

HNH-00015974 IP26-00006584
 Master Y. HIMANSHU
 26-04-2023 3 Y 1 M 21 D (M)
 Dr. S TEJASWI REDDY



DEFICIENCY CHECK LIST OF CASE SHEET

Sl.No.	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission sheet	1			
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3	Nursing Initial assessment	1			
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8	Consultation sheet				
9	General consent for treatment	1			
10	Consent for Surgery				
11	Consent for blood transfusion				
12	Consent for chemotherapy				
13	Consent for high risk				
14	Consent for Restraint				
15	LAMA consent				
16	Consent for special procedure / Sedation				
17	Consent for Formula feed				
18	Consent for MTP				
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21	Anaesthesia notes (Pre Anaesthesia & post)				
22	Neonatal Admission/Delivery/Physical Exam				
23	Medication Reconciliation	1			
24	Emergency Triage record	1			
25	Pre operative check list				
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29	TPR & BP chart	2			
30	Intake and Out take chart (fluid chart)	1			
31	Drug chart (Regular Prescription)	1			
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33	Nebulization chart				
34	Nutritional review chart				
35	Intensive care unit (ICU Charts)				
36	Consent for Admission in PICU / NICU				
37	The Humpty dumpty scale	1			
38	Braden Q Scale	1			
39	Bed side check list				
40	PICU bed formula Dilution feeds				
41	Gastro monitoring chart				
42	Rch ED doctors note				
43	BP Monitoring chart				
44	RBS monitoring chart				
	Billing	1			
	Others	5			
	Total No. of Pages	<u>27</u>			

Signature and Date : 16/06/26
 Jayashree (P.T.O)

DISCHARGE SUMMARY

Name	Master Y.HIMANSHU	UHID	HNH-00015974
Father/Guardian	Mr SAI PRASAD.Y	Age/Gender	0 Y 1 M 23 D/ Male
Address	H.NO-6-1-119/8,PADMARAO NAGAR,NEAR SP COLLEGE, Dilsukhnagar Colony, Hyderabad, Telangana, INDIA, 500060		
IP No	IP26-00006584	Admission Date	14-06-2026
Ref Doctor	Self.		
Discharge Date	16.06.2026		

Consultant:

Dr. S TEJASWI REDDY

MBBS, MD Pediatrics, DM Neonatology
APMC/FMR/94068

DIAGNOSIS	ICD CODE
A/H/O THYRONORM POISONING	

History: Master Y.HIMANSHU, 0 Y 1 M 23 D , old boy presented with history of accidental consumption of thyronorm 75 mcg tablets, bottle had 10 tablets, consumed ? 1 tablet at 9:15 pm at his home, prior to admission. For the above complaints he was admitted at Rainbow Children's Hospital - for further management.

Examination: He was afebrile, maintaining saturations at room air. His heart rate was 103/min, Blood pressure - 100/60 mmHg and Respiratory Rate - 33/min. Capillary Refill Time was <2 secs. Peripheries were warm & pulses well felt. On examination bluish discoloration of tongue 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

Name	Master Y.HIMANSHU	UHID	HNH-00015974
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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: 12.9 kilo grams.

Investigations: Enclosed reports.

VBG showed pH of 7.39, pCO₂ of 36.9 mmHg, pO₂ of 50 mmHg, HCO₃ of 22.1 mmol/L and BE of -2.9 mmol/L.

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

He was regularly monitored for fever spikes, tachycardia, hypotension hemodynamic status. Child maintaining saturations on room air.

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

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

Fever Management

* Syrup. Crocin DS (Paracetamol - 5ml/240mg) 3.5 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.

Name	Master Y.HIMANSHU	UHID	HNH-00015974
IP No	IP26-00006584	Admission Date	14-06-2026

Review consultation with Dr. S TEJASWI REDDY on Thursday(18.06.2026) at Himayatnagar in OPD with prior appointment (**Review consultation will be charged**).

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

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

Parent/ Attender

In case of emergency contact 9154865030 emergency pediatrician on duty.

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

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

Dr. S TEJASWI REDDY
MBBS, MD Pediatrics, DM Neonatology
APMC/FMR/94068

Registrar/Resident/C.M.O



ADMISSION SHEET

Registration Details :

Admission No : IP26-00006584 Admit Date : 14-Jun-2026 Admit Time : 10:38 PM UHID : HNH-00015974

Patient Details :

Patient Name : Master Y.HIMANSHU **Age** : 3 Y 1 M 20 D
Guardian : Mr SAI PRASAD.Y **DOB** : 26-04-2023
Gender : Male **Religion** :
Occupation : **Martial Status** :
Address (H) : H.NO-6-1-119/8,PADMARAO NAGAR,NEAR SP COLLEGE Dilsukhnagar Colony Hyderabad
 Telangana INDIA 500060 **Phone No** : 9347067011/ 7032209316
E-mail : NA@GMAIL.COM

Admission Details :

Bed Type : TWIN SHARING **Bed No** : SPVT-303 **Ward Name** : 3F -SEMI PRIVATE
Room No : SPVT-303 **Admission Type** : First Visit

