

ADMISSION SHEET



Registration Details :

Admission No : IP26-00006572 Admit Date : 12-Jun-2026 Admit Time : 07:12 PM UHID : HNH-00012687

Patient Details :

Patient Name : Master ATHARV TALLA Age : 0 Y 10 M 4 D
Guardian : Mr PAVAN KUMAR TALLA DOB : 08-08-2025 04:46 PM
Gender : Male Religion : Hindu
Occupation : Martial Status : Single
Address (H) : HNO. 3-5-869/a/1, HYDERGUDA, Phone No : 9618917361/ 9505020025
Himayathnagar Hyderabad Telangana INDIA E-mail : MANASA.MANNAVA@gmail.com
500029

Admission Details :

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

Contact Details :

Name : Mr PAVAN KUMAR TALLA Relationship : Father
Contact Address : HNO. 3-5-869/a/1, HYDERGUDA, Phone No : 9618917361
Himayathnagar Hyderabad Telangana INDIA
500029



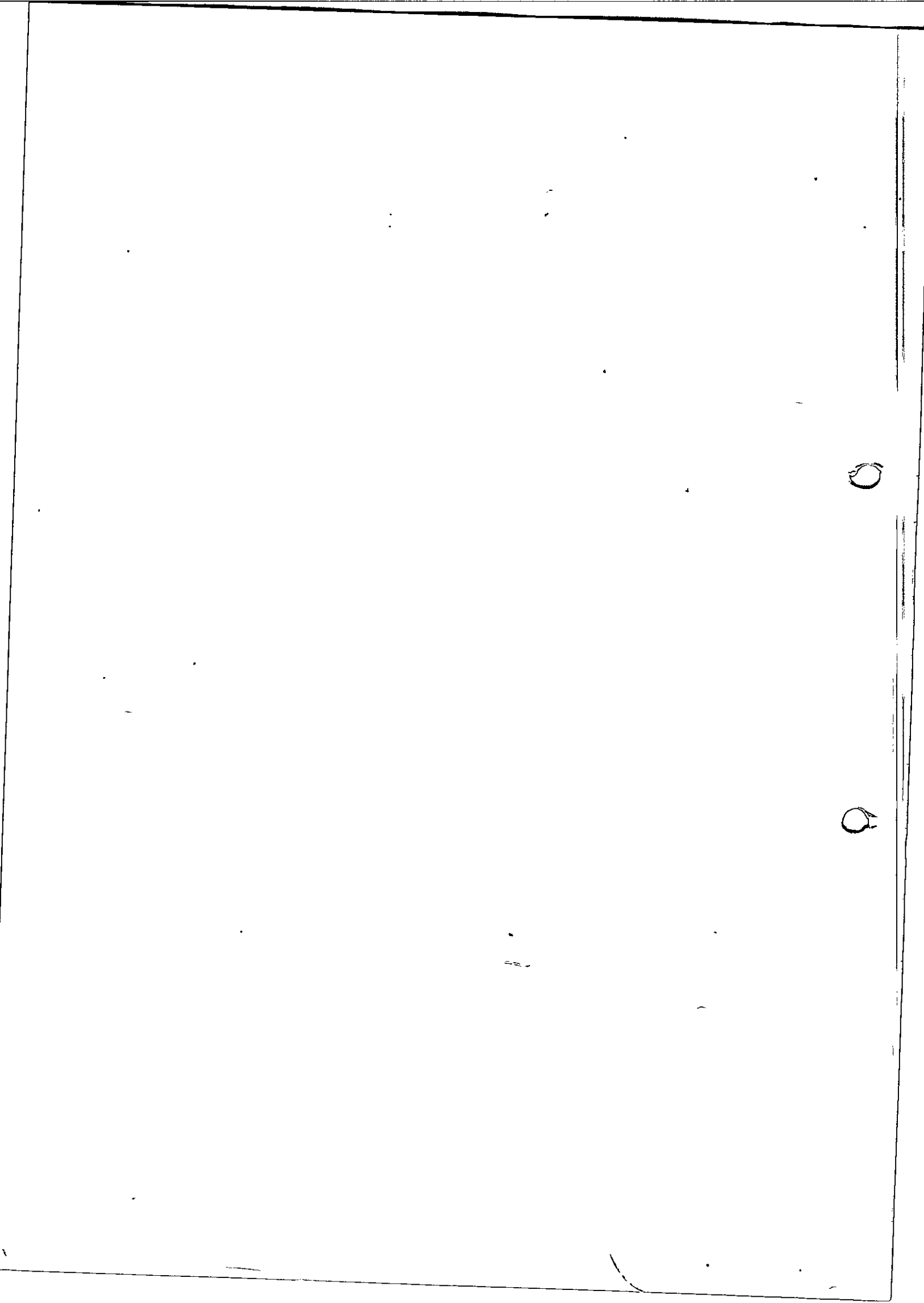
Signature

Doctor Details :

Doctor Name : Dr. PRITESH NAGAR Specialisation : GENERAL PEDIATRICS
Referral Doctor : Self Phone No :
Co-Consultant :

Payment Details :

Payment Mode : DC/CC Card Deposit Amount : 10000.00
Payor Name : HDFC ERGO GENERAL INSURANCE
CO LTD



MNH-00012667 IP26-00006572
Master ATHARV TALLA
08-08-2025 0 Y 10 M 5 D (M)
Dr. PRITESH NAGAR



CROSS CONSULTATION FORM

Doctor Name : Date : Time :

Diagnosis :

Hospital :

Type of Referral :

