

### DISCHARGE SUMMARY

<b>Name</b>	Master ABHINAV MISHRA	<b>UHID</b>	HNH-00016109
<b>Father/Guardian</b>	Mr AKELESH MISHRA	<b>Age/Gender</b>	1 Y 2 M 18 D/ Male
<b>Address</b>	seetharam bagh, Nampally, Hyderabad, Telangana, INDIA, 500001		
<b>IP No</b>	IP26-00006624	<b>Admission Date</b>	22-06-2026
<b>Ref Doctor</b>			
<b>Discharge Date</b>	25.06.2026		

**Consultant:**

**Dr. ANIKET ANIL PARASHAR**

MBBS - MD

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

<b>DIAGNOSIS</b>	<b>ICD CODE</b>
ACUTE FEBRILE ILLNESS	
COMPLEX FEBRILE SEIZURE (1ST EPISODE)	
ROTA VIRAL DIARRHOEA	
E.COLI URINARY TRACT INFECTION	

**History:** Master ABHINAV MISHRA , 1 Y 2 M 18 D , old boy presented with the history of fever since 4 days, 3 episodes of seizure in the form of uprolling of eyeballs with fisting of upper limbs, generalised tonic clonic movements of 30 seconds lasting for 1 minutes followed by post ictal drowsiness present. Multiple episodes of vomitings and loose stools for 2 days. For the above complaints, he was admitted at outside hospital, and in view of persisting symptoms baby was brought to Rainbow Children's Hospital - Himayatnagar for

<b>Name</b>	Master ABHINAV MISHRA	<b>UHID</b>	HNH-00016109
<b>IP No</b>	IP26-00006624	<b>Admission Date</b>	22-06-2026

further management.

**OUTSIDE Investigations:**

Initial hemogram showed Hemoglobin of 12.0 gm%, White Blood Cell count of 10250 cells/cumm, platelet count of 3.29 lakhs/cumm. Serum electrolytes showed sodium of 135 mmol/L, potassium of 4.2 mmol/L & Chloride of 99 mmol/L. Serum Creatinine was 0.85 mg/dl.

Blood Urea was 27.53 mg/dl. Serum Calcium was 9 mg/dl. Magnesium was 31 mg/dl. Uric acid was 5.1 mg/dl.

**Examination:** He was afebrile, maintaining saturations at room air. His heart rate was 112/min and Respiratory Rate - 32/min. Capillary Refill Time was <2 secs. Peripheries were warm & pulses well felt. Dry lips, oral mucosa, sunken eyes were present. On auscultation, air entry was bilaterally equal. Heart sounds were normal and there was no murmur. Abdomen was soft with no organomegaly.

On neurological examination, he was drowsy and in postictal state. 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 : 8.9 kilograms.

**Investigations:** Enclosed reports.

VBG showed pH of 7.28, pCO2 of 42.8 mmHg, pO2 of 37 mmHg, HCO3 of 18.8 mmol/L and BE of -6.1 mmol/L.

Initial hemogram showed Hemoglobin of 12.2 gm%, White Blood Cell count of 12460 cells/cumm, platelet count of 2.75 lakhs/cumm and C-Reactive Protein of 5 mg/l. Serum Creatinine was 0.4 mg/dl.

<b>Name</b>	Master ABHINAV MISHRA	<b>UHID</b>	HHH-00016109
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Complete urine examination was normal.  
Urine culture showed E.COLI

EEG was done, which was normal.  
Stool for rota virus was positive.  
Stool for reducing substance was positive.

G-6-PD was sent, report awaited.

Complete stool examination shows

Name	Master ABHINAV MISHRA	UHID	HNH-00016109
IP No	IP26-00006624	Admission Date	22-06-2026

COLOUR	YELLOWISH		
CONSISTENCY	S. FORMED		
pH	6.0	5 - 8.5	
MUCUS	PRESENT	ABSENT	
BLOOD	ABSENT		
UNDIGESTED FOOD	ABSENT	ABSENT	
HELMINTHES	NIL	NIL	
PUS CELLS	4 - 5		
RED BLOOD CELLS (Stool)	1 - 2	NIL	HPF
STARCH GRANULES	PRESENT + +	ABSENT	
YEAST CELLS	PRESENT +	NIL	
FAT GLOBULES	PRESENT + +	ABSENT	
PROTOZOA	NIL	NIL	

Blood culture was sterile.

**Management:** He was admitted in the ward and started on Intra Venous fluids and Intra Venous antibiotics. He was treated symptomatically with antipyretics. He was continued on antiepileptics which were started outside.

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<b>IP No</b>	IP26-00006624	<b>Admission Date</b>	22-06-2026

In view of complex febrile seizure, Dr. Abhishek neurologist consultation was done who advised to continue antiepileptic and do EEG.

In view of loose stools and vomitings, he was administered probiotics and advised gastrodiet.

He was regularly monitored for loose stool frequency and hydration status. His loose stools and other symptoms settled gradually.

In view of urine culture report showing E.Coli, antibiotic was changed according to sensitivity pattern.

He was regularly monitored for fever spikes, hemodynamic & neurological status. His fever spikes gradually settled and there were no further seizure episodes during hospital stay. He was regularly monitored for loose stool frequency and hydration status. His loose stools and other symptoms settled gradually.

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

Parents were counselled regarding the nature of febrile seizures and measures to reduce fever during future febrile episodes. They were also educated regarding use of intranasal Midazolam spray for termination of future seizure episodes, if any.

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

**Advice:**

<b>Name</b>	Master ABHINAV MISHRA	<b>UHID</b>	HNH-00016109
<b>IP No</b>	IP26-00006624	<b>Admission Date</b>	22-06-2026

\* Diet as advised.

<b>S.No</b>	<b>MEDICATION</b>	<b>DOSE</b>	<b>TIMINGS</b>	<b>DURATION</b>
1	Syrup. NITROFURANTOIN (5ml/25mg)	2.5 ml	6am- 2pm- 10pm (after food)	For 5 days.
2	Syrup. LEVIPIL (1ml/100mg)	1 ml	8am-8pm	Till further advice
3	Syrup. ONDEM (Ondansetron - 5ml/2mg)	3 ml	Max 3 times/day (30 minutes before food)	SOS for vomiting
4	PRO-GG drops	15 drops	9am-9pm (after food)	For 3 days
5	Z & D drops (1ml/20mg)	1 ml	9am (after food)	For 11 days

<b>Name</b>	Master ABHINAV MISHRA	<b>UHID</b>	HNH-00016109
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6	B4 NAPPI Cream	perianal region	As per need	Till rashes persist
7	Nasoclear nasal drops, 2 drops in each nostril <b>SOS</b> for nose block			

**Plan:**

- \* **To collect G-6-PD report on followup.**
- \* **To review with neurologist later in view of complex febrile seizure.**

**Febrile Seizure Prophylaxis:**

- \* Syrup. Crocin DS (Paracetamol = 5ml/240mg) 3 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.
- \* Syrup. Clobium (Clobazam - 1ml/2.5mg) 0.5 ml twice daily for 3 days every time with fever.
- \* Medistat - nasal spray (Midazolam = 1.25mg/puff), 1 puff intranasal (into each nostril) for future seizures.

Review consultation with Dr. ANIKET ANIL PARASHAR on Monday (29.06.2026) at Banjara Hills 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

<b>Name</b>	Master ABHINAV MISHRA	<b>UHID</b>	HNH-00016109
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after food based on tolerance of stomach.

\* **Antiemetics** can be taken before food.

\* By consuming your **probiotic** with food you provide a buffering system for the supplement and ensure its safe passage through the digestive tract. Aside from protection, food also provides the friendly bacteria in your probiotic the proper food and nourishment to ensure it survives, grows and multiplies in your gut. It is recommended to take probiotics at the END of a meal. Concurrent administration of antibiotics could kill a large number of the organisms, reducing the efficacy of probiotics. Separate administration of antibiotics from probiotics by **atleast two hours**.

Follow up immediately in Emergency Room if high grade fever, vomiting, abnormal behavior, altered sensorium or seizure occurs.

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

Parent/ Attender

In case of emergency contact 9154865030 emergency pediatrician on duty.

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

You can also take appointments at any time by going **online** to our website

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[www.rainbowhospitals.in](http://www.rainbowhospitals.in)

**Dr. ANIKET ANIL PARASHAR**  
MBBS - MD

TSMC/FMR/08568, [dr.aniket.p@rainbowhospitals.in](mailto:dr.aniket.p@rainbowhospitals.in)

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



**ADMISSION SHEET**



**Registration Details :**

Admission No : IP26-00006624      Admit Date : 22-Jun-2026      Admit Time : 01:43 PM      UHID : HNH-00016109

**Patient Details :**

Patient Name : Master ABHINAV MISHRA      Age : 1 Y 2 M 17 D  
Guardian : Mr AKELESH MISHRA      DOB : 05-04-2025 01:00 AM  
Gender : Male      Religion :  
Occupation :      Martial Status :  
Address (H) : seetharam bagh Nampally Hyderabad      Phone No : 9397051745/ 9059192304  
Telangana INDIA 500001      E-mail : akeleshmishra745@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 AKELESH MISHRA      Relationship : Father  
Contact Address : seetharam bagh Nampally Hyderabad      Phone No : 9397051745  
Telangana INDIA 500001

