

DISCHARGE SUMMARY

Name	Baby Of CHITRALEKHA VEDULA	UHID	HNH-00015919
Father/Guardian	Mr S S V KARTHIK	Age/Gender	0 Y 0 M 6 D/ Male
Address	Plot no.37, P, Secunderabad R S, Hyderabad, Telangana, INDIA, 500025		
IP No	IP26-00006602	Admission Date	17-06-2026
Ref Doctor	Self.		
Discharge Date	18.06.2026		

Consultant:
Dr. DILNAAZ FAROOQUI
MBBS DNB
56763

DIAGNOSIS	ICD CODE
NEONATAL HYPERBILIRUBINEMIA	

History: Baby Of CHITRALEKHA VEDULA is a 6 D old baby boy presented with history of yellowish discolouration of skin and eyes since 1 day prior to admission. For the above complaints, he was investigated on OPD basis (Transcutaneous bilirubin was 15.6 mg/dl). In view of hyperbilirubinemia, he was admitted to Rainbow Children's Hospital, Himayatnagar for further management.

Birth history: Baby Of CHITRALEKHA VEDULA is a term (37 weeks + 1 days)

Name	Baby Of CHITRALEKHA VEDULA	UHID	HNH-00015919
IP No	IP26-00006602	Admission Date	17-06-2026

baby boy, delivered to a G2P1L1 mother by elective LSCS on 11.06.2026 at 09:04 am with birth weight of 2.660 kgs in Rainbow Children's Hospital, Himayatnagar, Hyderabad. Baby cried immediately after birth. Apgar scores were 8/10 at 1 min, 9/10 at 5 min. Inj. Vitamin K 1mg IM was given after delivery. Delayed cord clamping done . Fetal presentation was Vertex.

Examination: He was euthermic, euvolemic & maintaining saturations at room air. Heart Rate- 134 /min and Respiratory Rate - 24/min. Icterus was present. Chest was clear with normal heart sounds. Abdomen was soft without organomegaly. Cry, tone, activity and newborn reflexes were normal. There were no obvious external congenital anomalies.

Weight on admission : 2.130 kilo grams.
Weight at discharge : 2.480 kilo grams.

Investigations: Enclosed reports.

Management: He was admitted in ward. His Transcutaneous bilirubin was 15.6 mg/dl on admission done on OP basis. He was started on double surface phototherapy. Baby was continued on demand breast feeds + measured feeds. Last serum bilirubin on 7 day of life was 10.4 mg/dl with indirect fraction of 10 mg/dl. This does not come under phototherapy range, hence phototherapy was stopped.

He remained hemodynamically stable and is being discharged with the following advice.

At the time of discharge : Baby was active, afebrile, hemodynamically stable, maintaining temperature, accepting & tolerating feeds well.

Name	Baby Of CHITRALEKHA VEDULA	UHID	HNH-00015919
IP No	IP26-00006602	Admission Date	17-06-2026

Advice:

Warmth care.
Exclusive breast feeding.
Continue direct breast feeds + measured feeds as advised.
Burping after each feed.
Monitor urine output.
Immunization to be given as per schedule.
Vitamin D3 Drops (1ml/800IU) 0.5ml once daily till further advice.
Nasoclear Nasal drops 2 drops in each nostril SOS for nose block.

Plan:

New born screening advanced / Newborn screening-4: To be done on follow up.

Review consultation with Dr. DILNAAZ FAROOQUI on Saturday (20.06.2026) in OPD at Himayatnagar with prior appointment (**Review consultation will be charged**).

Review back to Hospital:

If baby is not feeding continuously for > 6 hours, If breathing fast, Fever or poor activity or lethargy, Bluish discolouration of lips, Increase in jaundice, Abnormal movements 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.