Emergency

Urgent

Non Urgent

Referred for : Opinion Co-Management Transfer of care

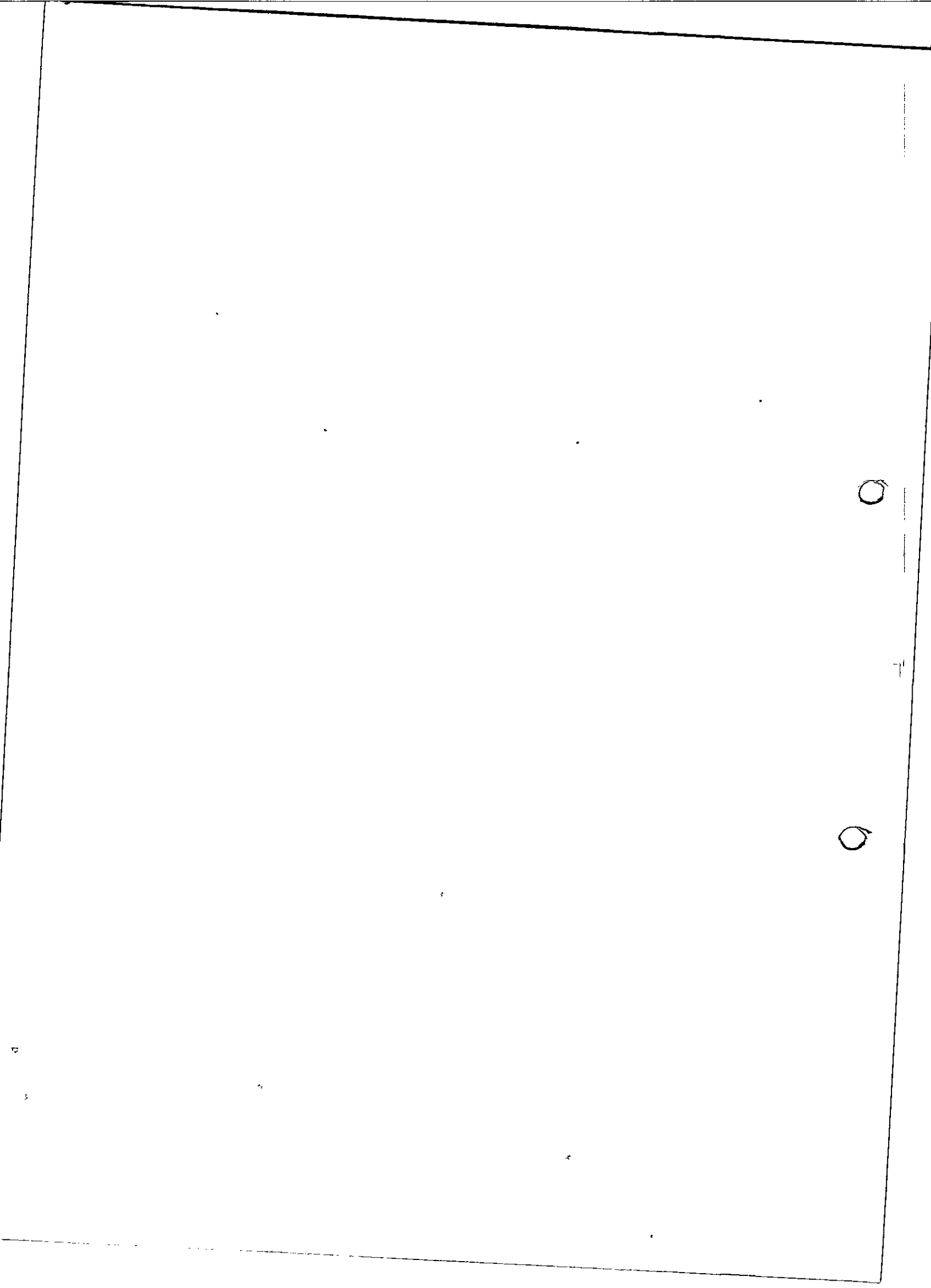
Reason for Referral : If for concurrent care specify the particular need, especially in the absence of a second diagnosis:

Signature: _____


Findings and Recommendations :

Consultant :

Name : Signature : Date & Time :



ACTIVITY RECORD FOR BILLING

Name: -----
 UHID No : **HNH-00012687 IP26-00006572** ----- Consultant : ----- Dept : -----
Master ATHARV TALLA
08-08-2026 0 Y 10 M 4 D (M)
Dr. PRITESH NAGAR
 Date of Adm  : ----- Date of Discharge : ----- Time: -----
 Room / Bed No : ----- Ward : ----- Suggested Billable bed type : -----

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
12/6/26	8 Am	ER	was mother spot	<i>[Signature]</i>
13/6/26	10 Am	215	212	<i>[Signature]</i>

Cross Consultation Visit

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

Ref.No. F/IN/PR/10



**Rainbow[®]
Children's
Hospital**

**PEDIATRIC IN-PATIENT
MEDICAL RECORD**

Patient Name :

HNH-00012687 IP26-00006572
Master ATHARV TALLA
08-08-2025 0 Y 10 M 4 D (M)
Dr. PRITESH NAGAR

Patient ID# :



Consultant :

Final Diagnosis :

Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Informant _____ Reliability _____

Chief Presenting Complaints & Duration (Chronologically):

dx fever since yesterday
dx 1 Episode of seizure @ 3:30pm today.

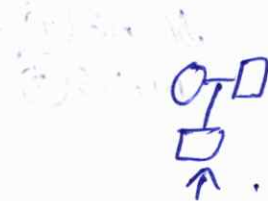
History of present illness :

- child had fever since yesterday high grade Intermittent after night not after nashu
- No H/o cold/cough.
- H/o 1 episode of seizure @ 3:30pm after stiffening of all 4 limbs after uprolling of supine, & tongue bite.
Lasts for 15 mins. jtb after post ictal dullness for ~60 mins.
- No loose stools & vomitings.

Pediatric Multiorgan History & Physical Examination

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

Birth & Neonatal History :



Birth & Socio Economic History :

About Father : _____

About Mother : Not Significant

Any additional Information : _____

Developmental History :

Appropriate

Immunization History :

upto date.

Pediatric Multiorgan History & Physical Examination

Anthropometry

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

Weight (kgs) 9.82 kg (Centile _____)

On Examination :

Temperature : 99F Pulse Rate: 150/min Description _____

B.P. _____ SPO2 98% at _____

Resp. rate and type of breathing : _____

tachypn (+) RR = 68/min.

