart maintain	→ pt is stable	→ Re-checked vitals	A Amulya

HNH-00015967 IP26-00006576  
 Master SAMUEL BATHWIK  
 20-08-2024 1 Y 9 M 26 D (M)  
 Dr. PRITESH NAGAR

Patient Stick



# NURSING CARE RECORD



Date: .....

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon							
Night							



## NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Pritesh Nagor Department: ..... Date of Admission: .....

SITUATION	Diagnosis:	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify: .....						
BACKGROUND	Area	13/6 N1	14/6/26 N1	14/6/26 E2	14/6 N1			
	Shift Time							
	Medical Condition (Any special condition to be noted):	Seizure	Seizure	Seizure	Seizure			
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 type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	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 type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Vital Signs:	Temp:	100.4°F	97.7°F	98.2°F	98.3°F		
		Res:	28b/m	20b/m	27b/m	27b/m		
		SpO <sub>2</sub> :	98%	100%	100%	98%		
		Pulse:	159b/m	133b/m	132b/m	141b/m		
		BP:	-	-	-	-		
Fall Risk Score:	-	-	-	-				
Pain Score:	-	-	-	-				
Recommendations	Safety Needs:	Yes	Yes	Yes	Yes			
	Physiotherapy	<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 type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Others Specify:	-	-	-	-			
	Special Diet:	<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 type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other Special Orders / Medications:		-	-	-	-			
Post Operative Procedure Special Orders:		-	-	-	-			
Handed Over By Name :		Sunam	Sunam	Arusha	Amruth			
Signature :		<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>			
Date:		13/6/24	14/6/24	14/6/26	14/6			
Time:		1 AM	2 PM	8 PM	8 AM			
Taken Over By Name :		Sunam	Arusha	Amruth				
Signature :		<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>				
Date:		14/6/26	14/6/26	14/6				
Time:		1 AM	2 PM	8 PM				

Patient Sticker



## NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: ..... Department: ..... Date of Admission: .....

<b>SITUATION</b>	Diagnosis:	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify: .....					
<b>BACKGROUND</b>	Area						
	Shift Time						
	Medical Condition (Any special condition to be noted):						
<b>ASSESSMENT</b>	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
	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 <sub>2</sub> :					
		Pulse:					
		BP:					
	Fall Risk Score:						
	Pain Score:						
<b>Recommendations</b>	Safety Needs:						
	Physiotherapy	<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
	Others Specify:						
	Special Diet:	<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
	Other Special Orders / Medications:						
	Post Operative Procedure Special Orders:						
	Handed Over By Name :						
	Signature :						
	Date:						
	Time:						
	Taken Over By Name :						
	Signature :						
	Date:						
	Time:						



# BRADEN 'Q' SCALE



					Date :	18/6	19/6	19/6	19/6
					Time :	N1	N2	F2	N1
Mobility	<b>1. Completely immobile:</b> Does not make even slight changes in body or extremity position without assistance.	<b>2. Very limited:</b> Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	<b>3. Slightly limited:</b> Makes frequent through slight changes in body or extremity position independently.	<b>4. No limitations:</b> Makes major and frequent changes in position without assistance.		3	3	3	3
"Activity The degree of physical activity"	<b>1. Bedfast :</b> Confined to bed	<b>2. Chairfast :</b> Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	<b>3. Walks occasionally:</b> Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	<b>4. All patients too young to ambulate; OR walks frequently:</b> Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.		3	3	3	3
Sensory Perception	<b>1. Completely limited:</b> 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.	<b>2. Very limited:</b> 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.	<b>3. Slightly limited:</b> 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.	<b>4. No impairment:</b> Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.		3	3	3	3
Moisture Degree to which skin is exposed to moisture	<b>1. Constantly moist:</b> Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	<b>2. Very moist:</b> Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	<b>3. Occasionally moist:</b> Skin is occasionally moist, requiring linen change every 12 hours.	<b>4. Rarely moist:</b> Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.		3	3	3	3
<b>FRICION-SHEAR</b> <b>Friction</b> Occurs when Skin moves against support surfaces <b>Shear</b> Occurs when skin and adjacent bony surface slide across one another	<b>1. Significant problem:</b> Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	<b>2. Problem:</b> 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.	<b>3. Potential problem:</b> 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.	<b>4. No apparent problem:</b> 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."		3	3	3	3
Nutritional Usual food intake pattern	<b>1. Very Poor:</b> 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.	<b>2. Inadequate:</b> 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.	<b>3. Adequate:</b> 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.	<b>4. Excellent:</b> 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 meat and dairy products. Occasionally eats between meals. Does not require supplementation.		3	3	3	3
Tissue Perfusion & Oxygenation	<b>1. Extremely compromised:</b> Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	<b>2. Compromised:</b> Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	<b>3. Adequate:</b> Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	<b>4. Excellent:</b> Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.		3	3	3	3
<b>TOTAL SCORE</b>						21	21	21	28
<b>Evaluator's Name</b>						Sh	Sc	Sh	Sh

