

Name	Master VEDULA SRIAANSH YAJAT	UHID	VIH-00135537
Father/Guardian	Mr SASHANK VEDULA	Age/Gender	4 Y 11 M 19 D/Male
Address	PLOT NO 28 FLAT NO 201 LAKSHMI ENCLAVE OLD VASAVI NAGAR, Kharkhana Main Road, Hyderabad, Telangana, INDIA, 400056		
IP No	IP-00060469	Admission Date	24-06-2026
Ref Doctor	SELF	Discharge Date	26-06-2026

DISCHARGE SUMMARY

Consultants:

Dr. Sindhura Pappula

MBBS, MD, DrNB (Pediatric Neurology),
FIPN, FIAMG
Consultant Pediatric Neurologist

Dr. GEETHA CHANDA

MBBS, MD, Pediatrics
PDF Pediatric Neurology
Consultant Pediatric Neurologist
APMC/FMR/87648

Dr. RAMESH KONANKI,

MD Pediatrics (AIIMS),
DM Pediatric Neurology (AIIMS),
CONSULTANT PEDIATRIC
NEUROLOGIST, APMC-49226

Diagnosis: Unprovoked focal to bilateral motor seizures under evaluation

History: Master VEDULA SRIAANSH YAJAT, 4 Y 11 M 19 D, boy presented with history of one episode of seizure in the form of uprolling of eyeballs, drooling of saliva, jerky movements of both upper & lower limbs lasting for 2-3 minutes followed by postictal drowsiness prior to admission. For the above complaints, he was admitted at Rainbow Children's Hospital for further management.

Birth History: Born to consanguineous couple, FT/AGA/Birth weight - 2.5 Kgs/Cried immediately after birth / No perinatal complications.

Name

Master VEDULA
SRIAANSH YAJAT

UHID

VIH-00135537

Developmental History: Appropriate for age.

Examination: He was afebrile, maintaining saturations at room air. HR- 94/min, BP- 100/70 mmHg and RR - 23/min. On auscultation of chest, air entry was bilaterally equal with normal heart sounds and there was no murmur. Abdomen was soft without organomegaly. Bowel sounds were heard.

Neurological examination: Child was drowsy. Pupils were bilaterally equal and reacting to light. EOM Full. DTR elicitable. Tone normal. Power moving all limbs against gravity. Plantars flexor. There were no focal neurological or cranial nerve deficits. There were no signs of raised intracranial pressure. No meningeal signs.

Weight on admission : 21.7 kgs.

Investigations: Enclosed.

Management: He was admitted in the ward and started on IV fluids and IV antibiotics. In view of seizures, he was loaded with Injection Levetiracetam.

His complete blood picture showed Hb 11.5 gm%, WBC count of 17,660 cells/cumm, platelet count of 2.80 lakhs/cumm and C-reactive protein was 6 mg/l. Serum electrolytes, calcium and magnesium were normal.

EEG done on 25.06.2026 - normal.

He was monitored for hemodynamic status, vital parameters & neurological status. His symptoms gradually settled & had no further seizure episodes during hospital stay. He remained hemodynamically stable during the hospital stay and is being discharged with the following advice.

Name

Master VEDULA
SRIAANSH YAJAT

UHID

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

Neurological condition at the time of discharge:

He is conscious.

EOM full.

Pupils are bilaterally equal and reacting to light.

Tone normal.

Power - 5/5.

DTR 2+.

Plantar flexor.

Advice:

1. Diet as advised.
2. Kindly consult Dr. P. Sindhura, Consultant Pediatric Neurologist, after 14 days in OPD with prior appointment (This consultation will be charged).

Syrup LEVETIRACETAM (1ml=100mg) 1.5ml, 12th hourly till further advice

** Midacip nasal spray (Midazolam = 1.25mg/puff), 2 puffs intranasal (into each nostril in sitting position) if seizure for more than 3 minutes.

Backup plan: If further seizures occur :

1. Inj. Levetiracetam, 20 mg/kg - in 20ml of NS over 20 mins loading.

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

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

Name

Master VEDULA
SRIAANSH YAJAT

UHID

VIH-00135537

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

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 : *T. Keerthana*

Signature : *T. Keerthana*

Relationship with patient : *Mother*

This summary has been explained by :

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

[Signature]
Registrar/Resident/C.M.O

Consultants:

Dr. Sindhura Pappula

MBBS, MD, DrNB (Pediatric
Neurology),
FIPN, FIAMG
Consultant Pediatric Neurologist

Dr. GEETHA CHANDA

MBBS, MD, Pediatrics
PDF Pediatric Neurology
Consultant Pediatric Neurologist
APMC/FMR/87648

Dr. RAMESH KONANKI,

MD Pediatrics (AIIMS),
DM Pediatric Neurology (AIIMS),
CONSULTANT PEDIATRIC
NEUROLOGIST, APMC-49226

PatientName : Master VEDULA SRIAANSH YAJAT
Age/Gender : 4 Y 11 M 19 D/ Male
Ward/Bed : N 0 GF-EMERGENCY/ ER 102

Inpatient No. : IP-00060469
Admit Date : 24-06-2026
Discharge Date :

Investigation	Result	Unit	Biological Reference Interval
CALCIUM (Specimen : SERUM)			TEST RESULT STATUS : REPORT AUTHORISED Order Date :24-06-2026 22:50
CALCIUM (Arsenazo dye)	9.9	mg/dl	8.8 - 10.1



