

DISCHARGE SUMMARY

Name	Baby NOMULA BHADRIKA REDDY	UHID	HNH-00004015
Father/Guardian	Mr N BHARATH REDDY	Age/Gender	1 Y 9 M 2 D/ Female
Address	FLAT NO 305, MEHTA TOWERS, ASHOKNAGAR, Himayatnagar, Hyderabad, Telangana, INDIA, 500029		
IP No	IP26-00006579	Admission Date	14-06-2026
Ref Doctor	Self.		
Discharge Date	15.06.2026		

Consultant:

Dr. PRITESH NAGAR

MBBS MD

Medical Registration No. 47184

DIAGNOSIS	ICD CODE
ACUTE FEBRILE ILLNESS WITH DEHYDRATION	
?UTI (CYSTITIS)	

History: Baby NOMULA BHADRIKA REDDY , 1 Y 9 M 2 D , old girl presented with the history of cough, cold and fever since 3 days, decreased oral intake and irritability since 1 day prior to admission. For the above complaints she was admitted at Rainbow Children's Hospital - for further management.

Examination: She was febrile (101.5°F). Her heart rate was 130/min and Respiratory Rate - 30 /min. Capillary Refill Time was <2 secs. Peripheries were warm & pulses well felt. On examination Signs of dehydration were present, dry lips, dry oral mucosa, dull looking, tachycardia were present. On auscultation, air entry was bilaterally equal were present. Heart sounds were normal and there was no murmur. Abdomen was soft with no organomegaly. On neurological examination, she 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: 12.06 kilo grams.

Investigations: Enclosed reports

Name	Baby NOMULA BHADRIKA REDDY	UHID	HNH-00004015
IP No	IP26-00006579	Admission Date	14-06-2026

GeneXpert FluA+FluB+RSV, SARS-CoV-2 were sent, which was negative.

VBG showed pH of 7.38, pCO₂ of 32.7 mmHg, pO₂ of 43 mmHg, HCO₃ of 19.3 mmol/L and BE of -5.8 mmol/L.

Initial hemogram showed Hemoglobin of 12.7 gm%, White Blood Cell count of 13520 cells/cumm, platelet count of 3.16 lakhs/cumm and C-Reactive Protein of 35 mg/l.

USG abdomen (15.06.26) shows features of cystitis.

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

She was regularly monitored for fever spikes, hemodynamic status. Her fever spikes and other symptoms gradually settled. Child maintaining saturations on room air.

In view of high grade fever and CRP positive planned to sent catheter sample for urine culture , but urine catheterization could not be performed easily .

In view of labial adhesions, Pediatric surgery opinion by Dr. Mukta Waghmare was taken. Reassured the parents, advised nil intervention and topical steroid cream application for 3 weeks.

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

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

RS: B/L AE EQUAL
B/L NVBS
NO ADDED SOUNDS

Medication during hospital stay:

Nasoclear nasal drops
Nasivion p nasal drops
Syrup. Xyzal
Injection. Ceftriaxone

Advice:

Name	Baby NOMULA BHADRIKA REDDY	UHID	HNH-00004015
IP No	IP26-00006579	Admission Date	14-06-2026

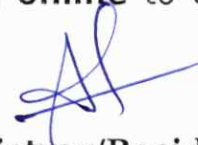
breathlessness or refusal to feed occurs.

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 **Himayatnagar / Banjara Hills / Rainbow Clinic Madhapur / Kukatpally / Vikrampuri / LB Nagar / dial just one toll free number 18002122.**

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



Registrar/Resident/C.M.O

Dr. PRITESH NAGAR
MBBS MD
Medical Registration No. 47184



Rainbow Childrens Hospital-Himayatnagar

Rainbow Children's Hospital, Door no. 3-6-267, opp. Cafe niloufer, Old MLA quarters road AP State Housing Board Himayatnagar ,Hyderabad ,Telangana, INDIA ,500029.

TEL NO :040-48873000

WEB : <https://rainbowhospitals.in>

ADMISSION SHEET



Registration Details :

Admission No : IP26-00006579 Admit Date : 14-Jun-2026 Admit Time : 02:58 AM UHID : HNH-00004015

Patient Details :

Patient Name	: Baby NOMULA BHADRIKA REDDY	Age	: 1 Y 9 M 2 D
Guardian	: Mr N BHARATH REDDY	DOB	: 12-09-2024 06:32 PM
Gender	: Female	Religion	:
Occupation	:	Martial Status	:
Address (H)	: FLAT NO 305, MEHTA TOWERS, ASHOKNAGAR Himayatnagar Hyderabad Telangana INDIA 500029	Phone No	: 9000774779/ 9505108221
		E-mail	: MAMATHAREDDY12092@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 N BHARATH REDDY Relationship : Father
Contact Address : FLAT NO 305, MEHTA TOWERS,
ASHOKNAGAR Himayatnagar Hyderabad
Telangana INDIA 500029 Phone No : 9000774779

Signature

Doctor Details :

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

Payment Details :

Payment Mode : DC/CC Card Deposit Amount : 10000.00
Payor Name : STAR HEALTH AND ALLIED
INSURANCE CO LTD



CROSS CONSULTATION FORM

Doctor Name: Dr. VAMUNU Date: 15/6/24 Time: 10AM

Diagnosis: ? VVF.

Hospital: RCH, HIMAYATNAGAR.

Type of Referral :

- Emergency
- Urgent
- Non Urgent

Referred for: Opinion Co-Management Transfer of care

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

AFI Ed dehydration
? VVF.

Signature: _____

Findings and Recommendations :

Adv: O/E
- Labial adhesions ⊕.

- Urethra visible.

①
Adv: - 2 lignocaine jelly
L/A TAD. X 1 week.

② BETAMIL GM L/A
x - 1 - x X 3 weeks.

Consultant :

Name: Dr. MUKTHA Signature: [Signature] Date & Time: 15/6/24

ACTIVITY RECORD FOR BILLING

HNH-00004015 IP26-00006579

Baby NOMULA BHADRIKA REDDY

Name: 12-09-2024 1 Y 9 M 2 D (F)
Dr. PRITESH NAGAR

UHID N



----- Consultant : -----

Dept : *pediatric*

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
<i>14/06/26</i>	<i>3:35 AM</i>	<i>ER</i>	<i>ward (302)</i>	<i>[Signature]</i>

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1.	<i>Dr. Mukta</i>	<i>15/6/26</i>	<i>6781</i>	<i>[Signature]</i>
2.				
3.	<i>Cross checked done by Supriya</i>			
4.				
5.				
6.				
7.				
8.				
9.				
10.				



PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
14/6/26	w placement	1	6568	<i>[Signature]</i>
14/6/26	NAA	①	6638	<i>[Signature]</i>
<i>cross checked done by Supriya</i>				

ANY OTHER INFORMATION

Date : _____ Time : _____ Prepared By : _____

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
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Ref.No. F/IN/PR/10



**Rainbow[®]
Children's
Hospital**

**PEDIATRIC IN-PATIENT
MEDICAL RECORD**

HNH-00004015 IP26-00006579
Baby NOMULA BHADRIKA REDDY
12-09-2024 1 Y 9 M 2 D (F)
Dr. PRITESH NAGAR



Patient Name : Nomula Bhadrিকা Reddy

Patient ID# : _____

Consultant : _____

Final Diagnosis : _____

Pediatric Multiorgan History

MNH-00004015 IP26-00006579
Baby NOMULA BHADRIKA REDDY
12-09-2024 1 Y 9 M 2 D (F)
Dr. PRITESH NAGAR



Age 1 y 8 m / F
Sex ~~Male~~
Reliability Good

Name: Nomula Bhadrika Reddy

Informant: Mother

Chief Presenting Complaints & Duration (Chronologically):

Cough (cold) since 3 days
Fever x 3 days (increasing intensity)
Decreased oral intake x 3 days
Tritatnibly since evening.

History of present illness :

A 1 y 8 month old girl is
c/o Cough, productive;
and Runny nose since 3 days
associated with
Fever x 3 days
initially low grade, responding to PCM
currently high grade $\approx 104^{\circ}F$ recorded at
home
not associated with chills, no rash
not touching baseline despite of regular PCM
decreased oral intake x 1 day
Tritatnibly since evening.

Pediatric Multiorgan History & Physical Examination

HNH-00004015 IP26-00006579
Baby NOMULA BHADRIKA REDDY
12-09-2024 1 Y 9 M 2 D (F)
Dr. PRITESH NAGAR

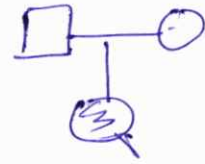


Past History : (Including details of any previous investigation or treatment)

Blank lined area for Past History.

Birth & Neonatal History :

No neonatal complications



Birth & Socio Economic History :

About Father : _____

About Mother : _____

Any additional Information : _____

Developmental History :

as per age

Immunization History :

as per schedule,
the vaccine received



Anthropometry

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

Weight (kgs) 12.06 kgs (Centile _____)

On Examination :

Temperature : 101.50 F. Pulse Rate: 130/min Description _____

B.P. _____ SPO2 98% at RA

Resp. rate and type of breathing : 30/min

Rash _____

Lymphadenopathy _____

Oedema : _____

*dull looking,
dry oral mucosa,
Sunken eyes,
Tachycardia;*

Respiratory system :

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

Air entry & breath sounds : WBS (F)

Any added sounds : _____

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

Cardiovascular System :

Inspection of precordium : (N)

Heart Sounds : WBS (N)

Any murmur : _____

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

Per Abdomen :

Inspection (N)

Palpation : soft


Auscultation : BS (F)

Spine: (N) External Genitalia : _____

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

Pediatric Multiorgan History & Physical Examination

HNH-00004015 IP26-00006579
Baby NOMULA BHADRIKA REDDY
12-09-2024 1 Y 9 M 2 D (F)
Dr. PRITESH NAGAR



Central Nervous System :

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

Cranial Nerves : _____
_____ (N)

Motor System :

Nutrition : _____
Tone : _____ Power _____
Co-ordinator : _____
Posture : _____ (N)
Involuntary Movements : _____

Reflexes :

DTR

Superficials :

Plantars _____

Sensory System :

Bladder / Bowel : _____

Clinical Summary & Diagnostic :

AFI (D3) & dehydration

Pediatric Multiorgan History & Physical Examination

HNH-00004015 IP26-00006579
Baby NOMULA BHADRIKA REDDY
12-09-2024 1 Y 9 M 2 D (F)
Dr. PRITESH NAGAR

Preventive aspects of the treatment :

prevent complications

Desired goals of the treatment :

Hemodynamic stability

Planned Labs :

CBP, CRP, VBG,
Lactate
Resp. panel (S-nain)
Chest Xray
CUE - due

MBS shivering

Planned Management :

- ① IVF
- ② Vasodean
- ③ Nainion - P.
- ④ Sp. xyal.
- ⑤ Monitor vitals
- ⑥ Fever management
- ⑦ .

MBS shivering

Dr
(Dhanan)

Please fill up the following details

- Name of the Referring Doctor : _____
- Name of the Referring Hospital : _____
(Including the name of City)
- Contact number of the Referring Doctor : _____
(Preferring Mobile #)
- Name of the doctor in Rainbow Team _____ on
whose name the patient is being referred

Doctor's Signature Name

[Signature]
Dr. Pritesh Nagar
Consultant Pediatrician & Intensivist
Reg. No. 57104

Date

14/6/26

Time

9AM



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
14/6 8:15am	<p>CSNB Dr. Pranam / Dr. Naggar</p> <p>API - D3 E Dehydrant</p>	
	<p>Fever @ (101.5° F) Cold & Cough @</p>	<p>Pln</p> <p>1) IVF</p>
	<p>Poor oral intake and activity</p>	<p>2) NASIVION-P 3) Syp Xyzal 4) Nasa-chin nasal spray</p>
	<p>Vital stable</p>	<p>5) Tra Labs 6) Serd CUE</p>
	<p>R/E - child asleep R/S - B/LAERD P/A - soft</p>	<p>7) Monitor Vitals</p>
		<p>N/B priyanka</p>
		<p><u>Priyanka</u></p>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
14/06/2024 9:30 am	8/18 Dr. Pritesh	
	AFI (D ₃)	
-	Fever spike (-) oral intake - fair chest - clear P/A soft	Plan
		① ct IV fluids
		② Encourage orally
		③ Send blood cts CUE venic cts } catheter sample
		④ Examine throat when awake
		⑤ start cephaxone after sending blood cts
		⑥ Trace Resp. panel.
		Noted by Madhu

Dr. Pritesh Nagar
 Consultant Pediatrician & Intensivist
 Reg. No: 47184

(M)



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
14/6 3:00pm.	<p>CLUB. Dr. Naipaya</p> <p>APR & dehydration.</p>	
	<p>No fever.</p>	<p>Plan</p>
	<p>oral intake - poor.</p>	<p>← Cont IV fluids</p>
	<p>Vitals - stable.</p>	<p>← Trace B/c's Respir</p>
	<p>BP -</p>	<p>✓ Pediatric Surgeon opinion tomorrow</p>
	<p>V/O/P -</p>	<p>← Cont. Zyc ceftriaxone ✓ Monitor vitals</p>
		<p>Noted by <i>Dr. Naipaya</i></p>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
15/6/24	c/sb - Dr. Prashanti / Dr. Nayunja	
8:30 Am	Acute febrile illness ? <u>VVF</u> No fever. ORAL intake better	Dehydration (D3) COE (N)
		plan
O/E	vitals stable	1) CE IV fluids @ 20 ml/hr
S/E	oral cavity → Bil G2 Tonsillitis	2) Trace BCIS BCIS
	Chest - clear	3) ceftriaxone D2
	PIA - soft, non tender	4) Trace kspi panel support
	CNS - wnl	5) VSG Abdomen Today
		6) Take paed surgeon (VVF) opinion
		Noted Divya @ 8:30 15/6/24 Prati

HNH-00004015 IP26-00006579
 Baby NOMULA BHADRIKA REDDY (F)
 12-09-2024 1 Y 9 M 2 D
 Dr. PRITESH NAGAR



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
15/9/26 9:00am	S/B. Dr. Pritesh	
	△ AFL Day 3 ? UVF	Keep panel 5 vials
	No fever	(-)
	oral vitals - fair	
	Wet cough (+)	
	<u>O/E</u> Vitals stable	<u>Adv</u>
	<u>S/L</u> ? Synaechae (+)	- Trace B/C/S
		- USG abdomen today
	<u>S/E</u> NAD.	- Paed surgeon opinion for UVF
		- Plan discharge after opinion
		<div style="border: 1px solid black; padding: 5px; display: inline-block;"> Noted by madhug </div>
		Dr. Pritesh Nagar Consultant Pediatrician & Intensivist Reg. No. 47184

HNH-00004015 IP26-00006579
 Baby NOMULA BHADRIKA REDDY
 12-09-2024 1 Y 9 M 2 D (F)
 Dr. PRITESH NAGAR



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
15/9/26	c/s/b for Muktha	
10:30AM	AFE \bar{c} dehydration	? VVF
	- NO fever.	
	- oral intake fair.	Plan
	- wet cough (+)	2 bid sym
	O/E:-	Paracetamol start.
	Labial adhesions -	① Lidocaine gel
	Separated.	L/A TID x 1 week.
	Urethra visible.	② BETAMICAM UA
		- 1 x 3wks.

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
15/6/26, 3:50pm.	<p><u>c/s/hy. Dis Amuck</u></p> <p>AFI & dehydration</p> <p>2UTI</p>	
	<p>No fever</p> <p>Active</p> <p>Hydets - Good.</p> <p>Intak - Good.</p> <p><u>vital</u> stable.</p>	<p><u>Plan</u></p> <p>— chye to oral</p> <p>Antibiotic.</p> <p>(Amoxycle).</p>
	<p>s/e</p> <p>— (Pb) B/L AC (+)</p> <p>NVBS (+)</p> <p>Nb add sound</p>	<p>— 3% AB NGB.</p> <p>— Dinehye. Today's.</p>
	<p><u>AP</u></p>	

Reddy

DRUG CHART

Date of Admission: 14/06/24 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.

12.06 kg

SOS / PRN (As Required Medication)

DRUG :				Date/Time
Dose	Route	Frequency	Start Date	
1/2ml	PO	QDS	14/6	
Doctor's Signature		Valid Period	Pharm.	
<u>Naw</u>			<u>@</u>	
Additional Instructions: (5ml/240mg)				
<u>If Temp > 100°F</u>				
DRUG :				Date/Time
Dose	Route	Frequency	Start Date	
3ml	PO	QDS	14/6	
Doctor's Signature		Valid Period	Pharm.	
<u>Naw</u>			<u>@</u>	
Additional Instructions: (5ml/100mg)				
<u>If Temp > 102°F</u>				
DRUG :				Date/Time
Dose	Route	Frequency	Start Date	
Doctor's Signature		Valid Period	Pharm.	
Additional Instructions:				

Verified by Dr. D. J. Kshayani
 Verified by Dr. D. J. Kshayani
 VERIFIED BY : Name

REGULAR PRESCRIPTIONS

Weight: 12.06 kg Ward:



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

DRUG : NASOCLEAR NASAL DROPS				Date Time	14/6																
Dose	Route	Frequency	Start Date																		
2/20	each nasal	Q6H	14/06	12PM	X																
Name & Signature of the Doctor Starting the Drugs:				6AM																	
Additional Instructions:				12PM																	
Daily Doctor's Endorsement by a Sign				6PM																	
DRUG : NASIMON-P nasal drops				Date Time	14/6																
Dose	Route	Frequency	Start Date																		
20/20	each nasal	BD	14/06	6AM	4:30																
Name & Signature of the Doctor Starting the Drugs:				6AM																	
Additional Instructions:				4PM																	
Daily Doctor's Endorsement by a Sign																					
DRUG : Lyp. XY2AL				Date Time	14/6																
Dose	Route	Frequency	Start Date																		
2.Sul	PO	OD-HS	14/06	10PM	4:30																
Name & Signature of the Doctor Starting the Drugs:				10PM																	
Additional Instructions:																					
Daily Doctor's Endorsement by a Sign																					
DRUG : Ceftriaxone				Date Time	14/6																
Dose	Route	Frequency	Start Date																		
1gm	IV	OD	14/06	9PM																	
Name & Signature of the Doctor Starting the Drugs:				9PM																	
Additional Instructions:																					
Daily Doctor's Endorsement by a Sign																					

HNH-00004015 IP26-00006579
 Baby NOMULA BHADRIKA REDDY
 12-09-2024 1 Y 9 M 2 D (F)
 Dr. PRITESH NAGAR



REGULAR PRESCRIPTIONS

Sheet No:

Weight ^{12 kg} Ward

DRUG : CIGNOCAINE GEL				Date Time																
Dose	Route	Frequency	Start Dt.																	
1/2	LA	TID	12/6																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
(2% GEL)																				
Daily Doctor's Endorsement by a Sign																				

DRUG : BETAMIC GH CREAM				Date Time																
Dose	Route	Frequency	Start Dt.																	
1/2		OD	12/6																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Afternoon application.																				
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

Patient Sticker



Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward

Signature
Name

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																			

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

VARIABLE DOSE

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses

VERIFIED BY Name Signature

HNH-00004015 IP26-00006579
 Baby NOMULA BHADRIKA REDDY
 12-09-2024 1 Y 9 M 2 D (F)
 Dr. PRITESH NAGAR



RESULT SHEET



Date	14/6/26				
Time					
Hb	12.7				
PCV	35.4				
RBC	4.44				
WBC	13.52				
N/L	58.9/29.5				
Platelets	316				
CRP	35				
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					

Date	14/6/20					
Time						
CUE-Alb						
CUE-Sugar	Nil					
CUE - Ketones	Present					
CUE-PUS Cells	6-8					
CUE - RBC Cells	6-8					
CUE Epithelial Cells	4-6					
Stool Pus Cell						
OVA/Cyst						
Occult Blood						

Culture and Sensitivities : Blood C/S →

.....

.....

.....

Radiology: USG :

 X-Ray:.....

 ECHO:

 CT:

 MRI

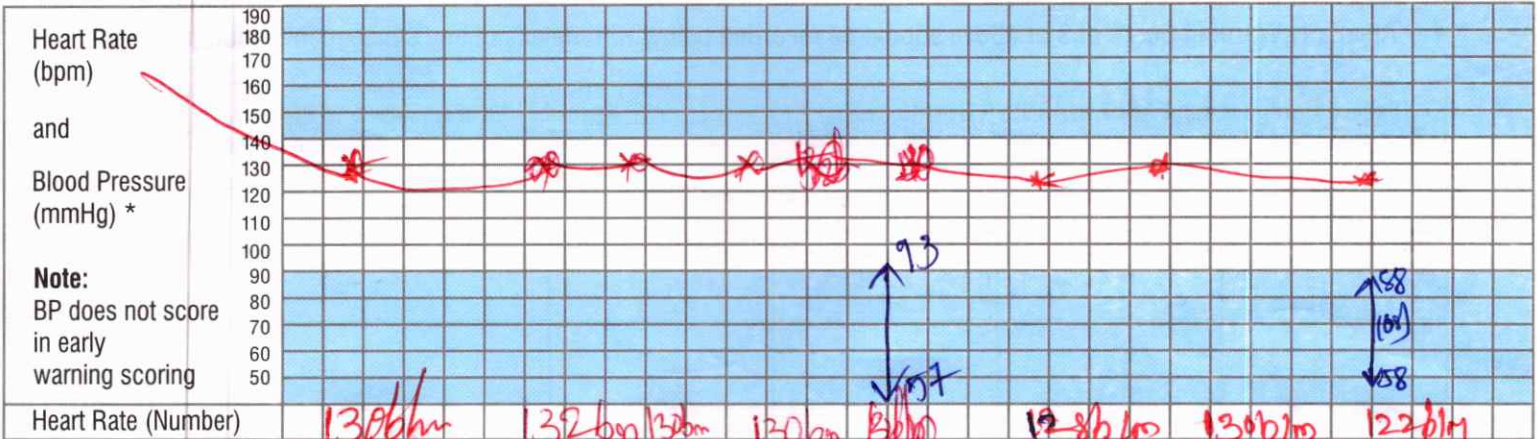
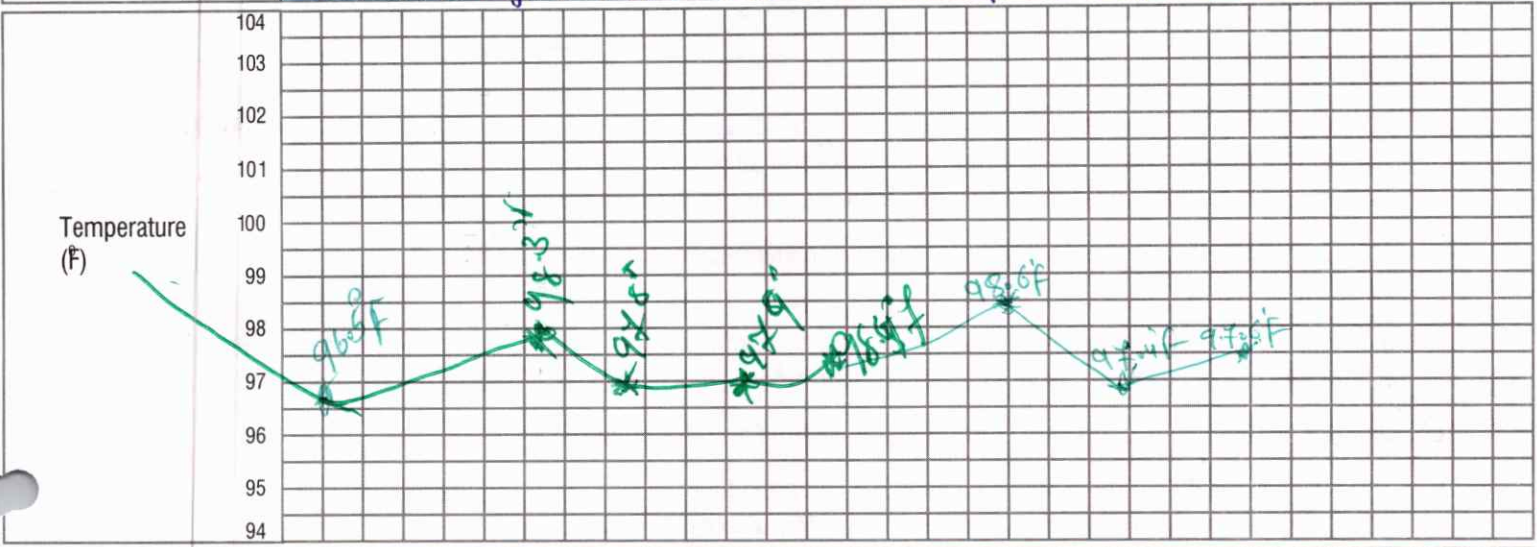
 Others (ECG, Contrast Studies etc.):

Patie



EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 14/6/24	Time: 6 AM	9 AM	10 AM	2 PM	6 PM	10 PM	2 AM	6 AM
Doctor / Nurse / Family Concern?								



Resp. Rate (bpm) (Over 1 Minute) *	70	60	50	40	30	20	10
Resp Rate (Number)	30	30	30	30	30	30	30

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

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

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)

HNH-00004015 IP26-00006579
 Baby NOMULA BHADRIKA REDDY
 12-09-2024 1 Y 9 M 2 D (F)
 Dr. PRITESH NAGAR




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.

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

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Baby **NOMULA BHADRIKA REDDY**
 12-09-2024 1 Y 9 M 2 D (F)
 Dr. **PRITESH NAGAR**



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 Thrombo-phlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
14/6/20	08:00 am	PlasmaLyte		20ml									Noble
	09:00 am			20ml									
	10:00 am		Tadef		20ml								
	11:00 am				20ml								
	12:00 pm				20ml								
	01:00 pm				20ml								
	Total Intake :						Total Output : 0-0						
14/6/20	02:00 pm	PlasmaLyte		20ml									Noble
	03:00 pm			20ml									
	04:00 pm		Milk		20ml								
	05:00 pm		Milk		20ml								
	06:00 pm		Milk		20ml								
	07:00 pm		Milk		20ml								
	Total Intake : Taken						Total Output : 0-2 M-0						
14/6/20	08:00 pm	PlasmaLyte		20ml									Noble
	09:00 pm			20ml									
	10:00 pm		H2O		20ml								
	11:00 pm				20ml								
	12:00 am		Milk		20ml								
	01:00 am				20ml								
	Total Intake : Taken						Total Output : 0-2 M-0						
15/6/20	02:00 am	PlasmaLyte		20ml									Noble
	03:00 am			20ml									
	04:00 am		H2O		20ml								
	05:00 am				20ml								
	06:00 am				20ml								
	07:00 am				20ml								
	Total Intake : Taken						Total Output : 0-2 M-0						

Total 24 hrs. Intake

Total 24 hrs. Output

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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 Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
15/6/26	08:00 am	PlasmaLyte		20ml							✓	Mada
	09:00 am			20ml								
	10:00 am			20ml								
	11:00 am			20ml								
	12:00 pm			20ml								
	01:00 pm			20ml								
Total Intake :						Total Output :						
15/6/26	02:00 pm	PlasmaLyte		20ml								
	03:00 pm			20ml								
	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

Patient Sticker



FLUID CHART

Sheet No. :

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

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

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

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

NURSING CARE RECORD

Date: 13/6/28

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							
Night	4:30pm	<ul style="list-style-type: none"> - Assess the pt. condition - Monitor vitals & record - maintain I/O chart - Give medication as prescribed by doctor 	4:30pm	<ul style="list-style-type: none"> - Assessed the pt. condition - Monitored vitals & record - Maintained I/O chart - Give medication as prescribed by the doctor - CUE pending 	patient is stable now	re-checked vitals	
	8am	cont. IV fluids 5ml/hr 8am					

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 12-09-2024 1 Y 9 M 2 D (F)
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NURSING CARE RECORD



Date:

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8Am to 2pm	→ Assess the Baby condition. → maintain I/O chart → check the vitals → send CUE, → Blood clg	8Am to 2pm	→ Assess the Baby condition → maintain I/O chart → check the vitals → send CUE →	PT is stable,	check the vitals	<i>[Signature]</i>
Afternoon	2pm to 8pm	→ assess the baby condition → monitor vitals & record → maintain I/O chart → Administer medication as per drug chart	2pm to 8pm	→ assessed the baby condition → monitored vitals & recorded → maintained I/O chart → Administer medication as per drug chart	⇒ Pt is stable	→ Rechecked vitals	<i>[Signature]</i>
Night	8pm to 8Am	- Assess the pt condition - monitor vital & I/O chart - drug as per chart - provided comfortable position		- Assessed the pt condition - monitor vital & I/O chart - drug as per chart - provided comfortable position	pt is stable	Rechecked vitals	<i>[Signature]</i>

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 Baby NOMULA BHADRIKA REDDY
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 Dr. PRITESH NAGAR



NURSING CARE RECORD



Date: 15/6/26

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	<ul style="list-style-type: none"> → Assess the pt condition → Maintain Ilo chest → check the vitals → Trace B/L's → USG. Abdomen today 	8Am to 2pm	<ul style="list-style-type: none"> → Assess the pt condition → check the vitals → Maintain Ilo chest → Trace B/L's → USG. abdomen today 	pt is a stable	check the vitals	<i>Madhya</i>
Afternoon							
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							

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 Baby NOMULA BHADRIKA REDDY
 Pat 12-09-2024 1 Y 9 M 2 D (F)
 Dr. PRITESH NAGAR



NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: AFE + dehydration	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	13/6/26 N1	14/6/26 N6	14/6/26 E2	15/6/26 N1			
	Shift							
	Medical Condition (Any special condition to be noted):	-	-	-	-			
	Diet:	-	-	-	-			
ASSESSMENT	Allergy:	<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input checked="" 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 checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Vital Signs:	Temp:	97.8 F	98.3	98.5 F	98.2 F		
		Res:	30b/m	30b/m	30b/m	30b/m		
		SpO ₂ :	98%	98%	98%	98%		
		Pulse:	130b/m	140b/m	138b/m	134b/m		
		BP:	-	-	-	-		
		LOC:	-	-	-	-		
		Fall Risk Score:	-	-	-	-		
Pain Score:	-	-	-	-				
Skin Integrity	-	-	-	-				
Recommendations	Safety Needs:	<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Physiotherapy:	-	-	-	-			
	Others Specify:	<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input checked="" 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 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	
	PU Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input 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 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		
ADL (Dependent / Non Dependent):	-	-	-	-				
Post Operative Procedure Special Orders:		-	-	-	-			
Handed Over By Name :		Priyanka	Madhu	Buzette	Dings			
Signature / ID :		[Signature]	[Signature]	[Signature]	[Signature]			
Date:		14/6/26	14/6/26	14/6/26	15/6/26			
Time:		8AM	2PM	8PM	8A			
Taken Over By Name :		Madhu	Buzette	Dings				
Signature / ID :		[Signature]	[Signature]	[Signature]				
Date:		14/6/26	14/6/26	15/6/26				
Time:		8AM	2PM	8PM				

Patient Sticker



NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify:				
	Surgery / Procedure:	Post OP Day:				
BACKGROUND	Date	/	/			
	Shift					
	Medical Condition (Any special condition to be noted):					
	Diet:					
ASSESSMENT	Allergy:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Ventilation (RA, NP, NIV, VENTI):					
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Vital Signs:	Temp:				
		Res:				
		SpO ₂ :				
		Pulse:				
		BP:				
		LOC:				
		Fall Risk Score:				
	Pain Score:					
	Skin Integrity					
Recommendations	Safety Needs:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Physiotherapy:					
	Others Specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Special Diet:					
	Critical Lab Test / Values:					
	Other Special Orders / Medications:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	ADL (Dependent / Non Dependent):					
	PU Prophylaxis:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	DVT Prophylaxis:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Post Operative Procedure Special Orders:					
	Handed Over By Name :					
	Signature / ID :					
	Date:					
	Time:					
	Taken Over By Name :					
	Signature / ID :					
	Date:					
	Time:					

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BRADEN 'Q' SCALE



					Date :	14/6	14/6	14/6	
					Time :	6 AM	10 AM	2 PM	
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	
"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	
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	
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	
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	
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	
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	
TOTAL SCORE						28	28	28	
Evaluator's Name						[Signature]	[Signature]	[Signature]	

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



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
14/6/26	6 Am	0/10	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input checked="" type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input checked="" type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input checked="" type="checkbox"/> Decreasing	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	NA	
14/6/26	8 Am	0/10	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	
14/6/26	12 pm	0/10	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	
14/6/26	2 pm	0/10	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	
14/6/26	10 pm	0/10	NA	<input type="checkbox"/> Continuous <input checked="" type="checkbox"/> Intermittent	<input checked="" type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input checked="" type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input checked="" type="checkbox"/> Decreasing	<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No	NA	
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		

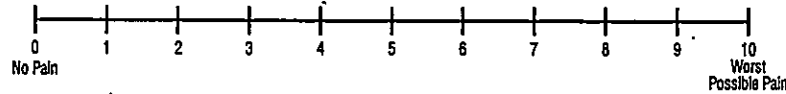
Re-assessment Frequency:
 1. Every eight hours for all hospitalized patients.
 2. For post-surgical patients, patients with chronic pain, patient with severe pain:
 a) At least every 2 hours for the first 24 hours b) Then every 4 hours.
 c) Prior to pain pain-relieving intervention. d) Within 30 – 60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

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

Numerical Pain Scale (Obstetric and Gynecology)



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

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR RR, BP, SaO₂	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO ₂ 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

Wong - Baker (Pediatrics) Above 7 Years



HNH-00004015 IP26-00006579
 Baby NOMULA BHADRIKA REDDY
 12-09-2024 1 Y 9 M 2 D (F)
 Dr. PRITESH NAGAR



CHECKLIST FOR THROMBOPHLEBITIS

14/8/26

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	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	-	-	-							
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				H (Signature)									

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

Signature of Shift In Charge :

Signature : *[Signature]* Name : *Supriya*

Signature of Ward In Charge :

Signature : *[Signature]* Name : *Balavane*

HNH-00004015 IP26-00006579
 Baby NOMULA BHADRIKA REDDY
 12-09-2024 1 Y 9 M 2 D (F)
 Dr. PRITESH NAGAR



MEDICATION RECONCILIATION FORM

Drug Allergies: nil 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 Shifting to: ward (302)

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	<u>Syp. Cloxin DS</u>	<u>3.5ml</u>	<u>PO</u>	<u>QDS</u>		<input checked="" 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. natreen

Date & Time : 14/06/26 @ 2:58 AM

Nurse Name & Signature: Shikha

Date & Time : 14/06/26 @ 3:36 AM

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



302

NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 14/6/26 Time: 9:30 AM

Weight: 12.06kg Centile: > 50th

Height: 82cm Centile: -

Inference: well nourished child

RDA: - Calories: 1200kcal/d Protein: 20gms/d

Diet Recommendations: soft diet with more liquids

Re-Assessment: Avoid spicy, chilli & outside foods

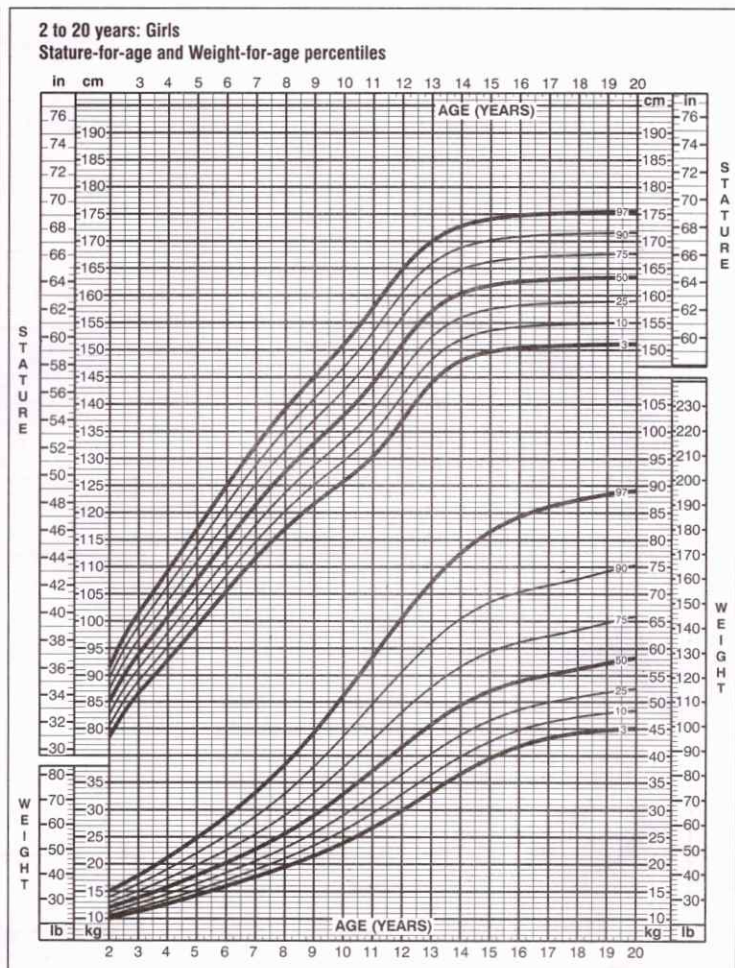
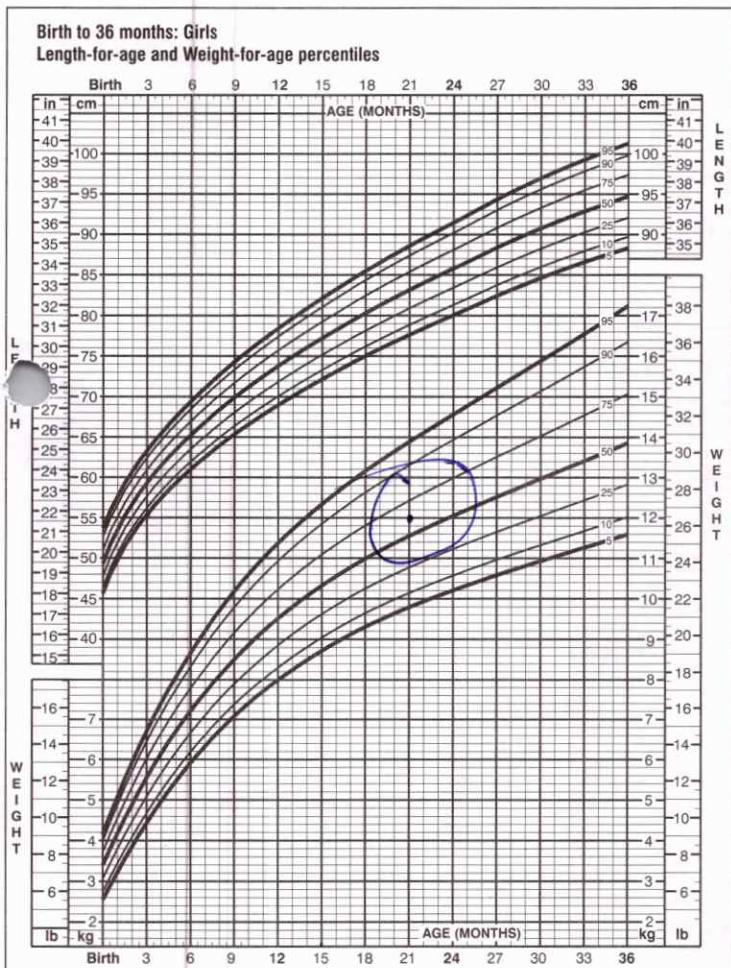
Food Allergies: NO Veg/Non-veg: NON-veg

Diagnosis: AFI with dehydration

Nutritional Intervention - Oral Enteral Parenteral

Patient's Signature: Bhadi


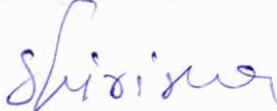
GROWTH CHART (GIRLS)



Dietician's Name: Sathnika-G

Dietician's Signature: [Signature]

PATIENT TRANSFER FORM

Patient Name & UHID No. HNH-00004015 IP26-00006579 Baby NOMULA BHADRIKA REDDY 12-09-2024 1 Y 9 M 2 D (F) Dr. PRITESH NAGAR 		Date & Time of Admission 14/06/26 @ 2:58 AM	Date & Time of Transfer Order 14/06/26 @ 3:35 AM
		Transfer Ordered by Dr. nazreen	Reason for Transfer Admission
From Unit ER	To Unit ward	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File 15	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. nazreen	
Patient & Clinical Records Received by : Pasyunka 14/6/26 @ 3:45 AM			
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



wt 2.06 kg



EMERGENCY ROOM TRIAGE FORM

Patient's Name : B/O marathu Age : 1 year Gender: Male Female

Date : 14/06/26 Time of Arrival : 2:26 AM

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: 101.5 F PR: 130b/M BP: RR: 30b/M SpO₂: 98%

Chief Complaints: 10 fever since 3 days cough and cold since 3 days

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

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

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

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian
 Triage Completion Time : 2:36 AM

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 : S/Prishu

Signature of Triage Nurse : [Signature]

Date & Time : 14/06/26 @ 2:28 AM



NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 14/06/26 Time of arrival : @ 2:29 AM
 Chief Complaints : Clostridia since 3 days cough and cold since 3 days RBS:

Height : Weight : 12.06 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 : @ 2:31 AM

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

Time	Nursing Notes
2:33 AM	Assess two patient condition monitor two vital signs

Samples collected by: / vijaya
 Samples sent by: / vijaya

Time: /
 Time: 3:02 AM

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1
2:33 AM	Ibuprofen	oral	3ml	[Signature]	[Signature]

Condition of patient at time of shift - out :	Details of Shift - out
HR: 130b/m BP: CFT: N/A RR: 30b/m SPO ₂ : 98% GCS: 15 Temperature: 99.8F Pain Score: Repeat RBS (if applicable): N/A	Shift - out from ER to: 3rd floor (302) Time of Shift - out: 3:35 AM Handover given to: (Nurse's Name)

Tick as applicable: MLC LAMA BROUGHT DEAD

Procedures done with details (if any):

..... Dr placement done

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

Date & Time: 14/06/26 @ 2:35 AM

DR. M. L. SHARMA, M.D. (PEDIATRICS) - CHEST APARTMENT 101
RAINBOW CHILDREN'S HOSPITAL, HIMAYATHI NAGAR

РАБОТА НА ПЕДИКРА ПЕДЕ ЗА СЪТЪН ДОКТОРИ ЧЕСТИ АКАДЕМИКЪТ НА НАУКАТА
РАБОТА НА ПЕДИКРА ПЕДЕ ЗА СЪТЪН ДОКТОРИ ЧЕСТИ АКАДЕМИКЪТ НА НАУКАТА

Р