

Name	Baby R NAGA ANUSHA	UHID	VIH-00075746
Father/Guardian	Mr MR.R.V.S.S.SRINIVAS	Age/Gender	10 Y 1 M 7 D/Female
Address	H.NO-20-31/1/1, GOWTHAM NAGAR MALKAJGIRI HYD-BAD, Safilguda, Hyderabad, Telangana, INDIA, 500047		
IP No	IP-00060468	Admission Date	24-06-2026
Ref Doctor	SELF	Discharge Date	27-06-2026

DISCHARGE SUMMARY

Consultant: Dr. AKHEEL S. RIZWAN

MBBS, DCH, MRCPCH (UK)

SENIOR CONSULTANT PEDIATRICS & NEONATOLOGY

TSMC-13579

Diagnosis: Acute gastroenteritis with some dehydration

History: Baby R. NAGA ANUSHA is a 10 Y 1 M 7 D old girl brought with complaints of multiple episodes of nonbilious nonprojectile vomitings, multiple episodes of loose stools since 3 days, headache prior to admission. For the above complaints, she was admitted at Rainbow Children's Hospital for further management.

Examination: She was afebrile, maintaining saturations at room air. Her heart rate was 100/min, blood pressure was 100/70 mmHg and RR 22/min. Signs of dehydration present. On auscultation of chest, air entry was 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 : 55.6 kgs.

Investigations: Enclosed.

Name	Baby R NAGA ANUSHA	UHID	VIH-00075746
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Management: She was rehydrated with NS bolus and admitted in ward. She was started on intravenous antibiotics and intravenous fluids. She was advised gastro diet and administered probiotics. She was treated symptomatically with antiemetics.

Her hemogram showed Hb 11.7gm%, WBC count of 6,290 cells/cumm, platelets of 2.60 lakhs/cumm and CRP 31 mg/L. Serum electrolytes and creatinine were normal. CUE was normal. Complete stool examination showed 4-5 pus cells, mucus present. Stool culture was sterile.

Her vitals were regularly monitored. Her symptoms gradually reduced. Parents were counselled about course of illness and continuation of gastrodiet for few more days. She remained hemodynamically stable throughout the hospital stay without any complication. She is being discharged with the following advice.

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

Advice:

1. Gastrodiet as advised.
2. Tablet Cefixime (200mg) 1 tablet, 12th hourly (after food) for 2 days.
3. Syrup Bifilac, 5ml, 12th hourly for 3 days.
4. Syrup Zinconia, 5ml once daily for 10 days.
5. Sporonorm-R sachet, 1 sachet, 12th hourly for 3 days.
6. Kindly consult Dr. Akheel S. Rizwan, Senior Consultant Pediatrics, on 02.07.2026 (Thursday) in OPD with prior appointment (This consultation will be charged).

DISCHARGE SUMMARY



Name	Baby R NAGA ANUSHA	UHID
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VH-00075746

In case of Fever:

Tablet Paracetamol (650mg), 1 tablet 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.

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	Baby R NAGA ANUSHA	UHID	VIH-00075746
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Name :

Signature :

Relationship with patient :

This summary has been explained by :

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

Dr. Vishwaja

Registrar/Resident/C.M.O

Dr

Dr. AKHEEL S. RIZWAN

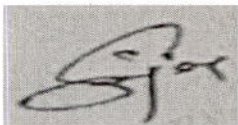
MBBS, DCH, MRCPCH (UK)

SENIOR CONSULTANT PEDIATRICS & NEONATOLOGY

TSMC-13579

PatientName : Baby R NAGA ANUSHA Inpatient No. : IP-00060468
 Age/Gender : 10 Y 1 M 4 D/ Female Admit Date : 24-06-2026
 Ward/Bed : N 0 GF-EMERGENCY/ ER 101 Discharge Date :

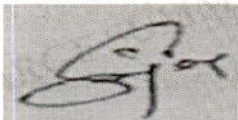
Investigation	Result	Unit	Biological Reference Interval
COMPLETE BLOOD PICTURE (Specimen : BLOOD)		TEST RESULT STATUS : REPORT AUTHORISED	
		Order Date :24-06-2026 21:38	
HEMOGLOBIN (Colorimetry)	11.7	g/dL	11.5 - 15.5
RBC COUNT (DC detection method)	4.79	10 ¹² /L	4 - 5.2
PCV/HCT (Calculated)	33.6	VOL%	L 35 - 45
MCV (Calculated)	70.1	fL	L 77 - 95
MCH (Calculated)	24.5	pg/cells	L 25 - 33
MCHC (Calculated)	35.0	g/dL	32 - 36
RDW-CV (Calculated)	13.3	%	11.5 - 15
PLATELET COUNT (DC Detection Method)	260	10 ⁹ /L	150 - 450
MPV (Calculated)	7.8	fL	6.5 - 10
WBC COUNT (DC Detection Method)	6.29	10 ⁹ /L	4.5 - 13.5
Differential Count			
NEUTROPHILS (Microscopy, Leishman stain)	62	%	H 33 - 61
LYMPHOCYTES (Microscopy, Leishman stain)	27	%	L 28 - 48
MONOCYTES (Microscopy, Leishman stain)	10	%	4 - 10
EOSINOPHILS (Microscopy, Leishman stain)	01	%	1 - 4
PERIPHERAL SMEAR (Microscopy, Leishman stain)	RBC : NORMOCYTIC / HYPOCHROMIC 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 :24-06-2026 21:38	
CRP (Immunoturbidimetry)	31	mg/L	H <10



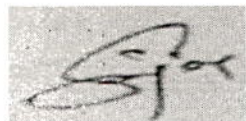
Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
CREATININE (Specimen : SERUM)		TEST RESULT STATUS : REPORT AUTHORISED	
		Order Date :24-06-2026 21:38	

PatientName	: Baby R NAGA ANUSHA	Inpatient No.	: IP-00060468
Age/Gender	: 10 Y 1 M 4 D/ Female	Admit Date	: 24-06-2026
Ward/Bed	: N 0 GF-EMERGENCY/ ER 101	Discharge Date	:

Investigation	Result	Unit	Biological Reference Interval
CREATININE (Enzymatic)	0.2	mg/dl	L 0.5 - 1



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 :24-06-2026 21:38			
SODIUM (Direct ISE)	138	mmol/L	134 - 143
POTASSIUM (Direct ISE)	4.5	mmol/L	3.7 - 5
CHLORIDE (Direct ISE)	110	mmol/L	H 98 - 108

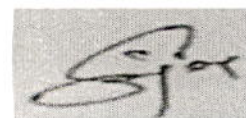


Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
COMPLETE STOOL EXAMINATION (Specimen : STOOL)			TEST RESULT STATUS : REPORT AUTHORISED
Order Date :24-06-2026 22:18			
PHYSICAL			
COLOUR (Visual Examination)	GREENISH		
CONSISTENCY (Gross Examination)	LOOSE		
pH (Double pH indicator)	7.0		5 - 8.5
MUCUS (Gross Examination)	PRESENT		ABSENT
BLOOD (Gross Examination)	ABSENT		ABSENT
UNDIGESTED FOOD (Gross Examination/Microscopy)	PRESENT		ABSENT
HELMINTHES (Gross Examination/Microscopy)	NIL		NIL

Investigation	Result	Unit	Biological Reference Interval
MICROSCOPY			
PUS CELLS	4-5	HPF	0 - 5
RED BLOOD CELLS (Stool)	NIL	HPF	NIL
STARCH GRANULES	ABSENT		ABSENT
YEAST CELLS	NIL		NIL
FAT GLOBULES	ABSENT		ABSENT
PROTOZOA	NIL		NIL



Dr. SRUJANA SHYAMALA, MD, DNB

PatientName : Baby R NAGA ANUSHA **Inpatient No.** : IP-00060468
Age/Gender : 10 Y 1 M 4 D/ Female **Admit Date** : 24-06-2026
Ward/Bed : N 0 GF-EMERGENCY/ ER 101 **Discharge Date** :

Investigation	Result	Unit	Biological Reference Interval
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Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
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COMPLETE URINE EXAMINATION (Specimen : URINE)

TEST RESULT STATUS : REPORT AUTHORISED

Order Date :25-06-2026 00:02

PHYSICAL

COLOUR (Visual Examination) PALE YELLOW
APPEARANCE (Gross Examination) CLEAR
pH (Double pH indicator) 6.5
SPECIFIC GRAVITY (PKA Reaction) 1.015
SEDIMENT (Gross Examination) NIL

5 - 8.5
1.005 - 1.030
NIL

CHEMICAL

PROTEIN (Protein error of pH indicator) NIL
GLUCOSE (GOD POD method) NIL
KETONE BODIES (Acetoacetic acid reaction) NEGATIVE

NIL
NIL
NEGATIVE

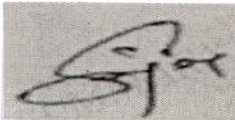
BILE SALTS (Hay's Sulfur Test) ABSENT
BILE PIGMENTS (Diazo reaction) ABSENT
NITRITE (Reflectance Photometry) NEGATIVE
BLOOD (Peroxidase reaction) ABSENT
LEUCOCYTES (Esterase reaction) NEGATIVE

ABSENT
ABSENT
NEGATIVE
ABSENT
NEGATIVE

MICROSCOPY

PUS CELLS 3-4 HPF
EPITHELIAL CELLS 4-5 HPF
RBCS. NIL HPF

L 0 - 5
L 0 - 5
0 - 2



Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Baby R NAGA ANUSHA

9848911677

10 Y 1 M 6 D

VI26021424

Female

24-06-2026 10:20 PM

IP-00060468

24-06-2026 10:54 PM

VIH-00075746

26-06-2026 04:20 PM

AKHEEL SYED RIZWAN

N 0 GF-EMERGENCY / ER 101

STOOL FOR CULTURE AND SENSITIVITY (Specimen :STOOL)

RESULT

GROSS EXAMINATION - GREENISH IN COLOUR, SEMI FORMED STOOL.

MODIFIED Z.N. STAINED SMEAR - DOES NOT SHOW THE OOCYSTS OF COCCIDIAN PARASITES.

CULTURE - NO SALMONELLA / SHIGELLA / ENTERO HAEMORRHAGIC E.COLI/ DIARRHEAGENIC. E.COLI / AEROMONAS SPECIES ISOLATED.

***** End of report *****



**Dr. RANGANATHAN N. IYER MD FRCPATH DNB
DPB**
(CONSULTANT MICROBIOLOGIST)

**Dr. VIJENDRA KAWLE
MD DNB
CONSULTANT MICROBIOLOGIST
Reg No :68234**

ACTIVITY REPORT

VIH-00075746 IP-00060468
Baby R NAGA ANUSHA
20-05-2016 10 Y 1 M 4 D (F)

Name:

Dr. AKHEEL SYED RIZWAN

UHID N



Consultant :

Dept :

pediatric

Date of Admission :

24/6/26

Time :

9:18 PM

Date of Discharge :

Time :

Room / Bed No :

106

Ward :

1st floor

Suggested Billable bed type :

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
<i>24/6/26</i>	<i>11 PM</i>	<i>ER</i>	<i>106</i>	<i>[Signature]</i>

Cross Consultation Visit

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

DEFICIENCY CHECK LIST OF MEDICAL CASE SHEET

VH-00075746 IP-00060468

Baby R NAGA ANUSHA

20-05-2016 10 Y 1 M 6 D (F)

Dr. AKHEEL SYED RIZWAN



Patient Name :

Ward:

IP.No:

DOA:



Sl.No	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission Sheet	01	-	-	
2	Discharge Summary	02	-	-	
3	Nursing Initial assessment form	02	-	-	
4	Patient Transfer Forms	01	-	-	
5	In-patient Medical Record	03	-	-	
6	Doctors Progress Sheets	02	-	-	
7	Nurses Progress notes	03	-	-	
8	Consultation Sheets				
9	General Consent for Treatment	01	-	-	
	Consent for Surgery				
11	Consent for Blood Transfusion				
12	Consent for Chemotherapy				
13	Consent for High Risk				
14	Consent for Restraint				
15	DAMA Consent				
16	Consent for Special Procedure				
17	Consent for Radiological Investigations				
18	Consent for HIV Test				
19	Anaesthesia consent form				
20	Anaesthesia notes (Pre Anaesthesia & Post)				
21	Pre Operative checklist				
22	Surgical safety Checklist				
23	Operation Theatre notes				
24	Nurses Clinical Presentation				
25	TPR & BP chart	04	-	-	
	Intake and Output chart (fluid Chart)	03	-	-	
27	Drug Chart (Regular prescription)	03	-	-	
28	Daily Investigation sheet				
29	Investigation Values (Result Sheet)	01	-	-	
30	Nebulization Chart				
31	Diabetic chart				
32	Nutritional Review chart	01	-	-	
33	MLC form (in case of MLC)				
34	Patient Education Form				
	Humpty Dumpty	02	-	-	
	Braden's scale	01	-	-	
	Pain Assessment	01	-	-	
	checklist for thrombo	02	-	-	
	Others	01			
	Total No. of Pages	42			

Noted by
Manasa
22/5/16
P. H. A.

Signature and Date :

ERROR LOG

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

ICD CODE :-

OBSERVATION: -

DATE :

MRD EXECUTIVE

ADMISSION SHEET

Registration Details :



Admission No : IP-00060468

Admit Date : 24-Jun-2026

Admit Time : 09:18 PM UHID : VIH-00075746

Patient Details :

Patient Name : Baby R NAGA ANUSHA

Age : 10 Y 1 M 4 D

Guardian : Mr MR.R.V.S.S.SRINIVAS

DOB : 20-05-2016

Gender : Female

Religion :

Occupation :

Martial Status : Single

Address (H) : H.NO-20-31/1/1, GOWTHAM NAGAR
MALKAJGIRI HYD-BAD Safilguda Hyderabad
Telangana INDIA 500047

Phone No : 9848911677

E-mail : na123@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 MR.R.V.S.S.SRINIVAS

Relationship : D/O

Contact Address : H.NO-20-31/1/1, GOWTHAM NAGAR
MALKAJGIRI HYD-BAD Safilguda Hyderabad
Telangana INDIA 500047

Phone No : 9848911677 / 8019561024



Signature

Doctor Details :

Doctor Name : Dr. AKHEEL SYED RIZWAN

Specialisation : GENERAL PEDIATRICS

Referral Doctor : SELF

Phone No :

Co-Consultant :


Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : STAR HEALTH AND ALLIED
INSURANCE CO LTD

PATIENT TRANSFER FORM

Patient Name & UHID No. VIH-00075745 IP-00060468 Baby R NAGA ANUSHA 20-05-2016 10 Y 1 M 4 D (F) Dr. AKHEEL SYED RIZWAN 		Date & Time of Admission <i>24/6/26 @ 9:18 PM</i>	Date & Time of Transfer Order <i>24/6/26 @ 11 PM</i>
		Transfer Ordered by <i>DR. wishwaga</i>	Reason for Transfer <i>for admission</i>
From Unit <i>ER</i>	To Unit	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File <i>(21)</i>	Number of Imaging Films —	Personal belongings including clinical documents. If any handed over to attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> <i>optically given to</i>	
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 <i>Shaukat / shy</i>		Name of Person Ordered Transfer <i>DR. wishwaga.</i>	
Patient & Clinical Records Received by : <i>Sr. Bevonika</i>			
Date & Time of Patient Received : <i>24/6/26 @ 11 pm</i>			


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

1 M 4
 VIH-00075746 IP-00060468
 Baby R NAGA ANUSHA
 20-05-2016 10 Y 1 M 4 D (F)
 Dr. AKHEEL SYED RIZWAN




NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 24/6/26 Time of arrival : 9:04pm
 Chief Complaints : loose stools, vomitings x yesterday RBS : —
 Height : 149cm Weight : 55.6kg 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> <input type="checkbox"/> If patient is < 6 years tick below fall risk intervention directly <input checked="" type="checkbox"/> If Patient is > 6 years Assess the below parameters History of Falling: within past 3 months <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Ambulatory Aids: • Wheelchair <input type="checkbox"/> Yes <input type="checkbox"/> No • Uses furniture for support <input type="checkbox"/> Yes <input type="checkbox"/> No Gait/Transferring: • Bedrest / immobile <input type="checkbox"/> Yes <input type="checkbox"/> No • Weak <input type="checkbox"/> Yes <input type="checkbox"/> No • Impaired <input type="checkbox"/> Yes <input type="checkbox"/> No Mental Status: Forgets limitations <input type="checkbox"/> Yes <input type="checkbox"/> No IF YES FOR ANY CATEGORY = RISK FOR FALLING Fall Risk Intervention: <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> <input type="checkbox"/> Mobility Problem <input type="checkbox"/> Walking Problem <input type="checkbox"/> Developmental Delay <input type="checkbox"/> Musculoskeletal Congenital Abnormality Inform consultant for positive criteria Nutritional Screening: <input checked="" type="checkbox"/> No Abnormalities Detected <input type="checkbox"/> Underweight <input type="checkbox"/> Overweight <input type="checkbox"/> Feeding Problem <input type="checkbox"/> Special diet <input type="checkbox"/> Special feeding method Inform consultant for positive criteria
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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?) 1
 Time of Initial assessment completed by ER Nurse : 9:06pm

Patient Name : Baby. R NAGA ANUSHA UHID : VIH-00075746 IPD : IP-00060468 Gender : Female Age : 10 Y
 1 M 4 D

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

Time	Nursing Notes
8:59pm	* Pt Came to ER
9pm	* vitals checked and recorded
9:05pm	* ER Doctor seen the pt & advised admission
9:10pm	* Admission Done
9:25pm	* Iv placement done
9:32pm	* Samples collected & sent to Lab
9:25pm	* nls Bolus given (250ml)
	* Pt shifted to ward

Samples collected by: } Sr. Liana
 Samples sent by: }

Time: 9:25pm
 Time: 9:32pm

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1
9:25pm	nls Bolus	Iv	250ml	[Signature]	[Signature]

Condition of patient at time of shift - out :	Details of Shift - out
HR: 104b/m BP: 109/79 (80) mmHg RR: 22b/m SPO ₂ : 100% GCS: 4, 5, 6 Temperature: 97°F Pain Score: 0 Repeat RBS (if applicable):	Shift - out from ER to: 106 Time of Shift - out: 24/6/26 @ 11PM Handover given to: Sr. Bereonke (Nurse's Name) Bre-Sabin

Tick as applicable: MLC LAMA BROUGHT DEAD

Procedures done with details (if any): Iv Placement

Name of the Nurse : Bre Sabin Signature of the Nurse : [Signature]

Date & Time : 24/6/26 @ 11PM

VIH-00075746 IP-00060468
 Baby R NAGA ANUSHA
 20-05-2016 10 Y 1 M 4 D (F)
 Dr. AKHEEL SYED RIZWAN



wt - 55.6kg
 ht - 149cm
 Gender: Male Female

EMERGENCY ROOM TRIAGE FORM

Patient's Name : Naga Anusha Age : 10 years
 Date : 24/6/26 Time of Arrival : 8:59pm

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: 97°F PR: 101b/m BP: 105/70/80 mmHg RR: 24b/m SpO₂: 100%

Chief Complaints: loose stools x yesterday, vomitings

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 checked="" type="checkbox"/> Normal <input type="checkbox"/> Increased <input type="checkbox"/> Decreased <input type="checkbox"/> Gasping / Apnea			

Triage Classification	CTAS
<input type="checkbox"/> Level 1 : Resuscitation	<input type="checkbox"/> Immediate
<input type="checkbox"/> Level 2 : EMERGENT : Life or limb threatening	<input type="checkbox"/> < 15 min
<input type="checkbox"/> Level 3 : URGENT : Significant illness / injury with potential to become life or limb threatening	<input 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 : 9:02pm

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 : Dr. Lema
 Date & Time : 24/6/26 @ 9:02pm

Signature of Triage Nurse : [Signature]

Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 11pm Mode of Arrival: lived by mother Admitting From: ER OPD Direct

Allergy / Adverse Reaction: - Body Weight: 55.6 Kg
 Height: 149 cm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
<u>yes</u>	<u>no</u>	<u>no</u>

Family History: no

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: 55.6kg Length: 149cm Head Circumference (< 2 years): -
 Temp: 98.6°F HR: 100 b/m RR: 28 b/m BP: -

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

Fall Risk Assessment: Yes No Score: 11 (Document in the Humpty Dumpty Sheet)

Risk of Pressure Sore (Braden Q Score 28) (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: - 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: (Date/Time):

Social History: Lives With family

Siblings in household Yes No (if yes How Many?) 1

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 father

Nurse's Name: Sr. Beonika Date: 24/6/26 Time: 11:20pm

Signature Beonika



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
25.6.26 5:00 PM	<p><u>3/13 Regular</u></p> <p><u>AGE with some dehydrate</u></p>	
	<p>3 episode of loose stool morning no fever Oral intake little of child stable CRT < 3sec. afebrile</p>	
	<p>H/L - NAD P/A - soft</p>	<p><u>Plan</u></p> <ul style="list-style-type: none"> - Encourage orally - Cont. Rehydration - Decrease IVF to 2/3rd maintenance - Hold 4th hly.
	<p><u>Sanusi</u> (Dr. Sanusi)</p>	
	<p>Noted by <u>Manasa</u> 25/6 @ 9 PM</p>	



Rainbow[®] Children's Hospital

It takes a lot to treat the little.

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: _____

VIH-00075746 IP-00060468

Baby R NAGA ANUSHA

20-05-2016 10 Y 1 M 4 D (F)

Dr. AKHEEL SYED RIZWAN

UHID ID: _____



Department: _____

Consultant: _____



Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

o/o Vomiting } since 7 days
o/o stools }
H/o Headache ⊕

History of present illness :

Child presented with H/o
Headache since Monday - events
↳ good tab Nardom

↓
persistent Headache - Tuesday

o/o Vomiting - multiple episodes
w/ (w/ or w/o) non Blood Stool

o/o stools - multiple episodes
↳ look watery yellowish

↳ initially managed on oral medicine

↓
Vomiting subsided

Today o/o persistent stools 25-20 episodes
watery, small - large quantity

↓
admitted in A&E

on presentation - Eyes sunken

tongue moist

Pulse good volume

child oriented

Serum - prof



Pediatric Multiorgan History & Physical Examination

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

h/o paroxysmal event → starting with giddiness,
pale colour of lips, face & stony fundus
↓
on Neuro dx ⇒ Used Feb. NaDDM-fos.

Birth & Neonatal History:

Birth & Socio Economic History:

About Father : _____
About Mother : _____
Any additional Information : _____ } class III

Developmental History :

Appropriate for age

Immunization History :

Received upto date



Pediatric Multiorgan History & Physical Examination

Anthropometry :

Head Circum (cms) _____ (Centile _____) Height (cms): _____ (Centile _____)
Weight (kgs)) 55.6 kg (Centile _____)

On Examination :

Temperature : 97°F Pulse Rate : 101/min B.P. 105/58 SPO2 100%

Resp.rate and type of breathing : _____

Rash ⊖

Lymphadenopathy _____

Oedema : ⊖

Allergies (if any): ⊖

Respiratory System :

Inspection (any s/o distress) : ⊖

Air entry & breath sounds : BAE ⊕

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 : BS ⊕

Spine : ⊖ External Genitalia : _____

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



Pediatric Multiorgan History & Physical Examination

Central Nervous System :

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

Cranial Nerves : intact

Motor System:

Nutriton : 2

Tone : 2 Power CPA all limbs

Co-ordinator : 2

Posture : 2

Involuntary Movements : NO

Reflexes : +

DTR +

Superficials: +

Plantars flexor

Sensory System : +

Bladder / Bowel : ↑ Bowel movements

Clinical Summary & Diagnostic:

Age i dehydration

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: To prevent complication

Desired goals of the treatment: To treat current condition

Planned Labs:

Planned Management

~~CBP~~ CBP ✓
~~CRP~~ CRP ✓
~~ESR~~ ESR ✓
~~S-Creat~~ S-Creat ✓
~~CUE~~ CUE ✓
 Stool microscopy
 Stool c/s
 noted by shawth
 24/6 @ 10:22pm

1) Purgulide - 80mg/hr
 2) Puj ceftriaxone
 3) Puj metronidazole
 4) Syp BIFILAC
 5) Syp Lincosone
 6) Sufamoxi.

Signature of the Doctor: AKheel Syed Rizwan

Signature of the Consultant:

Name of the Doctor: AKheel Syed Rizwan

Name of the Consultant:

Date & Time:

Date & Time:

24/6/2016 10:22pm



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
26/6/26	S/B Resident	
10 AM	Age 1c some dehydration	
	1 episode of loose stool since morning	
	No fever spikes	
	No abdominal pain	
	Oral intake - low	
	Child stable	
	Asthma	
	Urate stable	
	CRS-SS2 (+)	
	R/S - BAC (+)	
	PLA - soft	
		Plan
		1) Puj ceftriaxone - D2 (4th dose)
		2) Puj metronidazole - 2nd dose
		3) Syr Bepitac
		4) Syr. Zincora
		5) Tab. pantoprazole.
		6) Allow orally
		TO stop fluids from night
		Noted by
		Subham
		26/6/26
		@ 1 PM
	If more loose stools ↓ to start w/ fluids again.	

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
26/6/26 3pm	S/B Resident	
	<p>ASIS - AGE 3E some dehydration. 2 episodes of loose stools since morning O/E</p>	
	child alert	
	Futheer	
	Vitals stable	
	CVS - S1C2 (P)	
	Pfs - BAE (P)	
	P/A - soft	
		plan
		To stop IV fluids from 6pm
		↳ continue of loose stools
		(P) overnight
		2) CEJ
		3) Perform ros.
		noted by
		marale
		26/6/26
		@7pm

VIH-00075746
 Baby R NAGA ANUSHA
 20-05-2016 10 Y 1 M 6 D (F)
 Dr. AKHEEL SYED RIZWAN



IP-00060468

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	S/B Resident	
22/6/26 10 AM	<p>Sis: AGE ± some dehydration. no of loose stools since yesterday evening oral intake - better no other concerns</p>	
	O/E	
	child alert	
	Futurme	
	Uttan stable	
	CVR - NS2 (+)	
	R/o - RAE (+)	
	P/A - r/o	
		Plan
		1) Allow orally
		2) Pef ceftriaxone 6 th day
		3) Pef metrogyl 200's
		4) Syp Reglar
		5) Syp Zunosin
		6) Tab pantop
		7) Sporanorm R sach
	O/E Today	
	Oral ceftriaxone 2 day	
	Sporanorm R x 3 days	
	Syp Reglar x 2 days.	
	Syp Zunosin x 10 days	
		<p>noted by nurse 27/6 P/H</p>



NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: <i>AGE E some dehydration</i>		Any Infection: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Not Known				
	Surgery / Procedure: <i>Nil</i>		If Yes Specify:				
BACKGROUND	Date	<i>24/6/26</i>	<i>24/6/26</i>	<i>25/6/26</i>	<i>25/6/26</i>	<i>26/6/26</i>	
	Shift	<i>N</i>	<i>N</i>	<i>N</i>	<i>E</i>	<i>Night</i>	
	Medical Condition (Any special condition to be noted):	<i>Nil</i>	<i>Nil</i>	<i>Nil</i>	<i>Nil</i>	<i>Nil</i>	
ASSESSMENT	Diet:	<i>Normal</i>	<i>Normal</i>	<i>N diet</i>	<i>N diet</i>	<i>S diet</i>	
	Allergy:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Ventilation (RA, NP, NIV, VENTI):	<i>RA</i>	<i>RA</i>	<i>RA</i>	<i>RA</i>	<i>RA</i>	
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Vital Signs:	Temp:	<i>98.6°F</i>	<i>98.6°F</i>	<i>98.5°F</i>	<i>98.4°F</i>	<i>98°F</i>
		Res:	<i>20b/m</i>	<i>28b/m</i>	<i>22b/m</i>	<i>25b/m</i>	<i>22b/m</i>
		SpO ₂ :	<i>98%</i>	<i>99%</i>	<i>98%</i>	<i>99%</i>	<i>100%</i>
		Pulse:	<i>106b/m</i>	<i>104b/m</i>	<i>105b/m</i>	<i>103b/m</i>	<i>109b/m</i>
		BP:	<i>110/70</i>	<i>126/83(89)</i>	<i>126/83</i>	<i>100(82)</i>	<i>106/76(84)</i>
		LOC:	<i>conscious</i>	<i>conscious</i>	<i>conscious</i>	<i>conscious</i>	<i>conscious</i>
Fall Risk Score:		<i>11</i>	<i>11</i>	<i>11</i>	<i>11</i>	<i>11</i>	
Pain Score:	<i>0</i>	<i>0</i>	<i>0</i>	<i>0</i>	<i>0</i>		
Skin Integrity	<i>Intact</i>	<i>Intact</i>	<i>Intact</i>	<i>Intact</i>	<i>Intact</i>		
Recommendations	Safety Needs:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	Physiotherapy:	<i>Nil</i>	<i>Nil</i>	<i>Nil</i>	<i>Nil</i>	<i>Nil</i>	
	Others Specify:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Special Diet:	<i>NO</i>	<i>-</i>	<i>N diet</i>	<i>N diet</i>	<i>Soft diet</i>	
	Critical Lab Test / Values:	<i>-</i>	<i>-</i>	<i>Nil</i>	<i>Nil</i>	<i>Nil</i>	
	Other Special Orders / Medications:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	ADL (Dependent / Non Dependent):	<i>dependent</i>	<i>dependent</i>	<i>dependent</i>	<i>dependent</i>	<i>dependent</i>	
Post Operative Procedure Special Orders:		<i>Nil</i>	<i>Nil</i>	<i>Nil</i>	<i>Nil</i>	<i>Nil</i>	
Handed Over By Name :		<i>Sabir</i>	<i>Beonika</i>	<i>Rendu</i>	<i>manasa</i>	<i>Beonika</i>	
Signature / ID :		<i>S</i>	<i>B</i>	<i>R</i>	<i>M</i>	<i>B</i>	
Date:		<i>24/6/26</i>	<i>25/6/26</i>	<i>25/6/26</i>	<i>25/6/26</i>	<i>26/6/26</i>	
Time:		<i>@ 11PM</i>	<i>@ 8pm</i>	<i>7pm</i>	<i>@ 8pm</i>	<i>@ 8am</i>	
Taken Over By Name :		<i>Beonika</i>	<i>Rendu</i>	<i>manasa</i>	<i>Beonika</i>	<i>Subham</i>	
Signature / ID :		<i>B</i>	<i>R</i>	<i>M</i>	<i>B</i>	<i>S</i>	
Date:		<i>24/6/26</i>	<i>25/6/26</i>	<i>25/6/26</i>	<i>25/6/26</i>	<i>26/6/26</i>	
Time:		<i>11:20pm</i>	<i>@ 8am</i>	<i>@ 2pm</i>	<i>@ 8pm</i>	<i>@ 2pm</i>	

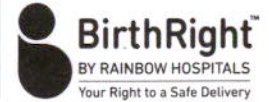
NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: AGE 2 Some dehydration		Any Infection: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify: Nil.....				
	Surgery / Procedure: -		Post OP Day: -				
BACKGROUND	Date	26/6	26/6	27/6			
	Shift	E	Night	M			
	Medical Condition (Any special condition to be noted):	nil	nil	nil			
	Diet:	s.diet	s.diet	s.diet			
ASSESSMENT	Allergy:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Ventilation (RA, NP, NIV, VENTI):	RA	RA	RA			
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Vital Signs:	Temp:	98.1 F	98.6 F	98.1 F		
		Res:	20b/m	22b/m	20b/m		
		SpO ₂ :	98%	99%	98%		
		Pulse:	96b/m	105b/m	96b/m		
		BP:	106/71(82)	116/77(75)	105/63(75)		
		LOC:	conscious	conscious	conscious		
	Fall Risk Score:	10	10	10			
Pain Score:	0	0	0				
Skin Integrity	intact	intact	intact				
Recommendations	Safety Needs:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Physiotherapy:	nil	nil	nil			
	Others Specify:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Special Diet:	s.diet	s.diet	s.diet			
	Critical Lab Test / Values:	nil	nil	nil			
	Other Special Orders / Medications:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	ADL (Dependent / Non Dependent):	dependent	dependent	dependent			
Post Operative Procedure Special Orders:	nil	nil	nil				
Handed Over By Name :	manasa	Benimika	manasa				
Signature / ID :	[Signature]	[Signature]	[Signature]				
Date:	26/6	27/6/26	27/6				
Time:	8pm	@ 8am	11am				
Taken Over By Name :	Benimika	manasa					
Signature / ID :	[Signature]	[Signature]					
Date:	26/6/26	27/6					
Time:	@ 8pm	8am					

Noted by
 manasa
 27/6
 8pm



NURSING CARE RECORD



Date: 24/6/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon							
Night	11pm	- Ensure safety - Maintain good nutritional support	8am	- Maintain to hydration - provide side rails kept	- vitals are normal.	Re-assessment is done patient is stable	Belenika 25/6/26 @SAM



NURSING CARE RECORD

Date: 25/6/25

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	9:00	maintain aseptic technique	9:30	maintained aseptic technique	prevent from Infection	patient is stable	Zindat 02 pro 20/6/25
	1:00	ensure safety	1:30	Side rails kept up	prevent from falls risk		
Afternoon	3 pm	→ IV fluids on	3:30 pm	→ DNS 80ml/hr is maintained	→ to maintain hydration	→ patient is stable	@ marasa
Night	11pm	→ maintain fluid Balance.		→ Administered IV fluid DNS 68ml/hr	→ to maintain Hydration.	Patient is stable	Bevonika 26/6 @ 8am
	1am	→ maintain good Nutritional status		→ to oral Intake is good	→ Provided soft diet		



NURSING CARE RECORD

Date: 26/6/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	9AM	→ maintain good nutritional status	9AM	→ Provided by soft diet	→ oral intake is good	→ Patient is stable	Subhen 26/6 @ 2pm
	10AM	→ Ensure safety	10AM	→ Side rails kept up	→ Prevent from fall risk		
Afternoon	3 pm	→ maintain fluid balance	3:30 pm	→ Advice the patient to take more oral intake	→ To maintain oral intake	→ patient is stable	@ noon
Night	11pm	→ Maintain Fluid Balance		→ to Administered IV Fluid DMS 50ml/hr	→ To maintain hydration	Patient is stable	Benorika 27/6 @ 8am
	1am	→ maintain good nutritional status		→ to Oral Intake is good	→ provided soft diet		

VIH-00075746 IP-00060468
 Baby R NAGA ANUSHA
 20-05-2016 10 Y 1 M 6 D (F)
 Dr. AKHEEL SYED RIZWAN

NURSING CARE RECORD



Date: 27/6

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	11 AM	Discharge notes		doctor came for rounds and advice for discharge			
Afternoon							noted by Manasa 27/6 21 AM
Night							



E HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
			25/6/2016	25/6/2016	25/6/2016	26/6/2016	26/6/2016
Age	Less than 3 years old	4					
	3 to less than 7 years old	3					
	7 to less than 13 years old	2	2	2	2	2	2
	13 years old and above	1					
Gender	Male	2					
	Female	1	1	1	1	1	1
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.)	3	3	3			
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1			1	1	1
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own ability	1	1	1	2	1	1
	History of Falls or Infant-Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2	2	2	2	2
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours/ None	1	1	1	1	1	1
Medication Usage	Sedatives (Excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1	1	1	1
Total		11	11	11	10	9	9

Intervention:

-Fall Risk: Low Humpty Dumpty Score = 7-11,

High Risk Humpty Dumpty Score = 12 or above

Bed in low position	✓	✓	✓	✓	✓	✓
Call device within reach	✓	✓	✓	✓	✓	✓
Wheels Locked	✓	✓	✓	✓	✓	✓
Room free of clutter	✓	✓	✓	✓	✓	✓
Adequate lighting	✓	✓	✓	✓	✓	✓
Wheel chair support	✓	✓	✓	✓	✓	✓
Other Intervention(s) Specify	✓	✓	✓	✓	✓	✓
Nurse's Name:	Shabli	Beenaif	And	Manasa	Beenaif	Subh
Signature:	Shabli	Beenaif	And	Manasa	Beenaif	Subh
Date:	24/6	25/6	25/6	25/6	26/6	26/6
Time:	9:10 AM	7 AM	10 AM	2 PM	2 AM	10 AM



THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
			26/6	26/6	27/6		
Age	Less than 3 years old	4					
	3 to less than 7 years old	3					
	7 to less than 13 years old	2	2	2	2		
	13 years old and above	1					
Gender	Male	2					
	Female	1	1	1	1		
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1	1		
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own ability	1	1	1	1		
	History of Falls or Infant-Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2	2	2		
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	1	1	1		
Medication Usage	Sedatives (Excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1	1		
Total			9	9	9		

Intervention:

-Fall Risk: Low Humpty Dumpty Score = 7-11,

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		✓	✓	✓		
Call device within reach		✓	✓	✓		
Wheels Locked		✓	✓	✓		
Room free of clutter		✓	✓	✓		
Adequate lighting		✓	✓	✓		
Wheel chair up		✓	✓	✓		
Other Intervention(s) Specify						
Nurse's Name:		marwa	Reem	marwa		
Signature:		<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>		
Date:		26/6	27/6	27/6		
Time:		noon	2am	10 AM		



BRADEN 'Q' SCALE

					Date :	24/6	25/6	25	25/6
					Time :		6:30 AM	10:30 AM	4:00 PM
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.		4	2	4	4
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.		4	2	4	4
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: Responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.		4	2	4	4
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.		4	2	4	4
FRICITION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."		4	2	4	4
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.		4	2	4	3
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.		4	2	4	4
TOTAL SCORE						28	28	29	27
Evaluator's Name						Shr Gan	kp		

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

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



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
24/6	9:10pm	0	-	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	-	gfy
25/6	5Am	0	-	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	-	Bevonika
25/6	12pm	0	-	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	nil	Indu
25/6	4pm	0	-	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	nil	(Signature)
26/6/26	2am	0	-	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nil	Bevonika
26/6/26	10Am	0	-	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nil	Subhan
26/6	4pm	0	-	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	nil	(Signature)
27/6	2am	0	-	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nil	Brij
27/6	10AM	0	-	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	nil	(Signature)
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Re-assessment Frequency:

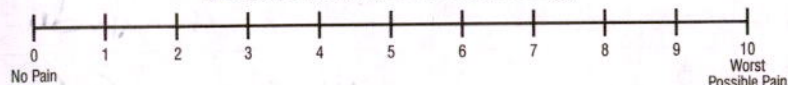
1. Every eight hours for all hospitalized patients.
2. For post-surgical patients, patients with chronic pain, patient with severe pain:
 - a) At least every 2 hours for the first 24 hours
 - b) Then every 4 hours.
 - c) Prior to pain pain-relieving intervention.
 - d) Within 30 – 60 minutes after pain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

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

Numerical Pain Scale (Obstetric and Gynecology)



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

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

Wong - Baker (Pediatrics) Above 7 Years



CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			26/6 DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0			-	0	0	0	0	0	0	
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1				-	-	-	-	-	-	
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2				-	-	-	-	-	-	
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3				-	-	-	-	-	-	
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4				-	-	-	-	-	-	
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord pyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5				-	-	-	-	-	-	
Signature of the Nurse				shu @ Brij Subin @ Brij									


NOTE : Phlebitis greater than grade 2 should be reported to physicians and other appropriate health care personal ongoing observation of the site should continue for 48 hours post removal to detect post infusion phlebitis.

Signature of Shift In Charge : shu Name : shaukat

Signature of Ward In Charge : ali Name : alizabeth



CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	27/6 DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0	0									
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1	-									
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	✓									
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3	✓									
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4	✓									
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord pyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5	✓									
Signature of the Nurse													

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Signature of Shift In Charge :

Signature :  Name : Cayathre

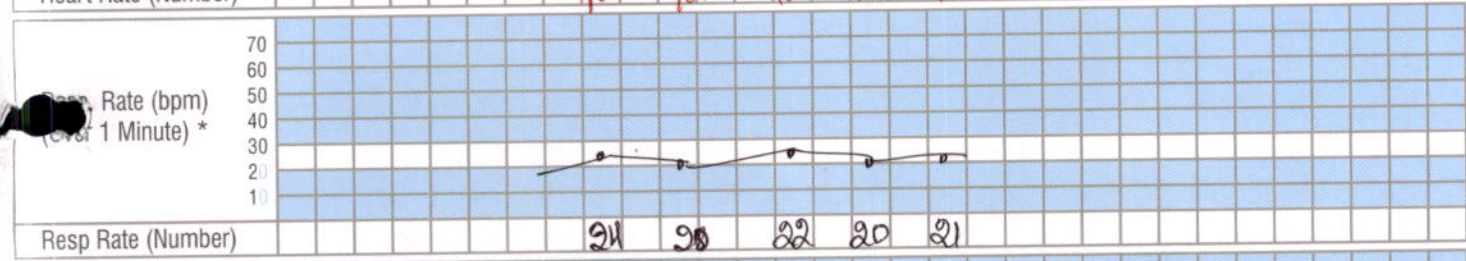
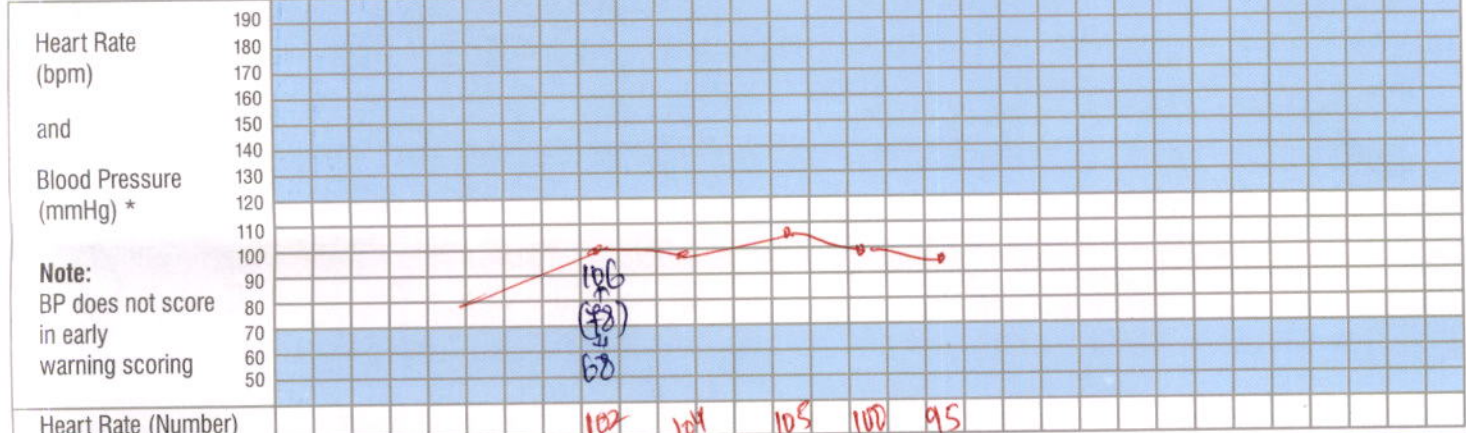
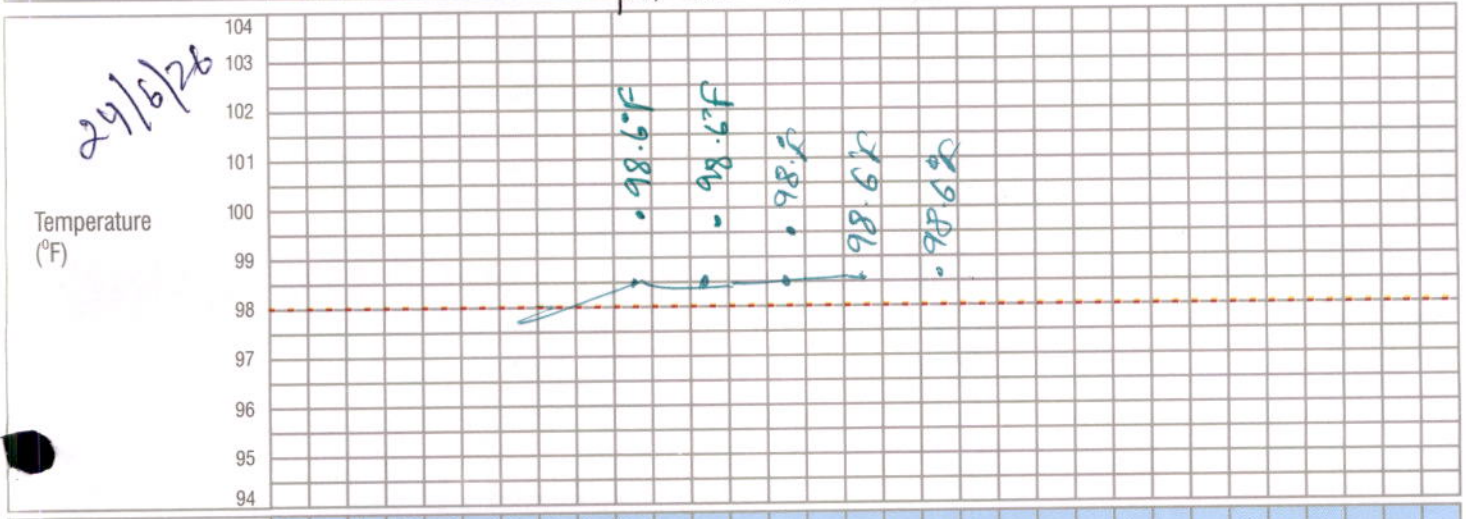
Signature of Ward In Charge :

Signature :  Name : Elizabeth



EARLY WARNING SCORE: CHILDREN'S UNIT

Date : Time: 11 1 3 5 7
 Doctor / Nurse / Family Concern? pm Am Am Am Am



Resp Distress	Mod/ Severe None / Mild	N	N	N	N	N
Receiving O ₂ (l/min)	O ₂ Saturations (%)	98	98	98	99	
Conscious Level	Normal / Altered	N	N	N	N	N
GCS *		15	15	15	15	15

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

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)

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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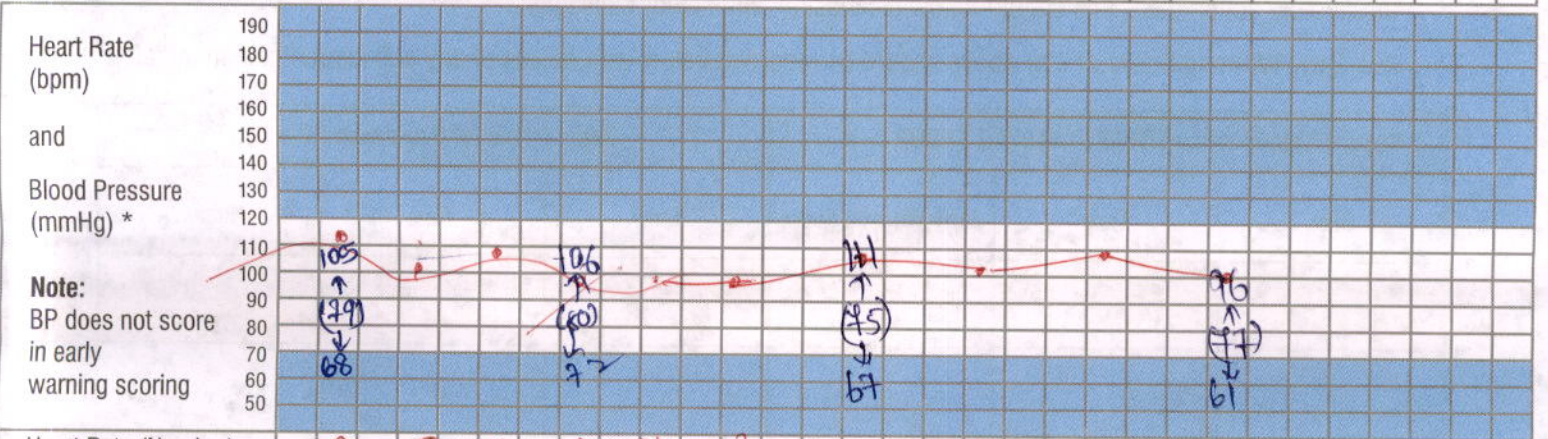
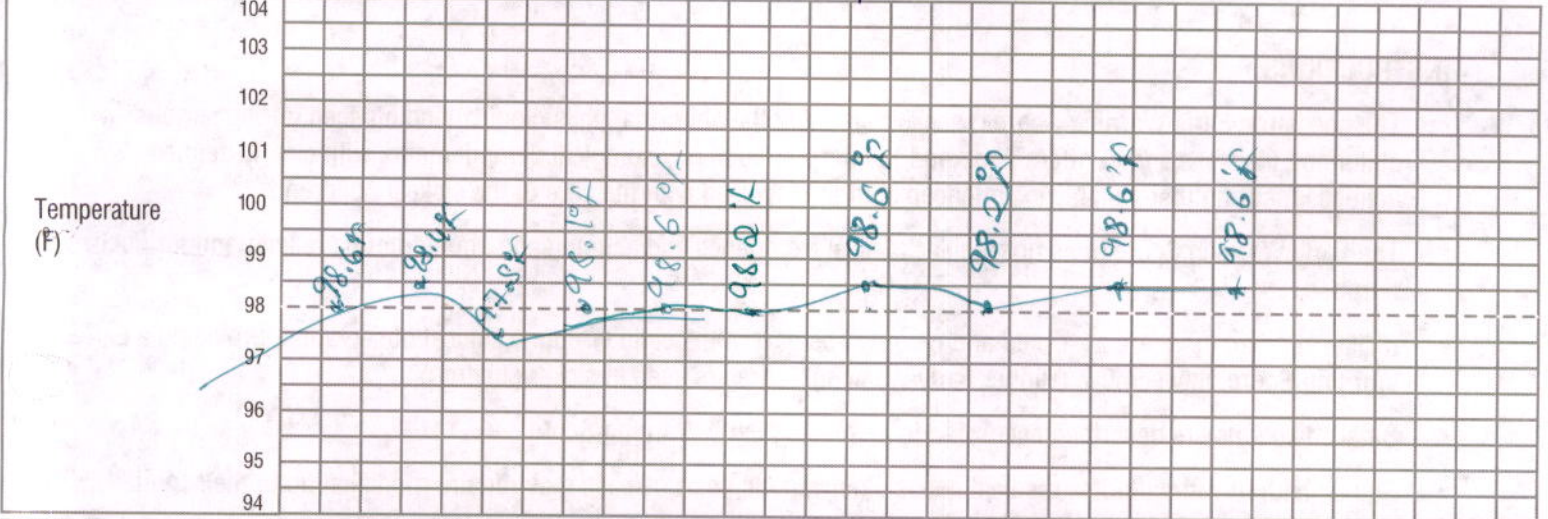
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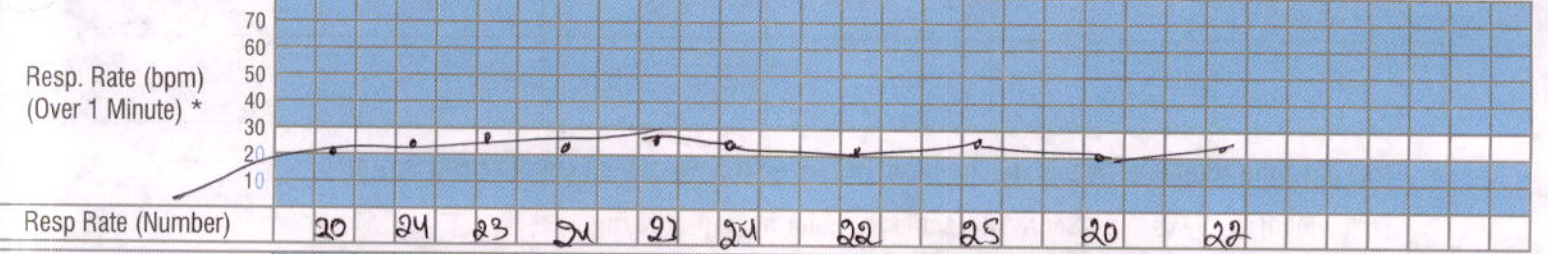
EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 26/6/26 Time: 9 11 1 3 5 7 10 1 4 7

Doctor / Nurse / Family Concern? AM AM PM PM PM PM PM AM AM AM



Heart Rate (Number) 112 100 102 96 91 98 105 101 107 100



Resp Rate (Number) 20 24 23 24 22 24 22 25 20 22

Resp Mod/ Severe Distress None / Mild N N N N N N N N N N

Receiving O₂ (l/min) O₂ Saturations (%) 99 100 96 97 98 97 99 100

Conscious Level Normal / Altered N N N N N N N N N N

GCS * 15 15 15 15 15 15 15 15 15 15

TOTAL SCORE	
Number of shaded boxes	0 0 0 0 0 0 0 0 0 0
Pain Score	0 0 0 0 0 0 0 0 0 0
Observer's Initials	SK SK SK M M M B B B B

- ACTIONS**
- Score 1 : Continue normal observation by staff nurse
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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)
- 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. :

24/6/26

- 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 :							
	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 :							
			500 ml										
Total 24 hrs. Intake						Total 24 hrs. Output							

Nil

Jelly water

ONS
80ml
80ml
80ml

25/6/26

Bevonta
25/6
@Fam



FLUID CHART

Sheet No. : (2)

25/6/26

- 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	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
		Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G							
25/6	08:00 am								✓	1	} 2nd 2pm 2nd	
	09:00 am			80ml						1		
	10:00 am			80ml		✓			✓	1		
	11:00 am			80ml						1		
	12:00 pm			80ml		✓			✓	1		
	01:00 pm					✓				1		
Total Intake : 360ml					Total Output :							
25/6	02:00 pm			80ml		✓				1	} mangg 25/6 2pm	
	03:00 pm			80ml						1		
	04:00 pm			80ml						1		
	05:00 pm			65ml		✓			✓	1		
	06:00 pm			65ml		✓				1		
	07:00 pm									1		
Total Intake : 370ml					Total Output :							
26/6/26	08:00 pm			65ml						1	} Beonika 26/6 @ 1am	
	09:00 pm		Rice			✓			✓	1		
	10:00 pm		water			✓			✓	1		
	11:00 pm			65ml		✓				1		
	12:00 am			65ml						1		
	01:00 am			65ml						1		
Total Intake : 260 ml					Total Output :							
26/6/26	02:00 am			65ml						1	} Beonika 26/6 @ 7Am	
	03:00 am		water	65ml						1		
	04:00 am			65ml						1		
	05:00 am			65ml						1		
	06:00 am									1		
	07:00 am								✓	1		
	Total Intake : 260 ml					Total Output :						

Total 24 hrs. Intake : 1250 ml

Total 24 hrs. Output : motion - 9time
 urine - 7time

VIH-00075746 IP-00060468
 Baby R NAGA ANUSHA
 20-05-2016 10 Y 1 M 5 D (F)
 Dr. AKHEEL SYED RIZWAN



FLUID CHART

Sheet No. : 3

26/6/20

- 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			
26/6	08:00 am											} 26/6 @ 2pm	
	09:00 am		salty										
	10:00 am		water				✓			✓			
	11:00 am												
	12:00 pm						✓						
	01:00 pm												
Total Intake :						Total Output :							
26/6	02:00 pm		rice									} mango 26/6 @ 7pm	
	03:00 pm		water										
	04:00 pm			coml						✓			
	05:00 pm			some									
	06:00 pm												
	07:00 pm												
Total Intake : 100 ml						Total Output :							
	08:00 pm						✓					} Benavika 26/6 @ 1am	
	09:00 pm		rice										
	10:00 pm		water										
	11:00 pm			50ml									
	12:00 am			50ml									
	01:00 am			50ml									
Total Intake :						Total Output :							
	02:00 am			150 ml								} Benavika 26/6 @ 5am	
	03:00 am			50 ml									
	04:00 am		water	50 ml									
	05:00 am												
	06:00 am												
	07:00 am												
Total Intake :						Total Output :							
Total 24 hrs. Intake			350 ml			Total 24 hrs. Output			6 time				



FLUID CHART

Sheet No. :

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

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

Total 24 hrs. Intake

Total 24 hrs. Output

Patient Sticker

FLUID CHART

Sheet No. :

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

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



MEDICATION RECONCILIATION FORM

Drug Allergies: Not known any Drug Allergies

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

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

Shifting From: ICU 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 : 24/6/26 @ 9 PM

Nurse Name & Signature: Sr. Lema / [Signature]

Date & Time : 24/6/26 @ 9 PM

Sheet No:

REGULAR PRESCRIPTIONS

Weight 55.6 kg Ward

Chik 25/6/26

DRUG : INT. METRONIDAZOLE				Date Time	25/6/26														
Dose	Route	Frequency	Start Dt.																
500mg	IV	8 th hly	25/6	6Am															
Name & Signature of the Doctor Starting the Drugs: Dr. Sameera																			
Additional Instructions: 10 mg/kg/day																			
Daily Doctor's Endorsement by a Sign																			

DRUG : TAB. PANTOPRAZOLE				Date Time	25/6														
Dose	Route	Frequency	Start Dt.																
1 tab	PO	once daily	25/6																
Name & Signature of the Doctor Starting the Drugs: Dr. Vishwaje																			
Additional Instructions: 1 tab = 40mg																			
Daily Doctor's Endorsement by a Sign																			

DRUG : SPORONORM - R ^{SACHET}				Date Time	26/6/26														
Dose	Route	Frequency	Start Dt.																
1 SACHET	PO	BD ^(twice daily)	26/6	9 Am															
Name & Signature of the Doctor Starting the Drugs: Dr. Neeraj																			
Additional Instructions: 1 SACHET IN 10ML OF DISTILLED WATER.																			
Daily Doctor's Endorsement by a Sign																			

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

Signature
 26/6/26
 4:45pm
 26/6/26



106



**MEDICATION
 NEBULISATION CHART**

Date	Time	Drug	Nurse	Parents Signature
25/6/26	00.00	6am		
	01.00	Inj CEPTRIAZONE 2gm (BD)		R.H.V. Jaleel
	02.00	Inj METRONIDAZOLE 550mg(TID)		
	03.00	10am		
	04.00	SYP BIFILAC 5ml (BD)		R.H.V. Jaleel
	05.00			
	06.00	2pm		
	07.00	Inj METRONIDAZOLE 550mg(TID)		R.H.V. Jaleel
	08.00			
	09.00			
	10.00	6pm		
	11.00	Inj CEPTRIAZONE 2gm (BD)		
	12.00			
	13.00			
	14.00	10pm		
	15.00	Inj METRONIDAZOLE 550mg(TID)		R.H.V. Jaleel
	16.00	SYP BIFILAC 5ml (BD)		
	17.00	SYP ZINCONIA 5ml (OD)		
	18.00			
	19.00			
	20.00			
	21.00			
	22.00			
	23.00			



RESULT SHEET

Date	24/6				
Time	9:38				
Hb	11.7				
PCV	33.6				
RBC	4.76				
WBC	6.29				
N/L	62.3/24.5				
Platelets	2.60				
CRP	31				
ESR					
PCT					
RBS					
Na	138				
K	4.5				
Cl	110				
Ca/Mg					
Phosphate					
Urea					
Creatinine	0.2				
ALP					
SGPT					
SGOT					
T.Bill/Conj					
T.Protein					
S.Albumin					
S.Globulin					
A/G Ratio					
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein / Sugar					
Cells					
N/L					

Date	25/6					
Time	12 AM					
CUE - Alb	Nil					
CUE - Sugar	Nil					
CUE - Ketones	Negative					
CUE - PUS Cells	3-4					
CUE - RBC Cells	Nil					
CUE <i>epithelial</i>	4-5					
Stool Pus Cell	4-5					
OVA / Cyst	Nil					
Occult Blood Nil	Nil					
<i>ruces</i>	Present					
<i>undigested food</i>	present					

Culture and Sensitivities : *S/c/s :-*

.....

.....

.....

Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI :

 Others (ECG, Contrast Studies etc.) :



I.V. FLUIDS CHART

Weight. 55.6..... Ward.

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
24/6	11:00 PM	DNS (70mg)	IV	80ml/hr	ll	Blf Bf	25/6	San	Blf Bf
25/6/26	3:30 PM	DNS 2/3 rd maintenance	IV	65	San	Blf Bf	26/6	ll	Blf Bf
26/6	7 PM	DNS	IV	50	ll	Blf Bf	24/6	Blf Bf	Blf Bf

Signature

VERIFIED BY : Name

Patient Sticker

Weight. Ward.

VARIABLE DOSE		Date Time						
			Nurse Sig.	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.	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
2/16	9:25pm	NS Prows	250ml	IV		Sabin Shanthi

Signature
VERIFIED BY : Name



REGULAR PRESCRIPTIONS

Weight. 55.6 Kg Ward.

S. maeey Komala
24/6/26

S. maeey Komala
24/6/26

S. maeey Komala
24/6/26

S. maeey Komala
24/6/26

DRUG : SYP. BIFILAC				Date Time	24/6	25/6	26/6													
Dose	Route	Frequency	Start Date	10 AM																
5ml	PO	12th hourly	24/6																	
Name & Signature of the Doctor Starting the Drugs: Dr. Vishwaje																				
Additional Instructions:				10 PM	ESW	ESW														
Daily Doctor's Endorsement by a Sign																				
DRUG : INJ. CEFTRIAXONE				Date Time	24/6	25/6	26/6													
Dose	Route	Frequency	Start Date	6 AM																
2gm	IV	12th hourly	24/6																	
Name & Signature of the Doctor Starting the Drugs: Dr. Vishwaje																				
Additional Instructions: complety done				6 PM	ESW	ESW														
Daily Doctor's Endorsement by a Sign																				
DRUG : INJ. METRONIDAZOLE				Date Time	24/6	25/6	26/6													
Dose	Route	Frequency	Start Date	6 AM																
550mg	IV	8th hourly	24/6																	
Name & Signature of the Doctor Starting the Drugs: Dr. Vishwaje				2 PM																
Additional Instructions: complety done				10 PM	ESW															
Daily Doctor's Endorsement by a Sign																				
DRUG : SYP. ZINCINIA				Date Time	24/6	25/6	26/6													
Dose	Route	Frequency	Start Date																	
5ml	PO	once daily	24/6																	
Name & Signature of the Doctor Starting the Drugs: Dr. Vishwaje				10 PM	ESW	ESW														
Additional Instructions: 5ml / 20mg																				
Daily Doctor's Endorsement by a Sign																				

Date changed
25.6.26