Contact Details :

Name : Mr SAI PRASAD.Y **Relationship** : Father
Contact-Address : H.NO-6-1-119/8,PADMARAO NAGAR,NEAR SP COLLEGE Dilsukhnagar Colony Hyderabad
 Telangana INDIA 500060 **Phone No** : 9347067011

Signature

Doctor Details :

Doctor Name : Dr. S TEJASWI REDDY **Specialisation** : GENERAL PEDIATRICS
Referral Doctor : Self. **Phone No** :
Co-Consultant :

Payment Details :

Payment Mode : DC/CC Card **Deposit Amount** : 20000.00
Payor Name : SELFPAY

ACTIVITY RECORD FOR BILLING

MLC

HNH-00015974 IP26-00006584

Master Y.HIMANSHU

Name: 23-04-2023 3 Y 1 M 22 D (M) Dr. S TEJASWI REDDY

UHID No: 

Consultant : _____ Dept : *pediatric*

Date of Admission : *14.10.2022* Time : _____ Date of Discharge : _____ Time: _____

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
<i>14/10/2022</i>	<i>11:25pm</i>	<i>ER</i>	<i>303</i>	<i>Tejaswi Reddy</i>

Cross Consultation Visit

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



PROCEDURE

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Date	Procedure	Quantity	Order No.	Signature
14/6/26	replacement	1	6705	[Signature]
14/6/26	MLC	1.	6776 6710	[Signature]
15/6/26 9:15 am	MFA	①	6832	[Signature]
<p><i>cross checked done by [Signature] @ 15/06</i></p>				

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date : _____ Time : _____ Prepared By : _____

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
-------------	--------------	-------------------	--------------------

Ref.No. F/IN/PR/10

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**Rainbow[®]
Children's
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**PEDIATRIC IN-PATIENT
MEDICAL RECORD**

MLC

HNH-00015974 IP26-00006584
Master Y.HIMANSHU
23-04-2023 3 Y 1 M 22 D (M)
Dr. S TEJASWI REDDY



Patient Name : Himanshu

Patient ID# : _____

Consultant : Dr. TEJASWI

Final Diagnosis : _____



Name: Himanshu Age/Sex Male / 3y 6m
Informant Mother Reliability Good

Chief Presenting Complaints & Duration (Chronologically):

Accidental consumption of Thyronorm tablets, at delshukrajar at 9:15 pm, quantity not known.

History of present illness :

→ A 3y 6m old child presented with complaints of ingestion of thyronorm tablets at home (delshukrajar) at 9:15pm, quantity - NOT known, Blue colour

Bottle had around 10 tablets, not much is missing from the bottle.

Post consumption child is active, interacting well

- last feed taken at 8:45pm
- last urine passed at 8:45pm

- Growth & Development (N) acc to Parents

- child not on any previous medications

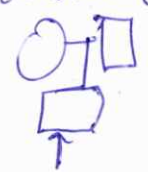


Past History : (Including details of any previous investigation or treatment)

Blank lined area for Past History.

Birth & Neonatal History :

Unremarkable, ^{KICLO} hypothyroidism on thyronorm 75mg
Term/LSCS/Bwt - 2.75kg
CIAB, Neonatal admission.



Birth & Socio Economic History :

About Father : _____

About Mother : _____

Any additional Information : _____

Developmental History :

(N)

Immunization History :

uptodate last at november-

Blank lined area for Immunization History.



Anthropometry

Head Circum (cms) _____ (Centile _____) Height (cm) : 92 (Centile _____)

Weight (kgs) 12.9 (Centile _____)

On Examination :

Temperature : 98F Pulse Rate: 103 Description Regular w/?

B.P. 100/60 SPO2 97% at RA

Resp. rate and type of breathing : 33/min

Rash No Bluish

Lymphadenopathy No Discoloration

Oedema : NO of Tongue

Respiratory system :

Inspection (any s/o distress) : (N) Shape

Air entry & breath sounds : NVBS+, BLACT

Any addes sounds : NO added sounds

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

Cardiovasclular System :

Inspection of procordium : (N) Shape

Heart Sounds : S1, S2+

Any murmur : NO murmur

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

Per Abdomen :

Inspection Soft, (N) Shape

Palpation : Non tender

Ausculation : BS+

Spine: n External Genitalia : n

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



Central Nervous System :

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

Cranial Nerves : none

Motor System :

Nutrition : _____

Tone : _____ Power _____

Co-ordinator : none

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR none

Superficials :

Plantars _____

Sensory System :

Bladder / Bowel : (N)

Clinical Summary & Diagnostic :

Accidental consumption of THYROXINE TABLETS at
home at 9:15pm.



Preventive aspects of the treatment :

Desired goals of the treatment :

monitoring for symptoms of Toxicity of Past Thyroxine emergency.

Planned Labs :

Collect - EDTA } Extra sample
- Plain }
- VBG

NIB studies

Planned Management :

NPO
Maintenance IV Fluids.

