DISCHARGE SUMMARY

Name	Master M.SHAURYANSH REDDY	UHID	HNH-00015527
Father/Guardian	Mr M. AVINASH REDDY	Age/Gender	4 Y 9 M 3 D/ Male
Address	1-8-700/23, falt no:102 ista central padma colony, Nallakunta, Hyderabad, Telangana, INDIA, 500044		
IP No	IP26-00006659	Admission Date	26-06-2026
Ref Doctor	Self.		
Discharge Date	28.06.2026		

Consultant:
Dr. SPANDANA PASUPULETI
MBBS, MRCPCH
30925

DIAGNOSIS	ICD CODE
ACUTE FEBRILE ILLNESS WITH DEHYDRATION	

History: Master M.SHAURYANSH REDDY, 4 Y 9 M 3 D , old boy presented with history of fever and intermittent pain abdomen since 3 days, cough since 3 days prior to admission. For the above complaints he was admitted at Rainbow Children's Hospital - for further management.

Outside investigations: Done on 25.06.2026: CBP showed Hemoglobin - 12.2 gm%, White blood cells - 6220 cell/cmm, Platelets -2.02 lakh/cmm, C-Reactive Protein **- 57** mg/L. Serum Creatinine was 0.3 mg/dl. Blood Urea was

Name	Master M.SHAURYANSH REDDY	UHID	HNH-00015527
IP No	IP26-00006659	Admission Date	26-06-2026

13 mg/dl. urine culture and sensitivity shows no growth after 24 hours of incubation.

Examination: He was (100.0*F) febrile, maintaining saturations at room air. His heart rate was 105/min, Blood pressure - 96/62 mmHg and Respiratory Rate - 24/min. Capillary Refill Time was <2 secs. Peripheries were warm & pulses well felt. On examination Signs of some dehydration were present, dry lips, oral mucosa, delayed skin turgor, 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: 15.2 kilo grams.

Investigations: Enclosed reports.

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

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

Baby's infective markers are high , hence started on iv antibiotics after sending blood and urine culture .
Both blood and urine culture showed no growth

He was regularly monitored for fever spikes, hemodynamic status, vital parameters, His fever spikes and other symptoms gradually settled.

Name	Master M.SHAURYANSH REDDY	UHID	HNH-00015527
IP No	IP26-00006659	Admission Date	26-06-2026

He remained hemodynamically stable during the hospital stay. He improved with the above line of management and is being discharged with the following advice.

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

Medication during hospital stay:
Injection. Augmentin
Syrup. Ambroxil
Injection. Esmaprazole

Advice:
* Diet as advised.

S.No	MEDICATION	DOSE	TIMINGS	DURATION
1	Syrup. AUGMENTIN DDS (Amoxycillin 400 + Potassium Clavulanate 57 mg/5ml)	4 ml	8am-8pm (after food)	For 4 days
2	Nasoclear nasal drops, 2 drops in each nostril **SOS** for nose block			

Plan: To collect final blood culture report on followup.
To review with CRP report on follow up (Monday)

Fever Management

Name	Master M.SHAURYANSH REDDY	UHID	HNH-00015527
IP No	IP26-00006659	Admission Date	26-06-2026

* Syrup. Crocin DS (Paracetamol - 5ml/240mg) 5 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. SPANDANA PASUPULETI on Monday (29.06.2026) with **CRP** report at Himayatnagar in OPD with prior appointment **(Review consultation will be charged).**

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

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

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

Parent/ Attender

In case of emergency contact 9154865030 emergency pediatrician on duty.

To take appointment for OPD consultation at Rainbow **Banjara Hills /** Rainbow

Name	Master M.SHAURYANSH REDDY	**UHID**	HNH-00015527
IP No	IP26-00006659	**Admission Date**	26-06-2026

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. SPANDANA PASUPULETI
MBBS, MRCPCH
30925

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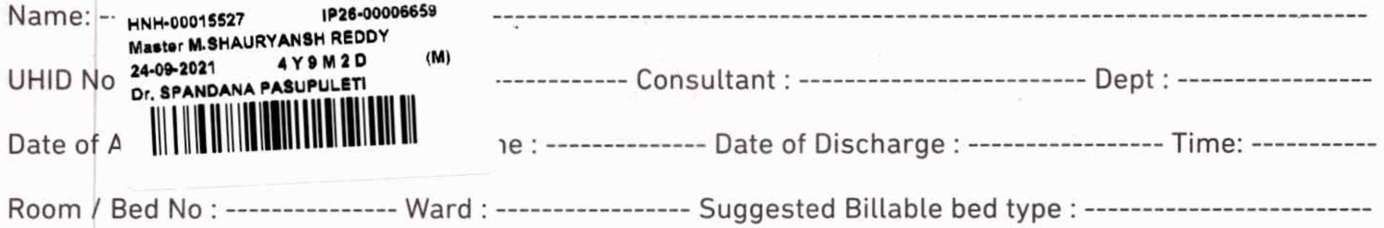
ACTIVITY RECORD FOR BILLING



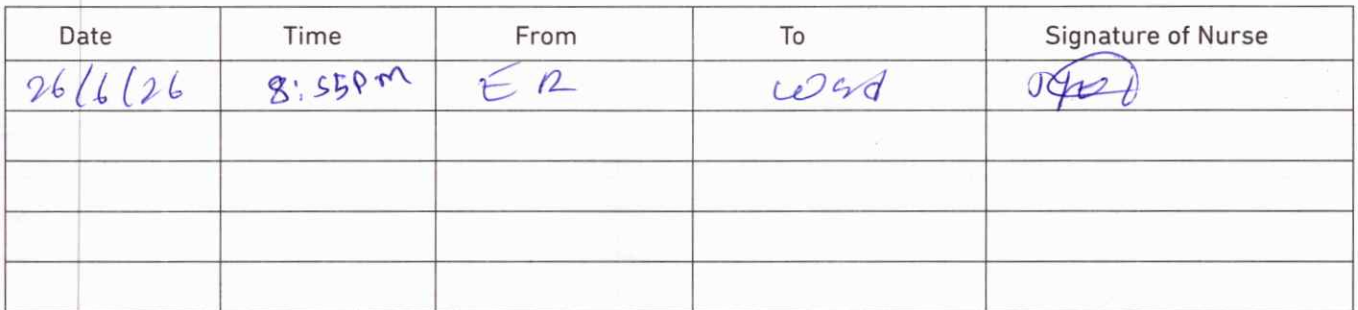
Name: HNH-00015527 IP26-00006659
Master M.SHAURYANSH REDDY
24-09-2021 4 Y 9 M 2 D (M)
Dr. SPANDANA PASUPULETI

