

**ADMISSION SHEET**

**Registration Details :**



Admission No : IP26-00006561

Admit Date : 11-Jun-2026

Admit Time : 07:18 PM UHID : CUV-00130047

**Patient Details :**

Patient Name : Master S KARTHIK

Age : 7 Y 9 M 7 D

Guardian : Mr KIRAN KUMAR

DOB : 04-09-2018

Gender : Male

Religion :

Occupation :

Martial Status :

Address (H) : Kamakoti Nagar Vijayawada Andhra Pradesh  
INDIA 520012

Phone No : 7207499416

E-mail : na123@rainbowhospitals.in

**Admission Details :**

Bed Type : DAY CARE

Bed No : ER01

Ward Name : GF -EMERGENCY

Room No : ER01

Admission Type : First Visit

**Contact Details :**

Name : Mr KIRAN KUMAR

Relationship : S/O

Contact Address : Kamakoti Nagar Vijayawada Andhra Pradesh  
INDIA 520012

Phone No : 7207499416



Signature

**Doctor Details :**

Doctor Name : Dr. SINDHURA MUNUKUNTLA

Specialisation : GENERAL PEDIATRICS

Referral Doctor : SELF

Phone No :

Co-Consultant :


**Payment Details :**

Deposit Amount : 10000.00

Payment Mode : DC/CC Card

Payor Name : HERITAGE HEALTH INSURANCE TPA  
PVT LTD

**ACTIVITY RECORD FOR BILLING**

Name: ----- CUV-00130047 IP26-00006561 -----  
 Master S KARTHIK  
 UHID No : ----- 04-09-2018 7 Y 9 M 7 D (M) -----  
 Dr. SINDHURA MUNUKUNTLA  
 Date of Admis  ----- Consultant : ----- Dept : *pediatrics*  
 ----- Date of Discharge : ----- Time: -----  
 Room / Bed No : ----- Ward : ----- Suggested Billable bed type : -----

**WARD TRANSFERS**

Date	Time	From	To	Signature of Nurse
<i>11/6/26</i>	<i>8:10pm</i>	<i>ER</i>	<i>Ward</i>	<i>[Signature]</i>

**Cross Consultation Visit**

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









## PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name : CUV-00130047      IP26-00006561  
Master S KARTHIK  
04-09-2018      7 Y 9 M 7 D      (M)  
Dr. SINDHURA MUNUKUNTLA

Patient ID# : 

Consultant : Dr. SINDHURA.

Final Diagnosis : AMI & DEHYDRATION.

Pediatric Multiorgan History

CUV-00130047 IP26-00006561  
Master S KARTHIK (M)  
04-09-2018 7 Y 9 M 7 D  
Dr. SINDHURA MUNUKUNTALA



Name: S KARTHIK

Age/Sex 7y 9m

Informant Mother

Reliability Good.

Chief Presenting Complaints & Duration (Chronologically):

fever x 2 days.  
cold x 2 days.

History of present illness :

- Child presented with complaints of high grade fever since 2 days associated with chills / rigors & relieving temp.

on medication & recurring every 4th hourly.

- Associated with watery nasal Dfs, nasal block & snoring (~~more~~ at night while sleeping) since 2 days.

- do dull activity & poor oral intake since 2 days.

- NO h/o cough, vomiting & loose stools.

- Sleep -> (N).

Urine? (N).  
Stool? (N).

- Activity -> ↓↓.

Pediatric Multiorgan History & Physical Examination

CUV-00130047 IP26-00006561  
Master S KARTHIK  
04-09-2018 7 Y 9 M 7 D (M)  
Dr. SINDHURA MUNUKUNTLA



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

Nil premorbid

Birth & Neonatal History :

Term / AGA / Male.

Birth & Socio Economic History :

About Father : \_\_\_\_\_

About Mother : \_\_\_\_\_

Any additional Information : \_\_\_\_\_

Developmental History :

Developmentally (N)

Immunization History :

As per NIS.

Pediatric Multiorgan History & Physical Exa



Anthropometry

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

Weight (kgs) 24.5 kgs (Centile \_\_\_\_\_)

**On Examination :**

Temperature 104.0°F Pulse Rate: 120/min Description \_\_\_\_\_

B.P. \_\_\_\_\_ SPO2 100% at RA.

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

Rash \_\_\_\_\_

Lymphadenopathy \_\_\_\_\_

Oedema : \_\_\_\_\_

(N) - Dry lips (+).  
- Dry buccal mucosa,  
dull look, skin turgor 7/2  
ne

**Respiratory system :**

Inspection (any s/o distress) : B XE (+), NUS (+).

Air entry & breath sounds : \_\_\_\_\_

Any addes sounds : \_\_\_\_\_

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

**Cardiovasclular System :**

Inspection of precordium : NO precordial bulge.

Heart Sounds : S<sub>1</sub>, S<sub>2</sub> (+); NO murmurs.

Any murmur : \_\_\_\_\_

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

**Per Abdomen :**

Inspection SNT, NT.

Palpation : \_\_\_\_\_

Ausculation : \_\_\_\_\_

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

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

Pediatric Multiorgan History & Physical Examination

CUV-00130047 IP26-00006561  
Master S KARTHIK  
04-09-2018 7 Y 9 M 7 D (M)  
Dr. SINDHURA MUNUKUNTLA



Central Nervous System :

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

Cranial Nerves : \_\_\_\_\_

Motor System :

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

Tone : \_\_\_\_\_ Power 5/5

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

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

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

Reflexes :

DTR

Superficials :

Plantars \_\_\_\_\_

Sensory System :

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

Clinical Summary & Diagnostic :

AFI & DEHYDRATIONS  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



Preventive aspects of the treatment :

Desired goals of the treatment :

**Planned Labs :**

**Planned Management :**

- CBP  
- CRP, LFT, CUE, Blood cfs.  
- SRS panel (Killed sample)  
- 2 extra pkim  
- Dengue NS1Ag presence sample.  
noted by jyoths

- IVF 2/3 rd M.  
- IV Ceftriaxone OD.  
- Syp. (rain DS) q6hr.  
- Syp. Ibuprofen SDS.  
noted by jyoths

**Please fill up the following details**

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

Doctor's Signature Name \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/5/26	C/S/b Dr. Sindhura	
7PM	<p>Asis - AFI. <math>\pm</math> dehydration.</p> <p>High grade fever <math>\oplus</math> since 2 days.</p> <p>Cold, Dull activity <math>\oplus</math>.</p> <p>Poor oral intake <math>\oplus</math>.</p> <p>A/E - vitals stable.</p> <p>A/E - R/S - BAE <math>\oplus</math>, NUBS <math>\oplus</math>.</p> <p>P/A - S/A, NI, spleen tip palpable, BS <math>\oplus</math>.</p>	<p><u>Plan</u> - admit ward side</p> <p>Snd - CBP, CPP, CUE, AFI, Blood C/S, 5 virus send.</p> <p>IVF 2/3 at M.</p> <p>IV Ceftriaxone.</p> <p>hyp. Grain DS Q 6H.</p> <p>hyp. hyp. Ibuprofen SOS.</p>
		<p>M. Sindhura        11/5/26        7PM</p>





...GRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
02/6 10 AM	<p>CS/B Dr-SINDHURA</p> <p><u>ARI c Dehydration</u></p>	
	<p>Fever ⊕            Eye redness ⊕            Poor Oral intake</p>	<p>Plan</p> <p>1) IVF - 2(3M) ⊕</p>
	<p>child activity both            vitals stable</p>	<p>2) By Ceftriaxone            Inj Ondem / Esomeprazole</p>
	<p>conjunctival congestion ⊕            R-S-B/LAE ⊕            P/A - soft</p>	<p>3) Tena Hemo, Blood CS</p> <p>4) PCM - soS</p> <p>5) Toba eye drops</p>
		<p>6) Send Dengue NS, in same sample</p> <p>7) NASIVION - P Nasal</p>
		<p>8) Xray - Nasopharynx &amp; decid on Metatop</p> <p>9) Nasochar Mist Nasal spray</p>
		<p>10) IVF - 2nd 1/2</p>
		<p><del>M. Sindhura            M. Sindhura</del></p>









# DRUG CHART

Date of Admission: 11/6/26 Drug Allergies: NP/1  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)

<b>DRUG :</b> <u>SYP. PARACETAMOL</u>				Date Time																
Dose	Route	Frequency	Start Date																	
<u>5ml</u>	<u>PO</u>	<u>Q6H</u>	<u>11/6</u>																	
Doctor's Signature		Valid Period	Pharm.																	
<u>[Signature]</u>		<u>I</u>																		
Additional Instructions:																				
<u>(240/5)</u>																				
<b>DRUG :</b> <u>SYP. IBUPROFEN</u>				Date Time																
Dose	Route	Frequency	Start Date																	
<u>5ml</u>	<u>PO</u>	<u>SOS</u>	<u>11/6</u>																	
Doctor's Signature		Valid Period	Pharm.																	
<u>[Signature]</u>																				
Additional Instructions:																				
<u>(100/5) if temp. &gt; 101° F.</u>																				
<b>DRUG :</b>				Date Time																
Dose	Route	Frequency	Start Date																	
Doctor's Signature		Valid Period	Pharm.																	
Additional Instructions:																				

VERIFIED BY : Name



CUV-00130047 IP26-00006561  
 Master S KARTHIK  
 04-09-2018 7 Y 9 M 7 D (M)  
 Dr. SINDHURA MUNUKUNTLA



Sheet No: .....

**REGULAR PRESCRIPTIONS**

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

<b>DRUG :</b> TOBRAMYCIN Eye Drop				Date Time	12/6															
Dose	Route	Frequency	Start Dt.																	
20	Each Eye	6 <sup>th</sup> hly	12/6																	
Name & Signature of the Doctor Starting the Drugs: Praveen				6Am	X															
				12Pm	Sy															
Additional Instructions:				6Pm																
				12Am																
<b>Daily Doctor's Endorsement by a Sign</b>																				

<b>DRUG :</b> NASIVION - P NASAL Drop				Date Time	12/6															
Dose	Route	Frequency	Start Dt.																	
20	P/N	BD	12/6																	
Name & Signature of the Doctor Starting the Drugs: Praveen				11Am	Sy															
				11Pm																
Additional Instructions:				11Pm																
<b>Daily Doctor's Endorsement by a Sign</b>																				

<b>DRUG :</b> Syz RELENT PLUS				Date Time																
Dose	Route	Frequency	Start Dt.																	
2.5ml	PO	BD	12/6																	
Name & Signature of the Doctor Starting the Drugs: Praveen																				
Additional Instructions:																				
<b>Daily Doctor's Endorsement by a Sign</b>																				

<b>DRUG :</b> NASOCLEAR MIST NASAL SPRAY				Date Time	12/6															
Dose	Route	Frequency	Start Dt.																	
2 Puffs	P/N	6 <sup>th</sup> hly	12/6																	
Name & Signature of the Doctor Starting the Drugs: Praveen				6Am	X															
				11A																
Additional Instructions:				12Pm	Sy															
				6Pm																
Additional Instructions:				12Am																
<b>Daily Doctor's Endorsement by a Sign</b>																				

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

CUV-00130047  
 Master S KARTHIK  
 04-09-2016 7 Y 9 M 7 D (M)  
 Dr. BINDHURA MUNUKUNTLA



Sheet ..... **REGULAR PRESCRIPTIONS** Weight ..... Ward .....

**DRUG :** METATOP NASAL SPRAY

Dose	Route	Frequency	Start Dt.	Date Time															
2 Puffs	IN	BD	12/6																

Name & Signature of the Doctor Starting the Drugs: *Pram*

Additional Instructions:

**Daily Doctor's Endorsement by a Sign**

**DRUG :** Syp RELENT PLUS

Dose	Route	Frequency	Start Dt.	Date Time															
5ml	PO	BD	12/6	11 AM															

Name & Signature of the Doctor Starting the Drugs: *Pram*

Additional Instructions: *11 PM*

**Daily Doctor's Endorsement by a Sign**

**DRUG :** METASPRAY NASAL SPRAY

Dose	Route	Frequency	Start Dt.	Date Time															
2 Puff	IN	BD	12/6	11 AM															

Name & Signature of the Doctor Starting the Drugs: *Pram*

Additional Instructions: *5 only*

**Daily Doctor's Endorsement by a Sign**

**DRUG :**

Dose	Route	Frequency	Start Dt.	Date Time															

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

**Daily Doctor's Endorsement by a Sign**

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






I.V. FLUIDS CHART

Weight. 24.5kg 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
11/6/26	10pm	PLASMA-LYTE 400ml + 100ml 25% D <sub>x</sub>	IV	40ml	K	A S	12/6	R	
12/6		IVK	IV	20 ml/h	R				

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

# PATIENT TRANSFER FORM

Patient Name & UHID No. CUV-00130047 IP26-00006561 Master S KARTHIK 04-09-2018 7 Y 9 M 7 D (M) Dr. SINDHURA MUNUKUNTLA 		Date & Time of Admission 11/6/25 @ 7:18pm	Date & Time of Transfer Order 11/6/25 @ 8:10pm
From Unit ER		Transfer Ordered by Dr. Varun	Reason for Transfer Admission
To Unit Ward		Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File 25 / -	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes <input type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring Bhargavi.		Name of Person Ordered Transfer Dr. varun	
Patient & Clinical Records Received by : Anurutha			
Date & Time of Patient Received : 11/6/26 @ 8:30pm			

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

CUV-00130047 IP26-00006561  
 Master S KARTHIK  
 04-09-2018 7 Y 9 M 7 D (M)  
 Dr. SINDHURA MUNUKUNTLA



## MEDICATION RECONCILIATION FORM

Drug Allergies: ..... Nil .....  Not known any Drug Allergies

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

Shifting From: ..... EK ..... 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						<input type="checkbox"/> C <input type="checkbox"/> DC
2						<input type="checkbox"/> C <input type="checkbox"/> DC
3						<input type="checkbox"/> C <input type="checkbox"/> DC
4						<input type="checkbox"/> C <input type="checkbox"/> DC
5						<input type="checkbox"/> C <input type="checkbox"/> DC
6						<input type="checkbox"/> C <input type="checkbox"/> DC
7						<input type="checkbox"/> C <input type="checkbox"/> DC
8						<input type="checkbox"/> C <input type="checkbox"/> DC
9						<input type="checkbox"/> C <input type="checkbox"/> DC
10						<input type="checkbox"/> C <input type="checkbox"/> DC

\* C- Continue, DC - Discontinue

**MEDICATION HISTORY RECORDED / VERIFIED BY**

Doctor Name & Signature : ..... Dr. Varun .....

Date & Time : ..... 11/6/26 @ 7:10 PM .....

Nurse Name & Signature: ..... Jyoti / Jyoti .....

Date & Time : ..... 11/6/26 @ 7:12 PM .....



wt - 24.53kg



# EMERGENCY ROOM TRIAGE FORM

Patient's Name : Master. Karthik Age : 7y Gender:  Male  Female

Date : 11/6/26 Time of Arrival : 6:30pm.

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

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

Mode of Arrival :  Ambulatory  Wheelchair  Ambulance

Initial Vital Signs: Temp: 100°F PR: 140b/m BP: ..... RR: 36b/m SpO<sub>2</sub>: 97%

Chief Complaints: clo. fever since 2 days high grade & dulacety

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

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

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

\* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian

Triage Completion Time : .....

## Communicable Disease Triage Screening

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

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 : Bhargava

Signature of Triage Nurse : (B)

Date & Time : 11/6/26 @ 6:32pm



## NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date: 11/6/26 Time of arrival: 6:34pm high grade dull  
Chief Complaints: clo. fever since 2 days activity RBS: .....

Height: ..... Weight: 24.5kg 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: Ba 6:36pm

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

Time	Nursing Notes
6:38pm	Assess the pt condition monitor the vitals.

Samples collected by: Jyothu  
 Samples sent by: Jyothu

Time: 2:10pm  
 Time: 2:10pm

**Medication given in ER:**

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1
11/6/26 5:30pm	crocin Syo	oral	7.5ml	<u>[Signature]</u>	

Condition of patient at time of shift - out :	Details of Shift - out
HR: <u>130b/m</u> BP: ..... CFT: ..... RR: <u>36b/m</u> SPO <sub>2</sub> : <u>97%</u> GCS: ..... Temperature : <u>104°F</u> Pain Score: ..... Repeat RBS (if applicable): .....	Shift - out from ER to: <u>ward</u> Time of Shift - out: <u>8:10pm</u> Handover given to: ..... (Nurse's Name)

Tick as applicable:  MLC  LAMA  BROUGHT DEAD

Procedures done with details (if any): Iv placement done

Name of the Nurse : Bhargavi Signature of the Nurse : [Signature]

Date & Time : 11/6/26 @ 6:40pm

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## NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 12/6/26 Time: 10 am

Weight: 24.5 kg Centile: <25

Height: Centile: -

Inference: Underweight child

RDA: - Calories: 1500 kcal/day Protein: 26 gms/day

Diet Recommendations: Balanced diet with liquids

Re-Assessment: No Junk food, Oily foods

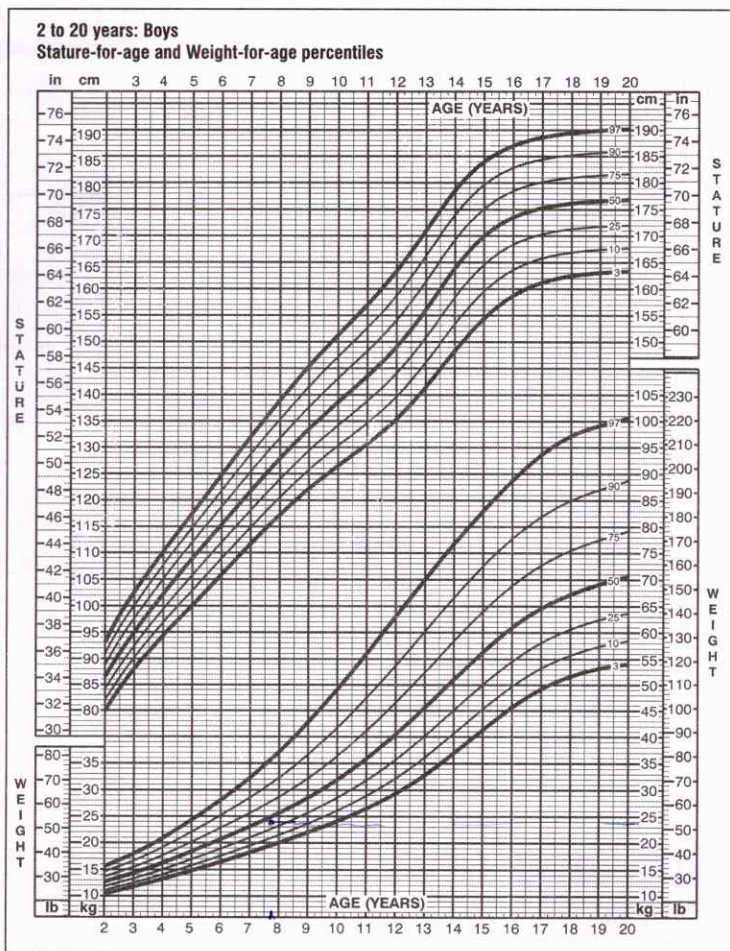
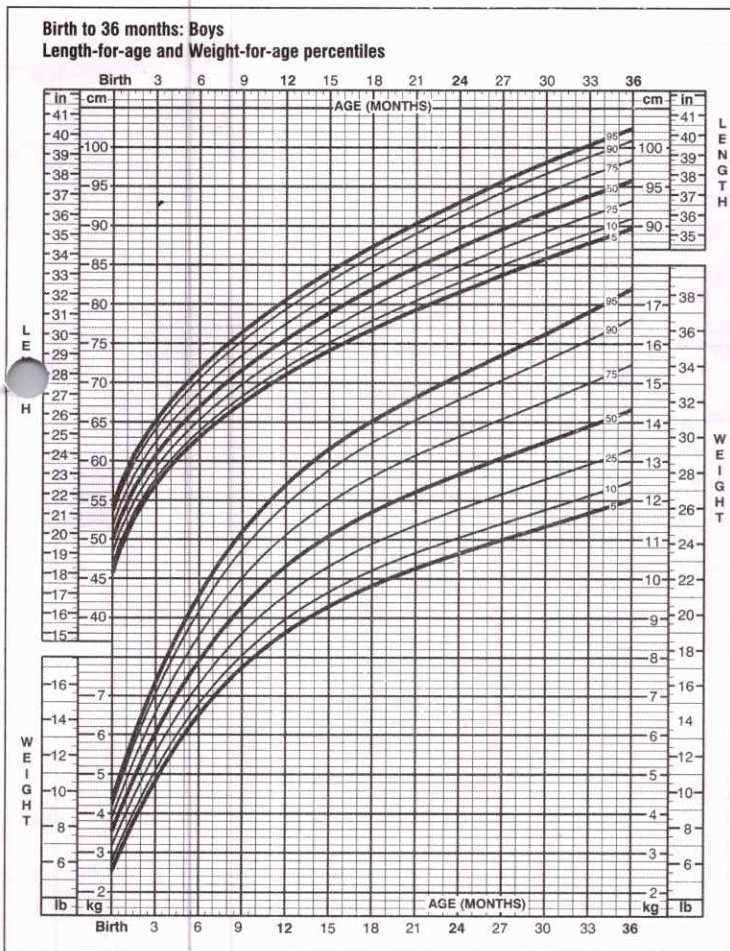
Food Allergies: No Veg/Non-veg Veg

Diagnosis: A/C dehydration

Nutritional Intervention -  Oral  Enteral  Parenteral

Patient's Signature: S. Syath

### GROWTH CHART (BOYS)



Dietician's Name: Syeda Sobiya Zaher

Dietician's Signature: Sobiya





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## RESULT SHEET

Date	11/6/26				
Time	7:45				
Hb	10.3				
PCV	29.2				
RBC	3.83				
WBC	4.73				
N/L	67.8/18.8				
Platelets	193				
CRP					
ESR					
PCT					
RBS					
Na					
K					
Cl					
Ca/Mg					
Phosphate					
Urea					
Creatinine					
ALP					
SGPT	10				
SGOT	24				
T.Bill/Conj	0.3/0.2				
T.Protein	6.3				
S.Albumin	3.7				
S.Globulin	2.6				
A/G Ratio	1.4				
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein / Sugar					
Cells					
N/L					

Date	11/6/26					
Time						
CUE - Alb						
CUE - Sugar	Nil					
CUE - Ketones	neg					
CUE - PUS Cells	3-4					
CUE - RBC Cells	2-3					
CUE nitrite	neg					
Stool Pus Cell						
OVA / Cyst						
Occult Blood						

11/6/26  
 Culture and Sensitivities : Blood (S-)  
 .....  
 .....  
 .....

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

CUV-00130047 IP26-00006561  
 Master S KARTHIK  
 04-09-2018 7 Y 9 M 7 D (M)  
 Dr. BINDHURA MUNUKUNTLA

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



Patient S

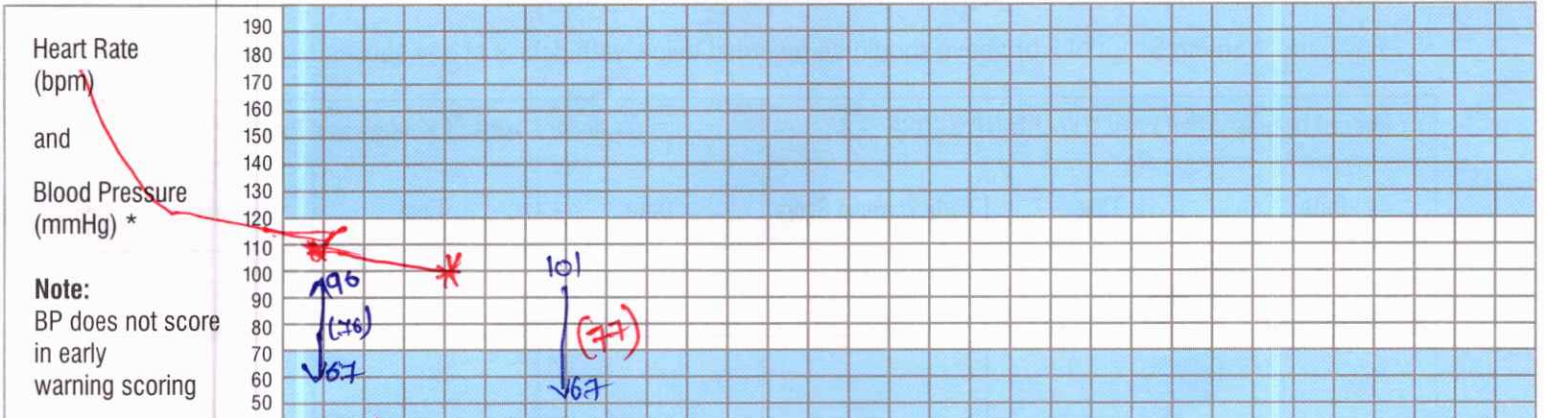
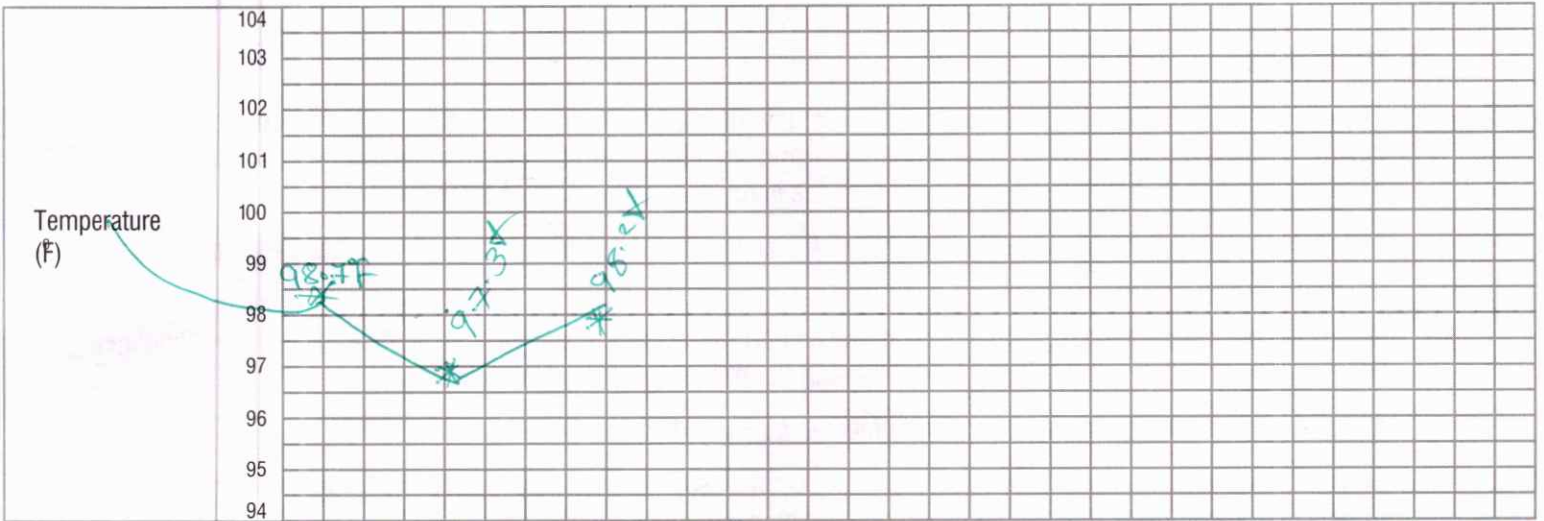


UNICAL / 126

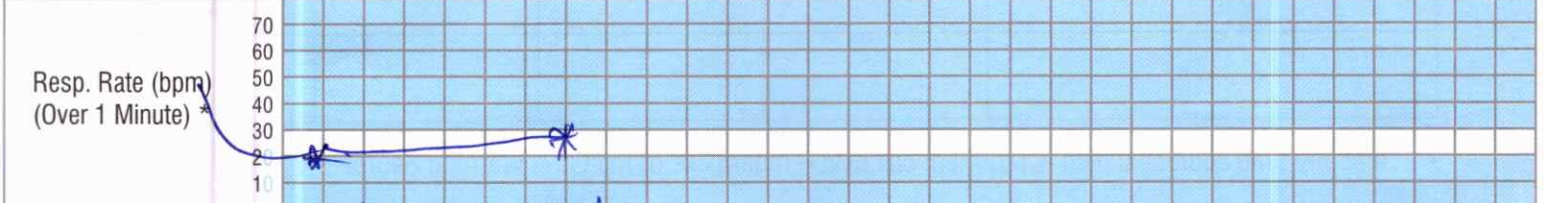
**EARLY WARNING SCORE: CHILDREN'S UNIT**

Date : 11/06/26 Time: 10 2Am 6Am

Doctor / Nurse / Family Concern? Pm



Heart Rate (Number) 113b/m 114b/m



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

Resp Mod/ Severe Distress None / Mild

Receiving O<sub>2</sub> (l/min) O<sub>2</sub> Saturations (%) 100% 98%

Conscious Level Normal Altered

GCS \*

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

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

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

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

## CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

### INSTRUCTIONS:

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

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

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

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

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

CUV-00130047 IP26-00006561  
 Master S KARTHIK  
 04-09-2018 7 Y 9 M 7 D (M)  
 Dr. SINDHURA MUNUKUNTLA

CLINICAL / 126

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



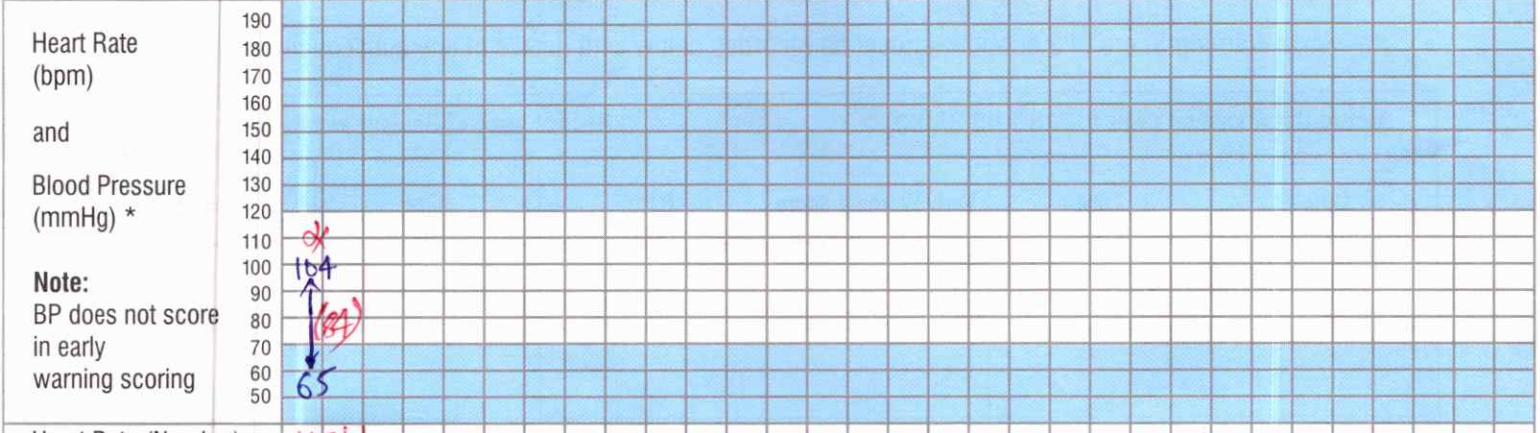
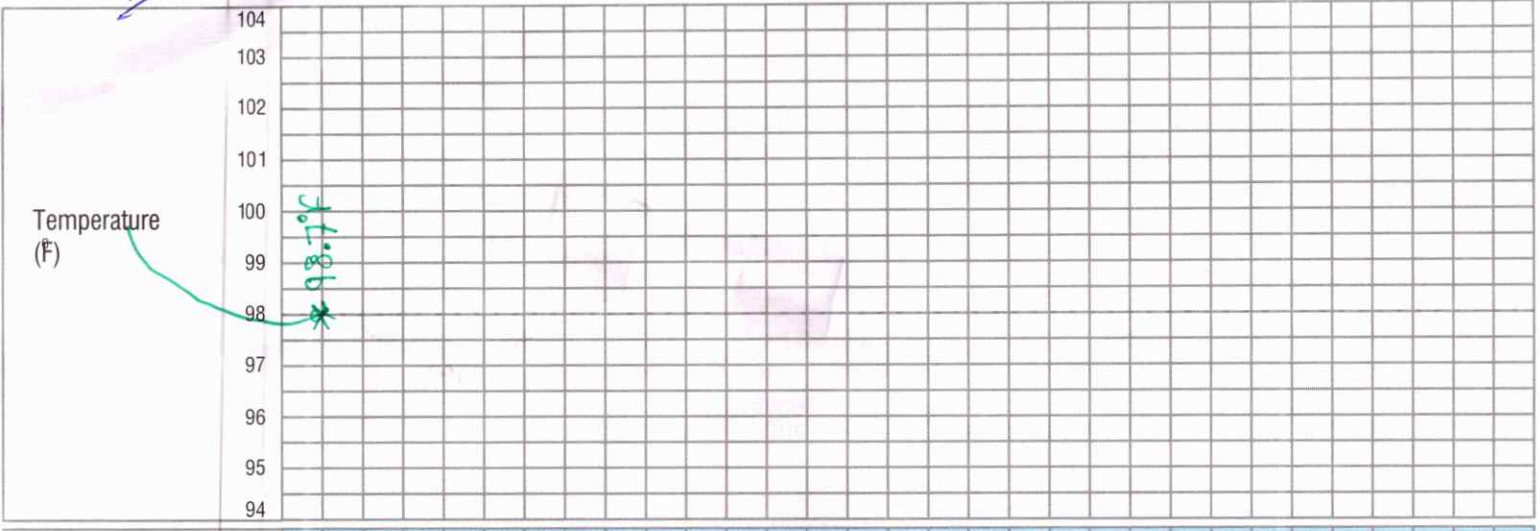
Patient



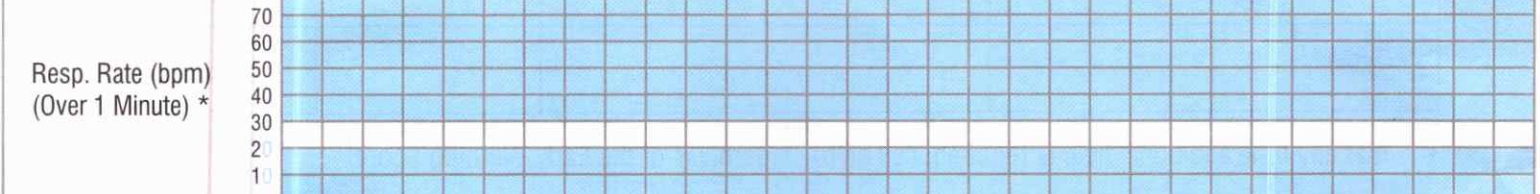
**EARLY WARNING SCORE: CHILDREN'S UNIT**

Date : 12/6/26 Time: 10

Doctor / Nurse / Family Concern? Am



Heart Rate (Number) 119 bpm



Resp Rate (Number) 30 bpm

Resp Distress Mod/ Severe None / Mild

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

Conscious Level Normal Altered

GCS \*

**TOTAL SCORE**  
 Number of shaded boxes 0  
 Pain Score 0  
 Observer's Initials AS

- ACTIONS**
- Score 1 : Continue normal observation by staff nurse
  - Score 2 : Shift in charge nurse to be informed and continue hourly observations
  - Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.
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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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<b>R</b>	<b>RECOMMENDATION:</b> 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)



## CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

### INSTRUCTIONS:

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CUV-00130047  
 Master S KARTHIK  
 04-09-2018 7 Y 9 M 7 D (M)  
 Dr. BINDHURA MUNUKUNTLA  




# FLUID CHART

Sheet No. : ..... ① .....

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
<b>Total Intake :</b>						<b>Total Output :</b>							
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
<b>Total Intake :</b>						<b>Total Output :</b>							
11/6/26	08:00 pm	Dextrose + 25% NaCl + 25% KCl + 25% CaCl <sub>2</sub>		40ml									
	09:00 pm			40ml									
	10:00 pm			40ml									
	11:00 pm			40ml									
	12:00 am			40ml									
	01:00 am			40ml									
<b>Total Intake : - 160ml</b>						<b>Total Output : U - 2M - 0</b>							
12/6/26	02:00 am	Dextrose + 25% NaCl + 25% KCl + 25% CaCl <sub>2</sub>		40ml									
	03:00 am			40ml									
	04:00 am			40ml									
	05:00 am			40ml									
	06:00 am			40ml									
	07:00 am			40ml									
<b>Total Intake : - 160ml</b>						<b>Total Output : U - 2M - 1</b>							
<b>Total 24 hrs. Intake</b>						<b>Total 24 hrs. Output</b>							



# FLUID CHART

Sheet No. : .....

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

		Intake				Output					IV Site Thrombophlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
12/6/20			Mouth	I.V	N.G								
	08:00 am	PlasmaLyte 100ml		100ml									
	09:00 am	PlasmaLyte 100ml	Orally										
	10:00 am	PlasmaLyte 100ml	+										
	11:00 am	H <sub>2</sub> O											
	12:00 pm												
	01:00 pm	100ml 0.5% DK											
<b>Total Intake :</b>						<b>Total Output :</b>							
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
<b>Total Intake :</b>						<b>Total Output :</b>							
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
<b>Total Intake :</b>						<b>Total Output :</b>							
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
<b>Total Intake :</b>						<b>Total Output :</b>							

**Total 24 hrs. Intake**

**Total 24 hrs. Output**

CUV-00130047 IP26-00006561  
 Master S KARTHIK  
 04-09-2018 7 Y 9 M 7 D (M)  
 Dr. BINDHURA MUNUKUNTLA



# FLUID CHART

Sheet No. : .....

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

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

**Total 24 hrs. Intake**

**Total 24 hrs. Output**

Patient Sticker



# FLUID CHART

Sheet No. : .....

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

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

<b>Total 24 hrs. Intake</b>	
-----------------------------	--

<b>Total 24 hrs. Output</b>	
-----------------------------	--

CUV-00130047 IP26-00006561  
 Master S KARTHIK  
 04-09-2018 7 Y 9 M 7 D (M)  
 Dr. SINDHURA MUNUKUNTLA



# 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							
Afternoon							
Night	8PM	<p>Assessed the General condition to the Patient</p> <p>checked the vital sign</p> <p>Maintain D/o chest</p> <p>Administer medication as per doctor.</p>	8PM	<p>Assessed the general condition</p> <p>checked the vital signs</p> <p>Maintain D/o chest</p> <p>Administer medication as per doctor.</p> <p>gt pleocds</p> <p>gt antibiotics</p>	checked the Vitals Sign	re checked vitals	Sy

CUV-00130047  
 Master S KARTHIK IP26-00006561  
 04-09-2018 7 Y 9 M 7 D (M)  
 Dr. SINDHURA MUNUKUNTALA



# NURSING CARE RECORD



Date: 12/6/20

**Goals**

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
<b>Morning</b>	8Am	→ Assess the pt condition. → monitor the vitals. → maintain I/O chart. → continue IV fluids. → continue medications.	8Am	→ Assessed the pt condition. → monitored the vitals. → maintained I/O chart. → continued IV fluids. → continued medications.	→ pt is stable now	→ Re assessed the vitals	
<b>Afternoon</b>	2pm		2pm				
<b>Night</b>							

Patient Sticker

# NURSING CARE RECORD



Date: .....

**Goals**

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

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

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
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- Early Ambulation Reduce Anxiety
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- Patient & Family Education

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



## NURSING SHIFT HAND OVER FORM

<b>SITUATION</b>	Diagnosis:	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify: .....					
	Surgery / Procedure:	Post OP Day:					
<b>BACKGROUND</b>	Date	11/6/26 NI	12/1/26 MO	/	/	/	
	Shift						
	Medical Condition (Any special condition to be noted):		-				
	Diet:	<del>soft diet</del>	soft diet				
<b>ASSESSMENT</b>	Allergy:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Ventilation (RA, NP, NIV, VENTI):	-	-				
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Vital Signs:	Temp:	97.6F	97.6F			
		Res:	20b/m	20b/m			
		SpO <sub>2</sub> :	99%	99%			
		Pulse:	20b/m	20b/m			
		BP:	90/60	90/68			
		LOC:	-	-			
		Fall Risk Score:	-	-			
	Pain Score:	-	4				
	Skin Integrity	-	Good				
<b>Recommendations</b>	Safety Needs:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Physiotherapy:	-	-				
	Others Specify:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Special Diet:	-	-				
	Critical Lab Test / Values:	-	-				
	Other Special Orders / Medications:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	PU Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
DVT Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
ADL (Dependent / Non Dependent):		-					
Post Operative Procedure Special Orders:			-				
Handed Over By Name :		Diva	Mahi				
Signature / ID :		D	M				
Date:		12/1/26	12/1/26				
Time:		8AM	2PM				
Taken Over By Name :		Mahi					
Signature / ID :		M					
Date:		12/1/26					
Time:		8AM					

Patient Sticker



## NURSING SHIFT HAND OVER FORM

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

UV-00130047

Master S KARTHIK

4-09-2018

7 Y 9 M 7 D

Dr. SINDHURA MUNUKUNTLA

IP26-0006561

(M)



# BRADEN 'Q' SCALE



Date: 12/6/20  
Time: NI Mo

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

<b>TOTAL SCORE</b>	28	22		
<b>Evaluator's Name</b>	[Signature]	[Signature]		

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

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

# BRADEN 'Q' SCALE

					Date:			
					Time:			
Mobility	<b>1. Completely immobile:</b> Does not make even slight changes in body or extremity position without assistance.	<b>2. Very limited:</b> Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	<b>3. Slightly limited:</b> Makes frequent through slight changes in body or extremity position independently.	<b>4. No limitations:</b> Makes major and frequent changes in position without assistance.				
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					<b>TOTAL SCORE</b>			
					<b>Evaluator's Name</b>			

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

Risk Score	Category	Action	<b>Support Surfaces</b> (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice)
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Master S KARTHIC  
 04-09-2018 7 Y 9 M 7 D (M)  
 Dr. SINDHURA MUNUKUNTALA



# CHECKLIST FOR THROMBOPHLEBITIS

11/6/26

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0			0	0						
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			NO	NA						
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2			NO	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						
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						
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						
Signature of the Nurse						<i>[Signature]</i>	<i>[Signature]</i>						

**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 of Ward In Charge :

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

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

## 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										
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1										
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2										
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3										
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4										
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5										
Signature of the Nurse													

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

Signature of Shift In Charge :

Signature of Ward In Charge :

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

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

CUV-00130047

IP26-00006561

Master S KARTHIK

04-09-2018 7 Y 9 M 7 D (M)

Dr. SINDHURA MUNUKUNTALA



# PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
11/8/20	10pm	0/10	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	D
12/1/20	8:20pm	0/10	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	(Signature)
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		

**Re-assessment Frequency:**

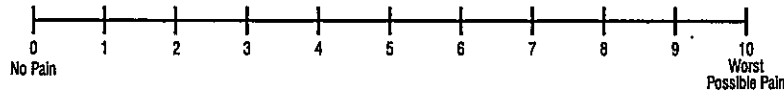
1. Every eight hours for all hospitalized patients.
2. For post-surgical patients, patients with chronic pain, patient with severe pain:
  - a) At least every 2 hours for the first 24 hours
  - b) Then every 4 hours.
  - c) Prior to pain pain-relieving intervention.
  - d) Within 30 – 60 minutes after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

# PAIN ASSESSMENT TOOLS

## FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

## Numerical Pain Scale (Obstetric and Gynecology)



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

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

## Wong - Baker (Pediatrics) Above 7 Years



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



## PAIN ASSESSMENT FORM

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

**Re-assessment Frequency:**

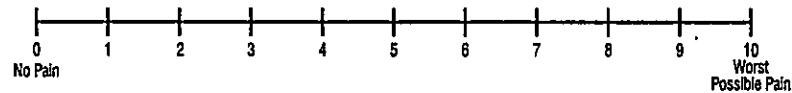
1. Every eight hours for all hospitalized patients.
2. For post-surgical patients, patients with chronic pain, patient with severe pain:
  - a) At least every 2 hours for the first 24 hours
  - b) Then every 4 hours.
  - c) Prior to pain pain-relieving intervention.
  - d) Within 30 – 60 minutes after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

# PAIN ASSESSMENT TOOLS

## 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, rigid, or Jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams of sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

## Numerical Pain Scale (Obstetric and Gynecology)



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

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

## Wong - Baker (Pediatrics) Above 7 Years



0  
No Hurt

2  
Hurts Little Bit

4  
Hurts Little More

6  
Even More

8  
Hurts Whole Lot

10  
Hurts Worst

1917

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WASHER, KARTHIK, M. 9M, 2D, QIV, 00130097, NASOPHARYNX LATERAL 12 JUN 2011 01 AM  
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