NIB studies

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 : _____
(Referring Mobile #)
4. Name of the doctor in Rainbow Team _____ on
whose name the patient is being referred

Doctor's Signature Name _____ Date _____ Time _____



MLC



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
14/8/26	C/S/B - Dr Prashant	
10pm	A - Accidental consumption of thyroxine tablets.	↓ BG (W)
	- Child, active, alert playful	
	- No fresh complaints	plan
		Monitor vitals Q4 hly
	O/E	Monitor for Tachy cardia.
	HR - 103/mr SpO2 - 97%	fever,
	RR - 33/m BP - 104/64 mmHg	irritability,
	V/O ✓ CFT < 3sec	sweating.
	P/P - well fed	dated by shrisha
	S/E	Pruthi
	R/S	
	CVS - WNL	
	CNS -	
	P/A ✓	

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
15/6/26	<u>C/S/B - Dr. Prashant / Dr. Naipunya n.</u>	
8:40 AM	<u>Δ - Accidental consumption of Thyroxine tabs.</u>	
	<u>Symptoms overnight</u> ↓ None	<u>Plan</u>
		- monitor for Tachycardia irritability Sweating
O/E	HR. 108bpm SpO2 99 BP - 90/60 RR - 32 CFT < 3 sec PP - well felt	- Break NPO > SPS > orally allow - monitor vitals QCH
S/E	NO Sweating RS - clear NS - wnl CVS - S1 S2, Normal P/A - wnl	- consider ps if no symptoms for 24h Purita

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 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	2/5/23 Dr. Tejaswi	
15/6/23 9:10 AM	<p>Accidental consumption of Myxovirine tabs.</p> <p>- Asymptomatic.</p> <p>- oral intake Good</p> <p>- NO fresh d/o.</p>	<p style="text-align: center; border: 1px solid black; padding: 5px;">Plan</p> <p>- observation.</p> <p>- Monitor vitals</p>
	<p>qE - vitals stable.</p> <p>HR - 100/min.</p>	<p>- Plan d/c if asymptomatic</p>
	<p>qE - well.</p>	<p>for 24 hrs</p> <p>- Stop IV fluids.</p>
		<p>Dr. S. TEJASWI REDDY Registration No: 94066</p> <p style="text-align: right;">Dr Tejan</p>

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IP26-00006584

Master Y. HIMANSHU

28-04-2023

3 Y 1 M 20 D

(M)

Dr. S TEJASWI REDDY



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
15/6 2pm	<p><u>C/S/R Dr. Prannav</u></p>	
	<p><u>Δ' - Accidental ingestion of Thyroxine tabs</u></p>	
	<p>No fresh vom</p>	<p><u>Plan</u></p>
	<p><u>Vitals</u></p>	<p>1) Encourage orally</p>
	<p>HR - 114/min</p>	<p>2) W/ tachycardia</p>
	<p>SpO₂ - 99%</p>	<p>Sweating</p>
	<p>RR - 26/min</p>	<p>Instability</p>
	<p>DP - 98/67 mmHg</p>	
	<p>O/E - child alert</p>	<p>3) Monitor Vitals</p>
	<p>IR-S - B/LAE ⊕</p>	<p>Infan SOS</p>
	<p>PIA - soft</p>	
		<p><u>Prannav</u></p>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
15/6 5:30pm	<p>cks/B Dr Spandana</p> <p><u>Accidental ingestion of Thyroxine</u> <u>? Thyroxine overdose</u></p>	<p>Ph</p> <p>1) Monitor vitals - HR/BP</p> <p>2) If stable plan O/C/TAs</p> <p>3) Enfor SOS w/ varying signs</p>
	<p>No fresh vom</p> <p>Vital stable</p> <p>child - calm</p> <p>R/S - B/AB @</p> <p>PLA - soft</p>	
	<p>PS</p> <p>Dr. Spandana Pasupuleti Consultant Neonatologist and Pediatrician Reg. No: 50925</p>	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	c/o/h. Dr. Sambanthi D. Shreegan	
16/06/26 SAM	Di. Accidental Trajectory of Foreign body	
	No fresh concern	
	O/E: AC - fair vitals: stable Hydration - good	
	S/G: CVS: S, S, ⊕ CW: AB NAD PA: soft RS: TSCAG ⊕ clear	
		<p>Adv</p> <ul style="list-style-type: none"> ✓ Watch any symptoms ✓ Monitor vitals and ✓ Inform doc <p>Sambanthi</p>
		<p>NB: Supriya 8:30 AM @ 16/6/26</p>



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DRUG CHART

Date of Admission: 14/6/26 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 **I** through it and a similar line through subsequent recording panels.
 - The date and time of stopping the drug along with the doctors name and sign must be mentioned.
 - Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.
- NURSES - Nurses must follow strictly the FIVE RIGHTS before administration of medication.
 1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time
 - AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

SOS / PRN (As Required Medication)

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

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

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

VERIFIED BY : Name

MLC

REGULAR PRESCRIPTIONS

Weight. Ward.



