

BP centiles.

Day time

Night time

Sys

Dia

Sys

Dia

5P

90

51

81

46

50P

101

62

91

56

90P

111

70

100

63

95P

114

73

103

66

99P

120

77

108

70

99P+5

125

82

113

74

110

70

105

70

# PATIENT TRANSFER FORM



HNH-00015746 IP26-00006477 Master HANEESH SHOBANBABU (M) 03-07-2017 8 Y 11 M 2 D Dr. ABHISHEK RAVINDRA JAIN 		Date & Time of Admission	Date & Time of Transfer Order
Treating Consultant Name Dr. Abhishek		Transfer Ordered by Dr. Pritam Nigam	Reason for Transfer stable
From Unit PICU	To Unit 2nd floor 219	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File 16	Number of Imaging Films -	Personal belongings including clinical documents. If any handed over to attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring Sujatha		Name of Person Ordered Transfer	
Patient & Clinical Records Received by : Divya J. [Signature] 5/6/26			
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



## Moderate Sedation Flow-Sheet

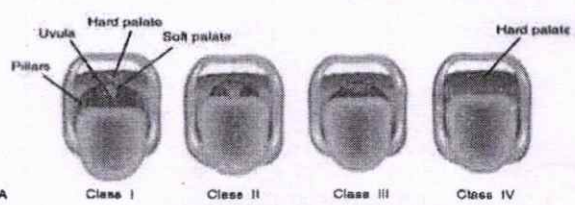
### Immediate Pre-Sedation Assessment

B.P	PR	R.R	Temp	SPO <sub>2</sub>	Pain Score	Weight
90/60	75	20	Afebrile	99	-	22kgs

Diagnosis: unprovoked seizures

Procedure: MRI Brain & contrast

Comorbidities: nil

<input checked="" type="checkbox"/> Risk, benefits & alternatives discussed; <input checked="" type="checkbox"/> Patient understand & elects to proceed <input checked="" type="checkbox"/> Consents for procedure and sedation signed and dated  <b>ASA Physical Status</b> <input checked="" type="checkbox"/> ASA PS 1: Healthy Patient <input type="checkbox"/> ASA PS 2: Mild Systemic Disease, no functional limitations <input type="checkbox"/> ASA PS 3: Severe Systemic Disease, functional limitations <input type="checkbox"/> ASA PS 4: Severe Systemic Disease, constant threat to life <input type="checkbox"/> ASA PS 5: Moribund Patient unlikely to survive 24 hrs. <input type="checkbox"/> ASA PS 6: A declared braindead patient whose organs are being removed for donor purposes  <input type="checkbox"/> E: Emergency procedure GCS: E            M            V  <input checked="" type="checkbox"/> IV Site:            Gauge: <u>22g</u>  Sedation Plan: <u>MAC &amp; drugs</u>  Allergies: <u>nil</u>	<b>AIRWAY EVALUATION</b> <b>Mouth:</b> <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Loose Teeth <input type="checkbox"/> Small Mouth <input type="checkbox"/> Protruding Incisors <input type="checkbox"/> Receding Lower Jaw <input type="checkbox"/> Dentures  <b>Neck:</b> <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Decreased ROM <input type="checkbox"/> Thyromental Distance Less Than 6 cm <input type="checkbox"/> Short Neck   Mallampati Class: <input type="checkbox"/> I <input checked="" type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV
---	--

### Monitoring of Patient Intra - Procedure

#### Procedure Monitoring

Heart Rate (HR), Respiratory Rate (RR), Oxygen Saturation (O<sub>2</sub> Sat) continuously monitored, and Level of Consciousness (LoC) to be monitored and recorded minimally every 15 minutes until 15 minutes after the last administration of any sedation, then every 30 minutes, then every 1 hour until stable. Respiratory status to be monitored continuously.

#### Level of Consciousness (LoC):

- A - Alert
- V - Verbally Responsive
- P - Painfully Responsive
- U - Unresponsive

Observation to be documented every 15 mins

TIME	BP CRT	PR	RR	O <sub>2</sub> Sat%	O <sub>2</sub> Supplementation	Comments / Initials
Baseline					Via NPA 2ht	-
3:00pm	< 3sec	75	20	98	"	-
3:15pm	< 3sec	79	20	99	"	-
3:30pm	< 3sec	82	22	98	"	-
3:40pm	< 3sec	76	20	100	"	-

DRUG & IV Fluid: (including Nitrous Oxide)	ROUTE	DOSE	TIME GIVEN	SUBSEQUENT DOSES AND TIME
Inj-MIDAZOLAM	IV	1mg	3:00pm	-
Inj-PROPOFOL	IV	30mg	3:00pm	-

Doctor Notes: procedure uneventful

Time of transportation to post sedation care room: 3:40 pm LOC: \_\_\_\_\_

Doctor Name: Dr. Anshu K Signature: [Signature]

**Post Sedation Care Room**

Time	3:40	3:55	4:10	4:30															
Monitoring																			
ECG																			
NBP																			
Oximeter																			
Pain Score (0-10)																			
Sedation Score (0-4)																			

**TOTAL ALDRETTE SCORE AT DISCHARGE =**  
(If 9 and more patient can discharge from post Sedation care unit)

Activity :	Consciousness:	Respiration:	Oxygen Saturation:	Circulation:
Four extremities = 2	Fully awake = 2	Breathe Deep = 2	Sat O <sub>2</sub> > 92 % on room air = 2	BP +/- 20 mm hg of pre-op = 2
Two extremities = 1	Arousal on calling = 1	Dyspnea, limited breathing = 1	Needs oxygen to maintain Sat O <sub>2</sub> > 90% = 1	BP +/- 20-50 mm hg of pre-op = 1
No extremities = 0	Unresponsive = 0	Apnea = 0	Saturation < 90% with oxygen = 0	Bp +/- 50 mm hg of Pre-Op = 0

Patient Discharge Time: \_\_\_\_\_

Nurse Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_

Consultant Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Stamp

HNH-00015746 IP26-00006477  
 Master HANEESH SHOBANBABU  
 03-07-2017 8 Y 10 M 30 D (M)  
 Dr. ABHISHEK RAVINDRA JAIN



## RESULT SHEET

Date	2/6/26				
Time	1-AM				
Hb	12.5				
PCV	35.2				
RBC	4.69				
WBC	7.07				
N/L	75.1/19.9				
Platelets	452				
CRP	5.0				
ESR					
PCT					
RBS					
Na	139				
K	5.1				
Cl	99				
Ca/Mg	10.2/2.1				
Phosphate					
Urea	27				
Creatinine	0.5				
ALP	266				
SGPT	35				
SGOT	33				
T.Bill/Conj	0.7/0.2				
T.Protein	9.3				
S.Albumin	5.3				
S.Globulin	4				
A/G Ratio	1.3				
Uric Acid	3.4				
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein / Sugar					
Cells					
N/L					

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						
CSF Analysis:- cell count - NO cells.						
pH - 8.0						
Appearance - clear.						
colour - colourless						
Clot formation - clear NO clot						
CSF protein - 35						
CSF Glucose - 71						

Culture and Sensitivities : .....

.....

.....

.....

Radiology :    USG : .....

                  X-Ray : .....

                  ECHO : .....

                  CT : .....

                  MRI : .....

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

### DISCHARGE SUMMARY

<b>Name</b>	Master HANEIESH SHOBANBABU MARGAM	<b>UHID</b>	HNH-00015746
<b>Father/Guardian</b>	Mr SHOBHAN BABU	<b>Age/Gender</b>	8 Y 11 M 0 D/ Male
<b>Address</b>	6-91 POST YOUSUF NAGAR , MDL:KORUTLA ,DIST: JAGITYAL, Ailapur, Korutla, Telangana, INDIA, 505330		
<b>IP No</b>	IP26-00006477	<b>Admission Date</b>	02-06-2026
<b>Ref Doctor</b>	SELF		
<b>Discharge Date</b>	08.06.2026		

**Consultant:**

**Dr. ABHISHEK RAVINDRA JAIN**

**MBBS, MD(Pediatrics), IAP POST DOCTOR FELLOWSHIP IN  
PEDIATRIC NEUROLOGY**

TSMC/FMR/02757

**Co-Consultant:**

**Dr. ANIKET ANIL PARASHAR**

MBBS - MD

TSMC/FMR/08568, dr.aniket.p@rainbowhospitals.in

<b>Name</b>	Master HANEIESH SHOBANBABU MARGAM	<b>UHID</b>	HNH-00015746
<b>IP No</b>	IP26-00006477	<b>Admission Date</b>	02-06-2026

<b>DIAGNOSIS</b>	<b>ICD CODE</b>
UNPROVED SEIZURE	
AUTOIMMUNE ENCEPHALITIS (? ADEM, ? MOGAD, ? NMOSD)	

**History:** Master HANEIESH SHOBANBABU MARGAM , 8 Y 11 M 0 D , old boy presented with history of GTCS type of seizures in the form of generalised tonic clonic movements , associated with uprolling of eye balls of lasting for 3-5 minutes followed by post ictal drowsiness for few minutes, 4 days back prior to admission. Child was started on oral Levipil at outside hospital after which child remained seizure free for 2 days. Child developed 8-10 episodes of seizures on 02.06.2026 with same semiology. Child also had multiple episodes of vomitings since 1 day greenish in colour(? bilious) not associated with blood. For the above complaints he was admitted at Rainbow Children's Hospital for further management.

**Examination:** He was afebrile. Her heart rate was 76/min, Blood pressure - 107/77 mmHg and Respiratory Rate - 18/min. On auscultation of chest, air entry was bilaterally equal with normal heart sounds and there was no murmur. Abdomen was soft without organomegaly. Bowel sounds were heard.

On neurological examination: Child was drowsy. Pupils were bilaterally equal and reacting to light. EOM - Full. DTRs - elicitable. Tone was normal. Power: Moving all limbs against gravity. Plantars - bilateral flexor. There were no focal neurological or cranial nerve deficits. There were no signs of raised intracranial pressure.

<b>Name</b>	Master HANEIESH SHOBANBABU MARGAM	<b>UHID</b>	HNH-00015746
<b>IP No</b>	IP26-00006477	<b>Admission Date</b>	02-06-2026

Weight on admission : 22 kgs.

**Investigations: Enclosed reports.**

**EEG (03.06.2026):**. The above findings suggestive of mild diffuse cerebral dysfunction(to correlate clinically)

**MRI Brain ( 02.06.2026):**

Mild claustral and mesial temporal lobe focal edematous changes with left optic neuritis. In the clinical setting of acute recurrent seizures/ status epilepticus, findings raise the possibility of an infection triggered encephalopathy / immune - mediated inflammatory encephalopathic process, MOG antibody-associated disease. Viral etiology is less like differential.

Date	On 02.06.2026
TEST	Result
<b>CBP: Hemoglobin</b>	12.5g/dl
<b>While blood cell</b>	7070cell/cmm
<b>Platelets</b>	4.52lakh/cmm
<b>CRP</b>	5.0mg/L
<b>S.electrolytes: Natrium (Na)</b>	139mmol/L
<b>Potassium (K)</b>	5.1mmol/L

Name	Master HANEIESH SHOBANBABU MARGAM	UHID	HNH-00015746
IP No	IP26-00006477	Admission Date	02-06-2026

Chloride (Cl)	99mmol/L
Serum.CREATININE	0.5mg/dl
BLOOD UREA	27mg/dl
URIC ACID	3.4
LFT: SBR	0.7mg/dl
DIRECT FRACTION	0.2mg/dl
SGOT	33U/L
SGPT	35U/L
ALP	266U/L
PROTEIN	9.3g/dl
ALBUMIN	5.3g/dl
GLOBULIN	4g/dl

### CSF CULTURE AND SENSITIVITY :

**Gram stained smear:** Shows no cells organisms or yeasts.

**Z.N stained smear :** Do not show any acid fast bacilli.

**Culture : -** No growth after 72 hrs of incubation.

<b>Name</b>	Master HANEIESH SHOBANBABU MARGAM	<b>UHID</b>	HNH-00015746
<b>IP No</b>	IP26-00006477	<b>Admission Date</b>	02-06-2026

## CSF ANALYSIS

### CSF ANALYSIS:

COLOUR	COLOURLESS			
APPEARANCE	CLEAR			
PH	8.0	7.35 - 7.45	unit	H
CLOT FORMATION	NO CLOT	-		-
CSF PROTEIN	35	15 - 45	mg/dl	-
CSF GLUCOSE	71	60 - 90	mg/dl	-
CELL COUNT	NO CELLS			

**Management:** He was admitted in the PICU and was started on IV anti seizure medications IV Valproate and started on 3% NS infusion. Child had one episode of staring look lasting for 1-2 mins after admission following which, loaded with IV Phenobarbitone followed by maintenance dose . In view of further seizures, IV Lacosamide was loaded followed by maintenance doses. MRI brain done

<b>Name</b>	Master HANEIESH SHOBANBABU MARGAM	<b>UHID</b>	HNH-00015746
<b>IP No</b>	IP26-00006477	<b>Admission Date</b>	02-06-2026

suggested the possibility of immune mediated inflammatory changes with signs of left optic neuritis. EEG done which shows mild diffuse cerebral dysfunction. Hence, IV Methylprednisolone was given for 5 days as pulse doses followed by oral maintenance steroids. IV fluids and IV antibiotics were started and continued for 7 days. In view of suspected meningitis / encephalitis, CSF analysis was done, which showed protein - 35 mg/dl, sugar - 71 mg/dl with no cells. CSF was sent for analysis and culture which was sterile after 72 hours. Ophthalmology consultation was done with Dr. Gowtham advised to continue IV methylprednisolone for 5 days and review after 5 days. Serum for NMO, MOG antibodies and NMDAR autoimmune encephalitis panel was sent (report awaited) -As there were no further episodes of seizures, IV anti seizure medications were changed to oral drugs.

He was regularly monitored for fresh seizure activity, hemodynamic status, vital parameters & neurological status, oxygen saturations and any signs of respiratory distress. His symptoms and sensorium gradually improved & had no further seizure episodes during hospital stay. He remained hemodynamically stable during the hospital stay and is being discharged with the following advice.

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

**Neurological condition at the time of discharge:**

He is conscious, awake.

EOM full

Pupils were bilaterally equal and reacting to light.

<b>Name</b>	Master HANEIESH SHOBANBABU MARGAM	<b>UHID</b>	HNH-00015746
<b>IP No</b>	IP26-00006477	<b>Admission Date</b>	02-06-2026

Tone normal.  
No focal neurological deficits.

**Advice:**

Diet as advised.  
Physiotherapy as advised.

S.No	MEDICATION	DOSE	TIMINGS	DURATION
1	TABLET. PHENOBARBITONE 60 MG	1 tablet	TWICE DAILY	Till further advice
2	TABLET. LACOSAMIDE 50 MG	1 tablet	TWICE DAILY	Till further advice
3	Syrup. SODIUM VALPROATE (5ml/200mg)	5.5 ml	TWICE DAILY	Till further advice
4	TABLET. OMNACORTIL-20 MG	1 Tablet	TWICE DAILY	Till further advice
4	TABLET. LANZOL JR -15 MG	1 tablet	once daily 30 mins before breakfast	For 1 week

Name	Master HANEIESH SHOBANBABU MARGAM	UHID	HNH-00015746
IP No	IP26-00006477	Admission Date	02-06-2026

**Medistat / Insed / Midacip - nasal spray (Midazolam = 1.25mg/puff), 3 puffs intranasal (2 puffs in one nostril and 1 puff in another nostril ) if seizure for more than 3 minutes.**

**Plan:**

To review with ophthalmologist (Dr. Gowtham) on follow up.

\* To collect Serum for NMO, MOG antibodies and NMDAR autoimmune encephalitis panel on follow up.

**Fever Management**

Syrup. Crocin DS (Paracetamol = 5ml/240mg) 7 ml after food as and whenever required, if temperature > 100 \*F (maximum 4 times a day at 6 hour intervals). Tepid sponging if fever > 101 \*F.

Review consultation with Dr. ABHISHEK RAVINDRA JAIN on Friday(12.06.2026) at 5pm Himayatnagar in OPD with prior appointment (**Review consultation will be charged**).

Review consultation with **Dr. Gowtham** on Friday(12.06.2026)

**Food instructions while taking medications:**

\* **Antibiotics** along with food & milk products prevent their absorption of drugs & supplements. Antibiotics can be given 1 hour before food or 2 hours after food.

\* **Steroids** can decrease the absorption of minerals, proteins & Vit-K from food & increase fluid retention. Take immediately after food & recommended diet to be followed.

<b>Name</b>	Master HANEIESH SHOBANBABU MARGAM	<b>UHID</b>	HHN-00015746
<b>IP No</b>	IP26-00006477	<b>Admission Date</b>	02-06-2026

\* **Anticonvulsants** along with food decreases absorption of nutrient vitamin D, K B6, B12, folate, calcium stores. Anticonvulsants can be taken at least one hour before food & recommended diet to be followed.

Follow up immediately in Emergency Room if high grade fever, vomiting, altered sensorium, abnormal behaviour, seizures, breathlessness or refusal to feed occurs.

