Rainbow Children's Hospital

BirthRight by Rainbow

Rainbow Childrens Hospital-Himayatnagar

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

ADMISSION SHEET

Registration Details :

Admission No : IP26-00006608 **Admit Date** : 18-Jun-2026 **Admit Time** : 11:34 PM **UHID** : BAH-00596541

Patient Details :

Patient Name	: Baby ARADHYA BIDHANIYA	**Age**	: 3 Y 4 M 21 D
Guardian	: Mr B.PRATIK KUMAR	**DOB**	: 28-01-2023
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	: Single
Address (H)	: 14-10-356 ,lower Dhoolpet , Jumerat bazar Dhoolpet Hyderabad Telangana INDIA 500006	**Phone No**	: 9948911911/ 9951911911
		E-mail	: pratikbidhaniya@gmail.com

Admission Details :

Bed Type : DAY CARE **Bed No** : ER01 **Ward Name** : GF -EMERGENCY

Room No : ER01 **Admission Type** : First Visit

Contact Details :

Name	: Mr B.PRATIK KUMAR	**Relationship**	: Father
Contact Address	: 14-10-356 ,lower Dhoolpet , Jumerat bazar Dhoolpet Hyderabad Telangana INDIA 500006	**Phone No**	: 9948911911

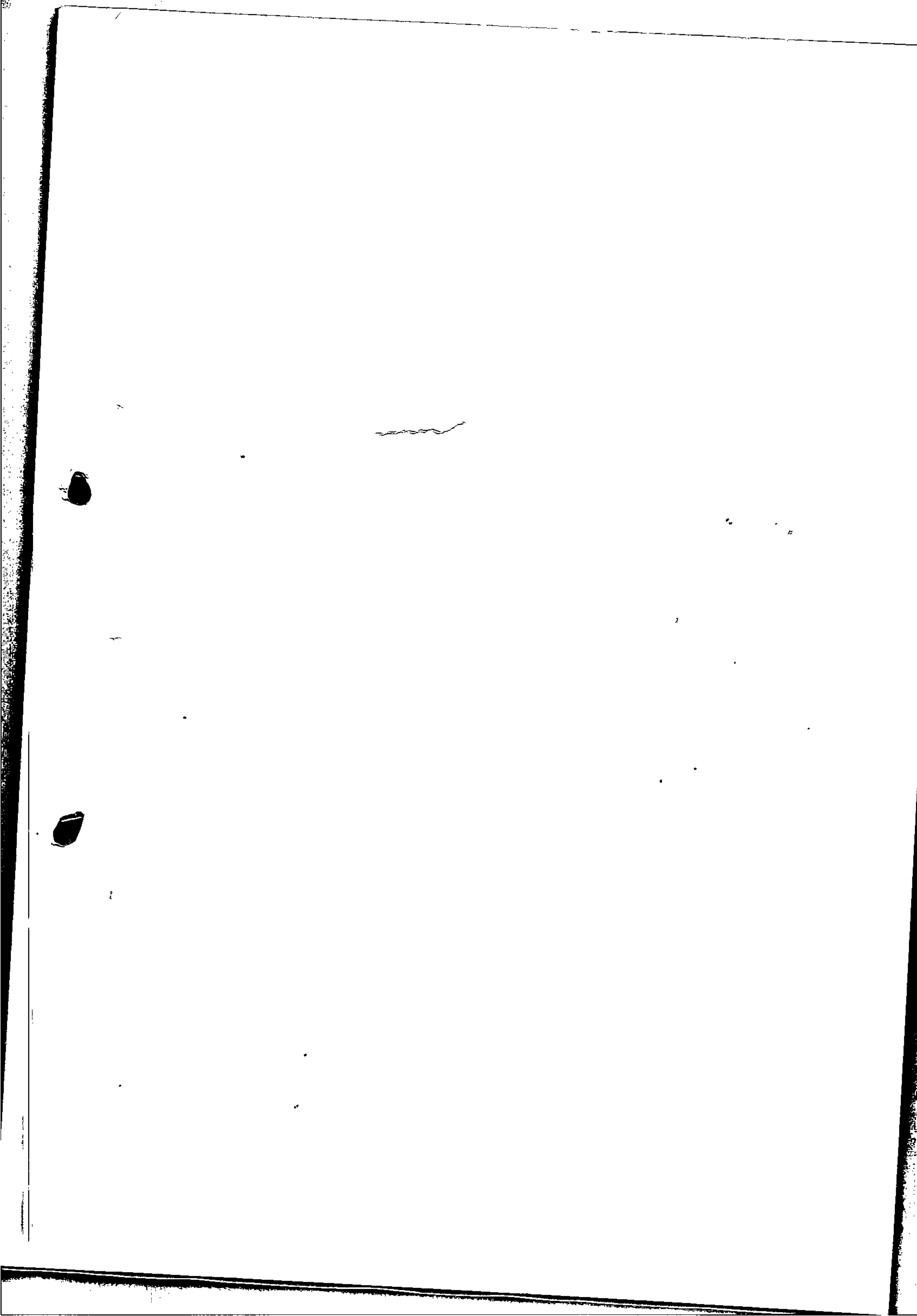
Signature

Doctor Details :