Rash _____

subcostal retractions (+)

Lymphadenopathy _____

Oedema : _____

Respiratory system :

Inspection (any s/o distress) : _____

Air entry & breath sounds : Bk AG (+)

Any addes sounds : NVBS (+)

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

Cardiovasclular System :

Inspection of procordium : _____

Heart Sounds : S1L2 (+)

Any murmur : No.

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

Per Abdomen :

Inspection _____

Palpation : Soft Not distnd

Ausculation : _____

Spine: No organomegaly External Genitalia : _____

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

Pediatric Multiorgan History & Physical Examination

Central Nervous System :

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

Cranial Nerves : _____

Motor System :

Nutrition : _____

Tone : (n) Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR

Superficials :

Plantars _____

Sensory System :

Bladder / Bowel : _____

Clinical Summary & Diagnostic :

AFI

febrile status Epilepticus.

? Aspiration pneum.

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment :

Prevent Resp. failure.

Desired goals of the treatment :

Planned Labs :

⇒ CBP
CRP, VBG.
CBE
CXR.
B/c/p.
2 Extrasamples.
NB 4hrs

Planned Management :

- O₂ support n/p 1lit/min
- IV (1/2M)
- CLOBAZAM syp.
- PCM Q6hly.
- Monitor vitals.
- 28 MOPRAZOLE sachet.
- DOMSTAL drops
[RR, SpO₂] Q2hly strict
↓ Monitoring
manual count

Please fill up the following details

NB 4hrs

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 _____ Date _____ Time _____



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<p>22/6/26 7:15pm</p>	<p>d/s/by Dr Anusha / Dr Pritesh AFI febrile Statu Epilepticum.</p>	
	<p>fever x 1 day. 1 Epim febrile Statu.</p>	
	<p>HR = 150/min</p>	
	<p>Temp = 99F</p>	
	<p>CFT < 3sec</p>	
	<p>RR = 67/min (↑)</p>	<p>- O2 support \bar{e} Np. (2lit/min) - 11</p>
	<p>RLS SCR (+)</p>	<p>- 1g LEFTRIAxONE</p>
	<p>tachypn (+)</p>	<p>- CROBAM syp</p>
	<p>B/L AC (+)</p>	<p>- CROSM DS syp Qdly.</p>
	<p>MVDS (+)</p>	<p>- [RR, spoz] Monitoring.</p>
		<p>- Infeun [sos]</p>
	<p><i>AP</i> <i>11/11/25</i></p>	<p>- Neurologist Opine (Tomorrow)</p>

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
12/6/26 10:30pm	<u>C/S/ly as dilms</u>	
	<u>Δ</u> :- febrile state epilepticus.	
	? Apical pneumonia	
	Tachypn (+)	
	Initalile (+)	- O ₂ support
	(R/S) Bk Ac (+) NVBS (+)	- CE CEFTRIAXONE
	-SR (+) mild	- ct oth Mx as Per ct.

P. Nag



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
13/6/26		
9:30 AM		
	e/s/by. Dr. Anand On prabha ft	
	← febrile status epilepticus	
	? Aspiration pneumonia	
	No fever spikes.	
	RR 32/min	← O ₂ support 1lit/min.
	SpO ₂ 98% on O ₂ 1L/min.	→ ct CEFTRIAXONE
	S/E	→ ct ESMOPIRAZOLE
	R/L B/L AC (+)	DOMESTAL.
	N/VBS (+)	
	P/A soft	→ Neurologist Opinion
	Not distended.	→ RR, SpO ₂ Monitor
		→ w/ further seizure activity
		→ Send CUE.
		N-B Amrutha
		7:30 AM

HNH-00012687
 Master ATHARV TALLA
 08-08-2025 0 Y 10 M 4 D (M)
 Dr. PRITESH NAGAR

IP26-00006572



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
13/6/20		
9am	<p>S/B. Dr. Prabhat.</p>	
	<p>Case D/w Dr. Abhishek</p>	
	<p>△ febrile status c? Aspiration Pneumonia</p>	
	<p>Consciousness</p>	<p>Adv</p>
	<p>serum (N)</p>	<p>① Inj Levipil LD</p>
		<p>↓</p>
		<p>f/s Maintenance (oral)</p>
		<p>② CT. Rest.</p>

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
13/6/26 9:10 AM	cl/hy Dr Pritesh	
	febrile status. Epilypt D Aspirate pneumonia	
	SpO ₂ = 100%	
	B/c Tachypn (+)	off or ↓ check RR, SpO ₂
	(RT) B/c AG (+) MVBS (+)	CE CEFTRIAXONE.
	→ No fever night	w/h ⇒ Do USG chest
		→ send [CUE]
		⇒ (T) B/c/p.
		⇒ RR, SpO ₂ Monitoring
		⇒ Do USG chest
	Stat Ij Lewis LD	
	Interval EEG plan.	↓ flb. oval leupil MD
	→ after 1 week	NB Snehu @ 9:10 AM



DRUG CHART

Date of Admission: 12/6/25 Drug Allergies: Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

SOS / PRN (As Required Medication)

DRUG : MIDAZOLAM Spray				Date Time															
Dose	Route	Frequency	Start Date																
2 puff	Nasal	SOS	12/6																
Doctor's Signature		Valid Period	Pharm.																
<i>[Signature]</i>																			
Additional Instructions:																			
(1.25mg/1 puff) (1.25mg/1 puff)																			

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

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

VERIFIED BY : Name



REGULAR PRESCRIPTIONS

Weight. Ward.

