

P.C.  
215

### DISCHARGE SUMMARY

<b>Name</b>	Master ASHTON NATHAN	<b>UHID</b>	HNH-00016042
<b>Father/Guardian</b>	Mr NICHOLAS NADAN	<b>Age/Gender</b>	6 Y 5 M 30 D/ Male
<b>Address</b>	HIG-11/BLOCK-12,FLAT-5,BAGHLINGAMPALLY,HYDERABAD, Bagh Lingampally, Hyderabad, Telangana, INDIA, 500044		
<b>IP No</b>	IP26-00006605	<b>Admission Date</b>	18-06-2026
<b>Ref Doctor</b>	Dr Milind Bhide		
<b>Discharge Date</b>	20.06.2026		

**Consultant:**

**Dr. Milind Prabhakar Bhide**  
MBBS, MD (Paediatrics)

**Consultant:**

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

<b>DIAGNOSIS</b>	<b>ICD CODE</b>
SEVERE ACUTE GASTRITIS WITH DEHYDRATION	

**History:** Master ASHTON NATHAN, 6 Y 5 M 30 D , old boy presented with history of abdomen pain and vomitings since 3 days, poor oral intake and dull activity since 2 days, reduced urine output since 1 day, prior to admission. For the above complaints he was admitted at Rainbow Children's Hospital - for further management.

Name	Master ASHTON NATHAN	UHID	HNH-00016042
IP No	IP26-00006605	Admission Date	18-06-2026

**Outside investigations:**

Ultrasound abdomen was done on 16.06.2026 which shows No obvious sonographic abnormality detected.

**Examination:** He was afebrile, maintaining saturations at room air. His heart rate was 78/min and Respiratory Rate - 24/min. Capillary Refill Time was <2 secs. Peripheries were warm & pulses well felt. On examination signs of dehydration like dry lips, oral mucosa, sunken eyes were present. On auscultation, air entry was bilaterally equal. 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: 20 kilo grams.

**Investigations:** Enclosed reports.

VBG showed pH of 7.38, pCO2 of 41.1 mmHg, pO2 of 33 mmHg, HCO3 of 23 mmol/L and BE of -0.8 mmol/L.

Initial hemogram showed Haemoglobin of 12.1 gm%, White Blood Cell count of 6210 cells/cumm, platelet count of 2.18 lakhs/cumm and C-Reactive Protein of 5.0 mg/l. Serum Creatinine was 0.5 mg/dl.

Liver function test showed total SBR of 0.5 mg/dl with indirect fraction of 0.1 mg/dl, SGOT - 31 U/L, SGPT - 16 U/L, ALP - U/L, protein - 7.7gm/dl, albumin - 3.4 gm/dl, globulin - 3.4 gm/dl, A/G ratio of 1.2.

Sr. Amylase 61, Sr. Lipase - 75.

Free T4 was 1.43 ng/dL. THYROID STIMULATING HORMONE (TSH) was 1.31<sub>μ</sub>U/ml

<b>Name</b>	Master ASHTON NATHAN	<b>UHID</b>	HNH-00016042
<b>IP No</b>	IP26-00006605	<b>Admission Date</b>	18-06-2026

Complete urine examination shows 3-5 pus cells, 2-3 epithelial cells

**X-ray abdomen shows**

No evidence of pneumoperitoneum.

No abnormal air-fluid levels.

Peritoneal fat planes normal.

Fecal loading noted in right colon and recto sigmoid.

Left sided curvature of thoraco lumbar spine noted - likely positional.

**Ultrasound abdomen shows**

\* Fecal loading of ascending colon and recto sigmoid.

\* Few non specific lower mesentery nodes.

\* Mild free fluid in the peritoneal cavity.

**Management:** He was admitted in the ward and was started on Intra Venous fluids. He was treated symptomatically with antacids and antiemetics for vomitings and gastritis.

In view of severe abdominal pain and X ray erect abdomen suggestive of fecal loading, Enema was given and was started on laxatives.

In view of severe pain abdomen, Paediatric surgeon consultation was done with Dr. Swapna and was advised to give dulcolax suppository and continue Smuth syrup.

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

Name	Master ASHTON NATHAN	UHID	HNH-00016042
IP No	IP26-00006605	Admission Date	18-06-2026

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. Ondansetron  
Injection. Esomeprazole  
Muout powder  
Syrup. Smuth

**Advice:**

\* Diet as advised.

<b>Name</b>	Master ASHTON NATHAN	<b>UHID</b>	HNH-00016042
<b>IP No</b>	IP26-00006605	<b>Admission Date</b>	18-06-2026

S.No	MEDICATION	DOSE	TIMINGS	DURATION
1	Tablet. LANZOL DT (Lansoprazole - 15mg)	1 tablet	7am (before breakfast)	For 3 days
2	VOMIKIND FAST STRIP (Ondansetron - 4g)	1 strip	Max 3 times/day(30 minutes before food)	SOS for vomintings
3	Syrup. SMUTH	10 ml	10pm (after food)	For 5 days.
4	MUOUT POWDER	mix 3 Scoops in 150 ml of water	10pm (after food)	For 3 months
5	Nasoclear nasal drops, 2 drops in each nostril <b>SOS</b> for nose block			

### Fever Management

- \* Syrup. Crocin DS (Paracetamol - 5ml/240mg) 6 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. Milind Prabhakar Bhide on Wednesday (24.06.2026) at his clinic.

Regular followup with Dr Milind Bhide, Primary Pediatrician.

Name	Master ASHTON NATHAN	UHID	HNH-00016042
IP No	IP26-00006605	Admission Date	18-06-2026

**Food instructions while taking medications:**

- \* **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.
- \* **Antiemetics** can be taken before food.
- \* **Laxatives** may deplete/decrease absorption of fat soluble vitamins A,D,E & K. Laxatives can be taken One hour before food or 2 to 4 hours after food & recommended diet to be followed.
- \* Food can decrease the absorption of **antihistamines**. Antihistamines can be taken on an empty stomach /before food to increase their effectiveness.

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**.

Name	Master ASHTON NATHAN	UHID	HNH-00016042
IP No	IP26-00006605	Admission Date	18-06-2026

You can also take appointments at any time by going **online** to our website [www.rainbowhospitals.in](http://www.rainbowhospitals.in)

*Pranav*



Registrar/Resident/C.M.O

**Dr. Milind Prabhakar Bhide**  
MBBS, MD (Paediatrics)

Handwritten marks or characters in the top right corner.



NH-00016042 IP26-00006605  
 aster ASHTON NATHAN  
 1-12-2019 6 Y 5 M 31 D (M)  
 r. Milind Prabhakar Bhide



## DEFICIENCY CHECK LIST OF CASE SHEET

Sl.No.	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission sheet	1			
2	Discharge Summary	1			
3	Nursing Initial assessment	1			
4	Patient Transfer form	1			
5	In-patient Medical record	1			
6	Doctors progress sheets	5			
7	Nursing plan of care and handover sheets	5			
8	Consultation sheet	1			
9	General consent for treatment	1			
10	Consent for Surgery				
11	Consent for blood transfusion				
12	Consent for chemotherapy				
13	Consent for high risk				
14	Consent for Restraint				
15	LAMA consent				
16	Consent for special procedure / Sedation				
17	Consent for Formula feed				
18	Consent for MTP				
19	Consent for Radiological Investigations				
20	Consent for HIV test				
21	Anaesthesia notes (Pre Anaesthesia & post)				
22	Neonatal Admission/Delivery/Physical Exam	1			
23	Medication Reconciliation	1			
24	Emergency Triage record				
25	Pre operative check list				
26	Surgical safety checklist				
27	Operation Theatre notes				
28	Nurses clinical Presentation				
29	TPR & BP chart	1			
30	Intake and Out take chart (fluid chart)	1			
31	Drug chart (Regular Prescription)	1			
32	Investigation Values (result sheet)	1			
33	Nebulization chart				
34	Nutritional review chart				
35	Intensive care unit (ICU Charts)				
36	Consent for Admission in PICU / NICU				
37	The Humpty dumpty scale				
38	Braden Q Scale				
39	Bed side check list				
40	PICU bed formula Dilution feeds				
41	Gastro monitoring chart				
42	Rch ED doctors note				
43	BP Monitoring chart				
44	RBS monitoring chart				
	<i>Billing</i>	1			
	<i>exsas</i>	6			
	<b>Total No. of Pages</b>	<u>32</u>			

**ADMISSION SHEET**

**Registration Details :**



**Admission No** : IP26-00006605      **Admit Date** : 18-Jun-2026      **Admit Time** : 08:36 PM      **UHID** : HNH-00016042

**Patient Details :**

<b>Patient Name</b> : Master ASHTON NATHAN	<b>Age</b> : 6 Y 5 M 29 D
<b>Guardian</b> : Mr NICHOLAS NADAN	<b>DOB</b> : 20-12-2019
<b>Gender</b> : Male	<b>Religion</b> :
<b>Occupation</b> :	<b>Martial Status</b> :
<b>Address (H)</b> : HIG-11/BLOCK-12,FLAT-5, BAGHLINGAMPALLY,HYDERABAD Bagh Lingampally Hyderabad Telangana INDIA 500044	<b>Phone No</b> : 8019542648/ 9391384983
	<b>E-mail</b> : NICKN230183@GMAIL.COM

**Admission Details :**

**Bed Type** : DAY CARE      **Bed No** : ER01      **Ward Name** : GF -EMERGENCY  
**Room No** : ER01      **Admission Type** : First Visit

**Contact Details :**

**Name** : Mr NICHOLAS NADAN      **Relationship** : Father  
**Contact Address** : HIG-11/BLOCK-12,FLAT-5,  
BAGHLINGAMPALLY,HYDERABAD Bagh  
Lingampally Hyderabad Telangana INDIA 500044      **Phone No** : 8019542648