**Any emergency visit nearest hospital (or) nearest Rainbow Branch.**

**Call 8121039503 for emergency.**

**Do not stop any medication without prior consultation**

- **Continue these medication even in presence of fever/cough/cold/diarrhoea**
- **Sudden stoppage causes recurrence of seizures.**

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

Parent/ Attender

In case of emergency contact 9154865030 emergency pediatrician on duty.

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

<b>Name</b>	Master HANEIESH SHOBANBABU MARGAM	<b>UHID</b>	HNH-00015746
<b>IP No</b>	IP26-00006477	<b>Admission Date</b>	02-06-2026

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

You can also take appointments at any time by going **online** to our website [www.rainbowhospitals.in](http://www.rainbowhospitals.in)

  
**Registrar/Resident/C.M.O**



**Dr. ABHISHEK RAVINDRA JAIN**

MBBS, MD(Pediatrics), IAP POST DOCTOR FELLOWSHIP IN PEDIATRIC  
NEUROLOGY

TSMC/FMR/02757

1NH-00016746 IP28-0006477  
Vasler HANIEESH BHOBANBABU  
13-07-2017 # Y 11 M 6 D (M)  
Dr. ABHISHEK RAVINDRA JAIN

# CROSS CONSULTATION FORM

Doctor Name : ..... Date : ..... Time : .....

Diagnosis : .....

Hospital : .....

Type of Referral :

- Emergency
- Urgent
- Non Urgent

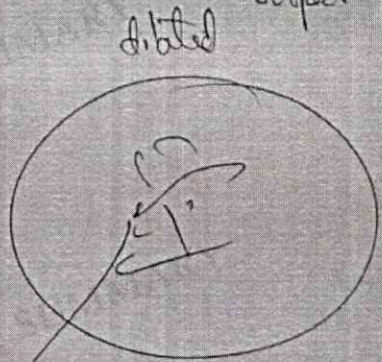
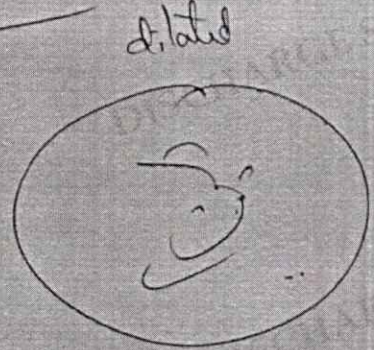
Referred for :  Opinion  Co-Management  Transfer of care

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

Signature: \_\_\_\_\_

Findings and Recommendations :

At 2wks c/s/b Dr. S. Gautham Reddy  
At 2wks dilated No multiple suture  
scraping



Inf bloodstain Margins

(e) : optic neuritis

Continue s/w MP for 5 days  
Plw oph 5 day

MP? :-  
\$2 ON

Consultant :

Name : ..... Signature : ..... Date & Time : .....

Doc No. : RCH / FRM / CLINICAL / 049

**ADMISSION SHEET**

**Registration Details :**



Admission No : IP26-00006477      Admit Date : 02-Jun-2026      Admit Time : 12:09 AM      UHID : HNH-00015746

**Patient Details :**

Patient Name	: Master HANEIESH SHOBANBABU MARGAM	Age	: 8 Y 10 M 30 D
Guardian	: Mr SHOBHAN BABU	DOB	: 03-07-2017
Gender	: Male	Religion	:
Occupation	:	Marital Status	:
Address (H)	: 6-91 POST YOUSUF NAGAR , MDL:KORUTLA , DIST: JAGITYAL Ailapur Korutla Telangana INDIA 505330	Phone No	: 9869310084/ 9030585501
		E-mail	: NO@GMAIL.COM

**Admission Details :**

Bed Type : DAY CARE      Bed No : ER02      Ward Name : GF -EMERGENCY  
Room No : ER02      Admission Type : First Visit

**Contact Details :**

Name : Mr SHOBHAN BABU      Relationship : Father  
Contact Address : 6-91 POST YOUSUF NAGAR , MDL:KORUTLA  
Phone No : 9869310084  
DIST: JAGITYAL Ailapur Korutla Telangana  
INDIA 505330

Signature

**Doctor Details :**

Doctor Name : Dr. ABHISHEK RAVINDRA JAIN      Specialisation : PEDIATRIC NEUROLOGY  
Referral Doctor : SELF      Phone No :  
Co-Consultant : Dr. ANIKET ANIL PARASHAR

**Payment Details :**

Payment Mode : DC/CC Card      Deposit Amount : 20000.00  
Payor Name : STAR HEALTH AND ALLIED INSURANCE CO LTD



**ACTIV**

HNH-00015746 IP26-00006477  
Master HANEESH SHOBANBABU  
03-07-2017 8 Y 10 M 30 D (M)  
Dr. ABHISHEK RAVINDRA JAIN

**NG**

Name: \_\_\_\_\_



UHID No \_\_\_\_\_

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
01/06/26	12:30 AM	ER	PICU	[Signature]
5/6/26	11 am	PICU	2nd floor 219	[Signature]

**Cross Consultation Visit**

	Doctors Name	Date	Order No.	Signature
1.	<del>DR. Gautham Raju (ophth)</del>	<del>3/6/26</del>	<del>4063</del>	<del>[Signature]</del>
2.	cross checked by Sunitha 5/6/26 at 1 AM			
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				



INVESTIGATIONS

Date	Investigations	Order No.	Sign
	VBG (1)	9190	}
	CBP, CRP, LFT, Urea, Creatinine	9189	
2/6/26	Uric acid, calcium, magnesium		
	(1) RBS - 165 mg/dl	9191	
2/6/26	(2) GRBS (122 mg/dl)	9192	
2/6/26	Electrolytes	9196	
cross checked by Sunita 3/6/26 at 2AM			
3/6/26	CSF Analysis CSF clb	9250	
3/6/26	(3) RBS 95 mg/dl	9268	
3/6/26	EEG	6683	
3/6/26	NHA	(+)	
4/6/26	EEG	6701	
cross checked by Sunita 5/6/26 at 1AM			
2/6/26	VBG (2)	3945	
cross checked by Sunita on 5/6/26 at 4AM			
2/6/26	MRI Brain with contrast	6632	
cross checked by Sunita on 5/6/26 at 11AM			



**PROCEDURE**

Date	Procedure	Quantity	Order No.	Signature
01/06/26	IV-Placement	①	203631	[Signature]
2/6/26	PAC		3717	[Signature]
cross checked by Sunita 3/2/26 at 2AM				
3/6/26	Lumberpuncher	①	3870	[Signature]
3/6/26	IV Placement	①	3912	[Signature]
3/6/26	NHA	①	4042	[Signature]
3/6/26	ROP	①	3966	[Signature]
"	ROP	①	66824	[Signature]
3/6/26	ROP	①	3966	[Signature]
"	ROP	①	66824	[Signature]
cross checked by Sunita 5/6/26 at 1AM				
5/6/26	IV placement	①	04628	Sunita

**ANY OTHER INFORMATION**

.....

.....

.....

.....

.....

.....

Date : \_\_\_\_\_ Time : \_\_\_\_\_ Prepared By : \_\_\_\_\_

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

Ref.No. F/IN/PR/10



# Rainbow<sup>®</sup> Children's Hospital

## PEDIATRIC IN-PATIENT MEDICAL RECORD

HNH-00015746      IP26-00006477  
Master HANEESH SHOBANBABU  
03-07-2017      8 Y 10 M 30 D      (M)  
Dr. ABHISHEK RAVINDRA JAIN



Patient Name : \_\_\_\_\_

Patient ID# : \_\_\_\_\_

Consultant : \_\_\_\_\_

Final Diagnosis : \_\_\_\_\_

Pediatric Multiorgan History & Physical Examination

Name : \_\_\_\_\_ Age/Sex \_\_\_\_\_

Informant \_\_\_\_\_ Reliability \_\_\_\_\_

Chief Presenting Complaints & Duration (Chronologically):

- do seizures :: today morning
- do vomitings :: today morning

History of present illness :

child was apparently normal till

4 days back jlb developed

4TUs type of seizures - tonic-clonic  
movements, uprolling of eyes,

lasts for 3-5 min & becomes conscious

in 10 min.

- started on oral leupil 2.5 ml/BD
- CT - (N)
- EEG - ?generalised seizure disorder

↓ 2 days seizure free

- then developed - 8-10 episodes of seizures  
:: morning & same semiology
- child also do vomitings :: morning  
8 episodes - greenish ?bilious no blood.
- no h/o fever / trauma

Pediatric Multiorgan History & Physical Examination

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

\_\_\_\_\_

\_\_\_\_\_

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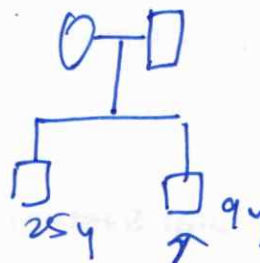
\_\_\_\_\_

\_\_\_\_\_

⊖

Birth & Neonatal History :

term / AFB / Uses  
- no NICU admission



Birth & Socio Economic History :

About Father : \_\_\_\_\_

About Mother : \_\_\_\_\_

no fam h/o seizure disorder

Any additional Information : \_\_\_\_\_

Developmental History :

normal.

Immunization History :

upto date.

last - 5y vaccines.

Pediatric Multiorgan History & Physical Examination

Anthropometry

Head Circum (cms) \_\_\_\_\_ (Centile \_\_\_\_\_) Height (cm) : \_\_\_\_\_ (Centile \_\_\_\_\_)

Weight (kgs) 22kg (Centile \_\_\_\_\_)

**On Examination :**

Temperature : 98°F Pulse Rate: \_\_\_\_\_ Description \_\_\_\_\_

B.P. 107/77 mmHg SPO2 96% at RA

Resp. rate and type of breathing : \_\_\_\_\_

Rash \_\_\_\_\_

Lymphadenopathy \_\_\_\_\_

Oedema : \_\_\_\_\_

- signs of dehydration (+)

- 4KBS : 165

**Respiratory system :**

RDE (+) clear

Inspection (any s/o distress) : \_\_\_\_\_

Air entry & breath sounds : \_\_\_\_\_

Any added sounds : \_\_\_\_\_

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

**Cardiovascular System :**

S1S2 (+) no murmurs

Inspection of precordium : \_\_\_\_\_

Heart Sounds : \_\_\_\_\_

Any murmur : \_\_\_\_\_

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

**Per Abdomen :**

- Soft  
- no HSM

Inspection \_\_\_\_\_

Palpation : \_\_\_\_\_

Auscultation : \_\_\_\_\_

Spine: \_\_\_\_\_ External Genitalia : \_\_\_\_\_

Relevant data from outside (CT, USG etc.,) \_\_\_\_\_

Pediatric Multiorgan History & Physical Examination

Central Nervous System :

4cs : 15/15

Level of Consciousness : AVPU/GCS Score : \_\_\_\_\_

Cranial Nerves : \_\_\_\_\_

Motor System :

Nutrition : \_\_\_\_\_

Tone : \_\_\_\_\_ Power \_\_\_\_\_

Co-ordinator : \_\_\_\_\_

Posture : \_\_\_\_\_

Involuntary Movements : \_\_\_\_\_

Reflexes :

(N)

DTR

Superficials :

Plantars \_\_\_\_\_

Sensory System :

Bladder / Bowel : \_\_\_\_\_

Clinical Summary & Diagnostic :

unprovoked seizures  
? Epilepsy.

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment :

Desired goals of the treatment :

**Planned Labs :**

- 1) USp, CRP, VBG
- 2) LFT, RFT.
- 3) S. calcium, S. mg.
- 4) MRI brain - T1M (Dial)

Noted By Prabir

**Planned Management :**

- 1) repeat loading
- 2) leupile maintain
- 3) 7. NS infusion
- 4) NPO till further orders.
- 5) MRI brain T1M.
- 6) inj ondemetion
- 7) inj leaupam / ses.

Noted By Prabir

**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 \_\_\_\_\_ on  
whose name the patient is being referred

Abhishek

Doctor's Signature Name \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

ABHISHEK RAVINDRAN JAIN  
Reg. No. 02757

HNH-00015746 IP26-00006477  
 Master HANEESH SHOBANBABU (M)  
 03-07-2017 8 Y 10 M 30 D  
 Dr. ABHISHEK RAVINDRA JAIN

1



## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/6/26 12am	<p>CI to Dr. Amket</p> <p><u>unprovoked seizure</u></p>	
	<p>- 8 episodes of UTCs seizures</p>	
	<p>- greenish vomitings (+)</p>	
	<p>- no fever.</p>	
	<p><u>O/E</u> - GCS: 15/15</p>	<p><u>Plan</u></p>
	<p>- afebrile</p>	<p>1) ct. lempil</p>
	<p>- vitals: stable</p>	<p>2) ct - 3% NS infusion</p>
		<p>3) NPO till further orders</p>
		<p>4) ct. IVF</p>
		<p>5) MRI brain - T/M.</p>
		<p>6) levetiracetam - sos if active seizures (+).</p>
	<p><u>h</u></p>	<p>7) if further seizure episodes (+)</p>
		<p>load phenytoin.</p>
		<p>8) keep intubation equipment ready</p>
		<p>9) monitor vitals.</p>



**PROGRESS NOTES AND DOCTOR'S ORDER**

Date & Time	Progress Notes	Doctor's Order
29:20am 6/26	c/d/t - Dr. Sandeep c/d/B - Dr. Alkdye	
	One more episode of abnormal strip back lasting for 1-2 mins.	
	↓ Ok - HR increased from 80bpm to 122bpm. BP increased to 122/82 CRBS - 123 mg/dl.	
	Advised: ① Load on Ij Phenytoin 2mg/kg in 20 @-30min. ② w/o further episodes. N/B Summa	



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**PROGRESS NOTES AND DOCTOR'S ORDER**

Date & Time	Progress Notes	Doctor's Order
26/12/26 9am	<p>MIB DS. Perish</p> <p>unprovoked seizures</p> <p>2 Repetitory seizures.</p>	
	<p>- no fever</p>	
	<p>- last SE @ 2am</p>	
	<p>brief</p>	
	<p>- no vomiting</p>	
	<p><u>OLE</u></p>	
	<p>vitals : stable</p>	<p>Plan</p>
	<p>SE - (N)</p>	<p>1) MRI @ contrast</p>
		<p>scan now</p>
		<p>2) inj phenobarbitone</p>
		<p>50mg / IV / BD</p>
		<p>3) inj valproate</p>
		<p>250mg / IV / BD</p>
		<p>4) send SE.</p>
		<p>5) monitor vitals</p>
	<p><i>(Signature)</i></p>	<p>6) STOP 3% N S ingestion</p>
	<p>Dr. Pritesh Nagar          Consultant Pediatrician &amp; Intensivist          Reg. No: 47184</p>	

PROGRESS NOTES AND DOCTOR'S ORDERS

Date & Time	Progress Notes	Doctor
9:45am	Counselled	✓
2/6/26	(fits) → Not Simple	go
	(80%) [ 60% - 1 <sup>st</sup> Med - Control ] - [ 20% - 2 <sup>nd</sup> Med - Control ]	
	(20%) - >3 Med - Control diff. [ 48-72hr Time ] = (1)	
	(2) MRI scan & EEG test ] =	
	(3) Brief Seizure - No Problem Long fits } - Danger ✓ Unconscious }	
(W)	Dr. Pritesh Nagar Consultant Pediatrician & Intensivist. Reg. No: 47184	<del>Dr. Pritesh Nagar</del> (Father)



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/6/20 6am	<p>child Dr. Prannii</p> <p>unprovoked seizures</p>	
	<p>- 1 episode of brief seizure at 2:30am          lasting for 1-2min.</p> <p>- no h/o fever.</p>	
	<p>o/e : vitals</p>	
	<p>HR : 76 bpm</p>	
	<p>RR : 18 bpm</p>	
	<p>SpO<sub>2</sub> : 100%</p>	
	<p>Bp : 86/54 (65)</p>	
	<p>stE</p>	<p>Plan</p>
	<p>PS : BDE ⊕          clear</p>	<p>1) ct. tempil</p>
	<p>US : S1 S2 ⊕          no omms.</p>	<p>2) ct. 3% NS injection</p>
	<p>CNS : 4US : 1+ / 15</p>	<p>3) leave reports</p>
	<p>Pyris; NSRL</p>	<p>4) w/f further          seizure episodes</p>
	<p><i>[Signature]</i></p>	<p>5) monitor vitals.</p>
		<p>Noted by Seetha</p>






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**PROGRESS NOTES AND DOCTOR'S ORDER**

Date & Time	Progress Notes	Doctor's Order
2/6/25 2 pm	S/B Dr. Prabhath	
	<p>⊆ Unprovoked            refractory seizures</p>	
	No fever	
	No further seizure episode	Adv
	+20cc	
	on 2L by NP	1) MRI to be done, EEG
	O/E HR: 80/min	2) CT. by Phenobarb.
	RR: 20/min	Valproate
	SpO <sub>2</sub> 100%	
	BP 91/59 (70)	
	CNS WNL	3) Monitor vitals
		Noted by Saisai



## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/6/26 7:50pm	<p>cf/s/by dr. Pritecham</p> <p>unprovoked seizure.</p>	
	<p>HR = 115/min.</p>	
	<p>Bp = 116/78 (88) mmHg</p>	
	<p>RR = 21/min.</p>	<p>— (P) MRI report</p>
		<p>— cl- AntiEpileptic</p>
	<p>S/E</p>	<p>Pheno valproate</p>
	<p>— NAD.</p>	<p>— start orals</p>
		<p>after awake</p>
	<p>child - drowsy</p>	<p>— Form sos</p>
		<p>— monitor GCS</p>
		<p>forthen seizure activity</p>
	<p></p>	
	<p>Dr. Pritecham Nagar        Consultant in Paediatrics</p>	
	<p>Reg. No. 71184</p>	<p>Noted by Sai Sri</p>



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## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5:15pm <hr/> 2/6/26	<u>Counselled</u>	
	Last 6hr No Fits 3 med Rx	
	MRI - Waiting Report	
	Oral Food/Diet ICU Contumace.	
/		
(N/A)		
		Nilis (Bothers)

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

## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/6	<u>ck/B Dr. Abhishek</u>	
7:30pm	Unprovoked Seizure	
	<u>? Refractory Seizure c Encephalopathy</u>	
		( ? AREPS ) ( JTES )
	GES - 15/13	Phn
	⊕ Encephalopathy ⊕	1) 3g Phenobarbiton
	Slurring of Speech ⊕	2g Valproate
	Conscious / <sup>Partially</sup> Oriented	2) Trace MRI brain report
	Nystagmus ⊕	3) EEG - Nov
		4) Decide on LP - T1n
		5) If further Seizure
		Midazolam infusion

Dr. ABHISHEK RAVINDRA JAIN  
 Reg. No. 02757

Abhishek  
 Noted by Saishli

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/6 7:45pm	<u>Counselling Notes</u> (Dr. Abhishek)	
	Parents/Attendees have been counselling in their understandable language about the condition of the child	
	→ Fits predominantly various types - child having focal type and multiple episodes in this week	
	→ If such seizure happens repeatedly on anti-epileptics will need different medications. Even immunomodulation might be needed.	
	→ Sometimes seizures can occur post fever upto 2 weeks	
	→ Fever probably due to infection - Late fits can be fever triggered / Post immune	
	→ Based on MRI brain, EEG and possibility of recurrence of seizures, decide on medication duration to tapering and decide about lumbar puncture	
	→ need to try to find cause	
	→ Some Based on reason - can comment possibility of recurrence & not. And how will be response to medication	
	→ EEG will be done to see non clinical seizures	
		Abhishek (Boothel)

H/O Fever  
1 week ago

## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/6/2016 8:45 PM	C/O/W <sup>o</sup> Dr - Abhishek S.	
	MRI Brain - s/o	
	PRES ITES / Immune mediated MOG Antibody associated	Inflammatory encephalopathic process
		Pln
		1) 2g Ceftriaxone
		2) 2g Methylpred - 30mg/kg stat
		3) CSF - Analysis
		- NMO - MOG Ab
		- CSF
		- 1 enter pin
		JR



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8:45pm 2/06/26	<u>Counselled</u>	
	MRI — <u>Brain Swelling</u> / Infection para infection Severe Fits ] ✓	Immunomodulation
		✓ 1st Step (MP) → (START) ✓
		✓ LP Test (CSF) testing
	① Time ✓	
	② Fits Severe Risk	
	③ Rx / Immunomodulation	
	LOC/unconsciousness + Risk	
(M)	Dr. Pritesh Nagar Consultant Pediatrician & Intensivist Reg. No: 47184	(Father)

**PROGRESS NOTES AND DOCTOR'S ORDER**

Date & Time	Progress Notes	Doctor's Order
3/6 2:00 AM	<p>CLs/RS for - Naipya / for - Nazmeen</p> <p>unprovoked seizures          ? viral encephalopathy</p>	
	<p>on room apr.</p> <p>Vitals - HR - 84 bpm          RR - 22 cpm          SpO<sub>2</sub> - 97%</p>	<p>Plan</p> <p>- Cont Phenobarbital          Valproate</p>
	<p>RLS - B/L AEP</p>	<p>- Cont Ceftriaxone</p>
	<p>PA - soft, NT</p>	<p>- Encourage orally</p> <p>- watch for seizures</p> <p>- Monitor vitals</p>
		<p>@neef</p>

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**PROGRESS NOTES AND DOCTOR'S ORDER**

Date & Time	Progress Notes	Doctor's Order
3/6 7:00 AM	<p>CLS/13 Dr. Naipanya / Dr. Nazmeen</p> <p>unprovoked seizures            ? viral encephalopathy</p>	
	<p>on room air.</p> <p>vitals - HR - 82            RR - 20            SpO<sub>2</sub> - 98%</p>	<p><u>Plan</u></p> <p>- Cont phenobarbital            Valproate.</p>
	<p>RLs - BIL AE (+)            PLA - Soft, NT</p>	<p>- Cont Ceftriaxone</p>
	<p>CNS - Conscious            Slurred Speech (+)</p>	<p>- Plan for LP today</p>
		<p>- <del>Cont</del> NPO for now</p>
		<p>- Cont IUF</p>
		<p>- Monitor vitals</p>
	<p>St. ANMOMOG Abd.            Cont Zid. methylpred            CSF Analysis, CSF C/S</p>	<p>Deef</p>

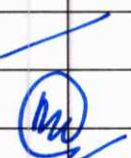



**PROGRESS NOTES AND DOCTOR'S ORDER**

Date & Time	Progress Notes	Doctor's Order
	<u>cf Plw for. Abhishek</u>	
3/6 9:00 AM	in room Air NO further. Seizure Vitals - stable.	<u>Plans</u> - Cont Phenytoin Valproate
	R/S - BIL AEP P/A - soft, not	- Cont Ceftriaxone
	CNS - Conscious. Slurred speech (+)	- LP study (CSF Analysis, CSF C/S.) - Cont IVF - Cont Zymetorol
3/6 9:00 AM	<u>CLSR for. Ganitesh</u>	- Sr. NMO - mag. Ab levels to send.
Ophthal Consult	No further Seizure	<u>Plans</u>
	Vitals - stable	ophthal Consultation
	R/S - NAD P/A -	- Send CSF Analysis - CSF C/S - Sr. NMO - mag. Ab levels - Cont ceftriaxone

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/6/26 9:45am	<u>Counselled</u>	
	Full now no fits x $\approx$ 20hr	
	Brain Swelling - R <u>***</u>	
	CSF Analysis Now $\rightarrow$	① 24hr ② 48-72h ③ <u>NMO/MOG</u> <u>2-3 weeks</u>
	Optic Nerveitis ] $\rightarrow$ eye/vision affected.	
	Dr. Pritesh Nagar Consultant Pediatrician & Intensivist Reg. No: 47184	 Pritesh



PROGRESS NOTES AND DOCTOR'S ORDER

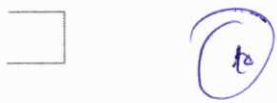
Date & Time	Progress Notes	Doctor's Order
		T. Schizodon O.Suf 1/2 tablet HS If behavioral issues are present
		- CF Methyl Prednisolone X 5 days
		- CF VALPARIN Phenytoin
		Dr. ABHISHEK RAVINDRA JAIN Reg. No. 02757 IVIG to be given if worsening Abhishek
3/6/26 5:40 PM	Counseling Note	
		- Requires 5 days of Methyl Prednisolone
		- If no further seizures - Tomorrow morning EEG to be done
		Dr. ABHISHEK RAVINDRA JAIN Reg. No. 02757 - If NMO-MOG Antibodies are positive - to give Rituximab/Tocilizumab
		- Optic neuritis on MRI Brain
		- IVIG to be given if there is any worsening of clinical condition Abhishek

HNH-00015746 IP26-00006477  
 Master HANIEESH SHOBANBABU  
 03-07-2017 8 Y 11 M 0 D (M)  
 Dr. ABHISHEK RAVINDRA JAIN



## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/6 9:45pm	<p>CLS/B D Pranon / Di-Thamri</p> <hr/> <p>6<sup>c</sup> - Unprovoked Seizure          ? Neurocysticercosis OSD / ? MOGAD / ? ADEM</p> <hr/> <p>Behavioral signs ⊕ - Crying</p> <p>Child Vital stable          HR - 126/min          RR - 22/min</p> <p>No fever          R-S - B/LAE ⊕          P/A - soft</p>	<p>Plm</p> <p>1) IVF - 1/2 ⊕ - Stop</p> <p>2) Tab. <del>Scizodon</del> <sup>Scizodon</sup> - 0.5mg          1/2 tab - stat</p> <p>3) 3 Methylpred          3mg Ceftriaxone</p> <p>4) To send Serum Anticardium encephalitis Panel</p> <p>5) EEG - T/m</p> <p>6) 4 Valproate          Phenytoin</p> <p>7) Monitor Vital</p> <p>8) SOS - IVIG - if worsening  <u>Ramon</u></p>



**PROGRESS NOTES AND DOCTOR'S ORDER**

Date & Time	Progress Notes	Doctor's Order
3/16/26 1pm	c/s/by. Dr. Anurag	
	Unprovoked seizure.	
	? Neuro myelitis OSD.	
	? MOG Ab associated ds (MOGAD)	
	2 ADEM.	
	HR = 99/min.	
	SpO <sub>2</sub> = 100/min.	
	Bp = 118/81 (93)	
	<u>GC</u> child drowsy.	
	Responds to verbal stimuli	
	answering to questions.	
	oriented to place/person	
		<u>Plan</u>
		- stat feed aft complete aware & awake
		- ct METHYLPRED
		ESMOPTASOL.
		- Monit vital
		w/ct with seizure activity
	<u>Dr. Anurag</u>	
		- ct valproic & phenobarbital.



## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/6/18 5:30pm	S/B Dr. Abhishek	S/B Dr. Abhishek
	△ Unprovoked seizure	CSF Routin (v)
	? Neurocytotoxic OSD	
	? MGAAD	
	? ADEN	Adv
	Child stable	
	No fever	→ 1/2 M IVF,
	No seizure episodes	→ Stop fluids after
	CNS WNL	Dinner
	Vital stable	→ BP Monitoring only
	Disoriented speech	→ CT scan
	Not able to walk	→ funduscopy to be done
	properly	
		- + CSF Viral panel <del>to be done</del>
		- Serum NMDA - Autoimmunity
		- Inceptibility panel <del>to be done</del>
		- ATIM Koch
		- If no further seizures
		- Repeat @ 6th to mono



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**PROGRESS NOTES AND DOCTOR'S ORDER**

Date & Time	Progress Notes	Doctor's Order
4/6 3 AM	<u>CS/B B. Prasad / Dr. Thamm</u>	
	<u>Δ' - Unprovoked Seiz</u> <u>? NMO SD / ? MCGAD / ? ADEM</u>	
	No Seizm child asleep	Plm 1) Ij Ceftriax Valproate Phenobarb
	<u>Vitals</u> RR - 78/min RR - 22/min SpO <sub>2</sub> - 97%	2) send Serum Anticoreum panel 3) EEG
P/E	R.S. - B/LAEC P/A - Soft	4) SOS - IV/S
		Plm
		Noted by <u>Vaishnavij</u>



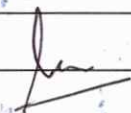
**PROGRESS NOTES AND DOCTOR'S ORDER**

Date & Time	Progress Notes	Doctor's Order
4/6	CLS/BS Dr. Prann / Dr. Tharini	
7:31 AM		
	Δ - Unprovoked Seizure	
	? Nonconvulsive Epileptic Spectrum / ? MOD SAD / ? ADEM	
	no further seizure	
	child asleep	Pls
		1) In Phenobarb
		In Valproate
	Vitals	
	HR - 70/min	2) In Ceftriaxone
	SpO <sub>2</sub> - 98%	In Esomeprazole
	RR - 18/min	3) In Melbexipen
	BP - 108/60 mmHg	
	R.S - B/2A/B	4) send Serum Anticonvulsant level
	PIA - soft	for NMDA-R (Attender want to discuss & decide)
		5) EEG
		6) SOS - IVIG
		Prann
		Noted by Sumitha



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## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
4/6/26 9:00 am	d/RS re. Parvosh upenacted seizures ? ADEM MOYAD ? neuromyelitis OSD	
	- no fever	
	- no seizures	
	O/E - <u>disoriented</u>	
	vitals: stable	
	STE - normal	Plan
	pupils: NSRL	1) it. inj pheno
	HR: 125 bpm	valproate
	RR: 20 bpm	2) it. uperone
	spo <sub>2</sub> : 98%	methoxyphenol
		esomeprazole
		3) send serum Autoimmune
		panel for NMDA-R
		4) SOS-IVIG
		5) monitor vitals
		6) Revt it. as per
		Rx chart
		

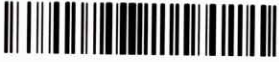
**PROGRESS NOTES AND DOCTOR'S ORDER**

Date & Time	Progress Notes	Doctor's Order
<p>9:20am  <u>4/6/26</u></p>	<p><u>Counselled</u>            Stable / No Fits            Eye spec. → Try MP continue ✓            Sos IVIG → Try if need            Later Flup. (Time) ✓            Swelling → Nerves Damage            (ANEC) <del>Time</del>      (effect) ✓</p>	<p>(Red flags)            ↳ Fits            ↳ Level of consciousness down            ↳ Fever</p> <p><del>Signature</del></p>
<p><u>Dr.</u></p>	<p>Dr. Pritesh Neger            Consultant Pediatrician &amp; Intensivist            Reg. No: 47184</p>	

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
4/16/20 2pm	C/S/B Pr. Prashanti	
	Δ - unprovoked Seizures NMO SD / ADEM /	Subimmune encephalitis
		PLAN
	No fever No further seizures	- inj. PHENOBARBITONE - VALPROATE
	Daily urine stool EEG - cerebral dysc. - fast Serum NMDA panel	- ct. methylpred corticakone Esomeprazole
	vitals - stable	- f/lup reports
	conscious CNS - Grand Abd DTR 3+ plantar	- Mon for vitals - IVIG to consider
	CVS RS CNS } wnl	noted by Sonam



## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
4/6	CNS/CS Dr. Paritosh	
4:30 PM	unprovoked. seizures ADEM / ? Autoimmune encephalitis	Plan
	No fever	
	No further seizures	- (T) NMDA panel
	Vitals HR - 88 bpm RR - 20 cpm SpO <sub>2</sub> - 98%	- Cont Zj phenobarbital Zj - Valproate
	RIs - BIL AG (+)	- Cont ceftriaxone
	CNS - slurred speech (+) Incoherent talk (+)	methylprednisolone - SOS IVC
	DTR 3 (+)	- Monitor vitals
		Noted by Ranyer



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
4/16	CLINICAL FOR - Abhishek	
7:00 PM	Unprovoked Seizures ADEM / D Autoimmune encephalitis	
	No fever	Plan
	No seizures	- Trace NMDA Panel
	vitals - stable.	- Cont phenobarbital
	RIs - BIL AE	Valproate
	CNS - GCC (N)	- Cont ceftriaxone
	Bone density (A)	Methylprednisolone
	DTR - (A)	- SOS IVIG X 5 days
		- monitor vitals
		- oral valproate now
		- Shift to ward tomorrow
		- Tab. lacosamide 50mg BD
		Noted by Ranjan



## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
25/6/16 12 AM	slb Dr. Sreyhan Δ? Autoimmune Encephalitis ? ADfm	PL <sub>1</sub>
	Akbaic	- Monitor vitals
	CVS-S <sub>11</sub> S <sub>10</sub> Rt-S <sub>11</sub> -ACE <sup>⊕</sup>	- CE LEVATHALVAL PROACE <del>WATER</del> PHENOBARBITONE
	HA-96 SpO <sub>2</sub> -92% on NA	- CE Methyl Prednisolone Celtroxone
		- w/lt seizure
5/6/26 3 AM	e/s/hy Dr. Anucha. Δ Autoimmune Encephalitis ? ADfm	? MOGAD c Encephalitis
	child sleeping	→ Anti MOG Ab
	<u>vital</u> stable. Gait abn <sup>⊕</sup> Behavioral iss <sup>⊕</sup> .	→ NIMDA panel CE Anti Epilept methyl/pred.
	? psychiatric sympt <sup>⊕</sup> .	→ w/lt sensorium/sa.
	<u>Bp</u> = 90/42 (57) ↓ <u>Recable</u> mmHg	- Tm shift - ward plan - Monitor vital.


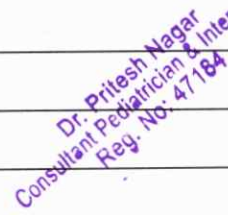
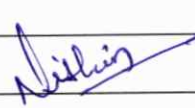
16

**PROGRESS NOTES AND DOCTOR'S ORDER**

Date & Time	Progress Notes	Doctor's Order
5/6/26	by. Dr. Anuha	
7:30 AM	Δ: ? Auto Immune Encephalit	
	, MOGAD & Encephalit	
	Child active.	
	oriented.	
	Behavior irrit (+).	<u>Plan</u>
	Overnight - slept well.	⊖ Anti MOG Ab.
	Bp = 119/73 (84) mmHg	ALPHA panel
	vital stable	- ct Anti epilep
		methy/prednisolo-
		- w/ seizure activity /
		Sensuum.
	Al	- shift to ward plan.
		- Monitor vitals.



**PROGRESS NOTES AND DOCTOR'S ORDER**

Date & Time	Progress Notes	Doctor's Order
<del>5/6/16</del> <del>9 AM</del>	S/B Da-Packer D? Auto immune Encephalitis ? ADON	Plan
	Akebox	- ct VALPROATE DITHEMBARBITONE
	LVS - 5/5/10 R - BU - AIF	- ct Methyl prednisolone
	HT - 1.04/m SpO <sub>2</sub> - 100% on RA	- 5mg - BUPROPRION 7.5m H <sub>2</sub> O
		- Shift to ward
5/6/26	<u>Counselled</u>	
9:30am	Swelling - Brain	
	Nerve Damage Optic Neuritis	(Rx)
	SLOW	> 3 months May be
	Dr Abhishek Jain	✓ Rev. No N Rev - permanent
	Swelling Decide	
	 Dr. Pritesh Nagar Consultant Pediatrician & Intensivist Reg. No: 47184	 Nilnis

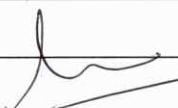
HNH-00015746 IP26-00006477  
 Master HANEESH SHOBANBABU  
 03-07-2017 8 Y 11 M 1 D (M)  
 Dr. ABHISHEK RAVINDRA JAIN



## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	<del>C/O Dr. Abhishek</del>	
	<u>C/O Dr. Abhishek</u>	
	Plan to shift out	Print
	<u>C/SR Dr. Naipya</u>	
5/6 2:00 PM	? Autoimmune encephalitis ? ADEM.	
	afebrile.	<u>Plan</u>
	oral intake - fair.	- Cont valproate.
	R/S - BL AEP	Phenobarbital Lacosamide.
	P/A - soft, NT.	- Cont Methylpred.
	CNS - GCS - 15/15.	- Cont Ceftriaxone
		- Monitor vitals
		Dr. J

## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	<p>MRB Re-Mami</p> <hr/>	
06/06/26 7 AM	<p>? ADAMS</p> <p>? Pulmonary emphysema</p> <hr/>	
	<p>- seizures : no</p> <p>- no fever</p> <p>- oral intake : good</p>	
	<p>o/e : delirious</p>	
	<p>intake : stable</p> <p>S/E : none</p>	
		<p><u>Plan</u></p> <p>1) It. naproxen phenobarb methylpred carbamazep</p> <p>2) It. ceftriaxone</p> <p>3) Rert it. on the Rx chart</p> <p>4) monitor vitals</p>
		
		<p>noted by sr. Sandhya 6/6/26 @ 7:30 a</p>





HNH-00015746

IP26-00006477

Master HANEESH SHOBANBABU  
03-07-2017 8 Y 11 M 2 D (M)  
Dr. ABHISHEK RAVINDRA JAIN



### PROGRESS NOTES AND DOCTOR'S ORDER

& Time	Progress Notes	Doctor's Order
6/6/26	S/O Dr. Sreehan	
2:41 PM	D? ADEM ? Autoimmune encephalitis	<u>Plan</u>
	No fresh seizures	- CE VALPROATE Phenobarbiton
	Afebrile Vitals Stable	Lacosamide
	CM: conscious oriented T/P/P	- CE methyl Prednisolone - w/ seizure
		13-14
6/6/26	S/O Dr. Aniketa	
5:30 PM	D? ADEM ? Auto immune Encephalitis	<u>Plan</u>
	No further seizures	- CE VALPROATE Phenobarbiton
	Afebrile Vitals Stable	Lacosamide
	conscious oriented T/T/P	- w/ seizure - Symp CROWN-DS - 6m sos for headache

Dr. Aniketa  
NB Scribe 5:30 PM (P.T.O)



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
7/6/26 7 AM	S/B Dr. Parthiv / Dr. Varun	
	Δ ? ADEM	
	? Autoimmune encephalitis	
	c/o Headache +	
	Seizure episodes - None	
	Afebrile	ADU
		- of Valproate
	o/c GC-fair	phenobarbitone
	Vitalu stable	Lacosamide
		- Trace MOG / NMDA Rf
	CNS WNL.	- w/ seizures
		- Start oral omnirolid
		- Sep Grocin 125 Sos. 2mg/kg / day
		- Rpt EEG - <del>See</del> Monitor
		noted by sr. sundhya
		7/6/26
		@ F.I.C



## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/2/26 11:40am	<p>uric acid re-ambal            ? ADEM            ? Heroinamine encephalitis</p>	
	<p>- no seizures : 3/2/26            - headache : ↓            - oral intake : good</p>	
	<p>O/E            GU: 15/15</p>	<p>Plan</p>
	<p>- vitals : stable            check BP            - S/E - normal</p>	<p>1) stop<sup>CF</sup> ceftriaxone            2) ct. valproate            Phenytoin            leucosamide</p>
	<p>CSF - us : neg            urine BP            uric acid</p>	<p>3) check BP - 8<sup>th</sup> hourly            4) ct. oral steroid</p>
	<p>HT: 133cm</p>	<p>5) Repeat EEG            6) syp melatonin - 7me            at night if            can't sleep</p>
		<p>7) Rent ct. as per Rx chart</p>
		<p>NB Suck @ 11:40am            Dr. Anshul</p>

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
7/16/26	<u>MRS re. Manan</u>	
6 pm	? ADEM	
	? Autoimmune encephalitis	
	- no fever	
	- no smells	
	- no headache	
	- oral intake good	
	OIE	Plan
	yes: 15/15	1) ct. ceftriaxone x 7 days <sup>total</sup>
	inlets: stable	2) check BP - q4h
	SE - (N)	3) ct. phenobarb
	lin.	lacosamide
		valproate
		methylpred
		esomeprazole
		4) plan to repeat EEG
		after rounds
		5) plan discharge T/M
		after rounds
		6) Pert ct. as per Rx
		chart.
		noted by sr sandya
		7/16/26
		6 pm



## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/6/26	S/B Dr. Sneethan	
7:30 AM	Δ? ADEM	
	? Autoimmune Encephelitis	
	Afebrile	Plan
	Vitals stable	✓ CF CEFTRIAZONE X 7 days (total)
	No further seizure	✓ Monitor B.P 8th H
	CM:- conscious	
	oriented to T/P/P.	✓ CF Phenobarbitone Levosamide Valproate
		✓ CF Methyl Prednisolone Esmoprazole
		✓ Plan discharge today
		✓ Trace NMO-MOG Study reports
		K 5/22
		NB Suranda

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









## DRUG CHART

Date of Admission: 2/6/26 Drug Allergies:  Not known any Drug Allergies

### FOR THE SAFETY OF THE PATIENT

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

### SOS / PRN (As Required Medication)

DRUG : <u>IMJ LORAZEPAM</u>				Date Time
Dose <u>2.5mg</u>	Route <u>IV</u>	Frequency <u>SOS</u>	Start Date <u>1/6</u>	
Doctor's Signature <u>[Signature]</u>		Valid Period	Pharm. <u>[Signature]</u>	
Additional Instructions: <u>if active seizure (+)</u>				
DRUG : <u>SYR PARACETAMOL</u>				Date Time
Dose <u>RA 16ml PO</u>	Route <u>PO</u>	Frequency <u>SOS</u>	Start Date <u>4/6</u>	<u>4/6</u> <u>6/6</u>
Doctor's Signature <u>[Signature]</u>		Valid Period	Pharm. <u>[Signature]</u>	<u>1pm</u> <u>5:30</u> <u>Med/Prn</u>
Additional Instructions:				
DRUG :				Date Time
Dose	Route	Frequency	Start Date	
Doctor's Signature		Valid Period	Pharm.	
Additional Instructions:				

Verified by: Dr. Dhakshayani  
 Signature: [Signature]  
 VERIFIED BY: Name



REGULAR PRESCRIPTIONS

Weight. 22kg Ward. ....

<b>DRUG :</b> INJ LEVIPIL				Date/Time	1/6 2/6
Dose	Route	Frequency	Start Date		
250mg	IV	BD	1/6	10AM	X
Name & Signature of the Doctor Starting the Drugs:					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					

<b>DRUG :</b> INJ ONDANSETRON				Date/Time	1/6 2/6 3/6 4/6
Dose	Route	Frequency	Start Date		
4mg	IV	TID	1/6	6AM	X
Name & Signature of the Doctor Starting the Drugs:					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					

<b>DRUG :</b> INJ PHENOBARBITONE				Date/Time	
Dose	Route	Frequency	Start Date		
100mg	IV	BD	2/6		
Name & Signature of the Doctor Starting the Drugs:					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					

<b>DRUG :</b> INJ VALPROATE				Date/Time	
Dose	Route	Frequency	Start Date		
200mg	IV	BD	2/6		
Name & Signature of the Doctor Starting the Drugs:					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					

Verified by  
Dr. Dhakshayani



Sheet No: .....

REGULAR PRESCRIPTIONS

Weight 22kg Ward .....

DRUG :	Dose	Route	Frequency	Start Dt.	Date Time														
INJ PHENOBARBITON	50mg	IV	BD	2/6	1 AM	2/6	3/6	4/6	5/6										
Name & Signature of the Doctor Starting the Drugs:					<div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p><i>[Signature]</i></p> </div> <div style="width: 60%;"> <p><i>changed to oral</i></p> </div> </div>														
Additional Instructions:																			
Daily Doctor's Endorsement by a Sign					<div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"><i>[Signature]</i></div> <div style="width: 60%;"><i>[Signature]</i></div> </div>														
INJ VALPROATE	250mg	IV	BD	2/6	1 AM	2/6	3/6	4/6	5/6										
Name & Signature of the Doctor Starting the Drugs:					<div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p><i>[Signature]</i></p> </div> <div style="width: 60%;"> <p><b>STOP</b> <i>Changed to oral.</i></p> </div> </div>														
Additional Instructions:					<p><i>1 PM</i></p>														
Daily Doctor's Endorsement by a Sign					<div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"><i>[Signature]</i></div> <div style="width: 60%;"><i>[Signature]</i></div> </div>														
INJ CEFTRIAXONE	1 gm	IV	BD	2/6															
Name & Signature of the Doctor Starting the Drugs:					<div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p><i>[Signature]</i></p> </div> <div style="width: 60%;"> <p><b>CHANGED</b></p> </div> </div>														
Additional Instructions:																			
Daily Doctor's Endorsement by a Sign																			
INJ CEFTRIAXONE	2g	IV	once Daily	2/6		2/6	3/6	4/6	5/6	6/6	2/6	2/6							
Name & Signature of the Doctor Starting the Drugs:					<div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p><i>[Signature]</i></p> </div> <div style="width: 60%;"> <p><i>[Signature]</i></p> </div> </div>														
Additional Instructions:																			
Daily Doctor's Endorsement by a Sign					<div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"><i>[Signature]</i></div> <div style="width: 60%;"><i>[Signature]</i></div> </div>														

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

HNH-00015746 IP26-00006477  
 Master HANEESH SHOBANABU  
 03-07-2017 8 Y 10 M 30 D (M)  
 Dr. ABHISHEK RAVINDRA JAIN



**REGULAR PRESCRIPTIONS**

Sheet No: ..... Weight 22kg Ward .....

DRUG : <u>3mj. Esmoprazole</u>				Date	Time
Dose	Route	Frequency	Start Dt.	2/6	3/6
20mg	IV	OD	2/6	3/6	4/6
Name & Signature of the Doctor				5/6	6/6
Starting the Drugs:				7/6	8/6
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					
DRUG : <u>3mj. Methylprednisolone</u>				Date	Time
Dose	Route	Frequency	Start Dt.	2/6	3/6
600mg	IV	OD	3/6	4/6	5/6
Name & Signature of the Doctor				6/6	7/6
Starting the Drugs:					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					
DRUG : <u>Tab. LACOSAMIDE</u>				Date	Time
Dose	Route	Frequency	Start Dt.	4/6	5/6
50mg	PO	BD	4/6	5/6	6/6
Name & Signature of the Doctor				7/6	8/6
Starting the Drugs:					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					
DRUG : <u>Syp. Sodium Valproate</u>				Date	Time
Dose	Route	Frequency	Start Dt.	4/6	5/6
5.5ml	PO	BD	4/6	5/6	6/6
Name & Signature of the Doctor				7/6	8/6
Starting the Drugs:					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					

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



Sheet No: .....

**REGULAR PRESCRIPTIONS**

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

<b>DRUG : T. PHENOBARBITONE</b>				Date/Time	5/6
Dose	Route	Frequency	Start Dt.		
1 tab	PO	BD	5/6		
Name & Signature of the Doctor Starting the Drugs:				9am	
Additional Instructions:				9pm	
(1 tab = 60mg)					
Daily Doctor's Endorsement by a Sign				5/6	
<b>DRUG : <del>INJ. PHENOBARBITONE</del></b>				Date/Time	<del>5/6</del>
Dose	Route	Frequency	Start Dt.		
<del>60mg</del>	<del>IV</del>	<del>12H</del>	<del>25/06</del>	<del>10am</del>	<del>X</del>
Name & Signature of the Doctor Starting the Drugs:					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					
<b>DRUG : <del>Syp GARDENAL</del></b>				Date/Time	
Dose	Route	Frequency	Start Dt.		
Name & Signature of the Doctor Starting the Drugs:					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					
<b>DRUG : Tab. PHENOBARBITONE</b>				Date/Time	26/6/16
Dose	Route	Frequency	Start Dt.		
1 tablet	oral	BD	6/6	10am	
Name & Signature of the Doctor Starting the Drugs:					
Additional Instructions:					
→ 60mg					
Daily Doctor's Endorsement by a Sign					

Signature.....

VERIFIED BY : Na 6



Sheet No: ..... **REGULAR PRESCRIPTIONS** Weight ..... Ward .....

**DRUG :** *SYP OMNACORTIL*

				Date Time
Dose	Route	Frequency	Start Dt.	

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:  
*(5mg/ml)*

**Daily Doctor's Endorsement by a Sign**

**DRUG :** *Tal. OMNACORTIL*

				Date Time
Dose	Route	Frequency	Start Dt.	
<i>1 tab</i>	<i>PO</i>	<i>BD</i>	<i>7/6/20</i>	

Name & Signature of the Doctor Starting the Drugs: *Dr. Prabhakar*

Additional Instructions:  
*@ 2mg/kg/day*  
*1 tab = 20 mg*

**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**

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



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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
11:30pm	1/6/26	INJ VALPROATE	500mg / IV stat	IV	h.	h. h.
12am	2/6/26	inj 3% NS	10ml/hr	IV injection	h.	h. h.
		(e.o. 5ml/kg/hr).				
2:30am	2/6/26	INJ. PHENOBARBITONE	440mg	IV	h.	Savitri vaishnavi
9:30AM	2/6/26	Inj. LORAZEPAM	2mg	IV	h.	Laxmi
12PM	2/6/26	INS LACOSAMIDE	200mg	IV	h.	h. h.
		(2mg/ml)	start at 16mg/hr	over 30m		
9pm	2/6/26	Inj METHYL PREDNISOLONE	600mg	IV over 30min	h.	Savitri h.
10pm	3/6/26	Tab SCI 2000N (0.5mg)	1/2 tab	PO	h.	Savitri h.

Signature: Name

Dr. Dhruv Nayam



915748 IP26-00006477  
 HANDESH SHOBANBABU  
 -2017 8 Y 11 M 2 D (M)  
 ABHISHEK RAVINDRA JAIN  


(219) (217)

**RESULT SHEET**

**Rainbow<sup>®</sup>  
 Children's  
 Hospital**  
 It takes a lot to treat the little.

**BirthRight<sup>™</sup>**  
 BY RAINBOW HOSPITALS  
 Your Right to a Safe Delivery

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



HNM-00015746 IP26-00006477  
 Master HANEESH SHOBANBABU  
 03-07-2017 8 Y 11 M 2 D (M)  
 Dr. ABHISHEK RAVINDRA JAIN

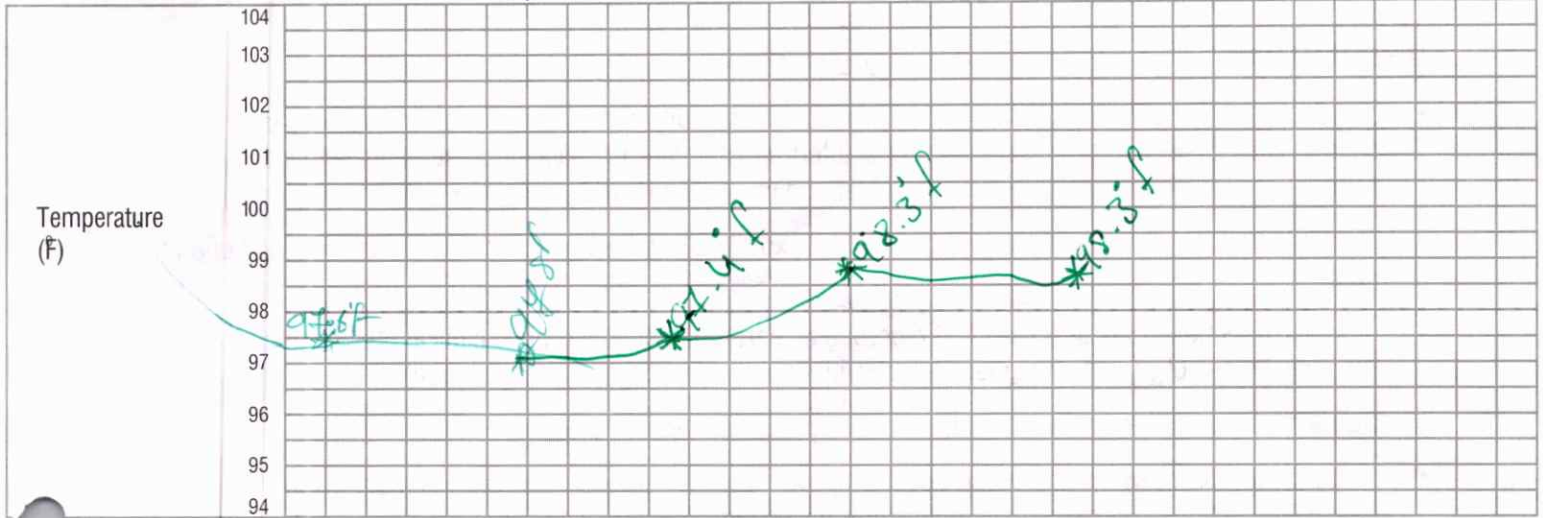
**SCHOOL AGE (5-12 years)**  
**Children's Observation & Early Warning Scoring Chart**

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

BirthRight  
 BY RAINBOW HOSPITALS  
 Your Right to a Safe Delivery

**NG SCORE: CHILDREN'S UNIT**

Date : 5/6/25 Time: 2 PM 6 PM 10 PM 2 AM 6 AM  
 Doctor / Nurse / Family Concern? PM PM PM PM PM



Heart Rate (bpm) and Blood Pressure (mmHg) *	2 PM	6 PM	10 PM	2 AM	6 AM
<b>Note:</b> BP does not score in early warning scoring					
Heart Rate (Number)	108b/m	109b/m	106b/m	106b/m	109b/m

Resp. Rate (bpm) (Over 1 Minute) *	2 PM	6 PM	10 PM	2 AM	6 AM
Resp Rate (Number)	20b/m	21b/m	25b/m	22b/m	20b/m

Resp Mod/ Severe Distress None / Mild	2 PM	6 PM	10 PM	2 AM	6 AM
Receiving O <sub>2</sub> (l/min) O <sub>2</sub> Saturations (%)	100%	100%	100%	100%	100%
Conscious Level Normal / Altered					
GCS *					

TOTAL SCORE	2 PM	6 PM	10 PM	2 AM	6 AM
Number of shaded boxes	0	0	0	0	0
Pain Score	0	0	0	0	0
Observer's Initials	PM	PM	PM	PM	PM

**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 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.

<b>I</b>	<b>IDENTITY:</b> I am (name), a nurse on ward (X). I am calling about (child X)
<b>S</b>	<b>SITUATION:</b> 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>B</b>	<b>BACK GROUND:</b> 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)
<b>A</b>	<b>ASSESSMENT:</b> 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.
<b>R</b>	<b>RECOMMENDATION:</b> 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)

Master HANIEESH SHOBANBABU  
 03-07-2017 8 Y 11 M 2 D (M)  
 Dr. ABHISHEK RAVINDRA JAIN

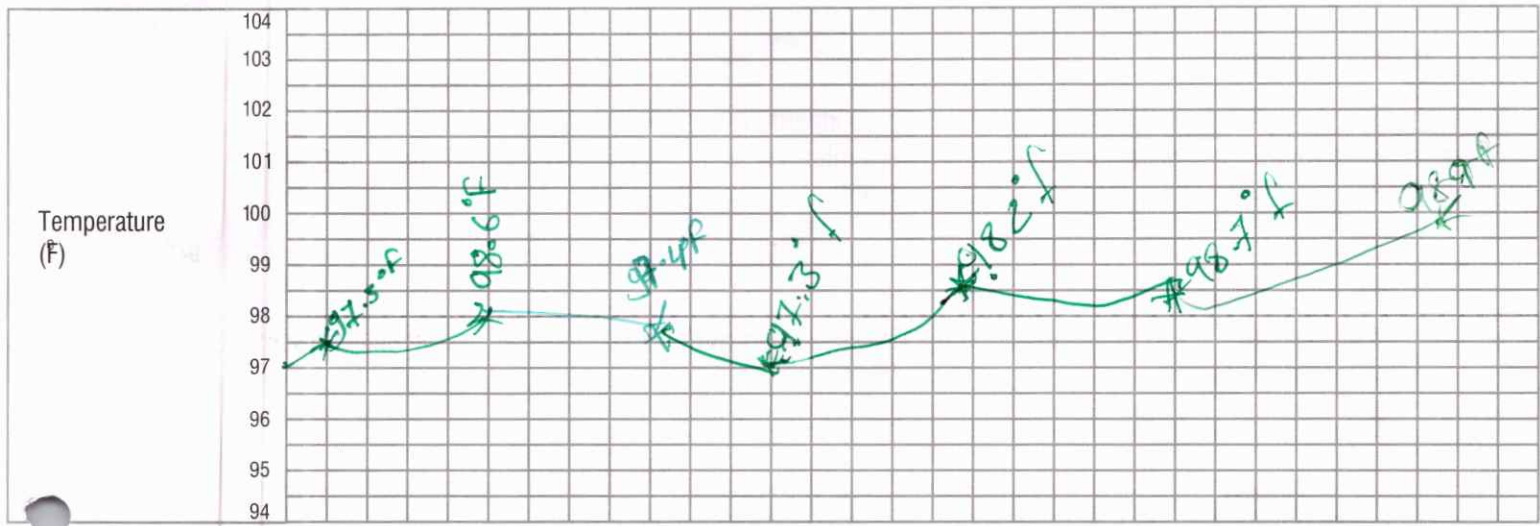
L/126

**SCHOOL AGE (5-12 years)**  
**Children's Observation & Early Warning Scoring Chart**



**EARLY WARNING SCORE: CHILDREN'S UNIT**

Date: 07/07/20 Time: 10 AM 2 PM 6 PM 10 PM 2 am 6 am 8 AM  
 Doctor / Nurse / Family Concern? 1 pm pm pm pm pm pm



Heart Rate (bpm)	Blood Pressure (mmHg) *
78	99/72
102	98/67
94	116/78
108	100/70
110	89/60
108	115/40
89	85/60

**Note:** BP does not score in early warning scoring

Heart Rate (Number)	Resp Rate (Number)
78	39
102	30
94	25
108	23
110	25
108	22
89	20

Resp Rate (bpm) (Over 1 Minute) *	Resp Mod/ Severe Distress	Receiving O <sub>2</sub> (l/min)	O <sub>2</sub> Saturations (%)	Conscious Level	Normal / Altered	GCS *
39	None	99%	99%	Normal	Normal	15
30	None	99%	99%	Normal	Normal	15
25	None	98%	98%	Normal	Normal	15
23	None	99%	99%	Normal	Normal	15
25	None	99%	99%	Normal	Normal	15
22	None	99%	99%	Normal	Normal	15
20	None	100%	100%	Normal	Normal	15

TOTAL SCORE	Number of shaded boxes	Pain Score	Observer's Initials
0	0	0	[Signature]
0	0	0	[Signature]
0	0	0	[Signature]
0	0	0	[Signature]
0	0	0	[Signature]
0	0	0	[Signature]
0	0	0	[Signature]

**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 in charge AND PICU fellow or PICU consultant to be informed.

\* If RR 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.

<b>I</b>	<b>IDENTITY:</b> I am (name), a nurse on ward (X). I am calling about (child X)
<b>S</b>	<b>SITUATION :</b> 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>B</b>	<b>BACK GROUND :</b> 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)
<b>A</b>	<b>ASSESSMENT :</b> 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.
<b>R</b>	<b>RECOMMENDATION :</b> 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)

Master HANEESH SHOBANABU  
 03-07-2017 8 Y 11 M 2 D (M)  
 Dr. ABHISHEK RAVINDRA JAIN

AL/126

**SCHOOL AGE (5-12 years)**  
**Children's Observation & Early Warning Scoring Chart**

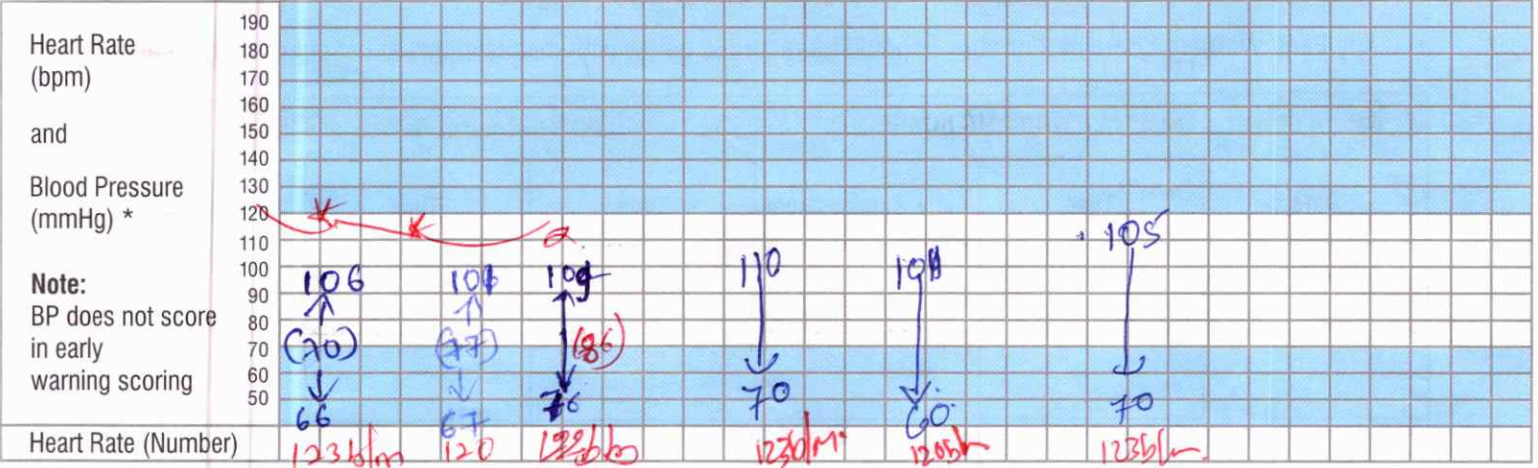
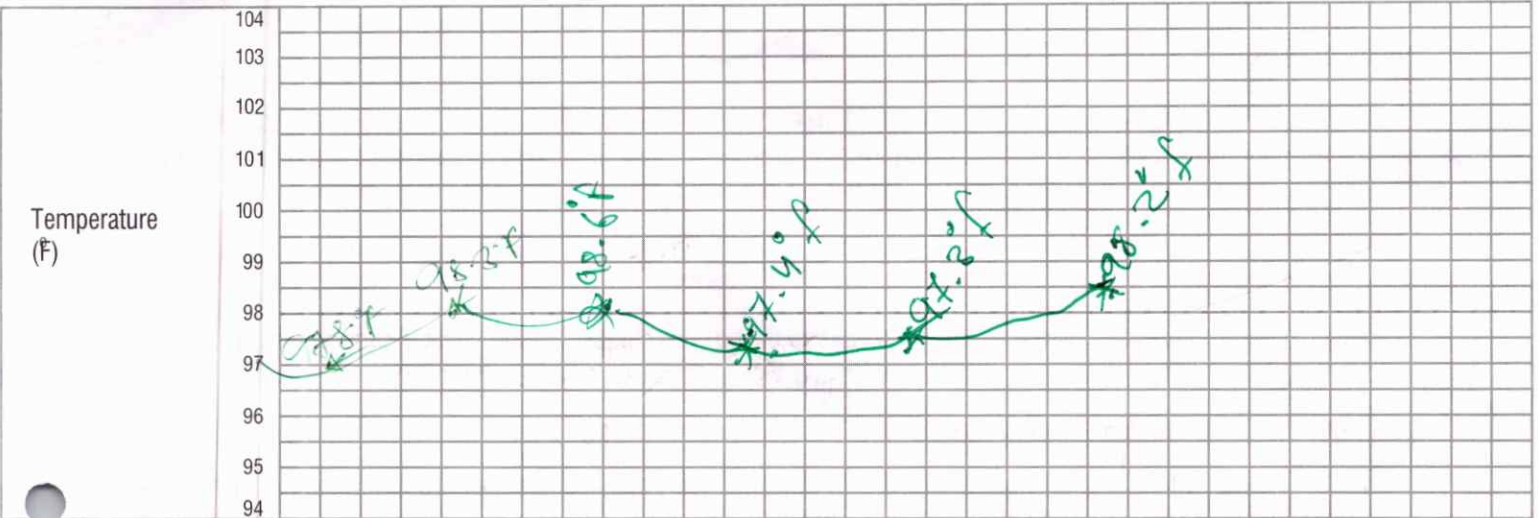
Rainbow Children's Hospital  
 It takes a lot to treat the little.

BirthRight  
 BY RAINBOW HOSPITALS  
 Your Right to a Safe Delivery

5/12  
 133

**WARNING SCORE: CHILDREN'S UNIT**

Date : ..... Time: 10 AM 9:30 6 10 PM 8 AM 6 AM.  
 Doctor / Nurse / Family Concern? 6 pm



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

<b>TOTAL SCORE</b>	
Number of shaded boxes	0 0 0 0 0 0
Pain Score	0 0 0 0 0 0
Observer's Initials	V V V B B B

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

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<b>I</b>	<b>IDENTITY:</b> I am (name), a nurse on ward (X). I am calling about (child X)
<b>S</b>	<b>SITUATION :</b> 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>B</b>	<b>BACK GROUND :</b> 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)
<b>A</b>	<b>ASSESSMENT :</b> 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.
<b>R</b>	<b>RECOMMENDATION :</b> I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)



# FLUID CHART

Sheet No. : .....

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

Date	Time	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											
<b>Total Intake :</b> taken						<b>Total Output :</b> 0-14-0						
5/6/12	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
<b>Total Intake :</b>						<b>Total Output :</b> 0-2 M-1						
5/6/26	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
<b>Total Intake :</b>						<b>Total Output :</b> 4-2 M-						
6/6/26	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
<b>Total Intake :</b>						<b>Total Output :</b> 4-2 M-						
<b>Total 24 hrs. Intake</b>						<b>Total 24 hrs. Output</b>						

# 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							
6/6/26	08:00 am					/			✓			
	09:00 am					/			✓			
	10:00 am	0	Jelly			/		NA		0		
	11:00 am		Supp			/		NA				
	12:00 pm					/			✓			
	01:00 pm					/			✓			
<b>Total Intake :</b>		Taken			<b>Total Output :</b> U-2 M-1							
6/6/26	02:00 pm					/			✓			
	03:00 pm					/			✓			
	04:00 pm	0	Rice			/		NA		0		
	05:00 pm		Supp			/		NA				
	06:00 pm					/			✓			
	07:00 pm					/			✓			
<b>Total Intake :</b>					<b>Total Output :</b> U-2 M-0							
6/6/26	08:00 pm					/			✓			
	09:00 pm					/			✓			
	10:00 pm	0	RICE			/		NA		0		
	11:00 pm					/		NA				
	12:00 am					/			✓			
	01:00 am					/			✓			
<b>Total Intake :</b>					<b>Total Output :</b> U-3 M-0							
7/6/26	02:00 am					/			✓			
	03:00 am					/			✓			
	04:00 am	0	PR20			/		NA		0		
	05:00 am					/		NA				
	06:00 am					/			✓			
	07:00 am					/			✓			
<b>Total Intake :</b>					<b>Total Output :</b> U-2 M-1							

**Total 24 hrs. Intake**

**Total 24 hrs. Output**

# FLUID CHART

Sheet No. : .....

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
8/6/26	08:00 am										0	S
	09:00 am		Tea								0	
	10:00 am	o			NA						0	
	11:00 am										0	
	12:00 pm		H2O								0	
	01:00 pm										0	
<b>Total Intake :</b> Taken			<b>Total Output :</b> U-1 m-1									
8/6/26	02:00 pm										0	S
	03:00 pm		Rice								0	
	04:00 pm	o	Chapati								0	
	05:00 pm										0	
	06:00 pm										0	
	07:00 pm										0	
<b>Total Intake :</b> Taken			<b>Total Output :</b> U-3 m-x									
8/6/26	08:00 pm										1	S
	09:00 pm										1	
	10:00 pm	o	Rice								0	
	11:00 pm		H2O								1	
	12:00 am										1	
	01:00 am										1	
<b>Total Intake :</b> Taken			<b>Total Output :</b> U-3 m-									
8/6/26	02:00 am										1	S
	03:00 am										1	
	04:00 am	o	H2O								0	
	05:00 am										1	
	06:00 am										1	
	07:00 am										1	
<b>Total Intake :</b>			<b>Total Output :</b> U-2 m-									

HNH-00015748 IP26-00006477  
 Master HANBESH SHOBANBABU  
 03-07-2017 8 Y 11 M 4 D (M)  
 Dr. ABHISHEK RAVINDRA JAIN



# FLUID CHART

Sheet No. : .....

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

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

**Total 24 hrs. Intake**

**Total 24 hrs. Output**



# NURSING CARE RECORD

Date: 5/6/26

- 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	12pm	→ Assess the pt condition → monitor vitals → maintain Dlochopt → IV cannula present → GT medication	1pm	→ Assess the pt condition → Monitor vitals → maintained Dlochopt → IV cannula present → GT medication	→ pt is stable	→ rechecked vitals	
	2pm		→ STOP IV fluid.				
Afternoon		→ Assess the pt condition. → mai	2pm	→ Assess the pt condition.	pt is stable	re-checked the vitals	
			→ maintained the → stop IV fluids				
Night	8pm	→ Assess the patient general condition → Provide comfortable position. → monitor vitals	8pm	→ Assessed the patient general condition → provided comfortable position → monitored vitals	Patient is stable	Rechecked vitals	
	8am						

Patient Sticker

# NURSING CARE RECORD

HNH-00015746 IP26-00006477  
 Master HANEESH SHOBANBABU  
 03-07-2017 8 Y 11 M 2 D (M)  
 Dr. ABHISHEK RAVINDRA JAIN



Date: 6/6/20

**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	8pm	- Assess the pt condition - monitor vitals - maintain S/O Chart - Medication Give as per drug chart	8pm	- Assessed the pt condition - monitor vitals - maintain S/O Chart - Medication Give as per drug chart	pt is stable	Re-checked vitals	Sumitha
Afternoon	2pm to 8pm	→ Assess the pt condition. → monitor vitals → maintain S/O Chart → per d	2pm to 8pm	→ Assess the pt condition → maintain S/O Chart → medication given as per drug chart	pt is stable	Re-checked the vitals	Abhishek
Night	8pm to 8am	→ Assess the patient general condition → monitor vitals → medication given as per doctor's orders	8pm to 8am	→ Assessed the patient general condition → monitor vitals → Administer medications as per doctor's orders	Patient is stable	→ Rechecked vitals	Abhishek

# NURSING CARE RECORD



Date: 24/12/2017

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8am	Assess the general conditions. → monitor vitals → maintain ECG chart → Administer medications		Assessed the general conditions → monitored vitals → maintained ECG chart → administered medications	PT is stable	Re checked vitals	<i>Carlyp</i>
Afternoon	2pm	→ Assess the pt condition → monitor vitals. → ECG chart maintain → Administer medication	3pm	→ Assessed the pt general condition. → ECG chart maintained → monitored vitals. → All medication given as per doctor order	→ pt is stable	→ Re checked the vitals.	<i>Carly</i>
Night	8pm	→ Assess the patient general condition → monitor vitals → Administer medication as per doctor's orders	8pm	→ Assessed the patient general condition → monitored vitals → maintain ECG → Administer medication as per orders	Patient is stable	→ Rechecked vitals → Tomorrow morning ECG plan	<i>Carly</i>

Patient Sticker

HNH-00015748 IP26-00006477  
 Master HANEESH SHOBANBABU  
 03-07-2017 8 Y 11 M 4 D (M)  
 Dr. ABHISHEK RAMNDRA JAIN

# 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
<b>Morning</b>							
<b>Afternoon</b>							
<b>Night</b>							

HNH-00015746 IP26-0006477  
 Master HANISH SHOBANBABU  
 03-07-2017 8 Y 11 M 2 D (M)  
 Dr. ABHISHEK RAVINDRA JAIN

# BRADEN 'Q' SCALE



Date : 5/8/20 5/6/16 6/6 6/6  
 Time : 2 PM 10 PM MG 2

Mobility	<b>1. Completely immobile:</b> Does not make even slight changes in body or extremity position without assistance.	<b>2. Very limited:</b> Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	<b>3. Slightly limited:</b> Makes frequent through slight changes in body or extremity position independently.	<b>4. No limitations:</b> Makes major and frequent changes in position without assistance.	4	4	4	4
"Activity The degree of physical activity"	<b>1. Bedfast :</b> Confined to bed	<b>2. Chairfast :</b> Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	<b>3. Walks occasionally:</b> Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	<b>4. All patients too young to ambulate; OR walks frequently:</b> Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4	4	4
Sensory Perception	<b>1. Completely limited:</b> 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.	<b>2. Very limited:</b> 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.	<b>3. Slightly limited:</b> 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.	<b>4. No impairment:</b> Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	4
Moisture Degree to which skin is exposed to moisture	<b>1. Constantly moist:</b> Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	<b>2. Very moist:</b> Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	<b>3. Occasionally moist:</b> Skin is occasionally moist, requiring linen change every 12 hours.	<b>4. Rarely moist:</b> Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	4
<b>FRICITION-SHEAR</b> Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	<b>1. Significant problem:</b> Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	<b>2. Problem:</b> 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.	<b>3. Potential problem:</b> 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.	<b>4. No apparent problem:</b> Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	4
Nutritional Usual food intake pattern	<b>1. Very Poor:</b> 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.	<b>2. Inadequate:</b> 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.	<b>3. Adequate:</b> 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.	<b>4. Excellent:</b> Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	4
Tissue Perfusion & Oxygenation	<b>1. Extremely compromised:</b> Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	<b>2. Compromised:</b> Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	<b>3. Adequate:</b> Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	<b>4. Excellent:</b> Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4
<b>TOTAL SCORE</b>					20	24	28	28
<b>Evaluator's Name</b>					Q	Q	Q	Q

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	<b>Support Surfaces</b> (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"> <li>• Regular Turning Schedule</li> <li>• Enable as much activity as possible</li> <li>• Protect the heels</li> <li>• Use pressure redistribution surfaces</li> <li>• Manage moisture, friction and shear</li> <li>• Advance to a higher level of risk if other major risk factors are present</li> </ul>	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	<ul style="list-style-type: none"> <li>• Use the Same Protocol as for “At Risk” Patients</li> <li>• Position patient at 30 degree lateral incline using foam wedges</li> </ul>	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	<ul style="list-style-type: none"> <li>• Follow the same protocol as for “Moderate Risk” Patients</li> <li>• In addition to regular turning schedule</li> <li>• Make small shifts in their position frequently</li> </ul>	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"> <li>• Use same protocol as for “High Risk” Patients</li> <li>• Add a pressure redistribution surface for patients with severe pain or with additional risk factors.</li> </ul>	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

# BRADEN 'Q' SCALE

					Date :				
					Time :	06	18		
Mobility	<b>1. Completely immobile:</b> Does not make even slight changes in body or extremity position without assistance.	<b>2. Very limited:</b> Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	<b>3. Slightly limited:</b> Makes frequent through slight changes in body or extremity position independently.	<b>4. No limitations:</b> Makes major and frequent changes in position without assistance.	4	4			
"Activity The degree of physical activity"	<b>1. Bedfast :</b> Confined to bed	<b>2. Chairfast :</b> Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	<b>3. Walks occasionally:</b> Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	<b>4. All patients too young to ambulate; OR walks frequently:</b> Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4			
Sensory Perception	<b>1. Completely limited:</b> 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.	<b>2. Very limited:</b> 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.	<b>3. Slightly limited:</b> 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.	<b>4. No impairment:</b> Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4			
Moisture Degree to which skin is exposed to moisture	<b>1. Constantly moist:</b> Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	<b>2. Very moist:</b> Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	<b>3. Occasionally moist:</b> Skin is occasionally moist, requiring linen change every 12 hours.	<b>4. Rarely moist:</b> Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4			
<b>FRICION-SHEAR</b> <b>Friction</b> Occurs when Skin moves against support surfaces <b>Shear</b> Occurs when skin and adjacent bony surface slide across one another	<b>1. Significant problem:</b> Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	<b>2. Problem:</b> 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.	<b>3. Potential problem:</b> 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.	<b>4. No apparent problem:</b> Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4			
Nutritional Usual food intake pattern	<b>1. Very Poor:</b> 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.	<b>2. Inadequate:</b> 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.	<b>3. Adequate:</b> 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.	<b>4. Excellent:</b> Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4			
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4			
<b>TOTAL SCORE</b>					20	20			
<b>Evaluator's Name</b>					Ue	8			

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	<b>Support Surfaces</b> (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"> <li>• Regular Turning Schedule</li> <li>• Enable as much activity as possible</li> <li>• Protect the heels</li> <li>• Use pressure redistribution surfaces</li> <li>• Manage moisture, friction and shear</li> <li>• Advance to a higher level of risk if other major risk factors are present</li> </ul>	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	<ul style="list-style-type: none"> <li>• Use the Same Protocol as for “<b>At Risk</b>” Patients</li> <li>• Position patient at 30 degree lateral incline using foam wedges</li> </ul>	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	<ul style="list-style-type: none"> <li>• Follow the same protocol as for “<b>Moderate Risk</b>” Patients</li> <li>• In addition to regular turning schedule</li> <li>• Make small shifts in their position frequently</li> </ul>	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"> <li>• Use same protocol as for “<b>High Risk</b>” Patients</li> <li>• Add a pressure redistribution surface for patients with severe pain or with additional risk factors.</li> </ul>	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
4/6/26	10pm	0	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	Be
5/6/26	5am	0	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	Be
5/6/26	10pm	0	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	Be
6/6/26	10pm	0	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	Be
6/6/26	2pm	0	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	Be
6/6/26	10pm	0	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	Be
7/6/26	8am	0	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	Be
7/6	2pm	0	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	Be
7/6	8pm	0	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	Be
7/6/26	10pm	0	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	Be

**Re-assessment Frequency:**

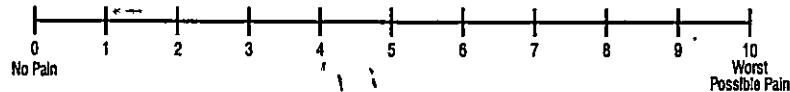
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
  - At least every 2 hours for the first 24 hours
  - Then every 4 hours.
  - Prior to pain relieving intervention.
  - Within 30 - 60 minutes after pain relief intervention.

# 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	0	1	2
<b>Crying Irritability</b>	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
<b>Behavior State</b>	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)
<b>Facial Expression</b>	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
<b>Extremities Tone</b>	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
<b>Vital Signs HR, RR, BP, SaO<sub>2</sub></b>	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 <sub>2</sub> 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO <sub>2</sub> less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

## Wong - Baker (Pediatrics) Above 7 Years



# PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
				<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		
				<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:**

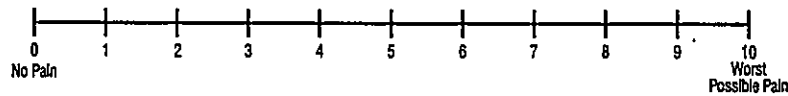
1. Every eight hours for all hospitalized patients.
2. For post-surgical patients, patients with chronic pain, patient with severe pain:
  - a) At least every 2 hours for the first 24 hours
  - b) Then every 4 hours.
  - c) Prior to pain pain-relieving intervention.
  - d) Within 30 – 60 minutes after 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 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	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR, RR, BP, SaO <sub>2</sub>	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 <sub>2</sub> 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO <sub>2</sub> less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

## Wong - Baker (Pediatrics) Above 7 Years





## CHECKLIST FOR THROMBOPHLEBITIS

5/6/26

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	4/6 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	0	0	0	0	0		
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1	NA	NA	NA	NA	NA	NA	NA	NA		
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	NA	NA	NA	NA	NA	NA	NA	NA		
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3	NA	NA	NA	NA	NA	NA	NA	NA		
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4	NA	NA	NA	NA	NA	NA	NA	NA		
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord pyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5	NA	NA	NA	NA	NA	NA	NA	NA		
Signature of the Nurse				5/6	5/6	5/6	5/6	5/6	5/6	5/6	5/6		

**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 : Beary Name : Swithe

Signature of Ward In Charge :

Signature : Be Name : Supathe

# CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1 <i>at 1hr</i>			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	NA	NA	NA							
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	NA	NA	NA							
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3	NA	NA	NA							
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4	NA	NA	NA							
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord pyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5	NA	NA	NA							
Signature of the Nurse				<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>							

**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 : *Sheenanda*

Signature of Ward In Charge :

Signature : *[Signature]* Name : *Balrani*



### THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
			4/6/26	4/6/26	4/6/26	6/5/26	2/6/26
Age	Less than 3 years old	4					
	3 to less than 7 years old	3					
	7 to less than 13 years old	2	2	2	2	2	2
	13 years old and above	1					
Gender	Male	2	2	2	2	2	2
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.)	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1	1	1	1
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own ability	1	1	1	1	1	1
	History of Falls or Infant-Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2	2	2	2	2
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2	2	2			
	More than 48 hours/ None	1			1	1	1
Medication Usage	Sedatives (Excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1	1	1	1
<b>Total</b>			11	11	10	10	10

**Intervention:**

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		✓	✓	✓	✓	✓
Call device within reach		✓	✓	✓	✓	✓
Wheels Locked		✓	✓	✓	✓	✓
Room free of clutter		✓	✓	✓	✓	✓
Adequate lighting		✓	✓	✓	✓	✓
Wheel chair support		-	-	-	-	-
Other Intervention(s) Specify		-	-	-	-	-
Nurse's Name:		Sunam	Dh	Smita	Pranav	Pranav
Signature:		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date:		4/6/26	4/6	5/6	6/5/26	2/6/26
Time:		10AM	2pm	8AM	10PM	8pm

HNM-00015746 IP26-00006477  
 Master HANIEESH SHOBANBABU 8 Y 11 M 2 D (M)  
 03-07-2017  
 Dr. ABHISHEK RAVINDRA JAIN

Patient Stit



## NURSING SHIFT HAND OVER FORM

<b>SITUATION</b>	Diagnosis:		Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Not Known						
	Surgery / Procedure:		If Yes Specify: .....						
<b>BACKGROUND</b>	Date	Shift	5/6/26	6/6/26 MG	6/6/26 E2	6/6/26 N8	6/6/26 MG	6/6/26 E4	
	Medical Condition (Any special condition to be noted):		-						
	Diet:		Soft						
	Allergy:		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
<b>ASSESSMENT</b>	Ventilation (RA, NP, NIV, VENTI):		-						
	Tubes/Drains/Catheter:		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
	Vital Signs:		Temp:	98.3 F	98.9 F	98.5	98.3 F	98.0 F	98.2 F
			Res:	20b/m	22b/m	20b/m	20b/m	22b/m	22b/m
			SpO <sub>2</sub> :	99%	99%	99%	99%	100%	99%
			Pulse:	109	75b/m	75b/m	73b/m	89b/m	82b/m
			BP:	100/70	100/70	100/67	100/60	110/70	112/62
			LOC:	-					
			Fall Risk Score:	-					
			Pain Score:	-					
		Skin Integrity	-						
<b>Recommendations</b>	Safety Needs:		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input 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 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						
	Physiotherapy:		-						
	Others Specify:		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
	Special Diet:		-						
	Critical Lab Test / Values:		-						
	Other Special Orders / Medications:		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
	ADL (Dependent / Non Dependent):		-						
Post Operative Procedure Special Orders:			NA						
Handed Over By Name :			Sandhya Sunada Madh						
Signature / ID :			[Signatures]						
Date:			6/6/26						
Time:			8 AM						
Taken Over By Name :			Sunada Madh Sandhya						
Signature / ID :			[Signatures]						
Date:			6/6/26						
Time:			8 AM						

## NURSING SHIFT HAND OVER FORM

<b>SITUATION</b>	Diagnosis:	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify: .....						
	Surgery / Procedure:	Post OP Day:						
<b>BACKGROUND</b>	Date	#16/26						
	Shift	NS						
	Medical Condition (Any special condition to be noted):	—						
	Diet:	—						
<b>ASSESSMENT</b>	Allergy:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Ventilation (RA, NP, NIV, VENTI):	—						
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Vital Signs:	Temp:	98.2 <sup>o</sup> F					
		Res:	22b/m					
		SpO <sub>2</sub> :	99%					
		Pulse:	75b/m					
		BP:	110/70					
		LOC:	—					
		Fall Risk Score:	—					
Pain Score:	—							
Skin Integrity	—							
<b>Recommendations</b>	Safety Needs:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Physiotherapy:	—						
	Others Specify:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Special Diet:	—						
	Critical Lab Test / Values:	—						
	Other Special Orders / Medications:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	PU Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	DVT Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
ADL (Dependent / Non Dependent):	—							
Post Operative Procedure Special Orders:		—						
Handed Over By Name :		Saindy						
Signature / ID :		CH						
Date:		8/16/26						
Time:		8:00						
Taken Over By Name :								
Signature / ID :								
Date:								
Time:								





## MEDICATION RECONCILIATION FORM

Drug Allergies: .....  Not known any Drug Allergies

**Medication Reconciliation will be done at the time of admission and also whenever there is change in the treating team or shifting from one unit to another unit.**

**(Example: at the time of admission shifting from ICU to Ward, or Ward to ICUs)**

Shifting From: ER ..... Shifted to: PICU .....

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

\* C- Continue, DC - Discontinue

### MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Tanvi .....

Date & Time : 01/06/20 @ 12:30 AM .....

Nurse Name & Signature : Debin .....

Date & Time : 01/06/20 @ 12:30 AM .....

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



## NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: ..... Department: ..... Date of Admission: .....

SITUATION	Diagnosis: <i>Seizures</i>	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify: .....						
BACKGROUND	Area	<i>2/6/26</i> <i>Ne</i>	<i>2/6/26</i> <i>Ne</i>	<i>2/6/26</i> <i>G2</i>	<i>2/6/26</i> <i>Ne</i>	<i>3/6/26</i> <i>M4</i>	<i>3/6/26</i> <i>E2</i>	
	Shift Time							
	Medical Condition (Any special condition to be noted):			<i>Seizures</i>	<i>Seizures</i>	<i>Seizures</i>	<i>Seizures</i>	
ASSESSMENT	Allergy:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Vital Signs:	Temp:	<i>96.7F</i>	<i>97.6</i>	<i>98.9F</i>	<i>98.6F</i>	<i>98.7F</i>	<i>98.7F</i>
		Res:	<i>22b/m</i>	<i>20b/m</i>	<i>21b/m</i>	<i>20b/m</i>	<i>17b/m</i>	<i>24b/m</i>
		SpO <sub>2</sub> :	<i>100%</i>	<i>100%</i>	<i>97%</i>	<i>99%</i>	<i>97%</i>	<i>99%</i>
		Pulse:	<i>82b/m</i>	<i>102b/m</i>	<i>92b/m</i>	<i>89b/m</i>	<i>75b/m</i>	<i>94b/m</i>
		BP:	<i>98/64</i>	<i>104/88</i>	<i>110/78</i>	<i>109/78</i>	<i>102/69</i>	<i>110/83(92)</i>
Fall Risk Score:	-	-	-	-	-	-		
Pain Score:	-	-	-	-	-	-		
Recommendations	Safety Needs:	-	-	-	-	-	-	
	Physiotherapy	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Others Specify:	-	-	-	-	-	-	
	Special Diet:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Other Special Orders / Medications:		<i>NA</i>	<i>NA</i>	<i>NA</i>	<i>NA</i>	<i>NA</i>	<i>NA</i>	
Post Operative Procedure Special Orders:		<i>NA</i>	<i>NA</i>	<i>NA</i>	<i>NA</i>	<i>NA</i>	<i>NA</i>	
Handed Over By Name :		<i>Sumitha</i>	<i>Laxmi</i>	<i>Saisli</i>	<i>Sumitha</i>	<i>Sumitha</i>	<i>Sumitha</i>	
Signature :		<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	
Date:		<i>2/6/26</i>	<i>2/6/26</i>	<i>2/6/26</i>	<i>2/6/26</i>	<i>2/6/26</i>	<i>3/6/26</i>	
Time:		<i>8:00 AM</i>	<i>2 PM</i>	<i>8 PM</i>	<i>5:00 PM</i>	<i>2 PM</i>	<i>8 PM</i>	
Taken Over By Name :		<i>Laxmi</i>	<i>Saisli</i>	<i>Sumitha</i>	<i>Sumitha</i>	<i>Sumitha</i>	<i>Sumitha</i>	
Signature :		<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	
Date:		<i>2/6/26</i>	<i>2/6/26</i>	<i>2/6/26</i>	<i>3/6/26</i>	<i>3/6/26</i>	<i>2/6/26</i>	
Time:		<i>8 PM</i>	<i>2 PM</i>	<i>8 PM</i>	<i>8 AM</i>	<i>2 PM</i>	<i>5:00 PM</i>	



## NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Patel Department: \_\_\_\_\_ Date of Admission: \_\_\_\_\_

<b>SITUATION</b>	Diagnosis: <u>Seizures</u>		Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify: _____					
	<b>BACKGROUND</b>	Area Shift Time	<u>3/6/26</u> <u>NL</u>	<u>4/6/26</u> <u>MG</u>	<u>4/6/26</u> <u>G2</u>	<u>4/6/26</u> <u>N1</u>	<u>5/6/26</u> <u>M4</u>	<u>6/6/26</u> <u>M2</u>
	Medical Condition (Any special condition to be noted):	<u>Seizure</u>	<u>Seizure</u>	<u>Seizure</u>	<u>Seizure</u>	<u>Seizure</u>	-	
<b>ASSESSMENT</b>	Allergy:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	Vital Signs:	Temp:	<u>98.0°F</u>	<u>98.6°F</u>	<u>98.6°F</u>	<u>98.6°F</u>	<u>98.1°F</u>	<u>98.6°F</u>
		Res:	<u>23b/m</u>	<u>22b/m</u>	<u>23b/m</u>	<u>30b/m</u>	<u>24b/m</u>	<u>24b/m</u>
		SpO <sub>2</sub> :	<u>100%</u>	<u>100%</u>	<u>100%</u>	<u>100%</u>	<u>100%</u>	<u>100%</u>
		Pulse:	<u>115b/m</u>	<u>109b/m</u>	<u>110b/m</u>	<u>111b/m</u>	<u>89b/m</u>	<u>88b/m</u>
		BP:	<u>09/24</u>	<u>116/98</u>	<u>110/69</u>	<u>108/73</u>	<u>95/66</u>	
Fall Risk Score:	-	-	-	-	-			
Pain Score:	-	-	-	-	-			
<b>Recommendations</b>	Safety Needs:	-	-	-	<u>Yes</u>	<u>Yes</u>		
	Physiotherapy	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Others Specify:	-	-	-	-			
	Special Diet:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Other Special Orders / Medications:	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>		
Post Operative Procedure Special Orders:		-	-	-	<u>NA</u>	<u>NA</u>		
Handed Over By Name :		<u>Sush</u>	<u>Dhan</u>	<u>Dhan</u>	<u>Sush</u>	<u>Sijak</u>		
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>		
Date:		<u>4/6/26</u>	<u>4/6/26</u>	<u>4/6</u>	<u>5/6/26</u>	<u>5/6/26</u>		
Time:		<u>8PM</u>	<u>2PM</u>	<u>8PM</u>	<u>8AM</u>			
Taken Over By Name :		<u>Dhan</u>	<u>Dhan</u>	<u>Sush</u>	<u>Sijak</u>			
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>			
Date:		<u>04/6/26</u>	<u>4/6</u>	<u>4/6/26</u>	<u>5/6/26</u>			
Time:		<u>8AM</u>	<u>2PM</u>	<u>8PM</u>	<u>8</u>			

Patient Sticker



## NURSING SHIFT HAND OVER FORM

<b>SITUATION</b>	Diagnosis:	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify: .....						
	Surgery / Procedure:	Post OP Day:						
<b>BACKGROUND</b>	Date							
	Shift							
	Medical Condition (Any special condition to be noted):							
	Diet:							
<b>ASSESSMENT</b>	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 <sub>2</sub> :						
		Pulse:						
		BP:						
		LOC:						
		Fall Risk Score:						
Pain Score:								
Skin Integrity								
<b>Recommendations</b>	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	
	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	<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	
	Post Operative Procedure Special Orders:							
	Handed Over By Name :							
	Signature / ID :							
	Date:							
	Time:							
	Taken Over By Name :							
	Signature / ID :							
	Date:							
	Time:							

Patient Sticker



## NURSING SHIFT HAND OVER FORM

<b>SITUATION</b>	Diagnosis:	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify: .....						
	Surgery / Procedure:	Post OP Day:						
<b>BACKGROUND</b>	Date							
	Shift							
	Medical Condition (Any special condition to be noted):							
	Diet:							
<b>ASSESSMENT</b>	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 <sub>2</sub> :						
		Pulse:						
		BP:						
		LOC:						
		Fall Risk Score:						
	Pain Score:							
	Skin Integrity							
<b>Recommendations</b>	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-00015746 IP26-00006477  
 Master HANEESH SHOBANBABU  
 03-07-2017 8 Y 10 M 30 D (M)  
 Dr. ABHISHEK RAVINDRA JAIN



# BRADEN 'Q' SCALE



Date: 2/6/2022  
 Time: 11:25 AM

Mobility	<b>1. Completely immobile:</b> Does not make even slight changes in body or extremity position without assistance.	<b>2. Very limited:</b> Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	<b>3. Slightly limited:</b> Makes frequent through slight changes in body or extremity position independently.	<b>4. No limitations:</b> Makes major and frequent changes in position without assistance.	3	3	3	3
"Activity The degree of physical activity"	<b>1. Bedfast :</b> Confined to bed	<b>2. Chairfast :</b> Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	<b>3. Walks occasionally:</b> Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	<b>4. All patients too young to ambulate; OR walks frequently:</b> Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4	4	4
Sensory Perception	<b>1. Completely limited:</b> 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.	<b>2. Very limited:</b> 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.	<b>3. Slightly limited:</b> 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.	<b>4. No impairment:</b> Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	4
Moisture Degree to which skin is exposed to moisture	<b>1. Constantly moist:</b> Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	<b>2. Very moist:</b> Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	<b>3. Occasionally moist:</b> Skin is occasionally moist, requiring linen change every 12 hours.	<b>4. Rarely moist:</b> Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	4
<b>FRICION-SHEAR</b> <b>Friction</b> Occurs when Skin moves against support surfaces <b>Shear</b> Occurs when skin and adjacent bony surface slide across one another	<b>1. Significant problem:</b> Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	<b>2. Problem:</b> 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.	<b>3. Potential problem:</b> 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.	<b>4. No apparent problem:</b> Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	4
Nutritional Usual food intake pattern	<b>1. Very Poor:</b> 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.	<b>2. Inadequate:</b> 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.	<b>3. Adequate:</b> 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.	<b>4. Excellent:</b> Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	3	3	3	3

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

<b>TOTAL SCORE</b>	26	26	26	26
<b>Evaluator's Name</b>	[Signature]	[Signature]	[Signature]	[Signature]

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



# BRADEN 'Q' SCALE

					Date :	3/6/26	3/6/26	3/6/26	4/6/26
					Time :	11:45	12:00	12:30	12:45
Mobility	<b>1. Completely immobile:</b> Does not make even slight changes in body or extremity position without assistance.	<b>2. Very limited:</b> Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	<b>3. Slightly limited:</b> Makes frequent through slight changes in body or extremity position independently.	<b>4. No limitations:</b> Makes major and frequent changes in position without assistance.		3	3	3	3
"Activity The degree of physical activity"	<b>1. Bedfast :</b> Confined to bed	<b>2. Chairfast :</b> Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	<b>3. Walks occasionally:</b> Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	<b>4. All patients too young to ambulate; OR walks frequently:</b> Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.		4	4	4	4
Sensory Perception	<b>1. Completely limited:</b> 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.	<b>2. Very limited:</b> 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.	<b>3. Slightly limited:</b> 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.	<b>4. No impairment:</b> Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.		4	4	4	4
Moisture Degree to which skin is exposed to moisture	<b>1. Constantly moist:</b> Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	<b>2. Very moist:</b> Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	<b>3. Occasionally moist:</b> Skin is occasionally moist, requiring linen change every 12 hours.	<b>4. Rarely moist:</b> Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.		4	4	4	4
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Nutritional Usual food intake pattern	<b>1. Very Poor:</b> 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.	<b>2. Inadequate:</b> 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.	<b>3. Adequate:</b> 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.	<b>4. Excellent:</b> Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.		4	4	4	4
Tissue Perfusion & Oxygenation	<b>1. Extremely compromised:</b> Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	<b>2. Compromised:</b> Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	<b>3. Adequate:</b> Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	<b>4. Excellent:</b> Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.		3	3	3	3
					<b>TOTAL SCORE</b>	26	26	26	26
					<b>Evaluator's Name</b>	[Signature]	[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	<b>Support Surfaces</b> (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"> <li>• Regular Turning Schedule</li> <li>• Enable as much activity as possible</li> <li>• Protect the heels</li> <li>• Use pressure redistribution surfaces</li> <li>• Manage moisture, friction and shear</li> <li>• Advance to a higher level of risk if other major risk factors are present</li> </ul>	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	<ul style="list-style-type: none"> <li>• Use the Same Protocol as for “<b>At Risk</b>” Patients</li> <li>• Position patient at 30 degree lateral incline using foam wedges</li> </ul>	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	<ul style="list-style-type: none"> <li>• Follow the same protocol as for “<b>Moderate Risk</b>” Patients</li> <li>• In addition to regular turning schedule</li> <li>• Make small shifts in their position frequently</li> </ul>	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"> <li>• Use same protocol as for “<b>High Risk</b>” Patients</li> <li>• Add a pressure redistribution surface for patients with severe pain or with additional risk factors.</li> </ul>	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
2/6/20	2AM	0/10		<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	ll
2	6AM	0/10		<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	ll
2/6/26	10AM	9/10		<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	ll
2/6/26	2PM	9/10		<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	ll
2/6/26	8pm	9/10		<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	ll
3/6/26	8~	0/10		<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	ll
3/6/26	2pm	0/10		<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	ll
8/2/26	8pm	0/10		<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	ll
4/6/26	10AM	0/10		<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	ll
4/6	2pm	0/10		<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	ll

**Re-assessment Frequency:**

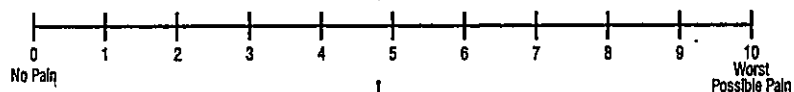
1. Every eight hours for all hospitalized patients.
2. For post-surgical patients, patients with chronic pain, patient with severe pain:
  - a) At least every 2 hours for the first 24 hours
  - b) Then every 4 hours.
  - c) Prior to pain pain-relieving intervention.
  - d) Within 30 - 60 minutes after 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
<b>Crying Irritability</b>	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
<b>Behavior State</b>	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)
<b>Facial Expression</b>	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
<b>Extremities Tone</b>	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
<b>Vital Signs HR RR, BP, SaO<sub>2</sub></b>	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 <sub>2</sub> 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO <sub>2</sub> less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

## Wong - Baker (Pediatrics) Above 7 Years



HNH-00015746 IP26-00006477  
 Master HANEIESH SHOBANBABU  
 03-07-2017 8 Y 10 M 30 D (M)  
 Dr. ABHISHEK RAVINDRA JAIN



## CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1 <sup>1/1</sup> <sup>2/6</sup>			DAY-2			DAY-3 <sup>3/6</sup>			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0	0		0	0	0	0	0	0	0	
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1	NA		NA	NA	NA	NA	NA	NA	NA	
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	NA		NA	NA	NA	NA	NA	NA	NA	
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3	NA		NA	NA	NA	NA	NA	NA	NA	
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4	NA		NA	NA	NA	NA	NA	NA	NA	
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord pyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5	NA		NA	NA	NA	NA	NA	NA	NA	
Signature of the Nurse													

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

Signature of Shift In Charge :

Signature : [Signature] Name : Sunitha

Signature of Ward In Charge :

Signature : [Signature] Name : Sujatha

HNH-00015746 IP26-00006477  
 Master HANEESH SHOBANBABU  
 03-07-2017 8 Y 10 M 30 D (M)  
 Dr. ABHISHEK RAVINDRA JAIN



## THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	2/6/26	2/6/26	2/6/26	3/6/26	3/6/26
	3 to less than 7 years old	3					
	7 to less than 13 years old	2	2	2	2	2	2
	13 years old and above	1					
Gender	Male	2	2	2	2	2	2
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.)	3	3				
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1	1	1	1
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own ability	1	1	1	1	1	1
	History of Falls or Infant-Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2	2	2	2	2
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2	2	2	2	2	2
	More than 48 hours/ None	1					
Medication Usage	Sedatives (Excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2				1	1
	Other Medications / None	1	1	1	1	1	1
<b>Total</b>			11	11	11	11	11

**Intervention:**

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position	2	✓	✓	✓	✓	✓
Call device within reach	✓	✓	✓	✓	✓	✓
Wheels Locked	✓	✓	✓	✓	✓	✓
Room free of clutter	✓	✓	✓	✓	✓	✓
Adequate lighting	✓	✓	✓	✓	✓	✓
Wheel chair support	-	-	-	-	-	-
Other Intervention(s) Specify	-	-	-	-	-	-
Nurse's Name:	Sushma	Caru	Arshi	Sujal	Suman	
Signature:	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	
Date:	2/6/26	2/6/26	2/6/26	3/6/26	3/6/26	
Time:	9 AM	8 PM	9 PM	8 AM	8 PM	



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## NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 3/6/26 Time: 3pm

Weight: 22 kg Centile: <10<sup>th</sup>

Height: Centile:

Inference: underweight child.

