

ADMISSION SHEET

Registration Details :

Admission No : IP26-00006644 Admit Date : 25-Jun-2026 Admit Time : 01:24 PM UHID : HNH-00015993

Patient Details :

Patient Name : Master DAIVIK SONTHALIA	Age : 0 Y 11 M 28 D
Guardian : Mr AYUSH SONTHALIA	DOB : 28-06-2025 01:00 AM
Gender : Male	Religion :
Occupation :	Martial Status :
Address (H) : 1-9-286/10/1 Vidyanagar Hyderabad Telangana INDIA 500044	Phone No : 8019025102
	E-mail : YUKTHIAGARWAL17@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 AYUSH SONTHALIA	Relationship : Father
Contact Address : 1-9-286/10/1 Vidyanagar Hyderabad INDIA 500044	Phone No : 8019025102


Doctor Details :

Doctor Name : Dr. SHRUTI SRIRAMPUR	Specialisation : GENERAL PEDIATRICS
Referral Doctor : Self.	Phone No :
Co-Consultant : Dr. PRITESH NAGAR	

Payment Details :

Payment Mode : Cash	Deposit Amount : 5000.00
	Payor Name : RELIANCE GENERAL INSURANCE COMPANY LTD

ACTIVI HNH-00015993 IP26-00006644
Master DAIK SONTALIA
28-06-2025 0 Y 11 M 28 D (M)
Dr. SHRUTI SRIRAMPUR

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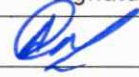
Name: ---  -----

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

Date of Admission: 25/6/26 Time: ----- Date of Discharge: ----- Time: -----

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
<u>25/06/26</u>	<u>2:53 pm</u>	<u>ER</u>	<u>ward</u>	

Cross Consultation Visit

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

Pediatric Multiorgan History & Physical Examination

HNH-00015993 IP26-00006644
 Master DAIK SONTALIA
 28-06-2025 0 Y 11 M 28 D (M)
 Dr. SHRUTI SRIRAMPUR



Name : Daivik Age/S

Informant _____ Reliability _____

Chief Presenting Complaints & Duration (Chronologically):

c/o Fever :: 9 day
 c/o Dull activity & reduced appetite :: 5 day
 c/o Vomiting :: 2 day
 loose stool :: on kaff :: 4 day

History of present illness :

child brought with

c/o Fever :: 9 day
 Persistent fever :: 9 day
 3-4 times / day
 102° F, not associated with chills
 no rashes
 no cold & cough

c/o Dull activity
 c/o Reduced oral intake } :: 5 day

c/o Vomiting :: 2 day
 Multiple episodes, Non bilious, non projectile
 Content food, foul smelling
 loose stool (3-4 multiple episodes) :: 4 day
 no c/o cold / cough
 no crying on micturition

(18/6) on OPD (Baby) } CBP - Hb - 10.1 / WBC - 6100 (N-65 / L-45) / PLT - 3.79
 CRP - 5
 5 Vials Respiratory Panel - Negative

Pediatric Multiorgan History & Physical Examination

HNH-00015993 IP26-00006644
Master DAIVIK SONTHALIA
28-06-2025 0 Y 11 M 28 D (M)
Dr. SHRUTI SRIRAMPUR



Anthropometry

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

Weight (kgs) 8.6 kg (Centile _____)

On Examination :

Temperature : 101°F Pulse Rate: 138/min Description _____

B.P. _____ SPO2 98% at _____

Resp. rate and type of breathing : 24/min

Rash _____ Signs of Dehydration (+) - Dull activity, sunken eye

Lymphadenopathy _____ Dry lips & oral mucosa

Oedema : _____

Respiratory system :

Throat - (-), Lungs - B/L wheezes

Inspection (any s/o distress) : _____

Air entry & breath sounds : B/L A/E (+)

Any added sounds : _____

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

Cardiovascular System :

Inspection of precordium : _____

Heart Sounds : S1S2 (+)

Any murmur : _____

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

Per Abdomen :

Inspection _____

Palpation : soft

Auscultation : _____

Spine: _____ External Genitalia : _____

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

Pediatric Multiorgan History & Physical Examination

HNH-00015993 IP26-00006644
Master DAIK SONTALIA
28-06-2025 0 Y 11 M 28 D (M)
Dr. SHRUTI SRIRAMPUR



Central Nervous System :

Level of Consciousness : AVPU/GCS Score : Dark & Irritable

Cranial Nerves : /

Motor System :

Nutrition : _____

Tone : _____ Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR

Superficials :

Plantars _____

Sensory System :

/

Bladder / Bowel : _____

Clinical Summary & Diagnostic :

Acute Febrile Illness - e Dehydration - Dg
? PVO

Pediatric Multiorgan History & Physical Examination

HNM-00015983 IP26-00006644
Master DAIK SONTALIA
28-06-2025 0 Y 11 M 28 D (M)
Dr. SHRUTI SRIRAMPUR



Preventive aspects of the treatment :

check

Desired goals of the treatment :

H'D stability

Planned Labs :

VBS

CBP , CRP

Blood c/s

CVE & Urine c/s (DUE)

WIDAL, LFT

Chest Xray + ventricle plan

VSG Abdomen

Noted By Brabin

Planned Management :

- Ij Ceftriaxon

- Ij Ondansetron

- Ij Esomeprazole

Noted By Brabin

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. Shantha / Dr. Prateek on _____
whose name the patient is being referred

Doctor's Signature Name [Signature] Date 25/6/26 Time _____



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
25/6/26	C/Plw Dr. Aniket / Dr. Shruti C/S/b - Dr. Prashant / Breghan	
6:06pm	A- PVO ↓ Evaluation	
	▲	
	Fever spike - 100.4 F	Hb ↓ N/L ⊕
	Orally ↓	
	Signs of dehydration better	<u>plan</u>
	o/e febrile	- Give Intradermal test dose → CEFTRIAXONE
	Vitals stable	Trace reports.
	o/e	Dnt.
	WAL -	

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
25/6/25 7:20 PM	S/D Dr. Pritish DPUO & dehydration Fever from 17 th	
	Loose stool 1-3-4 days - on wett	
	Vomiting: 2 days	
	No enlarged	Plan
	Cervical nodes	Send Mycoplasma IgM
	CVS - S ₁ & @	EBV Tetra panel (VCA) IgM
	M-DU-ACE@	CF CEFTRIAXONE
	PLA-JCC	- Add AZITHROMYCIN
	Concussion	- USG Chest - T/M
	X-ray chest	- Trace reports.
	Shows patchy opacities	- CF IV Fluids
		- send CUE
		/ (Signature)



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
- 25/6/26 7:50 PM	Case d/w Dr. Parkash Baby has erythematous rash over the face, limbs & back after 1hr of starting CEFTRIAXONE	PLG - stop CEFTRIAXONE - Inj. Hydrocortisone 2mg IV stat - Syp. Cetirizine 2.5ml bed time
		- Trace reports - PA (A) - (unpl) - NB - Moutushi @ 5:30 PM
25/6/26 10 PM	SIB Dr. Shrutika Δ PVO & dehydration erythematous rash on face & back	PLG - her subsided now - CE AZITHROMYCIN
	CVS - S ₁ S ₂ ⊕ M - 300-A ⊕ P/A 50/6 Conscious	- CE IV fluids @ 22ml - Trace reports
[Signature]	Jewel Intake	- USA chest - T/M - Monitor vital - NB - Moutushi @ 12 AM



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
26/6/26 7AM	SIB Dr. Sneegha Δ PVO & dehydration	Dr. Sneegha Plan
	Fever spike @ Loose stool (⊕) Multiple WS S ₁ S ₂ @ RS-BLW-ACF ⊕	CF AZITHROMYCLIN Trace Mycoplasma IgM EBV-VCA IgM WIDAC Blood C ^e
	PIA → S ₂ C conclusion.	cf IV fluids
		USG chest in the morning IV - NS 80ml over 1 hour prolyte ORS as accepted - Alentum rice feed NB - Monitor CBAM
26/6/26 8:45 AM	SIB Dr. Sneegha cf loose stool multiple loose stool 10-15 episodes since morning Wetley in consistency	Plan - Add Pao G G drops 15° BD - REDOTRIC Sack I Sack BD