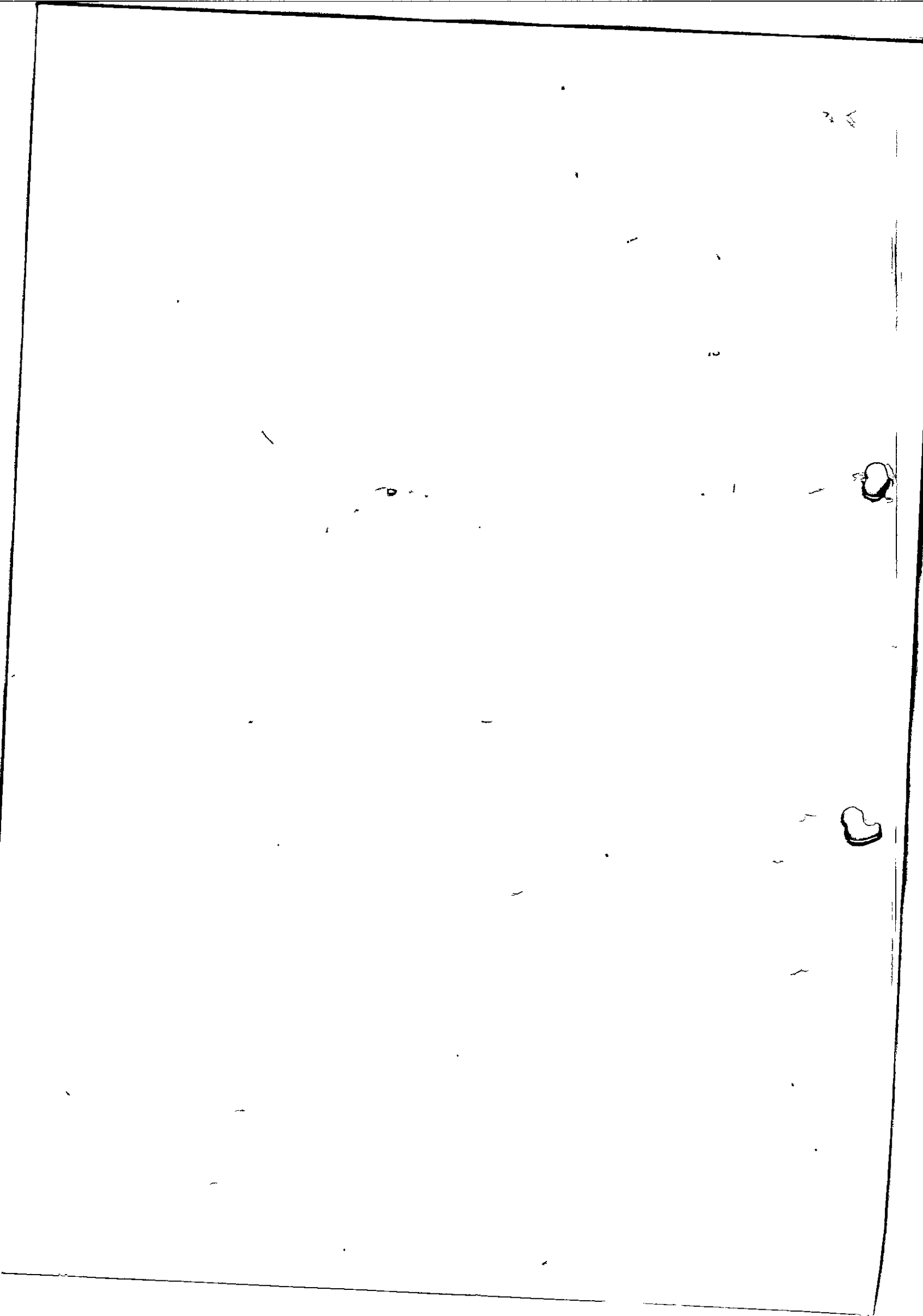
  
Signature

**Doctor Details :**

**Doctor Name** : Dr. Milind Prabhakar Bhide      **Specialisation** : GENERAL PEDIATRICS  
**Referral Doctor** : Dr Milind Bhide      **Phone No** : 9394867102  
**Co-Consultant** : Dr. ANIKET ANIL PARASHAR

**Payment Details :**

**Payment Mode** : DC/CC Card      **Deposit Amount** : 10000.00  
**Payor Name** : ADITYA BIRLA HEALTH INSURANCE CO. LTD



Ref.No. F/IN/PR/10



**PEDIATRIC IN-PATIENT  
MEDICAL RECORD**

Patient Name : Ashton

Patient ID# : \_\_\_\_\_

Consultant : \_\_\_\_\_

Final Diagnosis : \_\_\_\_\_

HNH-00016042 IP26-00006605  
Master ASHTON NATHAN  
20-12-2019 6 Y 5 M 29 D (M)  
Dr. Milind Prabhakar Bhide





**Pediatric Multiorgan History & Physical Examination**

Name : \_\_\_\_\_ Age/Sex \_\_\_\_\_

Informant \_\_\_\_\_ Reliability \_\_\_\_\_

**Chief Presenting Complaints & Duration (Chronologically):**

c/o Abdominal pain :: 3 day

c/o Vomiting :: 3 day

c/o Poor oral intake / Dull activity :: 2 day

c/o Reduced urine output :: 1 day

**History of present illness :**

Child brought with c/o

Abdominal pain :: 3 day

Worsening abdominal pain :: yesterday

Constant Pain, diffuse all over abdomen.

c/o Vomiting :: 3 day

Multiple episodes, Watery stools  
Non bilious / Non blood stained

c/o Poor oral intake

c/o Dull activity } :: 2 day

c/o Reduced urine output :: 1 day

Passed stools after 2 day as c/pain

USS Abdomen on 16/12 (outside) - @





**Pediatric Multiorgan History & Physical Examination**

**Anthropometry**

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

Weight (kgs) 20 kg (Centile \_\_\_\_\_ )

**On Examination :**

Temperature : 98°F Pulse Rate: 78 /min Description \_\_\_\_\_

B.P. \_\_\_\_\_ SPO2 97% at \_\_\_\_\_

Resp. rate and type of breathing : 24 /min

Rash \_\_\_\_\_ Signs of Dehydration - sunken eyes, dry lips, mouth

Lymphadenopathy \_\_\_\_\_ Delayed Skin Turgor

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

**Respiratory system :**

Inspection (any s/o distress) : \_\_\_\_\_

Air entry & breath sounds : B/LAE ⊕

Any added sounds : \_\_\_\_\_

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

**Cardiovascular System :**

Inspection of precordium : \_\_\_\_\_

Heart Sounds : S1, S2 ⊕

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

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

**Per Abdomen :**

Inspection \_\_\_\_\_

Palpation : Soft

Auscultation : BSA

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

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



### Pediatric Multiorgan History & Physical Examination

**Central Nervous System :**

Level of Consciousness : AVPU/GCS Score : 15/14

Cranial Nerves : 10

**Motor System :**

Nutrition : /

Tone : / Power /

Co-ordinator : 0

Posture : /

Involuntary Movements : /

**Reflexes :**

**DTR**

**Superficials :**

Plantars /

**Sensory System :**

/

Bladder / Bowel : /

**Clinical Summary & Diagnostic :**

Acute Gastritis = Dehydrated  
? Infective Colitis

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment :

HNH-00016042 IP26-00006605  
Master ASHTON NATHAN  
20-12-2019 6 Y 5 M 29 D (M)  
Dr. Milind Prabhakar Bhide



Desired goals of the treatment :

**Planned Labs :**

VBS

CBP, CRP

LFT, Amylase, Lipase  
Creatinine

+ Contrast plain

X ray erect Abdomen

- CUE (DUE)

VSS Abdomen - T/12

Noted By Doctor

**Planned Management :**

IV Fluid

-> Inj Ondansetron

-> Inj Esomeprazole

- Inj Buscopan - Stat

-> Clear liquids initially

if Tolerating then soft diet

Surgical consult - T/12

Noted By Doctor

**Please fill up the following details**

1. Name of the Referring Doctor : \_\_\_\_\_

2. Name of the Referring Hospital : \_\_\_\_\_  
(Including the name of City)

3. Contact number of the Referring Doctor : \_\_\_\_\_  
(Preferring Mobile #)

4. Name of the doctor in Rainbow Team Dr. Milind / Dr. Aniket on  
whose name the patient is being referred

Doctor's Signature Name [Signature] Date 18/6 Time \_\_\_\_\_

**ACTIVITY**

HNH-00016042 IP26-00006605  
Master ASHTON NATHAN  
20-12-2019 6 Y 5 M 29 D (M)  
Dr. Milind Prabhakar Bhide

IG

Name: ---  -----

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

Date of Admission: ----- Time: ----- Date of Discharge: ----- Time: -----

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

**WARD TRANSFERS**

Date	Time	From	To	Signature of Nurse
18/6/20	8:45 PM	ER	Ward	<i>[Signature]</i>

**Cross Consultation Visit**

	Doctors Name	Date	Order No.	Signature
1.	Dr Swapna Palast	19/6/20	7466	<i>[Signature]</i>
2.				
3.	<i>Cross checked done by [Signature]</i>			
4.				
5.				
6.				
7.				
8.				
9.				
10.				









## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
18/6	CBC/RS Dr. Pravin / Dr. Prashanthi	
10pm		
	<p>Acute Gastritis = Dehydration          ? Infective Colitis</p>	
	<p>Abdominal pain (+)          Vomiting - ↓</p>	<p>Plan          1) IV Fluids          2) Sig Ondans          Sig Esomeprazole</p>
	<p>child asleep          Vitals stable</p>	
	<p>afebrile          R-S - B/LAB ⊕</p>	<p>3) Encourage orally          clear liquids          ↓ if tolerating</p>
	<p>P/A - soft</p>	<p>soft diet</p>
	<p>P.V - Good</p>	<p>4) Proctoclysis enema - stat          5) Monitor Vitals          6) Trace lab</p>
		<p><u>Pravin</u></p>
		<p>N.B. A month          @ 10pm.</p>

**PROGRESS NOTES AND DOCTOR'S ORDER**

Date & Time	Progress Notes	Doctor's Order
18/6 10:15 pm	<p>CPK/CR Dr. Milind / Dr. Pritesh S</p> <p><u>Acute Gastritis &amp; Dehydration</u>  <u>? Infectious Colitis</u></p>	
	<p>Abdominal pain ⊕          Vomiting - ↓</p> <p>Child asleep</p>	<p>Pln</p> <p>1) SOS - Ery Travasol (of pain)          2) Proctoclysis norm - 5ml</p>
	<p>Vitals stable          R/S - B/L PE ⊕</p>	<p>3) Ery Esomeprazole          Ery Ondans</p>
	<p>PIA - Soft          Non tendr</p>	<p>4) USG Abdomen - T/m</p>
		<p>5) Duphalac Iron - T/m</p>
		<p>6) High fibre diet          Encourage orally</p>
		<p>7) Tena tabs</p>
		<p>N.B Amoxicillin 211pm -</p>



**PROGRESS NOTES AND DOCTOR'S ORDER**

Date & Time	Progress Notes	Doctor's Order
19/6 8 AM	<u>CLSB Dr. Prann / Dr. Prashanti</u>	
	<u>Acute Gastritis &amp; Dehydration</u> <u>? Infective Colitis</u>	
	Abdominal pain ⊕	Plu 1) 505 - 1/2 Tsp Tramadol
	Did not pass stool	2) 1/2 Tsp Esomeprazole 1/2 Tsp Ondans
	Child asleep Vitals stable	3) USS Abdomen today
	CFT < 3su	
	R-S-B/2/2/2/2	4) To start Duphalac
	PIA - soft.	5) High fiber diet
		6) Monitor Vitals
		Prann w.B Amoxicillin @ 8 AM

## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/6/26 11 AM	<p>cl/ly by Dr Aniket</p> <p>Severe acute gastric &amp; duodenal            cl. pain abdomen</p> <p>(CSB) jejunal loading</p>	
	<p>PIA - soft</p> <p>conscious.</p> <p>CVS - S4 S1 @</p> <p>PI - BII - AHO</p> <p>Small Intake.</p>	<p>Paed. surgeon opinion</p> <p>- ct w/ fluid</p> <p>- free T4, TSH = previous sample</p> <p>Echin orally.</p> <p>fibre rich diet</p>
		<p>- Plenty of oral liquids</p> <p>- Syp. SMUTR 1oz in the morning</p>
		<p>- MVBVT powder 3 scoops in 18oz water at bedtime</p>

Dr. Aniket Anil Parashar  
 Consultant Pediatrician & Intensivist  
 Reg. No. 9563

Dr. Aniket

noted by Dr. Aniket  
 19/6/26  
 11 AM



## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/6/26 2pm	<p><u>cl/ly</u> Dis <u>Anurie</u></p> <p>Sever Acute Gastritis &amp; dehydrate</p>	
	<ul style="list-style-type: none"> <li>- Pain abdomen (+)</li> <li>- Not passed stools</li> </ul>	
	<p><u>vital</u> stable</p>	<p>✓ ct xyluid</p>
	<p><u>S/E</u></p> <p><u>P/A</u> soft</p>	<p>✓ Paed surg. Opinion.</p>
	<p>Not distended</p>	<p>✓ ct syp SMOOTH MUCUS</p>
		<p>✓ Plate of oral liquid/ fibre diet</p>
	<p><u>Al</u> num.</p>	<p>✓ (+) Free Tu, FSH</p>
		<p>✓ Month vitals</p>
		<p>NB Sunanda</p>



## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/6/26 5:30am	<u>S/B Dr Aniket</u>	
	Severe acute gastritis & dehydration	
	Oral intake - fair	
	Did not pass stool yet	
		Add
	<u>O/e</u> vitals stable	✓ CT Muout at night
	PA: &A.	✓ ↓ IVP to 1hr
		✓ Pad sx open
		✓ Trace P <sub>a</sub> , T <sub>4</sub> , TCH
		✓ Fibre diet. ✓
		Dr. Aniket
		NB Sunanda

Dr. Aniket Anil Parashar  
 Consultant Pediatrician & Intensivist  
 Reg. No: 2568





## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/6 11am	US/B Dr. Aniket	
	Severe Acute Gastritis & Dehydration	
	Abdominal pain - rectal oral intake poor	1) D/C Today F/U w/ Dr. Michael
	Child alert Vitals stable	2) P after 3 days → Symp. SMVTA - 10ml - 5 days
	R-S - B/LAE@ PIA - soft	MVOUT + Powder - 3 scoops for 3 months
		SOS - order
		Aniket P
		D. Aniket P
		S. Scandhya 20/6/26 11am

Dr. Aniket Anil Parashar  
 Consultant: Pediatrician & Intensivist  
 Reg. No: 8533



# CROSS CONSULTATION FORM

Doctor Name : Dr. Sargan Date : 19/06/20 Time : 7 PM

Diagnosis : Acute Acarthritis with dehydration secondary to constipation

Hospital : .....

**Type of Referral :**

- Emergency
- Urgent
- Non Urgent

Referred for :  Opinion  Co-Management  Transfer of care

**Reason for Referral :** If for concurrent care specify the particular need, especially in the absence of a second diagnosis:

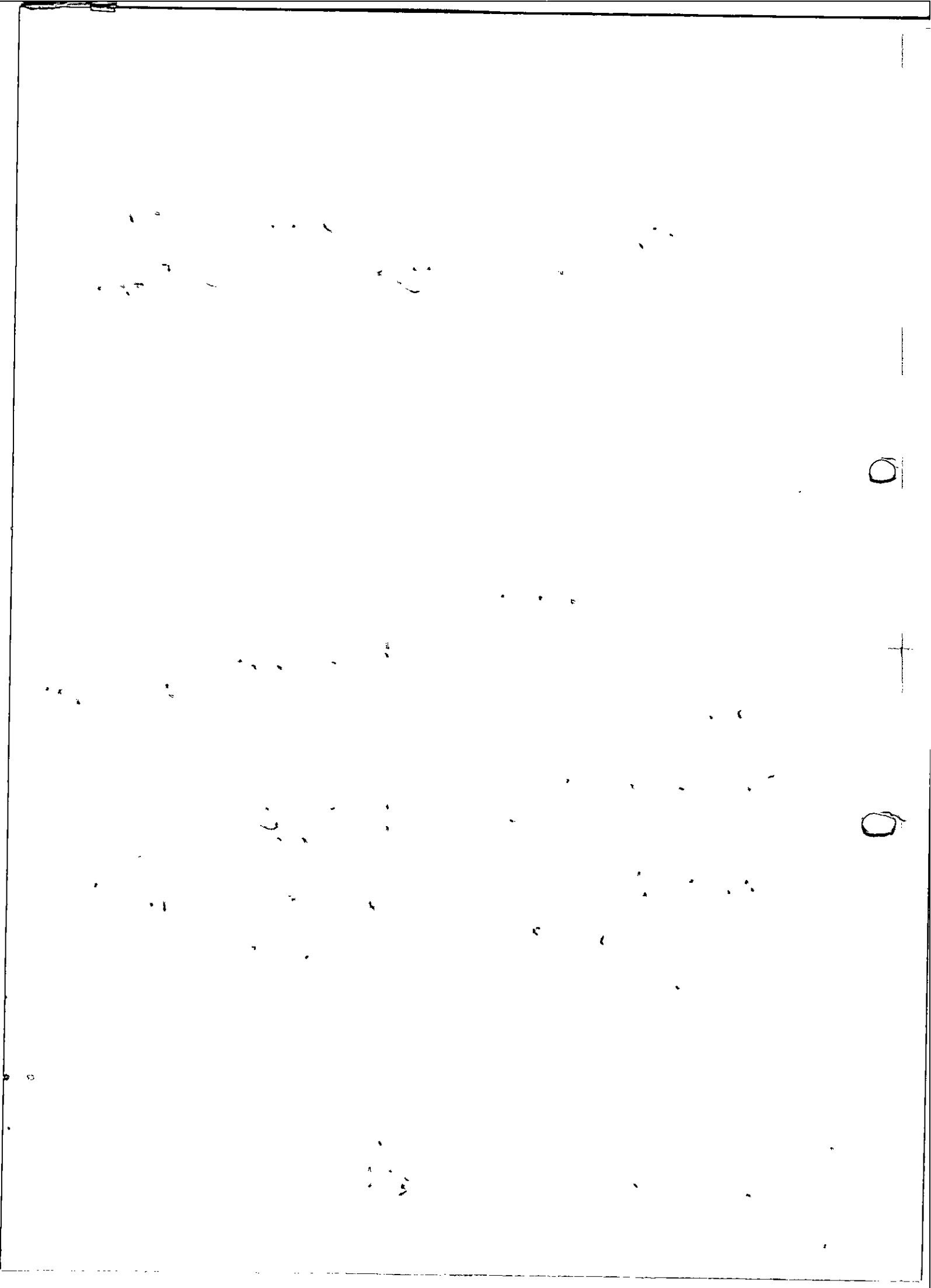
Signature: \_\_\_\_\_

**Findings and Recommendations :**

C/S - Dr. Sargan  
D:- Acute Acarthritis with dehydration secondary to constipation  
C/O pain abdomen  
O/E:- PA. mild tenderness around umbilicus/Suprapubic region  
Adx  
PR - Rovum  
- NO feces/layers  
x Distal loop supporting  
& continue somata sym.  
x. CST

**Consultant :**

Name : Dr. Sargan Signature : [Signature] Date & Time : .....





# DRUG CHART

Date of Admission: 18/6/26 Drug Allergies:  Not known any Drug Allergies

## FOR THE SAFETY OF THE PATIENT

- GENERAL DOCTOR**
- Ensure that all patient details are entered above. ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.
  - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
  - Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
  - Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
  - Discontinue a drug by drawing a line **I** through it and a similar line through subsequent recording panels.
  - The date and time of stopping the drug along with the doctors name and sign must be mentioned.
  - Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.
- NURSES**
- Nurses must follow strictly the FIVE RIGHTS before administration of medication.  
 1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time
  - AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

## SOS / PRN (As Required Medication)

<b>DRUG :</b> <u>Syp CROCIIN-DS</u>				Date Time																
Dose	Route	Frequency	Start Date																	
<u>6ml</u>	<u>PO</u>	<u>SOS</u>	<u>18/6</u>																	
Doctor's Signature		Valid Period	Pharm.																	
<u>Bann</u>			<u>(Signature)</u>																	
Additional Instructions: <u>If T &gt; 100°F</u> <u>(Sul = 240mg)</u>																				

<b>DRUG :</b> <u><del>APRILIAE Cream</del></u>				Date Time																	
Dose	Route	Frequency	Start Date																		
<u>200ad</u>	<u>PR</u>																				
Doctor's Signature		Valid Period	Pharm.																		
Additional Instructions:																					

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

Verified by  
Dr. Dhakshayani

Signature  
VERIFIED BY: Name



NH-00016042 IP26-00006605

aster ASHTON NATHAN  
 1-12-2019 6 Y 5 M 20 D (M)  
 r. Milind Prabhakar Bhide



**REGULAR PRESCRIPTIONS**

Sheet No: .....

Weight 20kg Ward .....

Verified by  
 Dr. Dhakshayahni

<b>DRUG :</b> <u>Syp. SMUTH</u>				Date Time																		
Dose	Route	Frequency	Start Dt.																			
<u>low oral</u>	<u>orally</u>	<u>morning</u>	<u>19/5</u>																			
Name & Signature of the Doctor Starting the Drugs: <u>B. Sreyal a.</u>																						
Additional Instructions:																						
<b>Daily Doctor's Endorsement by a Sign</b>																						
<b>DRUG :</b>				Date Time																		
Dose	Route	Frequency	Start Dt.																			
Name & Signature of the Doctor Starting the Drugs:																						
Additional Instructions:																						
<b>Daily Doctor's Endorsement by a Sign</b>																						
<b>DRUG :</b>				Date Time																		
Dose	Route	Frequency	Start Dt.																			
Name & Signature of the Doctor Starting the Drugs:																						
Additional Instructions:																						
<b>Daily Doctor's Endorsement by a Sign</b>																						
<b>DRUG :</b>				Date Time																		
Dose	Route	Frequency	Start Dt.																			
Name & Signature of the Doctor Starting the Drugs:																						
Additional Instructions:																						
<b>Daily Doctor's Endorsement by a Sign</b>																						

Signature  
 Name

Patient Sticker



Sheet No: .....

### REGULAR PRESCRIPTIONS

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

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

Patient Sticker

Weight. 20kg Ward. ....

VARIABLE DOSE		Date Time						
			Nurse Sig.		Nurse Sig.		Nurse Sig.	
DRUG :			Dose		Dose		Dose	
			Dr. Sign.		Dr. Sign.		Dr. Sign.	
Route	Start Date		Dose		Dose		Dose	
			Dr. Sign.		Dr. Sign.		Dr. Sign.	
Name & Signature of the Doctor			Dose		Dose		Dose	
			Dr. Sign.		Dr. Sign.		Dr. Sign.	
Additional Instructions:			Dose		Dose		Dose	
			Dr. Sign.		Dr. Sign.		Dr. Sign.	

VARIABLE DOSE		Date Time						
			Nurse Sig.		Nurse Sig.		Nurse Sig.	
DRUG :			Dose		Dose		Dose	
			Dr. Sign.		Dr. Sign.		Dr. Sign.	
Route	Start Date		Dose		Dose		Dose	
			Dr. Sign.		Dr. Sign.		Dr. Sign.	
Name & Signature of the Doctor			Dose		Dose		Dose	
			Dr. Sign.		Dr. Sign.		Dr. Sign.	
Additional Instructions:			Dose		Dose		Dose	
			Dr. Sign.		Dr. Sign.		Dr. Sign.	

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
18/6	9pm	Ij BUSCOPAN	10mg	IV	A	Poojita
18/6	10pm	PRACTOCLYSIS ENEMA	66ml	PR	Phan	Amrutha
18/6	10AM	15ml WIV GLYCERINE ENEMA	20ml	PR	dult	Bala anan
19/06	7PM	DULCOLAX SUPPOSITORY	5mg	PR	Singh	Sandhya
						Manisha

Dr. Dhakshayani

Verified by

Signature  
VERIFIED BY: Name



HNH-00016042 IP26-00006605  
 Master ASHTON NATHAN  
 20-12-2019 6 Y 5 M 29 D (M)  
 Dr. Milind Prabhakar Bhide



215



### RESULT SHEET

Date	18/6/26			
Time				
Hb	12.1			
PCV	33.9			
RBC	4.74			
WBC	6.21			
N/L	66.7/24.4			
Platelets	218			
CRP	5.0			
ESR				
PCT				
RBS				
Na				
K				
Cl				
Ca/Mg				
Phosphate				
Urea				
Creatinine	0.5			
ALP				
SGPT	16			
SGOT	31			
T.Bill/Conj	0.5/0.1			
T.Protein	7.7			
S.Albumin	3.4			
S.Globulin	3.4			
A/G Ratio	1.2			
Uric Acid				
S.Amylase	61			
Sr.Lipase	75			
Blood Lactate				
S.Cholesterol				
PT/INR				
APTT				
CSF Protein / Sugar				
Cells				
N/L	Free T <sub>4</sub> — 1.43			
	TSH — 1.31			

Date	19/6/26					
Time						
CUE - Alb						
CUE - Sugar	nil					
CUE - Ketones	negative					
CUE - PUS Cells	3-5					
CUE - RBC Cells	nil					
CUE nitrite	negative					
Epithelial cells	2/3					
Stool Pus Cell						
OVA / Cyst						
Occult Blood						

Culture and Sensitivities : .....

.....

.....

.....

Radiology :    USG : .....

                  X-Ray : .....

                  ECHO : .....

                  CT : .....

                  MRI : .....

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

HNH-00016042 IP26-00006605  
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H/ FRM / CLINICAL / 126

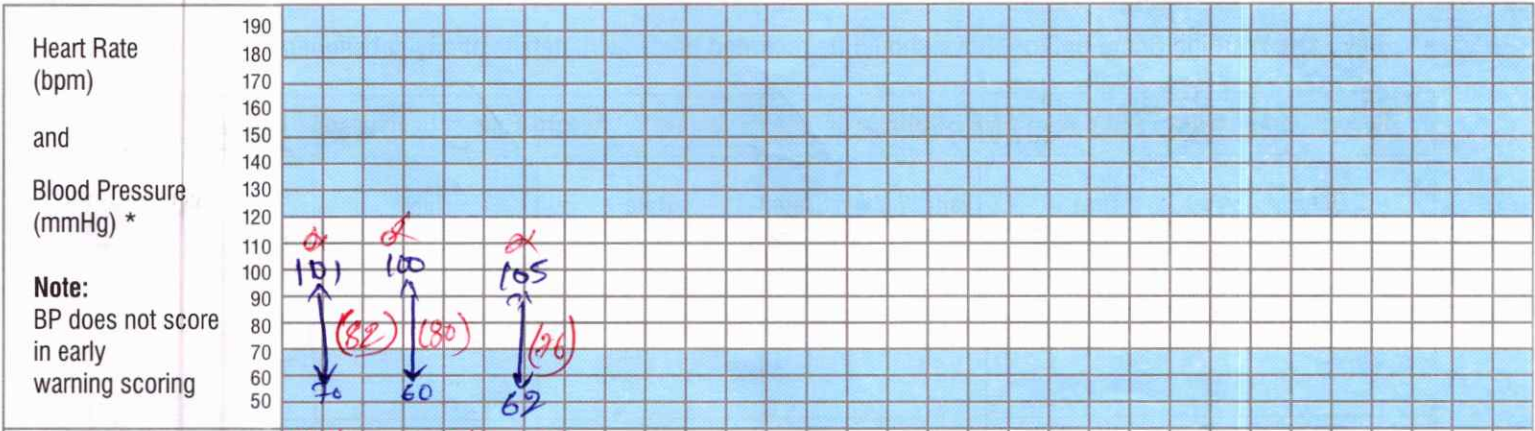
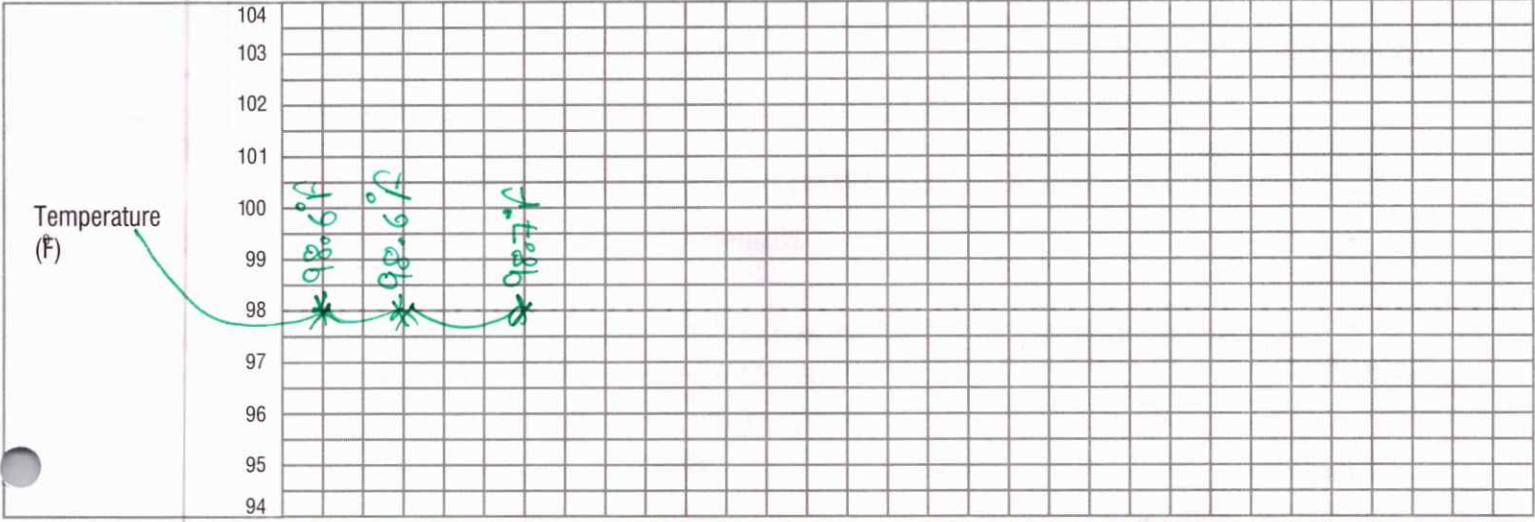
**SCHOOL AGE (5-12 years)**  
**Children's Observation & Early Warning Scoring Chart**



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

Date : 18/6/26 Time: 10 2 6

Doctor / Nurse / Family Concern? Pro Am Am



Heart Rate (Number) 126bpm 128bpm 126bpm

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

Resp Rate (Number) 28bpm 28bpm 26bpm

Resp Mod/ Severe Distress None / Mild

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

Conscious Level Normal Altered

GCS \*

**TOTAL SCORE**

Number of shaded boxes 0 0 0

Pain Score 0 0 0

Observer's Initials A B B

**ACTIONS**

NB: Scores 3 should be recorded overleaf

Score 1 : Continue normal observation by staff nurse

Score 2 : Shift in charge nurse to be informed and continue hourly observations

Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.

Score 4 : Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see

Score 5 & 6 : Shift in charge AND PICU fellow or PICU consultant to be informed.

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

## CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

### INSTRUCTIONS:

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

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

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

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

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

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 Master ASHTON NATHAN  
 20-12-2019 6 Y 5 M 29 D (M)  
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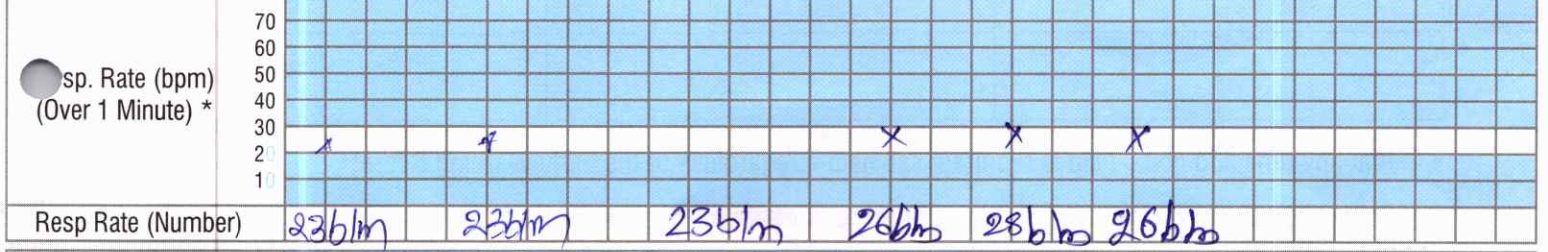
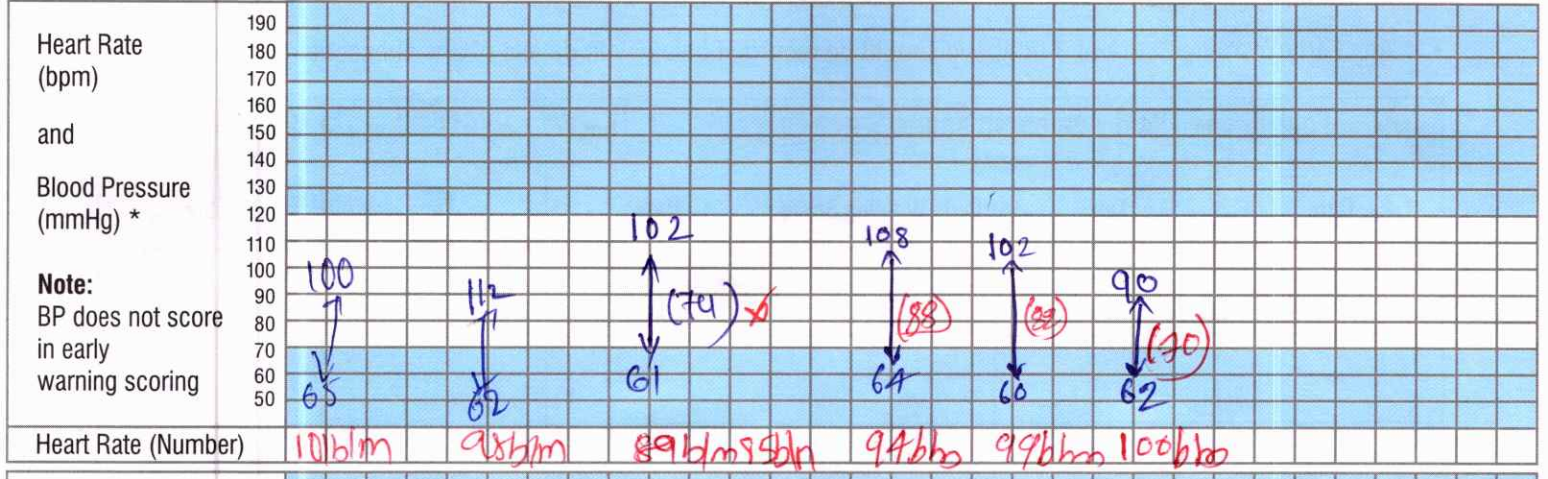
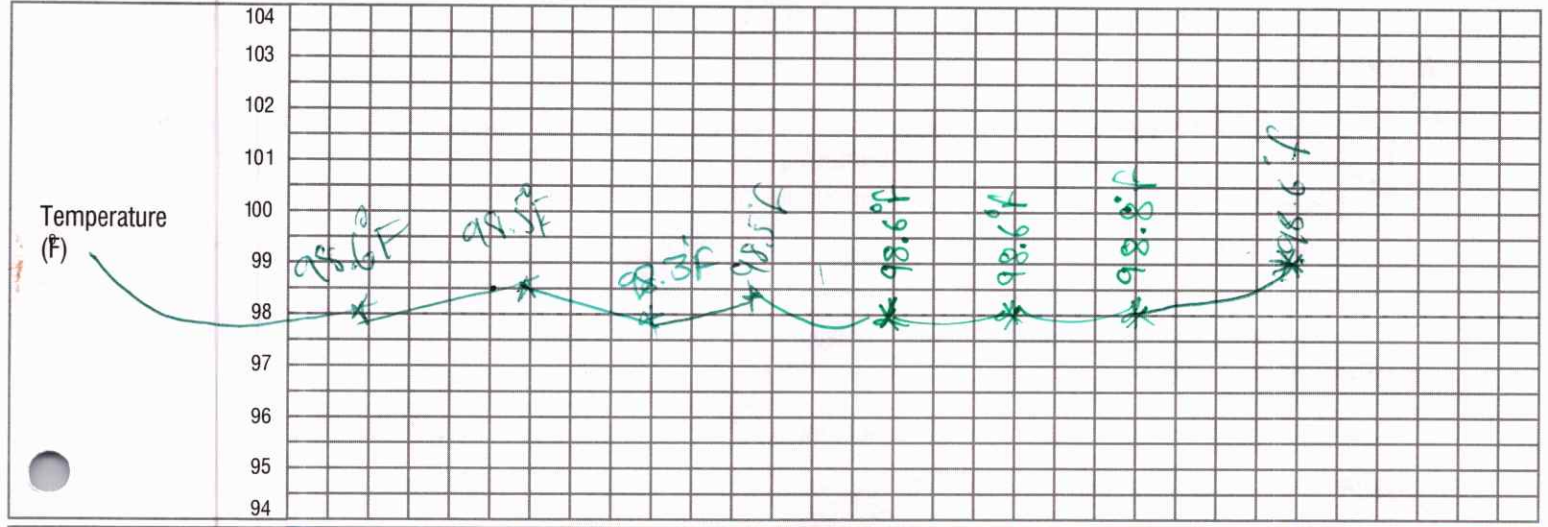
FRM / CLINICAL / 126

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



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

Date: 19/6/25	Time: 10 AM	2 PM	4 PM	8 PM	10 PM	2 AM	6 AM	8 AM
Doctor / Nurse / Family Concern?								



Resp Distress	Mod/ Severe	None / Mild
Receiving O <sub>2</sub> (l/min)		
O <sub>2</sub> Saturations (%)	100% 100% 99% 100% 100% 100%	
Conscious Level	Normal / Altered	
GCS *		

<b>TOTAL SCORE</b>	
Number of shaded boxes	0 0 0 0 0 0
Pain Score	0 0 0 0 0 0
Observer's Initials	A A S B A A

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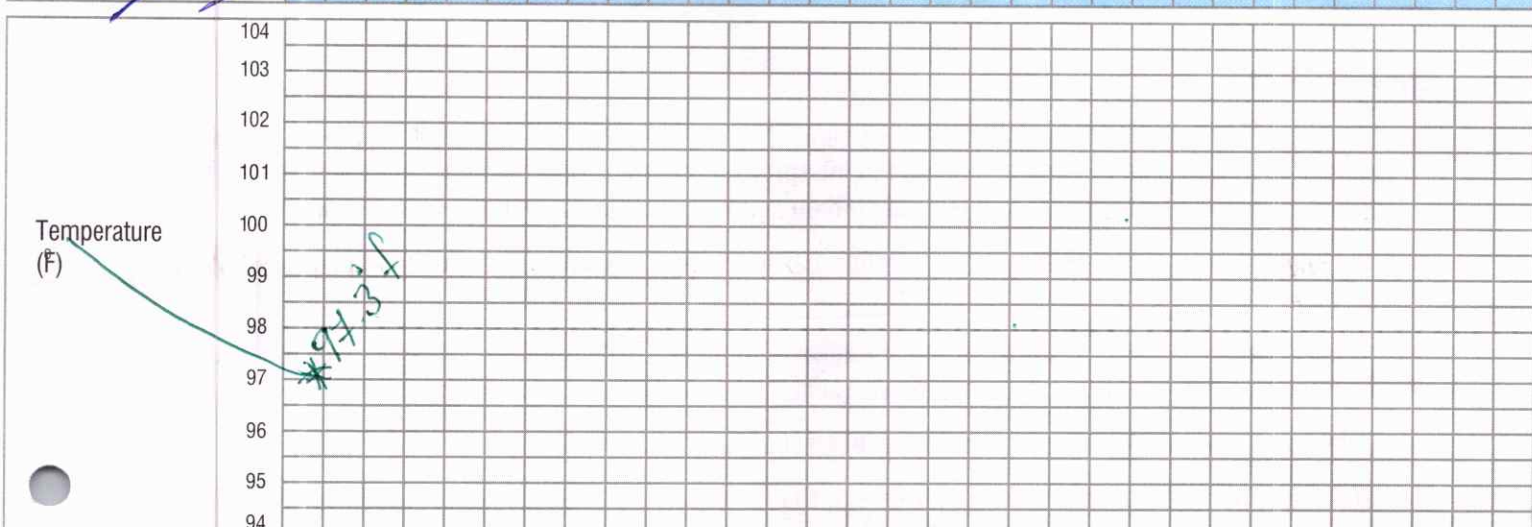
**SCHOOL AGE (5-12 years)**  
**Children's Observation & Early Warning Scoring Chart**



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

Date : 11/14 2016 Time: 10am

Doctor / Nurse / Family Concern?



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

Note: BP does not score in early warning scoring

Heart Rate (Number) 100/hr

100

70

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

Resp Rate (Number) 25/hr

25/hr

Resp Distress Mod/ Severe None / Mild

Receiving O<sub>2</sub>(l/min) O<sub>2</sub>Saturations (%) 99%

Conscious Level Normal Altered

GCS \*

**TOTAL SCORE**

Number of shaded boxes

Pain Score 0

Observer's Initials SK

**ACTIONS**

NB: Scores 3 should be recorded overleaf

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

MNH-00016042 IP26-00006605  
 Master ASHTON NATHAN  
 20-12-2019 6 Y 5 M 29 D (M)  
 Dr. Milind Prabhakar Bhide



# FLUID CHART

Sheet No. : ① .....

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

Date	Time	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
		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											
<b>Total Intake :</b>						<b>Total Output :</b>						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
<b>Total Intake :</b>						<b>Total Output :</b>						
18/6	08:00 pm	Plasmalyte		40ml								
	09:00 pm			40ml								
	10:00 pm		H2O	40ml								
	11:00 pm		+	40ml								
	12:00 am			40ml								
	01:00 am			40ml								
<b>Total Intake :</b> Taken						<b>Total Output :</b> m-x 0-1						
19/6	02:00 am	Plasmalyte		40ml								
	03:00 am			40ml								
	04:00 am		Soup	40ml								
	05:00 am		+ H2O	40ml								
	06:00 am			40ml								
	07:00 am			40ml								
<b>Total Intake :</b> Taken						<b>Total Output :</b> m-x 0-1						

**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	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
		Nature of Fluid	Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage			Urine
19/6/26		↑										
	08:00 am	PlasmaLyte		30ml	NA	/	/	/	/	/	/	/
	09:00 am		Whichee	40ml								
	10:00 am			40ml								
	11:00 am			40ml								
	12:00 pm			40ml								
01:00 pm	↓			40ml								
<b>Total Intake :</b> Taken					<b>Total Output :</b> U-2 M-							
19/6/26	02:00 pm	PlasmaLyte	↓		NA	/	/	/	/	/	/	/
	03:00 pm		↓	40ml								
	04:00 pm		↓	40ml								
	05:00 pm		↓	40ml								
	06:00 pm		↓	30ml								
	07:00 pm		↓	30ml								
<b>Total Intake :</b>					<b>Total Output :</b>							
19/6/26	08:00 pm	PlasmaLyte	↑	30ml	NA	/	/	/	/	/	/	/
	09:00 pm		Whichee	30ml								
	10:00 pm		H <sub>2</sub> O	30ml								
	11:00 pm			30ml								
	12:00 am			30ml								
	01:00 am		↓	30ml								
<b>Total Intake :</b> Taken					<b>Total Output :</b> U-1 M-1							
20/6/26	02:00 am	PlasmaLyte	↑	30ml	NA	/	/	/	/	/	/	/
	03:00 am			30ml								
	04:00 am			30ml								
	05:00 am			30ml								
	06:00 am			30ml								
	07:00 am			30ml								
<b>Total Intake :</b> Taken					<b>Total Output :</b> U-1 M-1							



# NURSING CARE RECORD

Date: 18/6/26

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					NA		
Night	8pm	→ Assess the pt condition → monitoring vitals checked and recorded	8pm	→ Assessed the pt condition → Administration of medication given as per doctor's orders	→ pt is stable	→ pt vitals re-checked	Amrutika A
	8Am	→ 2/0 chest maintain	8Am				

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 Dr. Milind Prabhakar Bhide

Patient



# NURSING CARE RECORD



Date: 19/6/26

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8am	→ Assess pt condition	8am	→ Assessed pt condition	patient is stable	re-checked vitals	Anushka
	7u	→ Monitor the vitals	7u	→ Monitored vitals			
Afternoon	2pm	→ Maintain I/O chart	2pm	→ Maintained I/O chart	Now patient is stable	Rechecked the v/s	S
	8pm	→ Administer medication as per drug chart	8pm	→ Administered medication as per drug chart			
	10	→ Assess the pt condition	10	→ Monitor the v/s			
Night	8pm	→ Maintain the I/O Drug as per chart	8pm	→ Maintain the I/O Drug as per chart	PT is stable.	Monitor v/s	Sneh
	8pm	→ Surger opinion pending	8pm	→ Surger opinion pending			
	10	→ Assess the pt condition	10	→ Assessed the pt condition			
Night	10	→ Monitor the v/s	10	→ Monitored v/s	Vital's normal	Maintain I/O chart	S
	8am	→ Maintain the I/O	8am	→ Maintained I/O			
Night	8am	→ Provide the comfortable position.	8am	→ Provided the comfortable position.			
	8am	→ medication given as per os doctor order.	8am	→ medication given as per os doctor order.			



# PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
18/6	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	ⓐ
19/6	6Am	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	ⓑ
19/6/26	2pm	0/10	NA	<input type="checkbox"/> Continuous <input checked="" 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	ⓑ
19/6/26	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	ⓑ
19/6/26	6pm	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	ⓑ
19/6	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	ⓑ
20/6	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	ⓑ
20/6	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	ⓑ
				<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:**

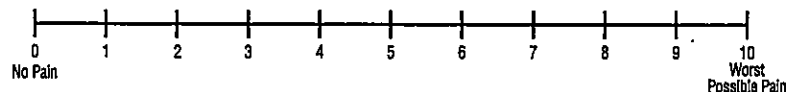
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
  - At least every 2 hours for the first 24 hours
  - Then every 4 hours.
  - Prior to pain-relieving intervention.
  - Within 30 – 60 minutes after pain relief intervention.

# 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 of sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

## Numerical Pain Scale (Obstetric and Gynecology)



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

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

## Wong - Baker (Pediatrics) Above 7 Years



HNH-00016042 IP26-00006605  
 Master ASHTON NATHAN  
 20-12-2019 6 Y 5 M 29 D (M)  
 Dr. Milind Prabhakar Shinde

# BRADEN 'Q' SCALE



Date : 18/6 19/6 19/6 19/6  
 Time : W1 M6 E2 N1

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

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

<b>TOTAL SCORE</b>	28	28	28	27
<b>Evaluator's Name</b>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>

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



## CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1 18/6			DAY-2			DAY-3 20/6			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0			0	0	0	0				
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							<del>NA</del>	<del>NA</del>	<del>NA</del>	SY			

**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: Sneha  
 Signature : ..... Name : Sneha

Signature of Ward In Charge : Balanani  
 Signature : ..... Name : Balanani

Patient Sticker



## CHECKLIST FOR THROMBOPHLEBITIS

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

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

Signature of Shift In Charge :

Signature of Ward In Charge :

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

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

HNH-00016042 IP26-00006605  
 Master ASHTON NATHAN  
 20-12-2019 6 Y 5 M 29 D (M)  
 Dr. Milind Prabhakar Bhide



### SHIFT HAND OVER FORM - WARD

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

SITUATION	Diagnosis:	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Not Known If Yes Specify: .....				
	Area	18/6/26 N1	18/6/26 M6	19/6/26 E2	19/6/26 N1	
BACKGROUND	Shift Time					
	Medical Condition (Any special condition to be noted):	-	-	-	-	
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	
	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	
	Vital Signs:	Temp:	98.4	98.3	98.4	98.2
		Res:	28b/m	25b/m	25b/m	25b/m
		SpO <sub>2</sub> :	100%	100%	99%	98%
		Pulse:	98b/m	97b/m	98b/m	97b/m
		BP:	101/60	100/65	103/62	102/61
	Fall Risk Score:	-	-	-	-	
Pain Score:	-	-	-	-		
Recommendations	Safety Needs:	-	-	Yes	Yes	
	Physiotherapy	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Others Specify:	-	-	-	-	
	Special Diet:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Other Special Orders / Medications:	NA	-	NA	-	
Post Operative Procedure Special Orders:		NA	-	Surgeon opinion	-	
Handed Over By Name :		Amruth	Amruth	Sunanda	Sru	
Signature :		<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	
Date:		19/6/26	19/6/26	8pm	20/6	
Time:		8Am	2pm	4/6/26	8Am	
Taken Over By Name :		Amruth	Sunanda	Sru		
Signature :		<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>		
Date:		19/6/26	19/6/26	8pm		
Time:		8Am	2pm	8pm		

## NURSING SHIFT HAND OVER FORM - WARD

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

<b>SITUATION</b>	Diagnosis:	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify: .....					
<b>BACKGROUND</b>	Area	/	/	/	/	/	/
	Shift Time						
	Medical Condition (Any special condition to be noted):						
<b>ASSESSMENT</b>	Allergy:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Vital Signs:	Temp:					
		Res:					
		SpO <sub>2</sub> :					
		Pulse:					
		BP:					
	Fall Risk Score:						
	Pain Score:						
<b>Recommendations</b>	Safety Needs:						
	Physiotherapy	<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
	Others Specify:						
	Special Diet:	<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
	Other Special Orders / Medications:						
	Post Operative Procedure Special Orders:						
	Handed Over By Name :						
	Signature :						
	Date:						
	Time:						
	Taken Over By Name :						
	Signature :						
	Date:						
	Time:						

HNH-00016042 IP26-00006605  
 Master ASHTON NATHAN  
 20-12-2019 6 Y 5 M 29 D (M)  
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## MEDICATION RECONCILIATION FORM

Drug Allergies: .....  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 : Dn. Pranav .....

Date & Time : 18/6/26 @ 8:45 PM .....

Nurse Name & Signature: Prabha .....

Date & Time : 18/6/26 @ 8:45 PM .....

11 11 11

1 1 1

1



1

11 11 11  
11 11 11  
11 11 11

# PATIENT TRANSFER FORM

HNH-00016042 IP26-00006605  
Master ASHTON NATHAN  
20-12-2019 6 Y 5 M 29 D (M)  
Dr. Milind Prabhakar Bhide



Date & Time of Admission 18/6/26 @ 8:36 PM		Date & Time of Transfer Order 18/6/26 @ 8:15 PM
Treating Consultant Name	Transfer Ordered by Dr. Branav	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 20	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input checked="" 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 Prabin	Name of Person Ordered Transfer Dr. Branav
--	---

Patient & Clinical Records Received by :

Amrutlee

Date & Time of Patient Received :

18/6/26 @ 8:30 PM.

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

- Unavailable Bed       Nurse not Available       Available Bed not ready



215

# NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 19/6/26 Time: 10:35 AM

Weight: 20 kg Centile: 25<sup>th</sup>

Height: Centile:

Inference: Underweight child

RDA: - Calories: 1450 Kcal/day Protein: 25 gm/day

Diet Recommendations: High fiber diet with liquids

Re-Assessment: No Junk, oily, spicy foods

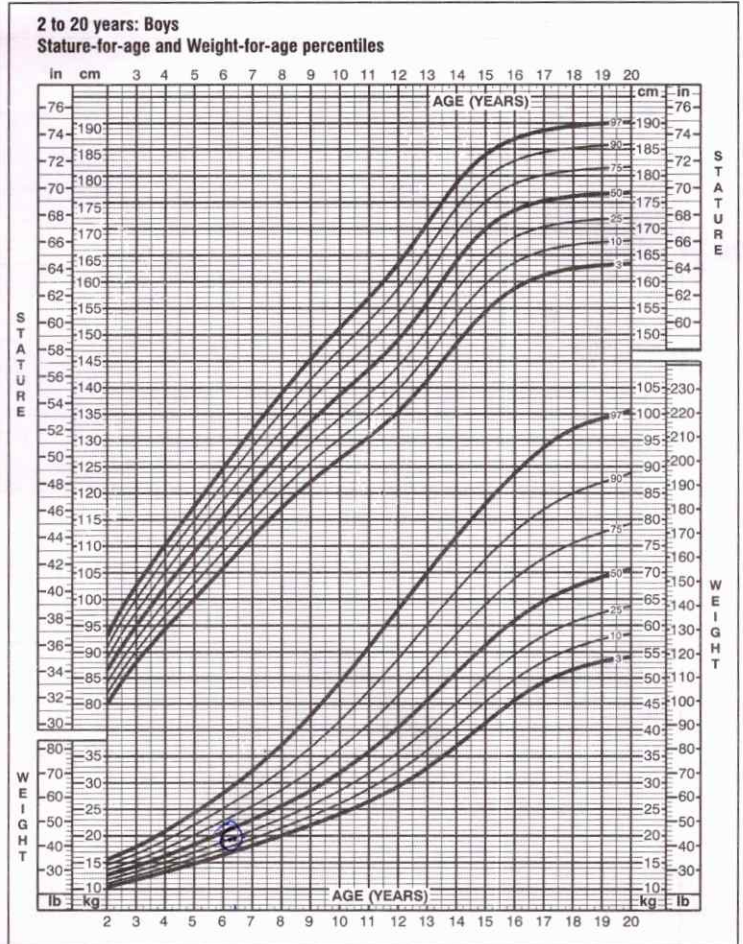
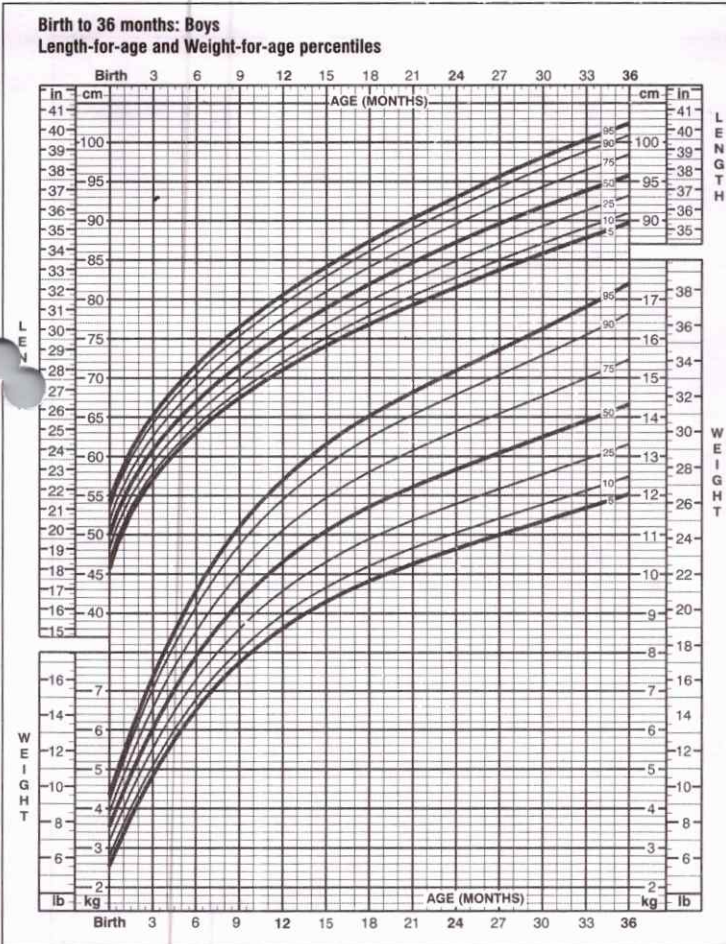
Food Allergies: NO Veg/Non-veg: NON-veg

Diagnosis: Acute gastritis, dehydration, infective colitis

Nutritional Intervention -  Oral  Enteral  Parenteral

Patient's Signature: *[Signature]*

## GROWTH CHART (BOYS)



Dietician's Name: Sathwikar

Dietician's Signature: *[Signature]*





wt - 19.7 kg



# EMERGENCY ROOM TRIAGE FORM

Patient's Name: Master Ashton Age: 6 year Gender:  Male  Female  
 Date: 18/6/26 Time of Arrival: 8:10pm

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: 97.7° PR: 76b BP: \_\_\_\_\_ RR: 26b SpO<sub>2</sub>: 98%

Chief Complaints: abdomine pain since 3 days

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

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: 8:15pm

## 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: Amulya Signature of Triage Nurse: \_\_\_\_\_  
 Date & Time: 18/6/26 @ 8:15pm  
 Docu. No.: RCH / FRM / CLINICAL / 085



HNH-00016042 IP26-00006605  
 Master ASHTON NATHAN  
 20-12-2019 6 Y 5 M 29 D (M)  
 Dr. Milind Prabhakar Bhide



## NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 18/6/26 Time of arrival : 8:10 PM

Chief Complaints : Abdominal pain since 3 days RBS: .....

Height : ..... Weight : 19.7kg BMI : ..... 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 N/A  Frequency N/A  Duration N/A

**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:** N/A (Date/Time): N/A

**Social History:** Lives With Family

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

Time of Initial assessment completed by ER Nurse Shreya @ 8:20 PM

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

Time	Nursing Notes
8:20pm	Assessed the general condition → vitals checked and recorded.

Samples collected by: /

Time: /

Samples sent by: /

Time: /

**Medication given in ER:**

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

Condition of patient at time of shift - out :	Details of Shift - out
HR: 78b/m ..... BP: ..... CFT: 25cc RR: 26 ..... SPO <sub>2</sub> : 98% GCS: 15/15 ..... Temperature: 97.8°F Pain Score: 0..... Repeat RBS (if applicable): .....	Shift - out from ER to: ward Time of Shift - out: 9:20 PM Handover given to: ..... (Nurse's Name)

Tick as applicable:  MLC  LAMA  BROUGHT DEAD

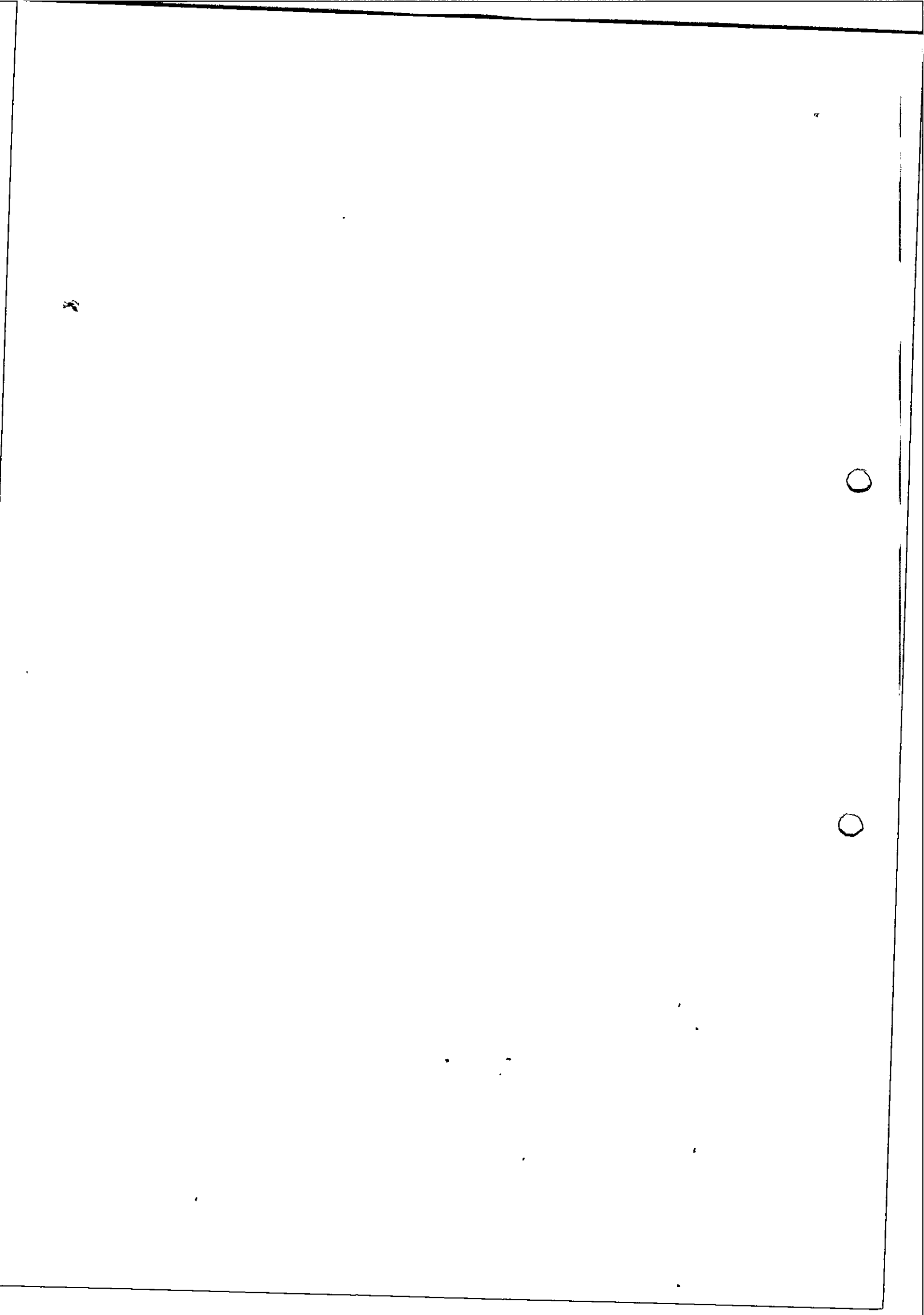
Procedures done with details (if any): .....

Name of the Nurse: Sweety Jay

Signature of the Nurse: [Signature]

Date & Time: 18/16/26 @





HNH-00016042 IP26-00006605  
Master ASHTON NATHAN 8 Y 6 M 29 D (M)  
20-12-2019  
Dr. Milind Prabhakar Bhide

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

BirthRight  
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Your Right to a Safe Delivery

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years  
of saving the greatest gift.  
Nurturing Lives. Inspiring Bright

## BILLING POLICY

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

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

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

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

### MODE OF PAYMENT & REFUNDS

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

*NICHOLAS NADAN*  
Name & signature of Patient/Attendant

*Sandeep Mawra*  
(Signature of Admission Desk executive)

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

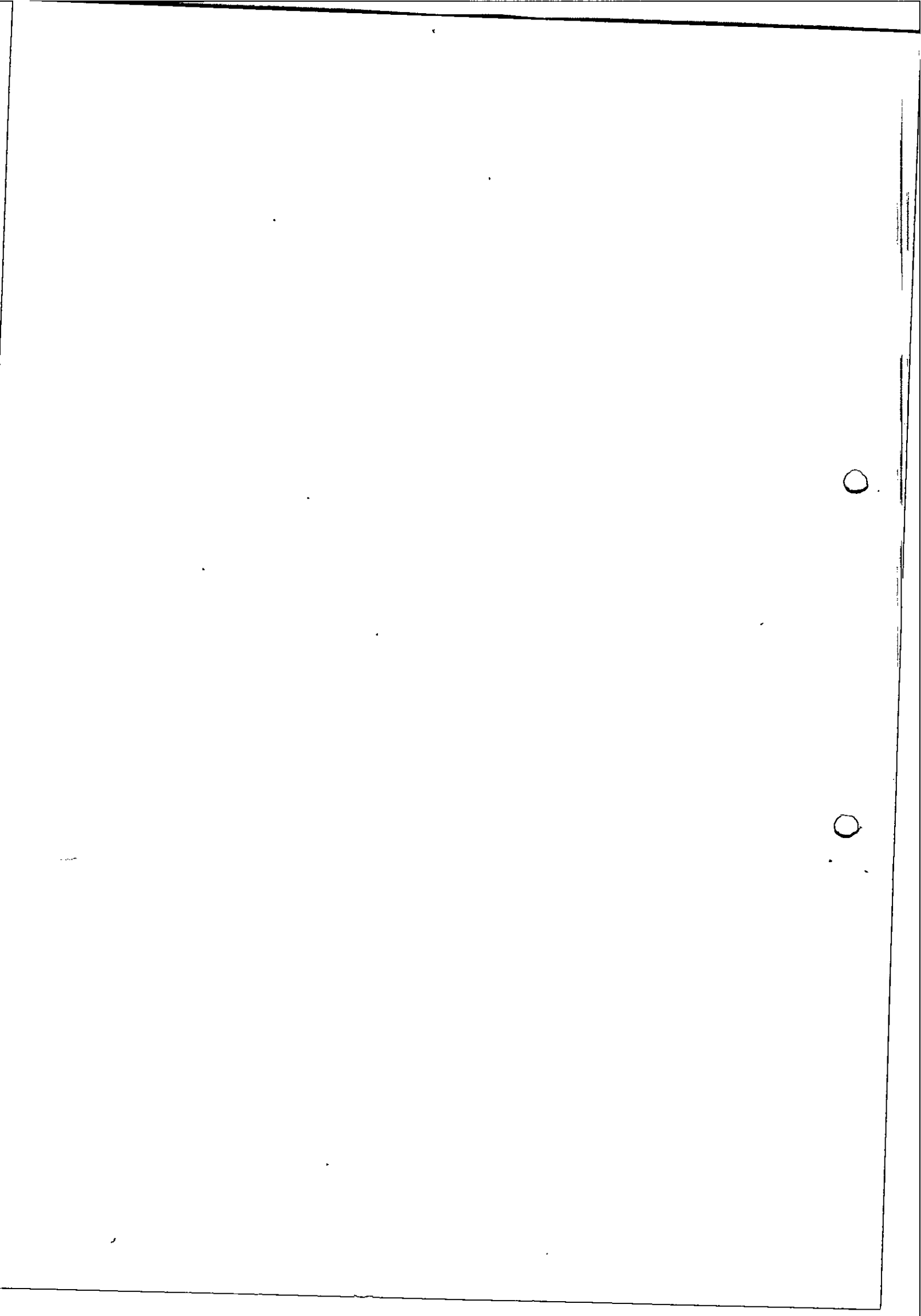
### RAINBOW CHILDREN'S MEDICARE PRIVATE LIMITED

Registered Office: Road No.2, Banjara hills, Near Hotel Park Hyatt, Hyderabad - 500 034, T: +91 40 2233 4455.  
Corporate Office: 8-2-19/1/A, Daulet Arcade, Karvy Line, Road No.11, Banjara Hills, Hyderabad - 500 034.  
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CIN: U85110 TG1998 PTC029914

email : [info@rainbowhospitals.in](mailto:info@rainbowhospitals.in)

[www.rainbowhospitals.in](http://www.rainbowhospitals.in)



HNN-00018042 IP26-00008605  
Master ASHTON NATHAN (M)  
20-12-2019 6 Y 5 M 29 D  
Dr. Milind Prabhakar Bhide

**PARENT OR PATIENT ATTENDANT  
(TPA / INSURANCE / AROGYA BHADRATA / CORPORATE)**



Date: .....

I have attended the financial counseling desk / billing desk and understood the approximate expected costs of treatment. I clearly understand and agree that the hospital would bill as per its (hospital's) existing terms and conditions or MOU with my TPA/ Insurance Company/ Corporate/ Arogya Bhadrata Scheme.

In case my claim is rejected by my TPA / Insurance Company / Corporate / Arogya Bhadrata Scheme at any point of time, i.e. before admission, during admission, during discharge or post discharge when hospital bill claim is submitted, I promise to settle the claim with the hospital. I understand and agree that there are certain TPA / Insurance Company / Corporate / Arogya Bhadrata Scheme Non - Coverable billing components which have to be paid totally by me like the following.

Registration charges, Insurance Processing fee, Medical Record Charges, MLC Charges, Tax Collected at Source (TCS), Dietician Consultation, F&B charges. Luxury Tax, Pharmacy and Consumables Non Medicals like Gloves, Masks, Draw Sheets, Diapers / Koochees, Intrafix, Q-Syte, Venflon, Sterilium, Splint, Gowns, Stockings, etc, Investigations like HIV, HbsAg, Pre Anesthesia Checkup (PAC), all Genetic Investigations, Double Occupancy, Vaccination Charges etc, instruments like Laparoscope, Thoracoscope, Harmonic, N-Seal, Morcellator, Cobulator, C-Arm, Micro Debrider, Medetronic Drill, Mann Mann Drill, Neuro Microscope, Neuro Endoscope, Endoscope etc, Maternity related like, Anti D, Muhurtham, Welt Baby Charges, Epidural, Entonox, Tubectomy etc. Any other facility used/ treatment/ investigation done which is not related to the present ailment is not covered.

I promise to clear my medical / non-medical bill dues during admission on daily basis or as and when applicable or whenever called for.

**Mandatory Documents to be submitted for cashless process (Corporate Policy)**

- 1. Employee ID Card.
- 2. Employee Government ID Proof (PAN /Aadhaar Card / Passport / Voter ID).
- 3. Patient TPA / Insurance Health Card or E-Card.
- 4. Patient Government ID Proof (PAN /Aadhaar Card / Passport / Voter ID / Birth Certificate)

**Mandatory Documents to be submitted for cashless process (Individual Policy)**

- 1. Proposer's ID Proof.
- 2. Patient TPA / Insurance Health Card or E-Card.
- 3. Patient Government ID Proof (PAN / Aadhaar Card / Passport / Voter ID / Birth Certificate)

Name of the Patient: ASHTON NATHAN Date & Time of Admission: 18/06/20 20:45 PM

Name of the Parent / Guardian: NICHOLAS NATHAN Mobile Number: 8019542648

Parent Aadhaar Card Number: .....

Nathan (FATHER)  
Signature & Relation

215

Acute Gastroenteritis  
dehydration

18

18

18

18

RAINBOW CHEL DREN K HOSPITAL HIMAYATH NAGAR  
MA THE RAINBOW NATHAN K 2M DREN K HOSPITAL HIMAYATH NAGAR