

DISCHARGE SUMMARY

Name	Baby ANVI SURYAVANSHI	UHID	HNH-00016049
Father/Guardian	Mr AMARDEEP SURYAVANSHI	Age/Gender	2 Y 11 M 3 D/ Female
Address	H NO 2-3-647/B/239 PREM NAGAR, Amberpet, Hyderabad, Telangana, INDIA, 500013		
IP No	IP26-00006619	Admission Date	20-06-2026
Ref Doctor	Self.		
Discharge Date	23.06.2026		

Consultant:
Dr. DILNAAZ FAROOQUI
MBBS DNB
56763

DIAGNOSIS	ICD CODE
ACUTE GASTROENTERITIS WITH DEHYDRATION	

History: Baby ANVI SURYAVANSHI is a 2 Y 11 M 3 D , old girl presented with history of loose stools (10-15 episodes/day) associated with multiple episodes of non bilious, non projectile vomiting and pain abdomen since 4 days, decreased oral intake since 2 days, prior to admission. For the above complaints she was admitted at Rainbow Children's Hospital - for further management.

Name	Baby ANVI SURYAVANSHI	UHID	HNH-00016049
IP No	IP26-00006619	Admission Date	20-06-2026

Examination: She was afebrile, maintaining saturations at room air. Her heart rate was 109/min, blood pressure was 105/65 mmHg and RR - 24/min. On examination Signs of dehydration were present such as dry lips, dry oral mucosa, dull look and sunken eyes were present. On auscultation of chest, air entry was bilaterally equal with normal heart sounds and there was no murmur. Abdomen was soft, non tender without organomegaly. On neurological examination, she was conscious & alert. Pupils were bilaterally equal & reacting to light. There were no focal neurological deficits.

Weight on admission: 11.18 kilo grams.

Investigations: Enclosed reports.

Initial hemogram showed Hemoglobin of 12.0 gm%, White Blood Cell count of 7470 cells/cumm, platelet count of 4.56 lakhs/cumm and C-Reactive Protein of 5.0 mg/l.

Complete urine examination shows: Pus cells - 30-35, epithelial cells - 8-10, RBCS - 15-20.

Urine culture and sensitivity shows: No growth after 24 hours incubation.

Blood culture and sensitivity shows: No growth after 48 hours incubation.

TYPHOID IGM was negative.

Ultrasound abdomen shows:

- * ? Cystitis changes in the bladder.
- * Mesenteric lymphadenopathy.
- Suggested clinical and CUE correlation

Management: She was admitted in the ward and started on intra venous

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fluids and In venous antibiotics. She was treated symptomatically with antiemetics, antacids and antipyretics. In view of loose stools, she was administered probiotics and advised gastrodiet.

She was regularly monitored for her loose stool frequency and hydration status. Her loose stools and other symptoms settled gradually. CUE showed 25-30 pus cells and hence urine culture was sent and started on IV antibiotics.

Urine culture was sterile after 48 hours and child's clinical condition improved. She remained hemodynamically stable throughout the hospital stay and is being discharged with the following advice.

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

Medications given during hospital stay:

- Injection. Ondansetron
- Injection. Ceftriaxone
- Injection. Esmoprazole
- Econorm sachet
- Z & D Suspension
- Syp. Cyclopam
- ORS WHO

Advice:

- * Diet as advised.

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S.No	MEDICATION	DOSE	TIMINGS	DURATION
1	Syrup. ZIPRAX (Cefixime - 5ml/100mg)	3 ml	8am - 8pm (after food)	For 3 days.
2	NEXPRO junior 10mg sachet	dilute in 10ml water and give 10ml	7am (before breakfast)	For 3 days
3	Syrup. Albendazole (5ml/200mg)	10 ml	10pm (bedti me)	tonight and repeat after 14 days
4	Candid cream	For local application	thrice daily	For 5 days
5	ECONORM SACHET	1 SACHET	9am-9pm (after food)	For 3 days
6	Z & D drops (1ml/20mg)	1 ml	9am (after food)	For 11 days
7	Nasoclear nasal drops, 2 drops in each nostril SOS for nose block			

Fever Management

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

* Tepid sponging if fever > 101 *F.

Review consultation with Dr. DILNAAZ FAROOQUI on (25.06.2026) Thursday at

Name	Baby ANVI SURYAVANSHI	UHID	HNH-00016049
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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.
- * **Anti ulcer drugs** can decrease the absorption of Iron&vit-B12. Anti ulcer drugs can be taken at least 1 hour before food (OR) 2hrs after food. Avoid caffeine that increases stomach acidity.
- * By consuming your **probiotic** with food you provide a buffering system for the supplement and ensure its safe passage through the digestive tract. Aside from protection, food also provides the friendly bacteria in your probiotic the proper food and nourishment to ensure it survives, grows and multiplies in your gut. It is recommended to take probiotics at the END of a meal. Concurrent administration of antibiotics could kill a large number of the organisms, reducing the efficacy of probiotics. Separate administration of antibiotics from probiotics by **atleast two hours**.

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

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

Parent/ Attender

Name	Baby ANVI SURYAVANSHI	UHID	HNH-00016049
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In case of emergency contact 9154865030 emergency pediatrician on duty.

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

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


Registrar/Resident/C.M.O



Dr. DILNAAZ FAROOQUI
MBBS DNB
56763

ADMISSION SHEET



Registration Details :

Admission No : IP26-00006619 Admit Date : 20-Jun-2026 Admit Time : 06:41 PM UHID : HNH-00016049

Patient Details :

Patient Name : Baby ANVI SURYAVANSHI Age : 2 Y 11 M 2 D
Guardian : Mr AMARDEEP SURYAVABSHI DOB : 18-07-2023
Gender : Female Religion :
Occupation : Martial Status :
Address (H) : H NO 2-3-647/B/239 PREM NAGAR Amberpet Phone No : 8019642718/ 8767838473
Hyderabad Telangana INDIA 500013 E-mail :
AMARDEEPSURYAVANSHI@GMAIL.C

Admission Details :

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

Contact Details :

Name : Mr AMARDEEP SURYAVABSHI Relationship : Father
Contact Address : H NO 2-3-647/B/239 PREM NAGAR Amberpet Phone No : 8019642718
Hyderabad Telangana INDIA 500013


Signature

Doctor Details :

Doctor Name : Dr. DILNAAZ FAROOQUI Specialisation : GENERAL PEDIATRICS
Referral Doctor : Self. Phone No :
Co-Consultant :

Payment Details :

Payment Mode : DC/CC Card Deposit Amount : 10000.00
Payor Name : Paramount Health Services&Insurance TPA Pvt Ltd

ACTIVITY HNH-00016049 IP26-00006619
Baby ANVI SURYAVANSHI
18-07-2023 2 Y (F)
Dr. DILNAAZ FAROOQUI

G

Name: -----

UHID No: ----- IP NO: ----- Consultant: ----- Dept: Pediatrics

Date of Admission: 20/6/26 Time: ----- Date of Discharge: ----- Time: -----

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
<u>20/6/26</u>	<u>7:50pm</u>	<u>ER</u>	<u>ward</u>	<u>Bhargava</u>

Cross Consultation Visit

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



INVESTIGATIONS

Date	Investigations	Order No.	Sign
20/6/26	CBP, CRP		
	Blood CLS	10091	Syahe
	Typhoid		
	VBT	10092	
Cross checked done by Sreha			
20/6	CWE, Cmirck	10100	Sre
21/6/26	USG Abdomen & pelvis	7416	sandhya
Cross checked done by Sre			

Ref.No. F/IN/PR/10



Rainbow[®] Children's Hospital

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name : _____

HNH-00016049 IP26-00006619

Patient ID# : _____

Baby ANVI SURYAVANSHI
18-07-2023 2 Y (F)
Dr. DILNAAZ FAROOQUI



Consultant : _____

Final Diagnosis : _____



Name : _____

Informant _____

Reliability _____

Chief Presenting Complaints & Duration (Chronologically):

- c/o loose stools since 4 days
- c/o vomiting since 4 days.
- c/o pain abdomen since 4 days.
- c/o decreased oral intake.