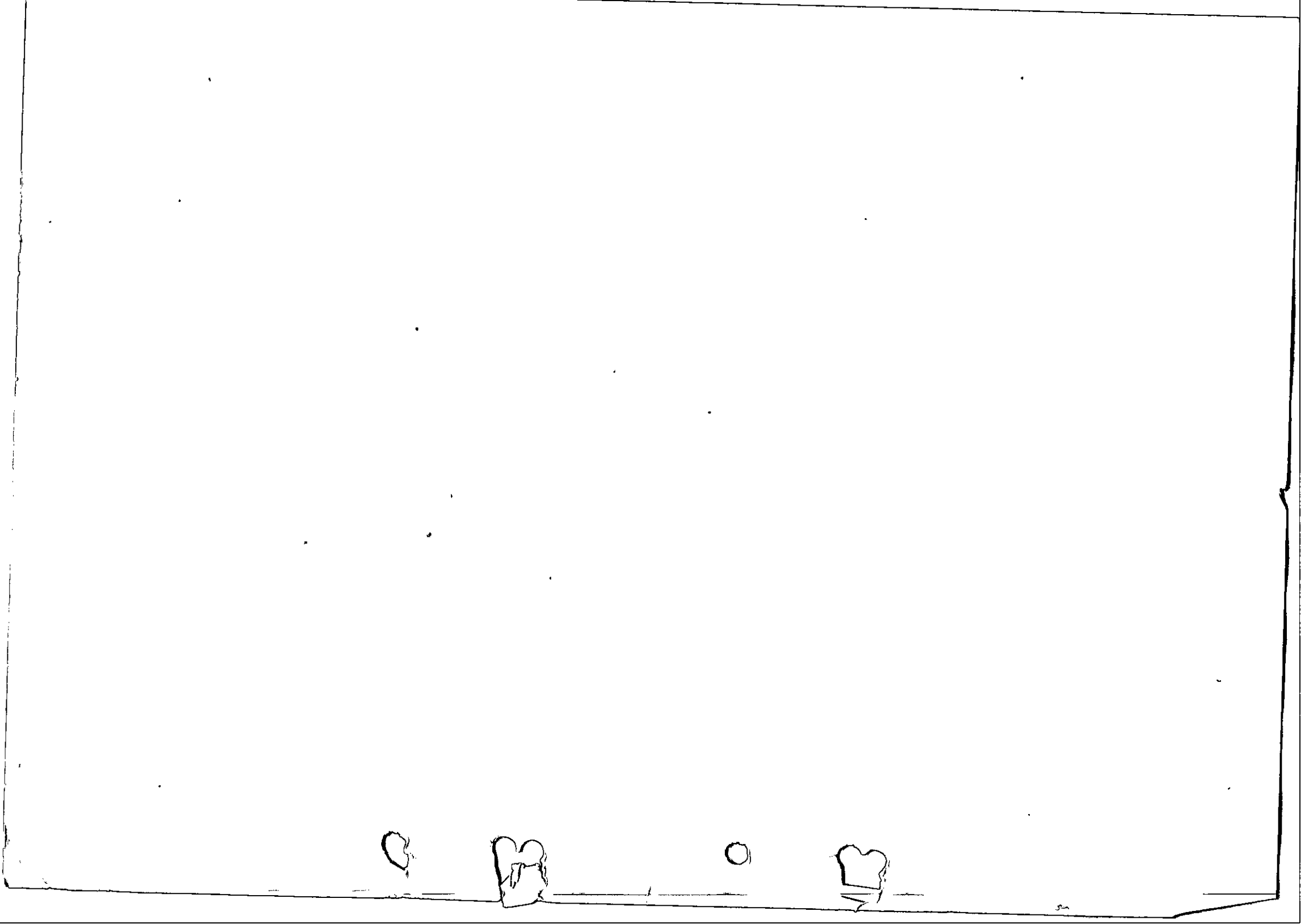
*Akelesh*  
Signature

**Doctor Details :**

Doctor Name : Dr. ANIKET ANIL PARASHAR      Specialisation : GENERAL PEDIATRICS  
Referral Doctor :      Phone No :  
Co-Consultant :

**Payment Details :**

Payment Mode : DC/CC Card      Deposit Amount : 20000.00  
Payor Name : RELIANCE GENERAL INSURANCE COMPANY LTD



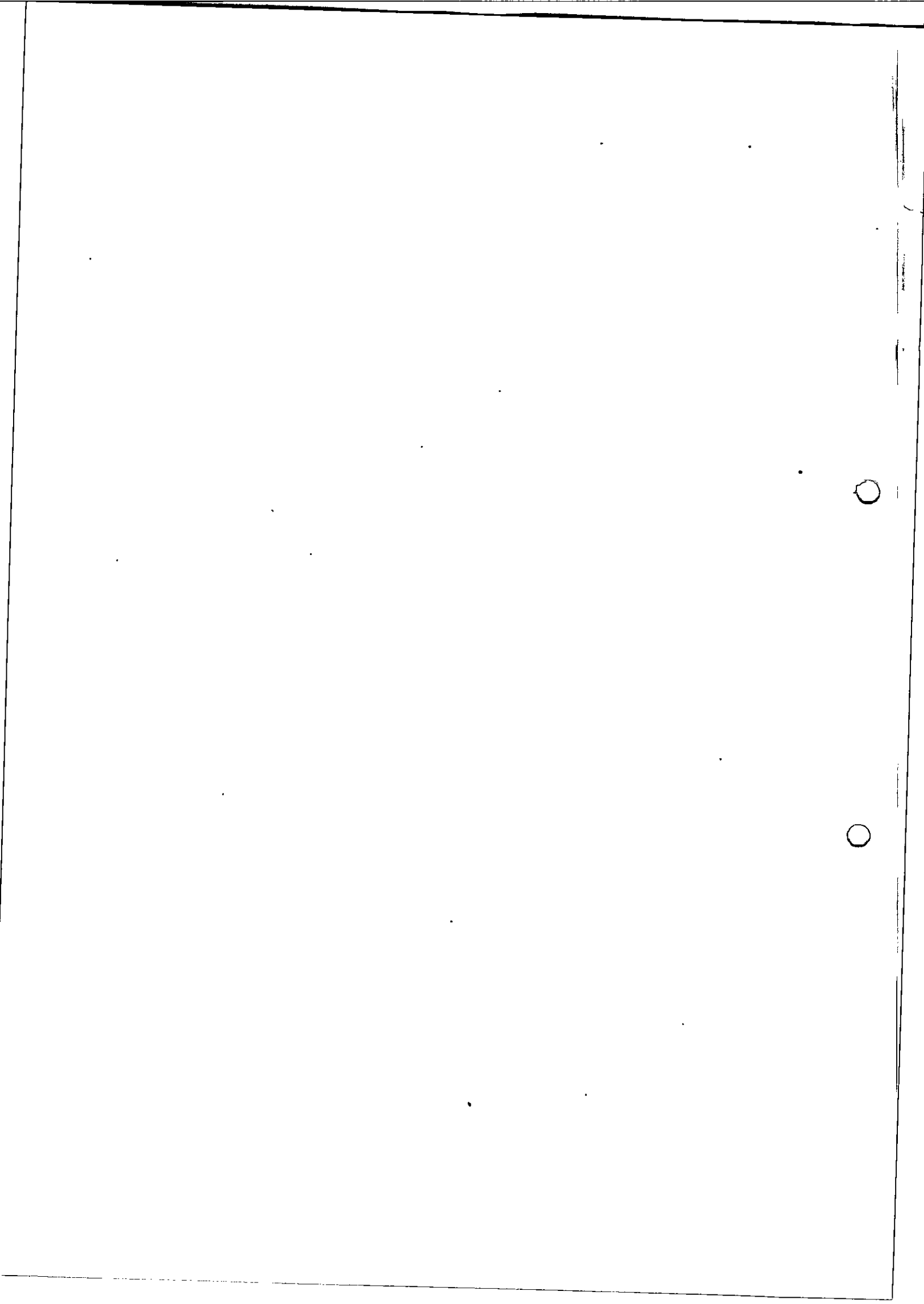
HNH-00016109 IP26-00006624  
 Master ABHINAV MISHRA  
 05-04-2025 1 Y 2 M 17 D (M)  
 Dr. ANIKET ANIL PARASHAR



## DEFICIENCY CHECK LIST OF CASE SHEET

Sl.No.	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission sheet	1			
2	Discharge Summary	1			
3	Nursing Initial assessment	1			
4	Patient Transfer form	1			
5	In-patient Medical record	1			
6	Doctors progress sheets	5			
7	Nursing plan of care and handover sheets	3			
8	Consultation sheet				
9	General consent for treatment	1			
10	Consent for Surgery				
11	Consent for blood transfusion				
12	Consent for chemotherapy				
13	Consent for high risk				
14	Consent for Restraint				
15	LAMA consent				
16	Consent for special procedure / Sedation				
17	Consent for Formula feed				
18	Consent for MTP				
19	Consent for Radiological Investigations				
20	Consent for HIV test				
21	Anaesthesia notes (Pre Anaesthesia & post)				
22	Neonatal Admission/Delivery/Physical Exam				
23	Medication Reconciliation	1			
24	Emergency Triage record	1			
25	Pre operative check list				
26	Surgical safety checklist				
27	Operation Theatre notes				
28	Nurses clinical Presentation				
29	TPR & BP chart	3			
30	Intake and Out take chart (fluid chart)	2			
31	Drug chart (Regular Prescription)	1			
32	Investigation Values (result sheet)	1			
33	Nebulization chart				
34	Nutritional review chart				
35	Intensive care unit (ICU Charts)				
36	Consent for Admission in PICU / NICU				
37	The Humpty dumpty scale				
38	Braden Q Scale	2			
39	Bed side check list				
40	PICU bed formula Dilution feeds				
41	Gastro monitoring chart				
42	Rch ED doctors note				
43	BP Monitoring chart				
44	RBS monitoring chart				
	<i>Billing</i>	1			
	<i>Others</i>	5			
	<b>Total No. of Pages</b>	<u>31</u>			

Signature and Date : 25/06/26  
*Jyotsna* (P.T.O)





# Cross CONSULTATION FORM

Doctor Name: Dr. Aniket Date: 22/6/26 Time: .....

Diagnosis: AGE 2 dehydration & complex febrile seizure

Hospital: RCH

**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 :**

ClO fever x 4 days  
ClO 3 episodes of uprolling of eyes, fisting of BLV UL during fever.  
ClO vomiting, loose stools

Vitals - stable.

GCS - 15/15

CNS - NAD

(22/6) 2m

CBP - Plt - 2.75 lakh

WBC - 12.46  
35/54

Recieved Inj. levipil. in Govt hospital. - watch for seizure

Plan

- Symptomatic treatment

- Continue

Inj. ceftriaxone

Inj. clonidine

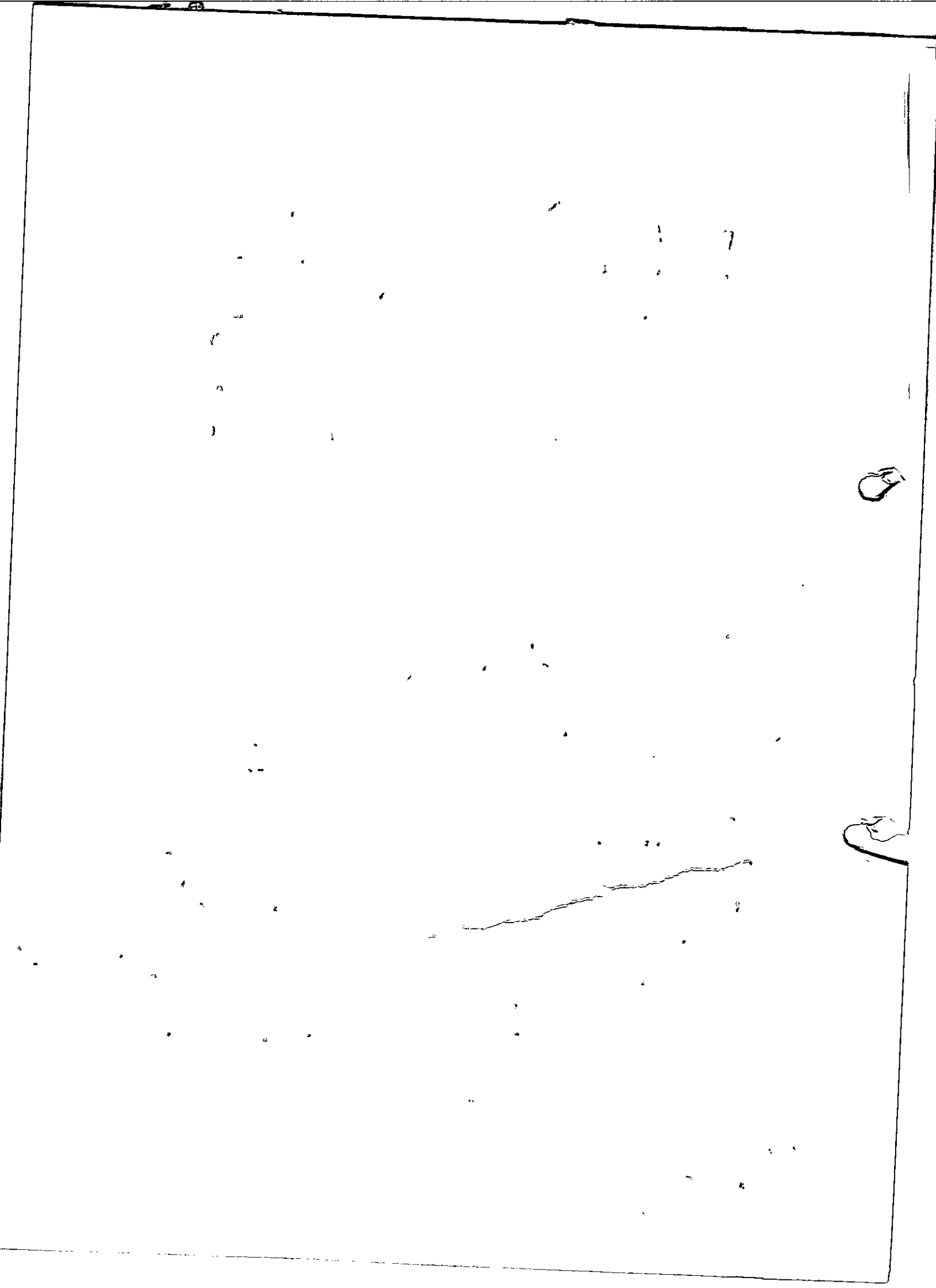
oral. levipil.

