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ACTI HNH-00015931 IP26-00006563 **LING**
Master SAI DEVANSH
01-09-2015 10 Y 9 M 10 D (M)
Dr. PAVULURI VENKATA

Name ----------

UHID ---------- Consultant : ---------- Dept : pediatrics

Date of Admission : 12/6/26 Time : ---------- Date of Discharge : ---------- Time: ----------

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
11/6/26	11:40PM	GR	218	
12/6/26	12:05AM	218	302	

Cross Consultation Visit

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

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INVESTIGATIONS

Date	Investigations	Order No.	Sign
11/6/26	CBP CRP RBG	9681 9680	
12/6/26	ESE	9682	

Cross check done by
S.V. Sandhya
13/6/26

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MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	
12/6/26	Infusion pump	12AM.	9:30 am.	6124	Dy.

cross check done.

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PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
22/6/26	W placement	1	6100	
12/6/26 (10:40am)	NHA	(1)	6204	

cross check done

ANY OTHER INFORMATION

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

Ref.No. F/IN/PR/10

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PEDIATRIC IN-PATIENT MEDICAL RECORD

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Patient Name : _____

Patient ID# : _____

Consultant : _____

Final Diagnosis : _____

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Pediatric Multi... ...ination

Name : _____ Age/Sex _____

Informant Father Reliability _____

Chief Presenting Complaints & Duration (Chronologically):

pain abdomen x 1 day
Loose stools x today morning
poor oral intake

History of present illness :

Child was apparently well 1 day back
Then started with pain abdomen around umbilicus
x 1 day
Loose stools (Multiple episodes) since today
morning. watery, not blood or mucous
also poor oral intake

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

Birth & Neonatal History :

Birth & Socio Economic History :

About Father :

About Mother :

Any additional Information :

Developmental History :

Normal

Immunization History :

Cyclo . due

Pediatric Multiorgan H

Anthropometry

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

Weight (kgs) 40 kg (Centile _____)

On Examination :

Temperature : 98 F Pulse Rate: _____ Description _____

B.P. 104/67 mm Hg SPO2 99% at RA

Resp. rate and type of breathing : _____

Signs of dehydration ⊕
dry tongue, lips
Sunken eyes ⊕
dull lethargic

Rash _____

Lymphadenopathy } No

Oedema : _____

Respiratory system :

Inspection (any s/o distress) : _____

Air entry & breath sounds : BSCAE ⊕, clear

Any addes sounds : _____

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

Cardiovasclular System :

Inspection of procordium : _____

Heart Sounds : $S_1 S_2$ ⊕

Any murmur : _____

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

Per Abdomen :

Inspection _____

Palpation : Soft non tender

Ausculation : _____

Spine: _____ External Genitelia : _____

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

Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS Score : _____

Cranial Nerves : _____

_____

_____

Motor System :

Nutrition : _____

Tone : _____ Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR **Superficials :**

Plantars _____

Sensory System :

_____

_____

_____

Bladder / Bowel : _____

Clinical Summary & Diagnostic :

Acute Gastroenteritis with dehydration

_____

_____

_____

Preventive aspects of the treatment :

Desired goals of the treatment :

Planned Labs :

CBP. CRP

VBG

(Stool Routine/Microscopy)

Extra plain sample

Planned Management :

IV fluids

Supportive care.

WHO ORS as accepted

Please fill up the following details

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

Doctor's Signature Name Sai Prasad. Date Time

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
12/06/26 7 AM	C/O 6- D. Suchandh / Dr. Varun D: AGE with dehydration Loosestools (2-3 episodes) after admission No fresh concern mild epigastric pain (+) Accepting orally O/E: GC - fair Vitals stable S/E: PA: Soft Non tender	Adv - IV fluids (4/3 m) - Inj Omeprazole - Progg Suchet - Monitor vitals and - Inform SOS - Trace stool Routine Suchandh NB- Supriya 8:20pm @ 12/6/26

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	c/o/v. Dr. Pritesh	
12/06/26 @ AM	D1: ALG with dehydration	
	Loose stools (3 episodes) overnight	
	No fresh vomiting	
	Accepting orally/passed urine.	
	O/E: AC-fair	
	Hemodynamically stable	
	Hydrating	
	S/E: PA: soft Non tender	
		Adv
		- IV fluids (2/3rd)
		- Supportive care
		- Trace stool Routine
		- Monitor vitals and ~~Inform SOF~~
		NB- Sympt
		9:10 AM @ 12/6/26

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

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
12/1 10 Am	c/s/B Dr. Sai Prasad Sir	
	s/- Acute Gastroenteritis c Dehydration	
	Loose Stool (+)	
	Cough (+)	Plan
	Oral intake - less but improving	1) IVF - 2/3rd (M)
		2) Inj Esomeprazole
	child alert	3) Pro GG
	Dehydration (+)	4) Zofer
		5) Monitor Vitals
	Afebrile	6) ORS / Gastro diet
	R-S - B/L AE (+)	
	P/A - Soft, Non tender	
	Passed Urine	NB- Supriya 10V. 16Apr @ 12/6/16

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
12/6 2:00pm.	C/s/13 POR. Naipunya AGE & dehydration loose stools - 3 episodes Oral intake - fair. No fever Vitals - Stable	plan Cont PROCG Zincmca Cont IVF 2/3 M Monitor vitals ORS sachet NB Mantush @ 3pm
(5pm)	S/B Dr Pritesh Stable Hydration fair U/O ok	

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

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
13/6/25 8 AM	S/o. Dr Prabhath / Dr. Anusha.	
	Δ AGE ⊃ Dehydration	CRP - 11.
	Loose stools - 6 episod (No count from night).	Adv.
	Oral intake - Improved	
	fresh clo - No	- Ct. Pro-GG Zencovia
Hydration Improved.	O/E Vitals stable	- Ct. IVF 2/5 M
	PA soft.	- ORS
		- Monitor vitals.
Af		- Tapu fluids & take breast feed well.
		N/B priyanka.

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
13/6/26. 9.30AM	c/s/by · Ds - Paitch.	
	N/o loosestools from Evening.	
	N/o fresh complaints	⇒ stop IV fluids.
	P/A soft Non tend	⇒. d/s plan ? after Ds Saiprasad Sir Review.
	vital stable	= Enhance orally
		noted by Sr. Sandhya 13/6/26 9:15 am

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

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

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
13/6 9:00 AM	C/S/I/B Dr. Sai prasad	
	AGE & dehydration	
	1 episode loose stool	Plan
	No fever	- Stop IVF
	Vitals stable.	
		- Discuss today
	R/S - BILAE (P)	
	P/A - Soft, NT	- Cont PROCG Syp. Zinconia ORS sachet
		- ~~Mon~~
		- F/U/P after 2 days/SOS
		Signature
		noted by Sr. Sandhya 13/6/26 9:a

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

(P.T.O)

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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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 : IP26-00006563 **Admit Date** : 11-Jun-2026 **Admit Time** : 10:56 PM **UHID** : HNH-00015931

Patient Details :

Patient Name	: Master SAI DEVANSH	**Age**	: 10 Y 9 M 10 D
Guardian	: Mr SUNNY VARUN	**DOB**	: 01-09-2015
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: FALT NO-201, ALPINE TOWERS Kavadi Guda Hyderabad Telangana INDIA 500080	**Phone No**	: 9000002292/ 9866905298
		E-mail	: A.SUNNYVARUN@GMAIL.COM

Admission Details :

Bed Type : DAY CARE **Bed No** : ER01 **Ward Name** : GF -EMERGENCY

Room No : ER01 **Admission Type** : First Visit

Contact Details :

Name : Mr SUNNY VARUN **Relationship** : Father

Contact Address : FALT NO-201, ALPINE TOWERS Kavadi Guda Hyderabad Telangana INDIA 500080 **Phone No** : 9000002292

A. Sai Vasu

Signature

Doctor Details :

Doctor Name	: Dr. PAVULURI VENKATA SAIPRASADA RAO	**Specialisation**	: GENERAL PEDIATRICS
Referral Doctor	: Dr Sai Prasad	**Phone No**	:
Co-Consultant	: Dr. PRITESH NAGAR		

Payment Details :

Payment Mode : DC/CC Card **Deposit Amount** : 20000.00

Payor Name : SELFPAY

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DRUG CHART

Date of Admission: 11/6/26 Drug Allergies: Nill ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

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

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

SOS / PRN (As Required Medication)

DRUG : SYP. CYCLOPAM				Date / Time
Dose: 8ml	Route: PO	Frequency: SOS/8H	Start Date: 11/06	
Doctor's Signature: Sumbath	Valid Period	Pharm. (a)		
Additional Instructions: (5ml/10mg)				

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

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

Verified by Dr. Dhakshavani
Signature
VERIFIED BY : Name

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REGULAR PRESCRIPTIONS

Weight. 40.4 kg Ward. .....

DRUG : INJ. ESOMEPRAZOLE

Dose	Route	Frequency	Start Date
20mg	IV	OD	11/06

Name & Signature of the Doctor Starting the Drugs: Sushanth

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time	12/6	13/6
	1Am	
6Am		

DRUG : SYP. ZINCONIA

Dose	Route	Frequency	Start Date
5ml	PO	OD	11/06

Name & Signature of the Doctor Starting the Drugs: Sushanth

Additional Instructions: (5ml/20mg)

Daily Doctor's Endorsement by a Sign

Date / Time	11/6	12/6
	1Am	
10Am		

DRUG : PROCQ SACHET

Dose	Route	Frequency	Start Date
1sachet	PO	12H	11/06

Name & Signature of the Doctor Starting the Drugs: Sushanth

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time	11/6	12/6
10Am	X	
10pm	1Am	

DRUG : ORS Sachet

Dose	Route	Frequency	Start Date
1sachet	PO		12/6

Name & Signature of the Doctor Starting the Drugs: After each loose stool.

Additional Instructions: Dilute 1 sachet in 1 litre water.

Daily Doctor's Endorsement by a Sign

Date / Time

Verified by Dr. Dhakshayani

Verified by Dr. Dhakshayani

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Sheet No. ....

REGULAR PRESCRIPTIONS

Weight .... Ward ....

DRUG : ORS Sachet

Dose	Route	Frequency	Start Dt.
1 sachet	PO		12/6

Name & Signature of the Doctor Starting the Drugs: [signature] After each loose stool

Additional Instructions:
1 sachet = 4.4gm.
Dilute in 200ml water.

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

VERIFIED BY : Name Signature

Patient Sticker

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Sheet No: .... **REGULAR PRESCRIPTIONS** Weight .... Ward ....

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

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

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

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

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

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01-09-2016 10 Y 9 M 10 D (M)
Dr. PAVULURI VENKATA

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.	

Signature : .....

VERIFIED BY : Name .....

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses

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I.V. FLUIDS CHART

Weight. 40.4kg 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
12/06/26	12AM	IVF - PLASMALYTE (400ml + 100ml 25D)	IV	80	Sunitha				
12/06/26	8AM			↓ 55	Sunitha				

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

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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: GR Shifted to: .....

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

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Sushanth

Date & Time : 12/6/26 @ 11pm

Nurse Name & Signature: Sweety Rao

Date & Time : 12/6/26 @ 11pm

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

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RESULT SHEET

Date	11/6/26					
Time	23:20					
Hb	12.8					
PCV	35.9					
RBC	4.84					
WBC	6.19					
N/L	62.5/28.3					
Platelets	369					
CRP	11					
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

Date	12/6/26					
Time	1:22AM					
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell	2-3					
OVA / Cyst						
Occult Blood						
RBC (Stool –	1-2					

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

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1/ FRM / CLINICAL / 126

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

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 12/6/26 Time: 12 2PM 6PM

Doctor / Nurse / Family Concern? AM

Temperature (F)

104 103 102 101 100 99 98 97 96 95 94

98.2 97.9 98.4

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

Note: BP does not score in early warning scoring

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

105/68 106/69 98/63 (26)

Heart Rate (Number) 93bpm 101bpm 92bpm

Resp. Rate (bpm) over 1 Minute) *

70 60 50 40 30 20 10

Resp Rate (Number) 25bpm 23bpm 24bpm

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

ACTIONS

NB: Scores 3 should be recorded overleaf

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

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

Patient Sticker

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

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FRM / CLINICAL / 126

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

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 12/6/25.... Time:	10 AM	2 PM	6 pm	10pm	2AM	6AM
Doctor / Nurse / Family Concern?						
Temperature (F)	97.4°F	97.1°F	98.2°F	97.5°F	97.8°F	97.8°F
Heart Rate (bpm) and Blood Pressure (mmHg) *	107 / 75 / 63	150 / 85 / 60	108 / 69	109 / 70	107 / 69	105 / 68
Note: BP does not score in early warning scoring						
Heart Rate (Number)	102b/m	86b/m	90b/m	92b/m	90b/m	88b/m
Resp. Rate (bpm) over 1 Minute) *						
Resp Rate (Number)	28b/m	28b/m	30b/m	31b/m	32b/m	33b/m
Resp Distress: Mod/ Severe / None / Mild						
Receiving O_2(l/min) O_2Saturations (%)	99%	100%	100%	100%	100%	99%
Conscious Level: Normal / 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						

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

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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A	**ASSESSMENT :** I think the problem is (XXX) and I have ...(e.g. given O2/ analgesia, stopped the infusion), OR I am not sure what the problem is but child (X) is deteriorating, OR I don't know what's wrong but I am really worried.
R	**RECOMMENDATION :** I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

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FLUID CHART

Sheet No. : 1

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

Date	Time	Intake: Nature of Fluid	Intake: Route – Mouth	Intake: Route – I.V	Intake: Route – N.G	Output: NG	Output: Diarrhoea	Output: Vomit	Output: Drainage	Output: 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 :**						
12/8/26	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						**Total Output :** U – M –						
12/8/26	02:00 am			80ml								
	03:00 am			80ml								
	04:00 am	Plasmalyte		80ml								
	05:00 am		Ho.	80ml								
	06:00 am			80ml								
	07:00 am			80ml								
Total Intake :						**Total Output :** U – M –						

Total 24 hrs. Intake		Total 24 hrs. Output	

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FLUID CHART

Sheet No. : .....

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

Date	Time	Intake: Nature of Fluid	Intake: Route – Mouth	Intake: Route – I.V	Intake: Route – N.G	Output: NG	Output: Diarrhoea	Output: Vomit	Output: Drainage	Output: Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
12/6/26	08:00 am	plasmalyte & 25% Dextrose	Upma	55 ml			✓			✓	0	
	09:00 am			55 ml							0	
	10:00 am		ORS	55 ml			10:43 AM			✓	0	
	11:00 am			55 ml			✓				0	
	12:00 pm			55 ml			✓			✓	0	
	01:00 pm			55 ml							0	
Total Intake :						**Total Output :** U-3 M-3						
12/6/26	02:00 pm	plasmalyte & 25% Dextrose		55 ml			✓			✓	1	
	03:00 pm			55 ml								
	04:00 pm			55 ml			✓			✓		
	05:00 pm			55 ml						✓	0	
	06:00 pm			55 ml								
	07:00 pm			55 ml							1	
Total Intake :						**Total Output :**						
12/6/26	08:00 pm	plasmalyte & 25% Dextrose		55 ml								
	09:00 pm			55 ml								
	10:00 pm			55 ml						✓		
	11:00 pm			55 ml							0	
	12:00 am			55 ml						✓		
	01:00 am			55 ml							1	
Total Intake :						**Total Output :**						
13/6/26	02:00 am	plasmalyte & 25% D5		55 ml								
	03:00 am			55 ml								
	04:00 am			55 ml								
	05:00 am			55 ml						✓	0	
	06:00 am			55 ml								
	07:00 am			55 ml							1	
Total Intake :						**Total Output :**						

Total 24 hrs. Intake		Total 24 hrs. Output	

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FLUID CHART

Sheet No. : .....

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

		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							
13/6/26	08:00 am	plasmalyte.	idly	50ml								
	09:00 am			50ml								
	10:00 am											
	11:00 am			RL fluid stopped								
	12:00 pm											
	01:00 pm											
Total Intake :						**Total Output :** 4 - 4						
	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**	

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NURSING CARE RECORD

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Date: 11/6/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon							
Night	12 Am ↓ 8 Am	→ Assess the Pt condition ↳ monitor vitals ↳ maintain I/O chart ↳ Pt on soft diet → IV cannula Present → Ct medication	12 Am ↓ 8 AM	↳ Assessed the Pt condition ↳ monitored Vitals recorded ↳ maintained I/O chart → IV cannula Present ↳ Ct Fluids → Ct medication	Pt is stable	→ rechecked Vitals	

Patie

NURSING CARE RECORD

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BirthRight™ BY RAINBOW HOSPITALS
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Date: 12/6/26

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 to 2PM	→ To assess the pt. condition → To check the vitals & record → To administer the medication as per drug chart → I/O chart maintain	8AM to 2PM	→ To assessed the pt. condition → To checked the vitals & recorded → To administered the medication as per drug chart → I/O chart maintained	→ Patient is stable → Gastro diet → Contd IVF plasmalyte +2.5% dextrose	→ Re-checked the vitals I/O	Supriya
Afternoon	2PM to 8PM	→ Assess the general condition of pt. → Monitor vitals → Maintain I/O chart → Administer medication	2PM / 8PM	→ Assessed the general condition → Administration medication as for drug.	→ patient stable.	→ vitals normal	Nurse
Night	8pm 8AM	- Assess the pt. condition - monitor vitals & records - Maintain I/O chart - Give medication as prescribed by doctor	8pm 8Am	- Assessed the pt. condition - Monitored vitals & records - Maintained I/O chart - Given medication as prescribed by doctor	patient is stable now	Re-checked vitals	

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NURSING CARE RECORD

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Date: 13/6/26

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 patient general Condition → Monitor vitals → Plasmalyte @ 55 ml/hr to Continue → Plan Discharge	8am 2pm	→ Assessed the patient general Condition → monitored vitals → plan Discharge after Dr. shivesh Rounds	Baby is stable	Rechecked vitals	
Afternoon							
Night							

Patient Sticker

NURSING CARE RECORD

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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							

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NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:				Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:		
	Surgery / Procedure:				Post OP Day:		
BACKGROUND	Date / Shift	11/6/26 N1	12/6/26 MS	12/6/26 N1	13/6/26 Morng		
	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:	94.4°F	98.6°F	97.8°F	98.3°F		
	Res:	20b/m	29b/m	30b/m	32b/m		
	SpO_2:	99%	98%	100%	99%		
	Pulse:	107b/m	106b/m	105b/m	108b/m		
	BP:	—	—	—	—		
	LOC:	—	—	—	—		
	Fall Risk Score:	—	—	—	—		
	Pain Score:	—	—	—	—		
	Skin Integrity	—	—	—	—		
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):		Dep NA	—	—		
Post Operative Procedure Special Orders:		,		—	—		
Handed Over By Name :		Divya	Madhuri	priyanka	Sandhya		
Signature / ID :		D					
Date:		12/6/26	12/6/26	13/6/26	13/6/26		
Time:		8am	8 pm	8AM			
Taken Over By Name :		Supriya	priyanka	Sandhya			
Signature / ID :							
Date:		12/6/26	12/6/26	13/6/26			
Time:		8 PM	8pm	8am			

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NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:				Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:		
	Surgery / Procedure:				Post OP Day:		
BACKGROUND	Date / Shift						
	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:						
	Res:						
	SpO_2:						
	Pulse:						
	BP:						
	LOC:						
	Fall Risk Score:						
	Pain Score:						
	Skin Integrity						
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:							
Handed Over By Name :							
Signature / ID :							
Date:							
Time:							
Taken Over By Name :							
Signature / ID :							
Date:							
Time:							

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THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE 11/8/15	DATE 12/8/15	DATE 13/8/15	DATE	DATE
Age	Less than 3 years old	4	4				
	3 to less than 7 years old	3					
	7 to less than 13 years old	2		2			
	13 years old and above	1					
Gender	Male	2	2	2	2		
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1	1		
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own ability	1	1				
	History of Falls or Infant-Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2		2	2	2	
	Outpatient Area	1	1				
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours/ None	1	1	1	1	1	
Medication Usage	Sedatives (Excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1	1	1	
	Total			9	8		

Intervention: -Fall Risk: Low Humpty Dumpty Score = 7-11, High Risk Humpty Dumpty Score = 12 or above

	Bed in low position		✓	✓	✓		
	Call device within reach		✓	✓	✓		
	Wheels Locked		✓	✓	✓		
	Room free of clutter		✓	✓	✓		
	Adequate lighting		✓	✓	✓		
	Wheel chair support		✓	✓	—		
	Other Intervention(s) Specify		✓	✓	—		
	Nurse's Name:		Divya	Sangeeta	Neeraja		
	Signature:		D				
	Date:		12/8/15	12/8/15	13/8/15		
	Time:		8PM	10AM	8 pm		

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01-09-2015 10 Y 9 M 10 D
Dr. PAVULURI VENKATA

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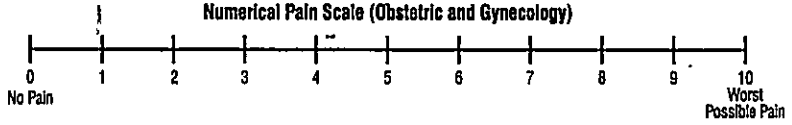
PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
11/6/26	11pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
12/6/26	10AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
12/6/26	4pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
12/6/26	10pm	0/10	NA	☐ Continuous ~~☐ Intermittent~~	~~☐ Acute~~ ☐ Chronic	~~☐ Sharp~~ ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ~~☐ Decreasing~~	~~☐ Yes~~ ☐ No	NA	[signature]
13/6/26	10 am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

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

PAIN ASSESSMENT TOOLS

Numerical Pain Scale (Obstetric and Gynecology)



Wong - Baker (Pediatrics) Above 7 Years

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
	0	1	2
Face	No Particular expression or smile	Occasional Grimace or Frown, withdraw, Disoriented	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs drawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, right, or Jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams of sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

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

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not Irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression Intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR RR, BP, SaO_2	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO_2 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO_2 less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

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CHECKLIST FOR THROMBOPHLEBITIS

11/6/26 12/6

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

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

Signature of Shift In Charge :

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

Signature of Ward In Charge :

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

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BRADEN 'Q' SCALE

					Date : 11/6/26	12/6/26	11/6/26	12/6
					Time : AM	ML	GL	AM
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
					Evaluator's Name			

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

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

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00015931 IP26-00006563 Master SAI DEVANSH 01-09-2015 10 Y 9 M 10 D (M) Dr. PAVULURI VENKATA	11/6/26	11/6/26
	Transfer Ordered by Dr. Seshanthi	Reason for Transfer Admission
From Unit ER	To Unit	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File 14	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
Sreelekha RN	Dr. Seshanthi

Patient & Clinical Records Received by :

Date & Time of Patient Received :

If the transfer order time & Completion time is more than 30 minutes, please tick the reason mentioned below :

☐ Unavailable Bed ☐ Nurse not Available ☐ Available Bed not ready

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EMERGENCY ROOM TRIAGE FORM

Patient's Name : Sai Devansh Age : 10Y **Gender:** ☑ Male ☐ Female

Date : 11/6/26 Time of Arrival : 10:40 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: 98.1 PR: 94 BP: 104/67 RR: SpO$_2$: 100

Chief Complaints: c/o loose stools since todays 24 times.

INITIAL PHYSIOLOGICAL CATEGORIZATION

Appearance
☑ Normal
☐ Sick Looking

Circulation / Colour
☑ Normal ☐ Abnormal ☐ Bleeding

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

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

Triage Classification	CTAS
☐ Level 1 : Resuscitation	☐ Immediate
☐ Level 2 : EMERGENT : Life or limb threatening	☐ < 15 min
☐ Level 3 : URGENT : Significant illness / injury with potential to become life or limb threatening	☐ 30 min
☐ Level 4 : LESS URGENT : Significant illness but not life threatening	☑ 60 min
☐ Level 5 : NON – URGENT : May receive care when convenient	☐ 120 min

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

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian

Triage Completion Time : 10:44 P.m

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 : Anupam

Signature of Triage Nurse : 10:42 Pm

Date & Time : 11/6/26 @ 10:42 P.m

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 11/6/26 Time of arrival : 10:40Am

Chief Complaints: loose stools since today 24 times RBS: .....

Height : ..... Weight : 40 kg BMI : ..... Head Circumference (<2 years) .....

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

If yes , identify .....

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

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

RISK FOR FALL:

☐ If patient is < 6 years
tick below fall risk intervention directly

☐ If Patient is > 6 years
Assess the below parameters

History of Falling: within past 3 months ☐ Yes ☑ No

Ambulatory Aids:

- Wheelchair ☐ Yes ☑ No
- Uses furniture for support ☐ Yes ☑ No

Gait/Transferring:

- Bedrest / immobile ☐ Yes ☑ No
- Weak ☐ Yes ☑ No
- Impaired ☐ Yes ☑ No

Mental Status: Forgets limitations ☐ Yes ☑ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening: ☑ No Abnormalities Detected

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

Inform consultant for positive criteria

.....

.....

Nutritional Screening: ☑ No Abnormalities Detected

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

Inform consultant for positive criteria

Psychological Screening: ☑ No Significant Findings

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

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

Social History: Lives With family.

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

Time of Initial assessment completed by ER Nurse : 10:45 Am

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

Time	Nursing Notes
	Assessed the patient condition
	vitals checked.
	Iv canula done.

Samples collected by: /

Samples sent by : / vidya

Time:

Time: / 11:40 Pm

Medication given in ER:

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

Condition of patient at time of shift - out :	**Details of Shift - out**
HR: 91 BP: 100/67 CFT: —	Shift - out from ER to: 218
RR: 20 SPO_2: 100	Time of Shift - out: 11:44
GCS: — Temperature : 98.2	Handover given to: ..... (Nurse's Name)
Pain Score: 0	
Repeat RBS (if applicable): — NO	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

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

.....

Name of the Nurse : Anupam Signature of the Nurse : A.P

Date & Time : 11/6/26

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NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 12/6/24 Time: 10:40am

Weight: 40.4 kg Centile: 50th

Height: – Centile: –

Inference: Well nourished child

RDA: – Calories: 1650 Kcal/day Protein: 29 gms/day

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

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

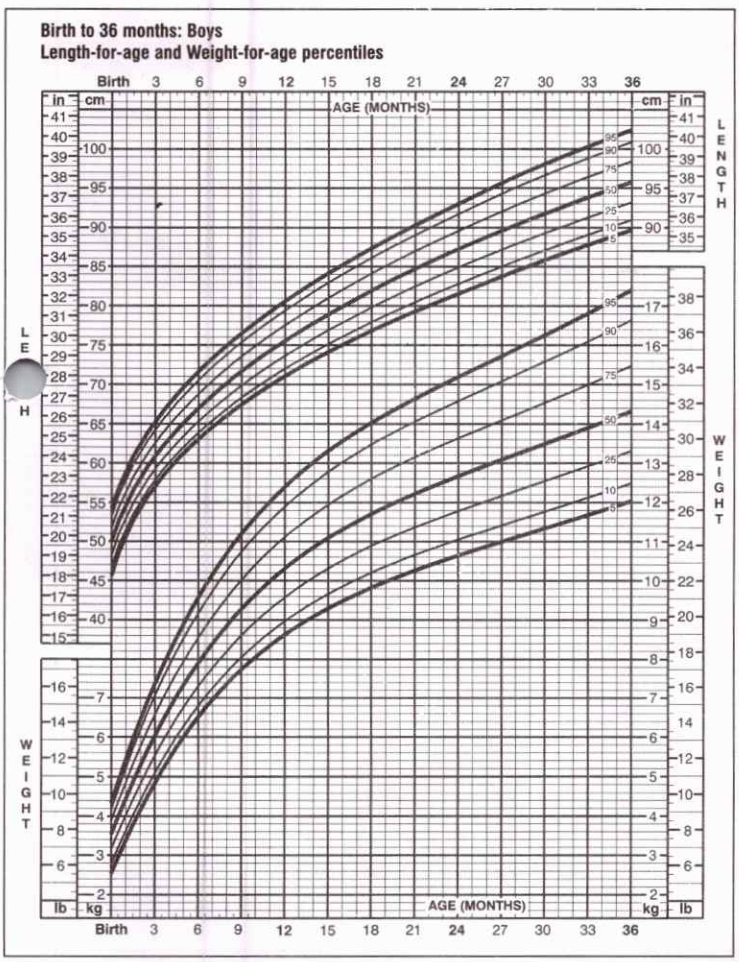
Food Allergies: NO ~~Veg~~/Non-veg Non Veg

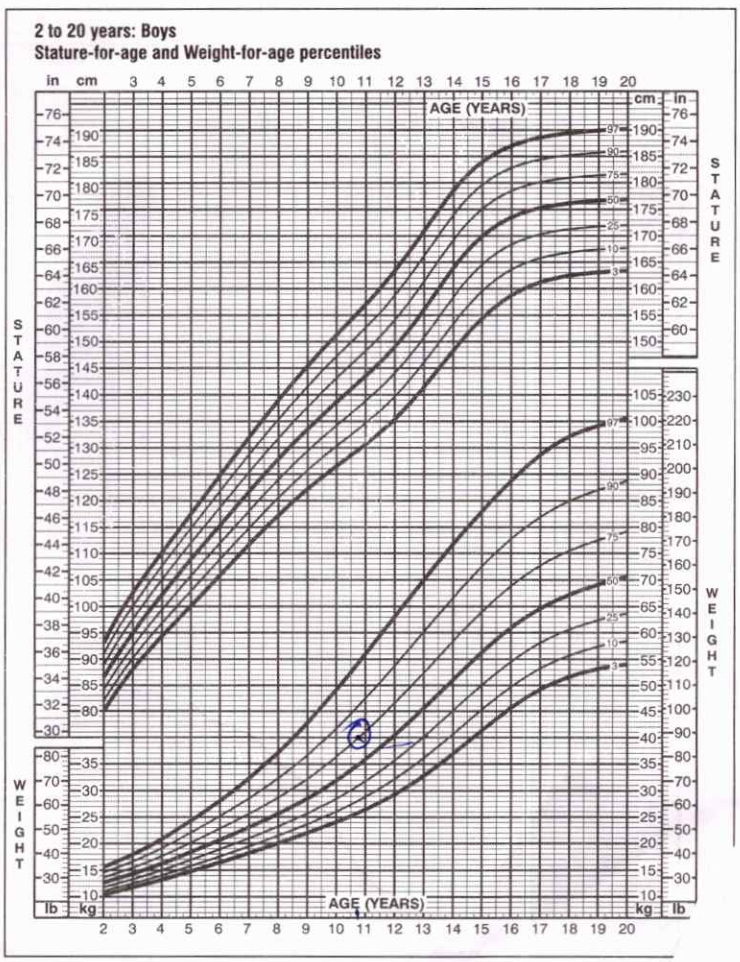
Diagnosis: Acute GE with dehydration

Nutritional Intervention - ☑ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: Effy

GROWTH CHART (BOYS)





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

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

Daily Notes:

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

GENERAL CONSENT FOR TREATMENT

Patient Name:	**Master SAI DEVANSH**	**Age :**	**10 Y 9 M 10 D**
IP No:	**IP26-00006563**	**Sex:**	**Male**
Consultant:	**Dr. PAVULURI VENKATA SAIPRASADA RAO**	**Ward/Bed No:**	**GF -EMERGENCY/ER01**

The undersigned patient and I or responsible relative or person hereby consent to and authorize Rainbow Hospitals doctors and medical personnel to perform medical examinations, conduct routine investigations and administer medical treatments, outpatient procedures, minor dressings, vaccinations and immunizations during the course of the patient's care, as in patient.

Patient, be deemed advisable or necessary.

I understand that the confidentiality of all medical records shall be protected to the full extent of the Law. The undersigned also consent to the use of health related information/ audiovisuals of the patient for research & training purpose or for insurance coverage and while doing so confidentiality of the patient will be maintained at all times and this will not affect the care of the patient.

In giving my general consent to treatment, I understand that I retain the right to refuse any particular examinations, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by treating doctors. I also understand that the practice of medicine is not an exact science and that no guarantee have been made to me as the results of my evaluation and I or treatment.

I understand that I shall not bring valuables to the Hospitals and that the Hospital will not be responsible for the loss, destruction or theft of my personal belongings. I assume full responsibility for all my personal items and release the Hospital from responsibility and liability for such personal items and valuables.

"I am aware that during the patient care it is inevitable that certain re-useable equipment shall be re-used after sterilization and disinfection. I am informed that the hospital assures maximum level of precaution and care in sterilizing and disinfecting the equipment and monitors the whole process as per evidence based guidelines".

Note:
1 We do not allow use of medication brought from outside by the patient.
2 I have received attendant passes as per my room category. I understand that I have to return it back at the time of final bill clearance. In case of failing the submission, I will pay 200/- Rs.
(Receivers Signature:.....A.Silva)

3 IP Guide book has been given to me and I have been explained about the Hospitals rules and policies.
4 Financial and billing counseling has been done to me.

Signature of Patient/Relative: A.Silva

Name: SUNNY VARUN
Relationship: Father
Date: 11/6/25 Time: 23:02
Witness Name:
Witness Signature:

Patient Address:
FALT NO-201, ALPINE TOWERS Kavadi Guda Hyderabad Telangana INDIA 500080

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BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

25 years

BILLING POLICY

- Billing cycle: - With effective from 1st January 2020, Our billing cycle to be start from 12 PM to 12 PM, Settlement post 12 PM, room rent will be charge for half day extra & post 6 pm, it will be charge for full day. Less than 24 hours stay will be considered as one day.
- As per the GOI guidelines, we can collect Rs 1,99,999/- only in cash mode, balance patient can pay through Card tpaIn the event of TPA/ Cashless denial or approval not received due to any reason then hospital tariff will be applicable and any discount or special rates given to TPA's / corporates won't be applicable.
- If the surgery / scans performed in Emergency hours (8pm - 7am), public holiday and on Sunday will be charged TPA processing charges Rs.720 for every TPA route cases.
- All charges vary as per Room category, except Pharmacy and consumables.
- We follows a "No Discounts Policy" kindly cooperate.
- No Duplicate/Second copy of OP OR IP bill is issued.
- ICU/Ward Charges DO NOT INCLUDE - Air Mattress, Monitor, Consultants/ Specialty Doctors Visit, Infusion/syringe pump, Ventilator/C pap, Oxygen, Investigations, Procedures, Consumables, Medicines or any other bedside equipment's/devices etc. (Detailed list can be taken from billing department).

Patient attendant can collect for Interim/provisional bill of the patient from the billing section on daily basis. Interim Bill shall be based on the acknowledged services in HIS. Final Bill of the patient may vary from the Interim bill based on actual update taken on the day of discharge. It is requested that patients/attendants inquire daily about the bill amount from billing section and pay the outstanding as on that day.

Patient bill outstanding should not be increase more than 10,000/-

You are requested to clear your outstanding amount on daily basis before 12 PM.

MODE OF PAYMENT & REFUNDS

- We accept payments by cash (up to Rs 1,99,999/- only), cards, online transfer and Demand Drafts.
- All refund more than Rs.2,000/- will be refund through NEFT in three Bank working days.

Name & signature of Patient/Attendant

(Signature of Admission Desk executive)

NOTE: Self - attested Govt. ID proof is mandatory whosoever is signing the undertaking.

RAINBOW CHILDREN'S MEDICARE PRIVATE LIMITED

Registered Office: Road No.2, Banjara hills, Near Hotel Park Hyatt, Hyderabad - 500 034, T: +91 40 2233 4455.
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CIN: U85110 TG1998 PTC029914 email : info@rainbowhospitals.in **www.rainbowhospitals.in**

DISCHARGE SUMMARY

Name	Master SAI DEVANSH	**UHID**	HNH-00015931
Father/Guardian	Mr SUNNY VARUN	**Age/Gender**	10 Y 9 M 11 D/ Male
Address	FALT NO-201, ALPINE TOWERS, Kavadi Guda, Hyderabad, Telangana, INDIA, 500080		
IP No	IP26-00006563	**Admission Date**	11-06-2026
Ref Doctor	Dr Sai Prasad		
Discharge Date	13.06.2026		

Consultant:
Dr. PAVULURI VENKATA SAIPRASADA RAO
GENERAL PEADIATRICS
02414

DIAGNOSIS	ICD CODE
ACUTE GASTROENTERITIS WITH DEHYDRATION	

History: Master SAI DEVANSH, 10 Y 9 M 11 D , old boy presented with history of Multiple episodes of loose stools, pain abdomen, poor oral intake since 1 day prior to admission. For the above complaints he was admitted at Rainbow Children's Hospital - Himayatnagar for further management.

Examination: He was afebrile, hemodynamically stable and maintaining saturation at room air. Heart rate - 94/min, blood pressure - 104/67 mmHg and Respiratory Rate - 20/min. On examination Signs of some dehydration were

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present, dry lips, dry tongue, sunken eyes, dull lethargic were present. On auscultation of chest, air entry was bilaterally equal with normal heart sounds and no murmur. Abdomen was soft with no organomegaly. On neurological examination, he was conscious, alert. Pupils were bilaterally equal & reacting to light. There were no focal neurological deficits.

Weight on admission: 40 kilo grams.

Investigations: Enclosed reports.

Initial hemogram showed Hemoglobin of 12.8 gm%, White Blood Cell count of 6190 cells/cumm, platelet count of 3.69 lakhs/cumm and C-Reactive Protein of 11 mg/l.

Complete stool examination

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COLOUR	YELLOWISH		
CONSISTENCY	S. FORMED		
pH	6.0	5 - 8.5	
MUCUS	PRESENT	ABSENT	
BLOOD	ABSENT		
UNDIGESTED FOOD	PRESENT + +	ABSENT	
HELMINTHES	NIL	NIL	
PUS CELLS	2 - 3		
RED BLOOD CELLS (Stool)	1 - 2	NIL	HPF
STARCH GRANULES	ABSENT	ABSENT	
YEAST CELLS	NIL	NIL	
FAT GLOBULES	ABSENT	ABSENT	
PROTOZOA	NIL	NIL	

Management : He was admitted in the ward and was started on Intra Venous fluids. He was treated symptomatically with antacids and antipyretics. In view of loose stools, he was administered probiotics and advised gastrodiet.

Stool routine examination showed normal.

He was regularly monitored for loose stool frequency and hydration status. His

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loose stools and other symptoms settled gradually.

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. Esmoprazole
Syrup. Zinconia
Pro GG sachet

Advice:
* Diet as advised.
* WHO ORS adlib

S.No	MEDICATION	DOSE	TIMINGS	DURATION
1	Syrup. ZINCONIA	5 ml	10am (after food)	For 12 days
2	PRO GG SACHET	1 SACHET	9am-9pm (after food)	For 3 days
3	Nasoclear nasal drops, 2 drops in each nostril **SOS** for nose block			

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Fever Management
* Syrup. Crocin DS (Paracetamol - 5ml/240mg) 8 ml after food as and whenever required, if temperature > 100 *F (maximum 4 times a day at 6 hour intervals).
* Tepid sponging if fever > 101 *F.

Review consultation with Dr. PAVULURI VENKATA SAIPRASADA RAO on Monday(15.06.2026) at his OPD

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

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

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

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Parent/ Attender

In case of emergency contact 9154865030 emergency pediatrician on duty.

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

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

RAINBOW CHILDREN'S MEDICARE LIMITED HYDERABAD

Registrar/Resident/C.M.O

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