Handwritten signature

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	cl/b Dr. Paiteek	
28/06/25 9AM	<p>Di PVO - with dehydration</p> <p>Loose stool (Maltipol)</p> <p>fever - low grade</p>	
	<p>O/S - Cal - fever</p> <p>Alert & active</p> <p>Hydration ok</p>	
	S/E - PA: soft, NT	
		<p style="text-align: center;">Act</p> <ul style="list-style-type: none"> - Mix feeds - Syp Azithromycin - Trac Widal <p style="text-align: center;">Blood C/S</p> <ul style="list-style-type: none"> - Mycoplasma IgM - EBV - VCA IgM - USG chest to be done - Monitor vitals and <p style="text-align: center;">Inform Sop</p> <ul style="list-style-type: none"> - Trobil feeds
		<p><i>[Signature]</i></p>
		<p>N.B Amoxicillin e10AM</p>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
26/6/26	Dr. Shruti	
7:45 AM	<p>A - Pyrexia of unknown origin (?) Pneumonia (?) Gastroenteritis (dehydration) (?) viral diarrhoea ? Pneumonia</p>	
	<p>fever spikes multiple episodes of loose stools</p>	<p>Plan</p>
		<p>- continue IVP</p>
	<p>o/e vitals stable</p>	<p>- eps of ORS</p>
	<p>stc P/A - Soft</p>	<p>- add 150ml Nestum rice - continue Azithromycin - Trau investigations</p>
		<p>- collect urine sample</p>
	<p>not</p>	<p>- AZITHROMYCIN</p>
		<p>- Rash cream - PROCTO GUARD-T/ oint</p>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
26/6 3:00pm.	<p>CLSIIS Dr. Naipuge</p> <p>puo 2 dehydration.</p>	
	<p>fever spikes (+).</p>	<p>Plan</p>
	<p>loose stools (+) (4 times)</p>	
	<p>Vitals - stable.</p>	<p>Cont. IVF.</p>
	<p>RIS - BILAE (+)</p>	<p>Cont Azithromycin</p>
	<p>PIA - soft, NT.</p>	<p>Cont Isomil.</p>
	<p>U/O/P - Adequate</p>	<p>Trace. Urine sample.</p>
		<p>Cont Z EID drops PRO GA. drops Radottid. Salt</p>
		<p>Monitor vitals</p>
		<p>NB Sntk ESD</p>
		<p>Deef</p>




PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/6/25 5pm	1/8/B - Dr. Prithesh Δ - AGE E Rehydration ? AT	Pneumonia evaluation
	Oral intake improving loose stools + diaper rash	Plan - ↑ Oral intake further
	fewer bottles	- Sitz Bath Juice daily
	O/E child sleeping	- (fluor)
	vital & stable	- of Azithromycin
	S/E diaper rash +	- Trace culture 3 to 4 urine Mycoplasma
	7/8 - Soft	- Trace EBV Igm rehydration N. B. Babbar (M)



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
26/6/26 9:45 AM	<p>ds/b Dr. Shruti</p> <hr/> <p>D-AGEE dehydration.</p> <hr/> <p>Oral intake improving.</p> <p>Diaper rash ⊕</p> <p>loose stools ⊕</p> <p>fever spikes ⊕</p> <p>FE - WNL.</p> <p>SE - WNL.</p> <p>PA - SNA, XT, BT.</p>	<p>Plan</p> <hr/> <p>Sitg bath twice daily.</p> <p>Cl. Agee sup.</p> <p>Trace blood urine ds.</p>
		<p>N/B of umb.</p>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
27/6/26	G/S/B Dr. Prateek	
9:30 AM	Δ - AGE	
<p>o/e vitally stable</p> <p>s/e wnl</p>	<p>No fever spikes ∴ 22 hours</p> <p>loose motions - better</p> <p>oral intake - fair</p>	<p><u>Adv</u></p> <ul style="list-style-type: none"> • ZVF (↓) to 15 cc/hour • CT Azithromycin • CT symptomatic support • CT sitz bath BS • ⊕ blood c&s, urine c&s (24 hrs no growth)
<p>N.B Amputia @ 10AM</p> <p><u>(M)</u></p>		
27/6/26 2pm	S/B Dr. Archana Δ : AGE & dehydration	
<p>o/e vitally stable</p> <p>s/e wnl</p>	<p>No fever spikes</p> <p>loose stools ⊕</p> <p>Good oral acceptance</p> <p>No fresh complaints</p>	<p><u>Advice</u></p> <ul style="list-style-type: none"> - Ct Azithromycin symp - Ct rest same <p><u>(A)</u> Dr. Archana</p>

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
27/6/25 2:30pm	S/B De Shanti	
	A: AGE c dehydration	Adv
	No fever spikes	Reassess tonight
	loose stools ⊖	Plan for discharge clm
	Urine } passing adequately	- Ct Azithromycin syrup.
	ok stool } vitally stable	- Ct rest same
	vital stable	- wait on IV cannulation
	vital stable	as patient is active &
	vital stable	accepting well orally.
	vital stable	
	vital stable	
	vital stable	
	vital stable	
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	vital stable	
	vital stable	
	vital stable	



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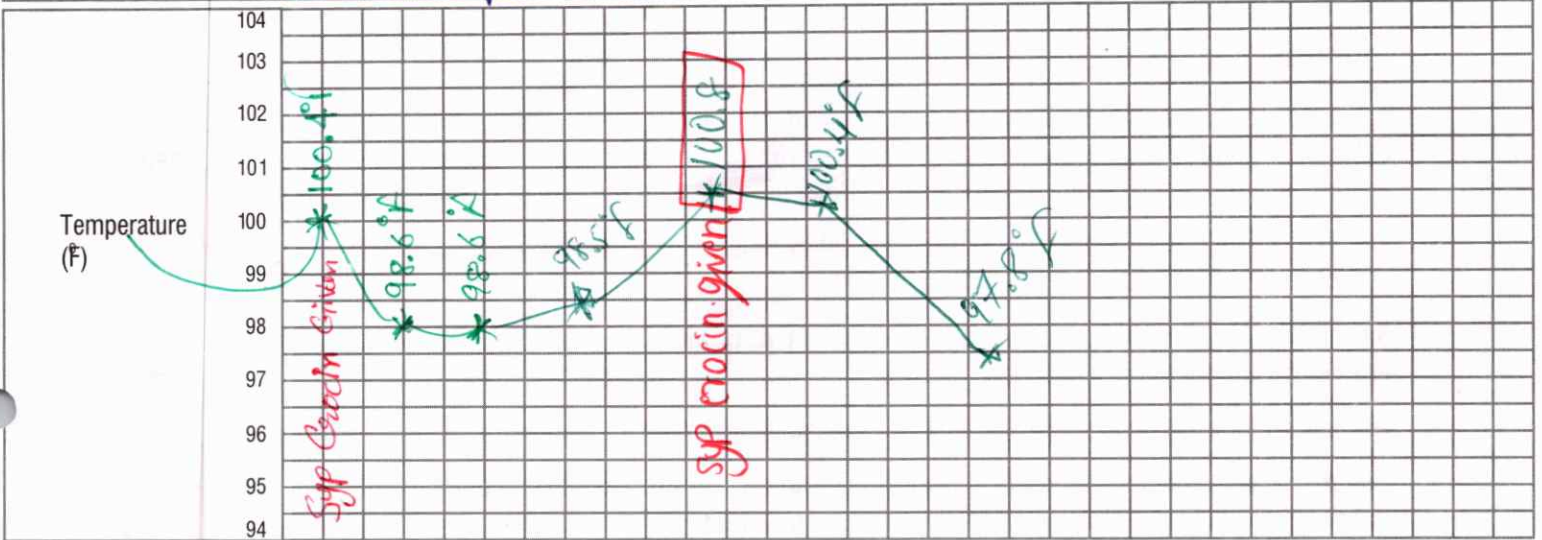
RESULT SHEET

Date	1866	25/6/25				
Time		3:30pm				
Hb	10.1	10.0				
PCV		28.6				
RBC		3.86				
WBC	6100	9.83				
N/L	45/6	40/53				
Platelets	377000	667				
CRP	5	5				
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT		18				
SGOT		39				
T.Bill/Conj		0.5/0.2				
T.Protein		6.7				
S.Albumin		4.2				
S.Globulin		2.5				
A/G Ratio		1.6				
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 25/6/26 Time: 3:30 5 6 10pm 2:30am 3Am 6Am