Name	Baby Of CHITRALEKHA VEDULA	UHID	HNH-00015919
IP No	IP26-00006602	Admission Date	17-06-2026

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. DILNAAZ FAROOQUI
MBBS DNB
56763

ADMISSION SHEET
Registration Details :

Admission No : IP26-00006602 **Admit Date** : 17-Jun-2026 **Admit Time** : 11:45 AM **UHID** : HNH-00015919

Patient Details :

Patient Name	: Baby Of CHITRALEKHA VEDULA	Age	: 0 Y 0 M 6 D
Guardian	: Mr S S V KARTHIK	DOB	: 11-06-2026 09:04 AM
Gender	: Male	Religion	:
Occupation	:	Martial Status	:
Address (H)	: Plot no.37, P Secunderabad R S Hyderabad Telangana INDIA 500025	Phone No	: 9949096232/ 9985136724
		E-mail	: chitralekhavedula@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 S S V KARTHIK	Relationship	: Father
Contact Address	: Plot no.37, P Secunderabad R S Hyderabad Telangana INDIA 500025	Phone No	: 9949096232



Signature


Doctor Details :

Doctor Name	: Dr. DILNAAZ FAROOQUI	Specialisation	: GENERAL PEDIATRICS
Referral Doctor	: Self.	Phone No	:
Co-Consultant	:		

Payment Details :

Payment Mode	: DC/CC Card	Deposit Amount	: 25000.00
		Payor Name	: SELFPAY


PATIENT TRANSFER FORM

HNH-00015919 IP26-00006602 Baby Of CHITRALEKHA VEDULA 11-06-2026 0 Y 0 M 6 D (M) Dr. DILNAAZ FAROOQUI 		Date & Time of Admission 17/6/26 @ 12pm	Date & Time of Transfer Order 17/6/26 @ 12:15pm
Treating Consultant Name DR Dilnaz	Transfer Ordered by DR. pranav	Reason for Transfer Admission	
From Unit ER	To Unit 209	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File 20	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring Prabis		Name of Person Ordered Transfer pranav	
Patient & Clinical Records Received by : Sandhya			
Date & Time of Patient Received : @ 12:20pm 17/6/26			

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

- Unavailable Bed
 Nurse not Available
 Available Bed not ready

ACTIVITY RECORD FOR BILLING

HNH-00015919 IP26-00006602
 Baby Of CHITRALEKHA VEDULA
 Name: 11-06-2026 0 Y 0 M 6 D (M) -----
 Dr. DILNAAZ FAROOQUI
 UHID  ----- Consultant : ----- Dept : -----
 Date of Admission : ----- Time : ----- Date of Discharge : ----- Time: -----
 Room / Bed No : ----- Ward : ----- Suggested Billable bed type : -----

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
17/6/26	12pm	ER	209	<i>Poojari Sandhya</i>

Cross Consultation Visit

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

Ref.No. F/IN/PR/10



Rainbow[®] Children's Hospital

PEDIATRIC IN-PATIENT MEDICAL RECORD

HNH-00015919 IP26-00006602
Baby Of CHITRALEKHA VEDULA
11-06-2026 0 Y 0 M 6 D (M)
Dr. DILNAAZ FAROOQUI



Patient Name : _____

Patient ID# : _____

Consultant : _____

Final Diagnosis : _____

Pediatric Multiorgan History & Physical Examination

Name : B/o Chitralekha Vedha Age/Sex _____

Informant _____ Reliability _____

Chief Presenting Complaints & Duration (Chronologically):

Cl0 Yellowish discoloration of eye & skin :: 1 day

History of present illness :

Cl0 Yellowish discoloration of eye & skin :: 1 day
FT / 37 wk / LSCS / 2.66 kg / male

BT - UT - ~~2.66 kg~~ 2.66 kg

T - UT - ~~2.63 kg~~ 2.47 kg . WT loss - 7%

MBS | 0 +ve

BB 4 | B +ve

TcB9 - 15.6 mg/dl

Pediatric Multiorgan History & Physical Examination

Anthropometry

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

Weight (kgs) 2.63kg (Centile _____)

On Examination :

Temperature : 36 Pulse Rate: _____ Description _____

B.P. _____ SPO2 97% at _____

Resp. rate and type of breathing : _____

Rash Fitzner ⊕

Lymphadenopathy _____

Oedema : _____

Respiratory system :