History of present illness :

Child presented with c/o loose stools since 4 days (10-15 episode/day) watery in consistency non mucoid/not blood stained.

c/o vomiting multiple episode since 4 days containing food particles. non projectile.

c/o pain abdomen intermittent squar-type per umbilical region. on & off.

c/o decreased oral intake & activity.

didnot pass urine since mng ?

Pediatric Multiorgan History & Physical Examination

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Baby ANVI SURYAVANSHI
18-07-2023 2 Y (F)
Dr. DILNAAZ FAROOQUI



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

Blank lined area for Past History.

Birth & Neonatal History :

Blank lined area for Birth & Neonatal History.

OTB
R

Birth & Socio Economic History :

About Father : _____

About Mother : *Not significant*

Any additional Information : _____

Developmental History :

Appropriate

Immunization History :

Cptodate .



Anthropometry

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

Weight (kgs) 11.18 kg (Centile _____)

On Examination :

Temperature : Afebrile Pulse Rate: 109 Description _____

B.P. 105/65 mmHg SPO2 99% at _____

Resp. rate and type of breathing : _____

Sign of dehydration (+)

Rash _____

Lymphadenopathy _____

Oedema : _____

Sunken eye.
dull look
dry lips/oral mucosa

Respiratory system :

Inspection (any s/o distress) : _____

Air entry & breath sounds : B/c AC (+)

Any added sounds : NVBS (+)

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

Cardiovascular System :

Inspection of precordium : _____

Heart Sounds : S1,2 (+)

Any murmur : No

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

Per Abdomen :

Inspection Soft, Not distended

Palpation : Non tender

Auscultation : _____

Spine: _____ External Genitalia : _____

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

Pediatric Multiorgan History & Physical Examination

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Dr. DILNAAZ FAROQUI



Central Nervous System :

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

Cranial Nerves : _____

Motor System :

Nutrition : (n)

Tone : _____ Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR

Superficials :

Plantars (n)

Sensory System :

Bladder / Bowel : (n)

Clinical Summary & Diagnostic :

Age c dehydration

Faint watermark text: "Dr. Dilnaaz Farooqui" and "Pediatric Multiorgan History & Physical Examination"

Pediatric Multiorgan History & Physical Examination

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Dr. DILNAAZ FAROOQUI



Preventive aspects of the treatment :

To prevent delayed hypovolemic shock.

Desired goals of the treatment :

Planned Labs :

CBP
CRP
CUE, U/c/s
B/c/s
VBG
1 Extra Sample
Typhidot
USG Abdomen

Planned Management :

- IV fluids
- 1g CEFTRIAXONE
- 14 ONDANSETRON.
- ECONORM.
- WHO ORS
- 3&D.
- Hyom sus
- [U/O, Bp] Monitoring.

collect CUE & o/c/s before Antibiotic

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

Dilnaaz
Dr. Dilnaaz Farooqui
Consultant Pediatrician
Reg. No: 27476

Date

22/6/26

Time

10:00 am



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
21/8/26	S/B Dr. Sreyhan	/ Dr. Anushe Plan
7:25 AM	Δ A/G F = dehydration	
	Cl ₂ loose stool,	CF IV fluids
		- CF CEFTRIAXONE
	CVS 3, 5, 10 RS-BU-ATP 0	CF ECONORM ZAD
	PIA 500 CONCIOL	Encourage orally
		WTO-OMY load each loose stool
		CUE
		Trace Blood C ₁
		Urine C ₁
		Typhidot IgM
		NB Screenshot 25/26



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
21/6 9:45 AM	<p>CLSB Dr. Tejani</p> <p>Acute Gastroenteritis, \bar{c} Dehydration</p> <p>Loose stool \oplus Abdominal pain</p> <p>Urine - Passing, less</p> <p>O/E - Child asleep Vitals stable R-S - B/LAE \oplus PIA - soft</p>	<p>Plan</p> <ol style="list-style-type: none"> 1) Add Radafil if further loose stools 2) CT-IVF - 2/3rd \oplus - Try to taper 3) Escoron 2x1 4) Zin Ceftriaxone 5) Monitor Vitals 6) SOS - Oral Cyclopro 7) USSG Abdomen - Today 8) Trace (Typhi Dot) { C/E & Urine CLS Blood CLS 9) Gastro diet 10) Encourage orally <p><i>[Signature]</i> Dr. Tejani</p>
		<p>noted by Sr. Sandhya 21/6/26 @ 10:00</p>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
21/6	c/s/Ds Dr. Prasad / Dr. Nazneen	
3:15pm	Acute Gastroenteritis - Dehydrated	
	UTI	
		Pls
	Loose stools - better	1) IVF
	Abdominal pain - better	2) Zj Ceftriaxone
	Passing Urine	3) Eclonaz
	Oral intake - less	2k D drop
	Child alert	4) Trace Viten c/s
	Vital stable	Blood c/s
	R-S - B/LAS @	5) Gastro diet
	PLA - soft	6) Monitor vitals
		w.B Amantle
		c 4pm.
		Prasad

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Baby ANVI SURYAVANSHI

18-07-2023 2 Y 11 M 2 D (F)

Dr. DILNAAZ FAROOQUI



LESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/6 7am	S/B Dr. Praveen / Dr. Alameer	
	Acute gastroenteritis c dehydration <u>UTI</u>	
	Loose stools - Reduced Abdominal pain - Both Fever - Reduced Urine output - Adequate Oral intake - Fair	<p>Plan</p> <ul style="list-style-type: none"> ① ct cephalosporins ② ct probiotic and zinc ③ ct carbohydrate ④ Monitor vitals ⑤ Trace urine ds, blood ds. ⑥ Plan d/c after rounds
	R-S-B/LAE @	
	PIA - safe	
		NB Suck & M
		<u>Praveen</u>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/7	C/S Dr. Dilnaaz	
10 AM		
	D. Acute Gastroenteritis & dehydration	
	UTI	
	Loose stool - 1 (↓) - ^{semisolid}	plan
	Intermittent stomach pain	
	No burning micturition	- ct. ceftriaxone
		- Trace urine c/s
		Blood c/s
	vitals stable	
		p/s → c/s reports (tomorrow)
		ct. soft diet
		Probiotic/kin
	P/A - Soft, BS+	
		Front back cleaning advised.
		1/2 maintenance IVF
		<u>Dilnaaz</u>

