

DISCHARGE SUMMARY

Name	Baby K. EVAANA	UHID	HNH-00011266
Father/Guardian	Mr K. UDAYA KUMAR	Age/Gender	6 Y 10 M 8 D/ Female
Address	FLAT NO-302, LAKSHMI SRI SAI NIVAN, C-13, 2-2-20/20, D.D. COLONY, D D Colony, Hyderabad, Telangana, INDIA, 500013		
IP No	IP26-00006629	Admission Date	23-06-2026
Ref Doctor	Self.		
Discharge Date	26.06.2026		

Consultant:

Dr. SINDHURA MUNUKUNTLA
MBBS, DCH, DNB PEDIATRICS
66970

DIAGNOSIS	ICD CODE
INFLUENZA A ILLNESS	

History: Baby K. EVAANA , 6 Y 10 M 8 D , old girl presented with the history of high grade fever since 4 days, cough and cold since 3 days, poor oral intake since 2 days, dull activity since 1 day prior to admission. For the above complaints she was admitted at Rainbow Children's Hospital - for further management.

Examination: She was febrile(100°F). Her heart rate was 130/min and Respiratory Rate - 28/min. Capillary Refill Time was <2 secs. Peripheries were warm & pulses well felt. On examination Signs of dehydration were present, dry oral mucosa, dull looking, tachycardia were present. On auscultation, air entry was bilaterally equal were present. Heart sounds were normal and there was no murmur. Abdomen was soft with no organomegaly. On neurological examination, she 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.

Weight on admission: 21 kilo grams.

Investigations: Enclosed reports

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Advice:

* Diet as advised.

S.No	MEDICATION	DOSE	TIMINGS	DURATION
1	Syrup. FLUVIR (OSELTAMIVIR - 5ml/60mg)	4 ml	9am-9pm (after food)	For 2 days.
2	JR LANZOLE 15MG	1 TAB	8 AM (BEFORE BREAKFAST)	FOR 2 SAYS
3	NASIVION -P DROPS	2 DROPS EACH NOSTRIL	9am-9pm	FOR 2 DAYS
4	Nasoclear nasal drops, 2 drops in each nostril SOS for nose block			

Plan: To collect final blood culture report on follow up.

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. SINDHURA MUNUKUNTLA on MONDAY (29 .06.2026) at Himayatnagar in OPD with prior appointment (**Review consultation will be charged**).

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.
- * **Anti ulcer drugs** can decrease the absorption of Iron&vit-B12. Anti ulcer drugs can be taken at least 1 hour before food (OR) 2hrs after food. Avoid caffeine that increases stomach acidity.
- * **Antiemetics** can be taken before food.
- * **Laxatives** may deplete/decrease absorption of fat soluble vitamins A,D,E & K. Laxatives can be taken One hour before food or 2 to 4 hours after food & recommended diet to be followed.

* Food can decrease the absorption of **antihistamines**. Antihistamines can be

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taken on an empty stomach /before food to increase their effectiveness.

* 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 **atleast two hours**.

* **Analgesics** without food/empty stomach can cause gastrointestinal irritation, frequent use of these drugs lowers the absorption of folate and Vit-C. **Analgesics** can be taken with food & recommended diet to be followed.

* **Steroids** can decrease the absorption of minerals, proteins & Vit-K from food & increase fluid retention. If not tolerated, take after food & recommended diet to be followed.

* Do not take **Iron supplements** and antacids or calcium supplements at the same time. It is best to space doses of these 2 products 1 to 2 hours apart each medicine or dietary supplement. **Iron supplements** can be taken 1hr before food or 2 hours after food & recommended diet to be followed.

* **Anticonvulsants** along with food decrease absorption of nutrient vitamin D, K B6, B12, folate, calcium stores. Anticonvulsants can be taken at least one hour before food & recommended diet to be followed.

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

If any Intra Venous antibiotics - will be given in Emergency Room between 7am - 8am for morning dose, between 2pm-3pm for afternoon dose and between 8pm-9pm for evening dose (Outside medication shall not be allowed within the hospital as per the hospital protocol).

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**

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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**


Registrar/Resident/C.M.O



Dr. SINDHURA MUNUKUNTLA
MBBS, DCH, DNB PEDIATRICS
66970

R

BABY K EYANNA SY RM 170 F HNH 00011256 CHEST PA 24-06-05 08:10 AM
RAINBOW CHILDREN'S HOSPITAL HIMAYATHI WAGAR

RAINBOW CHILDREN'S HOSPITAL, HINDUSTAN NAGAR
BABEL K LAKSHI EX 8M 2LD 4 NIN 00013306 CHEST PA 2A 300 3F 3 30 PM

R

ADMISSION SHEET

Registration Details :



Admission No : IP26-00006629 **Admit Date** : 23-Jun-2026 **Admit Time** : 10:47 PM **UHID** : HNH-00011266

Patient Details :

Patient Name : Baby K. EVAANA	Age : 6 Y 10 M 7 D
Guardian : Mr K. UDAYA KUMAR	DOB : 16-08-2019
Gender : Female	Religion :
Occupation :	Martial Status : Single
Address (H) : FLAT NO-302, LAKSHMI SRI SAI NIVAN, C-13, 2-2-20/20, D.D. COLONY D D Colony Hyderabad Telangana INDIA 500013	Phone No : 9916999539/ 9849430302
	E-mail : GAYATHRIGOLLA7@GMAIL.COM

Admission Details :

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

Contact Details :

Name : Mr K. UDAYA KUMAR **Relationship** : D/O
Contact Address : FLAT NO-302, LAKSHMI SRI SAI NIVAN, C-13, 2-2-20/20, D.D. COLONY D D Colony
Hyderabad Telangana INDIA 500013 **Phone No** : 9916999539

Gayathri Golla
Signature

Doctor Details :

Doctor Name : Dr. SINDHURA MUNUKUNTLA **Specialisation** : GENERAL PEDIATRICS
Referral Doctor : Self. **Phone No** :
Co-Consultant :

Payment Details :

Payment Mode : DC/CC Card **Deposit Amount** : 10000.00
Payor Name : ICICI ICICI LOMBARD GENERAL INSURANCE

HNH-00011266 IP26-00006629
Baby K. EVAANA
18-08-2019 6 Y 10 M 7 D (F)
Dr. SINDHURA MUNUKUNTLA

ACTIVITY RECORD FOR BILLING

Name: -----
UHID No : ----- IP No : ----- Consultant : ----- Dept : -----
Date of Admission : ----- Time : ----- Date of Discharge : ----- Time: -----
Room / Bed No : ----- Ward : ----- Suggested Billable bed type : -----

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
13/6/26	11:00 PM	ER	ward	[Signature]

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Sign
22/06/26	VBG CBP, CRP, Respiratory panel Blood cl c/s	10200 ✓ 10199 ✓	[Signature]
24/6	CUE	0/201 ✓	[Signature]
		Cross checked ✓	done by [Signature]
24/6/26	Dengue NS, + igm	10259	[Signature]
24/6/26	mycoplasma IgM	0273	[Signature]
24/6	X-ray	7524 ✓	[Signature]
		Cross checked by [Signature] @ 2AM, 25/6/26 ✓	

Ref.No. F/IN/PR/10



**Rainbow[®]
Children's
Hospital**

**PEDIATRIC IN-PATIENT
MEDICAL RECORD**

HNH-00011256 IP26-00006629
Baby K. EVAANA
16-08-2019 6 Y 10 M 7 D (F)
Dr. SINDHURA MUNUKUNTLA



Patient Name : Evaana

Patient ID# : _____

Consultant : _____

Final Diagnosis : _____



Pediatric Multiorgan History & Physical Examination

Name : Kaana Age/Sex 6y 10m 7d F.