Doctor Name	: Dr. VINAY KUMAR M	**Specialisation**	: GENERAL PEDIATRICS
Referral Doctor	: DR. VINAY KUMAR MANTHATI	**Phone No**	: 8639024469
Co-Consultant	: Dr. ANIKET ANIL PARASHAR		

Payment Details :

		Deposit Amount	: 5000.00
Payment Mode	: Cash	**Payor Name**	: FAMILY HEALTH PLAN INSURANCE TPA LTD



ACTIVI[illegible]NG

BAH-00596541 IP26-00006608
Baby ARADHYA BIDHANIYA
28-01-2023 3 Y 4 M 22 D (F)
Dr. VINAY KUMAR M

Name: --

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

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
18/6/26	11:40PM	ER	ward	[signature]

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
19/6/26	VBG	9990	[signature]
	CBP, CRP, PCT, Blood C/S, Creatinine, Respiratory panel	9989	
	Cross checked done by Amrutha 19/6/26 02Am		
19/6	CUE, Urine c/s	999	[signature]
19/6/26	USG Abdomen c̄ pelvis	07324	Sandhya

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
19/6/26.	Infusion pump	19/6/26 e1AM		7349	[illegible]

Cross checked done by Amorutha

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
19/6/24	I v placement	1	~~207~~345	[signature]
		cross checked done		

ANY OTHER INFORMATION

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

Ref.No. F/IN/PR/10

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name : Aradhya

Patient ID# :

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Baby ARADHYA BIDHANIYA
28-01-2023 3 Y 4 M 22 D (F)
Dr. VINAY KUMAR M

Consultant :

Final Diagnosis :

Pediatric Multiorgan History & Physical Examination

Name : ______ Age/Sex ______

Informant ______ Reliability ______

Chief Presenting Complaints & Duration (Chronologically):

c/o Fever :- 4 day
c/o Loose stool & Vomiting 3 day
c/o Abdominal pain :- 2 day
c/o Dull activity & reduced urine output :- 1 day

History of present illness :

Child brought with
c/o Fever :- 4 days
High grade, persistent fever, every 3-4 hrs
103° F, ass c̄ chills
c/o Vomiting :- 3 days, multiple episodes / non bilious
c/o Loose stool :- 3 day
Multiple episodes, watery loose stool
Non blood stained

c/o Abdominal pain :- 2 days

c/o Dull activity & reduced urine output :- 1 day
No c/o burning micturition

H/o Outside food intake

Pediatric Multiorgan History & Physical Examination

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

Birth & Neonatal History :

FT / 2SCS / CIAB / 2.8 kg

Birth & Socio Economic History :

About Father :

About Mother :

Any additional Information :

Developmental History :

Immunization History :

Upto 2yr

Pediatric Multiorgan History & Physical Examination

Anthropometry

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

Weight (kgs) 12 kg (Centile ________)

On Examination :

Temperature : 102.2°F Pulse Rate: 146/min Description ________

B.P. 105/72 (79) SPO2 97% at ________

Resp. rate and type of breathing : 24/m

Rash Sign of Dehydration (+) – Sunken eyes, dry lips & oral mucosa, Delayed skin turgor

Lymphadenopathy ________

Oedema : ________

Skin lesion over (L) lower jaw – Impetigo

Respiratory system :

Inspection (any s/o distress) : ________

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

Any addes sounds : ________

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

Cardiovasclular System :

Inspection of procordium : ________

Heart Sounds : S1 S2 (+)

Any murmur : ________

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

Per Abdomen :

Inspection ________

Palpation : Soft

Ausculation : ________

Spine: ________ External Genitelia : ________

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 : (N)

Motor System :

Nutrition :

Tone : Power

Co-ordinator : (N)

Posture :

Involuntary Movements :

Reflexes :

DTR

Superficials :

Plantars

Sensory System :

Bladder / Bowel :

Clinical Summary & Diagnostic :

Acute Febrile Illness c̄ Dehydration - D4
c̄ ~~Acute Ge~~ ? Infection colitis

Pediatric Multiorgan History & Physical Examination

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Baby ARADHYA BIDHANIYA
28-01-2023 3 Y 4 M 22 D (F)
Dr. VINAY KUMAR M

Preventive aspects of the treatment :

Desired goals of the treatment :

Planned Labs :

VBG
CBP, CRP, Blood C/S
Procalcitonin, Creatinine
CUE & Urine C/S
1 extra plain
Respiratory Panel

USG Abdomen

Planned Management :

IVF
Inj Ceftriaxone - after C/S
Inj Ondem
Inj Esomeprazole
Pro GG sachet
ZAD drops

N.B Probiot
@ 11:50pm

Please fill up the following details

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

Doctor's Signature Name ______ Date ______ Time ______

BAH-00596541 IP26-00006608
Baby ARADHYA BIDHANIYA
28-01-2023 3 Y 4 M 22 D (F)
Dr. VINAY KUMAR M

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/6 7AM	C/S/B Dr. Pranav / Dr. Prashanti	
	Acute Febrile Illness c Dehydration ? Infective colitis	Plan
	Fever ⊕ (High grade)	1) IVF - 2/3rd (M)
		2) Inj Ceftriaxone
	Loose stools ⊕ (4 times overnight)	3) Inj Ondem Inj Esomeprazole
	child asleep	4) Pro GS
	Vitals stable	5) ZA D drops
	Febrile	6) Trace Respiratory panel
	R-S - B/L AE ⊕	7) Send CUE & Urine C/S
	P/A - Soft.	8) USG Abdomen - Today
		9) Monitor vitals
		10) Inform SOS
		Pranav
		N.B Amrutha c 7AM.

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Baby ARADHYA BIDHANIYA
26-01-2023 3 Y 4 M 22 D (F)
Dr. VINAY KUMAR M

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

Patient Sticker

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Date & Time	Progress Notes	Doctor's Order

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

BAH-00598541 IP26-00006608
Baby ARADHYA BIDHANIYA
28-01-2023 3 Y 4 M 22 D (F)
Dr. VINAY KUMAR M

DRUG CHART

Date of Admission: .... 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 / 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 CROCIN-DS				Date▸ / Time▾
Dose	Route	Frequency	Start Date	
4ml	PO	SOS 6th hrly	18/6	
Doctor's Signature		Valid Period	Pharm.	
Pranav				
Additional Instructions: 5ml = 240mg If T > 100°F				

DRUG : Syp IBUGESIC				Date▸ / Time▾
Dose	Route	Frequency	Start Date	
5ml	PO	SOS 8th hrly	18/6	
Doctor's Signature		Valid Period	Pharm.	
Pranav				
Additional Instructions: If T > 102°F				

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

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REGULAR PRESCRIPTIONS

Weight. 12 kg Ward.

DRUG : Inj CEFTRIAXONE				Date ▸ Time ▾	19/6
Dose	Route	Frequency	Start Date		
1.2g	IV	once Daily	18/6		
Name & Signature of the Doctor Starting the Drugs: Pram				6AM	[signature]
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					

DRUG : Inj ONDANSETRON				Date ▸ Time ▾	19/6
Dose	Route	Frequency	Start Date		2AM
2mg	IV	TID	18/6	6AM	[signature]
Name & Signature of the Doctor Starting the Drugs: Pram				2pm	
Additional Instructions:				10pm	
Daily Doctor's Endorsement by a Sign					

DRUG : Inj ESOMEPRAZOLE				Date ▸ Time ▾	19/6
Dose	Route	Frequency	Start Date		2AM
10mg	IV	OD	18/6		
Name & Signature of the Doctor Starting the Drugs: Pram				6AM	[signature]
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					

DRUG : PRO-55 SACHET				Date ▸ Time ▾	19/6
Dose	Route	Frequency	Start Date		2AM
1 sachet	PO	BD	18/6		
Name & Signature of the Doctor Starting the Drugs: Pram				6AM	[signature]
Additional Instructions:				6pm	
Daily Doctor's Endorsement by a Sign					

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Sheet No: ....

REGULAR PRESCRIPTIONS

Weight .... Ward ....

DRUG : Z & D Drops

Dose	Route	Frequency	Start Dt.
1ml	PO	OD	18/6

Name & Signature of the Doctor Starting the Drugs: Pranav

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date ▸ Time ▾	19/6
	2Am
10Am	[signature]

DRUG : MUPIROCIN oint

Dose	Route	Frequency	Start Dt.
ointment LFU	L/A around lips	QID	18/6

Name & Signature of the Doctor Starting the Drugs: [signature]

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date ▸ Time ▾	19/6
12Am	✓
6Am	✓
12PM	
6PM	

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

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

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Dr. VINAY KUMAR M

Sheet No: ....

REGULAR PRESCRIPTIONS

Weight .... Ward ....

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date ▸ Time ▾

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date ▸ Time ▾

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date ▸ Time ▾

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date ▸ Time ▾

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

Docu. No. : RCH /FRM / CLINICAL / 108

(P.T.O.)

Patient Sticker

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

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses

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

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Baby ARADHYA BIDHANIYA
28-01-2023 3 Y 4 M 22 D (F)
Dr. VINAY KUMAR M

I.V. FLUIDS CHART

Weight. 12kg Ward. ....

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
18/6	11:50pm	IVF - PLASMALYTE (2/3 M)	IV	30	[signature]	[signature] [signature]			

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

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Baby ARADHYA BIDHANIYA
28-01-2023 3 Y 4 M 22 D (F)
Dr. VINAY KUMAR M

...DICATION RECONCILIATION FORM

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

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

Shifting From: ER .... Shifted to: ward ....

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

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Pranav

Date & Time : 18/6/26 @ 11:35 P.M

Nurse Name & Signature: Prabir

Date & Time : 18/6/26 @ 11:35 P.M

PATIENT TRANSFER FORM

BAH-00596541 IP26-00006608
Baby ARADHYA BIDHANIYA
28-01-2023 3 Y 4 M 22 D (F)
Dr. VINAY KUMAR M

	Date & Time of Admission	Date & Time of Transfer Order
	18/6/26 @ 11:34 pm	18/6/26 @ 11:30 pm
Treating Consultant Name	**Transfer Ordered by**	**Reason for Transfer**
	Dr. Pranav	Admission
From Unit	**To Unit**	**Information to Attendant**
ER	Ward	Yes ☑ No ☐
Number of Sheets in Clinical File	**Number of Imaging Films**	**Personal belongings including clinical documents. If any handed over to attendant**
26		Yes ☐ No ☑ If yes, what ?

Medications / Consumables / Surgicals / Hand over

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

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Brabin	Dr. Pranav

Patient & Clinical Records Received by : Amrutha

Date & Time of Patient Received : 18/6/26 , 12:40 pm

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

☐ Unavailable Bed ☐ Nurse not Available ☐ Available Bed not ready

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

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Baby ARADHYA BIDHANIYA
28-01-2023 3 Y 4 M 22 D (F)
Dr. VINAY KUMAR M

wt - 12 kg

TRIAGE FORM

Patient's Name : Aaradhya Age : 3 years Gender: ☐ Male ☑ Female

Date : 18/6/26 Time of Arrival : 11:20 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: 101.2°F PR: 136b/m BP: 105/72(79) RR: .... SpO_2: 98%

Chief Complaints: C/O Fever since 3 days

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

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

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

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian

Triage Completion Time : 11:22 PM

Communicable Disease Triage Screening

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

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

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

1. Have you travelled outside the INDIA? or had close contact with someone who has recently travelled outside the INDIA, in the past two weeks? ☐ Yes ☑ No

   If yes, State Location: ....

2. Are your parents / close contacts at home is/a healthcare worker? {please encircle the choices} (e.g., nurse, physician, ancillary services personnel, allied health services personnel, hospital volunteer, or laboratory worker, others) who has had a recent exposure to an individual with a highly communicable disease or unexplained, severe febrile respiratory or rash disease? ☐ Yes ☑ No

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

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

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

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

Name of Triage Nurse : Prabin

Signature of Triage Nurse : [signature]

Date & Time : 18/6/26 @ 11:22 PM

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

BAH-00596541 IP26-00006608
Baby ARADHYA BIDHANIYA
28-01-2023 3 Y 4 M 22 D (F)
Dr. VINAY KUMAR M

NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 18/6/26 Time of arrival : 11:20 PM

Chief Complaints: C/O High grade Fever since 2 days RBS: ....

Height : .... Weight : .... 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 .... ☐ Location .... ☐ Frequency .... ☐ Duration ....

RISK FOR FALL:

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

☐ If Patient is > 6 years
Assess the below parameters

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

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening: ☐ No Abnormalities Detected

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

Inform consultant for positive criteria

....

....

Nutritional Screening: ☐ No Abnormalities Detected

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

Inform consultant for positive criteria

Psychological Screening: ☐ No Significant Findings

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

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

Social History: Lives With Family

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

Time of Initial assessment completed by ER Nurse : 11:22 PM

Docu. No. : RCH /FRM / CLINICAL / 120

(P.T.O.)

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

Time	Nursing Notes
	→ Assessed the pt condition
	→ Checked the pt vitals
	→

Samples collected by: / Time: /

Samples sent by : 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: 141 b/m BP: .... CFT: 2sec	Shift - out from ER to: ward
RR: .... SPO2 : 98%	Time of Shift - out: 12:30 A.M
GCS: 15/15 Temperature :	Handover given to: .... (Nurse's Name)
Pain Score: 8	
Repeat RBS (if applicable):	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

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

Name of the Nurse : Babin

Signature of the Nurse : [signature]

Date & Time : 18/6/26 @ 11:22 P.M