(20mg/kg/day)


- Monitor vitals

**Consultant :**

Name: Dr. Abhishek Signature: \_\_\_\_\_ Date & Time: .....



**ACTIV** HNH-00016109 IP26-00006624  
Master ABHINAV MISHRA NG  
05-04-2025 1 Y 2 M 17 D (M)  
Dr. ANIKET ANIL PARASHAR

Name:  -----

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

Date of Admission : *22/6/26* Time : ----- Date of Discharge : ----- Time: -----

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

**WARD TRANSFERS**

Date	Time	From	To	Signature of Nurse
<i>22/6/26</i>	<i>3pm</i>	<i>ER</i>	<i>ward</i>	<i>Bhargava</i>

**Cross Consultation Visit**

	Doctors Name	Date	Order No.	Signature
1.	<i>Dr. Abhishek Ravin Jain</i>	<i>22/6/26</i>	<i>7839</i>	<i>[Signature]</i>
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

*Cross checked done by Sachin*

# INVESTIGATIONS

HNH-00016109 IP26-00006624  
 Master ABHINAV MISHRA  
 05-04-2025 1 Y 2 M 17 D (M)  
 Dr. ANIKET ANIL PARASHAR



Date	Investigations	Order No.	Sign
22/6/26	CBP + CRP blood cls	✓ 10146	
	Ser. Creatinine		
	<del>EXE</del>	10146	Shangari
	VBG	✓ 10149	
	CUE		
	Urin culture	✓ 10151	Ⓟ
Cross checked done by Sneha			
22/6/26	CSE	0140	Sm
22/6	Stool for rotavirus	0141	Sm
23/6	Stool Reducing substance	0145	Sm
Cross checked done by Sneha			
23/6/26	EEG	7501	Ⓟ
21/6	G6 PD	10289	R
cross checked done by Amrutha			



### MEDICAL EQUIPMENT ( WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
22/6/26	Infusion pump	3:15pm.	24/6/26 2:30am	✓ 7833	
					<i>Cross checked done by Sarker</i>




Ref.No. F/IN/PR/10



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

## PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name : HNH-00016109 IP26-00006624  
Master ABHINAV MISHRA  
05-04-2025 1 Y 2 M 17 D (M)  
Dr. ANKET ANIL PARASHAR

Patient ID# : 

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

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

Pediatric Multiorgan History & Physical Examination

HNH-00016109

IP26-00006624

Master ABHINAV MISHRA

05-04-2025

1 Y 2 M 17 D

(M)

Dr. ANIKET ANIL PARASHAR



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

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

Chief Presenting Complaints & Duration (Chronologically):

do fever since 4 days  
do 3 episodes of uprolling of eyes  
with fistings of upperlimbs. x. 3 days

History of present illness : do multiple episodes of vomiting x 2 days  
do multiple episodes of loose stools x 2 days

pt was apparently alright 4 days before  
then had fever moderate to high degree.  
not relieved w/ medication

do 3 episodes of uprolling of eyes w/  
fisting of upperlimbs each episode  
lasts for 30sec - 1 minute. post ictal  
drowsiness (+)

do Multiple episodes of vomitus, watery  
non-projectile, non-bilious

do multiple episodes of loose stools  
watery, non-blood tinged.

Pediatric Multiorgan History & Physical Examination

HNH-00016109 IP26-00006624  
Master ABHINAV MISHRA  
05-04-2025 1 Y 2 M 17 D (M)  
Dr. ANIKET ANIL PARASHAR



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

nothing significant.

Birth & Neonatal History :

14 20 15  
2500g 34  
V / AGA / CIAB / M.

Birth & Socio Economic History :

About Father :

About Mother :

Any additional Information :

Developmental History :

Developmentally normal.

Immunization History :

upto date. till 9 months of age.



**Pediatric Multiorgan History & Physical Examination**

**Anthropometry**

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

Weight (kgs) 8.9 kg (Centile \_\_\_\_\_)

**On Examination :**

Temperature : 99°F Pulse Rate: 112 Description \_\_\_\_\_

B.P. \_\_\_\_\_ SPO2 98% at RA

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

Rash \_\_\_\_\_

Lymphadenopathy \_\_\_\_\_

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

dry oral mucosa,  
Sunken eyes  
dry lips

(+)  
(-)  
(-)

**Respiratory system :**

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

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

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

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

B/L A/E (+)  
B/L NURS.

**Cardiovascular System :**

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

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

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

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

S<sub>1</sub>S<sub>2</sub> heard (+)

**Per Abdomen :**

Inspection \_\_\_\_\_

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

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

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

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

soft, nontender  
no organomegaly

Pediatric Multiorgan History & Physical Examination

HNH-00016109 IP26-00006624  
Master ABHINAV MISHRA  
05-04-2025 1 Y 2 M 17 D (M)  
Dr. ANIKET ANIL PARASHAR



Central Nervous System :

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

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

Motor System :

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

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

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

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

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

Reflexes :

DTR

Superficials :

Plantars \_\_\_\_\_

Sensory System :

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

Clinical Summary & Diagnostic :

AGE : E dehydration  
Complex febrile seizures  
(? Meningitis)

Pediatric Multiorgan History & Physical Examination

HNH-00016109 IP26-00006624  
Master ABHINAV MISHRA  
05-04-2025 1 Y 2 M 17 D (M)  
Dr. ANIKET ANIL PARASHAR



Preventive aspects of the treatment :

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Desired goals of the treatment :

\_\_\_\_\_  
\_\_\_\_\_

Planned Labs :

\_\_\_\_\_  
VBG  
\_\_\_\_\_  
CBP, CRP, CUE  
\_\_\_\_\_  
Blood c/s  
\_\_\_\_\_  
urine c/s.  
\_\_\_\_\_  
Sr. Creatinine  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Planned Management :

\_\_\_\_\_  
DNS  
\_\_\_\_\_  
- LVF 2/3 maintence.  
\_\_\_\_\_  
- Inj. ceftriaxone.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**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. Aniket on  
whose name the patient is being referred

Doctor's Signature Name \_\_\_\_\_ Date 22/6/25 Time \_\_\_\_\_

*Dr. Aniket Anil Parashar  
Consultant Pediatrician & Intensivist  
Reg. No. 8568*



**PROGRESS NOTES AND DOCTOR'S ORDER**

Date & Time	Progress Notes	Doctor's Order
20/06/26	20/06/26	
8:30 PM	8:30 PM	
	As per Dr. Aniket	
	AUG with dehydration	
	(Complex febrile seizures)	
	Aspirin 400mg qd - Multiple (small quantity)	
	No vomiting	
	No fresh vomit/seizures	
	O/E: well-appearing	
	vitals: stable	
	Ster PA: soft NO	
		As per
		Stool Routine, Rota Ag
		& Reducing substance
		IV fluids
		- Ty Ceftriaxone
		- Supportive care
		- Monitor vitals and
		Temp 4x
		- Non Lact formula feeds
		- Natural rice feed
		(once daily)
		Dr. Aniket Anil Parashar
		Consultant Pediatrician & Intensivist
		Reg. No: 8568



## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	<u>4/5/16 Dr. Aniket</u>	
23/02/25 9:15 AM	<p><u>D - AGE / Complex febrile seizures.</u></p> <p>fever - None.</p> <p>Loose stools - ⊕; 4-5 times</p> <p>Vomiting - None</p> <p>Oral intake - fair</p> <p>SE - vitals stable.</p> <p>SE - WNL.</p>	
		<u>Adm.</u>
		<ul style="list-style-type: none"> <li>✓ Ct. Inj. Ceftriaxone</li> <li>✓ Ct. IVF.</li> <li>✓ Ct. Zovipil.</li> </ul>
		<ul style="list-style-type: none"> <li>✓ Add Redotil sachet BD.</li> <li>✓ Infant Nuroloke / Nurotam sic feeds</li> </ul>
		<ul style="list-style-type: none"> <li>✓ Change to Z + D drops.</li> </ul>
		<p><u>Dr. Aniket Parashar</u>          Consultant Pediatrician &amp; Intensivist          Reg. No: 8563</p>
		<p>NB Suando</p>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
23/6/25 2 PM	SIB Dr. Sreehan Δ ALC & dehydration Complex febrile seizure, Plog	
		- CF CEFTRIAXONE
	CVS - S <sub>1</sub> , S <sub>2</sub> ⊙	
	M - BL - ALC ⊙	- CF CGVIPIC
	P/A Tak	- CF ZKD drops
	Conscious.	Pro-GG
		- Encourage oral
		M - Sup
23/6/25 2:15 pm	Core dia Dr. Abhishek No further seizures	EE G today
		M/S Parul



**PROGRESS NOTES AND DOCTOR'S ORDER**

Date & Time	Progress Notes	Doctor's Order
23/6/25	US/B - <u>Dr. Dilnaaz</u>	
8:30 pm	A - Acute Gastroenteritis c dehydration Complex febrile Seizure.	
	Urine ✓ - loose stool - 10 to 12 episodes (on acetohil Sachet)	None
	- No vomit - <del>Loose</del> on Non-pro (Low Lac)	- cont. low lactose - cont probiotic
o/e	vitals - stable	- Ceftriaxone
S/E	Ph. soft, BS-1	- 12m IV fluids - Antiemetics as S.
		<p>2/15 of pt. Dilnaaz          Dr. Dilnaaz Farooqui          Consultant Pediatrician          Reg. No: 27476</p>



## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<del>24/6/26</del>	<del>c/s/B - Dr. Prashant/Dr. NAREEN</del>	
7:45 AM	A - Acute Gastroenteritis + Dehydration (ROTAVIRAL ILLNESS) COMPLEX FEBRILE SEIZURES	
	Urine ✓ loose stools: No Fever	<u>Plan</u>
	Taking low lactose milk	- Trace
<del>o/e</del>	vitals - stable	Urine Blood c/s c/s
<del>o/e</del>		- Continue low lactose milk
	D/A - Soft, Non-tender BS+	- 1/2 maintenance IVF @ 20ml/hr
	<u>vaccination H/O</u>	- ceftriaxone (D3)
	immixed cytotec	- Continue Supportive Management monitor v. tals
		Ruth



## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
24/6 11am	<p>CS/B D. Aniket</p> <p>D<sup>o</sup> - Rotaviral Diarrhoea            Complex Febrile Seizures            Culture +ve V.T.I</p>	<p>Ph</p> <ol style="list-style-type: none"> <li>1) Treat Blood CS Via CU</li> <li>2) CT - Ceftriaxone</li> <li>3) IVF -</li> <li>4) Ct Probiotic 2kd</li> <li>5) Syp Leiripil</li> <li>6) Gastro diet - low lactose milk</li> </ol>
	<p>Loose stools ⊕            No fever            Accepting feeds - less            Vitals Stable            P.V - Normal            R-S - B/LAECB            P/A - Soft</p> <p>Activity better but still weak.</p>	
		<p><i>[Signature]</i>            Dr. Aniket Anil Parashar            Consultant Pediatrician &amp; Neonatologist            Reg. No. 8568</p>

**GROSS NOTES AND DOCTOR'S ORDER**

Date & Time	Progress Notes	Doctor's Order
24/6/26 2 PM	SIB Dr. Sreyhan D ACF & dehydration (Retroviral illness) E Complex febrile seizure Plan	
	Cl. loose stools Large volume - 7-8 Episodes since morning	<del>CF IV fluids @ 20ml/h</del> <del>CF CEFTRIAXONE</del>
	Wt - 5.5 kg M - BU - ACF	<del>Trace Urine G<sup>i</sup></del>
	PLA Tol Concomitant	<del>Encourage only</del>
	<del>15 kg</del>	<del>W.B Amomuda 6:30 PM</del>
24/6 3 PM	CIDW Dr. Aniket Sr Urine - E. Coli Loose stools - 10 times in morning (Mod - large volume)	Plan (1) Stop Ceftriaxone (2) Send G-6-PD (3) Add Z: Amikacin Later plan d/c on oral Nitrofurantoin W.B Sanchal 9 PM
		Plan



## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
24/6 8:00pm	<p>CLSB Dr. Aniket</p> <p>AGE ± dehydration (Rotaviral illness)</p> <p>Complex febrile seizure UTI (E-coli +ve)</p> <p>loose stools (+) (10-12).</p> <p>Activity - Impaired oral intake - fair</p> <p>RLS / NAI PIA / NA</p>	<p>plan</p> <p>Cont Amlicain.</p> <p>Cont. IVF</p> <p>Next poock VBG.</p> <p>Ⓡ 9-6-PD.</p> <p>Cont ZED drops.</p>
25/6 7:00 AM	<p>CLSB Dr. Naipuya / Dr. Anusha</p> <p>AGE ± dehydration (Rotaviral illness)</p> <p>Culture +ve (E-coli) UTI.</p> <p>Complex febrile seizure</p> <p>loose stools - (↓↓)</p> <p>oral intake - fair.</p> <p>RLS / NAD PIA / NA</p> <p>U/O/P - Adequate.</p>	<p>plan</p> <p>Cont 2nj. Amlicain.</p> <p>Next poock VBG.</p> <p>Ⓡ 9-6-PD.</p> <p>Cont ZED drops Raddatil.</p> <p>Monitor vitals</p>

Dr. Aniket Parashar  
 Consultant Pediatrician & Intensivist  
 Reg. No: 8568



## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2-16 AM	CD/W A Aniket Sur	
	<p>Completen Fekhib Serjin            Rota Viral Aniket            E-Coli VTJ</p>	<p>Plan</p> <p>1) CP Supporter on</p>
	<p>Loose stool keth            viral sthke</p>	<p>2) D/C Today k            R/P after 3 days</p>
	<p>R-S-B/2A2B            PLA-Salt</p>	<p>Nitrofurantoin 50mg            Pka 55            ZKD</p>
		<p>SOS-Cath            CT Temp</p>

HNH-00016109 IP26-00006624  
 Master ABHINAV MISHRA  
 05-04-2025 1 Y 2 M 17 D (M)  
 Dr. ANIKET ANIL PARASHAR



## DRUG CHART

Date of Admission: 22/6/26 Drug Allergies: NSI  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)

<b>DRUG :</b> <u>Syp. Crocin DS</u>				Date Time																
Dose	Route	Frequency	Start Date																	
<u>3ml</u>	<u>PO</u>	<u>SOS</u>	<u>22/6</u>																	
Doctor's Signature		Valid Period	Pharm.																	
<u>[Signature]</u>		<u>&gt;100%</u>	<u>[Signature]</u>																	
Additional Instructions:																				
<u>(240/5)</u>																				

<b>DRUG :</b> <u>Syp. ibugesic</u>				Date Time																
Dose	Route	Frequency	Start Date																	
<u>2.5ml</u>	<u>PO</u>	<u>SOS</u>	<u>22/6</u>																	
Doctor's Signature		Valid Period	Pharm.																	
<u>[Signature]</u>		<u>&gt;100%</u>	<u>[Signature]</u>																	
Additional Instructions:																				

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

VERIFIED BY: Name



REGULAR PRESCRIPTIONS

Weight. 8.9kg Ward. ....

DRUG: Inj. Ceftriaxone					Date Time	22/6	23/6	24/6												
Dose	Route	Frequency	Start Date		6AM	X	Sy	Sy	Sy											
500mg	IV	BD	22/6																	
Name & Signature of the Doctor																				
Starting the Drugs:																				
Additional Instructions:					6pm 4pm 11am 24/6															
Daily Doctor's Endorsement by a Sign																				
DRUG: PROGG drops					Date Time	22/6	23/6	24/6	25/6											
Dose	Route	Frequency	Start Date		6AM	X	Sy	Sy	Sy											
15 <sup>o</sup>	PO	BD	22/6																	
Name & Signature of the Doctor																				
Starting the Drugs:																				
Additional Instructions:					6pm 3pm															
Daily Doctor's Endorsement by a Sign																				
DRUG: Inj. ondansetron					Date Time	22/6	23/6	24/6	25/6											
Dose	Route	Frequency	Start Date		6AM	X	Sy	Sy	X											
1mg	IV	TID	22/6																	
Name & Signature of the Doctor																				
Starting the Drugs:																				
Additional Instructions:					7pm 3pm															
Daily Doctor's Endorsement by a Sign																				
DRUG: Sy. Zincnea					Date Time	22/6														
Dose	Route	Frequency	Start Date																	
205ml	PO	OD	22/6																	
Name & Signature of the Doctor																				
Starting the Drugs:																				
Additional Instructions:					7pm 5pm															
Daily Doctor's Endorsement by a Sign																				

CHARGE  
 23/6/26 @ 9:30AM

Verified by  
 Dr. Dhakshayani



Sheet No: .....

**REGULAR PRESCRIPTIONS**

Weight **8.9kg** Ward .....

DRUG :				Date				
				Time				
SYP. Levipil.				22/6	23/6	24/6	25/6	
Dose	Route	Frequency	Start Dt.					
1ml	PO	BD	22/6					
Name & Signature of the Doctor Starting the Drugs:				[Signature]				
Additional Instructions:				[Signature]				
Daily Doctor's Endorsement by a Sign				[Signature]				
DRUG : ORS Sachet				Date				
				Time				
Dose	Route	Frequency	Start Dt.					
1sachet	PO		22/6					
Name & Signature of the Doctor Starting the Drugs:				[Signature]				
Additional Instructions:				[Signature]				
Daily Doctor's Endorsement by a Sign				[Signature]				
DRUG : BY NAPPA CREAM				Date				
				Time				
Dose	Route	Frequency	Start Dt.					
	LA	BD	23/06/25					
Name & Signature of the Doctor Starting the Drugs:				[Signature]				
Additional Instructions:				[Signature]				
Daily Doctor's Endorsement by a Sign				[Signature]				
DRUG : REDTIL SACHET				Date				
				Time				
Dose	Route	Frequency	Start Dt.					
1	PO	BD	23/6					
Name & Signature of the Doctor Starting the Drugs:				[Signature]				
Additional Instructions:				[Signature]				
Daily Doctor's Endorsement by a Sign				[Signature]				

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



Sheet No: .....

**REGULAR PRESCRIPTIONS**

Weight 8.90g Ward .....

<b>DRUG :</b> <u>2 + D drops</u>				Date Time																		
Dose	Route	Frequency	Start Dt.	<u>23/6</u>	<u>24/6</u>	<u>25/6</u>																
<u>1ml</u>	<u>PO</u>	<u>OD</u>	<u>23/6</u>	<u>10am</u>	<u>10am</u>	<u>10am</u>																
Name & Signature of the Doctor Starting the Drugs:																						
Additional Instructions:																						
Daily Doctor's Endorsement by a Sign																						
<b>DRUG :</b> <u>Inj AMIKACIN</u>				Date Time																		
Dose	Route	Frequency	Start Dt.	<u>24/6</u>																		
<u>135mg</u>	<u>IV</u>	<u>once Daily</u>	<u>24/6</u>																			
Name & Signature of the Doctor Starting the Drugs:																						
Additional Instructions:																						
Daily Doctor's Endorsement by a Sign																						
<b>DRUG :</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 :</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																						

Verified by  
 Dr. Dhakshayani

Signature of the Doctor

VERIFIED BY: Name

Signature of the Doctor



Weight. 8.9kg Ward. ....

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

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

**STAT / ONCE ONLY DRUGS**

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
23/6	4 PM	Syp PEDICTOLYL	5ml	PO	Pan	[Signature]
23/6	7 PM	Inj PHENIRAMINE (AVIL)	0.3ml in 5ml NS (-5mg)	IV oral Sin	Pan	[Signature]

VERIFIED BY: [Signature]

Verified by

Dr. Dhakshayani



HNM-00016109 IP26-00006624  
 Master ABHINAV MISHRA  
 05-04-2025 1 Y 2 M 17 D (M)  
 Dr. ANIKET ANIL PARASHAR



## MEDICATION RECONCILIATION FORM

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

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

Shifting From: ..... 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						<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

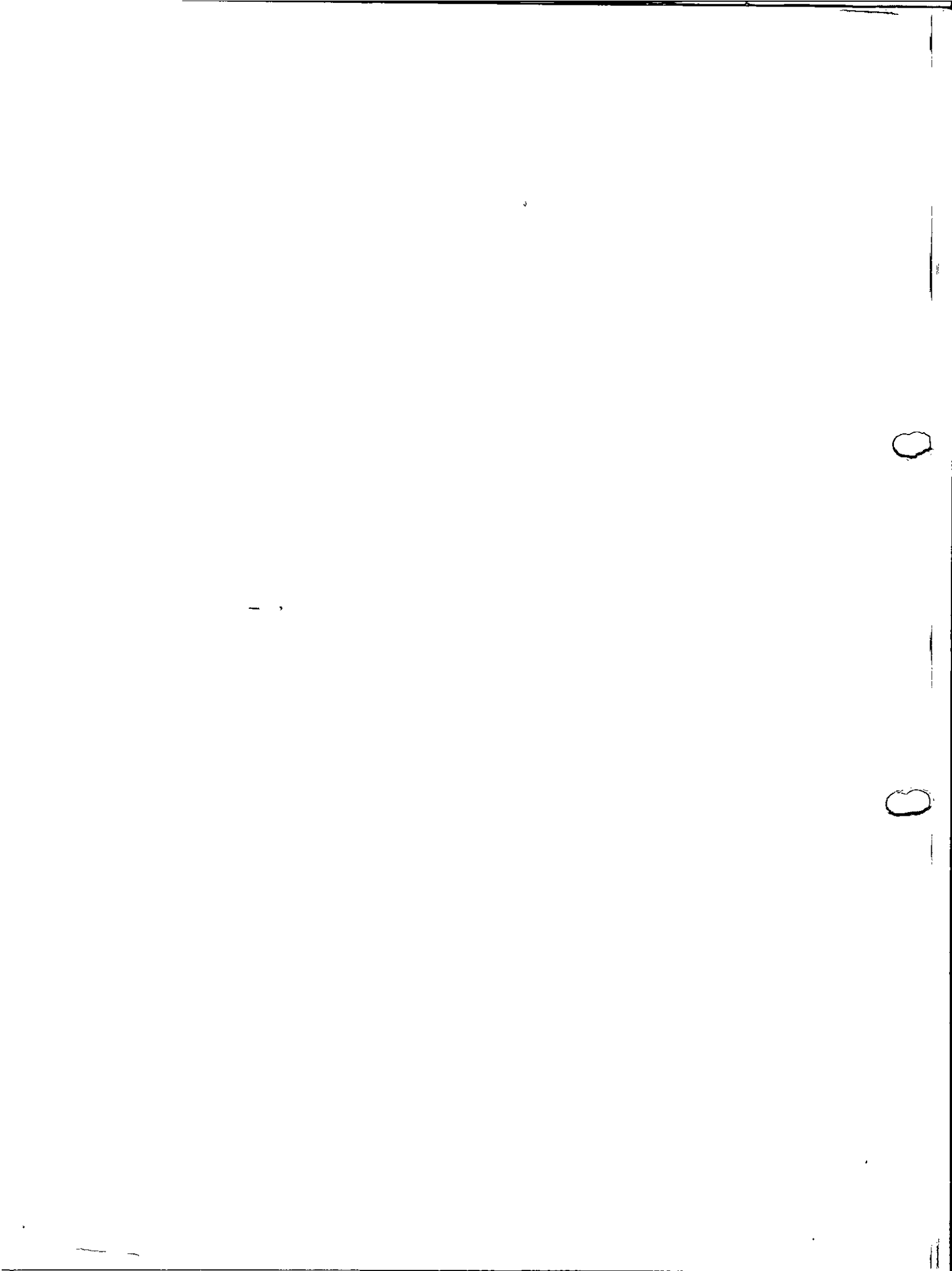
Doctor Name & Signature : ..... Dr. Nalpunya .....

Date & Time : ..... 22/6/26 @ 1:30pm .....

Nurse Name & Signature: ..... Bhargava .....

Date & Time : ..... 22/6/26 @ 1:35pm .....

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



HNH-00016109 IP26-00006624  
 Master ABHINAV MISHRA  
 05-04-2025 1 Y 2 M 17 D (M)  
 Dr. ANIKET ANIL PARASHAR

219



### RESULT SHEET

outside report  
 (18/6/26)

Date	(18/6/26)	22/6/26		
Time				
Hb	12.0	12.2		
PCV		34.3		
RBC	5.01	4.80		
WBC	10.25	12.46		
N/L	4.34/4.39	35.0/54.6		
Platelets	329	275		
CRP		5		
ESR				
PCT				
RBS				
Na	135			
K	4.2			
Cl	99			
Ca/Mg	9.31			
Phosphate				
Urea	<del>0.85</del> 27.53			
Creatinine	0.85	0.4		
ALP				
SGPT				
SGOT				
T.Bill/Conj				
T.Protein				
S.Albumin				
S.Globulin				
A/G Ratio				
Uric Acid	5.1			
S.Amylase				
Sr.Lipase				
Blood Lactate				
S.Cholesterol				
PT/INR				
APTT				
CSF Protein / Sugar				
Cells				
N/L				

Date	2/6/28					
Time						
CUE - Alb						
CUE - Sugar	NIL					
CUE - Ketones	Negative					
CUE - PUS Cells	3-4					
CUE - RBC Cells	NIL					
CUE - Epithelial	2-3					
Mitrite	OR					
Stool Pus Cell	4-5					
OVA / Cyst						
Occult Blood						
Stool Reducing						
Substances	Positive					
	(0.5%)					
Stool for Polio						
Virus	Positive					

Culture and Sensitivities : Blood cfs :-

Urine cfs :-

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI : .....

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

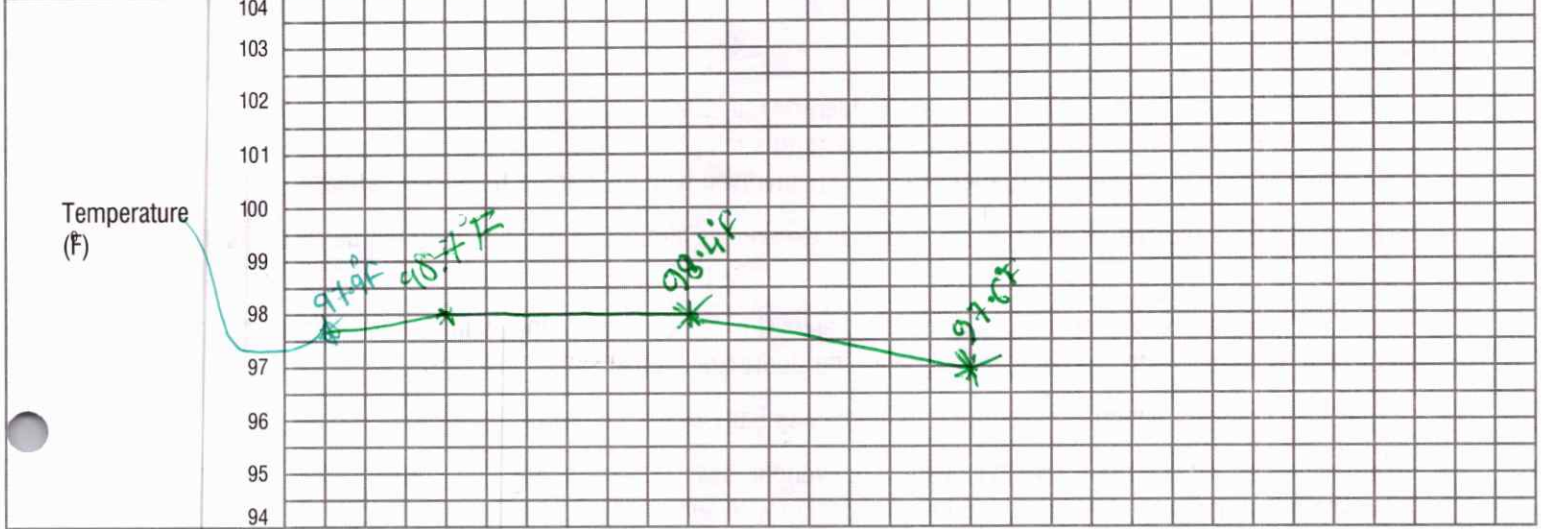
Patient Sticker



EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 20/6/26 Time: 6pm 10pm 2 AM 6 AM

Doctor / Nurse / Family Concern?



Heart Rate (bpm) and Blood Pressure (mmHg) \*

Note: BP does not score in early warning scoring

Time	Heart Rate (bpm)	Blood Pressure (mmHg)
6pm	118b/m	118/70
10pm	120b/m	120/70
2 AM	130b/m	130/70
6 AM	128b/m	128/70

Resp. Rate (bpm) (Over 1 Minute) \*

Time	Resp Rate (bpm)
6pm	28b/m
10pm	25b/m
2 AM	34b/m
6 AM	32b/m

Resp Mod/ Severe Distress None / Mild

Receiving O<sub>2</sub> (l/min) O<sub>2</sub> Saturations (%)

Time	O <sub>2</sub> Sat (%)
6pm	97%
10pm	98%
2 AM	99%
6 AM	100%

Conscious Level Normal / Altered

GCS \*

Time	GCS
6pm	-
10pm	-
2 AM	-
6 AM	-

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

Time	Number of shaded boxes	Pain Score	Observer's Initials
6pm	0	0	RV
10pm	0	0	RV
2 AM	0	0	RV
6 AM	0	0	RV

ACTIONS

NB: Scores 3 should be recorded overleaf

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

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

## CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

### INSTRUCTIONS:

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

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

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

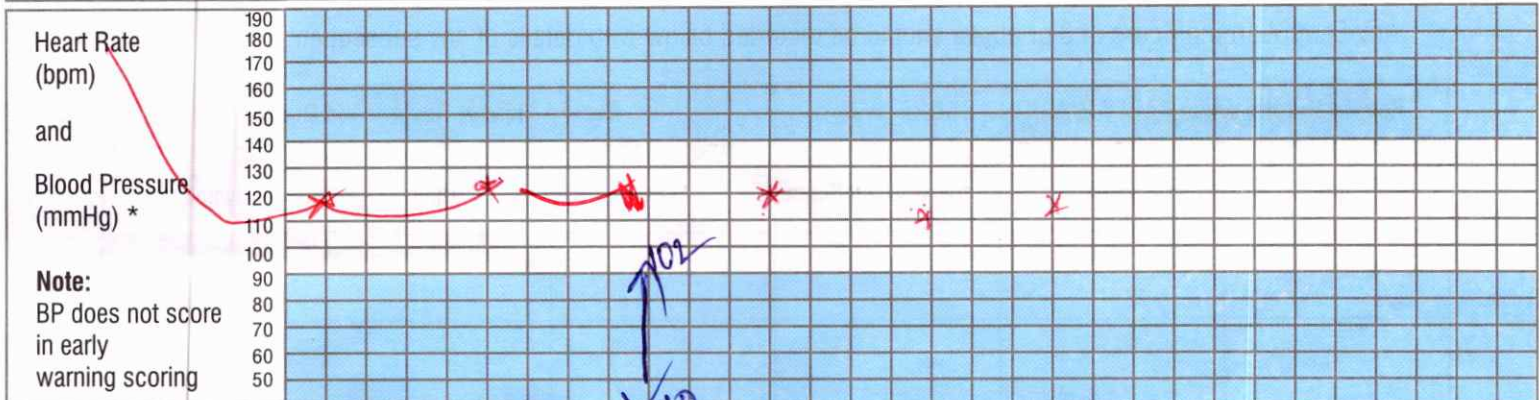
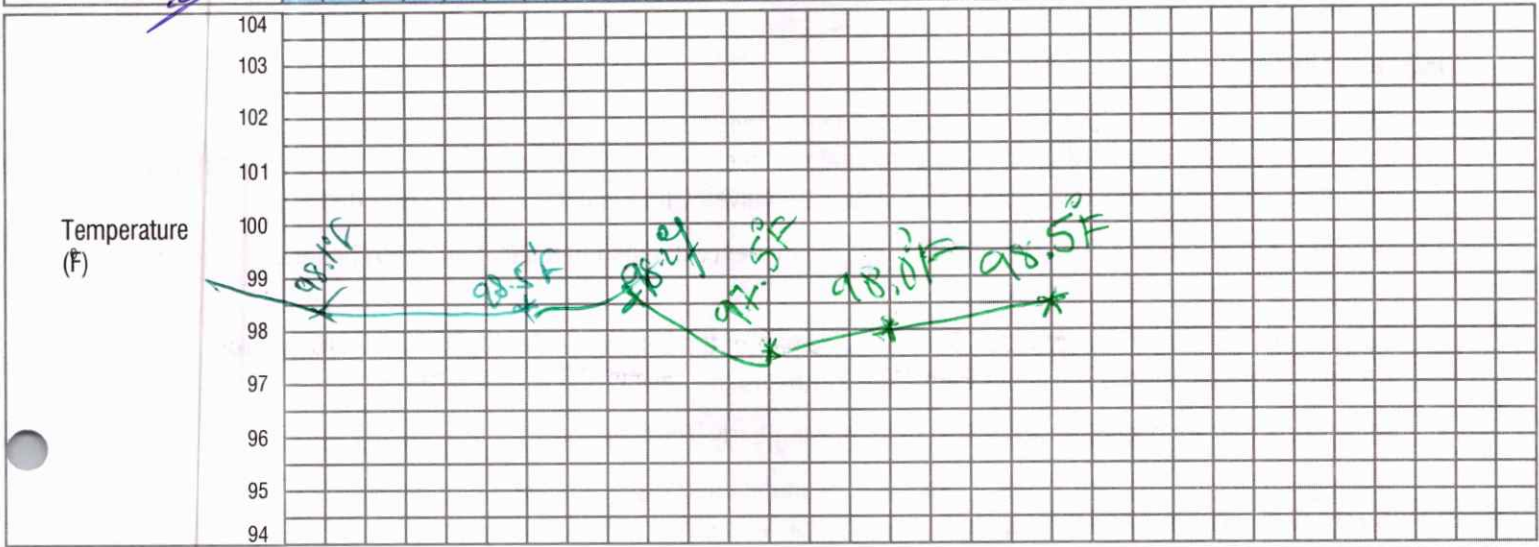
The SBAR communication tool (situation, background, assessment, recommendations) is a helpful mnemonic that can be used to describe a child's clinical condition to a colleague.

<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)

Patient Sticker

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

Date : 2-2-16 Time: 10am 2pm 5pm 10pm 2AM 6AM  
 Doctor / Nurse / Family Concern? \_\_\_\_\_



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

Parameter	10am	2pm	5pm	10pm	2AM	6AM
TOTAL SCORE	0	0	0	0	0	0
Number of shaded boxes	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0
Observer's Initials	AM	SA	SA	SA	SA	SA

**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: Scores 3 should be recorded overleaf

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

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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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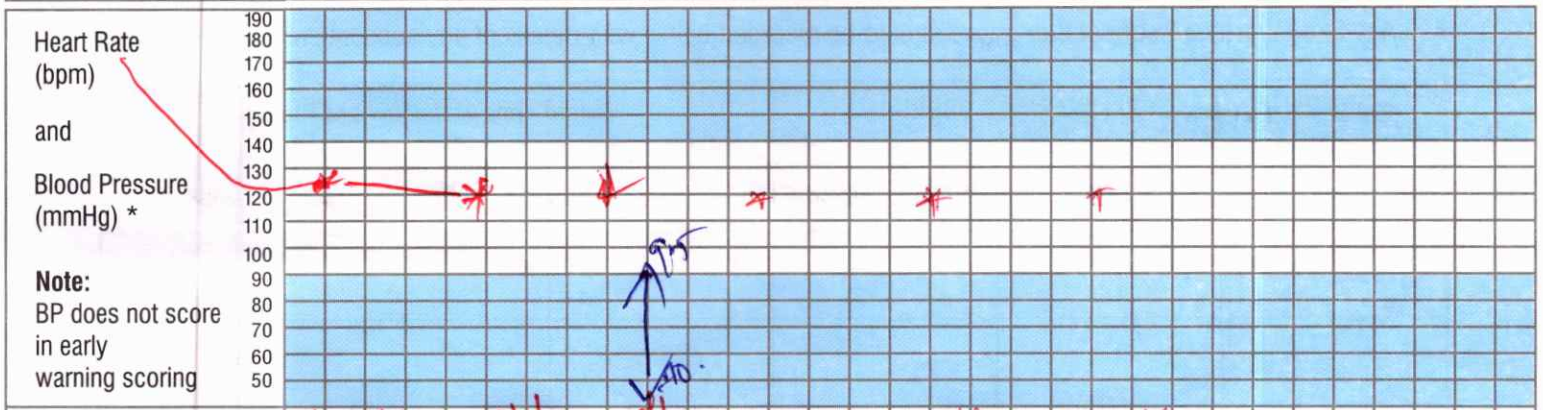
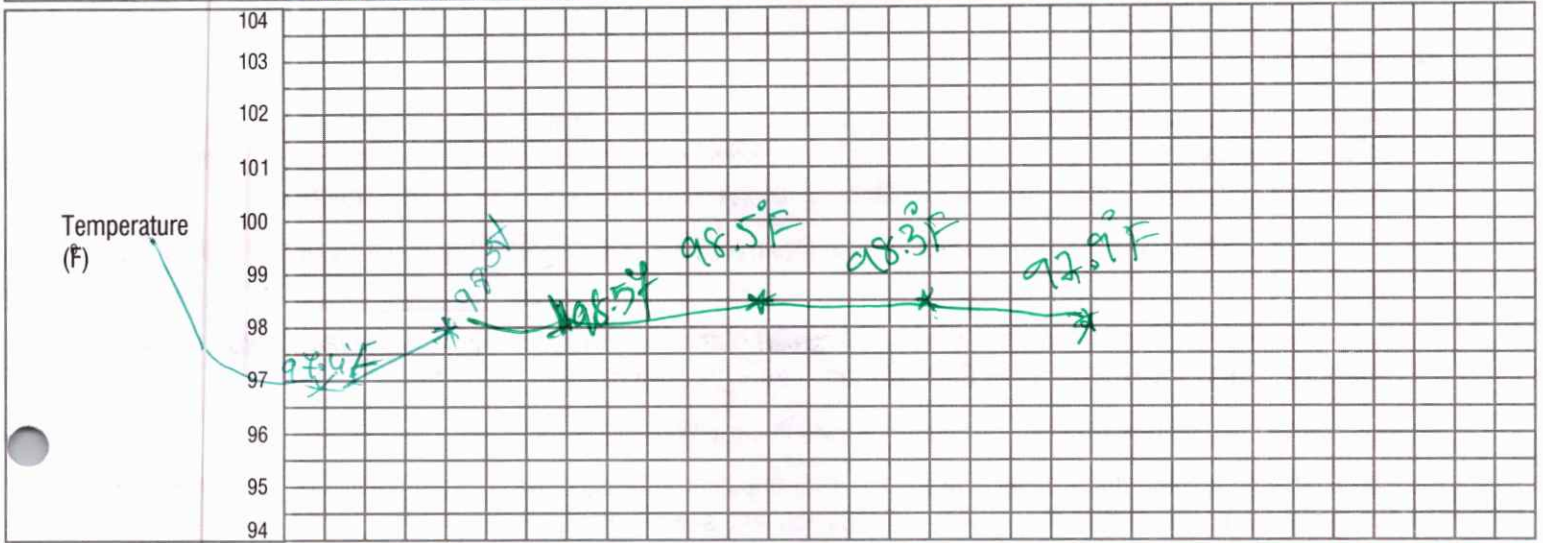
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<b>I</b>	<b>IDENTITY:</b> I am (name), a nurse on ward (X). I am calling about (child X)
<b>S</b>	<b>SITUATION:</b> I am calling because I am concerned that ... (e.g. BP is low/high, pulse is XXX, Temperature is XX, Early Warning Score is XX)
<b>B</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 is there anything I need to do in the meantime? (e.g. stop the fluid/ repeat observation)

Patient Stick

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

Date : 24/6/26 Time: 11:30 am 9pm 6PM 10PM 2AM 6AM  
 Doctor / Nurse / Family Concern? Am



Resp Distress	Mod/ Severe					
	None / Mild					
Receiving O <sub>2</sub> (l/min)	O <sub>2</sub> Saturations (%)	100%	98%	100%	100%	100%
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	Am	Am	Am	Am	Am	Am

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

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

# CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

## INSTRUCTIONS:

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

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

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

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

<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)

MNH-00016109 IP26-00006624  
 Master ABHINAV MISHRA  
 05-04-2025 1 Y 2 M 17 D (M)  
 Dr. ANIKET ANIL PARASHAR



# FLUID CHART

Sheet No. : 10

- 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		
22/6	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>					
22/6	02:00 pm											
	03:00 pm											
	04:00 pm		Jelli	25ml								
	05:00 pm	DNS	H2O	25ml		NA						
	06:00 pm		ORS	25ml								
	07:00 pm			25ml								
<b>Total Intake :</b>						<b>Total Output :</b> U-1 M-2						
22/6	08:00 pm			25ml							0	
	09:00 pm			25ml							0	
	10:00 pm	DNS	Milk	25ml		NA					0	
	11:00 pm			25ml							0	
	12:00 am		H2O	25ml							0	
	01:00 am			25ml							0	
<b>Total Intake :</b>						<b>Total Output :</b> U-2 M-3						
23/6	02:00 am			25ml								
	03:00 am			25ml								
	04:00 am			25ml								
	05:00 am	DNS	Milk	25ml		NA					0	
	06:00 am			25ml								
	07:00 am			25ml								
	<b>Total Intake :</b>						<b>Total Output :</b> U-2 M-2					

**Total 24 hrs. Intake**

**Total 24 hrs. Output**



# FLUID CHART

Sheet No. : 2

- 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			
<u>23/6</u>		↑ DNS	Mouth	I.V	N.G							
	08:00 am			25ml	/	✓		/		0	} <u>23/6</u>	
	09:00 am		idly khichdi	25ml	/	✓		/	✓	0		
	10:00 am			—	NA	✓		NA	✓	0		
	11:00 am			—	/	✓		/	✓	0		
	12:00 pm			25ml	/	✓		/	✓	0		
01:00 pm		25ml	/	✓		/	✓	0				
<b>Total Intake :</b>					<b>Total Output :</b> U-6 M-8							
<u>23/6</u>	02:00 pm	↓ DNS	25ml	/	✓		/		0	} <u>23/6</u>		
	03:00 pm		25ml	/	✓		/	✓	0			
	04:00 pm		25ml	/	✓		NA	✓	0			
	05:00 pm		20ml	/	✓		NA	✓	0			
	06:00 pm		20ml	/	✓		NA	✓	0			
	07:00 pm		20ml	/	✓		NA	✓	0			
<b>Total Intake :</b>					<b>Total Output :</b>							
<u>23/6</u>	08:00 pm	↓ DNS	20ml	/	✓		/		0	} <u>23/6</u>		
	09:00 pm		20ml	/	✓		/	✓	0			
	10:00 pm		20ml	/	✓		NA	✓	0			
	11:00 pm		20ml	/	✓		NA	✓	0			
	12:00 am		20ml	/	✓		NA	✓	0			
	01:00 am		20ml	/	✓		NA	✓	0			
<b>Total Intake :</b>					<b>Total Output :</b> U-1 M-1							
<u>24/6</u>	02:00 am	↓ DNS	20ml	/	✓		/		0	} <u>24/6</u>		
	03:00 am		20ml	/	✓		/	✓	0			
	04:00 am		20ml	/	✓		NA	✓	0			
	05:00 am		20ml	/	✓		NA	✓	0			
	06:00 am		20ml	/	✓		NA	✓	0			
	07:00 am		20ml	/	✓		NA	✓	0			
<b>Total Intake :</b>					<b>Total Output :</b> U-1 M-0							

**Total 24 hrs. Intake**

**Total 24 hrs. Output** U-1 M-0

1NH-00016109 IP26-00006624  
 Master ABHINAV MISHRA  
 15-04-2025 1 Y 2 M 17 D (M)  
 Patient: Dr. ANIKET ANIL PARASHAR



# FLUID CHART

Sheet No. : 3

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
24/6	08:00 am	↑		20ml			✓				0	J
	09:00 am	↑		20ml			✓				0	
	10:00 am	DNS	20ml				✓				0	
	11:00 am	↓		20ml			✓				0	
	12:00 pm	↓		20ml			✓				0	
	01:00 pm	↓		20ml			✓				0	
Total Intake :			taken			Total Output :					0-24-2	
24/6	02:00 pm	↓		20ml			✓				0	J
	03:00 pm	↓		20ml			✓				0	
	04:00 pm	DNS	20ml				✓				0	
	05:00 pm	↓		20ml			✓				0	
	06:00 pm	↓		20ml			✓				0	
	07:00 pm	↓		20ml			✓				0	
Total Intake :						Total Output :					0-24-2	
24/6	08:00 pm	↑		20ml			✓				0	J
	09:00 pm	↑		20ml			✓				0	
	10:00 pm	DNS	20ml				✓				0	
	11:00 pm	↓		20ml			✓				0	
	12:00 am	↓		20ml			✓				0	
	01:00 am	↓		20ml			✓				0	
Total Intake :						Total Output :					0-24-2	
25/6	02:00 am	↑		20ml			✓				0	J
	03:00 am	↑					✓				0	
	04:00 am	DNS					✓				0	
	05:00 am	↓					✓				0	
	06:00 am	↓					✓				0	
	07:00 am	↓					✓				0	
Total Intake :						Total Output :					0-24-	

Total 24 hrs. Intake

Total 24 hrs. Output 0-24-

HNH-00016109 IP26-00006624  
 Master ABHINAV MISHRA  
 05-04-2026 1 Y 2 M 18 D (M)  
 Dr. ANIKET ANIL PARASHAR



# 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			
25/6	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>							

<b>Total 24 hrs. Intake</b>	
-----------------------------	--

<b>Total 24 hrs. Output</b>	
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# NURSING CARE RECORD

Date: 22/6/26

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				NA			
Afternoon	3pm	Assess the pt. condition - Monitor vitals & sugars - Maintain I/O chart - Give medication as prescribed by doctor.	3pm	Assessed the pt. condition - Monitored vitals & sugars - Maintained I/O chart - Given medication as prescribed by doctor	Patient is Stable now	Re-checked vitals	
Night	8pm	Assess the pt condition Monitor vitals & sugars maintain I/O chart. Provide the comfortable position. Medication give as per os as per order.	8pm	Assessed the pt condition Monitored vitals & sugars maintained I/O chart. Provided the comfortable position. Medication given as per os as per order.	pt is stable. vitals okay.	Monitor vitals Maintain I/O Chart.	Sneha 

INH-00018109 IP26-00006624  
 Master ABHINAV MISHRA 1 Y 2 M 17 D (M)  
 15-04-2025  
 Dr. ANIKET ANIL PARASHAR

# NURSING CARE RECORD



Date: ~~23/6/2025~~ 23/6

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

*AFE & dehydration (P) Seizure.*

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8am	- Assess the pt condition	8am	- Assess the pt condition	- Now baby is stable	- Rechecked the v/s	
	10am	- Monitor the v/s	10am	- Monitor the v/s			
Afternoon	2pm	- Maintain the I/O	2pm	- Maintain the I/O	Administered medicine	Reassess the patient	
	2pm	- ct IVF & antibiotics drug as per chart	2pm	- Drug as per chart			
Night	5pm	Assess the baby	5pm	Assess the baby	- pt is stable.	- Monitor vitals	Sneh
	8pm	Monitor the v/s	8pm	Monitor the v/s			
Night	8pm	Administered Meds	8pm	Administered Meds	- pt's roomy	- Maintaining chart	
	8pm	Maintain the chart	8pm	Maintain the chart			



# NURSING CARE RECORD

Date: 24/6/25

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	<ul style="list-style-type: none"> <li>→ Assess the pt. condition</li> <li>→ monitor vitals</li> <li>→ maintain I/O chart</li> <li>→ Administer medication as per drug chart</li> <li>→ IV cannula present</li> </ul>	8am	<ul style="list-style-type: none"> <li>→ Assessed the pt condition</li> <li>→ monitored vitals &amp; recorded</li> <li>→ maintained I/O chart</li> <li>→ medication as per drug chart</li> </ul>	→ baby is stable	→ rechecked vitals	<i>[Signature]</i>
Afternoon	2pm	<ul style="list-style-type: none"> <li>→ Assess the pt. condition</li> <li>→ Monitor vitals &amp; records</li> <li>→ Maintain I/O chart</li> <li>→ Give medication as prescribed by doctor.</li> </ul>	2pm	<ul style="list-style-type: none"> <li>→ Assessed the pt. condition</li> <li>→ monitored vitals &amp; record</li> <li>→ maintained I/O chart</li> <li>→ Given medication as per drug chart</li> </ul>	→ Baby is stable	→ Rechecked vitals	<i>[Signature]</i>
Night	8pm	<ul style="list-style-type: none"> <li>→ Assess the pt condition</li> <li>→ monitor vitals &amp; record</li> <li>→ maintain I/O chart</li> <li>→ provide the comfortable position.</li> </ul>	8pm	<ul style="list-style-type: none"> <li>→ Assessed the pt condition</li> <li>→ monitored vitals &amp; record</li> <li>→ maintained I/O chart</li> <li>→ provided the comfortable position.</li> </ul>	→ Baby is stable.	→ monitor vitals	<i>[Signature]</i>
	8pm	<ul style="list-style-type: none"> <li>→ medication give as per as doctor order.</li> </ul>	8pm	<ul style="list-style-type: none"> <li>→ medication give as per as doctor order.</li> </ul>	→ vitals normal	→ maintain I/O chart.	<i>[Signature]</i>

HNH-00016109 IP26-00006624  
Master ABHINAV MISHRA  
05-04-2025 1 Y 2 M 19 D (M)  
Dr. ANIKET ANIL PARASHAR



Patient St

# NURSING CARE RECORD

Date: 25/6/26

**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							
Afternoon							
Night							



# BRADEN 'Q' SCALE



					Date :	22/6	22/6	22/6	22/6
					Time :	E2	NI	MG	20
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	3	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 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>	28	27	28	28
					<b>Evaluator's Name</b>	AB	my	SA	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 :	25/6/2025	24/6/25	24/6	24/6
					Time :	8 PM	10	12	11
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.	3	3	4	3	
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 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 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>	27	28	28	27
					<b>Evaluator's Name</b>	AN	AN	AN	AN

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



# PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
22/6	4pm	0/10	NA	<input type="checkbox"/> Continuous <input checked="" type="checkbox"/> Intermittent	<input checked="" type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input checked="" type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input checked="" type="checkbox"/> Decreasing	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	NA	[Signature]
23/6	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	[Signature]
23/6	2Am	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	[Signature]
23/6	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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No	NA	[Signature]
23/6	10am	0/10	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	NA	[Signature]
23/6	4pm	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	[Signature]
23/6	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	[Signature]
24/6	2Am	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	[Signature]
24/6	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	[Signature]
24/6	10Am	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	[Signature]

**Re-assessment Frequency:**

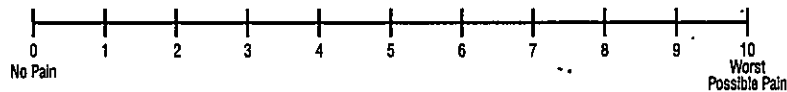
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
  - At least every 2 hours for the first 24 hours
  - Then every 4 hours.
  - Prior to pain relieving intervention.
  - Within 30 – 60 minutes after pain relief intervention.

# PAIN ASSESSMENT TOOLS

## FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

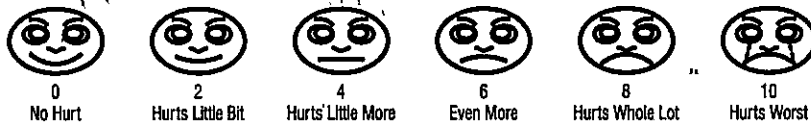
## Numerical Pain Scale (Obstetric and Gynecology)



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

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1		1	2
<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



INH-00016109 IP26-00006624  
 Master ABHINAV MISHRA  
 5-04-2026 1 Y 2 M 17 D (M)  
 Dr. ANIKET ANIL PARASHAR

# PAIN ASSESSMENT FORM



Date	Time	Frequency (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
24/6	8pm	0/10	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	[Signature]
24/6	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	[Signature]
25/6	2Am	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	[Signature]
25/6	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	[Signature]
				<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		

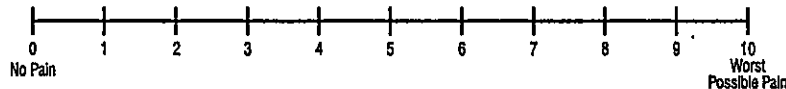
**Re-assessment Frequency:**  
 1. Every eight hours for all hospitalized patients.  
 2. For post-surgical patients, patients with chronic pain, patient with severe pain:  
 a) At least every 2 hours for the first 24 hours      b) Then every 4 hours.  
 c) Prior to pain relieving intervention.     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





# CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	22/6/26 DAY-1			23/6 DAY-2			24/6/26 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	* New 23/6/26
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	0	NA	NA	NA	NA	NA	Cannula done by Sushma at 9 PM
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2		NA	NA	0	NA	NA	NA	NA	NA	* 25/6/26
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	0	NA	NA	NA	NA	NA	@ 3 AM Removed cannula
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	0	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	0	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 : ..... Name : Sushma

Signature of Ward In Charge :  
 Signature : Balanani Name : Balanani

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### NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: <i>AGE &amp; Dehydration.</i>		Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Not Known If Yes Specify: .....					
	Surgery / Procedure:		Post OP Day:					
BACKGROUND	Date	<i>22/6/26</i>	<i>22/6</i>	<i>23/6</i>	<i>23/6</i>	<i>23/6</i>	<i>24/6/26</i>	
	Shift	<i>E2</i>	<i>N1</i>	<i>N1</i>	<i>SD</i>	<i>N1</i>	<i>ntb</i>	
	Medical Condition (Any special condition to be noted):	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	
ASSESSMENT	Diet:	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	
	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	
	Ventilation (RA, NP, NIV, VENTI):	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	
	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>97.8F</i>	<i>98.2F</i>	<i>98.3F</i>	<i>98.4F</i>	<i>98.2F</i>	<i>97.2F</i>
		Res:	<i>28b/m</i>	<i>28b/m</i>	<i>28b/m</i>	<i>26</i>	<i>28b/m</i>	<i>28b/m</i>
		SpO <sub>2</sub> :	<i>100%</i>	<i>99%</i>	<i>99%</i>	<i>100%</i>	<i>99%</i>	<i>100%</i>
		Pulse:	<i>138b/m</i>	<i>132b/m</i>	<i>132b/m</i>	<i>124</i>	<i>132b/m</i>	<i>130b/m</i>
		BP:	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>
		LOC:	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>
Fall Risk Score:		<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	
Pain Score:	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>		
Skin Integrity	<i>-</i>	<i>-</i>	<i>Good</i>	<i>-</i>	<i>-</i>	<i>-</i>		
Recommendations	Safety Needs:	<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	
	Physiotherapy:	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	
	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:	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	
	Critical Lab Test / Values:	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	
	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	
	ADL (Dependent / Non Dependent):	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	
Post Operative Procedure Special Orders:	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>		
Handed Over By Name :	<i>Priyanka</i>	<i>Sneha</i>	<i>Suranda</i>	<i>Amit</i>	<i>Sneha</i>	<i>Riya</i>		
Signature / ID :	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>		
Date:	<i>22/6/26</i>	<i>23/6</i>	<i>23/6/26</i>	<i>23/6</i>	<i>24/6</i>	<i>24/6/26</i>		
Time:	<i>8pm</i>	<i>8pm</i>	<i>8pm</i>	<i>8pm</i>	<i>8pm</i>	<i>8pm</i>		
Taken Over By Name :	<i>Sneha</i>	<i>Suranda</i>	<i>Amit</i>	<i>Sneha</i>	<i>Amit</i>	<i>Riya</i>		
Signature / ID :	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>		
Date:	<i>22/6/26</i>	<i>23/6/26</i>	<i>23/6</i>	<i>23/6</i>	<i>24/6/26</i>	<i>24/6/26</i>		
Time:	<i>9pm</i>	<i>8am</i>	<i>8pm</i>	<i>8pm</i>	<i>8pm</i>	<i>2pm</i>		



## NURSING SHIFT HAND OVER FORM

<b>SITUATION</b>	Diagnosis: <u>AGE T dehydration</u>	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Not Known If Yes Specify: .....						
	Surgery / Procedure:	Post OP Day:						
<b>BACKGROUND</b>	Date	24/6	24/6					
	Shift	E2	N1					
	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 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	
	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:	98.5 f	98.6 f				
		Res:	38 b/m	38 b/m				
		SpO <sub>2</sub> :	99%	99%				
		Pulse:	110	140 b-				
		BP:	/	/				
		LOC:	-	/				
		Fall Risk Score:	-	/				
	Pain Score:	-	/					
	Skin Integrity	/	/					
<b>Recommendations</b>	Safety Needs:	<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	
	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	
	PU Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
DVT Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
ADL (Dependent / Non Dependent):	-	/						
Post Operative Procedure Special Orders:		-	/					
Handed Over By Name :		Sudh	Sudha					
Signature / ID :		[Signature]	[Signature]					
Date:		24/6/20	25/6					
Time:		2 PM	8 AM					
Taken Over By Name :		Sudha	Sudha					
Signature / ID :		[Signature]	[Signature]					
Date:		24/6						
Time:		8 PM						

HNM-00015109  
 Master ABHINAV MISHRA  
 05-04-2025 1 Y 2 M 17 D (M)  
 Dr. ANIKET ANIL PARASHAR

219

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

BirthRight  
 BY RAINBOW HOSPITALS  
 Your Right to a Safe Delivery

# NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 22/6/26 Time: 5:20pm

Weight: 8.9kg Centile: 25<sup>th</sup>

Height: Centile:

Inference: underweight child

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

Diet Recommendations: Gaskara Diet

Re-Assessment: Avoid spicy, chilli & outside foods

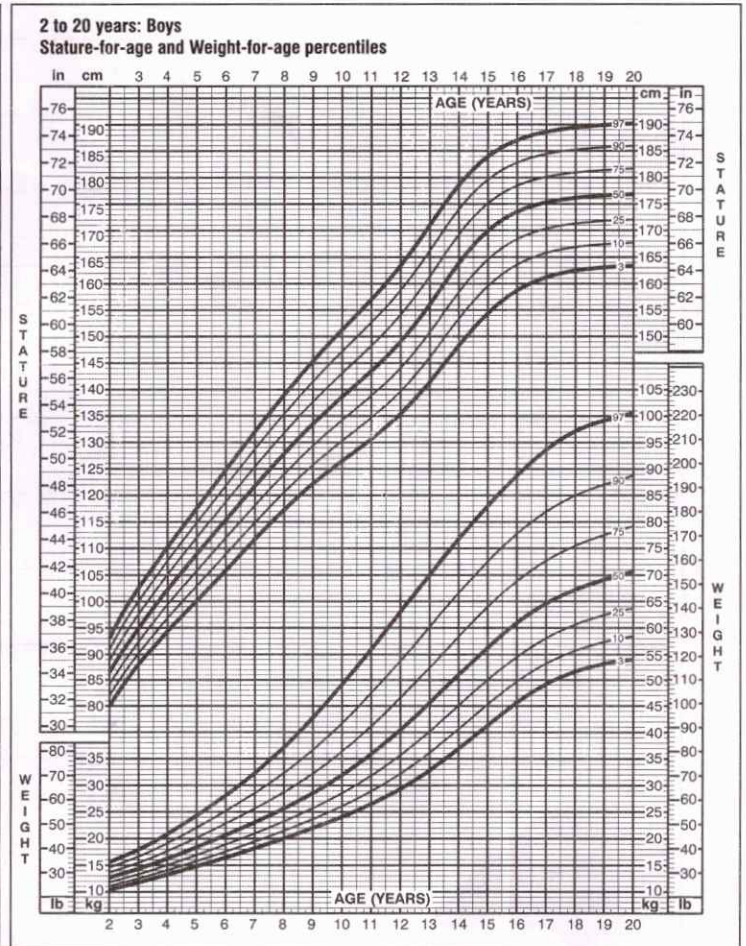
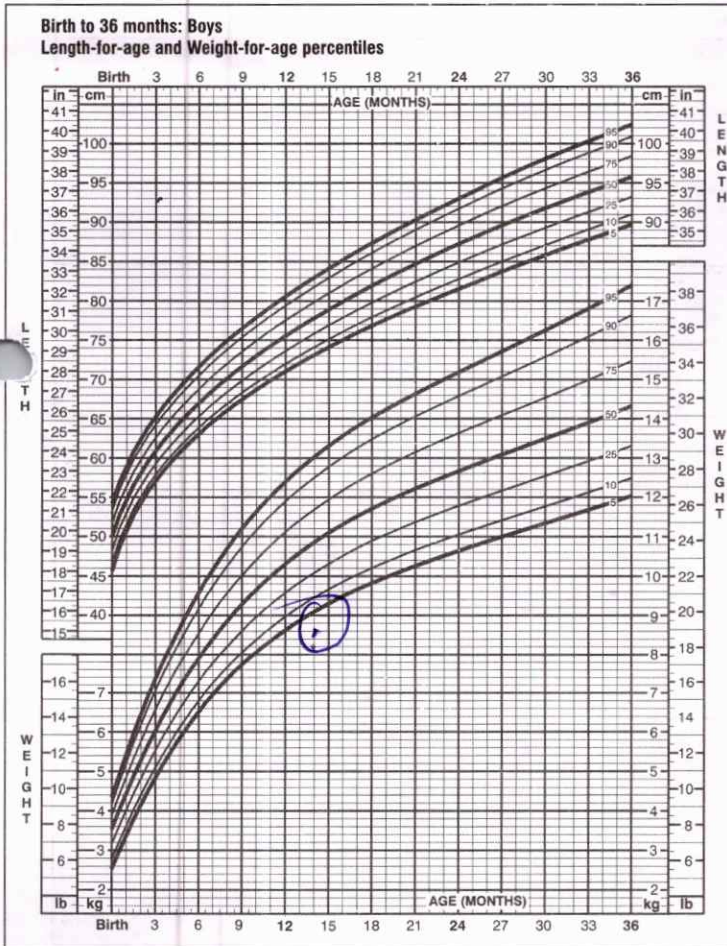
Food Allergies: No Veg/Non-veg: veg

Diagnosis: AGE E Dehydration & complex febrile seizures

Nutritional Intervention -  Oral  Enteral  Parenteral

Patient's Signature: [Signature]

## GROWTH CHART (BOYS)



Dietician's Name: Sathwika-G

Dietician's Signature: [Signature]



wt - 8.9 kg

# EMERGENCY ROOM TRIAGE FORM

Patient's Name : Abhinav Age : 1 yr 4 month Gender :  Male  Female

Date : 22/6/26 Time of Arrival : 11:00pm

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: 98.7°F PR: 100b/m BP: ..... RR: ..... SpO<sub>2</sub>: 100%

Chief Complaints: fever, vomiting since 2 days, loose stools

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

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

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

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:**

- 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 : Bhargava

Signature of Triage Nurse : [Signature]

Date & Time : 22/6/26 @ 11:2pm



## NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 22/6/26 Time of arrival : 1:14pm

Chief Complaints: do fever since 4 days

Height : ..... Weight : 8.9kg 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 .....

<p><b>RISK FOR FALL:</b></p> <p>If patient is &lt; 6 years <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No          If 'Yes' tick below fall risk intervention directly</p> <p>If Patient is &gt; 6 years          If 'Yes' Assess the below parameters</p> <p>History of Falling: within past 3 months <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p><b>Ambulatory Aids:</b></p> <ul style="list-style-type: none"> <li>• Wheelchair <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</li> <li>• Uses furniture for support <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</li> </ul> <p><b>Gait/Transferring:</b></p> <ul style="list-style-type: none"> <li>• Bedrest / immobile <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</li> <li>• Weak <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</li> <li>• Impaired <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</li> </ul> <p><b>Mental Status:</b> Forgets limitations <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p><b>IF YES FOR ANY CATEGORY = RISK FOR FALLING</b></p> <p><b>Fall Risk Intervention:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Escort while ambulating</li> <li><input checked="" type="checkbox"/> Assist Patient</li> <li><input checked="" type="checkbox"/> Educate patient and family on fall precautions/prevention</li> </ul>	<p><b>Functional Screening:</b> <input checked="" type="checkbox"/> No Abnormalities Detected</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Mobility Problem</li> <li><input type="checkbox"/> Walking Problem</li> <li><input type="checkbox"/> Developmental Delay</li> <li><input type="checkbox"/> Musculoskeletal Congenital Abnormality</li> </ul> <p><b>Inform consultant for positive criteria</b></p> <p><b>Nutritional Screening:</b> <input checked="" type="checkbox"/> No Abnormalities Detected</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Underweight</li> <li><input type="checkbox"/> Overweight</li> <li><input type="checkbox"/> Feeding Problem</li> <li><input type="checkbox"/> Special diet</li> <li><input type="checkbox"/> Special feeding method</li> </ul> <p><b>Inform consultant for positive criteria</b></p>
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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 Care Plan (Including Labs / Medications / Other Care):**

Time	Nursing Notes
11:50pm	Assess the pt condition monitor the vitals

Samples collected by: / Sugandha  
 Samples sent by : / Sugandha

Time: / 21:30pm  
 Time: / 21:30pm

**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: 110b/m BP: ..... CFT: ..... RR: ..... SPO2 at FiO2: 100% GCS: ..... Temperature : 98.1°F Pain Score: ..... Repeat RBS (if applicable): .....	Shift - out from ER to: ward Time of Shift - out: 3pm Handover given to: Priyanka (Nurse's Name)


Tick as applicable:  MLC  LAMA  BROUGHT DEAD

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

Name of the Nurse : Shargan Signature of the Nurse : B

Date & Time : 22/6/2020

# PATIENT TRANSFER FORM

HNH-00016109 IP26-00006624 Master ABHINAV MISHRA 05-04-2025 1 Y 2 M 17 D (M) Dr. ANIKET ANIL PARASHAR 		Date & Time of Admission 22/6/26 @ 1.43 pm	Date & Time of Transfer Order 22/6/26 @ 3 pm
Treating Consultant Name		Transfer Ordered by Dr - Nalpunya	Reason for Transfer ADMISSION
From Unit ER	To Unit ward	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File 251-	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant Yes <input 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 type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring Bhargava		Name of Person Ordered Transfer Dr. Nalpunya	
Patient & Clinical Records Received by : Biswantha			
Date & Time of Patient Received : 22/6/26 @ 3pm.			

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