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

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Your Right to a Safe Delivery

DISCHARGE SUMMARY

Name	Baby S.SREENIKA	UHID	HNH-00016003
Father/Guardian	Mr M.S.UDAY SHANKAR	Age/Gender	4 Y 11 M 25 D/ Female
Address	H.NO:2-2-185/91/C/3, RAMAKRISHNA NAGAR, Bagh Amberpet, Hyderabad, Telangana, INDIA, 500013		
IP No	IP26-00006596	Admission Date	16-06-2026
Ref Doctor	DR HARINATH		
Discharge Date	18.06.2026		

Consultant:
Dr. SINDHURA MUNUKUNTLA
MBBS, DCH, DNB PEDIATRICS
66970

Referral Doctor
DR HARINATH

DIAGNOSIS	ICD CODE
PNEUMONIA(BILATERAL) WITH DEHYDRATION	
INFLUENZA A AND MYCOPLASMA ILLNESS	

History: Baby S.SREENIKA , 4 Y 11 M 25 D , old girl presented with the history of fever since 5 days, associated with cough since 3 days, decreased oral

Name	Baby S.SREENIKA	UHID	HNH-00016003
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intake and decreased acceptance of feeds since 2 days prior to admission. For the above complaints she was investigated and treated at nearby hospital. In view of persistence of symptoms, she was referred to Rainbow Children's Hospital - Himayath nagar for further management.

Examination: She was afebrile, maintaining saturations 98%at room air. Her heart rate was 127/min and Respiratory Rate - 38 /min. Capillary Refill Time was <2 secs. Peripheries were warm & pulses well felt. On examination Signs of dehydration were present such as dry lips, dry oral mucosa, dull look, tachycardia and sunken eyes were present. On auscultation, air entry was reduced on left side with right sided crepitations were present. Heart sounds were normal and there was no murmur. Abdomen was soft with no organomegaly. On neurological examination, she was conscious and alert. Pupils were bilaterally equal and reacting to light. There were no focal neurological or cranial nerve deficits. There were no signs of raised intracranial pressure.

Weight on admission: 16.3 kilo grams.

Investigations: Enclosed reports

GeneXpert FluA+FluB+RSV were sent, which was positive for Influenza A virus. Adenovirus PCR not detected.

VBG showed pH of 7.35, pCO2 of 38.1mmHg, pO2 of 54 mmHg, HCO3 of 20.9mmol/L and BE of -4.3 mmol/L.
Complete urine examination shows: Pus cells - 6-8, epithelial cells - 3-5.
Initial hemogram showed Hemoglobin of 11.3 gm%, White Blood Cell count of 3490 cells/cumm, platelet count of 2.34 lakhs/cumm and C-Reactive Protein of 5.0 mg/l.

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Blood culture shows : No growth after 24 hrs of incubation

Ultrasound chest shows:
Few B lines noted at posterior aspect of both lungs (L>R) -
Subpleural septal mild congestion.
No obvious consolidation noted on either side.
Both domes of diaphragm are moving normally with respiration.
No evidence of effusion noted bilaterally.
No focal lesions.
- For clinical correlation.

Chest X-ray was normal.

Management: She was admitted in the ward and started on oxygen by nasal prongs 2lit/min. Intra Venous fluids and Intra Venous antibiotics were started. She was treated symptomatically with antacids and antipyretics. In view of chest signs, she was frequently nebulised with Levolin and Budecort. Respiratory panel(5 viruses)was sent which was positive for Influenza A and hence child was started on Oseltamivir.

She was regularly monitored for fever spikes, hemodynamic status, vital parameters, oxygen saturations and any signs of respiratory distress. Her fever spikes and other symptoms gradually settled. Child's saturations levels improved gradually and oxygen support tapered and stopped. Child maintaining saturations on room air. Mycoplasma IgM was sent and empirically started on Azithromycin. Later Mycoplasma IgM was positive(verbal report) and hence Azithromycin continued.

She remained hemodynamically stable during the hospital stay. She improved

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with the above line of management and is being discharged with the following advice.

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

Medication during hospital stay:
Injection. Ceftriaxone
Syrup. Azithromycin
Syp. Relent plus
Syp. Oseltamavir
Nasivion - P drops

Advice:
* Diet as advised.

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S.No	MEDICATION	DOSE	TIMINGS	DURATION
1	Syrup. CEFUROXIME (CEFUROXIME - 5ml/250mg)	5 ml (mix with honey or sugar water)	8am - 8pm (after food)	till final blood culture report is available
2	Syrup. AZEE (AZITHROMYCIN- 5ml/200mg)	5ml	8am (after food)	For 5 days
3	Syrup. FLUVIR (OSELTAMIVIR – 5ml/60mg)	4 ml	9am-9pm (after food)	For 3 days.
4	Syrup. RELENT PLUS (Cetrizine 5mg, Ambroxol 30mg/5ml)	5 ml	8am-8pm (1 hour before food)	For 5 days.
5	NEBULISATION with Levolin (0.31)	1 respule	6th hourly	For 2 days
6	NEBULISATION with 3% NaCl	1 respule	6th hourly	For 2 days
7	Nasoclear nasal drops, 2 drops in each nostril **SOS** for nose block			

Plan: To collect Mycoplasma IgM report and final blood culture report on followup.
Plan Influenza vaccine on follow-up.

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Fever Management
* Syrup. Crocin DS (Paracetamol - 5ml/240mg) 4.5 ml after food as and whenever required, if temperature > 100 *F (maximum 4 times a day at 6 hour intervals).

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

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 based on tolerance of stomach.
* Food can decrease the absorption of **antihistamines.** Antihistamines can be taken on an empty stomach /before food to increase their effectiveness.

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

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

Parent/ Attender

In case of emergency contact 9154865030 emergency pediatrician on duty.
To take appointment for OPD consultation at Rainbow **Himayatnagar / Banjara Hills /** Rainbow Clinic **Madhapur / Kukatpally / Vikrampuri / LB**

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Nagar / dial just one toll free number **18002122.**

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

Registrar/Resident/C.M.O

Dr. SINDHURA MUNUKUNTLA
MBBS, DCH, DNB PEDIATRICS
66970

208
LRTI c̄ dehydration

R

BABY S SREENIKA 1Y [illegible]M 15D F HNH 0001 5003 CHEST PA 15-JUL-05 [illegible]:36 PM
RAINBOW CHILDREN'S HOSPITAL,HIMAYATH NAGAR

RAINBOW CHILDREN'S HOSPITAL HIMAYATH NAGAR

Rainbow Childrens Hospital-Himayatnagar

Rainbow Children's Hospital, Door no. 3-6-267, opp. Cafe niloufer, Old MLA quarters road AP State Housing Board Himayatnagar ,Hyderabad ,Telangana, INDIA ,500029.
TEL NO :040-48873000
WEB : https://rainbowhospitals.in

ADMISSION SHEET

Registration Details :

Admission No : IP26-00006596 **Admit Date** : 16-Jun-2026 **Admit Time** : 12:20 PM **UHID** : HNH-00016003

Patient Details :

Patient Name	: Baby S.SREENIKA	**Age**	: 4 Y 11 M 25 D
Guardian	: Mr M.S.UDAY SHANKAR	**DOB**	: 22-06-2021
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: H.NO:2-2-185/91/C/3, RAMAKRISHNA NAGAR Bagh Amberpet Hyderabad Telangana INDIA 500013	**Phone No**	: 9292501646/ 8121127775
		E-mail	: uday0401@gmail.com

Admission Details :

Bed Type	: DAY CARE	**Bed No**	: ER01	**Ward Name**	: GF -EMERGENCY
Room No	: ER01	**Admission Type**	: First Visit		

Contact Details :

Name	: Mr M.S.UDAY SHANKAR	**Relationship**	: Father
Contact Address	: H.NO:2-2-185/91/C/3, RAMAKRISHNA NAGAR Bagh Amberpet Hyderabad Telangana INDIA 500013	**Phone No**	: 9292501646

