


ACTI **VIH-00189093** **IP-00060275** **ING**

Baby ROOHAANSI MANGALAPALLY
17-07-2024 1 Y 10 M 22 D (F)
Dr. JARJAPU KIREETI

Name  _____

UHID No. _____ Consultant : _____ Dept : pediatrics

Date of Admission : 8/6/26 Time : @ 3:50 PM Date of Discharge : _____ Time : _____

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
8/6/26	@ 6pm	GR	U	<u>[Signature]</u>

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1.	Dr. Mohd. Abdul. Khelid	10/6/26	3088161	<u>[Signature]</u>
2.	Dr. Sruithi Bella.	10/6/26	3088999	
3.	<u>Cross checked by [Signature] 11/6/26</u>			
4.				
5.				
6.				
7.				
8.				
9.				
10.				

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
8/6/26	IV placement	1	3088167	Lm
<i>Cross checked by [signature] 9/6/26</i>				
10/6	IV placement	1	3088610	[signature]
<i>Cross checked by Geizabel ✓</i>				

ANY OTHER INFORMATION

void out → neg

Date : _____ Time : _____ Prepared By : _____

Staff Nurse	Shift / Ward <i>Geizabel [signature]</i>	Billing Assistant	Billing Supervisor
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Name	Baby ROOHAANSI MANGALAPALLY .	UHID	VIH-00189093
Father/Guardian	Mr ARUN KUMAR. M	Age/Gender	1 Y 10 M 24 D/Female
Address	H.NO 7-2-1087/A/112, BK GUDA S.R. NAGAR HYDERABAD, B K Guda, Hyderabad, Telangana, INDIA, 500038		
IP No	IP-00060275	Admission Date	08-06-2026
Ref Doctor	Self	Discharge Date	11-06-2026

DISCHARGE SUMMARY

Consultant:

Dr. JARJAPU KIREETI

MBBS MD (Pediatrics) DrNB (Neonatology)

Fellowship in Neonatology (Oxford University Hospitals, U.K)

MRCPCH (UK)

Diagnosis: Urinary Tract Infection (E.coli)

History: Baby ROOHAANSI MANGALAPALLY . is a 1 Y 10 M 24 D old girl brought with complaints of moderate to high grade intermittent fever since 4 days, decreased oral intake, decreased urine output and 1 episodes of nonbilious nonprojectile vomiting since 1 day prior to admission. For the above complaints, she was admitted at Rainbow Children's Hospital for further management.

OPD Investigations: Complete blood picture done on 08.06.2026 showed hemoglobin 12.1 gm/%, white blood cells count of 19,680 cells/cumm, platelet count of 2.71 lakhs/cumm and C. Reactive protein 138 mg/L. CUE showed 15-18 pus cells, 4-6 epithelial cells, protein trace, KB ++, nitrate +, ketones ++, bacteria present.

Examination: She was febrile (102°F), maintaining saturations at room air. Her heart rate was 140/min, RR 26/min. On auscultation of chest, air entry was

Name

Baby ROOHAANSI
MANGALAPALLY .

UHID

VIH-00189093

bilaterally equal with normal heart sounds and there was no murmur. Abdomen was soft, non tender without organomegaly. She was conscious and oriented. There was no focal neurological deficits or meningeal signs. Examination of other systems including spine was normal.

Weight on admission : 11.4 kgs.

Investigations: Enclosed.

Management: She was admitted in ward and was started on intravenous antibiotics and intravenous fluids. She was treated symptomatically with antacids and antipyretics.

Serum electrolytes showed serum sodium - 141 mmol/L, serum potassium - 4.9 mmol/L, serum chloride - 107 mmol/L. Blood culture was sterile after 48 hours of incubation. Urine culture was showed growth of E. coli isolated ($>10^5$ cfu/ml). X-ray erect abdomen showed fecal loaded colon. Ultrasound abdomen was suggestive of multiple mobile internal echoes with in urinary bladder for CUE correlation to rule out cystitis.

Child was seen by Dr. Sruthi Balla, Consultant Pediatric Neurologist who advised to continue IV antibiotics for total 5 days and later to chage it to oral, Neotonic enema and Syrup Duphalac. She advised for spot urine for uric acid 10.9, spot creatinine 11.6 mg/dl, spot calcium 4.9.

Her vitals were regularly monitored. Her fever spikes and other symptoms gradually settled and was afebrile for last 36 hours. Her hemogram done on 10.06.2026 showed Hb 11.8 gm%, WBC count of 17,620 cells/cumm, platelets of 2.79 lakhs/cumm and CRP 124 mg/L. Liver function test was normal. She remained hemodynamically stable throughout the hospital stay without any complication. She is being discharged with the following advice.

Name

Baby ROOHAANSI
MANGALAPALLY .

UHID

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

 BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

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

Advice:

1. Diet as advised.
2. Injection Amoxicillin + Clavulanic acid 350mg IV at 10pm today (11.06.2026).
Followed by Injection Amoxicillin + Clavulanic acid 500 mg IV 12th hourly (8am-8pm) from 12.06.2026 morning dose till 13.06.2026 morning dose
Followed by Syrup. Augmentin DDS (5ml=400mg) 3 ml 12th hourly (after food) for 5 days (Refrigerate after reconstitution).
3. Injection Amikacin 170 mg IV once daily till 13.06.2026.
4. Syrup Duphalac, 10ml once daily (at bed time) for 3 months.
5. Syrup Colax, 5ml once daily (at bed time) for 3 months.
6. To do CBP, CRP on Saturday (13.06.2026).
7. Kindly consult Dr. Jarjapu Kireeti, Consultant Pediatrician & Neonatologist, on Monday (15.06.2026) in OPD with prior appointment (This consultation will be charged).
8. Kindly consult Dr. Sruthi Balla, Consultant Pediatric Nephrologist Monday (15.06.2026) in OPD with prior appointment (This consultation will be charged).

In case of Fever:

Syrup. Paracetamol (5ml=240mg), 3.5 ml for fever >99.6°F (maximum 4-6 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

Now booking appointments is much easy, download Rainbow Application for Free from Google play store.

Name

Baby ROOHAANSI
MANGALAPALLY .

UHID

VIH-00189093

In Case of high fever, vomitings and decreased activity or decreased urine output, Contact Emergency 040-42462200 Extn: 2010 (or) 7337357870.

The discharge advice and details on how to obtain emergency care has been explained to me in the language that i understand.

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 not 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 :

Signature :

Relationship with patient :

This summary has been explained by :

Summary prepared by: Dr.Sameera

Typist : Kalyan

Registrar/Resident/C.M.O



Dr. JARJAPU KIREETI

MBBS MD (Pediatrics) DrNB (Neonatology)

Fellowship in Neonatology

(Oxford University Hospitals, U.K) MRCPCH (UK)

APMC/FMR/80261

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.