Inspection (any s/o distress) : _____

Air entry & breath sounds : B/LAE ⊕

Any addes sounds : _____

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

Cardiovasclular System :

Inspection of procordium : _____

Heart Sounds : S₁ S₂ ⊕

Any murmur : _____

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

Per Abdomen :

Inspection _____

Palpation : soft

Ausculation : _____

Spine: _____ External Genitelia : _____

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

Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS Score : C/T/A - Good

Cranial Nerves : / (N)

Motor System :

Nutrition : _____

Tone : _____ Power _____

Co-ordinator : (N)

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR

Superficials :

Plantars _____

Sensory System :

(N)

Bladder / Bowel : _____

Clinical Summary & Diagnostic :

N/A HIS

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment :

BIND

Desired goals of the treatment :

Treat WNT

Planned Labs :

SBR - T/m - 10AM

Noted By Pradi

Planned Management :

- DSPT c eye & genital cones

- Wan Cam

- DBF j/lb palpating Q24

- Vit - P3 drug

- MUPISONE oint

- DAE

- Lactation consultation

Noted By Pradi

Please fill up the following details

1. Name of the Referring Doctor : _____

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

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

4. Name of the doctor in Rainbow Team Dr - DILNAAZ on
whose name the patient is being referred

Doctor's Signature Name Dilnaaz

Date 17/6/26 Time _____



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
17/6	CLINIC Dr. Naipuzh	
2:00 PM	CLINIC	
	T / AAR / 2-66lg / LSS / mce.	
	Eutremic.	Plan
	C/T/A - Good.	
	Vitals - Stable.	DBF 2nd hours for biopsy
	R/S / NAD.	DSPT & eye & genital coverage
	P/A	
	Intermittent feed well.	OAG
		Lactational consultation
		SBR @ 10:00A tomorrow
		@ref
		Noted by Sr. Sandhya
		17/6/26
		2:00 PM

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	Progress Notes	
17/6/26	o/b Dr Dilnaaz	
7pm	T AGA 2.66 kg Male.	
	Baby euthenic ↓ DSPT	
	accepting feed.	
	Paired up/s	<u>Adv</u>
	No clo	
	O/E vitals	SBR SBR 8 am
	stable	T/M
	PA SGT-	Lactational Counseling
		DBR Q24 - good bones
		OAG to be done
		<u>Dilnaaz</u>
		noted by Sr. Anusutha
		7pm



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
18/6/26	S/B. Dr. Prabhakar	Dr Anusha.
7:30 AM	T AGA 2.66kg	LSC Male.
	Baby ↓ DSPT	
	Y. wt = 2.63-470.	euthenic
	Twt 2.480	Adu
	150g ↓	accepting feed
	10g ↑	pass yls
	No clo.	SBR at 8am
	o/g vitals	DBF Q2H C good here
	Stable	
	PA logt	OAG to be done
		Recheck wt
	At	
		noted by Sv. Anusha.
		18/6/26
		7:5
		7:5



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
18/6/26	SAB Dr. Dilnaz	
9:20 AM	Term / AGA / B.Wt - 2.6 kgs / Male	
	y. wt - 2.47 kgs	
	Today's wt - 2.68 kgs (↑10gms)	Continue phototherapy
	Alert, active	Plan for bath after discharge following oil massage
	Euthermic	Continue EBF 2 hourly
	Accepting feeds well	- collect TSB report
	Biceps (+)	
	ole vitally stable	
	ole	
	CVS - S1S2 (+)	
	RS - AEBE	Dilnaz
	PIA - soft, nl	
	TSB = 10.4 mg/dL (N)	- Discharge

noted by Sr. Sreenithya
 18/6/26
 9:20 am

HNH-00015919 IP26-0006602
 Baby Of CHITRALEKHA VEDULA (M)
 11-06-2026 0 Y 0 M 6 D
 Dr. DILNAAZ FAROOQUI



DRUG CHART

Date of Admission: 17/6/26 Drug Allergies: Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

SOS / PRN (As Required Medication)

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



REGULAR PRESCRIPTIONS

Weight. 2.6kg Ward.