Doctor / Nurse / Family Concern? pm pm pm



Heart Rate (bpm) and Blood Pressure (mmHg) *					
Note: BP does not score in early warning scoring					
Heart Rate (Number)	134bbs	130bbs	137blm	135blm	127blm

Resp. Rate (bpm) (Over 1 Minute) *					
Resp Rate (Number)	30bbs	28bbs	30blm	30blm	30blm

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

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

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

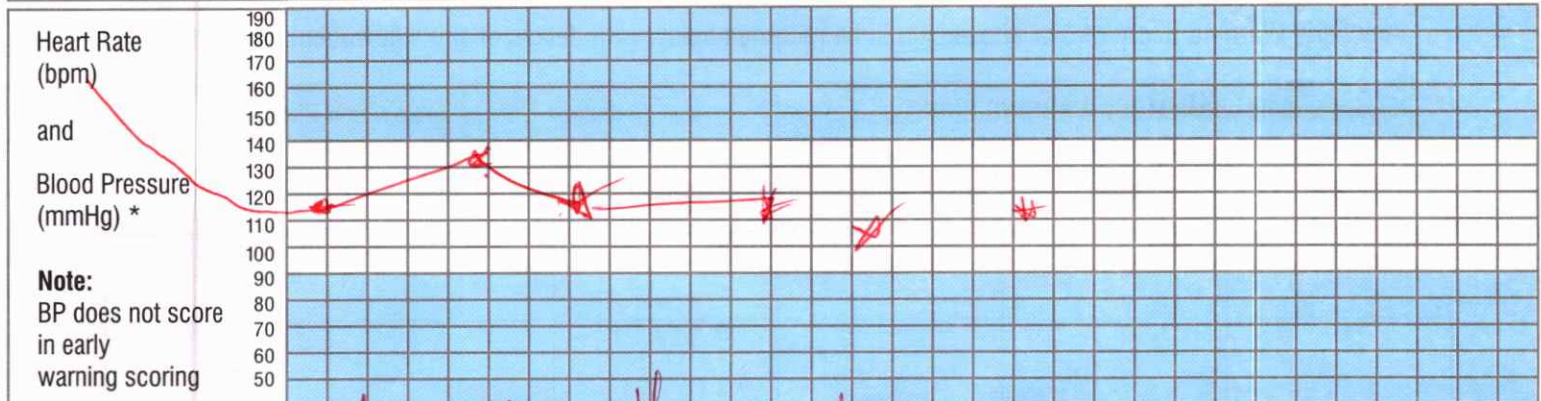
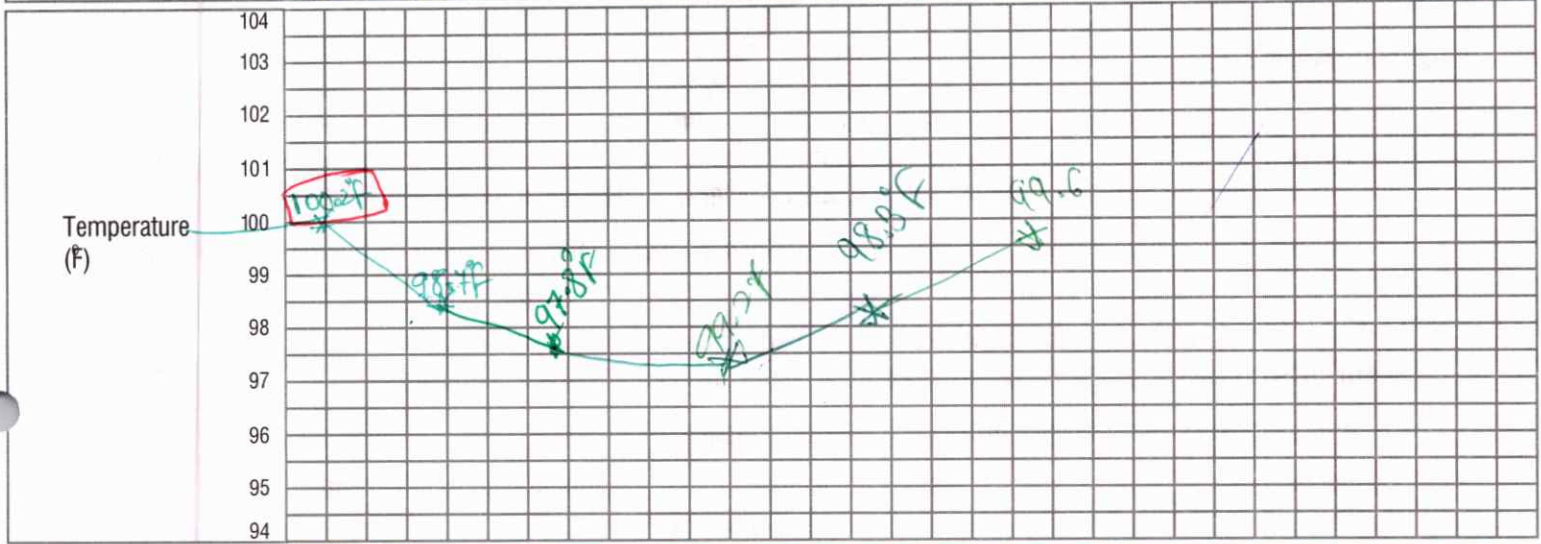
- If at any time additional help is required, call help – regardless of the Early Warning Score!
- Following a Early Warning Score assessment, senior help may be required

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

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date	26/6/25	Time:	11 AM	2 PM	6 PM	10 PM	2 AM	6 AM
Doctor / Nurse / Family Concern?	Am	PM						



Note:
 BP does not score in early warning scoring

Heart Rate (Number)	108b/m	131b/m	118b/m	124b/m	126b/m	108b/m
Resp. Rate (bpm) (Over 1 Minute)	20	20	20	20	20	20
Resp Rate (Number)	20b/m	20b/m	20b/m	20b/m	20b/m	20b/m