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	<b>Support Surfaces</b> (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"> <li>• Regular Turning Schedule</li> <li>• Enable as much activity as possible</li> <li>• Protect the heels</li> <li>• Use pressure redistribution surfaces</li> <li>• Manage moisture, friction and shear</li> <li>• Advance to a higher level of risk if other major risk factors are present</li> </ul>	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	<ul style="list-style-type: none"> <li>• Use the Same Protocol as for “<b>At Risk</b>” Patients</li> <li>• Position patient at 30 degree lateral incline using foam wedges</li> </ul>	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	<ul style="list-style-type: none"> <li>• Follow the same protocol as for “<b>Moderate Risk</b>” Patients</li> <li>• In addition to regular turning schedule</li> <li>• Make small shifts in their position frequently</li> </ul>	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"> <li>• Use same protocol as for “<b>High Risk</b>” Patients</li> <li>• Add a pressure redistribution surface for patients with severe pain or with additional risk factors.</li> </ul>	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
13/6/26	1 Am	0/10	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 type="checkbox"/> Yes <input type="checkbox"/> No	NA	<i>[Signature]</i>
14/6/26	8 AM	0/10	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 type="checkbox"/> Yes <input type="checkbox"/> No	NA	<i>[Signature]</i>
14/6/26	2 AM	1/10	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 type="checkbox"/> Yes <input type="checkbox"/> No	NA	<i>[Signature]</i>
14/6/26	10 pm	0/10	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 type="checkbox"/> Yes <input type="checkbox"/> No	NA	<i>[Signature]</i>
15/6/26	6 AM	0/10	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 type="checkbox"/> Yes <input type="checkbox"/> No	NA	<i>[Signature]</i>
				<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		

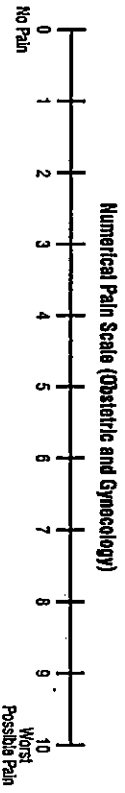
**Re-assessment Frequency:**

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 relieving intervention.
  - d) Within 30 – 60 minutes after pain relief intervention.

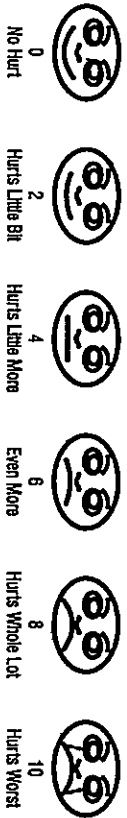
# PAIN ASSESSMENT TOOLS

## FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
	0	1	2
Face	No Particular expression or smile	Occasional Grimaces or Frown, withdrawn, 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 of sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort



## Wong - Baker (Pediatrics) Above 7 Years



## 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	Arching, 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, SaO <sub>2</sub>	No variability with stimuli Hyperventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO <sub>2</sub> 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO <sub>2</sub> less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator		



## CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	12/6 DAY-1			DAY-2 14/08/24			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0	0		0	0	0					
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	0		0	0	0					
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	0		0	0	0					
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	0		0	0	0					
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	0		0	0	0					
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord pyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5	0		0	0	0					
Signature of the Nurse				<i>[Signature]</i>		<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>					

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

Signature of Shift In Charge :

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

Signature of Ward In Charge :

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



60  
A 100



## THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
<b>Age</b>	Less than 3 years old	4	13/6	14/5			
	3 to less than 7 years old	3	4	4			
	7 to less than 13 years old	2					
	13 years old and above	1					
<b>Gender</b>	Male	2	2	2			
	Female	1					
<b>Diagnosis</b>	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych/ Behavioral Disorders	2					
	Other Diagnosis	1	1	1			
<b>Cognitive Impairments</b>	Not aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own ability	1					
	History of Falls or Infant-Toddler Placed in Bed	4					
<b>Environmental Factors</b>	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2	2			
	Outpatient Area	1					
<b>Response to Surgery / Sedation Anesthesia</b>	Within 24 hours	3					
	Within 48 hours	2	2	2			
	More than 48 hours/ None	1					
<b>Medication Usage</b>	Sedatives (Excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1			
<b>Total</b>							

**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		-	-			
Other Intervention(s) Specify		-	-			
Nurse's Name:		Suman				
Signature:		Suman				
Date:		13/6/24	14/6/24			
Time:		1AM	8AM			

# CONSENT FOR ADMISSION IN PEDIATRIC INTENSIVE CARE UNIT



Name: HNM-00015967 IP26-00006578  
Master SAMUEL SATHWIK Age: 1y 9m Gender:  Male  Female   
20-08-2024 1 Y 9 M 25 D (M)  
Dr. PRITESH NAGAR  
 UHID.No :  Date: \_\_\_\_\_

I \_\_\_\_\_ S/o, D/o, W/o, \_\_\_\_\_ hereby declare that our patient Master/Baby \_\_\_\_\_ who is related to me as \_\_\_\_\_ is getting admitted in the Pediatric Intensive Care Unit of Rainbow Children's Hospital on \_\_\_\_\_

The doctors have explained to me in a language understood by me that my child has following health related issues :  
1st Episode Febrile Seizure

The doctors have clearly explained to me that my patient Master / Baby \_\_\_\_\_ during his / her stay in the Pediatric Intensive Care Unit may undergo various medical and surgical procedures like airway management, mechanical ventilation, Central Line Insertion, Peripherally Inserted Central Catheter Line and arterial line placements, chest drain, or peritoneal drain insertion etc.

I have been told by the doctors that while performing such procedures I will be informed and a separate consent for this procedure shall be taken. However, in case of any life threatening emergency if the time is not available for taking informed consent it is implied that I give consent for various invasive procedure to save the life of my child.

I understand that a sick child in Pediatric Intensive Care Unit has life threatening medical conditions.  
 I understand that when a child is sick in the Pediatric Intensive Care Unit with multiple medical and surgical procedures performed upon him/her, there are inherent risks due to these high risk procedures, and high risk medications, in the form of infections, bleeding, air leaks, skin and other tissue damage etc.

I give my consent to the team of doctors to go ahead and admit the child Master / Baby : \_\_\_\_\_ in the Pediatric Intensive Care Unit fully understanding the associated risk, benefits and alternatives involved from various procedures, high risk medications and infections in the Pediatric Intensive Care Unit and treat him/her with all necessary means.


The doctors have explained to me in the language best understood to me.

**Patient Attendant :**  
 Signature: Santhi Priya  
 Name: O. Santhi Priya  
 Relationship with Patient: Mother  
 Date & Time: 14/6/26 @ 8:00 am

**Witness :**  
 Signature: \_\_\_\_\_  
 Name: \_\_\_\_\_  
 Date & Time: \_\_\_\_\_

**Doctor (who is taking the consent) :**  
 Signature: [Signature]  
 Name: Dr. Pritesh  
 Date & Time: 14/6/26

# PATIENT TRANSFER FORM

Patient Name & UHID No. HNH-00015967      IP26-00006578 Master SAMUEL SATHWIK 20-08-2024      1 Y 9 M 25 D (M) Dr. PRITESH NAGAR 		Date & Time of Admission 14/6/26 at 12.36 Am	Date & Time of Transfer Order 14/6/26 at 2.40pm
		Transfer Ordered by DR. Nayipunya	Reason for Transfer stable
From Unit PICU	To Unit 218	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File (27)	Number of Imaging Films VBG-1	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input checked="" 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 Swathy   Beuf		Name of Person Ordered Transfer DR. Nayipunya	
Patient & Clinical Records Received by : Sneha    14/6/26 @ 2:40pm			
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



203

# NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 14/6/26 Time: 9:30Am

Weight: 7.6 kg Centile: 25<sup>th</sup>

Height: Centile:

Inference: underweight child

RDA: Calories: 1200 kcal/d Protein: 20gms/d

Diet Recommendations: Simlac classic (1:30ml dilution)

Re-Assessment: Avoid spicy, Chilled & outside foods.

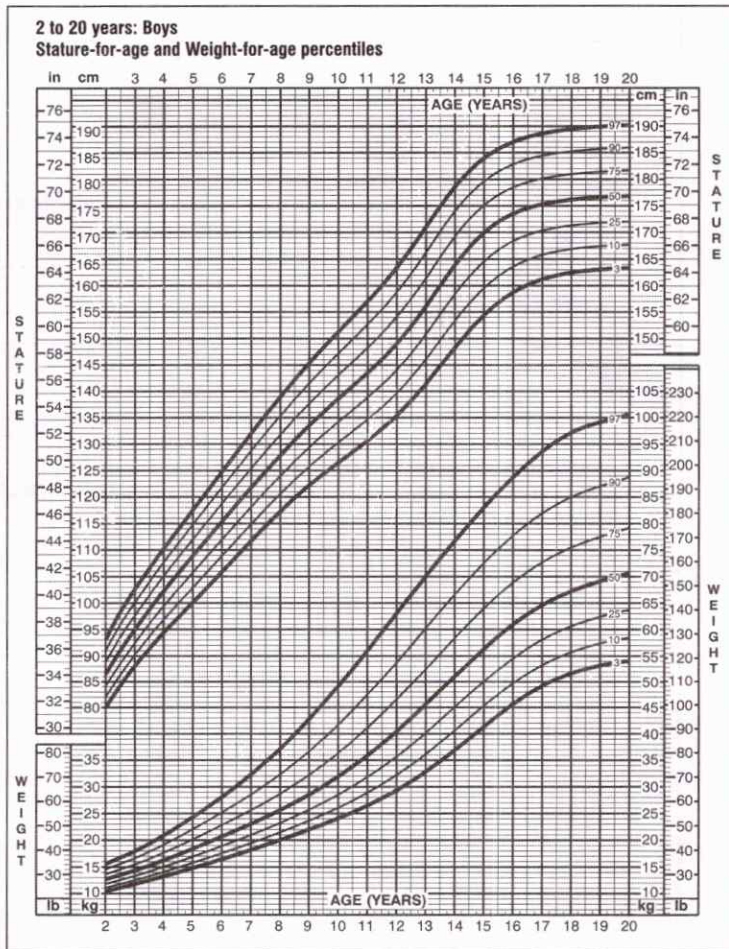
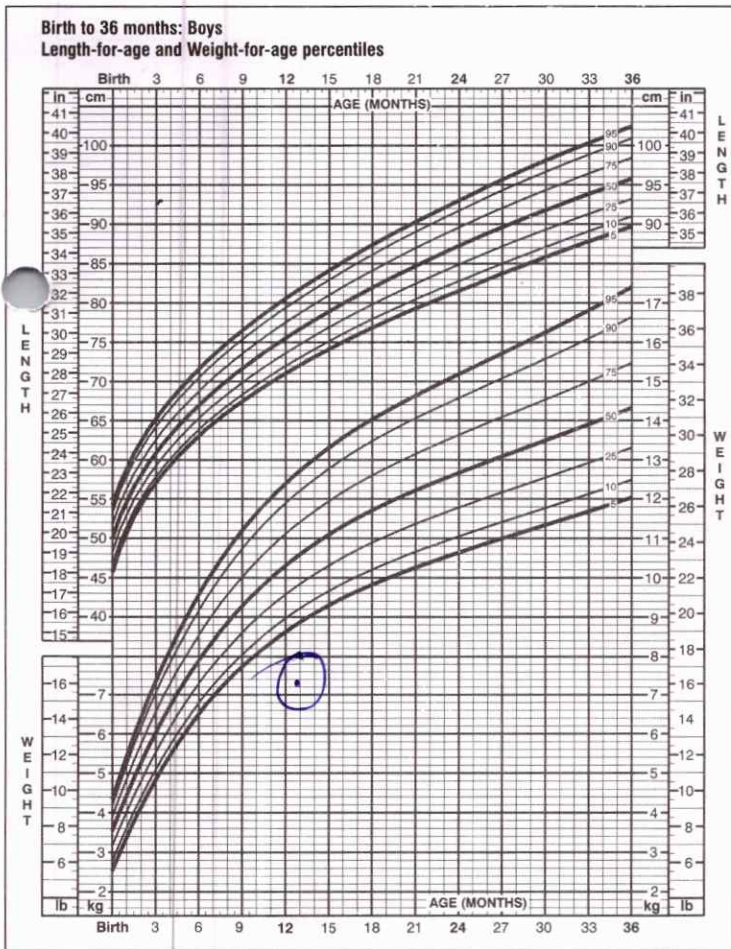
Food Allergies: NO Veg/Non-veg: NON-veg