PatientName : Baby ROOHAANSI MANGALAPALLY . Inpatient No. : IP-00060275
Age/Gender : 1 Y 10 M 22 D/ Female Admit Date : 08-06-2026
Ward/Bed : N 0 GF-EMERGENCY/ ER 101 Discharge Date :

Investigation	Result	Unit	Biological Reference Interval
CREATININE (Specimen : SERUM)			TEST RESULT STATUS : REPORT AUTHORISED
			Order Date :08-06-2026 17:16
CREATININE (Enzymatic)	0.4	mg/dl	0.03 - 0.5

Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
ELECTROLYTES (Specimen : SERUM)			TEST RESULT STATUS : REPORT AUTHORISED
			Order Date :08-06-2026 17:16
SODIUM (Direct ISE)	136	mmol/L	134 - 143
POTASSIUM (Direct ISE)	4.4	mmol/L	3.7 - 5
CHLORIDE (Direct ISE)	100	mmol/L	98 - 108

Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
UREA (Specimen : SERUM)			TEST RESULT STATUS : REPORT AUTHORISED
			Order Date :08-06-2026 17:16
UREA (Kinetic, Urease)	25.2	mg/dl	6 - 30

Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

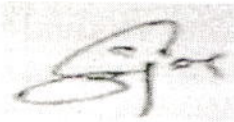
Investigation	Result	Unit	Biological Reference Interval
COVID ANTIGEN RAPID TEST (Specimen : SWAB)			TEST RESULT STATUS : REPORT ENTERED
			Order Date :08-06-2026 17:18
COVID ANTIGEN RAPID TEST	negative		

Investigation	Result	Unit	Biological Reference Interval
COMPLETE BLOOD PICTURE (Specimen : BLOOD)			TEST RESULT STATUS : REPORT AUTHORISED
			Order Date :10-06-2026 05:12
HEMOGLOBIN (Colorimetry)	11.8	g/dL	10.5 - 13.5
RBC COUNT (DC detection method)	4.76	10 ¹² /L	3.7 - 5.6
PCV/HCT (Calculated)	32.6	VOL%	L 33 - 49
MCV (Calculated)	68.5	fL	L 70 - 86

MCH (Calculated) 24.7 pg/cells

PatientName : Baby ROOHAANSI MANGALAPALLY . Inpatient No. : IP-00060275
Age/Gender : 1 Y 10 M 24 D/ Female Admit Date : 08-06-2026
Ward/Bed : N 0 GF-EMERGENCY/ ER 101 Discharge Date :

Investigation	Result	Unit	Biological Reference Interval
MCHC (Calculated)	36.1	g/dL	H 30 - 36
RDW-CV (Calculated)	12.5	%	11.5 - 16
PLATELET COUNT (DC Detection Method)	279	10 ⁹ /L	150 - 450
MPV (Calculated)	7.4	fL	6.5 - 10
WBC COUNT (DC Detection Method)	17.62	10 ⁹ /L	H 6 - 17
Differential Count			
NEUTROPHILS (Microscopy, Leishman stain)	50	%	H 15 - 35
LYMPHOCYTES (Microscopy, Leishman stain)	40	%	L 45 - 76
MONOCYTES (Microscopy, Leishman stain)	09	%	4 - 12
EOSINOPHILS (Microscopy, Leishman stain)	01	%	1 - 7
PERIPHERAL SMEAR (Microscopy, Leishman stain)	RBC : NORMOCYTIC / HYPOCHROMIC MICROCYTES(+) WBC : LEUCOCYTOSIS 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 :10-06-2026 05:12			
CRP (Immunoturbidimetry)	124	mg/L	H <10



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Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
ELECTROLYTES (Specimen : SERUM)			
TEST RESULT STATUS : REPORT AUTHORISED			
Order Date :10-06-2026 05:12			
SODIUM (Direct ISE)	141	mmol/L	134 - 143
POTASSIUM (Direct ISE)	4.9	mmol/L	3.7 - 5
CHLORIDE (Direct ISE)	107	mmol/L	98 - 108



Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
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Rainbow Children's Hospital - Secunderabad

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040-42462200, Ext 2000,2001,2002,



PatientName : Baby ROOHAANSI MANGALAPALLY
Age/Gender : 1 Y 10 M 24 D/ Female
Ward/Bed : N 0 GF-EMERGENCY/ ER 101

Inpatient No. : IP-00060275
Admit Date : 08-06-2026
Discharge Date :

Investigation	Result	Unit	Biological Reference Interval
LIVER FUNCTION TEST (Specimen : SERUM)		TEST RESULT STATUS : REPORT AUTHORISED	
		Order Date :10-06-2026 05:12	
TOTAL BILIRUBIN (Azobilirubin)	0.4	mg/dl	<1.3
CONJUGATED BILIRUBIN (Spectrophotometric)	0.2	mg/dl	<0.3
UNCONJUGATED BILIRUBIN (Spectrophotometric)	0.2	mg/dl	<1.1
SGOT (AST) (Kinetic with P5P)	22	U/L	20 - 60
SGPT (ALT) (Kinetic with P5P)	12	U/L	5 - 45
ALKALINE PHOSPHATASE (pNPP/AMP buffer)	189	U/L	145 - 420
PROTEIN (Biuret method)	6.4	g/dL	5.9 - 7
ALBUMIN (Bromocresol Green)	3.3	g/dL	L 3.4 - 4.7
GLOBULIN (Calculated)	3.1	g/dL	1.6 - 3.5
A/G RATIO (Calculated)	1		L 1.4 - 3.4

Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
SPOT URINE CALCIUM (Specimen : Spot Urine)		TEST RESULT STATUS : REPORT AUTHORISED	
		Order Date :10-06-2026 19:35	
SPOT CALCIUM (Arsenazo)	4.9	mg/dl	

Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
SPOT URINE CREATININE (Specimen : URINE)		TEST RESULT STATUS : REPORT AUTHORISED	
		Order Date :10-06-2026 19:35	
SPOT CREATININE (Modified Jaffe Kinetic)	11.6	mg/dl	L 24 - 392

Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
SPOT URINE FOR URIC ACID (Specimen : URINE)		TEST RESULT STATUS : REPORT AUTHORISED	
		Order Date :10-06-2026 19:35	



MC-7373

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PatientName : Baby ROOHAANSI MANGALAPALLY .	Inpatient No. : IP-00060275
Age/Gender : 1 Y 10 M 24 D/ Female	Admit Date : 08-06-2026
Ward/Bed : N 0 GF-EMERGENCY/ ER 101	Discharge Date :

URINE CULTURE AND SENSITIVITY (Specimen :URINE)

RESULT

TEST RESULT STATUS : REPORT AUTHORISED

Order Date : 08-06-2026 18:26:12

Gross examination : Yellow in colour, clear.**Gram stained smear** - Shows no polymorphs or organisms.**Colony count** : - >10⁵cfu/ml**Culture** : - E. coli isolated.**Susceptible to** -

Amoxycillin-Clavulanic acid, Ampicillin-sulbactam, Cefoxitin, Gentamicin, Amikacin, Tobramycin, Sulfamethoxazole-Trimethoprim, Trimethoprim and Nitrofurantoin.

Resistant to -

Ampicillin, Cephalexin, Cefuroxime, Cefotaxime, Ceftriaxone, Ceftazidime, Ceftizoxime, Cefoperazone, Cefpodoxime, Cefepime, Cefixime, Piperacillin and Aztreonam.

Remarks : This isolate is most probably an ESBL (Extended Spectrum Beta Lactamase) producer and would be resistant to all the beta lactam antibiotics. They would be susceptible either to one of the beta lactam - beta lactamase inhibitor combinations or the Carbapenems.**Possible CTXM.****Significant in a 1 year child with acute febrile illness and who is symptomatic with pus cells and on antibiotics.***Interpretation by version 16. EUCAST standard for ABST testing January 2026.*

Dr. RANGANATHAN N. IYER MD FRCPATH DNB DPB

(CONSULTANT MICROBIOLOGIST)

Dr. VIJENDRA KAWLE MD DNB

(CONSULTANT MICROBIOLOGIST)

..... End of the Report

PatientName	: Baby ROOHAANSI MANGALAPALLY .	Inpatient No.	: IP-00060275
Age/Gender	: 1 Y 10 M 24 D/ Female	Admit Date	: 08-06-2026
Ward/Bed	: N 0 GF-EMERGENCY/ ER 101	Discharge Date	:

BLOOD CULTURE AND SENSITIVITY (Specimen :BLOOD)

RESULT TEST RESULT STATUS : REPORT ENTERED
Order Date : 08-06-2026 17:16:54

Culture : -

Second Report - No growth after 48 hrs of incubation

..... End of the Report

Baby ROOHAANSI MANGALAPALLY .

1 Y 10 M 22 D

Female

IP-00060275

VIH-00189093

JARJAPU KIREETI

R26-009198

08-06-2026 06:40 PM

09-06-2026 11:20 AM

DRAFT

ULTRASOUND ABDOMEN

LIVER : Normal in size 10.5 cm and echotexture. No intra hepatic biliary duct dilatation. Portal vein is normal. No focal lesions.

GALL BLADDER : Distended well and appears normal. No evidence of calculi or wall thickening. Common bile duct appears normal.

SPLEEN :Normal in size 7.3 cm and echotexture.

PANCREAS : Normal in size and echotexture. MPD not dilated. No calcification noted.

KIDNEYS :

Right kidney : 69x28 mm. Normal in size and echotexture and shows smooth contour. No hydronephrosis or calculi.

Left kidney : 69x32 mm. Normal in size and echotexture and shows smooth contour. No hydronephrosis or calculi.

URINARY BLADDER : Distended well. Multiple mobile internal echoes within urinary bladder.

No ascites / lymphadenopathy. No evidence bowel wall thickening /edema.

Print Date/Time : 09-06-2026 11:20 AM

Printed By : A HARISH
CHANDRA KALYAN

Page: 1 of 2

Baby ROOHAANSI MANGALAPALLY .

7760067755

1 Y 10 M 22 D

R26-009198

Female

08-06-2026 06:40 PM

IP-00060275

09-06-2026 11:20 AM

VIH-00189093

JARJAPU KIREETI

Impression

**Multiple mobile internal echoes within urinary bladder.
For CUE correlation to rule out cystitis.**

Suggested clinical correlation.

ERROR LOG

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

ICD CODE :-

OBSERVATION: -

DATE :

MRD EXECUTIVE

ADMISSION SHEET

Registration Details :



Admission No : IP-00060275

Admit Date : 08-Jun-2026

Admit Time : 04:48 PM UHID : VIH-00189093

Patient Details :

Patient Name : Baby ROOHAANSI MANGALAPALLY .

Age : 1 Y 10 M 22 D

Guardian : Mr ARUN KUMAR. M

DOB : 17-07-2024 03:09 PM

Gender : Female

Religion :

Occupation :

Marital Status : Single

Address (H) : H.NO 7-2-1087/A/112, BK GUDA S.R. NAGAR
HYDERABAD B K Guda Hyderabad Telangana
INDIA 500038

Phone No : 7760067755/ 7760067755

E-mail : 7760067755@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

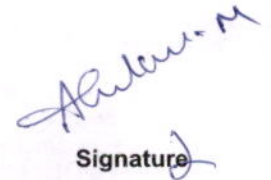
Contact Details :

Name : Mr ARUN KUMAR. M

Relationship : Father

Contact Address : H.NO 7-2-1087/A/112, BK GUDA S.R. NAGAR
HYDERABAD B K Guda Hyderabad Telangana
INDIA 500038

Phone No : 7760067755 / 9177264614


Signature

Doctor Details :

Doctor Name : Dr. JARJAPU KIREETI

Specialisation : GENERAL PEDIATRICS

Referral Doctor : Self

Phone No :

Co-Consultant :


Payment Details :

Payment Mode : Cash

Deposit Amount : 0.00

Payor Name : MEDI ASSIST INSURANCE TPA PVT
LTD

PATIENT TRANSFER FORM

Patient Name & UHID No. VIH-00189093 IP-00060275 Baby ROOHAANSI MANGALAPALLY 17-07-2024 1 Y 10 M 22 D (F) Dr. JARJAPU KIREETI 		Date & Time of Admission 8/6/26 @ 4:48pm	Date & Time of Transfer Order 8/6/26 @ 6pm
		Transfer Ordered by Dr. vishwaja	Reason for Transfer Admission
From Unit ER	To Unit 14	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 [Signature]		Name of Person Ordered Transfer Dr. vishwaja	
Patient & Clinical Records Received by : [Signature]			
Date & Time of Patient Received : 8/6/26 @ 6:05pm.			

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

Patient Name : Baby. ROOHAANSI MANGALAPALLY UHID : VIH-00189093 IPD : IP-00060275 Gender : Female Age : 1 Y 10 M 22 D

VIH-00189093 IP-00060275
Baby ROOHAANSI MANGALAPALLY
17-07-2024 1 Y 10 M 22 D (F)
Dr. JARJAPU KIREETI



EMERGENCY ROOM TRIAGE FORM

Patient's Name : Roohaansi Age : 1Y Gender: Male Female

Date : 8/6/26 Time of Arrival : 4:25pm

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: 102°F PR: 140b/m BP: ca/ling RR: 26b/m SpO₂: 98%

Chief Complaints: Fever x 4 days

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		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.

* CTAS - Canadian Triage and Acuity Scale

[Signature]
Signature of Parent / Guardian

Triage Completion Time : 4:28 pm

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 : Samuel

Date & Time : 8/6/26 @ 4:28pm

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

[Signature]
Signature of Triage Nurse :

Patient Name : Baby. ROOHAANSI MANGALAPALLY UHID : VIH-00189093 IPD : IP-00060275 Gender : Female Age : 1 Y 10 M 22 D

Patient Sticker



NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 8/6/26 Time of arrival : 4:29pm

Chief Complaints : Fever RBS:

Height : Weight : 11.4kg 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 parents

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

Time of initial assessment completed by ER Nurse : 4:32pm

Patient Name : Baby. ROOHAANSI MANGALAPALLY UHID : VIH-00189093 IPD : IP-00060275 Gender : Female Age : 1 Y 10 M 22 D

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

Time	Nursing Notes
4:23pm	* vitals checked & recorded
4:25pm	* Doctor assessed the pt & advised admission
4:48pm	* Admission done
5:25pm	* IV placement done
5:35pm	* samples collected & sent to lab
6pm	* pt shifted to ward.

Samples collected by: Samuel

Time: 5:25pm

Samples sent by: Parvatharani

Time: 5:35pm

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1
4:23pm	Syp. Ibuprofen	PO	5.5ml	G.V	Lam

Condition of patient at time of shift - out :	Details of Shift - out
HR: 132/61mm BP: crying CFT: 25 sec RR: 26/61mm SPO ₂ : 98% GCS: 15/15 Temperature: 98.2°F Pain Score: 0 Repeat RBS (if applicable): -	Shift - out from ER to: III Time of Shift - out: 8/6/26 @ 6pm Handover given to: Smt. Akasha (Nurse's Name) by

Tick as applicable: MLC LAMA BROUGHT DEAD

Procedures done with details (if any): IV cannulation

Name of the Nurse: Samuel

Signature of the Nurse: [Signature]

Date & Time: 8/6/26 @ 6pm



Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 6 pm Mode of Arrival: delivery Admitting From: ER OPD Direct

Allergy / Adverse Reaction: Nil Body Weight: 11.4 Kg
 Height: - cm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
<u>Nil</u>	<u>Nil</u>	<u>Nil.</u>

Family History: -

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

If yes please list, Nil

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: 11.4 kg Length: - Head Circumference (< 2 years): -

Temp: 96.3°F HR: 143b/m RR: 26b/m BP: 92/51(73)

Pain Score: 0 Specify Site: - Nil (Follow Pain Assessment Sheet & Document)

Fall Risk Assessment Yes No Score: 12 (Document in the Humpty Dumpty Sheet)

Risk of Pressure Sore (Braden Q Score 27) (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 - Frequency - Duration -

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: ^{all} (Date/Time):

Social History: Lives With ^{Family}

Siblings in household Yes No (if yes How Many?) ^{Nil}

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 ^{Parents}

Nurse's Name: ^{Skashie} Date: ^{8/6/26} Time: ^{@ 6:15 pm} Signature: ^[Signature]



Rainbow[®] Children's Hospital

It takes a lot to treat the little.

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name:

Roohansa Manjelaly

UHID ID:

VIH-00189093 IP-00060275
Baby ROOHAANSI MANGALAPALLY .
17-07-2024 1 Y 10 M 22 D (F)
Dr. JARJAPU KIREETI

Department:



Consultant:



Pediatric Multiorgan History & Physical Examination

Name : Roohansa Age/Sex 1y 10m/F
Information given by: Mother Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

efo Fever since 4 days.
↓ Urine output
↓ Oral intake } since 2 days
vomiting ↓

History of present illness :

child asymptomatic 4 days back
then developed Fever since 4 days
↓
insidious onset
gradually progressive
moderate - high grade (100-101°F)
Receiving on medication
afw ↓ Oral intake since yesterday
↓ Urine output - 1/day since yesterday
efo vomiting - 1 episode/day since yesterday
Content - food/water
np/nr/ non Blood stained
stools - not passed since yesterday



Pediatric Multiorgan History & Physical Examination

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

H/O pneumonia - last year
admitted for 2 days.

8/6/26

CRP - 13.8

Hb : 12.1

RBC - 4.83

WBC - 19.68 $\times 10^9$ - 70.2%.

plt - 2.71 $\times 10^9$

CVS : protein - trace

KB - ++

Ureter +ve

Bacteriuria (+)

Leucocytes ++

pus cells : 15-18 / HPF

epi cell - 4-6 / HPF

Birth & Neonatal History:

Term (2.7kg) / LSC (olego) / no NICU stays



Birth & Socio Economic History:

About Father : _____

About Mother : _____

Any additional Information : _____

} class III

Developmental History :

Appropriate for age in all 4 domains.

Immunization History :

Received up to date



Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs)) 11.4 kg (Centile _____)

On Examination :

Temperature : 102°F Pulse Rate : 140/min B.P. crying SPO2 98%

Resp. rate and type of breathing : 26/min.

Rash ⊖

Lymphadenopathy ⊖

Oedema : ⊖

Allergies (if any): ⊖

Respiratory System :

Inspection (any s/o distress) : ⊖

Air entry & breath sounds : MLAE ⊕

Any addes sounds : NO

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

Cardiovascular System :

Inspection of procordium : ⊖

Heart Sounds : S1S2 ⊕

Any murmur : NO

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

Per Abdomen :

Inspection ⊖

Palpation : soft

Ausculation : RCS ⊕

Spine : ⊖ External Genitelia : _____

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



Pediatric Multiorgan History & Physical Examination

Central Nervous System :

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

Cranial Nerves : Intact

Motor System:

Nutrition : _____

Tone : _____ Power 4/5 all limbs

Co-ordinator : _____

Posture : _____

Involuntary Movements : NO

Reflexes : +

DTR +A

Superficials: +

Plantars flexor

Sensory System : +

Bladder / Bowel : NO incontinence

Clinical Summary & Diagnostic:

AEI (UTI)



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: To prevent further complications.

Desired goals of the treatment: To treat current condition

Planned Labs:

CBP }
 CRP } done on OPD basis.
 CVT }

S/E ✓

S. urea ✓ UCG ✓
 S. creat ✓ abdomen ✓

Blood c/s ✓

Urine c/s ✓

Dr. Kireeti S.R
Planned Management

- 1) IV fluids
- 2) Puj Piptaz
- 3) Puj Amoxiclav

Noted By Dr. Rajyalakshmi on 08/06/24 @ 6 PM

Signature of the Doctor: [Signature]

Signature of the Consultant: [Signature]

Name of the Doctor: M. Kishwaja

Name of the Consultant: KIREETI

Date & Time: 8/6/24

Date & Time: 8/6/24



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/6/26		
10:00 AM	<p><u>CLAB Resident</u></p>	
	<p>2 families 11:20pm & 4 AM.</p>	
	<p>(101.5f) (105.5f)</p>	
	<p>C/O - 2 times since admission</p>	<p>pain while passing urine</p>
	<p>oral intake - low</p>	
	<p>O/E</p>	
	<p>Child irritable</p>	
	<p>Extremities</p>	
	<p>Vitals stable</p>	
	<p>CVR-SIS 2 (+)</p>	
	<p>R/S - BAC (+)</p>	
	<p>R/A CRP</p>	
<p>Dr. Vichaya</p>		<p>Plan</p>
		<p>1) Paj peptas 2nd dose</p>
		<p>2) Purgelids (full M)</p>
		<p>3) monitor vitals</p>
		<p>informers</p>
		<p>4) Add IV Amikacin</p>
		<p>5) CBP, CRP → T12</p>
<p>Noted by Maganado 4/6 @ 1 PM</p>		
		<p>J. Kireeti Kireeti</p>
		<p>9/6/26</p>



GRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	<u>Ch/B Resident</u>	
<u>2/6/24</u> <u>5:30pm</u>	Ch/B Resident 2-fur/pike @ 2:30pm & 12:20pm (101) f (100.2 f)	
0	IS - Better.	
4	0 - Afebrile. No pain while paracetamol. Vitals stable no fever C4: 65.2 (T) Hb: 13.6 (T) Plt: 401T Ca: 1.04	<u>Plan</u>
<u>Dr. Prakash</u>		<ul style="list-style-type: none"> - CBP (crp) - 11m - S.E, LFT - Inj - pipton - Inj - Amikacin - monitor vitals - Inj m (td)
		- Trace c/c/s & B/c/s.

Noted By
 Manisha
 2/6/24
 @8pm



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/6/23 10:00pm	<p><u>cl/B Resident</u></p> <p># Δ His: ? UTI.</p>	
	<p>1 fever spike @ 11:00pm (102.2°F)</p>	<p>Not passed stools: 3 days.</p>
<p>B/Us → No growth gyn subx.</p>	<p><u>O/c</u> Chud Abul & Activ vs vitals stable</p>	
<p>138 ↓ CRP → 124</p>	<p>CV: S/S ⊕ TM: B/LAC ⊕ PLA: w/t CNI: NAD.</p>	<p><u>Plan</u></p>
<p>WBC → 12k → 12k.</p>		<p>- Ijy: p/ptcl (r/dct)</p>
<p>Prachin</p>	<p>Noted by Manasa 10/6/26 @ 12:45pm</p>	<p>- Ijy: Anticon - D2</p> <p>- montmoridol</p> <p>- Ijy (2)</p>
	<p>→ Abdomen x ray → Trace urine c/s → nephroconsultation after urine c/s</p>	<p>→ Trace u/c/s.</p>

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/6/20		
12:30pm	y/ds - positive for E coli	D/w Dr. Kireeti sir.
		Ddr
		- Nephro consultation
10/6/20 5:00pm	C/I/B Resident No fecalites - many. ↓ oral Intake. y/ds - Aderite.	
Dr. B. Prabhakar	O/E Chud Alert CTA - Good CPT L3 see Cx: S12 ⊕ Rx: B12 ⊕ P/A: both CNI: NAD	Plan - Give Mebolic enemas @ 7:00pm
		- Send spot urine for calcr/uric acid.
		- Continue Inj. Augmentin total 750
		- Inj - Amikacin.



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11.6.26 9.00am	S/B Registration	
	Urinary Tract Infection (urine c/s +ve for $E. coli \times 10^5$)	
	no fever > 24 hrs oral intake better o/e child better	
	CRT C 35cc.	
	ofloxacin c/s - S, T	Plan → cont. IV antibiotics
	RS - BAC (+), shay	→ hct 4 th July
	P/a - soft	→ CBP, CRP T/m - HOLD
	Sameera (Dr. Sameera)	→ 5 days → IV antibiotics till 13/6/26 (CBP/CRP on 13/6/26)
		→ after 13/6/26 → change to oral amoxicillin for 5 more days
		→ Flu on Monday
		→ Flu on Monday
		→ Flu on Monday
	Noted by S. J. Kireeti 11/6 @ 10:45pm	J. Kireeti Kireeti 11/6/26

CONSULTATION FORM



Doctor Name :

Date : Hour :

Hospital :

Type of Referral : Emergency (within one hr.)

Urgent (within 6 hrs.) Non Urgent (within 24 hrs.)

Referred for : Opinion Co-Management

Date : Time : By :

Transfer of care

Reason for Consultation:
 VIH-00189093 IP-00060275
 Baby ROOHAANSI MANGALAPALLY
 17-07-2024 1 Y 10 M 24 D (F)
 Dr. JARJAPU KIREETI

specify the particular need, especially in the absence of a second diagnosis:



Signature: _____

M.D. _____

Report of Findings and Recommendations :

*c/o Culture +ve U72
2° E coli.*

Adv

*Afebrile after
4 hrs today. 1)*

*Consider IV Augmentin
Continue Amikacin*

*Total IV 5 days
↓*

*5 days oral
Augmentin*

2) Neotonic enema tomorrow

*3) Syp Diphtheriae - 10ml -
Hrs x 3m*

*USG - No HUN
RFT - WNL*

Consultant :

Name : *DR. Suvithi* Signature : *[Signature]* Date & Time : *10/6/2016*

NOTE : If more space is required use another consultation sheet as continuation

A) Symp Colax - 5ml - #/s x 3 months

5) To do spot urine for Ca/Cr/uric acid

6) Reiv in OPD after IV Antibiotic Course



\bar{c} (WE)

letter

VIH-00189093

Ist Floor

ULTRA SOUND ABDOMEN REQUEST FORM

VIH-00189093 IP-00060275
Baby ROOHAANSI MANGALAPALLY .
17-07-2024 1 Y 10 M 22 D (F)
Dr. JARJAPU KIREETI

PATIENT NAME :

DATE:

08/6/2026
Time: 6:45 PM



LIVER : Normal in size ^{10.5cm} and echotexture. No intra hepatic biliary duct dilatation. Portal vein is normal. No focal lesions.

GALL BLADDER : Distended well and appears normal. No evidence of calculi or wall thickening. Common bile duct appears normal.

SPLEEN : Normal in size ^{7.3cm} and echotexture.

PANCREAS : Normal in size and echotexture. MPD not dilated. No calcification noted.

KIDNEYS : Right kidney : ^{69x28} mm. Normal in size and echotexture and shows smooth contour. No hydronephrosis or calculi.

Left kidney : ^{69x32} mm. Normal in size and echotexture and shows smooth contour. No hydronephrosis or calculi.

URINARY BLADDER : Distended well and appears normal. *Multiple mobile internal echoes within urinary bladder*
No ascites / Lymphadenopathy. No evidence bowel wall thickening / edema.

IMPRESSION: No obvious sonological abnormality in abdomen.

Rest unremarkable

Suggested clinical correlation.

Multiple mobile internal echoes with in urinary bladder.

for CUE correlation to x/o cystitis.

DR MOHD ABDUL KHALID MD, DNB.

DR V. MAHIDHAR (MD)

Vpk

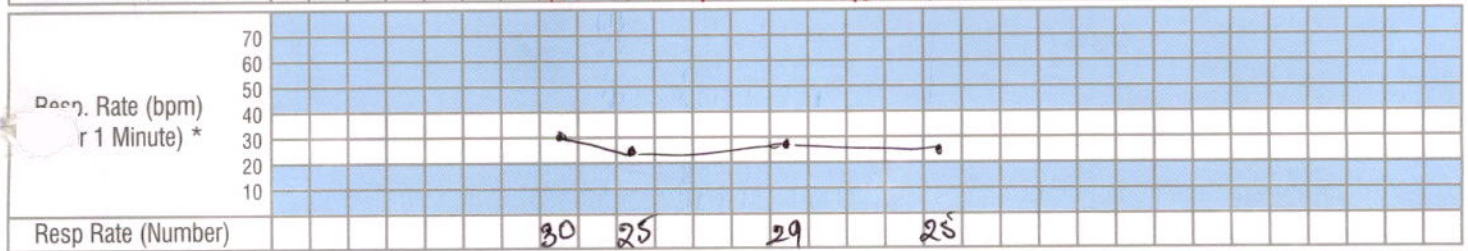
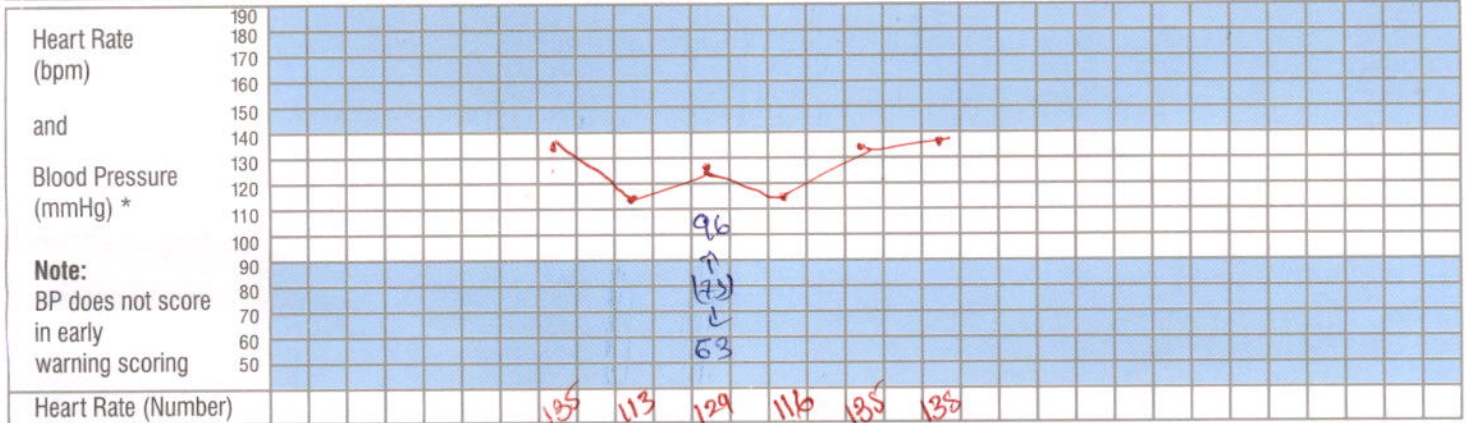
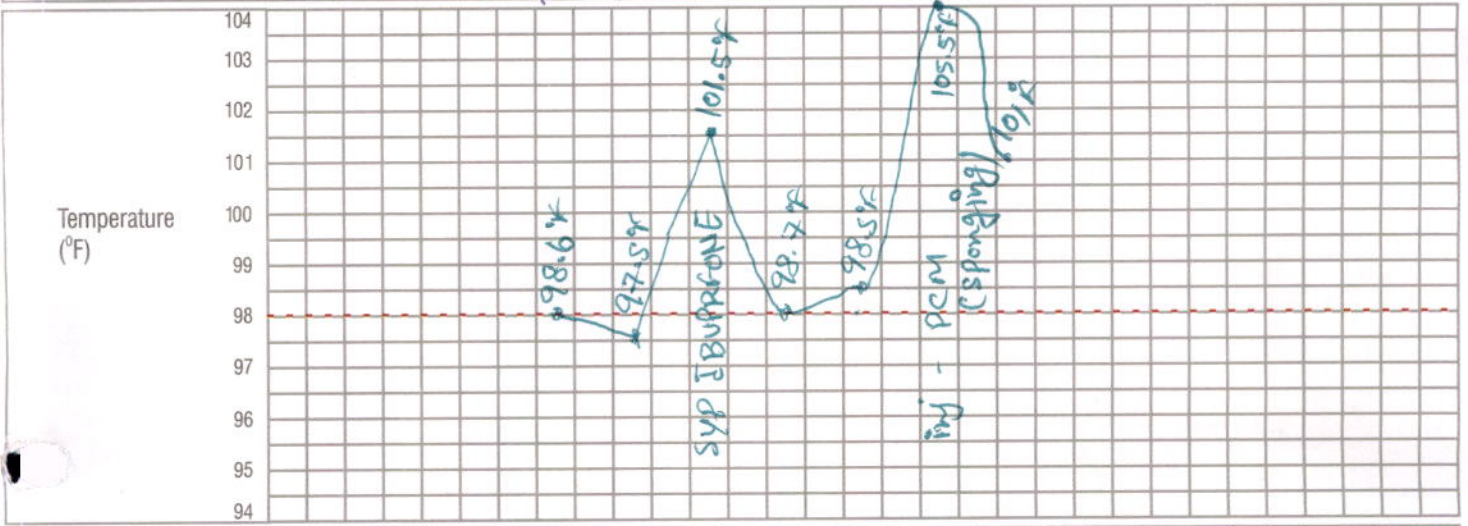
DR VAISHNAVI REDDY-B (MD)

(Consultant Radiologist)



EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 8/6/26	Time: 7	9	11:20	1	4	7	8
Doctor / Nurse / Family Concern?	PM	PM	PM	AM	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	0	0	1	0	0	1
Pain Score	0	0	0	0	0	0
Observer's Initials	SK	SK	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

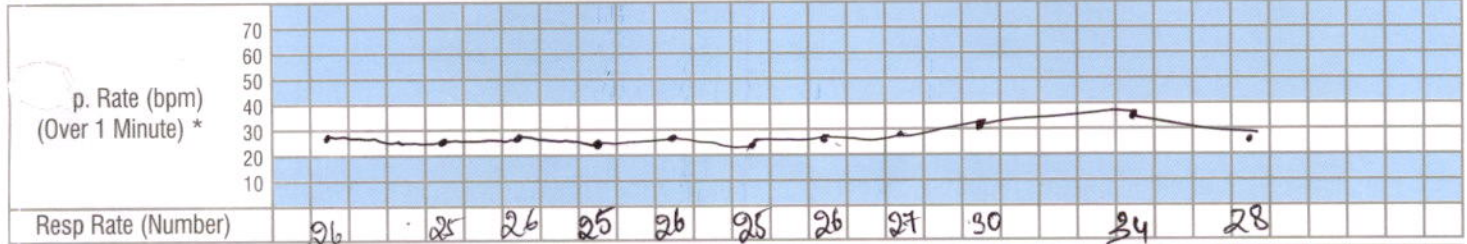
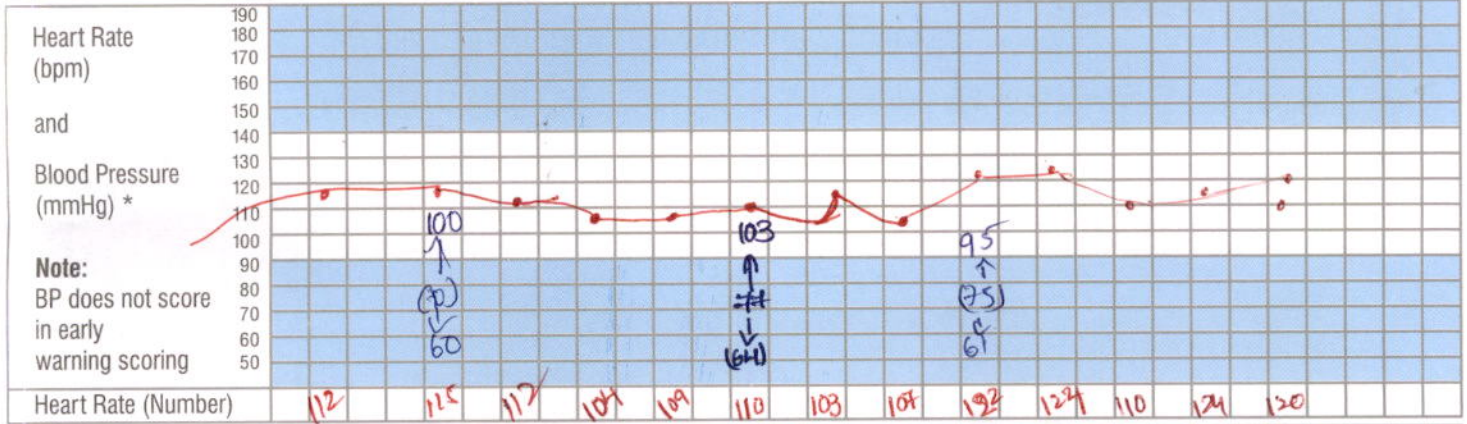
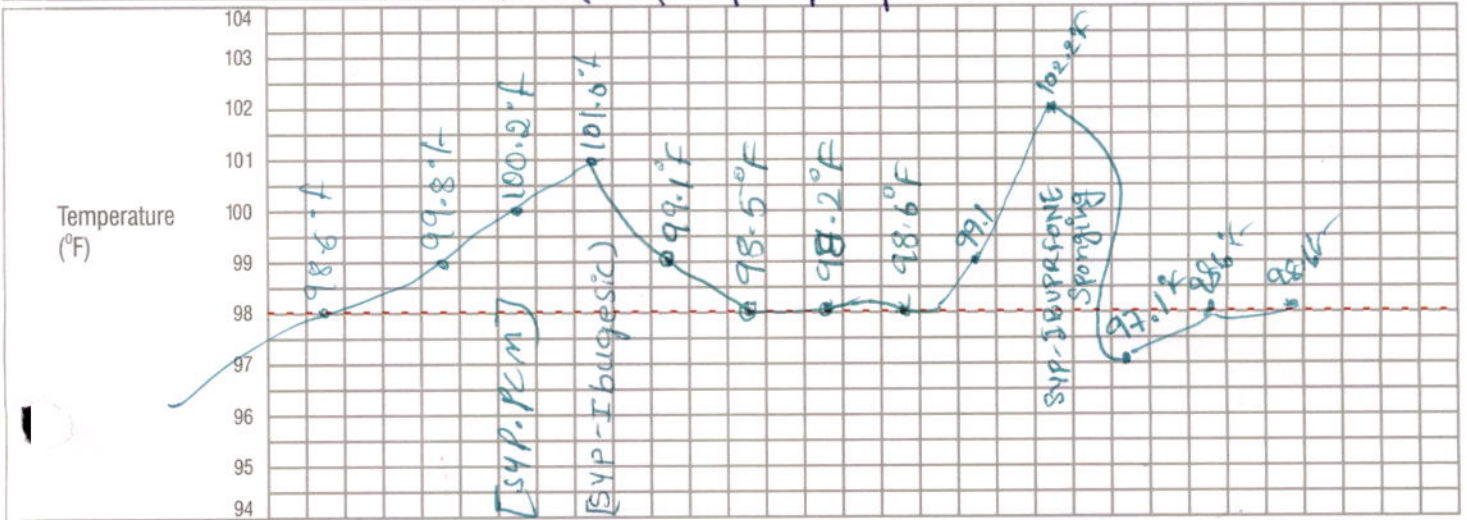
- If at any time additional help is required, call help – regardless of the Early Warning Score!
- Following a Early Warning Score assessment, senior help may be required

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 : 9/6	Time: 9	12	12:30	1:30	H	5	6	7	10:30	11	1:20	H	7
Doctor / Nurse / Family Concern?	AM	PM	PM	PM	PM	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	0
Pain Score	0
Observer's Initials	SK

ACTIONS	Score 1 : Continue normal observation by staff nurse
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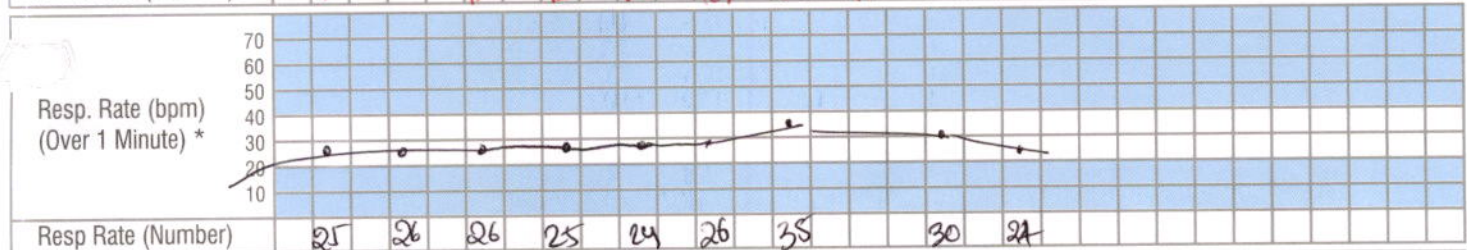
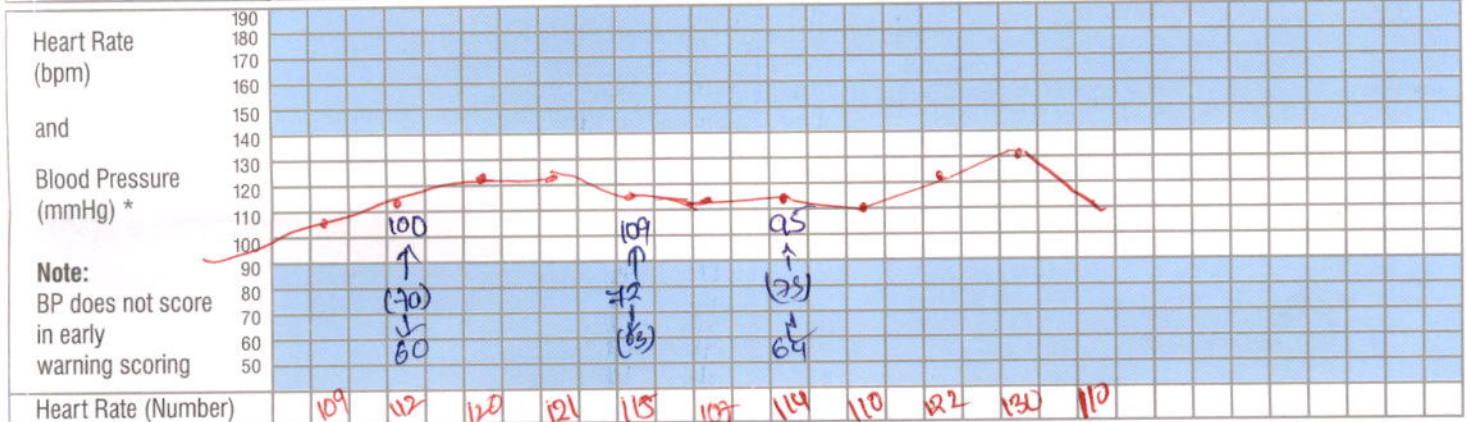
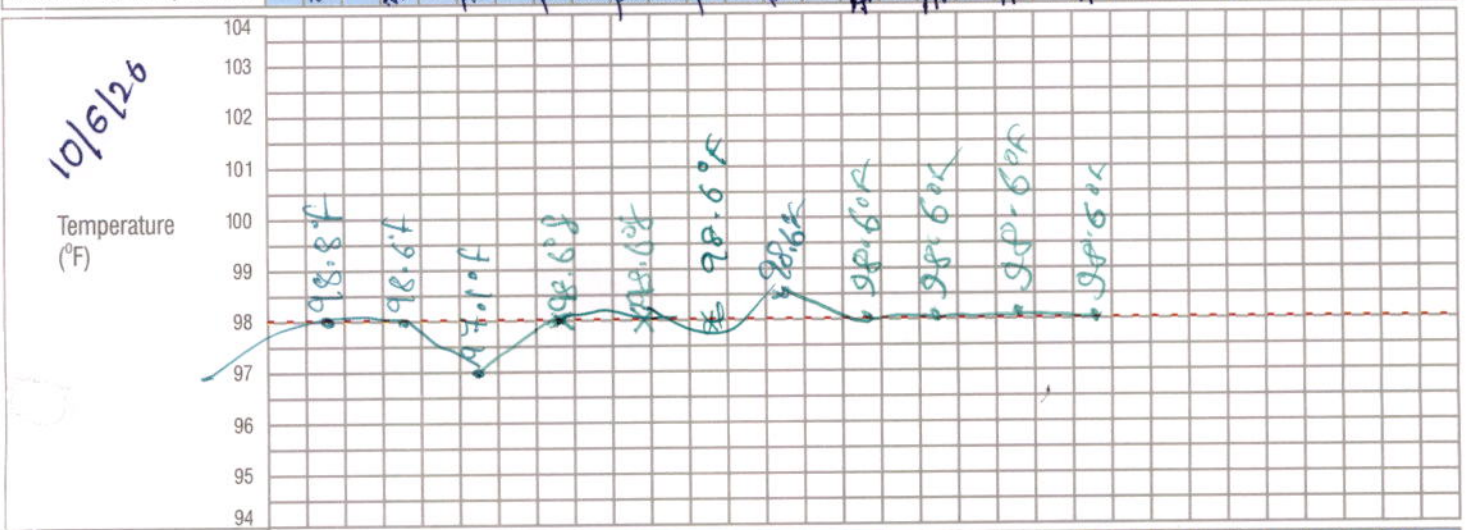
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R	RECOMMENDATION: I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)



EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 10/6	Time: 9	11	1	3	5	7	10	12	2	4	6
Doctor / Nurse / Family Concern?	AM	AM	PM	PM	PM	PM	PM	AM	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	0
Pain Score	0
Observer's Initials	MA MA MA SA SA SA SA SA SA P

ACTIONS	Score 1 : Continue normal observation by staff nurse
	Score 2 : Shift in charge nurse to be informed and continue hourly observations
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- 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)

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



FLUID CHART

Sheet No. : 0

8/6/26

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

		Intake				Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	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 :							
8/6	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm	DNS milk.											
	06:00 pm			42ml									
	07:00 pm			42ml									
Total Intake : 84ml						Total Output :							
8/6/26	08:00 pm			42ml									
	09:00 pm												
	10:00 pm			42ml									
	11:00 pm	water		42ml									
	12:00 am			42ml									
	01:00 am			42ml									
Total Intake : 210ml						Total Output :							
9/6/26	02:00 am			42ml									
	03:00 am			42ml									
	04:00 am			42ml									
	05:00 am			42ml									
	06:00 am												
	07:00 am												
Total Intake : 168ml						Total Output :							
Total 24 hrs. Intake			462ml			Total 24 hrs. Output			24 Sub times				

FLUID CHART

Sheet No. : 2

9/6/26

- 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 Thrombo-phlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
9/6	08:00 am		Mouth	I.V	N.G								Anuradha 9/6/26 @ 2pm
	09:00 am		poly water	42ml					✓				
	10:00 am			42ml									
	11:00 am			42ml									
	12:00 pm			42ml									
	01:00 pm								✓				
Total Intake : 168 ml						Total Output :							
9/6/26	02:00 pm		kichidi	42ml									Anuradha 9/6/26 @ 8pm
	03:00 pm		+ water	42ml					✓				
	04:00 pm			42ml									
	05:00 pm			42ml									
	06:00 pm			42ml									
	07:00 pm			42ml									
Total Intake : 262 ml						Total Output :							
9/6	08:00 pm												Subha 9/6
	09:00 pm												
	10:00 pm		kichidi										
	11:00 pm		water						✓				
	12:00 am												
	01:00 am												
Total Intake :						Total Output :							
10/6/26	02:00 am			42ml									Subha 10/6 @ 7AM
	03:00 am			42ml									
	04:00 am			42ml									
	05:00 am			42ml					✓				
	06:00 am			42ml									
	07:00 am												
Total Intake : 210 ml						Total Output :							

Total 24 hrs. Intake 640ml

Total 24 hrs. Output 5 times



FLUID CHART

Sheet No. : 3

10/6/26

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

		Intake				Output					IV Site Thrombophlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G								
10/6	08:00 am			42ml						✓	Mandaa 10/6 @ 1 pm	}	
	09:00 am	ORAL		42ml									
	10:00 am												
	11:00 am			42ml									
	12:00 pm			42ml						✓			
	01:00 pm			42ml				✓					
Total Intake : 210ml						Total Output :							
10/6	02:00 pm			42ml							}	Subham 10/6/26 @ 5 pm	
	03:00 pm			42ml						✓			
	04:00 pm			42ml									
	05:00 pm			42ml									
	06:00 pm			42ml						✓			
	07:00 pm			42ml									
Total Intake : 252ml						Total Output : 2 times							
10/6	08:00 pm										}	Subham 10/6	
	09:00 pm		knichti water										
	10:00 pm												
	11:00 pm		DRP	42ml									
	12:00 am			42ml						✓			
	01:00 am			42ml									
Total Intake : 126ml						Total Output :							
11/06/26	02:00 am			42ml							}	Subham 11/06/26 @ 7 am	
	03:00 am			42ml									
	04:00 am			42ml									
	05:00 am									✓			
	06:00 am												
	07:00 am												
Total Intake : 126ml						Total Output :							

Total 24 hrs. Intake 600ml

Total 24 hrs. Output 6 times

VIH-00189093 IP-00060275
 Bbby ROOHAANSI MANGALAPALLY .
 17-07-2024 1 Y 10 M 24 D (F)
 Dr. JARJAPU KIREETI

FLUID CHART

Sheet No. : 3

11/06/26

- 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			
11/4	08:00 am												
	09:00 am		Elow	42ml									
	10:00 am		water	42ml									
	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 Paton
 Srikanth
 11/4
 010:40AM*



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: ICU

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. Vishwaja

Date & Time : 2/6/26 @ 5:00 PM

Nurse Name & Signature : Aec. Kothu / As

Date & Time : 2/6/26 @ 5:00 PM



DRUG CHART

Date of Admission: 8/6/26 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)

VERIFIED BY Name: Chitra 8/6/26
 Chitra 8/6/26

DRUG : <u>SYP. PARACETAMOL</u>				Date Time
Dose	Route	Frequency	Start Date	
<u>3.5ml</u>	<u>PO</u>	<u>as required</u>	<u>8/6</u>	
Doctor's Signature		Valid Period	Pharm.	
<u>[Signature]</u>		<u>max 6th hourly</u>	<u>[Signature]</u>	
Additional Instructions: <u>5ml = 240mg</u> <u>15mg/kg/dow if temp > 100°F</u>				

DRUG : <u>SYP. IBUPROFEN</u>				Date Time
Dose	Route	Frequency	Start Date	
<u>5.5ml</u>	<u>PO</u>	<u>as required</u>	<u>8/6</u>	
Doctor's Signature		Valid Period	Pharm.	
<u>[Signature]</u>		<u>max 8th hourly</u>	<u>[Signature]</u>	<u>4:23pm</u> <u>[Signature]</u>
Additional Instructions: <u>5ml = 100mg</u> <u>10mg/kg/dow if temp > 100°F</u>				

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



REGULAR PRESCRIPTIONS

Weight. 11.4kg Ward.

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

DRUG : INJ. PIPERACILLIN + TAZOBACTAM				Date Time
Dose	Route	Frequency	Start Date	
1.1g	IV	8th hourly	8/6	8/6 9/6 10/6 6AM / 2PM / 10PM
Name & Signature of the Doctor Starting the Drugs: Dr. Vishwaja				
Additional Instructions: 100mg/kg/dose				
Daily Doctor's Endorsement by a Sign				

DRUG : INJ. ESOMEPRAZOLE				Date Time
Dose	Route	Frequency	Start Date	
11mg	IV	once daily	8/6	8/6 9/6 10/6 11/6
Name & Signature of the Doctor Starting the Drugs: Dr. Vishwaja				
Additional Instructions: 1mg/kg/dose				
Daily Doctor's Endorsement by a Sign				

DRUG : INJ. AMIKACIN				Date Time
Dose	Route	Frequency	Start Date	
85mg	IV	12 th hourly	9/6	9/6 10/6 11/6 6AM / 2PM / 6PM
Name & Signature of the Doctor Starting the Drugs: Dr. Sankar				
Additional Instructions: 7.5 mg/kg/dose				
Daily Doctor's Endorsement by a Sign				

Do Jaldar
 Chk 8/6/26
 Do Jaldar
 Chk 8/6/26
 Do Jaldar
 Chk 9/6/26
 Do Jaldar
 Chk 9/6/26

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
9/5	7AM	PNJ. PARACETAMOL	150mg	IV	[Signature]	Rizunka
10/6/22	1pm	PG-ENEMA	100ml	P/R	[Signature]	Loalpan marasa
10/6/22	7pm	Nislonic enema		P/R	[Signature]	Gayalt Pufe

VERIFIED BY : [Signature]

[Signatures]



Sheet No:

REGULAR PRESCRIPTIONS

Weight Ward

Dr. Jarjapu Kireeti 10/6/26 6 AM
 Dr. Jarjapu Kireeti 10/6/26 6 AM
 Dr. Jarjapu Kireeti 10/6/26 6 AM
 Dr. Jarjapu Kireeti 10/6/26 6 AM

DRUG : Symp. Duphalac				Date Time	10/6															
Dose	Route	Frequency	Start Dt.																	
10ml	PO	BED TIME	10/6/26																	
Name & Signature of the Doctor Starting the Drugs:				10 PM																
Additional Instructions:																				
10ml - Bedtime																				
Daily Doctor's Endorsement by a Sign																				
DRUG : Symp. Colafy				Date Time	10/6															
Dose	Route	Frequency	Start Dt.																	
5ml	PO	BED TIME	10/6/26																	
Name & Signature of the Doctor Starting the Drugs:				10 PM																
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG : Inj. Amoxicillin				Date Time	10/6	11/6														
Dose	Route	Frequency	Start Dt.																	
350mg	IV	8 hourly	10/6/26	6 AM	2 PM	10 PM														
Name & Signature of the Doctor Starting the Drugs:				2 PM																
Additional Instructions:				10 PM																
Songlydon																				
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																				



RESULT SHEET

Date	8/6	10/6/26			
Time	5:20pm	5AM			
Hb	12.1	11.8			
PCV	33.2	32.6			
RBC	4.83	4.76			
WBC	19,68	17,62			
N/L	70/23	47.8/40.8			
Platelets	2.71	2.79			
CRP	138	124			
ESR					
PCT					
RBS					
Na	136	141			
K	4.4	4.9			
Cl	100	107			
Ca/Mg					
Phosphate					
Urea	25.2				
Creatinine	0.4				
ALP		189			
SGPT		12			
SGOT		22			
T.Bill/Conj		0.2/0.2			
T.Protein		6.4			
S.Albumin		3.3			
S.Globulin		3.1			
A/G Ratio		1.1			
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein / Sugar					
Cells					
N/L					