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

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

ACTIONS	Score 1 : Continue normal observation by staff nurse
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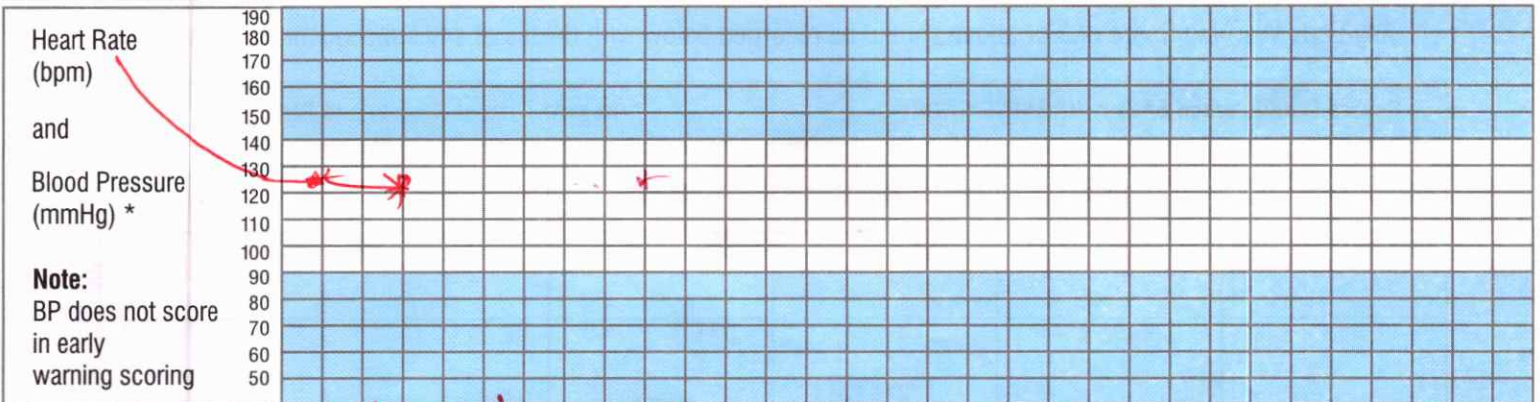
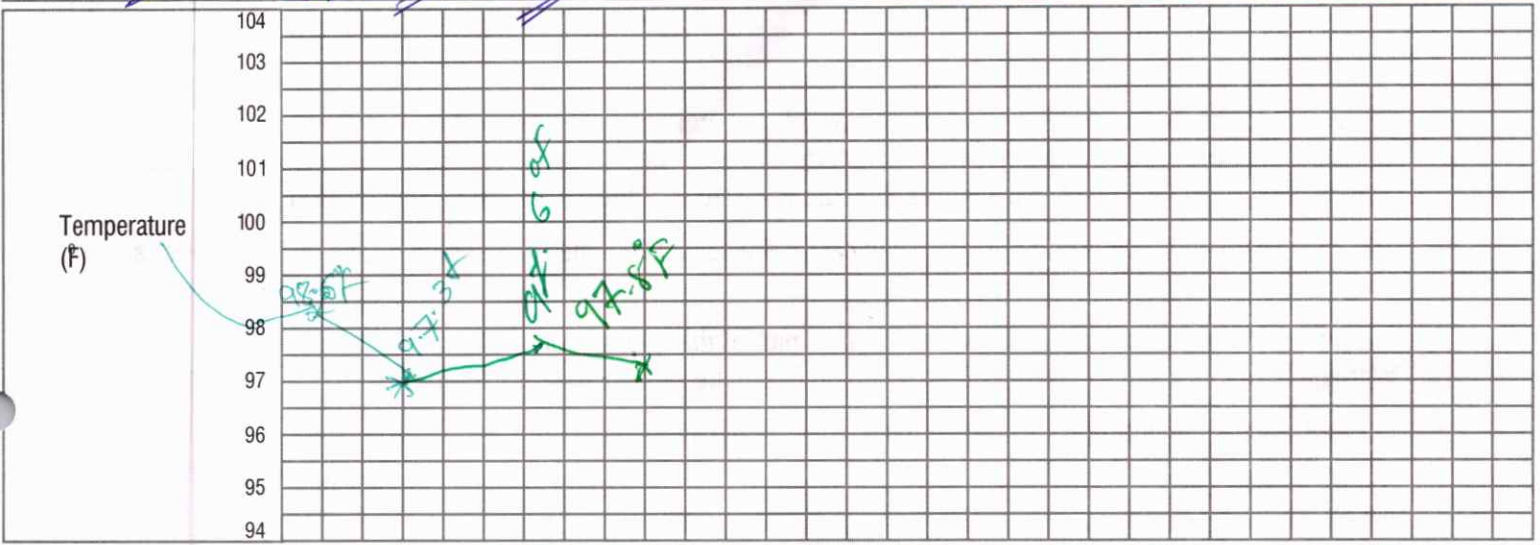
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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 27/6 Time: 10 am 1pm 4 pm 6 pm
 Doctor / Nurse / Family Concern? Am pm pm



Note:
 BP does not score in early warning scoring



Heart Rate (Number)	128b/m	126b/m	128b/m
Resp Rate (Number)	28b/m	26b/m	28b/m
Resp Mod/ Severe Distress			
Receiving O ₂ (l/min)			
O ₂ Saturations (%)	100%	98%	99%
Conscious Level	Normal	Normal	Normal
GCS *			

TOTAL SCORE			
Number of shaded boxes	0	0	0
Pain Score	0	0	0
Observer's Initials	<u>SH</u>	<u>SH</u>	<u>SH</u>

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- 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)



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 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 :							
25/6/26	02:00 pm											
	03:00 pm	PlasmaLyte		22ml								
	04:00 pm	milk		22ml								
	05:00 pm			22ml								
	06:00 pm			22ml								
	07:00 pm			22ml								
Total Intake : Taken					Total Output : U-2 M-1							
25/6/26	08:00 pm			22ml								
	09:00 pm	PlasmaLyte		22ml								
	10:00 pm			22ml								
	11:00 pm	milk		22ml								
	12:00 am			22ml								
	01:00 am	milk		22ml								
Total Intake :					Total Output :							
26/6/26	02:00 am			22ml								
	03:00 am			22ml								
	04:00 am	PlasmaLyte		22ml								
	05:00 am	milk		22ml								
	06:00 am			22ml								
	07:00 am			22ml								
Total Intake :					Total Output :							
Total 24 hrs. Intake					Total 24 hrs. Output							

FLUID CHART

Sheet No. :

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
26/6/26	08:00 am			20ml							1	} (K)
	09:00 am	plasmalyte	Milk	22ml		✓	NA		urine motion	6		
	10:00 am		Milk	22ml								
	11:00 am	25% D	Milk	22ml	NA	✓			urine motion	1		
	12:00 pm			22ml								
	01:00 pm			22ml		✓						
Total Intake : taken						Total Output : U - M -						
26/6	02:00 pm			22ml		✓				0	} (K)	
	03:00 pm		ORS	22ml		✓			✓	0		
	04:00 pm	plasmalyte	Shabudam	22ml	NA		NA			0		
	05:00 pm	25% D		22ml		✓				0		
	06:00 pm			22ml		✓				0		
	07:00 pm			22ml		✓				0		
Total Intake :						Total Output : U - M -						
26/6	08:00 pm					✓				0	} (K)	
	09:00 pm	plasmalyte	Milk	22ml		✓				0		
	10:00 pm									0		
	11:00 pm	25% D			NA		NA			0		
	12:00 am		Milk	22ml		✓				0		
	01:00 am									0		
Total Intake :						Total Output : U - M -						
26/6	02:00 am			22nd		✓				0	} (K)	
	03:00 am									0		
	04:00 am	plasmalyte	Milk	22ml	NA	✓				0		
	05:00 am	25% D				✓				0		
	06:00 am		Milk							0		
	07:00 am			22nd		✓				0		
Total Intake :						Total Output :						

Total 24 hrs. Intake

Total 24 hrs. Output



FLUID CHART

Sheet No. :

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
27/6/26			Mouth	I.V	N.G								
	08:00 am			15ml						✓			
	09:00 am	PlasmoLyte	Milk	5ml						✓			
	10:00 am	25:10	Milk	15ml						✓			
	11:00 am		Milk	15ml						✓			
	12:00 pm			15ml						✓			
	01:00 pm			15ml						✓			
Total Intake : <i>taker</i>						Total Output : <i>U-3m-0</i>							
27/6/26	02:00 pm			15ml									
	03:00 pm	PlasmoLyte		15ml									
	04:00 pm		Milk	15ml						✓			
	05:00 pm	25:10		15ml						✓			
	06:00 pm		Milk	15ml						✓			
	07:00 pm			15ml						✓			
Total Intake :						Total Output :							
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
Total Intake :						Total Output :							
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
Total Intake :						Total Output :							
Total 24 hrs. Intake						Total 24 hrs. Output							

Patient Sticker



FLUID CHART

Sheet No. :

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

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

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

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



NURSING CARE RECORD



Date: 25/6/26

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				NA			
Afternoon	2pm	<ul style="list-style-type: none"> - Assess the pt Condition - Monitor vitals - maintain I/O Chart - medication Given as per drug chart 	2pm	<ul style="list-style-type: none"> - Assessed the pt Condition - monitored vitals - main I/O Chart - medication Given as per drug chart 	pt is stable	Rechecked vitals	} Manisha
Night	8pm	<ul style="list-style-type: none"> Assess the Baby conditions Monitor vital Maintain I/O chart medication given as per drug chart 	8pm	<ul style="list-style-type: none"> Assessed Baby general condition Monitor vital Maintain I/O chart medication given as per drug chart 	pt is stable	Rechecked vital	



NURSING CARE RECORD

Date: 26/6/25

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8am	→ Assess the pt condition	8am	→ Assessed the pt condition	→ pt is stable	→ rechecked vitals	Gie
	2pm	→ monitor vitals → maintain I/O chart → medication as per drug chart	2pm	→ monitored vitals & recorded → maintained I/O chart → Administered medication as per drug chart			
Afternoon	2pm	Assess the pt condition.	2pm	Assessed the pt condition	→ pt is stable	→ monitor vitals.	Sud
	6pm	Monitor vitals, record I/O chart. Provide the comfortable position.	6pm	Monitored vitals, record I/O chart. Provided the comfortable position.			
	8pm	Medication given as per doctor order.	8pm	Medication given as per doctor order.	→ vitals normal	→ maintained I/O chart	by
Night	8pm	Assess the baby condition	8pm	Assess the baby condition	→ pt is stable	→ checked vitals	G
	8am	check vitals & record Administer medication as per doctor advice maintain I/O chart	8am	checked vitals & recorded Administered medication as per doctor order maintained I/O chart			