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

Date of A... ...ne : -------------- Date of Discharge : ----------------- Time: -----------

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

WARD TRANSFERS



Date	Time	From	To	Signature of Nurse
26/6/26	8:55PM	ER	Ward	[signature]

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
28/6/26	blood culture.	1044 ✓	[signature]

Cross Checked done by [illegible]

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
26/6	Infusion Pump	10pm	27/6/26 6pm	208538.	[signature]

Cross checked done by Sir

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
26/6/26	IV canula	1	8484	[signature]
27/6/26 9:30am	NHA	1	8363	[signature]

Cross Checked Done by [signature]

ANY OTHER INFORMATION

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

Ref.No. F/IN/PR/10

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name : S... DDY.

Patient ID# :

Consultant :

Final Diagnosis : AGE c̄ DEHYDRATION.

Pediatric Multiorgan History & Physical Examination

Name : SHAURYANSH REDDY Age/Sex 4yr 9m.

Informant Mother. Reliability Good.

Chief Presenting Complaints & Duration (Chronologically):

c/o fever x 3 days.

Pain abdomen x 3 days.

Cough x 3 days.

History of present illness :

- Child came with complaints of fever, high grade associated with chills / rigor and relieved on taking medication & recurring. Last fever spike at 5:30pm yesterday evening.

- Also c/o pain abdomen associated with passing mild reddish colored urine since 3 days.

- Urine stream / color / frequency (N).

- No c/o burning pain / crying while passing urine.

- Also c/o cough, dry type, mild not affecting his sleep.

Pediatric Multiorgan History & Physical Examination

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

Nil premorbid.

Birth & Neonatal History :

Term/AGA/ Male.

Birth & Socio Economic History :

About Father :

About Mother :

Any additional Information :

Developmental History :

Developmentally N.

Immunization History :

As per NIS.

Pediatric Multiorgan History & Physical Examination

Anthropometry

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

Weight (kgs) 15.2kgs. (Centile ________)

On Examination :

Temperature : 100.0°F. Pulse Rate: ________ Description ________

B.P. ________ SPO2 100% at RA.

Resp. rate and type of breathing : ________

- Dull look

Rash ________ Absent

Lymphadenopathy ________ - Absent tears, sunken eyes, skin turgor) Lose.

Oedema : ________

Respiratory system :

Inspection (any s/o distress) : BAE(+), NVBS(+).

Air entry & breath sounds : ________

Any addes sounds : ________

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

Cardiovasclular System :

Inspection of procordium : S1, S2(+), No murmurs.

Heart Sounds : ________

Any murmur : ________

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

Per Abdomen :

Inspection S/T, NT, BS(+).

Palpation : ________

Ausculation : ________

Spine: ________ External Genitelia : ________

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

Pediatric Multiorgan History & Physical Examination

Central Nervous System :

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

Cranial Nerves :

Motor System :

Nutrition :

Tone : Power 5/5

Co-ordinator :

Posture :

Involuntary Movements :

Reflexes :

DTR

Superficials :

Plantars

Sensory System :

Bladder / Bowel : (N).

Clinical Summary & Diagnostic :

ACUTE FEBRILE ILLNESS c̄ DEHYDRATION.

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment :

Desired goals of the treatment :

Planned Labs :

Blood C/S.
1 extra plain sample:
CBP
CRP
Urea
Creatinine
Urine WE, Urine C/S.
USG A+P

Pour in OP basis.

Planned Management :

- IVF 2/3rd M.
- Inj. AUGMENTIN 3D dose.
- Syp. Crocin DS.
- Syp. Ibugesic.
- Mucolite syp.

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. Spandana on whose name the patient is being referred

Doctor's Signature Name [signature] Date 26/6 Time 10pm

HNH-00015527 IP26-00006659
Master M.SHAURYANSH REDDY
24-09-2021 4 Y 9 M 2 D (M)
Dr. SPANDANA PASUPULETI

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
26/1 9:50 pm	c/s/b Dr. Spandana	
	AFI ē Dehydration, ? UTI	Plan
		1) IVF
	Fever ⊕	2) Inj Augmentin
	Poor oral intake ⊕	3) BP monitor - 4th hrly
	Child alert	4) Syp Crocin / Ibugesic - SOS
	Vitals stable	5) Send labs
	Afebrile	6) Inj Zofer SOS
	RS - B/L AE ⊕	
	P/A - soft	N I/R Abv.
	[signature]	

Dr. SPANDANA PASUPULETI Reg. No: 3092

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Master M.SHAURYANSH REDDY
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
27/6/26 8AM.	C/s/b Dr. Varma	
	- AFI c̄ dehydration / ? UTI	
	fever spikes - None	Plan
	Oral intake - Good.	- Ct. Amoxyclav.
	O/E - vitals stable.	- BP monitoring Q4H.
	S/E - WNL.	- CHASE blood/urine (TP) C/s (on OPD).
		- Monitor vitals.
		d/b Dr. Spandana [signature]

