

ACTIV VIH-00181214 IP-00060312 **NG**

Master **DAVID JACOB FERNANDEZ**
14-04-2025 1 Y 1 M 28 D (M)
Dr. **SURENDER RAO DUSA**

Name: -



UHID No

----- Consultant : ----- Dept : -----

Date of Admission : 11/6/26 Time : ----- 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>11/6/26</u>	<u>12:10PM</u>	<u>FR</u>	<u>110</u>	<u>[Signature]</u>

Cross Consultation Visit

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

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
11/6/26	Iv Placement	1	3089138	
<i>Cross checked by [Signature] 12/6/26</i>				

ANY OTHER INFORMATION

Covid test → negative.

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward <i>Leizasee mon</i>	Billing Assistant	Billing Supervisor
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Name	Master DAVID JACOB FERNANDEZ	UHID	VIH-00191214
Father/Guardian	Mr JOSEPH FERNANDEZ	Age/Gender	1 Y 1 M 30 D/Male
Address	.., Malkajgiri, Hyderabad, Telangana, INDIA, 500047		
IP No	IP-00060312	Admission Date	11-06-2026
Ref Doctor	SELF	Discharge Date	13-06-2026

DISCHARGE SUMMARY

Consultant: Dr. SURENDER RAO DUSA
MD (Pediatrics), Fellowship in Neonatology
SENIOR CONSULTANT PEDIATRICS
47776

Diagnosis: Acute febrile illness with febrile seizures

History: Master DAVID JACOB FERNANDEZ is a 1 Y 1 M 30 D boy presented with the history of moderate grade fever, decreased oral intake, one episode of seizure activity in the form of stiffening of limbs, uprolling of eyeballs, deviation of mouth, drooling of saliva lasted for about 2-5 minutes followed by postictal drowsiness for 30 minutes. For the above complaints, he was treated on OPD basis, but in view of persistence of symptoms, he was admitted at Rainbow Children's Hospital for further management.

Outside Investigations: MRI brain and EEG were normal.

Examination: He was afebrile, maintaining saturations at room air. HR-110/min, BP- 90/60 mmHg and RR 26/min. On auscultation of chest, air entry was bilaterally equal. Heart sounds were normal and there was no murmur. Abdomen was soft without organomegaly. Bowel sounds were heard. Neurologically, he was conscious and alert. Examination of other systems including spine was normal.

Name

Master DAVID JACOB
FERNANDEZ

UHID

VIH-00191214

Weight on admission : 7.8 kgs.

Investigations: Enclosed.

Management: He was admitted in the ward and started on intravenous fluids and intravenous antibiotics. He was started on prophylaxis with Syrup Clobazam. He was treated symptomatically with antipyretics.

His complete blood picture showed hemoglobin 12.1 gm%, white blood cells count of 8,400 cells/cumm, platelet count of 2.14 lakhs/cumm and C-reactive protein was 12 mg/l. Serum electrolytes, calcium and magnesium were normal. Complete urine examination was normal.

Her vitals were regularly monitored. He remained hemodynamically stable and there were no further seizure episodes during hospital stay. He is being discharged with the following advice.

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

Advice:

1. Diet as advised.
2. Syrup Azithromycin (5ml=200mg) 4ml once daily for 5 days.
3. Nasivion-P nasal drops, 2 drops in each nostril, 8th hourly for 3 days.
4. Nebulization with 3% Hyperneb, 1 respule 8th hourly (if required).
5. Kindly consult Dr. Surender Rao Dusa, Senior Consultant Pediatrics, after 3 days in OPD with prior appointment (This consultation will be charged).

Name

Master DAVID JACOB
FERNANDEZ

UHID



Febrile Seizure Prophylaxis

1. Syrup Paracetamol (5ml=240mg), 2.5ml for fever >99.6°F (maximum 4-6 hourly).
2. Syrup. Ibuprofen (5ml=100mg), 3.5ml for fever >101°F (maximum 8 hourly).
3. Tepid sponging SOS if fever >102°F.
4. Syrup Clobazam (1ml=2.5mg), 0.5ml in morning & 1ml at night for 3 days every time with fever.
5. Midazolam nasal spray (1.25mg/puff), 1 puff intranasal (into each nostril in sitting position) for future seizures more than 3 minutes.

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 lethargy, respiratory distress, refusal of feeds, decreased activity, seizures, jaundice, feeding difficulty.

If any IV antibiotics - will be given in Emergency Room between 6am - 7am for morning dose, between 2pm - 3pm for afternoon dose and between 10pm - 11pm for evening dose (Outside IV medication shall not be allowed with in the hospital as per the hospital protocol).

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

Name

Master DAVID JACOB
FERNANDEZ

UHID

VIH-00191214

Name :

Signature :

Relationship with patient :

This summary has been explained by : *Dr. Prashanthi*

Summary prepared by : Dr. B. Prashanthi
DEO : MD Younus Pasha

Dr. Prashanthi
Registrar/Resident/C.M.O

Fr R

Dr. SURENDER RAO DUSA

MD (Pediatrics), Fellowship in Neonatology
SENIOR CONSULTANT PEDIATRICS
47776

ADMISSION SHEET

Registration Details :



Admission No : IP-00060312

Admit Date : 11-Jun-2026

Admit Time : 11:28 AM UHID : VIH-00191214

Patient Details :

Patient Name : Master DAVID JACOB FERNANDEZ

Age : 1 Y 1 M 28 D

Guardian : Mr JOSEPH FERNANDEZ

DOB : 14-04-2025 06:34 PM

Gender : Male

Religion :

Occupation :

Martial Status :

Address (H) : .. Malkajgiri Hyderabad Telangana INDIA
500047

Phone No : 9573718810

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 JOSEPH FERNANDEZ

Relationship : S/O

Contact Address : .. Malkajgiri Hyderabad Telangana INDIA
500047

Phone No : 9573718810



Signature

Doctor Details :

Doctor Name : Dr. SURENDER RAO DUSA

Specialisation : GENERAL PEDIATRICS

Referral Doctor : SELF

Phone No :

Co-Consultant :

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : Paramount Health
ServicesInsurance TPA Pvt Ltd

Patient Name : Mast. David Jacob Fernandez UHID : 5295 IPD : 5329 Gender : Male Age : 1 Y

VIH-00191214 IP-00060312
 Master DAVID JACOB FERNANDEZ
 14-04-2025 1 Y 1 M 28 D (M)
 Dr. SURENDER RAO DUSA



wt - 7.80kg
 Ht - 74cm



EMERGENCY ROOM TRIAGE FORM

Patient's Name : Mast. David Jacob Age : 1 Y Gender : Male Female

Date : 11/6/26 Time of Arrival : 11:10am

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

Source of Information : Parents Others (Specify):

Mode of Arrival : Ambulatory Wheelchair Ambulance

Initial Vital Signs: Temp: 97.9F PR: 118b/m RR: 26b/m SpO₂: 100%

Chief Complaints: CB - Fever x 1 day. Seizures x yesterday, 1 episode

INITIAL PHYSIOLOGICAL CATEGORIZATION Appearance <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Sick Looking Circulation / Colour <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Bleeding		Work of Breathing <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Decreased <input type="checkbox"/> Increased <input type="checkbox"/> Gasping / Apnea		INITIAL PHYSIOLOGICAL STATUS <input checked="" type="checkbox"/> Stable <input type="checkbox"/> Unstable : <input type="checkbox"/> Not - Life - Threatening <input type="checkbox"/> Life -Threatening
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Triage Classification	CTAS
<input type="checkbox"/> Level 1 : Resuscitation	<input type="checkbox"/> Immediate
<input type="checkbox"/> Level 2 : EMERGENT : Life or limb threatening	<input type="checkbox"/> < 15 min
<input type="checkbox"/> Level 3 : URGENT : Significant illness / injury with potential to become life or limb threatening	<input type="checkbox"/> 30 min
<input type="checkbox"/> Level 4 : LESS URGENT : Significant illness but not life threatening	<input checked="" type="checkbox"/> 60 min
<input type="checkbox"/> Level 5 : NON - URGENT : May receive care when convenient	<input type="checkbox"/> 120 min

NOTE : All immunocompromised children and preterm babies to be considered Level 2.
 All Children less than 2 years age with high fever to be considered Level 3.