HNH-00015993
 Master DAIVIK SONTALIA
 28-06-2025 0 Y 11 M 30 D (M)
 Dr. SHRUTI SRIRAMPUR



NURSING CARE RECORD



Date: 27/6/26

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 the pt condition	8am	→ assessed the pt condition	→ pt is stable	→ rechecked vitals	Dix
	2pm	→ monitor vitals → maintain I/O chart → Administer medication as per drug chart → IV cannula present	2pm	→ monitored vitals → maintained I/O chart → medication as per drug chart → G IV fluids.			
Afternoon	2pm	→ assess pt condition	2pm	→ assessed pt condition	Patient is stable	Re-checked vitals	Anusha Ad
	8pm	→ monitor the vitals → maintain I/O chart → Administer medical → Administer medication as per drug chart	8pm	→ monitored vitals → maintained I/O chart → administered medication as per drug chart			
Night							

Patient Sticker

NURSING CARE RECORD



Date:

Goals

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

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



CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	25/6/26 DAY-1			26/6/26 DAY-2			27/6/26 DAY-3			Remarks
				M	(E)	N	(M)	E	N	(M)	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0		NA	NA	NA	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	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	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	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	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	NA	NA	NA		
Signature of the Nurse					NA	NA	NA	NA	NA	NA	NA		

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

Signature of Shift In Charge:

Signature: Sneha Name: Sneha

Signature of Ward In Charge :

Signature: Balarani Name: Balarani

IP26-00006644
 Master DAJVIK SONTALJA
 28-06-2025 0 Y 11 M 30 D (M)
 Dr. SHRUTI BRIRAMPUR



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 :



BRADEN 'Q' SCALE

				Date :	25/6/25	25/6	26/6/25	26/6
				Time :	8:30	10:00	11:00	12:00
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	3
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	4
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	4
FRICION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	4
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings of meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4
				TOTAL SCORE	28	28	28	27
				Evaluator's Name	SR	SR	SR	SR

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

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



BRADEN 'Q' SCALE

				Date:	23/6/25	27/6		
				Time:	N/G	E		
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		
"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		
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4		
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		
FRICION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4		
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		
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		
				TOTAL SCORE	28	28		
				Evaluator's Name	<i>[Signature]</i>	<i>[Signature]</i>		

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

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

NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: AFI = day diet	Any Infection: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify:					
	Surgery / Procedure:	Post OP Day:					
BACKGROUND	Date	25/6/26	25/6/26	26/6/26	26/6/26	26/6/26	27/6/26
	Shift	E2	NU	MG	EL	NU	NS
	Medical Condition (Any special condition to be noted):	-	-	-	-	-	-
Diet:	-	-	-	-	-	-	
ASSESSMENT	Allergy:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	Ventilation (RA, NP, NIV, VENTI):	-	-	-	-	-	-
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	Vital Signs:	Temp: 98.6°F	98.1°F	98.2°F	98.2°F	98.5°F	97.2°F
	Res:	30b/m	28b/m	20b/m	22b/m	30b/m	20b/m
	SpO ₂ :	100%	99%	100%	99%	100%	99%
	Pulse:	137b/m	128b/m	120b/m	128b/m	124b/m	120b/m
	BP:	-	-	-	-	-	-
	LOC:	-	-	-	-	-	-
	Fall Risk Score:	-	-	-	-	-	-
Pain Score:	-	-	-	-	-	-	
Skin Integrity	-	-	-	-	-	-	
Recommendations	Safety Needs:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	Physiotherapy:	-	-	-	-	-	-
	Others Specify:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	Special Diet:	-	-	-	-	-	-
	Critical Lab Test / Values:	-	-	-	-	-	-
	Other Special Orders / Medications:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	ADL (Dependent / Non Dependent):	-	-	-	-	-	-
Post Operative Procedure Special Orders:	-	-	-	-	-	-	
Handed Over By Name :	Sushma	Abhishek	Arushi	Sru	Mansi	Divy	
Signature / ID :	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	
Date:	25/6/26	25/6/26	26/6/26	26/6	26/6/26	27/6/26	
Time:	8pm	8pm	2pm	8pm	8pm	2pm	
Taken Over By Name :	Abhishek	Arushi	Sushma	Sru	Divy	Arushi	
Signature / ID :	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	
Date:	25/6/26	26/6	26/6/26	26/6	27/6/26	27/6/26	
Time:	8pm	8am	2pm	8pm	8am	2pm	

NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify:						
	Surgery / Procedure:	Post OP Day:						
BACKGROUND	Date	27/6						
	Shift	E2						
	Medical Condition (Any special condition to be noted):	-						
	Diet:	-						
ASSESSMENT	Allergy:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Ventilation (RA, NP, NIV, VENTI):	-						
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input 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:	98.3p					
		Res:	22b/m					
		SpO ₂ :	100%					
		Pulse:	87b/m					
		BP:	102/61					
		LOC:	-					
		Fall Risk Score:	-					
	Pain Score:	0						
	Skin Integrity	Good						
Recommendations	Safety Needs:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Physiotherapy:	-						
	Others Specify:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Special Diet:	-						
	Critical Lab Test / Values:	-						
	Other Special Orders / Medications:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	PU Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input 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 type="checkbox"/> No	
DVT Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
ADL (Dependent / Non Dependent):	-							
Post Operative Procedure Special Orders:		-						
Handed Over By Name :		Anusha						
Signature / ID :		[Signature]						
Date:		27/6/26						
Time:		8pm						
Taken Over By Name :								
Signature / ID :								
Date:								
Time:								



REGULAR PRESCRIPTIONS

Weight. 8.3 kg Ward.

DRUG : Inj CEFTRIAZONE

Dose	Route	Frequency	Start Date	Date/Time
800mg	IV	once Daily	25/6	25/6

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

Additional Instructions: *1 vord 2 hem - After Test Dose*

Daily Doctor's Endorsement by a Sign

DRUG : Inj ONDANSETRON

Dose	Route	Frequency	Start Date	Date/Time
1.5mg	IV	TID	25/6	25/6, 26/6, 27/6

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

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG : SYP. AZEE

Dose	Route	Frequency	Start Date	Date/Time
2ml	PO	OD	25/08	25/6, 26/6

Name & Signature of the Doctor Starting the Drugs: *Sudhith D. Sankarthy*

Additional Instructions: *(5ml / 200mg)*

Daily Doctor's Endorsement by a Sign

DRUG : Z & O drops

Dose	Route	Frequency	Start Date	Date/Time
1ml	PO	OD	26/06	26/6, 27/6

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

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Verified by Dr. Dhakshayani

HNH-00015993 IP26-00006644
 Master DAJVIK SONTHALIA
 26-06-2025 0 Y 11 M 28 D (M)
 Dr. SHRUTI SRIRAMPUR



Sheet No:

REGULAR PRESCRIPTIONS

Weight 8.36g Ward

DRUG : Pro GA drops

Date/Time: 26/6/27/6

Dose	Route	Frequency	Start Dt.
15	oral	BD	26/6

Name & Signature of the Doctor Starting the Drugs:
B. Sange

Additional Instructions:
 10 AM @
 10 PM @

Daily Doctor's Endorsement by a Sign

DRUG : REDOTRIL Sachet

Date/Time: 26/6/27/6

Dose	Route	Frequency	Start Dt.
Sachet	oral	BD	26/6

Name & Signature of the Doctor Starting the Drugs:
B. Sange

Additional Instructions:
 10 AM @
 10 PM @

Daily Doctor's Endorsement by a Sign

DRUG : TSA NAPPA CREAM

Date/Time: 26/6/27/6

Dose	Route	Frequency	Start Dt.
1/4	TID	TID	26/06

Name & Signature of the Doctor Starting the Drugs:
Sanket

Additional Instructions:
 Change
 kit

Daily Doctor's Endorsement by a Sign

DRUG : PROCTOGUARD - Taint

Date/Time: 26/6/27/6

Dose	Route	Frequency	Start Dt.
1/4	Rectal	TID	26/6

Name & Signature of the Doctor Starting the Drugs:
Rint

Additional Instructions:
 SUCRALFATE
 OXETACAIN

Daily Doctor's Endorsement by a Sign

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

Signature
 VERIFIED BY - Name

Patient Sticker



Sheet No:

REGULAR PRESCRIPTIONS

Weight Ward

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

Signature
VERIFIED BY NAME



Weight. 8.3kgs Ward.