Verified by
 Dr. Dhakshayani

DRUG : VITAMIN - D ₃ Drop				Date Time
Dose 0.5ml	Route PO	Frequency Once Daily	Start Date 17/6	
Name & Signature of the Doctor Starting the Drugs: <i>Pranav</i>				
Additional Instructions: 1ml = 800IU				
Daily Doctor's Endorsement by a Sign				

DRUG : MUPISONNE OINTMENT				Date Time
Dose -	Route Local	Frequency TID	Start Date 17/6	<i>6am X</i>
Name & Signature of the Doctor Starting the Drugs: <i>Pranav</i>				
Additional Instructions: <i>Around Umbilicus</i>				<i>7PM ✓</i> <i>10PM ✓</i>
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:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

HNH-00015919 IP26-00006602
 Baby Of CHITRALEKHA VEDULA (M)
 11-06-2026 0 Y 0 M 6 D
 Dr. DILNAAZ FAROOQUI



MEDICATION RECONCILIATION FORM

Drug Allergies: Not known any Drug Allergies

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

Shifting From: Shifted to:

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 : *Pranav / PF*

Date & Time : *17/6/26 at 12pm*

Nurse Name & Signature: *Pengaj (Suyandh)*

Date & Time : *17/6/26 @ 12pm*

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

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Baby Of CHITRALEKHA VEDULA
11-06-2026 0 Y 0 M 6 D (M)
Dr. DILNAAZ FAROOQUI



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

BirthRight[™]
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

RESULT SHEET

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						

IM-00015919 IP26-00006602
 by Of CHITRALEKHA VEDULA
 06-2028 0 Y 0 M 6 D
 DILNAAZ FAROOQUI (M)

INFANT (<1 year)