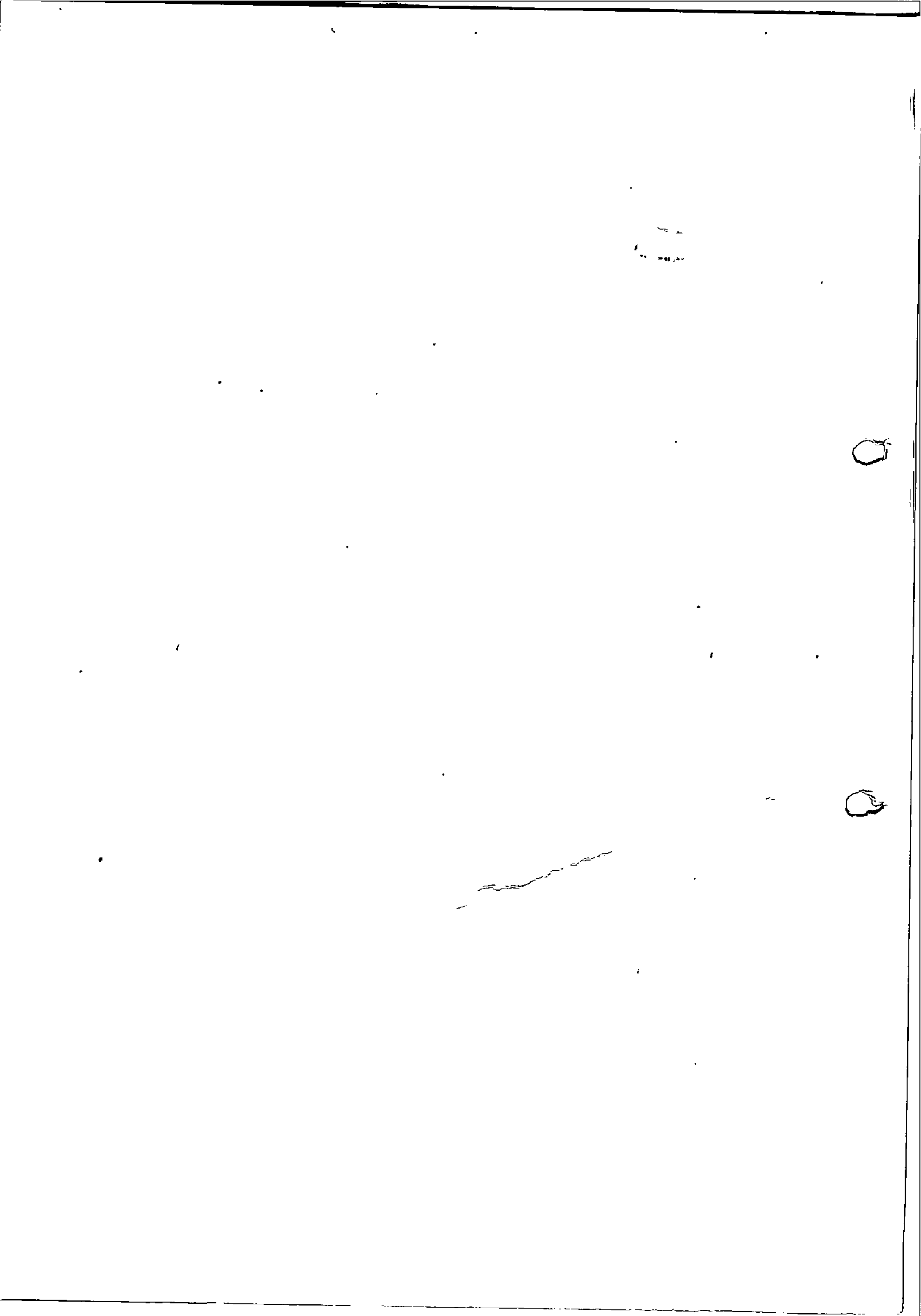
Signature

Doctor Details :

Doctor Name	: Dr. SINDHURA MUNUKUNTLA	**Specialisation**	: GENERAL PEDIATRICS
Referral Doctor	: DR HARINATH	**Phone No**	: 8897934233
Co-Consultant	:		

Payment Details :

		Deposit Amount	: 10000.00
Payment Mode	: DC/CC Card	**Payor Name**	: SELFPAY



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HNH-00016003 IP26-00006596
Baby S.SREENIKA
22-06-2021 4 Y 11 M 25 D (F)
Dr. SINDHURA MUNUKUNTLA

ACT... LING

Name --

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

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
16/6/26	1620pm	ER	ward	(B) [signature]

Cross Consultation Visit

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

HNH-00016003 IP26-00006596
Baby S.SREENIKA
22-06-2021 4 Y 11 M 25 D (F)
Dr. SINDHURA MUNUKUNTLA

INVESTIGATIONS

Date	Investigations	Order No.	Sign
16/6/26	CBP, CRP blood c/s mycoplasma IgM Respiratory panel	9905	Sugandha
	VBG	9904	
	chest Xray	7204.	
	CUE	9906.	
16/6	USG chest	7258	Sandhya

Cross checked done by Amrutha 16/6/26 @ 8pm

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Baby S.SREENIKA
22-06-2021 4 Y 11 M 25 D (F)
Dr. SINDHURA MUNUKUNTLA

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
16/6/26	Infusion Pump	1:30 pm	~~17~~/6/26 @ 1pm	207003	Sandhya
16/6/20	Oxygen	3:30pm	16/6/26 @ 7pm	207016	Ravi

Cross checked done by Amrutha

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Baby S.SREENIKA
22-06-2021 4 Y 11 M 25 D (F)
Dr. SINDHURA MUNUKUNTLA

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
16/6/26	IV placement	01	6993.	Sugandha
16/6/26, (2:30pm)	NHA	1	7086	[illegible]
		Cross checked done by Amrutha.		

ANY OTHER INFORMATION

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

3% NS NEB 6th hly
Levolin 4th hrly
Budecort 12th hrly

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Baby S.SREENIKA
12-06-2021 4 Y 11 M 25 D (F)
Dr. SINDHURA MUNUKUNTLA

NEBULISATION CHART

Date	Time	Drug	Nurse	Parents Signature
16/06/26	00.00			
	01.00			
	02.00			
	03.00			
	04.00			
	05.00			
	06.00			
	07.00			
	08.00			
	09.00			
	10.00			
	11.00			
	12.00			
	13.00			
	14.00	3% NS (1)	Madhu	[signature]
	15.00			
	16.00	Levolin + Budecort (2)	Anusha	[signature]
	17.00			
	18.00			
	19.00			
	20.00	3% NS + levolin (3)	[signature]	[signature]
	21.00			
	22.00	7071		
	23.00			

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Baby S.SREENIKA
22-06-2021 4 Y 11 M 25 D (F)
Dr. SINDHURA MUNUKUNTLA

Levolin 4th hourly
3% NS 6th hourly
Budecort 12th hourly

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NEBULISATION CHART

Date	Time	Drug	Nurse	Parents Signature
17/6/26	00.00	Levolin ①	[signature]	[signature]
	01.00			
	02.00	3% NS ②	[signature]	[signature]
	03.00			
	04.00	Levolin + Budecort ③	[signature] 7108	[signature]
	05.00			
	06.00			
	07.00			
	08.00	Levolin + 3% NS ④ 7108	④ - [signature]	[signature]
	09.00			
	10.00			
Levolin 6 hly	11.00			
	12.00	levolin ①	[signature]	
	13.00			
	14.00	3% NS ② 07136	[signature]	
	15.00			
	16.00	levolin + Budecort ①	[signature]	[signature]
	17.00	② - 7177		
	18.00			
	19.00			
	20.00	3% NS ②	[signature]	[signature]
	21.00			
	22.00	levolin ①	[signature]	[signature]
	23.00			

Doc. No. : RCH / FRM / CLINICAL / 170

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Levolin 4th hourly
3% NS 6th hourly
Budecort 12th hourly

NEBULISATION CHART

Date	Time	Drug	Nurse	Parents Signature
	00.00			
	01.00			
	02.00	Levolin + 3% NS (2)	[signature]	[signature]
	03.00			
	04.00	Budecort (3)	[signature]	[signature]
	05.00			
	06.00	Levolin (4)	[signature]	[signature]
	07.00			
	08.00	3% NS (5)	[signature]	[signature]
	09.00	7/22 8-(5)		
	10.00			
	11.00			
	12.00			
	13.00			
	14.00	(14) neb	[signature]	
	15.00			
	16.00	cues 4r		
	17.00			
	18.00			
	19.00			
	20.00			
	21.00			
	22.00			
	23.00			

Ref.No. F/IN/PR/10

PEDIATRIC IN-PATIENT MEDICAL RECORD

HNH-00016003 IP26-00006596
Baby S.SREENIKA
22-06-2021 4 Y 11 M 26 D (F)
Dr. SINDHURA MUNUKUNTLA

Patient Name : ka.

Patient ID# :

Consultant :

Final Diagnosis :

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Baby S.SREENIKA
22-06-2021 4 Y 11 M 25 D (F)
Dr. SINDHURA MUNUKUNTLA

Pediatric Multiorgan History & Physical Examination

Name : ______ Age/Sex ______

Informant ______ Reliability ______

Chief Presenting Complaints & Duration (Chronologically):

c/o fever since 5 days
c/o cough since 3 days
c/o decreased activity & decreased acceptance of feeds.

History of present illness :

Child presented with h/o fever since 5 days high grade intermittent, not a/w rash, chills & rigors. Relieving on medication & recurring again.

c/o cough since 3 days, not a/w post tussive vomiting, progressive in nature, a/w fast breathing since morning.

c/o decreased activity & decreased oral intake.

No h/o loose stools
No h/o vomiting

Pediatric Multiorgan History & Physical Examination

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

—

Birth & Neonatal History :

Birth & Socio Economic History :

About Father :

About Mother : Not Signifiut

Any additional Information :

Developmental History :

Appropritc

Immunization History :

Upto date

Pediatric Multiorgan History & Physical Examination

Anthropometry

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

Weight (kgs) 16.3 kg. (Centile ________)

On Examination :

Temperature : 99.F Pulse Rate: 127/min Description ________

B.P. ________ SPO2 98% RA. at ________

Resp. rate and type of breathing : Mild tachypn (+)
SCR (+).