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian
 Triage Completion Time : 11:13am

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 : Swarna
 Date & Time : 11/6/26 @ 11:13am
 Docu. No. : RCH / FRM / CLINICAL / 085

Signature of Triage Nurse :

Patient: **Master David Jacob Fernandez** UHID : 5295 IPD : 5329 Gender : Male Age : 1 Y

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Master **DAVID JACOB FERNANDEZ**
14-04-2025 1 Y 1 M 28 D (M)
Dr. **SURENDER RAO DUSA**



NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date: 17/6/26 Time of arrival: 11:14 AM
Chief Complaints: cb. Fever x 1 day, Seizure's yesterday (1 episode) RBS: -
Height: 79cm Weight: 7.80kg BMI: - Head Circumference (<2 years): -
Allergies: Yes No Medications Blood Transfusion Food Other: -
If yes, identify _____
Pain Screening: Yes No If Yes, Pain Score: 0 Pain Tool Used: N Pass FLACC Wong Baker
 Character _____ Location _____ Frequency _____ Duration _____

<p>RISK FOR FALL:</p> <p><input checked="" type="checkbox"/> If patient is < 6 years tick below fall risk intervention directly</p> <p><input type="checkbox"/> If Patient is > 6 years Assess the below parameters</p> <p>History of Falling: within past 3 months <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Ambulatory Aids:</p> <ul style="list-style-type: none"> • Wheelchair <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No • Uses furniture for support <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <p>Gait/Transferring:</p> <ul style="list-style-type: none"> • Bedrest / immobile <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No • Weak <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No • Impaired <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <p>Mental Status: Forgets limitations <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>IF YES FOR ANY CATEGORY = RISK FOR FALLING</p> <p>Fall Risk Intervention:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Escort while ambulating <input checked="" type="checkbox"/> Assist Patient <input type="checkbox"/> Educate patient and family on fall precautions/prevention 	<p>Functional Screening: <input checked="" type="checkbox"/> No Abnormalities Detected</p> <ul style="list-style-type: none"> <input type="checkbox"/> Mobility Problem <input type="checkbox"/> Walking Problem <input type="checkbox"/> Developmental Delay <input type="checkbox"/> Musculoskeletal Congenital Abnormality <p>Inform consultant for positive criteria</p> <p>_____</p> <p>_____</p> <p>Nutritional Screening: <input checked="" type="checkbox"/> No Abnormalities Detected</p> <ul style="list-style-type: none"> <input type="checkbox"/> Underweight <input type="checkbox"/> Overweight <input type="checkbox"/> Feeding Problem <input type="checkbox"/> Special diet <input type="checkbox"/> Special feeding method <p>Inform consultant for positive criteria</p> <p>_____</p> <p>_____</p>
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Psychological Screening: No Significant Findings
Unusual concerns about patient's Psychological Status: Yes No
If Yes Consultant Notified: _____ (Date/Time): _____
Social History: Lives With Family
Siblings in household Yes No (if yes How Many?) 1 (Sister)
Time of Initial assessment completed by ER Nurse: 11:18 AM

Patient Name : Mast. David Jacob Fernandez UHID : 5295 IPD : 5329 Gender : Male Age : 1 Y

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

Time	Nursing Notes
11:10 AM	→ Patient come to ER
11:13 AM	→ vitals checked and recorded
11:15 AM	→ Dr. Vishwaja seen the patient & advised Admission
11:28 AM	→ Admission done
11:50 AM	→ ZV placement done & Sample collected & send to lab
12:00 PM	→ patient shift to ward.

Samples collected by: Sr. Hema

Time: @ 11:50 AM

Samples sent by: Sr. Jyothi

Time @ 11:55 AM

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: 118b/m BP: crying CFT: 53sec	Shift - out from ER to: 110
RR: 26b/m SPO ₂ : 100%	Time of Shift - out: 11/6/26 @ 12:10 PM
GCS: 15/15 Temperature: 99.9F	Handover given to: Sr. Menaka (Nurse's Name)
Pain Score: -	
Repeat RBS (if applicable):	

Tick as applicable: MLC LAMA BROUGHT DEAD

Procedures done with details (if any):


ZV placement done

Name of the Nurse : Suvarna

Signature of the Nurse : 

Date & Time : 11/6/26 @ 12:10 PM

PATIENT TRANSFER FORM

Patient Name & UHID No. VIH-00191214 IP-00060312 Master DAVID JACOB FERNANDEZ 14-04-2025 1 Y 1 M 28 D (M) Dr. SURENDER RAO DUSA 		Date & Time of Admission <i>11/6/26 @ 11:28 AM</i>	Date & Time of Transfer Order <i>11/6/26 @ 12:10 PM</i>
		Transfer Ordered by <i>Dr. Vishwaja</i>	Reason for Transfer <i>Admission</i>
From Unit <i>ER</i>	To Unit <i>110</i>	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File <i>21</i>	Number of Imaging Films <i>—</i>	Personal belongings including clinical documents. If any handed over to attendant Yes <input 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 <i>Dr. Suresh</i>		Name of Person Ordered Transfer <i>Dr. Vishwaja</i>	
Patient & Clinical Records Received by : <i>Manasa</i>			
Date & Time of Patient Received : <i>11/6 @ 12:10 PM</i>			

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

- Unavailable Bed Nurse not Available Available Bed not ready

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Nursing General Admission Assessment Form For Pediatrics

Diagnosis: Febrile Seizures
Arrival Time: 12:15 PM **Mode of Arrival:** By mother hold **Admitting From:** ER OPD Direct
Allergy / Adverse Reaction: Nil **Body Weight:** 7.80 Kg
Height: 74 cm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
Yes	Nil	Yes Admitted for febrile seizure

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: 7.80 kg Length: 74 cm Head Circumference (< 2 years): Nil

Temp.: 98.6 F HR: 107 bpm RR: 26 bpm BP: 100/60 (70)

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

Fall Risk Assessment: Yes No **Score:** 14 (Document in the Humpty Dumpty Sheet)

Risk of Pressure Sore (Braden Q Score): 27 (Document in the Braden Q Assessment Sheet)

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

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

FUNCTIONAL SCREENING: No Abnormalities Detected
 Mobility Problem Walking Problem
 Developmental Delay Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING: No Abnormalities Detected
 Underweight Overweight Special Feeding Method
 Feeding Problem Special diet No Abnormality Detected

Inform consultant for positive criteria

Psychological Screening: No Significant Findings

Unusual concerns about patient's Psychological Status: Yes No

If Yes Consultant Notified:^{19/} (Date/Time):

Social History: Lives With^{Family}.....