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																							
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																							
DRUG :				Date Time																			
Dose	Route	Frequency	Start Date																				
Name & Signature of the Doctor Starting the Drugs:																							
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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																							

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Master Y. HIMANSHU

28-04-2023 3 Y 1 M 20 D (M)

Dr. S TEJASWI REDDY



303

RESULT SHEET

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Your Right to a Safe Delivery

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

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.

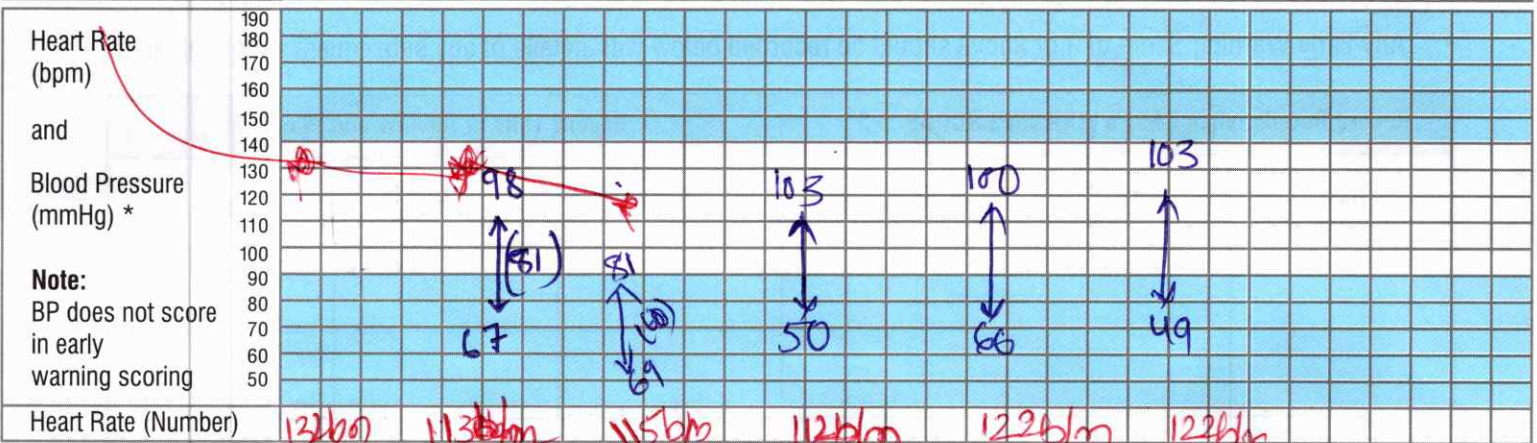
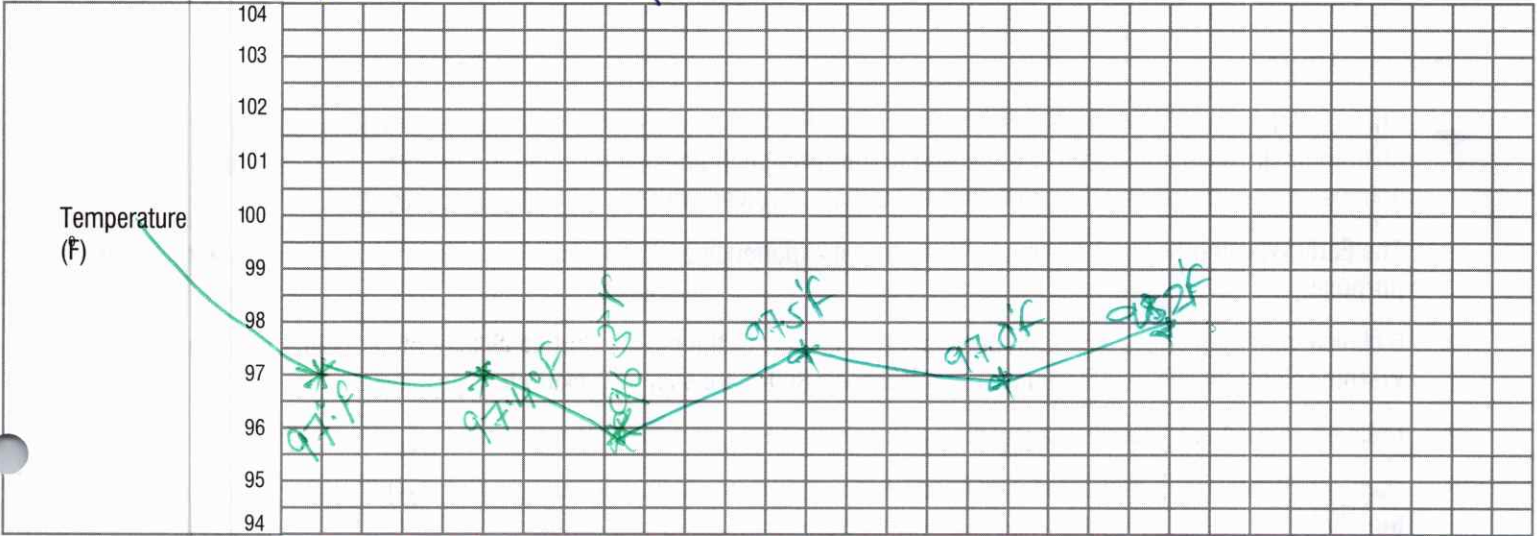
I	IDENTITY: I am (name), a nurse on ward (X). I am calling about (child X)
S	SITUATION: I am calling because I am concerned that ... (e.g. BP is low/high, pulse is XXX, Temperature is XX, Early Warning Score is XX)
B	BACK GROUND: Child (X) was admitted on (XX date) with (e.g. respiratory infection). 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)