(2PM)
 (M)

DRUG : 1g CEFTRIAZONE				Date	12/6	13/6														
				Time																
Dose	Route	Frequency	Start Date																	
750mg	iv	OD	12/6																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:				750mg in 20ml NS over 2 hours																
Daily Doctor's Endorsement by a Sign																				

Sachet

DRUG : ESMOPRABOLE Sachet				Date	12/6															
				Time																
Dose	Route	Frequency	Start Date																	
10mg	po	OD	12/6																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

1-202

DRUG : DOMSTAL dropp				Date	12/6	13/6														
				Time																
Dose	Route	Frequency	Start Date																	
2ml	po	TID	12/6																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:				(1mg/1ml)																
Daily Doctor's Endorsement by a Sign																				

3ml

DRUG : DYP CROBIN DS				Date	12/6	13/6														
				Time																
Dose	Route	Frequency	Start Date																	
3ml	po	QID	12/6																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:				(200mg/5ml)																
Daily Doctor's Endorsement by a Sign																				



Sheet No: **REGULAR PRESCRIPTIONS** Weight Ward

DRUG : CLONAZAM SYP				Date Time	12/6/23/6
Dose	Route	Frequency	Start Dt.		
1ml	PO	BD	12/6		
Name & Signature of the Doctor Starting the Drugs:				10pm	
Additional Instructions:					
(2.5mg/1ml)					
Daily Doctor's Endorsement by a Sign					

DRUG : 1/4 LEVETIRACITAM SYP				Date Time	
Dose	Route	Frequency	Start Dt.		
1ml	PO	BD	13/6		
Name & Signature of the Doctor Starting the Drugs:					
Additional Instructions:					
SYP. (100mg/1ml) MD					
Daily Doctor's Endorsement by a Sign					

DRUG : SYP · LEVETIRACITAM				Date Time	13/6
Dose	Route	Frequency	Start Dt.		
1ml	PO	BD	13/6	9am	
Name & Signature of the Doctor Starting the Drugs:					
Additional Instructions:					
(100mg/1ml)					
Daily Doctor's Endorsement by a Sign					

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

Signature
 VERIFIED BY : Name

Weight. Ward.



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.	

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
13/6/26.	930AM	TJ LEVITERACITAM.	200mg iv over 30min	iv	AL	Sam

Signature VERIFIED BY : Name



MEDICATION RECONCILIATION FORM

Drug Allergies: Not known any Drug Allergies

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

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

Shifting From: ICU 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. Anusha

Date & Time : 12/6/26 @ 6:40 pm

Nurse Name & Signature: Jyoti

Date & Time : 12/6/26 @ 6:42 pm

PATIENT TRANSFER FORM

Patient Name & UHID No. HNH-00012687 IP26-00006572 Master ATHARV TALLA 08-08-2025 0 Y 10 M 4 D (M) Dr. PRITESH NAGAR 		Date & Time of Admission 12/6/26 @ 7:12pm	Date & Time of Transfer Order 12/6/26 8am
		Transfer Ordered by Dr. Anusha	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 25	Number of Imaging Films NB-1	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.	DNS ——— (1)		
2.	BCV ——— (1)		
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes <input type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring Sis vyoti / vyoti		Name of Person Ordered Transfer Dr. Anusha	
Patient & Clinical Records Received by : Anusha			
Date & Time of Patient Received : 12/6/26 8pm			

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



Wt - 9.82 kg



EMERGENCY ROOM TRIAGE FORM

Patient's Name : Master Atharv Age : 10 months Gender : Male Female

Date : 12/6/26 Time of Arrival : 6:40 pm

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

Source of Information : Parents Others (Specify)

Mode of Arrival : Ambulatory Wheelchair Ambulance

Initial Vital Signs: Temp: 99.9 F PR: 153 bpm BP: RR: 60 bpm SpO₂: 98%

Chief Complaints: C/O fever since 1 day x seizure activity

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

Triage Classification	CTAS
<input type="checkbox"/> Level 1 : Resuscitation	<input type="checkbox"/> Immediate
<input type="checkbox"/> Level 2 : EMERGENT : Life or limb threatening	<input type="checkbox"/> < 15 min
<input type="checkbox"/> Level 3 : URGENT : Significant illness / injury with potential to become life or limb threatening	<input type="checkbox"/> 30 min
<input type="checkbox"/> Level 4 : LESS URGENT : Significant illness but not life threatening	<input 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

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 : Jyoti

Signature of Triage Nurse : [Signature]

Date & Time : 12/6/26 @ 6:42n



NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date: 12/6/26 Time of arrival: 6:24 AM
Chief Complaints: C/O Fever since 1 days* RBS:
Height: Weight: 9.82kg BMI: Head Circumference (<2 years)
Allergies: Yes No Medications Blood Transfusion Food Other:
If yes, identify
Pain Screening: Yes No If Yes, Pain Score: 0 Pain Tool Used: N Pass FLACC Wong Baker
 Character NA Location Frequency Duration

RISK FOR FALL:

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

History of Falling: within past 3 months Yes No

Ambulatory Aids:

- Wheelchair Yes No
- Uses furniture for support Yes No

Gait/Transferring:

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

Mental Status: Forgets limitations Yes No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening: No Abnormalities Detected

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

Inform consultant for positive criteria

.....
.....

Nutritional Screening: No Abnormalities Detected

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

Inform consultant for positive criteria

Psychological Screening: No Significant Findings

Unusual concerns about patient's Psychological Status: Yes No

If Yes Consultant Notified: (Date/Time):

Social History: Lives With family

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

Time of Initial assessment completed by ER Nurse : 6:24 PM

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

Time	Nursing Notes
	- ASSESS the pt condition
	- monitor vitals
	- IV placement Done
	- Sample collected

Samples collected by: APR 6
 Samples sent by :

Time: 3:30 PM
 Time:

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: <u>153/62</u> BP: CFT: RR: <u>60</u> SPO ₂ : <u>98+</u> GCS: <u>—</u> Temperature: <u>98.6</u> Pain Score: Repeat RBS (if applicable):	Shift - out from ER to: <u>2nd floor</u> Time of Shift - out: <u>8 PM</u> Handover given to: <u>[Signature]</u> (Nurse's Name)