Children's Observation & Early Warning Scoring Chart

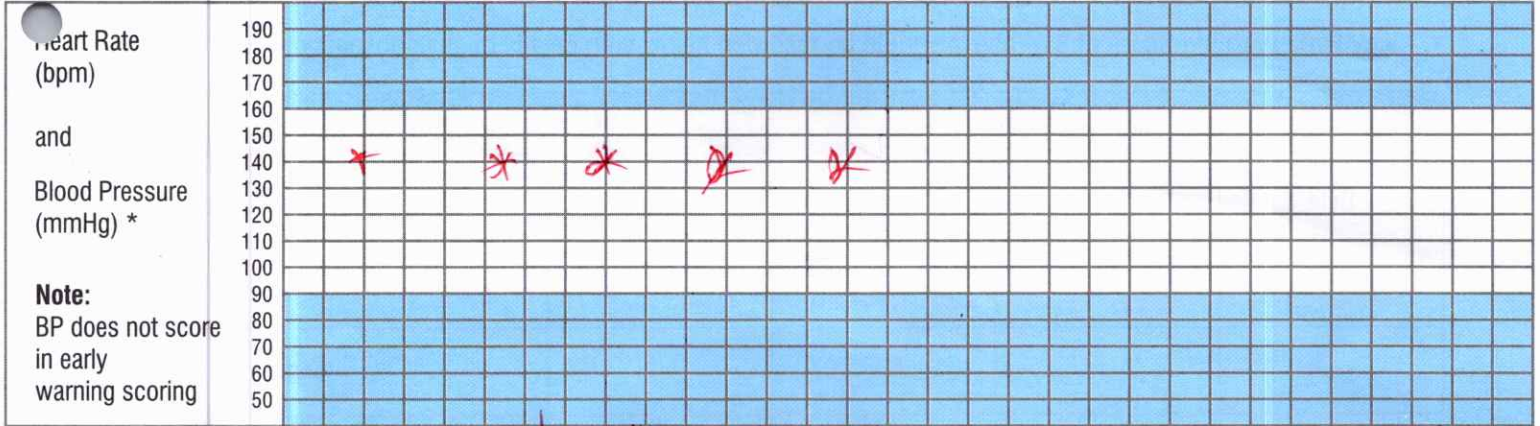
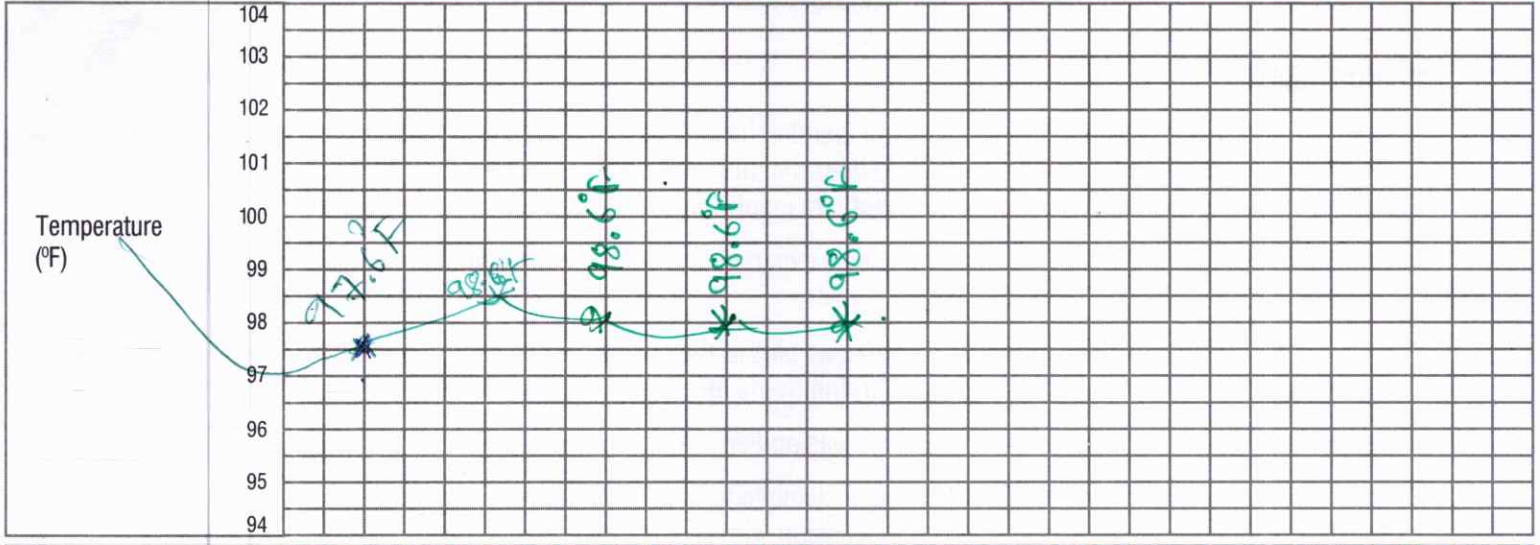


Patient Sticker

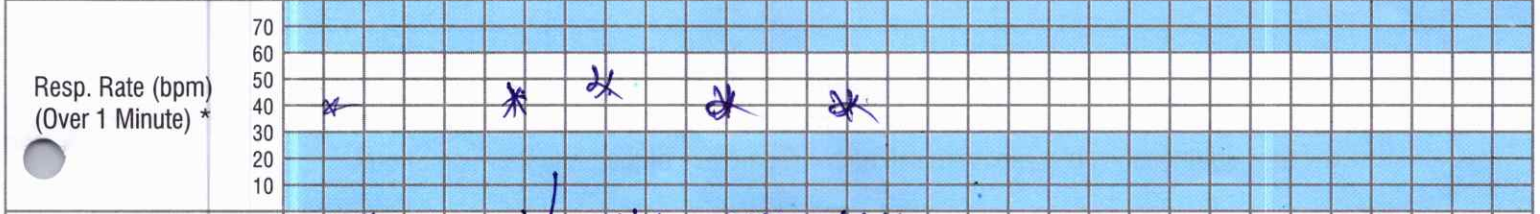
EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 17/6/26 Time: 2pm 6pm 10pm 2am 6am