Siblings in household Yes No (if yes How Many?)^{0/}.....

All Information Obtained From Patient Mother Father Other Family Member

Orientation has been given regarding the following aspects:

Call Bell in Reach : Yes No

Waste Disposal Explained: Yes No

Infusion Pump : Yes No

Hand hygiene Explained: Yes No Others

Patient Rights & Responsibilities: Yes No

Information given to^{mother}.....

Nurse's Name:^{manasa}.....

Date:^{11/6/26}.....

Time:^{12:30pm}.....

Signature 



Rainbow[®] Children's Hospital

It takes a lot to treat the little.

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: _____

UHID ID: _____

Department: _____

Consultant: _____

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Master DAVID JACOB FERNANDEZ
14-04-2025 1 Y 1 M 28 D (M)
Dr. SURENDER RAO DUSA



Pediatric Multiorgan History & Physical Examination

Name : David Jacob Age/Sex 1 year / M

Information given by: Mother Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

c/o Fever since yesterday
also 1 episode of seizure activity - (2nd episode since birth)
No H/O cold, cough

History of present illness :

Child was apparently healthy 1 day back
then developed

Fever - since yesterday morning
moderate grade

Receiving on medication: a/w ↓ oral intake
since yesterday

a/w 1 episode of seizure activity Oral, tonic (N)
with stiffening of limbs, UROC, deviation of mouth
drooling of saliva

lasted for 2-5 min

Parents gave midas. Pyl - orally

Baby stabilized

post seizure consciousness for 30 min.

consulted Dr. Sindhu nam @ OPD. - yesterday

advised - Symp. CLOBA - 3 days.

EEG (N)
MR Brain (N)



Pediatric Multiorgan History & Physical Examination

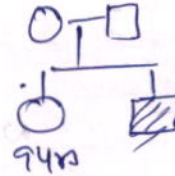
Past History : (Including details of any previous investigation or treatment)

#fo admission D₃ of life - Severe Anemia (Jaundice) 20 days.

#fo admission 8 months of life - febrile seizures (1st episode)
↓
Used leucosamide for 2 months.

Birth & Neonatal History:

FT / NVD / 2.70kg / CPAB / Perinatal
NICU admission
D₃ - Anemia for 20 days.



M : B +ve
B : A +ve.

Birth & Socio Economic History:

About Father : _____

About Mother : _____

Any additional Information : _____

} class III

Developmental History :

Appropriate for age & sex
Motor delay & speech delay (+)

Immunization History :

Received Vaccination upto date



Pediatric Multiorgan History & Physical Examination

Anthropometry :

Head Circum (cms) _____ (Centile _____) Height (cms): 74cm (Centile _____)
Weight (kgs) : 7.8kg (Centile _____)

On Examination :

Temperature : 97.9°F Pulse Rate : 118/min B.P. crying SPO2 100%
Resp. rate and type of breathing : 26/min

Rash ⊖
Lymphadenopathy _____
Oedema : ⊖
Allergies (if any): ⊖

Respiratory System :

Inspection (any s/o distress) : B/symmetrical chest movements
Air entry & breath sounds : R/LAE ⊕
Any addes sounds : NO
Relevant data from outside (Chest X-Ray, ABG, etc..) _____

Cardiovascular System :

Inspection of procordium : ⊕
Heart Sounds : S1S2 ⊕
Any murmur : NO.
Relevant data from outside (Chest X-Ray, ECG, ECHO, etc..) : _____

Per Abdomen :

Inspection ⊕
Palpation : SOFT
Auscultation : BS ⊕
Spine : ⊕ External Genitalia : _____
Relevant data from outside (CT, USG etc..) _____

Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : Awake w/ix

Cranial Nerves : Intact

Motor System:

Nutriton : _____

Tone: _____ Power 4/5 all limbs

Co-ordinator : _____

Posture : _____

Involuntary Movements : (-)

Reflexes : +

DTR +2

Superficials: +

Plantars flexor

Sensory System : +

Bladder / Bowel : No incontinence

Clinical Summary & Diagnostic:

Febriile Seizures. (2nd episode)



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: To prevent complications.

Desired goals of the treatment : To treat current conditions

Planned Labs:

- CRP ✓
- CRP ✓
- S/E ✓
- S. Calcium ✓
- S. Mg ✓
- CE ✓

Planned Management

- 1) Iugluide
- 2) Pnj ceftriaxone IV BID
- 3) Syp clonazepam BD
- 4) Antepyrretics - SOS
- 5) Monitor vitals

Noted by
Suresh
@ 11:50 AM

Signature of the Doctor: [Signature]

Name of the Doctor: Dr. Vishwaja

Date & Time: 11/6/25

Signature of the Consultant: [Signature]

Name of the Consultant: Dr. Surender Rao Sir

Date & Time: _____

VH-00191214 IP-00060312
 Master DAVID JACOB FERNANDEZ
 14-04-2025 1 Y 1 M 29 D (M)
 Dr. SURENDER RAO DUSA



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
12/6/24	C/S/B Resident	
9:00 AM	Dis; AFIc febrile seizures.	
	5 fever spikes 6pm, 8pm, 11:50, 3:15, 6:40 AM	
	(100-102) f	
Feeling well u/o Adenite.		
	O/S child Alert Vital stable	
Dr. Prabhakar.	CW: SISU (+) M: B/LAE (+) P/A: GALT CNI: WAD.	plan
		- Inj. ceftriaxone - 12 th day
		- syp. clobazam - (4 doses completed)
	- if fever spike (+) ↓ CBP / CRP - 1/2m.	
Noted by Boravika 12/6 @ 8pm		Dr. Surender Rao 12/6/24 10:30 AM



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
12/6/26 4:00pm	c/s/B Resident Dat: Aft E Schussler. 1 full pike @ 4:00pm. (101.13)	
O/I - Beckm Y/o - Adente. Dr. Prabhakar	<u>O/E</u> chud Alert Vitals stable CK: 124 M: BLACE PLA: 6/6 CNI: NAD	<u>plan</u> - Inj. apixione - CRP, cer - Am. if jumpant. - stop clozapine 10m.
Noted by Bevanika 12/6 @ 8pm		Dr. Surender Rao 12/6/26

VIH-00191214 IP-00060312
 Master DAVID JACOB FERNANDEZ (M)
 14-04-2025 1 Y 1 M 29 D
 Dr. SURENDER RAO DUSA



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
13/6/26 9:00 AM	<p><u>CL/B Resident</u></p> <p>Ans: AFI c Schickelismus.</p> <p>2 fecal pikes @ 8:30 pm & 2 Am. (100°F) (101.4°F)</p>	
Dr. Mankar	<p><u>O/E</u></p> <p>Child Alert</p> <p>vital stable</p> <p>Wt: 11.1 ⊕</p> <p>Ht: 81.0 ⊕</p> <p>BP: soft</p> <p>CR: NAD.</p>	<p><u>Plan</u></p> <p>send</p> <p>- Draw CBP, CRP.</p> <p>- Inj. Cefixime - D2</p> <p>- Symp. clobazam - 10mg</p>
- D) today	<p>on oral Azithromycin <u>500</u>.</p> <p>Hypunk (60)</p> <p>Naurox-p nasal drops.</p>	<p>- Nasal drops</p> <p>Dr. Surender Rao</p> <p>13/6/26</p> <p>1:50 PM</p>