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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 15/6	Time: 10 Am	2 Pm	6 pm	10 pm	2 am	6 am
Doctor / Nurse / Family Concern?						



Heart Rate (Number)	132bpm	113bpm	115bpm	112bpm	122bpm	122bpm
Resp. Rate (bpm) (Over 1 Minute) *	22bpm	25bpm	26bpm	25bpm	28bpm	28bpm

Resp Mod/ Severe Distress None / Mild						
Receiving O ₂ (l/min)						
O ₂ Saturations (%)	100%	100%	100%	100%	99%	99%
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	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]

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

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

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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)

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Master Y. HIMANSHU

23-04-2023

3 Y 1 M 22 D

(M)

Dr. S TEJASWI REDDY



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	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse		
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine				
	08:00 am													
	09:00 am													
	10:00 am													
	11:00 am													
	12:00 pm													
	01:00 pm													
Total Intake :						Total Output :								
	02:00 pm													
	03:00 pm													
	04:00 pm													
	05:00 pm													
	06:00 pm													
	07:00 pm													
Total Intake :						Total Output :								
14/6/26	08:00 pm													
	09:00 pm													
	10:00 pm													
	11:00 pm	plst	PO	used										
	12:00 am	plst	PO	used										
	01:00 am	plst	PO	used										
Total Intake :						Total Output :								
15/6/26	02:00 am													
	03:00 am													
	04:00 am	plst	PO	used										
	05:00 am	plst	PO	used										
	06:00 am	plst	PO	used										
	07:00 am	plst	PO	used										
Total Intake :						Total Output :								
Total 24 hrs. Intake						Total 24 hrs. Output								



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							
15/6/26	08:00 am	PlasmaLyte	NPO	45ml						✓		
	09:00 am			45ml						✓		
	10:00 am			stop						✓		
	11:00 am			stop						✓		
	12:00 pm			stop						✓		
	01:00 pm			stop						✓		
Total Intake :						Total Output : 0-3						
15/6/26	02:00 pm	H2O	idly							✓		
	03:00 pm								✓			
	04:00 pm								✓			
	05:00 pm								✓			
	06:00 pm								✓			
	07:00 pm								✓			
Total Intake :						Total Output :						
15/6/28	08:00 pm	H2O	idly							✓		
	09:00 pm								✓			
	10:00 pm								✓			
	11:00 pm								✓			
	12:00 am								✓			
	01:00 am								✓			
Total Intake :						Total Output :						
16/6/28	02:00 am	H2O	idly							✓		
	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: 14/04/23

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon							
Night	18:00pm	<p>Armed kept - rivo angula present - monitor vitals I/O chart - drug a pt chest - 8AM - 4pt fluids</p>		<p>→ Armed kept - monitor vitals - 4pt 150g NPO - drug aspt chest</p>	<p>pt is stable 4pt is on NPO</p>	<p>Rechecked vitals</p>	

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Patient Stic

NURSING CARE RECORD

Date: 16/6/26

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 to 2pm	⇒ Assess the pt condition. ⇒ check the vitals ⇒ Maintain I/O chart	8Am to 2pm	⇒ Assess the pt condition ⇒ check the vitals ⇒ Maintain I/O chart	pt is a stable	check the vitals	Madhavi
Afternoon	day						
Night	8pm to 8am	- Assess the pt condition - Monitor the v/s - Maintain the I/O - Drug as per chart	8pm to 8am	- Assess the pt condition - Monitor the v/s - Maintain the I/O - Give Nutrition diet	- Now pt is stable	- Rechecked the v/s	



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission: 14/6/26

SITUATION	Diagnosis:	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify:						
	Area	14/6/26 N	15/6/26 N/G	15/6/26 N1				
BACKGROUND	Shift Time							
	Medical Condition (Any special condition to be noted):	-	-	-				
ASSESSMENT	Allergy:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input 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 type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Vital Signs:	Temp:	98.1°	98.3	98.3°			
		Res:	23b/m	24b/m	25b/m			
		SpO ₂ :	99%	99%	99%			
		Pulse:	126b/m	122b/m	126b/m			
		BP:						
		Fall Risk Score:	-	-	-			
Pain Score:	-	-	-					
Recommendations	Safety Needs:	Yes	Yes	Yes				
	Physiotherapy	<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 type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Others Specify:	-	-	-				
	Special Diet:	<input type="checkbox"/> Yes <input 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 type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Other Special Orders / Medications:	-	-	-				
Post Operative Procedure Special Orders:		-	-	-				
Handed Over By Name :		Divy	Madhuf	Sunanda D/C				
Signature :		[Signature]	[Signature]	[Signature]				
Date:		14/6/26	15/6/26	15/6/26				
Time:		8AM	8PM	8AM				
Taken Over By Name :		Madhuf	Sunanda	Supriya				
Signature :		[Signature]	[Signature]	[Signature]				
Date:		15/6/26	15/6/26	16/6/26				
Time:		8AM	8PM	8AM				