Doctor/Nurse/Family Concern? Pro Pro Pro Pro Pro



Heart Rate (Number) 142b/m 146b/m 144b/m 149b/m 148b/m



Resp Rate (Number) 40b/m 44b/m 44b/m 44b/m 44b/m

Resp Distress Mod/ Severe None / Mild

Receiving O₂ (l/min) O₂ Saturations (%) 100% 99% 100% 100% 100%

Conscious Level Normal Altered

GCS *

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

- ACTIONS**
- 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 incharge and PICU /NICU fellow or PICU/NICU consultant to be informed
- NB: Scores 3 should be recorded overleaf

* 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 I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

HNH-00015919 IP26-00006602
 Baby Of CHITRALEKHA VEDULA
 11-06-2026 0 Y 0 M 6 D (M)
 Dr. DILNAAZ FAROOQUI



FLUID CHART

Sheet No. :

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

Date	Time	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
		Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G							
17/6/26	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm		Milk	—	—		—	—	—		g	du
	01:00 pm											
Total Intake :					Total Output :							
17/6/26	02:00 pm											
	03:00 pm		DR2									
	04:00 pm		DR2	—	—							
	05:00 pm		DR2	—	—							
	06:00 pm		DR2	—	—							
	07:00 pm		DR2	—	—							
Total Intake : Taken					Total Output : U-1 M-1							
17/6/26	08:00 pm		DBF									
	09:00 pm		DBF									
	10:00 pm		DBF	—	—							
	11:00 pm		DBF	—	—							
	12:00 am		DBF	—	—							
	01:00 am		DBF	—	—							
Total Intake : Taken					Total Output : U-2 M-1							
18/6/26	02:00 am		DBF									
	03:00 am		DBF									
	04:00 am		DBF	—	—							
	05:00 am		DBF	—	—							
	06:00 am		DBF	—	—							
	07:00 am		DBF	—	—							
Total Intake :					Total Output : U-2 M-2							

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.

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			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: 17/6/26

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	2:30 pm	→ Assess baby condition → monitor the vitals → maintain I/O chart	12:30 pm	→ Assessed Baby condition → monitored the vitals → maintained I/O chart	Baby is stable	Re-checked vitals	[Signature]
	to	→ DBF 2nd hourly → continuous DSPT	to	→ DBF every 2nd hourly → continuous DSPT			
Afternoon	2pm	→ give medication as per chart	2pm	→ given medication as per chart	Baby is stable	Rechecked vitals	[Signature]
	8pm	→ Assess the Baby Condition → monitor vitals → maintain I/O chart → DBF 2nd hourly	8pm	→ Assessed the Baby Condition → monitored vitals → maintained I/O chart → DBF 2nd hourly			
Night	8pm	→ Assess the Baby Condition → monitor vitals → maintain I/O chart → DBF every 2 hourly	8pm	→ Assessed the Baby Condition → monitor vitals → maintain I/O chart → DBF every 2 hourly	Baby is stable	Rechecked vitals	[Signature]