Rash ________ Sign of dehydrat :- (+)

Lymphadenopathy Cervical LN path (+). dry lipp, oral muc

Oedema : ________ Sunken eye

Respiratory system : dull look

Inspection (any s/o distress) : ________

Air entry & breath sounds : B/L AE (+) (Lt ↓↓)

Any addes sounds : Crepts (+) Rt sides. (Basal region)

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

Cardiovasclular System :

Inspection of procordium : ________

Heart Sounds : S1 S2 (+)

Any murmur : No

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

Per Abdomen :

Inspection ________

Palpation : Soft Non tender

Ausculation : No organomegaly

Spine: ________ External Genitelia : ________

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

Pediatric Multiorgan History & Physical Examination

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Baby S.SREENIKA
22-06-2021 4 Y 11 M 25 D (F)
Dr. SINDHURA MUNUKUNTLA

Central Nervous System :

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

Cranial Nerves :

Motor System :

Nutrition :

Tone : (N) Power

Co-ordinator :

Posture :

Involuntary Movements :

Reflexes :

DTR **Superficials :**

Plantars (N)

Sensory System :

(N)

Bladder / Bowel :

Clinical Summary & Diagnostic :

AFI

CRTI c̄ dehydration

c̄ Resp. distress.

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Baby S.SREENIKA
22-06-2021 4 Y 11 M 25 D (F)
Dr. SINDHURA MUNUKUNTLA

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment :

Prvnt Respiratory failure.

Desired goals of the treatment :

Planned Labs :

CBP
CRP, CUE
B/c/s (2 sample)
~~CUE~~
CXR PA view.
Resp panel
Mycoplasma IgM.
[USG chest - SOS]. aft CXR.

Planned Management :

- O2 (SOS).
- IV fluids.
- Inj CEFTRIAXONE.
- Syp RECONT plus
- 3% NS NEB.
- Nasivion - P drops TID.
- Azithromycin to decide after CX Ray.
- Monitor RR, SpO2

Please fill up the following details

1. Name of the Referring Doctor :
2. Name of the Referring Hospital : (Including the name of City)
3. Contact number of the Referring Doctor : (Preferring Mobile #)
4. Name of the doctor in Rainbow Team Dr. Sindhura. M on whose name the patient is being referred

Doctor's Signature Name [signature] Date 16/6/[illegible] Time 4 pm

Dr. Sindhura Munukuntla
Consultant Pediatrician
Reg. No: 66970

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Baby S.SREENIKA
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Dr. SINDHURA MUNUKUNTLA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16/6/26 12pm	S/B Dr. Sindhura.(D)	
	C/o fever twice 5 days	
	high grade	
	cough (+)	
	poor oral intake	
	dull activity.	
	reduced urine output.	
	O/E - Child dull	
	eyes sunken	
		signs of dehydration (+)
	Adv	RR - 40 cy/min.
	- CBP	mild SCR.
	- VBG	SpO2 - 96% c RA.
	- CRP	tachycardia (+)
	- Bld c/s - (2 samples)	Lungs - Bae (+)
	- CUE	↓ BS on (Lt) side
	- CXR PA view	B/L crepts (+) Lt > Rt
	- Respiratory Panel I mini.	P/A soft
	- Mycoplasma IgM	No organomegaly
		CNS - No signs of meningeal irritation
	LRTI c dehydration	
		Adv
		1) Inj. Ceftriaxone.

Docu. No. : RCH /FRM / CLINICAL / 088

(P.T.O)

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
		2) [illegible]
		3) Neb c̄ 3% NS Q6H
		4) [illegible]
		[illegible] to [illegible] CXR.
	Dr. Sindhura Munukuntla Consultant Pediatrician Reg. No: 66970	[illegible signature] AMRUTHA-M
		Noted by mother

Docu. No. : RCH /FRM / CLINICAL / 088

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16/6/26	S/B Dr Prabhath.	
3pm		
	Δ LRTI ē dehydration ē Resp distress	
	Child febrile	
		TLC 3490.
	Oral intake - fair	N/L 53/38.
	Cough ⊕	Adv
	Temp: 101.7°F.	
	O/E GC fair, febrile	- CT. Ceftriaxone
	Vitals stable	- CT 3% NS Neb Q6H
	SpO2 92% on RA	
	RS: BAE+	- Plan to add azithromycin
	Creps ⊕. Basal	
	Dyspn	- CT. Nasivion - P Nasal drops
		- Trace CRP
		CUE.
		Resp panel ē virus
		Mycoplasma IgM.
		B/C/S
	Start.	Start.
	- syp. Azithromycin	- O2 at 2L/min
	- Levolin Q4H.	- SpO2 Monitoring Q2H
	- Budecort Q12H	

Noted by Sr. S[illegible] 16/6/2[illegible]

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16/6 6 pm	C/S/B Dr Prasa[illegible]	
	LRTI c̄ RD c̄ Dehydration (Flu A +)	Plan
		1) Add Fluids / [illegible]
	Mild Tachypnea Room Air SpO2 - 91-92%	2) USG chest [illegible]
		3) ~~Ct. Low flow O2~~
	On low flow O2 - 2 lit/min	4) Inj Ceftriaxone Syp Azee
	Child asleep HR - 112/min	
	SpO2 - 98% on 2 lit O2	5) Neb c̄ Levolin 3% NaCl Budecort
	R.S - B/L AE ⊕ ↓AE on Ⓡ Inframammary & Infraaxillary Crept ⊕ (Minimal)	
		6) Monitor Vitals
		[signature]
		noted by sr. sandhya 16/6/26 6:PM

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	C/S/B Dr. Sindhura	
16/6 6:30PM	– LRTI c̄ RD. (Influenza A +ve).	
	– On 2lit. O2.	
	– oral intake – fair.	
	– cough (+).	Plan
		– Ct. LPRC.
		– Ct. ceftriaxone
	O/E – HR – 110/min.	– Syp. Azee, fluvir.
	RR – 32/min.	
	SpO2 – 98% on 2l.	– Ct. Neb: Levolin.
		Budecort.
	S/E – R/S – AE ↓ over	3% NS.
	right side.	– Tracheomycoplasma,
		blood c/s.
		– Reassess after 30 min.
		if maint SpO2
		↓
		Stop O2.
		Dr. Sindhura Munukuntla Consultant Pediatrician Reg. No: 66970

Docu. No. : RCH /FRM / CLINICAL / 088

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Your Right to a Safe Delivery

...GRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
17/6/26 8AM.	c/s/b Dr. Varun	/ Dr. Nazneen
	D - Influenza A LRTI c̄ RAD.	
	- On room air; last fever (102.2°F) @ 9:30PM yesterday.	
	- Oral intake - good.	
	- Cough ↓ same.	
	- Had 1 e/o vomiting yesterday.	
	O/E - vitals stable.	Plan
	SpO2 - 98% @RA.	↑ Ct. Ceftriaxone, Azee & Tamiflu.
	S/E - WNL.	- Ct. Nebs.
		- Trace mycoplasma, resp. panel & blood c/s.
		D.13 Amrutha @8AM.
		[signature]

HNH-00016003 IP26-00006596
Baby S.SREENIKA
22-06-2021 4 Y 11 M 25 D (F)
Dr. SINDHURA MUNUKUNTLA

Rainbow® Children's Hospital
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
17/6/26 11 AM	S/B Dr. Sindhura.	
	Δ Influenza A Illness	Plan
	Fever spikes ⊝	
	CVS - S1S2 ⊕	- c/t FLUVIR
	RS - BLAE ⊕	
	RE - AE better - B/L crepts ⊕	- Trace Mycoplasma IgM Adenovirus
	P/A soft	
	conscious	
		- c/t Neb c̄ Levolin c̄ 3% NS 6th ly
		- c/t CEFTRIAXONE
		- Plan to stop IV fluids by evening
		- c/t IV fluids @ 20ml/hr

Dr. Sindhura Munukuntla
Consultant Pediatrician
Reg. No: 68970

noted by sr. sandhya
17/6/26
11:am

Docu. No. : RCH /FRM / CLINICAL / 088

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	C/s/c/3 Dr. Naipunya	
17/6 2:00pm.		
	Influenza A illness.	
	Fever (+).	Plan
	Oral intake - fair.	- Cont flui.
	R/S - B/L AE (+)	- Trace Mycoplasma IgM
	B/L Creps (+)	Adenovirus
	P/A - Soft, NT	
		- Cont Neb ē levolin
		Neb ē 3% NS
		Neb ē Budecort
		- Cont Syp. Azithromycin
		N/B Supriya
		@ 2pm

Docu. No. : RCH /FRM / CLINICAL / 088

(P.T.O)

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	C/S/B Dr. Aniket	
17/6 5:00pm	Influenza A illness	
	On room Air	Plan
	Fevers (P)	- Cont fluvir.
	Oral intake - improved	- (T) Mycoplasma IgM Adenovirus
	R/S - B/L AE (P) B/L Crepts (↓).	- Cont neb levolin Q6H Neb 3% NS Q6H Neb Budecort Q12H
	P/A - Soft, NT	- Cont ceftriaxone Azithromycin
		- monitor RR, SpO2
		Dr. Aniket [signature] N/B [signature] @ 5pm