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
27/6 9:15am	C/S/D Dr Tejaswi	
	AFI c Dehydration ? UTI	(CRP - 57)
		Plan
	Fever - Better Oral intake - fair Abdominal pain - on & off	1) Inj Amoxyclav / Syp Meftal 2) Trace Blood c/s 3) Monitor Vitals Inform SOS
	Child alert Vitals stable R.S - B/L AE (+) P/A - soft	Dr. S. TEJASWI REDDY Registration No: 94068 Dr. Tejaswi
	N.B Amoxyclav @ 10AM	
27/6/26 2pm	S/B Dr. Archana AFI c dehydration (?UTI) No fever spikes oral intake fair O/E vitally stable S/E P/A - soft	Adv · Ct Inj AMOXYCLAV · Ct rest same · TRACE C&S (Blood) Dr. Archana 2pm

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

HNH-00015527 IP26-00006659
Master M.SHAURYANSH REDDY
24-09-2021 4 Y 9 M 2 D (M)
Dr. SPANDANA PASUPULETI

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
27/6 8:00 Am	C/s/b Dr. Spandana	
	AFI c dehydration ? UTI	
		Plan
	fever - better.	
		Ⓕ U/cls B/cls
	Vitals - stable.	
	R/S - B/L AE(+)	Pt Canula out
	P/A - pain abdomen (+)	send CRP
		Cont. Inj. Amoxiclav
	[signature]	NB Sm/h e 8 Am
		[signature]

Dr. SPANDANA PASUPULETI Reg. No: [illegible]

HNH-00015527 IP26-00006659
Master M.SHAURYANSH REDDY
24-09-2021 4 Y 9 M 2 D (M)
Dr. SPANDANA PASUPULETI

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	C/I/B Dr Naipunya	Dr. Prashanthi
28/6 7:00 Am	AFI c̄ dehydration ? UTI.	
		Plan
	fever - Absent.	- Trace B/Cs
	Vitals - stable.	- Cont Inj. Amoxiclav.
	R/S - B/L AE ⊕	- Plan D/C today
	P/A - soft, NT	- F/Up on monday c̄ CRP report
	U/Cs - No growth.	
		N/A [signature]

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

HNH-00015527 IP26-00006659
Master M.SHAURYANSH REDDY
24-09-2021 4 Y 9 M 4 D (M)
Dr. SPANDANA PASUPULETI

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
28/6	U/S/B - Dr. Spandana	
10:30 AM	Δ - AGE c Rehydration UTI	
	No fever	Plan
		24 h sterile ↓ Blood c/s
	Vitals stable	- Urine c/s
	S/E WNL	- Oral Amoxyclav ↓ Discharge.
		- F/up on monday c CRP
	[signature] Dr. SPANDANA PASUPULETI Reg. No: 3032	

HNH-00015527 IP26-00006659
Master M.SHAURYANSH REDDY
24-09-2021 4 Y 9 M 4 D (M)
Dr. SPANDANA PASUPULETI

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...SS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

HNH-00015527 IP26-00006659
Master M.SHAURYANSH REDDY
24-09-2021 4 Y 9 M 2 D (M)
Dr. SPANDANA PASUPULETI

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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						☐ C ☐ DC
2						☐ C ☐ DC
3						☐ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

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

Date & Time : ....26/6/26 @ 8 Pm....

Nurse Name & Signature: ....[illegible] / [signature]....

Date & Time : ....26/6/26 @ 8:02 pm....

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

HNH-00015527 IP26-00006659
Master M.SHAURYANSH REDDY
24-09-2021 4 Y 9 M 2 D (M)
Dr. SPANDANA PASUPULETI

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DRUG CHART

Date of Admission: 26-6-26 Drug Allergies: NIL ☐ 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 / through it and a similar line through subsequent recording panels.
- The date and time of stopping the drug along with the doctors name and sign must be mentioned.
- Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.

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

SOS / PRN (As Required Medication)

DRUG : SYP. CROCIN DS				Date ▸ Time ▾
Dose	Route	Frequency	Start Date	
5ml	PO	SOS	26/6	
Doctor's Signature		Valid Period	Pharm.	
[signature]				
Additional Instructions: (240/5)				

DRUG : SYP. IBUGESIC				Date ▸ Time ▾
Dose	Route	Frequency	Start Date	
5ml	PO	SOS	26/6	
Doctor's Signature		Valid Period	Pharm.	
[signature]				
Additional Instructions: (100/5); if temp. >101°F.				

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

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

HNH-00015527 IP26-00006659
Master M.SHAURYANSH REDDY (M)
24-09-2021 4 Y 9 M 2 D
Dr. SPANDANA PASUPULETI

REGULAR PRESCRIPTIONS

Weight. 15.27kg Ward. ....

DRUG : Inj. AMOXYCLAV.				Date ▸ Time	26/6	27/6/25	28/6
Dose	Route	Frequency	Start Date				
600mg	IV	Q12H	26/6	10PM			
Name & Signature of the Doctor Starting the Drugs:							
Additional Instructions:				10pm			
Daily Doctor's Endorsement by a Sign							

DRUG : SYP. AMBROXOL (MUCOLITE)				Date ▸ Time	26/6	27/6/25	28/6
Dose	Route	Frequency	Start Date				
2.5ml	PO	BD	26/6	10PM			
Name & Signature of the Doctor Starting the Drugs:							
Additional Instructions: MUCOLITE (30mg/5ml)				10pm			
Daily Doctor's Endorsement by a Sign							

DRUG : Inj. ESMAPRAZOLE				Date ▸ Time	27/6	28/6
Dose	Route	Frequency	Start Date			
15mg	IV	OD	27/6			
Name & Signature of the Doctor Starting the Drugs:				6am		
Additional Instructions:						
Daily Doctor's Endorsement by a Sign						

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

HNH-00015527 IP26-00006659
Master M.SHAURYANSH REDDY
24-09-2021 4 Y 9 M 2 D (M)
Dr. SPANDANA PASUPULETI

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

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

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

VERIFIED BY · Name .... Signature

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses

HNH-00015527 IP26-00006659
Master M.SHAURYANSH REDDY
24-09-2021 4 Y 9 M 2 D (M)
Dr. SPANDANA PASUPULETI

I.V. FLUIDS CHART

Weight. 15 Kgs. Ward. ....