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							



NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: <u>NNJ</u>			Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known			
	Surgery / Procedure:			If Yes Specify:			
BACKGROUND	Date	<u>17/6/26</u>	<u>17/6/26</u>	<u>17/6/26</u>			
	Shift	<u>09h</u>	<u>12h</u>	<u>NI</u>			
ASSESSMENT	Medical Condition (Any special condition to be noted):	<u>-</u>	<u>-</u>	<u>-</u>			
	Diet:	<u>Milk</u>	<u>DSB</u>	<u>DSB</u>			
RECOMMENDATIONS	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 type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Ventilation (RA, NP, NIV, VENTI):	<u>-</u>	<u>-</u>	<u>-</u>			
	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	
	Vital Signs:	Temp:	<u>98.3F</u>	<u>98.4F</u>	<u>98.6F</u>		
		Res:	<u>25b/m</u>	<u>25b/m</u>	<u>28b/m</u>		
		SpO ₂ :	<u>100%</u>	<u>100%</u>	<u>100%</u>		
		Pulse:	<u>138b/m</u>	<u>130b/m</u>	<u>149b/m</u>		
		BP:	<u>-</u>	<u>-</u>	<u>-</u>		
		LOC:	<u>-</u>	<u>-</u>	<u>-</u>		
	Fall Risk Score:	<u>"0"</u>	<u>"0"</u>	<u>"0"</u>			
Pain Score:	<u>"0"</u>	<u>"0"</u>	<u>"0"</u>				
Skin Integrity	<u>Good</u>	<u>Good</u>	<u>Good</u>				
RECOMMENDATIONS	Safety Needs:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Physiotherapy:	<u>-</u>	<u>-</u>	<u>-</u>			
	Others Specify:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Special Diet:	<u>-</u>	<u>-</u>	<u>-</u>			
	Critical Lab Test / Values:	<u>-</u>	<u>-</u>	<u>-</u>			
	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 type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
RECOMMENDATIONS	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 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 type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	ADL (Dependent / Non Dependent):	<u>-</u>	<u>-</u>	<u>-</u>			
	Post Operative Procedure Special Orders:	<u>-</u>	<u>-</u>	<u>-</u>			
Handed Over By Name :		<u>Anusha</u>	<u>Apurva</u>	<u>Anusha</u>			
Signature / ID :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>			
Date:		<u>17/6/26</u>	<u>17/6/26</u>	<u>17/6/26</u>			
Time:		<u>2PM</u>	<u>8PM</u>	<u>8AM</u>			
Taken Over By Name :		<u>Apurva</u>	<u>Anusha</u>				
Signature / ID :		<u>[Signature]</u>	<u>[Signature]</u>				
Date:		<u>17/6/26</u>	<u>17/6/26</u>				
Time:		<u>12PM</u>	<u>8PM</u>				

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	<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	<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	<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	<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	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	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	<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	<input type="checkbox"/> Yes <input type="checkbox"/> No		
ADL (Dependent / Non-Dependent):								
Post Operative Procedure Special Orders:								
Handed Over By Name :								
Signature / ID :								
Date:								
Time:								
Taken Over By Name :								
Signature / ID :								
Date:								
Time:								

HNH-00015919 IP26-00006602
 Baby Of CHITRALEKHA VEDULA
 11-06-2026 0 Y 0 M 6 D (M)
 Dr. DILNAAZ FAROOQUI

RADEN 'Q' SCALE



Date: 17/6/26 17/6/26
 Time: M6 Ni

Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4		
"Activity The degree of physical activity"	1. Bedfast: Confined to bed	2. Chairfast: Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	1	4		
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	3	4		
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4		
FRICION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	2	4		
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	2	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.	2	4		
TOTAL SCORE					20	28		
Evaluator's Name					AK	10		

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
17/6/26	2pm	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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No	NA	<i>[Signature]</i>
17/6/26	10pm	0/10	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	<i>[Signature]</i>
18/6/26	6Am	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 type="checkbox"/> No	NA	<i>[Signature]</i>
				<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		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Re-assessment Frequency:

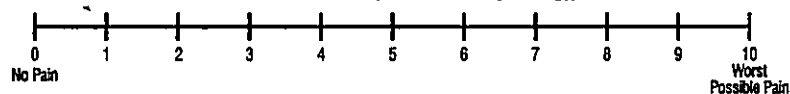
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

Numerical Pain Scale (Obstetric and Gynecology)



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

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1		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



Wf - 2.13 kg



EMERGENCY TRIAGE FORM

HNH-00015919 IP26-00006602
 Baby Of CHITRALEKHA VEDULA
 11-06-2026 0 Y 0 M 6 D (M)
 Dr. DILNAAZ FAROOQUI

Patient's Name: Age: 6 days (M) Gender: Male Female
 Date: Time of Arrival: 11:26 AM
 Allergies: Blood Transfusion Other (Specify): Not known
 Source of Information: Parents Others (Specify)
 Mode of Arrival: Ambulatory Wheelchair Ambulance
 Initial Vital Signs: Temp: 98.5 F PR: 149 bpm BP: RR: SpO₂: 100%
 Chief Complaints: Yellowish color on the over of Body.

