

DISCHARGE SUMMARY

Name	Master S KARTHIK	UHID	CUV-00130047
Father/Guardian	Mr KIRAN KUMAR	Age/Gender	7 Y 9 M 9 D/ Male
Address	Kamakoti Nagar, Vijayawada, Andhra Pradesh, INDIA, 520012		
IP No	IP26-00006561	Admission Date	11-06-2026
Ref Doctor	SELF		
Discharge Date	14.06.2026		

Consultant:

Dr. SINDHURA MUNUKUNTLA
MBBS, DCH, DNB PEDIATRICS
66970

DIAGNOSIS	ICD CODE
ADENOVIRAL ILLNESS WITH DEHYDRATION	

History: Master S KARTHIK, 7 Y 9 M 9 D , old boy presented with history of fever, cold since 2 days, dull activity and poor oral intake prior to admission. For the above complaints he was admitted at Rainbow Children's Hospital - for further management.

Examination: He was febrile(104°F). His heart rate was 120/min, and Respiratory Rate - 38/min. Capillary Refill Time was <2 secs. Peripheries were warm & pulses well felt. On examination signs of dehydration were present in

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form of dry lips, oral mucosa, dull activity and skin turgor. On auscultation, air entry was bilaterally equal were present. Heart sounds were normal and there was no murmur. Abdomen was soft with no organomegaly. On neurological examination, he was conscious and alert. Pupils were bilaterally equal and reacting to light. There were no focal neurological or cranial nerve deficits. There were no signs of raised intracranial pressure.

Weight on admission: 24.5 kilo grams.

Investigations: Enclosed reports.

GeneXpert FluA+FluB+RSV, SARS-CoV-2 were sent, which was negative. Adenovirus was **detected**.

Initial hemogram showed Hemoglobin of 10.3 gm%, White Blood Cell count of 4730 cells/cumm, platelet count of 1.93 lakhs/cumm and C-Reactive Protein of 52 mg/l. Liver function test showed total SBR of 0.3 mg/dl with indirect fraction of 0.1 mg/dl, SGOT - 24 U/L, SGPT - 10 U/L, ALP - 110 U/L, protein - 6.3 gm/dl, albumin - 3.7 gm/dl, globulin - 2.6 gm/dl, A/G ratio of 1.4. Complete urine examination was normal.

Blood culture and sensitivity shows no growth after 24 hours of incubation. Dengue NS1 negative.

NASOPHARYNX X-ray

Lobulated soft tissue along posterior nasopharyngeal wall causing severe narrowing of nasopharyngeal air way - Likely enlarged adenoid.

Prevertebral soft tissues normal.

Cervical spine normal.

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

In view of enlarged adenoids and persistent snoring, intranasal steroid spray was started.

In view of cold and fever symptoms Respiratory panel was sent in which Adenovirus detected.

He was regularly monitored for fever spikes, hemodynamic status. His fever spikes and other symptoms gradually settled. Child maintaining saturations on room air.

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. Ceftriaxone
- Injection. Ondansetron
- Injection. Esmoprazole
- Tobramycin eye drops
- Nasivion P nasal drops
- Nasoclear mist nasal spray
- Syrup. Relent plus
- Metaspray nasal spray

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Advice:

* Diet as advised.

S.No	MEDICATION	DOSE	TIMINGS	DURATION
1	Syrup. PECEF (CEFPODOXIME - 5ml/100mg)	5.5ml (mix with honey or sugar water)	8am - 8pm (after food)	Till further advise
2	METASPRAY NASAL SPRAY 50mcg	1 PUFF	9AM-9PM	For 2 weeks
3	NASIVION-P NASAL DROPS	2 DROPS each nostril	10am-10pm (after food)	For 3 days.
4	Syrup. RELENT PLUS (Cetirizine 5mg, Ambroxol 30mg/5ml)	5 ml	8am-8pm (1 hour before food)	For 2 days.
5	Tobramycin eye drops	2 drops	twice daily	For 2 days
6	Nasoclear nasal drops, 2 drops in each nostril SOS for nose block			

Plan: To collect final blood culture report on followup.

Fever Management

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

* Tepid sponging if fever > 101 *F.

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Review consultation with Dr. SINDHURA MUNUKUNTLA on Tuesday(16.06.2026) at Himayatnagar in OPD with prior appointment (**Review consultation will be charged**).

Food instructions while taking medications:

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

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

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


Parent/ Attender

In case of emergency contact 9154865030 emergency pediatrician on duty.

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

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

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Dr. SINDHURA MUNUKUNTLA
MBBS, DCH, DNB PEDIATRICS
66970


Registrar/Resident/C.M.O



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	:	Marital 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 Phone No : 7207499416
INDIA 520012


Signature

Doctor Details :

Doctor Name : Dr. SINDHURA MUNUKUNTLA Specialisation : GENERAL PEDIATRICS
Referral Doctor : SELF Phone No :
Co-Consultant :

Payment Details :

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

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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. ----- Date of Discharge: ----- Time: -----
 Room / Bed No: ----- Ward: ----- Suggested Billable bed type: -----

Dept: *pediatrics*

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.				



PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
11/6/26	IV Placemnt	①	6079	Sujatha
cross checked done by Amrutha				
12/6/26 (10am)	WHA.	①	6223	Sujatha
cross checked by Sujatha on 12/6/26 at 10am				

ANY OTHER INFORMATION

Date : _____ Time : _____ Prepared By : _____

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
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Ref.No. F/IN/PR/10



**Rainbow[®]
Children's
Hospital**

**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 : API & DEHYDRATION.

Pediatric Multiorgan History

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



Name : S KARTHIK

Age/Sex 7yrs

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 IP26-00006551
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

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



Anthropometry

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

Weight (kgs) 24.5 kgs (Centile _____)

On Examination :

Temperature: 104.00F Pulse Rate: 120/min Description _____

B.P. _____ SPO2 100% at RA.

Resp. rate and type of breathing : _____

Rash _____
(M) - Dry lips (+)

Lymphadenopathy _____
Absent - Dry buccal mucosa,

Oedema : _____
dull look, skin turgor 7/10

Respiratory system :

Inspection (any s/o distress) : Bx (+), N3 (+)

Air entry & breath sounds : _____

Any addes sounds : _____

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

Cardiovascluar System :

Inspection of procordium : NO precordial bulge

Heart Sounds : S1, S2 (+); NO murmurs

Any murmur : _____

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

Per Abdomen :

Inspection SGA, 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 & DEHYDRATION

Pediatric Multiorgan History & Physical Ex:

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



Preventive aspects of the treatment :

Desired goals of the treatment :

Planned Labs :

- CBP
- CRP, LFT, CUE, Blood cfs. (Kired sample)
- SRSP and
- 2 extra pkim
- Dengue NS1Ag presence sample.

noted by jyoths

Planned Management :

- IVF 2/3 rd M.
- IV Ceftriaxone OD.
- Symp. (rain DS) q6hr.
- Symp. Ibuprofen SOS.