Dr. Dilnaaz Farooqui
Consultant Pediatrician
Reg. No: 27476



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/6/26	S/B Dr. Archana	
2:30pm	c/o Acute GE & dehydration, UTI	
	No fever spikes	
	No c/o loose motions in morning	<u>Advice</u>
	c/o abdominal pain (+)	✓ c/o Zinj Ceftriaxone
	<u>ole</u>	✓ c/o Econorm, ondem,
	vitality stable	Esmoprazole, 2 + D drops
	<u>ole</u>	✓ (P) urine c/s
	Plt: soft, nt	(P) blood c/s
		✓ c/o soft diet
		MB Suranda 3pm

~~Dr. Archana~~
 22/6/26
 2:30pm



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/6/23 4:30pm	S/B Dr. Dilnaaz	
	Case of Acute GE & dehydration UTI	Advise ✓ Stop probiotics
	pain per abdomen (P) no fever spikes	✓ Continue 2 f D drops ✓ (1) 48 hours growth of blood cts, urine cts
	vital stable	Stop IVF
		NB Sumda
		Dilnaaz
		Dr. Dilnaaz Farooqui Consultant Pediatrician Reg. No: 27476



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
23/6/23	S/B Dr. Dilnaaz	
9:40 AM	D AGE & dehydration	Plg
	Pain Abdominal	✓ discharge
	CVS - S4S0	- Syp. Albendazole
	Rx BU-ACE0	(5ml/200g)
	PIA - sac	1ou bed fire - tough & regular
	consec	- 2KD drops (14dg - total) ^{also 14dg}
		- Flip on Thursday
		- CEFIXIME X 3 days
		- T. LANZOLINOL - 2 dg
		- FLONORM - 2 dg
		- CANDID Cream for LA
		N/B Gurardha
		@ 10:00 AM

Dilnaaz
 Dr. Dilnaaz Farooqui
 Consultant, Pediatrician
 Reg. No.: 27476

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Baby ANVI SURYAVANSHI
18-07-2023 2 Y (F)
Dr. DILNAAZ FAROOQUI



MEDICATION RECONCILIATION FORM

Drug Allergies: N.S.I. Not known any Drug Allergies

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

Shifting From: ER Shifted to: ward

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

Date & Time: 20/6/26 @ 6:40pm

Nurse Name & Signature: Bhargava

Date & Time: 20/6/26 @ 6:45pm

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



DRUG CHART

Date of Admission: 20/6/26 Drug Allergies: N/A 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 : CROSI N DS SYP				Date Time																
Dose	Route	Frequency	Start Date																	
3ml	po	sos	20/6																	
Doctor's Signature		Valid Period	Pharm.																	
<u>[Signature]</u>			<u>[Signature]</u>																	
Additional Instructions:																				
<u>2uomg/5ml</u>																				

DRUG : ORS (WHTO)				Date Time																
Dose	Route	Frequency	Start Date																	
	po	adlib	20/6																	
Doctor's Signature		Valid Period	Pharm.																	
<u>[Signature]</u>																				
Additional Instructions:																				
<u>adlib 100ml per stool.</u>																				

DRUG : SYP CYCLOPAM				Date Time																
Dose	Route	Frequency	Start Date																	
5ml	po	sos	20/6																	
Doctor's Signature		Valid Period	Pharm.																	
<u>[Signature]</u>			<u>[Signature]</u>																	
Additional Instructions:																				
<u>if stomach pain (askly)</u>																				

VERIFIED BY Name: Signature:

Dr. Dhakshayani

Dr. Dhakshayani

Verified by

Verified by

REGULAR PRESCRIPTIONS

Weight. 11.18kg Ward.

Verified by

Verified by

Verified by

Verified by

Dr. Dhakshayani

Dr. Dhakshayani

Dr. Dhakshayani

Dr. Dhakshayani

DRUG : 4' CEFTRIAXONE Date/Time 20/6/26

Dose	Route	Frequency	Start Date
<u>500mg</u>	<u>iv</u>	<u>BD</u>	<u>20/6</u>

Name & Signature of the Doctor Starting the Drugs: [Signature]

Additional Instructions: 500mg in 20ml NS over 1 hour. ~~100mg~~

Daily Doctor's Endorsement by a Sign: [Signature]

DRUG : ECONORM sachet Date/Time 20/6/26

Dose	Route	Frequency	Start Date
<u>1</u>	<u>po</u>	<u>BD</u>	<u>20/6</u>

Name & Signature of the Doctor Starting the Drugs: [Signature]

Additional Instructions: [Signature]

Daily Doctor's Endorsement by a Sign: [Signature]

STOP

22/6/26
@SPM

DRUG : 17' ONDANSETRON Date/Time 20/6/26

Dose	Route	Frequency	Start Date
<u>2mg</u>	<u>iv</u>	<u>TID</u>	<u>20/6</u>

Name & Signature of the Doctor Starting the Drugs: [Signature]

Additional Instructions: [Signature]

Daily Doctor's Endorsement by a Sign: [Signature]

DRUG : 2 ED Suspension Date/Time 20/6/26

Dose	Route	Frequency	Start Date
<u>1ml</u>	<u>po</u>	<u>OD</u>	<u>20/6</u>

Name & Signature of the Doctor Starting the Drugs: [Signature]

Additional Instructions: (20mg/1ml)

Daily Doctor's Endorsement by a Sign: [Signature]

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 Dr. DILNAAZ FAROOQUI



REGULAR PRESCRIPTIONS

Sheet No:

Weight 11.18kg Ward

DRUG : <u>Li ESOMOPRAZOLE</u>				Date Time	<u>20/6/2023</u>															
Dose	Route	Frequency	Start Dt.																	
<u>10mg</u>	<u>iv</u>	<u>OD</u>	<u>20/6</u>																	
Name & Signature of the Doctor Starting the Drugs:				<u>[Signature]</u>																
Additional Instructions:				<u>(1mg/kg/day)</u>																
Daily Doctor's Endorsement by a Sign				<u>[Signature]</u>																
DRUG :				Date Time																
Dose	Route	Frequency	Start Dt.																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG :				Date Time																
Dose	Route	Frequency	Start Dt.																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG :				Date Time																
Dose	Route	Frequency	Start Dt.																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

Dr. Dhakshayani
 Verified by

Signature
 VERIFIED BY : Name

HNH-00016049 IP26-00006619

Baby ANVI SURYAVANSHI

18-07-2023 2 Y (F)

Dr. DILNAAZ FAROOQUI



Sheet No:

REGULAR PRESCRIPTIONS

Weight Ward

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

SIGNATURE

VERIFY BY NAME

HNH-00016049 IP26-00006619
 Baby ANVI SURYAVANSHI
 16-07-2023 2 Y 11 M 2 D (F)
 Dr. DILNAAZ FAROOQUI



208



RESULT SHEET

U

Date	20/6/26				
Time					
Hb	12.0				
PCV	35.1				
RBC	5.57				
WBC	7.47				
N/L	57.8/387				
Platelets	456				
CRP	0.5				
ESR					
PCT					
RBS					
Na					
K					
Cl					
Ca/Mg					
Phosphate					
Urea					
Creatinine					
ALP					
SGPT					
SGOT					
T.Bill/Conj					
T.Protein					
S.Albumin					
S.Globulin					
A/G Ratio					
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein / Sugar					
Cells					
N/L					

202

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						
TYPHOID IGM Negative						

Culture and Sensitivities: 20/6/26 Blood C/S -> no growth 24 hrs.
Urine c/s - no growth 24 hrs.