Patient Sticker



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

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

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THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	11/6/23	15/6/23			
	3 to less than 7 years old	3	3	3			
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	2	2			
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1			
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own ability	1					
	History of Falls or Infant-Toddler Placed in Bed	4	4	4			
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3	3	3			
	Patient Placed in Bed	2		2			
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours/ None	1		1			
Medication Usage	Sedatives (Excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
Other Medications / None		1	1	1			
Total				14			

Intervention:

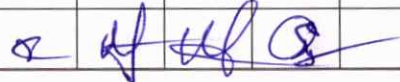
-Fall Risk: Low Humpty Dumpty Score = 7-11,

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		✓	✓			
Call device within reach		✓	✓			
Wheels Locked		✓	✓			
Room free of clutter		✓	✓			
Adequate lighting		✓	✓			
Wheel chair support		✓	✓			
Other Intervention(s) Specify		✓	✓			
Nurse's Name:		[Signature]	[Signature]			
Signature:		[Signature]				
Date:		15/6/23	16/6			
Time:		8am	8pm			



CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1 ^{sub/hr}				DAY-2		DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0			0	0	-	-				
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				
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2			2	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			3	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				
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				
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 :

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Master Y. HIMANSHU

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(M)

Dr. S TEJASW REDDY



BRADEN 'Q' SCALE



					Date :	15/6	15/6	15/6	15/6
					Time :	12	12	12	12
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.		4	4	4	4
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.		4	4	4	4
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.		4	4	4	4
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.		4	4	4	4
FRICITION-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 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						28	28	28	28
Evaluator's Name						S	S	S	S

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



MLC

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: ICU Shifted to: 3rd floor (C303)

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. Prasanthi

Date & Time: 14/6/20 @ 10:30 PM

Nurse Name & Signature: [Signature]

Date & Time: 14/6/20 @ 10:30 PM



MLC

wt - 12.93 kgs



EMERGENCY ROOM TRIAGE FORM

Patient's Name : Master Himanshu Age : 3 years Gender: Male Female

Date : 14/06/26 Time of Arrival : 9:49


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

Source of Information : Parents Others (Specify) _____

Mode of Arrival : Ambulatory Wheelchair Ambulance

Initial Vital Signs: Temp: 97.7F PR: 101b/m BP: _____ RR: _____ SpO₂: 100% at 9:15 PM

Chief Complaints: 10 ingestion of tyxonom tablets at home yesterday

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

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

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

* CTAS - Canadian Triage and Acuity Scale

P. Srinani

Signature of Parent / Guardian

Triage Completion Time : 10:02 PM

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 : Shrisika

Signature of Triage Nurse : *[Signature]*

Date & Time : 14/06/26 @ 9:51 PM

NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 14/06/26 Time of arrival : 9:53 PM

Chief Complaints : C/O ingestion of thyroxine tablets at home at 9:15 PM RBS:

Height : Weight : 12.93 kg BMI : Head Circumference (<2 years)

Allergies: Yes No Medications Blood Transfusion Food Other:
 If yes, identify

Pain Screening: Yes No If Yes, Pain Score: Pain Tool Used: N Pass FLACC Wong Baker
 Character Location Frequency Duration

RISK FOR FALL:

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

If Patient is > 6 years
 Assess the below parameters

History of Falling: within past 3 months Yes No

Ambulatory Aids:

- Wheelchair Yes No
- Uses furniture for support Yes No

Gait/Transferring:

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

Mental Status: Forgets limitations Yes No

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?)

Time of Initial assessment completed by ER Nurse : @ 9:55 PM

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

MLC

Time	Nursing Notes
9:57 AM	Assess the patient condition monitor the vital signs

Samples collected by:

Time:

Samples sent by:

vijaya

Time:

10:30 PM

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: 99 b/m BP: CFT: N/A RR: SPO ₂ : 98% GCS: 15/15 Temperature: 98.5° Pain Score: Repeat RBS (if applicable): N/A	Shift - out from ER to: 3rd floor (303) Time of Shift - out: 11:25 PM Handover given to: (Nurse's Name)

Tick as applicable: MLC LAMA BROUGHT DEAD

Procedures done with details (if any):

IV placement done

Name of the Nurse: skiving


Signature of the Nurse: [Signature]