Noted by
 Manisha
 13/6/26
 @ 2 PM



NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: <i>Febrile seizures</i>	Any Infection: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> Not Known If Yes Specify:						
	Surgery / Procedure: <i>-</i>	Post OP Day: <i>-</i>						
BACKGROUND	Date	<i>11/6/26</i>	<i>11/6</i>	<i>11/6</i>	<i>11/6/26</i>	<i>12/6/26</i>	<i>12/6</i>	
	Shift	<i>Morning</i>	<i>M</i>	<i>E</i>	<i>NIGHT</i>	<i>M</i>	<i>E</i>	
	Medical Condition (Any special condition to be noted):	<i>Nil</i>	<i>Nil</i>	<i>Nil</i>	<i>Nil</i>	<i>Nil</i>	<i>Nil</i>	
ASSESSMENT	Diet:	<i>SBF</i>	<i>D3F S.diet</i>	<i>S.diet</i>	<i>S.diet</i>	<i>S.diet</i>	<i>S.diet</i>	
	Allergy:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<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>	<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	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Vital Signs:	Temp:	<i>97.9 F</i>	<i>98.1 F</i>	<i>98.6 F</i>	<i>100.9 F</i>	<i>99.3 F</i>	<i>101.1 F</i>
		Res:	<i>29 blm</i>	<i>27 blm</i>	<i>26 blm</i>	<i>25 blm</i>	<i>28 blm</i>	<i>30 blm</i>
		SpO ₂ :	<i>99%</i>	<i>98%</i>	<i>97%</i>	<i>98%</i>	<i>96%</i>	<i>99%</i>
		Pulse:	<i>108 blm</i>	<i>120 blm</i>	<i>117 blm</i>	<i>153 blm</i>	<i>118 blm</i>	<i>112 blm</i>
		BP:	<i>Crying</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>
		LOC:	<i>conscious</i>	<i>conscious</i>	<i>conscious</i>	<i>conscious</i>	<i>conscious</i>	<i>conscious</i>
Fall Risk Score:		<i>14</i>	<i>14</i>	<i>14</i>	<i>14</i>	<i>14</i>	<i>14</i>	
Pain Score:	<i>0</i>	<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>	<i>Intact</i>		
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 type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Physiotherapy:	<i>Nil</i>	<i>Nil</i>	<i>Nil</i>	<i>Nil</i>	<i>Nil</i>	<i>Nil</i>	
	Others Specify:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Special Diet:	<i>DBF</i>	<i>S.diet</i>	<i>S.diet</i>	<i>S.diet</i>	<i>S.diet</i>	<i>S.diet</i>	
	Critical Lab Test / Values:	<i>Nil</i>	<i>Nil</i>	<i>Nil</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	<input type="checkbox"/> Yes <input checked="" 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 checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" 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 checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
ADL (Dependent / Non Dependent):	<i>Dependent</i>	<i>Dependent</i>	<i>Dependent</i>	<i>dependent</i>	<i>dependent</i>	<i>dependent</i>		
Post Operative Procedure Special Orders:	<i>Nil</i>	<i>Nil</i>	<i>Nil</i>	<i>Nil</i>	<i>Nil</i>	<i>Nil</i>		
Handed Over By Name :	<i>Suresh Manasa</i>	<i>Manasa</i>	<i>Manasa</i>	<i>Subham</i>	<i>Indu</i>	<i>Bevanika</i>		
Signature / ID :	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>		
Date:	<i>11/6/26</i>	<i>11/6</i>	<i>11/6</i>	<i>12/6/26</i>	<i>12/6/26</i>	<i>12/6/26</i>		
Time:	<i>@ 12:10</i>	<i>2pm</i>	<i>8pm</i>	<i>@ 8pm</i>	<i>2pm</i>	<i>@ 8pm</i>		
Taken Over By Name :	<i>Manasa</i>	<i>Manasa</i>	<i>Priva</i>	<i>Indu</i>	<i>Bevanika</i>	<i>Manasa</i>		
Signature / ID :	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>		
Date:	<i>11/6</i>	<i>11/6</i>	<i>11/6/26</i>	<i>12/6/26</i>	<i>12/6/26</i>	<i>12/6</i>		
Time:	<i>12:10</i>	<i>2pm</i>	<i>@ 8pm</i>	<i>@ 8pm</i>	<i>@ 2pm</i>	<i>8pm</i>		

NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: <i>AFI & febrile seizures</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: <i>-</i>		Post OP Day: <i>-</i>				
BACKGROUND	Date	<i>12/6</i>	<i>12/6/26</i>				
	Shift	<i>N</i>	<i>M</i>				
	Medical Condition (Any special condition to be noted):	<i>Nil</i>	<i>Nil</i>				
	Diet:	<i>S. diet</i>	<i>S. 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 type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Ventilation (RA, NP, NIV, VENTI):	<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 type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Vital Signs:	Temp:	<i>98.6°</i>	<i>98.6°</i>			
		Res:	<i>27 b/m</i>	<i>28 b/m</i>			
		SpO ₂ :	<i>98%</i>	<i>99%</i>			
		Pulse:	<i>120 b/m</i>	<i>112 b/m</i>			
		BP:	<i>100/60/70</i>	<i>100/70/62</i>			
	LOC:	<i>conscious</i>	<i>conscious</i>				
	Fall Risk Score:	<i>14</i>	<i>14</i>				
Pain Score:	<i>0</i>	<i>0</i>					
Skin-Integrity	<i>Intact</i>	<i>Intact</i>					
Recommendations	Safety Needs:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Physiotherapy:	<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 type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Special Diet:	<i>S. diet</i>	<i>S. diet</i>				
	Critical Lab Test / Values:	<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 type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	ADL (Dependent / Non Dependent):	<i>Dependent</i>	<i>Dependent</i>				
Post Operative Procedure Special Orders:	<i>Nil</i>	<i>Nil</i>					
Handed Over By Name :	<i>Manak</i>	<i>Manisha</i>					
Signature / ID :	<i>[Signature]</i>	<i>[Signature]</i>					
Date:	<i>13/6</i>	<i>12/6/26</i>					
Time:	<i>CSAM</i>	<i>@ 2pm</i>					
Taken Over By Name :	<i>Manisha</i>						
Signature / ID :	<i>[Signature]</i>						
Date:	<i>13/6/26</i>						
Time:	<i>@ 8AM</i>						

Noted by Anshu
22pm
13/6/26



NURSING CARE RECORD

Date: 11/6/26

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	1:30 PM	→ Ensure safety	1:30 PM	→ Side rails kept up	→ prevent from fall risk	→ patient is stable	<i>[Signature]</i> manasa
Afternoon	4 PM	→ IV fluids on flow	4:30 PM	→ Dns 20ml/hr is maintained	→ to maintain hydration	→ patient is stable	<i>[Signature]</i> manasa
Night	9 PM	→ maintain personal hygiene	9 PM	→ maintained hand hygiene & hand washing	→ prevent infection	→ Patient is stable	<i>[Signature]</i> Subher 12/6 @ 8 AM
	10 PM	→ maintain fluid balance	10 PM	→ Administered IV fluid Dns 20ml/hr	→ maintain hydration		