RDA: Calories: 1550 kcal/d Protein: 27 gms/d

Diet Recommendations: Normal calcium rich diet

Re-Assesment: Avoid spicy, chilled & outside foods

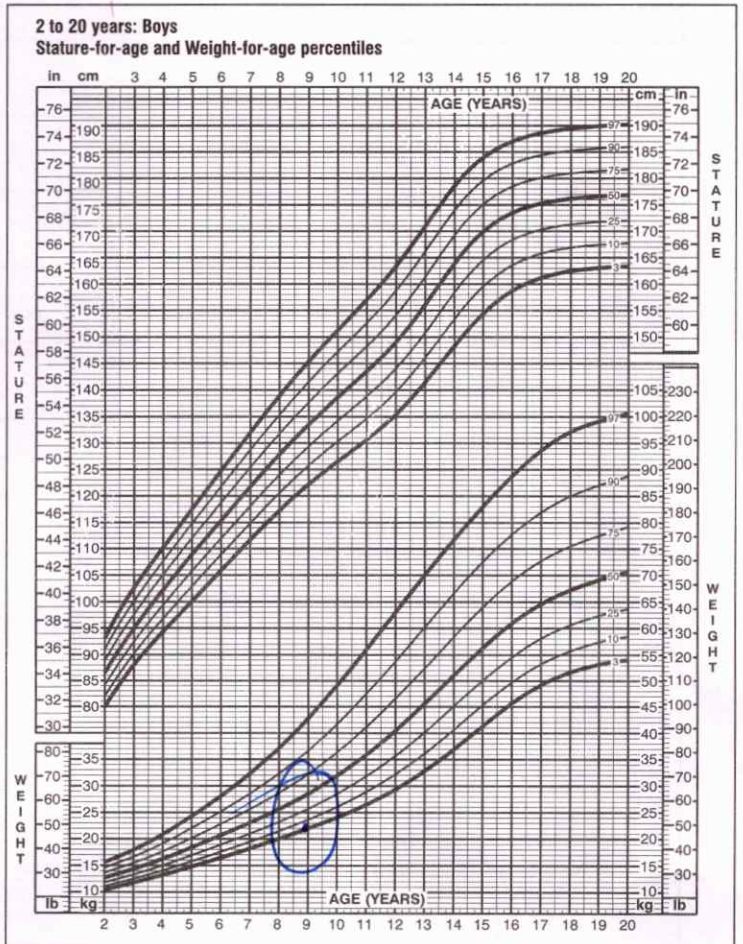
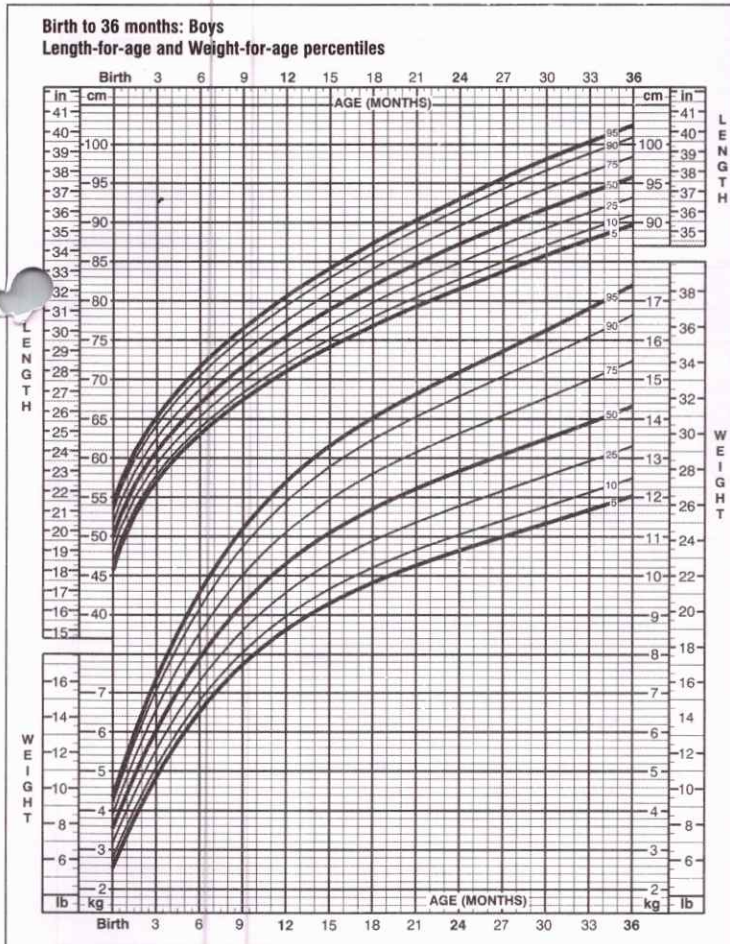
Food Allergies: NO Veg/Non-veg: NON-veg

Diagnosis: unprovoked seizures

Nutritional Intervention -  Oral  Enteral  Parenteral

Patient's Signature: M. Sathwik

### GROWTH CHART (BOYS)



Dietician's Name: Sathwika G

Dietician's Signature: [Signature]





Wt - 22 kg

GRBS - 165 mg



# EMERGENCY ROOM TRIAGE FORM

Patient's Name: Hanish Hanish Age: 9 years Gender:  Male  Female  
 Date: 01/06/20 Time of Arrival: 11 PM

Allergies:  No  Yes  Food  Medications  Blood Transfusion  Other (Specify):  Not known  
 Source of Information:  Parents  Others (Specify) \_\_\_\_\_  
 Mode of Arrival:  Ambulatory  Wheelchair  Ambulance

Initial Vital Signs: Temp: 99.1°f PR: 86/min BP: 106/77/67 RR: \_\_\_\_\_ SpO<sub>2</sub>: 97% + 2L/O<sub>2</sub>  
 Chief Complaints: C/O seizure and eye making new red sclerote

<b>INITIAL PHYSIOLOGICAL CATEGORIZATION</b> Appearance <input type="checkbox"/> Normal <input checked="" type="checkbox"/> Sick Looking Circulation / Colour <input checked="" 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		<b>INITIAL PHYSIOLOGICAL STATUS</b> <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: 11:02 PM

## Communicable Disease Triage Screening

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

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

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

- Have you travelled outside the INDIA? or had close contact with someone who has recently travelled outside the INDIA, in the past two weeks?  Yes  No  
 If yes, State Location: \_\_\_\_\_
- Are your parents / close contacts at home is/a healthcare worker? (please encircle the choices) (e.g., nurse, physician, ancillary services personnel, allied health services personnel, hospital volunteer, or laboratory worker, others) who has had a recent exposure to an individual with a highly communicable disease or unexplained, severe febrile respiratory or rash disease?  Yes  No

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

- Any patient with Fever / Rash / Vesicles / Discharge from Eyes and Cough
- Any patient with fever and respiratory symptoms who answered "YES" to any of the questions on epidemiologic risk factors in "PART B" of the triage screening above.

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

- Patients should be immediately isolated in a negative pressure room or a single room (as appropriate) for pending evaluation.
- The patient should be given a surgical mask immediately, if not already wearing one.
- Both patient and triage staff should perform hand hygiene.
- The staff should use PPE (as appropriate).

Name of Triage Nurse: B. B. B.  
 Date & Time: 01/06/20 @ 11:02 PM

Signature of Triage Nurse: \_\_\_\_\_



## NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 11/8/26 Time of arrival : 11 PM  
 Chief Complaints: No seizure since morning & cpi  
 Height : ..... Weight : ..... Head Circumference (<2 years) .....  
 Allergies:  Yes  No  Medications  Blood Transfusion  Food  Other: .....  
 If yes, identify .....  
 Pain Screening:  Yes  No If Yes, Pain Score: 7/10 Pain Tool Used:  N Pass  FLACC  Wong Baker  
 Character .....  Location .....  Frequency .....  Duration .....

### RISK FOR FALL:

If patient is < 6 years  Yes  No

If 'Yes' tick below fall risk intervention directly

If Patient is > 6 years

If 'Yes' 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 : 11:02 PM

**Nursing Care Plan (Including Labs / Medications / Other Care):**

Time	Nursing Notes
	→ Assessed the pt condition
	→ checked the pt vitals
	→ IV placement done

Samples collected by: /  
 Samples sent by: /

Time: /  
 Time: /

**Medication given in ER:**

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1
11:35	Valproate	IV	5ml (500mg)		[Signature]
11:35 PM	lividil	IV	2.5ml (250mg)		[Signature]
12 AM	order	IV	4ml		[Signature]

Condition of patient at time of shift - out :	Details of Shift - out
HR: 64 b/m BP: ..... CFT: 2.5 ✓ RR: ..... SPO2 at FiO2: 100% O2 GCS: 15/15 Temperature: 99.2 F Pain Score: 10 / Repeat RBS (if applicable): .....	Shift - out from ER to: 1:40 AM PICU Time of Shift - out: 1:40 AM Handover given to: ..... (Nurse's Name)


Tick as applicable:  MLC  LAMA  BROUGHT DEAD

Procedures done with details (if any): .....

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

Date & Time: 01/06/26 @ 11:02 PM

# PATIENT TRANSFER FORM

HNH-00015746      IP26-00006477 Master HANEESH SHOBANBABU 03-07-2017      8 Y 10 M 30 D (M) Dr. ABHISHEK RAVINDRA JAIN 		Date & Time of Admission <i>01/06/26 @</i>	Date & Time of Transfer Order <i>01/06/26</i>
Treating Consultant		Transfer Ordered by <i>Dr. Tanvi</i>	Reason for Transfer <i>Admission</i>
From Unit <i>ER</i>	To Unit <i>Picu</i>	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File <i>20</i>	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 <i>Prabir</i>		Name of Person Ordered Transfer <i>Dr. Tanvi</i>	
Patient & Clinical Records Received by : <i>Sunitha</i>			
Date & Time of Patient Received : <i>01/06/26 at 1:30 AM</i>			

**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



# CROSS CONSULTATION FORM

Doctor Name : Dr. Abhishek Ravinder Date : ..... Time : .....

Diagnosis : .....

Hospital : .....

**Type of Referral :**

- Emergency
- Urgent
- Non Urgent

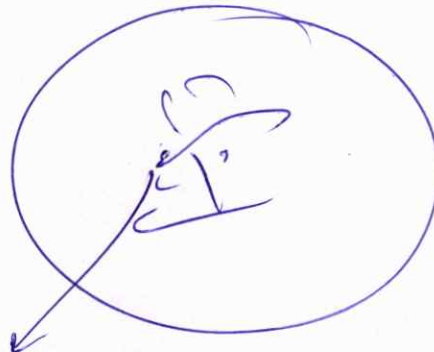
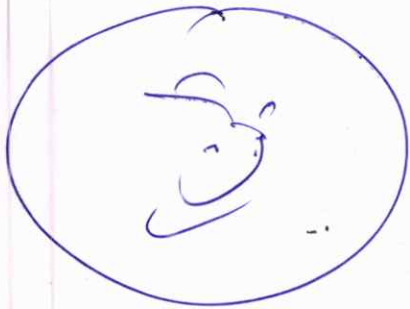
Referred for :  Opinion  Co-Management  Transfer of care

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

Signature: \_\_\_\_\_

**Findings and Recommendations :**

GA 2wt  
 GA 2wt  
 Dilated  
 Dilated  
 No multiple segs suspecting



Inf Bleared Maxilla

(c) : optic neuritis

AD  
 Continue 2/10 MP for 5 days  
 R/W after 5 day

MP:-  
 2 ON

**Consultant :**

Name : Dr. S. Gautham Raju Signature : \_\_\_\_\_ Date & Time : 3/6/26 at 6:20

# CONSENT FOR ADMISSION IN PEDIATRIC INTENSIVE CARE UNIT



Name: HNH-00015746 IP26-00006477  
 Master HANEESH SHOBANBABU Age: 3y Gender: Male  Female   
 03-07-2017 8 Y 11 M 0 D (M)  
 UHID.No: Dr. ABHISHEK RAVINDRA JAIN Date: .....



I ..... S/o, D/o, W/o, ..... hereby declare that our patient Master/Baby ..... who is related to me as ..... is getting admitted in the Pediatric Intensive Care Unit of Rainbow Children's Hospital on .....

The doctors have explained to me in a language understood by me that my child has following health related issues :

*Multiple Seizures / ? Encephalopathy*

The doctors have clearly explained to me that my patient Master / Baby ..... during his/ her stay in the Pediatric Intensive Care Unit may undergo various medical and surgical procedures like airway management, mechanical ventilation, Central Line Insertion, Peripherally Inserted Central Catheter Line and arterial line placements, chest drain, or peritoneal drain insertion etc.

I have been told by the doctors that while performing such procedures I will be informed and a separate consent for this procedure shall be taken. However, in case of any life threatening emergency if the time is not available for taking informed consent it is implied that I give consent for various invasive procedure to save the life of my child.

I understand that a sick child in Pediatric Intensive Care Unit has life threatening medical conditions.

I understand that when a child is sick in the Pediatric Intensive Care Unit with multiple medical and surgical procedures performed upon him/her, there are inherent risks due to these high risk procedures, and high risk medications, in the form of infections, bleeding, air leaks, skin and other tissue damage etc.

I give my consent to the team of doctors to go ahead and admit the child Master / Baby : ..... in the Pediatric Intensive Care Unit fully understanding the associated risk, benefits and alternatives involved from various procedures, high risk medications and infections in the Pediatric Intensive Care Unit and treat him/her with all necessary means.

The doctors have explained to me in the language best understood to me.

**Patient Attendant :**

Signature: *[Signature]*  
 Name: Shoban Babu  
 Relationship with Patient: father  
 Date & Time: 2/6/26

**Witness :**

Signature: *[Signature]*  
 Name: Sunita  
 Date & Time: 2/6/26

**Doctor (who is taking the consent) :**

Signature: *[Signature]*  
 Name: Dr. PRANAV  
 Date & Time: 2/6/26



# CONSENT FOR SPECIAL PROCEDURES

Patient Name : HANEESH Gender:  Male  Female

UHID No : HNH 00015476 Department : Pediatrics Date : 3/6/26

I Shoban babu S/D/W/O Kiran

Here by give consent for procedure of : Insertion puncher

For my patient, Named : HANEESH

The doctors have clearly explained to me that the procedure has following possible complications:

bleedy tissue puncher etc

The doctor have explained to me about the alternatives, risks and benefits for this procedure that :

I have understood the matter mentioned above in language known to me and give consent for the procedure.

Name of the Doctor performing the procedure: Dr. Neeraj

**Patient Attendant :**

Signature : [Signature]

Name : Shoban babu

Relationship with Patient: Father

Date & Time : 3/6/26 12:20 AM

**Witness :**

Signature : [Signature]

Name : Smitha (RCH)

Date & Time : 3/6/26 at 10 AM

**Doctor (who is taking the consent) :**

Signature : [Signature]

Name : B-Singh

Date & Time : 3/6/26 12:20 AM

# CONSENT FORM FOR ANAESTHESIA

Patient Name : Master Maneesh Shoban Babu Age : 8y Gender : Male  Female   
 UHID NO: KNH-00015746 Surgeon Name: \_\_\_\_\_  
 Anaesthesiologist : Dr. Samir Operative procedure planned : MRI Brain

**PLEASE READ THIS BEFORE YOU CONSENT FOR ANAESTHESIA**

General anaesthesia involves rendering a patient unconscious before an operation. This ensures the patient is not aware of events and does not feel pain during the operation. Drugs given through a vein and / or inhaled from an anaesthesia machine produce it. Regional anaesthesia involves using a local anaesthetic to numb a specific area of the body for surgery: Prolonged pain relief without numbness can be achieved by infusing weak solutions of local anaesthetics and narcotic drugs to particular parts of the body after surgery or injury, using catheters.

**Specific High Risk (s) :** The doctors have explained to me the details of the high risk involved due to the following medical problems and I have sought necessary clarification on all my doubts.

- Heart disease       Hypertension       Diabetes mellitus       Renal failure
- Hepatic disorders       Shock       Multiple organ failure       Polytrauma / Renal Tubular Acidosis
- Incapacitating Chronic Obstructive Pulmonary Disease       Others : laryngospasm, Desaturation

• Doctor to document in medical record also if necessary (Cross-out if not applicable)

**DECLARATION BY PATIENT / GUARDIAN / PROXY**

I hereby authorize Rainbow Hospital & its authorized doctors to perform upon me / my patient the above mentioned operation / Diagnostic / Therapeutic procedures.

I authorize and give consent for anaesthesia (  Regional /  General Anesthesia  Monitored Anesthesia Care as considered appropriate by the anaesthesia team.

I acknowledge that the anaesthetists have informed me about the anaesthetic procedure, risk, benefits and alternative treatments and answered my specific queries and concerns about this matter. I have read and understood the information provided in this form I acknowledge that I have discussed with the anaesthetists any significant risk and Complications specific to my individual circumstances, and I have considered them before Consenting for anaesthesia.

I understand that there are some infrequent complications that can occur due to use of anaesthesia, these include pain or some injury at the site of injections, temporary breathing difficulties, asthmatic reactions, headaches.

I authorize the anaesthesia team to perform any additional procedures (for example, Central Venous Pressure line, arterial line, use of nerve blocks for pain relief, changing from regional to general anaesthesia etc), which are considered necessary by them during the course of surgery.

That I authorize and give consent to the team of doctors attending on me to administer blood products during the course of operative period and immediately thereafter in need arises.

I understand that the above mentioned consultant anaesthesiologist or occasionally a colleague deputed by him / her will administer the Anaesthesia.

I have been explained all my queries in the language understood by me.

**Patient / Patient Attendant :**

Signature : M. Suresh  
 Name : M. Suresh  
 Relationship with Patient: Mother  
 Date & Time : 2/6/26, 10:30am

**Witness :**

Signature : \_\_\_\_\_  
 Name : \_\_\_\_\_  
 Date & Time : \_\_\_\_\_

**Doctor (who is taking the consent) :**

Signature : B. Binda

Name : Dr. Binda Date & Time : 2/6/26, 10:30 Am