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

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

NOTE : All immunocompromised children and preterm babies to be considered Level 2.
 All Children less than 2 years age with high fever to be considered Level 3.
 * CTAS - Canadian Triage and Acuity Scale
 Signature of Parent / Guardian
 Triage Completion Time :

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 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 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 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 : Pragna
 Date & Time : 17/6/26 @ 11:27 AM
 Docu. No. : RCH / FRM / CLINICAL / 085
 Signature of Triage Nurse : [Signature]

Patient Sticker

NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date: 17/6/20 Time of arrival: 11:25 AM

Chief Complaints: c/o yellowish colour over the body RBS:

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

Allergies: Yes No Medications Blood Transfusion Food Other:

If yes, identify

Pain Screening: Yes No If Yes, Pain Score: -01 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: 11:27 AM

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

Time	Nursing Notes

Samples collected by: *[Signature]*

Time: *[Signature]*

Samples sent by: *[Signature]*

Time: *[Signature]*

Medication given in ER:

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

Condition of patient at time of shift - out :	Details of Shift - out
HR: <i>119 bpm</i> BP: CFT: <i>25cc</i> RR: SPO ₂ : <i>100%</i> GCS: <i>15/15</i> Temperature: <i>98.2 F</i> Pain Score: <i>0</i> Repeat RBS (if applicable):	Shift - out from ER to: <i>ward</i> Time of Shift - out: <i>12:20 AM</i> Handover given to: (Nurse's Name)

Tick as applicable: MLC LAMA BROUGHT DEAD

Procedures done with details (if any):

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

Date & Time : *17/6/26 @ 12:27 AM*

GENERAL CONSENT FOR TREATMENT

Patient Name: Baby Of CHITRALEKHA VEDULA Age : 0 Y 0 M 6 D
IP No: IP26-00006602 Sex: Male
Consultant: Dr. DILNAAZ FAROOQUI Ward/Bed No: GF -EMERGENCY/ER01

The undersigned patient and I or responsible relative or person hereby consent to and authorize Rainbow Hospitals doctors and medical personnel to perform medical examinations, conduct routine investigations and administer medical treatments, outpatient procedures, minor dressings, vaccinations and immunizations during the course of the patient's care, as in patient.

Patient, be deemed advisable or necessary.

I understand that the confidentiality of all medical records shall be protected to the full extent of the Law. The undersigned also consent to the use of health related information/ audiovisuals of the patient for research & training purpose or for insurance coverage and while doing so confidentiality of the patient will be maintained at all times and this will not affect the care of the patient.

In giving my general consent to treatment, I understand that I retain the right to refuse any particular examinations, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by treating doctors. I also understand that the practice of medicine is not an exact science and that no guarantee have been made to me as the results of my evaluation and I or treatment.

I understand that I shall not bring valuables to the Hospitals and that the Hospital will not be responsible for the loss, destruction or theft of my personal belongings. I assume full responsibility for all my personal items and release the Hospital from responsibility and liability for such personal items and valuables.

"I am aware that during the patient care it is inevitable that certain re-useable equipment shall be re-used after sterilization and disinfection. I am informed that the hospital assures maximum level of precaution and care in sterilizing and disinfecting the equipment and monitors the whole process as per evidence based guidelines".

Note:

1 We do not allow use of medication brought from outside by the patient.

2 I have received attendant passes as per my room category. I understand that I have to return it back at the time of final bill clearance. In case of failing the submission, I will pay 200/- Rs.

(Receivers Signature:.....)

3 IP Guide book has been given to me and I have been explained about the Hospitals rules and policies.

4 Financial and billing counseling has been done to me.

Signature of Patient/Relative:

Name:

Sai Venkate Kadik. Saipella

Relationship:

Father

Date:

17/06/26

Time:

11:55

Witness Name:

Witness Signature:

} @

Patient Address:

Plot no.37, P Secunderabad R S
Hyderabad Telangana INDIA 500025



BILLING POLICY

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

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

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

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

MODE OF PAYMENT & REFUNDS

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

Name & signature of Patient/Attendant

(Signature of Admission Desk executive)

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

RAINBOW CHILDREN'S MEDICARE PRIVATE LIMITED

Registered Office: Road No.2, Banjara hills, Near Hotel Park Hyatt, Hyderabad - 500 034, T: +91 40 2233 4455.

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