Dr. Aniket Anil Parashar
Consultant Pediatrician & Intensivist
Reg. No. 3568

HNH-00016003 IP26-00006596
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
18/6/26 7:40AM.	S/B. Dr Prabhath	Dr Anusha
	Δ Influenza A illness	
	on RA:	
	Fever — No.	
	Oral intake — fair.	Adv
	O/E G.C. fair	
	Vitals stable	① CT Fluvir
	RS — B/L Gepts.	
	PA — Soft.	② Trace Mycoplasma IgM
		Adenovirus
		∟ Neg.
		③ CT Neb Levolin Q 6th
		Neb 3% NS Q 6th
		Neb Budecort Q12th
		④ CT. ~~Ceftriaxone~~
		(Azithromycin)
	Sd/-	Stop if Mycoplasma IgM ⊖.
		⑤ Monitor RR, SpO2.
		D.B Amrutha C8AM

IH-00016003 IP26-00006596
by S.SREENIKA
-06-2021 4 Y 11 M 26 D (F)
SINDHURA MUNUKUNTLA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
18/6/[illegible] 12:30 PM	S/B Dr. Sindhura	
	D Influenza A Illness	
		Plan
	Afebrile	
		– Cf FLUVIR x 5 days tablet
	CVS – S1S2 (+)	
	RS – B/L AE (+)	
	B/L creps (+)	– Discharge
	P/A – soft	– Trace Mycoplasma IgM
	conscious	
		– Flup c Dr Hemanth at [illegible] OPD on Saturday
	c/o Bld c/s report	
	Hypoglycemia	– Neb c 3% Nacl 6th hourly c Levolin 6th h } 2 days
		– Influenza vaccine on followup.
	Dr. Sindhura Munukuntla Consultant Pediatrician Reg. No: 66970	[signature]

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

HNH-00016003 IP26-00006596
Baby S.SREENIKA 4 Y 11 M 25 D (F)
22-06-2021
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MEDICATION RECONCILIATION FORM

Drug Allergies: NPLL ☑ Not known any Drug Allergies

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

Shifting From: ER Shifted to: ward

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

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Anusha

Date & Time : 16/6/26 @ 12:20pm

Nurse Name & Signature: Bhargavi

Date & Time : 16/6/26 @ 12:25pm

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

HNH-00016003
Baby S.SREENIKA IP26-00006596
22-06-2021 4 Y 11 M 25 D (F)
Dr. SINDHURA MUNUKUNTLA

DRUG CHART

Date of Admission: 16/6/26 Drug Allergies: Nil ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

GENERAL - Ensure that all patient details are entered above. ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.

DOCTOR
- Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
- Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
- Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
- Discontinue a drug by drawing a line / 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: CROSIN DS SYP				Date / Time		
Dose	Route	Frequency	Start Date		3:30 pm	17/6 9:30 am
5ml	po	SOS	16/6			
Doctor's Signature	Valid Period	Pharm.				
[signature]		[signature]				
Additional Instructions: (240mg/5ml)						

DRUG: IBUGESIC SYP				Date / Time
Dose	Route	Frequency	Start Date	
5ml.	PO	SOS	16/6	
Doctor's Signature	Valid Period	Pharm.		
[signature]		[signature]		
Additional Instructions: (100mg/5ml)				

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

Verified by Dr. Dhakshayani

VERIFIED BY: Name Dr. Dhakshayani Signature

HNH-00016003 IP26-00006596
Baby S.SREENIKA
22-06-2021 4 Y 11 M 25 D (F)
Dr. SINDHURA MUNUKUNTLA

REGULAR PRESCRIPTIONS

Weight. 16.3 kg Ward. ....

DRUG: 1/7 CEFTRIAXONE.				Date/Time	16/6	17/6
Dose	Route	Frequency	Start Date			
1.6 gm	iv	OD.	16/6.			
Name & Signature of the Doctor Starting the Drugs: Af				2pm		
Additional Instructions: 1.6g in 50ml NS over 2 hours. @ 25ml/hr						
Daily Doctor's Endorsement by a Sign						

Stop 17/6/26

DRUG: RELENT PLUS SYP.				Date/Time	16/6	17/6
Dose	Route	Frequency	Start Date			
5ml	po	BD.	16/6.	10AM		
Name & Signature of the Doctor Starting the Drugs: Af						
Additional Instructions: CETIRIZINE (5mg/5ml) AMBROXOL (30mg/5ml)				10pm		
Daily Doctor's Endorsement by a Sign						

DRUG: 3% NS NEB				Date/Time
Dose	Route	Frequency	Start Date	
1 respule	NEB	Q6hly	16/6.	
Name & Signature of the Doctor Starting the Drugs: Af				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

See the chart

DRUG: NASIVION-P drops.				Date/Time	16/6	17/6	18/6
Dose	Route	Frequency	Start Date				
2	nasal	Q8hly	16/6	6AM	X		
Name & Signature of the Doctor Starting the Drugs: Af				2pm			
Additional Instructions:				10pm			
Daily Doctor's Endorsement by a Sign							

Verified by Dr. Dhakshayani

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REGULAR PRESCRIPTIONS

Sheet No: .... Weight 16.3kg Ward ....

DRUG: NEB LEVOLIN				Date/Time
Dose	Route	Frequency	Start Dt.	
0.31mg	Neb	Q 4H	16/6	
Name & Signature of the Doctor Starting the Drugs: Dr Prabhath				see the chart
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

DRUG: NEB BUDECORT				Date/Time
Dose	Route	Frequency	Start Dt.	
0.5mg	Neb	Q12H	16/6	
Name & Signature of the Doctor Starting the Drugs: Dr Prabhath				see the chart
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

DRUG: Syp Azithromycin				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: SYP AZITHROMYCIN				Date/Time	16/6	17/6
Dose	Route	Frequency	Start Dt.			
5mL	Po	OD	16/6			
Name & Signature of the Doctor Starting the Drugs: Dr. Prabhath				6PM	[illegible]	[illegible]
Additional Instructions: 12mg/kg (200mg/5ml).						
Daily Doctor's Endorsement by a Sign					[illegible]	

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

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Baby S.SREENIKA
22-06-2021 4 Y 11 M 25 D (F)
Dr. SINDHURA MUNUKUNTLA

Sheet No: ....

REGULAR PRESCRIPTIONS

Weight 16.3kg Ward ....

DRUG : Syp OSELTAMIVIR				Date ▸ Time ▾	16/6	17/6	18/6
Dose	Route	Frequency	Start Dt.				
4ml	Po	BD	16/6				
Name & Signature of the Doctor Starting the Drugs: Pravin				10am	X	✓	✓
					7pm		
Additional Instructions: 5ml = 60mg				10pm	✓	✓	
Daily Doctor's Endorsement by a Sign					✓	✓	

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

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

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

22-06-2021 4 Y 11 M 25 D (F)
Dr. SINDHURA MUNUKUNTLA

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

VARIABLE DOSE	Date➤ / Time								
			Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.
DRUG :		Dose		Dose		Dose		Dose	
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Route / 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.	

VARIABLE DOSE	Date➤ / Time								
			Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.
DRUG :		Dose		Dose		Dose		Dose	
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Route / 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.	

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses

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I.V. FLUIDS CHART

Weight. 16 kg Ward. ....

		ion of I.V. Fluid (ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
16/6/26	12pm.	IV fluids DNS. (2/3)	iv 30	ml/h	[signature]	[signature] [signature]		[signature]	
				2 [illegible]	[signature]				

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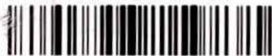

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RESULT SHEET

Date	16/6					
Time	2pm					
Hb	11.3					
PCV	32.7					
RBC	4.74					
WBC	3.49					
N/L	53/38					
Platelets	234					
CRP	5					
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						

(P.T.O)

Date	16/6					
Time						
CUE - Alb	Nil					
CUE - Sugar	Nil					
CUE - Ketones	Negative					
CUE - PUS Cells	6-8					
CUE - RBC Cells	Nil					
CUE - Nitrits	Negative					
Stool Pus Cell						
OVA / Cyst						
Occult Blood						

Culture and Sensitivities : ....

....

....

....

Radiology : USG : ....

X-Ray : ....

ECHO : ....

CT : ....

MRI ....