VIH-00191214 IP-00060312
 Master DAVID JACOB FERNANDEZ (M)
 14-04-2025 1 Y 1 M 29 D
 Dr. SURENDER RAO DUSA

NURSING CARE RECORD



Date: 12/6/26

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	9:00	maintain aseptic technique	9:30	maintained aseptic technique	-prevent from Infection	-patient is stable	Indo
	1:00	-ensure safety	1:30	side rails kept up	-prevent from falls risk	-no fresh complaints	@ 2pm 12/6/26
Afternoon	4pm	→ Maintain fluid Balance.		→ Administered IV fluid 2NS 20ml/hr	→ Maintain Hydration	Patient is stable	Benuika 12/6
	6pm	→ Ensure Safety		→ Side rails kept up	→ prevent from fall risk		@ 8pm
Night	10 pm	→ Ensure safety	10:30 pm	→ side rails kept up	→ prevent from fall risk	→ patient is stable	of newson



NURSING CARE RECORD



Date: 13/6/26

Goals

- Maintain Airway and Oxygenation
- Maintain Personal Hygiene
- Identify Potential Complications
- Relieve Pain & Discomfort
- Prevent Infection
- Any Others. Specify... nil
- 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	9am	maintain aseptic technique		- maintained aseptic technique	- prevent from infection.	- patient is stable	Manisha 13/6/26 @2pm
	11am	- Ensure safety		- side rail kept up	- prevent from fall risk		
Afternoon		discharge notes: 298		Came for rounds	patient	is stable	
		advice for discharge					
Night					noted	by Doh SLM 13/6/26	

VIH-00191214 IP-00060312
 Master DAVID JACOB FERNANDEZ
 14-04-2025 1 Y 1 M 29 D (M)
 Dr. SURENDER RAO DUSA



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							



THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	11/6/26	11/6/26	12/6	12/6	12/6
	3 to less than 7 years old	3	4	4	4	4	4
	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	3	3	3	3	3
	Forget Limitations	2					
	Oriented to own ability	1					
	History of Falls or Infant-Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture/ Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2	2	2	2	2
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours/ None	1	1	1	1	1	1
Medication Usage	Sedatives (Excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives/ Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications/ None	1	1	1	1	1	1
Total			14	14	14	14	14

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	X	X	X	✓	✓	✓
Wheels Locked	✓	✓	✓	✓	✓	✓
Room free of clutter	✓	✓	✓	✓	✓	✓
Adequate lighting	✓	✓	✓	✓	✓	✓
Wheel chair cup	✓	✓	X	✓	X	X
Other Intervention(s) Specify	✓	✓	✓	✓	✓	✓
Nurse's Name:	Hema Gayate	Smita	And	Beetika	Manasa	
Signature:	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	
Date:	11/6/26	11/6/26	12/6	12/6	12/6	
Time:	11:30 AM	6 PM	2 PM	4 PM	4 PM	12:30 PM



THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	4				
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	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				
Cognitive Impairments	Not aware of Limitations	3	3				
	Forget Limitations	2					
	Oriented to own ability	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				
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	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				
Total			4				

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 secured		✓				
Other Intervention(s) Specify						
Nurse's Name:		RD				
Signature:		<i>[Signature]</i>				
Date:		13/8				
Time:		12:18				



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
11/6/26	11:30 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	—	AB
11/6/26	6pm	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	GGP
11/6/26	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	NIL	Subhas
12/6/26	6 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	Subram
12/6/26	12 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	Subh
12/6	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	Sub
12/6	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	NIL	GGP
13/6/26	9 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	manisha
				<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:

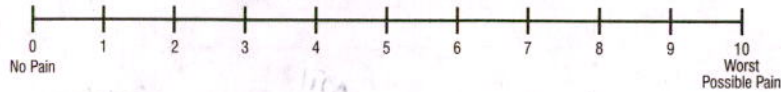
1. Every eight hours for all hospitalized patients.
2. For post-surgical patients, patients with chronic pain, patient with severe pain:
 - a) At least every 2 hours for the first 24 hours
 - b) Then every 4 hours.
 - c) Prior to pain-relieving intervention.
 - d) Within 30 – 60 minutes after pain relief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

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

Wong - Baker (Pediatrics) Above 7 Years





CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	11/6 DAY-1			12/2 DAY-2			13/6 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 cord pyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5	-	-	-	-	-	-	-			
Signature of the Nurse				<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>			

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 : *Jasho*

Signature of Ward In Charge :

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



BRADEN 'Q' SCALE

					Date :	11/6/26	11/6	11/6	11/6
					Time :	11:30 AM	6 PM	11 PM	11 AM
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.		4	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.		4	4	3	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.		4	4	3	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	3	3	3
FRICION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."		4	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 mean and dairy products. Occasionally eats between meals. Does not require supplementation.		4	4	3	3
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.		4	4	4	4
					TOTAL SCORE	27	27	24	24
					Evaluator's Name	AD	AD	AD	AD