Informant Mother Reliability _____

Chief Presenting Complaints & Duration (Chronologically):

Fever x 4 days (high grade)

Cough & cold x 3 days

Poor oral intake x 2 days

History of present illness : Dull activity x 1 day

A 6y 10 month old girl care is do.

Fever x 4 days; high grade.

associated with chills,

~~not~~ not responding on oral medication

now antd is

Cough & cold x 3 days

Poor oral intake x 2 days

Dull activity x 1 day

already on OPD basis treatment since 2 days

admitted in view of persistent symptoms.

Pediatric Multiorgan History & Physical Examination

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Baby K. EVAANA
16-08-2019 6 Y 10 M 7 D (F)
Dr. SINDHURA MUNUKUNTLA

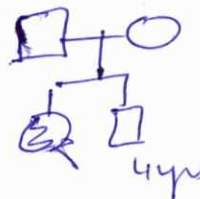


Past History : (Including details of any previous investigation or treatment)

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
The vaccine - ~~not~~

Pediatric Multiorgan History & Physical Examination



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

Weight (kgs) 21 kgs (Centile _____)

On Examination :

Temperature : 100° F. Pulse Rate: 130/min Description _____

B.P. _____ SPO2 98% at RA

Resp. rate and type of breathing : _____

Rash _____

Lymphadenopathy _____

Oedema : _____

*Dull looking.
dry oral mucosa
Tachycardia*

Respiratory system :

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

Air entry & breath sounds : WTBS (+)

Any addes sounds : _____

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

Cardiovasclular System :

Inspection of procordium : (N)

Heart Sounds : sbh (N)

Any murmur : _____

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

Per Abdomen :

Inspection (N)

Palpation : Soft

Ausculation : BS (+)

Spine: (N) External Genitelia : _____

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

Pediatric Multiorgan History & Physical Examination

HNH-00011266 IP26-00006629
Baby K. EVAANA
16-08-2019 6 Y 10 M 7 D (F)
Dr. SINDHURA MUNUKUNTLA



Central Nervous System :

Level of Consciousness : AVPU/GCS Score : afir

Cranial Nerves : _____

Motor System :

Nutrition : _____

Tone : _____ Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR

Superficials :

Plantars _____

Sensory System :

Bladder / Bowel : _____

Clinical Summary & Diagnostic :

AFI (D_u)

Pediatric Multiorgan History & Physical Examination

treatment :

prevent complications

Desired goals of the treatment :

Hemodynamic stability

Planned Labs :

CBP, CRP, VBG

Blood c/s

CVE (DUE)

5 views Resp. Panel

2 Extrapan

NB Probiotic

Planned Management :

① IVF 2/3rd Mantance

② Inj Ceftriaxone

③ Syp. Relent Plus

④ Nasonix - P nasal drops

⑤ Monitor vitals

NB Probiotic

Please fill up the following details

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

Doctor's Signature Name [Signature] Date 24/6/26 Time 10:30 Am

Dr. Sindhura Munukuntla
Consultant Pediatrician
Reg. No: 66970



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
23/6/2019	c/s/b - Dr. Rashanti	
11:20 pm	A - Acute febrile illness	
	- 100°F on admission	
	↓ Reduced	Plan
	- Oral intake ↓	- Trace
	o/e	- CBC / CRP / VBG
	HR - 130/min RR - 20/min	- Blood c/s / CUE
	SpO ₂ - 98% on RA	- 5-virus Respir panel
	CFT 2 3 sec	et. Rx as per chart
	S/E Nose - Nasal discharge o/e congestion Rx - clear	Monitor vitals Ur/He o/p NB Sncpa @ 11:20am Rashanti

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	c/s/B - Dr. Prashanti / Dr. Nazneen	
24/6/26 1:50 AM	A - Acute febrile illness. (INFLUENZA - A)	
	- Fever spikes - 102.5 F @ 5:30 AM	PLAN
	- Urine ✓ Stool ✓ oral intake reduced activity dull	- Influenza A (+) - Verbal Trace Adeno Blood Cx
O/E		- Ceftriaxone
Temp: - 100.2 F	HR - 117 bpm	- Cefelent plus
RR - 25 bpm	SpO2 99% (RA)	- Nasivion - P Nasal
P/well felt	BP 100/60	drops
	CFTC 38sec	- monitor vitals
P/E	O/C - congested	
	Nose - Nasal d/s +	- add Fluvir (21kg)
	Rs - clear	45 mg 1 dose BD x 5 days
	I/A - Soft	3 4ml - 0.4ml
	- Suspected Dengue NS1 +	DI/D5 IGM. NB Zucme



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
24/6 6:00pm,	<p>CLS 113 Dr. Sindhura.</p> <p>Influenza A illness & dehydration</p>	
	<p>Fever (+) - 101.2°</p>	<p>plan</p>
	<p>Vitals - Stable.</p>	
	<p>R/S - BIL A (+)</p>	<p>→ Trace Mycoplasma Dengue NS1 IgM</p>
	<p>pla - soft, NT</p>	<p>→ Cont ceftriaxone fluric syp</p>
	<p>oral intake - fair.</p>	<p>→ Cont IVF (1/2 m)</p>
		<p>→ Neb C 3% NS Q6H</p>
		<p>→ Monitor vitals</p>
		<p>NB Suck @ 8 PM</p>

Dr. Sindhura Munukuntla
 Consultant Pediatrician
 Reg. No. 66970

~~Dr. Sindhura Munukuntla~~

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
25/6 7:00 AM	<p>Chlrs Dr. Naipunya / Dr. Anusha</p> <p>Influenza A illness & dehydration.</p>	
	<p>Fever - 100.5 F (1:00 AM)</p> <p>Vitals - Stable</p> <p>oral intake - fair.</p>	<p>Plas</p> <p>Ⓡ Mycoplasma Igm</p> <p>Dengue NS1 ; Igm</p>
	<p>RLs - B/L AE</p>	
	<p>PIA - soft, NT</p>	<p>✓ Cont 2x ceftriaxone.</p>
	<p>UO/P - Adequate.</p>	<p>✓ Cont syp. FLUVIR.</p>
	<p><i>[Faint handwritten notes]</i></p>	<p>✓ Neb C 3 Y. NS</p> <p>✓ Monitor vitals</p> <p>✓ <u>Accl.</u></p>
	<p><i>[Faint handwritten notes]</i></p>	<p>N.B. Steha 28 AM</p>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
28/6 10:30 AM	<u>CS/B Dr. Sindhura</u>	
	<u>Influenza A like & Dehydrated</u>	
	Fever @ Oral intake - fair	Pla 1) Stop IVF 2) Trazo Mycophenol 3) CT - Fluoro 4) not in 3y. NaCl 5) Sig. Ceftriaxone 6) Manta Vitals - Influenza 7) Stable glu/D/c - Flu
	child activity - improving Vitals stable R-S - B/LAEB PIA - soft	Noted by Anurag 28/6/26 10:30 AM Dr. Sindhura (Signature)
	Dr. Sindhura Munukuntla Consultant Pediatrician Reg. No: 66970	