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

Dr. Sindhura Munukuntla
Consultant Pediatrician
Reg. No: 66970

Doctor's Signature Name _____ Date 10/9/2018 Time 9:30pm

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/5/28	c/s/b Dr. Sindhura	
7 PM	Asis - AFI & dehydration.	
	- High grade fever (+) since 2 days.	
	- Cold, Dull activity (+).	
	- Poor oral intake (+).	<div style="border: 1px solid black; padding: 2px; display: inline-block;">Plan</div> - Admit room - Send CBP, CPP, CUE, AFI, Blood c/s, 5 Virus pend.
	S/E - vitals stable.	- IVF 2/3 AM.
	S/E - R/S - BAE (+), NUBS (+)	- IV Ceftriaxone.
	P/A - S/A, NI, spleen hip palpable,	- hyp. Grain DS Q6H. - hyp. hyp. Ibuprofen 5 DS.
	BS (+)	
		Dr. Sindhura Munukuntla Consultant Pediatrician Reg. No: 66970 <i>Sindhura</i> <i>Munukuntla</i>
		N.B Sandhya e 7pm



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
12/06/26 7 AM	c/s 16: Dr. Sindhurath/ Dr Varun	
	D: AFI with dehydrating	
	Sera ⊕ poor oral intake	
	O/G: GC Jain vitals stable	
	S/G: PLS TSCAG ⊕. Chem PA: Soft. Nontender	
	Flu - Negative (verbal) Adeno - Averted	<p>Adx</p> <ul style="list-style-type: none"> - IV fluids (2/3m) - Drg Ceftriaxone - Trice respiratory panel
		<ul style="list-style-type: none"> - Monitor vitals and Inform doc
		<p>Sindhurath</p> <p>N.B Amouthe @ 7 AM.</p>

...GRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
02/6 10 AM	<p>CS/B Di-SINDHURA</p> <p><u>ARI c Dehydration</u></p> <p>Fever ⊕</p> <p>Eye redness ⊕</p> <p>Poor Oral intake</p> <p>Child activity both vitals still</p> <p>Conjunctival congestion ⊕</p> <p>R-S-B/LAB ⊕</p> <p>PIA - soft</p>	<p>Plan</p> <ol style="list-style-type: none"> 1) IVF - 2(3M) ⊕ 2) By Ceftriaxone Inj. Oxidem / Esomeprazole 3) Temp. Hemo, Blood c/s 4) PCM - sos 5) Toba eye drops 6) Send Dengue NS, in same sample 7) NASIVION - P Nasal 8) Xray - Nasopharynx & decide on Metatop 9) Nasochar Mist Nasal spray 10) IVF - 2nd 1/2
		<p>TVB Sindhura c 100%</p> <p>Dr. Sindhura Munukuntla Consultant Pediatrician Reg. No: 66970</p> <p><i>[Signature]</i></p>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
12/6 2:00pm.	<p><u>CLSIIS for Naipunya</u></p> <p>AFB & dehydration</p>	
	fever spikes (P)	<u>Plan</u>
	Oral intake - Poor.	- Trace Adeno
	Vitals - stable	Blood C/S
	R/S - B/L AEP	Denge NS 1
	PA - soft, NT	- cont Tobira drops.
		- Cont Ceftriaxone
		- Cont IV fluids
		- Metaspray Nasal Spray
		- Monitor vitals
		<p>noted by Sr. Sundry</p> <p>12/6/26</p> <p>2:30pm</p>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
12/6	C/S/LOS Dr. Sindhura	
4:30 PM	AFB c dehydration	
	fever spike (f)	Plan
	oral intake - poor.	- Trace Adeno
	R/S PIA / NAD	Denge NS ₁ Blood C/S.
		- Cont ceftriaxone
		- Cont Metaspray Syp. select P/B/S.
		- Cont Tobradrops.
		<p>Dr. Sindhura Munukuntala Consultant Pediatrician Reg. No: 66970</p> <p><i>[Signature]</i></p>
		noted by sr. sandhya
		12/6/26
		4:30 PM

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<u>13/6/20</u>	s/p. Dr Pralhad / Dr Anusha	
7:30 Am	Δ AFI & Dehydration	
	Adenoviral illness - Dengue NS. ⊕	
	Fever spikes - 7pm 103.6°F	Adv
	Oral intake - fair	
	fusch c/o - None	1) Trace Dengue NS - 1
		Blood c/s
	<u>O/G</u> Gr. fair	
	PA soft	2) CT. Ceftriaxone
		Prelent plus
		Metaxpress
		Tobac eye drops
		3) Encourage orally.
		N.B Anusha @ 7:30 Am



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
13/6/26	c/s/s - Dr. Sindhura	
10:55 AM	A - Adeno viral illness	
	(AFI + dehydration)	
	1 fever spike	Dengue NSI
	oral intake - fair	- 200 c/s amoxicillin
	fresh c/o - none	Plan
	o/e	- f/lop 40h c/s
	GC - fair	- ct oral Abs [CEFPodoxime]
	Plan	- R/w on Monday
	p/a soft	- discuss c parents & p/s.
	ls - clear	as they are not available
	✓ Paracetamol	Dr. Sindhura Munukuntala
	✓ Ondans	Consultant Pediatrician
	✓ Etonoxiprone	Reg. No. 16897J
	✓ Iba c/d	SINDHURA - M
	✓ Nasiniop - P	
	✓ Nasoclear	
	✓ Meta spray N/s.	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
13/06/26 2 PM	<p>Dr. Sindhura Munukuntla</p> <p>Δ: Admitted Icterus ARI with dehydration</p>	
	<p>Fever spike - yesterday No fever today - CC - Fein vitals stable</p>	
	<p>SGE: NAD</p>	
		<p>Adm</p>
		<p>- IV Fluids</p>
		<p>- Tab Ceftriaxone</p>
		<p>- Supportive care</p>
		<p>- Monitor vitals and</p>
		<p>Inform Sr</p>
		<p>Sindhura</p>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
13/6 6:15pm	<p><u>C/S/B Dr. SINDHURA</u></p> <p><u>Adenoidal Illness</u> <u>ATI c Dehydration</u></p> <p>Int Fever - Yest</p> <p>Anal intake - fair</p> <p>Snoozing ⊕ - better</p> <p>Activity - better</p> <p>child akit</p> <p>Vital stable</p> <p>Afebrile</p> <p>R-S - B/LAE ⊕</p> <p>PIA - soft</p>	<p>Pls</p> <ol style="list-style-type: none"> 1) Inj Ceftriaxone 2) Inj Esomeprazole 3) Inj Ondansetron X 4) Tobramycin ✓ 5) Nasivion - P ✓ 6) Nasocheal Mist ✓ 7) Metasparg ✓ 8) Syp Rebat + ✓ 9) Monitor Vital 10) If stable pha D/C - T/m 11) Trace C/S
		<p>NB Sw</p> <p><i>[Signature]</i></p> <p>Dr. Sindhura Munukuntla Consultant Pediatrician Reg. No: 65970</p> <p><i>[Signature]</i></p>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
14/6 8 AM	<u>cks/B Di. Pranam / Di-Mazneen</u>	
	Adenoviral illness	
	<u>AFI e Dehydration</u>	
	Fever - ↓	Ph 1) Ceftriaxone
	Sneezing - ↓	
	Oral intake - fair	2) Tobex eye drops
	Vitals stable	3) Nebrocen mist 4mg
	R-S - B/LAE ⊕	4) Metaspang
	PIA - soft	5) Syp Relent +
	Passing Urine	6) Mornite Vitals
	Stool	