Tick as applicable: MLC LAMA BROUGHT DEAD

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

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

Date & Time : 12/6/26

MNH-00012687 IP26-0000b/z
Master ATHARV TALLA
08-08-2025 0 Y 10 M 4 D (M)
Dr. PRITESH NAGAR



215 to 212

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

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

RESULT SHEET

Date	12/6/26				
Time					
Hb	12.1				
PCV	33.8				
RBC	4.82				
WBC	15.82				
N/L	50.6/89.8				
Platelets	364				
CRP	31.0				
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					

HNH-00012687 IP26-00006572
 Master ATHARV TALLA
 08-08-2025 0 Y 10 M 4 D (M)
 Dr. PRITESH NAGAR

INFANT (<1 year)
Children's Observation & Early Warning Scoring Chart

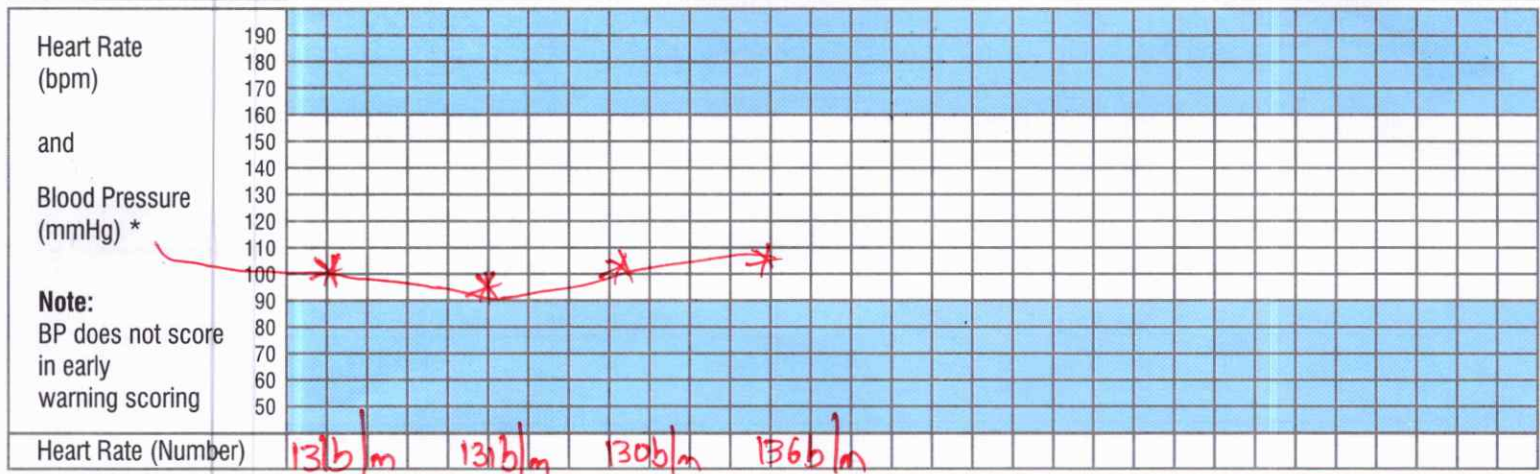
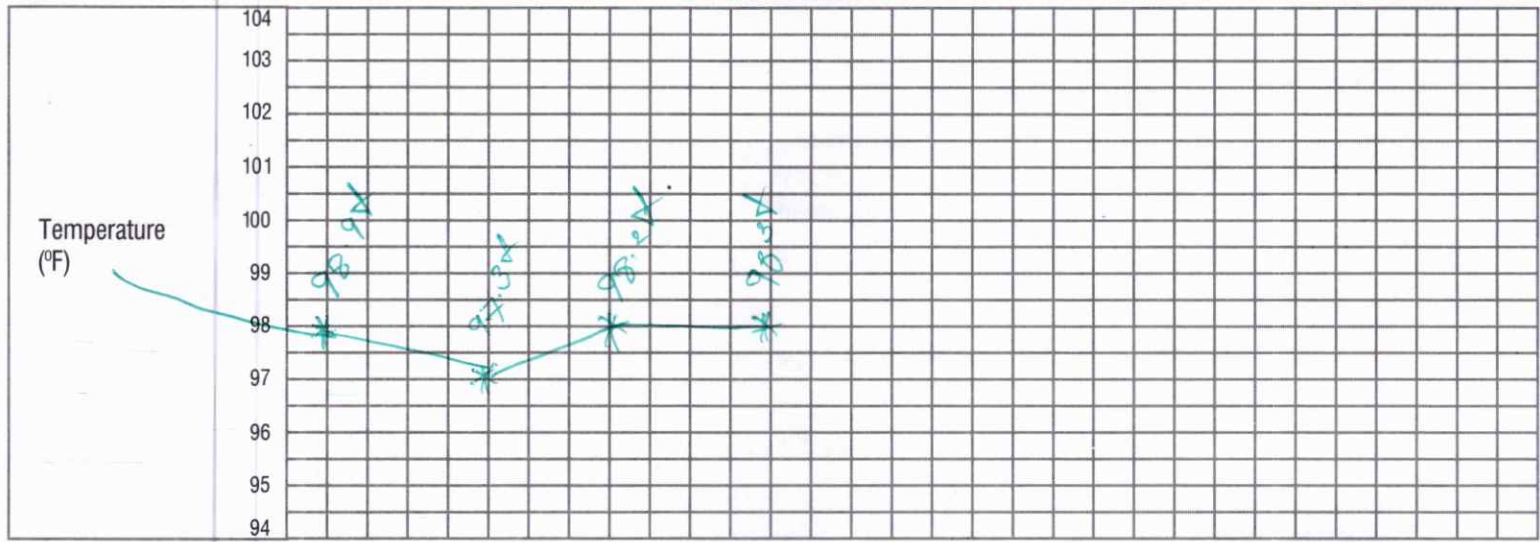


WICAL / 124

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 12/6/26 Time: 9pm 11pm 2Am 6Am

Doctor/Nurse/Family Concern?