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

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FRM / CLINICAL / 125

PRESCHOOL (1-5 years)

Children's Observation & Early Warning Scoring Chart

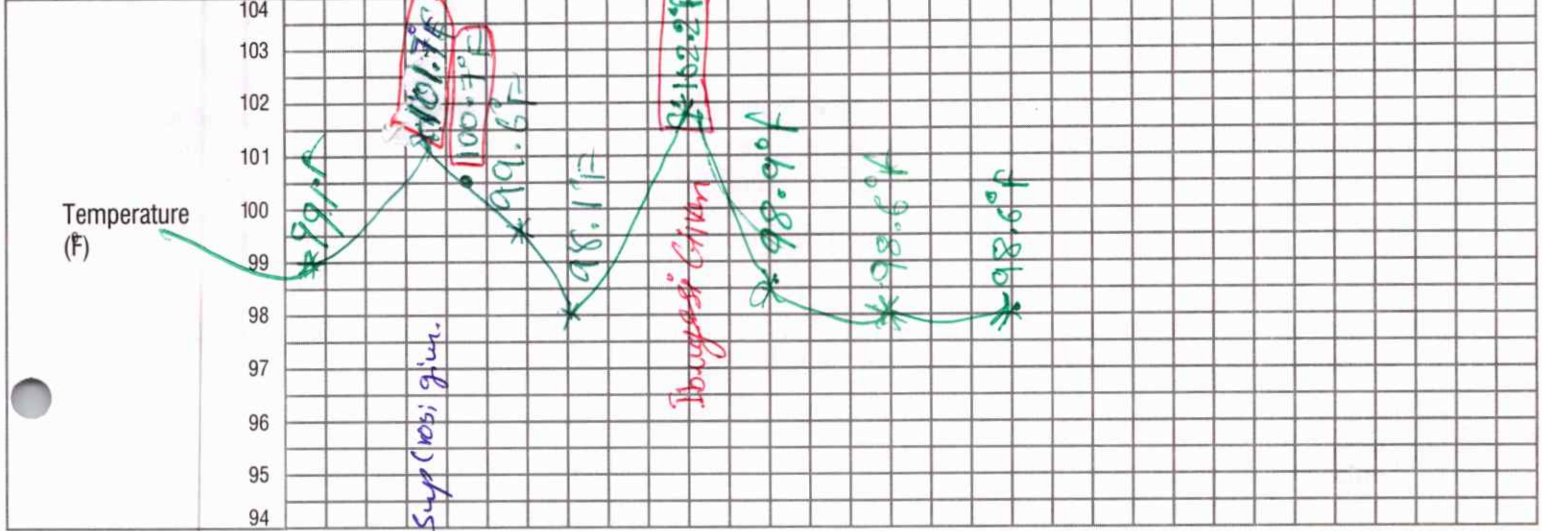
Rainbow® Children's Hospital — It takes a lot to treat the little.

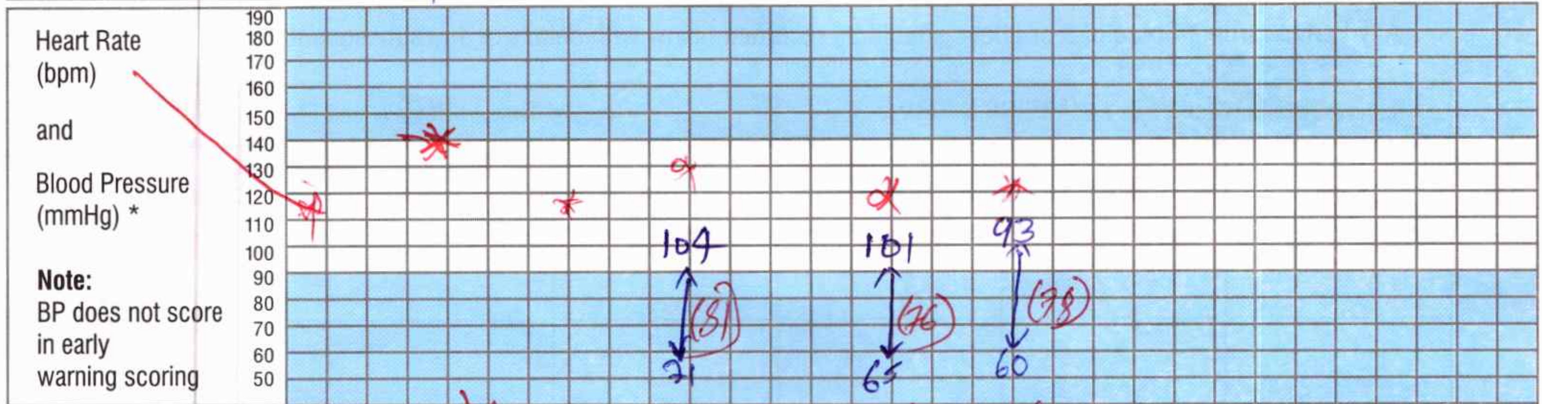
BirthRight — BY RAINBOW HOSPITALS — Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

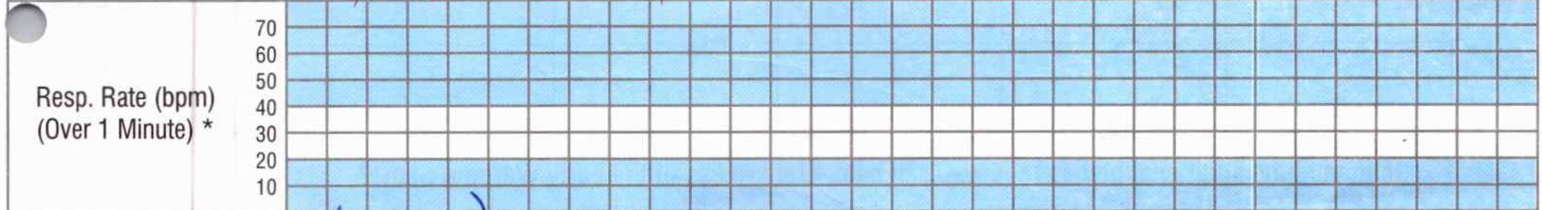
Date : 16/6/26 Time: 1:50 pm | 3:30 | 4:30 | 5pm | 8pm | 9:30 pm | 11 pm | 2pm | 6 Am

Doctor / Nurse / Family Concern?





Heart Rate (Number): 110bpm | 140bpm | 120b/m | 118bpm | 118bpm | 116bpm



Resp Rate (Number): 25b/m | 25b/m | 25b/m | 24bpm | 26bpm | 28bpm

Resp Distress	Mod/ Severe
	None / Mild

Receiving O_2(l/min): 2L | 6

O_2Saturations (%): 100% | 92 | 100 O_2 2 liters | 100% | 99% | 99%

Conscious Level	Normal
	Altered

GCS *

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

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

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

Patient Sticker

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

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Patient Sticker

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PRESCHOOL (1-5 years)

Children's Observation & Early Warning Scoring Chart

Rainbow® Children's Hospital
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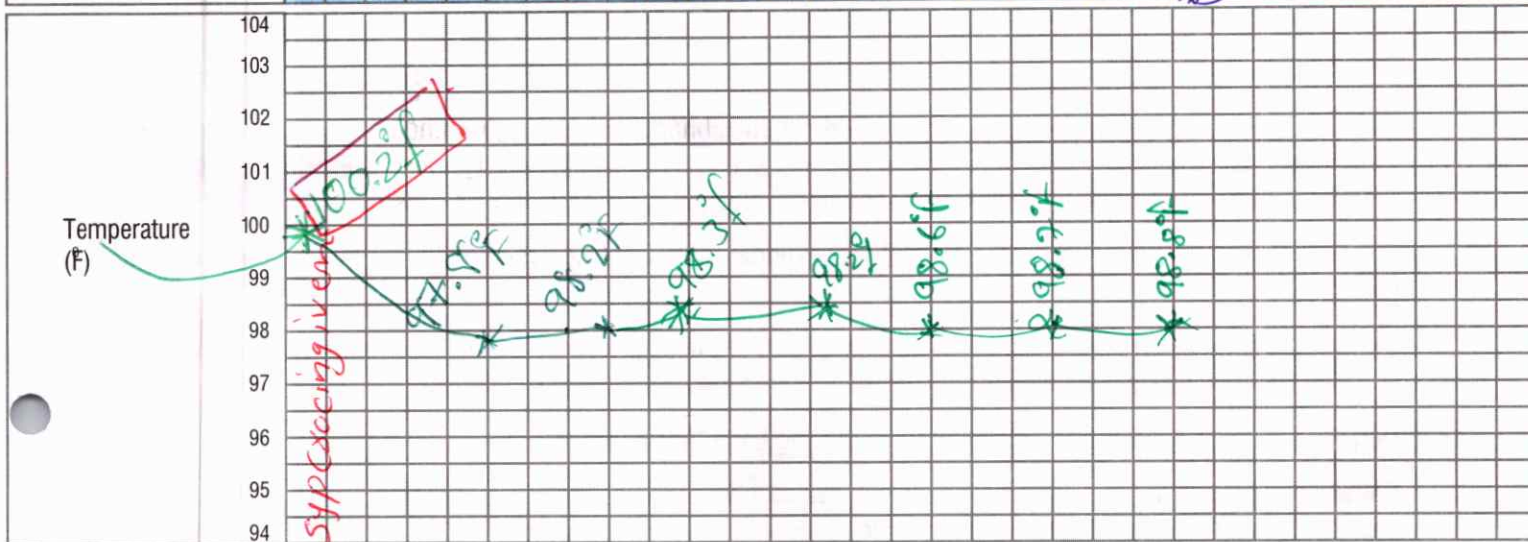
Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 17/6/26

Time:	9:am	10AM	11AM	2PM	6pm	10 PM	2 AM	6 AM
Doctor / Nurse / Family Concern?								