W. B. Anstuta
P. B.A. Sum



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
14/6/26	C/C/B - Dr. Sindhura	
18 AM	A - AFI c Dehydration	
	[Adenoviral illness]	
	Fever ↓	
	Snoring ↓	
	oral intake ↑	plan
	Stool ✓ urine ✓	
	vitals stable	Discharge today
		IV Abs
		Oral +/m (ceftioxime) R/W
		Blood c/s flop at P/S
		R/W Toes day
		Snoring flop.
		Nasal spray 2 weeks.
		<p>Dr. Sindhura Munukuntla Consultant Pediatrician Reg. No: 68970</p> <p><i>Sindhura</i></p> <p><i>ANNUNA-M</i></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)

DRUG : <u>SYP. PARACETAMOL</u>				Date																
Dose	Route	Frequency	Start Date	Time																
<u>7.5ml</u>	<u>PO</u>	<u>Q6H/PRN</u>	<u>11/6</u>																	
Doctor's Signature		Valid Period	Pharm.																	
<u>[Signature]</u>		<u>1</u>																		
Additional Instructions:																				
<u>(240/5)</u>																				

DRUG : <u>SYP. IBUPROFEN</u>				Date																
Dose	Route	Frequency	Start Date	Time																
<u>7.5ml</u>	<u>PO</u>	<u>SOS</u>	<u>11/6</u>	<u>7:30 PM</u>																
Doctor's Signature		Valid Period	Pharm.																	
<u>[Signature]</u>			<u>@</u>																	
Additional Instructions:																				
<u>(100/5) if temp. > 101° F. P.</u>																				

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

VERIFIED BY : Name

Verified by
Dr. Dhakshayani



REGULAR PRESCRIPTIONS

Weight. 24.5kgs Ward.

Verified by
 Dr. Dhakshayani

DRUG: <u>500mg. CEFTRIAXONE</u>				Date Time	<u>11/6</u>	<u>12/6</u>	<u>13/6</u>																
Dose	Route	Frequency	Start Date																				
<u>500mg</u>	<u>IV</u>	<u>OD</u>	<u>11/6</u>																				
Name & Signature of the Doctor Starting the Drugs:				<u>8pm</u> <u>8:30pm</u> <u>5/4</u> 																			
Additional Instructions:				<u>slow IV infusion over 2 hrs.</u>																			
Daily Doctor's Endorsement by a Sign																							
DRUG: <u>500mg. PARACETAMOL</u>				Date Time	<u>11/6</u>	<u>12/6</u>																	
Dose	Route	Frequency	Start Date																				
<u>750mg</u>	<u>PO</u>	<u>Q6H</u>	<u>11/6</u>																				
Name & Signature of the Doctor Starting the Drugs:				<u>3am</u> <u>9am</u> <u>3pm</u> <u>9pm</u> 																			
Additional Instructions:				<u>stop SA</u>																			
Daily Doctor's Endorsement by a Sign																							
DRUG: <u>500mg. ONDANSETRON</u>				Date Time	<u>11/6</u>	<u>12/6</u>	<u>13/6</u>																
Dose	Route	Frequency	Start Date																				
<u>500mg</u>	<u>IV</u>	<u>Q8H</u>	<u>11/6</u>																				
Name & Signature of the Doctor Starting the Drugs:				<u>6am</u> <u>2pm</u> <u>10pm</u> 																			
Additional Instructions:				<u>stop</u>																			
Daily Doctor's Endorsement by a Sign																							
DRUG: <u>500mg. ECONEPRAZOLE</u>				Date Time	<u>11/6</u>	<u>12/6</u>	<u>13/6</u>																
Dose	Route	Frequency	Start Date																				
<u>500mg</u>	<u>IV</u>	<u>Q24H</u>	<u>11/6</u>																				
Name & Signature of the Doctor Starting the Drugs:				<u>6am</u> <u>9pm</u> 																			
Additional Instructions:				<u>stop</u>																			
Daily Doctor's Endorsement by a Sign																							

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 2.5 kg Ward

DRUG : TOBRAMYCIN Eye Drop				Date/Time	12/6	1/6	1/6													
Dose	Route	Frequency	Start Dt.																	
20	Each Eye	6 th hly	12/6	6Am	X															
Name & Signature of the Doctor Starting the Drugs: Pran					12Pm															
Additional Instructions:					6Pm															
Daily Doctor's Endorsement by a Sign																				
DRUG : NASIVION - P NASAL Drop				Date/Time	12/6	1/6	1/6													
Dose	Route	Frequency	Start Dt.																	
20	P/N	BD	12/6	11Am																
Name & Signature of the Doctor Starting the Drugs: Pran					11Pm															
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG : Symp RELENT PLUS				Date/Time																
Dose	Route	Frequency	Start Dt.																	
2.5ml	PO	BD	12/6																	
Name & Signature of the Doctor Starting the Drugs: Pran																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG : NASOCLEAR MIST NASAL SPRAY				Date/Time	12/6	1/6	1/6													
Dose	Route	Frequency	Start Dt.																	
2 Puff	P/N	6 th hly	12/6	6Am	X															
Name & Signature of the Doctor Starting the Drugs: Pran					11A															
Additional Instructions:					6Pm															
Daily Doctor's Endorsement by a Sign					12Am															

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

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



Sheet

REGULAR PRESCRIPTIONS

Weight 24.5kg Ward

DRUG : METATOP NASAL SPRAY				Date Time																	
Dose	Route	Frequency	Start Dt.																		
2 Puffs	PN	BD	12/6																		
Name & Signature of the Doctor Starting the Drugs:																					
Additional Instructions:																					
Daily Doctor's Endorsement by a Sign																					
DRUG : Syp RELENT PLUS				Date Time	12/6	12/6	12/6														
Dose	Route	Frequency	Start Dt.																		
5ml	PO	BD	12/6																		
Name & Signature of the Doctor Starting the Drugs:																					
Additional Instructions:																					
Daily Doctor's Endorsement by a Sign																					
DRUG : METASPRAY NASAL SPRAY				Date Time	12/6	12/6	12/6														
Dose	Route	Frequency	Start Dt.																		
2 Puff	PN	BD	12/6																		
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

Verified by

Dr. Dhakeshvarani
 Dr. Dhakeshvarani



I.V. FLUIDS CHART

Weight. 24.5kg Ward.

Signature
 VERIFIED BY : Name

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% Dx	IV	40ml	K	A S	12/1	R	✓ ✓
12/6	10AM	IVK	IV	20 ml/h	R	✓ ✓	12/6	✓ B	✓ B

CUV-00130047 IP26-00005561
Master S KARTHIK
04-09-2018 7 Y 9 M 7 D (M)
Dr. SINDHURA MUNUKUNTLA



219

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

RESULT SHEET

Date	11/6/26				
Time	7:45				
Hb	10.3				
PCV	29.2				
RBC	3.83				
WBC	4.73				
N/L	67.8/188				
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						
Dengue NS1	- ⊖ve					
Adenovirus	⊕ve					

Culture and Sensitivities : 11/6/26 Blood C/S (-) 24 hrs no growth

.....

.....

.....

Radiology : USG :

X-Ray :

ECHO :

CT :

MRI :

Others (ECG, Contrast Studies etc.) :

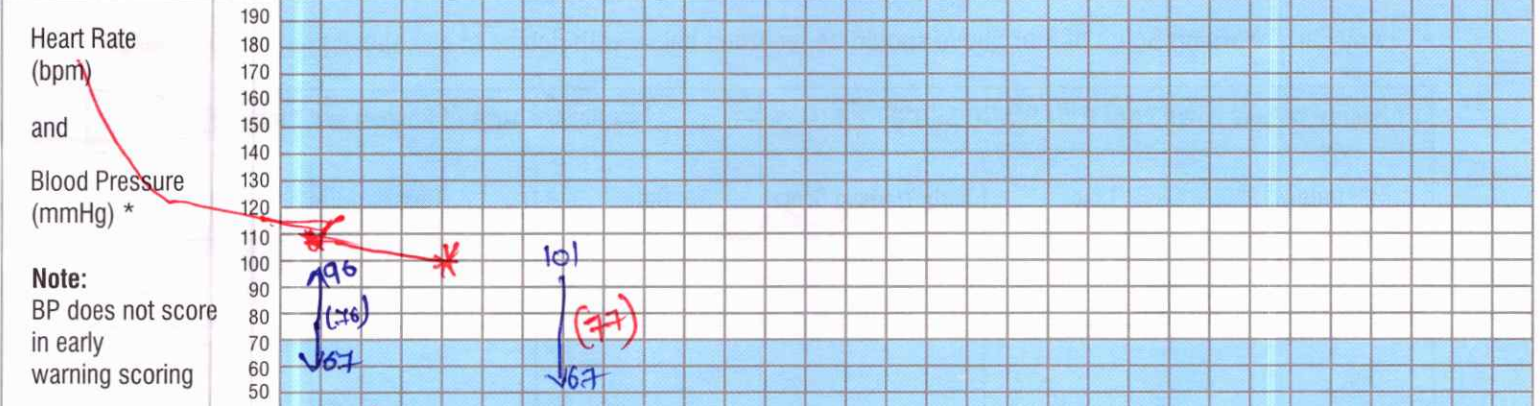
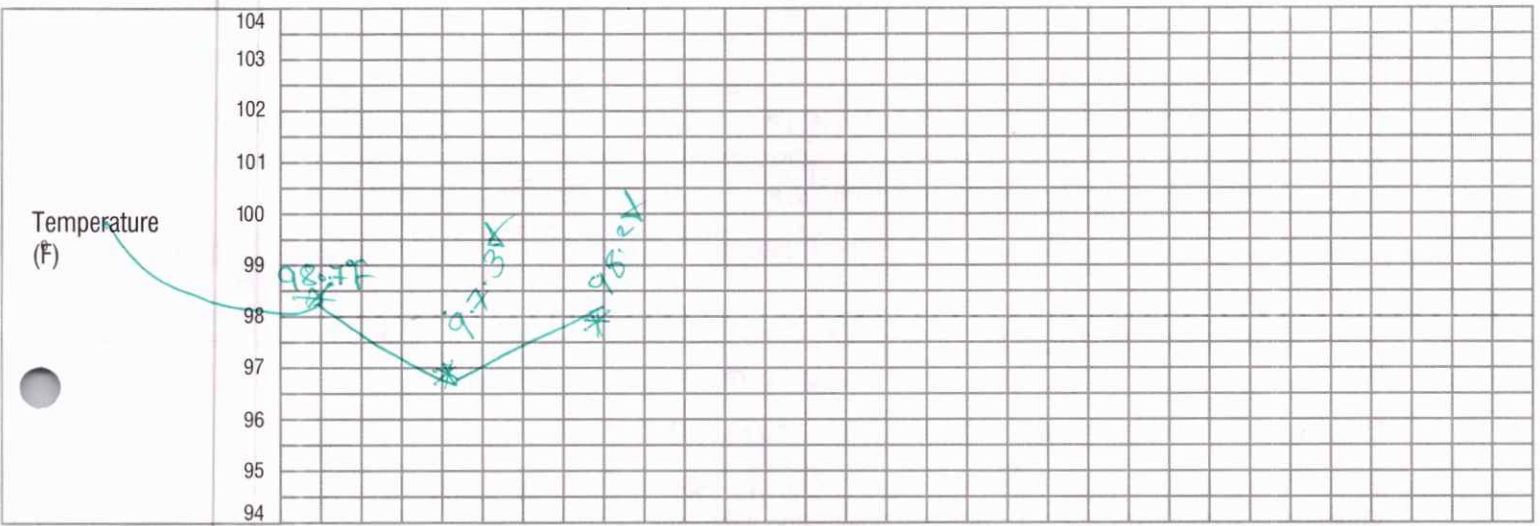
Patient S



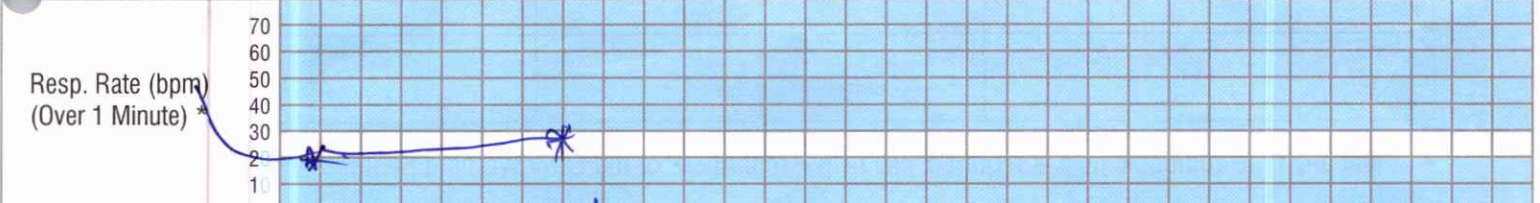
INICAL / 126

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 11/6/26 Time: 10 2Am 6Am
 Doctor / Nurse / Family Concern? Pm



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



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

Resp Distress Mod/ Severe None / Mild

Receiving O₂ (l/min) O₂ 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.

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)

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

CLINICAL / 126

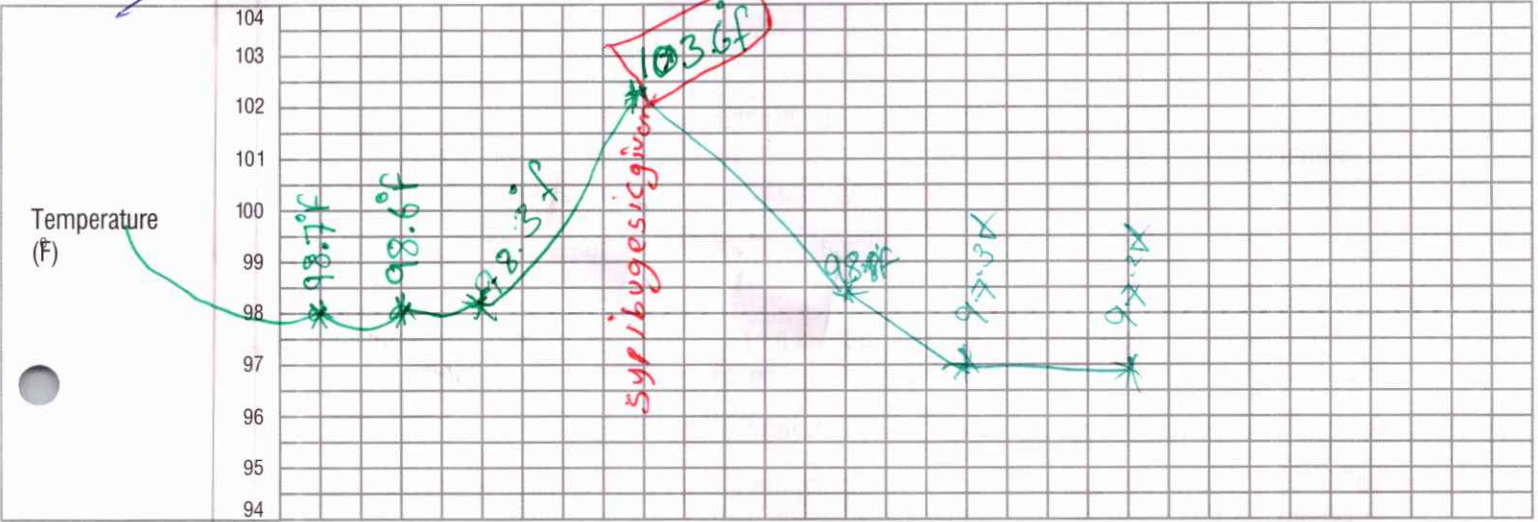
SCHOOL AGE (5-12 years)
Children's Observation & Early Warning Scoring Chart

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

WARNING SCORE: CHILDREN'S UNIT

Date: 12/6/24 Time: 10 2 6PM 7PM 10 PM 2AM 6AM
 Doctor / Nurse / Family Concern? Am Pm Pm Pm Pm Pm



Heart Rate (bpm) and Blood Pressure (mmHg) *	190	180	170	160	150	140	130	120	110	100	90	80	70	60	50
Note: BP does not score in early warning scoring	104	100	100	101	103										
	65	88	60	62	63										

Heart Rate (Number) 119b/m 93b/m 115b/m 110b/m 115b/m 113b/m

Resp. Rate (bpm) (Over 1 Minute) *	70	60	50	40	30	20	10
Resp Rate (Number)	30b/m	28b/m	30b/m	20b/m	20b/m	23b/m	

Resp Mod/ Severe Distress None / Mild

Receiving O₂ (l/min) O₂ Saturations (%) 100% 100% 99% 100% 98% 100%

Conscious Level Normal Altered
 GCS *

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

- ACTIONS**
- Score 1 : Continue normal observation by staff nurse
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- NB: Scores 3 should be recorded overleaf

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

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

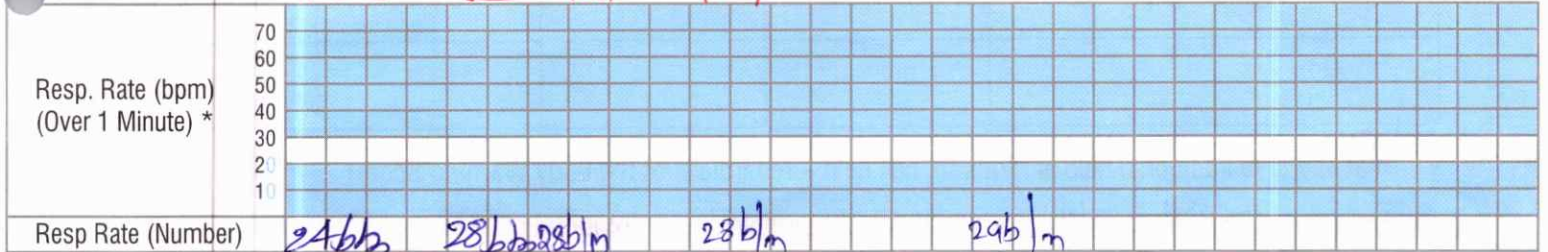
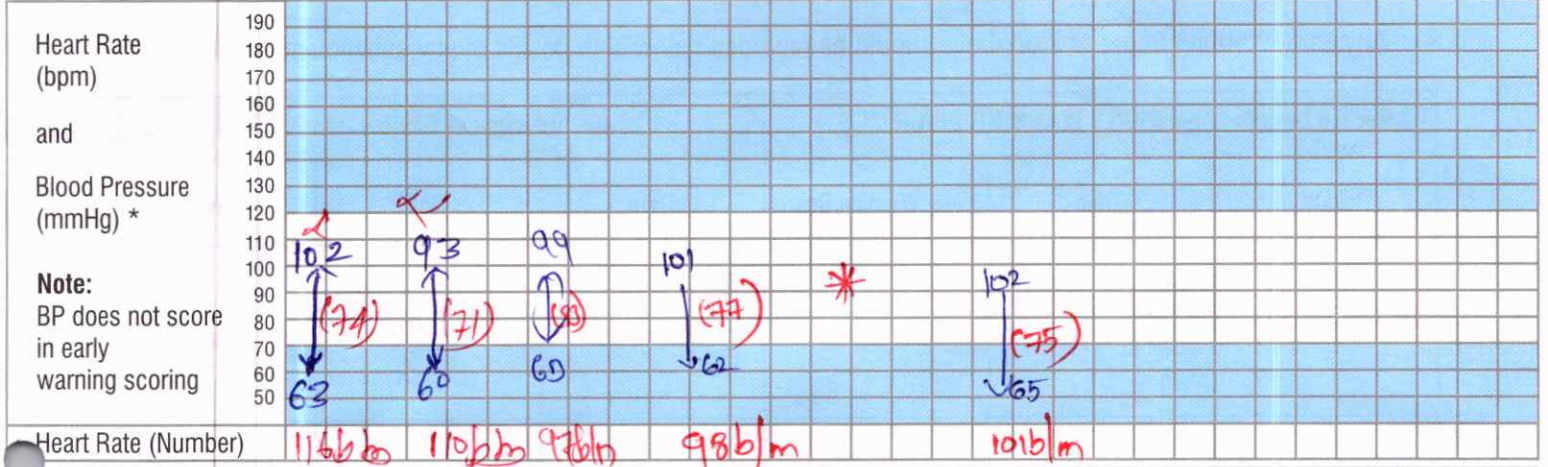
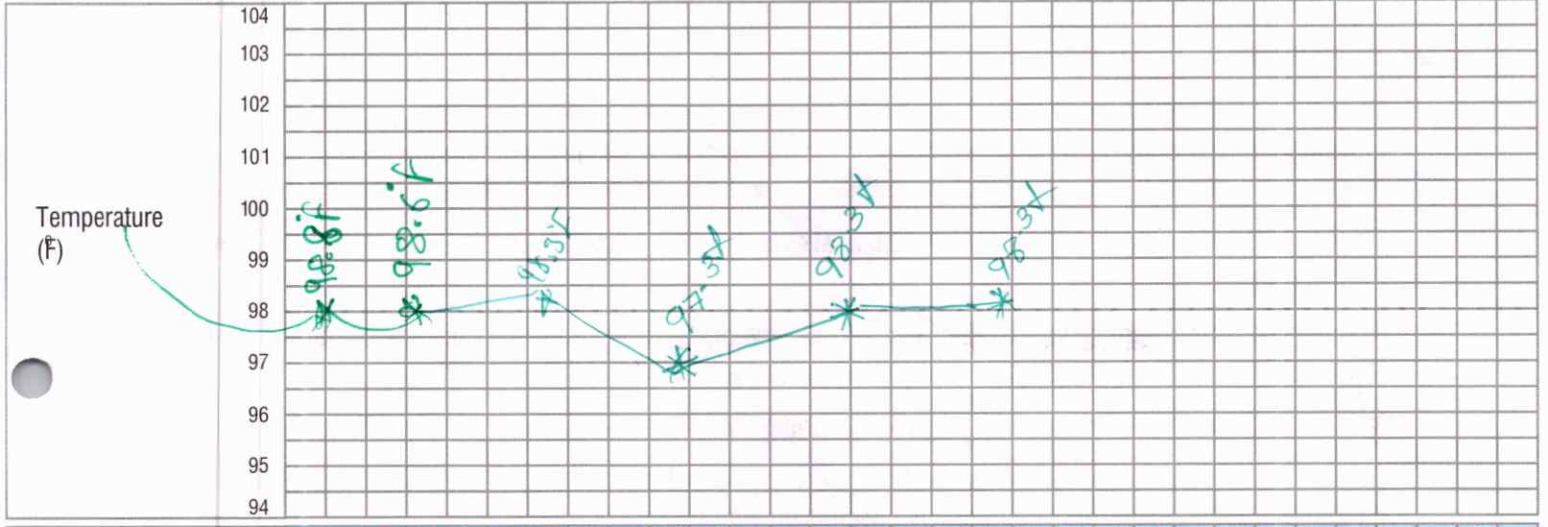
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R	RECOMMENDATION : I need you to ... come to see the child in the next (XX mins) AND Is there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 13/6/21 Time: 10 2 6pm 10pm 2AM 6AM
 Doctor / Nurse / Family Concern? PN PN



Resp Distress	Mod/ Severe	
	None / Mild	
Receiving O ₂ (l/min)		
O ₂ Saturations (%)		100%, 100%, 98%, 100%
Conscious Level	Normal / Altered	
GCS *		

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

- 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.

10

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

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Date	Time	Early Warning Score	Date	Time	Name

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R	RECOMMENDATION: I need you to ... come to see the child in the next (XX mins) AND is there anything I need to do in the meantime? (e.g. stop the fluid/ repeat observation)

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

IP26-00006561



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	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
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 :						
11/6/26	08:00 pm	Dextrose + 25% + 25% + 25% + 25% + 25% + 25%		40ml								
	09:00 pm			40ml								
	10:00 pm			40ml								
	11:00 pm			40ml								
	12:00 am			40ml								
	01:00 am			40ml								
Total Intake : - taken						Total Output : U - 2M - 0						
12/6/26	02:00 am	Dextrose + 25% + 25% + 25% + 25% + 25%		40ml								
	03:00 am			40ml								
	04:00 am			40ml								
	05:00 am			40ml								
	06:00 am			40ml								
	07:00 am			40ml								
Total Intake : - taken						Total Output : U - 2M - 1						

Total 24 hrs. Intake

Total 24 hrs. Output



FLUID CHART

Sheet No. :

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
19/6/20													
	08:00 am	Plasmaolyte 400ml +		400ml									
	09:00 am		idly	400ml									
	10:00 am	Plasmaolyte 257.0A	+ H ₂ O.	200ml									
	11:00 am			200ml									
	12:00 pm			200ml									
	01:00 pm	100ml 257.0A		200ml									
Total Intake :			Taken			Total Output :					U-1	M-x	
12/6/26	02:00 pm	Plasmaolyte +		20ml									
	03:00 pm			20ml									
	04:00 pm			20ml									
	05:00 pm												
	06:00 pm			stop									
	07:00 pm												
Total Intake :						Total Output :							
12/6/25	08:00 pm												
	09:00 pm		Rice										
	10:00 pm		+ H ₂ O										
	11:00 pm												
	12:00 am												
	01:00 am												
Total Intake :			taken			Total Output :					M-0	U-2	
13/6/26	02:00 am												
	03:00 am												
	04:00 am		H ₂ O										
	05:00 am		+ Ric.										
	06:00 am												
	07:00 am												
Total Intake :			taken			Total Output :					U-1	M-0	

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
- 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	8PM	Assessed the General condition to the Patient → checked the vital sign → Maintain I/O chart	8PM	Assessed the general condition → checked the vital signs → Maintain I/O chart → Administer medication as per doctor. → ct fluids → ct antibiotics	checked the Vitals sign	→ re checked vitals	Sy
	8AM	Administer medication as per doctor.	8AM				

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



NURSING CARE RECORD



Date: 12/12/20

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	→ Assess the pt condition. → monitor the vitals. → maintain I/O chart. → continue IV fluids. → continue medications.	9Am	→ Assessed the pt condition. → monitored the vitals. → maintained I/O chart. → continued IV fluids. → continued medications.	→ pt is stable now	→ Re assessed the vitals	
	2pm		2pm				
Afternoon	2pm	→ Assess the pt condition → monitor the vitals → maintain I/O chart → Administer medication as per drug chart	8pm	→ Assessed pt condition → monitored vitals → maintained I/O chart → Administered medi- cation as per drug chart	Patient is stable	Re-checked vitals	
	8pm		8pm				
Night	8pm	→ Assess the pt condition → monitor vitals → maintain I/O chart → medication as per drug chart	8pm	→ Assessed the pt condition → monitored vitals → maintained I/O chart → Administer medication as per drug chart → Stop IV fluids	→ pt is stable	→ rechecked vitals	
	8am		8am				



NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:				Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known			
	Surgery / Procedure:				If Yes Specify:			
BACKGROUND	Date	Shift	11/16/26 NI	12/16/26 Mo	12/16/26 E	12/16/26 NI		
	Medical Condition (Any special condition to be noted):							
Diet:			soft diet	soft diet	soft diet	soft diet		
ASSESSMENT	Allergy:		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	Ventilation (RA, NP, NIV, VENTI):		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
	Tubes/Drains/Catheter:		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	Vital Signs:		Temp:	97.5F	97.6°F	98.3°F	97.8F	
			Res:	20b/m	20b/m	23 b/m	20b/m	
			SpO ₂ :	99%	99%	99%	99%	
			Pulse:	20b/m	20b/m	105b/m	110b/m	
			BP:	90/62	90/68	98/65		
			LOC:	—	—	—	—	
			Fall Risk Score:	—	—	—	—	
		Pain Score:	—	4	—	—		
		Skin Integrity	—	Good	Good	good		
Recommendations	Safety Needs:		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<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
	Physiotherapy:		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
	Others Specify:		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	Special Diet:		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
	Critical Lab Test / Values:		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
	Other Special Orders / Medications:		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	PU Prophylaxis:		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
DVT Prophylaxis:		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
ADL (Dependent / Non Dependent):			—	—	—	—		
Post Operative Procedure Special Orders:								
Handed Over By Name :			Divya	Mahi	Anusha	Divya		
Signature / ID :								
Date:			12/16/26	12/16/26	12/16/26	12/16/26		
Time:			8AM	2pm	8pm	8AM		
Taken Over By Name :			Mahi	Anusha	Divya			
Signature / ID :								
Date:			12/16/26	12/16/26	12/16/26			
Time:			8AM	2pm	8pm			

Patient Sticker



NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify:					
	Surgery / Procedure:	Post OP Day:					
BACKGROUND	Date	Shift					
	Medical Condition (Any special condition to be noted):						
	Diet:						
ASSESSMENT	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 ₂ :					
		Pulse:					
		BP:					
		LOC:					
		Fall Risk Score:					
	Pain Score:						
	Skin Integrity						
Recommendations	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):						
Post Operative Procedure Special Orders:							
Handed Over By Name :							
Signature / ID :							
Date:							
Time:							
Taken Over By Name :							
Signature / ID :							
Date:							
Time:							

JUV-00130047

Anster S KARTHIK

4-09-2018

7 Y 9 M 7 D

Dr. SINDHURA MUNUKUNTLA

IP26-00006561

(M)



BRADEN 'Q' SCALE



Date: 12/6/20 12/10/20 12/6/20 12/8/20
Time: NI Mc Fz NI

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
FRICION-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	3	3	3

TOTAL SCORE

Evaluator's Name

28 22 20 20
[Signatures]

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

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

Risk Score	Category	Action	Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice)
15-18	At Risk	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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

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



CHECKLIST FOR THROMBOPHLEBITIS

11/6/26

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			12/6/	DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N		
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0			0	0	0	0					
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1			NO	NA	NA	NA					
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2			NO	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			NO	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			NO	NA	NA	NO					
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord pyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5			NO	NA	NA	NO					
Signature of the Nurse						<i>[Signature]</i>	<i>[Signature]</i>	<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 : Name :

Signature of Ward In Charge :
 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
11/0/26	10PM	0/10	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	D
12/0/26	02PM	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	DR
12/6/26	1PM	0/10	PA	<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	Acus
14/6/26	11PM	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	DR
				<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:

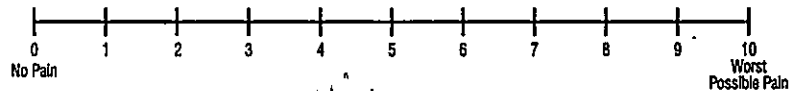
1. Every eight hours for all hospitalized patients.
2. For post-surgical patients, patients with chronic pain, patient with severe pain:
 - a) At least every 2 hours for the first 24 hours
 - b) Then every 4 hours.
 - c) Prior to pain pain-relieving intervention.
 - d) Within 30 – 60 minutes after pain 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' brawn 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	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
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, SaO₂	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


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

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
	Transfer Ordered by Dr. Varun	Reason for Transfer Admission
From Unit ER	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 No

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 / [Signature]

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: 104°F PR: 170b/m BP: RR: 36b/m SpO₂: 97%

Chief Complaints: clo. fever since 2 days high grade

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

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

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

Signature of Parent / Guardian
 Triage Completion Time :

Communicable Disease Triage Screening

- PART A. The following questions should be asked to all patients at the initial screening:**
- Have you had fever (elevated temperature) in the past 2 weeks Yes No
 - Have you had cough or a rash in the past 2 weeks Yes No
 - Have you had shortness of breath or difficulty breathing in the past 2 weeks Yes No

- PART B. For patients reporting fever and respiratory/rash symptoms:** Not applicable
- Have you travelled outside the INDIA? or had close contact with someone who has recently travelled outside the INDIA, in the past two weeks? Yes No
 If yes, State Location:
 - Are your parents / close contacts at home is/a healthcare worker? {please encircle the choices} (e.g., nurse, physician, ancillary services personnel, allied health services personnel, hospital volunteer, or laboratory worker, others) who has had a recent exposure to an individual with a highly communicable disease or unexplained, severe febrile respiratory or rash disease? Yes No

- PART C. A positive communicable disease triage screening is considered for any patient who meets one of the two following criteria:**
- Any patient with Fever / Rash / Vesicles / Discharge from Eyes and Cough
 - Any patient with fever and respiratory symptoms who answered "YES" to any of the questions on epidemiologic risk factors in "PART B" of the triage screening above.

- PART D. ACTION / INTERVENTION:** (for positive suspected communicable disease triage screening)
- Patients should be immediately isolated in a negative pressure room or a single room (as appropriate) for pending evaluation.
 - The patient should be given a surgical mask immediately, if not already wearing one.
 - Both patient and triage staff should perform hand hygiene.
 - The staff should use PPE (as appropriate).

Name of Triage Nurse : Bhargava

Signature of Triage Nurse : (B)

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



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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

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

Height : Weight : 24.15kg 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

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

IF YES FOR ANY CATEGORY = RISK FOR FALLING
Fall Risk Intervention:
 Escort while ambulating
 Assist Patient
 Educate patient and family on fall precautions/prevention

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 : @ 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*

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	<i>[Signature]</i>	

Condition of patient at time of shift - out :	Details of Shift - out
HR: <i>130b/m</i> BP: CFT: RR: <i>36b/m</i> SPO ₂ : <i>97%</i> GCS: Temperature: <i>104°F</i> Pain Score: Repeat RBS (if applicable):	Shift - out from ER to: <i>ward</i> Time of Shift - out: <i>8:10pm</i> 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: < 25th

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

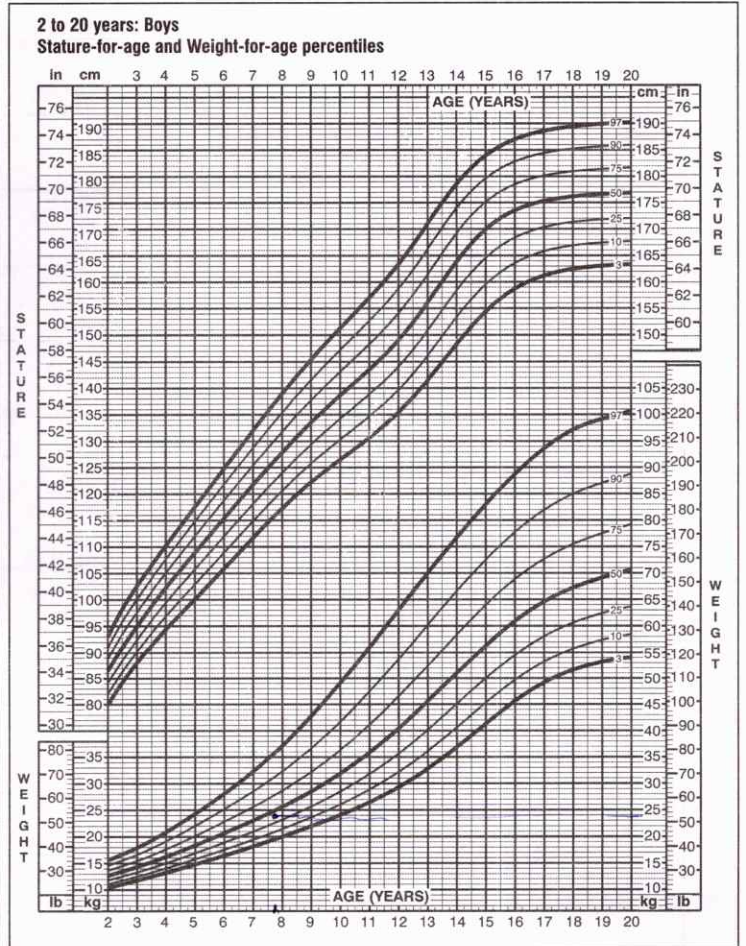
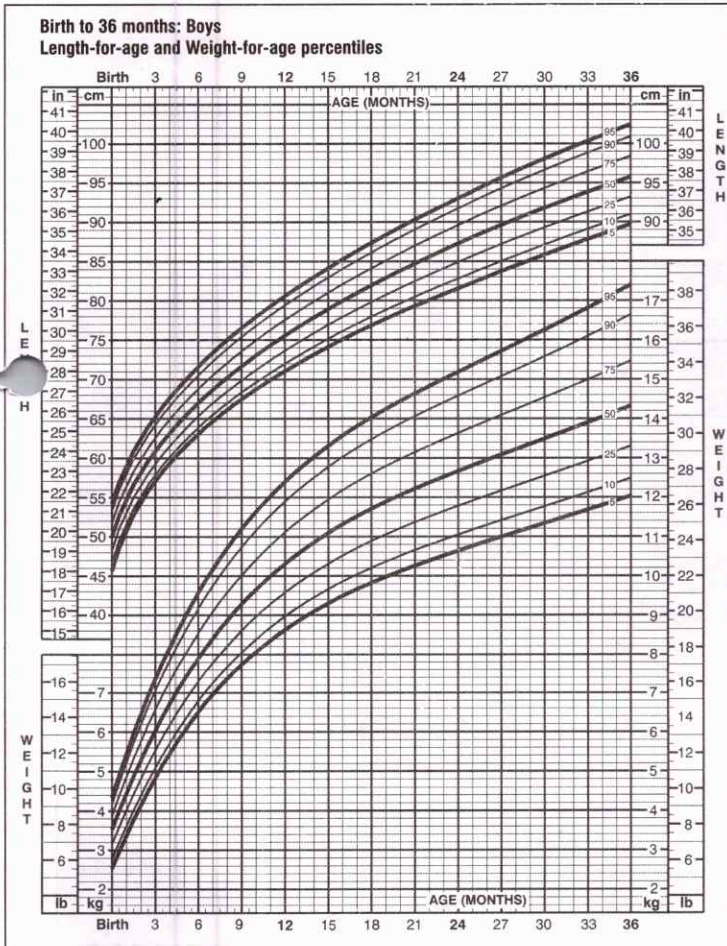
Food Allergies: no Veg/Non-veg: Veg

Diagnosis: A.I.C dehydration

Nutritional Intervention - Oral Enteral Parenteral

Patient's Signature: S. Syothi

GROWTH CHART (BOYS)



Dietician's Name: Syeda Sobiya Zahoor

Dietician's Signature: Sobiya

RAINBOW CHILDREN'S HOSPITAL, HIMAYATH MALLAP
HOSPITAL, WAPDA HOUSE, 9th FLOOR, GURUPURAM, HYDRABAD

11. 11. 2011

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КЕТИРДАН СӨЗӨВДӨ А ЧӨРӨНДӨ ПРАКТИКАЛДЫК
КӨРӨНӨ АРКЫНДА АРКЫНДА АРКЫНДА АРКЫНДА АРКЫНДА

ATI - 1
Dehydration