HNH-00011266
 Baby K. EVAANA
 16-08-2019 8 Y 10 M 7 D (F)
 Dr. SINDHURA MUNUKUNTLA

IP26-00006629



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
25/6 1:30pm	S/B Dr - Sindhu M child alert vitals stable	
	 signed child will be seen by Dr. Sindhu in evening 	 Adv - stop ppi - S. Sindhu MUNUKUNTLA M
		Dr. Sindhu Munukuntla Consultant Pediatrician Reg. No: 66970
25/6/26 2pm	S/B Dr - Archana Influenza A illness & dehydration	
	No fever spikes ∴ 12 hours generalised aches ⊕ Oral intake - good No fresh complaints. vitally stable	Adv - Ct ceftriaxone - Ct flucloxacillin - Ct Nebis & 3% NaCl - Ct rest same
26/6/26	SE P/A - soft, nt	S/B Dr Archana

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
25/6/20	<u>U/S/b Dr. Aniket</u>	
<u>5PM</u>	<u>Diis - Suppurative A+ve</u>	
	- fever spikes @	
	- oral intake - good.	
	R/E - vitals stable.	Plan
	R/E - R/S - BAC @.	- Ct. Ceftriaxone.
		- Ct. flucloxacillin.
		- Ct. rest Rx as per orders.
		- Change IV order status to stop.
		Dr. Aniket P
		R/B. Manjunath
		@ 8:30 PM

Dr. Aniket Anil Parashar
 Consultant Pediatrician & Intensivist
 Reg. No: 8568

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
26/6/26 7.15 AM	S/B Dr. Sreeghen Influenza A Illness	Plg
	Afebrile CNS - S, L, C ⊕ R - BLU - AC ⊕ P/A SOB Conscious.	CT CEFTRIAZONE CT FLUVIA Plan discharge NB - Mouthwash @ 8 AM.
26/6/26 10 AM.	cp/by Dr. Sindhu M Influenza A illness.	
	Afebrile.	
	Vital stable.	If ultra neg - stop Antibiotics.
	CNS S, L, C ⊕ Norma	- CT CEFTRIAZONE - CT FLUVIA
	(RB) BLU AC ⊕ AIVDS ⊕	Mother - FLUVIR Capsule
		- plan dis. today Dr. Sindhu M Consultant Pediatrician Reg. No: 66970 H. Mallikarjun (MNH-10)



REGULAR PRESCRIPTIONS

Weight. 21.25kg Ward.

Verified by Dr. Dhakshayani

DRUG : <u>Syr CEFTRIAXONE</u>				Date Time	<u>23/6</u>	<u>24/6</u>	<u>25/6</u>	<u>26/6</u>
Dose	Route	Frequency	Start Date					
<u>1gm</u>	<u>IV</u>	<u>BD</u>	<u>23/6</u>	<u>10Am</u>	X	X	X	X
Name & Signature of the Doctor Starting the Drugs: <u>Nau</u> <u>(Dr Nameen)</u>								
Additional Instructions:				<u>10Pm</u> <u>20mg</u> <u>Syr</u> <u>Syr</u> X				
Daily Doctor's Endorsement by a Sign				<u>Dr</u>				

DRUG : <u>NASINON - 1. nasal drop</u>				Date Time	<u>23/6</u>	<u>24/6</u>	<u>25/6</u>	<u>26/6</u>
Dose	Route	Frequency	Start Date					
<u>10/10</u>	<u>each. nostril</u>	<u>BD</u>	<u>23/6</u>	<u>10Am</u>	X	X	X	X
Name & Signature of the Doctor Starting the Drugs: <u>Nau</u> <u>(Dr Nameen)</u>								
Additional Instructions:				<u>10Pm</u> <u>10mg</u> <u>Syr</u> <u>Syr</u> X				
Daily Doctor's Endorsement by a Sign				<u>Dr</u>				

DRUG : <u>Syr. REENT PLUS</u>				Date Time	<u>23/6</u>	<u>24/6</u>	<u>25/6</u>	<u>26/6</u>
Dose	Route	Frequency	Start Date					
<u>5ml</u>	<u>PO</u>	<u>BD</u>	<u>23/6</u>	<u>10Am</u>	X	X	X	X
Name & Signature of the Doctor Starting the Drugs: <u>Nau</u> <u>(Dr Nameen)</u>								
Additional Instructions:				<u>10Pm</u> <u>2mg</u> <u>Syr</u> <u>Syr</u> X				
Daily Doctor's Endorsement by a Sign				<u>Dr</u>				

DRUG : <u>SYP FLOVIR</u>				Date Time	<u>24/6</u>	<u>25/6</u>	<u>26/6</u>	
Dose	Route	Frequency	Start Date					
<u>48 (4ml)</u>	<u>PO</u>	<u>BD</u>	<u>24/6</u>	<u>10Am</u>	X	X	X	
Name & Signature of the Doctor Starting the Drugs: <u>Pruti</u>								
Additional Instructions: <u>SYP</u> <u>OSELTAMAVIR</u> <u>(12mg/ml)</u>				<u>10Pm</u> <u>2mg</u> <u>Syr</u> <u>Syr</u> X				
Daily Doctor's Endorsement by a Sign				<u>Dr</u>				

Sheet No:

REGULAR PRESCRIPTIONS

Weight 21.25kg Ward

DRUG : <u>2mg ESMOPRAZOLE</u>				Date/Time	<u>24/6</u>	<u>25/6</u>	<u>26/6</u>													
Dose	Route	Frequency	Start Dt.																	
<u>20mg</u>	<u>slw</u>	<u>OD</u>	<u>24/6/26</u>																	
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Archana</u>																				
Additional Instructions: <u>(40 mg)</u>																				
Daily Doctor's Endorsement by a Sign																				
DRUG : <u>2mg ONDANSETRON</u>				Date/Time	<u>24/6</u>	<u>25/6</u>														
Dose	Route	Frequency	Start Dt.																	
<u>4mg</u>	<u>slw</u>	<u>TID</u>	<u>24/6/26</u>																	
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Archana</u>																				
Additional Instructions: <u>(2mg/ml)</u>																				
Daily Doctor's Endorsement by a Sign																				
DRUG : <u>Neb C 3% NS</u>				Date/Time																
Dose	Route	Frequency	Start Dt.																	
<u>Inspirator Neb</u>	<u>Neb</u>	<u>Q6H</u>	<u>24/6</u>																	
Name & Signature of the Doctor Starting the Drugs: <u>Deep</u>																				
Additional Instructions: <u>See the chart</u>																				
Daily Doctor's Endorsement by a Sign																				
DRUG :				Date/Time																
Dose	Route	Frequency	Start Dt.																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

Verified by Dr. Archana

Verified by Dr. Dhakshayani

Signature

VERIFIED BY: Name

Patient Sticker



Sheet No:

REGULAR PRESCRIPTIONS

Weight Ward

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

VERIFIED BY Name Signature



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: ICU 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	NASINON - P nasal drops	2 ^o /2 ^o	each nostril	BD	✓	<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
2	Syp. ROVENT AWS	3ml	PO	BD	✓	<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. Nameer Bann *slan*

Date & Time: 23/08/2026 @ 11 pm

Nurse Name & Signature: *slan*

Date & Time: 24/8/26 @ 11 pm



208

NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 24/6/26 Time: 10:30A

Weight: 21.25kg Centile: 25th

Height: 120cm Centile: 50th

Inference: well nourished child

RDA: - Calories: 1450kcal/d Protein: 25gms/d

Diet Recommendations: Normal Diet

Re-Assessment: Avoid spicy, chilled & outside foods

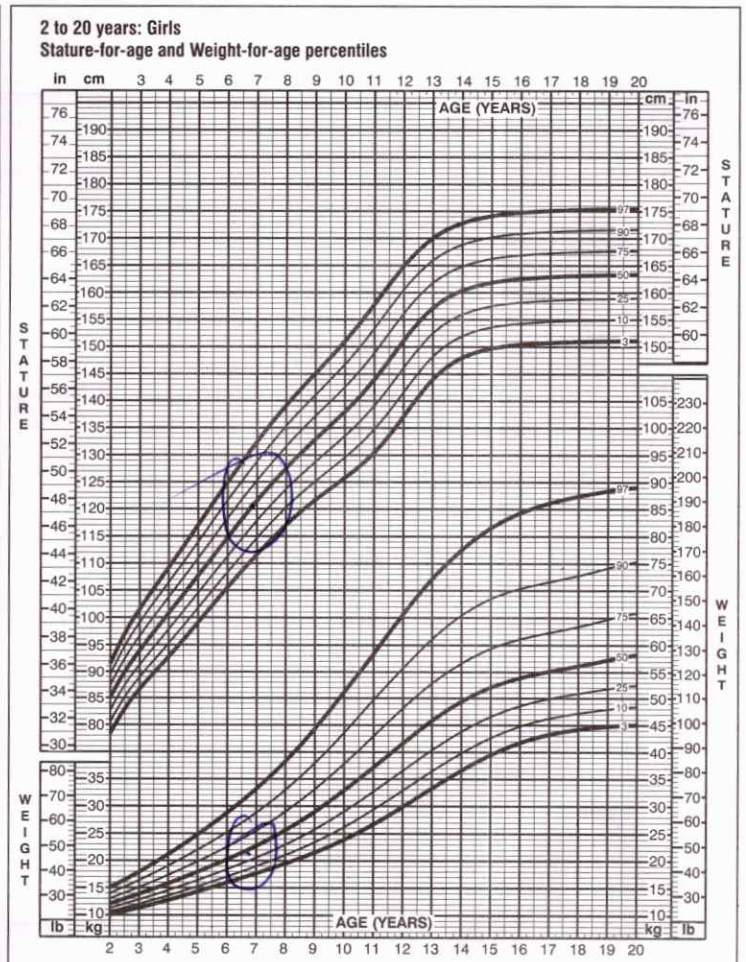
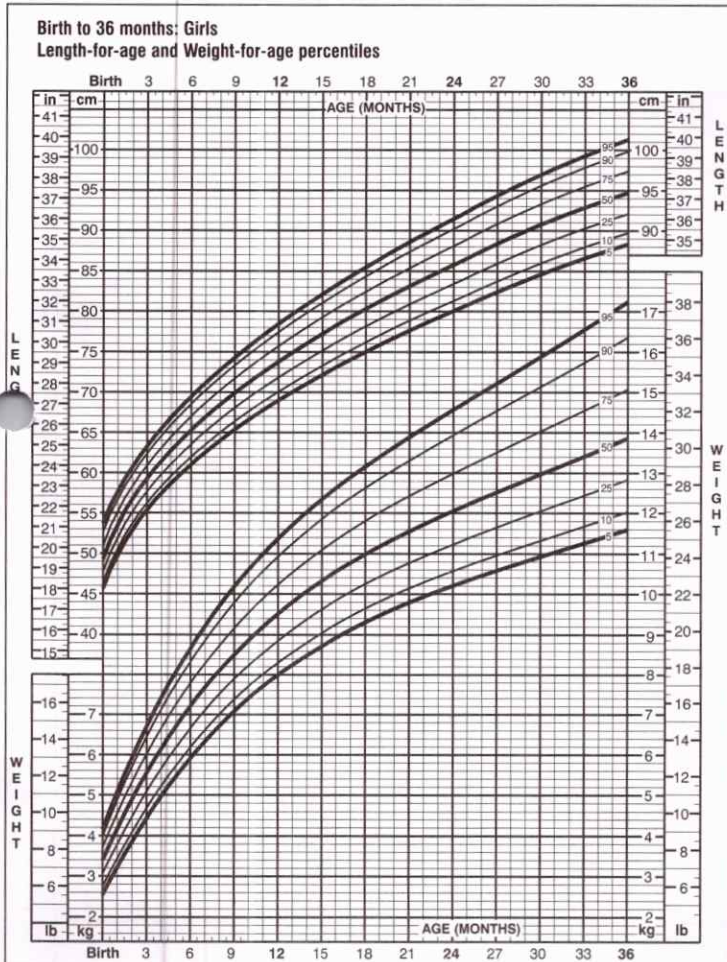
Food Allergies: NO Veg/Non-veg: NON-veg

Diagnosis: AFI_D with Influenza "A"

Nutritional Intervention - Oral Enteral Parenteral

Patient's Signature: Gayatri G

GROWTH CHART (GIRLS)



Dietician's Name: Sathwika

Dietician's Signature: [Signature]



3% NS - 6th hourly

NEBULISATION CHART

Date	Time	Drug	Nurse	Parents Signature
	00.00			
	01.00			
	02.00			
	03.00			
	04.00			
	05.00	3% NS.	AM	<i>Signature</i>
	06.00	4 8/11		
	07.00			
	08.00			
	09.00			
	10.00			
	11.00			
	12.00			
	13.00			
	14.00			
	15.00			
	16.00			
	17.00			
	18.00			
	19.00			
	20.00			
	21.00			
	22.00			
	23.00			



3% NS 6th hourly

NEBULISATION CHART

Date	Time	Drug	Nurse	Parents Signature
	00.00			
	01.00			
<u>25/6/26</u>	02.00			
	03.00			
	04.00			
	05.00	3% NS + CO2 (2)	Srida	Gayathri
	06.00	7 (2)	208054	
	07.00			
	08.00			
	09.00			
	10.00			
	11.00	3% NS (1)	GA	Gayathri
	12.00			
	13.00			
	14.00			
	15.00			
	16.00			
	17.00	3% NS (2)	GA	Gayathri
	18.00			
	19.00			
	20.00			
	21.00			
	22.00			
	23.00	3% NS (3)	MSI	Gayathri

MNH-00011266 IP26-00006629

Baby K. EVAANA

16-08-2019 6 Y 10 M 8 D (F)

Dr. SINDHURA MUNUKUNTLA



NEBULISATION CHART

Date	Time	Drug	Nurse	Parents Signature
	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			
	19.00			
	20.00			
	21.00			
	22.00			
24/6/26	23.00	3% NS T O2 (1)	Sneha	Gayathri