	9:am	10AM	11AM	2PM	6pm	10 PM	2 AM	6 AM
Heart Rate (bpm) and Blood Pressure (mmHg) *			99/70	100/60	102/65	100/61 (74)	98/60 (70)	94/57 (67)
Heart Rate (Number)	120b/m		125b/M	118b/M	119b/m	122bpm	126bpm	124bpm
Resp. Rate (bpm) (Over 1 Minute) *								
Resp Rate (Number)	23b/m		20b/m	20b/m	21b/m	24bpm	26bpm	28bpm
Resp Distress — Mod/ Severe								
Resp Distress — None / Mild								
Receiving O_2 (l/min)								
O_2 Saturations (%)	99%		99%	99%	99%	100%	100%	100%
Conscious Level — Normal								
Conscious Level — Altered								
GCS *								
TOTAL SCORE Number of shaded boxes	0		0	0	6	0	0	0
Pain Score	0		0	0	0	0	0	0
Observer's Initials	[illegible]		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

Note: BP does not score in early warning scoring

ACTIONS

NB: Scores 3 should be recorded overleaf

Score	Action
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.

Patient Sticker

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

BirthRight
BY RAINBOW HOSPITALS
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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

Patient Sticker

Doc. No. : RCHBH / FRM / CLINICAL / 125

PRESCHOOL (1-5 years)

Children's Observation & Early Warning Scoring Chart

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : .... Time:	
Doctor / Nurse / Family Concern?	
Temperature (°F) 104	
103	
102	
101	
100	
99	
98	
97	
96	
95	
94	
Heart Rate (bpm) and Blood Pressure (mmHg) * 190	
180	
170	
160	
150	
140	
130	
120	
110	
100	
90	
80	
70	
60	
50	
Note: BP does not score in early warning scoring	
Heart Rate (Number)	
Resp. Rate (bpm) (Over 1 Minute) * 70	
60	
50	
40	
30	
20	
10	
Resp Rate (Number)	
Resp Distress: Mod/ Severe	
Resp Distress: None / Mild	
Receiving O_2(l/min)	
O_2Saturations (%)	
Conscious Level: Normal	
Conscious Level: Altered	
GCS *	
TOTAL SCORE Number of shaded boxes	
Pain Score	
Observer's Initials	

ACTIONS

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Patient Sticker

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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R	**RECOMMENDATION :** I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

Patient HNH-00016003 IP26-00006596
Baby S.SREENIKA 4 Y 11 M 25 D (F)
22-06-2021
Dr. SINDHURA MUNUKUNTLA

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	Intake: Nature of Fluid	Route: Mouth	Route: I.V	Route: N.G	Output: NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
16/6/26	08:00 am											
	09:00 am											Weedle
	10:00 am											
	11:00 am					NA		NA				
	12:00 pm											
	01:00 pm	DNS		30ml						✓		
Total Intake :						Total Output :				U-1	M-0	
16/6/26	02:00 pm			30 ml								
	03:00 pm			30ml						✓		
	04:00 pm		Idly	30ml			0				0	KT
	05:00 pm	DNS	+	30 ml		NA		NA				
	06:00 pm		H₂O	30ml						✓		
	07:00 pm			30ml								
Total Intake : Taken						Total Output :				U-2	M-	
16/6	08:00 pm			30ml							0	
	09:00 pm	DNS	Rice	30ml							0	
	10:00 pm		+	30ml							0	
	11:00 pm			30ml		NA	0	NA			0	A
	12:00 am	DNS	H₂O	30ml							0	
	01:00 am			30ml							0	
Total Intake : Taken						Total Output :				M-	U-	
17/6	02:00 am			30ml							0	
	03:00 am	DNS	H₂O	30ml							0	
	04:00 am			30ml		NA	0	NA			0	
	05:00 am	DNS		30ml							0	A
	06:00 am	DNS		30ml						✓	0	
	07:00 am			30ml							0	
Total Intake : Taken						Total Output :				M-x	U-1	

Total 24 hrs. Intake		Total 24 hrs. Output	

Docu. No. : RCH /FRM / CLINICAL / 092

HNH-00016003 IP26-00006596
Baby S.SREENIKA
22-06-2021 4 Y 11 M 25 D (F)
Dr. SINDHURA MUNUKUNTLA

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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	Intake				Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
		Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
17/6/26	08:00 am	DNS	idly H2O	30 ml		NA		NA		✓	0	[signature]
	09:00 am			30 ml								
	10:00 am			20 ml								
	11:00 am			20 ml						✓		
	12:00 pm			20 ml								
	01:00 pm			20 ml						✓		
Total Intake : Taken						Total Output : U-3 M-						
17/6/26	02:00 pm	PN		20ml		NA	0	NA			0	[signature]
	03:00 pm			20ml						✓		
	04:00 pm			20ml								
	05:00 pm			20ml						✓		
	06:00 pm			20ml								
	07:00 pm			20ml						✓		
Total Intake : taken						Total Output : U-2 M-0						
17/6/26	08:00 pm	DNS	Iddli + H2O	20ml		NA	0	NA			0	[signature]
	09:00 pm			20ml								
	10:00 pm			20ml						✓		
	11:00 pm											
	12:00 am			stop								
	01:00 am			IVF								
Total Intake : Taken						Total Output : U. 1 M-x						
18/6/26	02:00 am	0			NA	NA	0	NA		0	0	[signature]
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						Total Output : U- M.						

Total 24 hrs. Intake		Total 24 hrs. Output	

HNH-00016003 IP26-00006596
Baby S.SREENIKA
Patie 22-06-2021 4 Y 11 M 26 D (F)
Dr. SINDHURA MUNUKUNTLA

FLUID CHART

Sheet No. :.................................

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

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

Total 24 hrs. Intake		Total 24 hrs. Output	

Patient Sticker

FLUID CHART

Sheet No. : ....

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

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

Total 24 hrs. Intake	

Total 24 hrs. Output	

Docu. No. : RCH /FRM / CLINICAL / 092

HNH-00016003 IP26-00006596
Baby S.SREENIKA
22-06-2021 4 Y 11 M 25 D (F)
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PAIN ASSESSMENT FORM

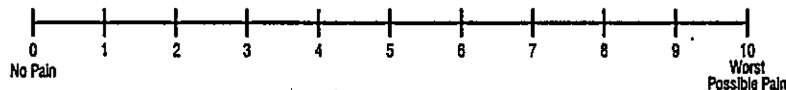
Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
16/6/26	2pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
16/6/26	8pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
16/6/26	10pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
17/6	6AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
17/6	12pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
17/6/26	10am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
17/6/26	4pm	0/10	NA	☐ Continuous ☐ ~~Intermittent~~	☐ ~~Acute~~ ☐ Chronic	☐ ~~Sharp~~ ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ ~~Decreasing~~	☐ ~~Yes~~ ☐ No	NA	[signature]
17/6/26	10pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
18/6/26	6Am	0/10	NA	☐ Continuous ☑ Intermittent	☐ ~~Acute~~ ☐ Chronic	☐ ~~Sharp~~ ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☑ Decreasing	☐ ~~Yes~~ ☐ No	NA	[signature]
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ 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

Numerical Pain Scale (Obstetric and Gynecology)



Wong - Baker (Pediatrics) Above 7 Years

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 brawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, right, 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

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_2	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO_2 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO_2 less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

HNH-00016003 IP26-00006596
Baby S.SREENIKA
22-06-2021 4 Y 11 M 25 D (F)
Dr. SINDHURA MUNUKUNTLA

BRADEN 'Q' SCALE

				Date :	16/6	16/6	16/6	17/6
				Time :	M6	E2	N1	M6
Mobility	**1. Completely immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	**3. Slightly limited:** Makes frequent through slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.	4	4	4	4
"Activity The degree of physical activity"	**1. Bedfast :** Confined to bed	**2. Chairfast :** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	**3. Walks occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. All patients too young to ambulate; OR walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4	4	4
Sensory Perception	**1. Completely limited:** Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	**2. Very limited:** responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	**3. Slightly limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	**4. No impairment:** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	4
Moisture Degree to which skin is exposed to moisture	**1. Constantly moist:** Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	**2. Very moist:** Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	**3. Occasionally moist:** Skin is occasionally moist, requiring linen change every 12 hours.	**4. Rarely moist:** Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	4
FRICTION-SHEAR **Friction** Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another	**1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	**2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	**3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	**4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	4
Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4
				TOTAL SCORE	28	28	20	20
				Evaluator's Name	[illegible]	[illegible]	[illegible]	[illegible]

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

Risk Score	Category	Action	**Support Surfaces** **(Please Note:** Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice
15-18	At Risk	• Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • Advance to a higher level of risk if other major risk factors are present	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	• Use the Same Protocol as for **"At Risk"** Patients • Position patient at 30 degree lateral incline using foam wedges	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	• Follow the same protocol as for **"Moderate Risk"** Patients • In addition to regular turning schedule • Make small shifts in their position frequently	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	• Use same protocol as for **"High Risk"** Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

HNH-00016003 IP26-00006596
Baby S.SREENIKA
22-06-2021 4 Y 11 M 25 D (F)
Dr. SINDHURA MUNUKUNTLA

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It takes a lot to treat the little.