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 :24-06-2026 22:50
HEMOGLOBIN (Colorimetry)	11.5	g/dL	11.5 - 15.5
RBC COUNT (DC detection method)	4.20	10 ¹² /L	3.9 - 5.3
PCV/HCT (Calculated)	31.1	VOL%	L 34 - 40
MCV (Calculated)	74.0	fL	L 75 - 87
MCH (Calculated)	27.5	pg/cells	24 - 30
MCHC (Calculated)	37.1	g/dL	H 32 - 36
RDW-CV (Calculated)	12.8	%	11.5 - 15
PLATELET COUNT (DC Detection Method)	280	10 ⁹ /L	150 - 450
MPV (Calculated)	8.4	fL	6.5 - 10
WBC COUNT (DC Detection Method)	17.66	10 ⁹ /L	H 5.5 - 15.5
Differential Count			
NEUTROPHILS (Microscopy, Leishman stain)	72	%	H 23 - 45
LYMPHOCYTES (Microscopy, Leishman stain)	20	%	L 35 - 65
MONOCYTES (Microscopy, Leishman stain)	06	%	4 - 10
EOSINOPHILS (Microscopy, Leishman stain)	02	%	1 - 6
PERIPHERAL SMEAR (Microscopy, Leishman stain)	RBC : NORMOCYTIC / HYPOCHROMIC WBC : LEUCOCYTOSIS PLATELETS : ADEQUATE		



Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
C REACTIVE PROTEIN (Specimen : SERUM)			TEST RESULT STATUS : REPORT AUTHORISED Order Date :24-06-2026 22:50

PatientName : Master VEDULA SRIAANSH YAJAT Inpatient No. : IP-00060469
Age/Gender : 4 Y 11 M 19 D/ Male Admit Date : 24-06-2026
Ward/Bed : N 0 GF-EMERGENCY/ ER 102 Discharge Date :

Investigation	Result	Unit	Biological Reference Interval
CRP (Immunoturbidimetry)	6.0	mg/L	<10



Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
ELECTROLYTES (Specimen : SERUM)			TEST RESULT STATUS : REPORT AUTHORISED Order Date :24-06-2026 22:50
SODIUM (Direct ISE)	137	mmol/L	134 - 143
POTASSIUM (Direct ISE)	4.4	mmol/L	3.7 - 5
CHLORIDE (Direct ISE)	103	mmol/L	98 - 108



Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
MAGNESIUM (Specimen : SERUM)			TEST RESULT STATUS : REPORT AUTHORISED Order Date :24-06-2026 22:50
MAGNESIUM (Formazon dye)	2.1	mg/dl	1.5 - 2.4



Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
RANDOM BLOOD GLUCOSE(POCT) (Specimen : PLASMA)			TEST RESULT STATUS : REPORT ENTERED Order Date :24-06-2026 22:50
RANDOM BLOOD GLUCOSE (GOD/POD)	206	mg/dl	H 70 - 140

ACTIVITY RECORD FOR BILLING

Name: -----
 UHID No: ----- IP No: ----- Dept: pediatric
 Date of Admission: 24/6/26 Time: ----- Discharge: ----- Time: -----
 Room / Bed No: 112 Ward: 1st floor Suggested Billable bed type: -----

VIH-00135537 IP-00060469
 Master VEDULA SRIANSH YAJAT
 06-07-2021 4 Y 11 M 18 D (M)
 Dr. PAPPULA SINDHURA



WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
24/6/26	11 PM	ER	112	ghm.

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1.				
2.				
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-00060469 **Admit Date** : 24-Jun-2026 **Admit Time** : 09:54 PM **UHID** : VIH-00135537

Patient Details :

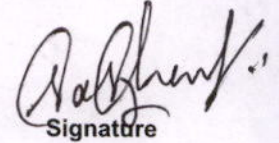
Patient Name : Master VEDULA SRIAANSH YAJAT	Age : 4 Y 11 M 18 D
Guardian : Mr SASHANK VEDULA	DOB : 06-07-2021
Gender : Male	Religion :
Occupation :	Martial Status :
Address (H) : PLOT NO 28 FLAT NO 201 LAKSHMI ENCLAVE OLD VASAVI NAGAR Kharkhana Main Road Hyderabad Telangana INDIA 400056	Phone No : 8978956615
	E-mail : tkeerthana16@yahoo.co.uk

Admission Details :

Bed Type : SHARED WARD	Bed No : ER 102	Ward Name : N 0 GF-EMERGENCY
Room No : ER 102	Admission Type : First Visit	

Contact Details :

Name : Mr SASHANK VEDULA	Relationship : S/O
Contact Address : PLOT NO 28 FLAT NO 201 LAKSHMI ENCLAVE OLD VASAVI NAGAR Kharkhana Main Road Hyderabad Telangana INDIA 400056	Phone No : 8978956615 / 7981918276



Signature

Doctor Details :

Doctor Name : Dr. PAPPULA SINDHURA	Specialisation : PEDIATRIC NEUROLOGY
Referral Doctor : SELF	Phone No :
Co-Consultant :	

Payment Details :

Payment Mode : Cash	Deposit Amount : 0.00
	Payor Name : VOLO HEALTH INSURANCE TPA PVT LTD

Patient Name : Mast. VEDULA SRIAANSH YAJAT UHID : VIH-00135537 IPD : IP-00060469 Gender : Male
Age : 4 Y 11 M 18 D

