

ACTIVITY RECORD F

VIH-00205997 IP-00060380
Master SHAKKARAGARI NIHAN
27-02-2022 4 Y 3 M 21 D (M)
Dr. SIVA NARAYANA REDDY



Name: -----

UHID No : ----- IP

Attendant : ----- Dept: pediatrics

Date of Admission : 17/6/26 Time : ----- Date of Discharge : ----- Time: -----

Room / Bed No : 102 Ward : 1st floor Suggested Billable bed type : -----

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
17/6/26	@ 4:45 PM	ER	102	<i>[Signature]</i>

Cross Consultation Visit

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

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
12/16/26	IV placement	①	3091373	①
	nebs	4	3091547	✗
	IV placement	①	3091539	✗
	nebs	2	3092018	✗
	Woks checked by Leigasee			S

ANY OTHER INFORMATION

 covid RAT Negative

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward Leigasee B2mo-	Billing Assistant	Billing Supervisor
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VIH-00205997 IP-00060380
 Master SHAKKARAGARI NIHAN
 27-02-2022 4 Y 3 M 21 D (M)
 Dr. SIVA NARAYANA REDDY

102



NEBULISATION CHART

Date	Time	Drug	Nurse	Parents Signature
17/6	00.00	6:00pm - Levolin + budicort	manasa	S. Maheshwari
	01.00	10pm - Levolin	Subham	S. Maheshwari
18/6/26	02.00	2am - Levolin	Subham	S. Maheshwari
	03.00	6 am - Levolin + Budecort	Subham	S. Maheshwari
	04.00	(u) 3091547		
	05.00	11:00AM - Levolin	manasa	S. Maheshwari
	06.00	3pm - Levolin	Bevonika	S. Maheshwari
	07.00	6pm - Budecort	Bevonika	S. Maheshwari
	08.00	8pm - Levolin	Bevonika	S. Maheshwari
19/6/26	09.00	2pm - Levolin	Subham	(Signature)
	10.00	6am - Budecort	Subham	(Signature)
	11.00	8am - Levolin	Subham	(Signature)
	12.00	(7) 3092018 -		
	13.00			
	14.00			
	15.00			
	16.00			
	17.00			
	18.00			
	19.00			
	20.00			
	21.00			
	22.00			
	23.00			

Window
Unit
Number

NEBULIZATION CHART

Time	Medication	Rate	Flow	Volume	Notes
08:00	Albuterol	2.5	6	150	
09:00	Bambuterol	2.5	6	150	
10:00	Bambuterol	2.5	6	150	
11:00	Bambuterol	2.5	6	150	
12:00	Bambuterol	2.5	6	150	
13:00	Bambuterol	2.5	6	150	
14:00	Bambuterol	2.5	6	150	
15:00	Bambuterol	2.5	6	150	
16:00	Bambuterol	2.5	6	150	
17:00	Bambuterol	2.5	6	150	
18:00	Bambuterol	2.5	6	150	
19:00	Bambuterol	2.5	6	150	
20:00	Bambuterol	2.5	6	150	
21:00	Bambuterol	2.5	6	150	
22:00	Bambuterol	2.5	6	150	
23:00	Bambuterol	2.5	6	150	
00:00	Bambuterol	2.5	6	150	
01:00	Bambuterol	2.5	6	150	
02:00	Bambuterol	2.5	6	150	
03:00	Bambuterol	2.5	6	150	
04:00	Bambuterol	2.5	6	150	
05:00	Bambuterol	2.5	6	150	
06:00	Bambuterol	2.5	6	150	
07:00	Bambuterol	2.5	6	150	

210590 (F)

10/10

10/10

Name	Master SHAKKARAGARI NIHAN REDDY	UHID	VIH-00205997
Father/Guardian	Mr SHAKKARAGARI SHIVARAM REDDY	Age/Gender	4 Y 3 M 23 D/Male
Address	H,NO:3-54,KERELLY,KARVELLI,DHARUR,VIKARABAD,TELANGANA., Dharur, Ranga Reddy, Telangana, INDIA, 501121		
IP No	IP-00060380	Admission Date	17-06-2026
Ref Doctor	Dr Muralidhar	Discharge Date	19-06-2026

DISCHARGE SUMMARY

Consultant: Dr. SIVA NARAYANA REDDY VENNAPUSA

DCH, DNB, FELLOWSHIP IN NEONATOLOGY
SENIOR CONSULTANT PEDIATRICS
48300

Diagnosis: Pneumonia

History: Master SHAKKARAGARI NIHAN REDDY is a 4 Y 3 M 23 D, boy presented with history of moderate grade intermittent fever, cold since 2 days, 3-4 episodes of non-bilious non-projectile vomiting (subsided now), increased work of breathing since 1 day prior to admission. For the above complaints, he was investigated and treated at referral center, but in view of persistence of symptoms, he was referred to Rainbow Children's Hospital for further management.

Outside Investigations: Chest x-ray showed right upper lobe consolidation.

Examination: He was febrile (100.3°F), maintaining saturations at room air. His heart rate was 140/min, blood pressure 100/70 mmHg and respiratory rate 35/min. Respiratory distress was present in the form of tachypnea, mild intercostal retractions. On auscultation of chest, air entry was equal with bronchial breath sounds. Heart sounds were normal and there was no murmur. Abdomen was soft with no organomegaly. Neurologically, he was conscious and oriented. Other systemic examination was normal.

Name	Master SHAKKARAGARI NIHAN REDDY	UHID	VIH-00205997
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Weight on admission : 16.10 kgs.

Investigations: Enclosed.

Management: He was admitted in the ward and started on intravenous antibiotics and intravenous fluids. In view of chest signs, he was nebulised with Levolin and Budecort. Child was empirically started on Oseltamivir.



His venous blood gas showed pH 7.41, pCO₂ 33.9 mmHg, pO₂ 63 mmHg, HCO₃ 21.6 mmol/L, BE -3.0 mmol/L. Complete blood picture showed hemoglobin 12.0 gm%, white blood cells count of 14,080 cells/cumm, platelet count of 3.42 lakhs/cumm and C-Reactive protein 17 mg/L. Serum electrolytes and creatinine were normal. Blood culture was sterile after 24 hours of incubation. X-ray nasopharynx showed mild adenoid hypertrophy.

His vitals were regularly monitored. His symptoms gradually settled and was afebrile for last 36 hours. Repeat hemogram done on 19.06.2026 showed hemoglobin 12.1 gm%, white blood cells count of 9,800 cells/cumm, platelet count of 3.51 lakhs/cumm and C-Reactive protein 1 mg/L. He remained hemodynamically stable during the hospital stay and is being discharged with the following advice.

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

Advice:

1. Diet as advised.
2. Injection Ceftriaxone 1.3 grams, slow intravenous in 50ml normal saline over 30 minutes once daily till 21.06.2026 followed by Syrup Cefixime (5ml=100mg) 4ml, 12th hourly (after food) for 3 days (Refrigerate after reconstitution).

Name	Master SHAKKARAGARI NIHAN REDDY	UHID	 Rainbow Children's Hospital It takes a lot to treat the little.	 BirthRight BY RAINBOW HOSPITALS Your Right to a Safe Delivery
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3. Syrup Azithromycin (5ml=200mg) 4ml once daily till 21.06.2026.
4. Syrup Relent Plus, 2.5ml, 12th hourly for 2 days.
5. Syrup Oseltamivir (1ml=12mg) 2.5ml, 12th hourly till 22.06.2026 morning dose (To be refrigerated).
6. Nebulization with Levolin (0.63mg), 1 respule 8th hourly for 2 days followed by 1 respule 12th hourly for 3 days and stop.
7. Nebulization with Budecort (0.5mg), 1 respule 12th hourly for 3 days.
8. Follow up with Dr. Muralidhar Garu, Consultant Pediatrician.

In case of Fever:

Syrup Paracetamol (5ml=240mg), 5ml for fever >99.6°F (maximum 4-6 hourly).

Syrup Ibugesic (5ml=100mg), 8ml for fever >101°F (maximum 8 hourly).

To take appointment for OPD consultation at Rainbow Children's Hospital, just dial one number 1800-2122 (between 8 a.m. to 8 p.m.) (or) log on to www.rainbowhospitals.in

In Case of increasing breathing difficulty, dullness or high fever, Contact Emergency 040-42462200 Extn: 2010 (or) 7337357870.

If any IV antibiotics - will be given in Emergency Room between 6am - 7am for morning dose, between 2pm - 3pm for afternoon dose and between 10pm - 11pm for evening dose (Outside IV medication shall Dnot be allowed with in the hospital as per the hospital protocol).

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

Name	Master SHAKKARAGARI NIHAN REDDY	UHID	VIH-00205997
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Name :

Signature :

Relationship with patient :

This summary has been explained by :

Summary prepared by: Dr. Sameera
DEO : MD Younus Pasha

Registrar/Resident/C.M.O

For Sameera

Dr. SIVA NARAYANA REDDY VENNAPUSA
DCH, DNB, FELLOWSHIP IN NEONATOLOGY
SENIOR CONSULTANT PEDIATRICS
48300

Rainbow Children's Hospital - Secunderabad

H.No.3-7-222/223,Sy.No.51 to 54,Opp.Karkhana P S,Karkhana Main Road,Kakaguda, Karkhana ,Hyderabad ,Telangana, INDIA ,500009
040-42462200, Ext 2000,2001,2002,



INSURANCE COPY

PatientName : Master SHAKKARAGARI NIHAN REDDY **Inpatient No.** : IP-0000380
Age/Gender : 4 Y 3 M 21 D/ Male **Admit Date** : 17-06-2026
Ward/Bed : N 0 GF-EMERGENCY/ ER 101 **Discharge Date** :

Investigation	Result	Unit	Biological Reference Interval
COMPLETE BLOOD PICTURE (Specimen : BLOOD)		TEST RESULT STATUS : REPORT AUTHORISED	
Order Date :17-06-2026 16:22			
HEMOGLOBIN (Colorimetry)	12.0	g/dL	11.5 - 15.5
RBC COUNT (DC detection method)	4.47	10 ¹² /L	3.9 - 5.3
PCV/HCT (Calculated)	32.8	VOL%	L 34 - 40
MCV (Calculated)	73.3	fL	L 75 - 87
MCH (Calculated)	26.8	pg/cells	24 - 30
MCHC (Calculated)	36.5	g/dL	H 32 - 36
RDW-CV (Calculated)	12.7	%	11.5 - 15
PLATELET COUNT (DC Detection Method)	342	10 ⁹ /L	150 - 450
MPV (Calculated)	7.8	fL	6.5 - 10
WBC COUNT (DC Detection Method)	14.08	10 ⁹ /L	5.5 - 15.5
Differential Count			
NEUTROPHILS (Microscopy, Leishman stain)	77	%	H 23 - 45
LYMPHOCYTES (Microscopy, Leishman stain)	14	%	L 35 - 65
MONOCYTES (Microscopy, Leishman stain)	08	%	4 - 10
EOSINOPHILS (Microscopy, Leishman stain)	01	%	1 - 6
PERIPHERAL SMEAR (Microscopy, Leishman stain)	RBC - NORMOCYTIC / NORMOCHROMIC WBC - MORPHOLOGY NORMAL PLATELETS - ADEQUATE		

Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
C REACTIVE PROTEIN (Specimen : SERUM)		TEST RESULT STATUS : REPORT AUTHORISED	
Order Date :17-06-2026 16:22			
CRP (Immunoturbidimetry)	17	mg/L	H <10

Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
CREATININE (Specimen : SERUM)		TEST RESULT STATUS : REPORT AUTHORISED	
Order Date :17-06-2026 16:22			
CREATININE (Enzymatic)	0.4	mg/dl	0.04 - 0.6

PatientName : Master SHAKKARAGARI NIHAN REDDY Inpatient No. : IP-00060380
Age/Gender : 4 Y 3 M 21 D/ Male Admit Date : 17-06-2026
Ward/Bed : N 0 GF-EMERGENCY/ ER 101 Discharge Date :

Investigation	Result	Unit	Biological Reference Interval
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Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
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ELECTROLYTES (Specimen : SERUM)

TEST RESULT STATUS : REPORT AUTHORISED

Order Date :17-06-2026 16:22

SODIUM (Direct ISE)	144	mmol/L	H 134 - 143
POTASSIUM (Direct ISE)	4.6	mmol/L	3.7 - 5
CHLORIDE (Direct ISE)	106	mmol/L	98 - 108



Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
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RANDOM BLOOD GLUCOSE(POCT) (Specimen : PLASMA)

TEST RESULT STATUS : REPORT ENTERED

Order Date :17-06-2026 16:23

RANDOM BLOOD GLUCOSE (GOD/POD)	102	mg/dl	70 - 140
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Investigation	Result	Unit	Biological Reference Interval
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VENOUS BLOOD GAS (POCT) (Specimen : BLOOD)

TEST RESULT STATUS : REPORT ENTERED

Order Date :17-06-2026 16:23

PH (Reagent Strip/Double PH Indicator)	7.41	unit	7.35 - 7.45
pCO2	33.9	mm Hg	L 35 - 48
pO2	63	mm Hg	L 83 - 108
HCO3	21.6	mmol/L	
BE	-2.6	mmol/L	
O2 Sat	92	mmol/L	

Investigation	Result	Unit	Biological Reference Interval
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COVID ANTIGEN RAPID TEST (Specimen : SWAB)

TEST RESULT STATUS : REPORT ENTERED

Order Date :17-06-2026 17:25

COVID ANTIGEN RAPID TEST	negative		
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Investigation	Result	Unit	Biological Reference Interval
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COMPLETE URINE EXAMINATION (Specimen : URINE)

TEST RESULT STATUS : REPORT AUTHORISED

Order Date :17-06-2026 17:28

PHYSICAL

COLOUR (Visual Examination)	PALE YELLOW		
APPEARANCE (Gross Examination)	CLEAR		
pH (Double pH indicator)	6.0		5 - 8.5
SPECIFIC GRAVITY (PKA Reaction)	1.010		1.005 - 1.030
SEDIMENT (Gross Examination)	NIL		NIL

PatientName : Master SHAKKARAGARI NIHAN REDDY
Age/Gender : 4 Y 3 M 21 D/ Male
Ward/Bed : N 0 GF-EMERGENCY/ ER 101

Inpatient No. IP-00060380
Admit Date : 17-06-2026
Discharge Date :

Investigation	Result	Unit	Biological Reference Interval
CHEMICAL			
PROTEIN (Protein error of pH indicator)	NIL		NIL
GLUCOSE (GOD POD method)	NIL		NIL
KETONE BODIES (Acetoacetic acid reaction)	NEGATIVE		NEGATIVE
BILE SALTS (Hay's Sulfur Test)	ABSENT		ABSENT
BILE PIGMENTS (Diazo reaction)	ABSENT		ABSENT
NITRITE (Reflectance Photometry)	NEGATIVE		NEGATIVE
BLOOD (Peroxidase reaction)	ABSENT		ABSENT
LEUCOCYTES (Esterase reaction)	NEGATIVE		NEGATIVE
MICROSCOPY			
PUS CELLS	3-4	HPF	L 0 - 5
EPITHELIAL CELLS	2-3	HPF	L 0 - 5
RBCS.	NIL	HPF	0 - 2



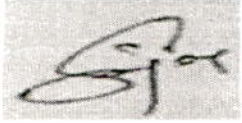
Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
COMPLETE BLOOD PICTURE (Specimen : BLOOD)			
TEST RESULT STATUS : REPORT ENTERED Order Date :19-06-2026 11:21			
Differential Count			
NEUTROPHILS (Microscopy, Leishman stain)	61.7	%	H 23 - 45
LYMPHOCYTES (Microscopy, Leishman stain)	23.1	%	35 - 65
MONOCYTES (Microscopy, Leishman stain)	10.4	%	H 4 - 10
EOSINOPHILS (Microscopy, Leishman stain)	4.3	%	1 - 6
MPV (Calculated)	7.6	fL	6.5 - 10
RBC COUNT (DC detection method)	4.51	10 ¹² /L	3.9 - 5.3
PCV/HCT (Calculated)	33.0	VOL%	34 - 40
MCV (Calculated)	73.1	fL	75 - 87
MCH (Calculated)	26.8	pg/cells	24 - 30
MCHC (Calculated)	36.7	g/dL	H 32 - 36
RDW-CV (Calculated)	12.5	%	11.5 - 15
PLATELET COUNT (DC Detection Method)	351	10 ⁹ /L	150 - 450
WBC COUNT (DC Detection Method)	9.80	10 ⁹ /L	5.5 - 15.5
HEMOGLOBIN (Colorimetry)	12.1	g/dL	11.5 - 15.5

PatientName : Master SHAKKARAGARI NIHAN REDDY Inpatient No. : IP-00060380
Age/Gender : 4 Y 3 M 23 D/ Male Admit Date : 17-06-2026
Ward/Bed : N 0 GF-EMERGENCY/ ER 101 Discharge Date :

Investigation	Result	Unit	Biological Reference Interval
C REACTIVE PROTEIN (Specimen : SERUM)			TEST RESULT STATUS : REPORT AUTHORISED Order Date :19-06-2026 11:21
CRP (Immunoturbidimetry)	1.0	mg/L	<10



Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Interim Report

This is an interim report. The final report will be released after 24 hours

Laboratory Report



Master SHAKKARAGARI NIHAN REDDY

4 Y 3 M 23 D

Male

IP-00060380

VIH-00205997

Dr. SIVA NARAYANA REDDY VENNAPUSA

VI26020665

17-06-2026 04:27 PM

17-06-2026 04:45 PM

N 0 GF-EMERGENCY / ER 101

BLOOD CULTURE AND SENSITIVITY (Specimen :BLOOD)

RESULT TEST RESULT STATUS : REPORT ENTERED

Culture: -

Initial Report: No growth after 24 hrs of incubation

..... End of the Report

Interim Report

ERROR LOG

LOCATION: - NICU / PICU / HDU / OT / GENERAL WARD

ICD CODE :-

OBSERVATION: -

DATE :

MRD EXECUTIVE

ADMISSION SHEET

Registration Details :



Admission No : IP-00060380

Admit Date : 17-Jun-2026

Admit Time : 03:52 PM UHID : VIH-00205997

Patient Details :

Patient Name : Master SHAKKARAGARI NIHAN REDDY

Age : 4 Y 3 M 21 D

Guardian : Mr SHAKKARAGARI SHIVARAM REDDY

DOB : 27-02-2022

Gender : Male

Religion :

Occupation :

Martial Status :

Address (H) : H,NO:3-54,KERELLY,KARVELLI,DHARUR,
VIKARABAD,TELANGANA. Dharur Ranga
Reddy Telangana INDIA 501121

Phone No : 9618363858/ 8008469871

E-mail : NA@GMAIL.COM

Admission Details :

Bed Type : SHARED WARD

Bed No : ER 101

Ward Name : N 0 GF-EMERGENCY

Room No : ER 101

Admission Type : First Visit


Contact Details :

Name : Mr SHAKKARAGARI SHIVARAM REDDY

Relationship : Father

Contact Address : H,NO:3-
54,KERELLY,KARVELLI,DHARUR,VIKARABAD,
TELANGANA. Dharur Ranga Reddy Telangana
INDIA 501121

Phone No : 9618363858


Signature

Doctor Details :

Doctor Name : Dr. SIVA NARAYANA REDDY VENNAPUSA

Specialisation : GENERAL PEDIATRICS

Referral Doctor : Dr Muralidhar

Phone No :

Co-Consultant :

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : NIVA BUPA HEALTH INSURANCE
COMPANY LIMITED

Patient Name : Mast. SHAKKARAGARI NIHAN REDDY UHID : VIH-00205997 IPD : IP-00060380 Gender : Male Age : 4 Y 3 M 21 D

VIH-00205997 IP-00060380
Master SHAKKARAGARI NIHAN
27-02-2022 4 Y 3 M 21 D (M)
Dr. SIVA NARAYANA REDDY



H - 108cm



wt - 16.10kg

EMERGENCY ROOM TRIAGE FORM

Patient's Name : mst. Nihan Reddy Age : 4y Gender: Male Female

Date : 17/6/26 Time of Arrival : 2.40pm

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: 100.3°F PR: 137b/m BP: 107/70 RR: 38b/m SpO₂: 100%

Chief Complaints: Fever, cough, cold x 5 days, fast breathing x yesterday

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

Triage Classification	CTAS
<input type="checkbox"/> Level 1: Resuscitation	<input type="checkbox"/> Immediate
<input type="checkbox"/> Level 2: EMERGENT: Life or limb threatening	<input type="checkbox"/> < 15 min
<input type="checkbox"/> Level 3: URGENT: Significant illness / injury with potential to become life or limb threatening	<input 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.
* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian : S. Nalini
Triage Completion Time : 2.45pm

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 : Bns. Seeraj
Date & Time : 17/6/26 2.45pm

Signature of Triage Nurse : Seeraj

Patient Name : Mast. SHAKKARAGARI NIHAN REDDY UHID : VIH-00205997 IPD : IP-00060380 Gender : Male Age : 4 Y 3 M 21 D

VIH-00205997 IP-00060380
Master SHAKKARAGARI NIHAN
27-02-2022 4 Y 3 M 21 D (M)
Dr. SIVA NARAYANA REDDY



NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 17/02/22 Time of arrival : 2:46 PM
 Chief Complaints : fever, cough, cold x 5 days, fast breathing x yesterday RBS: _____
 Height : 108 cm Weight : 16.1 kg BMI : _____ Head Circumference (<2 years) : _____
 Allergies: Yes No Medications Blood Transfusion Food Other: _____
 If yes, identify _____
 Pain Screening: Yes No If Yes, Pain Score: 0 Pain Tool Used: N Pass FLACC Wong Baker
 Character _____ Location _____ Frequency _____ Duration _____

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

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 : 2:48 PM

Patient Name : Mast. SHAKKARAGARI NIHAN REDDY UHID : VIH-00205997 IPD : IP-00060380 Gender : Male Age : 4 Y 3 M 21 D

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

Time	Nursing Notes
2:40 PM	Pt came TO ER.
2:42 PM	Pt vitals checked and Records Done.
2:45 PM	Dr. Prashanti seen the pt advice Admission.
3:40 PM	Pt Admission process Done.
4:17 PM	Pt IV Placement Done and Sample sent to Lab. Pt shift ER to ward
	* Covid RAT Negative, VBS done in ER.

Samples collected by: S srkiran
 Samples sent by: Hema

Time: S 4 PM

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1
2:50 PM	2yp. Crocin DS	P/O	Smul	[Signature]	[Signature]

Condition of patient at time of shift - out :	Details of Shift - out
HR: 140b/m BP: 109/70 ⁽⁸²⁾ CFT: Lejecc	Shift - out from ER to: 102
RR: 25b/m SPO ₂ : 98%	Time of Shift - out: 17/6/26 @ 4:45 PM
GCS: 15/15 Temperature: 99.2°F	Handover given to: Sr Manasa
Pain Score: 0	(Nurse's Name) by Dr. Archithe
Repeat RBS (if applicable): -	


Tick as applicable: MLC LAMA BROUGHT DEAD

Procedures done with details (if any):

Name of the Nurse : Sr. Archithe Signature of the Nurse : [Signature]

Date & Time : 17/6/26 @ 4:45 PM

PATIENT TRANSFER FORM

VIH-00205997 IP-00060380 Master SHAKKARAGARI NIHAN 27-02-2022 4 Y 3 M 21 D (M) Dr. SIVA NARAYANA REDDY 		Date & Time of Admission 17/6/26 @ 3:52 PM	Date & Time of Transfer Order 17/6/26 @ 4:45 PM
		Transfer Ordered by Dr. prashanthi	Reason for Transfer Admission
From Unit ER	To Unit 102	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File 21	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring Architha Hg		Name of Person Ordered Transfer Dr. prashanthi	
Patient & Clinical Records Received by : Manasa			
Date & Time of Patient Received : 17/6/26 @ 4:55 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



Nursing General Admission Assessment Form For Pediatrics

Diagnosis: Lower respiratory tract infection
Arrival Time: 4:55pm **Mode of Arrival:** By walk **Admitting From:** ER OPD Direct

Allergy / Adverse Reaction: no **Body Weight:** 16.1 Kg
Height: 108 cm

Past Medical History: Obtained From Patient Family Member Medical Record Other (specify)

Past Medical History	Past Surgical History	Previous Hospital Admission
yes	nil	yes Admitted for Pneumonia

Family History: nil

Has the child or close family member had recent contact with a communicable disease? Yes No

If yes please list,

Was the child's birth normal? Yes No If No, please describe problems:

Are the child's immunization up to date? Yes No

Current Medication: None Yes, If Yes, fill reconciliation form

Observations: Weight: 16.1 kg Length: 108 cm Head Circumference (< 2 years): nil
 Temp.: 98.1°F HR: 107b/m RR: 26 b/m BP: 105/66(7/6)

Pain Score: 0 **Specify Site:** nil (Follow Pain Assessment Sheet & Document)

Fall Risk Assessment: Yes No **Score:** 10 (Document in the Humpty Dumpty Sheet)

Risk of Pressure Sore (Braden Q Score): 23 (Document in the Braden Q Assessment Sheet)

Pain Screening: Yes No If Yes, Pain Score: 0 Pain Tool Used: N Pass FLACC Wong Baker

Character of Pain: nil **Location:** nil **Frequency:** nil **Duration:** nil

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 Special Feeding Method
 Feeding Problem Special diet No Abnormality Detected

Inform consultant for positive criteria

Psychological Screening: No Significant Findings

Unusual concerns about patient's Psychological Status: Yes No

If Yes Consultant Notified: ^{NI} (Date/Time):

Social History: Lives With ^{Family}

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

All Information Obtained From Patient Mother Father Other Family Member

Orientation has been given regarding the following aspects:

Call Bell in Reach : Yes No

Waste Disposal Explained: Yes No

Infusion Pump : Yes No

Hand hygiene Explained: Yes No

Others

Patient Rights & Responsibilities: Yes No

Information given to ^{mother}

Nurse's Name: ^{Manasa} Date: ^{17/6/26} Time: ^{8.00pm}


Signature



Rainbow[®] Children's Hospital

It takes a lot to treat the little.

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: _____

VIH-00205997 IP-00060380

Master SHAKKARAGARI NIHAN

27-02-2022 4 Y 3 M 21 D (M)

Dr. SIVA NARAYANA REDDY

UHID ID: _____



Department: _____

Consultant: _____

Pediatric Multiorgan History & Physical Examination

Name : Nihanth Reddy Age/Sex 4y/male
Information given by: Mother Relationship Good

Chief Presenting Complaints & Duration (Chronologically)

c/o fever :: 2 days
c/o cold :: 2 days
c/o ↑WOB :: yesterday.

History of present illness :

Child was apparently asymptomatic 2 days back
then developed
c/o fever :: 2 days.
mod-grade - Intermittent fever.
T-F period - Active.
Subsiding on medication - remitting again.
& cough → productive cough.
c/o cold :: 2 days
In the form of nasal Blockade.
c/o Vomiting - 2 days back
(3-4) episodes NB/vpl Non blood stained.
↓
lubricated stool.
o/s - Better.
c/o Breathlessness :: yesterday night
y/o - Adequate.
↑WOB (F)
lenolin
consulted outside hospital - on Nebulizer
Budecort
Syr. Amoxiclav - for 1 day.
Syr. efepodexime - for 1 day.



Pediatric Multiorgan history & Physical Examination

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

Admitted @ 8 months p Age i/o pneumonia.

Chest xray done outside

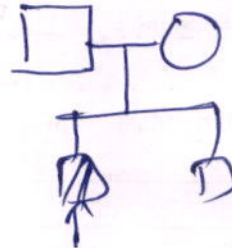
↓

(P) UL consolidation (+nt)

Birth & Neonatal History:

Term 2.4kg / 44

CIAB, NO NJu Admission.



Birth & Socio Economic History:

About Father : _____

About Mother : _____

Any additional Information : _____

} class III

Developmental History :

Development achieved as per Age - In all 4 domains.

Immunization History :

Immunized as per Age.



Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs)) 16.10 kgs (Centile _____)

On Examination :

Temperature : 100.3 F Pulse Rate : 140-145 B.P. 90/75 SPO2 99% on RA.
b/m

Resp. rate and type of breathing : 35 B/m.

Rash _____

Lymphadenopathy _____

Oedema : Go.

Allergies (if any): _____

Respiratory System :

Inspection (any s/o distress) : Tachypnea (+)

Air entry & breath sounds : Clear (+) Bronchial Breath sounds.

Any added sounds : wild

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

Cardiovascular System :

Inspection of precordium : (N)

Heart Sounds : 112 (+)

Any murmur : (+)

Relevant data from outside (Chest X-Ray, ECG, ECHO, etc.,) : _____

Per Abdomen :

Inspection : (N)

Palpation : PA: soft

Auscultation : (N)

Spine : (N) External Genitalia : (N)

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

Pediatric Multiorgan history & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : Alert 15/15

Cranial Nerves : (N)

Motor System:

Nutrition : _____

Tone: g (N) Power (R) (L)

Co-ordinator : g (N) S/R S/L

Posture : _____

Involuntary Movements : (-)

Reflexes :

DTR +nt

Superficials: +nt

Plantars flexor

Sensory System :

(N)

Bladder / Bowel : (N)

Clinical Summary & Diagnostic:

LRTI



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: _____
_____ To prevent further complications

Desired goals of the treatment: _____
_____ To treat the symptoms.

1/12/20 Dr. Siva Narayan Reddy

Planned Labs:

CBP, CRP, SLG, S. creat, ✓
VBG, cue. ✓
Blood ✓
a Extra plain. ✓

CXR - done outside.

Planned Management

↳ Continuous monitoring.
- IVF
- Inj. Cefixime - Iv - 12 hourly
- Neb - levolin - 6 hourly
Budecort - 12 hourly.

- Mannoion - p-Nasal Drops.

- Inj. Chlorzoxazone.
- sup. Relent Plus

Noted by Sr. Liza A.V
17/6/26 @ 4:20 pm

Signature of the Doctor: _____
Name of the Doctor: Dr. Prabhakar
Date & Time: 17/6/26

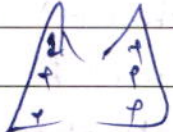
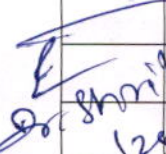
Signature of the Consultant: _____
Name of the Consultant: _____
Date & Time: 17/6/26 9 AM



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
17/6/21 4:00pm.	<p><u>Counselling notes</u> By Dr. thanuja (PICU fellow).</p>	
	<p>Parents were explained about the condition of the child. The xray findings & symptoms suggestive of LRTI in the form of pneumonia. there is a need for admission & having the child on Iv Antibiotics, Nebulizations. As the child is looking stable & saturations are maintainy, There is a need for ward-admission. If the symptoms worsen & Distress (+) there is a need for PICU Admission. And need for continuous monitoring in the ward to check for saturations & heart rate.</p>	
Dr. prashanthi		
17/6/21 5:40pm.	<p>-D/W <u>Dr. Siva sir</u>, informed reports.</p>	
<p>noted by ananasa 17/6 2:58pm</p>	<p><u>Adv</u></p> <ol style="list-style-type: none"> 1) change Neb. levoflox 4th hourly 2) Add Azithromycin 3) Add fever 4) Continuous monitoring 5) Perform test of SpO₂ < 95% or. fast breathing (+) 	<p>Dr. Vishwak</p>

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
17/6 8:30 pm	S/B resident D: CRTI.	
	→ Issues: - no fever, admission. - NO RD.	
	on Examination.	
	→ WOB - (N) CRT < 3sec. CVS - S1C (A)	Reports awaited Stds
	RS - mild ↓ oxygen in the (R) infraclear region - es (A).	
	PIA - soft	<div style="border: 1px solid black; padding: 5px; display: inline-block;"> PR - 120 SpO₂ - 97-100 RR - 20 </div>
	CNS - normal	
	plan	
	- CPR if PO-worsen	
	- (Sas) picu if ROT.	
	- Continuous monitoring	
	- Continue Medication.	
 Dr. Shrikant 125536		DTD by Subham 17/6 @ 10PM



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
18/6/26	S/B Resident	
8:00 AM	A: URTI	
	1 fever spike - 100.3°F. 10:15 PM	
	RD ⊖.	
	on exam ⁿ .	Reports awaited
	- WOB ⊕	
	CET < 3 sec	- B/cf.
	CNS - IIC ⊕	
	MS - BAE ⊕	
	PIA soft	
	CNS - no FND.	
	Plan	
	Zyg. ceftriaxone → D ₁	
	Sup. Ace → D ₂	
	Sup. Oxetamir → D ₂	
	rebutilizations	
	stop	
	- CRP (COC) ; (COC) P/W.	
	- continuous monitoring	
Dr. Smita 25535	S. Narayana 18/6/26 10:00	Noted by Benmika 18/6 @ 2 pm

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	<u>S/B Resident</u>	
18/6/26		
11:40pm	<p>ASIS - CRTI</p> <p>No fever spikes</p> <p>afebrile > 15 hours.</p>	
	o/e	
	Child active	
	Euthymic	
	MDB (N)	
	Urtals stable.	
	CVS - S1S2 (A)	
	P/C - BAE (+)	
	P/A - soft	
		<u>Plan</u>
		1) Trace B/c/s report
		2) Pyl. leftmost dose - 2
		3) Neb. levoflo. 6 th hrs
		Pudocor 12 th hrs
		↓ change to 6 th hrs
	→ CXR FRM	4) Nasivon-p drops
	→ Xray Nasopharynx	5) Syp. Relent plus
		6) Syp. AZEklomoxyl P2
		7) Syp. Ontarnur 2 nd dose
		noted by Narayana KRL (B) CFM



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	S/R Resident	
19/6/26		
8 AM	S/S - CRTI	
	NO fever spikes	
	apnoeic 24hrs.	Mouthbreathing (+)
	No distress.	Snoring (+)
	e/c	
	Clear auscult	
	Euthymic	
	Vitals stable	
	Cv - SpO2 (+)	
	Rr - BAE (+)	
	PA - soft	
		Plan
		1) Trace steth report
		2) Puj ceftriaxone D2
		3) Neb levoflox - 6th hrly Budecort 12th hrly
		4) Nasivion p drops
		5) Syp. Relent plus
		6) Syp. Azithromycin D3
		7) Syp. Octanem D2
		8) Discharge on 10
		CBP, CRP maw

Dr. Krishna

Dr. Nung
 19/6/26
 10A

Noted by
 Bevanica
 19/6
 @ 12pm



EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 17/6	Time: 5 PM	7 PM	09:30 PM	10:15 PM	1 AM	3 AM	5 AM	7 AM
Doctor / Nurse / Family Concern?								
Temperature (°F)		98.6°F	97.5°F	99.4°F	100.8°F Syr-Panacetamol	98.9°F	98.0°F	98.4°F
Heart Rate (bpm) and Blood Pressure (mmHg) *		105 / 76 / 66	115 / 76 / 66	108 / 76 / 66	118 / 76 / 66	109 / 76 / 66	116 / 76 / 66	120 / 76 / 66
Heart Rate (Number)		113	115	108	118	109	116	120
esp. Rate (bpm) (Over 1 Minute) *		28	26	27	29	30	28	22
Resp Rate (Number)		28	26	27	29	30	28	22
Resp Distress	Mod/ Severe							
Receiving O ₂ (l/min)	None / Mild							
O ₂ Saturations (%)		99	100	98	95	97	98	100
Conscious Level	Normal / Altered	N	N	N	N	N	N	N
GCS *		15	15	15	15	15	15	15
TOTAL SCORE								
Number of shaded boxes		0	0	0	0	0	0	0
Pain Score		0	0	0	0	0	0	0
Observer's Initials		NR	MR	SR	SK	SK	SK	SK

ACTIONS

NB: Scores 3 should be recorded overleaf

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

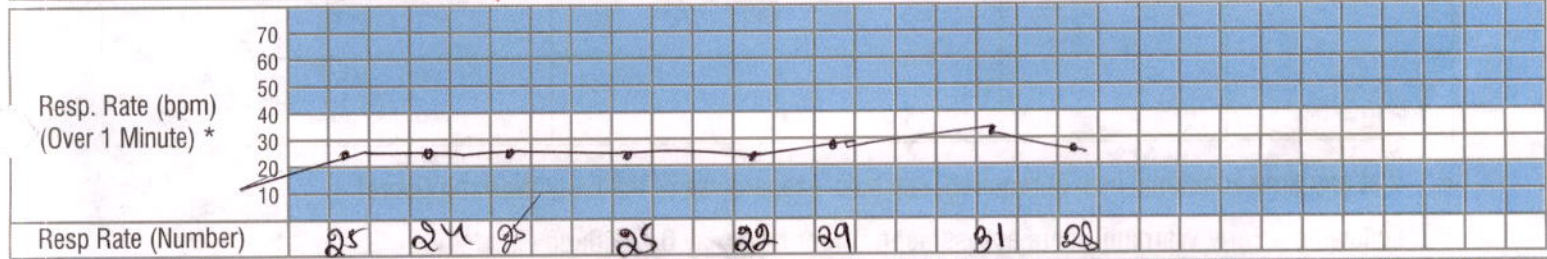
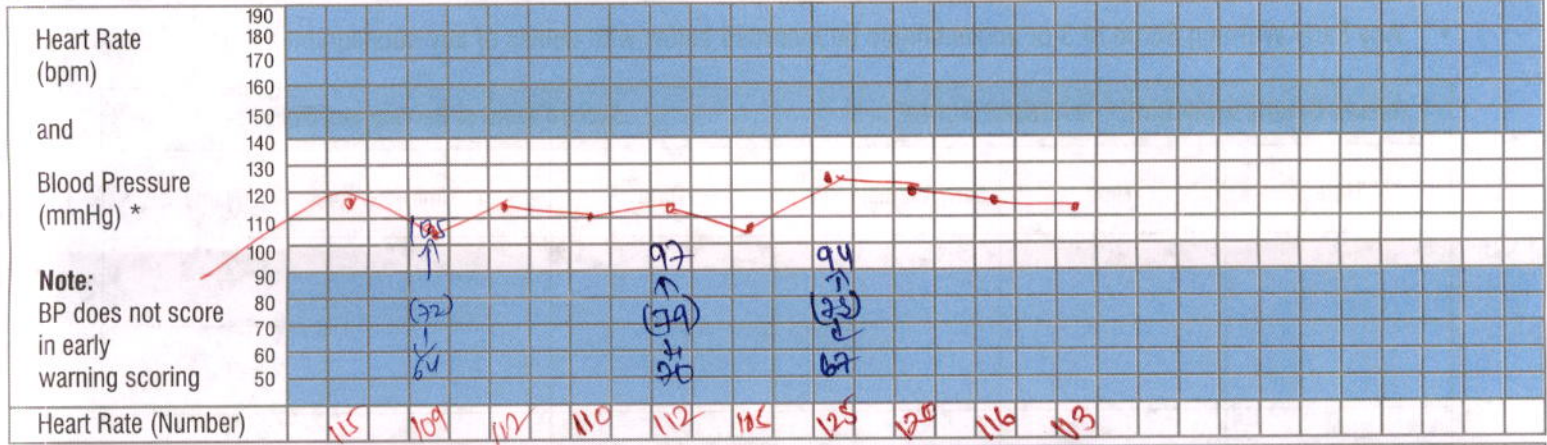
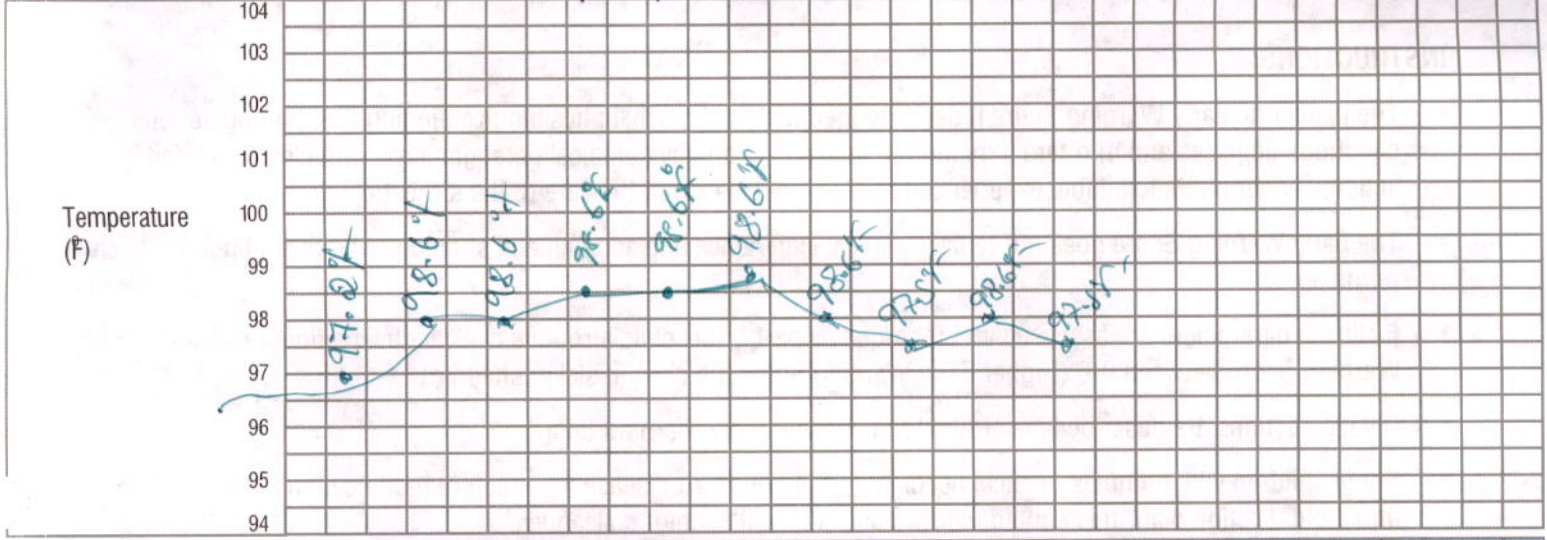
- If at any time additional help is required, call help – regardless of the Early Warning Score!
- Following a Early Warning Score assessment, senior help may be required

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

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : ... 18/6/2020	Time: 9 AM	11 AM	1 PM	3 PM	5 PM	7 PM	10 PM	1 AM	4 AM	7 AM
Doctor / Nurse / Family Concern?	AM	AM	PM	PM	PM	PM	PM	AM	AM	AM



Resp Distress	Mod/ Severe	None / Mild								
Receiving O ₂ (l/min)	O ₂ Saturations (%)									
Conscious Level	Normal / Altered									
GCS *										
TOTAL SCORE	Number of shaded boxes									
Pain Score										
Observer's Initials										

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.
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	Score 5 & 6 : Shift in charge AND PICU fellow or PICU consultant to be informed.

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

01/11/17

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

- If at any time additional help is required, call help – regardless of the Early Warning Score!
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R	RECOMMENDATION : I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)



EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 19/6/26 Time: 9

Doctor / Nurse / Family Concern? [Signature]

Temperature (F)	104	
	103	
	102	
	101	
	100	98-6 P
	99	
	98	
	97	
	96	
	95	
	94	

Heart Rate (bpm) and Blood Pressure (mmHg) *	190	
	180	
	170	
	160	
	150	
	140	
	130	
	120	98
	110	(112)
	100	68
	90	
80		
70		
60		
50		
Heart Rate (Number)	112	

Resp. Rate (bpm) (Over 1 Minute) *	70		
	60		
	50		
	40		
	30		
	20		
	10		
	Resp Rate (Number)	26	

Resp Distress	Mod/ Severe None / Mild	0
Receiving O ₂ (l/min)		0
O ₂ Saturations (%)		98
Conscious Level	Normal Altered	0
GCS *		5

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

*Noted by Reshma, ka
 19/6 @ 10:45 AM*

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

23/10/11

INSTRUCTIONS:

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

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

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

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

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

FLUID CHART

Sheet No. : 10

17/6/26

- 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				25ml									
	06:00 pm				25ml					✓				
	07:00 pm													
Total Intake : 50ml						Total Output :								
	08:00 pm													
	09:00 pm													
	10:00 pm				25ml									
	11:00 pm				25ml					✓				
	12:00 am				25ml									
	01:00 am				25ml									
Total Intake : 100ml						Total Output :								
	02:00 am				25ml									
	03:00 am				25ml									
	04:00 am				25ml									
	05:00 am				25ml									
	06:00 am				0									
	07:00 am									✓				
Total Intake : 100ml						Total Output :								

Total 24 hrs. Intake : 250ml

Total 24 hrs. Output : 3times

FLUID CHART

Sheet No. : (2)

18/6/26

- 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			
18/6	08:00 am		Mouth										M... 18/6 @ 8am
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
Total Intake :						Total Output :							
18/6	02:00 pm												B... 18/6 @ 2pm
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :							
18/6	08:00 pm												S... 18/6 @ 8pm
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
Total Intake :						Total Output :							
19/6	02:00 am												19/6 @ 8am
	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 7 times

VIH-00205997 IP-00060380
 Master SHAKKARAGARI NIHAN (M)
 27-02-2022 4 Y 3 M 21 D
 Dr. SIVA NARAYANA REDDY



FLUID CHART

Sheet No. : 3

19/6/20

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		
			Mouth	I.V	N.G							
19/6	08:00 am											
	09:00 am	Baby waters										
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
	Total Intake :						Total Output :					
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						Total Output :						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						Total Output :						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						Total Output :						
Total 24 hrs. Intake						Total 24 hrs. Output						

Noted by Anitha
19/6
@ 10.45 AM

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: ER Shifted to:

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. prashanthi

Date & Time : 17/6/26 @ 3:20 PM

Nurse Name & Signature: K. Architha

Date & Time : 17/6/26 @ 3:20 PM



DRUG CHART

Date of Admission: 17/6/26 Drug Allergies: Nil Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

- GENERAL** - Ensure that all patient details are entered above. ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.
- DOCTOR** - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
 - Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
 - Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
 - Discontinue a drug by drawing a line **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 : <u>SUP. PARACETANOL</u>				Date Time	<u>17/6</u>
Dose	Route	Frequency	Start Date		
<u>5ml</u>	<u>P/O</u>	<u>4-6 hourly</u>	<u>17/6/26</u>		
Doctor's Signature		Valid Period	Pharm.		
<u>[Signature]</u>			<u>[Signature]</u>		
Additional Instructions:					
<u>10-15mg/kg/dose</u>					
DRUG : <u>SUP. IBUPROFEN</u>				Date Time	
Dose	Route	Frequency	Start Date		
<u>5ml</u>	<u>P/O</u>	<u>4 hourly</u>	<u>17/6/26</u>		
Doctor's Signature		Valid Period	Pharm.		
<u>[Signature]</u>			<u>[Signature]</u>		
Additional Instructions:					
<u>10mg/kg/dose</u>					
DRUG :				Date Time	
Dose	Route	Frequency	Start Date		
Doctor's Signature		Valid Period	Pharm.		
Additional Instructions:					

17/6/26 5:30pm
 Engal...
 Signature
 Verified by: Name



Patient Name :	I.P. No.	Sheet No.	Wards	Weight (kg)
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REGULAR PRESCRIPTIONS

DRUG : SYP. OSELTAMIVIR				Date															
				Time	17/6	18/6	19/6	20	21	22									
Dose	Route	Frequency	Start Dt.																
2.5ml	PO	12th hourly	17/6	Amy / [Signature] / [Signature]															
Name & Signature of the Doctor starting the Drugs:				Dr. Vishwaja															
Additional Instructions:				6 PRN [Signature] [Signature] 30mg/dose															
Daily Doctor's Endorsement by a Sign.																			

DRUG : NEB. LEVOSALBUTAMOL				Date															
				Time															
Dose	Route	Frequency	Start Dt.																
0.62mg	PN	6th hourly	18/6																
Name & Signature of the Doctor starting the Drugs:				Dr. Vishwaja															
Additional Instructions:				0.62mg															
Daily Doctor's Endorsement by a Sign.																			

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

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

Dr. Vishwaja
 27/02/2022
 Dr. Vishwaja
 18/6/22
 MERCY