VARIABLE DOSE		Date Time	Nurse Sig.	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.	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
25/06	7:30 AM	Syr. XYZAL	2.5 ml	PO	Sunil	(Hold)
		(5ml/2.5mg)				
25/6	7:50 PM	Inj. Hydrocort	2mg	IV slow push	N	low sub
25/06	7:20 AM	Syr. XYZAL	2.5 ml	PO	Sunil	low sub
25/06	7 AM	IVF - NS	80ml over (hour)	IV	Sunil	low sub

Signature
Verified by: Name

Verified by
Dr. Dhakshayani

HNH-00015993 IP26-00006644
 Master DAIK SONTALIA
 28-06-2025 0 Y 11 M 28 D (M)
 Dr. SHRUTI SRIRAMPUR



MEDICATION RECONCILIATION FORM

Drug Allergies: None Not known any Drug Allergies

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

Shifting From: ER Shifted to: ward

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1						<input type="checkbox"/> C <input type="checkbox"/> DC
2						<input type="checkbox"/> C <input type="checkbox"/> DC
3						<input type="checkbox"/> C <input type="checkbox"/> DC
4						<input type="checkbox"/> C <input type="checkbox"/> DC
5						<input type="checkbox"/> C <input type="checkbox"/> DC
6						<input type="checkbox"/> C <input type="checkbox"/> DC
7						<input type="checkbox"/> C <input type="checkbox"/> DC
8						<input type="checkbox"/> C <input type="checkbox"/> DC
9						<input type="checkbox"/> C <input type="checkbox"/> DC
10						<input type="checkbox"/> C <input type="checkbox"/> DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: Dr. pranav

Date & Time: 25/6/26 @ 11:10pm

Nurse Name & Signature: Atonu / [Signature]

Date & Time: 25/06/26 @ 11:15pm

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



210

NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 25/6/26 Time: 6:40 PM

Weight: 8.74 kg Centile: 10th

Height: - Centile: -

Inference: underweight child

RDA: - Calories: 88 kcal/kg/d Protein: 1.6 gms/kg/d

Diet Recommendations: NAN PRO (2) 1:30ml dilution.

Re-Assessment: stage (3) weaning foods & HEE advised

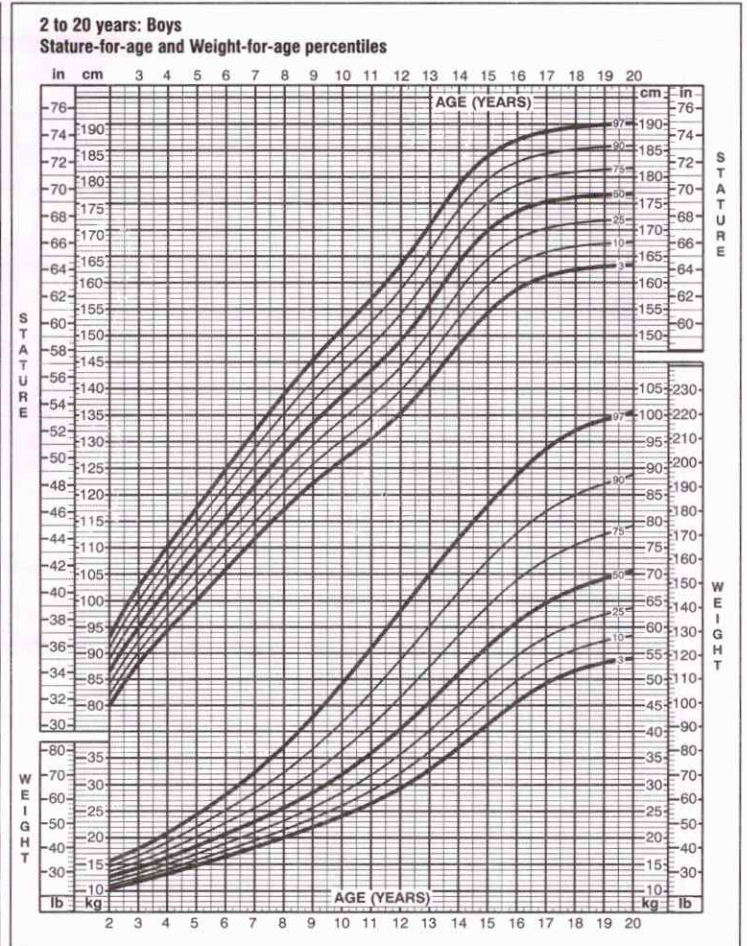
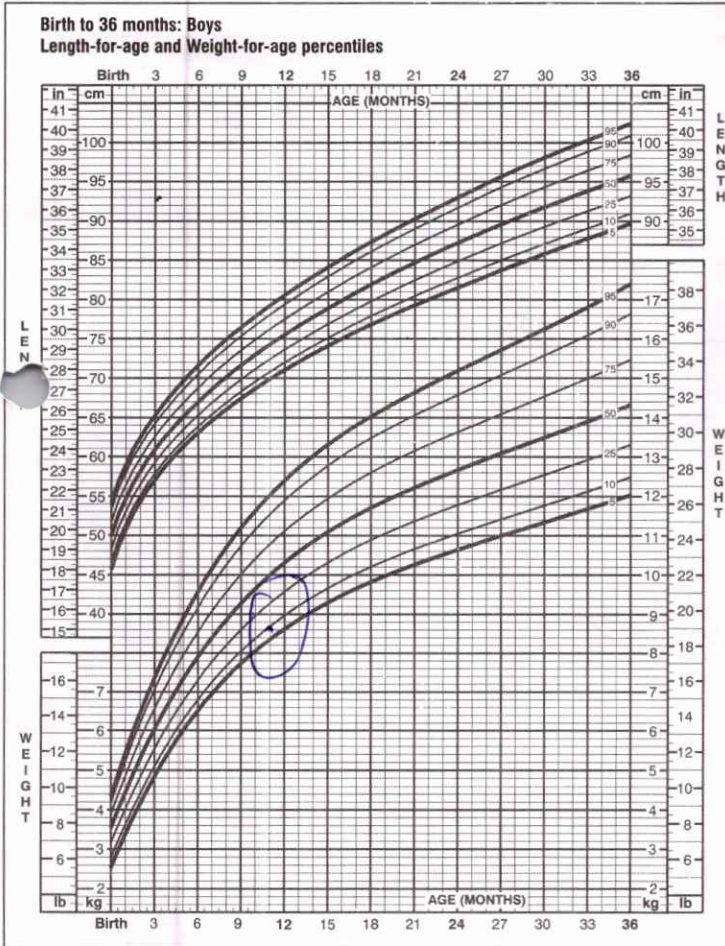
Food Allergies: ND Veg/Non-veg: veg

Diagnosis: PRO & malnutrition

Nutritional Intervention - Oral Enteral Parenteral

Patient's Signature: *Yudethi*

GROWTH CHART (BOYS)



Dietician's Name: Sathwika-G

Dietician's Signature: *SS*

wt - 8.7kg



EMERGENCY ROOM TRIAGE FORM

Patient's Name : Master DAIVIK SONTHALIA Age : 11 months Gender : Male Female
 Date : 25/06/26 Time of Arrival : 1:15pm

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: 99.8°F PR: 130b/m BP: RR: SpO₂: 98%
 Chief Complaints: elo Fever since 0 dose

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

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 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 : 1:17pm

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 : ~~Alamy~~ Apurba

Signature of Triage Nurse : [Signature]

Date & Time : 25/06/26 @ 1:17pm



NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 25/06/26 Time of arrival : 1:10 pm.