Diagnosis: TSS

Nutritional Intervention -  Oral  Enteral  Parenteral

Patient's Signature: Sathwika

## GROWTH CHART (BOYS)



Dietician's Name: Sathwika G

Dietician's Signature: [Signature]





wt: 10.57

GRBS 130mg/dl



# EMERGENCY ROOM TRIAGE FORM

Patient's Name : Master Samuel Sathwik Age : 1 year Gender :  Male  Female

Date : 13/06/26 Time of Arrival : 11:50 PM

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: 100.6 F PR: 146 b BP: \_\_\_\_\_ RR: 38 b SpO<sub>2</sub>: 100% Scabies. 1 episode since 2 days in ER

Chief Complaints: CTD fever since 9pm evening cough since 2 days in ER

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 checked="" type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Life -Threatening	
<input type="checkbox"/> Abnormal	<input type="checkbox"/> Gasping / 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.

Signature of Parent / Guardian \_\_\_\_\_

\* CTAS - Canadian Triage and Acuity Scale

Triage Completion Time : \_\_\_\_\_

## Communicable Disease Triage Screening

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

- Have you had fever (elevated temperature) in the past 2 weeks  Yes  No
- Have you had cough or a rash in the past 2 weeks  Yes  No
- 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

- 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: \_\_\_\_\_
- 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 : S. Prithvi

Signature of Triage Nurse : \_\_\_\_\_

Date & Time : 13/06/26 @ 11:52 PM

HNH-00015967 IP26-00006578  
 Master SAMUEL SATHWIK  
 20-08-2024 1 Y 9 M 25 D (M)  
 Dr. PRITESH NAGAR



**Nursing INITIAL ASSESSMENT IN EMERGENCY ROOM**

Date : 13/06/26 Time of arrival : 11:54pm  
 Chief Complaints : c/o fever since 9pm evening confusion 2 days RBS:

Height : Weight : 10.57kg BMI : Head Circumference (<2 years)

Allergies:  Yes  No  Medications  Blood Transfusion  Food  Other:  
 If yes, identify

Pain Screening:  Yes  No If Yes, Pain Score: 0 Pain Tool Used:  N Pass  FLACC  Wong Baker  
 Character N/A  Location N/A  Frequency N/A  Duration N/A

**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:** N/A (Date/Time): N/A  
**Social History:** Lives With family  
 Siblings in household  Yes  No (if yes How Many?)  
 Time of Initial assessment completed by ER Nurse : @ 11:56pm

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

Time	Nursing Notes
11:58 PM	Assess The patient condition Monitor the vital signs w placement done. Sample collected

Samples collected by: Kunipay  
 Samples sent by: Kunipay

Time: 12:40 PM  
 Time: 12:40 PM

**Medication given in ER:**

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1
11/6/2014 AM	<del>andam syp</del> Aamol Support rectal	rectal	17mg	Dr. [Signature]	[Signature]
12:15 PM	Midazolam spray	s/p	2 1/2 puffs	Dr. [Signature]	[Signature]

Condition of patient at time of shift - out :	Details of Shift - out
HR: <u>140b</u> BP: ..... CFT: <u>428.4</u> RR: <u>36b</u> SPO <sub>2</sub> : <u>99%</u> GCS: <u>15</u> Temperature: <u>100°K</u> Pain Score: ..... Repeat RBS (if applicable): <u>130mg IV</u>	Shift - out from ER to: <u>puw</u> Time of Shift - out: <u>1:05 AM</u> Handover given to: ..... (Nurse's Name)

Tick as applicable:  MLC  LAMA  BROUGHT DEAD

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

Name of the Nurse: Kunipay Signature of the Nurse: [Signature]  
 Date & Time: 11/6/2014 @ 12:40 PM

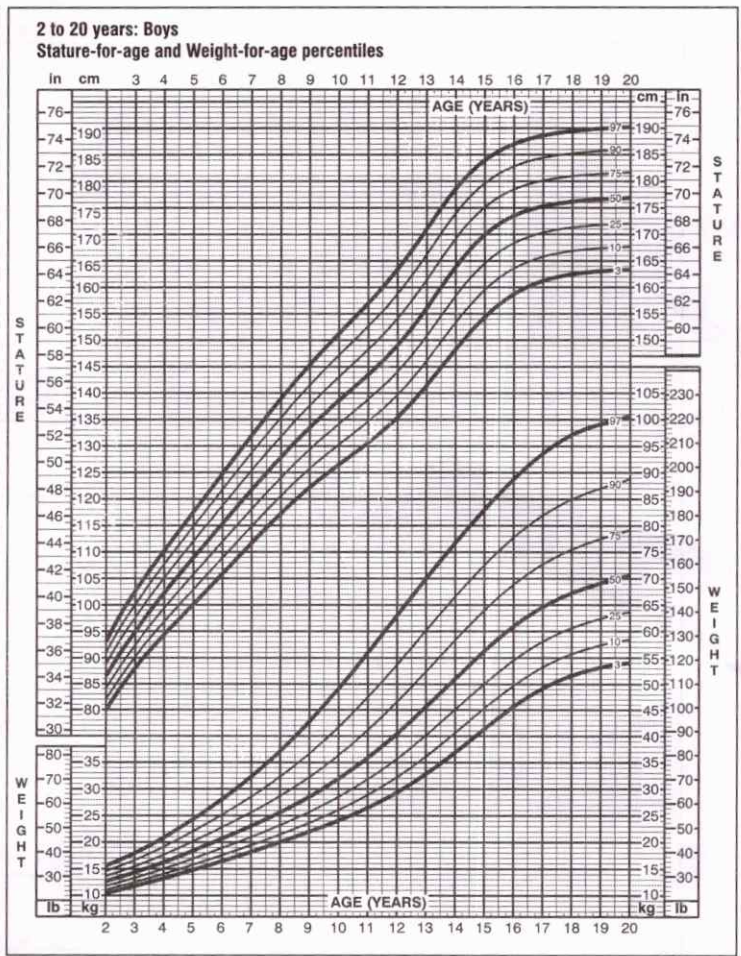
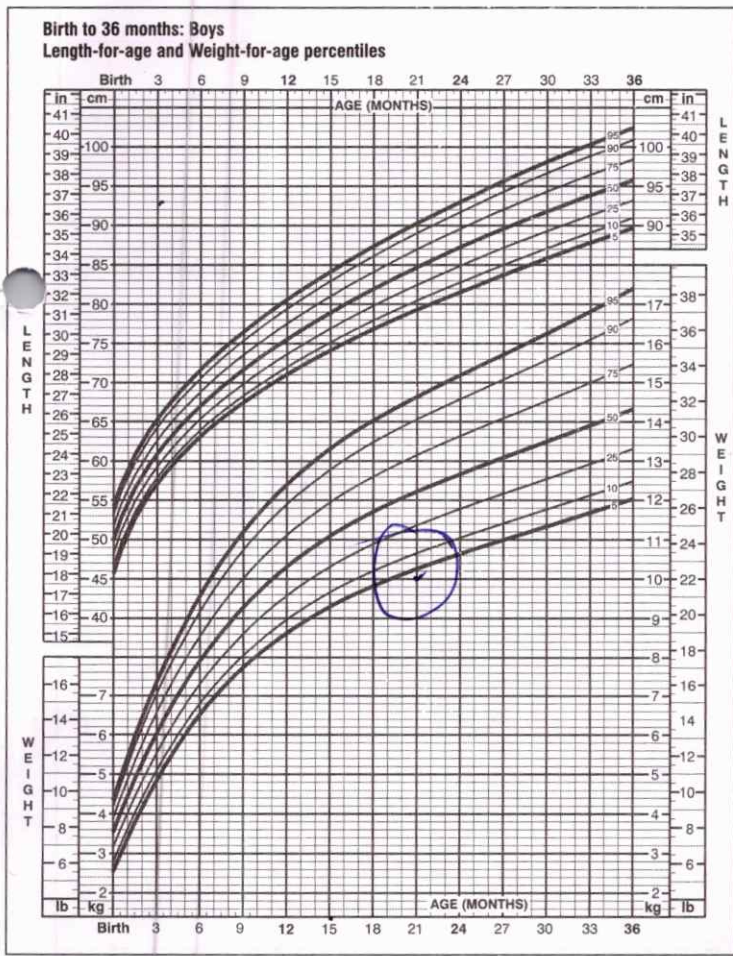
201

## NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 14/6/26 Time: 8:20 AM

Weight: 10.5 kg Centile: 25th  
 Height: Centile:  
 Inference: underweight child  
 RDA: Calories: 1200 kcal/d Protein: 20 gms/d  
 Diet Recommendations: soft calcium rich diet  
 Re-Assessment: Avoid spicy, chilled & outside foods  
 Food Allergies: No Veg/Non-veg: NON-VEG  
 Diagnosis: 1st episode febrile seizures  
 Nutritional Intervention -  Oral  Enteral  Parenteral  
 Patient's Signature: Sathwika

### GROWTH CHART (BOYS)



Dietician's Name: Sathwika G. Dietician's Signature: [Signature]



# PATIENT TRANSFER FORM

Patient Name & UHID No. HNH-00015967 IP26-00006578 Master SAMUEL SATHWIK 20-08-2024 1 Y 9 M 25 D (M) Dr. PRITESH NAQAR		Date & Time of Admission 14/6/26 @ 12:36 AM	Date & Time of Transfer Order 14/6/26 @ 1:05 AM
Transfer Ordered by Dr. praneer		Reason for Transfer Admission	
From Unit ER	To Unit P214	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File 1w	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant Yes <input checked="" 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 checked="" type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring Dr. Preeti Singh		Name of Person Ordered Transfer Dr. praneer	
Patient & Clinical Records Received by : Sunan			
Date & Time of Patient Received : 14/6/26 11AM			

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



## MEDICATION RECONCILIATION FORM

Drug Allergies: penicillin  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: CR Shifted to: PIU

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. Praneer

Date & Time: 17/6/26 @ 12:30 AM

Nurse Name & Signature: K. S. S. S. S.

Date & Time: 17/6/26 @ 12:30 AM