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



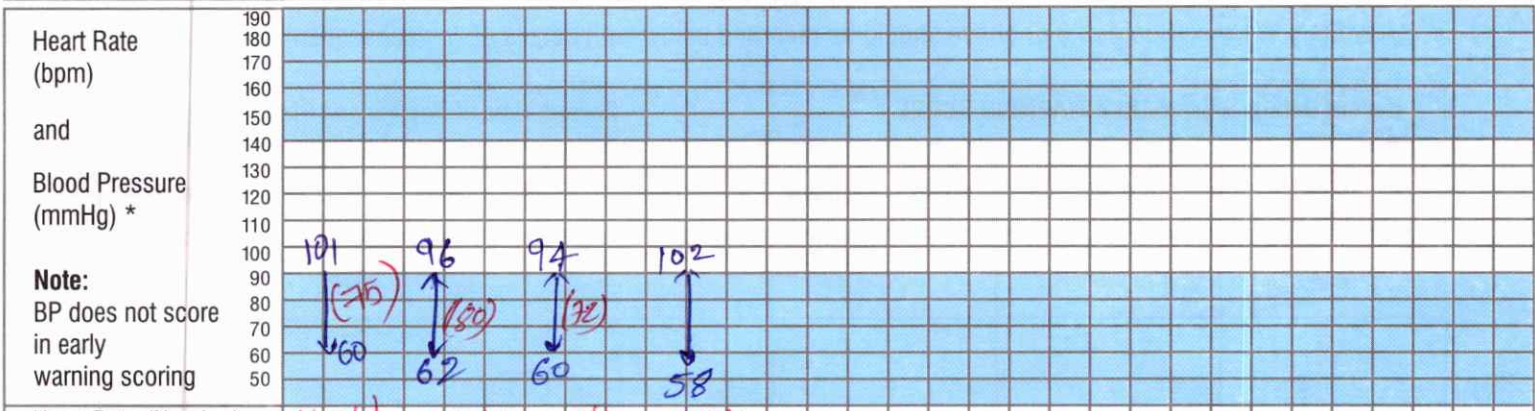
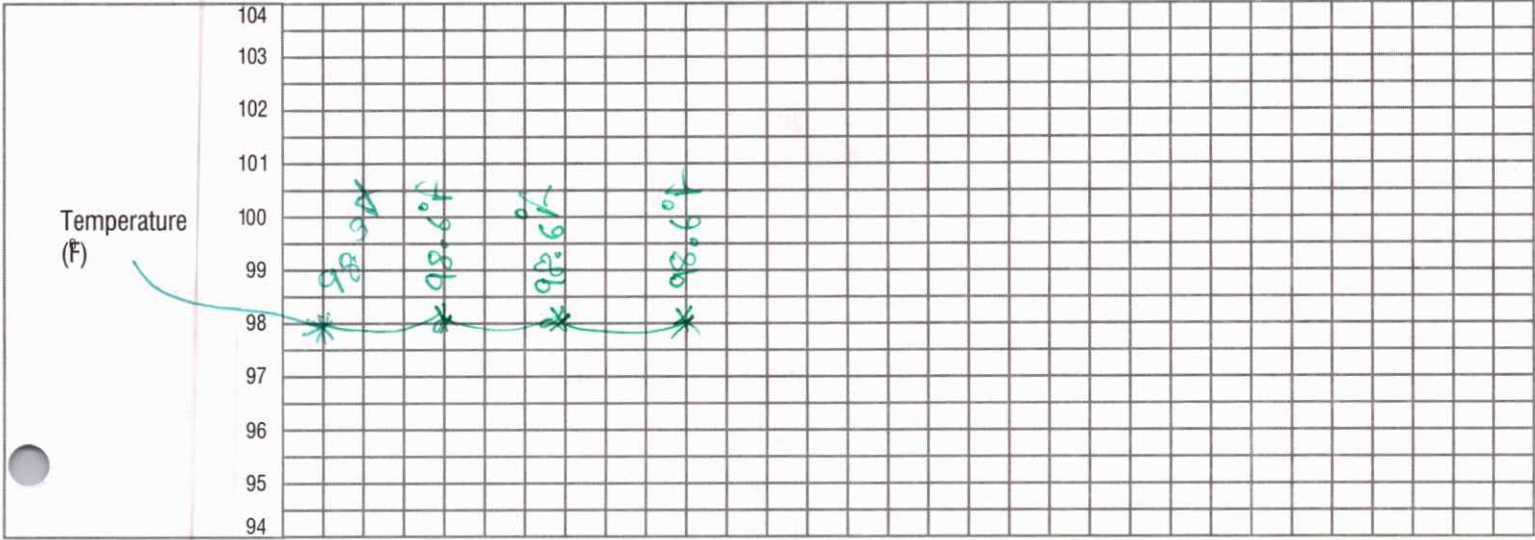
Patient



EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 20/6 Time: 8pm 10 2:30 6

Doctor / Nurse / Family Concern? Pro Am Am



Resp Distress Mod/ Severe None / Mild

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

Conscious Level Normal Altered

GCS *

TOTAL SCORE	8pm	10	2:30	6
Number of shaded boxes	0	0	0	0
Pain Score	0	0	0	0
Observer's Initials	FD	FD	FD	FD

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.

