Rainbow® Children's Hospital
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Your Right to a Safe Delivery

DISCHARGE SUMMARY

Name	Master N HARSH SINGH	**UHID**	HNH-00016172
Father/Guardian	Mr N SATYA PRAKASH SINGH	**Age/Gender**	11 Y 4 M 17 D/ Male
Address	H NO 1-28 NANAKRAMGUDA RR DIST SHERILINGAMPALLY MONDAL, Nanakramguda, Hyderabad, Telangana, INDIA, 500008		
IP No	IP26-00006650	**Admission Date**	25-06-2026
Ref Doctor	Dr Vinay Kumar Manthati		
Discharge Date	27.06.2026		

Consultant:
Dr. VINAY KUMAR MANTHATI
MBBS DNB (Pediatrics)
Reg No:91733

DIAGNOSIS	ICD CODE
NEPHROTIC SYNDROME (1st EPISODE)	

History: Master N HARSH SINGH , 11 Y 4 M 17 D , boy presented with the history of periorbital edema, swelling within whole body since 1 week, swelling around eyes noticed since 1 week, gradually progressed to whole body and limbs, prior to admission. For the above complaints he was admitted at Rainbow Children's Hospital - for further management.

Examination: He was afebrile, maintaining saturations at room air. His heart

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rate was 124/min, Blood pressure - 127/91 mmHg and Respiratory Rate - 23 /min. Pedal edema was present. Generalised anasarca was present. On auscultation of chest, air entry was bilaterally equal with __ bilateral wheeze & occasional crepitations were present. Heart sounds were normal and there was no murmur. Abdomen was soft without organomegaly. Bowel sounds were heard. On neurological examination, he was conscious and alert. Pupils were bilaterally equal and reacting to light. There were no focal neurological or cranial nerve deficits. There were no signs of raised intracranial pressure.

Weight on admission: 35.6 kilo grams.

Investigations: Enclosed reports.

Initial hemogram showed Hemoglobin of 11.2 gm%, White Blood Cell count of 7960 cells/cumm, platelet count of 3.01 lakhs/cumm
C3 Quantitation - 69.7 mg/dl, C4 Quantitation - 15.0 mg/dl
Cholesterole was 313 mg/dl. Serum Creatinine was 0.5 mg/dl. Blood Urea was 18 mg/dl.
ASO Titers test was negative.
Complete urine examination was : Pus cells - 4-6, epithelial cells - 1-2. Vitamin D - 8.0
Serum Calcium was 8.0 mg/dl.
Albumin - 1.7 gm/dl,
Repeat Complete urine examination was : Pus cells - 6-8, epithelial cells - 1-2

Name	Master N HARSH SINGH	**UHID**	HNH-00016172
IP No	IP26-00006650	**Admission Date**	25-06-2026

SPOT PROTEIN / CREATIINE RATIO

SPOT PROTEIN	228.9	-	mg/dl	-
SPOT CREATININE	18.7	24 - 392	mg/dl	L
RATIO	12.24			

Ultrasound abdomen shows:
* Mild diffuse bilateral increased renal cortical echogenicity, in keeping with renal parenchymal disease in the given clinical setting.
* Mild ascites.
- For clinical and RFT correlation.

Management: He was admitted in the ward and AmlodipinE was given for elevated BP. Patient was started on salt restricted and high protein diet after sending labs. Strict urine output monitoring was adviced.

His investigations revealed hypoalbuminemia, nephrotic range proteinuria and hyper cholesterolemia, so he was diagnosed as nephrotic syndrome and was started on Prednisolone according to the recommendations. His blood pressure, input output and weight were closely monitored which showed improvement. In view of hypo-albuminemia he received 20% albumin transfusion along with diuretics.
Serum Calcium and Vitamin D levels were in deficiency zone, hence supplements were added.

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Parents were counselled regarding the nature of illness, possible complications and need for prolonged treatment with regular followup.

He was regularly monitored for fever spikes, hemodynamic status, vital parameters, oxygen saturations and any signs of respiratory distress. His symptoms gradually settled, edema decreased & urine output improved. He remained hemodynamically stable during the hospital stay.

He improved with the above line of management and is being discharged with the following advice.

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

Advice:

* Diet as advised.
* Low salt, low fat diet.
* Avoid NSAIDS, Ayurvedic medications.
* Tablet. Omnacortil (Prednisolone - 30 mg) 1 tablet twice daily after food for 6 weeks.
* Tablet. Lasix (40mg), 3/4th tablet twice daily after food for 3days.
* Tablet Shelcal 500mg , 1 tablet once daily for 1month.
* Tablet Pantoprazole 40mg , 1 tablet once daily 30 minutes before breakfast till further advice.
* Tablet Vitamin D3 60,000 IU , 1 tablet/week - 6doses
* Nasoclear nasal drops, 2 drops in each nostril 30 minutes before each feed as and whenever required for nose block.

Plan:

Name	Master N HARSH SINGH	**UHID**	HNH-00016172
IP No	IP26-00006650	**Admission Date**	25-06-2026

1. **To do Urine protein creatinine ratio, Renal Profile-2, Serum Calcium, HbsAg, C3 levels - on followup.**
2. **To monitor BP 2-3 times/week on OPD basis regularly.**
3. **To change Omnacortil to alternate days after 6 weeks of course.**

Fever Management
* Syrup. Crocin DS (Paracetamol - 5ml/240mg) 10 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. Shruthi (Nephrologist) on (01.07.2026) Wednesday at Banjarahills OPD Rainbow childrens hospital with prior appointment **(Review consultation will be charged)**.

(or)

Review consultation with Dr. Prathima (Nephrologist) on (01.07.2026) Wednesday at Financial District OPD Rainbow childrens hospital with prior appointment **(Review consultation will be charged)**.

Review consultation with Dr. VINAY KUMAR M at his clinic with prior appointment

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

If any IV 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).

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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 8121039503 emergency pediatrician on duty.

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

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

Registrar/Resident/C.M.O

Consultant:
Dr. VINAY KUMAR MANTHATI
MBBS DNB (Pediatrics)
Reg No:91733

Rainbow Children's Hospital | BirthRight by Rainbow

Rainbow Childrens Hospital-Himayatnagar

Rainbow Children's Hospital, Door no. 3-6-267, opp. Cafe niloufer, Old MLA quarters road AP State Housing Board Himayatnagar ,Hyderabad ,Telangana, INDIA ,500029.
TEL NO :040-48873000
WEB : https://rainbowhospitals.in

ADMISSION SHEET

Registration Details :

Admission No : IP26-00006650 **Admit Date** : 25-Jun-2026 **Admit Time** : 11:15 PM **UHID** : HNH-00016172

Patient Details :

Patient Name	: Master N HARSH SINGH	**Age**	: 11 Y 4 M 15 D
Guardian	: Mr N SATYA PRAKASH SINGH	**DOB**	: 10-02-2015
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: H NO 1-28 NANAKRAMGUDA RR DIST SHERILINGAMPALLY MONDAL Nanakramguda Hyderabad Telangana INDIA 500008	**Phone No**	: 9177912190/ 7569482686
		E-mail	: NSATYASINGH143@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 N SATYA PRAKASH SINGH **Relationship** : Father

Contact Address : H NO 1-28 NANAKRAMGUDA RR DIST SHERILINGAMPALLY MONDAL Nanakramguda Hyderabad Telangana INDIA 500008 **Phone No** : 9177912190

Signature

Doctor Details :

Doctor Name : Dr. VINAY KUMAR M **Specialisation** : GENERAL PEDIATRICS

Referral Doctor : Dr Vinay Kumar Manthati **Phone No** : 9533799099

Co-Consultant : Dr. ANIKET ANIL PARASHAR

Payment Details :

Deposit Amount : 20000.00

Payment Mode : DC/CC Card **Payor Name** : SELFPAY

HNH-00016172 IP26-00006650
Master N HARSH SINGH
10-02-2015 11 Y 4 M 16 D (M)
Dr. VINAY KUMAR M

BP Centile
50th SBP/DBP 104/61
90th 117/76
95th 121/80
95+12 129/88

Nephrotic Syndrome
Monitoring Sheet

Patient Name: Mr. N Harsh Singh		Age: 11Y	Sex: M
Unit:	DOA: 25/6/26	CR No:	Weight: 35.6 Kg

Date	Fluid in	Fluid out (ml/kg/hr)	Edema	Urine Protein	BP	Weight in kg	Abdominal Girth (cm)	Drugs
25/6			+	?nil	119/88 95th centile	35.6	65	Amlodipine.
26/6		2ml/kg/hr	+		95th	34.87	64	Prednisolone Albumin, Lasix, Amlodipine SOS.
26/6 9pm	1Lit						64 cm	
27/6/26 10am						33.58	62 cm	
26/6/25 9pm		200ml						
10.20pm		250ml						
27/6 12.15pm		200ml						
3.00am		150ml						
5.5		100ml						
6.00		100ml						
6.18		100ml						
7.00		100ml						
8.01		300ml						
27/6/26								
	idly							

Nephrotic Syndrome
Monitoring Sheet

Patient Name :		Age :	Sex :
Unit :	DOA :	CR No :	Weight :

Date	Fluid in	Fluid out	Edema	Urine Protein	BP	Weight in kg	Abdominal Girth (cm)	Drugs

Doctor Name: ..... Date: ..... Time .....

HNH-00016172 IP26-00006650

Diagnosis: Master N HARSH SINGH

10-02-2015 11 Y 4 M 16 D (M)

Dr. VINAY KUMAR M

Hospital: .....

Referred for: ☐ Opinion ☐ Co-Management ☐ Transfer of care

Type of Referral :
☐ Emergency
☐ Urgent
☐ Non Urgent

Reason for Referral: If for concurrent care specify the particular need, especially in the absence of a second diagnosis:

Periorbital edema ⟶ progressive Anasarca

Imp: New Onset Nephrotic Signature:

Findings and Recommendations :

O/E: B/L Grade III Pitting PE ⊕

Periorbital edema ⊕

V/o - good

UPCR - 12

C3 - 69 ↓

C4 - 15 (N)

CUE - No RBC

CR - D+C

Alb - (1.7)

TC - 313

USG - Ascites ⊕

Kidneys ok

Adv

1) To do

[25-OH vit D3
S. calcium
in same sample

2) Repeat CUE 4/M 6am (1st morning sample)

3) Do Mantoux test

Consultant : (502313)

Name : DR. SRUTI T Signature : Date & Time : 26/6/2016 12:41pm

3) Daily wt charting

4) Strict I/O charting

5) Low salt diet

6) BP 3rd Hrly Charting

7) Inj Lasix 35mg IV BD.

8) T. Omnacortil 30mg BD.

9) Review c̄ reports

10) To give Inj 20% H albumin
100 ml IV over 4 hours
c̄ Lasix 35mg mid way
& 35 mg end way.

11) Add T. Stilosal 100mg OD

Date	Weight	AG
26/6/26	34.87 kg	65 cm
26/6/26		64cm (11:45pm)
		64cm (8pm)
27/6/26	33.58 kg	62cm (6AM)

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ACTIVITY RECORD F(

HNH-00016172 IP26-00006650
Master N HARSH SINGH
10-02-2015 11 Y 4 M 15 D (M)
Dr. VINAY KUMAR M

Name: ---------- ----------

UHID No : ---------- IF ltant : ---------- 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
25/6/26	11:50pm	ER	302	A.D
26/6/26	4pm	3rd (302	203	
26/6/26	8pm	(203) PICU	302	Renuja.

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1.	Dr. Sruthi Balla (Nephrologist	26/6/26	8371	
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

HNH-00016172 IP26-00006650
Master N HARSH SINGH
10-02-2015 11 Y 4 M 15 D (M)
Dr. VINAY KUMAR M

INVESTIGATIONS

Date	Investigations	Order No.	Sign
25/6/26	CBP,		
	ASO ~~titre~~		
	Sr. creatinine		
	Sr. Urea		
	Albumine	10354	
	Sr. cholesterol		
	C3		
	C4 } Quantitative		
	VBG		
		10353	
26/6/26	CUE	0355	
26/6/26	Spot urine protein Creatinine ratio	03587	
26/6/26	USG Abdomen	7577	
26/6/26	vit D (25 hydroxy)	3940	
	~~Sr. Creatinine~~ Calcium	3940	
26/6/26	Sr. calcium.	10396	
27/6/26	CUE	0427	

cross check done by Sr. sandhya

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Master N HARSH SINGH
10-02-2015 11 Y 4 M 15 D (M)
Dr. VINAY KUMAR M

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
26/6/26	Invasive monitor	4pm	26/6/26 8.30 pm	8453	Renuka
				Cross check done by SV Sandhya	

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10-02-2015 11 Y 4 M 15 D (M)
Dr. VINAY KUMAR M

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
26/6/26	IV canula.	1	8245	
26/6/26	NHA	1	8451	
26/6/26 (9:15am)	Albumin transfusion	1	8469	

Cross checkedone by Sr. Sandhya

ANY OTHER INFORMATION

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

Ref.No. F/IN/PR/10

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PEDIATRIC IN-PATIENT MEDICAL RECORD

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Master N HARSH SINGH
10-02-2015 11 Y 4 M 15 D (M)
Dr. VINAY KUMAR M

Patient Name : _____

Patient ID# : _____

Consultant : _____

Final Diagnosis : _____

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Master N HARSH SINGH
10-02-2015 11 Y 4 M 15 D (M)
Dr. VINAY KUMAR M

& Physical Examination

Name : _____ _____ Age/Sex _____

Informant _____ Reliability _____

Chief Presenting Complaints & Duration (Chronologically):

periorbital swelling and body × 1 week.

History of present illness :

c/o swelling started around eye noticed since 1 week, gradually progressed to whole body and limbs

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Master N HARSH SINGH
10-02-2015 11 Y 4 M 15 D (M)
Dr. VINAY KUMAR M

atric Multiorgan History & Physical Examination

P... history : (including details of any previous investigation or treatment)

Birth & Neonatal History :

Birth & Socio Economic History :

About Father :

About Mother :

Any additional Information :

Developmental History :

Normal

Immunization History :

Updated

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Master N HARSH SINGH
10-02-2015 11 Y 4 M 15 D (M)
Dr. VINAY KUMAR M

diatric Multiorgan History & Physical Examination

Anthropometry

Head Circum (cms)_____(Centile _____) Height (cm) : 143 cm (Centile_____)

Weight (kgs) 35.6 (Centile _____)

On Examination :

Temperature :_____ Pulse Rate:_____Description _____

B.P. 127/91 mm Hg SPO2 99% at RA.

Resp. rate and type of breathing :_____

Rash_____

Lymphadenopathy No

Oedema : (+) periorbital and pedal edema

Respiratory system :

Inspection (any s/o distress) :_____

Air entry & breath sounds : BS CAB (+) , Clear

Any addes sounds :_____

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

Cardiovasclular System :

Inspection of procordium :_____

Heart Sounds : S1 S2 (+)

Any murmur :_____

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

Per Abdomen :

Inspection _____

Palpation : Soft Nondistended

Ausculation :_____

Spine:_____ External Genitelia :_____

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

HNH-00016172 IP26-00006650
Master N HARSH SINGH
10-02-2015 11 Y 4 M 15 D (M)
Dr. VINAY KUMAR M

Pediatric Multiorgan History & Physical Examinati

Central Nervous System :

Level of Consciousness : AVPU/GCS Score : ______

Cranial Nerves : ______

Motor System :

Nutrition : ______

Tone : ______ Power ______

Co-ordinator : ______

Posture : ______

Involuntary Movements : ______ NAD

Reflexes :

DTR **Superficials :**

Plantars ______

Sensory System : ______

Bladder / Bowel : ______

Clinical Summary & Diagnostic :

Generalised Anasarca (? Nephrotic Syndrome) with Hypertension

Preventive aspects of the treatment :

Desired goals of the treatment :

Planned Labs :

CBP, VBG

Sr. Creatinine, Sr. Urea

Sr. Albumin / Sr. Cholesterol.

CUE

Spot urine protein creatinine ratio

ASO titre, (C_3, C_4) – levels

USG whole Abdomen 7/07

Extra plain sample (2)

Planned Management :

- Salt restricted diet
- High protein diet
- Strict urine output monitoring
- daily weight check
- BP monitoring.
- Nephrologist opinion

Please fill up the following details

1. Name of the Referring Doctor : Dr. Vinay
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 whose name the patient is being referred Dr. Aniket? on

Dr. Aniket Parashar
Consultant Pediatric Intensivist
Reg. No. [illegible]

Doctor's Signature Name Date Time

HNH-00016172
Master N HARSH SINGH IP26-00006650
10-02-2015 11 Y 4 M 15 D (M)
Dr. VINAY KUMAR M

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	C/w/b. Dr. Sankeerth / Dr. Shreeya	
26/06/26 12AM	D:- ? Nephrotic Syndrome	
		ē Hypertension
	Swelling x 1 week	
	Accepting orally	BP. Centiles
		SBP DBP
	O/E: GC-fair 50th -	~~101~~ 104 ~~62~~ 61
	Vitals- 90th -	~~112~~ 117 ~~75~~ 76
	BP:- 127/91 (95th) -	~~116~~ 121. ~~78~~ 80
	mmHg 95th + 12 -	~~128~~ 129. ~~90~~ 88.
	HR:- 77/min	
	RR:- 26/min	
	SpO_2:- 99% @RA	
	periorbital & pedal	edema (+)
	S/E: P/A soft, No	
	mild distension (+)	[signature]
		- Tab Amlodipine 5mg/stat
		- BP Monitoring 4H
		- Strict urine output monitoring
		- Trace blood reports
		- Send CUE & urine protein creat ratio,
		- Salt restricted diet
		- High protein diet
		[signature]

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Master N HARSH SINGH
10-02-2015 11 Y 4 M 15 D (M)
Dr. VINAY KUMAR M

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2:30 AM	BP - 119/88	

10016172 IP26-00006650
HARSH SINGH (M)
2015 11 Y 4 M 15 D
VAY KUMAR M

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
26/06/26 8 Am	Rounds: D. Sukanth / D. Sreejay	
	Swelling ⊕ periorbital	
	No fresh concern	
	Accepting orally	Spot UPCR - (T)
		ASO Neg
	O/E vitals	C3 - 69 ↓
	TSP:- 123/84 mmHg	C4 - (N)
	HR: 86/min	
	RR:- 22/min	UO - 2ml/kg/hr
	SpO2 - 99% @ RA	
	pedal edema ⊕	
	S/E: PA: soft, Nontender	
		Adv
		✓ TSP. Monitoring
		✓ USG whole Abdomen
		✓ Strict Urine output, BP monitoring
		Sukanth
		N/B - Supriya 8:15 AM @ 26/6/26

Docu. No. : RCH /FRM / CLINICAL / 088

HNH-00016172 IP26-00006650
Master N HARSH SINGH
10-02-2015 11 Y 4 M 15 D (M)
Dr. VINAY KUMAR M

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
26/6/26 11 30 AM.	c/s/by. Dr. Aniketh	
	? Nephrotic Syndrome	
	Edema (+)	
	ASO Neg. Periorbital swelling (+)	
	UPCR (12).	
	O/o 2 ml/kg/h.	
	Bp ↑	→ Nephrology consultation
	AG - 64 cm.	strict - O/o, Bp Monitor.
		— T. AMLODIPINE 5mg stat
	BSA :- 1.19 m²	— PREDNISOLONE OD (morning) (60mg/m²/day)
	after Nephro Opinion. ↓	60mg po OD.
	— Albumin 20g transfusion. → K+ supplement.	— Stat Calcium.
	→ Mid Tx Lasix	— Daily wt check /
	→ Vinay sir consultation.	— T PANTOP 40mg OD
		→ Tm mng urine dipstick test
		— AG Daily Monitor. Dr. Aniketh

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

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Master N HARSH SINGH
10-02-2015 11 Y 4 M 15 D (M)
Dr. VINAY KUMAR M

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
26/6/26 12:45 pm	C/O/a - Dr. Shruthi (Nephrologist) Δ - New onset Nephrotic Syndrome.	
		Plan
	O/E B/L Grade-III pitting edema O/o - Good. BP - 130/90 mmHg (at 95+12 Centile)	1) To do 25-OH Vit D3 S. calcium in Same Sample. 2) Repeat CUE T/m 6AM 1st morning Sample 3) Do mantoux test 4) Daily weight charting. 5) strict IO charting. 6) low Salt diet 7) BP 8 3rd hrly charting. 8) add T. Shelcal 500 mg, 1 OD 9) Inj. 20% H. Albumin 100ml IV over 4hours C lasix 35 mg IV mid way & End way 10) T. OMNACORTIL 10 + 20 mg BD 11) Inj. Lasix 35mg IV 80 mg 12) AG monitoring Q8h
	I/E P/A - mild distention +	

Docu. No. : RCH /FRM / CLINICAL / 088

HNH-00016172 IP26-00006650
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	C/S/B- Dr. Prashanti / Dr. Naipunya / Dr. Archana	
26/6/26 3pm	A - New onset Nephrotic Syndrome	
	Urine -	
	Abdominal dist +	Plan
	Orally ✓	
	low Salt diet	- To do
		Sr. calcium
	O/E	25-OH Vit D3.
		- Repeat CUE T/m 6Am 1st morning sample
	BP-124/96 mmhg (>95th centile)	
		- Do mantoux
	S/E	- Daily weight charting
		- Strict I O sample charting.
	P/A - mild distention + BS+	- low Salt diet
		- BP charting Q 3h
	no shifting dullness.	- AG monitoring Q 8h.
		- T. Omnacortil 10mg + 20mg PO BD.
	CVS - S1 S2 +, NO murmur	- Inj. Lasix 35mg IV midway / end way
		-
26/6/26 4pm	Parents have been counselled about the risk of reactions & the need for monitoring. & are willing for the same	- Shift to ICU for Albumin infusion
	Attender sign:	

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	C/S/I/B Dr. Vinay	
26/6 5:00pm.	New onset Nephrotic Syndrome.	
	No fever, oral intake - fair.	Plan
	Vitals - stable.	- (T) Sr. Ca^{+2}, Vit D_3 levels
	Abdominal distension (+)	- Repeat CUE T/m 6am (1st mng sample)
	BP - 124/96 mmHg	- Strict I/O Charting.
	P/A - distension (+).	- Cont. 20% Albumin over 4hrs
	R/S - B/L NVBS.	- Cont T. omnocetil. 30mg.
		- Cont. Inj. lasix 35mg BD.
		- BP charting 03H.
		- low salt diet.
		- Cont T. Shelcal. 500mg OD
		- AG monitoring

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Master N HARSH SINGH
10-02-2015 11 Y 4 M 16 D (M)
Dr. VINAY KUMAR M

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
26/6/26 7:20pm	S/B Dr-Aniket	
	New onset Nephrotic syndrome	Adv.
	t.wt → 34.87 kgs	✓ SOS Amlodipine if BP is >95th %ile
	AG - 64 cms	✓ Monitor H/O
	Albumin infusion underway	✓ (S) CVE (clm) - first pass
	Urine output → 4.7 cc/kg/hr (8 hours)	✓ Ct omnacortil BD.
		✓ Ct furosemide BD.
	No fever spikes.	✓ Ct rest same.
	facial edema (+)	✓ (1) Sr. Ca^{12}
	O/E ANASARCA (+) ↓.	vit D_3 levels
	HR - 78 bpm	
	BP - 126/90 mm Hg (95th - 95+12 %ile)	NB Sunday @ 7.20 PM
	S/E P/A: Abdominal distension (+) Non tender.	
	Dr. Aniket Anil Parashar Consultant Pediatrician & Intensivist Reg. No: 8568	Dr. Aniket

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
27/6/26 8 AM	C/S/O Dr. Vinay Δ- Nephrotic syndrome (1st episode). - Afebrile since admission. - No c/o headache. - No c/o cough, cold. - Periorbital/pedal edema ↓. - NO ~~testicular~~ scrotal edema. S/E- HR - 80/min. RR - 20/min. SpO2 - 100% @ RA. BP - 100/56 mmHg. (51%-50%) → U/O - 1730ml (2ml/kg/hr) in last 24 hrs. S/E - P/A - Soft, NT, Mod. distension ↓. T.W = 33.58 (↓1.3 kgs). Ag = 62 cms (↓3 cms from admission).	Plan - Ct. Ommacortil BD. - Ct. 2CSix BD. - Monitor I/O, BP. - Trace UE. N/B - Supriya 8:03AM @ 27/6/26

1100/1730 (-630)

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	c/s/by Aniket	
27/6/26 9:45 pm	Nephrotic syndrome (1st Episode	
	Afebrile.	
	wt ↓	
	Bp - (N)	
	U/o = 2ml/kg/h	- D/s c Request after Vinay Sir's Opinion.
		- 60,000 IU Every 2 wk x 5 dos.
		- Calcium x 1 month
		- Prednisolone x 6 wk.
		- Nephrology Opinion — d/s & f/u.
		- Salt restriction
	(copy)	- BP - twice weekly c home.
		for Dr. Aniket P
		noted by Sr. Sandhya 27/6/26 9:0'c

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

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DRUG CHART

Date of Admission: 21/6/26 Drug Allergies: ..... ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

GENERAL - Ensure that all patient details are entered above. ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.

DOCTOR
- Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
- Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
- Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
- Discontinue a drug by drawing a line *I* through it and a similar line through subsequent recording panels.
- The date and time of stopping the drug along with the doctors name and sign must be mentioned.
- Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.

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

35.6 kg

SOS / PRN (As Required Medication)

DRUG : TAB. AMLODIPINE				Date / Time
Dose	Route	Frequency	Start Date	
5mg-1tab	PO	SOS	26/6	
Doctor's Signature		Valid Period	Pharm.	
Rmathi				
Additional Instructions: Only after Doctor's advice (if BP > 95th centile)				

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

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

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Adm wt 35.6kg.

REGULAR PRESCRIPTIONS

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

				Date / Time		
DRUG : T. PREDNISOLONE						
Dose	Route	Frequency	Start Date			
60mg	PO	OD (mng)	26/6			
Name & Signature of the Doctor Starting the Drugs: [signature]				Change		
Additional Instructions:						
Daily Doctor's Endorsement by a Sign						

				Date / Time	26/6	27/6
DRUG : T. OMNACORTIL						
Dose	Route	Frequency	Start Date			
30mg	PO	BD(1-0-1)	26/6	6AM		[signature]
Name & Signature of the Doctor Starting the Drugs: Rinki. Dr. Prashanti						
Additional Instructions: PREDNISOLONE				6pm	3PM [signature]	
Daily Doctor's Endorsement by a Sign						

				Date / Time	26/6	
DRUG : T. SHELCAL 500mg						
Dose	Route	Frequency	Start Date			
1tab	PO	OD	26/6			
Name & Signature of the Doctor Starting the Drugs: Rinki. Dr. Prashanti				8pm	[signature]	
Additional Instructions: CALCIUM						
Daily Doctor's Endorsement by a Sign						

				Date / Time	26/6	27/6
DRUG : Inj. FUROSEMIDE						
Dose	Route	Frequency	Start Date			
35mg	IV	BD	26/6 27/6	6AM		[signature]
Name & Signature of the Doctor Starting the Drugs: Rinki. Dr. Prashanti						
Additional Instructions:				6pm	[signature]	
Daily Doctor's Endorsement by a Sign						

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Sheet No: ....

REGULAR PRESCRIPTIONS

Weight .... Ward ....

DRUG : T. PANTOPRAZOLE

Dose	Route	Frequency	Start Dt.	Date ▸ Time ▾	26/6	27/6
40mg (Hab)	PO	OD	26/6		6AM	6AM

Name & Signature of the Doctor Starting the Drugs: Dr. Prashanti

Additional Instructions: PANTOP

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Dt.	Date ▸ Time ▾

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Dt.	Date ▸ Time ▾

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Dt.	Date ▸ Time ▾

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

VERIFIED BY : Name .... Signature ....

Patient Sticker

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Sheet No: ....

REGULAR PRESCRIPTIONS

Weight .... Ward ....

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date/Time

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date/Time

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date/Time

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date/Time

VERIFIED BY : Name .... Signature ....

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10-02-2015 11 Y 4 M 16 D (M)
Dr. VINAY KUMAR M

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

	Date ▸ / Time		Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.
DRUG :		Dose		Dose		Dose		Dose	
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Route / Start Date		Dose		Dose		Dose		Dose	
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Name & Signature of the Doctor		Dose		Dose		Dose		Dose	
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Additional Instructions:		Dose		Dose		Dose		Dose	
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	

VARIABLE DOSE	Date ▸ / Time		Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.
DRUG :		Dose		Dose		Dose		Dose	
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Route / Start Date		Dose		Dose		Dose		Dose	
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Name & Signature of the Doctor		Dose		Dose		Dose		Dose	
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Additional Instructions:		Dose		Dose		Dose		Dose	
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
25/06	11PM	TAB. AMLODIPINE	5mg	PO	[signature]	12:30AM [signature]
26/6	11:40AM	TAB AMLODIPINE	5mg	Po	Ruchi.	[signature]
26/6	~~1/3pm~~ 4pm	Inj. 20 %				[signature]
		HUMAN ALBUMIN		IV		Ramya
		100ml IV				
		over 4 hours				
26/6	3:30pm	Inj. LASIX (FUROSEMIDE)	35mg midway (Albumin)	IV.	Ruchi.	Ramya (6:3[illegible]
26/6	5:30pm	Inj. LASIX (FUROSEMIDE)	35mg. endway (Albumin)		Ruchi.	Ramya (8:30
26/6	3:15pm	TAB. AMLODIPINE	5mg	Po	Ruchi.	[signature]

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I.V. FLUIDS CHART

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

		Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign

VERIFIED BY Name .. .. Signature

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MEDICATION RECONCILIATION FORM

Drug Allergies: ..... ☐ Not known any Drug Allergies

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

Shifting From: ..... Shifted to: .....

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						☐ C ☐ DC
2						☐ C ☐ DC
3						☐ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Susant

Date & Time : 25/6/26 @ 11:30 pm

Nurse Name & Signature: Anupam

Date & Time : 25/6/26 @ 11:30 pm

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

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302

RESULT SHEET

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Date	25/6/26					
Time						
Hb	11.2					
PCV	32.7					
RBC	4.59					
WBC	7.96					
N/L	42.5/51.6					
Platelets	301					
CRP						
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg	8.					
Phosphate						
Urea	18					
Creatinine	0.5					
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin	1.7					
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol	313					
PT/INR						
APTT						
CSF Protein/Sugar						
Cells						
N/L						

P.T.O.

OPCK 12

Date	26/6/26	27/6/26				
Time						
CUE-Alb						
CUE-Sugar	Nil	Nil				
CUE - Ketones	Negative	Negative				
CUE-PUS Cells	4-6	6-8				
CUE - RBC Cells	Nil	Nil				
CUE Epithelial cells	1-2	1-2				
Stool Pus Cell						
OVA/Cyst						
Occult Blood						
Vit. D —	8.					
ASO Titers	Negative					

Culture and Sensitivities : .....

.....

.....

.....

Radiology: USG : .....

X-Ray:.....

ECHO: .....

CT: .....

MRI .....

Others (ECG, Contrast Studies etc.,) : .....

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M / CLINICAL / 126

SCHOOL AGE (5-12 years)
Children's Observation & Early Warning Scoring Chart

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 25/5/26 Time:	12:30	2	2:30	6:40
Doctor / Nurse / Family Concern?	AM	AM	AM	AM
Temperature (F)	98.6°F	98.4°F		97.9°F
Heart Rate (bpm) and Blood Pressure (mmHg) *	125/94	123/66	119/85	123/84
Heart Rate (Number)	76b/m	86b/m		86b/m
Resp. Rate (bpm) (Over 1 Minute) *				
Resp Rate (Number)	22b/m	22b/m		22b/m
Resp Distress: Mod/ Severe / None / Mild				
Receiving O_2 (l/min) O_2 Saturations (%)	99%	100%		99%
Conscious Level: Normal / Altered				
GCS *	15/15	15/15		15/15
TOTAL SCORE Number of shaded boxes	0	0		0
Pain Score	0	0		0
Observer's Initials				

Note: BP does not score in early warning scoring

ACTIONS

NB: Scores 3 should be ... 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.

* If Oxygen requirement is >3 Lit./min. , then irrespective of rest of the score, the Nurse MUST inform the PICU team.

26/6/26

Patient Sticker

Wt — 34.87 kg

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

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Patient ... ster N HARSH SINGH
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SCHOOL AGE (5-12 years)
Children's Observation & Early Warning Scoring Chart

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WARNING SCORE: CHILDREN'S UNIT

Date : 26/6/21

Time:	10AM	5AM	2pm	3pm	4pm	5pm	6pm	7pm	8pm	10PM	1AM	4AM
Doctor / Nurse / Family Concern?												
Temperature (F)	98.4									97.3	97.1°F	
Heart Rate (bpm) and Blood Pressure (mmHg) *	115/86	130/90		124/96	120/86	123/87	118/75	122/78	120/78	126/76 (91)	123/82 (96)	121/76 (86)
Heart Rate (Number)	88b/m			89b/m			75b/m			85b/m	87b/m	84b/m
Resp. Rate (bpm) (Over 1 Minute) *												
Resp Rate (Number)	23b/m			25b/m	20b/m	26b/m	25	20	25	22b/m	22b/m	
Resp Distress Mod/Severe / None/Mild												
Receiving O_2(l/min) / O_2 Saturations (%)	99%			99%	100%	100%	100%	100%	100%	100%	99%	99%
Conscious Level Normal / Altered												
GCS *					14/14	14/14	14/14	14/14	14/14	15/15	15/15	15/15
TOTAL SCORE Number of shaded boxes	0			0	0	0	0	0	0	0	0	0
Pain Score	0			0	0	0	0	0	0	0	0	0
Observer's Initials	[illegible]			[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

Note: BP does not score in early warning scoring

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.

Patient Sticker

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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- 6 clinical parameters are assessed and recorded as part of the child's routine clinical observation, providing a Early Warning Score between 0-6 (Higher Early Warning Score are seen in sicker children)
- Detailed actions are described according to increasing Early Warning Score.
- Some children with complex medical needs e.g. cyanotic heart disease may require modification to their trigger thresholds/ action plan- this should follow discussion with senior colleagues.
- Any Early Warning Score of 3 or above should be recorded below with details of any subsequent action initiated

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

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

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

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

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VINAY KUMAR M

Patient

CLINICAL / 126

SCHOOL AGE (5-12 years)
Children's Observation & Early Warning Scoring Chart

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 27/6/26 Time: 7

Doctor / Nurse / Family Concern? AM

Temperature (F)

104 103 102 101 100 99 98 97 96 95 94

97.4 F

Heart Rate (bpm) and Blood Pressure (mmHg) *

Note: BP does not score in early warning scoring

190 180 170 160 150 140 130 120 110 100 90 80 70 60 50

101/71

57

Heart Rate (Number) 79

Resp. Rate (bpm) (Over 1 Minute) *

70 60 50 40 30 2 1

Resp Rate (Number) 22/m

Resp Distress	Mod/ Severe / None / Mild
Receiving O_2 (l/min)	
O_2 Saturations (%)	99 %
Conscious Level	Normal / Altered
GCS *	15/15
TOTAL SCORE Number of shaded boxes	0
Pain Score	0
Observer's Initials	

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.

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

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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.

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						**Total Output :**						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						**Total Output :**						
25/6/26	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm					NA						
	12:00 am	.	H2O						120 AM →	30ml 120ml	0 0	SD
	01:00 am	.										
Total Intake :						**Total Output :** U- M						
26/6/26	02:00 am	1									0	
	03:00 am	0								200ml	0	
	04:00 am					NA					0	
	05:00 am									150ml	0	SD
	06:00 am	1				65cm				100ml	0	
	07:00 am										0	
Total Intake :						**Total Output :** U- M-						

Total 24 hrs. Intake		Total 24 hrs. Output	

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FLUID CHART

Sheet No. : .....

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

Date	Time	Intake: Nature of Fluid	Intake: Route – Mouth	Intake: Route – I.V	Intake: Route – NG	Output: NG	Output: Diarrhoea	Output: Vomit	Output: Drainage	Output: Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
26/6/26												
	08:00 am										0	
	09:00 am		Belly									
	10:00 am		H2O									
	11:00 am											
	12:00 pm											
	01:00 pm				NA			NA				
Total Intake :						**Total Output :**						
26/6/26	02:00 pm										0	
	03:00 pm		Rice								0	
	04:00 pm	0	+							80 ml	0	
	05:00 pm		Roti		NA			NA		150 ml	0	
	06:00 pm										0	
	07:00 pm									350 ml	0	
Total Intake :		Taken				**Total Output :**				U. 580 M-		
26/6/26	08:00 pm		Rice		64cm					250 ml	0	
	09:00 pm		Idly							✓	0	
	10:00 pm	0	+ H2O							✓	0	
	11:00 pm				NA					250 ml	0	
	12:00 am										0	
	01:00 am										0	
Total Intake :						**Total Output :**				U- 500 M-		
27/6/26	02:00 am										0	
	03:00 am		H2O							150 ml	0	
	04:00 am	0			NA						0	
	05:00 am									100 ml	0	
	06:00 am									100 ml	0	
	07:00 am		Milk							300 ml	0	
Total Intake :						**Total Output :**				U- 650 M-		

Total 24 hrs. Intake		Total 24 hrs. Output	U- 1730 ml

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NURSING CARE RECORD

Date: 25/6/26

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	12AM	→ To assess the pt. condition → To check the vitals & record	12AM	→ To assessed the pt. condition → To checked the vitals & record	→ Pt. is stable	→ Re-checked the vitals → I/O → AG, checking Morning & wt	Supriya
	10	→ T. Amlodipine Given. 12:30 AM	10	→ T. Amlodipine given	→ T/M USG Whole abdomen & nephrologist opinion		
	8AM	→ Strictly I/O → High protein diet	8AM	→ Strictly I/O → High protein diet			

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NURSING CARE RECORD

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Date: 26/6/26

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	- Assmen the pt Condition - Monitor vitals & I/o chart - dmg as per chart → proved Comfortable pos?/on.		- Assmed the pt Condition - Monitored vitals I/o chart - dmged as per chart → provided Comfortable pos?/on.	pt is stable	Rechecked vitals	
Afternoon	2pm – 8pm	- Assess the pt condition - monitored vitals - maintain I/O Chart - medicine given as per drug chart	2pm – 8pm	- Assessed the pt condition - monitored vitals - Maintained I/O chart - Medicine Given as per drug chart	pt is stables	Re-Assessment vitals	Manisha
Night	8pm to 8AM	→ To assess the pt. condition → To check the vitals & record → To administered the medication as per drug chart → I/O chart strictly monitor → IVF stop	8pm to 8AM	→ To assessed the pt. condition → To checked the vitals & recorded → To administer the medication as per drug chart → I/O chart strictly monitored → IVF stop	→ Patient is stable → Bp 3rd hourly monitoring → T/M CUE → Inj Albumin Given	→ Re-checked the Vitals I/O → AG 8th hourly → T/M morning weight check	Supriya

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CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1 25/6/26			DAY-2 26/6/26			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			NA	NA	NA	NA				
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2			NA	NA	NA	NA				
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3			NA	NA	NA	NA				
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4			NA	NA	NA	NA				
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5			NA	NA	NA	NA				
		Signature of the Nurse											

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

Signature of Shift In Charge :

Signature : ..... Name : .....

Signature of Ward In Charge :

Signature : ..... Name : .....

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BRADEN 'Q' SCALE

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					Date : 25/6	26/6	26/6	26/6
					Time : N1	M6	E2	N1
Mobility	**1. Completely immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	**3. Slightly limited:** Makes frequent through slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.	4	4	4	4
"Activity The degree of physical activity"	**1. Bedfast :** Confined to bed	**2. Chairfast :** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	**3. Walks occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. All patients too young to ambulate; OR walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	3	4	4
Sensory Perception	**1. Completely limited:** Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	**2. Very limited:** responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	**3. Slightly limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	**4. No impairment:** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	4
Moisture Degree to which skin is exposed to moisture	**1. Constantly moist:** Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	**2. Very moist:** Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	**3. Occasionally moist:** Skin is occasionally moist, requiring linen change every 12 hours.	**4. Rarely moist:** Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	4
FRICTION-SHEAR **Friction** Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another	**1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	**2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	**3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	**4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	3	4	4
Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4
				TOTAL SCORE	28	26	28	28
				Evaluator's Name				

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

Risk Score	Category	Action	Support Surfaces (**Please Note:** Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice
15-18	At Risk	• Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • Advance to a higher level of risk if other major risk factors are present	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	• Use the Same Protocol as for **"At Risk"** Patients • Position patient at 30 degree lateral incline using foam wedges	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	• Follow the same protocol as for **"Moderate Risk"** Patients • In addition to regular turning schedule • Make small shifts in their position frequently	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	• Use same protocol as for **"High Risk"** Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

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PAIN ASSESSMENT FORM

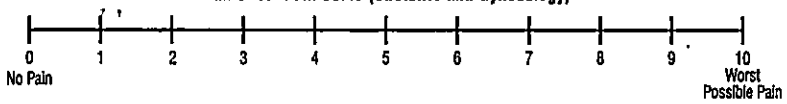
Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
26/6/26	12Am	0/10	NA	☐ Continuous ☑ Intermittent	☑ Acute ☐ Chronic	☐ Sharp ☑ Dull ☐ Aching ☐ Burning	☐ Increasing ☑ Decreasing	☑ Yes ☐ No	NA	[signature]
26/6/26	10AM	0/10	NA	☐ Continuous ☑ Intermittent	☑ Acute ☐ Chronic	☐ Sharp ☑ Dull ☐ Aching ☐ Burning	☐ Increasing ☑ Decreasing	☑ Yes ☐ No	NA	[signature]
26/6/26	2pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
26/6/26	8pm	0/10	NA	☐ Continuous ☑ Intermittent	☑ Acute ☐ Chronic	☑ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☑ Decreasing	☑ Yes ☐ No	NA	[signature]
26/6/26	10pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
27/6/26	6Am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

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

PAIN ASSESSMENT TOOLS

Numerical Pain Scale (Obstetric and Gynecology)



Wong - Baker (Pediatrics) Above 7 Years

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
	0	1	2
Face	No Particular expression or smile	Occasional Grimace or Frown, withdraw, Disoriented	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs drawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, right, 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

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_2	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

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...d SHIFT HAND OVER FORM - WARD

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

SITUATION

Diagnosis: Nephrotic Syndrome + Hypertension

Any Infection: ☐ Yes ☐ No ☐ Not Known
If Yes Specify: .....

BACKGROUND							
Area / Shift Time	25/6/26 N1	26/6/26 M	26/6/26 E	26/6/26 N1		
Medical Condition (Any special condition to be noted):	–	–	–	–		

ASSESSMENT							
Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
Vital Signs: Temp:	98.6°F	98.2°F	98.6°F	98.1°F			
Res:	22b/m	22b/m	22b/m	24b/m			
SpO_2:	99%	99%	99%	99%			
Pulse:	78b/m	76b/m	78b/m	79b/m			
BP:	125/91	120/90	–	120/69			
Fall Risk Score:	–	–	–	–			
Pain Score:	"0"	"0"	"0"	"0"			

Recommendations							
Safety Needs:	Yes	yes	Yes	Yes			
Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
Others Specify:	–	–	–	–			
Special Diet:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
Other Special Orders / Medications:	–	–	–	–			
Post Operative Procedure Special Orders:	USG Abdomen	–	–	CUE T/PC			
Handed Over By Name :	Supriya	Supriya	Sumandeep	Supriya			
Signature :							
Date:	26/6/26	26/6/26	26/6/26	27/6/26			
Time:	8AM	8pm	8pm	8AM			
Taken Over By Name :	Supriya	Sumandeep	Supriya				
Signature :							
Date:	26/6/26	26/6/26	26/6/26				
Time:	8AM	2pm	8pm				

Patient Sticker

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NURSING SHIFT HAND OVER FORM - WARD

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

SITUATION	Diagnosis:	Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
BACKGROUND	Area / Shift Time						
	Medical Condition (Any special condition to be noted):						
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:						
	Res:						
	SpO_2:						
	Pulse:						
	BP:						
	Fall Risk Score:						
	Pain Score:						
Recommendations	Safety Needs:						
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:						
	Special Diet:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:						
Post Operative Procedure Special Orders:							
Handed Over By Name :							
Signature :							
Date:							
Time:							
Taken Over By Name :							
Signature :							
Date:							
Time:							

HNH-00016172 IP26-00006650
Master N HARSH SINGH
10-02-2015 11 Y 4 M 15 D (M)
Dr. VINAY KUMAR M

wt 35.6 kg

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EMERGENCY ROOM TRIAGE FORM

Patient's Name : master Harsh Age : 11 years **Gender:** ☑ Male ☐ Female

Date : 25/6/26 Time of Arrival : 10:40 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: 98.2 PR: 77 BP: 127/91 (103) mmHg RR: 26 SpO_2: 100%

Chief Complaints: c/o .....

INITIAL PHYSIOLOGICAL CATEGORIZATION

Appearance
☑ Normal
☐ Sick Looking

Circulation / Colour
☐ Normal ☐ Abnormal ☐ Bleeding

Work of Breathing
☑ Normal ☐ Increased
☐ Decreased ☐ Gasping / Apnea

INITIAL PHYSIOLOGICAL STATUS
☑ Stable
☐ Unstable :
- ☐ Not – Life - Threatening
- ☐ Life – Threatening

Triage Classification	CTAS
☐ Level 1 : Resuscitation	☐ Immediate
☐ Level 2 : EMERGENT : Life or limb threatening	☐ < 15 min
☐ Level 3 : URGENT : Significant illness / injury with potential to become life or limb threatening	☐ 30 min
☐ Level 4 : LESS URGENT : Significant illness but not life threatening	☑ 60 min
☐ Level 5 : NON – URGENT : May receive care when convenient	☐ 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 : 10:45 pm

Communicable Disease Triage Screening

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

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

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

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

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

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

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

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

Name of Triage Nurse : Sujaya

Signature of Triage Nurse : .....

Date & Time : 25/6/26 @ 10:45 pm

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 25/6/26 Time of arrival : 10.40 PM

Chief Complaints: c/o RBS: .....

Height : 143 cm Weight : 35.6 kg 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 [signature] @ 10:50 PM

(P.T.O.)

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10-02-2015 11 Y 4 M 15 D (M)
Dr. VINAY KUMAR M

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

Time	Nursing Notes
10:30pm	⇒ Assessed the general Condition → Vitals checked and recorded

Samples collected by: Time:

Samples sent by : vinaya Time: 11:20 Pm

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: 72 BP: 127/91 CFT: -	Shift - out from ER to: 302
RR: 19 SPO_2 : 99	Time of Shift - out: 11:40 PM
GCS: - Temperature : 98.2	Handover given to: ..... (Nurse's Name)
Pain Score: 0	
Repeat RBS (if applicable):	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any): .....

.....

Name of the Nurse : Anupam Signature of the Nurse : AP

Date & Time : 28/6/22 @ 11:45 pm

PATIENT TRANSFER FORM

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HNH-00016172 IP26-00006650 Master N HARSH SINGH 10-02-2015 11 Y 4 M 15 D (M) Dr. VINAY KUMAR M	Date & Time of Admission 25/6/26	Date & Time of Transfer Order 26/06/26 @ 12AM
	Transfer Ordered by Dr. Susant	Reason for Transfer Admission
From Unit ER	To Unit 302	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File	Number of Imaging Films 1	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☐ 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 ☑ No ☐

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Anupam	Dr Susant.

Patient & Clinical Records Received by : Supriya

Date & Time of Patient Received : 12AM @ 26/6/26

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

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10-02-2015 11 Y 4 M 16 D (M)
Dr. VINAY KUMAR M

302

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NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 26/6/26 Time: 9:15am

Weight: 35.6kg Centile: <25th

Height: — Centile: —

Inference: Underweight child.

RDA: ..... Calories: 1700 KCal/day Protein: 30 gms/day

Diet Recommendations: Balanced diet with liquids

Re-Assesment: NO Junk, Oily, Spicy food

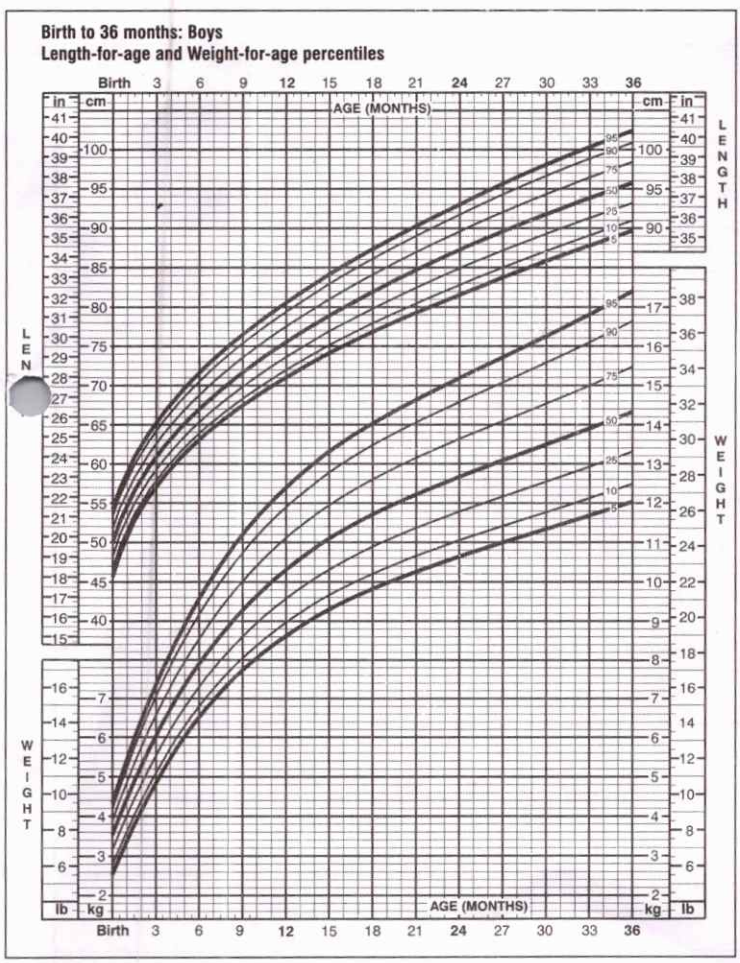
Food Allergies: NO Veg/Non-veg Veg

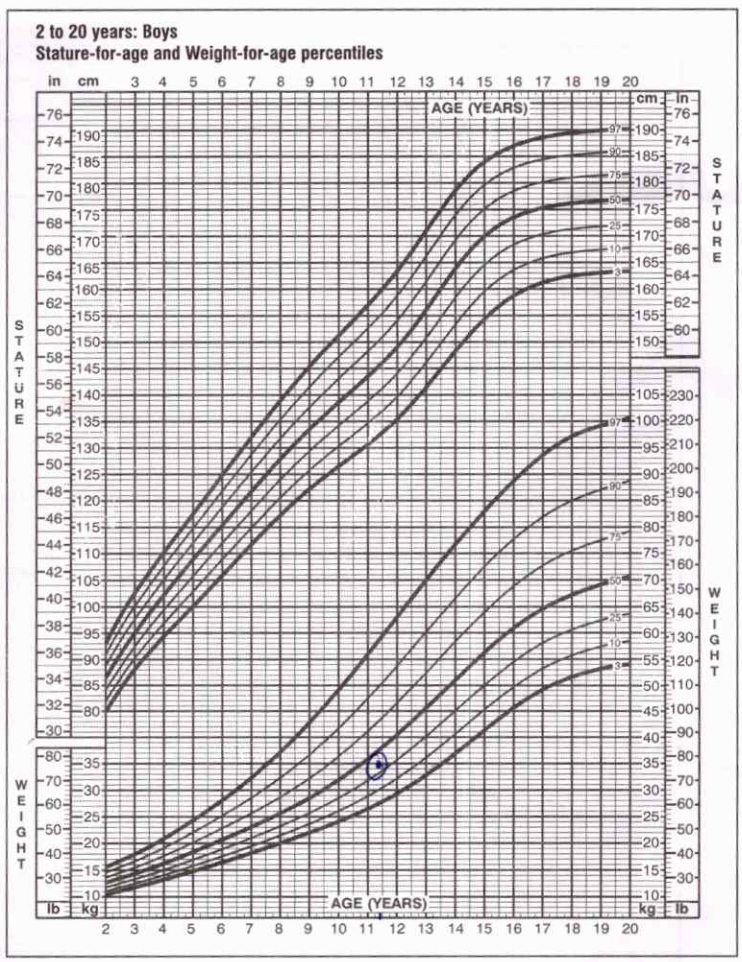
Diagnosis: ? Nephrotic Syndrome ē Hypertension

Nutritional Intervention - ☑ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: .....

GROWTH CHART (BOYS)





Dietician's Name Syeda Sobiya Zaheer Dietician's Signature Sobiya

Daily Notes: