

DISCHARGE SUMMARY

Name	Baby SITARA THOMMANDRU	UHID	LBH-00027884
Father/Guardian	Mr SANTOSH	Age/Gender	6 Y 11 M 11 D/ Female
Address	1-2-217/3/a, c-1 hari recidency DOMALAGUDA, Domalguda, Hyderabad, Telangana, INDIA, 500029		
IP No	IP26-00006656	Admission Date	26-06-2026
Ref Doctor	Self.		
Discharge Date	28.06.2026		

Consultant:
Dr. PRITESH NAGAR
MBBS MD
Medical Registration No. 47184

DIAGNOSIS	ICD CODE
INFLUENZA A ILLNESS WITH DEHYDRATION	

History: Baby SITARA THOMMANDRU is a 6 Y 11 M 11 D , old girl presented with history of loose stools (8-10 episodes/day) associated with 7-8 episodes of non bilious, non projectile vomiting and fever since 2 days, decreased oral intake since 2 days, prior to admission. For the above complaints she was admitted at Rainbow Children's Hospital - for further management.

Name	Baby SITARA THOMMANDRU	UHID	LBH-00027884
IP No	IP26-00006656	Admission Date	26-06-2026

Outside investigations: Done on 25.06.2026: Complete urine examination was : Pus cells - 6-8, RBCS - 18-20.

GeneXpert FluB+RSV were sent, which was negative.

FluA - were sent, which was positive

Examination: She was afebrile, maintaining saturations at room air. Her heart rate was 112/min and RR - 20/min. On examination Signs of some dehydration were present, dry lips, dry oral mucosa, sunken eyes were present. On auscultation of chest, air entry was bilaterally equal with normal heart sounds and there was no heart murmur. Abdomen was soft, non tender without organomegaly. On neurological examination, she was conscious & alert. Pupils were bilaterally equal & reacting to light. There were no focal neurological deficits.

Weight on admission: 16 kilo grams.

Investigations: Enclosed reports.

Initial hemogram showed Hemoglobin of 13.6 gm%, White Blood Cell count of 3390 cells/cumm, platelet count of 1.82 lakhs/cumm and C-Reactive Protein of 6 mg/l. Complete urine examination shows 4-6 pus cells, 3-5 epithelial cells. Chest X ray was normal.

Management: She was admitted in the ward and started on intra venous fluids. She was treated symptomatically with antiemetics, antacids and

Name	Baby SITARA THOMMANDRU	UHID	LBH-00027884
IP No	IP26-00006656	Admission Date	26-06-2026

antipyretics. In view of Flu A positive child empirically started on Oseltamivir.

She was regularly monitored for her loose stool frequency and hydration status. Her loose stools and other symptoms settled gradually.

She remained hemodynamically stable throughout the hospital stay and is being discharged with the following advice.

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

Medications given during hospital stay:

Injection. Ondansetron
Injection. Esmoprazole
Syrup. Fluvir
Syp. Domperidome

Advice:

* Diet as advised.

Name	Baby SITARA THOMMANDRU	UHID	LBH-00027884
IP No	IP26-00006656	Admission Date	26-06-2026

S.No	MEDICATION	DOSE	TIMINGS	DURATION
1	Syrup. FLUVIR (OSELTAMIVIR - 5ml/60mg)	4ml	9am-9pm (after food)	For 4 days.
2	Domperidone suspension(1mg/ml)	3ml		SOS
3	Nasoclear nasal drops, 2 drops in each nostril SOS for nose block			

Fever Management

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

Review consultation with Dr. PRITESH NAGAR on Monday at Himayatnagar in OPD, with prior appointment (**Review consultation will be charged**).

Food instructions while taking medications:

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

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

Name	Baby SITARA THOMMANDRU	UHID	LBH-00027884
IP No	IP26-00006656	Admission Date	26-06-2026

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

Parent/ Attender

In case of emergency contact 9154865030 emergency pediatrician on duty.

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

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


Registrar/Resident/C.M.O



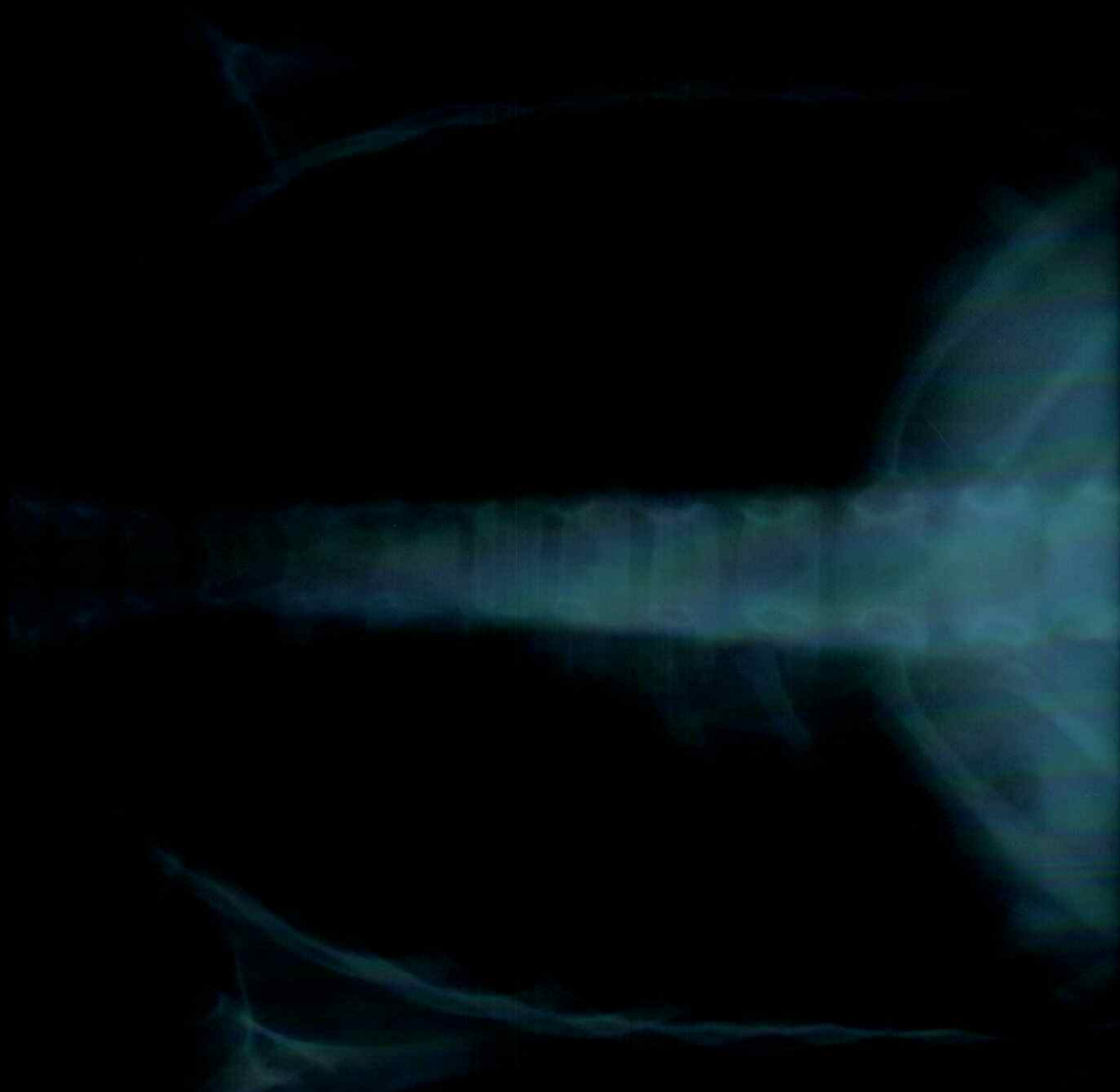
Dr. PRITESH NAGAR
MBBS MD
Medical Registration No. 47184

AGE is Dehydration

RAJESH KUMAR CHOMMANDRU 5Y 11M 11D FLBH 00027884 CHEST PA 25-106-26 12.01.20

RAINBOW CHILDREN'S HOSPITAL, HIMAYATH NAGAR

РАЈИВОВ, СЕЉДРЕВ, С. БОСПИТАЛНИМАЈАТИНАГАЈЕ
РАЈИВОВ, С. БОСПИТАЛНИМАЈАТИНАГАЈЕ




R



ACTIVITY RECORD FOR BILLING

LBH-00027884 IP26-00006656
Baby SITARA THOMMANDRU
15-07-2019 6 Y 11 M 11 D (F)
Dr. PRITESH NAGAR

Name: -----

UHID No: ---  ----- Consultant: ----- Dept: -----

Date of Admission: 26/06/20 Time: 11:38 AM Date of Discharge: ----- Time: -----

Room / Bed No: 201/201 Ward: 214 Suggested Billable bed type: -----

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
<u>26/06/20</u>	<u>12:00 pm</u>	<u>ER</u>	<u>W005/214</u>	<u>[Signature]</u>

Cross Consultation Visit

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



INVESTIGATIONS

Date	Investigations	Order No.	Sign
26/06/26	CBP, CRP Chest X-ray VBG	0378 7584 10377	
26/6	CF (du)	20	
Cross checked by Sneha on 27/6/26 at 11:00			

Ref.No. F/IN/PR/10



**Rainbow[®]
Children's
Hospital**

**PEDIATRIC IN-PATIENT
MEDICAL RECORD**

Patient Name : _____ LBH-00027884 IP26-00006656
Baby SITARA THOMMANDRU
Patient ID# : _____ 15-07-2019 8 Y 11 M 11 D (F)
Dr. PRITESH NAGAR
Consultant : _____
Final Diagnosis : _____

Pediatric Multiorgan History & Physical Examination

LBH-00027884

IP26-00006656

Baby SITARA THOMMANDRU

15-07-2019 6 Y 11 M 11 D (F)

Dr. PRITESH NAGAR

Name : _____ Age/Sex _____

Informant _____ Reliability _____



Chief Presenting Complaints & Duration (Chronologically):

ClO fever. since 2 days.

ClO Vomiting since 2 days.

ClO loose stools since 1 day

History of present illness : ClO decreased oral intake. x 2 days

pt was apparently alright 2 days before then had fever on/off type, high degree, not also shills, rigors.

ClO vomiting (7-8 episodes) since 2 days non-projection, contain food particles.

ClO loose stools (8-10 episodes / day) since 1 day, non-blood tinged, watery

ClO decreased oral intake since 2 day

OPD 2mv (25/6)

PLU PANEL - Influenza A positive.

CUG - 6-8 pus cells
18-20 RBC.

Pediatric Multiorgan History & Physical Examination

LBH-00027884 IP26-00006656
Baby SITARA THOMMANDRU
15-07-2019 6 Y 11 M 11 D (F)
Dr. PRITESH NAQAR



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

Nothing significant.

Birth & Neonatal History :

T/AGA/CIAB.

Birth & Socio Economic History :

About Father : _____

About Mother : _____

Any additional Information : _____

Developmental History :

Developmentally normal.

Immunization History :

upto date till 5 years of age. acc to NIS.

Pediatric Multiorgan History & Physical Examination

LBH-00027884 IP26-00006656
Baby SITARA THOMMANDRU
15-07-2019 8 Y 11 M 11 D (F)
Dr. PRITESH NAGAR



Anthropometry

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

Weight (kgs) 16 kg (Centile _____)

On Examination :

Temperature : 99.8 F Pulse Rate: 112 bpm Description _____

B.P. _____ SPO2 98% at RA

Resp. rate and type of breathing : 20 bpm

Rash _____ dry lips
dry oral mucosa

Lymphadenopathy _____ Sunken eyes

Oedema : _____

Respiratory system :

Inspection (any s/o distress) : _____

Air entry & breath sounds : BIL AE (+)

Any addes sounds : BIL NVRS.

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

Cardiovasclular System :

Inspection of procordium : _____

Heart Sounds : S1S2 heard.

Any murmur : no murmur

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

Per Abdomen :

Inspection _____

Palpation : Soft nontender

Ausculation : no organomegaly

Spine: _____ External Genitalia : _____

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

Pediatric Multiorgan History & Physical Examination

LBH-00027884 IP26-00006656
Baby SITARA THOMMANDRU
15-07-2019 8 Y 11 M 11 D (F)
Dr. PRITESH NAGAR



Central Nervous System :

Level of Consciousness : AVPU/GCS Score : _____

Cranial Nerves : _____

↑
②

Motor System :

Nutrition : _____

Tone : _____ Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

②

Reflexes :

DTR

Superficials :

Plantars _____

Sensory System :

②

Bladder / Bowel : _____

Clinical Summary & Diagnostic :

Influenza A illness
AGE ± dehydration

Pediatric Multiorgan History & Physical Examination

LBH-00027884 IP26-00006656
Baby SITARA THOMMANDRU
15-07-2019 8 Y 11 M 11 D (F)
Dr. PRITESH NAGAR



Preventive aspects of the treatment :

Desired goals of the treatment :

Planned Labs :

Planned Management :

CBP, CRP
chest X-ray
VBG

Syp. FLUVIR. 4ml BID
IVF DNS 2/3 Maintenance
Syp Crocin DS (240/5)
5ml.
Syp. ibugesic. 4ml.

ALB shisimur

ALB shisimur

Please fill up the following details

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

Doctor's Signature Name 
Consultant Pediatrician & Intensivist
Reg. No: 47184

Date 28/6/26 Time 5pm

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	C/S/B Dr. pritesh	
26/6 5:00pm	Influenza A illness & dehydration	
	fever (+)	Plan
	oral intake - poor.	- Cont fluvir syp
	Vitals - stable.	- Cont IVF
	R/S NAID.	- Cont symptomatic treatment
	PLA	- Encourage orally
		- Monitor vitals
		- Pomstel 30min. before fluivir
		- Stop end em -
		- COE to send raw


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

(Signature)

N/B Sehe

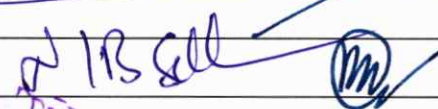


PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
27/6/26	c/s/b Dr. Pritesh	
<u>9:15 AM</u>	Δ - Influenza A illness.	
	① fever better	
	② $\text{kg} \uparrow$	
	③ Oral intake - fair.	
	VE vitals stable.	<div style="border: 1px solid black; padding: 2px; display: inline-block;">Plan</div>
	VE - WNL.	① Dulcolax 5mg PR supp. stat.
		② Ct. fluvid.
		③ Probable D/S
		for admission - today
		Discharge @ request
		

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

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
27/6/26. 5pm	c/s/by dr's pritesh Mylase A illm.	
	Intake - Modest 1 episode vomiting.	
	Not passed stools	
	<u>vital stable</u>	<u>Plan</u>
		- ct fluids
		- Enhance orally
		- Give rich fruits/vegetables
		- Toilet training/life style Modification
		- * MUOUT - stat from Tomorrow
		- <u>NEOTONIC ENEMA P/R</u> stat
		
		<p>Dr. Pritesh Nagar Consultant Pediatrician & Intensivist Reg. No. 47184</p>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
28/6/26	c/s/by Dr pritch	
	Hymn A illon.	
	stool paud - night	
	no distre.	
	vfab stable	flavis total x 5 days
	S/E NAD	- MOVOUT (d/s)
		(1 scoop)
		- fluvaxime aft 2wk
		- plan
		- Tody (d/s)

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

LBH-00027884 IP26-00006656
 Baby SITARA THOMMANDRU
 15-07-2019 6 Y 11 M 11 D (F)
 Dr. PRITESH NAGAR



MEDICATION RECONCILIATION FORM

Drug Allergies: Nil Not known any Drug Allergies

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

Shifting From: ER Shifted to: ICU (214)

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. Maydanya

Date & Time: 26/06/26 @ 4:55 AM

Nurse Name & Signature: Atomi @ [Signature]

Date & Time: 26/06/26 @ 12 pm

Handwritten notes at the top of the page, including the word "separation" and other illegible text.

Handwritten notes on the left side of the page, including the word "method" and other illegible text.

Handwritten text "EN" located in the lower-left quadrant of the page.

Handwritten text "June 1941" located in the lower-right quadrant of the page.

Handwritten text "11/1" located near the bottom center of the page.



DRUG CHART

Date of Admission: 26/06/26 Drug Allergies: N/A Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

SOS / PRN (As Required Medication)

DRUG: Syp. Cocain DS				Date/Time																
Dose	Route	Frequency	Start Date																	
5ml	PO	SOS	26/6																	
Doctor's Signature		Valid Period	Pharm.																	
[Signature]		>100F	[Signature]																	
Additional Instructions:																				

DRUG: Syp. ibugesic.				Date/Time																
Dose	Route	Frequency	Start Date																	
4ml	PO	SOS	26/6																	
Doctor's Signature		Valid Period	Pharm.																	
[Signature]		>102F	[Signature]																	
Additional Instructions:																				

DRUG: IM ONDANSETRON				Date/Time																
Dose	Route	Frequency	Start Date																	
2mg	IV	SOS	27/6/22																	
Doctor's Signature		Valid Period	Pharm.																	
[Signature]																				
Additional Instructions:																				
Dilute in 4cc NS.																				

Verified by Dr. Dhakshayani

VERIFIED BY Name

REGULAR PRESCRIPTIONS

Weight: 16 kg Ward:

DRUG : syr. FLUVIR.

Date/Time 26/6 27/6 28/6

Dose	Route	Frequency	Start Date
4ml	PO	BD	26/6

Name & Signature of the Doctor Starting the Drugs:
 @neef

10am 12pm
 @neef @neef @neef

Additional Instructions:

10pm 11pm
 @neef @neef

Daily Doctor's Endorsement by a Sign

DRUG : 2mg ONDANSETRON

Date/Time 26/6

Dose	Route	Frequency	Start Date
2mg	IV	TID	26/6

Name & Signature of the Doctor Starting the Drugs:
 @neef

2mg 12:30pm
 @neef

Additional Instructions:

Stop
 Pruthi

Daily Doctor's Endorsement by a Sign

DRUG : 2mg ESCMAPRAZOLE

Date/Time 26/6 27/6

Dose	Route	Frequency	Start Date
16mg	IV	OD	26/6

Name & Signature of the Doctor Starting the Drugs:
 @neef

6am 11am
 @neef @neef

Additional Instructions:

Stop
 27/6
 R

Daily Doctor's Endorsement by a Sign

DRUG : Dom PERIDOME sup

Date/Time 26/6 27/6 28/6

Dose	Route	Frequency	Start Date
3ml	PO	BD	26/6

Name & Signature of the Doctor Starting the Drugs:
 Pruthi

9:30am 12:30pm
 @neef @neef

Additional Instructions: (1mg/ml)
 30 mins before Fluvir

@neef @neef

Daily Doctor's Endorsement by a Sign

Verified by Dr. Dhakshayani

Verified by Dr. Dhakshayani

Verified by Dr. Dhakshayani



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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
26/6/26	10 AM	Dulcolax suppository (5mg)		P/R	[Signature]	Amritha Babu
		PROCTOCYSTS ENEMA		P/R	[Signature]	
27/6/26	5pm	NEOTONIC ENEMA	20ml stat	P/R	[Signature]	[Signature]

LBH-00027884 IP26-00006656
 Baby SITARA THOMMANDRU
 15-07-2019 6 Y 11 M 11 D (F)
 Dr. PRITESH NAGAR

214
 208



RESULT SHEET

Date	26/6/26				
Time					
Hb	13.6				
PCV	38.9				
RBC	4.95				
WBC	3.39				
N/L	74.7/21.5				
Platelets	182				
CRP	6				
ESR					
PCT					
RBS					
Na					
K					
Cl					
Ca/Mg					
Phosphate					
Urea					
Creatinine					
ALP					
SGPT					
SGOT					
T.Bill/Conj					
T.Protein					
S.Albumin					
S.Globulin					
A/G Ratio					
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein / Sugar					
Cells					
N/L					

LBH-00027884 IP26-00006656
 Baby SITARA THOMMANDRU
 15-07-2019 6 Y 11 M 11 D (F)
 Dr. PRITESH NAGAR

WAL / 126

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

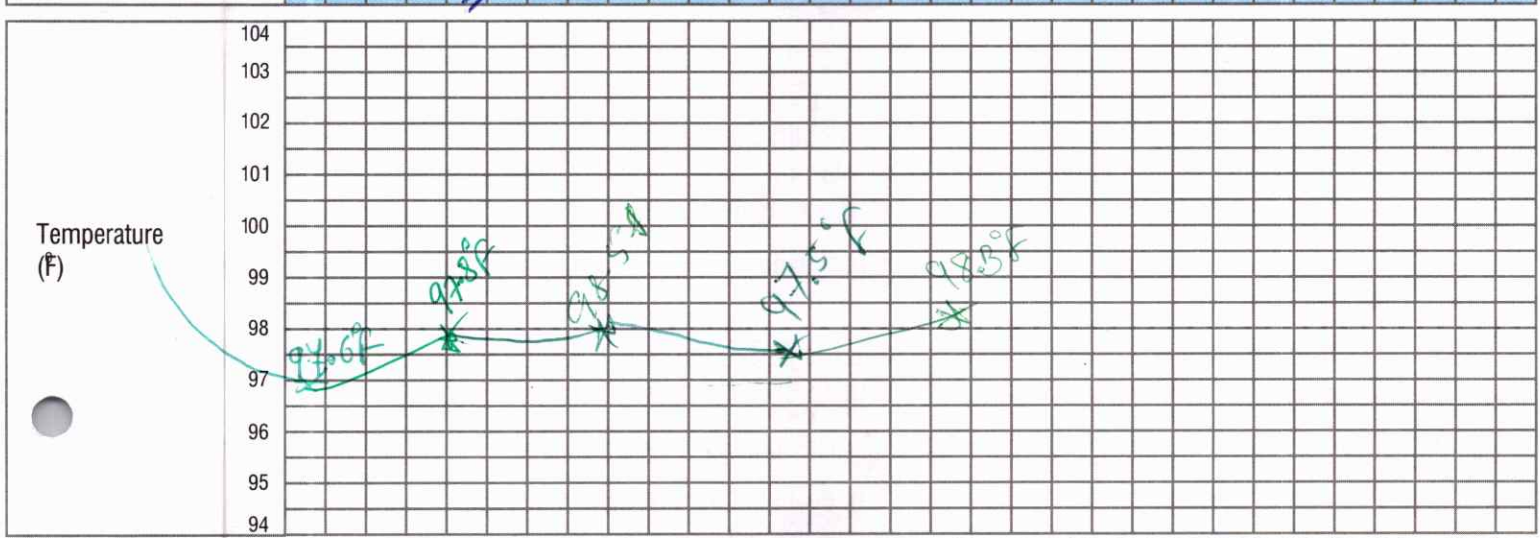


Patient Stic



WARNING SCORE: CHILDREN'S UNIT

Date : 25/6/26 Time: 4pm 5pm 10pm 2Am 6Am
 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)
4pm	112b/m	98/71
5pm	118b/m	102/70
10pm	96b/m	98/50
2Am	103b/m	91/61
6Am	80b/m	90/67

Resp. Rate (bpm) (Over 1 Minute)

Time	Resp Rate (Number)
4pm	20/r
5pm	28b/h
10pm	21b/m
2Am	28b/m
6Am	20b/h

Resp Distress	Mod/ Severe	None / Mild
Receiving O ₂ (l/min)	98% 99% 100% 100% 90%	
O ₂ Saturations (%)		
Conscious Level	Normal	Altered
GCS *		

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

ACTIONS

NB: Scores 3 should be recorded overleaf

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

LBH-00027884 IP26-00006656
 Baby SITARA THOMMANDRU 6 Y 11 M 13 D (F)
 15-07-2019
 Dr. PRITESH NAGAR

No. : RCH/ FRM / CLINICAL / 126

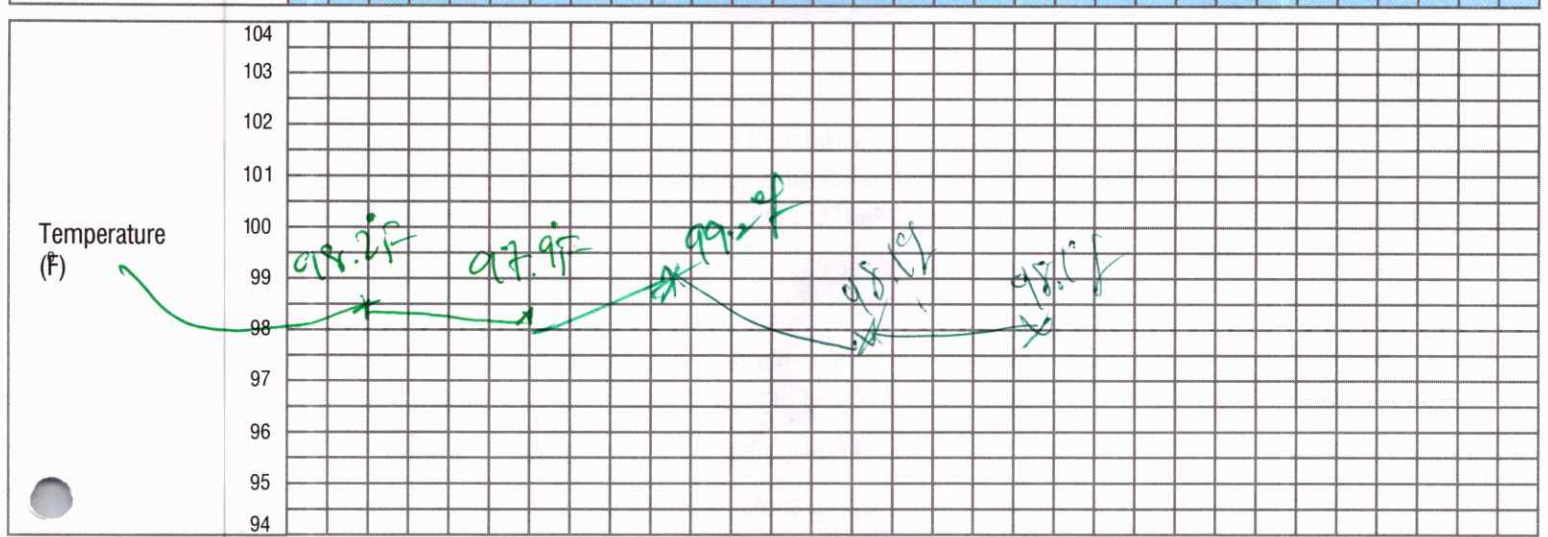
SCHOOL AGE (5-12 years)
Children's Observation & Early Warning Scoring Chart

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 15/6/26 Time: 2pm 6pm 10pm 2Am 6Am
 Doctor / Nurse / Family Concern?



Heart Rate (bpm)	Blood Pressure (mmHg) *
100	100/63
102	102/65
92	92/64
150	150/61
102	102/60

Note: BP does not score in early warning scoring

Heart Rate (Number)
102b/m
100b/m
102b/m
92b/m
102b/m

Resp. Rate (bpm) (over 1 Minute) *
23
25
26
25
25

Resp Rate (Number)
23b/m
25b/m
26b/m
25b/m
25b/m

Resp Distress	Mod/ Severe	None / Mild

Receiving O ₂ (l/min)	O ₂ Saturations (%)
	100+
	100+
	100+
	100+
	100+

Conscious Level	Normal	Altered

GCS *
15/15

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

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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



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				
	08:00 am													
	09:00 am													
	10:00 am													
	11:00 am													
	12:00 pm	DNS	H2O	35ml	NA									
	01:00 pm			35ml										
Total Intake : <i>taken</i>						Total Output :								
	02:00 pm			35ml										
	03:00 pm			35ml										
	04:00 pm	DNS	Fluicel	35ml										
	05:00 pm		H2O	25ml	NA	NP								
	06:00 pm			25ml										
	07:00 pm			25ml										
	Total Intake :						Total Output :							
	08:00 pm			25ml										
	09:00 pm			25ml										
	10:00 pm			25ml										
	11:00 pm	DNS	Rice	25ml										
	12:00 am		H2O	25ml										
	01:00 am			25ml										
	Total Intake :						Total Output :							
	02:00 am			25ml										
	03:00 am			25ml										
	04:00 am	DNS		25ml										
	05:00 am			25ml										
	06:00 am			25ml										
	07:00 am			25ml										
	Total Intake :						Total Output :							
Total 24 hrs. Intake						Total 24 hrs. Output								



FLUID CHART

Sheet No. :

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

Date	Time	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
		Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am			SOP								
	10:00 am			IVF								
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :					Total Output :							
	02:00 pm											
	03:00 pm											
	04:00 pm		kechi		NA							
	05:00 pm											
	06:00 pm		tho									
	07:00 pm											
Total Intake :					Total Output : 0-2 M-1							
	08:00 pm											
	09:00 pm		tho	SOP								
	10:00 pm			IVF								
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :					Total Output :							
	02:00 am											
	03:00 am			SOP								
	04:00 am			IVF								
	05:00 am											
	06:00 am		tho									
	07:00 am											
Total Intake :					Total Output :							

Total 24 hrs. Intake

Total 24 hrs. Output

NURSING CARE RECORD

Date: 26/6/26

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	12Pm	→ assess the pt condition → monitor vitals → maintain knee block → administer medication as per drug chart → IV cannula present	12Pm	→ assessed the pt condition → monitored vitals & recorded → maintained block → medication as per drug chart	→ pt is stable	→ rechecked vitals	[Signature]
	2Pm	→ c + IV fluids	2Pm	→ c + fluids			
Afternoon	2Pm	Assess the pt condition monitor vitals maintain block provide the comfortable position.	2Pm	Assessed the pt condition monitored vitals maintained block provided the comfortable position.	→ pt is stable	→ monitor vitals	[Signature]
	8Pm	medication give as per as doctor order.	8Pm	medication give as per as doctor order.	→ vitals remain	→ maintain the chart	[Signature]
Night	8Pm	→ continue fluid & syp. → stop order → drugs give as per drug chart.	8Pm	→ continued fluid & syp. → stop order → drugs give as per drug chart.	→ pt is stable now.	→ reviewed the vitals.	[Signature]
	8Am		8Am				

1-00027884 IP26-00006656
 Baby SITARA THOMMANDRU
 15-07-2019 6 Y 11 M 11 D (F)
 Dr. PRITESH NAGAR

NURSING CARE RECORD



Date: 27/6/26

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	2pm No 8pm	Assess the Baby condition Monitor vitals, record. Maintain T10 Clean. Provide the comfortable position. Give 2nd hourly feed.	2pm No 8pm	Assessed the Baby Condition monitored vitals maintained T10 Clean. provided the comfortable position. given 2nd hourly feed.	Baby is stable. vitals normal.	Monitor vitals. Maintain T10 Clean	Sm y
Night	8pm	Assess the baby Administer the vitals administer medicine maintain the clean	8pm	Assessed the baby monitored the vitals administer medicine maintain the clean	administer medic	Reassess the pt	ll D



G SHIFT HAND OVER FORM

SITUATION	Diagnosis: <u>AGIB dehydration</u>	Any Infection: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify:					
	Surgery / Procedure:	Post OP Day:					
BACKGROUND	Date / Shift	<u>26/6/26</u> <u>MS</u>	<u>26/6</u> <u>EL</u>	<u>26/6</u> <u>NI</u>	<u>27/6</u> <u>EL</u>	<u>28/6</u> <u>SOON</u>	
	Medical Condition (Any special condition to be noted):	—	—	—	—	—	
	Diet:	<u>soft diet</u>	—	—	—	—	
ASSESSMENT	Allergy:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	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	
	Vital Signs:	Temp:	<u>97.6F</u>	<u>98.6F</u>	<u>98.1F</u>	<u>98.0F</u>	<u>98.0F</u>
		Res:	<u>28b/min</u>	<u>28b/min</u>	<u>28b/min</u>	<u>18b/min</u>	<u>28b/min</u>
		SpO ₂ :	<u>94%</u>	<u>98%</u>	<u>95%</u>	<u>99%</u>	<u>100%</u>
		Pulse:	<u>118b/min</u>	<u>117b/min</u>	<u>117b/min</u>	<u>117b/min</u>	<u>117b/min</u>
		BP:	—	<u>98/71</u>	<u>99/70</u>	<u>99/62</u>	<u>98/64</u>
		LOC:	—	—	—	—	—
		Fall Risk Score:	—	—	—	—	—
	Pain Score:	—	—	—	—	—	
	Skin Integrity:	—	—	<u>Good</u>	—	—	
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	
	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	
	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	
	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	
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		
ADL (Dependent / Non Dependent):	—	—	—	—	—		
Post Operative Procedure Special Orders:	—	<u>RUE done</u>	—	—	—		
Handed Over By Name :	<u>Anurita</u>	<u>Su</u>	<u>maurika</u>	<u>Su</u>	<u>Shou</u>		
Signature / ID :	<u>(Signature)</u>	<u>(Signature)</u>	<u>(Signature)</u>	<u>(Signature)</u>	<u>(Signature)</u>		
Date:	<u>26/6/26</u>	<u>26/6</u>	<u>27/6/26</u>	<u>27/6</u>	<u>28/6</u>		
Time:	<u>2pm</u>	<u>8pm</u>	<u>9am</u>	<u>8pm</u>	<u>8pm</u>		
Taken Over By Name :	<u>Sneha</u>	<u>(Signature)</u>	<u>Su</u>	<u>(Signature)</u>	<u>(Signature)</u>		
Signature / ID :	<u>(Signature)</u>	<u>(Signature)</u>	<u>(Signature)</u>	<u>(Signature)</u>	<u>(Signature)</u>		
Date:	<u>26/6</u>	<u>26/6</u>	<u>27/6</u>	<u>27/6</u>	<u>28/6</u>		
Time:	<u>2pm</u>	<u>8pm</u>	<u>2pm</u>	<u>8pm</u>	<u>8pm</u>		

Patient Sticker



NURSING SHIFT HAND OVER FORM

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

BH-00027884
 Baby SITARA THOMMANDRU
 13-07-2019 6 Y 11 M 11 D
 Dr. PRITEBH NAGAR
 IP26-00006656
 (F)



CHECKLIST FOR THROMBOPHLEBITIS

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

Signature of Ward In Charge :
 Signature : Name :



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
26/6/26	1 PM	0/10	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	NA	D
26/6	2 PM	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	S
26/6	8 PM	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	S
27/6	6 AM	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	S
27/6	2 PM	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	S
27/6	8 PM	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	S
28/6	6 AM	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		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Re-assessment Frequency:

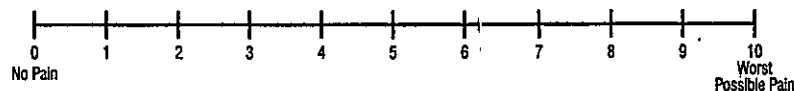
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

Numerical Pain Scale (Obstetric and Gynecology)



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

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

Wong - Baker (Pediatrics) Above 7 Years





BRADEN 'Q' SCALE

					Date :	20/10/20	26/10	26/10	28/10
					Time :	10	12	11	8:30
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4	4	4	
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	3	4	4	
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	4	
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	4	
FRICION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	4	
Nutritional Usual food intake pattern	1. Very Poor: NPC/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings of meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	4	
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	3	4	
TOTAL SCORE					28	27	27	28	
Evaluator's Name					D	by	D	D	

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

Risk Score	Category	Action	Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice)
15-18	At Risk	<ul style="list-style-type: none"> • Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • Advance to a higher level of risk if other major risk factors are present 	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	<ul style="list-style-type: none"> • Use the Same Protocol as for “At Risk” Patients • Position patient at 30 degree lateral incline using foam wedges 	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	<ul style="list-style-type: none"> • Follow the same protocol as for “Moderate Risk” Patients • In addition to regular turning schedule • Make small shifts in their position frequently 	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	<ul style="list-style-type: none"> • Use same protocol as for “High Risk” Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors. 	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay



214

NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 20/6/20 Time: 2:40 PM

Weight: 16 kg Centile: 63rd

Height: Centile: -

Inference: Underweight child

RDA: - Calories: 1450 kcal/day Protein: 25g/day

Diet Recommendations: High fiber diet with liquids

Re-Assesment: NO Junk, Oily, Spicy food

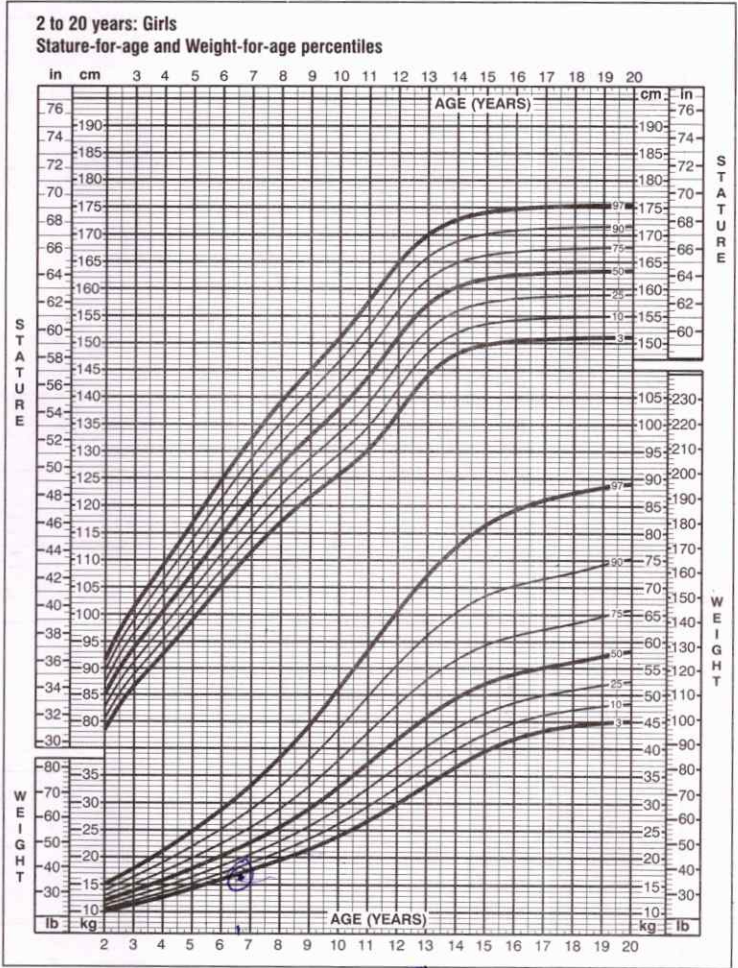
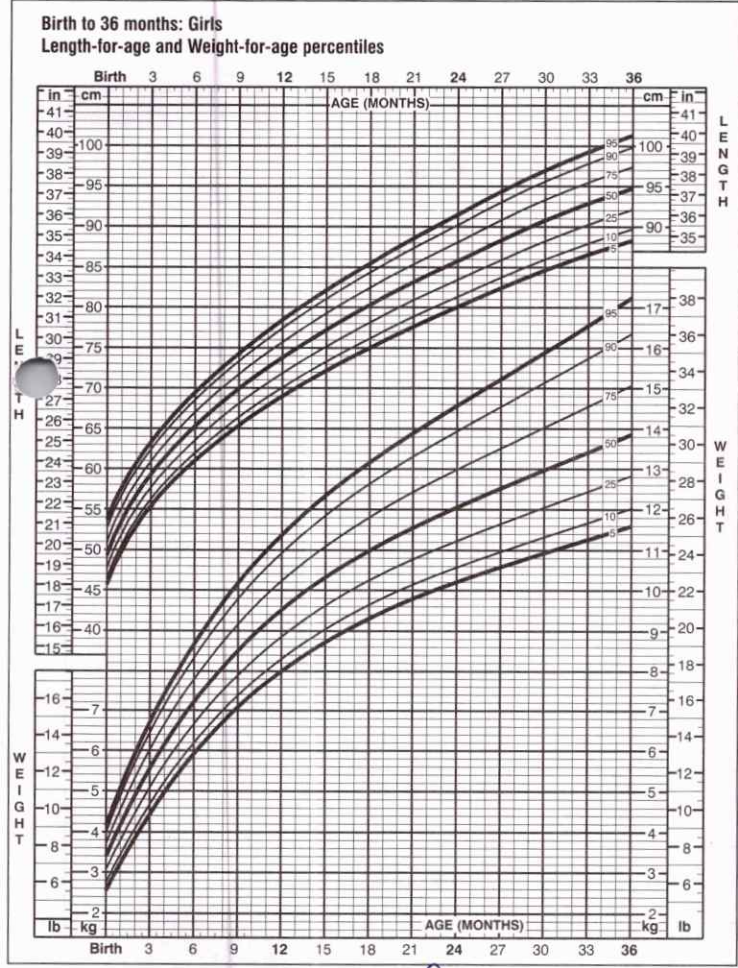
Food Allergies: NO Veg/Non-veg Veg

Diagnosis: Influenza A illness AGE c dehabitation

Nutritional Intervention - Oral Enteral Parenteral

Patient's Signature: T. Sai Sath

GROWTH CHART (GIRLS)



Dietician's Name: Syeda Sobiya Zaher

Dietician's Signature: Sobiya



**DECLARATION BY PATIENT OR PATIENT ATTENDANT
(TPA / INSURANCE / AROGYA BHADRATA / CORPORATE)**



Date:

I have attended the financial counseling desk / billing desk and understood the approximate expected costs of treatment. I clearly understand and agree that the hospital would bill as per its (hospital's) existing terms and conditions or MOU with my TPA/ Insurance Company/ Corporate/Arogya Bhadrata Scheme.

In case my claim is rejected by my TPA / Insurance Company / Corporate / Arogya Bhadrata Scheme at any point of time, i.e. before admission, during admission, during discharge or post discharge when hospital bill claim is submitted, I promise to settle the claim with the hospital. I understand and agree that there are certain TPA / Insurance Company / Corporate / Arogya Bhadrata Scheme Non - Coverable billing components which have to be paid totally by me like the following.

Registration charges, Insurance Processing fee, Medical Record Charges, MLC Charges, Tax Collected at Source (TCS), Dietician Consultation, F&B charges. Luxury Tax, Pharmacy and Consumables Non Medicals like Gloves, Masks, Draw Sheets, Diapers / Koochees, Intrafix, Q-Syte, Venflon, Sterilium, Splint, Gowns, Stockings, etc, Investigations like HIV, HbsAg, Pre Anesthesia Checkup (PAC), all Genetic Investigations, Double Occupancy, Vaccination Charges etc, instruments like Laparoscope, Thoracoscope, Harmonic, N-Seal, Morcellator, Cobulator, C-Arm, Micro Debrider, Medetronic Drill, Mann Mann Drill, Neuro Microscope, Neuro Endoscope, Endoscope etc, Maternity related like, Anti D, Muhurtham, Welt Baby Charges, Epidural, Entonox, Tubectomy etc. Any other facility used / treatment / investigation done which is not related to the present ailment is not covered.

I promise to clear my medical / non-medical bill dues during admission on daily basis or as and when applicable or whenever called for.

Mandatory Documents to be submitted for cashless process (Corporate Policy)

1. Employee ID Card.
2. Employee Government ID Proof (PAN /Aadhaar Card / Passport / Voter ID).
3. Patient TPA / Insurance Health Card or E-Card.
4. Patient Government ID Proof (PAN /Aadhaar Card / Passport / Voter ID / Birth Certificate)

Mandatory Documents to be submitted for cashless process (Individual Policy)

1. Proposer's ID Proof.
2. Patient TPA / Insurance Health Card or E-Card.
3. Patient Government ID Proof (PAN / Aadhaar Card / Passport / Voter ID / Birth Certificate)

Name of the Patient: T. SITARA Date & Time of Admission:

Name of the Parent / Guardian: SAI SANTOSH.T Mobile Number: 9703970212

Parent Aadhaar Card Number:

T. Sai Sital FATHER
Signature & Relation



wt - 16.78 kg



EMERGENCY ROOM TRIAGE FORM

Patient's Name: Baby SITARA THOMMANDRU Age: 6y 11m Gender: Male Female

Date: 26/06/20 Time of Arrival: 11:25 AM

Allergies: No Yes Food Medications Blood Transfusion Other (Specify): Not known

Source of Information: Parents Others (Specify)

Mode of Arrival: Ambulatory Wheelchair Ambulance

Initial Vital Signs: Temp: 99.8°F PR: 101 b/m BP: 99/78(82) RR: 26 b/m SpO₂: 98%

Chief Complaints: UO Fever, cold cough, stomach pain, vomiting since 2 days

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

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 checked="" type="checkbox"/> 30 min
<input type="checkbox"/> Level 4: LESS URGENT: Significant illness but not life threatening	<input type="checkbox"/> 60 min
<input type="checkbox"/> Level 5: NON - URGENT: May receive care when convenient	<input type="checkbox"/> 120 min

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

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian

Triage Completion Time: 11:27 AM

Communicable Disease Triage Screening

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

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

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

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

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

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

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

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

Name of Triage Nurse: Ashu

Signature of Triage Nurse:

Date & Time: 26/06/20 @ 11:27 AM

10/10/20

10/10/20
10/10/20
10/10/20

10/10/20
10/10/20
10/10/20

10/10/20

10/10/20

10/10/20
10/10/20



NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date: 26/06/26 Time of arrival: 11:29 Am

Chief Complaints: elo Fever, cold cough, vomiting since 2 days ^{sharp Pain} RBS:

Height: Weight: 18.78 kg BMI: Head Circumference (<2 years)

Allergies: Yes No Medications Blood Transfusion Food Other:

If yes, identify

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

Character Location Frequency Duration

RISK FOR FALL:

- If patient is < 6 years
tick below fall risk intervention directly
- If Patient is > 6 years
Assess the below parameters

History of Falling: within past 3 months Yes No

Ambulatory Aids:

- Wheelchair Yes No
- Uses furniture for support Yes No

Gait/Transferring:

- Bedrest / immobile Yes No
- Weak Yes No
- Impaired Yes No

Mental Status: Forgets limitations Yes No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening: No Abnormalities Detected

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

Inform consultant for positive criteria
.....
.....

Nutritional Screening: No Abnormalities Detected

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

Inform consultant for positive criteria

Psychological Screening: No Significant Findings

Unusual concerns about patient's Psychological Status: Yes No

If Yes Consultant Notified: (Date/Time): 26/06/26 @ 11:31 Am

Social History: Lives With Family

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

Time of Initial assessment completed by ER Nurse: 11:31 Am @

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

Time	Nursing Notes
	Assess the patient condition
	monitor vitals

Samples collected by: / *Sugandha @ 26/06/25* Time: / *11:40 Am*
 Samples sent by: / *Sugandha @ 26/06/25* Time: / *11:40 Am*

Medication given in ER:

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

Condition of patient at time of shift - out :	Details of Shift - out
HR: <i>110b/m</i> BP: <i>97/76⁸³</i> CFT: RR: <i>24b/m</i> SPO ₂ : <i>98%</i> GCS: <i>-</i> Temperature: <i>99.8 F</i> Pain Score: <i>0</i> Repeat RBS (if applicable):	Shift - out from ER to: <i>1002 214</i> Time of Shift - out: <i>12pm</i> Handover given to: <i>Antha</i> (Nurse's Name)

Tick as applicable: MLC LAMA BROUGHT DEAD


Procedures done with details (if any): *IV Place ment done*

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

Date & Time: *26/06/25 @ 12pm*

PATIENT TRANSFER FORM



Patient Name & IHD No. LBH-00027884 IP26-00006656 Baby SITARA THOMMANDRU 15-07-2019 8 Y 11 M 11 D (F) Dr. PRITESH NAGAR 		Date & Time of Admission 26/06/26 @ 11:33 AM	Date & Time of Transfer Order 26/06/26 @ 12 PM
		Transfer Ordered by Dr. Nayyanna	Reason for Transfer Abortion.
From Unit ER	To Unit 2LU	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File (16)	Number of Imaging Films (1)	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If yes, what?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes <input type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring Abonu / @		Name of Person Ordered Transfer Dr. Nayyanna.	
Patient & Clinical Records Received by : Anurtha 26/06/26 @ 12:20 PM			
Date & Time of Patient Received :			

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

- Unavailable Bed
 Nurse not Available
 Available Bed not ready