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

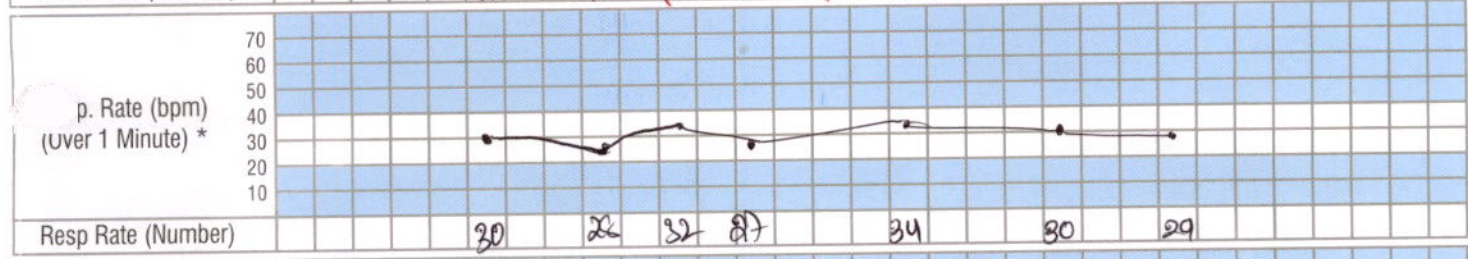
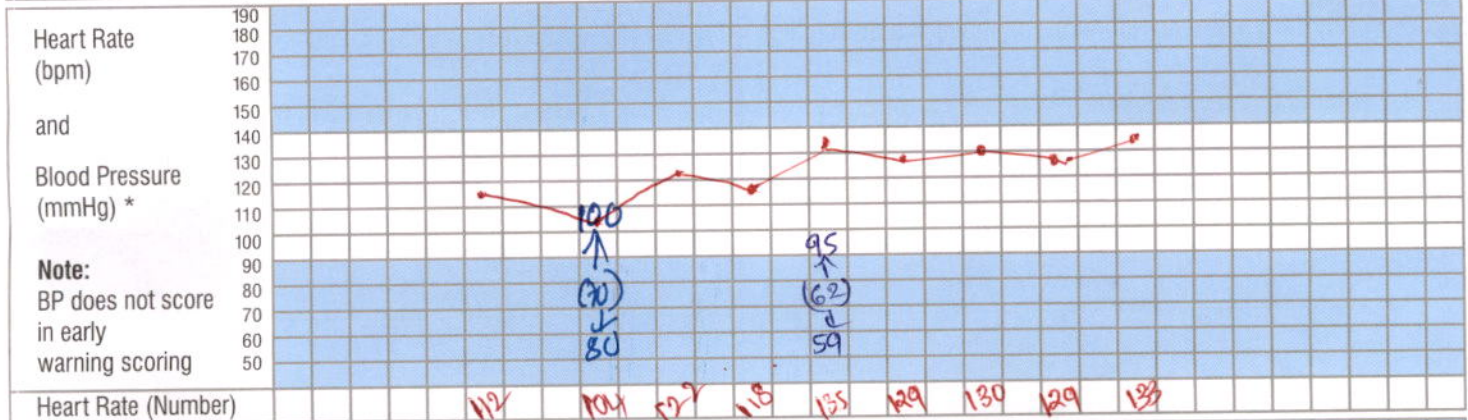
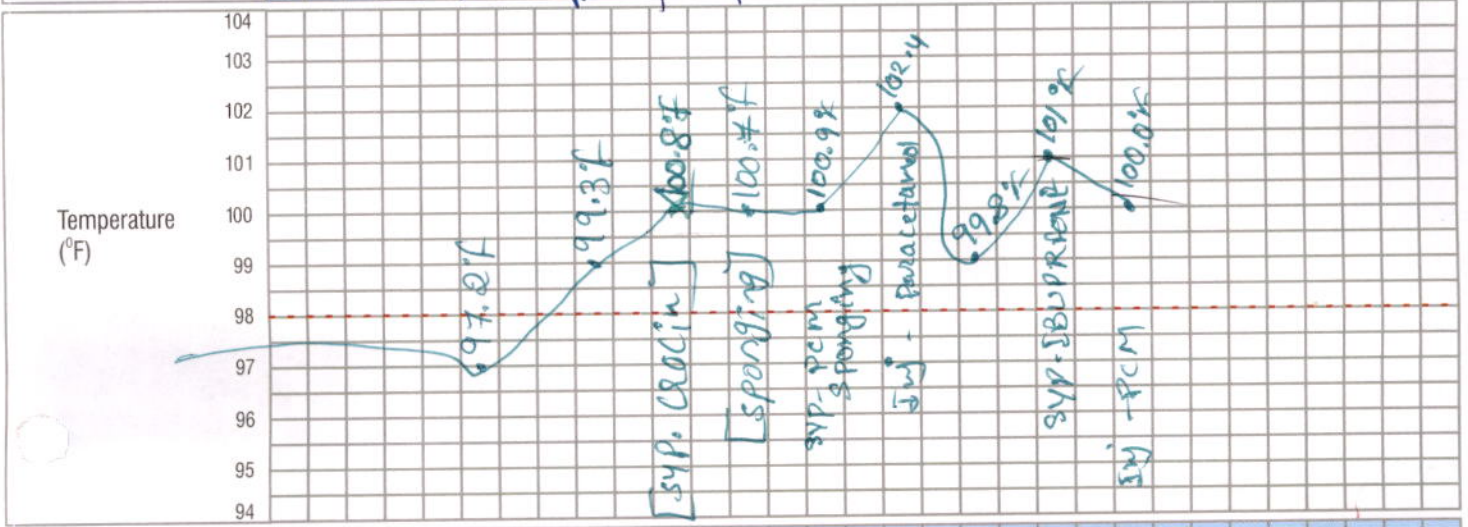
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Risk Score	Category	Action	Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice)
15-18	At Risk	<ul style="list-style-type: none"> • Regular Turning 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



EARLY WARNING SCORE: CHILDREN'S UNIT

Date: <u>11.16</u> Time:	1	4	6	8	9:45	11:50	11:30	3:15	6:40
Doctor / Nurse / Family Concern?	pm	pm	pm	pm	pm	pm	am	am	am



Resp Distress	Mod/ Severe	None / Mild							
	N	N	N	N					
Receiving O ₂ (l/min)									
O ₂ Saturations (%)	99	98	99	99	98	95	96	97	99
Conscious Level	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	0	1	0	1	1	0	0	0
Pain Score	0	0	0	0	0	0	0	0	0
Observer's Initials	SK	SK	SK	SK	SK	SK	SK	SK	SK

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

- 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

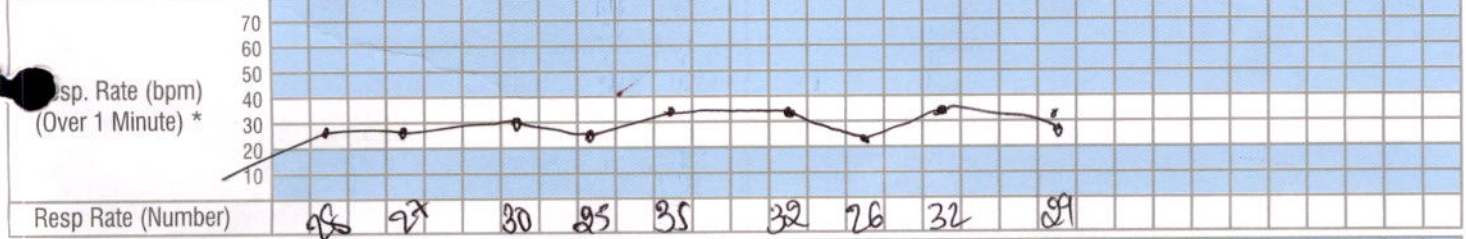
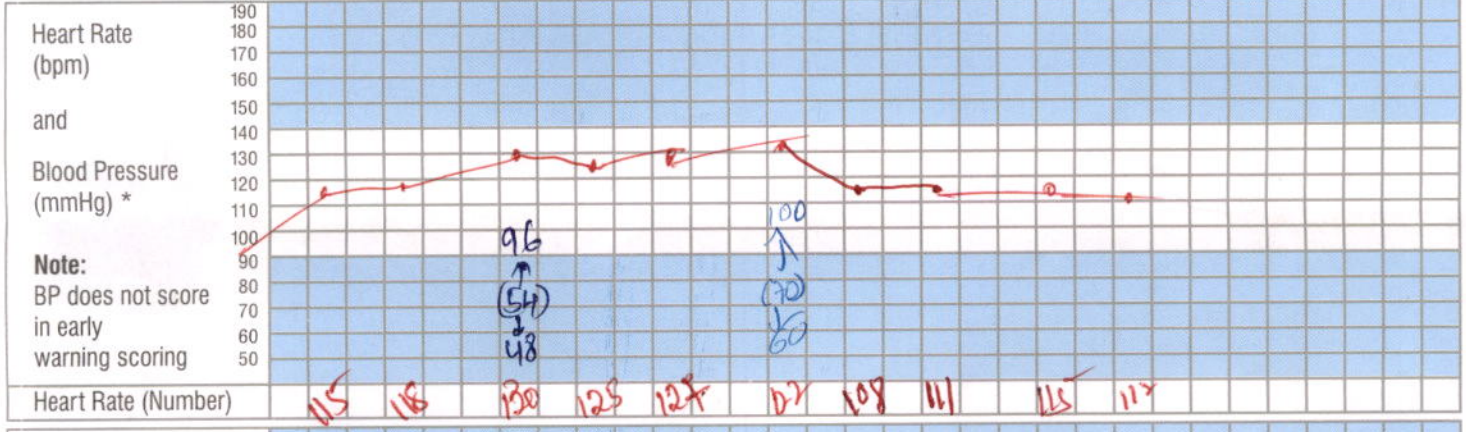
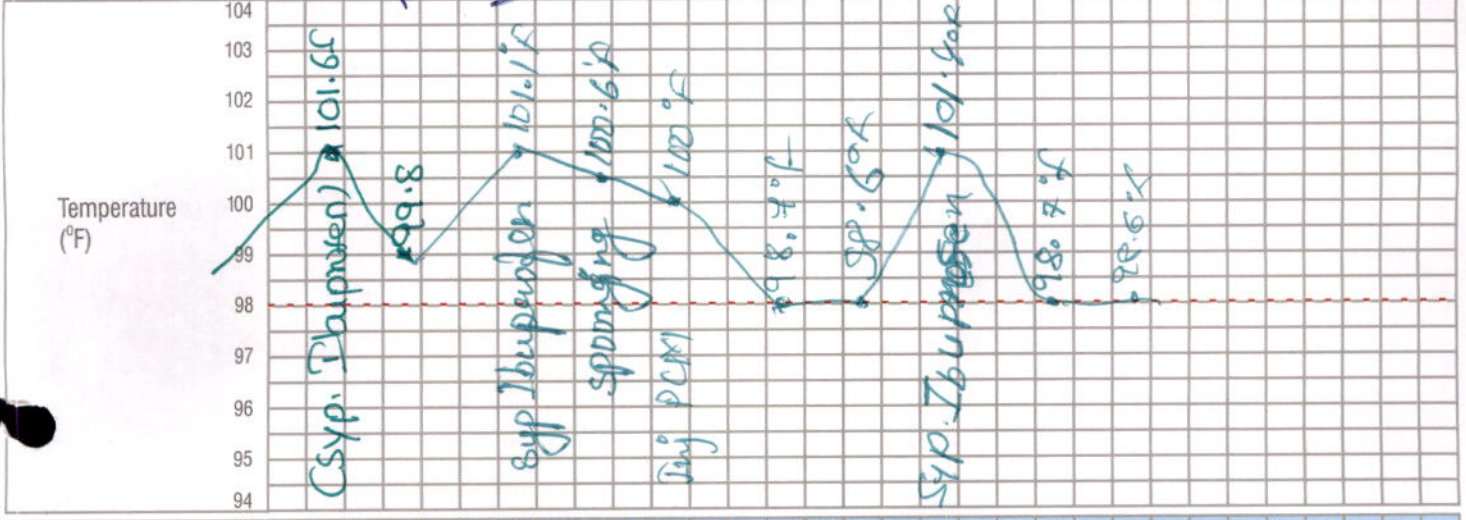
The SBAR communication tool (situation, background, assessment, recommendations) is a helpful mnemonic that can be used to describe a child's clinical condition to a colleague.