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Your Right to a Safe Delivery

BRADEN 'Q' SCALE

				Date : / Time :	17/6/26 E2	17/6/26 N1		
Mobility	**1. Completely immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	**3. Slightly limited:** Makes frequent through slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.	4	4		
"Activity The degree of physical activity"	**1. Bedfast :** Confined to bed	**2. Chairfast :** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	**3. Walks occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. All patients too young to ambulate; OR walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4		
Sensory Perception	**1. Completely limited:** Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	**2. Very limited:** responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	**3. Slightly limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	**4. No impairment:** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4		
Moisture Degree to which skin is exposed to moisture	**1. Constantly moist:** Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	**2. Very moist:** Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	**3. Occasionally moist:** Skin is occasionally moist, requiring linen change every 12 hours.	**4. Rarely moist:** Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4		
FRICTION-SHEAR **Friction** Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another	**1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	**2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	**3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	**4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4		
Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4		
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4		
				TOTAL SCORE	28	28		
				Evaluator's Name	[signature]	[signature]		

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

Docu. No. : RCH /FRM / CLINICAL / 119

Risk Score	Category	Action	**Support Surfaces** (**Please Note:** Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice
15-18	At Risk	• Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • Advance to a higher level of risk if other major risk factors are present	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	• Use the Same Protocol as for **"At Risk"** Patients • Position patient at 30 degree lateral incline using foam wedges	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	• Follow the same protocol as for **"Moderate Risk"** Patients • In addition to regular turning schedule • Make small shifts in their position frequently	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	• Use same protocol as for **"High Risk"** Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

HNH-00016003 IP26-00006596
Baby S.SREENIKA
22-06-2021 4 Y 11 M 25 D (F)
Dr. SINDHURA MUNUKUNTLA

NURSING CARE RECORD

Date: 16/6/26

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				Ex			
Afternoon	2pm to 8pm	→ Assess pt condition → monitor the vitals → maintain I/O chart → O_2 2 litters → Administer medication as per drug chart	2pm to 8pm	→ Assessed pt condition → monitored vitals → Maintained I/O chart → O_2 2 litters → Administred medication as per drug chart	Patient is stable	Re-checked vitals	Asy
Night	8pm to 8am	→ Assess the pt condition → monitoring vitals checked and recorded → I/O chart maintain	8pm to 8am	→ Assessed the pt condition → Administration medication & given as per chart doctor order's	→ pt is stable	Re-checked vitals	Ammu

Docu. No: RCH /FRM / CLINICAL / 148

HNH-00016003 IP26-00006596
Baby S.SREENIKA
22-06-2021 4 Y 11 M 25 D (F)
Dr. SINDHURA MUNUKUNTLA

Patient Sticker

NURSING CARE RECORD

Rainbow® Children's Hospital — It takes a lot to treat the little.
BirthRight™ BY RAINBOW HOSPITALS — Your Right to a Safe Delivery

Date: ....

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8Am – 2pm	Assist the child general condition Check vital Administer medication as per doctor advice I/O chart main	8Am – 2pm	Assisted the child general condition Checked vital Administered medication as per doctor advice I/O chart maintained	Child is stable	Re-checked vital	[signature]
Afternoon	2pm – 8pm	- Assess the pt condition - Monitor vitals & I/O chart - drug as per chart → provide comfortable position		- Assessed the pt condition → Monitored vitals & I/O chart - drugs as per chart	pt is stable	Rechecked vitals	[signature]
Night	8pm – 8Am	- Assess the Pt Condition - Monitor vitals - maintain I/O Chart - Medication Given as per drug chart	8pm – 8Am	- Assessed the Pt condition - Monitored vitals - maintained I/O Chart - Medication Given as per drug chart	Pt is stable	Rechecked vitals	[signature]

Patient Sticker

HNH-00016003 IP26-00006596
Baby S.SREENIKA 4 Y 11 M 25 D (F)
22-06-2021
Dr. SINDHURA MUNUKUNTLA

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:			Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:		
	Surgery / Procedure:			Post OP Day:		

	Date / Shift	16/6/26 M6	16/6/26 E2	16/6/26 N1	17/6/26 M6	17/6/26 E2	17/6/26 N1
BACKGROUND	Medical Condition (Any special condition to be noted):	soft	soft	soft	soft	soft	soft
	Diet:	—	—	—	—	—	soft
ASSESSMENT	Allergy:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
	Ventilation (RA, NP, NIV, VENTI):	—	—	—	—	—	—
	Tubes/Drains/Catheter:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
	Vital Signs: Temp:	99.1°F	99.6°F	98.3°F	98.1°F	98.4°F	98.6°F
	Res:	29	23	23 b/m	28 b/m	28 b/m	28 b/m
	SpO_2:	100	100%	98%	100%	100%	100%
	Pulse:	112	118 b/m	117 b/m	118 b/m	117 b/m	118 b/m
	BP:	—	—	—	—	—	—
	LOC:	—	—	—	—	—	—
	Fall Risk Score:	—	—	—	—	—	—
	Pain Score:	—	—	—	—	—	"0"
	Skin Integrity	—	—	—	—	—	Good
Recommendations	Safety Needs:	☐ Yes ☑ No	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☑ No	☑ Yes ☐ No	☑ Yes ☐ No
	Physiotherapy:	—	—	—	—	—	—
	Others Specify:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
	Special Diet:	—	—	—	—	—	—
	Critical Lab Test / Values:	—	—	—	—	—	—
	Other Special Orders / Medications:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
	PU Prophylaxis:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
	DVT Prophylaxis:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
	ADL (Dependent / Non Dependent):	—	—	—	—	—	—
	Post Operative Procedure Special Orders:	NA	—	NA	NA	NA	—
	Handed Over By Name :	Madhu	Anusha	Amrutha	Sandhya	Aparna	Amrutha
	Signature / ID :	[signature]	[signature]	[signature]	[signature]	[signature]	[signature]
	Date:	16/6	16/6/26	17/6	17/6/26	17/6/26	18/6/26
	Time:	2pm	8PM	8Am	8pm	8p	8Am
	Taken Over By Name :	Anusha	Amrutha	Sandhya	Aparna	Amrutha	
	Signature / ID :	[signature]	[signature]	[signature]	[signature]	[signature]	
	Date:	16/6/26	16/6/26	17/6/26	17/6/26	17/6/26	
	Time:	2PM	8pm	8Am	2pm	8Am	

Patient Sticker

NURSING SHIFT HAND OVER FORM

SITUATION		
	Diagnosis:	Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify: ....
	Surgery / Procedure:	Post OP Day:

Section	Item						
BACKGROUND	Date / Shift						
	Medical Condition (Any special condition to be noted):						
	Diet:						
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Ventilation (RA, NP, NIV, VENTI):						
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:						
	Res:						
	SpO_2:						
	Pulse:						
	BP:						
	LOC:						
	Fall Risk Score:						
	Pain Score:						
	Skin Integrity						
Recommendations	Safety Needs:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Physiotherapy:						
	Others Specify:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Special Diet:						
	Critical Lab Test / Values:						
	Other Special Orders / Medications:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	PU Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	DVT Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ 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:						

PATIENT TRANSFER FORM

HNH-00016003 IP26-00006596
Baby S.SREENIKA
22-06-2021 4 Y 11 M 25 D (F)
Dr. SINDHURA MUNUKUNTLA

	Date & Time of Admission	Date & Time of Transfer Order
	16/6/26 @ 12:20pm	16/6/26 @ 1:30pm
Treating Consultant Name	**Transfer Ordered by**	**Reason for Transfer**
	Dr. Anusha	Admission
From Unit	**To Unit**	**Information to Attendant**
ER	ward	Yes ☑ No ☐
Number of Sheets in Clinical File	**Number of Imaging Films**	**Personal belongings including clinical documents. If any handed over to attendant**
25		Yes ☑ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

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

Shifting Summary / Notes Written by Doctor : Yes ☐ No ☐

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Bhargavi	Dr. Anusha

Patient & Clinical Records Received by : Madhavi 16/6/26

Date & Time of Patient Received : @ 1:30pm

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

Docu. No. : RCH /FRM / CLINICAL / 102

Patient Sticker 4Y11M

208

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NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 16/6/26 Time: 2:30pm