VIH-00135537 IP-00060469
Master VEDULA SRIAANSH YAJAT
06-07-2021 4 Y 11 M 18 D (M)
Dr. PAPPULA SINDHURA

Rainbow
Children's
Hospital

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 24/6/26 Time of arrival : 9:37 pm

Chief Complaints : vomiting, seizures RBS : 206 mg/dl

Height : — Weight : 21.7 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?) _____

Time of Initial assessment completed by ER Nurse : 9:40 pm

Patient Name : Mast. VEDULA SRIAANSH YAJAT UHID : VIH-00135537 IPD : IP-00060469 Gender : Male
 Age : 4 Y 11 M 18 D

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

Time	Nursing Notes
9:32pm	*PT Came to ER
9:33pm	*vitals checked and recorded
9:35pm	*ER Doctor seen the pt & advised admission
9:54pm	*Admission done
10:10pm	*IV placement done
10:11pm	*Samples collected & sent to lab *PT shifted to ward

Samples collected by: *J. V. Lema*
 Samples sent by: *J. V. Lema*

Time: *9:10:11pm*
 Time: *10:25pm*

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1
10:50pm	Inj. levipil	IV	400mg	<i>[Signature]</i>	<i>[Signature]</i>

Condition of patient at time of shift - out :	Details of Shift - out
HR: <i>103b/m</i> BP: <i>102/69(70)mmHg</i> CFT: <i>23sec</i>	Shift - out from ER to: <i>112</i>
RR: <i>26b/m</i> SPO ₂ : <i>99%</i>	Time of Shift - out: <i>24/6/26@</i>
GCS: <i>4, 5, 6</i> Temperature: <i>97.2°F</i>	Handover given to: <i>[Signature]</i>
Pain Score: <i>0</i>	(Nurse's Name)
Repeat RBS (if applicable):	

Tick as applicable: MLC LAMA BROUGHT DEAD

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

Name of the Nurse : *Sr. Nikitha* Signature of the Nurse : *[Signature]*

Date & Time : *24/6/26@*

M 18 D
 3537 IP-00060469
 VEDULA SRIAANSH YAJAT
 7-2021 4 Y 11 M 18 D (M)
 PAPPULA SINDHURA

GRBS - 206 mg/dl



wt - 21.7 kgs

EMERGENCY ROOM TRIAGE FORM

Patient's Name : Mst. Sriansh Age : 4y Gender : Male Female

Date : 24/6/26 Time of Arrival : 9:52 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: 98.6 F PR: 99 b/m BP: 102/65 (75) RR: 23 b/m SpO₂: 99%

Chief Complaints: vomiting, seizures

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.

Rashmi
 Signature of Parent / Guardian

Triage Completion Time : 9:55 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 : Nikhitha

Signature of Triage Nurse : [Signature]

Date & Time : 24/6/26 @ 9:35 pm

PATIENT TRANSFER FORM

Patient Name & UHID No. VIH-00135537 IP-00060469 Master VEDULA SRIANSH YAJAT 06-07-2021 4 Y 11 M 18 D (M) Dr. PAPPULA SINDHURA 		Date & Time of Admission 24/6/26 @ 9:54 PM	Date & Time of Transfer Order 24/6/26 @ 11 PM
		Transfer Ordered by DR. vishwaga	Reason for Transfer for admission
From Unit ER	To Unit 112	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File 21	Number of Imaging Films —	Personal belongings including clinical documents. If any handed over to attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> If yes, what? op file given to	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.	nil		
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 Shanthi Ishy		Name of Person Ordered Transfer DR. vishwaga.	
Patient & Clinical Records Received by : Vaishnavi			
Date & Time of Patient Received : 24/6/26 @ 11 PM			

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

- Unavailable Bed Nurse not Available Available Bed not ready



Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 11:10 pm Mode of Arrival: By walking Admitting From: ER OPD Direct

Allergy / Adverse Reaction: Nil Body Weight: 21.7 Kg
 Height: — cm

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

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

Family History: —

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

If yes please list, —

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: 21.7 kg Length: — Head Circumference (< 2 years): —
 Temp.: 98.6°F HR: 102 b/m RR: 29 b/m BP: 104/63 (94/55) mmHg

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

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

Risk of Pressure Sore (Braden Q Score 21) (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?)

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 *Family*

Nurse's Name: *Sr. vaishnavi* Date: *24/6/26* Time: *11pm*

(vaishnavi)
Signature



Rainbow[®] Children's Hospital

If takes a lot to treat the little.

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: _____

VIH-00135537 IP-00060469
Master VEDULA SRIANSH YAJAT
06-07-2021 4 Y 11 M 18 D (M)
Dr. PAPPULA SINDHURA

UHID ID: _____



Department: _____

Consultant: _____



Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

Child episode of seizure activity
lasted for 2-3 min.

History of present illness :

Child brought by parents with
H/O episode of seizure activity while child playing
with CROBB
deviation of mouth/drooling of saliva
Tearing movements of both UL & LL
lasting for 2-3 minutes.
followed by post seizure drowsiness.
↓
recovered on its own
↓
no H/O fever

On presentation - child drowsy
vitals stable
KRI - 206 mg/dl
SpO2 - 98% RA



History & Physical Examination

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

_____ *None significant* _____

Birth & Neonatal History:

_____ *Term / 9.5 kg* _____

Birth & Socio Economic History:

About Father : _____

About Mother : _____ *class 10*

Any additional Information : _____

Developmental History :

_____ *Appropriate for age* _____

Immunization History :

_____ *Received upto date* _____



Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs)) 21.7kg (Centile _____)

On Examination :

Temperature : 38.6°C Pulse Rate : 94/min B.P. 102/68 SPO2 99%

Resp.rate and type of breathing : 23/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 : lub ⊕

Any murmur : NO

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

Per Abdomen :

Inspection ⊖

Palpation : Soft

Ausculation : BAE ⊕

Spine : ⊖ External Genitelia : _____

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



Pediatric Neurological History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : _____

Cranial Nerves : _____

Motor System:

Nutriton : _____

Tone: *f* _____ Power *q/s all limbs*

Co-ordinator : _____

Posture : _____

Involuntary Movements : *e* _____

Reflexes :

DTR

Superficials:

Plantars _____

Sensory System :

Bladder / Bowel : *no incontinence*

Clinical Summary & Diagnostic:

Seizure & evaluation



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: _____

Desired goals of the treatment : _____

Planned Labs:

Ca ✓
Mg ✓
gF ✓ EEG
CBP ✓
CRP ✓

Planned Management

1) Purgicide
2) Perf. curra Act
3) EEG T/m.

Noted by
Dr. Rama
24/6/26 @ 10:55 PM

Signature of the Doctor: C.M.

Name of the Doctor: M. Srinivas

Date & Time: 24/6/26 10:50 PM

Signature of the Consultant: _____

Name of the Consultant: _____

Date & Time: _____

VIH-00135537 IP-00060469
 Maester VEDULA SRIANSH YAJAT (M)
 06-07-2021 4 Y 11 M 18 D
 Dr. PAPPULA SINDHURA

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<u>28/6/26</u>	<u>IB NLEP report</u>	
	LTM - Unprovoked focal to bilateral motor first episode	(Amn)
	No further seizure spreads	T/D EEG
		↓
		To decide about Amn / MRI after EEG.
		↓
	(Amn) Vial (Amn) NO NL markers	After EEG - discharge
	conscious oriented	- SUP LENIPIL
	Pupils equal, reacting	1.5ml — 1.5ml BD
	font - full	
	(Amn) PNC	
	Pupils → R L	
	OL 5/5 4/5	
	LL 5/5 5/5	
	OTC - f2 Pupils - PRC	Noted by Dr. Sindhya 2/6/26



NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: <u>Seizures & Evaluation</u>		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	<u>24/6</u>	<u>24/6</u>	<u>24/6</u>	<u>25/6</u>	<u>25/6</u>		
	Shift	<u>N</u>	<u>N</u>	<u>N/M</u>	<u>B</u>	<u>N</u>		
	Medical Condition (Any special condition to be noted):	-	-	<u>nil</u>	<u>nil</u>	<u>nil</u>		
ASSESSMENT	Diet:	<u>S-diet</u>	<u>S-diet</u>	<u>S-diet</u>	<u>S-diet</u>	<u>S-diet</u>		
	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	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Ventilation (RA, NP, NIV, VENTI):	<u>RA</u>	<u>RA</u>	<u>RA</u>	<u>RA</u>	<u>RA</u>		
	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	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Vital Signs:	Temp:	<u>98.6°F</u>	<u>98.6°F</u>	<u>98.5°F</u>	<u>98.5°F</u>	<u>98.3°F</u>	
		Res:	<u>23b/m</u>	<u>22b/m</u>	<u>26b/m</u>	<u>24b/m</u>	<u>27b/m</u>	
		SpO ₂ :	<u>99%</u>	<u>100%</u>	<u>99%</u>	<u>98%</u>	<u>99%</u>	
		Pulse:	<u>94b/m</u>	<u>99b/m</u>	<u>92b/m</u>	<u>93b/m</u>	<u>95b/m</u>	
		BP:	<u>102/63(81)</u>	<u>101/63(83)</u>	<u>103/67(87)</u>	<u>102/68(79)</u>	<u>105/67(83)</u>	
		LOC:	<u>conscious</u>	<u>conscious</u>	<u>conscious</u>	<u>conscious</u>	<u>conscious</u>	
Fall Risk Score:	<u>0</u>	<u>1</u>	<u>0</u>	<u>1</u>	<u>1</u>			
Pain Score:	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>			
Skin Integrity	<u>intact</u>	<u>intact</u>	<u>intact</u>	<u>intact</u>	<u>intact</u>			
Recommendations	Safety Needs:	<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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Physiotherapy:	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>		
	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	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Special Diet:	<u>S-diet</u>	<u>S-diet</u>	<u>S-diet</u>	<u>S-diet</u>	<u>S-diet</u>		
	Critical Lab Test / Values:	-	-	-	-	-		
	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	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	ADL (Dependent / Non Dependent):	<u>dependent</u>	<u>dependent</u>	<u>dependent</u>	<u>dependent</u>	<u>dependent</u>		
Post Operative Procedure Special Orders:	-	-	-	<u>nil</u>	<u>nil</u>			
Handed Over By Name :	<u>nikhitha</u>	<u>vaishnavi</u>	<u>Indu</u>	<u>Anitha</u>	<u>Vaishnavi</u>			
Signature / ID :	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>			
Date:	<u>25/6</u>	<u>25/6/26</u>	<u>25/6/26</u>	<u>25/6</u>	<u>26/6</u>			
Time:	<u>10:30pm</u>	<u>@ 8pm</u>	<u>62 pm</u>	<u>@ 8pm</u>	<u>@ 8pm</u>			
Taken Over By Name :	<u>vaishnavi</u>	<u>Indu</u>	<u>Anitha</u>	<u>Vaishnavi</u>	<u>[Signature]</u>			
Signature / ID :	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>			
Date:	<u>24/6/26</u>	<u>25/6</u>	<u>25/6</u>	<u>25/6</u>	<u>25/6</u>			
Time:	<u>@ 11pm</u>	<u>280</u>	<u>@ 2pm</u>	<u>@ 8pm</u>	<u>@ 8pm</u>			



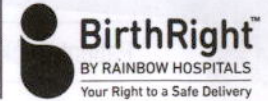
NURSING SHIFT HAND OVER FORM

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	Shift	/	/	/	/	/
	Medical Condition (Any special condition to be noted):						
	Diet:						
ASSESSMENT	Allergy:	<input 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	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Ventilation (RA, NP, NIV, VENTI):						
	Tubes/Drains/Catheter:	<input 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	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Vital Signs:	Temp:					
		Res:					
		SpO ₂ :					
		Pulse:					
		BP:					
		LOC:					
		Fall Risk Score:					
	Pain Score:						
	Skin Integrity						
Recommendations	Safety Needs:	<input 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	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Physiotherapy:						
	Others Specify:	<input 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	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Special Diet:						
	Critical Lab Test / Values:						
	Other Special Orders / Medications:	<input 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	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	ADL (Dependent / Non Dependent):						
Post Operative Procedure Special Orders:							
Handed Over By Name :							
Signature / ID :							
Date:							
Time:							
Taken Over By Name :							
Signature / ID :							
Date:							
Time:							

VIH-00135537 IP-00060469
 Master VEDULA SRIANSH YAJAT
 08-07-2021 4 Y 11 M 19 D (M)
 Dr. PAPPULA SINDHURA



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	11pm	- Ensure safety - Maintain good nutritional support	8AM	- kept side rails - Maintained input output chart	- vitals are normal	patient is stable	Vaishnavi 25/6/26 @8AM

VIH-00135537 IP-00060469
 Master VEDULA BRIANSH YAJAT
 08-07-2021 4 Y 11 M 19 D (M)
 Dr. PAPPULA SINDHURA



NURSING CARE RECORD



Date: 20/07/2021

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		discharge notes		NR came for		hand	
		patient is stable		advice for		discharge	
Afternoon							
Night	noted by <u>sh</u> <u>08PM</u> <u>20/7</u>						



NURSING CARE RECORD

Date: 25/6/2026

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: NI

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
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		→ To side rails kept up	→ provided by falls risk.		
Night	10 pm	Maintain Good Nutritional status	10:30	- Oral intake is good <u>Discharge notes</u> Doctor Came For Rounds Patient is stable & Advised For Discharge	- To Maintain Nutrition	- patient is stable	Vaishali 25/6 @ 8 PM

VIH-00135537 IP-00060469
 Master VEDULA SRIAANSH YAJAT
 08-07-2021 4 Y 11 M 19 D (M)
 Dr. PAPPULA SINDHURA



NURSING CARE RECORD



Date:

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon							
Night							



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:
			Time:	Time:	Time:	Time:	Time:	Time:
			25/6	26/6				
			2AM	2AM				
1	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)	1	0	0				
2	Bedridden recently >3 days or major surgery within four weeks	1	0	0				
3	Calf swelling >3cm compared with asymptomatic side, measured at 10 cm below tibial tubercle (Assess for both legs)	1	0	0				
4	Collateral (non varicose) superficial veins present (Assess for both legs)	1	0	0				
5	Entire leg swollen (Assess for both legs)	1	0	0				
6	Localized tenderness along the deep venous system (Assess for both legs)	1	0	0				
7	Pitting edema, greater in the symptomatic leg (Assess for both legs)	1	0	0				
8	Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs)	1	0	0				
9	Previously documented DVT (Assess for both legs)	1	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				
Total Score			0	0				
Signature of the Nurse			vaishya Pappula					

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



THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE 24/6	DATE 25/6	DATE 26	DATE 25/6	DATE 26/6
Age	Less than 3 years old	4					
	3 to less than 7 years old	3	3	3	3	3	3
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	2	2	2	2	2
	Female	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			1		
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			2		
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours/ None	1	1	1	1	1	1
Medication Usage	Sedatives (Excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1	1	1	1
Total			11	11	11	11	11

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
Other Intervention(s) Specify		2X	✓	✓	✓	✓
Nurse's Name:		nikli vaishnavi	nikli vaishnavi	nikli vaishnavi	Anitha Vaishnavi	Anitha Vaishnavi
Signature:		<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>
Date:		24/6	25/6	26	25/6	26/6
Time:		10:30pm	6 AM	12	8pm	4 AM

CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	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	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 : *[Signature]* Name : *Sadiya*

Signature of Ward In Charge :

Signature : *[Signature]* Name : *Elizabeth*

VIH-00135537
 Master VEDULA SRIANSH YAJAT
 06-07-2021 4 Y 11 M 18 D (M)
 Dr. PAPPULA SINDHURA



BRADEN 'Q' SCALE

		Date : 24/6/2021			
		Time : 10pm			
M	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.	3
"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.	3
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.	3
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.	3
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."	3
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.	3
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	3
TOTAL SCORE					21
Evaluator's Name					Dr. Pappula Sindhura

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

GENERAL CONSENT FOR TREATMENT

Patient Name: Master VEDULA SRIAANSH YAJAT **Age :** 4 Y 11 M 18 D
IP No: IP-00060469 **Sex:** Male
Consultant: Dr. PAPPULA SINDHURA **Ward/Bed No:** N 0 GF-EMERGENCY/ER 102

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 also 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.

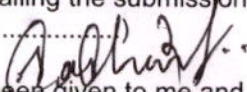
In giving my general consent to treatment, I understand that I retain the right to refuse any particular examinations, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by treating doctors. I also understand that the practice of medicine is not an exact science 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.

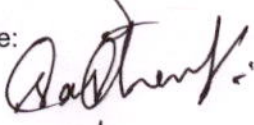
"I am aware that during the patient care it is inevitable that certain re-useable equipment shall be re-used after sterilization and disinfection. I am informed that the hospital assures maximum level of precaution and care in sterilizing and disinfecting the equipment and monitors the whole process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

Relationship: Father

Date: 24/06/26.

Time: 09.54 P.M

Witness Name: Sashank Vedula .

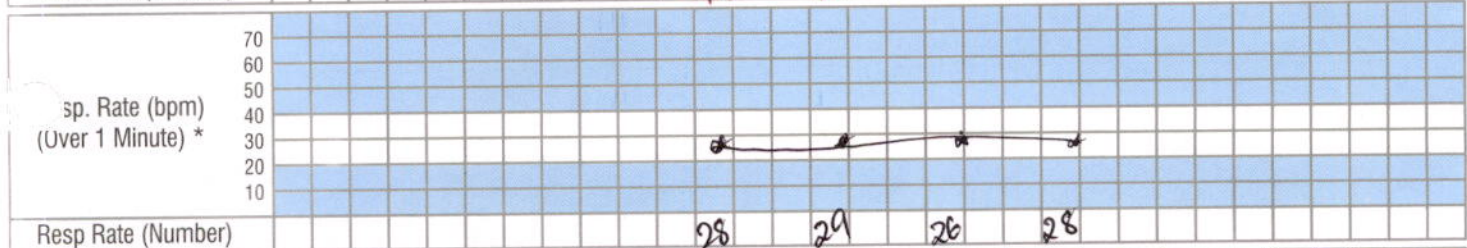
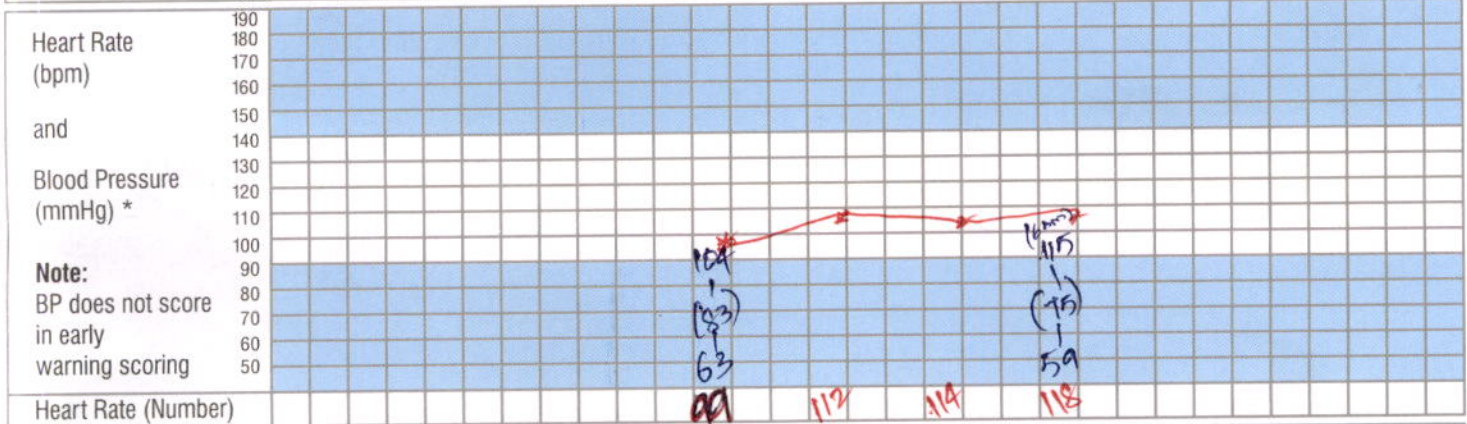
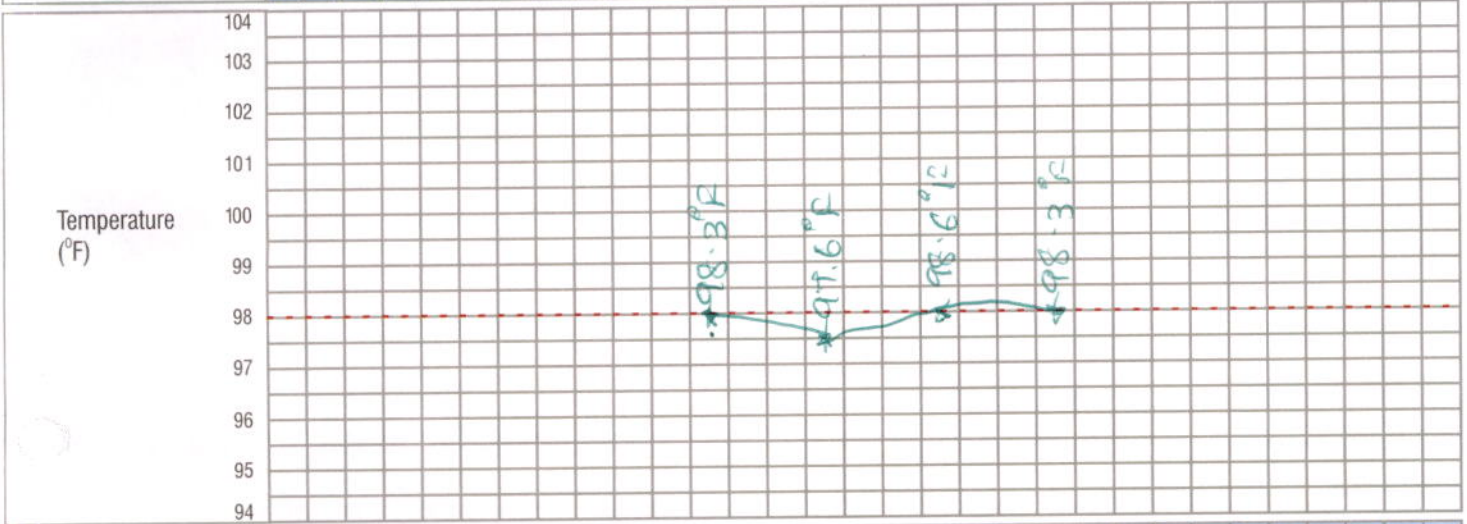
Witness Signature:


Patient Address:
 PLOT NO 28 FLAT NO 201 LAKSHMI
 ENCLAVE OLD VASAVI NAGAR
 Kharkhana Main Road Hyderabad
 Telangana INDIA 400056

EARLY WARNING SCORE: CHILDREN'S UNIT

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

Doctor / Nurse / Family Concern? AM AM AM AM



Resp Distress	Mod/ Severe None / Mild				
Receiving O ₂ (l/min)	O ₂ Saturations (%)	99	98	98	99
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: Scores 3 should be recorded overleaf

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



CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

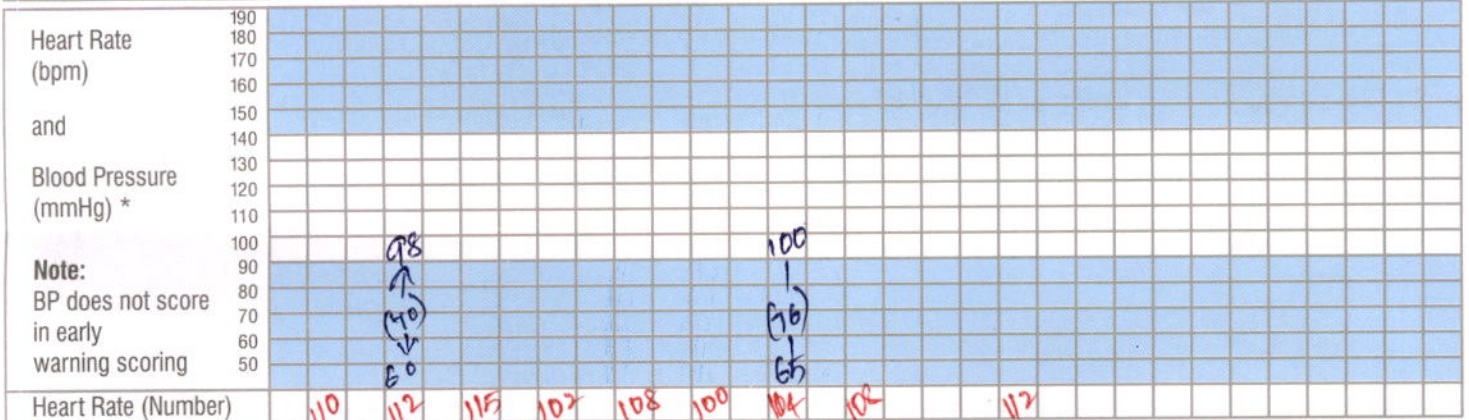
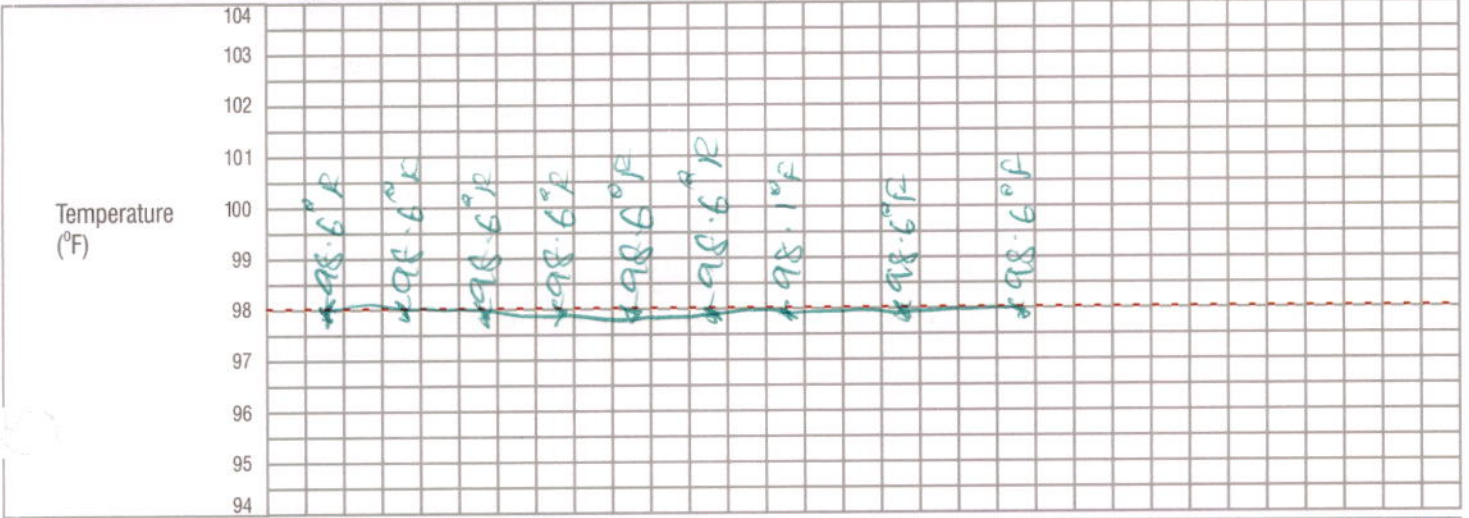
The SBAR communication tool (situation, background, assessment, recommendations) is a helpful mnemonic that can be used to describe a child's clinical condition to a colleague.

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 25/6..... Time: 9 11 1 3 5 7 9 12 3 6

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



Resp Distress	Mod/ Severe None / Mild	
Receiving O ₂ (l/min)	O ₂ Saturations (%)	98 99 98 98 99 100 99 99 98
Conscious Level	Normal / Altered	N N N N N N N N N
GCS *		15 15 15 15 15 15 15 15 15

TOTAL SCORE	
Number of shaded boxes	0
Pain Score	0
Observer's Initials	S S S A A A V V V

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NB: Scores 3 should be recorded overleaf

Noted by Vairbhava 26/6/26 WGM

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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)



①

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			
24/6/20	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 :							
24/6/20	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm	D	Water	30ml									
	12:00 am	N		30ml									
	01:00 am	S		30ml									
Total Intake :						Total Output :							
25/6/20	02:00 am			30ml									
	03:00 am	D		30ml									
	04:00 am	N		30ml									
	05:00 am			30ml									
	06:00 am	S		30ml									
	07:00 am			30ml									
	Total Intake :						Total Output :						
Total Intake :						Total Output :							

Total 24 hrs. Intake

Total 24 hrs. Output

VIH-00135537 IP-00060469
 Master VEDULA SRIANSH YAJAT
 06-07-2021 4 Y 11 M 19 D (M)
 Dr. PAPPULA SINDHURA



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		
25/6	08:00 am									✓	1	Sindhu
	09:00 am	Bar									0	
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
	Total Intake :						Total Output :					
25/6	02:00 pm									✓	1	Pratheek
	03:00 pm	Rice										
	04:00 pm	Water										
	05:00 pm									✓	0	
	06:00 pm											
	07:00 pm											
Total Intake :						Total Output :						
25/6	08:00 pm	Rice										Vaishnav
	09:00 pm	H ₂ O										
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						Total Output :						
26/6	02:00 am									✓	1	Vaishnav
	03:00 am											
	04:00 am											
	05:00 am	Water										
	06:00 am											
	07:00 am											
Total Intake :						Total Output :						
Total 24 hrs. Intake						Total 24 hrs. Output						

VIH-00135537 IP-00060469
 Master VEDULA SRJAANSH YAJAT
 06-07-2021 4 Y 11 M 18 D (M)
 Dr. PAPPULA SINDHURA



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: 112

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. V. S. H. W. A. G. Y.

Date & Time : 24/6/26 @ 10:33pm

Nurse Name & Signature: Shanthi P. S.

Date & Time : 24/6/26 @ 10:33pm

VIH-00135537 IP-00060469
 Master VEDULA SRIJAANSH YAJAT
 06-07-2021 4 Y 11 M 18 D (M)
 Dr. PAPPULA SINDHURA



DRUG CHART

Date of Admission: 24/6/26 Drug Allergies: Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

SOS / PRN (As Required Medication)

DRUG : <u>INS. LEVITERACETAM</u>				Date Time															
Dose	Route	Frequency	Start Date																
<u>400mg</u>	<u>IV</u>	<u>as required</u>	<u>24/6</u>																
Doctor's Signature		Valid Period	Pharm.																
<u>[Signature]</u>		<u>max 12th hourly</u>	<u>[Signature]</u>																
Additional Instructions:																			
<u>(20mg/kg/dose)</u> <u>40mg/kg/day</u>																			

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

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

Signature
Verified by Name



Weight. Ward.

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
24/6	9:30pm	INJ. LEVITRACETAM (20mg/kg)	400mg	IV	[Signature]	[Signature]
25/6		HP. Pedicology	10ml	PO	[Signature]	Priya
25/6		Two A/CIT	10mg	iv	[Signature]	Priya

VERIFIED BY: Name Signature

REGULAR PRESCRIPTIONS

Weight 21.7 kg Ward

As per doctor order
 S. macy Conale
 25/6/26



DRUG : SYP-LEVITIRACETAM				Date Time																
Dose	Route	Frequency	Start Date																	
1.5ml	PO	12 th ly	25/6																	
Name & Signature of the Doctor Starting the Drugs:																				
<i>S. macy Conale</i>																				
Additional Instructions:																				
1ml = 100mg																				
Daily Doctor's Endorsement by a Sign																				
DRUG :				Date Time																
Dose	Route	Frequency	Start Date																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG :				Date Time																
Dose	Route	Frequency	Start Date																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG :				Date Time																
Dose	Route	Frequency	Start Date																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				