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
26/6/24	10:30	IVF DNS (1/3rd M)	IV	35ml	[signature]	[signature]	2?/6	[signature]	[signature]

HNH-00015527 IP26-00006659
Master M.SHAURYANSH REDDY
24-09-2021 4 Y 9 M 2 D (M)
Dr. SPANDANA PASUPULETI

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RESULT SHEET

(opbarts)

Date	25/6/26					
Time	12.2					
Hb	12.2					
PCV	34.6					
RBC	4.41					
WBC	6.22					
N/L	52/37					
Platelets	202					
CRP	57.0					
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea	13					
Creatinine	0.3					
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells	2-4					
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						

Culture and Sensitivities : ....

Blood culture & sensitivity

....

....

Radiology : USG : ....

X-Ray : ....

ECHO : ....

CT : ....

MRI ....

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

RCH/ FRM / CLINICAL / 125

PRESCHOOL (1-5 years)
Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 2/6 ... Time: 10pm | 2Am. | 6Am

Doctor / Nurse / Family Concern?

	10pm	2Am	6Am
Heart Rate (Number)	103b/m	101b/m	118b/m
Resp. Rate (bpm) (Over 1 Minute) * (70 / 60 / 50 / 40 / 30 / 20 / 10)			
Resp Rate (Number)	26b/m	30b/m	26b/m
Resp Distress — Mod/ Severe			
Resp Distress — None / Mild			
Receiving O_2(l/min)			
O_2Saturations (%)	100%	100%	99%
Conscious Level — Normal			
Conscious Level — Altered			
GCS *			
TOTAL SCORE Number of shaded boxes	0	0	0
Pain Score	0	0	0
Observer's Initials	[illegible]	[illegible]	[illegible]

ACTIONS

NB: Scores 3 should be recorded overleaf

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

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

Patient Sticker

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Your Right to a Safe Delivery

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

HNH-00015527 IP26-00006659
Master M.SHAURYANSH REDDY
24-09-2021 4 Y 9 M 2 D (M)
Dr. SPANDANA PASUPULETI

FRM / CLINICAL / 125

PRESCHOOL (1-5 years)

Children's Observation & Early Warning Scoring Chart

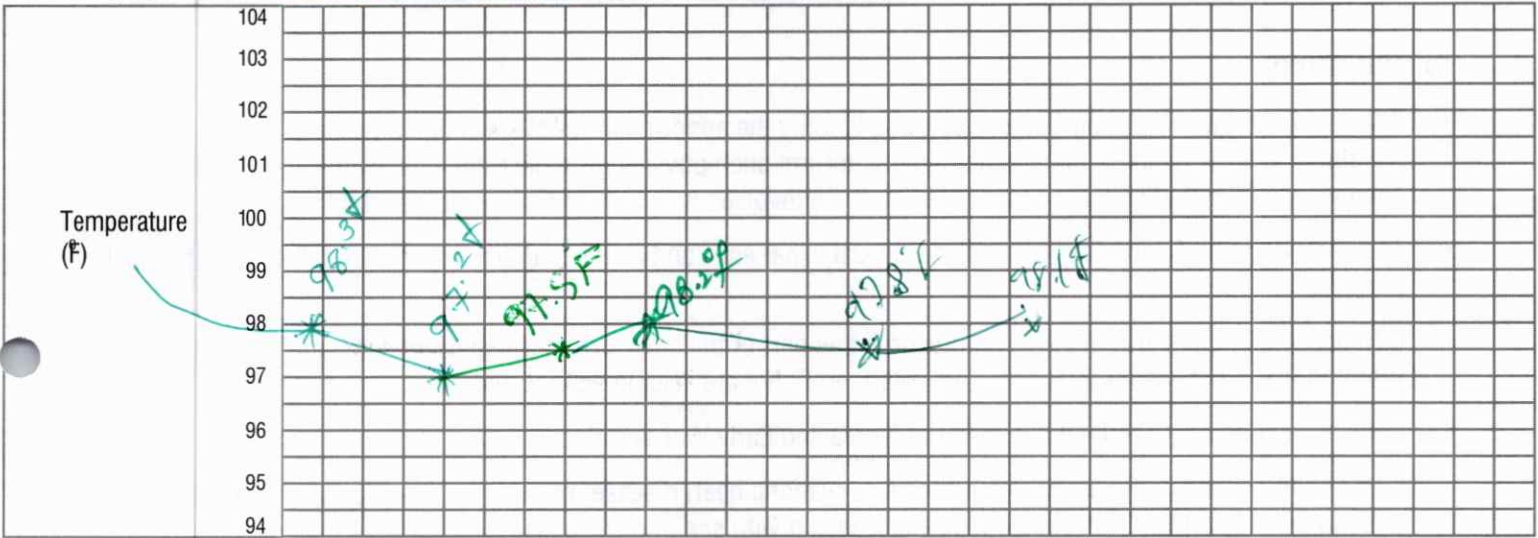
Pratiksha Rainbow Children's Hospital — It takes a lot to treat the little.

BirthRight BY RAINBOW HOSPITALS — Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 27/6 Time:	10Am	1pm	6pm	10pm	2Am	6Am
Doctor / Nurse / Family Concern?						