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 is there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 14/6/25 Time: 10:15

Doctor / Nurse / Family Concern? Dr. Pm Pm Pm Pm Pm Pm Am Am Am Am



Resp Distress	Mod/ Severe None / Mild										
Receiving O ₂ (l/min)	O ₂ Saturations (%)	<u>28</u>	<u>28</u>	<u>99</u>	<u>98</u>	<u>97</u>	<u>99</u>	<u>98</u>	<u>100</u>	<u>100</u>	<u>96</u>
Conscious Level	Normal / Altered	<u>2</u>	<u>2</u>	<u>N</u>	<u>N</u>	<u>N</u>	<u>N</u>	<u>N</u>	<u>N</u>	<u>N</u>	<u>N</u>
GCS *		<u>15</u>	<u>15</u>	<u>15</u>	<u>15</u>	<u>15</u>	<u>15</u>	<u>15</u>	<u>15</u>	<u>15</u>	<u>15</u>

TOTAL SCORE											
Number of shaded boxes	<u>1</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>
Pain Score	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>
Observer's Initials	<u>Dr</u>	<u>Dr</u>	<u>B</u>	<u>B</u>	<u>B</u>	<u>B</u>	<u>MD</u>	<u>P</u>	<u>P</u>	<u>P</u>	<u>M</u>

ACTIONS

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NB: Scores 3 should be recorded overleaf

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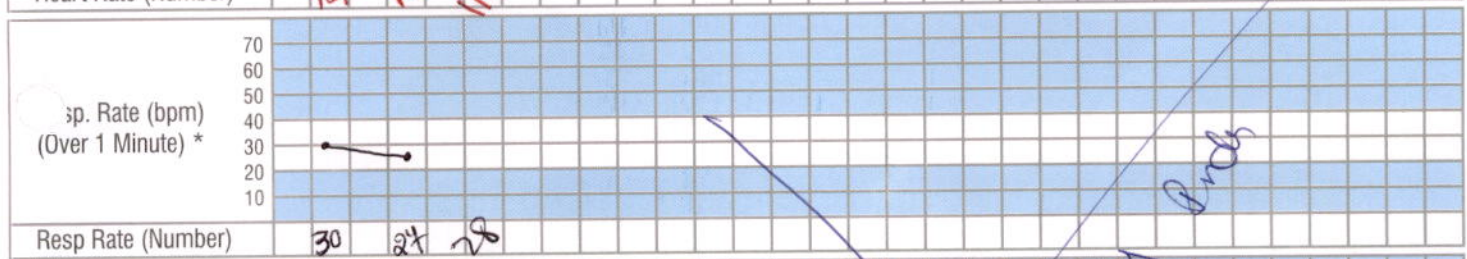
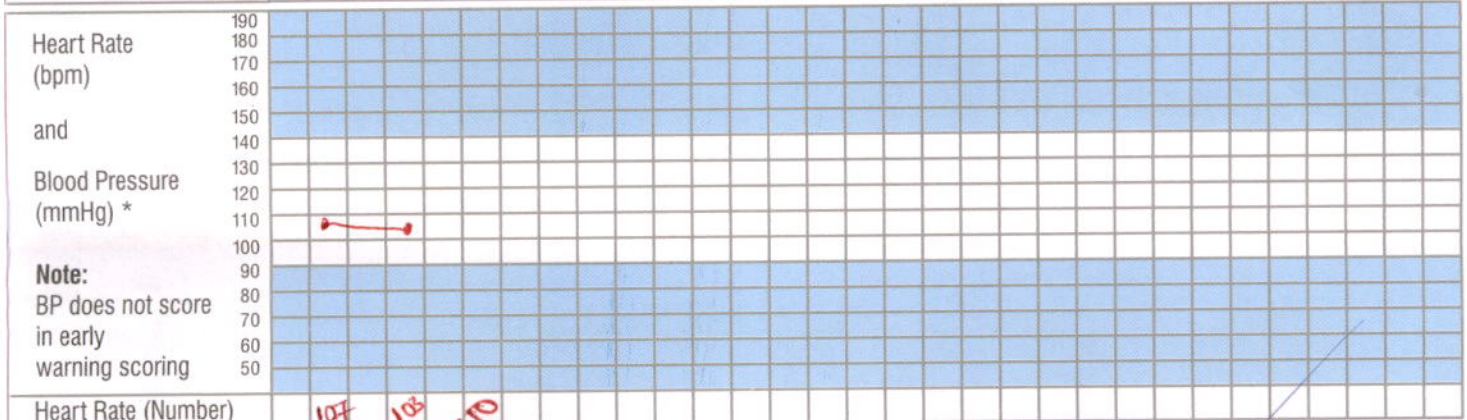
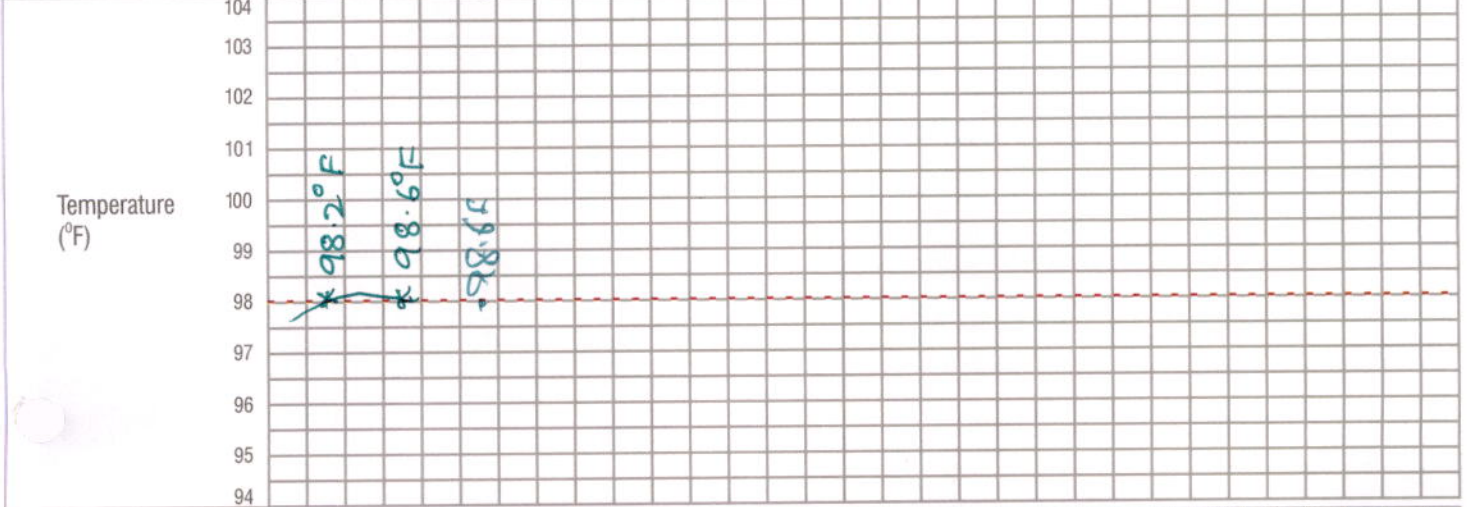
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R	RECOMMENDATION: I need you to ... come to see the child in the next (XX mins) AND is there anything I need to do in the meantime? (e.g. stop the fluid/ repeat observation)

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 12/6/26 Time: 9 11 1

Doctor / Nurse / Family Concern? AM AM PM



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

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

ACTIONS
 NB: Scores 3 should be recorded overleaf

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noted by PM
 209 bpm
 13/6/26

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

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FLUID CHART

Sheet No. : 0

11/06/26

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis 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			20ml									
Total Intake :			20ml			Total Output :							
11/6/26	02:00 pm	DBF	20ml							✓	1	Manasa 11/06/26 @ 8pm	
	03:00 pm		20ml								1		
	04:00 pm	DBF	20ml								0		
	05:00 pm		20ml								1		
	06:00 pm	Self									1		
	07:00 pm										1		
Total Intake :			80ml			Total Output :							
12/6	08:00 pm											Subhe 11/6	
	09:00 pm	DBF											
	10:00 pm												
	11:00 pm	DBF											
	12:00 am		20ml							✓			
	01:00 am	DBF	20ml										
Total Intake :			40ml			Total Output :							
12/6	02:00 am		20ml									Subhe 12/6 @ 7AM	
	03:00 am	DBF	20ml										
	04:00 am		20ml										
	05:00 am	DBF								✓			
	06:00 am												
	07:00 am												
Total Intake :			60ml			Total Output :							

Total 24 hrs. Intake	200ml
-----------------------------	-------

Total 24 hrs. Output	4 times
-----------------------------	---------

FLUID CHART

Sheet No. : (2)

12/6/26

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
12/6	08:00 am									✓	12/6/26 @ 2pm	2nd
	09:00 am	DBM										
	10:00 am	x										
	11:00 am		20ml									
	12:00 pm	DBM	20ml						✓			
	01:00 pm		20ml									

Total Intake : 60ml

Total Output :

12/6	02:00 pm										12/6 @ 7pm	Bevynke
	03:00 pm	DBM	20ml						✓			
	04:00 pm	DBM	20ml									
	05:00 pm											
	06:00 pm											
	07:00 pm	DBM							✓			

Total Intake : 60ml

Total Output :

12/6	08:00 pm										12/6/26 at 1Am	P
	09:00 pm	DBM										
	10:00 pm								✓			
	11:00 pm	DBM										
	12:00 am								✓			
	01:00 am	DBM										

Total Intake :

Total Output :

12/6/26	02:00 am										12/6/26 at 1Am	P
	03:00 am	DBM							✓			
	04:00 am											
	05:00 am	DBM										
	06:00 am								✓			
	07:00 am	DBM										

Total Intake :

Total Output :

Total 24 hrs. Intake 120ml

Total 24 hrs. Output 8 times

VIH-00191214 IP-00060312
 Master DAVID JACOB FERNANDEZ (M)
 14-04-2025 1 Y 1 M 29 D
 Dr. SURENDER RAO DUSA

FLUID CHART

Sheet No. :

13/6/26

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

		Intake				Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G							
13/6/26	08:00 am		DBM						✓		1 0 1	} Manisha } Anu } 13/6/26
	09:00 am											
	10:00 am		DBM									
	11:00 am											
	12:00 pm								✓			
	01:00 pm		DB									
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							

Note SS
 02pm
 13/6

REGULAR PRESCRIPTIONS

Weight. 7.8kg Ward. 110



Dr. Jetha

DRUG : <u>PNJ. CEFTRIAKONE</u>				Date Time	<u>11/6</u>	<u>12/6</u>	<u>13/6</u>
Dose	Route	Frequency	Start Date				
<u>350mg</u>	<u>IV</u>	<u>12th hourly</u>	<u>11/6</u>	<u>6 am</u>	<u>6 pm</u>	<u>6 pm</u>	
Name & Signature of the Doctor Starting the Drugs:							
<u>Dr. Vichwaja</u>							
Additional Instructions: <u>after test done</u>				<u>2pm</u> <u>6 pm</u>			
<u>50mg/kg/dose</u>							
Daily Doctor's Endorsement by a Sign							

Dr. Jetha

DRUG : <u>SUP. CLOBAZAM</u>				Date Time	<u>11/6</u>	<u>12/6</u>	<u>13/6</u>
Dose	Route	Frequency	Start Date				
<u>8</u>	<u>PO</u>	<u>12th hourly</u>	<u>11/6</u>	<u>8 AM</u>	<u>8 AM</u>	<u>8 AM</u>	
Name & Signature of the Doctor Starting the Drugs:							
<u>Dr. Vichwaja</u>							
Additional Instructions: <u>x 2 days.</u>							
<u>1ml = 2.5mg</u>							
<u>0.5ml : 8AM , 1ml - 8pm</u>							
Daily Doctor's Endorsement by a Sign							

shop
13/6/20
10:00 AM

Dr. Jetha
Chik 12/6/20

DRUG : <u>HABOLITAN NALAL</u>				Date Time	<u>12/6</u>	<u>13/6</u>
Dose	Route	Frequency	Start Date			
<u>2 Drops</u>	<u>PLN</u>	<u>8 hourly</u>	<u>12/6</u>	<u>6 am</u>	<u>6 pm</u>	
Name & Signature of the Doctor Starting the Drugs:						
<u>Dr. prakash.</u>						
Additional Instructions:				<u>10 AM</u>		
<u>2 Drops IN each</u>						
<u>NaChl.</u>						
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						