Weight: 16 kg Centile: 25th

Height: – Centile: –

Inference: underweight child

RDA: – Calories: 1350kcal/d Protein: 23gms/d

Diet Recommendations: Normal soft Diet with more liquids

Re-Assesment: Avoid Spicy, chilled & outside foods

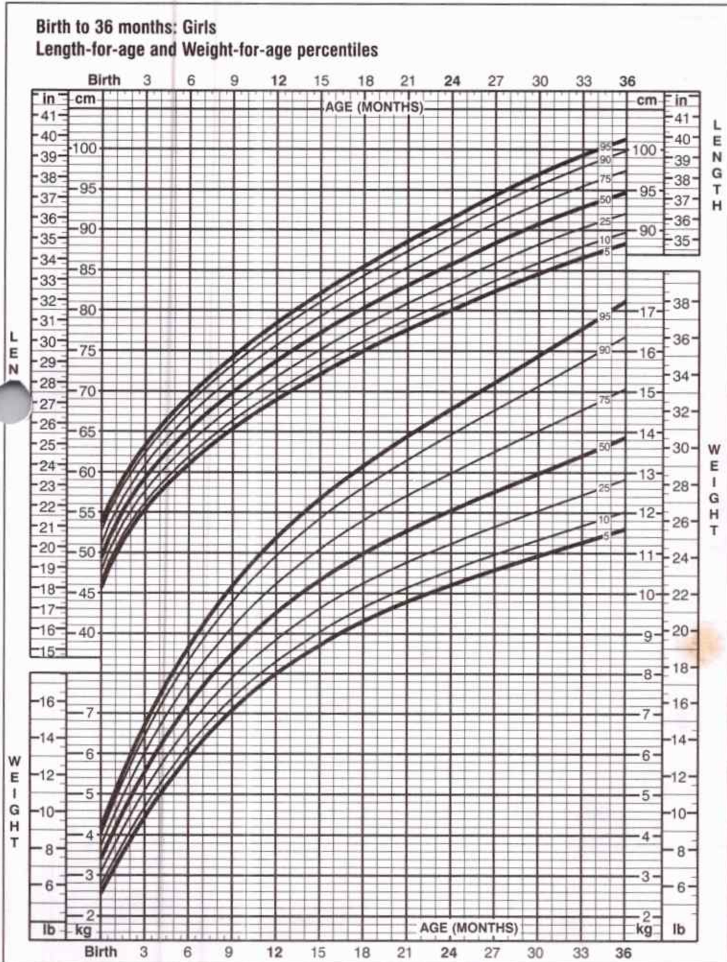
Food Allergies: NO Veg/Non-veg NON-veg

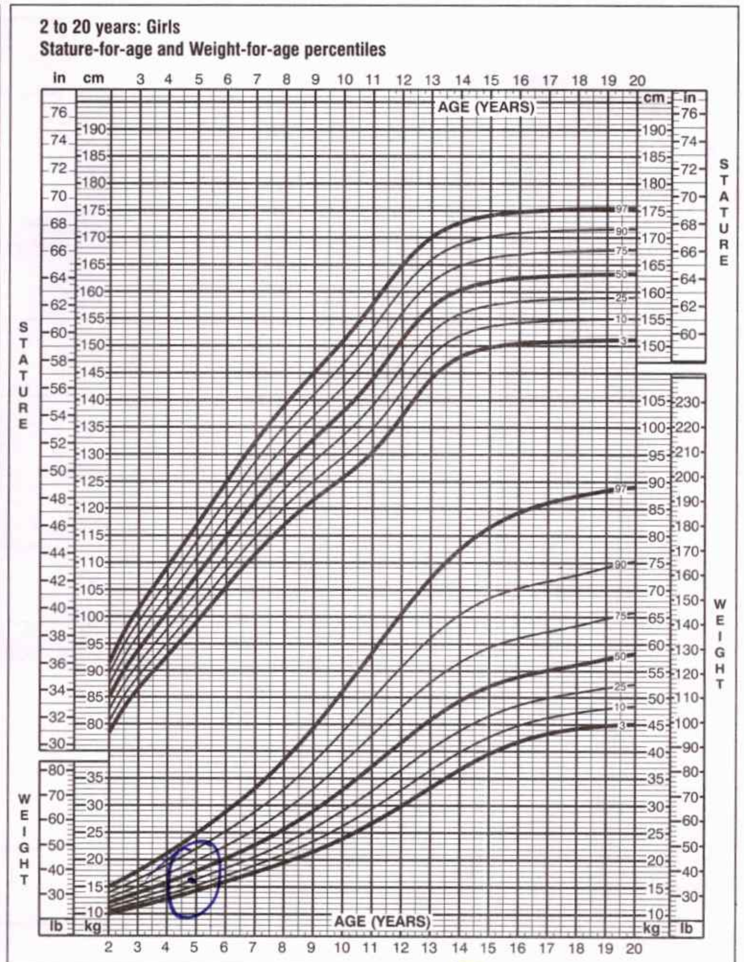
Diagnosis: AFI with Dehydration

Nutritional Intervention - ☑ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: [signature]

GROWTH CHART (GIRLS)





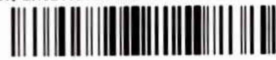
Dietician's Name: Sathwika.G Dietician's Signature: [signature]

Docu. No. : RCH /FRM / CLINICAL / 161

(P.T.O.)

Daily Notes:

HNH-00016003 IP26-00006596
Baby S.SREENIKA
22-06-2021 4 Y 11 M 25 D (F)
Dr. SINDHURA MUNUKUNTLA



TRB (POST)

wt - 16.3kg

EMERGENCY ROOM TRIAGE FORM

Patient's Name : Sreenika Age : 4 yr **Gender:** ☐ Male ☑ Female

Date : 16/6/26 Time of Arrival : 11:50 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: 99.2°F PR: 130 b/m BP: .... RR: .... SpO_2: 97%.

Chief Complaints: C/o. high grade fever, cough since 3days.

INITIAL PHYSIOLOGICAL CATEGORIZATION	**INITIAL PHYSIOLOGICAL STATUS**
Appearance: ☑ Normal ☐ Sick Looking Work of Breathing: ☑ Normal ☐ Increased ☐ Decreased ☐ Gasping / Apnea Circulation / Colour: ☑ Normal ☐ Abnormal ☐ Bleeding	☑ Stable ☐ Unstable : ☐ Not – Life - Threatening ☐ Life – Threatening

Triage Classification	**CTAS**
☐ Level 1 : Resuscitation	☐ Immediate
☐ Level 2 : EMERGENT : Life or limb threatening	☐ < 15 min
☐ Level 3 : URGENT : Significant illness / injury with potential to become life or limb threatening	☐ 30 min
☐ Level 4 : LESS URGENT : Significant illness but not life threatening	☑ 60 min
☐ Level 5 : NON – URGENT : May receive care when convenient	☐ 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.

Signature of Parent / Guardian

* CTAS - Canadian Triage and Acuity Scale

Triage Completion Time : ....

Communicable Disease Triage Screening

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

1. Have you had fever (elevated temperature) in the past 2 weeks ☐ Yes ☑ No
2. Have you had cough or a rash in the past 2 weeks ☐ Yes ☑ No
3. 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**

1. 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: ....

2. 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 : Bhargavi

Signature of Triage Nurse : B

Date & Time : 16/6/26 @ 11:52 pm

Docu. No. : RCH /FRM / CLINICAL / 085

HNH-00016003 IP26-00006596
Baby S.SREENIKA
22-06-2021 4 Y 11 M 25 D (F)
Dr. SINDHURA MUNUKUNTLA

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Your Right to a Safe Delivery

NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 16/6/26 Time of arrival : 11:54 am

Chief Complaints: c/o - high grade fever RBS: ....

Height : .... Weight : 16.3 kg BMI : .... Head Circumference (<2 years) ....

Allergies: ☐ Yes ☑ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other: ....

If yes , identify ....

Pain Screening: ☐ Yes ☑ No If Yes, Pain Score: .... Pain Tool Used: ☐ N Pass ☐ FLACC ☐ Wong Baker

☐ Character .... ☐ Location .... ☐ Frequency .... ☐ Duration ....

RISK FOR FALL:

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

☐ If Patient is > 6 years
Assess the below parameters

History of Falling: within past 3 months	☐ Yes	☑ No
Ambulatory Aids:		
• Wheelchair	☐ Yes	☑ No
• Uses furniture for support	☐ Yes	☑ No
Gait/Transferring:		
• Bedrest / immobile	☐ Yes	☑ No
• Weak	☐ Yes	☑ No
• Impaired	☐ Yes	☑ No
Mental Status: Forgets limitations	☐ Yes	☑ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

☐ Escort while ambulating
☑ Assist Patient
☑ Educate patient and family on fall precautions/prevention

Functional Screening: ☑ No Abnormalities Detected

☐ Mobility Problem
☐ Walking Problem
☐ Developmental Delay
☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

....

....

Nutritional Screening: ☑ No Abnormalities Detected

☐ Underweight
☐ Overweight
☐ Feeding Problem
☐ Special diet
☐ Special feeding method

Inform consultant for positive criteria

Psychological Screening: ☑ No Significant Findings

Unusual concerns about patient's Psychological Status: ☐ Yes ☑ No

If Yes Consultant Notified: .... (Date/Time): ....

Social History: Lives With family

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

Time of Initial assessment completed by ER Nurse : ....

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

Time	Nursing Notes
11:56pm	Assess the pt condition
	monitore the vitals

Samples collected by: Sugandha
Samples sent by :

Time:
Time: 12pm

Medication given in ER:

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

Condition of patient at time of shift - out :	Details of Shift - out
HR: 130b/m BP: .... CFT:	Shift - out from ER to: ward
RR: .... SPO_2: 97%	Time of Shift - out: 1:30pm
GCS: .... Temperature : 99.2°F	Handover given to: [illegible] (Nurse's Name)
Pain Score:	
Repeat RBS (if applicable):	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any): IV placement Done.

Name of the Nurse : Bhargavi   Signature of the Nurse : B

Date & Time : 16/6/26 @ 12pm