Date & Time: 14/06/26 @ 9:59 PM

PATIENT TRANSFER FORM

MLC




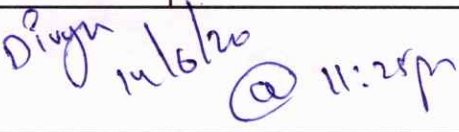
Patient Name & UHID No. HNH-00015974 IP26-00006584 Master Y.HIMANSHU 23-04-2023 3 Y 1 M 22 D (M) Dr. S TEJASWI REDDY 	Date & Time of Admission 14/6/20 @ 10:40pm	Date & Time of Transfer Order 14/6/20 @ 11:25pm
	Transfer Ordered by Dr. presenthu	Reason for Transfer Admission
From Unit ER	To Unit (303)	Information to Attendant Yes <input type="checkbox"/> No <input type="checkbox"/>
Number of Sheets in Clinical File 14	Number of Imaging Films -	Personal belongings including clinical documents. If any handed over to attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> If yes, what ?

Medications / Consumables / Surgicals / Hand over

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

Shifting Summary / Notes Written by Doctor : Yes No

Name & Signature of Person who is Transferring 	Name of Person Ordered Transfer Dr. presenthu
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Patient & Clinical Records Received by :  14/6/20 @ 11:25pm

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

303

NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 15/6/20 Time: 9:15am

Weight: 12.9 Kg Centile: < 3rd

Height: Centile: _____

Inference: Underweight child

RDA: _____ Calories: 1300 Kcal/day Protein: 23gms/day

Diet Recommendations: Soft and bland diet with liquids

Re-Assessment: No Junk Spicy, Oil, Food

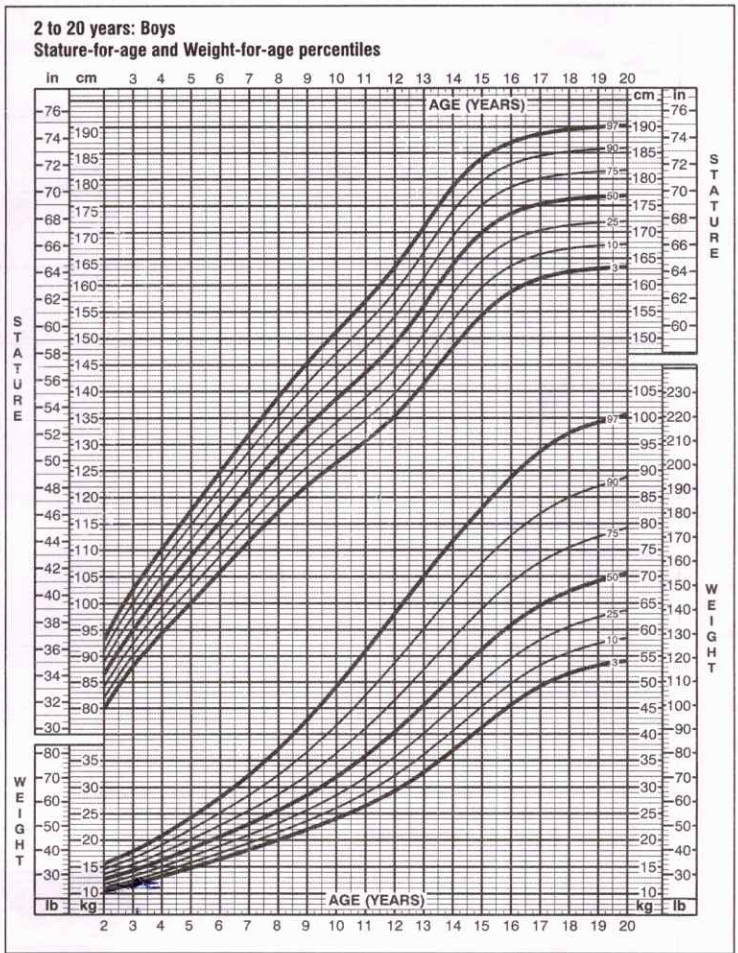
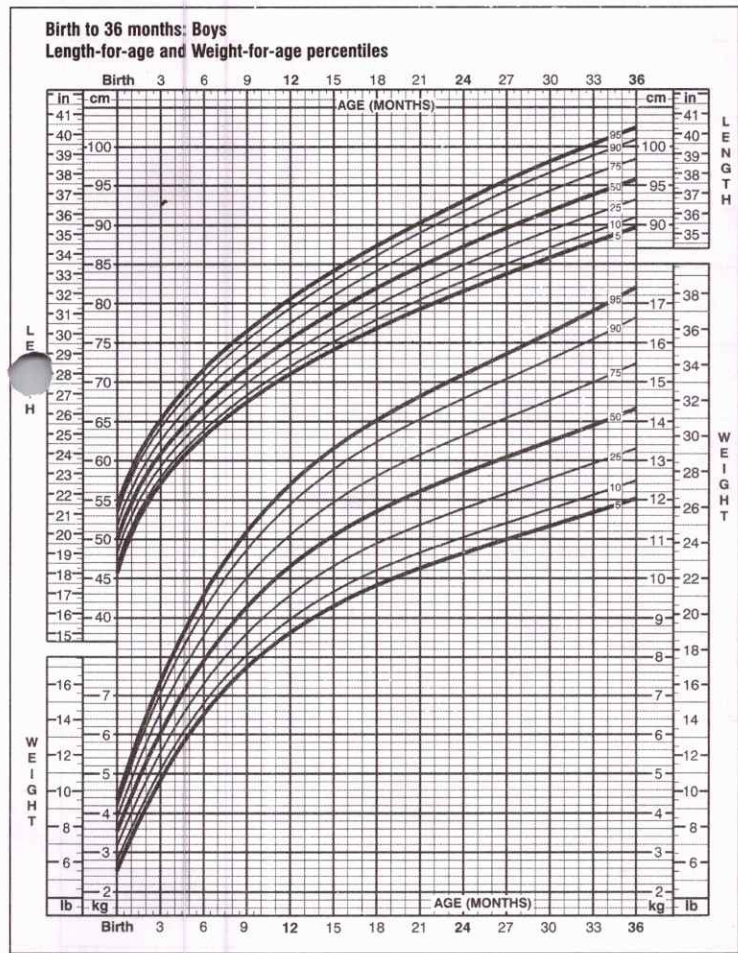
Food Allergies: No Veg/Non-veg: Non veg