Temperature (F)



	10Am	1pm	6pm	10pm	2Am	6Am
Heart Rate (bpm) and Blood Pressure (mmHg) * (Note: BP does not score in early warning scoring)	101/65 (75)	102/67 (77)	98/65 (72)	100/60 (72)	108/65	97/60 (70)
Heart Rate (Number)	117b/m	120b/m	108b/m	102b/m	79b/m	75b/m
Resp Rate (Number)	25b/m	26b/m	23b/m	23b/m	23b/m	25b/m
Resp Distress — Mod/ Severe / None / Mild						
Receiving O_2(l/min)						
O_2Saturations (%)	100%	98%	99%	100%	100%	99%
Conscious Level — Normal / Altered						
GCS *				15/15		
TOTAL SCORE Number of shaded boxes	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0
Observer's Initials	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

Scale labels: Heart Rate 190, 180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60, 50; Resp. Rate (bpm) (Over 1 Minute) * 70, 60, 50, 40, 30, 20, 10

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
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Patient Sticker

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

HNH-00015527 IP26-00006659
Master M.SHAURYANSH REDDY
24-09-2021 4 Y 9 M 2 D (M)
Dr. SPANDANA PASUPULETI

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FLUID CHART

Sheet No. : ①

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

Date	Time	Intake				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											
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			35ml								
	09:00 pm			35ml								
	10:00 pm			35ml			0			0	0	
26/6	11:00 pm	DNS	RiLP	35ml	NO			NO				
	12:00 am		+	35ml								
	01:00 am		H₂O	35ml								
Total Intake :						Total Output :						
	02:00 am			35ml								
	03:00 am			35ml								
	04:00 am	DNS		35ml			0			0	0	
27/6	05:00 am			35ml	NO			NO				
	06:00 am			35ml								
	07:00 am			35ml								
Total Intake :						Total Output :						

Total 24 hrs. Intake		Total 24 hrs. Output	

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FLUID CHART

Sheet No. : ....

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

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							
27/6/26	08:00 am	DNS	Milk	35ml	NA		0		NA	2	0	[illegible]
	09:00 am		H2O	35ml								
	10:00 am			35ml								
	11:00 am			35ml								
	12:00 pm			35ml								
	01:00 pm			35ml								
Total Intake : Taken						Total Output : U—2M—O						
27/6/26	02:00 pm	DNS	Rice	35ml	NA			NA		✓	0	[illegible]
	03:00 pm		+	35ml								
	04:00 pm		H2O	35ml								
	05:00 pm			35ml								
	06:00 pm			35ml						✓		
	07:00 pm			35ml								
Total Intake :						Total Output : U-2 M-						
28/6	08:00 pm		Liq		Nil		✓	Nil		✓	0	[illegible]
	09:00 pm		H2O									
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						Total Output :						
28/6	02:00 am		H2O		Nil			Nil		✓	0	[illegible]
	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	

Docu. No. : RCH /FRM / CLINICAL / 092

HNH-00015527 IP26-00006659
Master M.SHAURYANSH REDDY
24-09-2021 4 Y 9 M 2 D (M)
Dr. SPANDANA PASUPULETI

NURSING CARE RECORD

Date: ....

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon							
Night	8pm 8Am	Assess the Baby condition → Checked vital & recorded Administer medication as per doctor advice → maintain I/o chart	8pm 8Am	Assisted the Baby condition Checked vital & recorded Administered medication as per doctor advice I/o maintained	It is stable	rechecked vital	[signature]

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NURSING CARE RECORD

Rainbow® Children's Hospital
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Date: 24/6/26

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 – 2pm	→ Assess the pt condition → monitor vitals → maintain I/O chart → ct IV fluids → ct antibiotics → pt on soft diet → IV cannula present	8am – 2pm	→ Assessed the pt condition → monitored vitals & recorded → maintained I/O chart → IV cannula present → ct fluids → pt on soft diet	→ pt is stable	→ rechecked vitals	[illegible]
Afternoon	2pm to 8pm	→ Assess the pt condition → monitor the vitals → maintain I/O chart → Administer medicat-ion as per drug chart	2pm to 8pm	→ Assessed pt condition → monitored vitals → maintained I/O chart → Administered medica-tion as per drug chart	Patient is stable	Re-checked vitals	[illegible]
Night	8pm – 8am	Assess the baby Check the vitals administer medication [illegible]	8pm – 8am	Assessed the baby Checked the vitals administered [illegible] [illegible]	administer [illegible]	Reassess the pt [illegible]	[illegible]

Docu. No: RCH /FRM / CLINICAL / 148

HNH-00015527 IP26-00006659
Master M.SHAURYANSH REDDY
24-09-2021 4 Y 9 M 2 D (M)
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NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:			Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:			
	Surgery / Procedure:			Post OP Day:			
BACKGROUND	Date / Shift	28/6/26 N	24/6/26 M	27/6/26 E2	28/6		
	Medical Condition (Any special condition to be noted):	–	–	–	–		
	Diet:	–	–	–	–		
ASSESSMENT	Allergy:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No
	Ventilation (RA, NP, NIV, VENTI):	–	–	–	–		
	Tubes/Drains/Catheter:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:	97.8 F	98.4F	98.3°F	98.6		
	Res:	30 b/m	20 b/m	23 b/m	24		
	SpO₂:	99%	100%	100%	99%		
	Pulse:	123 b/m	124 b/m	102 b/m	106		
	BP:	–	–	–	–		
	LOC:	–	–	–	–		
	Fall Risk Score:	–	–	–	–		
	Pain Score:	–	–	–	–		
	Skin Integrity	–	–	–	–		
Recommendations	Safety Needs:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No
	Physiotherapy:	–	–	–	–		
	Others Specify:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No
	Special Diet:	–	–	–	–		
	Critical Lab Test / Values:	–	–	–	–		
	Other Special Orders / Medications:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No
	PU Prophylaxis:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No
	DVT Prophylaxis:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No
	ADL (Dependent / Non Dependent):	–	–	–	–		
Post Operative Procedure Special Orders:		NA	NA	NA	–		
Handed Over By Name :		Niharika	Amrutha	Anusha	[illegible]		
Signature / ID :		[signature]	[signature]	[signature]	[signature]		
Date:		28/6/26	24/6/26	27/6/26	28/6		
Time:		8pm	2PM	8PM	8PM		
Taken Over By Name :		Amrutha	Anusha	[illegible]			
Signature / ID :		[signature]	[signature]	[signature]			
Date:		24/6/26	27/6/26	27/6			
Time:		8Am	2PM	8pm			

Docu. No. : RCH /FRM / CLINICAL / 097

Patient Sticker

NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:			Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:			
	Surgery / Procedure:			Post OP Day:			
BACKGROUND	Date / Shift						
	Medical Condition (Any special condition to be noted):						
	Diet:						
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Ventilation (RA, NP, NIV, VENTI):						
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:						
	Res:						
	SpO_2:						
	Pulse:						
	BP:						
	LOC:						
	Fall Risk Score:						
	Pain Score:						
	Skin Integrity						
Recommendations	Safety Needs:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Physiotherapy:						
	Others Specify:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Special Diet:						
	Critical Lab Test / Values:						
	Other Special Orders / Medications:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	PU Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	DVT Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	ADL (Dependent / Non Dependent):						
Post Operative Procedure Special Orders:							
Handed Over By Name :							
Signature / ID :							
Date:							
Time:							
Taken Over By Name :							
Signature / ID :							
Date:							
Time:							

HNH-00015527 IP26-00006659
Master M.SHAURYANSH REDDY (M)
24-09-2021 4 Y 9 M 2 D
Dr. SPANDANA PASUPULETI

CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1 26/6			DAY-2 24/6/26			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0			0	0	0	0				
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1			NA	NA	NA	0				
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2			NA	NA	NA	0				
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	0				
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	0				
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5			NA	NA	NA	0				
		Signature of the Nurse				[signature]	[signature]	[signature]	[signature]				

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 : [signature] Name : [signature]

Signature of Ward In Charge :

Signature : [signature] Name : [signature]

Docu. No. : RCH /FRM / CLINICAL / 137

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 cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5										
			Signature of the Nurse										

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

Signature of Shift In Charge :

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

Signature of Ward In Charge :

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

Docu. No. : RCH /FRM / CLINICAL / 137

HNH-00015527 IP26-00006659
Master M.SHAURYANSH REDDY
24-09-2021 4 Y 9 M 2 D (M)
Dr. SPANDANA PASUPULETI

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PAIN ASSESSMENT FORM

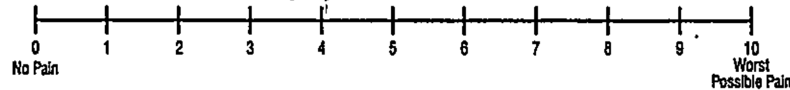
Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
26/6/26	10pm	0/10		☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	NAD	[signature]
27/6/26	10am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	NA	[signature]
28/6	6am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	NA	[signature]
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

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

PAIN ASSESSMENT TOOLS

Numerical Pain Scale (Obstetric and Gynecology)



Wong - Baker (Pediatrics) Above 7 Years

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

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

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

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Master M.SHAURYANSH REDDY
24-09-2021 4 Y 9 M 2 D (M)
Dr. SPANDANA PASUPULETI

BRADEN 'Q' SCALE

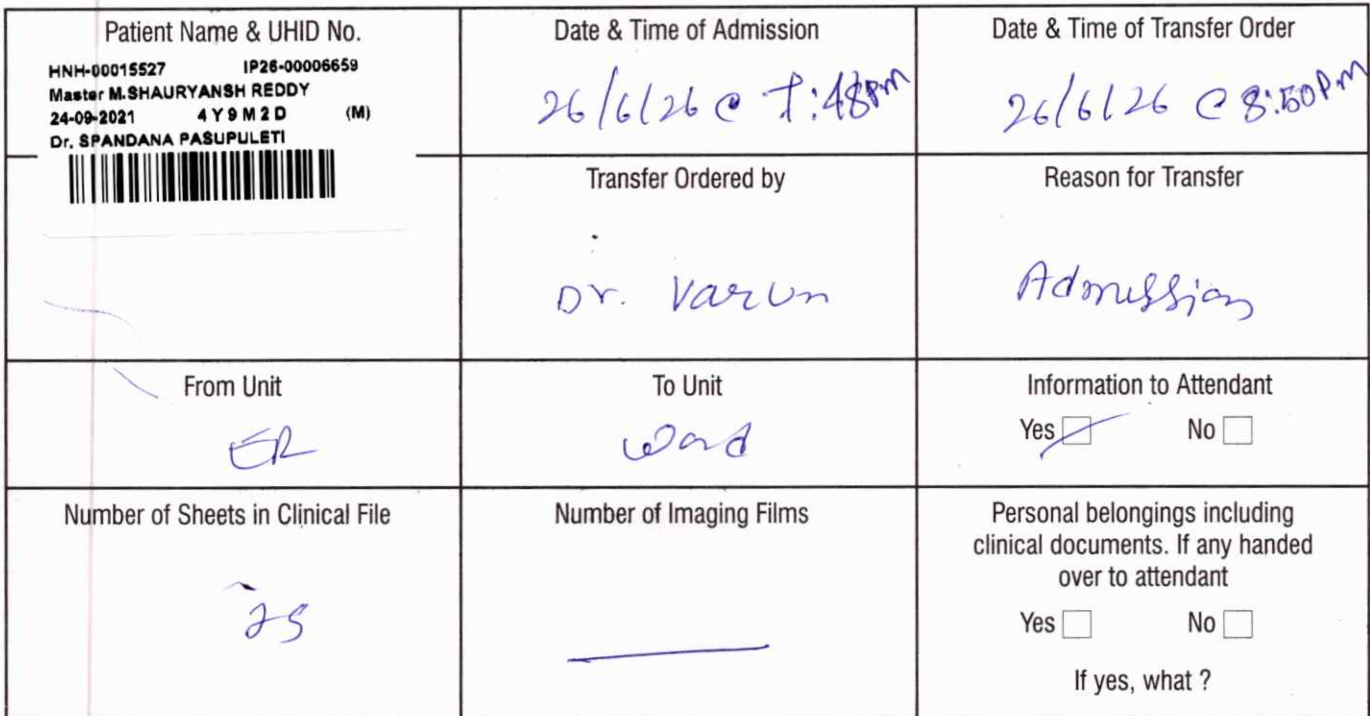
				Date : / Time :	26/6	27/6/26	27/6	28/6
					[illegible]	[illegible]	E2	[illegible]
Mobility	**1. Completely immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	**3. Slightly limited:** Makes frequent through slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.	4	4	4	4
"Activity The degree of physical activity"	**1. Bedfast :** Confined to bed	**2. Chairfast :** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	**3. Walks occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. All patients too young to ambulate; OR walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4	4	4
Sensory Perception	**1. Completely limited:** Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	**2. Very limited:** responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	**3. Slightly limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	**4. No impairment:** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	3	4	4	4
Moisture Degree to which skin is exposed to moisture	**1. Constantly moist:** Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	**2. Very moist:** Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	**3. Occasionally moist:** Skin is occasionally moist, requiring linen change every 12 hours.	**4. Rarely moist:** Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	4
FRICTION-SHEAR **Friction** Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another	**1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	**2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	**3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	**4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	4
Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4
				TOTAL SCORE	[illegible]	28	28	28
				Evaluator's Name	[illegible]	[illegible]	[illegible]	[illegible]