MNH-00011266 IP26-00006629
 Baby K. EVAANA
 16-08-2019 6 Y 10 M 7 D (F)
 Dr. SINDHURA MUNUKUNTLA



208



RESULT SHEET

Date	23/6/26				
Time					
Hb	12.4				
PCV	34.9				
RBC	4.44				
WBC	3.20				
N/L	64.4/316				
Platelets	163				
CRP	5				
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					

Date	24/6/26				
Time					
CUE - Alb					
CUE - Sugar	Nil				
CUE - Ketones	Negative				
CUE - PUS Cells	2-4				
CUE - RBC Cells	Nil				
CUE					
Stool Pus Cell					
OVA / Cyst					
Occult Blood					
Flu	→ A +ve				
Adenovirus PCR	-ve				

Culture and Sensitivities : ^{23/6/26} Blood (15-)

Radiology : USG :

X-Ray :

ECHO :

CT :

MRI :

Others (ECG, Contrast Studies etc.) :

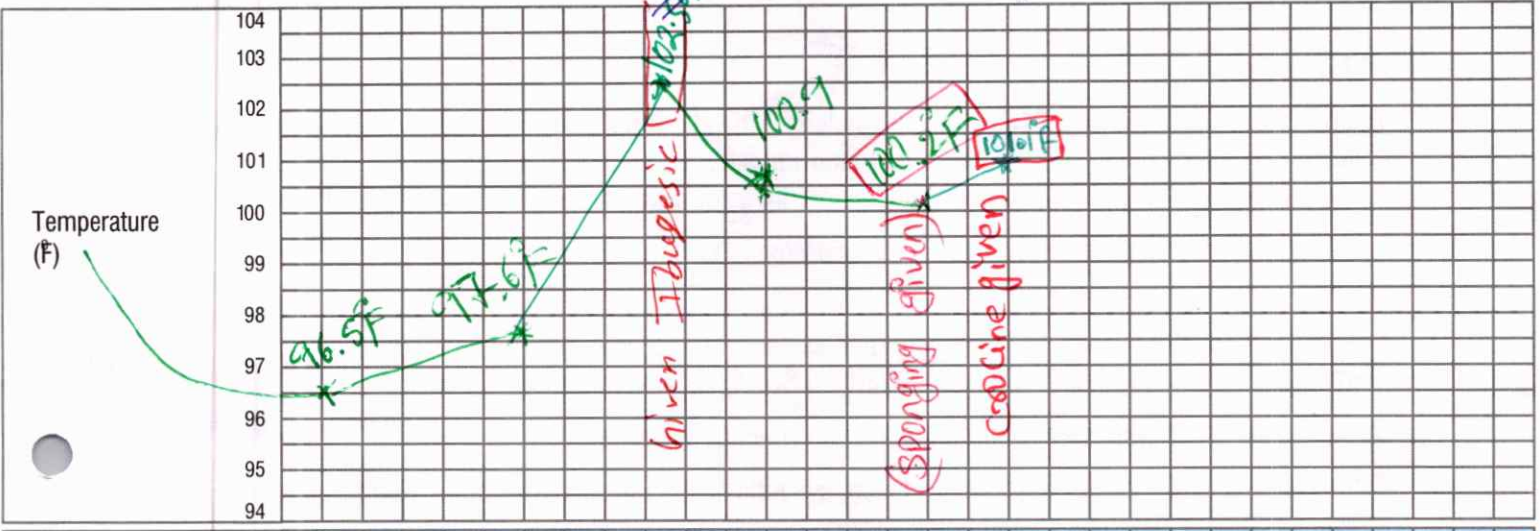
Patient



CLINICAL / 126

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 24/6/26	Time: 12 AM	2 AM	5:30 AM	6:40 AM	7:00 AM	11 AM
Doctor / Nurse / Family Concern?						



Heart Rate (bpm) and Blood Pressure (mmHg) *	190	180	170	160	150	140	130	120	110	100	90	80	70	60	50
Note: BP does not score in early warning scoring															
Heart Rate (Number)	98 bpm	100 bpm	117 bpm												

Resp. Rate (bpm) (Over 1 Minute) *	70	60	50	40	30	20	10
Resp Rate (Number)	23 bpm	25 bpm	25 bpm	28 bpm			

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

TOTAL SCORE				
Number of shaded boxes	0	0	0	0
Pain Score	0	0	2	0
Observer's Initials	A	A	A	A

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

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

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

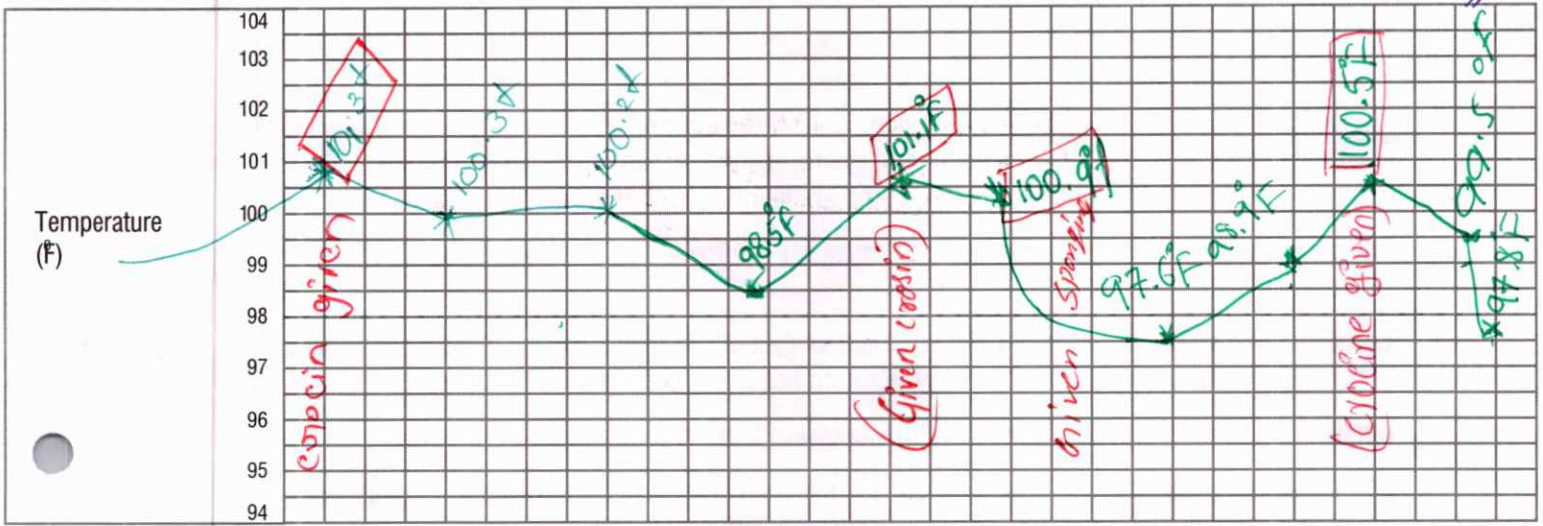
The SBAR communication tool (situation, background, assessment, recommendations) is a helpful mnemonic that can be used to describe a child's clinical condition to a colleague.

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	BACKGROUND: 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)



WARNING SCORE: CHILDREN'S UNIT

Date: <u>2/16/16</u> Time: <u>11Am</u> <u>12Am</u> <u>1pm</u> <u>2:40pm</u> <u>5pm</u> <u>6pm</u> <u>9pm</u> <u>10pm</u> <u>11:30pm</u> <u>1:30AM</u> <u>3AM</u>
Doctor / Nurse / Family Concern?



Heart Rate (bpm) and Blood Pressure (mmHg) *	
Note: BP does not score in early warning scoring	
Heart Rate (Number)	117b/m, 112b/m, 113b/m, 103b/m, 112b/m
Blood Pressure (mmHg)	101/65, 103/69, 102/67, 100/67

Resp. Rate (bpm) (Over 1 Minute) *	
Resp Rate (Number)	29b/m, 22b/m, 24b/m, 23b/m, 23b/m

Resp Distress	Mod/ Severe / None / Mild
Receiving O ₂ (l/min)	
O ₂ Saturations (%)	100%, 98%, 100%, 100%, 100%
Conscious Level	Normal / Altered
GCS *	

TOTAL SCORE	
Number of shaded boxes	0, 0, 0, 0, 0
Pain Score	0, 0, 0, 0, 0
Observer's Initials	[Signatures]

ACTIONS NB: Scores 3 should be recorded overleaf	Score 1 : Continue normal observation by staff nurse
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Date	Time	Early Warning Score	Date	Time	Name

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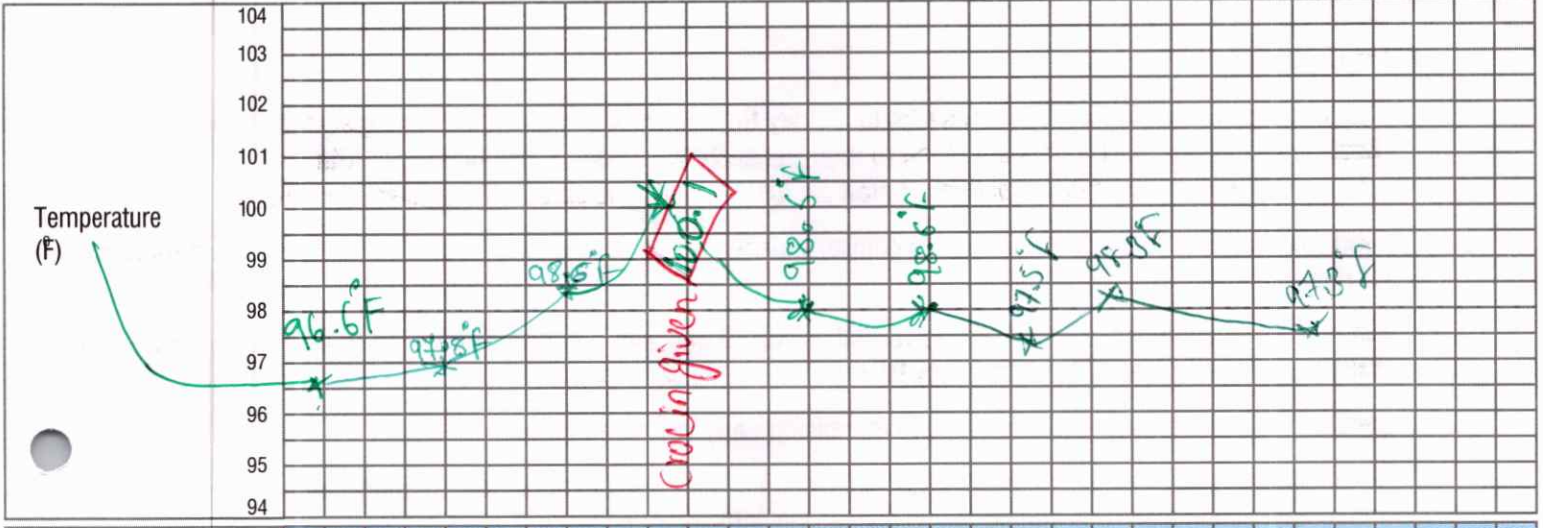
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R	RECOMMENDATION : I need you to ... come to see the child in the next (XX mins) AND I-s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

Patient's

LINICAL / 126

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 25/6	Time: 6 AM	10 AM	2 PM	4:30 PM	5:20 PM	6 PM	10 PM	2 AM	6 AM
Doctor / Nurse / Family Concern?	Am	Am	Am	Am	Am	Am	Am	Am	Am



Heart Rate (bpm) and Blood Pressure (mmHg) *	190	180	170	160	150	140	130	120	110	100	90	80	70	60	50
Note: BP does not score in early warning scoring	93	100	90	90	80	80	80	80	80	90	92	80	80	61	100
	62	68	60	54	57	61	61	61	61	59	59	59	59	59	59
Heart Rate (Number)	103b/m	120b/m	117b/m	116b/m	108b/m	100b/m	100b/m	100b/m	100b/m	90b/m	90b/m	90b/m	90b/m	90b/m	90b/m

Resp. Rate (bpm) (Over 1 Minute) *	70	60	50	40	30	20	10	1
Resp Rate (Number)	23b/m	23b/m	26b/m	26b/m	20b/m	20b/m	25b/m	28b/m

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

TOTAL SCORE							
Number of shaded boxes	0	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0	0
Observer's Initials	df	ca	ca	mb	mb	mb	mb

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
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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

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Date	Time	Early Warning Score	Date	Time	Name

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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)
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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)



FLUID CHART

Sheet No. : 2

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

Date	Time	Nature of Fluid	Intake			NG	Diarrhoea	Vomit	Output		IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G				Drainage	Urine		
24/6/26	08:00 am	DNS		40ml					120ml		1	}
	09:00 am		40ml									
	10:00 am		40ml						100ml			
	11:00 am		40ml									
	12:00 pm		40ml									
	01:00 pm		40ml									
Total Intake : taken			Total Output : U - M -									
24/6/26	02:00 pm	DNS		40ml					150ml		1	}
	03:00 pm		40ml									
	04:00 pm		40ml									
	05:00 pm		40ml						120ml			
	06:00 pm		40ml									
	07:00 pm		40ml									
Total Intake : taken			Total Output : U - M -									
24/6	08:00 pm	DNS		30ml					0		0	}
	09:00 pm		30ml						150ml			
	10:00 pm		30ml						120ml			
	11:00 pm		30ml									
	12:00 am		30ml									
	01:00 am		30ml									
Total Intake :			Total Output : U - M -									
25/6	02:00 am	DNS		30ml					0		0	}
	03:00 am		30ml									
	04:00 am		30ml									
	05:00 am		30ml									
	06:00 am		30ml									
	07:00 am		30ml									
Total Intake :			Total Output :									

Total 24 hrs. Intake

Total 24 hrs. Output



FLUID CHART

Sheet No. : 3

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
<u>25/6</u>	08:00 am	DNS		30ml						140ml		[Signature]
	09:00 am	DNS		30ml								
	10:00 am	DNS	Orally + H ₂ O	30ml						140ml		
	11:00 am											
	12:00 pm	Sleep										
	01:00 pm											
Total Intake :			← taken			Total Output :					U-2 M-1	
<u>25/6/26</u>	02:00 pm											[Signature]
	03:00 pm											
	04:00 pm		Roti + H ₂ O									
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :			Taken			Total Output :					U-2 M-0	
<u>25/6/26</u>	08:00 pm											[Signature]
	09:00 pm											
	10:00 pm		Rice + roti									
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						Total Output :						
<u>26/6/26</u>	02:00 am											[Signature]
	03:00 am											
	04:00 am											
	05:00 am		H ₂ O									
	06:00 am											
	07:00 am											
Total Intake :						Total Output :						

Total 24 hrs. Intake

Total 24 hrs. Output

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			
	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
Total Intake :						Total Output :							
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :							
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
Total Intake :						Total Output :							
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
Total Intake :						Total Output :							

Total 24 hrs. Intake

Total 24 hrs. Output

MNH-00011266 IP26-00006629
 Baby K. EVAANA
 16-08-2019 6 Y 10 M 7 D (F)
 Dr. SINDHURA MUNUKUNTLA



NURSING CARE RECORD

Date: 23/6/26

- 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							
Afternoon							
Night	12am to 8am	<ul style="list-style-type: none"> → Assess pt condition → monitor the vitals → Maintain I/O chart → Administer medication as per drug chart 	12am to 8am	<ul style="list-style-type: none"> → Assessed pt condition → monitored vitals → Maintained I/O chart → Administered medication as per drug chart 	Patient is stable	Re-checked vitals	Arusha



Patient Sticker

NURSING CARE RECORD



Date: 24/6/20

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	→ checked vitals	Dhe
		→ monitor vitals		→ monitored vitals			
		→ maintain I/O chart		→ maintained I/O chart			
		→ administer medication		→ medication as per chart			
		→ IV cannula present		→ CT fluids			
	2pm	→ CT fluids	2pm	→ IV cannula presented			
Afternoon	3pm	Assess the baby	3pm	Assess the baby	Continue IV fluids	Reassess the baby	Dhe
		Monitor the vitals		Obtained vitals			
		Administer medicine		Administered medicine			
		Maintain I/O chart		Maintain I/O chart			
Night	8pm	Assess the pt condition.	8pm	Assess the pt condition	Pt is stable.	→ monitor vitals	Sekar
		Monitor vitals		Monitored vitals			
	10pm	Maintain I/O chart.	10pm	Maintained I/O chart			
		Provide the comfortable position.		Provided the comfortable position			
	8Am	Medication given as per doctor order.	8Am	Medication given as per doctor order.	→ vitals normal.	→ maintain I/O chart.	Dhe



NURSING CARE RECORD

Date: 25/6/26

- 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	8am 2pm	→ Assess the pt condition → monitoring vitals checked and recorded → I/O chart - maintain	8am 2pm	Assess the patient condition → Administration of medication given as per doctor orders	→ pt is stable	→ Re-checked the vitals	A
Afternoon	2pm 8pm	- Assess the pt condition - monitor vitals - maintain I/O chart - medication given as per drug chart	2pm 8pm	- assessed the pt condition - monitored vitals - maintained I/O chart - medication given as per drug chart	pt is stable	rechecked vitals	M
Night	8pm 8pm	Assess the pt condition - monitor vitals & recorded - maintain I/O chart - administer medication as per doctor advice	8pm 8pm	Assessed the baby condition monitor vitals & recorded maintain I/O chart administered medication as per doctor advice	pt is stable	rechecked vitals	De

HNH-00011266 IPZ6-00006629
 Baby K. EVAANA
 16-00-2019 6 Y 10 M 10 D (F)
 Dr. SINDHURA MUNUKUNTLA

NURSING CARE RECORD



Date:

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							
Afternoon							
Night							

HNH-00011266 IP26-00006629
 Baby K. EVAANA
 16-08-2019 6 Y 10 M 7 D (F)
 Dr. SINDHURA MUNUKUNTLA



NG SHIFT HAND OVER FORM

SITUATION	Diagnosis: AFT		Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Not Known					
	Surgery / Procedure:		If Yes Specify:					
BACKGROUND	Date	23/6 Ni	24/6/26 Mg	24/6 SF	24/6 Ni	25/6/26 Mg	25/6/26 S2	
	Shift							
	Medical Condition (Any special condition to be noted):	-	-	Influenza	-	-	-	-
Diet:	-	-	Normal	-	-	-	-	
ASSESSMENT	Allergy:	<input checked="" type="checkbox"/> Yes <input 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	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Ventilation (RA, NP, NIV, VENTI):	-	-	-	-	-	-	
	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	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Vital Signs:	Temp:	98.3°F	97.2°F	98.5°F	98.2°F	98.5°F	98.6°F
		Res:	23b/m	20b/m	22b	22b/m	25b/m	24b/m
		SpO ₂ :	98.1	99.5	100	99%	100%	100%
		Pulse:	122b/m	110b/m	125	102b/m	112b/m	116b/m
		BP:	110/65	-	100/60	92/62	101/60	100/60
		LOC:	-	-	-	-	-	-
	Fall Risk Score:	0	0	10	10	-	-	
Pain Score:	-	-	0	0	-	0		
Skin Integrity	Good	good	good	Good	Good	Good		
Recommendations	Safety Needs:	<input checked="" type="checkbox"/> Yes <input 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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	Physiotherapy:	-	-	-	-	-	-	
	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	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Special Diet:	-	-	-	-	-	-	
	Critical Lab Test / Values:	-	-	-	-	-	-	
	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	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
PU Prophylaxis:	<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	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
DVT Prophylaxis:	<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	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
ADL (Dependent / Non Dependent):	-	-	-	-	NA	NA		
Post Operative Procedure Special Orders:	-	-	-	-	NA	NA		
Handed Over By Name :	Amurthy	Amurthy	Payal	Sru	Amurthy	Manisha		
Signature / ID :	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]		
Date:	24/6/26	24/6/26	24/6	25/6	25/6/26	25/6/26		
Time:	8AM	2PM	8PM	8AM	2PM	8PM		
Taken Over By Name :	Divya	Divya	Sneha	Amurthy	Manisha	Manisha		
Signature / ID :	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]		
Date:	24/6/26	24/6	24/6	25/6/26	25/6/26	25/6/26		
Time:	8AM	2PM	8AM	8AM	2PM	8PM		

HNH-00011266 IP26-00006629
 Baby K. EVAANA
 16-08-2019 6 Y 10 M 10 D (F)
 Dr. SINDHURA MUNUKUNTLA



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	28/8/20 16					
	Shift						
	Medical Condition (Any special condition to be noted):						
	Diet:						
ASSESSMENT	Allergy:	<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	<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 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	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Vital Signs:	Temp: 98.5 F					
		Res: 24 bpm					
		SpO ₂ : 99%					
		Pulse: 75 bpm					
		BP: 101/60					
		LOC: -					
		Fall Risk Score: -					
	Pain Score: -						
	Skin Integrity: -						
Recommendations	Safety Needs:	<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	<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 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	<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:	N/A					
	Handed Over By Name :	Moukunda					
	Signature / ID :	[Signature]					
	Date:	28/8/20					
	Time:	8:00					
	Taken Over By Name :						
	Signature / ID :						
	Date:						
	Time:						



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
24/6/26	12Am	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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No	NA	[Signature]
24/6/26	6Am	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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No	NA	[Signature]
24/6/26	10Am	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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No	NA	[Signature]
24/6	2pm	0	n/a	<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	[Signature]
24/6	8pm	0	n/a	<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	[Signature]
24/6	10pm	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 type="checkbox"/> Yes <input type="checkbox"/> No	NA	[Signature]
25/6	2Am	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 type="checkbox"/> Yes <input type="checkbox"/> No	NA	[Signature]
25/6	8Am	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 type="checkbox"/> Yes <input type="checkbox"/> No	NA	[Signature]
25/6/26	10Am	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 type="checkbox"/> Yes <input type="checkbox"/> No	NA	[Signature]
25/6/26	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 type="checkbox"/> Yes <input type="checkbox"/> No	NA	[Signature]

Re-assessment Frequency:

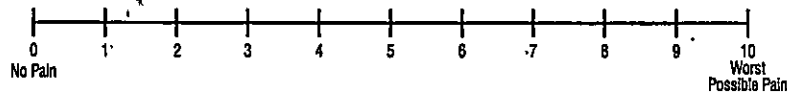
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 - 60 minutes after pain relief intervention.

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' brawn 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	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, 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





PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
25/6/28	6pm	0/10	NA	<input type="checkbox"/> Continuous <input checked="" type="checkbox"/> Intermittent	<input checked="" type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input checked="" type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input checked="" type="checkbox"/> Decreasing	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	NA	NA
26/6/26	8Am	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	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		
				<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		
				<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:

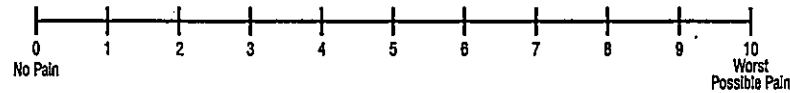
1. Every eight hours for all hospitalized patients.
2. For post-surgical patients, patients with chronic pain, patient with severe pain:
 - a) At least every 2 hours for the first 24 hours
 - b) Then every 4 hours.
 - c) Prior to pain relieving intervention.
 - d) Within 30 – 60 minutes after pain relief 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 Grimace or Frown, withdraw, Disoriented	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs: brawn 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

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	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, 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



CHECKLIST FOR THROMBOPHLEBITIS

24/6/26

25/6/26

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			0	0	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			NA	NA	0	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	0	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	0	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	0	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	0	NA	NA	NA	NA	
Signature of the Nurse						NA	NA	0	NA	NA	NA	NA	

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 :  Name : 

Signature of Ward In Charge :

Signature :  Name : 



Wt- 22kg



EMERGENCY ROOM TRIAGE FORM

Patient's Name : K. Evaana Age : 6 Y 10 M Gender: Male Female
 Date : 22/10/22 Time of Arrival : 10:30pm
 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: 100.0° PR: 100 BP: RR: 24 SpO₂: 100%
 Chief Complaints: 10 Fever x 4 days.

INITIAL PHYSIOLOGICAL CATEGORIZATION Appearance <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Sick Looking Work of Breathing <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Increased <input type="checkbox"/> Decreased <input type="checkbox"/> Gasping / Apnea Circulation / Colour <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Bleeding		INITIAL PHYSIOLOGICAL STATUS <input checked="" type="checkbox"/> Stable <input type="checkbox"/> Unstable : <input type="checkbox"/> Not - Life - Threatening <input type="checkbox"/> Life -Threatening
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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 : 10:33pm

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 : Arulba Signature of Triage Nurse : [Signature]
 Date & Time : 22/10/22 @ 10:33pm
 Docu. No. : RCH / FRM / CLINICAL / 085

HNH-00011286 IP26-00006629
 Baby K. EVAANA
 15-08-2019 6 Y 10 M 7 D (F)
 Dr. SINDHURA MUNUKUNTLA



NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date: 23/6/20 Time of arrival: 10:30pm

Chief Complaints: c/o fever since 4 days

Height: Weight: Head Circumference (<2 years)

Allergies: Yes No Medications Blood Transfusion Food Other:

If yes, identify

Pain Screening: Yes No If Yes, Pain Score: 10/10 Pain Tool Used: N Pass FLACC Wong Baker

Character Location Frequency Duration

<p>RISK FOR FALL: If patient is < 6 years <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If 'Yes' tick below fall risk intervention directly If Patient is > 6 years If 'Yes' Assess the below parameters History of Falling: within past 3 months <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Ambulatory Aids: • Wheelchair <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No • Uses furniture for support <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Gait/Transferring: • Bedrest / immobile <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No • Weak <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No • Impaired <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Mental Status: Forgets limitations <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>IF YES FOR ANY CATEGORY = RISK FOR FALLING Fall Risk Intervention: <input type="checkbox"/> Escort while ambulating <input type="checkbox"/> Assist Patient <input type="checkbox"/> Educate patient and family on fall precautions/prevention</p>	<p>Functional Screening: <input type="checkbox"/> No Abnormalities Detected <input type="checkbox"/> Mobility Problem <input type="checkbox"/> Walking Problem <input type="checkbox"/> Developmental Delay <input type="checkbox"/> Musculoskeletal Congenital Abnormality</p> <p>Inform consultant for positive criteria</p> <p>Nutritional Screening: <input type="checkbox"/> No Abnormalities Detected <input type="checkbox"/> Underweight <input type="checkbox"/> Overweight <input type="checkbox"/> Feeding Problem <input type="checkbox"/> Special diet <input type="checkbox"/> Special feeding method</p> <p>Inform consultant for positive criteria</p>
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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?)

Time of Initial assessment completed by ER Nurse: 10:32pm

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

Time	Nursing Notes
	→ Assessed the pt condition
	→ checked the pt vitals

Samples collected by: _____

Time: _____

Samples sent by : _____

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: 108 bpm BP: CFT: 25cc	Shift - out from ER to:
RR: SPO2 at FiO2: 98%	Time of Shift - out:
GCS: 15/15 Temperature: 99.6 F	Handover given to:
Pain Score: 0	(Nurse's Name)
Repeat RBS (if applicable):	

Tick as applicable: MLC LAMA BROUGHT DEAD


Procedures done with details (if any):

Name of the Nurse : Prabha

Signature of the Nurse : _____

Date & Time : 23/6/26 @ 10:32 AM

PATIENT TRANSFER FORM

HNH-00011266 Baby K. EVAANA 16-08-2019 Dr. SINDHURA MUNUKUNTLA 8 Y 10 M 7 D (F)  IP26-00006629			Date & Time of Admission <i>23/6/26 @ 10:47pm</i>	Date & Time of Transfer Order <i>23/6/26 @ 11:40</i>
Treating Consultant Name <i>Dr. Nazneen</i>	Transfer Ordered by <i>Dr. Nazneen</i>	Reason for Transfer <i>Admission</i>		
From Unit <i>ER</i>	To Unit <i>ward</i>	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
Number of Sheets in Clinical File <i>20</i>	Number of Imaging Films	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 <i>Pradip</i>		Name of Person Ordered Transfer <i>Dr Nazneen</i>		
Patient & Clinical Records Received by : <i>Sneha @ 23/6/26 @ 11:40pm</i>				
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