Resp Mod/ Severe Distress None / Mild

Receiving O₂ (l/min) O₂ Saturations (%) 98%_{o2} 98%_{o2} 98%_{o2} 98%_{o2}

Conscious Level Normal / Altered

GCS *

TOTAL SCORE	9pm	11pm	2Am	6Am
Number of shaded boxes	0	0	0	0
Pain Score	0	0	0	0
Observer's Initials	P	P	P	P

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

* NB: 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

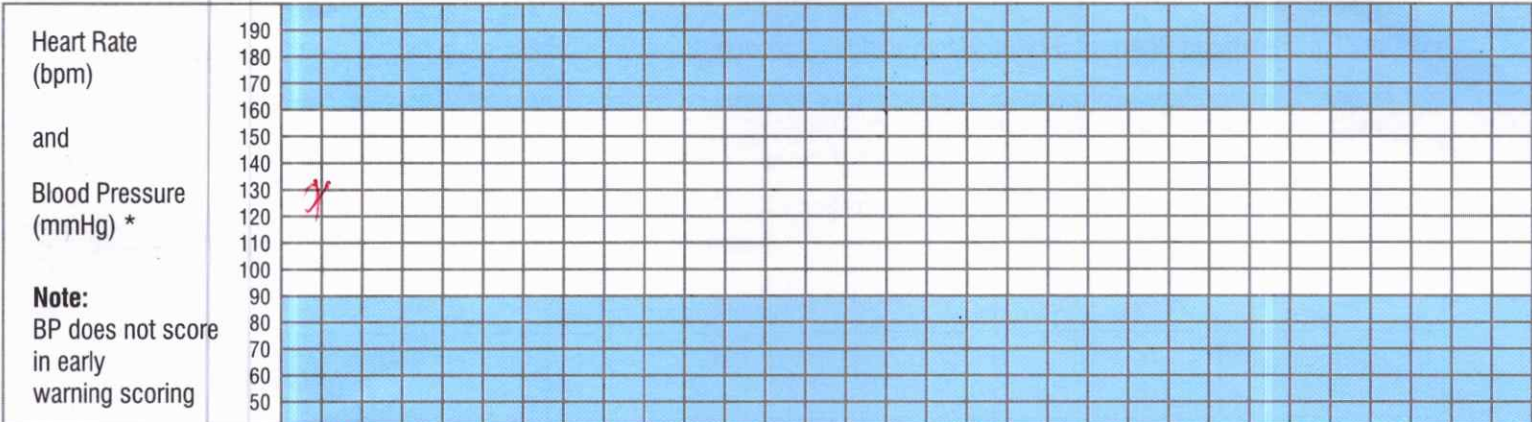
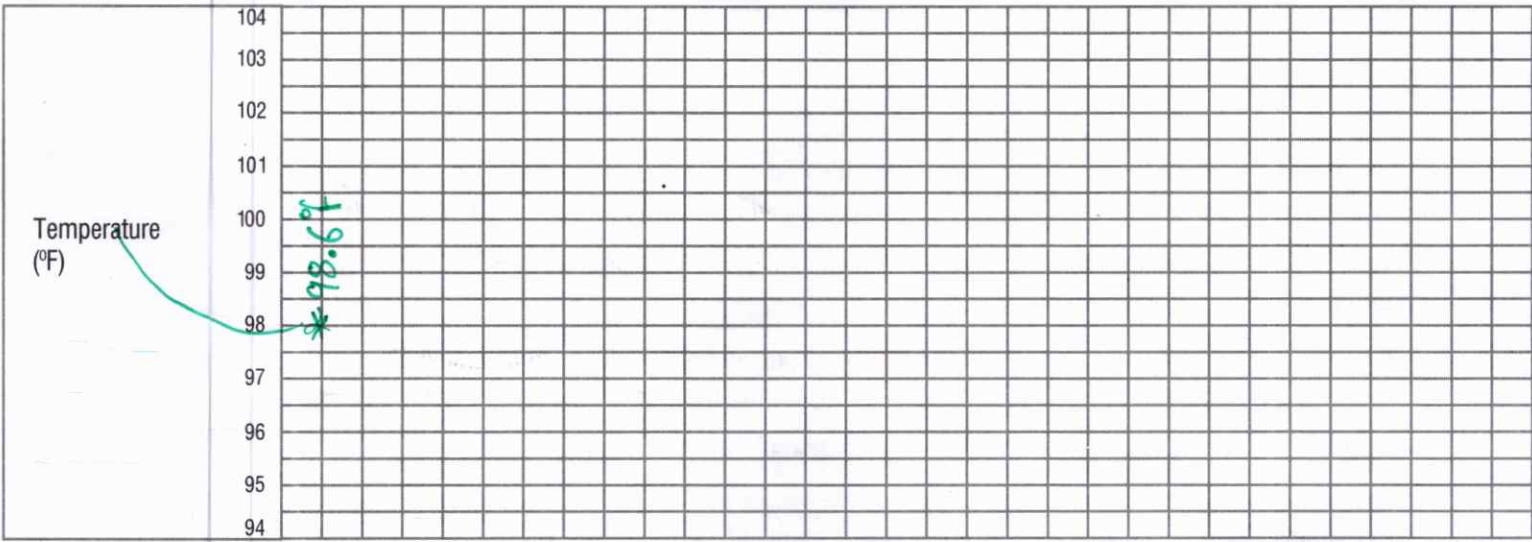
The SBAR communication tool (situation, background, assessment, recommendations) is a helpful mnemonic that can be used to describe a child's clinical condition to a colleague.

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)

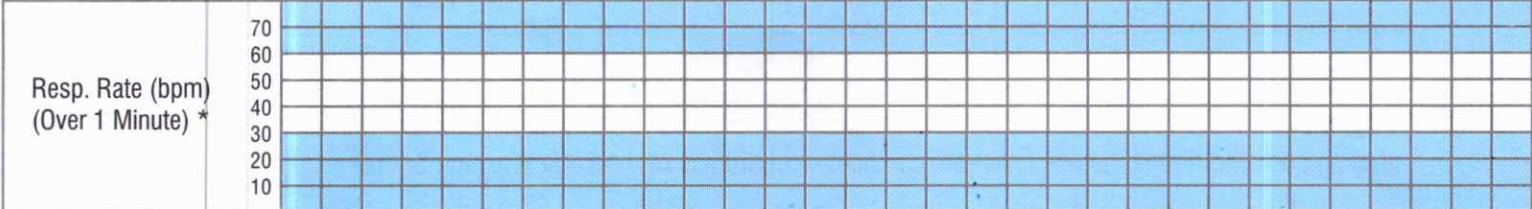
EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 13/6/26 Time: 10

Doctor/Nurse/Family Concern? Am



Heart Rate (Number) 136 bpm



Resp Rate (Number) 30 bpm

Resp Distress | Mod/ Severe Distress | None / Mild

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

Conscious Level | Normal | Altered

GCS *

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

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

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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)

Patie

HNH-00012687 IP26-00006572
 Master ATHARV TALLA
 08-08-2025 0 Y 10 M 4 D (M)
 Dr. PRITESH NAGAR



FLUID CHART

Sheet No. : 1

- 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												
	01:00 pm												
Total Intake :						Total Output :							
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
	Total Intake :						Total Output :						
12/6	08:00 pm			20ml							0		
	09:00 pm			20ml			L				0		
	10:00 pm	DOS	milk	20ml							0		
	11:00 pm		+	20ml			0		NA		0		
	12:00 am	DOS	H2O	20ml			J				0		
	01:00 am			20ml							0		
	Total Intake : Taken						Total Output : M-0 U-1						
	02:00 am			20ml							0		
	03:00 am			20ml							0		
13/6	04:00 am	DOS	milk	20ml			L				0		
	05:00 am		+	20ml			0		NA		0		
	06:00 am	DOS	H2O	20ml			J				0		
	07:00 am			20ml							0		
	Total Intake : Taken						Total Output : M-0 U-1						
Total 24 hrs. Intake						Total 24 hrs. Output							

HNH-00012687 IP26-00006572
 Master ATHARV TALLA
 08-08-2025 0 Y 10 M 4 D (M)
 Dr. PRITESH NAGAR



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.

		Intake				Output					IV Site Thrombophlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G							
B/6/25	08:00 am											
	09:00 am						✓			✓		
	10:00 am					NA		NA				
	11:00 am						✓			✓		
	12:00 pm											
	01:00 pm											
	Total Intake :		Taken				Total Output :					U-
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						Total Output :						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						Total Output :						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						Total Output :						
Total 24 hrs. Intake												
Total 24 hrs. Output												

Patient Sticker



FLUID CHART

Sheet No. :

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

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

Total 24 hrs. Intake

Total 24 hrs. Output

Patient Sticker



FLUID CHART

Sheet No. :

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

Total 24 hrs. Intake	
-----------------------------	--

Total 24 hrs. Output	
-----------------------------	--

Patient Sticker



FLUID CHART

Sheet No. :

1. All measurements in ml.
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Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse		
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	08:00 am													
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	01:00 pm													
Total Intake :						Total Output :								
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	06:00 pm													
	07:00 pm													
Total Intake :						Total Output :								
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	11:00 pm													
	12:00 am													
	01:00 am													
Total Intake :						Total Output :								
	02:00 am													
	03:00 am													
	04:00 am													
	05:00 am													
	06:00 am													
	07:00 am													
Total Intake :						Total Output :								

Total 24 hrs. Intake	
-----------------------------	--

Total 24 hrs. Output	
-----------------------------	--

Patient Sticker



FLUID CHART

Sheet No. :

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

		Intake				Output					IV Site Thrombophlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
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	08:00 am												
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Total Intake :						Total Output :							
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	07:00 pm												
Total Intake :						Total Output :							
	08:00 pm												
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	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
Total Intake :						Total Output :							
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
Total Intake :						Total Output :							

Total 24 hrs. Intake	
-----------------------------	--

Total 24 hrs. Output	
-----------------------------	--

HNH-00012667 IP26-00006572
 Master ATHARV TALLA 0 Y 10 M 4 D (M)
 08-08-2025
 Dr. PRITESH NAGAR



NURSING CARE RECORD

Date: 12/6/26

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				PA			
Night	8pm 8am	→ Assess the pt condition. → monitoring vitals checked and recorded → z/o chart maintain	8pm 8am	→ Assessed the pt condition → Administration of medication given as per doctor's order's → z/o chart maintain	→ pt is stable	→ Re-Assessment the checked vital	A Amurth

Patient Sticker

HNH-00012687
 Master ATHARV TALLA IP26-00006572
 08-08-2025 0 Y 10 M 4 D (M)
 Dr. PRITESH NAGAR

NURSING CARE RECORD



Date: 13/6/26

- Goals**
- Maintain Airway and Oxygenation
 - Relieve Pain & Discomfort
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 - Patient & Family Education
 - Identify Potential Complications
 - Any Others. Specify.....

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8Am	Assess the pt condition.	8Am	Assessed the pt condition.	PT is stable.	Monitor vital	Sneh
	10	Monitor vitals & record. Maintain I to chart. Provide the comfortable position.	10	Monitored vitals & record. Maintain I to chart. Provided the comfortable position.			
	2Pm	Medication give as per as doctor ord.	2Pm	Medication given as per as doctor ord.	Vital's normal.	Maintain I to chart.	
Afternoon							
Night							

Patient Sticker

NURSING-CARE-RECORD



Date:

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon							
Night							

Patient Sticker

NURSING CARE RECORD



Date:

Goals

- Maintain Airway and Oxygenation
- Maintain Personal Hygiene
- Identify Potential Complications
- Relieve Pain & Discomfort
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	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon							
Night							

Patient Sticker

NURSING CARE RECORD



Date:

Goals

- Maintain Airway and Oxygenation
- Maintain Personal Hygiene
- Identify Potential Complications
- Relieve Pain & Discomfort
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	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon							
Night							

Patient Sticker

NURSING CARE RECORD



Date:

Goals

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	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon							
Night							

Patient Sticker

NURSING CARE RECORD



Date:

Goals

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	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon							
Night							

Patient Sticker

NURSING CARE RECORD



Date:

- Goals**
- Maintain Airway and Oxygenation
 - Relieve Pain & Discomfort
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 - Identify Potential Complications
 - Any Others. Specify.....

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon							
Night							

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	12/6/26						
	Shift	N1						
	Medical Condition (Any special condition to be noted):	-						
	Diet:	-						
ASSESSMENT	Allergy:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	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:	98.3F					
		Res:	8/20b/m					
		SpO ₂ :	98%					
		Pulse:	131b/m					
		BP:	-					
		LOC:	-					
		Fall Risk Score:	-					
	Pain Score:	-						
	Skin Integrity:							
Recommendations	Safety Needs:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Physiotherapy:	-						
	Others Specify:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Special Diet:	-						
	Critical Lab Test / Values:	-						
	Other Special Orders / Medications:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	PU Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
DVT Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
ADL (Dependent / Non Dependent):	NA							
Post Operative Procedure Special Orders:	NA							
Handed Over By Name :	Anouka							
Signature / ID :	[Signature]							
Date:	12/6/26							
Time:	8Am.							
Taken Over By Name :								
Signature / ID :								
Date:								
Time:								

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

INH-00012687
 Master ATHARV TALLA
 08-08-2025 0 Y 10 M 4 D (M)
 Dr. PRITESH NAGAR

IP26-00006572

BRADEN 'Q' SCALE



It takes a lot to treat the little.

BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

					Date :	12/6/26	13/6		
					Time :	21	145		
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4			
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	3			
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4			
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4			
FRICITION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4			
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4			
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4			
					TOTAL SCORE	28	27		
					Evaluator's Name				

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

Patient ID _____

BRADEN 'Q' SCALE



					Date :				
					Time :				
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.					
"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.					
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.					
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.					
FRICITION-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.*					
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.					
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.					
					TOTAL SCORE				
					Evaluator's Name				

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

Patient ID

BRADEN 'Q' SCALE

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

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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
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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

Patient ID _____

BRADEN 'Q' SCALE



					Date :			
					Time :			
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					TOTAL SCORE			
					Evaluator's Name			

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)
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13-14	Moderate Risk	<ul style="list-style-type: none"> • Use the Same Protocol as for “At Risk” Patients • Position patient at 30 degree lateral incline using foam wedges 	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	<ul style="list-style-type: none"> • Follow the same protocol as for “Moderate Risk” Patients • In addition to regular turning schedule • Make small shifts in their position frequently 	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	<ul style="list-style-type: none"> • Use same protocol as for “High Risk” Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors. 	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
12/6	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	CA
13/6	6Am	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	AD
13/6	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	GA
13/6	2Pm	0	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	SA
				<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:

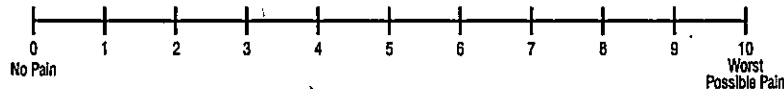
1. Every eight hours for all hospitalized patients.
2. For post-surgical patients, patients with chronic pain, patient with severe pain:
 - a) At least every 2 hours for the first 24 hours
 - b) Then every 4 hours.
 - c) Prior to pain relieving intervention.
 - d) Within 30 – 60 minutes after pain relief 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 or sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

Numerical Pain Scale (Obstetric and Gynecology)



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

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR, RR, BP, SaO₂	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO ₂ 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

Wong - Baker (Pediatrics) Above 7 Years



0
No Hurt

2
Hurts Little Bit

4
Hurts Little More

6
Even More

8
Hurts Whole Lot

10
Hurts Worst

PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
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Re-assessment Frequency:

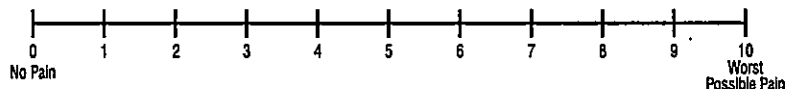
1. Every eight hours for all hospitalized patients.
2. For post-surgical patients, patients with chronic pain, patient with severe pain:
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PAIN ASSESSMENT TOOLS

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
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Numerical Pain Scale (Obstetric and Gynecology)



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

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Wong - Baker (Pediatrics) Above 7 Years



0

No Hurt

2

Hurts Little Bit

4

Hurts Little More

6

Even More

8

Hurts Whole Lot

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Hurts Worst

PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
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				<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		
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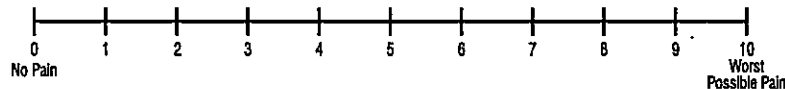
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Wong - Baker (Pediatrics) Above 7 Years



0
No Hurt

2
Hurts Little Bit

4
Hurts Little More

6
Even More

8
Hurts Whole Lot

10
Hurts Worst

[at-cannula's]
 Patient ~~is~~ are not willing
 431 vstobag I asked 3 0 1 4
 time 2 [9pm, 11Am, 2Am, 6Am]
 Sing :- I Panam
 Sing :- I Panam

HNH-00012687 IP26-00006572
 Master ATHARV TALLA
 08-08-2025 0 Y 10 M 4 D (M)
 Dr. PRITESH NAGAR



CHECKLIST FOR THROMBOPHLEBITIS



S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1 12/6			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						
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						
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2			NA	NA						
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3			NA	NA						
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						
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						
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 : Sneha
 Signature : Name : Sneha

Signature of Ward In Charge :
 Signature : Balarani Name : Balarani

Patient Sticker



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										
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										
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2										
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										
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										
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5										
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 :