

307

**DISCHARGE SUMMARY**

<b>Name</b>	Master SHAIK MOHAMMAD SAFWAN	<b>UHID</b>	VIH-00200533
<b>Father/Guardian</b>	Mr SHAIK RIYAZ BASHA	<b>Age/Gender</b>	1 Y 6 M 29 D/ Male
<b>Address</b>	HNO:7-35/5,PLOT NO:10,SRI SAI PARADISE APARTMENT,OLD BOWENPALLY,HYDERABAD,TELANGANA., Old Bowenpally, Hyderabad, Telangana, INDIA, 500011		
<b>IP No</b>	IP26-00006501	<b>Admission Date</b>	04-06-2026
<b>Ref Doctor</b>	DR. SHAILAJA		
<b>Discharge Date</b>	07.06.2026		

**Consultant:**

**Dr. SINDHURA MUNUKUNTLA**  
MBBS, DCH, DNB PEDIATRICS  
66970

<b>DIAGNOSIS</b>	<b>ICD CODE</b>
ACUTE FEBRILE ILLNESS WITH DEHYDRATION	
RIGHT FOOT CELLULITIS WITH ABSCESS (MRSA)	

**History:** Master SHAIK MOHAMMAD SAFWAN, 1 Y 6 M 29 D , old boy presented with history of fever, vomitings since 4 days and decreased activity and decreased acceptance of feeds prior to admission. For the above complaints he was admitted at Rainbow Children's Hospital - for further management.

**Examination:** He was febrile(100°F). His heart rate was 136/min, Blood

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pressure - 112/67 (70) mmHg and Respiratory Rate - 28 /min. Capillary Refill Time was <2 secs. Peripheries were warm & pulses well felt. On examination Signs of some dehydration and maculopapular erythematous rash 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, 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: 10.2 kilo grams.

**Investigations:** Enclosed reports.

GeneXpert FluA+FluB+RSV, SARS-CoV-2 were sent, which was negative.  
Adenovirus PCR was not detected.  
Myco plasma IgM was non reactive.

MEASLES - IGM ANTIBODIES - 0.49 Negative

Initial hemogram showed Hemoglobin of 10.5 gm%, White Blood Cell count of 17920 cells/cumm, platelet count of 2.40 lakhs/cumm and C-Reactive Protein of 141 mg/l. Blood culture and sensitivity shows no growth after 48 hours of incubation. Complete urine examination shows 8-10 pus cells, 3-4 epithelial cells. Serum Procalcitonin was 1.50 ng/ml. Liver function test showed total SBR of 0.3 mg/dl with indirect fraction of 0.2 mg/dl, SGOT - 24 U/L, SGPT - 17 U/L, ALP -243 U/L, protein -6.3 gm/dl, albumin - 3.6 gm/dl, globulin -2.7 gm/dl, A/G ratio of 1.3.

**Pus culture and sensitivity shows**

**Gross examination :** - Received two swabs with material.

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**Gram stained smear** - Shows moderately cellular background with degenerated polymorphs with gram positive cocci in clusters, no yeasts noted.

**Z.N stained smear** : Do not show any acid fast bacilli.

**Culture :- Methicillin resistant staphylococcus aureus (MRSA) isolate.**

**Susceptible to -**

Amikacin, Vancomycin, Teicoplanin and Linezolid.

**Resistant to -**

Ampicillin, Penicillin (2U), Amoxicillin-Clavulanic acid, Ampicillin-sulbactam, Cephalexin, Cefuroxime, Cefotaxime, Ceftriaxone, Ciprofloxacin, Gentamicin, Erythromycin, Clindamycin, Lincomycin, Methicillin, Oxacillin and Cloxacillin.

Dengue NS1 & IgM were negative.

Repeat hemogram Hemoglobin of 10.7 gm/dl, White Blood cell count of 15690 cell/cmm, platelet count of 2.60 lakh/cmm. C-Reactive Protein of 20.0 mg/l.

**Management:** He was admitted in the ward and was started on Intra Venous fluids and Intra Venous antibiotics. He was treated symptomatically with antacids and antipyretics.

In view of right foot cellulitis Dr. Swapna Palkurthy (Peadiatric surgeon) consultation was taken who advised incision and drainage and pus culture of the fluid.

Incision and drainage of the right foot swelling was done and pus sent for culture and sensitivity. Measles IGM was sent which was negative. Respiratory panel (five virus ) was sent which was negative. Mycoplasma IGM was sent which was negative. Xray of right foot AP and lateral was done which was

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normal.

He was regularly monitored for fever spikes, hemodynamic status, vital parameters, His fever spikes and other symptoms gradually settled. Pus culture and sensitivity showed Methicillin resistant staphylococcus aureus (MRSA) isolate which is sensitive to linezolid and hence antibiotic changed.

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

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

**Medication during hospital stay:**

Injection. Piptaz

Injection. Clindamycin

Syrup. Crocin Ds

Injection. Ondansetron

Syrup. Ibugesic

Cetaphil restodem

Syrup. Xyzal

Syrup. Atarax

**Advice:**

\* Diet as advised.

\* Alternate day antiseptic dressing at hospital.

Name	Master SHAIK MOHAMMAD SAFWAN	UHID	VIH-00200533
IP No	IP26-00006501	Admission Date	04-06-2026

S.No	MEDICATION	DOSE	TIMINGS	DURATION
1	Syp. Linezolid (5ml/100mg)	5 ml	Thrice daily (7am - 3pm-11pm)	To continue till follow up.
2	Syrup. Xyzal	2.5 ml	10pm (after food)	For 3 days.
3	Cetaphil Restoderm	for local application	twice daily	For 3 days
4	Syp. Ibugesic	3 ml	Thrice daily	For 3 days
5	Nasoclear nasal drops, 2 drops in each nostril <b>SOS</b> for nose block			

### Fever Management

- \* Syrup. Crocin DS (Paracetamol - 5ml/240mg) 3 ml after food as and whenever required, if temperature > 100 \*F (maximum 4 times a day at 6 hour intervals).
- \* Tepid sponging if fever > 101 \*F.

Review consultation with Dr. SINDHURA MUNUKUNTLA on (11.06.2026) Thursday at Himayatnagar in OPD with prior appointment (**Review consultation will be charged**).

Review consultation with Dr. Swapna Palakurthy on (11.06.2026) Thursday at Himayatnagar in OPD with prior appointment (**Review consultation will be charged**).

Name	Master SHAIK MOHAMMAD SAFWAN	UHID	VIH-00200533
IP No	IP26-00006501	Admission Date	04-06-2026

Regular followup with DR. SHAILAJA, Primary Pediatrician.

**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.
- \* Food can decrease the absorption of **antihistamines**. Antihistamines can be taken on an empty stomach /before food to increase their effectiveness.

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

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

Parent/ Attender

In case of emergency contact 9154865030 emergency pediatrician on duty.

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

You can also take appointments at any time by going **online** to our website **[www.rainbowhospitals.in](http://www.rainbowhospitals.in)**

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<b>IP No</b>	IP26-00006501	<b>Admission Date</b>	04-06-2026

*RL*

**Registrar/Resident/C.M.O**

**Dr. SINDHURA MUNUKUNTLA**  
MBBS, DCH, DNB PEDIATRICS  
66970

**ADMISSION SHEET**



**Registration Details :**

Admission No : IP26-00006501      Admit Date : 04-Jun-2026      Admit Time : 07:53 PM      UHID : VIH-00200533

**Patient Details :**

<b>Patient Name</b> :	Master SHAIK MOHAMMAD SAFWAN	<b>Age</b> :	1 Y 6 M 27 D
<b>Guardian</b> :	Mr SHAIK RIYAZ BASHA	<b>DOB</b> :	08-11-2024 11:25 PM
<b>Gender</b> :	Male	<b>Religion</b> :	
<b>Occupation</b> :		<b>Marital Status</b> :	
<b>Address</b> :	HNO:7-35/5,PLOT NO:10,SRI SAI PARADISE APARTMENT,OLD BOWENPALLY,HYDERABAD, TELANGANA. Old Bowenpally Hyderabad Telangana INDIA 500011	<b>Phone No</b> :	9701389262
		<b>E-mail</b> :	shaikriyazb@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 SHAIK RIYAZ BASHA      **Relationship** : Father  
**Contact Address** : HNO:7-35/5,PLOT NO:10,SRI SAI PARADISE APARTMENT,OLD BOWENPALLY,HYDERABAD,TELANGANA. Old Bowenpally Hyderabad Telangana INDIA 500011  
**Phone No** : 9701389262

