302
FC

DISCHARGE SUMMARY

Name	Master DOMAKONDA SHREYANSH	**UHID**	HNH-00015802
Father/Guardian	Mr D.RAMACHANDER	**Age/Gender**	10 Y 3 M 27 D/ Male
Address	HNO: 2-2-186/13/A, RAMAKRISHNA NAGAR, NEAR RED BUILDING, Amberpet, Hyderabad, Telangana, INDIA, 500013		
IP No	IP26-00006502	**Admission Date**	04-06-2026
Ref Doctor	Dr P V S Sivesh		
Date	10.06.2026		

Consultant:
Dr. P V S Sivesh
MBBS MD
TSMC/FMR/07022

Consultant:
Dr. ANIKET ANIL PARASHAR
MBBS - MD
TSMC/FMR/08568, dr.aniket.p@rainbowhospitals.in

DIAGNOSIS	ICD CODE
ENTERIC FEVER (WIDAL POSITIVE)	

History: Master DOMAKONDA SHREYANSH, 10 Y 3 M 27 D , old boy presented with history of fever, vomitings, decreased oral intake since 2 days prior to admission. For the above complaints he was admitted at Rainbow Children's

Name	Master DOMAKONDA SHREYANSH	UHID	HNH-00015802
IP No	IP26-00006502	Admission Date	04-06-2026

Hospital - for further management.

Examination: He was febrile, maintaining saturations at room air and was hemodynamically stable . His heart rate was 131 /min and Respiratory Rate - 24/min. Capillary Refill Time was <2 secs. Peripheries were warm & pulses well felt. On examination Signs of dehydration were present, dry lips, dry oral mucosa, decreased skin turgor 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: 21.91 kilo grams.

Investigations: Enclosed reports.

Done on 04.06.2026 Complete urine examination was : pus cells - 6-8, epithelial cells - 3-5, Liver function test showed total SBR of 0.4 mg/dl with indirect fraction of 0.2 mg/dl, SGOT - 109 U/L, SGPT - 80 U/L, ALP - 154 U/L, protein - 6.8 gm/dl, albumin - 3.7 gm/dl, globulin -3.1 gm/dl, A/G ratio of 1.1.. Dengue NS1 was negative. Blood culture shows: No growth after 48 hrs of incubation

Done on 05.06.2026 Stool culture and sensitivity
GROSS EXAMINATION - YELLOW IN COLOUR, SEMI FORMED STOOL.
MODIFIED Z.N. STAINED SMEAR - DOES NOT SHOW THE OOCYSTS OF COCCIDIAN PARASITES.
CULTURE - NO SALMONELLA / SHIGELLA / ENTERO HAEMORRHAGIC E.COLI/

Name	Master DOMAKONDA SHREYANSH	UHID	HNH-00015802
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DIARRHEAGENIC. E.COLI / VIBRIO SPECIES / AEROMONAS SPECIES ISOLATED.

Urine culture and sensitivity shows no growth after 24 hours of incubation.

Initial done on 07.06.2026 hemogram showed Hemoglobin of 10.9 gm%, White Blood Cell count of 2940 cells/cumm, platelet count of 1.88 lakhs/cumm and C-Reactive Protein of 21 mg/l. Liver function test showed total SBR of 0.2 mg/dl with indirect fraction of 0.1 mg/dl, SGOT -351 U/L, SGPT - 265 U/L, ALP - 142 U/L, protein -6.1 gm/dl, albumin - 3.2 gm/dl, globulin - 2.9 gm/dl, A/G ratio of 1.1.

Done on 08.06.2026 Widal test -
SALMONELLA TYPHI O - AGGLUTINATION SEEN IN TITRE 1 : 480
SALMONELLA TYPHI H - AGGLUTINATION SEEN IN TITRE 1 : 250

Done on 09.06.2026 Liver function test showed total SBR of 0.2 mg/dl with indirect fraction of 0.1 mg/dl, SGOT - 355 U/L, SGPT - 334 U/L, ALP - 159 U/L, protein - 6.2 gm/dl, albumin - 3.4 gm/dl, globulin -2.8 gm/dl, A/G ratio of 1.2.
Coagulation profile showed PT- 14 sec, INR- 1.0, APTT - 36 sec.
ANTI HEV ANTIBODY (IGM) and ANTI HAV ANTIBODY (IGM) was non reactive.
Hepatitis B surface antigen (HBSAG) was not detected.

Done on 10.06.2026 Liver function test showed total SBR of 0.2 mg/dl with indirect fraction of 0.1 mg/dl, SGOT - 269 U/L, SGPT - 326 U/L, ALP - 157 U/L, protein - 6.5 gm/dl, albumin - 3.4 gm/dl, globulin -3.1 gm/dl, A/G ratio of 1.1.

Ultrasound abdomen shows
* Gall bladder wall thickening.
* Few fine internal echoes in urinary bladder - Suggested CUE correlation.

Name	Master DOMAKONDA SHREYANSH	UHID	HNH-00015802
IP No	IP26-00006502	Admission Date	04-06-2026

* Submucosal wall thickening involving ascending colon and distal ileum with increased wall vascularity and increased adjacent mesenteric echogenicity, suggestive of colitis - likely infective etiology.
* Multiple small lymph-
nodes along the mesentery in the RIF and periumbilical region
- in keeping with mesenteric adenopathy.
* Mild free fluid in the peritoneal cavity.

Ultrasound abdomen done on 08.06.2026
* Findings in keeping with infective / inflammatory ileocolitis.
* Multiple small lymph-nodes along the mesentery in the RIF and periumbilical region - in keeping with mesenteric adenopathy.
* Mild ascites.
* Mild gall bladder wall thickening with sludge.

Management: He was admitted in the ward and was started on Intra Venous fluids and Intra Venous antibiotics (IV Ceftriaxone). He was treated symptomatically with antacids, antiemetics and antipyretics. In view loose stools and pain abdomen USG abdomen done showed features of infective ileocolitis . Hence stool cuture sent and started on IV Metronidazole .Child was started on supportive medication with probiotics , ORS and gastro diet .

In view of persistent fever spikes and pain abdomen, repeat CBP and LFT was done which showed leukopenia and transaminitis. Coagulation profile and hepatitis profile sent came negative. Possibility of enteric fever was considered and Widal test sent which came positive. Child was continued on IV Ceftriaxone. Repeat LFT done showed improving trend.

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He was regularly monitored for fever spikes, hemodynamic status. His fever spikes and other symptoms gradually settled.

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 Esomeprazole
Injection Ceftriaxone
Injection Metronidazole
Injection Ondansetron
Syrup. Zinc
Pro GG drops

Advice:
* Diet as advised.

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S.No	MEDICATION	DOSE	TIMINGS	DURATION
1	Syrup. ZIPRAX (Cefixime - 5ml/100mg)	10 ml	8am - 8pm (after food)	For 7 days.
2	Syrup. ZINC (20 mg/5ml)	5 ml	10am (after food)	For 7 days
3	ONDANSETRON TAB 4MG	1 tablet	SOS	(MAX 3 TIMES PER DAY)

Fever Management

* Syrup. Crocin DS (Paracetamol - 5ml/240mg) 6.5ml 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. P V S Sivesh on Monday(15.06.2026) at his OPD.

Food instructions while taking medications:

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

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

Name	Master DOMAKONDA SHREYANSH	UHID	HNH-00015802
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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.

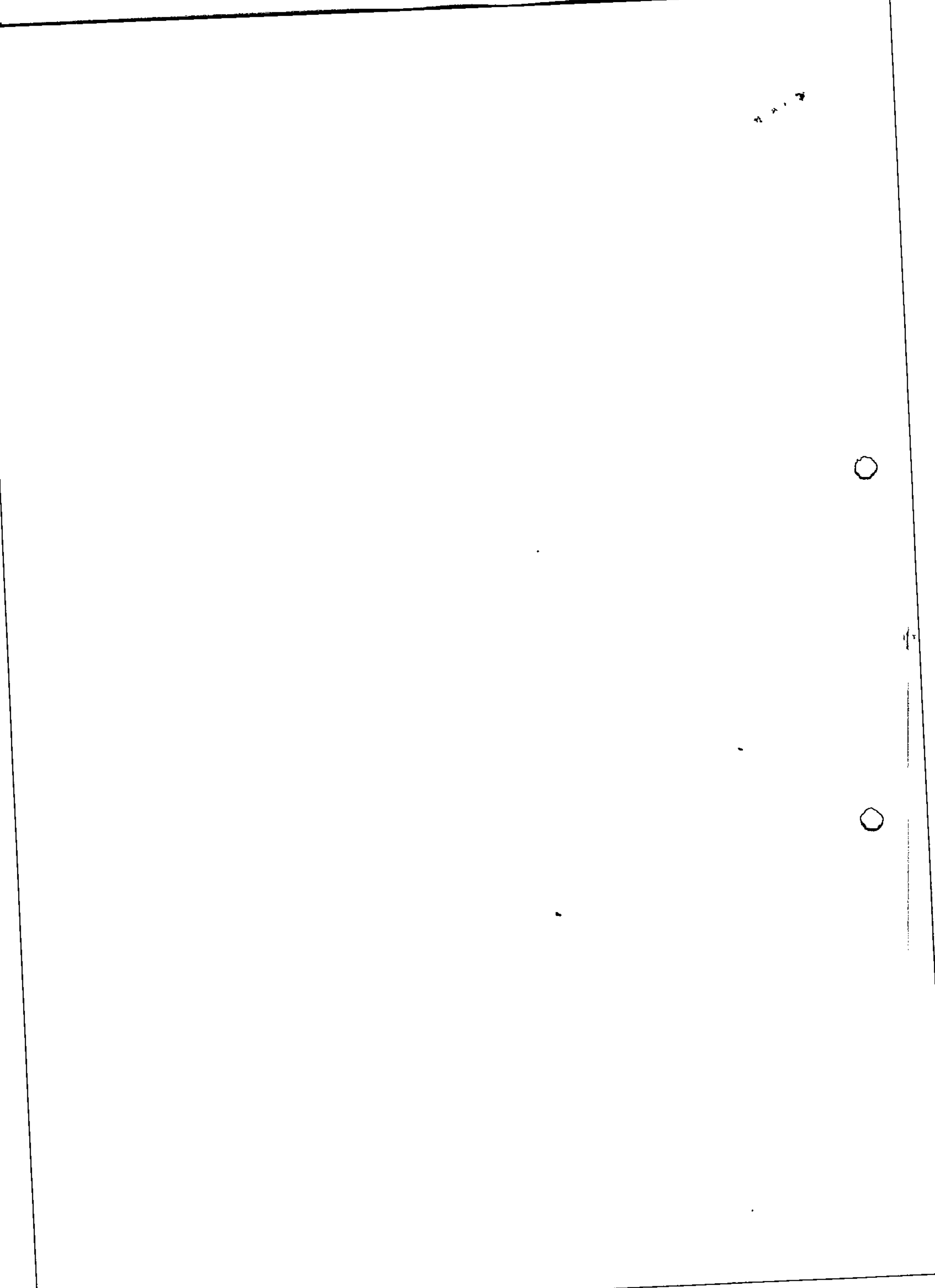
Parent/ Attender

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**

Registrar/Resident/C.M.O

Dr. P V S Sivesh
MBBS MD
TSMC/FMR/07022



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 : IP26-00006502 **Admit Date** : 04-Jun-2026 **Admit Time** : 08:13 PM **UHID** : HNH-00015802

Patient Details :

Patient Name	: Master DOMAKONDA SHREYANSH	**Age**	: 10 Y 3 M 26 D
Guardian	: Mr D.RAMACHANDER	**DOB**	: 09-02-2016
Gender	: Male	**Religion**	:
ion	:	**Martial Status**	:
(H)	: HNO: 2-2-186/13/A, RAMAKRISHNA NAGAR, NEAR RED BUILDING Amberpet Hyderabad Telangana INDIA 500013	**Phone No**	: 9052190201
		E-mail	: dk.ramchander@gmail.com

...ssion Details :

Bed Type	: DAY CARE	**Bed No**	: ER02	**Ward Name**	: GF -EMERGENCY
Room No	: ER02	**Admission Type**	: First Visit		

Contact Details :

Name	: Mr D.RAMACHANDER	**Relationship**	: Father
Contact Address	: HNO: 2-2-186/13/A, RAMAKRISHNA NAGAR, NEAR RED BUILDING Amberpet Hyderabad Telangana INDIA 500013	**Phone No**	: 9052190201

Signature

Doctor Details :

Doctor Name	: Dr. P V S Sivesh	**Specialisation**	: GENERAL PEDIATRICS
Referral Doctor	: Dr P V S Sivesh	**Phone No**	: 8143818234
Co-Consultant	: Dr. ANIKET ANIL PARASHAR		

Payment Details :

Payment Mode	: DC/CC Card	**Deposit Amount**	: 10000.00
		Payor Name	: VIDAL HEALTH INSURANCE TPA PVT LTD

ACTIVI HNH-00015802 IP26-00006502 NG

Master DOMAKONDA SHREYANSH
09-02-2016 10 Y 3 M 26 D (M)
Dr. P V S Sivesh

Name: --

UHID No ------------ Consultant : ------------------------ Dept : pedeatric

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	ward (302)	[signature]

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Sign
4/6/26	LFT	9339	[illegible]
	Blood C/S		
	Dengue NS1		
4/6/26	CUE	9343	Santhiya
4/6/26	USG Abdomen	6759	Bala
5/6/26	urine culture & Sensitivity	9390	Bala
5/6/26	Stool C & S	9397	[illegible]
7/6/26	VBG	9482	[illegible]
7/6/26	CBP, CRP, LFT	9480	[illegible]
8/6/26	USG Abdomen + Pelvis	6879	Bala
8/6/26	widal	9531	[illegible]
9/6/26	LFT, PT/INR, HepA IgM, HBsAg, HepC IgM	9564	[illegible]
10/6/26	LFT	9596	[illegible]

cross check done by sr. santhya

Cross check by [illegible]

Cross checked done by [illegible] @ 10/6/26

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
4/6/26	Infusion Pump	10:30 pm	3pm @ ~~[illegible]~~ 9/6/26	04328	Sandhya

cross check done.

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Master DOMAKONDA SHREYANSH
09-02-2016 10 Y 3 M 26 D (M)
Dr. P V S Sivesh

PR

Date	Proceedure	Quantity	Order No.	Signature
4/6/26	IV placement	01	4273	[illegible]
5/6/26	NHA	1	4476	[illegible]
7/6/26	IV placement	1	5038	[illegible]

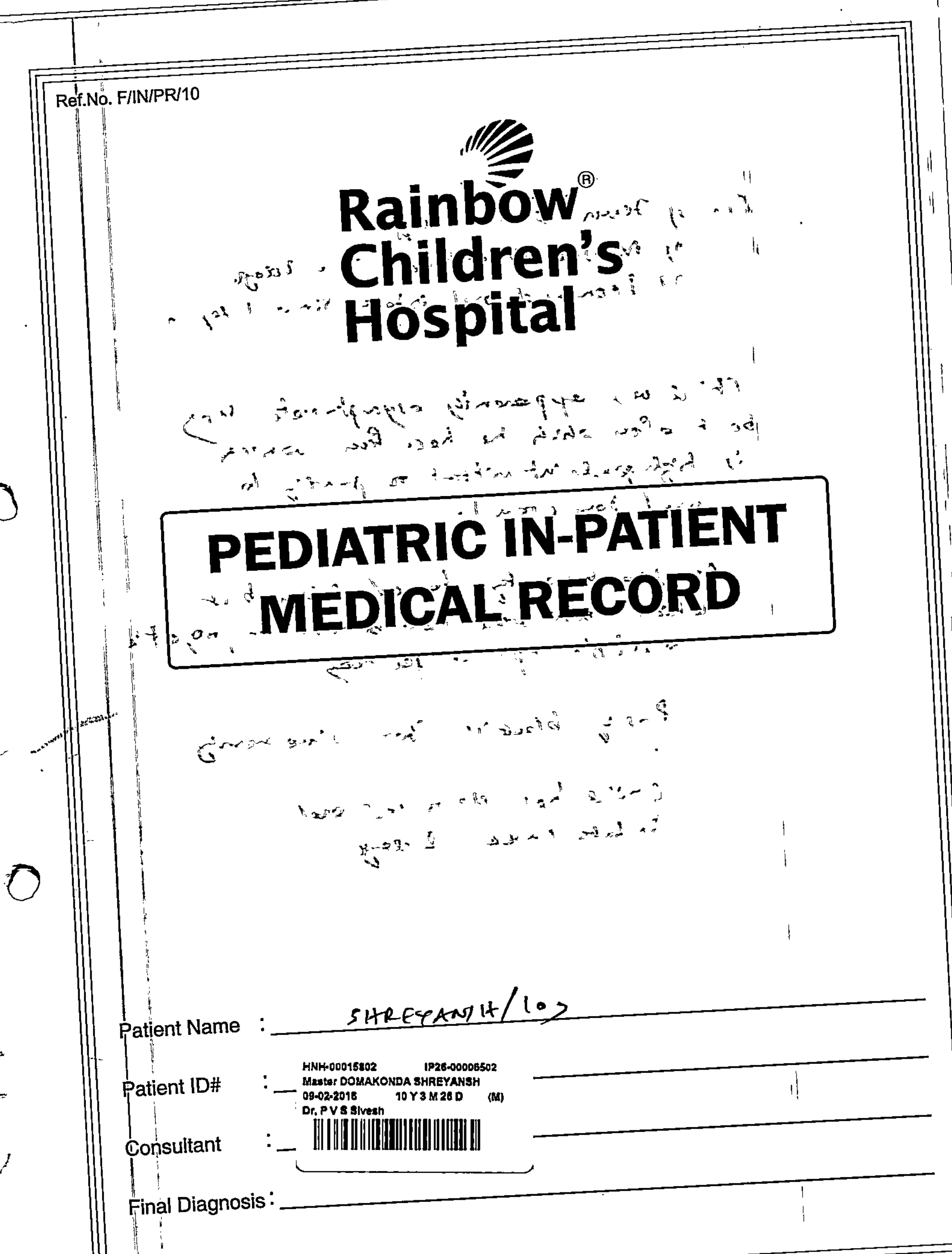
cross check done

cross checked done

ANY OTHER INFORMATION

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor



Ref.No. F/IN/PR/10

Rainbow® Children's Hospital

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name : SHREYANSH/10Y

Patient ID# : HNH-00015802 IP26-00006502
Master DOMAKONDA SHREYANSH
09-02-2016 10 Y 3 M 26 D (M)
Dr. P V S Sivesh

Consultant :

Final Diagnosis :

Pediatric Multiorgan History & Physical Examination

Name : ______________________ Age/Sex ________

Informant ______________________ Reliability ________

Chief Presenting Complaints & Duration (Chronologically):

C/o 1) Fever since 4 days
2) Nausea & vomiting since 2 days.
3) Decreased oral intake since 2 days

History of present illness :

Child was apparently asymptomatic 4 days back after which he had fever which is high grade, intermittent, responding to oral paracetamol.

Nausea & vomiting started 2 day back which ~~wh~~ were non-bilious, non-projectile multiple episodes per day

Passing blackish stools since morning

Child has decreased oral intake since 2 days.

Pediatric Multiorgan History & Physical Examination

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

Birth & Neonatal History :

Term / 2.8 kg / LSCS / CIAB

12y 10y

Birth & Socio Economic History :

About Father :

About Mother :

Any additional Information :

Developmental History :

Normal.

Immunization History :

Pediatric Multiorgan History & Physical Examination

Anthropometry

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

Weight (kgs) 21.9 kg (Centile ________)

On Examination :

Temperature : ________ Pulse Rate: ________ Description ________

B.P. ________ SPO2 96% at RA

Resp. rate and type of breathing : ________

dry lips ⊕

Rash ________ dry oral mucosa ⊕

Lymphadenopathy ________ ↓ skin turgor

Oedema : ________

Respiratory system :

Inspection (any s/o distress) : ________

Air entry & breath sounds : B/L AE ⊕

Any addes sounds : ________

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

Cardiovasclular System :

Inspection of procordium : ________

Heart Sounds : S_1S_2 ⊕

Any murmur : ________

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

Per Abdomen :

Inspection ________

Palpation : P/A soft

Ausculation : ________

Spine: ________ External Genitelia : ________

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

Pediatric Multiorgan History & Physical Examination

HNH-00015802 IP25-00006502
Master DOMAKONDA SHREYANSH
09-02-2015 10 Y 3 M 26 D (M)
Dr. P V S Sivesh

Central Nervous System :

Level of Consciousness : AVPU/GCS Score : 15/15

Cranial Nerves : (N)

Motor System :

Nutrition : (N)

Tone : Power

Co-ordinator :

Posture :

Involuntary Movements :

Reflexes :

DTR

Superficials :

Plantars

Sensory System : (N)

Bladder / Bowel :

Clinical Summary & Diagnostic :

DAGE c dehydration

? Enteric fever

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment :

IV fluids

Desired goals of the treatment :

Fever subsidence

Planned Labs :	Planned Management :
Blood C/S - paired culture	
LFT	- Inj. CEFTRIAXONE 1gm
Dengue NS1	IV BD
Extra sample - 1	- Inj. ONDANSETRON 4mg IV TID
(Done) ✓ CUE	- Inj. ESOMEPRAZOLE 20mg IV OD
✓ USG Abdomen - T/M	

Please fill up the following details

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

Doctor's Signature Name Dr. Aniket Anil Parashar Consultant Pediatrician & Intensivist Reg. No. 8568 Date 4/6/26 Time

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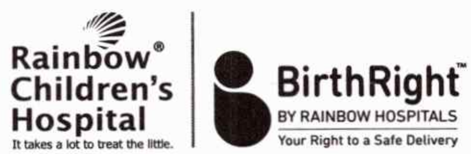
Master DOMAKONDA SHREYANSH
09-02-2016 10 Y 3 M 26 D (M)
Dr. P V S Sivesh



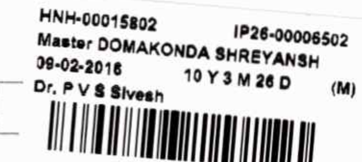
PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/6/26 7:15 AM	S/B Dr. Sandhya	- Plan
	Δ AFI ē dehydration	
		- C/F CEFTRIAXONE
	Fever spikes ⊕	
		- C/F ONDANSETRON
	CVS - S₁S₂ ⊕	ESMOPRAZOLE
	RS - BLL - AE ⊕	
		- C/F IV fluids
	P/A - soft	
	Conscious.	- Trace reports
	C/o Loose stools	Syp. ZINC SU OD
		Dr. Sandhya
		noted by Sr. Sandhya 5/6/26 7:05 am
5/6/26 9:15 AM	S/B Dr. Aniket	
	Δ AFI ē dehydration	
	Δ? Enteric fever	Plan
	Fever spikes ⊕	- C/F CEFTRIAXONE
	CVS - S₁S₂ ⊕	- C/F ONDANSETRON
	RS - BLL - AE ⊕	ESMOPRAZOLE
		- USG Abdomen - NOW
	P/A - soft	
	Conscious.	- C/F ZINC
		start Probiotics
		ORS
		Tpr IV fluids

Dr. Aniket Anil Parashar
Consultant Pediatric Intensivist
Reg. No: 5588

Dr. Aniket

Docu. No. : RCH /FRM / CLINICAL / 088 (P.T.O)



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/6/26	S/B Dr. Sivesh	Plan
10 AM	D: Enteric Fever	
		- c/c CEFTRIAXONE
	Fever spikes (+)	
		- Neff prick
	CVS - S1, S2 (+)	CBP, CBP.
	P/A - BS - AIFO	
		- c/c IV Fluids
	P/A - Soft	
	Conscious	- Monitor vitals
		- Encourage orals
		for Dr. Sivesh

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Master DOMAKONDA SHREYANSH
09-02-2016 10 Y 3 M 26 D (M)
Dr. P V S Sivesh

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/6/26	Dr. Prashanti	
2pm	Δ - Enteric fever	
	Fever spikes +	PLAN
	taking orally	
	urine ✓	c/- IV fluids Plasmalyte @ 40 ml/hr
	stool ✓	
	O/E vitals stable	c/- ceftriaxone
		esomeprazole
		Ondan
	S/E	Zinc
	P/A: soft	Pro GG
	nt	ORS
	no hsm	monitor vitals. Prashanti
		Next prick CBP/CRP
	Dengue NS1 - neg	
	USG abd Abdomen → DONE	N/B Supriya @3pm

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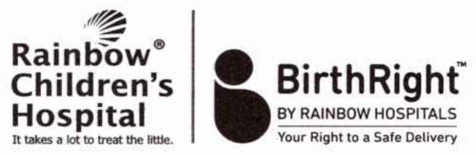
Dr. P V S Sivesh



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	C/s/b Dr. Sivesh	
5/6/26 4PM	Dx - AGE c dehydration. Enteric fever / ? colitis.	
	- fever spikes (+)	
	- c/o pain abdomen.	
	oral intake - fair	Plan
	O/E - vitals stable.	- Send urine c/s.
	S/E - P/A - Soft, NT.	- Add IV metronidazole.
		- Continue other medications as per Rx chart.
		- ~~change to~~ continue ~~to~~ surgical bed.
		- Send CBP, CRP tomorrow morning at 6AM.
		- Encourage orally.
		NB-Mounika @ 4PM
	Dr. Sivesh	

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

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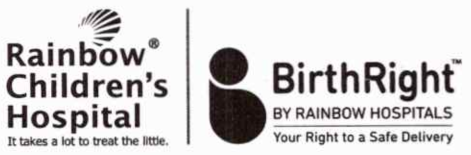
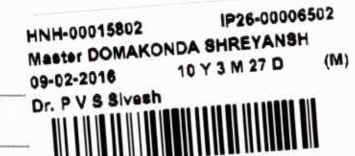
09-02-2016 10 Y 3 M 26 D (M)
Dr. P V S Sivesh



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/6/26 07:48 pm	S/B Dr. Aniket P	
	Intermittent high grade fever.	
	Loose stools 5-6 episodes with blood in stool over	
	oral intake decreased.	
	vitals stable.	
	P/A soft non-tender	
		Advice.
		✓ send stool culture
		✓ Trace pending reports
		✓ VBG, CBP, CRP next prick
		NB - Monika 7:45PM
	Dr. Aniket Anil Parashar Consultant Pediatrician & Intensivist Reg. No: 8568	Dr. Aniket P


HNH-00015802 IP26-00006502
Master DOMAKONDA SHREYANSH
09-02-2016 10 Y 3 M 27 D (M)
Dr. P V S Sivesh

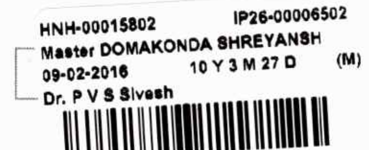
PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	C/o/b - Dr. Sankalp / Dr. Thanvi	
06/06/26 11 AM	A/c AFI (? Enteric fever) with dehydration	
	fever (+)	
	pain abdomen (+)	
	loose stools	
	O/E: a/c - fair	
	vitals stable	
	Hydration - good	
	S/E: PA: soft, tenderness (+) in epigastric region	
		Adv
		CBC, CBP, CRP - next prick
		Trace stool C/S, urine C/S
		- Inj Ceftriaxone
		- Inj Metrogyl
		- Supportive care

HNH-00015802 IP26-00006502
Master DOMAKONDA SHREYANSH
09-02-2016 10 Y 3 M 27 D (M)
Dr. P V S Sivesh

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/6/26 10:15 AM	S/B Dr. Sivesh	
	Δ ? Infective Colitis	
		Plan
	Fever spikes ⊕	
		C/C CEFTRIAXONE
	CVS – S1S2 ⊕	METRONIDAZOLE
	RS – BL AE ⊕	
		CBP, CRP – Next prick
	P/A – Soft	
	Conscious	Encourage orally
		C/C IV fluids @ 90ml
		Trace Urine C/S
		Blood C/S
		DR SIVESH
		DR SIVESH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Master DOMAKONDA SHREYANSH
09-02-2016 10 Y 3 M 27 D (M)
Dr. P V S Sivesh

Rainbow® Children's Hospital
It takes a lot to treat the little.
BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/6/26 11:20 am	S/B Dr. Aniket	
	D ? Infective Colitis	
		P/a
	Fever spikes (+)	– Inj CEFTRIAXONE
	CVS – S1 S2 (+)	METRONIDAZOLE
	RS – B/L – AE (+)	– Stop IV fluids
	PLA – soft	
	conscious	– Neck prick CBP / CRP
		– Trace Urine c/s
		Blood c/s
		– Encourage orals
		Noted by [illegible] 6/6/26 @ 11:20am
	Dr. Aniket Anil Parashar Consultant Pediatrician & Intensivist Reg. No: 8568	S/B Dr. Aniket

HNH-00015802 IP26-00006502
Master DOMAKONDA SHREYANSH
09-02-2016 10 Y 3 M 27 D (M)
Dr. P V S Sivesh

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/6/26 3PM	S/B Dr. Sreyhan D ? Infective colitis ? Enteric fever Fever spike (+) CVS - S1S2 (+) RS - BLL - AEE (+) P/A Soft Conscious.	Plan - Cont CEFTRIAXONE METRONIDAZOLE - Encourage orally - Next prick CBP CRP - Trace Urine C/S Blood C/S
6/6/26 5.35PM	S/B Dr. Aniketh D ? Infective colitis ? Enteric Fever Plan Low grade fever spikes (+) C/o pain Abdomen CVS - S1 S2 (+) RS - BLL - AEE (+) P/A Soft Conscious	- Cont CEFTRIAXONE METRONIDAZOLE - Next prick CBP CRP. - Trace Urine C/S Blood C/S - 48hr Dr. Aniket Anil Parashar Consultant Pediatrician & Intensivist Reg. No: 8568 Noted by Divya 6/6/26 5:35PM Dr. Aniketh

Docu. No. : RCH /FRM / CLINICAL / 088 (P.T.O)

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Master DOMAKONDA SHREYANSH
09-02-2016 10 Y 3 M 27 D (M)
Dr. P V S Sivesh

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	S/B Dr Prabhath	Dr Varun
7/6/26 8AM	? Infective colitis	
	? Enteric fever	
	Fever spikes -	at 5:30AM (100.6°F)
	pain abdomen - Better	
	fresh c/o - None	Adv
	o/e Vitals Stable	- ct Ceftriaxone Metronidazole
	CVS S1S2 +	Next prick CBP
	CNS WNL	CRP
	RS BAE +	
	PA Soft	Trace Urine c/s
		Blood c/s - 48Hrs
		Noted by Divya 7/6/26 8am

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

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
7/6/26 11am	C/S/B Dr. Aniket	
	? infective colitis	
	? enteric fever	
	– fever spikes (+) [5:30am 100·6°F]	
	– Pain abdomen (+)	
	– No vomitings	
	– No blood in stools	
	O/E	
	vitals : stable	Plan
	S/E – (N).	1) Inj. Ceftriaxone Metronidazole
		2) next prick CBP CRP
		3) Fecal Blood c/s – neg, urine c/s, stool c/s
		Noted by Divy 7/6/26 @11am
		Dr. Aniket
	Dr. Aniket Anil Parashar, Consultant Pediatrician & Intensivist, Reg. No: 8568	

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Dr. P V S Sivesh

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
7/6/26 2:30pm	UMB Dr. [illegible] ? Infective colitis	
	– last spike e/sam – 100'6 – no further blood in stools / loose stools – no vomitings – oral intake : fair – mild pain abdomen (+).	
	O/E vitals : stable S/E : P/A : soft. non tender.	Plan 1) ct. ceftriaxone metronidazole 2) next peak UBP CRP VBG 3) trace urine c/s stool c/s 4) monitor vitals Noted by Divya 7/6/26 @ 2:30pm
	[signature]	

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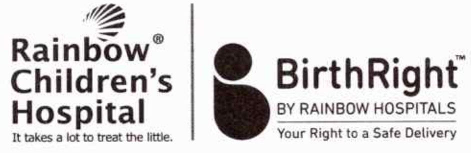
Master DOMAKONDA SHREYANSH
09-02-2016 10 Y 3 M 28 D (M)
Dr. P V S Sivesh



ROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/6/26 8am	[illegible] Re-assessment	
	? infective colitis	
	- last fever spike @100.4 at 11pm	
	- Pain abdomen ↓	
	- no vomitings	- WBC ↓ 2K
		- CRP ↑.
	- oral intake : fair.	
	O/E	
	vitals : stable	
	S/E	Plan
	P/A = soft	1) Ct. ceftriaxone metronidazole
	CVS : S1S2 (+)	
	no murmurs	2) leave urine c/s stool c/s
		3) Rest Ct. as per Rx chart
		4) monitor vitals.
		N/B [illegible]

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Dr. P V S Sivesh

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/6/26 10 AM	c/s/b Dr. Aniket.	
	? Enteric fever	
	fever spikes (+).	
	oral intake - poor	
	pain abdomen (+).	Plan - Stop PCM;
	P/E - vitals stable.	give Ibuprofen / Tepid Sponging.
	S/E - WNL.	- Widal if extra sample (+).
		Rpt. USG A+P.
		Trace stool c/s.
		Next prick CBP, CRP, LFT PT-INR.
		Syp. Hepamerz 5ml BD.
		Noted by Divya 8/6/26
		DDM - Dr. Aniket

Dr. Aniket Anil Parashar
Consultant Pediatrician & Intensivist
Reg. No: 8563

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

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Master DOMAKONDA SHREYANSH
09-02-2016 10 Y 3 M 30 D (M)
Dr. P V S Sivesh

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	c/s/by Dr Anusha	
8/6/26 2:30pm	? Enteric fever.	
	- fever spikes (+) (Also since mng)	
	oral Intake ↓	stool/tube - NG.
	Pain abdomen (+) (no/.)	
		Plan.
	vital stable.	- ct IV fluid
		- (T) widal.
		- ct IBUGESI syp
		- Next prick → CBP, CRP, CFT PT/INR.
	[signature]	- ct oth as per chart.
		- Enhance orally.

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Dr. P V S Sivesh

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	C/o Dr. Shivesh	
08/06/26 4:00PM	Afebrile today	
	poor oral intake	
	pain abdomen (+)	
	vitals stable	
	S/E:- PA soft Nontender	
		Adv
		/ Typhi Widal
		/ Continue same treatment
		/ CBP, CRP, LFT, PT/INR
		/ IV flush
	(Dr. PVS Shivesh) Sr.	Sambit
		Noted by Divya
		8/6/26 @ 4:40PM

Dr. Pritesh Nagar
Consultant Pediatrician & Intensivist
Reg. No: 47184

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

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Master DOMAKONDA SHREYANSH
09-02-2016 10 Y 3 M 30 D (M)
Dr. P V S Sivesh

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/6/26 7:45pm	S/B Dr Pritesh	
	Fever Ileo Colitis Hepatitis	
	Fever ↓↓	
	O/E	
	vitals stable	(Plan)
	S/E	LFT PT c̄ INR Hep A IgM HBSAg Hep E IgM — T/M
	P/A - tenderness +	
	Dr. Pritesh Nagar Consultant Pediatrician & Intensivist Reg. No: 47184	After discussion with Dr. Shivesh

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Master DOMAKONDA SHREYANSH
09-02-2016 10 Y 3 M 30 D (M)
Dr. P V S Sivesh

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	C/S/B - Dr Pritesh	
8/06/26 7:50 pm	Δ - ileocolitis ? Hepatitis ? Typhoid	
	Jaundice ↓, Transaminitis	
	O/E - No icterus vitals stable	Plan
	S/E P/A - soft Tenderness +	LFT PT c INR Hep A IgM HBsAg Hep E IgM After discussion c Dr Shivesh
		Advised to continue Hepatitis evaluation

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09-02-2016 10 Y 3 M 29 D (M)
Dr. P V S Sivesh

Shreyansh

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/6/26 8:40pm	c/D/w - Dr. Shivesh	
	Δ - ?Typhoid ?Ileocolitis ?Hepatitis	
	Plan	
	To send - LFT - PT c INR HepA IgM - HBsAg HepE IgM.	T/m 6am
	N/B priyanka.	[signature]

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

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09-02-2016 10 Y 3 M 30 D (M)
Dr. P V S Sivesh

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	C/S/B Dr. Naipunya	Dr. Prashanthi
9/6 7:00 AM	AFI c dehydration	
	& Ileocolitis	
	? Hepatitis.	
		Plan
	Pain Abdomen (+)	
	No fever	- Ceftriaxone to continue
	Vitals - HR - 82	
	RR -	- Cont Zinc
	SpO2 - 98%.	PROGG.
	P/A - soft, NT	- Cont Syp. Hepamerz OA
		- (Trace) LFT, PT INR
		Hep A IgM, Hep E IgM
		HBsAg.
		- Monitor vitals
		- Encourage orally
		[signature]
9/6. 11AM	c/D/w Dr Sivesh	D/B priyanka
		Plan
	- Reports Informed	- ct CEFTRIAXONE
	- Widal +ve.	Inform sos.
		- Cont & Review by
		after/evening
	[signature]	

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09-02-2016 10 Y 3 M 30 D (M)
Dr. P V S Sivesh

GRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/6 3pm	C/S/B Dr. Pranav / Dr. Sreeghan	
	Enteric Fever	
	Fever - ↓	Plan
	Abdominal pain - better	1) Inj Ceftriaxone / Inj Metronidazole
		2) Rx ORS
	child alert	3) Syp Zinc
	Vitals stable.	4) Syp Ibuprofen
		5) Monitor Vitals
	R.S - B/L AE ⊕	6) Inform SOS
	P/A - Soft	7) Encourage orally
		8) Stop IVF
		Pranav
		N/B - Supriya / 3:30pm @ 9/6/2[illegible]

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Dr. P V S Sivesh

NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
04/06/26 7:30PM	C/o/b. Dr. PVS Sivesh D/ Gastroenteritis Afebrile pain abdomen + O/E - GC: fair vitals: stable Hydration - good	Adv ✓ Inj Ceftriaxone ✓ Supportive care ✓ LFT T/M 6AM ✓ Monitor vitals and Enforce SOP ✓ IV fluids stop. [signature] DR SIVESH NB - Supriya 8PM @ 9/6/26

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09-02-2016 10 Y 3 M 29 D (M)
Dr. P V S Sivesh

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/6/26 7:45 AM	S/B: Dr Prabhath	Dr Nazreen
	Δ Enteric fever.	
	No fever spikes. Pain abdomen – ↓ Oral intake – fair.	
	O/E G: fair Vitals stable	Adv ① CT Ceftriaxone ② Trace LFT. ③ Supportive care ④ Monitor vitals i/for SOS
		N/B Supriya @ 7:45 AM
10/6/26 10 30 AM	C/D/W Dr Sivesh Δ Enteric fever.	
	vital stable. 1 Episode vomiting Now.	Plan
		– CT CEFTRIAXONE.
	LFT Informed.	– Monitor vitals.
		– Tm db plan.
		noted by Sr. Sreenidhya 10/6/26 10:30 a

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09-02-2016 10 Y 3 M 30 D (M)
Dr. P V S Sivesh

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/6/26 11:30 am	S/B Dr. Aniket P	
	Fever decreased	
	Pain abdomen decreased	
	oral intake better	
	vitals stable	
		Advice:
		Treatment as per chart
	Dr. Aniket Anil Parashar Consultant Pediatrician & Intensivist Reg. No: 3533	Dr. Aniket P
		noted by Sr. Sandhya 10/6/26 11:30

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Master DOMAKONDA SHREYANSH
09-02-2016 10 Y 4 M 1 D (M)
Dr. P V S Sivesh

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/6/26 05:30 pm	S/B Dr. Aniket P	
	Afebrile	
	one episode of vomiting	
	pain abdomen decreased	
	oral intake fair	
	vitals stable.	
	P/A: soft, non-tender	Advice:
		- Treatment as per Chart.
		- Soft diet
		Dr. Aniket Anil Parashar Consultant Pediatrician & Intensivist Reg. No: 8568
		Dr. Aniket P
		noted by Sr. sandhya 10/6/26 6 pm

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Master DOMAKONDA SHREYANSH
09-02-2016 10 Y 4 M 1 D (M)
Dr. P V S Sivesh

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/6/26 7AM	S/B Dr. Sreeghar / Dr. Praneer	
	Δ Enteric fever	Plan
	No fever	- cf ZINC
	CVS - S1, S2 (+)	
	RS - BLL - AEE (+)	- cf CEFTRIAXONE - D7
	P/A Soft	- Encourage orally
	Conscious	
		- Plan discharge
		N/B Supriya @ 8Am
11/6/26 10 Am	Case d/w Dr. Sivesh	
		Plan
	Δ Enteric fever	
		- ZINC - 14 days
	Afebrile	
	Vitals stable	- Discharge
		- Flup on Saturday in OPD
		- CEFIXIME - 7 days more ↳ Enteric dose

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Master DOMAKONDA SHREYANSH
09-02-2016 10 Y 4 M 2 D (M)
Dr. P V S Sivesh

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/6/26 10AM	c/s/by. Dr Shivesh	
	Δ: Enteric fever.	
	Afebrile.	Plan
	vital stable.	- Enhance orally.
	S/E	- CEFTRIAXONE OD dose Now.
	P/A Soft non tender.	- discharge today. ↓ CEFIXAME × 7 more days
		[signature] DRS[illegible]
		NB - [signature] 10:28 AM @ 11/6/26

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

HNH-00015802 IP26-00006502
Master DOMAKONDA SHREYANSH
09-02-2016 10 Y 3 M 26 D (M)
Dr. P V S Sivesh

DRUG CHART

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

FOR THE SAFETY OF THE PATIENT

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

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

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

SOS / PRN (As Required Medication)

DRUG: SYP CROCIN DS.				Date / Time	4/6/26 10:40 pm		5/6/26	6/6/26	7/6	7/6
Dose	Route	Frequency	Start Date							
6.5mL	PO	SOS T>100°F	4/6/26.							
Doctor's Signature	Valid Period	Pharm.								
[signature]		[initial]								
Additional Instructions: (240mg/5mL)										

DRUG: IBUGESIC SYP				Date / Time
Dose	Route	Frequency	Start Date	
6ml	PO	SOS	8/6/L	
Doctor's Signature	Valid Period	Pharm.		
[signature]		[initial]		
Additional Instructions: (100mg/5ml)				

DRUG: SYP CYCLOPAM				Date / Time
Dose	Route	Frequency	Start Date	
5ml	PO	SOS	8/6.	
Doctor's Signature	Valid Period	Pharm.		
[signature]		[initial]		
Additional Instructions: (20mg/5ml)				

Verified by Dr. Dhakshayani

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Master DOMAKONDA SHREYANSH
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Dr. P V S Sivesh

REGULAR PRESCRIPTIONS Weight. 21.9 kg Ward. ....

DRUG : INJ CEFTRIAXONE				Date/Time
Dose	Route	Frequency	Start Date	
2g	IV	OD	4/6/26	
Name & Signature of the Doctor Starting the Drugs: Dr. Prabhath				
Additional Instructions: In 50 mL NS over 1-2 hrs.				
Daily Doctor's Endorsement by a Sign				

DRUG : INJ ESMOPRAZOLE				Date/Time	4/6	5/6	6/6	7/6	8/6
Dose	Route	Frequency	Start Date						
20mg	IV	OD	4/6/26						
Name & Signature of the Doctor Starting the Drugs: Dr Prabhath				6am	11pm				
Additional Instructions:				STOP					
Daily Doctor's Endorsement by a Sign									

DRUG : INJ ONDANSETRON				Date/Time	4/6	5/6	6/6	7/6
Dose	Route	Frequency	Start Date					
3mg	IV	TID	4/6/26					
Name & Signature of the Doctor Starting the Drugs: Dr Prabhath.				6am	X			
				2pm	X	11pm		
Additional Instructions: 0.15mg/kg.				10pm				
Daily Doctor's Endorsement by a Sign								

STOP 7/6/26

DRUG : INJ CEFTRIAXONE				Date/Time	4/6	5/6	6/6/26	7/6	8/6/26	9/6	10/6
Dose	Route	Frequency	Start Date								
1g	IV	BD	4/6/26	10am	X						
Name & Signature of the Doctor Starting the Drugs: Dr Prabhath				10PM	11pm						
Additional Instructions: In 50mL NS over 1-2hr.											
Daily Doctor's Endorsement by a Sign											

Verified by Dr. Dhakshayani

Verified by Dr. Dhakshayani

Verified by Dr. Dhakshayani

HNH-00015802 IP26-00006502
Master DOMAKONDA SHREYANSH
09-02-2016 10 Y 3 M 26 D (M)
Dr. P V S Sivesh

REGULAR PRESCRIPTIONS

Weight 21.9 kg Ward ....

DRUG : Syp. ZINC				Date/Time	5/6	6/6/26	7/6/26	8/6/26	9/6	10/6
Dose	Route	Frequency	Start Dt.							
5ml	oral	OD	4/6	10AM						
Name & Signature of the Doctor Starting the Drugs: B. Sreyth										
Additional Instructions: Zinc (5ml/20mg)										
Daily Doctor's Endorsement by a Sign										

DRUG : PROGG				Date/Time	5/6	6/6	7/6	8/6/26	9/6	10/6
Dose	Route	Frequency	Start Dt.							
1 sachet	oral	BD	5/6	10Am				not taken	not given	not given
Name & Signature of the Doctor Starting the Drugs: B. Sreyth										
Additional Instructions:				10pm				Not taken	not given	not given
Daily Doctor's Endorsement by a Sign										

Stop

DRUG : ORS Sachet				Date/Time	5/6
Dose	Route	Frequency	Start Dt.		
1 sachet	PO		5/6.		
Name & Signature of the Doctor Starting the Drugs: After each loose stool					
Additional Instructions: 1 sachet in 200ml water.					
Daily Doctor's Endorsement by a Sign					

DRUG : TAB CYCLOPAM				Date/Time	5/6	6/6
Dose	Route	Frequency	Start Dt.			
1 tab	PO	BD	5/6	6AM	X	
Name & Signature of the Doctor Starting the Drugs:						
Additional Instructions:				6PM		
Daily Doctor's Endorsement by a Sign						

STOP

Docu. No. : RCH /FRM / CLINICAL / 108

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

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Master DOMAKONDA SHREYANSH
09-02-2016 10 Y 3 M 26 D (M)
Dr. P V S Sivesh

Sheet No: ....

REGULAR PRESCRIPTIONS

Weight .... Ward ....

DRUG : Inj. METROGYL

Dose	Route	Frequency	Start Dt.
200mg	IV	Q8H	5/6

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions: Metronidazole

Daily Doctor's Endorsement by a Sign

Date/Time: 5/6, 6/6, 7/6, 8/6, 9/6 — 6AM, 2PM, 10PM — STOP 9/6

DRUG : SYP. HEPAMERZ OA

Dose	Route	Frequency	Start Dt.
5ml	PO	BD	8/6

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date/Time: 8/6, 9/6, 10/6 — 11AM, 11PM — STOP

DRUG : Syp. CYCLOPAM

Dose	Route	Frequency	Start Dt.
5ml	PO	BD	5/6

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions: (20mg/5ml)

Daily Doctor's Endorsement by a Sign

Date/Time: 7/6, 8/6 — 6AM, 6pm — stop sent

DRUG : SYP. CEFIXIME.

Dose	Route	Frequency	Start Dt.
10ml	PO	BD	11/6

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions: BD (100mg/5ml)

Daily Doctor's Endorsement by a Sign

Date/Time:

Docu. No. : RCH /FRM / CLINICAL / 108

(P.T.O.)

Verified by Dr. Dhakshayani

HNH-00015802 IP26-00006502
Master DOMAKONDA SHREYANSH
09-02-2016 10 Y 3 M 26 D (M)
Dr. P V S Sivesh

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
06/06	12 AM	Inj Esomeprazole	20 mg	IV	[signature]	[signature]
7/6	10 AM	Inj CEFTRIAXONE	2gm in 50ml NS over 2hrs	IV	[signature]	[signature]

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

HNH-00015802 IP26-00006502
Master DOMAKONDA SHREYANSH (M)
09-02-2016 10 Y 3 M 26 D
Dr. P V S Sivesh

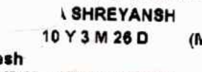
I.V. FLUIDS CHART

Weight. 21.9 kg Ward.

Date	Time	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
9/6/26	8.20pm	IVF PLASMALYTE (2/3 Maintenance)	IV	40	[signature]	[signature] / [signature]		[signature]	[signature] / [signature]
6/6/26	9pm	IVF PLASMALYTE (1/2 Maintenance)	IV	30	[signature]	[signature] / [signature]	9/6	[signature]	[signature] / [signature]

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

HNH-00015802 IP26-00006502
Master DOMAKONDA SHREYANSH
09-02-2016 10 Y 3 M 26 D (M)
Dr. P V S Sivesh



IP26-00006502
SHREYANSH
10 Y 3 M 26 D (M)
Dr. P V S Sivesh

302

RESULT SHEET

Date	4/6/26	7/6/26	9/6/26	10/6/26		
Time outside						
Hb 12.1		10.9				
PCV 32.4		30.3				
RBC 4.1		4.62				
WBC 6700		2.94				
N/L 78/15		53.8/34.4				
Platelets 1,30,000		188				
CRP 12.3		21.0				
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP	154	142	159	157		
SGPT	80	266	334	326		
SGOT	109	351	355	269		
T.Bill/Conj	0.4/0.2	0.2/0.1	0.2/0.1	0.2/0.1		
T.Protein	6.8	6.1	6.2	6.5		
S.Albumin	3.7	3.2	3.4	3.4		
S.Globulin	3.1	2.9	2.8	3.1		
A/G Ratio	1.1	1.1	2.8	3.1		
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR			14/1.0			
APTT			36			
CSF Protein/Sugar						
Cells						
N/L						

Date	4/6/26					
Time						
CUE-Alb	present +					
CUE-Sugar	Nill					
CUE - Ketones	present ++					
CUE-PUS Cells	6-8					
CUE - RBC Cells	Nill					
CUE - Nitrite	Negative					
PH	7.0					
Stool Pus Cell						
OVA/Cyst						
Occult Blood						
Dengue NS1	Negative					
Anti-HAV Antibody IgM –	Negative					
Anti-HEV Antibody IgM –	Negative					
HBSAG —	Not detected					

Blood c/s : 48h no growth.

Culture and Sensitivities : Urine c/s – 24 No growth

stool c/s — Negative

Radiology: USG :

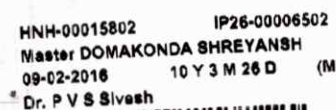
X-Ray:

ECHO:

CT:

MRI

Others (ECG, Contrast Studies etc.,) :



RM / CLINICAL / 126

SCHOOL AGE (5-12 years)

Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 4/6/26 Time:	10:30pm	11:40pm	12:30pm	2:30pm	3:30pm	4:30AM	6AM
Doctor / Nurse / Family Concern?							
Temperature (F)	102.2°F (Crocin Given)	101.3°F (Sponging Given)	99.3°F	100.1°F (Sponging Given)	99.0°F	101.2°F (Crocin Given)	99.2°F
Heart Rate (bpm) and Blood Pressure (mmHg) *	95/56 (67)			100/62 (73)			98/.. (70)
Heart Rate (Number)	112 bpm			100 bpm			118 bpm
Resp. Rate (bpm) (Over 1 Minute) *							
Resp Rate (Number)	22 bpm			20 bpm			22 bpm
Resp Distress (Mod/ Severe; None / Mild)							
Receiving O_2(l/min) / O_2Saturations (%)	99%			99%			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	[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.

*: 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

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)

HNH-00015802 IP26-00006502
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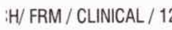

H/ FRM / CLINICAL / 126

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 5/1/26

Time	8 Am	10 Am	11 Am	12 Pm	1 Pm	2 Pm	4:40 PM	6 PM	11:05 (?)	12:30 AM	2 am (?)	5 Am	7 Am
Temperature (F)	98.6°F	99.3°F	101.2°F	100.6°F	99.8°F	99.3°F	101.4°F	98.4°F (?)	100.6°F	99.8°F	98.9°F	101.8	100.1°F
Remarks			Crocin Given				Syp. crocin given		Crocin			Crocin given	Sponging given
Heart Rate (Number)		114 b/m				116 b/m		105 b/m			112 b/m	118 b/m	
Resp Rate (Number)		26 b/m				24 b/m		25 b/m			28 b/m	30 b/m	
O₂ Saturations (%)		100%				100%		100%			100%	99%	
TOTAL SCORE (Number of shaded boxes)		0				0		0			0	0	
Pain Score		0				0		0			0	0	
Observer's Initials		[illegible]				[illegible]		[illegible]			[illegible]	[illegible]	

Form rows: Doctor / Nurse / Family Concern?; Temperature (F) 94–104; Heart Rate (bpm) and Blood Pressure (mmHg) * 50–190; Note: BP does not score in early warning scoring; Heart Rate (Number); Resp. Rate (bpm) (Over 1 Minute) * 1–70; Resp Rate (Number); Resp Distress Mod/ Severe, None / Mild; Receiving O_2 (l/min); O_2 Saturations (%); Conscious Level Normal, Altered; GCS *; TOTAL SCORE Number of shaded boxes; Pain Score; Observer's Initials.

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

NB: Scores 3 should be recorded overleaf

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

Patient Sticker

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)

HNH-00015802 IP26-00006502
Master DOMAKONDA SHREYANSH
09-02-2016 10 Y 3 M 27 D (M)
Dr. P V S Sivesh

Patie... / CLINICAL / 126

SCHOOL AGE (5-12 years)

Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 6/1/26	Time:	10AM	2PM	4:12pm	6pm	10pm	5:33AM	8PM
Doctor / Nurse / Family Concern?								
Temperature (F)	104 – 94	98.2°F	97.9°F	100.6°F (Crocin given)	99.8°F	98.1F	100.7°F (Crocin Given)	98.3°F
Heart Rate (bpm) and Blood Pressure (mmHg) *	190 – 50	110/60						
Heart Rate (Number)		110b/m	108b/m		108b/m	112b/m		118b/m
Resp. Rate (bpm) (Over 1 Minute) *	70 – 10							
Resp Rate (Number)		20b/m	20b/m		20b/m	22b/m		20b/m
Resp Distress	Mod/ Severe							
	None / Mild							
Receiving O_2(l/min)								
O_2Saturations (%)		100%	97%		99%	100%		99%
Conscious Level	Normal							
	Altered							
GCS *								
TOTAL SCORE Number of shaded boxes		0	0		0	0		0
Pain Score		0	0		0	0		0
Observer's Initials								

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
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Patient Sticker

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B	**BACK GROUND :** Child (X) was admitted on (XX date) with (e.g. respiratory infection). They have had (X operation/ procedure/ investigation). Child (X)'s condition has changed in the last (XX mins). Their last set of observations were (XXX). The child's normal condition is ... (e.g. alert/ drowsy/ confused, pain free)
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Master DOMAKONDA SHREYANSH
09-02-2016 10 Y 3 M 28 D (M)
Dr. P V S Sivesh

Patient

CLINICAL / 126

SCHOOL AGE (5-12 years)

Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 7/6/26

Time:	10 AM	2 PM	5 PM	10pm	12am	2am	6am	7am
Doctor / Nurse / Family Concern?								
Temperature (F) (104–94)	97.8°F	98.6	99.1°F	100.3°F (Crocin)	98.4°F	97.6°F	97.8°F	99.4°F
Heart Rate (bpm) and Blood Pressure (mmHg) * (190–50)			101/61 (76)	95/64 (74)			91/67 (75)	
Heart Rate (Number)	108 b/m	104 b/m	104 b/m	118 b/m			98 b/m?	
Resp. Rate (bpm) (Over 1 Minute) * (70–10)								
Resp Rate (Number)	20 b/m	22 b/m	28 b/m	20 b/m			20 b/m	
Resp Distress: Mod/ Severe / None / Mild								
Receiving O_2 (l/min) / O_2 Saturations (%)	100%	100%	98%	99%			100%	
Conscious Level: Normal / Altered								
GCS *			15/15	15/15			15/15	
TOTAL SCORE Number of shaded boxes	6	0	6	1			1	
Pain Score	0	0	0	0			0	
Observer's Initials	[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
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Patient Sticker

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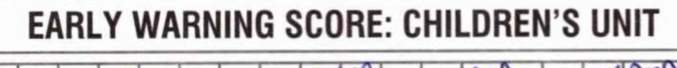
Dr. P V S Sivesh

CHBH / FRM / CLINICAL / 125

PRESCHOOL (1-5 years) (corrected by hand to 6-12)
Children's Observation & Early Warning Scoring Chart



EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 6/6/26 Time:	10 Am	2 Pm	6 pm	10pm	2AM	7AM
Doctor / Nurse / Family Concern?						
Temperature (F)	98.2F	98.6F	97.6F	98.7F	97.8F	98.7F
Heart Rate (bpm) and Blood Pressure (mmHg) *						
Heart Rate (Number)	120b/m	108b/m	112b/m	124b/m	98b/m	
Resp. Rate (bpm) (Over 1 Minute) *						
Resp Rate (Number)	20b/m	20b/m	20b/m	20b/m	20b/m	
Resp Distress: Mod/ Severe; None / Mild						
Receiving O_2(l/min)						
O_2Saturations (%)	99%	99%	98%	99%	100%	
Conscious Level: Normal; Altered						
GCS *						
TOTAL SCORE Number of shaded boxes	0	0	0	0	0	
Pain Score	0	0	0	0	0	
Observer's Initials						

Temperature scale: 104, 103, 102, 101, 100, 99, 98, 97, 96, 95, 94

Heart Rate / BP scale: 190, 180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60, 50

Note: BP does not score in early warning scoring

Resp. Rate scale: 70, 60, 50, 40, 30, 20, 10

ACTIONS		
	Score 1	: Continue normal observation by staff nurse
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Patient Sticker

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

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09-02-2016 10 Y 3 M 29 D (M)
Dr. P V S Sivesh

Patient Sticker

126

SCHOOL AGE (5-12 years)

Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 9/6/26

Time:	10 AM	2 PM	5:30 PM	10PM	2AM	6AM
Doctor / Nurse / Family Concern?						
Temperature (F)	97.1°F	96.9°F	96.3°F	98F	98F	98F
Heart Rate (bpm) and Blood Pressure (mmHg) *	100/66 (73)	98/63 (79)	96/66 (70)	98/65 (80)	98/70	96/74
Heart Rate (Number)	110b/m	112b/m	109b/m	110b/m	109b/m	108b/m
Resp. Rate (bpm) (Over 1 Minute) *						
Resp Rate (Number)	28b/m	28b/m	28b/m	31b/m	30b/m	30b/m
Resp Distress: Mod/ Severe						
Resp Distress: None / Mild						
Receiving O_2(l/min)						
O_2Saturations (%)	99%	99%	99%	99%	99%	99%
Conscious Level: Normal						
Conscious Level: Altered						
GCS *	15/15	15/15	15/15	15/15	15/15	15/15
TOTAL SCORE Number of shaded boxes	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0
Observer's Initials	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

Chart scales: Temperature 94–104; Heart Rate / Blood Pressure 50–190; Resp. Rate 10–70.

Note: BP does not score in early warning scoring

ACTIONS

NB: Scores 3 should be recorded overleaf

Score	Action
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

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)

Patient

CLINICAL / 126

SCHOOL AGE (5-12 years)

Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 10/6/26 Time:	10 am	2pm	6pm	10pm	2AM	6AM
Doctor / Nurse / Family Concern?						
Temperature (F) (104–94)	97.5°F	97.3°F	95.6°F	98°F	98°F	97.5°F
Heart Rate (bpm) and Blood Pressure (mmHg) * (190–50)	99/66 (77)	100/70	98/60	99/68	98/67	99/68
Heart Rate (Number)	98b/m	95b/m	110b/m	110b/m	111b/m	112b/m
Resp. Rate (bpm) (Over 1 Minute) * (70–10)						
Resp Rate (Number)	25b/m	30b/m	35b/m			
Resp Distress — Mod/ Severe						
Resp Distress — None / Mild						
Receiving O_2(l/min)						
O_2Saturations (%)	99%	99%	99%			
Conscious Level — Normal						
Conscious Level — Altered						
GCS *						
TOTAL SCORE Number of shaded boxes	0	0	0			
Pain Score	0	0	0			
Observer's Initials	Sh	S	S			

Note: BP does not score in early warning scoring

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

NB: Scores 3 should be recorded overleaf

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

Patient Sticker

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

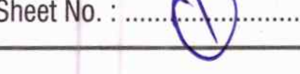
- If at any time additional help is required, call help – regardless of the Early Warning Score!
- Following a Early Warning Score assessment, senior help may be required

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)

HNH-00015802 IP26-00006502
Master DOMAKONDA SHREYANSH
09-02-2016 10 Y 3 M 26 D (M)
Dr. P V S Sivesh

FLUID CHART



Sheet No. : 1

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	Route: Mouth	Route: I.V	Route: N.G	Output: NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
	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 :**						
4/6/26	08:00 pm	plasmalyte	Botley + H_2O.			NA						
	09:00 pm											
	10:00 pm										0	Sign
	11:00 pm						✓	0	✓			
	12:00 am			40ml								
	01:00 am			40ml			✓		✓	✓		
Total Intake : Taken						**Total Output :** U-1 M-0						
5/6/26	02:00 am	plasmalyte		40ml		NA						
	03:00 am			40ml						✓		
	04:00 am			40ml							0	
	05:00 am			40ml			✓					Sign
	06:00 am			40ml						✓		
	07:00 am			40ml								
Total Intake : Taken						**Total Output :** U-2 M–						

Total 24 hrs. Intake	

Total 24 hrs. Output	

HNH-00015802 IP26-00006502
Master DOMAKONDA SHREYANSH (M)
09-02-2016 10 Y 3 M 26 D
Dr. P V S Sivesh

FLUID CHART

Sheet No. : ......②......

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	Route: Mouth	Route: I.V	Route: N.G	Output: NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
5/6/26												
	08:00 am	Plasmalyte	Idli	40ml		NA	✓	NA	NA	✓	0	[illegible]
	09:00 am			40ml								
	10:00 am			40ml								
	11:00 am			40ml								
	12:00 pm			40ml			✓			✓		
	01:00 pm			40ml								
Total Intake :						**Total Output :** U2					M-1	
5/6/26	02:00 pm	plasmalyte		40ml		NA	✓	NA	NA		0	[illegible]
	03:00 pm			40ml			✓					
	04:00 pm			40ml						✓		
	05:00 pm		kichidi + H_2O	40ml			✓					
	06:00 pm			40ml						✓		
	07:00 pm			40ml			✓					
Total Intake :						**Total Output :** U-					M-	
5/6/26	08:00 pm	plasmalyte		40ml		NA		NA	NA		0	[illegible]
	09:00 pm			40ml								
	10:00 pm			40ml			✓			✓		
	11:00 pm			40ml								
	12:00 am			40ml			✓			✓		
	01:00 am			40ml						✓		
Total Intake :						**Total Output :**						
6/6/26	02:00 am	plasmalyte		40ml		NA		NA	NA		0	[illegible]
	03:00 am			40ml			✓					
	04:00 am			40ml						✓		
	05:00 am			40ml			✓					
	06:00 am			40ml						✓		
	07:00 am			40ml			✓			✓		
Total Intake :						**Total Output :**						

Total 24 hrs. Intake		Total 24 hrs. Output	

HNH-00015802 IP26-00006502
Master DOMAKONDA SHREYANSH
09-02-2016 10 Y 3 M 27 D (M)
Dr. P V S Sivesh

FLUID CHART

Sheet No. : 3

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							
6/6/26	08:00 am	plasmolyte		40ml							0	
	09:00 am		Dal	40ml		NA	✓	NA		✓		
	10:00 am		+ H2O	40ml								
	11:00 am											
	12:00 pm	Stop										
	01:00 pm											
Total Intake : taken						Total Output :				U — M —		
6/6/26	02:00 pm	0				NA	✓	NA		✓	0	
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm									✓		
	07:00 pm											
Total Intake :						Total Output :				U — M —		
6/6/26	08:00 pm	plasmolyte	Rice	40ml		NA		NA			0	
	09:00 pm		+	40ml								
	10:00 pm		H2O	40ml						✓		
	11:00 pm			–								
	12:00 am			–						✓		
	01:00 am			–								
Total Intake :						Total Output :						
7/6/26	02:00 am	plasmolyte		40ml		NA		NA			0	
	03:00 am			40ml						✓		
	04:00 am		H2O	40ml								
	05:00 am			40ml								
	06:00 am			40ml						✓		
	07:00 am			40ml								
Total Intake :						Total Output :						

Total 24 hrs. Intake		Total 24 hrs. Output	

Docu. No. : RCH /FRM / CLINICAL / 092

HNH-00015802 IP26-00006502
Master DOMAKONDA SHREYANSH
09-02-2016 10 Y 3 M 28 D (M)
Dr. P V S Sivesh

FLUID CHART

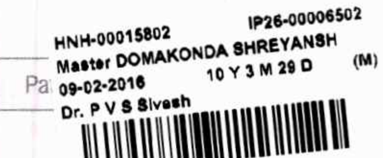
Sheet No. : ....

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

Date	Time	Nature of Fluid	Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
	08:00 am			30ml								
	09:00 am		Oral	30ml			✓	NA		✓		
	10:00 am	Plasmolyte	H2O	30ml	NA						0	
7/6/26	11:00 am			30ml						✓		
	12:00 pm			30ml								
	01:00 pm			30ml						✓		
Total Intake : Taken									**Total Output :**	U – 3	M – 1	
	02:00 pm		Rice				✓			✓		
	03:00 pm		Chapati									
	04:00 pm	Plasmolyte		30ml						✓		
	05:00 pm			30ml	NA			NA			0	
	06:00 pm			30ml						✓		
	07:00 pm			30ml								
Total Intake : Taken									**Total Output :**	U - 3	M - 1	
	08:00 pm			30ml								
	09:00 pm			30ml						✓		
	10:00 pm	Plasmolyte	H2O	30ml			NP				0	
	11:00 pm			30ml		NP		NA		✓		
	12:00 am			30ml								
	01:00 am			30ml								
Total Intake :									**Total Output :**			
	02:00 am		H2O	30ml								
	03:00 am			30ml						✓		
	04:00 am	Plasmolyte		30ml		NP	NP					
	05:00 am			30ml				NA			0	
	06:00 am			30ml						✓		
	07:00 am		H2O	30ml								
Total Intake :									**Total Output :**			

Total 24 hrs. Intake	

Total 24 hrs. Output	



FLUID CHART

Sheet No. : ....

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

Date	Time	Intake: Nature of Fluid	Route: Mouth	Route: I.V	Route: N.G	Output: NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
8/6	08:00 am	plasmalyte		30ml						✓		
	09:00 am		dosa	30ml	NA			NA				
	10:00 am		+ H2O	30ml			0				0	
	11:00 am			30ml						✓		
	12:00 pm			30ml								
	01:00 pm			30ml								
Total Intake : taken						Total Output :				U — I	M — I	
	02:00 pm	plasmalyte		30ml								
	03:00 pm		Rice	30ml								
	04:00 pm		+ H2O	30ml	NA		0		NA	✓	0	
	05:00 pm			30ml								
	06:00 pm			30ml						✓		
	07:00 pm			30ml								
Total Intake : taken						Total Output :				U —	M —	
8/6/26	08:00 pm	plasmalyte	Rice	30ml								
	09:00 pm		+	30ml								
	10:00 pm		H2O	30ml							0	
	11:00 pm			30ml	NA			NA				
	12:00 am			30ml								
	01:00 am			30ml								
Total Intake :						Total Output :						
9/8/26	02:00 am	plasmalyte		30ml								
	03:00 am			30ml								
	04:00 am			30ml								
	05:00 am			30ml	NA			NA			0	
	06:00 am			30ml								
	07:00 am			30ml								
Total Intake :						Total Output :						

Total 24 hrs. Intake		Total 24 hrs. Output	

HNH-00015802 IP26-00006502
Master DOMAKONDA SHREYANSH
09-02-2016 10 Y 3 M 30 D (M)
Dr. P V S Sivesh

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				Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
		Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
9/6/26	08:00 am	Plasmalyte	Bambino	–							0	
	09:00 am			–						✓	0	
	10:00 am			30ml			✓			✓	0	
	11:00 am			30ml							0	
	12:00 pm			30ml							0	
	01:00 pm			–						✓	0	
Total Intake :						Total Output : U –					M –	
9/6/26	02:00 pm	Plasmalyte	Paneer rice								0	
	03:00 pm			Stop						✓	0	
	04:00 pm			IVF							0	
	05:00 pm									✓	0	
	06:00 pm	Stop									0	
	07:00 pm										0	
Total Intake :						Total Output : U –					M –	
9/6/26	08:00 pm											
	09:00 pm											
	10:00 pm	0	Bdly + H2O	0		NA		NA		✓	0	
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						Total Output :						
10/6/26	02:00 am											
	03:00 am											
	04:00 am	0	Bdly + H2O	0		NA		NA		✓	0	
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						Total Output :						

Total 24 hrs. Intake	

Total 24 hrs. Output	

HNH-00015802 IP26-00006502
Master DOMAKONDA SHREYANSH
09-02-2016 10 Y 3 M 29 D (M)
Dr. P V S Sivesh

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				Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
		Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
10/6/26	08:00 am									✓		
	09:00 am		idly									
	10:00 am	0		NA				NA			0	
	11:00 am									✓		
	12:00 pm											
	01:00 pm											
Total Intake :						**Total Output :**				U-2	M-	
10/6/26	02:00 pm											
	03:00 pm		Rice							✓		
	04:00 pm	0	+								0	
	05:00 pm		H2O									
	06:00 pm			NA				NA		✓		
	07:00 pm											
Total Intake :						**Total Output :**				U-2	M-	
10/6/26	08:00 pm											
	09:00 pm									✓		
	10:00 pm		Rice					NA				
	11:00 pm	0	+	NA							0	
	12:00 am		H2O							✓		
	01:00 am											
Total Intake :						**Total Output :**						
11/6/26	02:00 am											
	03:00 am											
	04:00 am	0		NA				NA		✓		
	05:00 am		Idly								0	
	06:00 am		+									
	07:00 am		H2O									
Total Intake :						**Total Output :**						

Total 24 hrs. Intake		Total 24 hrs. Output	

HNH-00015802 IP26-00006502
Master DOMAKONDA SHREYANSH
09-02-2016 10 Y 3 M 29 D (M)
Dr. P V S Sivash

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

Total 24 hrs. Intake	

Total 24 hrs. Output	

Patient HNH-00015802
Master DOMAKONDA SHREYANSH IP26-00006502
09-02-2016
Dr. P V S Sivesh 10 Y 3 M 29 D (M)

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

Total 24 hrs. Intake			Total 24 hrs. Output	

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

Total 24 hrs. Intake		**Total 24 hrs. Output**	

Docu. No. : RCH /FRM / CLINICAL / 092

HNH-00015802 IP26-00006502
Master DOMAKONDA SHREYANSH (M)
10 Y 3 M 26 D
09-02-2016
Dr. P V S Sivesh

NURSING CARE RECORD

Date: 4/6/26

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	10:30 PM – 8am	→ Assess the patient general condition → Trace Lab Reports → plasmalyte @ 40 ml/hr to Continue.	10:30 PM – 8am	→ Assessed the patient general condition → monitored vitals → Administered medications as Per doctor's orders	Patient is stable	Rechecked vitals	[signature]

HNH-00015802 IP26-00006502
Master DOMAKONDA SHREYANSH
09-02-2016 10 Y 3 M 27 D (M)
Dr. P V S Sivesh

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
Morning	8Am – 2pm	- Assess the pt condition - Monitor vitals - Maintain I/O Chart - Medication given as per doctor order	8Am – 2pm	- Assessed the pt condition - Monitor vitals - Maintained I/O Chart - medication given as per Drug Chart	pt is Stable	Rechecked Vitals	[signature]
Afternoon	2PM – 8PM	→ Assess the general Condition of pt. → Monitor vitals → Maintain I/O chart. → Administer medication	2PM – 8PM	→ Assessed the general Condition of pt. → Monitored vitals → Maintained I/O chart. → Administered medication.	Pt is Stable.	Re-assessed vitals.	[signature]
Night	8pm – 8am	Assess the baby Monitor the vls administer Medicine Maintain I/O Chart	8pm – 8am	Assessed the baby Monitor vls administer Medicine Maintain I/O Chart	administered Medicine	Reassessed the Pat [illegible]	[signature]

HNH-00015802 IP26-00006502
Master DOMAKONDA SHREYANSH (M)
10 Y 3 M 27 D
09-02-2016
Dr. P V S Sivesh

NURSING CARE RECORD

Date: 6/6/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8AM – 2Pm	→ Assess the Pt condition → monitor vitals → maintain I/O chart → medication as per drug chart → IV cannula present → next prick UBG, CBP, CRP	8am – 2Pm	→ Assessed the Pt condition → monitored vitals & recorded → maintained I/O chart → medication as per drug chart → c/t IV fluids	→ Pt is stable	→ rechecked vitals.	[signature]
Afternoon				DAY			
Night	8PM – 8am	→ Assess the patient general condition. → monitor vitals → next prick CBP, CRP → administer medication as per doctor's orders	8PM – 8am	→ Assessed the patient general condition → monitored vitals → maintain I/O → administered medications as per doctor's orders	Patient is stable	Rechecked vitals	[signature]

HNH-00015802 IP26-00006502
Master DOMAKONDA SHREYANSH
09-02-2016 10 Y 3 M 29 D (M)
Dr. P V S Sivesh

HNH-00015802 IP26-00006502
Master DOMAKONDA SHREYANSH
09-02-2016 10 Y 3 M 28 D (M)
Dr. P V S Sivesh

Patient Sticker

NURSING CARE RECORD

Date: 7/6/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8am – 2pm	→ Assess the pt condition → monitor vitals → maintain I/O chart → IV cannula presented → next prick CBP, CRP → plasmolyte 30ml/hr → IV antibiotics	8am – 2pm	→ Assessed the pt condition → monitored vitals & recorded → maintained I/O chart → IV cannula presented → IV fluids. → IV antibiotics	→ pt is stable	→ rechecked vitals.	[signature]
Afternoon				Day	→ IV placement done		
Night	8pm – 8am	Assess the baby monitor the v/s administer medicine maintain I/O chart	8pm – 8am	Assessed the baby monitored v/s administered medicine maintain I/O chart	[illegible]	Reassessed the pt	[signature]

HNH-00015802 IP26-00006502
Master DOMAKONDA SHREYANSH
09-02-2016 10 Y 3 M 29 D (M)
Dr. P V S Sivesh

NURSING CARE RECORD

Date: 8/6/26

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 to 2pm	→ Assess the baby condition → monitor vitals → maintain I/o chart → Administer medications	8Am to 2pm	→ Assessed the baby condition → continue IV-fluid → Maintained I/o chart	Now pt is stable	Re-check vitals	Mouni [signature]
Afternoon		DAY					
Night	8PM to 8Am	- Assess the pt. condition - Monitor vitals & records - Maintaine I/o chart - Give medication as prescribed by doctor - plan for sample thn	8pm to 8AM	- Assessed the baby condition - Monitored vitals & record - Maintained I/o chart - Given medication as prescribed by doctor.	Patient is Stable Now	Re-checked vitals	[signature]

HNH-00015802 IP26-00006502
Master DOMAKONDA SHREYANSH
09-02-2016 10 Y 3 M 30 D (M)
Dr. P V S Sivesh

NURSING CARE RECORD

Date: 9/6/26

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 – 2PM	→ Assess the general condition of pt. → Monitor vitals → Maintain I/O chart. → Administer medication.	8AM – 2PM	→ Assessed the general condition of pt. → Monitored vitals → Maintained I/O chart → Administered medication.	Pt is stable.	Re-assess vitals.	[illegible signature]
Afternoon		Day Duty					
Night	8pm – 8A	– Assess the pt condition. – Monitor vitals & I/O chart – drug as per chart		– Assessed the pt condition – Monitored vitals & I/O chart – drugs as per order	pt is stable	Recheck vitals	[illegible signature]

HNH-00015802 IP26-00006502
Master DOMAKONDA SHREYANSH
09-02-2016 10 Y 3 M 29 D (M)
Dr. P V S Sivesh

NURSING CARE RECORD

Date: 10/6/26

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 to 2pm	– Assess the pt condition – Monitor the v/s – Maintain the I/O – Drug as per chart	8am to 2pm	– Assess the pt condition – Monitor the v/s – Maintain the I/O – Drug as per chart	– Now baby is stable	– Rechecked the v/s	[signature]
Afternoon		DAY					
Night	8pm 8Am	– Assess the pt condition – Monitor the vitals & I/O Drug as per chart		→ Assessed the pt condition → Monitored the vitals & I/O chart → Drugs as per chart	→ pt is stable	Rechecked vitals	[signature]

HNH-00015802 IP26-00006502
Master DOMAKONDA SHREYANSH
09-02-2016 10 Y 3 M 29 D (M)
Dr. P V S Sivesh

Patient

NURSING CARE RECORD

Date: ....

Goals

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

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

Patient Sticker

NURSING CARE RECORD

Date: ....

Goals

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

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

Patient Sticker

NURSING CARE RECORD

Date: ....

Goals

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

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

HNH-00015802 IP26-00006502
Master DOMAKONDA SHREYANSH
09-02-2016 10 Y 3 M 26 D (M)
Dr. P V S Sivesh

Patient Sticker

NURSING SHIFT HAND OVER FORM

SITUATION	
Diagnosis: AFI c̄ dehydration	Any Infection: ☐ Yes ☐ No ☑ Not Known If Yes Specify: ....
Surgery / Procedure:	Post OP Day:

Section	Item	4/6/26 N8	5/6/26 M6	5/6/26 F2	6/6 8pm	6/6/26 M5	6/6/26 N8
BACKGROUND	Medical Condition (Any special condition to be noted):	—	—	—	—	—	—
	Diet:	—	—	—	—	—	—
ASSESSMENT	Allergy:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
	Ventilation (RA, NP, NIV, VENTI):	—	—	—	—	—	—
	Tubes/Drains/Catheter:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
	Vital Signs: Temp:	99.8°f	98.6°F	98.4°F	98.5 F	97.6°F	98.4°F
	Res:	20b/m	20b/m	20b/.	24	20b/m	20b/m
	SpO_2:	99%	99%	99%	100	99%	99%
	Pulse:	110b/m	100 b/m	100b/.	112	120b/m	130b/m
	BP:	100/60	100/61	110/63	99/62	100/60	100/70
	LOC:	—	—	—	—	—	—
	Fall Risk Score:	—	—	—	—	—	—
	Pain Score:	—	'0'	'0'	—	—	—
	Skin Integrity	—	Good	'Good'	—	—	—
Recommendations	Safety Needs:	☑ Yes ☐ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
	Physiotherapy:	—	—	—	—	—	—
	Others Specify:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
	Special Diet:	—	—	—	—	—	—
	Critical Lab Test / Values:	—	—	—	—	—	—
	Other Special Orders / Medications:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
	PU Prophylaxis:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
	DVT Prophylaxis:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
	ADL (Dependent / Non Dependent):	—	—	—	—	—	—
Post Operative Procedure Special Orders:		NA	—	—	—	—	—
Handed Over By Name :		Sandhya	Supriya	Mounika	[illegible]	Divya	Sandhya
Signature / ID :		[signature]	[signature]	[signature]	[signature]	[signature]	[signature]
Date:		4/6/26	5/6/26	5/6/26	6/6	6/6/26	7/6/26
Time:		8am	2pm	8pm	8am		8am
Taken Over By Name :		Supriya	Mounika	[illegible]	Divya	Sandhya	Divya
Signature / ID :		[signature]	[signature]	[signature]	[signature]	[signature]	[signature]
Date:		5/6/26	5/6/26	6/6	6/6/26	6/6/26	7/6/26
Time:		8Am	2pm	6pm	8AM	8pm	8am

NURSING SHIFT HAND OVER FORM

SITUATION		
Diagnosis: Infective colitis		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify: ....
Surgery / Procedure:		Post OP Day:

Section	Item	7/6/26 M6	7/6/26 E2	8/6 8PM	8/6 MS	8/6/26 N1	9/6/26 MS
BACKGROUND	Medical Condition (Any special condition to be noted):	—	—	—	—	—	—
	Diet:	—	Soft	—	Soft	—	—
ASSESSMENT	Allergy:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
	Ventilation (RA, NP, NIV, VENTI):	—	—	—	—	—	—
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
	Vital Signs: Temp:	98.2°F	98.4°F	98.6°F	98.V	98.7°F	98.4°F
	Res:	20b/m	26b/m	20b/m	26b/m	28b/m	28b/m
	SpO_2:	99%	99%	100%	99%	100%	100%
	Pulse:	108b/m	104b/m	106b/m	102b/m	112b/m	114b/m
	BP:	—	102/61	99/63	99/70	109/72	110/76
	LOC:	—	—	—	—	—	—
	Fall Risk Score:	—	—	—	—		—
	Pain Score:	—	"0"	—	—	—	—
	Skin Integrity	—	Good	good	good		—
Recommendations	Safety Needs:	☐ Yes ☑ No	☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No
	Physiotherapy:	—	—	N/O	—	—	—
	Others Specify:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
	Special Diet:	—	Soft	—	—	—	—
	Critical Lab Test / Values:	—	—	—	—	—	—
	Other Special Orders / Medications:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
	PU Prophylaxis:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
	DVT Prophylaxis:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
	ADL (Dependent / Non Dependent):		—	—	dependent	—	—
Post Operative Procedure Special Orders:			CBP, CRP, LFT, VBG (1)	Reports	NA	—	—
Handed Over By Name :		Divya	Supriya	[illegible]	Mouni	Priyanka	Mouthesh
Signature / ID :		[signature]	[signature]	[signature]	[signature]	[signature]	[signature]
Date:		7/6/26	7/6/26	8/6	8/6	9/6/26	9/6/26
Time:		8PM	8am	8am	8pm	8AM	8PM
Taken Over By Name :		Supriya	[illegible]	Mouni	Priyanka	Mouthesh	
Signature / ID :		[signature]	[signature]	[signature]	[signature]	[signature]	
Date:		7/6/26	8/6	8/6	8/6/26	9/6/26	
Time:		2pm	8am	8am	8pm	8am	

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	9/6/24 N1	10/6/20 M6	10/6/24 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°F	98.5°F	98°F			
	Res:	30b/m	32b/m	30b/m			
	SpO_2:	99%	99%	99%			
	Pulse:	110b/m	110b/m	112b/m			
	BP:	110/69	99/62	99/65			
	Fall Risk Score:	–	–	–			
	Pain Score:	–	–	–			
Recommendations	Safety Needs:	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:		–	–	–			
Handed Over By Name :		Anusha	Sunanda	Anusha			
Signature :		[signature]	[signature]	[signature]			
Date:		10/6/24	10/6/24	10/6/24			
Time:		8A	2pm	8Am			
Taken Over By Name :		Sunanda	Anusha				
Signature :		[signature]					
Date:		10/6/20					
Time:		8am					

Patient Sticker

NURSING SHIFT HAND OVER FORM - WARD

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

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

Section	Item						
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:						

CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			5/6/26 DAY-2			6/6/26 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	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	0	0	0		0	
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	NA		NA	NA	0	0	0		0	
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3			NA	NA	0	0	0		0	
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4			NA	NA	0	0	0		0	
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5			NA	NA	0	0	0		0	
		Signature of the Nurse				[signature]	[signature]	[signature]	[signature]	[signature]		[signature]	

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

Signature of Shift In Charge :

Signature : [signature] Name : [signature]

Signature of Ward In Charge :

Signature : [signature] Name : Balarani

Docu. No. : RCH /FRM / CLINICAL / 137

Patient Sticker

HNH-00015802 IP26-00006502
Master DOMAKONDA SHREYANSH
09-02-2016 10 Y 3 M 29 D (M)
Dr. P V S Sivesh

...CKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1 (7/C)			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						
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1	0	0	0	0						
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	0	0	0	0						
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3	0	0	0	0						
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4	0	0	0	0						
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5	0	0	0	0						
		Signature of the Nurse		[signature]	[signature]	[signature]	[signature]						

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

Signature of Shift In Charge :

Signature : [signature] Name : [handwritten name]

Signature of Ward In Charge :

Signature : [signature] Name : Balani

Docu. No. : RCH /FRM / CLINICAL / 137

CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1 (8/6)			DAY-2 (9)			DAY-3 (10/6)			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			
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	[illegible]		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]			

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

Signature of Ward In Charge :

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

Patient Sticker

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										
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			Signature of the Nurse										

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

Signature of Ward In Charge :

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

Docu. No. : RCH /FRM / CLINICAL / 137

Patient Sticker

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										
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Docu. No. : RCH /FRM / CLINICAL / 137

Patient Sticker

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

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

Docu. No. : RCH /FRM / CLINICAL / 137

HNH-00015802 IP26-00006502
Master DOMAKONDA SHREYANSH
09-02-2016 10 Y 3 M 26 D (M)
Dr. P V S Sivesh

BRADEN 'Q' SCALE

				Date :	4/6/26	5/6/26	5/6/26	
				Time :	11 PM	M6	E2	
Mobility	**1. Completely immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	**3. Slightly limited:** Makes frequent through slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.	4	4	4	4
"Activity The degree of physical activity"	**1. Bedfast :** Confined to bed	**2. Chairfast :** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	**3. Walks occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. All patients too young to ambulate; OR walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4	4	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	4	4	4
Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4
				TOTAL SCORE	28	28	28	28
				Evaluator's Name	[illegible]	[illegible]	[illegible]	[illegible]

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

Docu. No. : RCH /FRM / CLINICAL / 119

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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Master DOMAKONDA SHREYANSH
09-02-2016 10 Y 4 M 1 D (M)
Dr. P V S Sivesh

BRADEN 'Q' SCALE

				Date :	6/6/26	6/6/26	7/6	8/6
				Time :	M5	N7	M5	M5
Mobility	**1. Completely immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	**3. Slightly limited:** Makes frequent through slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.	4	4	4	4
"Activity The degree of physical activity"	**1. Bedfast :** Confined to bed	**2. Chairfast :** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	**3. Walks occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. All patients too young to ambulate; OR walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4	4	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	4	4	4
Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	3	4
				TOTAL SCORE	28	28	27	28
				Evaluator's Name	[signature]	[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

Docu. No. : RCH /FRM / CLINICAL / 119

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
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Master DOMAKONDA SHREYANSH
09-02-2016 10 Y 4 M 1 D (M)
Dr. P V S Sivesh

BRADEN 'Q' SCALE

				Date : / Time :	8/6 N1	9/6/26 M6	10/6 M6	
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	
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				TOTAL SCORE	28	28	28	
				Evaluator's Name	[illegible]	[illegible]	[illegible]	

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

Docu. No. : RCH /FRM / CLINICAL / 119

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
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09-02-2016 10 Y 3 M 26 D (M)
Dr. P V S Sivesh

PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
4/6/26	11PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
5/6/26	10Am	0/10	NA	☐ Continuous ☑ Intermittent	☑ Acute ☐ Chronic	☑ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☑ Decreasing	☑ Yes ☐ No	NA	[signature]
5/6/26	6pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
5/6	5pm	01	Abdom Pain	☐ Continuous ☑ Intermittent	☑ Acute ☐ Chronic	☐ Sharp ☑ Dull ☐ Aching ☐ Burning	☐ Increasing ☑ Decreasing	☑ Yes ☐ No	Cyclopam	[signature]
5/6	8pm	0	[illegible]	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	[illegible]	[signature]
6/6/26	2AM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
6/6/26	10PM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
6/6/26	2pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
7/6/26	6am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
7/6/26	6pm	10/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]

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)

0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10

0 No Pain ... 10 Worst Possible Pain

Wong - Baker (Pediatrics) Above 7 Years

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

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

HNH-00015802 IP26-00006502
Master DOMAKONDA SHREYANSH
09-02-2016 10 Y 3 M 28 D (M)
Dr. P V S Sivesh

PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
8/6	8 am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	NA	[signature]
8/6	10Am	0/0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA NA	[signature]
8/6	2pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
8/6/26	10pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☑ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
9/6/26	2Am	0/10	NA	☐ Continuous ☐ Intermittent	☑ Acute ☐ Chronic	☑ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	NA	[signature]
9/6/26	6Am	0/10	NA	☐ Continuous ☑ Intermittent	☑ Acute ☐ Chronic	☑ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	NA	[signature]
9/6/26	10AM	0/0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
9/6/26	6pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
10/6/26	10am	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		

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)

0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10

0 No Pain ... 10 Worst Possible Pain

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

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
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				☐ 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		
				☐ 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		

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PAIN ASSESSMENT TOOLS

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

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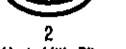
Wong - Baker (Pediatrics) Above 7 Years



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

302

NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 5/6/26 Time: 11:30 Am

Weight: 21.91kg Centile: <3th

Height: – Centile: –

Inference: Underweight child

RDA: Calories: 1650kcal/d Protein: 29gms/d

Diet Recommendations: Gastrodiet Can have :- ORS(WHO), Coconut Water, Sago Water, Rice base food

Re-Assesment: Avoid :- Ragi, Wheat, Oats, Citrus, Sugar, Egg, Milk.

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

Diagnosis: AFI c ? Enteric fever

Nutritional Intervention - ☐ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: [signature]

GROWTH CHART (BOYS)

Birth to 36 months: Boys
Length-for-age and Weight-for-age percentiles

2 to 20 years: Boys
Stature-for-age and Weight-for-age percentiles

Dietician's Name: Sathwika

Dietician's Signature: [signature]

Docu. No. : RCH /FRM / CLINICAL / 160

(P.T.O.)

Daily Notes:

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

PATIENT TRANSFER FORM

HNH-00015802 IP26-00006502 Master DOMAKONDA SHREYANSH 09-02-2016 10 Y 3 M 26 D (M) Dr. P V S Sivesh	Date & Time of Admission 4/6/26 @ 8:13 pm	Date & Time of Transfer Order 4/6/26 @ 9:30 pm
Treating Consultant Name	Transfer Ordered by Dr. Anusha	Reason for Transfer Admission
From Unit ER	To Unit Ward (302)	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File 20	Number of Imaging Films	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
Prabin	Dr. Anusha

Patient & Clinical Records Received by : Sr. Sandhya

Date & Time of Patient Received : 4/6/26 @10 pm

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

Docu. No. : RCH /FRM / CLINICAL / 102

HNH-00015802 IP26-00006502
Master DOMAKONDA SHREYANSH
09-02-2016 10 Y 3 M 26 D (M)
Dr. P V S Sivesh

wt - 21.91 kgs

EMERGENCY ROOM TRIAGE FORM

Patient's Name : shreyansh Age : 10 years **Gender:** ☑ Male ☐ Female

Date : 4/06/26 Time of Arrival : 7.43 p.m.

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: 99.9°F PR: 131/M BP: 100/67 (76) mmHg RR: SpO₂: 100%.

Chief Complaints: c/o fever since 3 days stomach pain since 1 days

INITIAL PHYSIOLOGICAL CATEGORIZATION	INITIAL PHYSIOLOGICAL STATUS
Appearance: ☐ Normal ☑ Sick Looking Circulation / Colour: ☑ Normal ☐ Abnormal ☐ Bleeding Work of Breathing: ☑ Normal ☐ Increased ☐ Decreased ☐ Gasping / Apnea	☑ 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.

Signature of Parent / Guardian

* CTAS - Canadian Triage and Acuity Scale

Triage Completion Time : 7.54 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 : Shirisha Signature of Triage Nurse : [signature]

Date & Time : 4/06/26 @ 7.45 pm

Docu. No. : RCH /FRM / CLINICAL / 085

HNH-00015802 IP26-00006502
Master DOMAKONDA SHREYANSH
09-02-2016 10 Y 3 M 26 D (M)
Dr. P V S Sivesh

NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 4/06/26 Time of arrival : 7:47PM

Chief Complaints: c/o fever since 3days Abdominal pain since 1days

Height : .... Weight : 21.91kgs Head Circumference (<2 years) ....

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

If yes , identify ....

Pain Screening: ☑ Yes ☐ No If Yes, Pain Score: -1 Pain Tool Used: ☐ N Pass ☐ FLACC ☐ Wong Baker

☐ Character Acute ☐ Location stomach pain ☐ Frequency .... ☐ Duration ....

RISK FOR FALL:

If patient is < 6 years	☐ Yes	☑ No
If **'Yes'** tick below fall risk intervention directly		
If Patient is > 6 years		
If **'Yes'** Assess the below parameters		
History of Falling: within past 3 months	☐ Yes	☑ No
Ambulatory Aids:		
• Wheelchair	☐ Yes	☑ No
• Uses furniture for support	☐ Yes	☑ No
Gait/Transferring:		
• Bedrest / immobile	☐ Yes	☑ No
• Weak	☐ Yes	☑ No
• Impaired	☐ Yes	☑ No
Mental Status: Forgets limitations	☐ Yes	☑ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening: ☐ No Abnormalities Detected

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

Inform consultant for positive criteria

Nutritional Screening: ☐ No Abnormalities Detected

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

Inform consultant for positive criteria

Psychological Screening: ☐ No Significant Findings

Unusual concerns about patient's Psychological Status: ☐ Yes ☐ No

If Yes Consultant Notified: .... (Date/Time): ....

Social History: Lives With family

Siblings in household ☐ Yes ☐ No (if yes How Many?) ....

Time of Initial assessment completed by ER Nurse : [signature] 7:49PM

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

Time	Nursing Notes
7:50 PM	Assess the patient condition monitor the vital sigs

Samples collected by: / Vijaya
Time: / 8:30pm

Samples sent by :
Time:

Medication given in ER:

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

Condition of patient at time of shift - out :	Details of Shift - out
HR: 131 b/m BP: 100/67 (70mmHg) CFT:	Shift - out from ER to: 3rd floor (302)
RR: .... SPO2 at FiO2: 100%	Time of Shift - out: 9:30pm
GCS: .... Temperature : 99.9°F	Handover given to: .... (Nurse's Name)
Pain Score:	
Repeat RBS (if applicable):	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

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

Name of the Nurse : S. Hiriswor Signature of the Nurse : [signature]

Date & Time : 4/06/26 @ 7:52pm

HNH-00015802 IP26-00006502
Master DOMAKONDA SHREYANSH
09-02-2016 10 Y 3 M 26 D (M)
Dr. P V S Sivesh

MEDICATION RECONCILIATION FORM

Drug Allergies: ....Nill............ ☑ Not known any Drug Allergies

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

Shifting From: ....ER.... Shifted to: ....Ward....

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

Date & Time : ....4/6/26 @ 9:30 PM....

Nurse Name & Signature: ....Prabin....

Date & Time : ....4/6/26 @ 9:30 PM....

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