Diagnosis: Accidental Consumption of Thyroxine tablets

Nutritional Intervention - Oral Enteral Parenteral

Patient's Signature: P. Sravani

GROWTH CHART (BOYS)



Dietician's Name: Syeda Sobiya Zaher

Dietician's Signature: Sobiya

To _____ Date 14/6/26
The Station House officer, _____ Time 9:45pm
P.S. Chilkalguda P.S M.L.C No. 072
Dist. / City Hyderabad - UHID / I.P. No. HNH-CC015974
Ref : Our Telephone Intimation Dated 14/6/26, 10PM
Received by : Mr. Ramesh, H.C-6116 PH: 8712661252
Patient Name : MASTER Y. HIMANSHU Accompanied by P.C. / Attendant
S/o., W/o., D/o. MR. SAI PRASAD. Y Name : Mr/ Mrs. Mr. Sai prasad Y
Age : 3y1m Sex : Male / Female MALE Relation : Father
Address : H.NO - 6-1-119/B, PADMARAO Phone No : 9347067011
AGAR, NEAR SP COLLEGE, DILSUKH NAGAR, Hyderabad Signature : _____

Identification Marks
1) Birth mark over R hand forearm
2) Birth mark over L leg (L-THYROXINE)
Signature / LTI of Patient _____

Brief History of the case as stated by the patient / attendant :
c/o accidental ingestion of THYRONORM 75mcg tablets at home, at 9:45 pm, quantity unknown.
Post ingestion - child has been asymptomatic, is active & playful

General Examination of the Patient on arrival at Emergency Conscious Unconscious Semi - Conscious Brought Dead
Pulse : 101 /mt B.P. : _____ /mm Hg Resp. Rate 30 /mt Temp : 98F of
Heart : S1 & T Lungs : NUBST Abdomen : Soft Pupils : B/L pupil RTL
No murmurs B/LAE + sounds Non Tender
No Adhd No Adhd

S.No.	Description of wounds	Dimensions
	<u>nil</u>	<u>nil</u>

Name & Sign. of Doctor : Dr. Prashanti Dying Declaration Required : Yes / No
Regn. No. 18888

MLC Received by : _____ Investigation Advised : VBG Treatment given : NPO
Signature : _____ Name : _____ Designation : _____
Maintenance IV fluids
Monitoring / observed

1. Admitted in _____ Ward / ICU
2. Left Against Medical Advice
3. Patient condition at the time of transfer _____
Name & Sign. of Doctor : _____ Regn. No. _____

ADMISSION SHEET

Registration Details :



Admission No : IP26-00006584 Admit Date : 14-Jun-2026 Admit Time : 10:38 PM UHID : HNH-00015974

Patient Details :

Patient Name : Master Y.HIMANSHU Age : 3 Y 1 M 22 D
Guardian : Mr SAI PRASAD.Y DOB : 23-04-2023
Gender : Male Religion :
Occupation : Martial Status :
Address (H) : H.NO-6-1-119/8,PADMARAO NAGAR,NEAR SP COLLEGE Dilsukhnagar Colony Hyderabad
Telangana INDIA 500060 Phone No : 9347067011/ 7032209316
E-mail : NA@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 SAI PRASAD.Y Relationship : Father
Contact Address : H.NO-6-1-119/8,PADMARAO NAGAR,NEAR SP COLLEGE Dilsukhnagar Colony Hyderabad
Telangana INDIA 500060 Phone No : 9347067011

P. S. Swami
Signature

Doctor Details :

Doctor Name : Dr. S TEJASWI REDDY Specialisation : GENERAL PEDIATRICS
Referral Doctor : Self. Phone No :
Co-Consultant :

Payment Details :

Payment Mode : DC/CC Card Deposit Amount : 20000.00
Payor Name : SELFPAY