Chief Complaints: elo Fever since admit. RBS:

Height : Weight : 8.74kg 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 Location Frequency Duration

<p>RISK FOR FALL:</p> <p><input checked="" type="checkbox"/> If patient is < 6 years tick below fall risk intervention directly</p> <p><input type="checkbox"/> If Patient is > 6 years Assess the below parameters</p> <p>History of Falling: within past 3 months <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Ambulatory Aids:</p> <ul style="list-style-type: none"> Wheelchair <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Uses furniture for support <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <p>Gait/Transferring:</p> <ul style="list-style-type: none"> Bedrest / immobile <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Weak <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Impaired <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <p>Mental Status: Forgets limitations <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>IF YES FOR ANY CATEGORY = RISK FOR FALLING</p> <p>Fall Risk Intervention:</p> <p><input type="checkbox"/> Escort while ambulating</p> <p><input checked="" type="checkbox"/> Assist Patient</p> <p><input checked="" type="checkbox"/> Educate patient and family on fall precautions/prevention</p>	<p>Functional Screening: <input checked="" type="checkbox"/> No Abnormalities Detected</p> <p><input type="checkbox"/> Mobility Problem</p> <p><input type="checkbox"/> Walking Problem</p> <p><input type="checkbox"/> Developmental Delay</p> <p><input type="checkbox"/> Musculoskeletal Congenital Abnormality</p> <p>Inform consultant for positive criteria</p> <p>.....</p> <p>.....</p> <p>Nutritional Screening: <input checked="" type="checkbox"/> No Abnormalities Detected</p> <p><input type="checkbox"/> Underweight</p> <p><input type="checkbox"/> Overweight</p> <p><input type="checkbox"/> Feeding Problem</p> <p><input type="checkbox"/> Special diet</p> <p><input type="checkbox"/> Special feeding method</p> <p>Inform consultant for positive criteria</p>
---	---

Psychological Screening: No Significant Findings

Unusual concerns about patient's Psychological Status: Yes No

If Yes Consultant Notified: (Date/Time):

Social History: Lives With Family

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

Time of Initial assessment completed by ER Nurse : 1:10 pm

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

Time	Nursing Notes
	Assessed the Patient Condition
	maintain vitals Done.

Samples collected by: / *Bejatha @ 25/06/26*

Time: / *2pm*

Medication given in ER:

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

Condition of patient at time of shift - out :	Details of Shift - out
HR: <i>120b/m</i> BP: CFT: <i>25°C</i> RR: SPO ₂ : <i>98%</i> GCS: <i>15/15</i> Temperature: <i>98°F</i> Pain Score: <i>1/10</i> Repeat RBS (if applicable):	Shift - out from ER to: <i>ward</i> Time of Shift - out: <i>1:19pm</i> Handover given to: <i>[Signature]</i> (Nurse's Name)

Tick as applicable: MLC LAMA BROUGHT DEAD




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

Name of the Nurse : *Ahmed* Signature of the Nurse : *[Signature]*

Date & Time : *25/06/26 @ 1:19pm*

PATIENT TRANSFER FORM



HNH-00015993 IP26-00006644 Master DAIVIK SONTHALIA 28-06-2025 0 Y 11 M 28 D (M) Dr. SHRUTI SRIRAMPUR 		Date & Time of Admission 25/06/26 @ 1:24pm	Date & Time of Transfer Order 25/06/26 @ 8:30pm
Treating Consultant _____		Transfer Ordered by Dr. Pranav	Reason for Transfer Abortion.
From Unit ER	To Unit ward	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File 251-	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 <input type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring 		Name of Person Ordered Transfer Dr. pranav	
Patient & Clinical Records Received by :  @ 8:30pm			
Date & Time of Patient Received : 25/6/26			

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

- Unavailable Bed
 Nurse not Available
 Available Bed not ready

Patient Name	Master DAIVIK SONTALIA	Patient Ph. No	8019025102
Age	0 Y 11 M 29 D	Requisition No	R2626-007573
Gender	Male	Collected on	26-06-2026 09:41 AM
IP / Bill No.	IP26-00006644	Received on	26-06-2026 10:55 AM
UHID No.	HNH-00015993	Reported on	26-06-2026 10:55 AM
Ref. Doctor	SHRUTI SRIRAMPUR	Ward / Bed No	

ULTRASOUND CHEST

FINDINGS:

Multiple B lines noted in the bilateral posterior lung fields, predominantly in the mid and lower zones - suggestive subpleural septal congestion.

Both domes of diaphragm are moving normally with respiration.

Minimal non tappable bilateral pleural effusion noted, posteriorly thickness measuring 2 mm.

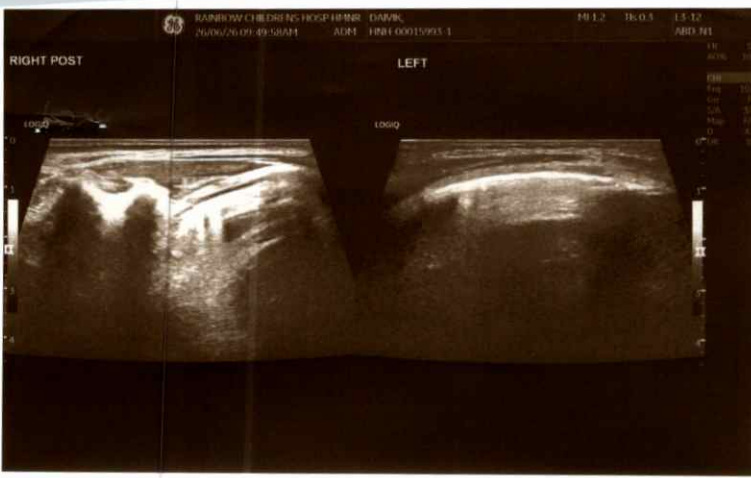
No obvious focal mediastinal lesions.

- **Suggested clinical correlation.**



Dr. YELMAREDDY POOJA REDDY
MD, CONSULTANT RADIOLOGIST
Reg No: 74406





Patient Ph. No	8019025102
Acquisition No	R2626-007560
Collected on	25-06-2026 02:13 PM
Received on	26-06-2026 01:23 PM
Reported on	26-06-2026 01:24 PM
Ward / Bed No	

AP VIEW

Dr. YELMAREDDY POOJA REDDY
MD, CONSULTANT RADIOLOGIST
Reg No: 74406

Patient Name	Master DAIVIK SONTHALIA	Patient Ph. No	8019025102
Age	0 Y 11 M 28 D	Requisition No	R2626-007561
Gender	Male	Collected on	25-06-2026 02:35 PM
IP / Bill No.	IP26-00006644	Received on	25-06-2026 02:44 PM
UHID No.	HNH-00015993	Reported on	25-06-2026 02:44 PM
Ref. Doctor	SHRUTI SRIRAMPUR	Ward / Bed No	

ULTRASOUND ABDOMEN

LIVER : Normal in size (8.7 cm) and echotexture. No intra hepatic biliary duct dilatation. Portal vein is normal. No focal lesions.

GALL BLADDER : Distended well and appears normal. No evidence of calculi or wall thickening. Common bile duct appears normal.

SPLEEN : Normal in size (6.1 cm) and echotexture.

PANCREAS : Normal in size and echotexture in head and proximal body. Rest obscured due to bowel gas.

KIDNEYS : Right kidney : 5.2 x 2.3 cm. Size just below the normal for the age and normal echotexture and shows smooth contour. No hydronephrosis or calculi.

Left kidney : 5.6 x 2.4 cm. Normal in size and echotexture and shows smooth contour. No hydronephrosis or calculi.

URINARY BLADDER : Empty.

No ascites.

Few non specific lower mesentery nodes noted.

Visualised bowel loops appear grossly normal. No obvious wall thickening noted in the visualised bowel loops.

Impression

- * Right kidney size just below the normal for the age.
- * Few non specific lower mesentery nodes.
- For clinical correlation.



Dr. YELMAREDDY POOJA REDDY

MD, CONSULTANT RADIOLOGIST

Reg No: 74406





Report

Patient Ph. No	8019025102
Acquisition No	HN26010115
Collected on	21-06-2026 08:11 PM
Received on	21-06-2026 08:31 PM
Reported on	22-06-2026 06:54 PM
Room / Bed No	

Influenza A or Influenza B or Respiratory syncytial

-2, Influenza A, Influenza B, and Respiratory syncytial viruses in the genes that encode the proteins: Influenza A matrix (M), influenza A basic polymerase (PB2), Influenza A surface protein (NS), and the RSV A and RSV B

GeneXpert System
Children's Medicare Limited, Road No.2, Banjara Hills,

Dr. RANGANATHAN N. IYER MD FRCPATH DNB DPB
(CONSULTANT MICROBIOLOGIST)

Report

For Further Details
Scan QR Code



Laboratory Report

Patient Name	Master DAIK SONTALIA	Patient Ph. No	8019025102
Age	0 Y 11 M 25 D	Requisition No	HN26010115
Gender	Male	Collected on	21-06-2026 08:11 PM
IP / Bill No.	2606-004320	Received on	21-06-2026 08:31 PM
UHID No.	HNH-00015993	Reported on	22-06-2026 06:54 PM
Ref. Doctor	Dr. SPANDANA PASUPULETI	Ward / Bed No	

RESPIRATORY PANEL (5 VIRUSES) (Specimen :THROAT SWAB)

RESULT

TEST RESULT STATUS : REPORT AUTHORISED

ADENOVIRUS PCR.