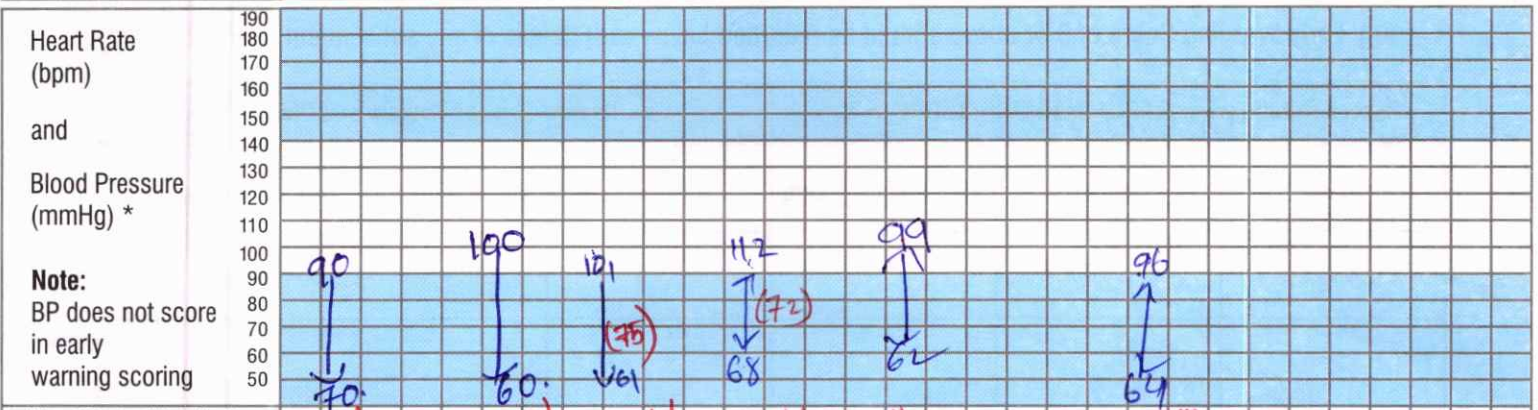
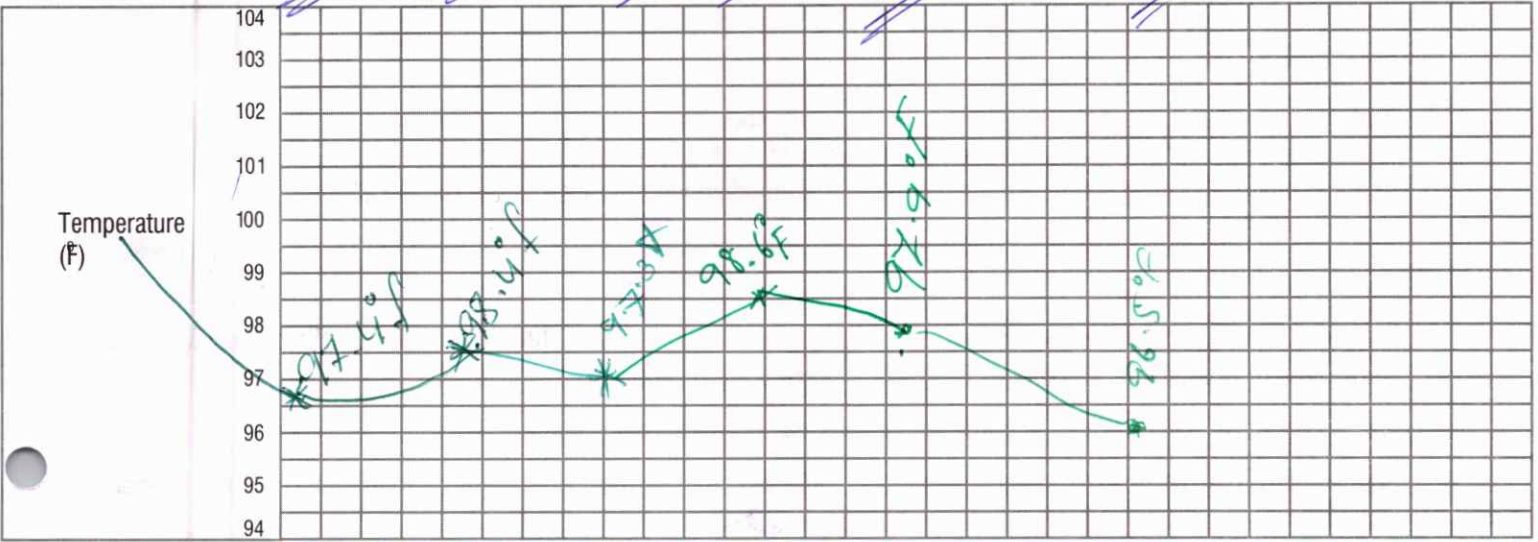
I	IDENTITY: I am (name), a nurse on ward (X). I am calling about (child X)
S	SITUATION: I am calling because I am concerned that ... (e.g. BP is low/high, pulse is XXX, Temperature is XX, Early Warning Score is XX)
B	BACK GROUND: Child (X) was admitted on (XX date) with (e.g. respiratory infection). 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 is there anything I need to do in the meantime? (e.g. stop the fluid/ repeat observation)

Patient St



EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 21/6/26 Time: 10am 2pm 6pm 10pm 1:30 Am 6 Am
 Doctor / Nurse / Family Concern? / / / / / /



Heart Rate (Number) 119b/m 115b/m 106b/m 108b/m 110b/m 95b/m

Resp. Rate (bpm) (Over 1 Minute) *

Resp Rate (Number) 25b/m 24b/m 25b/m 28b/m 28b/m 25b/m

Resp Mod/ Severe Distress None / Mild

Receiving O₂(l/min) O₂Saturations (%) 99% 99% 100% 100% 99% 100%

Conscious Level Normal / Altered

GCS * 14/15

TOTAL SCORE

Number of shaded boxes 0 0 0 0 0 0

Pain Score 0 0 0 0 0 0

Observer's Initials S S S A S S

ACTIONS

NB: Scores 3 should be recorded overleaf

Score 1 : Continue normal observation by staff nurse
 Score 2 : Shift in charge nurse to be informed and continue hourly observations
 Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.
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* NB: If GCS is below 12 or the Oxygen requirement is >3 Lit./min. , then irrespective of rest of the score, the Nurse MUST inform the PICU team.

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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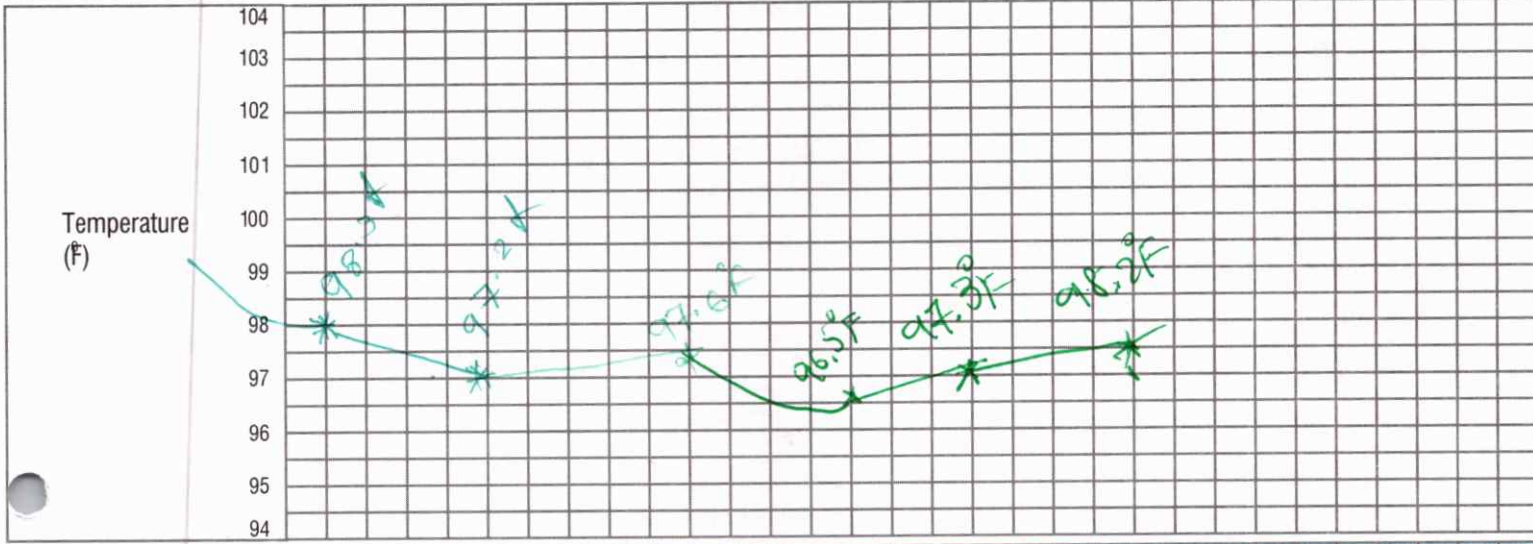
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R	RECOMMENDATION : I need you to ... come to see the child in the next (XX mins) AND is there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)



EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 2/5 Time: 10Am 2pm 5pm 10pm 2am 6am

Doctor / Nurse / Family Concern?



