

Name	Baby ARUTLA SMIGDHA	UHID	VIH-00206222
Father/Guardian	Mr ARUTLA SAGAR	Age/Gender	13 Y 11 M 18 D/Female
Address	2-18-19/A PRASHANTH NAGAR,UPPAL, Uppal, Hyderabad, Telangana, INDIA, 500039		
IP No	IP-00060466	Admission Date	24-06-2026
Ref Doctor		Discharge Date	27-06-2026

DISCHARGE SUMMARY

Consultant: Dr. PREETHAM KUMAR

MBBS, DNB(PEDS), DCH, FELLOW NEONATOLOGY
SENIOR CONSULTANT PEDIATRICS
39859

Co-Consultant:

Dr. M. NAGA VENKATA POUISHYA SAI

MBBS, MD

MD (Pediatrics), FNB (Pediatric Gastroenterology and Hepatology)

Consultant Pediatric Gastroenterologist and Hepatologist

Diagnosis: Viral Hepatitis (Hepatitis A Positive)

History: Baby ARUTLA SMIGDHA is a 13 Y 11 M 18 D girl presented with the history of multiple episodes of nonbilious non-projectile vomitings associated with abdominal pain, no passage of stools since 4 days prior to admission. For the above complaints, she was investigated and treated elsewhere, but in view of persistent symptoms, she was admitted at Rainbow Children's Hospital for further management.

Outside Investigations: Complete blood picture done on 24.06.2026 showed hemoglobin 13 gm%, white blood cells count of 4,900 cells/cumm, platelet count of 1.93 lakhs/cumm and C-reactive protein was 4.98 mg/l. Liver function

Name	Baby ARUTLA SMIGDHA	UHID	VIH-00206222
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tests showed SGPT 3462 U/L, SGOT 3325 U/L, ALP 161 U/L, total serum bilirubin was 5.2 mg/dl with direct fraction 3.6 mg/dl and indirect fraction 1.6 mg/dl, serum albumin was 4.0 g/dl, total protein was 7.3 g/dl, S.globulin was 3.3 g/dl. GGT 280. CUE showed 10-12 pus cells, 9-10 RBCs, 15-20 epithelial cells, albumin trace, bile salts bile pigments positive.

Examination: She was afebrile, maintaining saturations at room air. Her heart rate was 78/min, blood pressure - 110/80 mmHg and respiratory rate - 22/min. On auscultation, air entry was bilaterally equal with normal heart sounds and there was no murmur. Abdomen was soft with no organomegaly. Neurologically, she was conscious and oriented. Other systemic examination was normal.

Weight on admission : 47.9 kgs.

Investigations: Enclosed.

Management: She was admitted in the ward and started on intravenous fluids and Tablet Udiliv. She was treated symptomatically with antacids, antiemetics and antipyretics.

On evaluation, coagulation profile showed PT 19 sec, INR 1.3, APTT 28sec. Anti HAV antibody was reactive. Anti HEV antibody was non-reactive. Ultrasound abdomen showed diffuse circumferential edematous wall thickening of gallbladder with maximum thickness of 8.4mm, minimal ascites in right lumbar and iliac region.

Her vitals were regularly monitored. Her repeat liver function test showed decreased transaminitis. Her symptoms gradually settled. As hemodynamically stable, she is being discharged with the following advice.

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

Name	Baby ARUTLA SMIGDHA	UHID
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Advice:

1. Diet as advised (No non-veg diet for 2 weeks).
2. Tablet Udiliv (300mg) 1 tablet, 12th hourly (after food) for 4 weeks.
3. Tablet Pantoprazole (40mg) 1 tablet once daily (1/2 hour before breakfast) for 3 days.
4. To do LFT, PT APTT INR after 2 weeks and review.
5. Kindly consult Dr. Preetham Kumar, Senior Consultant Pediatrics, after 3 days in OPD with prior appointment (This consultation will be charged).
6. Kindly consult Dr. M. Naga Venkata Poushya Sai, Consultant Pediatric Gastroenterologist & Hepatologist, after 2 weeks with LFT, PT APTT INR reports in OPD with prior appointment (This consultation will be charged).

In case of Fever:

Tablet Paracetamol (650mg), 1 tablet for fever more than 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 Emergency Contact 040-42462200 Extn: 2010 (or) 7337357870 for increasing breathing difficulty, dullness or high fever.

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).

Name	Baby ARUTLA SMIGDHA	UHID	VIH-00206222
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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. Vishwaja
DEO : MD Younus Pasha


Registrar/Resident/C.M.O

Dr. PREETHAM KUMAR
MBBS,DNB(PEDS),DCH,FELLOW NEONATOLOGY
SENIOR CONSULTANT PEDIATRICS
39859

PatientName : Baby ARUTLA SMIGDHA Inpatient No. : IP-00060466
Age/Gender : 13 Y 11 M 15 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 19:52
HEMOGLOBIN (Colorimetry)	11.9	g/dL	L 12 - 16
RBC COUNT (DC detection method)	4.49	10 ¹² /L	4.1 - 5.1
PCV/HCT (Calculated)	33.2	VOL%	33 - 51
MCV (Calculated)	74.0	fL	L 78 - 102
MCH (Calculated)	26.6	pg/cells	25 - 35
MCHC (Calculated)	35.9	g/dL	32 - 36
RDW-CV (Calculated)	14.5	%	H 11.5 - 14
PLATELET COUNT (DC Detection Method)	194	10 ⁹ /L	150 - 450
MPV (Calculated)	9.9	fL	6.5 - 10
WBC COUNT (DC Detection Method)	5.77	10 ⁹ /L	4.5 - 13
Differential Count			
NEUTROPHILS (Microscopy, Leishman stain)	55	%	34 - 64
LYMPHOCYTES (Microscopy, Leishman stain)	35	%	25 - 45
MONOCYTES (Microscopy, Leishman stain)	09	%	4 - 10
EOSINOPHILS (Microscopy, Leishman stain)	01	%	1 - 4
PERIPHERAL SMEAR (Microscopy, Leishman stain)	RBC - NORMOCYTIC / NORMOCHROMIC WBC - MORPHOLOGY NORMAL PLATELETS - ADEQUATE		



Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
C REACTIVE PROTEIN (Specimen : SERUM)		TEST RESULT STATUS : REPORT AUTHORISED	
			Order Date :24-06-2026 19:52
CRP (Immunoturbidimetry)	6.0	mg/L	<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 19:52
CREATININE (Enzymatic)	0.3	mg/dl	L 0.5 - 1.1

PatientName : Baby ARUTLA SMIGDHA Inpatient No. : IP-00060466
Age/Gender : 13 Y 11 M 15 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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Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

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

TEST RESULT STATUS : REPORT AUTHORISED

Order Date :24-06-2026 19:52

SODIUM (Direct ISE)	141	mmol/L	134 - 143
POTASSIUM (Direct ISE)	4.3	mmol/L	3.7 - 5
CHLORIDE (Direct ISE)	104	mmol/L	98 - 108



Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
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LIVER FUNCTION TEST (Specimen : SERUM)

TEST RESULT STATUS : REPORT AUTHORISED

Order Date :24-06-2026 19:52

TOTAL BILIRUBIN (Azobilirubin)	4.6	mg/dl	H <1.3
CONJUGATED BILIRUBIN (Spectrophotometric)	3.7	mg/dl	H <0.3
UNCONJUGATED BILIRUBIN (Spectrophotometric)	0.9	mg/dl	<1.1
SGOT (AST) (Kinetic with P5P)	3119	U/L	H 10 - 30
SGPT (ALT) (Kinetic with P5P)	3255	U/L	H 5 - 30
ALKALINE PHOSPHATASE (pNPP/AMP buffer)	198	U/L	70 - 230
PROTEIN (Biuret method)	7.6	g/dL	6.3 - 8.6
ALBUMIN (Bromocresol Green)	4.2	g/dL	3.7 - 5.6
GLOBULIN (Calculated)	3.4	g/dL	1.6 - 3.5
A/G RATIO (Calculated)	1.2		L 1.4 - 3.4



Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
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PT/APTT (PROTHROMBIN TIME / ACTIVATED PARTIAL THROMBOPLASTIN TIME) (Specimen : PLASMA)

TEST RESULT STATUS : REPORT AUTHORISED

Order Date :24-06-2026 19:52

PT (Optical Clot Detection)	19.0	Seconds	
PT Calculated Biological Reference Interval	12.5 - 14.5 secs		

PatientName : Baby ARUTLA SMIGDHA **Inpatient No.** : IP-00060466
Age/Gender : 13 Y 11 M 15 D/ Female **Admit Date** : 24-06-2026
Ward/Bed : N 0 GF-EMERGENCY/ ER 101 **Discharge Date** :

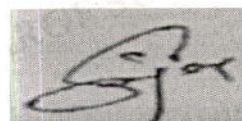
Investigation	Result	Unit	Biological Reference Interval
INR	1.3		
APTT (Optical Clot Detection)	28.0	Seconds	
APTT Calculated Biological Reference Interval	28.5 - 35.1 secs		



Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
COMPLETE BLOOD PICTURE (Specimen : BLOOD)			TEST RESULT STATUS : REPORT AUTHORISED Order Date :26-06-2026 09:22
HEMOGLOBIN (Colorimetry)	11.6	g/dL	L 12 - 16
RBC COUNT (DC detection method)	4.29	10 ¹² /L	4.1 - 5.1
PCV/HCT (Calculated)	31.3	VOL%	L 33 - 51
MCV (Calculated)	73.1	fL	L 78 - 102
MCH (Calculated)	27.0	pg/cells	25 - 35
MCHC (Calculated)	36.9	g/dL	H 32 - 36
RDW-CV (Calculated)	14.4	%	H 11.5 - 14
PLATELET COUNT (DC Detection Method)	178	10 ⁹ /L	150 - 450
MPV (Calculated)	9.4	fL	6.5 - 10
WBC COUNT (DC Detection Method)	5.84	10 ⁹ /L	4.5 - 13
Differential Count			
NEUTROPHILS (Microscopy, Leishman stain)	55	%	34 - 64
LYMPHOCYTES (Microscopy, Leishman stain)	35	%	25 - 45
MONOCYTES (Microscopy, Leishman stain)	9	%	4 - 10
EOSINOPHILS (Microscopy, Leishman stain)	1	%	1 - 4
PERIPHERAL SMEAR (Microscopy, Leishman stain)	RBC : NORMOCYTIC / HYPOCHROMIC WBC : MORPHOLOGY NORMAL PLATELETS : ADEQUATE		



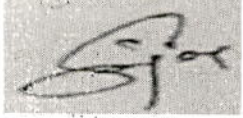
Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
C REACTIVE PROTEIN (Specimen : SERUM)			TEST RESULT STATUS : REPORT AUTHORISED Order Date :26-06-2026 09:22

PatientName : Baby ARUTLA SMIGDHA Inpatient No. : IP-00060466
Age/Gender : 13 Y 11 M 17 D/ Female Admit Date : 24-06-2026
Ward/Bed : N 0 GF-EMERGENCY/ ER 101 Discharge Date :

Investigation	Result	Unit	Biological Reference Interval
CRP (Immunoturbidimetry)	2.0	mg/L	<10



Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

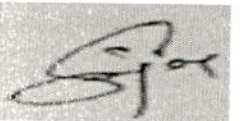
Investigation	Result	Unit	Biological Reference Interval
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LIVER FUNCTION TEST (Specimen : SERUM)

TEST RESULT STATUS : REPORT AUTHORISED

Order Date :27-06-2026 05:37

TOTAL BILIRUBIN (Azobilirubin)	4.6	mg/dl	H <1.3
CONJUGATED BILIRUBIN (Spectrophotometric)	3.8	mg/dl	H <0.3
UNCONJUGATED BILIRUBIN (Spectrophotometric)	0.8	mg/dl	<1.1
SGOT (AST) (Kinetic with P5P)	583	U/L	H 10 - 30
SGPT (ALT) (Kinetic with P5P)	1480	U/L	H 5 - 30
ALKALINE PHOSPHATASE (pNPP/AMP buffer)	206	U/L	70 - 230
PROTEIN (Biuret method)	6.5	g/dL	6.3 - 8.6
ALBUMIN (Bromocresol Green)	3.5	g/dL	L 3.7 - 5.6
GLOBULIN (Calculated)	3	g/dL	1.6 - 3.5
A/G RATIO (Calculated)	1.1		L 1.4 - 3.4



Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356



MC-7373

Laboratory Report

Rainbow
Children's
HospitalRainbow
Children's
Hospital

Patient Name	Baby ARUTLA SMIGDHA	Patient Ph. No	9849438058
Age	13 Y 11 M 16 D	Requisition No	VI26021419
Gender	Female	Collected on	24-06-2026 07:53 PM
IP / Bill No.	IP-00060466	Received on	24-06-2026 08:18 PM
UHID No.	VIH-00206222	Reported on	25-06-2026 09:26 AM
Ref Doctor	Dr. PREETHAM KUMAR	Ward/Bed No	N 0 GF-EMERGENCY / ER 101

ANTI HEV ANTIBODY (IGM) (Specimen :SERUM)

RESULT TEST RESULT STATUS : REPORT AUTHORISED
REPORT : NON REACTIVE
METHODOLOGY: ELISA

Dr. VIJENDRA KAWLE MD DNS
(CONSULTANT MICROBIOLOGIST)

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

..... End of the Report



MC-7373

Rainbow
Children's
Hospital

Laboratory Report

Patient Name	Baby ARUTLA SMIGDHA	Patient Ph. No	9849438058
Age	13 Y 11 M 16 D	Requisition No	VI26021419
Gender	Female	Collected on	24-06-2026 07:53 PM
IP / Bill No.	IP-00060466	Received on	24-06-2026 08:18 PM
UHID No.	VIH-00206222	Reported on	25-06-2026 09:26 AM
Ref Doctor	Dr. PREETHAM KUMAR	Ward/Bed No	N 0 GF-EMERGENCY / ER 101

ANTI HAV ANTIBODY (IGM) (Specimen :SERUM)

RESULT

TEST RESULT STATUS : REPORT AUTHORISED

REPORT : REACTIVE

METHODOLOGY: ELISA

Dr. VIJENDRA KAWLE MD DNS
(CONSULTANT MICROBIOLOGIST)Dr. RANGANATHAN N. IYER MD FRCPATH DNB DPB
(CONSULTANT MICROBIOLOGIST)

..... End of the Report

Baby ARUTLA SMIGDHA

13 Y 11 M 15 D

Female

IP-00060466

VIH-00206222

PREETHAM KUMAR

R26-010117

24-06-2026 07:55 PM

27-06-2026 10:36 AM

DRAFT

ULTRASOUND ABDOMEN

LIVER : Normal in size 13.2 cm and echotexture. No intrahepatic biliary duct dilatation. Portal vein is normal. No focal lesions.

GALLBLADDER : Distended partially. No evidence of calculi. Common bile duct appears normal.

SPLEEN :Normal in size 10 cm and echotexture.

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

KIDNEYS :

Right kidney : 9x4cm. Normal in size and echotexture and shows smooth contour. No hydronephrosis or calculi.

Left kidney : 8.9x5.1 cm. Normal in size and echotexture and shows smooth contour. No hydronephrosis or calculi.

URINARY BLADDER : Distended partially and appears normal.

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

Print Date/Time : 27-06-2026 10:36 AM

Printed By : YOUNUS PASHA
MOHAMMAD

Page: 1 of 2

Baby ARUTLA SMIGDHA

9849438058

13 Y 11 M 15 D

R26-010117

Female

24-06-2026 07:55 PM

IP-00060466

27-06-2026 10:36 AM

VIH-00206222

PREETHAM KUMAR

Impression

- 1. Diffuse circumferential edematous wall thickening of gallbladder with maximum thickness of 8.4mm.**
- 2. Minimal ascites in right lumbar and iliac region.**

Suggested clinical correlation.

ACTIVITY RECORD

VIH-00206222 IP-00060466
Baby ARUTLA SMIGDHA
09-07-2012 13 Y 11 M 15 D (F)
Dr. PREETHAM KUMAR



Name: -----

UHID No : -----

Consultant : ----- Dept: pediatrics

Date of Admission : 24/6 Time : 6:50 PM Date of Discharge : ----- Time: -----

Room / Bed No : 110 Ward : 1st floor Suggested Billable bed type : -----

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
<u>24/6/26</u>	<u>8:40 PM</u>	<u>ER</u>	<u>110</u>	<u>AS</u>

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1.	<u>Dr. Nagesh Kumar</u>	<u>24/6/26</u>	<u>3095101</u>	<u>CK</u>
2.	<u>Poushey Sai</u>			
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

ERROR LOG

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

ICD CODE :-

OBSERVATION: -

DATE :

MRD EXECUTIVE

ADMISSION SHEET

Registration Details :
Admission No : IP-00060466 **Admit Date** : 24-Jun-2026 **Admit Time** : 07:14 PM **UHID** : VIH-00206222

Patient Details :

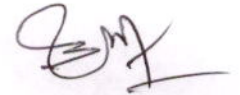
Patient Name : Baby ARUTLA SMIGDHA	Age : 13 Y 11 M 15 D
Guardian : Mr ARUTLA SAGAR	DOB : 09-07-2012
Gender : Female	Religion :
Occupation :	Martial Status :
Address (H) : 2-18-19/A PRASHANTH NAGAR,UPPAL Uppal Hyderabad Telangana INDIA 500039	Phone No : 9849438058
	E-mail : NA@GMAIL.COM

Admission Details :

Bed Type : SHARED WARD	Bed No : ER 101	Ward Name : N 0 GF-EMERGENCY
Room No : ER 101	Admission Type : First Visit	

Contact Details :

Name : Mr ARUTLA SAGAR	Relationship : Father
Contact Address : 2-18-19/A PRASHANTH NAGAR,UPPAL Uppal Hyderabad Telangana INDIA 500039	Phone No : 9849438058


Signature
Doctor Details :

Doctor Name : Dr. PREETHAM KUMAR	Specialisation : GENERAL PEDIATRICS
Referral Doctor :	Phone No :
Co-Consultant : Dr. M N V POUHYA SAI	

Payment Details :

Payment Mode : Cash	Deposit Amount : 0.00
	Payor Name : CARE HEALTH INSURANCE LIMITED

Patient Name : Baby. ARUTLA SMIGDHA UHID : VIH-00206222 IPD : IP-00060466 Gender : Female Age : 13 Y 11 M 15 D

VIH-00206222 IP-00060466
Baby ARUTLA SMIGDHA
09-07-2012 13 Y 11 M 15 D (F)
Dr. PREETHAM KUMAR



NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 24/6/26 Time of arrival : 6:20 PM

Chief Complaints: 1.0 Headache, Fever, Vomiting RBS: —

Height : 151 CM Weight : 47.9 kg BMI : — Head Circumference (<2 years) —

Allergies: Yes No Medications Blood Transfusion Food Other: —

If yes, identify —

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

Character — Location — Frequency — Duration —

RISK FOR FALL:

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

History of Falling: within past 3 months Yes No

Ambulatory Aids:

- Wheelchair Yes No
- Uses furniture for support Yes No

Gait/Transferring:

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

Mental Status: Forgets limitations Yes No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening: No Abnormalities Detected

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

Inform consultant for positive criteria

Nutritional Screening: No Abnormalities Detected

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

Inform consultant for positive criteria

Psychological Screening: No Significant Findings

Unusual concerns about patient's Psychological Status: Yes No

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

Social History: Lives With Family

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

Time of Initial assessment completed by ER Nurse : 6:25 PM

Patient Name : Baby. ARUTLA SMIGDHA UHID : VIH-00206222 IPD : IP-00060466 Gender : Female Age : 13 Y 11 M 15 D

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

Time	Nursing Notes
6:15 PM	* patient came to ER
6:17 PM	* vitals checked and Recorded
6:22 PM	* Doctor seen the patient Advised Admission
6:26 PM	* Admission Process done
7:45 PM	* IV placement done
7:50 PM	* Blood sampler collect set to lab
	* patient shifted to ward

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

Time: @ 7:45 PM

Time @ 7:50 PM

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1
Nil					

Condition of patient at time of shift - out	Details of Shift - out
HR: 72 b/m BP: 110/59 (82) CRT: <2sec RR: 22 b/m SPO ₂ : 97% GCS: 15/15 Temperature: 98°F Pain Score: 0 Repeat RBS (if applicable): -	Shift - out from ER to: 110 Time of Shift - out: 24/6/26 @ 8:40 PM Handover given to: Sr. Vaisnavi (Nurse's Name) Bro-sabin

Tick as applicable: MLC LAMA BROUGHT DEAD

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

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

Date & Time: 24/6/26 @ 8:40 PM

Patient Name : Baby. ARUTLA SMIGDHA UHID : VIH-00206222 IPD : IP-00060466 Gender : Female Age : 13 Y 11 M 15 D

VIH-00206222 IP-00060466
 Baby ARUTLA SMIGDHA
 09-07-2012 13 Y 11 M 15 D (F)
 Dr. PREETHAM KUMAR



wt: - 47.9 kg
 ht: - 151 cm

EMERGENCY ROOM TRIAGE FORM

Patient's Name : Baby. Smigdhe Age : 13y 11m Gender: Male Female
 Date : 24/6/20 Time of Arrival : 6:15 PM

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

Source of Information : Parents Others (Specify)

Mode of Arrival : Ambulatory Wheelchair Ambulance

Initial Vital Signs: Temp: 98.7°F PR: 75/L/M BP: 112/79(89) RR: 22/L/M SpO₂: 98/L/M

Chief Complaints: 10. Headache x Friday, Fever, vomiting x 5 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		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.

[Signature]
 Signature of Parent / Guardian
 Triage Completion Time : 6:18 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 : Achitta
 Date & Time : 24/6/20 @ 6:18 PM

[Signature]
 Signature of Triage Nurse :



Nursing General Admission Assessment Form For Pediatrics

Diagnosis: Pain abdomen / Evaluation
Arrival Time: 8:50 pm **Mode of Arrival:** Ambulatory **Admitting From:** ER OPD Direct

Allergy / Adverse Reaction: Nil **Body Weight:** 47.9 Kg
Height: 151 cm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
Nil	Nil	Nil

Family History: Nil

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

If yes please list, _____

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

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

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

Observations: Weight: 47.9 kgs Length: 151 cm Head Circumference (< 2 years): _____
 Temp.: 98.6°F HR: 102 b/m RR: 28 b/m BP: 114/86 (93) mmHg

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

Fall Risk Assessment: Yes No **Score:** 9 (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 (Brother)*

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 vaishnavi* Date: *24/6/26* Time: *8:50pm* Signature *C. Vaishnavi*

PATIENT TRANSFER FORM

Patient Name & UHID No. VIH-00206222 IP-00060466 Baby ARUTLA SMIGDHA 09-07-2012 13 Y 11 M 15 D (F) Dr. PREETHAM KUMAR		Date & Time of Admission 24/6/26 @ 7:14 PM	Date & Time of Transfer Order 24/6/26 @ 8:40 PM
Transfer Ordered by Dr. Vishwaja		Reason for Transfer Admission	
From Unit ER	To Unit 100	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File 21	Number of Imaging Films USG (1)	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 Anil Kumar [AS]		Name of Person Ordered Transfer Dr. Vishwaja	
Patient & Clinical Records Received by : Vaishnavi			
Date & Time of Patient Received : 24/6/26 @ 8:40 pm			

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

Unavailable Bed

Nurse not Available

Available Bed not ready



Rainbow[®] Children's Hospital

It takes a lot to treat the little.

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: _____

UHID ID: _____

Department: _____

Consultant: _____

VIH-00206222 IP-00060466
Baby ARUTLA SMIGDHA
09-07-2012 13 Y 11 M 15 D (F)
Dr. PREETHAM KUMAR





Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

c/o Abdominal pain
vomiteings
No passage of stools } Since 4 days.

History of present illness :

Child was asymptomatic 4 days back then developed
fever, headache on Friday (last week)

↳ moderate grade
fever spike → subsided

↳ by c/o vomiteings / NP / NR / non mood eating
↳ multiple episodes

content - food / water.

also Abdominal pain - in epigastric region
and hypochondrium

↳ 100% stools - last week

↳ episodes, watery

followed by no passage of stools since Sunday

↓
admitted outside hospital
managed symptomatically



Pediatric Multiorgan History & Physical Examination

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

Outside investigation (24/6/26)

Hb-13

TSB - 5.28

3.62

RBC-4.4

1.66

WBC-4900

Alp-161

TP-7.32

N^o-50%

SGPT-3462

Albumin-4.0

Plt-1.93

SGOT-3325

S.globulin-2.92

CRP → 4.68

SGT-280.

CUF-10-12pus cells-

Birth & Neonatal History:

Birth & Socio Economic History:

About Father :

About Mother :

Any additional Information :

class III

Developmental History :

Appropriate for age in all domains

Immunization History :

Received appropriate



Pediatric Multiorgan History & Physical Examination

Anthropometry :

Head Circum (cms) _____ (Centile _____) Height (cms): 151 cm (Centile _____)

Weight (kgs) : 47.9 kg (Centile _____)

On Examination :

Temperature : 98.7 F Pulse Rate : 70/min B.P. 112/79 SPO2 98%

Resp. rate and type of breathing : 22/min

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 : RI ⊕

Any murmur : NO

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

Per Abdomen :

Inspection ⊖

Palpation : ⊖

Ausculation : RS ⊕

Spine : ⊖ External Genitelia : _____

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

Pediatric History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : Awake

Cranial Nerves : (2)

Motor System:

Nutrition : _____

Tone: _____ Power 9/5 all limbs

Co-ordinator : (2)

Posture : _____

Involuntary Movements : (2)

Reflexes :

⁺²
DTR

Plantars flexor

Superficials:

Sensory System :

(2)

Bladder / Bowel : No incontinence

Clinical Summary & Diagnostic:

paraabdomen ↓ evaluation

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: PO prevent complications

Desired goals of the treatment: TO treat Current condition

Planned Labs:

- Hep A Igm ✓
- Hep E Igm ✓
- CRP ✓
- CRP ✓
- LEI ✓
- S/e ✓
- S. creatinin ✓
- PT/INR, APTT ✓
- USG Abdomen. ✓

Planned Management *Dr. Poushya, Dr. Preetham mem.*

- 1) IV fluids
- 2) Pnj analgesia
- 3) Pnj antemeprotile
- 4) Tab ceflex 300mg PO
- 5) INJ. PARACETAMOL 650mg stat (if pain ⊕)

Noted by Sr. Lekan 24/6/26 at 8:30pm

Signature of the Doctor: *C. L.*

Name of the Doctor: *Dr. Nishwaja*

Date & Time: *24/6/26*

Signature of the Consultant: *[Signature]*

Name of the Consultant: *[Name]*

Date & Time: *24/6/26 3:30pm*



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
25/6/26 8 AM	<p><u>.S/R Resident</u></p> <p>sh - pain abdomen ↓ resolution.</p>	
	<p>NO fever spikes abdominal pain (↓) ofc Child alert Euthermic vitals stable CVC - ASA (+) NPE - BAE (+)</p>	<p>Nausea (+)</p>
<p>Dr. Vishwanath IND. VIT. IC start Dr. Arunthara 25/6/26 9 AM.</p>		<p><u>plan</u></p> <ol style="list-style-type: none"> 1) IV fluids 2) Perf Ondansetron 3) Perf Erythromycin 4) Tab Udilur 2mg 5) Trace Hep A Igm Hb E Igm. 6) Dr. pournhys 4a man <p>Noted by <u>Indu</u> 2:20pm 25/6/26</p>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
25-6-26 3:05 PM	S/A Regimen	
	Urinal Dipstick	(Hep-A +ve)
	Oral intake better	
	of child awake	
	severe icterus (+)	
	CRT < 3 sec.	
	afebrile	
	H/C - MOD	
	P/A - soft	
	Jaundice	Pbcu
	(Dr. Sameer)	→ LFT on Saturday
		→ Re. Labs on Saturday
		→ Lig. Vitamin K 10 mg
		1.V x 3 days
		→ Total 4 th day.

Noted by Anitha
 25/6/26
 @ 4pm



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
26/6/26 8 AM	S/B Resident Urinal hepatitis (step A +ve)	
	Pterous (⊕)	
	Abdominal pain - Intermittent	
	o/e	
	child alert	
	Eutermic	
	Vitals stable	
	CVC - S/S (⊕)	
	Rf. BBE (⊕)	
	P/A - S/S	
		plan
		1) Dr. Pouchya c/w r/m
		LET r/m
		2) CST.

Dr. V. Chandra



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/6/26	S/B Resolved.	
	Viral hepatitis (Hep A+ve). 1 episode vomiting - up/wc/ non blood stained o/e child alert Afebrile vitals stable CX - S/G (+) R/S - BAE (+) P/A - soft	Nausea (+)
		Plan 1) OR. pouchy c/o Today 2) Plan d/o after consultation. 3) CST
Dr. Preetham Kumar 22/6/26 9 AM	22/6/26 S/B	OR. pouchy morn (Gastroenteritis) Adv - 4 weeks vdi'v. - No non veg diet for weeks - 2w weeks OPD
replei		noted by Anitha 22/6 @ 9.40 AM

NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: <i>Post Abdomen & Evaluation</i>		Any Infection: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify: <i>Nil</i>				
	Surgery / Procedure:		Post OP Day:				
BACKGROUND	Date	<i>24/6</i>	<i>24/6</i>	<i>25/6</i>	<i>25/6</i>	<i>26/6/26</i>	
	Shift	<i>N</i>	<i>N</i>	<i>M</i>	<i>E</i>	<i>N</i>	
BACKGROUND	Medical Condition (Any special condition to be noted):	<i>Nil</i>	<i>Nil</i>	<i>Nil</i>	<i>Nil</i>	<i>Nil</i>	
	Diet:	<i>Normal</i>	<i>Normal</i>	<i>2 diet</i>	<i>N diet</i>	<i>N diet</i>	
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 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>98.6 F</i>	<i>98.6 F</i>	<i>98.6 F</i>
		Res:	<i>20 blm</i>	<i>22 blm</i>	<i>25 blm</i>	<i>21 blm</i>	<i>24 blm</i>
		SpO ₂ :	<i>98%</i>	<i>98%</i>	<i>98%</i>	<i>99%</i>	<i>99%</i>
		Pulse:	<i>92 blm</i>	<i>83 blm</i>	<i>88 blm</i>	<i>92 blm</i>	<i>76 blm</i>
		BP:	<i>110/70</i>	<i>114/83</i>	<i>110/70</i>	<i>102/62 (HT)</i>	<i>101/65 (HT)</i>
		LOC:	<i>conscious</i>	<i>conscious</i>	<i>conscious</i>	<i>conscious</i>	<i>conscious</i>
	Fall Risk Score:	<i>U</i>	<i>U</i>	<i>U</i>	<i>U</i>	<i>U</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 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	
	Physiotherapy:	<i>nil</i>	<i>-</i>	<i>oil</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>nil</i>	<i>solid</i>	<i>N diet</i>	<i>N 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>Depen</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>Sabin vaishnavi</i>	<i>Srinu</i>	<i>Anitha</i>	<i>Vaishnav</i>	<i>Anitha</i>		
Signature / ID :	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</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>@ 8:40 AM</i>	<i>@ 8 AM</i>	<i>8 PM</i>	<i>@ 8 PM</i>	<i>@ 8 PM</i>		
Taken Over By Name :	<i>Vaishnav</i>	<i>Srinu</i>	<i>Anitha</i>	<i>Vaishnav</i>	<i>Anitha</i>		
Signature / ID :	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</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>@ 8:50 PM</i>	<i>8 PM</i>	<i>@ 8 PM</i>	<i>@ 8 PM</i>	<i>@ 8 PM</i>		



NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify:						
	Surgery / Procedure:	Post OP Day:						
BACKGROUND	Date	26/6/26	26/6/26	27/6				
	Shift	E	N	M				
	Medical Condition (Any special condition to be noted):	Nil	Nil	Nil				
	Diet:	N diet	N diet	N diet				
ASSESSMENT	Allergy:	<input checked="" 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	<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	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Vital Signs:	Temp:	98.4f	98.3f	98.6f			
		Res:	25blm	25blm	26blm			
		SpO ₂ :	99%	98%	99%			
		Pulse:	99blm	82blm	84blm			
		BP:	100/78	97/67(TT)	102/68(79)			
		LOC:	conscious	conscious	conscious			
		Fall Risk Score:	11	11	11			
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	<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	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Special Diet:	N diet	N diet	N 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	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	PU Prophylaxis:	<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	<input type="checkbox"/> Yes <input type="checkbox"/> No	
DVT Prophylaxis:	<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	<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 :		Manisha	Kaishnavi					
Signature / ID :		Manisha	Kaishnavi					
Date:		26/6/26	27/6/26					
Time:		@3pm	@5AM					
Taken Over By Name :		Kaishnavi	Anitha					
Signature / ID :		Kaishnavi	Anitha					
Date:		26/6/26	27/6/26					
Time:		@5pm	@8AM					

Noted by Anitha
 27/6
 @ 9:30AM

VH-00206222 IP-00060466
 Baby ARUTLA SMIGDHA
 09-07-2012 13 Y 11 M 15 D (F)
 Dr. PREETHAM KUMAR



NURSING CARE RECORD



Date: 24/6/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon							
Night	8pm	- Assessment - vitals - Medications	8pm	- Assessed the general condition - Monitored vitals & recorded	- vitals are normal	hemodynamically stable.	Besoni/CA 25/6/26 @ 8PM

VIH-00206222 IP-00060466
 Baby ARUTLA SMIGDHA
 09-07-2012 13 Y 11 M 15 D (F)
 Dr. PREETHAM KUMAR



NURSING CARE RECORD



Date: 25/6

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	9:00	maintain aseptic technique	9:30	Maintained aseptic technique	prevent from infection	Patient is stable	Indu Srp 25/6
	2:00	Ensure safety	7:30	side rails kept up	prevent from falls risk		
Afternoon	3pm	→ Maintain Good Nutritional Status		→ To oral intake is Good	→ provided by Soft diet	patient is stable	Anitha 25/6 @ 3pm
	5pm	→ Ensure Safety		→ Side rails kept up	→ prevent from falls risk		
Night	11 pm	Maintain Fluid Balance - Ensure Safety	11:10	- Maintained input/output chart - provided side rails	- To prevent dehydration - To prevent falls	Re-Assessment is done, patient is stable	Vaishnavi 26/6/20 @ 8 AM



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		→ To oral intake is Good	→ provided by normal diet	→ patient is stable	Anilika 26/6 @2pm
Afternoon	3pm	→ maintain fluid balance - ensure safety		- Administered IV fluid DNS 50ml/hr - side rail kept up	- TO maintain hydration - prevent from fall risk	- patient is stable.	manisha 26/6/26 @3pm
Night	11 pm	Maintain fluid balance - Ensure safety	11:10	- Maintained input/output chart - provided side rails	- To prevent dehydration - To prevent falls	- patient is stable	Vijayani 26/6/26 @8AM



NURSING CARE RECORD

Date: 24/6/2016

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	9:30 AM	Discharge note :-		Doctor Come for rounds & advice	Discharge		
Afternoon							
Night							

*Noted by Anitha
24/6
@ 9.30 AM*



THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
			24/6	25/6	25/6	25/6	26/6
Age	Less than 3 years old	4					
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1	1	1	1	1	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					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1	1	1	1
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own ability	1	1	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	2	2
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2	2	2	2	2	2
	More than 48 hours/ None	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			9	9	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 support	x	x	x	x	x	x
Other Intervention(s) Specify	✓	✓	✓	✓	✓	✓
Nurse's Name:	Archita	Varishna	Anita	Varishna	Varishna	Varishna
Signature:	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date:	24/6	25/6	25/6	25/6	26/6	
Time:	6:50 PM	2 AM	3 PM	11 PM	1 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					
	13 years old and above	1	1	1	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	2	2	2		
	More than 48 hours / None	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 cup		X	X	X		
Other Intervention(s) Specify		✓	✓	✓		
Nurse's Name:		manjira	Varishu	Varishu		
Signature:		MP	Varishu	Varishu		
Date:		26/6/20	26/6	27/6		
Time:		@3pm	11pm	7am		



CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	24/6 DAY-1			25/6 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	0		
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1		-	-	-	-	-	-	-		
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2		-	-	-	-	-	-	-		
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3		-	-	-	-	-	-	-		
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4		-	-	-	-	-	-	-		
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5		-	-	-	-	-	-	-		
Signature of the Nurse													

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

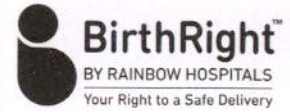
Signature of Shift In Charge :

Signature : Name :

Signature of Ward In Charge :

Signature : Name :

VIH-00206222 IP-00060466
 Baby ARUTLA SMIGDHA
 09-07-2012 13 Y 11 M 13 D (F)
 Dr. PREETHAM KUMAR

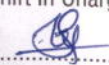


CHECKLIST FOR THROMBOPHLEBITIS

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 cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5	-									
Signature of the Nurse				shf									

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

Signature of Shift In Charge :

Signature :  Name : Padiya

Signature of Ward In Charge :

Signature :  Name : Elizabeth



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
24/6	6:50 PM	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	AS
25/6	2 AM	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	-	Vishwanth
25/6	4 PM	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	Aneel
26/6	12 AM	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	-	Vaishal
26/6	8 AM	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	Aneel
26/6/26	3 PM	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	Manisha
26/6/26	11 PM	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	-	Vaishal
27/6/26	7 AM	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	-	Vaishal
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Re-assessment Frequency:

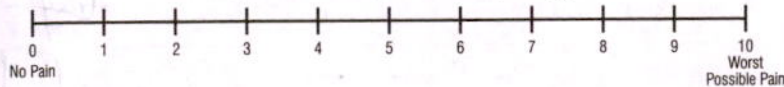
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 - 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
	0	1	2
Face	No Particular expression or smile	Occasional Grimace or Frown, withdraw, Disoriented	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs drawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, rigid, or Jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams 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		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



BRADEN 'Q' SCALE

					Date :	09/16	25/6	25/6	26/6
					Time :	08:50am	9:10	4pm	12am
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.	9	4	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.	9	4	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.	9	4	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.	9	4	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."	9	4	4	4	
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	9	4	4	4	
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	9	4	4	4	
TOTAL SCORE					28	28	28	28	
Evaluator's Name					At	Vaishna	At	Vaishal	

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

VH-00206222 IP-00060466
 Baby ARUTLA SMIGDHA
 09-07-2012 13 Y 11 M 15 D (F)
 Dr. PREETHAM KUMAR



WELL'S CRITERIA FOR ASSESSING DVT

NOTE: Assign a score of 1 if 'YES' in parameter 1 to 9 and Assign a score of -2 if 'YES' in parameter No 10

S.No	Assessment Criteria	Score	Date:	Date:	Date:	Date:	Date:	Date:
			25/6	26/6	27/6			
			Time:	Time:	Time:	Time:	Time:	Time:
			2AM	2AM	2AM			
1	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)	1	0	0	0			
2	Bedridden recently >3 days or major surgery within four weeks	1	0	0	0			
3	Calf swelling >3cm compared with asymptomatic side, measured at 10 cm below tibial tubercle (Assess for both legs)	1	0	0	0			
4	Collateral (non varicose) superficial veins present (Assess for both legs)	1	0	0	0			
5	Entire leg swollen (Assess for both legs)	1	0	0	0			
6	Localized tenderness along the deep venous system (Assess for both legs)	1	0	0	0			
7	Pitting edema, greater in the symptomatic leg (Assess for both legs)	1	0	0	0			
8	Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs)	1	0	0	0			
9	Previously documented DVT (Assess for both legs)	1	0	0	0			
10	Alternative diagnosis to DVT as likely or more likely (Assess for both legs)/ Co-morbidity like ESLD /Renal disease, Renal failure, CCF Cellulitis (commonly mistaken as DVT), Dependent (stasis) oedema, Lymphatic obstruction.	-2	0	0	0			
Total Score			0	0	0			
Signature of the Nurse			<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>			

Intervention: _____

- High Risk = >2 Score
- Moderate Risk = 1-2 Score
- Low Risk = <1 Score

Note : Daily assessment shall be carried out once every 24 hours and documented

GENERAL CONSENT FOR TREATMENT

Patient Name: Baby ARUTLA SMIGDHA **Age :** 13 Y 11 M 15 D
IP No: IP-00060466 **Sex:** Female
Consultant: Dr. PREETHAM KUMAR **Ward/Bed No:** N 0 GF-EMERGENCY/ER 101

The undersigned patient and I or responsible relative or person hereby consent to and authorize Rainbow Hospitals doctors and medical personnel to perform medical examinations, conduct routine investigations and administer medical treatments, outpatient procedures, minor dressings, vaccinations and immunizations during the course of the patient's care, as in patient.

Patient, be deemed advisable or necessary.

I understand that the confidentiality of all medical records shall be protected to the full extent of the Law. The undersigned consent to the use of health related information/ audiovisuals of the patient for research & training purpose or for insurance coverage and while doing so confidentiality of the patient will be maintained at all times and this will not affect the care of the patient.

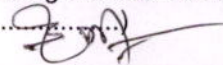
In giving my general consent to treatment, I understand that I retain the right to refuse any particular examinations, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by treating doctors. I also understand that the practice of medicine is not an exact science and that no guarantee have been made to me as the results of my evaluation and I or treatment.

I understand that I shall not bring valuables to the Hospitals and that the Hospital will not be responsible for the loss, destruction or theft of my personal belongings. I assume full responsibility for all my personal items and release the Hospital from responsibility and liability for such personal items and valuables.

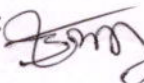
"I am aware that during the patient care it is inevitable that certain re-useable equipment shall be re-used after sterilization and disinfection. I am informed that the hospital assures maximum level of precaution and care in sterilizing and disinfecting the equipment and monitors the whole process as per evidence based guidelines".

Note:

1 We do not allow use of medication brought from outside by the patient.
 2 I have received attendant passes as per my room category. I understand that I have to return it back at the time of final bill clearance. In case of failing the submission, I will pay 200/- Rs.

(Receivers Signature: )


3 IP Guide book has been given to me and I have been explained about the Hospitals rules and policies.
 4 Financial and billing counseling has been done to me.

Signature of Patient/Relative: 

Name: Arutla Smigdha

Relationship: Father

Date: 24-06-2026

Witness Name: 

Witness Signature: 

Patient Address:
 2-18-19/A PRASHANTH NAGAR, UPPAL
 Uppal Hyderabad Telangana INDIA
 500039

Time:



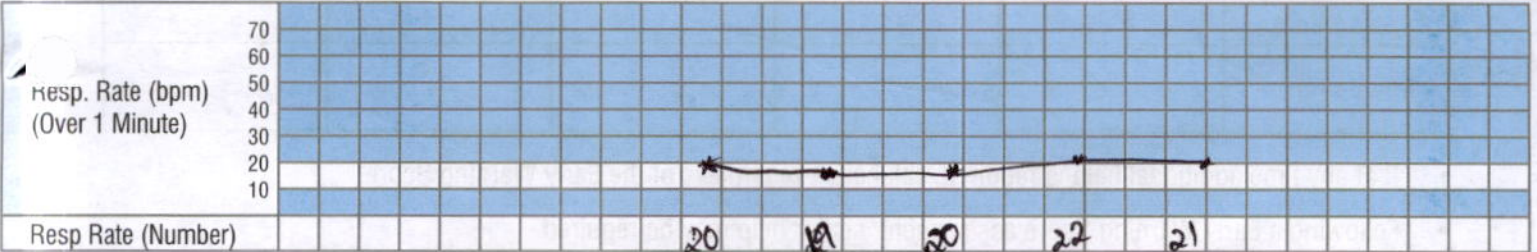
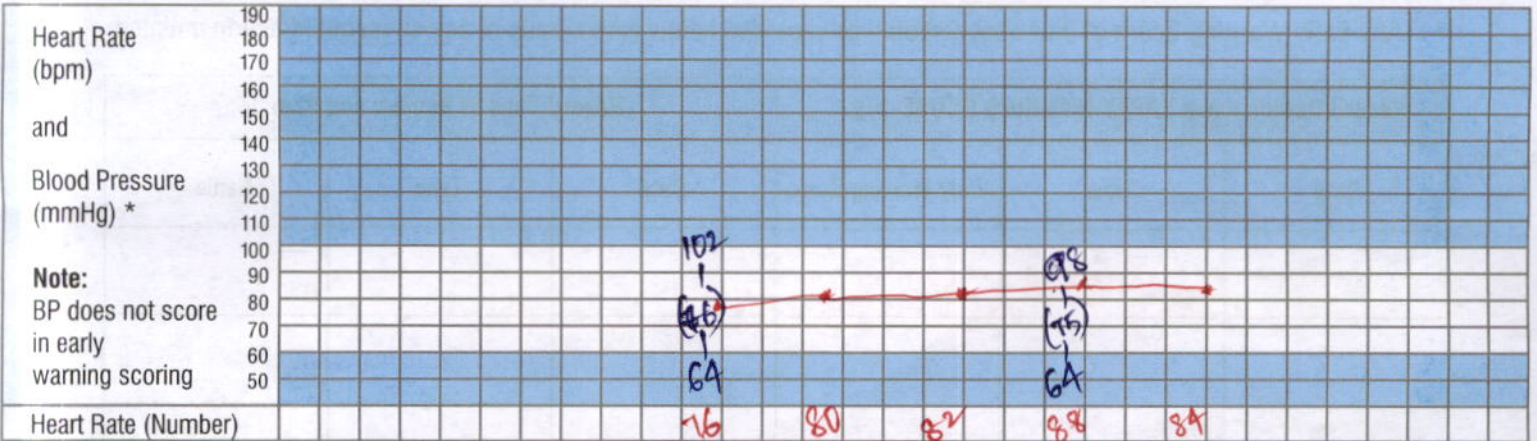
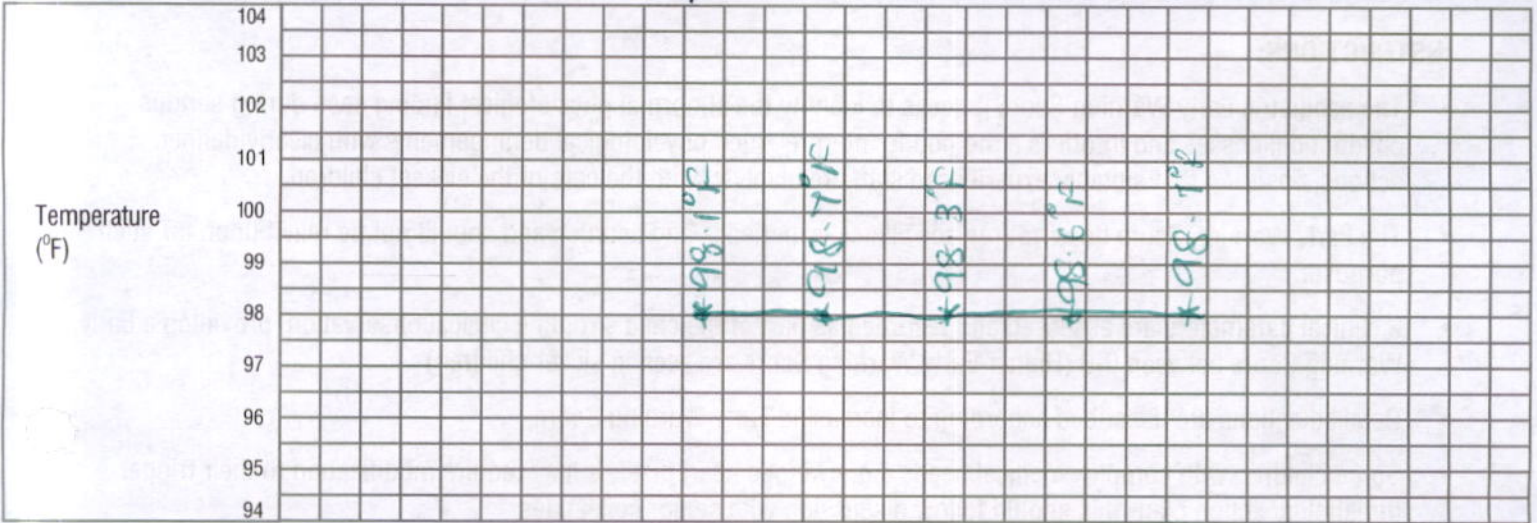
TEENAGE (12 + years)
Children's Observation & Early Warning Scoring Chart



EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 24/6/26 Time: 9 12 3 6 8

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



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

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

- ACTIONS**
- Score 1 : Continue normal observation by staff nurse
 - Score 2 : Shift in charge nurse to be informed and continue hourly observations
 - Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.
 - 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

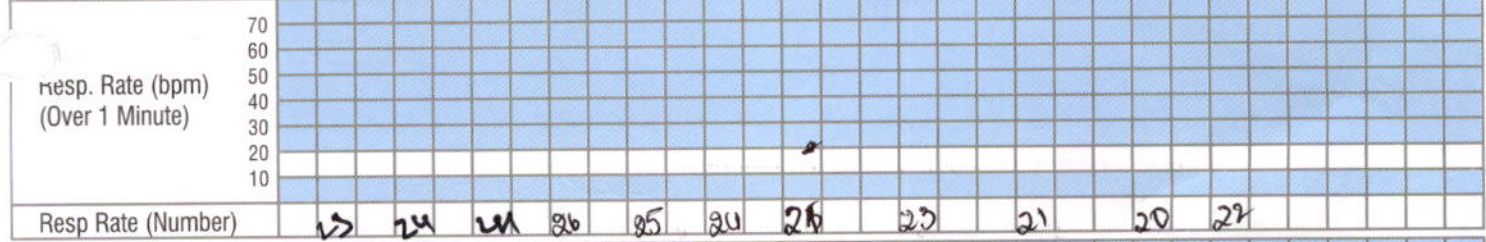
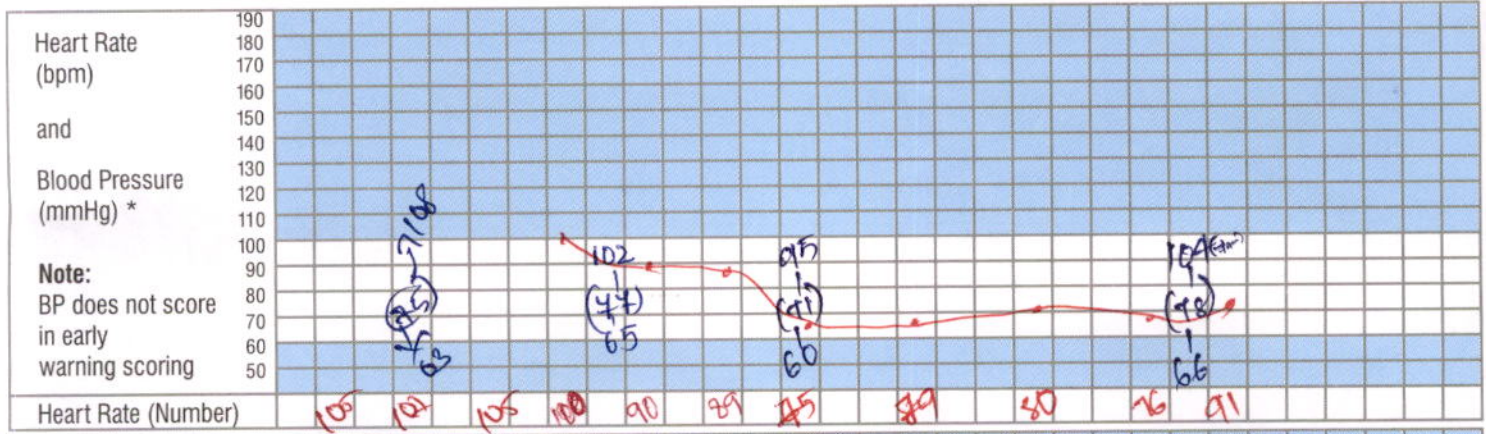
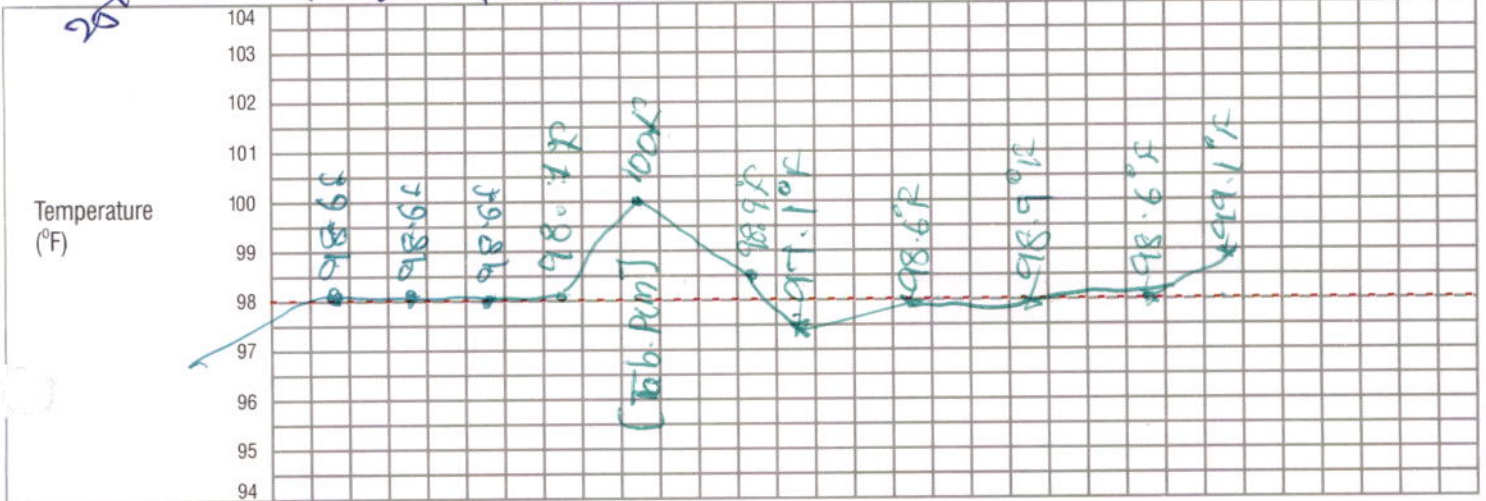
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The SBAR communication tool (situation, background, assessment, recommendations) is a helpful mnemonic that can be used to describe a child's clinical condition to a colleague.

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 : Time: 9 11 1 3 5 7 9 11 1 3 5 7
 Doctor / Nurse / Family Concern? AM AM PM PM PM PM PM AM AM AM



Resp Distress	Mod/ Severe None / Mild	
Receiving O ₂	O ₂ Saturations (%)	98 97 98 98 99 100 99 99 98 98 97
Conscious Level	Normal / Altered	N N N N N N N N N N N
GCS *		15 15 15 15 15 15 15 15 15 15 16
TOTAL SCORE	Number of shaded boxes	0 0 0 0 0 0 0 0 0 0 0
Pain Score		0 0 0 0 0 0 0 0 0 0 0
Observer's Initials		Preetham End A A A A A A A A A A

ACTIONS

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NB: Scores 3 should be recorded overleaf

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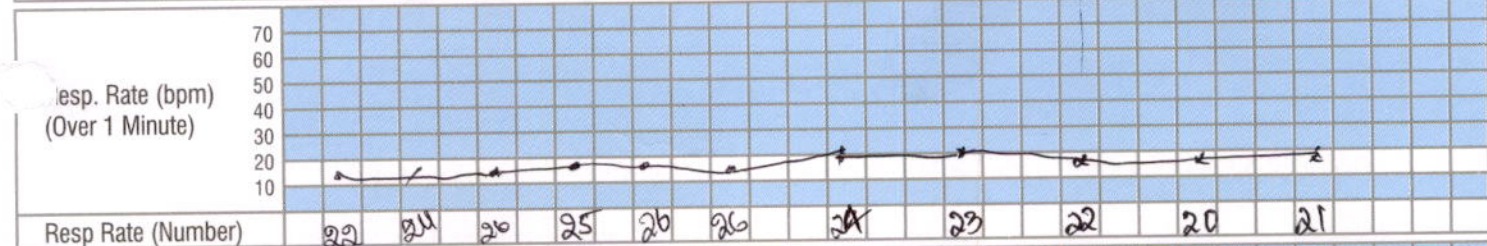
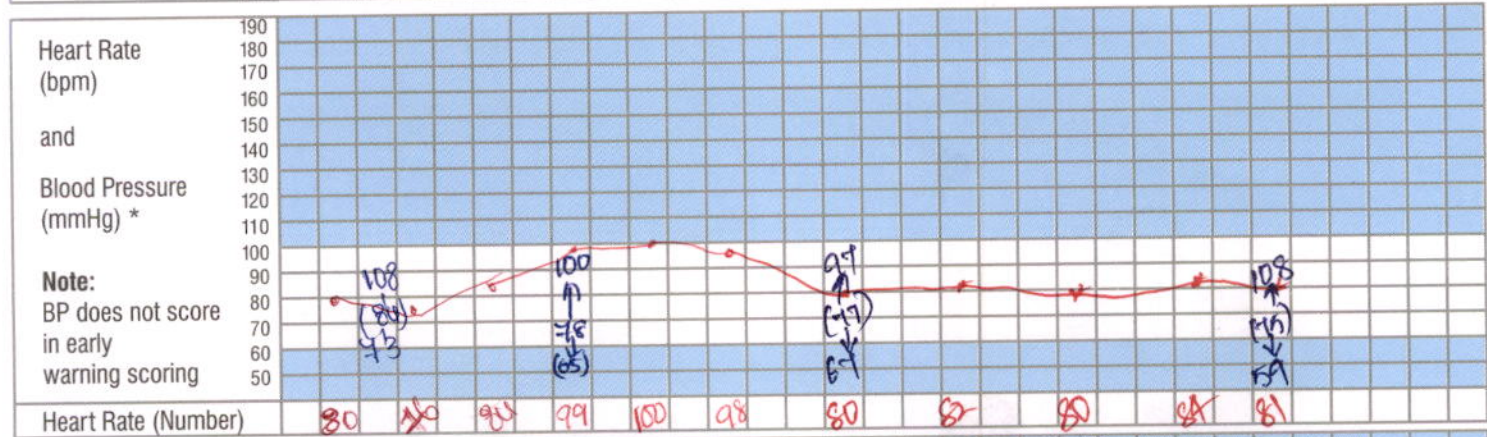
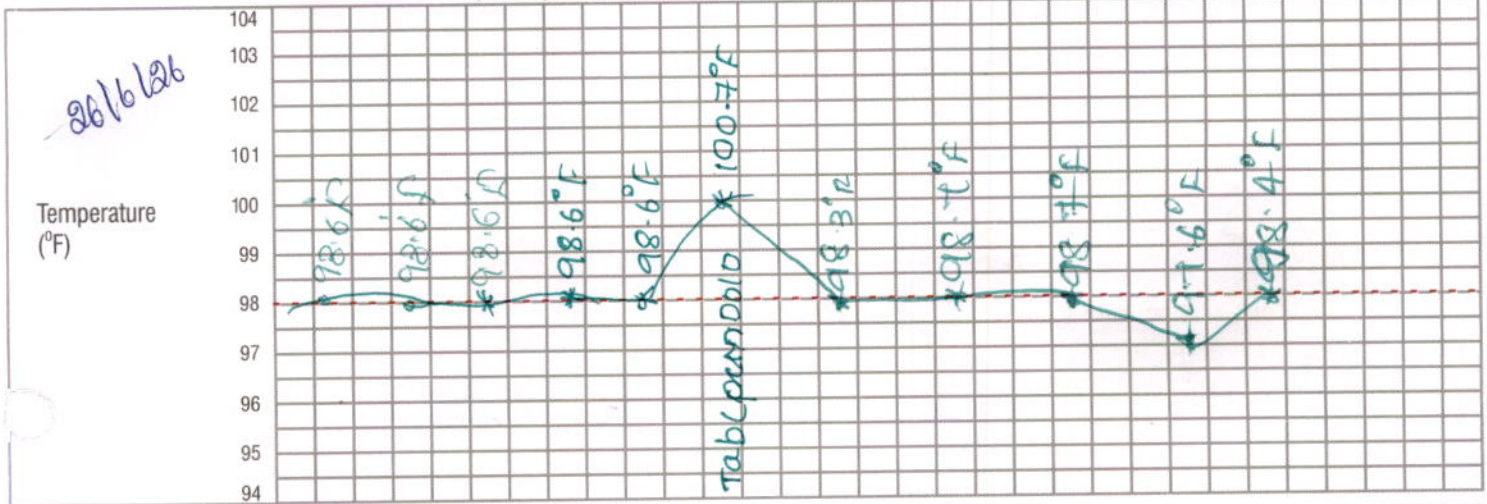


TEENAGE (12 + years)
Children's Observation & Early Warning Scoring Chart



EARLY WARNING SCORE: CHILDREN'S UNIT

Date :	Time:	9	11	1	3	5	7 ³⁰	9	11	2	5	7		
Doctor / Nurse / Family Concern?		Am	Am	pm	pm	pm	pm	pm	pm	Am	Am	Am		



Resp Distress	Mod/ Severe None / Mild	N	N	N	N	N	N	N	N	N	N	N		
Receiving O ₂ (l/min)	O ₂ Saturations (%)	98	99	100	100	99	100	98	99					
Conscious Level	Normal / Altered	N	N	N	N	N	N	N	N	N	N	N		
GCS *		15	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	0	0	0
Pain Score		0	0	0	0	0	0	0	0	0	0	0	0	0
Observer's Initials		P	P	P	M	M	M	V	V	V	V	V	V	V

ACTIONS

NB: Scores 3 should be recorded overleaf

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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)

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VIH-00206222 IP-00060466
 Baby ARUTLA SMIGDHA
 09-07-2012 13 Y 11 M 15 D (F)
 Dr. PREETHAM KUMAR



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 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	D	Adly	50ml								
	10:00 pm		H ₂ O	50ml								
	11:00 pm	N		50ml								
	12:00 am			50ml								
	01:00 am	S		50ml					✓			
Total Intake :					Total Output :							
	02:00 am			50ml								
	03:00 am	D		50ml								
	04:00 am	N		50ml					✓			
	05:00 am			50ml								
	06:00 am	S		50ml								
	07:00 am											
Total Intake :					Total Output :							
Total 24 hrs. Intake					Total 24 hrs. Output							



FLUID CHART

Sheet No. :

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G								
25/6	08:00 am											↓ ↓ ↓ ↓ ↓ ↓ ↓	} } } } } } }
	09:00 am		200y	50ml						✓			
	10:00 am		water	50ml									
	11:00 am			50ml									
	12:00 pm			50ml						✓			
	01:00 pm												
	Total Intake :			200ml			Total Output :						
25/6	02:00 pm			50 ml							↓ ↓ ↓ ↓ ↓ ↓	} } } } } }	
	03:00 pm		Rice	50 ml						✓			
	04:00 pm		water	50 ml									
	05:00 pm			50 ml									
	06:00 pm		Snacks	50 ml						✓			
	07:00 pm												
Total Intake :			250ml			Total Output :							
25/6	08:00 pm			50 ml							↓ ↓ ↓ ↓ ↓ ↓	} } } } } }	
	09:00 pm		Rice	50ml									
	10:00 pm		water	50ml									
	11:00 pm			50ml									
	12:00 am			50 ml						✓			
	01:00 am			50ml									
Total Intake :			300ml			Total Output :							
26/6	02:00 am			50 ml							↓ ↓ ↓ ↓ ↓ ↓	} } } } } }	
	03:00 am			50 ml									
	04:00 am												
	05:00 am									✓			
	06:00 am												
	07:00 am												
Total Intake :			50ml			Total Output :							

Total 24 hrs. Intake 850 ml

Total 24 hrs. Output _____



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.

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
26/6/26	08:00 am											} Anitha 26/6 @
	09:00 am		Orally water	50ml								
	10:00 am			50ml								
	11:00 am											
	12:00 pm											
	01:00 pm											

Total Intake : 100ml **Total Output :** 100ml

26/6/26	02:00 pm		RICE	h							} Manisha 26/6/26 @ 8pm
	03:00 pm		water	50ml							
	04:00 pm			50ml							
	05:00 pm			50ml							
	06:00 pm			50ml							
	07:00 pm			50ml							

Total Intake : 250ml **Total Output :** 100ml

26/6/26	08:00 pm			50ml							} Vaishnavi 26/6/26 @ 2am
	09:00 pm	D	Rice +	50ml							
	10:00 pm	N	Water	50ml							
	11:00 pm			50ml							
	12:00 am			50ml							
	01:00 am	S		50ml							

Total Intake : **Total Output :** 100ml

27/6/26	02:00 am			50ml							} Vaishnavi 27/6/26 @ 8am
	03:00 am			50ml							
	04:00 am			50ml							
	05:00 am										
	06:00 am										
	07:00 am										

Total Intake : **Total Output :** 100ml

Total 24 hrs. Intake

Total 24 hrs. Output

VIH-00206222 IP-00060466
 Baby ARUTLA SMIGDHA
 09-07-2012 13 Y 11 M 16 D (F)
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FLUID CHART

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		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								
<i>24/16</i>	08:00 am									✓			
	09:00 am	<i>Tally</i>											
	10:00 am	<i>water</i>											
	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 :							

Noted by Anitha
 24/16
 @9:30 AM

Total 24 hrs. Intake

Total 24 hrs. Output

Patient Sticker

FLUID CHART

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Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
	02:00 pm											
	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: ER Shifted to: 110

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 : 24/6/20 @ 6:50 PM

Nurse Name & Signature : Arushi

Date & Time : 24/6/20 @ 6:50 PM



Sheet No:

REGULAR PRESCRIPTIONS

Weight 47.94 Ward

Chills 25/6/26

DRUG : INJ. VITAMIN - K				Date Time	26/6																			
Dose	Route	Frequency	Start Dt.																					
10 mg	IV	ONCE DAILY	26/6																					
Name & Signature of the Doctor Starting the Drugs: Dr. Sameera				6pm GAK																				
Additional Instructions: 0.3 mg/kg/100ml x 2 DAYS (max 10mg)																								
Daily Doctor's Endorsement by a Sign																								
DRUG :				Date Time																				
Dose	Route	Frequency	Start Dt.																					
Name & Signature of the Doctor Starting the Drugs:																								
Additional Instructions:																								
Daily Doctor's Endorsement by a Sign																								
DRUG :				Date Time																				
Dose	Route	Frequency	Start Dt.																					
Name & Signature of the Doctor Starting the Drugs:																								
Additional Instructions:																								
Daily Doctor's Endorsement by a Sign																								
DRUG :				Date Time																				
Dose	Route	Frequency	Start Dt.																					
Name & Signature of the Doctor Starting the Drugs:																								
Additional Instructions:																								
Daily Doctor's Endorsement by a Sign																								
DRUG :				Date Time																				
Dose	Route	Frequency	Start Dt.																					
Name & Signature of the Doctor Starting the Drugs:																								
Additional Instructions:																								
Daily Doctor's Endorsement by a Sign																								

Signature

CERTIFIED BY : NAME

Patient Sticker

Sheet No:

REGULAR PRESCRIPTIONS

Weight Ward

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

VERIFIED BY : Name Signature



DRUG CHART

Date of Admission: 2+6/28 Drug Allergies: Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

SOS / PRN (As Required Medication)

DRUG : ENT. PARACETAMOL				Date															
				Time															
Dose	Route	Frequency	Start Date																
Doctor's Signature		Valid Period	Pharm.																
Additional Instructions:																			
15mg/kg/dose (if pain +)																			
DRUG : T. PARACETAMOL				Date	25/6/26														
				Time	5:20pm														
Dose	Route	Frequency	Start Date																
1 tab	PO	SO3	25/6																
Doctor's Signature		Valid Period	Pharm.																
[Signature]			[Signature]																
Additional Instructions:																			
(2-15 mg/kg/dose) 1 tab = 650mg																			
DRUG : [IF T > 100 F]				Date															
				Time															
Dose	Route	Frequency	Start Date																
Doctor's Signature		Valid Period	Pharm.																
Additional Instructions:																			

Signature
 Date 25/6/26
 VERIFIED BY: Name



I.V. FLUIDS CHART

Weight. 47.9 Ward. 110

S. Meeay Komar
24/6/26

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	8:45 pm	DNS (2/3M)	IV	50ml/hr	[Signature]	[Signature]	24/6	[Signature]	[Signature]

Signature
 VERIFIED BY : Name



		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
24/6	12 PM	INT VITAMIN K	4mg	IV	[Signature]	[Signature]
25/6	3:00 PM	INT. VITAMIN -K	6mg	IV	[Signature]	[Signature]

Signature
VERIFIED BY: [Signature]

[Signature]



REGULAR PRESCRIPTIONS

Weight. 47.9 kg Ward. 110

DRUG :				Date	Time
Dose	Route	Frequency	Start Date		
DRUG : <u>INJ ONDANSETRON</u>				<u>24/6</u>	<u>9 AM</u>
<u>4mg</u>	<u>IV</u>	<u>8th hourly</u>	<u>24/6</u>	<u>6 AM</u>	<u>ESW ESW</u>
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Vishwaje</u>				<u>9 PM</u>	<u>ESW ESW</u>
Additional Instructions: <u>0.1-0.2 mg/kg/don</u>				<u>10 PM</u>	<u>ESW ESW</u>
Daily Doctor's Endorsement by a Sign					
DRUG : <u>INJ. ECOMEDRAZOLE</u>				<u>24/6</u>	<u>6 AM</u>
<u>40mg</u>	<u>IV</u>	<u>once daily</u>	<u>24/6</u>	<u>6 AM</u>	<u>ESW ESW</u>
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Vishwaje</u>				<u>6 AM</u>	<u>ESW ESW</u>
Additional Instructions: <u>1mg/kg/don</u>				<u>6 AM</u>	<u>ESW ESW</u>
Daily Doctor's Endorsement by a Sign					
DRUG : <u>TAB. UDILIV</u>				<u>24/6</u>	<u>10 AM</u>
<u>1tab</u>	<u>PO</u>	<u>12th hourly</u>	<u>24/6</u>	<u>10 AM</u>	<u>ESW ESW</u>
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Vishwaje</u>				<u>10 PM</u>	<u>ESW ESW</u>
Additional Instructions: <u>1tab = 300mg</u> <u>5-10 mg/kg/don</u>				<u>10 PM</u>	<u>ESW ESW</u>
Daily Doctor's Endorsement by a Sign					

S. maceep kumar 24/6/26

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