Test	Result
Specimen Type	Nasopharyngeal swab
ADENOVIRUS	NOT DETECTED

Comments :

Principle :

Real time polymerase chain reaction (PCR) for the amplification of specific target sequences of Adenovirus DNA and target specific probes for the detection of the amplified DNA

Note :

- 1.Test done using RealStar® Adenovirus PCR kit on QuantStudio™ 5 Real Time PCR System
- 2.Specimen processed at Molecular Testing Laboratory, Rainbow Children's Medicare Private Limited, Road No.2, Banjara Hills, Hyderabad.

For Further Details
Scan QR Code



Laboratory Report

Patient Name		Patient Ph. No	
Age	Master DAIVIK SONTHALIA	Requisition No	8019025102
Gender	0 Y 11 M 21 D	Collected on	HN26009974
IP / Bill No.	Male	Received on	18-06-2026 04:48 PM
UHID No.	2606-003669	Reported on	18-06-2026 05:11 PM
Ref. Doctor	HNH-00015993	Ward / Bed No	19-06-2026 12:05 AM
	Dr. SPANDANA PASUPULETI		

Investigation	Result	Unit	Biological Reference Interval
TEST RESULT STATUS : REPORT AUTHORISED			
C REACTIVE PROTEIN (Specimen : SERUM)			
CRP (Immunoturbidimetry)	5.0	mg/L	<10

Rashida

Dr. RASHIDA MAHREEN
MBBS,MD
CONSULTANT BIOCHEMIST
Reg No : HMC13081





Laboratory Report

Form containing patient details: Patient Name (Master DAIVIK SONTHALIA), Age (0 Y 11 M 21 D), Gender (Male), IP / Bill No. (2606-003669), UHID No. (HHH-00015993), Ref. Doctor (Dr. SPANDANA PASUPLETI), Patient Ph. No., Requisition No. (8019025102), Collected on (18-06-2026 04:48 PM), Received on (18-06-2026 05:11 PM), Reported on (19-06-2026 12:01 PM), Ward / Bed No.

Table with 4 columns: Investigation, Result, Unit, Biological Reference Interval. Includes 'COMPLETE BLOOD PICTURE (Specimen : BLOOD)' with values for Hemoglobin (10.1), RBC Count (3.85), PCV/HCT (28.5), MCV (73.8), MCH (26.1), MCHC (35.4), RDW-CV (13.1), Platelet Count (379), MPV (8.3), WBC Count (6.10), and Differential Count (Neutrophils 45, Lymphocytes 45, Monocytes 9, Eosinophils 1). Summary: RBC - NORMOCYTIC / NORMOCHROMIC, WBC - MORPHOLOGY NORMAL, PLATELETS - ADEQUATE.

INTERPRETATION

A Complete blood picture (CBP) is a screening test which can aid in the diagnosis of a variety of conditions and diseases such as anemia, leukemia, bleeding disorders and infections. This test is also useful in monitoring a person's reaction to treatment when a condition which affects blood cells has been diagnosed. All the abnormal results are to be correlated clinically.

DISCLAIMER

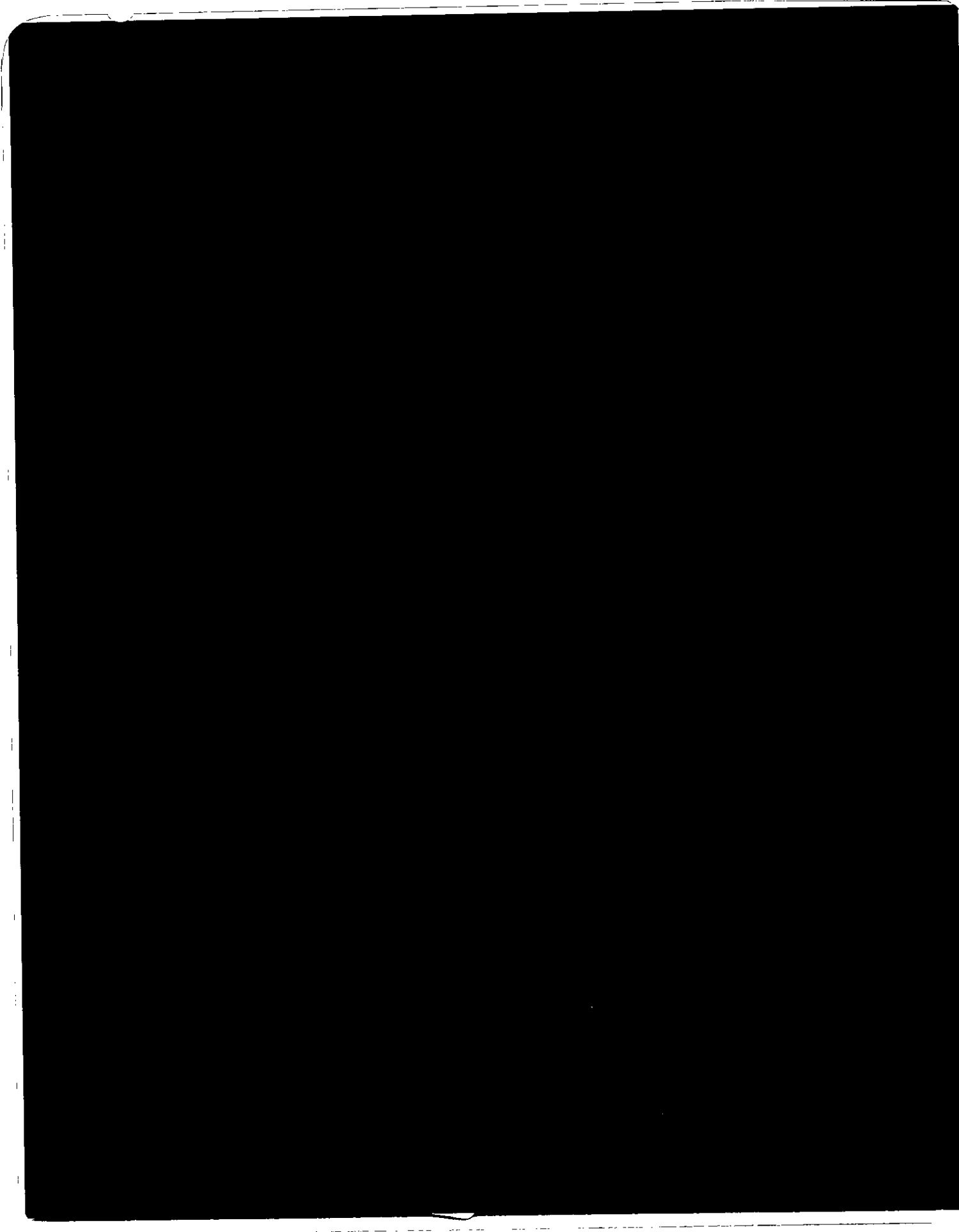
Test results released pertain to the specimen submitted. All test results are dependent on the quality of the sample received by the laboratory. Test Result may show interlaboratory variations. Laboratory investigations are only a tool to facilitate in arriving at a diagnosis and should be clinically correlated by the referring physician.

Handwritten signature of Dr. Muppala Raaga Sneha

Dr. MUPPALA RAAGA SNEHA

MD Pathology, Reg No: TSMC/FMR/20831

Results: Clinically Correlate Kindly discuss if necessary.



MASTER DADVIK SONTALIA 11M 28D M HNH 00015993 CHEST AP 25 JUN 25 2 43 PM
RAINBOW CHILDREN S HOSPITAL HIMAYATH NAGAR

Asis: -
puo 2 cephadryl