*Signature*  
 Signature

**Doctor Details :**

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

**Payment Details :**

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

ACTIV

VIH-00200533 IP26-00006501  
Master SHAIK MOHAMMAD SAFWAN  
08-11-2024 1 Y 6 M 27 D (M)  
Dr. BINDHURA MUNUKUNTLA

IG

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

UHID No \_\_\_\_\_

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

Dept: \_\_\_\_\_

Date of Admission: 4/6/26

Time: \_\_\_\_\_

Date of Discharge: \_\_\_\_\_

Time: \_\_\_\_\_

Room / Bed No: \_\_\_\_\_

Ward: \_\_\_\_\_

Suggested Billable bed type: \_\_\_\_\_

**WARD TRANSFERS**

Date	Time	From	To	Signature of Nurse
4/6/26	9:30pm	ER	3rd Floor (310)	[Signature]

**Cross Consultation Visit**

	Doctors Name	Date	Order No.	Signature
1.	Dr. Swapna	4/6/26	11397	[Signature]
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				



**INVESTIGATIONS**

Date	Investigations	Order No.	Sign
4/6/26	<del>CBP, CRP</del> <del>blood culture and sensitivity</del> <del>Dengue NS1 + Dengue IgM</del> <del>PUS culture and sensitivity</del>	9333	Vijaya
	<del>LFTs</del> <del>Respiratory panel</del> <del>procalcitonin</del> <del>mycoplasma</del> <del>measles IgM antibodies</del>	9337	
<p><i>cross check done by Sr. Sandhya</i></p>			
5/6/26	CUE	9352	A
5/6/26	x-ray chest PA	6779	B
	x-ray RA foot	6780	B
7/6/26	CBP, CRP	9460	B
<p><i>copy over 7/6/26</i></p>			





Ref.No. F/IN/PR/10



**Rainbow<sup>®</sup>  
Children's  
Hospital**

**PEDIATRIC IN-PATIENT  
MEDICAL RECORD**

VIH-00200533      IP26-00006501  
Master SHAIK MOHAMMAD SAFWAN  
08-11-2024      1 Y 6 M 27 D      (M)  
Dr. SINDHURA MUNUKUNTLA



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

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

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

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

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

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

Informant \_\_\_\_\_

Reliability \_\_\_\_\_

Chief Presenting Complaints & Duration (Chronologically):

H/o trauma to Rt foot  
5 days back

c/o pain since 4 days

c/o vomiting since 4 day

c/o decreased activity & decreased

acceptance of feeds.

History of present illness :

Child apparently normal 5 days back presented with. H/o fall while playing & trauma to Rt foot (great toe) 5 days back. followed by swelling which is progressive in nature.

c/o pain since 4 days, high grade intermittent a/w rash not a/w rigour.  
a/w decreased activity.

c/o decreased acceptance of feeds.



Pediatric Multiorgan History & Physical Examination

VIH-00200533 IP26-00006501  
Master SHAIK MOHAMMAD SAFWAN  
08-11-2024 1 Y 6 M 27 D (M)  
Dr. SINDHURA MUNUKUNTLA



Anthropometry

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

Weight (kgs) 10.2 kg (Centile \_\_\_\_\_)

**On Examination :**

Temperature : 100 F Pulse Rate: 136/min Description \_\_\_\_\_

B.P. 112/67 (70) SPO2 98% at RA.

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

Rash Macropapular Erythematous rash.

Lymphadenopathy sluhy (+)

Oedema : signs of dehydration.

**Respiratory system :**

Inspection (any s/o distress) : \_\_\_\_\_

Air entry & breath sounds : B/L AE (+)

Any addes sounds : NI/BS (+)

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

**Cardiovasclular System :**

Inspection of procordium : \_\_\_\_\_

Heart Sounds : Scal (+)

Any murmur : No

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

**Per Abdomen :**

Inspection \_\_\_\_\_

Palpation : Soft Not disten

Ausculation : No tendan.

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

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

Pediatric Multiorgan History & Physical Examination

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08-11-2024 1 Y 6 M 27 D (M)  
Dr. SINDHURA MUNUKUNTLA

Central Nervous System :

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

Cranial Nerves : \_\_\_\_\_ 15/15

Motor System :

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

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

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

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

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

Reflexes :

DTR

Superficials :

Plantars \_\_\_\_\_

Sensory System :

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

Clinical Summary & Diagnostic :

fever + Rash + dehydrat  
Rt foot abscess.

**Pediatric Multiorgan History & Physical Examination**

VIH-00200533 IP26-00006501  
 Master SHAIK MOHAMMAD SAFWAN  
 08-11-2024 1 Y 6 M 27 D (M)  
 Dr. BINDHURA MUNUKUNTLA



Preventive aspects of the treatment :

*Prevent septic shock*

Desired goals of the treatment :

**Planned Labs :**

*CBP, CRP*  
*B/c/p - Mycoplasma IgM*  
*pus/c/p - Neader IgM*  
*CVE (C) - procalcitonin*  
 *dengue NS, IgM*  
*CFT*  
*Resp. panel, Extra plain samph*  
*(Rt) foot end elevation*

**Planned Management :**

*- IV fluids. DNP @*  
*- Ij PIPTAZ*  
*Ij CLINDAMYCIN*  
*- CROSIN DS syp QID*  
*- IBUGESIC syp (SOS)*  
*- Monitor vitals*  
*- Paed Surgs Opinion*

*Nick -> J/B wheel  
 dress  
 J/B leg elevation  
 Send pus/c/p*

**Please fill up the following details**

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

Doctor's Signature Name *M. Bindhura* Date \_\_\_\_\_ Time \_\_\_\_\_



## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/6/26 7:15 AM	S/B Dr. Sreehan Δ AKI = dehydration = cellularity of (R) Foot	Plg
		- CF PIPTAZ CLINDAMYCIN
	CNS - S <sub>11</sub> S <sub>12</sub> ⊕ R - DU - ACE ⊕	- ct IV fluids
	PIA Job Contion.	- ct CROCI (syn) 6hr - <del>Food: sugar - op</del> - X-ray (R) Foot AP & lateral TB - sup
		noted by Sr. Sandhya 5/6/26 7:15 AM

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/6/26	S/B Dr Sindhura	
9 AM	<p>ARI is dehydrated          cellulitis of (R) foot          cough (+)          facial flushing (+)</p>	fluparol (-)
	<p>O/E vital          stable</p>	<p>Adv          Trace adenovirus  <del>fluparol</del>          Measles IgM</p>
	<p>S/E CVS S, S, +          CBC WNC          R1 BAE + Conducty          PA Bgl</p>	<p>Blk - CT. piptaz          Clindamycin          Sonda</p>
		<p>- CX R, X Rafe (R)          foot Ar/Lot.</p>
		<p>- Vit A drops x 2 days</p>
		<p>- sup Ataxal 30</p>
		<p>- sup xyzal 1HS</p>
		<p>- Stop los Per</p>
		<p>- Ibulgeric 100mg</p>
		<p>- Ataphil Restodan          lotion LA BD</p>

~~Handwritten signature~~  
~~Sindhura~~





## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<p>08/10/26 6 PM</p>	<p>C/S/G. D. Sachin</p> <p>Q: AFE i dehydration i (Plt) Jst collection          Juv (P), Irritable          Cough (P)</p>	
	<p>Q/G ac fair          Hemodynamically stable          Hydration good</p>	
<p><del>adenovirus: neg</del>  <del>measles: neg</del>  <del>dengue: neg</del>  <del>mycoplasma: neg</del></p>		<p>Hdx</p> <p>Trace procalcitonin Blood U/s  <del>Trace Adenovirus PCR - neg</del></p> <p>Zij PENTAC, Clindamycin          Vit A clay  <del>Trace Hctus IgM</del>          U. Xyzal, Atarax.</p>
		<p><del>Muridin</del>  <del>Aspirin</del></p>

HNH-0000078 IP26-00006489  
 Master ARYANSH REDDY GUTTA  
 17-05-2022 4 Y 0 M 20 D (M)  
 Dr. SINDHURA MUNUKUNTLA



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
06/06/20	c/s/b. Dr. Kiran / Dr. Tharun	
7 AM	AS: AFI with dehydration with	(RT) food
	fever @ - up to 101 (last fever yesterday)	Cellulitis
	cough @	GPM
	O/tv ac-fair	
	vitals: Stable	
	Hydration - good	
		Acw
		- true pos culture / blood c/s
		- Tx: PEPTAZ / Clindamycin
		- Supportive care
		Sindhura



## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/6/26	18/B - D. Prashant.	
	1 - Fever & Rash 2 - foot cellulitis	
	- No fever.	
	- parviti	
	vitals stable	Plans Next prick CRP CBP
	Dressing + Rash like	cl Fipfaz clndamycin
	go w/w	Paed surgeon RTW today
		noted by Divya @ 8PM Prashant

VIH-00200533 IP26-00006501  
 Master SHAIK MOHAMMAD SAFWAN  
 08-11-2024 1 Y 6 M 29 D (M)  
 Dr. SINDHURA MUNUKUNTLA



## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/6/26 10 pm	<u>S/S. Per Sundlines</u>	
	- Δ Fever & Rash <u>R/foot cellulitis</u>	
	- No fever.	
	- pain ⊕	
	PE - vitals stable.	<u>Plan</u>
	PE - WNL.	- Stop Clindamycin - Ac-A Linzolid
	Pus culture <u>- MRSA</u>	- ct. pivaz. <span style="float: right;">T/m 6 am ↑</span>
		- <del>Next</del> <u>USP, CRP.</u>
		- wound dressing to be done.
		<del>Wound dressing</del>
		<del>DR. SINDHURA</del>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
7/6/26	S/B Dr Prabhat / Dr Varun	
8 AM	<p>△ Fever + Rash (R) foot cellulitis.</p> <p>Fever spikes - None.</p> <p>pain - ↓↓</p> <p>fresh c/o - None.</p> <p>of GC - fair</p> <p>Vitals stable.</p> <p>Pus culture <u>MRSA</u>.</p> <p>S/E WNL.</p>	<p>Adv</p> <p>CT linezolid</p> <p>Trace</p> <p>CBP, CRP</p> <p>CT - Piptar</p> <p>Wound dressing to be done.</p>
7/6/26	S/B Dr Sindhu	
10 AM	<p>△ Fever + Rash (R) foot cellulitis</p> <p>fever - None</p> <p>pain ↓</p> <p>No fresh c/o</p> <p>of GC fair, Vitals.</p> <p>S/E WNL.</p> <p>Pw culture - MRSA.</p> <p>Blood ds U&amp;H - neg</p>	<p>Adv</p> <p>CT. linezolid</p> <p>Trace, CBP, CRP</p> <p>CT - Piptar</p> <p>Wound dress.</p>
	<p>discharge after LPP report</p> <p>take surgeons opinion</p>	<p><del>H. Sindhu</del></p> <p><del>Dr. Sindhu</del></p>













# ATION FORM

Doctor Name: Dr. Swapn (paed surger) Date: 4/6/26 Time: .....

Diagnosis: .....

Hospital: RCH HMNR

**Type of Referral :**

- Emergency
- Urgent
- Non Urgent

Referred for:  Opinion  Co-Management  Transfer of care

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

Rt foot abscess.

AL  
Signature:

**Findings and Recommendations :**

Care discussed to Dr. Swapn

Paed Surge.  
H/o trauma/fall 5 days back.

Rt foot - abscess (thumb) ↓

clo fur since 4 days.  
also Rash

Plan

Plan to drain pus/fluid  
by giving nick

↓  
slth (white dressing)

send pus/c/s

leg elevation.

**Consultant :**

Name : ..... Signature : ..... Date & Time : .....

S/C  
19:00pm

CLS 113 Dr. swafana

Rt foot cellulitis abscess

Pus (+)

Incision & drainage of pus  
done. Sent for pus c/s.

Debridement done. (+)

Dressing every day.

Plan

- Debridement  
done

- Cuticle dressing  
done

- Trace Pus c/s

- Dressing every 24 hours  
- Foot and elevation

*Dr. Swafana*



## DRUG CHART

Date of Admission: 4/6/26 Drug Allergies: Jill  Not known any Drug Allergies

### FOR THE SAFETY OF THE PATIENT

- GENERAL DOCTOR**
- Ensure that all patient details are entered above. ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.
  - 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.
- SES**
- Nurses must follow strictly the FIVE RIGHTS before administration of medication.  
 1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time
  - AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

### SOS / PRN (As Required Medication)

<b>DRUG :</b> <u>IBUGESIC syp</u>				Date Time															
Dose	Route	Frequency	Start Date																
<u>3ml</u>	<u>po</u>	<u>sos.</u>	<u>4/6</u>																
Doctor's Signature		Valid Period	Pharm.																
<u>[Signature]</u>																			
Additional Instructions:																			
<u>(room/sym)</u>																			
<b>DRUG :</b>				Date Time															
Dose	Route	Frequency	Start Date																
Doctor's Signature		Valid Period	Pharm.																
Additional Instructions:																			
<b>DRUG :</b>				Date Time															
Dose	Route	Frequency	Start Date																
Doctor's Signature		Valid Period	Pharm.																
Additional Instructions:																			

VERIFIED BY : Name

REGULAR PRESCRIPTIONS

Weight. 10.2 kg Ward. ....

Verified by  
 Dr. Dhakshayani

DRUG : <u>17 PIPITAB</u>				Date Time	<u>u/6</u>	<u>s/6</u>	<u>6/6</u>	<u>7/6</u>
Dose	Route	Frequency	Start Date					
<u>1gm</u>	<u>iv</u>	<u>TID</u>	<u>u/6</u>	<u>6am</u>	<u>x</u>	<u>10am</u>	<u>2pm</u>	<u>6pm</u>
Name & Signature of the Doctor Starting the Drugs:				<u>AP</u>				
Additional Instructions:				<u>Mix. [in some NS]</u> <u>90mg/kg/dose 6-8 hourly</u> - Give over <u>60min</u> <u>2 hours</u>				
Daily Doctor's Endorsement by a Sign								

Verified by  
 Dr. Dhakshayani

DRUG : <u>17 CLINDAMYCIN</u>				Date Time	<u>u/6</u>	<u>6/6</u>	<u>6/6</u>
Dose	Route	Frequency	Start Date				
<u>60mg</u>	<u>iv</u>	<u>QID</u>	<u>u/6</u>	<u>12am</u>	<u>x</u>	<u>6am</u>	<u>12pm</u>
Name & Signature of the Doctor Starting the Drugs:				<u>AP</u>			
Additional Instructions:				<u>(3-6 mg/kg - QID)</u> - <u>in 20m NS</u> <u>Give over 60min</u>			
Daily Doctor's Endorsement by a Sign							

Verified by  
 Dr. Dhakshayani

DRUG : <u>CROSI Ds SYP</u>				Date Time	<u>u/6</u>
Dose	Route	Frequency	Start Date		
<u>3ml</u>	<u>po</u>	<u>QID</u>	<u>u/6</u>	<u>12am</u>	<u>x</u>
Name & Signature of the Doctor Starting the Drugs:				<u>AP</u>	
Additional Instructions:				<u>(20mg/5ml)</u>	
Daily Doctor's Endorsement by a Sign					

DRUG : <u>17 OLANSETRON</u>				Date Time	<u>u/6</u>	<u>s/6</u>	<u>6/6</u>	<u>7/6</u>
Dose	Route	Frequency	Start Date					
<u>2mg</u>	<u>iv</u>	<u>TID</u>	<u>u/6</u>	<u>6am</u>	<u>x</u>	<u>10am</u>	<u>2pm</u>	
Name & Signature of the Doctor Starting the Drugs:				<u>AP</u>				
Additional Instructions:				<u>(0.2mg/kg/dose)</u>				
Daily Doctor's Endorsement by a Sign								

VIM-00200533 IP26-00006501  
 Master SHAJK MOHAMMAD SAFWAN  
 08-11-2024 1 Y 6 M 28 D (M)  
 Dr. SINDHURA MUNUKUNTLA



**REGULAR PRESCRIPTIONS**

Weight 10.2 kg Ward .....

Sheet No: .....

<b>DRUG :</b> <u>SYP IBULGESIC</u>				Date/Time	<u>5/6/26 7/6</u>																		
Dose	Route	Frequency	Start Dt.																				
<u>3ml</u>	<u>PO</u>	<u>Q8H</u>	<u>5/6/26</u>	<u>6AM</u>																			
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Prabhakar</u>																							
Additional Instructions:																							
Daily Doctor's Endorsement by a Sign																							
<b>DRUG :</b> <u>CETAPHIL PEGIDERM</u>				Date/Time	<u>5/6/26 7/6</u>																		
Dose	Route	Frequency	Start Dt.																				
	<u>LA</u>	<u>BD</u>	<u>5/6/26</u>																				
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Prabhakar</u>																							
Additional Instructions:																							
Daily Doctor's Endorsement by a Sign																							
<b>DRUG :</b> <u>SYP XYZAL</u>				Date/Time	<u>5/6/26</u>																		
Dose	Route	Frequency	Start Dt.																				
<u>2.5ml</u>	<u>PO</u>	<u>HS</u>	<u>5/6/26</u>																				
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Prabhakar</u>																							
Additional Instructions:																							
(2.5mg / 5ml) Levocet																							
Daily Doctor's Endorsement by a Sign																							
<b>DRUG :</b> <u>SYP ATARAX</u>				Date/Time	<u>5/6/26 7/6</u>																		
Dose	Route	Frequency	Start Dt.																				
<u>2.5ml</u>	<u>PO</u>	<u>BD</u>	<u>5/6/26</u>	<u>6AM</u>																			
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Prabhakar</u>																							
Additional Instructions:																							
(2mg/ml) 0.5mg/kg 6pm																							
Daily Doctor's Endorsement by a Sign																							

Verified by Dr. Dhakshayani  
 Verified by Dr. Dhakshayani  
 Verified by Dr. Dhakshayani  
 Verified by Dr. Dhakshayani





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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
5/6/26	10am	CAROT A DROPS (2 Lab I/O / 2mL)	2mL	PO (DI/2)	MA	MA, [Signature]

VERIFIED BY: MA Signature





307

# RESULT SHEET

Date	21/6/26	7/6			
Time					
Hb	10.5	10.7			
PCV	29.3	29.5			
RBC	4.07	4.11			
WBC	17.92	15.69			
N/L	53/32	19/64			
Platelets	240	260			
CRP	141	25			
ESR					
PCT					
RBS					
Na					
K					
Cl					
Ca/Mg					
Phosphate					
Urea					
Creatinine					
ALP	243				
SGPT	17				
SGOT	24				
T.Bill/Conj	0.3/0.1				
T.Protein	6.3				
S.Albumin	3.6				
S.Globulin	2.7				
A/G Ratio	1.3				
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein/Sugar					
Cells					
N/L					

PCT → 1.50

Date	5/6/28					
Time						
CUE-Alb						
CUE-Sugar						
CUE - Ketones	Trace					
CUE-PUS Cells	8-10					
CUE - RBC Cells	Nil					
CUE						
Leucocyte →	present					
Stool Pus Cell						
OVA/Cyst						
Occult Blood						
Unconjugated Bilirubin	0-2					
bio:						
Ronchi - Tgm + NSI →	Negative					
Mycoplasma - Tgm -	Negative					

Culture and Sensitivities : ..... us hwt blood cls no growth  
 .....  
 .....

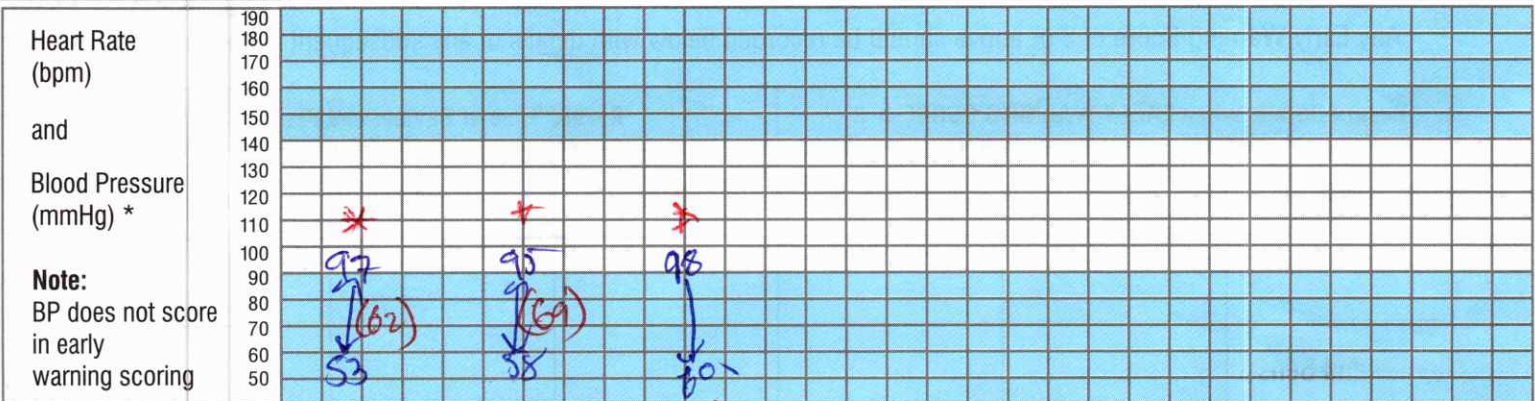
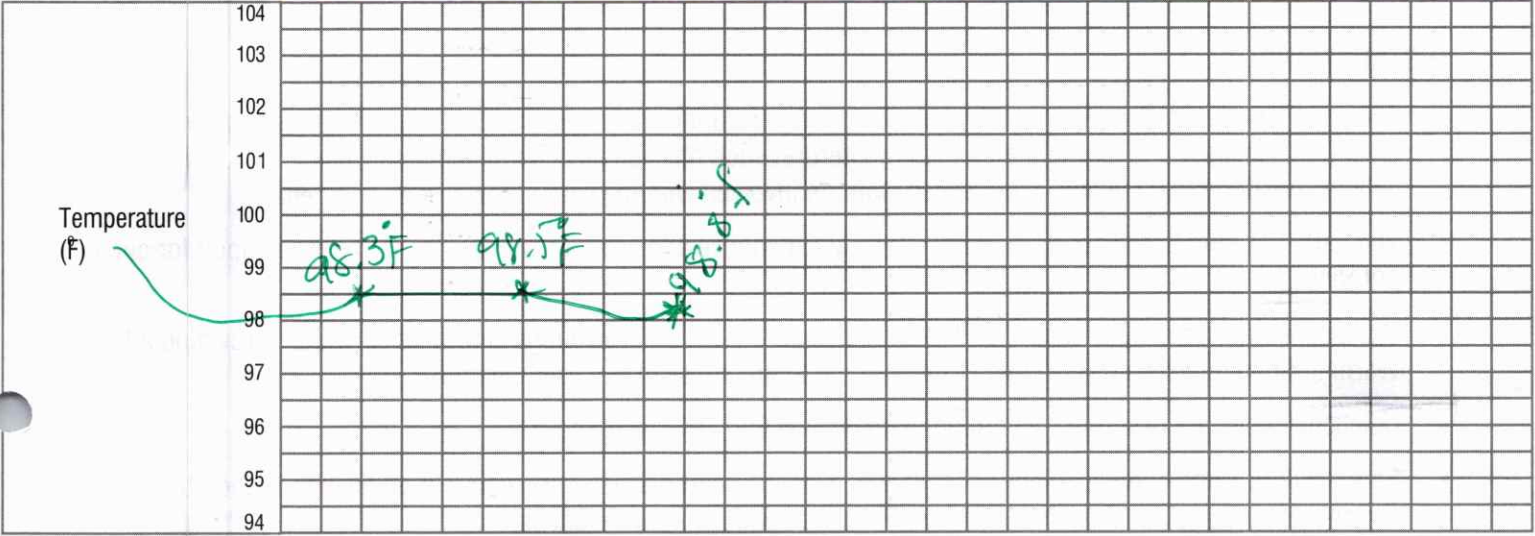
Radiology:    USG : .....  
                   X-Ray: .....  
                   ECHO: .....  
                   CT: .....  
                   MRI .....  
                   Others (ECG, Contrast Studies etc.): .....



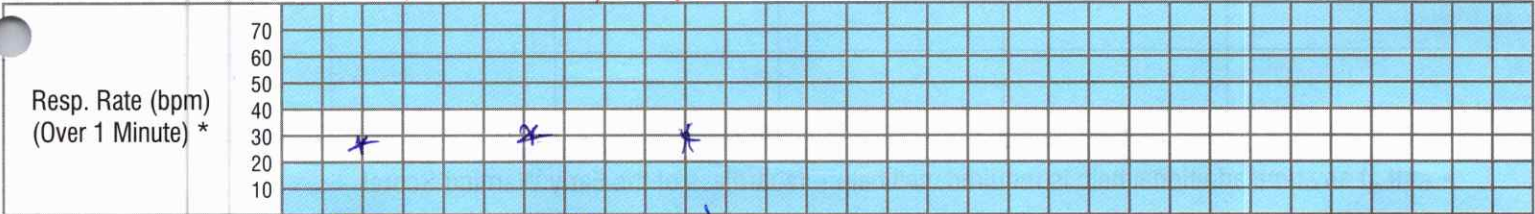
**EARLY WARNING SCORE: CHILDREN'S UNIT**

Date : 4/5/26 Time: 10pm 2am 6am

Doctor / Nurse / Family Concern?



Heart Rate (Number)



Resp Rate (Number)

Resp Mod/ Severe Distress None / Mild

Receiving O<sub>2</sub>(l/min) O<sub>2</sub>Saturations (%)

Conscious Level Normal / Altered

GCS \*

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

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

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

## CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

### INSTRUCTIONS:

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

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

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

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

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

VIH-00200533  
 Master SHAIK MOHAMMAD SAFWAN  
 08-11-2024 1 Y 6 M 27 D  
 Dr. SINDHURA MUNUKUNTLA (M)

RCH/ FRM / CLINICAL / 125

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

Pratiksha  
**Rainbow Children's Hospital**  
 It takes a lot to treat the little.

**BirthRight**  
 BY RAINBOW HOSPITALS  
 Your Right to a Safe Delivery

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

Date: 5.11.24 Time: 10am 2 4 6 8:30 10pm 200 600  
 Doctor / Nurse / Family Concern?



Heart Rate (bpm)	
and	
Blood Pressure (mmHg) *	
<b>Note:</b> BP does not score in early warning scoring	

Heart Rate (Number) 136b/m 130b/m 128b/m 130b/m 123b/m 110b/m

Resp. Rate (bpm) (Over 1 Minute) *	
Resp Rate (Number)	32b/m 30b/m 31b/m 30b/m 28b/m 26b/m

Resp Mod/ Severe Distress None / Mild

Receiving O<sub>2</sub>(l/min) O<sub>2</sub>Saturations (%) 99% 99% 99% 99% 99% 100%

Conscious Level Normal / Altered

GCS \*

<b>TOTAL SCORE</b>	
Number of shaded boxes	0 0 0 0 0 0
Pain Score	0 0 0 0 0 0
Observer's Initials	[Signatures]

- ACTIONS**
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  - Score 5 & 6 : Shift in charge AND PICU fellow or PICU consultant to be informed.
- NB: Scores 3 should be recorded overleaf

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

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VIH-00200533  
 Master SHAIK MOHAMMAD SAFWAN  
 08-11-2024 1 Y 6 M 28 D (M)  
 Dr. SINDHURA MUNUKUNTLA

IP26-00006501

Doc. No. : RCH/ FRM / CLINICAL / 125

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

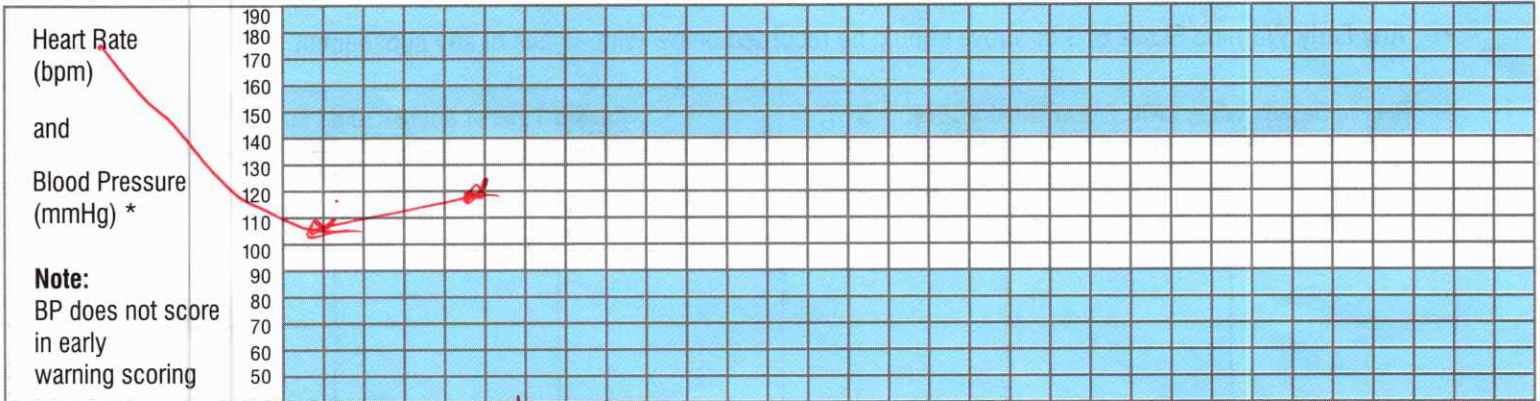
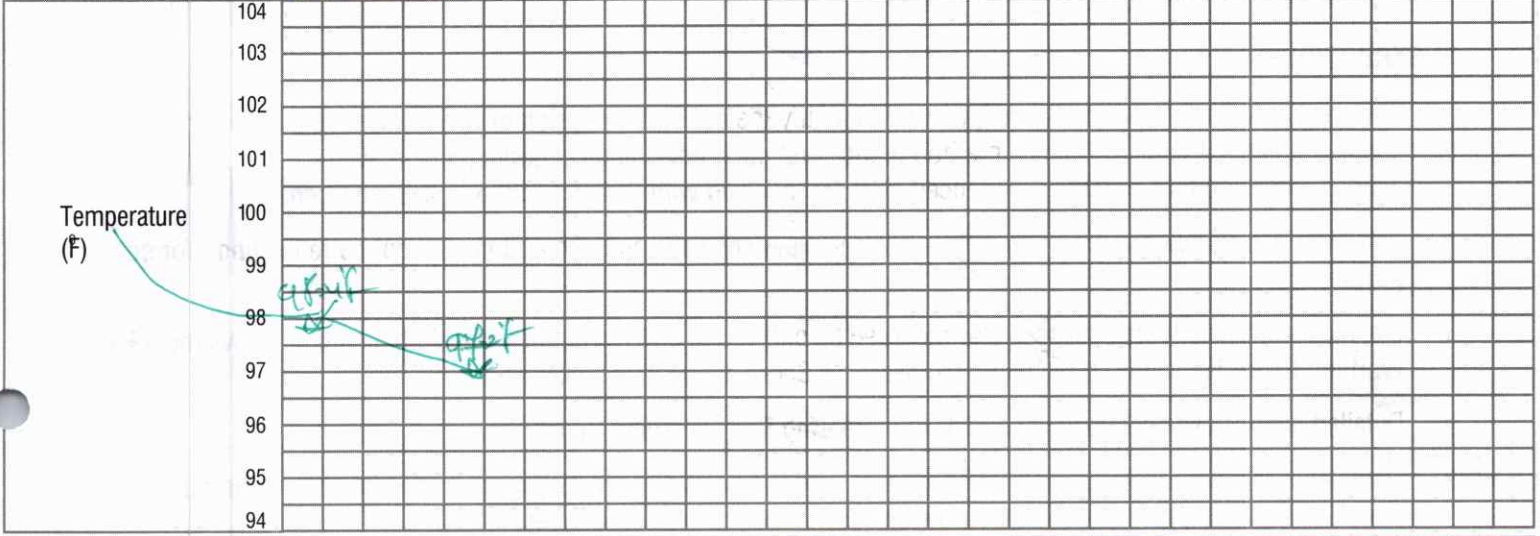
Pratiksha  
**Rainbow Children's Hospital**  
 It takes a lot to treat the little.

**BirthRight™**  
 BY RAINBOW HOSPITALS  
 Your Right to a Safe Delivery

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

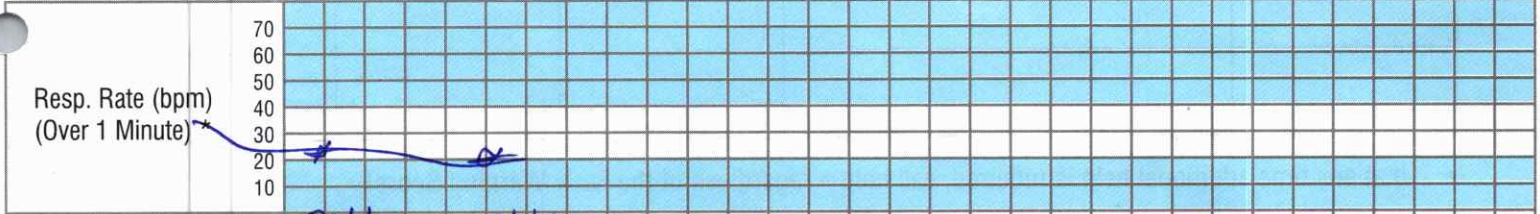
Date : 08/11/2024 Time: 10:20 AM

Doctor / Nurse / Family Concern? AM PM



**Note:**  
 BP does not score in early warning scoring

Heart Rate (Number) 180b/m 110b/m



Resp Rate (Number) 40b/m 20b/m

Resp Distress Mod/ Severe None / Mild

Receiving O<sub>2</sub> (l/min) O<sub>2</sub> Saturations (%) 99% 100%

Conscious Level Normal Altered

GCS \*

**TOTAL SCORE**  
 Number of shaded boxes 0 0  
 Pain Score 0 0  
 Observer's Initials [Signature] [Signature]

**ACTIONS**  
 NB: Scores 3 should be recorded overleaf

- Score 1 : Continue normal observation by staff nurse
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VIH-00200533 IP26-00006501  
 Master SHAIK MOHAMMAD SAFWAN  
 08-11-2024 1 Y 6 M 27 D (M)  
 Dr. SINDHURA MUNUKUNTLA



# FLUID CHART

Sheet No. :     

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
<b>Total Intake :</b>						<b>Total Output :</b>							
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
<b>Total Intake :</b>						<b>Total Output :</b>							
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm	DNS		30ml									
	12:00 am	DNS	milk	30ml									
	01:00 am	DNS		30ml									
<b>Total Intake :</b>						<b>Total Output :</b>							
	02:00 am	DNS		30ml									
	03:00 am	DNS	milk	30ml									
	04:00 am	DNS	#20	30ml									
	05:00 am	DNS		30ml									
	06:00 am	DNS		30ml									
	07:00 am	DNS		30ml									
<b>Total Intake :</b>						<b>Total Output :</b>							
<b>Total 24 hrs. Intake</b>												<b>Total 24 hrs. Output</b>	

# 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			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
5/6/26	08:00 am		30ml									
	09:00 am		30ml									
	10:00 am	DNS	30ml									
	11:00 am		30ml									
	12:00 pm		30ml									
	01:00 pm		30ml									
<b>Total Intake :</b>			Tablets			<b>Total Output :</b>					V-2	M-1
5/6/26	02:00 pm		30ml									
	03:00 pm		30ml									
	04:00 pm	DNS	30ml									
	05:00 pm	Actidi	30ml									
	06:00 pm	Ho	30ml									
	07:00 pm		30ml									
<b>Total Intake :</b>						<b>Total Output :</b>						
	08:00 pm		30ml									
	09:00 pm		30ml									
	10:00 pm	DNS	30ml									
	11:00 pm	Lev	30ml									
	12:00 am		30ml									
	01:00 am		30ml									
<b>Total Intake :</b>						<b>Total Output :</b>						
	02:00 am		30ml									
	03:00 am		30ml									
	04:00 am	DNS	30ml									
	05:00 am		30ml									
	06:00 am		30ml									
	07:00 am		30ml									
<b>Total Intake :</b>						<b>Total Output :</b>					M-5	O-4

**Total 24 hrs. Intake**

**Total 24 hrs. Output**



Patient Sticker

# 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					IV Site Thrombophlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine				
			Mouth	I.V	N.G								
	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
<b>Total Intake :</b>						<b>Total Output :</b>							
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
<b>Total Intake :</b>						<b>Total Output :</b>							
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
<b>Total Intake :</b>						<b>Total Output :</b>							
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
<b>Total Intake :</b>						<b>Total Output :</b>							

**Total 24 hrs. Intake**

**Total 24 hrs. Output**



# NURSING CARE RECORD

Date: 4/6/26

**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	11PM	<ul style="list-style-type: none"> <li>→ Assess the patient general condition</li> <li>→ monitor vitals</li> <li>→ maintain BLo</li> <li>→ Ev fluids DNS @ 30 mL/h to Cont</li> </ul>	11PM	<ul style="list-style-type: none"> <li>→ Assessed the patient general condition</li> <li>→ monitored vitals</li> <li>→ Administer medication as per doctor's orders</li> </ul>	Patient is stable	Rechecked vitals	<i>[Signature]</i>
	8am		8am				



# NURSING CARE RECORD

Date: 5/6/26

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	8am	Assess the pt condition - Monitor vitals - maintain I/O chart - Medication Giving as per drug chart	8am	Assessed the pt condition - Monitor vitals - maintain I/O chart - Medication Given as per drug chart	pt is stable	Re checked vitals	Sainth
Afternoon	2pm	Assess the pt condition → monitor vitals of the pt → maintain I/O chart. → drugs give as per drug chart.	2pm	Assessed the pt condition. → monitored the vitals. → maintained I/O chart. → drugs given as per drug chart.	→ pt is stable now	→ Re assessed the vitals	DS
Night	8pm	Assess the pt condition → maintain I/O chart → Administer medication as per drug chart	8pm	Assessed the pt condition → monitored vitals → maintain I/O chart → Administered medication as per drug chart	Patient is stable	Rechecked vitals	AS

Master SHAIK MOHAMMAD SAFWAN  
 08-11-2024 1 Y 6 M 27 D (M)  
 Dr. SINDHURA MUNUKUNTLA



# NURSING CARE RECORD



Date: 6/8/26

**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	<ul style="list-style-type: none"> <li>- assessed the pt condition</li> <li>- monitor vitals</li> <li>- maintain I/O chart</li> <li>- IV cannula present</li> <li>- pt on soft diet</li> </ul>	8am 2pm	<ul style="list-style-type: none"> <li>- assessed the pt condition</li> <li>- monitored vitals &amp; I/O</li> <li>- maintained I/O chart</li> <li>- IV cannula presented</li> <li>- next stick CBP, CRP</li> <li>- ET antibiotics</li> </ul>	→ pt is stable	→ rechecked vitals	JR
Afternoon	DAY						
Night	8pm 8am	<ul style="list-style-type: none"> <li>- Assesed the pt. condition</li> <li>- monitor vitals &amp; records</li> <li>- maintain I/O chart</li> <li>- Give medication as prescribed by doctor</li> </ul>	8pm 8am	<ul style="list-style-type: none"> <li>- Assesed the pt. condition</li> <li>- monitored vitals &amp; records</li> <li>- Maintained I/O chart</li> <li>- Given medication as prescribed by doctor</li> </ul>	patient is stable now	Re-checked vitals	JR

Patient Sticker

# NURSING CARE RECORD

Date: .....

**Goals**

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

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



### NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:		Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known					
	Surgery / Procedure:		If Yes Specify: .....					
BACKGROUND	Date	Shift	4/6/26 NS	5/6/26 M	5/6/26 E	6/6/26 S	6/6/26 NS	6/6/26 NI
	Medical Condition (Any special condition to be noted):		-	-	-	-	-	-
	Diet:		soft	Soft	soft	-	-	-
ASSESSMENT	Allergy:		<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" 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: 98.3F	98.6F	98.1F	98.3F	98.4F	97.8F
	Res:		20b/m	20b/m	20b/m	20	20b/m	20b/m
	SpO <sub>2</sub> :		99%	99%	99%	100%	99%	100%
	Pulse:		136b/m	136b/m	120b/m	120	120b/m	120b/m
	BP:		99/70	99/92	99/75	100/60	100/60	112/74
	LOC:		-	-	-	-	-	-
	Fall Risk Score:		-	-	-	-	-	-
Pain Score:		-	0	10	-	-	-	
Skin Integrity		-	Good	Good	-	-	-	
Recommendations	Safety Needs:		<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input checked="" 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):		-	-	-	-	-	-	
Post Operative Procedure Special Orders:		NA	NA	NA	-	-	-	
Handed Over By Name :		Sandhya	Supriya mahi	Supriya mahi	Divyanshu	Divyanshu	Priyanka	
Signature / ID :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	
Date:		5/6/26	5/6/26	5/6/26	6/6/26	6/6/26	7/6/26	
Time:		8am	2pm	8pm	8am	8pm	8am	
Taken Over By Name :		Supriya mahi	Supriya mahi	Supriya mahi	Divyanshu	Priyanka	Priyanka	
Signature / ID :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	
Date:		5/6/26	5/6/26	5/6/26	6/6/26	6/6/26	6/6/26	
Time:		8am	8pm	8am	8pm	8am	8pm	

Patient Sticker



## NURSING SHIFT HAND OVER FORM

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



# BRADEN 'Q' SCALE



Date: 4/6/26 5/6/24 5/6/24 5/6/24  
 Time: 12PM 12PM 12PM 6

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

<b>TOTAL SCORE</b>	28	21	28	22
<b>Evaluator's Name</b>	S	C	D	A

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

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

VIM-00200533 IP26-00006501  
 Master SHAIK MOHAMMAD SAFWAN  
 08-11-2024 1 Y 6 M 27 D (M)  
 Dr. SINDHURA MUNUKUNTLA



# BRADEN 'Q' SCALE



					Date :	5/6/26	6/6/26	5/6/26	
					Time :	M	AM	MS	NI
Mobility	Does not make even slight changes in body or extremity position without assistance.	<b>2. Very limited:</b> Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	<b>3. Slightly limited:</b> Makes frequent through slight changes in body or extremity position independently.	<b>4. No limitations:</b> Makes major and frequent changes in position without assistance.		4	4	4	4
"Activity The degree of physical activity"	<b>1. Bedfast :</b> Confined to bed	<b>2. Chairfast :</b> Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	<b>3. Walks occasionally:</b> Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	<b>4. All patients too young to ambulate; OR walks frequently:</b> Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.		4	4	4	4
Sensory Perception	<b>1. Completely limited:</b> Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	<b>2. Very limited:</b> responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	<b>3. Slightly limited:</b> Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	<b>4. No impairment:</b> Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.		4	4	4	4
Moisture Degree to which skin is exposed to moisture	<b>1. Constantly moist:</b> Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	<b>2. Very moist:</b> Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	<b>3. Occasionally moist:</b> Skin is occasionally moist, requiring linen change every 12 hours.	<b>4. Rarely moist:</b> Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.		4	4	4	4
<b>FRICION-SHEAR</b> Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	<b>1. Significant problem:</b> Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	<b>2. Problem:</b> Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	<b>3. Potential problem:</b> Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	<b>4. No apparent problem:</b> Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."		4	4	4	4
Nutritional Usual food intake pattern	<b>1. Very Poor:</b> NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	<b>2. Inadequate:</b> Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	<b>3. Adequate:</b> Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	<b>4. Excellent:</b> Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.		4	4	4	4
Tissue Perfusion & Oxygenation	<b>1. Extremely compromised:</b> Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	<b>2. Compromised:</b> Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	<b>3. Adequate:</b> Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	<b>4. Excellent:</b> Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.		3	4	4	4
<b>TOTAL SCORE</b>						21	28	28	
<b>Evaluator's Name</b>						[Signature]	[Signature]	[Signature]	

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

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

VHM-00200553 1P20-0000501  
 Master SHAIK MOHAMMAD SAFWAN (M)  
 08-11-2024 1 Y 6 M 27 D  
 Dr. SINDHURA MUNUKUNTLA

# PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
4/6/26	1pm	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	
5/6/26	10pm	4/10	Abdominal	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input checked="" 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 checked="" type="checkbox"/> Decreasing	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Syp Ibuprofen	
5/6/26	12pm	1/10	NA	<input checked="" type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input checked="" type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input checked="" type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input checked="" type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	NA	
5/6/26	4pm	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	
5/6/26	10pm	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	
6/6	6am	0	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	NA	
6/6/26	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 type="checkbox"/> Yes <input type="checkbox"/> No	NA	
6/6/26	10pm	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 type="checkbox"/> Yes <input checked="" type="checkbox"/> No	NA	
7/6/26	2AM	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	
7/6/26	6AM	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 type="checkbox"/> Yes <input checked="" type="checkbox"/> No	NA	

**Re-assessment Frequency:**

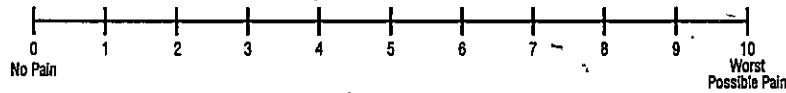
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
  - At least every 2 hours for the first 24 hours
  - Then every 4 hours.
  - Prior to pain pain-relieving intervention.
  - Within 30 – 60 minutes after pain relief 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, Disorientad	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs drawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, rigid, or Jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams of sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

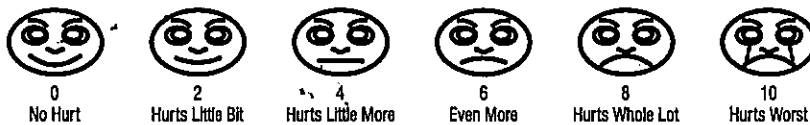
## Numerical Pain Scale (Obstetric and Gynecology)



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

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
<b>Crying Irritability</b>	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
<b>Behavior State</b>	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)
<b>Facial Expression</b>	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
<b>Extremities Tone</b>	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
<b>Vital Signs HR, RR, BP, SaO<sub>2</sub></b>	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 <sub>2</sub> 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO <sub>2</sub> less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

## 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

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				<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		
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				<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		
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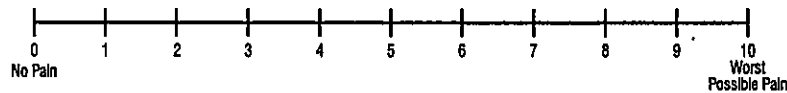
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## Wong - Baker (Pediatrics) Above 7 Years



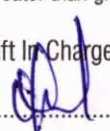
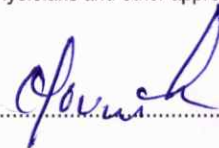


## CHECKLIST FOR THROMBOPHLEBITIS

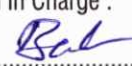

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0			0	0	0	0	0	0	0	
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1			-	-	-	-	-	-	-	
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2			-	-	-	-	-	-	-	
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			-	-	-	-	-	-	-	
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			-	-	-	-	-	-	-	
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			-	-	-	-	-	-	-	
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 : 

Patient Sticker



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S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
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6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord pyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5										
Signature of the Nurse													

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

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

Patient Sticker



## CHECKLIST FOR THROMBOPHLEBITIS

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Signature of Shift In Charge :

Signature of Ward In Charge :

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

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

4  
 Patient Sticker



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Signature of Shift In Charge :

Signature of Ward In Charge :

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

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



## MEDICATION RECONCILIATION FORM

Drug Allergies: ..... Nil .....  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: .....

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1						<input type="checkbox"/> C <input type="checkbox"/> DC
2						<input type="checkbox"/> C <input type="checkbox"/> DC
3						<input type="checkbox"/> C <input type="checkbox"/> DC
4						<input type="checkbox"/> C <input type="checkbox"/> DC
5						<input type="checkbox"/> C <input type="checkbox"/> DC
6						<input type="checkbox"/> C <input type="checkbox"/> DC
7						<input type="checkbox"/> C <input type="checkbox"/> DC
8						<input type="checkbox"/> C <input type="checkbox"/> DC
9						<input type="checkbox"/> C <input type="checkbox"/> DC
10						<input type="checkbox"/> C <input type="checkbox"/> DC

\* C - Continue, DC - Discontinue

### MEDICATION HISTORY RECORDED / VERIFIED BY


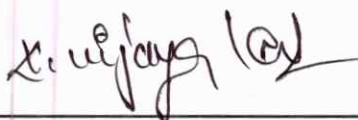
Doctor Name & Signature: Dr. Anurag .....

Date & Time: 4/6/26 @ 7:30 PM .....

Nurse Name & Signature: Shruti .....

Date & Time: 4/6/26 @ 7:30 PM .....

# PATIENT TRANSFER FORM

VIH-00200533 Master SHAIK MOHAMMAD SAFWAN 08-11-2024 1 Y 6 M 27 D (M) Dr. SINDHURA MUNUKUNTLA 		Date & Time of Admission 4/6/26 @ 7:53 pm	Date & Time of Transfer Order 4/6/26 @ 9:13 pm
		Transfer Ordered by Dr. Anushe	Reason for Transfer Admission
From Unit ED	To Unit 3 <sup>rd</sup> floor (310)	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File 100	Number of Imaging Films —	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring 		Name of Person Ordered Transfer Dr. Anushe	
Patient & Clinical Records Received by : Sandhya @ 9:05 PM 4/6/26			
Date & Time of Patient Received : 4/6/26			

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

101 → 310

# NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 5/6/26 Time: 9:45 am

Weight: 10.2 kg Centile: <10<sup>th</sup>

Height: - Centile: -

Inference: Underweight child

RDA: - Calories: 1200 kcal/day Protein: 20 gms/day

Diet Recommendations: Soft diet with liquids

Re-Assessment: NO JUNK, Oily, Spicy food

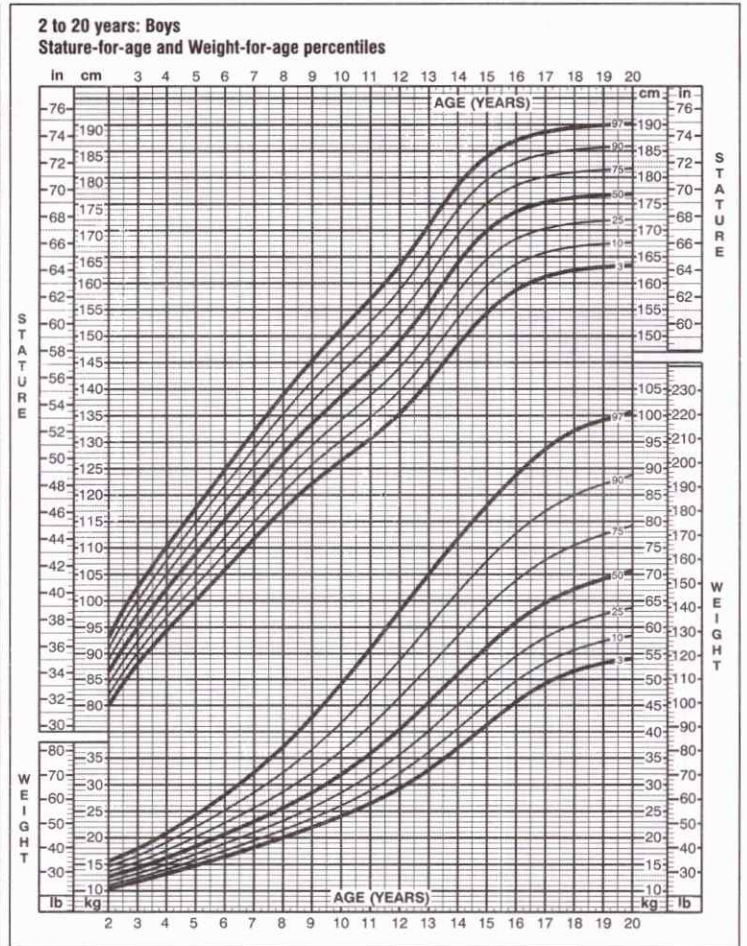
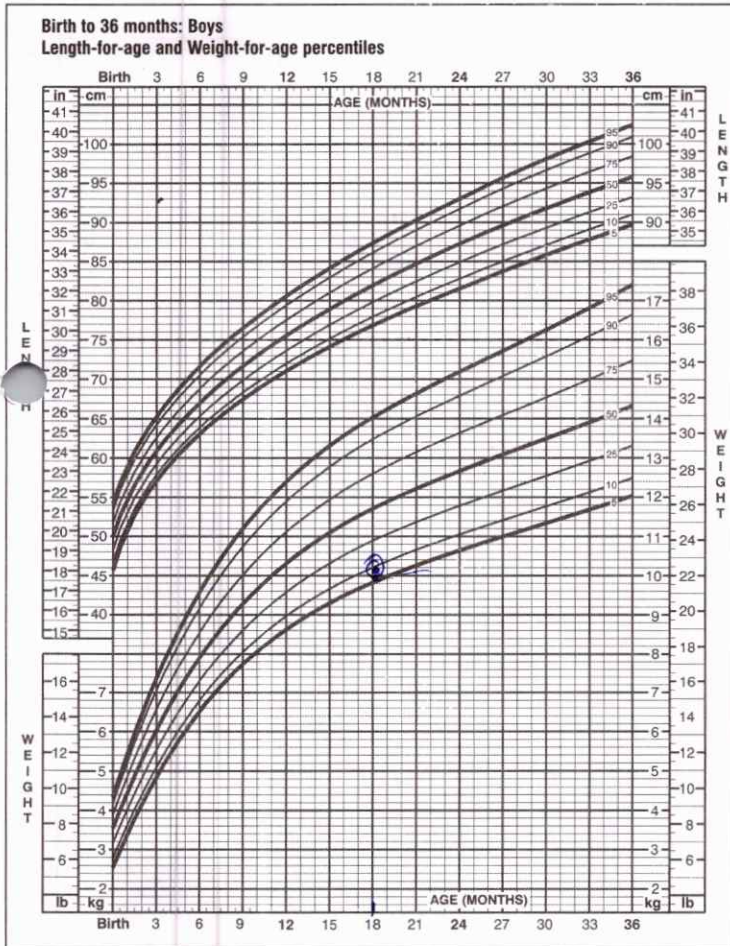
Food Allergies: NO Veg/Non-veg: NON-veg

Diagnosis: AflC - dehydration c cellulitis of Right foot

Nutritional Intervention -  Oral  Enteral  Parenteral

Patient's Signature: M.D. Arshiyah Fatima

## GROWTH CHART (BOYS)



Dietician's Name: Syeda Sobiya Zaher

Dietician's Signature: Sobiya





Wt 10.2kg



# EMERGENCY ROOM TRIAGE FORM

Patient's Name : Mahar. Saifwan Age : 1 1/2 y Gender :  Male  Female

Date : 4/6/26 Time of Arrival : 7:20 pm

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

Source of Information :  Parents  Others (Specify) .....

Mode of Arrival :  Ambulatory  Wheelchair  Ambulance

Initial Vital Signs: Temp: 100.3F PR: 136b BP: ..... RR: 36b SpO<sub>2</sub>: 97%

Chief Complaints: cfp fever since 3 days vomiting since 4 days

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

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

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

\* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian

Triage Completion Time : .....

## Communicable Disease Triage Screening

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

- 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 : [Signature]

Signature of Triage Nurse : [Signature]

Date & Time : 4/6/26 @ 7:30 pm

## NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 4/06/26 Time of arrival : 7:32 PM

Chief Complaints: 10 fever since 4 days vomiting since 4 days

Height : ..... Weight : 10.2 kg Head Circumference (<2 years) .....

Allergies:  Yes  No  Medications  Blood Transfusion  Food  Other: .....

If yes, identify .....

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

Character .....  Location .....  Frequency .....  Duration .....

<p><b>RISK FOR FALL:</b>          If patient is &lt; 6 years <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No          If 'Yes' tick below fall risk intervention directly          If Patient is &gt; 6 years          If 'Yes' Assess the below parameters          History of Falling: within past 3 months <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  <b>Ambulatory Aids:</b>          • Wheelchair <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No          • Uses furniture for support <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  <b>Gait/Transferring:</b>          • 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  <b>Mental Status:</b> Forgets limitations <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p><b>IF YES FOR ANY CATEGORY = RISK FOR FALLING</b>  <b>Fall Risk Intervention:</b>  <input type="checkbox"/> Escort while ambulating  <input type="checkbox"/> Assist Patient  <input type="checkbox"/> Educate patient and family on fall precautions/prevention</p>	<p><b>Functional Screening:</b> <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><b>Inform consultant for positive criteria</b></p> <p><b>Nutritional Screening:</b> <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><b>Inform consultant for positive criteria</b></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 : @ 7:34 PM

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

Time	Nursing Notes
7:36 PM	Assess the patient condition monitor the vital signs

Samples collected by:

Time:

Samples sent by :

Time:

**Medication given in ER:**

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1
4/06/16 7:30 PM	Ibuprofen	oral	3ml	Dr. Anyke	[Signature]

Condition of patient at time of shift - out :	Details of Shift - out
HR: 136 b/m BP: ..... CFT: ..... RR: 36 b/m SPO2 at FiO2: 97% GCS: ..... Temperature : 100.3°F Pain Score: ..... Repeat RBS (if applicable): .....	Shift - out from ER to: 3rd floor (310) Time of Shift - out: 9:30 pm Handover given to: ..... (Nurse's Name)

Tick as applicable:  MLC  LAMA  BROUGHT DEAD

Procedures done with details (if any):

IV placement done

Name of the Nurse :

Signature of the Nurse :

Date & Time :

MASTEE CHATI MOHAMMAD SAEMAN 12.06.2003 08:30:52 FOOT AP/AL 05-JUN-26 2:41 PM  
RAINBOW CHILDREN'S HOSPITAL, HIMAYATH NAGAR



КВИТРОМ ШТЕДКЕМ С НОРКТА КЕ ЧИВА АЧЕ ИУОК  
РАОАН ТААРИН ЧОД ЧОУДОД АЧЕ ЧИВА РАА РАМНОМ КАНД ТААМ  
МАРТЕК ШАТК МОРАВИРАД РА МАИ ЧЕ РА ЧОД АЧЕ ЧОУДОД АЧЕ ЧИВА РАА РАМНОМ КАНД ТААМ



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MASTER SHAIK MOHAMMAD SAFWAN 1/5/2002 / JH 00200533 CHEST AP 05 000 25 2 11 201  
RAINBOW CHILDREN'S HOSPITAL HIMAYATHI MAGAR

RAJIBOM CHILDREN'S HOSPITAL, JIMAYATIN NAGAR

INSTITUTE SHAKI MOHAMMAD SAHIBAN 31 RM 36D JLN 00200533 CHEST APERTURE 2023 2023 RM

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