Heart Rate (bpm)	Blood Pressure (mmHg) *
101	100/62
100	100/60
99 (7u)	99/63
110	110/80
100 (7u)	100/68
112 (7u)	112/65

Heart Rate (Number) 121b/m 120b/m 123b/m 110b/m 110b/m 100b/m

Resp. Rate (bpm) (Over 1 Minute) *
22b/m
26b/m
28b/m
28b/m
23b/m
25b/m

Resp Mod/ Severe Distress None / Mild

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

Conscious Level Normal / Altered

GCS *

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

- ACTIONS**
- Score 1 : Continue normal observation by staff nurse
 - Score 2 : Shift in charge nurse to be informed and continue hourly observations
 - Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.
 - Score 4 : Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see
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A	ASSESSMENT : I think the problem is (XXX) and I have ... (e.g. given O2/ analgesia, stopped the infusion), OR I am not sure what the problem is but child (X) is deteriorating, OR I don't know what's wrong but I am really worried.
R	RECOMMENDATION : I need you to ... come to see the child in the next (XX mins) AND is there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)



FLUID CHART

Sheet No. :

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
Total Intake :						Total Output :							
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :							
	08:00 pm			30ml									
	09:00 pm	khichdi		30ml									
	10:00 pm	DNS		30ml									
	11:00 pm	HLD		30ml									
	12:00 am			30ml									
	01:00 am			30ml									
Total Intake : Taken						Total Output : U-1 ml-3							
	02:00 am			30ml									
	03:00 am			30ml									
	04:00 am			30ml									
	05:00 am	DNS		30ml									
	06:00 am			30ml									
	07:00 am			30ml									
Total Intake : Taken						Total Output : U-2 ml-0							
Total 24 hrs. Intake						Total 24 hrs. Output							
						U-3 ml-3							

FLUID CHART

Sheet No. : 2

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
21/6	08:00 am			30ml								} <i>Dr</i>
	09:00 am		2dly	30ml					✓	0	}	
	10:00 am		+ H ₂ O	30ml						0		
	11:00 am	DNS		30ml						0		
	12:00 pm		milk	30ml					✓	0		
	01:00 pm			30ml						0		
Total Intake : Taken			Total Output : U-2 m-									
21/6	02:00 pm			30ml						0	} <i>Dr</i>	
	03:00 pm		Rice	30ml					✓	0		
	04:00 pm	DNS	+ H ₂ O	20ml						0		
	05:00 pm			20ml						0		
	06:00 pm	DNS		20ml					✓	0		
	07:00 pm			20ml						0		
Total Intake : Taken			Total Output : m-1 U-2									
21/6	08:00 pm			20ml						0	} <i>Dr</i>	
	09:00 pm		Khichri	-						0		
	10:00 pm	DNS	+ H ₂ O	-						0		
	11:00 pm			-						0		
	12:00 am			-						0		
	01:00 am			-						0		
Total Intake :			Total Output : U-m-									
22/6	02:00 am									0	} <i>Dr</i>	
	03:00 am									0		
	04:00 am		H ₂ O							0		
	05:00 am	DNS								0		
	06:00 am		H ₂ O							0		
	07:00 am									0		
Total Intake :			Total Output : U-m-									
Total 24 hrs. Intake			Total 24 hrs. Output									
			U-4-									



FLUID CHART

Sheet No. : 9

- 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	Intake				Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
		Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
22/6			Mouth	I.V	N.G								
	08:00 am						✓				0	} 0 0 0 0 0 0	
	09:00 am							NA		✓	0		
	10:00 am	0	lady			NA	0	NA			0		
	11:00 am						✓				0		
	12:00 pm		H ₂ O				✓				0		
01:00 pm										0			
Total Intake : 70/50						Total Output : m-0						U-2	
22/6	02:00 pm										0	} 0 0 0 0 0 0	
	03:00 pm										0		
	04:00 pm	0	midich			NA	✓	NA		✓	0		
	05:00 pm		H ₂ O								0		
	06:00 pm										0		
	07:00 pm										0		
Total Intake :						Total Output : U -						M -	
22/6/26	08:00 pm										0	} 0 0 0 0 0 0	
	09:00 pm										0		
	10:00 pm	2	rice			NA		NA		✓	0		
	11:00 pm										0		
	12:00 am		H ₂ O								0		
	01:00 am										0		
Total Intake :						Total Output : U -						M -	
23/6/26	02:00 am										0	} 0 0 0 0 0 0	
	03:00 am										0		
	04:00 am										0		
	05:00 am	2	H ₂ O			NA		NA		✓	0		
	06:00 am										0		
	07:00 am										0		
Total Intake :						Total Output : U -						M -	

Total 24 hrs. Intake

Total 24 hrs. Output

Patient Sticker



FLUID CHART

Sheet No. :

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

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

Total 24 hrs. Intake	
-----------------------------	--

Total 24 hrs. Output	
-----------------------------	--

HNH-00016049 IP26-00006619
 Baby ANVI SURYAVANSHI
 18-07-2023 2 Y 11 M 2 D (F)
 Dr. DILNAAZ FAROOQUI



NURSING CARE RECORD



Date: 20/6/26

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon							
Night	8pm	Assess the Pt condition Monitor vitals & record. Maintain T10 clamp. Provide the comfortable position.	8pm	Assessed the Pt condition. Monitored vitals & record. Maintained T10 clamp. Provided the comfortable position.	Pt is stable.	Monitor vitals	Soh
	8pm	Medication give as per as doctor's order.	8pm	Medication given as per as doctor's order.	Vitals normal.	Maintain T10 clamp.	if

016049 IP26-0006619
ANVI SURYAVANSHI
07-2023 2 Y 11 M 2 D (F)
Dr. DILNAAZ FAROOQUI



NURSING CARE RECORD



Date: 2/16/23

- 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	<ul style="list-style-type: none"> → Assess the patient general condition → monitor vitals → Administered medications as per doctor's orders. 	8am	<ul style="list-style-type: none"> → Assessed the patient general condition → monitored vitals → Administered medications as per doctor's orders. 	Patient is stable USG abdomen done	Rechecked vitals	
	2pm		2pm				
Afternoon	2pm	<ul style="list-style-type: none"> → Assess the pt condition → monitoring vitals checked and recorded 	2pm	<ul style="list-style-type: none"> → Assessed the pt condition → Administration of medication given as per doctor's orders 	→ pt is stable	→ Re-checked vitals	
	8pm		8pm				
Night	8pm	<ul style="list-style-type: none"> Assess the pt condition. Monitor vitals & chart. maintain I/O chart. Provide the comfortable position. medication given as per doctor's. 	8pm	<ul style="list-style-type: none"> Assessed the pt condition. monitored vitals & chart. Maintained I/O chart. Provided the comfortable position. medication given as per doctor's. 	→ pt is stable → vitals normal	→ monitor vitals → maintain I/O chart.	
	8am		8am				



NURSING CARE RECORD

Date: 22/5/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon	2pm to 8pm	- Assess the patient condition - Monitor the v/s - Maintain the I/O - Drug as per chart	2pm to 8pm	- Assess the pt condition - Monitor the v/s - Maintain the I/O - Drug as per chart	- Now patient is stable	- Rechecked the v/s	
Night	8pm to 8am	→ Assess pt condition → Monitor the vitals → Maintain I/O chart → Administer medication as per drug chart	8pm to 8am	→ Assessed pt condition → Monitored vitals → maintained I/O chart → Administered medication as per drug chart	patient is stable	Rechecked vitals	

Patient Sticker

NURSING CARE RECORD



Date:

Goals

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

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



NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: <u>AGE T dehydration.</u>	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Not Known If Yes Specify:						
	Surgery / Procedure:	Post OP Day:						
BACKGROUND	Date	<u>20/6</u> NI	<u>21/6/26</u> Ming.	<u>21/6</u> R2	<u>22/6</u> NI	<u>22/6</u> E2	<u>22/6</u> M1	
	Shift							
	Medical Condition (Any special condition to be noted):	<u>AGE</u>	<u>AGE</u>	<u>AGE</u>				
Diet:	<u>Soft</u>	<u>Soft</u>	<u>Soft</u>					
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):							
	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:	<u>98.2F</u>	<u>98.3F</u>	<u>98.2F</u>	<u>98.2F</u>	<u>98.3F</u>	<u>98.3F</u>
		Res:	<u>28b/m</u>	<u>29b/m</u>	<u>30b/m</u>	<u>30b/m</u>	<u>22b/m</u>	<u>22b/m</u>
		SpO ₂ :	<u>98%</u>	<u>99%</u>	<u>100%</u>	<u>99%</u>	<u>99%</u>	<u>99%</u>
		Pulse:	<u>112</u>	<u>115b/m</u>	<u>113b/m</u>	<u>113b/m</u>	<u>120b/m</u>	<u>120b/m</u>
		BP:	<u>99/56</u>	<u>100/70</u>	<u>101/60</u>	<u>100/62</u>	<u>100/62</u>	<u>118/83</u>
		LOC:						
		Fall Risk Score:						
	Pain Score:							
	Skin Integrity							
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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" 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 checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Special Diet:							
	Critical Lab Test / Values:							
	Other Special Orders / Medications:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	PU Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	DVT Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
ADL (Dependent / Non Dependent):								
Post Operative Procedure Special Orders:				<u>NA</u>				
Handed Over By Name :		<u>Gneha</u>	<u>Sandhya</u>	<u>Amrutha</u>	<u>Sru</u>	<u>Sunanda</u>	<u>Anusha</u>	
Signature / ID :		<u>(40/6031)</u>	<u>(R)</u>	<u>(R)</u>	<u>(40/6031)</u>	<u>(R)</u>	<u>(R)</u>	
Date:		<u>21/6</u>	<u>21/6/26</u>	<u>21/6</u>	<u>22/6</u>	<u>22/6/26</u>	<u>23/6/26</u>	
Time:		<u>8AM</u>	<u>2PM</u>	<u>8PM</u>	<u>8AM</u>	<u>8PM</u>		
Taken Over By Name :		<u>Sandhya</u>	<u>Amrutha</u>	<u>Gneha</u>		<u>Anusha</u>		
Signature / ID :		<u>(R)</u>	<u>(R)</u>	<u>(40/6031)</u>		<u>(R)</u>		
Date:		<u>21/6/26</u>	<u>21/6</u>	<u>21/6</u>		<u>22/6/26</u>		
Time:		<u>8PM</u>	<u>2PM</u>	<u>8PM</u>		<u>8PM</u>		

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):						
	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:						



CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1 <i>20/6</i>			DAY-2 <i>21/6</i>			DAY-3 <i>24/6</i>			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			NA	NA	NA	NA				
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2			NA	NA	NA	NA				
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3			NA	NA	NA	NA				
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4			NA	NA	NA	NA				
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			NA	NA	NA	NA				
Signature of the Nurse						<i>Sneha</i>	<i>Sneha</i>	<i>Sneha</i>	<i>Sneha</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 : *Sneha* Name : *Sneha*

Signature of Ward In Charge :

Signature : *Balanani* Name : *Balanani*



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
20/6	10pm	0	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	SR
21/6	2Am	0	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	SR
21/6	8Am	0	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	SR
21/6/26	10:am	0	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	SR
21/6	6pm	0	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	SR
21/6	10Pm	0	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	SR
22/6	2Am	0	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	SR
22/6	8Am	0	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	SR
22/6	4pm	0/10	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	SR
				<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:

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

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
	0	1	2
Face	No Particular expression or smile	Occasional Grimace or Frown, withdraw, 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
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





BRADEN 'Q' SCALE

					Date :	20/6/23	26	22/6
					Time :	8 PM	11	12
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.	3	3	3	3
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 meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4
TOTAL SCORE					27	28	28	28
Evaluator's Name					BY	af	af	af

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

Risk Score	Category	Action	Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice)
15-18	At Risk	<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

wt - 11.18 kg



EMERGENCY ROOM TRIAGE FORM

Patient's Name : Baby Anvi Suryavanshi Age : 2Y Gender: Male Female
 Date : 20/6/26 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: 98.5F PR: 109bpm BP: 105/65mmHg RR: SpO₂: 100%

Chief Complaints: LOI loose stools since 4 days & pain Abdomen 4 days

INITIAL PHYSIOLOGICAL CATEGORIZATION Appearance <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Sick Looking Circulation / Colour <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Bleeding		INITIAL PHYSIOLOGICAL STATUS <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:

- 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 : Jyoti

Signature of Triage Nurse : Jyoti

Date & Time : 20/6/26 @ 6:32pm



NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 20/6/26 Time of arrival : 6:34 PM
 Chief Complaints: L.O loose stool since 4 days Abdomen pain since 4 days

Height : Weight : 11.18 kg Head Circumference (<2 years)

Allergies: Yes No Medications Blood Transfusion Food Other:

If yes, identify

Pain Screening: Yes No If Yes, Pain Score: 0 Pain Tool Used: N Pass FLACC Wong Baker

Character: N/A Location: Frequency: Duration:

RISK FOR FALL:

If patient is < 6 years Yes No

If 'Yes' tick below fall risk intervention directly

If Patient is > 6 years

If 'Yes' Assess the below parameters

History of Falling: within past 3 months Yes No

Ambulatory Aids:

- Wheelchair Yes No
- Uses furniture for support Yes No

Gait/Transferring:

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

Mental Status: Forgets limitations Yes No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening: No Abnormalities Detected

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

Inform consultant for positive criteria

Nutritional Screening: No Abnormalities Detected

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

Inform consultant for positive criteria

Psychological Screening: No Significant Findings

Unusual concerns about patient's Psychological Status: Yes No

If Yes Consultant Notified: (Date/Time):

Social History: Lives With family

Siblings in household Yes No (if yes How Many?) N/A

Time of Initial assessment completed by ER Nurse : 6:36 PM

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

Time	Nursing Notes
	- Assess the pt condition
	- monitor vitals
	- IV placement done
	- Sample collected

Samples collected by: *Jyotha*
 Samples sent by: *Jyotha*

Time: *7:10pm*
 Time: *7:10pm*

Medication given in ER:

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

Condition of patient at time of shift - out :	Details of Shift - out
HR: <i>109b/min</i> BP: <i>105/65mmHg</i> CFT: RR: SPO2 at FiO2: <i>100%</i> GCS: Temperature: <i>98.5°F</i> Pain Score: Repeat RBS (if applicable):	Shift - out from ER to: <i>ward</i> Time of Shift - out: <i>7:50pm</i> Handover given to: <i>Amrutha</i> (Nurse's Name)

Tick as applicable: MLC LAMA BROUGHT DEAD

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

Name of the Nurse : *Jyoti* Signature of the Nurse : *Jyoti*

Date & Time : *20/6/26 @*

PATIENT TRANSFER FORM

HNH-00016049 IP26-00006619

Baby ANVI SURYAVANSHI
18-07-2023 2 Y (F)
Dr. DILNAAZ FAROOQUI



Date & Time of Admission <i>20/6/26 @ 6:45pm</i>		Date & Time of Transfer Order <i>20/6/26 @ 7:50pm</i>
Treating Consultant Name	Transfer Ordered by <i>Dr. Anusha</i>	Reason for Transfer <i>ADMISSION</i>
From Unit <i>ER</i>	To Unit <i>ward</i>	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Number of Sheets in Clinical File <i>25/-</i>	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.		
2.		
3.		
4.		
5.		

Shifting Summary / Notes Written by Doctor : Yes No

Name & Signature of Person who is Transferring <i>Bhargavi</i>	Name of Person Ordered Transfer <i>Dr. Anusha</i>
-------------------------------------------------------------------	------------------------------------------------------

Patient & Clinical Records Received by :

Anusha @ 7.50pm

Date & Time of Patient Received :

20/6/26

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

- Unavailable Bed Nurse not Available Available Bed not ready



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NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 21/6/26 Time: 10 am

Weight: 11.18 kg Centile: 10th

Height: Centile:

Inference: Underweight child.

RDA: Calories: 1250 Kcal/day Protein: 21 gms/day

Diet Recommendations: Gasler diet :- Can have :- ORS (WHO), Sago, Water, Coconut Water, Rice paper food

Re-Assessment: Acid :- Ragi, Oats, Wheat, Citrus Milk, Egg.

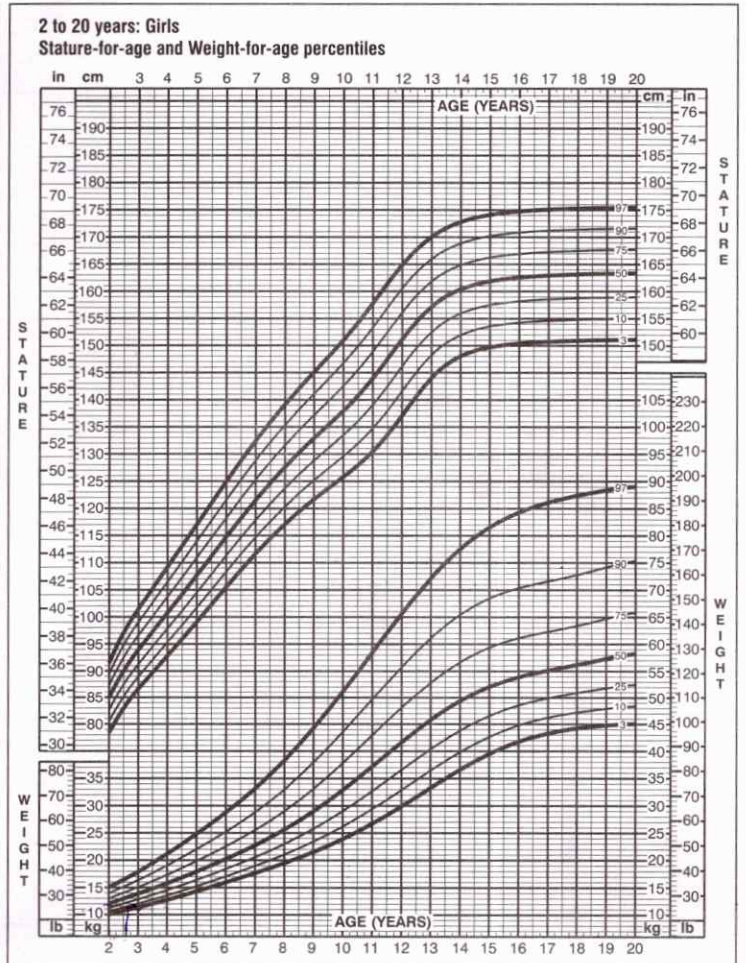
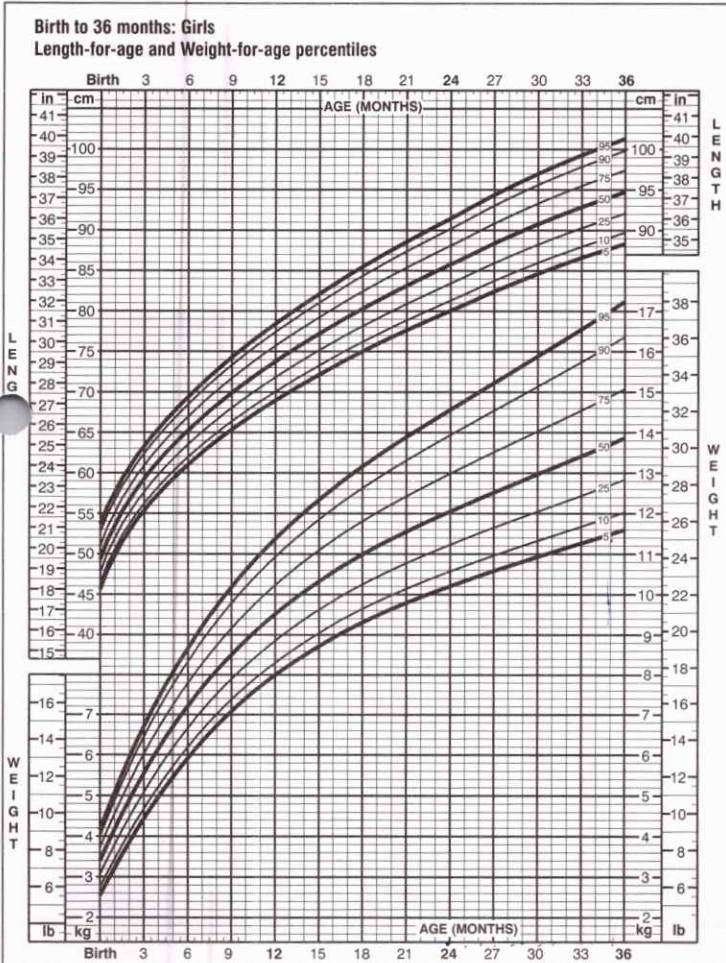
Food Allergies: No Veg/Non-veg Non-veg

Diagnosis: Acute gastroenteritis & dehydration

Nutritional Intervention - Oral Enteral Parenteral

Patient's Signature: Farooqui

GROWTH CHART (GIRLS)



Dietician's Name: Syeda Sobiya Zaher

Dietician's Signature: Sobiya