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

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

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

PATIENT TRANSFER FORM



Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00015527 IP26-00006659 Master M.SHAURYANSH REDDY 24-09-2021 4 Y 9 M 2 D (M) Dr. SPANDANA PASUPULETI	26/6/26 @ 7:48pm	26/6/26 @ 8:50pm
	Transfer Ordered by Dr. Varun	**Reason for Transfer** Admission
From Unit ER	**To Unit** Ward	**Information to Attendant** Yes ☑ No ☐
Number of Sheets in Clinical File 25	**Number of Imaging Films** —	**Personal belongings including clinical documents. If any handed over to attendant** Yes ☐ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

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

Shifting Summary / Notes Written by Doctor : Yes ☑ No ☐

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Anupam	Dr. Varun

Patient & Clinical Records Received by : [signature] 26/6/26 @ 9pm

Date & Time of Patient Received :

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

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

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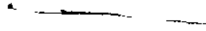

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Master M.SHAURYANSH REDDY
24-09-2021 4 Y 9 M 2 D (M)
Dr. SPANDANA PASUPULETI

W7 - 15.27

EMERGENCY ROOM TRIAGE FORM

Patient's Name : Master M. Shuryansh Age : 4 Y **Gender:** ☑ Male ☐ Female

Date : 26/6/26 Time of Arrival : 8 pm

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

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

Mode of Arrival : ☑ Ambulatory ☐ Wheelchair ☐ Ambulance

Initial Vital Signs: Temp: 100°F PR: 105 b/m BP: 96/62 RR: .... SpO_2: 100%

Chief Complaints: c/o fever since 3 days

INITIAL PHYSIOLOGICAL CATEGORIZATION	**INITIAL PHYSIOLOGICAL STATUS**
Appearance: ☑ Normal ☐ Sick Looking Circulation / Colour: ☑ Normal ☐ Abnormal ☐ Bleeding Work of Breathing: ☑ Normal ☐ Increased ☐ Decreased ☐ Gasping / Apnea	☑ Stable ☐ Unstable : ☐ Not – Life - Threatening ☐ Life – Threatening

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

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

Signature of Parent / Guardian

* CTAS - Canadian Triage and Acuity Scale

Triage Completion Time : 8:2P.M.

Communicable Disease Triage Screening

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

1. Have you had fever (elevated temperature) in the past 2 weeks ☐ Yes ☑ No
2. Have you had cough or a rash in the past 2 weeks ☐ Yes ☑ No
3. Have you had shortness of breath or difficulty breathing in the past 2 weeks ☐ Yes ☑ No

PART B. For patients reporting fever and respiratory/rash symptoms: ☐ **Not applicable**

1. Have you travelled outside the INDIA? or had close contact with someone who has recently travelled outside the INDIA, in the past two weeks? ☐ Yes ☑ No

   If yes, State Location: ....

2. Are your parents / close contacts at home is/a healthcare worker? {please encircle the choices} (e.g., nurse, physician, ancillary services personnel, allied health services personnel, hospital volunteer, or laboratory worker, others) who has had a recent exposure to an individual with a highly communicable disease or unexplained, severe febrile respiratory or rash disease? ☐ Yes ☑ No

PART C. A positive communicable disease triage screening is considered for any patient who meets one of the two following criteria:

☐ Any patient with Fever / Rash / Vesicles / Discharge from Eyes and Cough

☐ Any patient with fever and respiratory symptoms who answered "YES" to any of the questions on epidemiologic risk factors in "PART B" of the triage screening above.

PART D. ACTION / INTERVENTION: (for positive suspected communicable disease triage screening)

☐ Patients should be immediately isolated in a negative pressure room or a single room (as appropriate) for pending evaluation.

☐ The patient should be given a surgical mask immediately, if not already wearing one.

☐ Both patient and triage staff should perform hand hygiene.

☐ The staff should use PPE (as appropriate).

Name of Triage Nurse : Jyesh

Signature of Triage Nurse : ....

Date & Time : 26/6/26 @ 8:02 pm

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 26/6/26 Time of arrival : 8:04 pm

Chief Complaints: C/O fever since 3 days RBS: ....

Height : .... Weight : .... 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 NIL ☐ Location — ☐ Frequency — ☐ Duration —

RISK FOR FALL:

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

☐ If Patient is > 6 years
Assess the below parameters

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

Ambulatory Aids:

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

Gait/Transferring:

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

Mental Status: Forgets limitations ☐ Yes ☑ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening: ☑ No Abnormalities Detected

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

Inform consultant for positive criteria

....

....

Nutritional Screening: ☑ No Abnormalities Detected

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

Inform consultant for positive criteria

Psychological Screening: ☑ No Significant Findings

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

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

Social History: Lives With family

Siblings in household ☑ Yes ☐ No (if yes How Many?) 1

Time of Initial assessment completed by ER Nurse : 8:06 pm

Docu. No. : RCH /FRM / CLINICAL / 120

(P.T.O.)

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

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

Samples collected by: Apurba

Samples sent by :

Time: 8 Pm

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: 105 BP: 96/60 CFT: N/A	Shift - out from ER to: 216
RR: 25 SPO_2 : 99	Time of Shift - out: 8:55 Pm
GCS: 15/15 Temperature : 99	Handover given to: (Nurse's Name) [illegible signature]
Pain Score: 01	
Repeat RBS (if applicable): NO	

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 : [signature]

Date & Time : 26/6/21 @ 8:07

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Master M.SHAURYANSH REDDY
24-09-2021 4Y9M2D (M)
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NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 27/6/26 Time: 9:30am

Weight: 15.2 Kg Centile: 10th

Height: – Centile: –

Inference: Underweight child

RDA: – Calories: 1350 Kcal/day Protein: 23gms/day

Diet Recommendations: Balanced diet with dehydration

Re-Assesment: No Junk, Oily, spicy food

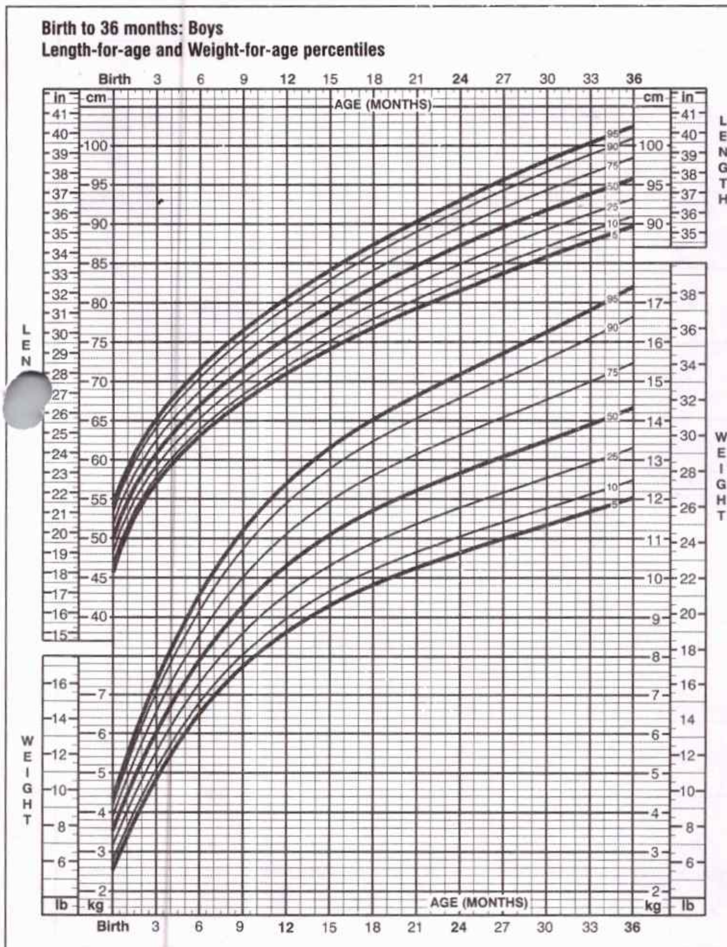
Food Allergies: NO Veg/Non-veg: Non Veg

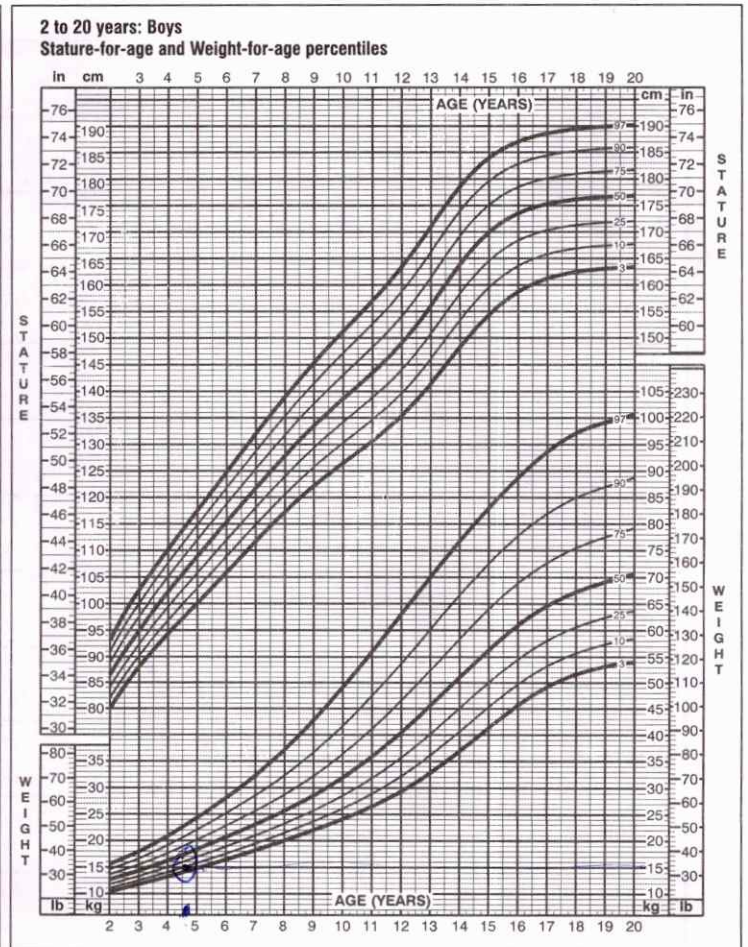
Diagnosis: AFI c dehydration ? UTI

Nutritional Intervention - ☑ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: Shubeetha

GROWTH CHART (BOYS)





Dietician's Name: Syeda Sobiya Zahar

Dietician's Signature: Sobiya

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

(P.T.O.)

Daily Notes: