
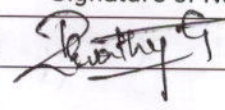


**ACTIVITY RECORD FOR BILLING**

VIH-00119067 IP-00060307  
Master SHOURYA  
14-02-2019 7 Y 3 M 27 D (M)  
Dr. PREETHAM KUMAR

Name: -----  
UHID No : ----- II    
Date of Admission : 10/6/26 Time : @ Date of Discharge : ----- Time: -----  
Room / Bed No : 102 Ward : 1st floor Suggested Billable bed type : -----  
Attendant : ----- Dept : LR

**WARD TRANSFERS**

Date	Time	From	To	Signature of Nurse
10/6/26	@ 11:35pm	LR	102	

**Cross Consultation Visit**

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







DISCHARGE SUMMARY



<b>Name</b>	Master SHOURYA CHAKRAVARTHULA	<b>UHID</b>	VIH-00119067
<b>Father/Guardian</b>	Mr CH. SANTHOSH SRIKARAN	<b>Age/Gender</b>	7 Y 3 M 29 D/Male
<b>Address</b>	PLOT NO:43, H.NO:4-1-225/1, RAJIVNAGAR COLONY, NACHARAM, HYDERABAD, Nacharam, Hyderabad, Telangana, INDIA, 500076		
<b>IP No</b>	IP-00060307	<b>Admission Date</b>	10-06-2026
<b>Ref Doctor</b>	Self	<b>Discharge Date</b>	12-06-2026

### DISCHARGE SUMMARY

**Consultant: Dr. PREETHAM KUMAR**

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

**Diagnosis: Acute febrile illness**

**History:** Master SHOURYA CHAKRAVARTHULA is a 7 Y 3 M 29 D boy presented with history of moderate grade intermittent fever, cold since 3 days, multiple episodes of non-bilious non-projectile vomitings, decreased oral intake, decreased urine output since 2 days, dull activity, redness both eyes prior to admission. For the above complaints, he was treated at referral center, but in view of persistence of symptoms, he was referred to Rainbow Children's Hospital for further management.

**Examination:** He was febrile (104.3°F), maintaining saturations at room air. Heart rate- 120/min, blood pressure - 110/60 mmHg and respiratory rate 22/min. Throat was congested. 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. Neurologically, he was conscious and oriented. Examination of other systems including spine was normal.

Weight on admission : 18.5 kgs.

**Investigations:** Enclosed.

Name

Master SHOURYA  
CHAKRAVARTHULA

UHID

VIH-00119067

**Management:** He was admitted in the ward and started on intravenous fluids and intravenous antibiotics. He was treated symptomatically with antipyretics and antihistamines.

His venous blood showed pH 7.43, pCO<sub>2</sub> 29.8 mmHg, pO<sub>2</sub> 45 mmHg, HCO<sub>3</sub> 20.8 mmol/L, BE -4.7 mmol/L. Complete blood picture showed hemoglobin 12.3 gm%, white blood cells count of 10,950 cells/cumm, platelet count of 2.66 lakhs/cumm and C-reactive protein was 20 mg/l. Serum electrolytes and creatinine were normal. Blood culture was sterile after 24 hours of incubation. X-ray nasopharynx showed Grade-3 adenoids.

His vitals were regularly monitored. His fever spikes and other symptoms gradually settled. Repeat hemogram done on 12.06.2026 showed hemoglobin 11.6 gm%, white blood cells count of 6,580 cells/cumm, platelet count of 2.42 lakhs/cumm and C-reactive protein was 15mg/l. He remained hemodynamically stable during the hospital stay and 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 Cefixime (5ml=100mg), 4.5ml, 12<sup>th</sup> hourly (after food) for 3 days (Refrigerate after reconstitution).
3. Syrup Relent Plus 5ml, 12<sup>th</sup> hourly for 3 days.
4. Refresh eye drops, 2 drops in each eye, 8<sup>th</sup> hourly for 2 days.
5. Nasivion-P nasal drops, 2 drops in each nostril, 8<sup>th</sup> hourly for 3 days.
6. Metaspray nasal spray, 2 puffs in each nostril once daily (7pm) for 2 weeks.
7. Syrup Bevon 5ml once daily for 1 month.
8. Kindly consult Dr. Preetham Kumar, Senior Consultant Pediatrics, after 3 days in OPD with prior appointment (This consultation will be charged).

Name

Master SHOURYA  
CHAKRAVARTHULA

UHID

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

  
**BirthRight™**  
BY RAINBOW HOSPITALS  
Your Right to a Safe Delivery

**In case of Fever:**

Syrup Paracetamol (5ml=240mg), 6ml (if needed) if fever more than 99.6°F (maximum 4-6 hourly).

Syrup Ibuprofen (5ml=100mg), 9ml (if needed) (after food) for fever more than 101°F (maximum 8 hourly).

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

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

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

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

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 doctor .....in the language that I understand and I have understood the same.

Name

Master SHOURYA  
CHAKRAVARTHULA

UHID

VIH-00119067

Name : *Sarathy Srikaran Chakravarthula*

Signature : 

Relationship with patient : *Father*

This summary has been explained by :

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

*for R*

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

**Dr. PREETHAM KUMAR**

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

**Rainbow Children's Hospital - Secunderabad**

H.No.3-7-222/223,Sy.No.51 to 54,Opp.Karkhana P S,Karkhana Main Road,Kakaguda, Karkhana ,Hyderabad ,Telangana, INDIA ,500009.  
040-42462200, Ext 2000,2001,2002.



**INSURANCE COPY**



**PatientName** : Master SHOURYA CHAKRAVARTHULA  
**Age/Gender** : 7 Y 3 M 28 D/ Male  
**Ward/Bed** : N 0 GF-EMERGENCY/ ER 101

**Inpatient No.** : IP-00060307  
**Admit Date** : 10-06-2026  
**Discharge Date** :

Investigation	Result	Unit	Biological Reference Interval
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**COMPLETE BLOOD PICTURE (Specimen : BLOOD)**

TEST RESULT STATUS : REPORT AUTHORISED

Order Date :10-06-2026 22:45

HEMOGLOBIN (Colorimetry)	12.3	g/dL	11.5 - 15.5
RBC COUNT (DC detection method)	5.00	10 <sup>12</sup> /L	4 - 5.2
PCV/HCT (Calculated)	33.1	VOL%	L 35 - 45
MCV (Calculated)	66.2	fL	L 77 - 95
MCH (Calculated)	24.6	pg/cells	L 25 - 33
MCHC (Calculated)	37.2	g/dL	H 32 - 36
RDW-CV (Calculated)	13.6	%	11.5 - 15
PLATELET COUNT (DC Detection Method)	266	10 <sup>9</sup> /L	150 - 450
MPV (Calculated)	7.6	fL	6.5 - 10
WBC COUNT (DC Detection Method)	10.95	10 <sup>9</sup> /L	5 - 14.5

**Differential Count**

NEUTROPHILS (Microscopy, Leishman stain)	83	%	H 32 - 54
LYMPHOCYTES (Microscopy, Leishman stain)	12	%	L 28 - 48
MONOCYTES (Microscopy, Leishman stain)	04	%	4 - 10
EOSINOPHILS (Microscopy, Leishman stain)	01	%	1 - 6

PERIPHERAL SMEAR (Microscopy, Leishman stain) **RBC - NORMOCYTIC / NORMOCHROMIC  
WBC - TC NORMAL WITH RELATIVE NEUTROPHILIC  
PLATELETS - ADEQUATE**

Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
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**C REACTIVE PROTEIN (Specimen : SERUM)**

TEST RESULT STATUS : REPORT AUTHORISED

Order Date :10-06-2026 22:45

CRP (Immunoturbidimetry)	20	mg/L	H <10
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Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
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**CREATININE (Specimen : SERUM)**

TEST RESULT STATUS : REPORT AUTHORISED

Order Date :10-06-2026 22:45

**Rainbow Children's Hospital - Secunderabad**

H.No.3-7-222/223,Sy.No.51 to 54,Opp.Karkhana P S,Karkhana Main Road,Kakaguda, Karkhana ,Hyderabad ,Telangana, INDIA ,500009.  
040-42462200, Ext 2000,2001,2002,

<b>PatientName</b> : Master SHOURYA CHAKRAVARTHULA	<b>Inpatient No.</b> : IP-00060307
<b>Age/Gender</b> : 7 Y 3 M 27 D/ Male	<b>Admit Date</b> : 10-06-2026
<b>Ward/Bed</b> : N 0 GF-EMERGENCY/ ER 101	<b>Discharge Date</b> :

Investigation	Result	Unit	Biological Reference Interval
CREATININE (Enzymatic)	0.7	mg/dl	H 0.2 - 0.6



Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
<b>ELECTROLYTES (Specimen : SERUM)</b>			TEST RESULT STATUS : REPORT AUTHORISED Order Date :10-06-2026 22:45
SODIUM (Direct ISE)	130	mmol/L	L 134 - 143
POTASSIUM (Direct ISE)	4.0	mmol/L	3.7 - 5
CHLORIDE (Direct ISE)	96	mmol/L	L 98 - 108



Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
<b>COVID ANTIGEN RAPID TEST (Specimen : SWAB)</b>			TEST RESULT STATUS : REPORT ENTERED Order Date :10-06-2026 22:46
COVID ANTIGEN RAPID TEST	negative		

Investigation	Result	Unit	Biological Reference Interval
<b>RANDOM BLOOD GLUCOSE(POCT) (Specimen : PLASMA)</b>			TEST RESULT STATUS : REPORT ENTERED Order Date :10-06-2026 22:46
RANDOM BLOOD GLUCOSE (GOD/POD)	104	mg/dl	70 - 140

Investigation	Result	Unit	Biological Reference Interval
<b>COMPLETE URINE EXAMINATION (Specimen : URINE)</b>			TEST RESULT STATUS : REPORT AUTHORISED Order Date :11-06-2026 08:18
<b>PHYSICAL</b>			
COLOUR (Visual Examination)	PALE YELLOW		
APPEARANCE (Gross Examination)	CLEAR		
pH (Double pH indicator)	6.0		5 - 8.5
SPECIFIC GRAVITY (PKA Reaction)	1.005		1.005 - 1.030
SEDIMENT (Gross Examination)	NIL		NIL
<b>CHEMICAL</b>			
PROTEIN (Protein error of pH indicator)	NIL		NIL
GLUCOSE (GOD POD method)	NIL		NIL
KETONE BODIES (Acetoacetic acid reaction)	NEGATIVE		NEGATIVE

**Rainbow Children's Hospital - Secunderabad**

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040-42462200, Ext 2000,2001,2002,



**PatientName** : Master SHOURYA CHAKRAVARTHULA  
**Age/Gender** : 7 Y 3 M 28 D/ Male  
**Ward/Bed** : N 0 GF-EMERGENCY/ ER 101

**Inpatient No.** : IP-00060307  
**Admit Date** : 10-06-2026  
**Discharge Date** :

Investigation	Result	Unit	Biological Reference Interval
BILE SALTS (Hay's Sulfur Test)	ABSENT		ABSENT
BILE PIGMENTS (Diazo reaction)	ABSENT		ABSENT
NITRITE (Reflectance Photometry)	NEGATIVE		NEGATIVE
BLOOD (Peroxidase reaction)	ABSENT		ABSENT
LEUCOCYTES (Esterase reaction)	NEGATIVE		NEGATIVE
<b>MICROSCOPY</b>			
PUS CELLS	4 - 6	HPF	L 0 - 5
EPITHELIAL CELLS	2 - 4	HPF	L 0 - 5
RBCS.	NIL	HPF	0 - 2

**Dr. SRUJANA SHYAMALA, MD, DNB**

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
<b>COMPLETE BLOOD PICTURE (Specimen : BLOOD)</b>			<b>TEST RESULT STATUS : REPORT AUTHORISED</b>
			Order Date :12-06-2026 05:50
HEMOGLOBIN (Colorimetry)	11.6	g/dL	11.5 - 15.5
RBC COUNT (DC detection method)	4.75	10 <sup>12</sup> /L	4 - 5.2
PCV/HCT (Calculated)	31.5	VOL%	L 35 - 45
MCV (Calculated)	66.3	fL	L 77 - 95
MCH (Calculated)	24.3	pg/cells	L 25 - 33
MCHC (Calculated)	36.7	g/dL	H 32 - 36
RDW-CV (Calculated)	13.5	%	11.5 - 15
PLATELET COUNT (DC Detection Method)	242	10 <sup>9</sup> /L	150 - 450
MPV (Calculated)	7.4	fL	6.5 - 10
WBC COUNT (DC Detection Method)	6.58	10 <sup>9</sup> /L	5 - 14.5
<b>Differential Count</b>			
NEUTROPHILS (Microscopy, Leishman stain)	27	%	L 32 - 54
LYMPHOCYTES (Microscopy, Leishman stain)	61	%	H 28 - 48
MONOCYTES (Microscopy, Leishman stain)	10	%	4 - 10
EOSINOPHILS (Microscopy, Leishman stain)	02	%	1 - 6
PERIPHERAL SMEAR (Microscopy, Leishman stain)	<b>RBC : NORMOCYTIC / HYPOCHROMIC MICROCYTES(+)</b> <b>WBC : MORPHOLOGY NORMAL</b> <b>PLATELETS : ADEQUATE</b>		

**Rainbow Children's Hospital - Secunderabad**

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040-42462200, Ext 2000,2001,2002,

<b>PatientName</b>	: Master SHOURYA CHAKRAVARTHULA	<b>Inpatient No.</b>	: IP-00060307
<b>Age/Gender</b>	: 7 Y 3 M 29 D/ Male	<b>Admit Date</b>	: 10-06-2026
<b>Ward/Bed</b>	: N 0 GF-EMERGENCY/ ER 101	<b>Discharge Date</b>	:

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

Investigation	Result	Unit	Biological Reference Interval
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**C REACTIVE PROTEIN (Specimen : SERUM)**

TEST RESULT STATUS : REPORT AUTHORISED  
Order Date :12-06-2026 05:50

CRP (Immunoturbidimetry)	15	mg/L	H <10
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Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Laboratory Report



Master SHOURYA CHAKRAVARTHULA

7 Y 3 M 29 D

Male

IP-00060307

VIH-00119067

Dr. PREETHAM KUMAR

VI26019939

10-06-2026 10:58 PM

10-06-2026 11:03 PM

N 0 GF-EMERGENCY / ER 101

**BLOOD CULTURE AND SENSITIVITY ( Specimen :BLOOD )**

**RESULT**

TEST RESULT STATUS : REPORT ENTERED

Culture: -

Initial Report: No growth after 24 hrs of incubation

..... End of the Report .....

# DEFICIENCY CHECK LIST OF MEDICAL CASE SHEET

VIH-00119067  
 IP-00060307  
 Master SHOURYA  
 14-02-2019 7 Y 3 M 29 D (M)  
 Dr. PREETHAM KUMAR



Patient Name :

IP.No:

Ward:

DOA: 10/6/26 time - 10:27 Pm



Sl.No	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission Sheet	01	—	—	
2	Discharge Summary	02	—	—	
3	Nursing Initial assessment form	03	—	—	
4	Patient Transfer Forms	01	—	—	
5	In-patient Medical Record	03	—	—	
6	Doctors Progress Sheets	02	—	—	
7	Nurses Progress notes	02	—	—	
8	Consultation Sheets				
9	General Consent for Treatment	01	—		
10	Consent for Surgery				
	Consent for Blood Transfusion				
12	Consent for Chemotherapy				
13	Consent for High Risk				
14	Consent for Restraint				
15	DAMA Consent				
16	Consent for Special Procedure				
17	Consent for Radiological Investigations				
18	Consent for HIV Test				
19	Anaesthesia consent form				
20	Anaesthesia notes (Pre Anaesthesia & Post)				
21	Pre Operative checklist				
22	Surgical safety Checklist				
23	Operation Theatre notes				
24	Nurses Clinical Presentation				
25	TPR & BP chart	02+	—	—	
26	Intake and Output chart (fluid Chart)	02	—	—	
	Drug Chart (Regular prescription)	04	—	—	
28	Daily Investigation sheet				
29	Investigation Values (Result Sheet)	01	—	—	
30	Nebulization Chart				
31	Diabetic chart				
32	Nutritional Review chart				
33	MLC form (in case of MLC)				
34	Patient Education Form				
	Humpty Dumpty	2	—	—	
	Other	10	—	—	
	X-ray	01	—	—	
		39			
	Total No. of Pages				

noted by Sadia  
 Signature and Date : 12/6 @ 10AM

# ERROR LOG

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

ICD CODE :-

OBSERVATION: -

DATE :

MRD EXECUTIVE

### ADMISSION SHEET

#### Registration Details :



Admission No : IP-00060307      Admit Date : 10-Jun-2026      Admit Time : 10:27 PM      UHID : VIH-00119067

#### Patient Details :

Patient Name : Master SHOURYA CHAKRAVARTHULA      Age : 7 Y 3 M 27 D  
Guardian : Mr CH. SANTHOSH SRIKARAN      DOB : 14-02-2019  
Gender : Male      Religion : Hindu  
Occupation :      Martial Status : Single  
Address (H) : PLOT NO;43, H.NO;4-1-225/1, RAJIVNAGAR      Phone No : 9849033170  
COLONY, NACHARAM, HYDERABAD      E-mail : santhoshsrikan@gmail.com  
Nacharam Hyderabad Telangana INDIA  
500076

#### 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 CH. SANTHOSH SRIKARAN      Relationship : S/O  
Contact Address : PLOT NO;43, H.NO;4-1-225/1, RAJIVNAGAR      Phone No : 9849033170  
COLONY, NACHARAM, HYDERABAD  
Nacharam Hyderabad Telangana INDIA 500076

  
Signature


#### Doctor Details :

Doctor Name : Dr. PREETHAM KUMAR      Specialisation : GENERAL PEDIATRICS  
Referral Doctor : Self      Phone No :  
Co-Consultant :

#### Payment Details :

Payment Mode : Cash      Deposit Amount : 0.00  
Payor Name : ICICI LOMBARD GENERAL  
INSURANCE CO LTD

# PATIENT TRANSFER FORM

Patient Name: <b>Maester SHOURYA</b> IP-00060307 14-02-2019 7 Y 3 M 27 D (M) Dr. PREETHAM KUMAR 		Date & Time of Admission <b>10/6/26 @ 10:21 pm</b>	Date & Time of Transfer Order <b>10/6/26 @ 11:35 pm</b>
		Transfer Ordered by <b>Dr. Prashanthi</b>	Reason for Transfer <b>Admission</b>
From Unit <b>ER</b>	To Unit <b>102</b>	Information to Attendant Yes <input type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File <b>21</b>	Number of Imaging Films <b>-</b>	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 <b>op regimen to attendant</b>			
Sl.No.	Item Name	Quantity <b>Indent</b>	
1.	<b>inj. Ceftriaxone - ①</b>		
2.	<b>Intrafix - ①</b>		
3.	<b>100ml NS - ①</b>		
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes <input type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring <b>Sr. Revathy</b>		Name of Person Ordered Transfer <b>Dr. Prashanthi</b>	
Patient & Clinical Records Received by: <b>Subhan</b>			
Date & Time of Patient Received : <b>10/6/26 @ 11:35 pm</b>			

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

- Unavailable Bed
  Nurse not Available
  Available Bed not ready

Patient Name : Mast. SHOURYA CHAKRAVARTHULA UHID : VIH-00119067 IPD : IP-00060307 Gender :

Male Age : 7 Y 3 M 28 D

VIH-00119067 IP-00060307  
Master SHOURYA  
14-02-2019 7 Y 3 M 28 D (M)  
Dr. PREETHAM KUMAR



wt - 18.50kg  
RBS - 10u mg/dl



wt :- 125cm

### EMERGENCY ROOM TRIAGE FORM

Patient's Name : Mst. Ch Shourya Age : 7y/3m Gender:  Male  Female

Date : 10/5/26 Time of Arrival : 2.10.15 PM

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

Source of Information:  Parents  Others (Specify):

Mode of Arrival:  Ambulatory  Wheelchair  Ambulance

Initial Vital Signs: Temp: 104.2 f PR: 120b/m BP: 109/57 RR: 22b/m SpO<sub>2</sub>: 98% (2 episodic)  
Chief Complaints: Fever and cough since 2 days vomiting since today 2 episodes

<b>INITIAL PHYSIOLOGICAL CATEGORIZATION</b> 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		<b>INITIAL PHYSIOLOGICAL STATUS</b> <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 checked="" type="checkbox"/> 30 min
<input type="checkbox"/> Level 4 : LESS URGENT : Significant illness but not life threatening	<input 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.

Surya  
Signature of Parent / Guardian

Triage Completion Time : 10.20 PM

\* CTAS - Canadian Triage and Acuity Scale

### 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 : Bro. Sanjay

Signature of Triage Nurse : Sanjay

Date & Time : 10/5/26 10.20 PM

Patient Name : Mast. SHOURYA CHAKRAVARTHULA UHID : VIH-00119067 IPD : IP-00060307 Gender : Male Age : 7 Y 3 M 27 D

VIH-00119067 IP-00060307  
Master SHOURYA  
14-02-2019 7 Y 3 M 28 D (M)  
Dr. PREETHAM KUMAR



### NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 16/6/26 Time of arrival : 10:21 PM  
Chief Complaints : Clo Fever and cough x 4 days, Vomiting 2 episodes  
Height : 125 cm Weight : 18.5 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 \_\_\_\_\_

<p><b>RISK FOR FALL:</b></p> <p><input type="checkbox"/> If patient is &lt; 6 years tick below fall risk intervention directly</p> <p><input checked="" type="checkbox"/> If Patient is &gt; 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><b>Ambulatory Aids:</b></p> <ul style="list-style-type: none"> <li>Wheelchair <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</li> <li>Uses furniture for support <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</li> </ul> <p><b>Gait/Transferring:</b></p> <ul style="list-style-type: none"> <li>Bedrest / immobile <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</li> <li>Weak <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</li> <li>Impaired <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</li> </ul> <p><b>Mental Status:</b> Forgets limitations <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p><b>IF YES FOR ANY CATEGORY = RISK FOR FALLING</b></p> <p><b>Fall Risk Intervention:</b></p> <ul style="list-style-type: none"> <li>Escort while ambulating <input type="checkbox"/></li> <li>Assist Patient <input type="checkbox"/></li> <li>Educate patient and family on fall precautions/prevention <input checked="" type="checkbox"/></li> </ul>	<p><b>Functional Screening:</b> <input checked="" type="checkbox"/> No Abnormalities Detected</p> <ul style="list-style-type: none"> <li>Mobility Problem <input type="checkbox"/></li> <li>Walking Problem <input type="checkbox"/></li> <li>Developmental Delay <input type="checkbox"/></li> <li>Musculoskeletal Congenital Abnormality <input type="checkbox"/></li> </ul> <p><b>Inform consultant for positive criteria</b></p> <p>_____</p> <p>_____</p> <p><b>Nutritional Screening:</b> <input checked="" type="checkbox"/> No Abnormalities Detected</p> <ul style="list-style-type: none"> <li>Underweight <input type="checkbox"/></li> <li>Overweight <input type="checkbox"/></li> <li>Feeding Problem <input type="checkbox"/></li> <li>Special diet <input type="checkbox"/></li> <li>Special feeding method <input type="checkbox"/></li> </ul> <p><b>Inform consultant for positive criteria</b></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 (Brother)  
Time of Initial assessment completed by ER Nurse : 10:25 PM

Patient Name : Mast. SHOURYA CHAKRAVARTHULA UHID : VIH-00119067 IPD : IP-00060307 Gender : Male Age : 7 Y 3 M 27 D

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

Time	Nursing Notes
10:15 pm	Pt came to ER.
10:17 pm	Pt vitals checked and records Done.
10:19 pm	Dr. Prabhanti seen the Pt Advice Admission
10:25 pm	Pt admission process Done.
	Pt IV placement done and sample sent to lab.
	Pt RBS (10mg/dL) Done, Covid RAT Negative.
	Blood samples collected and send to the Lab.
	* Patient shifted to the ward.

Samples collected by:

SR Lakshmi

Time:

Time:

11 pm

**Medication given in ER:**

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1
10/6/26 10:30 pm	Syr. Ibuprofen	PO	9 ml	Prabhanti	SR
11:10 pm	Inj ondansetron	IV	3.5 mg	Prabhanti	(10)

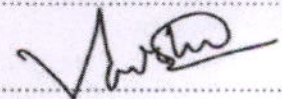
Condition of patient at time of shift - out :	Details of Shift - out
HR: 120b/m BP: 109/67 CFT: 12Sec	Shift - out from ER to: 102
RR: 20b/m SPO <sub>2</sub> : 98%	Time of Shift - out: 10/6/26 @ 11:35 pm
GCS: 15/15 Temperature: 101.1 F	Handover given to: SR Prishanka
Pain Score: 0	(Nurse's Name)
Repeat RBS (if applicable):	by SR vaishnavi

Tick as applicable:  MLC  LAMA  BROUGHT DEAD

Procedures done with details (if any): IV cannulization

Name of the Nurse : SR. Vaishnavi

Signature of the Nurse :



Date & Time : 10/6/26 @ 11:35 pm



## Nursing General Admission Assessment Form For Pediatrics

**Diagnosis:**  
 Arrival Time: 11:35pm Mode of Arrival: walking Admitting From:  ER  OPD  Direct

Allergy / Adverse Reaction ..... Body Weight: 18.50 Kg  
No allergy ..... Height: 104 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:** .....  
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: 18.50kg Length: 104cm Head Circumference (< 2 years): .....  
 Temp.: 96.8°F HR: 122b/m RR: 24b/m BP: 104/63(78)

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

Fall Risk Assessment:  Yes  No Score: 10 ..... (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 ..... 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:** ..... *NIL* ..... (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 ..... *mother* .....

Nurse's Name: ..... *Subhan* ..... Date: *10/6/26* ..... Time: *12:10 AM* .....  Signature



# Rainbow<sup>®</sup> Children's Hospital

It takes a lot to treat the little.

## PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: \_\_\_\_\_

UHID ID: \_\_\_\_\_

Department: \_\_\_\_\_

Consultant: \_\_\_\_\_

VIH-00119067 IP-00060307

Master SHOURYA

14-02-2019 7 Y 3 M 27 D (M)

Dr. PREETHAM KUMAR





### Pediatric Multiorgan History & Physical Examination

Name : \_\_\_\_\_ Age/Sex \_\_\_\_\_

Information given by: \_\_\_\_\_ Relationship \_\_\_\_\_

#### Chief Presenting Complaints & Duration (Chronologically)

↓  
c/o fever - 3 days  
c/o cold - 3 days  
c/o vomitngs - 2 days

#### History of present illness :

child was apparently asymptomatic 3 days back

then c/o fever - 3 days

Moderate grade fever

Continuous fever.

Not subsiding on medications.

Intermittent period - Afebrile.

c/o cold - 3 days

Sneezing (int)

Also going to swimming classes  
(int)

Nasal bleed (int)

c/o vomitngs - 2 days

10-12 episodes

Non-bloody non-bile stained.

Not passed stool - 2 days -

↓

Now subsided.

↓  
Oral Intake & urine output.

Pupils (int)

Redness both eyes (int).

↓

used Acyclovir

↓  
L idon



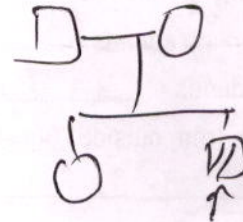
### Pediatric Multiorgan History & Physical Examination

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

k/do ADHD.

**Birth & Neonatal History:**

Term baby | Bwt = 3 kg | MMS  
CIPB | No NICU Admission



**Birth & Socio Economic History:**

About Father : \_\_\_\_\_  
About Mother : \_\_\_\_\_ } class III  
Any additional Information : \_\_\_\_\_

**Developmental History :**

Developmental achieved as per age in all domains.

**Immunization History :**

k/do ADHD  
Immunized as per age.



### Pediatric Multiorgan History & Physical Examination

#### Anthropometry :

Head Circum (cms) \_\_\_\_\_ (Centile \_\_\_\_\_) Height (cms): \_\_\_\_\_ (Centile) \_\_\_\_\_  
Weight (kgs) 18.5 kgs (Centile \_\_\_\_\_)

#### On Examination :

Temperature : 104.2 f Pulse Rate : 126/m B.P. 110/60 SPO2 95%  
Resp. rate and type of breathing : 28/m multig

Rash \_\_\_\_\_  
Lymphadenopathy ly throat lymph on (ent)  
Oedema : \_\_\_\_\_  
Allergies (if any): \_\_\_\_\_

#### Respiratory System :

Inspection (any s/o distress) : ⊖  
Air entry & breath sounds : B/LA ⊕  
Any addes sounds : ⊖  
Relevant data from outside (Chest X-Ray, ABG, etc.,) \_\_\_\_\_

#### Cardiovascular System :

Inspection of procordium : (M)  
Heart Sounds : h/h ⊕  
Any murmur : ⊖  
Relevant data from outside (Chest X-Ray, ECG, ECHO, etc.,) : \_\_\_\_\_

#### Per Abdomen :

Inspection \_\_\_\_\_  
Palpation : \_\_\_\_\_  
Ausculation : ly (M)  
Spine : \_\_\_\_\_ External Genitelia : (N)  
Relevant data from outside (CT, USG etc.,) \_\_\_\_\_



### Pediatric Multiorgan History & Physical Examination

#### Central Nervous System :

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

Cranial Nerves : (N)

#### Motor System:

Nutrition : \_\_\_\_\_

Tone : \_\_\_\_\_ Power (2) (2)

Co-ordinator : (S) 4/5 4/5

Posture : (D)

Involuntary Movements : \_\_\_\_\_

#### Reflexes :

#### DTR

Plantars Flexor.

#### Superficials:

#### Sensory System :

(N)

Bladder / Bowel : (N)

#### Clinical Summary & Diagnostic:

Alert evaluation.

### Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: \_\_\_\_\_  
\_\_\_\_\_

Desired goals of the treatment: \_\_\_\_\_  
\_\_\_\_\_

<b>Planned Labs:</b>	RBS-110mg/dL	<b>Planned Management</b>
CBP, CRP, c/e, s/e, ✓		- IVF
C. crecetine, ✓		
B/c/s, ✓		- Ij. upivione- 12 <sup>th</sup> day
NBG, ✓		- Syp. Relax plus - P/O
Extraplain, ✓		- Mawion-p Navel dupr.

~~Noted by Sr. Liza 4:00  
11pm 10/6/26~~

Signature of the Doctor: [Signature]  
Name of the Doctor: Dr. Prashant  
Date & Time: 10/6/26

Signature of the Consultant: [Signature]  
Name of the Consultant: Dr. Heena  
Date & Time: 11/6/26 9d



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/6/26 8:00 Am.	<p><u>CL/B Resident</u>            AHS: AFI + evaluation.</p>	
	<p>1 fever spike @ 6:30 Am (100.5 f)</p>	
O/I + (D)	<p>Snoring (ent)            Nasal Blockade + etc</p>	
4/6/26 Admit	<p><u>O/E</u></p>	
	<p>Chest Auscult <del>clear</del>            Vitals stable</p>	
<del>Dependent</del>	<p>CU: 112 (P)            M: 112 (P)            P/A: 10/6            CNI: 10/10</p>	<p><u>plan</u>            - Ty: Uptirone + DI            - Sy p. Relut plus - 10-12 times            - Mawion. p + Maw deok.</p>
<p>11/6/26            2 hours</p>		<p>- Trau Bld's.            X-ray lat neck of neck</p>
<p>Noted by            Benavice            11/6            @ 2pm</p>		<p>- CB p. exp - 11/6.</p>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11.6.26	S/B Regular	
4.00 PM	<u>Acute febrile illness</u>	
	no fever	
	o/e child better	
	CRT < 3sec.	
	apfels	
	W5-S, S(+)	Plan
	RS - BAET, close	→ CBP, CRP, Jm
	P/A - soft	→ Kitch 4-14 hely
		→ Cant Sug - leptuixer
	Samra (Dr. Sameer)	
		Noted by
		naarasa
		11/6/26
		2:30 PM



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
12/6/20	<u>C/S/B Resident</u>	
6:30 AM	A&I.	
	No fever spikes > 2hrs.	
	Coughing → Improved.	
	Cold (+) → Rainy season.	
0/I → Better.	<u>0/E</u>	
4/0 → Adequate.	child Active & Alert	
	Vital Stable	
	CN: S.I.C.H (+)	<u>Plan</u>
	M: P.L.A.E.C (+)	
<u>Dr. Prakash</u>	P/A: Soft	- Inj. cephalosporins - D2.
	CNS: NAD.	- sup. Resent Plus.
B/C/S → No growth after 2 hrs.		- Moxifloxacin Nasal drops
<u>Dr. Pradeep</u>		- Mucospray Nasal Spray.
	6/6/20	<u>Dr. Pradeep</u>
	12/6/20	- hyp. B.wt.
	1/0/20	<u>oral Ab</u>
	1/0/20	
Noted by Shourya 0/6		
@ 9 AM		



### NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: <u>AFI ↓ Evaluation.</u>		Any Infection: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify: <u>Nil</u>					
	Surgery / Procedure: <u>Nil</u>		Post OP Day: <u>Nil</u>					
BACKGROUND	Date	<u>10/6/26</u>	<u>10/6/26</u>	<u>11/6/26</u>	<u>11/6</u>	<u>11/6/26</u>	<u>12/6/26</u>	
	Shift	<u>N</u>	<u>N</u>	<u>M</u>	<u>E</u>	<u>Night</u>	<u>M</u>	
ASSESSMENT	Medical Condition (Any special condition to be noted):	<u>Nil</u>	<u>Nil</u>	<u>Nil</u>	<u>Nil</u>	<u>Nil</u>	<u>Nil</u>	
	Diet:	<u>Regular</u>	<u>S-diet</u>	<u>S-diet</u>	<u>S-diet</u>	<u>S-diet</u>	<u>Soft diet</u>	
ASSESSMENT	Allergy:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<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>	<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>99.3°F</u>	<u>98.6°F</u>	<u>97.6°F</u>	<u>98.1°F</u>	<u>97.6°F</u>	<u>98.6°F</u>
		Res:	<u>24 blm</u>	<u>28 blm</u>	<u>27 blm</u>	<u>26 blm</u>	<u>23 blm</u>	<u>24 blm</u>
	SpO <sub>2</sub> :	<u>98%</u>	<u>100%</u>	<u>99%</u>	<u>98%</u>	<u>100%</u>	<u>100%</u>	
	Pulse:	<u>112 blm</u>	<u>104 blm</u>	<u>105 blm</u>	<u>106 blm</u>	<u>82 blm</u>	<u>92 blm</u>	
	BP:	<u>101/72(72)</u>	<u>102/63(73)</u>	<u>100/60(70)</u>	<u>105/63(72)</u>	<u>95/77(84)</u>	<u>92/67(77)</u>	
	LOC:	<u>conscious</u>	<u>conscious</u>	<u>conscious</u>	<u>conscious</u>	<u>conscious</u>	<u>conscious</u>	
	Fall Risk Score:	<u>10</u>	<u>10</u>	<u>10</u>	<u>10</u>	<u>10</u>	<u>10</u>	
Pain Score:	<u>0</u>	<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>	<u>intact</u>		
Recommendations	Safety Needs:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	Physiotherapy:	<u>Nil</u>	<u>Nil</u>	<u>Nil</u>	<u>Nil</u>	<u>Nil</u>	<u>Nil</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>Regular</u>	<u>Regular</u>	<u>Regular</u>	<u>S-diet</u>	<u>S-diet</u>	<u>S-diet</u>	
	Critical Lab Test / Values:	<u>-</u>	<u>-</u>	<u>-</u>	<u>Nil</u>	<u>Nil</u>	<u>Nil</u>	
	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):	<u>Dependent</u>	<u>Dependent</u>	<u>Dependent</u>	<u>Dependent</u>	<u>dependent</u>	<u>Dependent</u>		
Post Operative Procedure Special Orders:		<u>-</u>	<u>-</u>	<u>-</u>	<u>Nil</u>	<u>Nil</u>	<u>Nil</u>	
Handed Over By Name :		<u>Vaishnavi</u>	<u>Subham</u>	<u>Beeponika</u>	<u>Manasa</u>	<u>Subham</u>	<u>Sudha</u>	
Signature / ID :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>10/6/26</u>	<u>11/6/26</u>	<u>11/6/26</u>	<u>11/6</u>	<u>11/6</u>	<u>12/6</u>	
Time:		<u>@ 11:35pm</u>	<u>@ 8AM</u>	<u>@ 2pm</u>	<u>@ 8pm</u>	<u>@ 8AM</u>	<u>10PM</u>	
Taken Over By Name :		<u>Subham</u>	<u>Beeponika</u>	<u>Manasa</u>	<u>Subham</u>	<u>Sudha</u>	<u>[Signature]</u>	
Signature / ID :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>10/6/26</u>	<u>11/6/26</u>	<u>11/6/26</u>	<u>11/6/26</u>	<u>11/6/26</u>	<u>11/6/26</u>	
Time:		<u>@ 11:35PM</u>	<u>@ 8am</u>	<u>@ 2pm</u>	<u>@ 8pm</u>	<u>@ 8am</u>	<u>[Time]</u>	



## NURSING SHIFT HAND OVER FORM

<b>SITUATION</b>	Diagnosis:	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify: .....				
	Surgery / Procedure:	Post OP Day:				
<b>BACKGROUND</b>	Date	Shift				
	Medical Condition (Any special condition to be noted):					
	Diet:					
<b>ASSESSMENT</b>	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
	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
	Vital Signs:	Temp:				
		Res:				
		SpO <sub>2</sub> :				
		Pulse:				
		BP:				
		LOC:				
		Fall Risk Score:				
	Pain Score:					
	Skin Integrity					
<b>Recommendations</b>	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
	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
	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
	PU Prophylaxis:	<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
DVT Prophylaxis:	<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:						

# NURSING CARE RECORD



Date: 10/6/26

**Goals**

- Maintain Personal Hygiene
- Identify Potential Complications
- Relieve Pain & Discomfort
- Prevent Infection
- Any Others. Specify *mic*
- 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	12AM	→ maintain fluid balance	12AM	→ Administered IV fluid DNS 55ml/hr	→ maintain hydration	→ Patient is stable	Sudha 11/6 @ 8AM



# NURSING CARE RECORD

Date: 11/6/26

**Goals**

- Maintain Airway and Oxygenation
- Maintain Personal Hygiene
- Identify Potential Complications
- Relieve Pain & Discomfort
- Prevent Infection
- Any Others. Specify NPL
- 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	2pm	maintain fluid Balance → Ensure safety	8:30 Am	Administered IV fluid → Side rails kept up	maintain Hydration → prevent from fall risk	Patient is stable	Benonika @ 2pm 11/6/26
Afternoon	4 PM	→ IV fluids on flow	4:30 PM	→ Dns smell/ke es maintained	→ To maintain hydration	→ patient is stable	(signature) nurse
Night	9pm	→ maintain good nutritional status	9pm	→ oral intake is good	→ maintain Hydration	→ patient is stable	Subho 12/6 @ 8pm



# NURSING CARE RECORD



Date: 12/06/20

**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				<u>DISCHARGE NOTE</u> - Doctor's work done; advised for discharge			
Afternoon							
Night							

Patient Sticker

# 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							

**GENERAL CONSENT FOR TREATMENT**

**Patient Name:** Master SHOURYA CHAKRAVARTHULA      **Age :** 7 Y 3 M 27 D  
**IP No:** IP-00060307      **Sex:** Male  
**Consultant:** Dr. PREETHAM KUMAR      **Ward/Bed No:** N 0 GF-EMERGENCY/ER 101

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

Patient, be deemed advisable or necessary.

I understand that the confidentiality of all medical records shall be protected to the full extent of the Law. The undersigned 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: Mr. Sathish Babu

Relationship: Father

Date: 10/6/26

Witness Name: Mukesh

Witness Signature: [Signature]

Time: 10:27 pm

Patient Address:

PLOT NO;43, H.NO;4-1-225/1,  
 RAJIVNAGAR COLONY, NACHARAM,  
 HYDERABAD Nacharam Hyderabad  
 Telangana INDIA 500076



### THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
			10/6/20	11/6/20	11/6	11/6	12/6
Age	Less than 3 years old	4					
	3 to less than 7 years old	3					
	7 to less than 13 years old	2	2	2	2	2	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					
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		1			
	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
<b>Total</b>			10	10	10	10	10

**Intervention:**

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		✓	✓	✓	✓	✓
Call device within reach		✗	✗	✓	✓	✗
Wheels Locked		✓	✓	✓	✓	✓
Room free of clutter		✓	✓	✓	✓	✓
Adequate lighting		✓	✓	✓	✓	✓
Wheel chair support		✓	✓	✓	✓	✓
Other Intervention(s) Specify		✓	✓	✓	✓	✓
Nurse's Name:		P. R. D.	P. R. D.	P. R. D.	P. R. D.	P. R. D.
Signature:		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date:		10/6/20	11/6/20	11/6	11/6	12/6
Time:		10:30 PM	12:00 PM	2 PM	4 PM	12 AM



### THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	12/6				
	3 to less than 7 years old	3					
	7 to less than 13 years old	2	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					
	Forget Limitations	2					
	Oriented to own ability	1	1				
	History of Falls or Infant-Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2				
	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				
<b>Total</b>			10				

**Intervention:**

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position	✓				
Call device within reach	✓				
Wheels Locked	✓				
Room free of clutter	✓				
Adequate lighting	✓				
Wheel chair support	✓				
Other Intervention(s) Specify	✓				
Nurse's Name:	Arde				
Signature:	<i>[Signature]</i>				
Date:	12/6				
Time:	9:10				



## PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
10/6/26	10:39pm	0	NI	<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	
11/6/26	12 Am	0	NI	<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	
11/6	2pm	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	
11/6	5pm	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	
11/6/26	11P	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	subm
12/6	5Am	0	-	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	nil	subm
12/6	10Am	0	-	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	nil	
				<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		
				<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:**

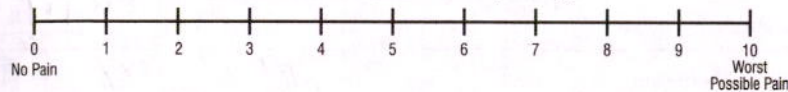
1. Every eight hours for all hospitalized patients.
2. For post-surgical patients, patients with chronic pain, patient with severe pain:
  - a) At least every 2 hours for the first 24 hours
  - b) Then every 4 hours.
  - c) Prior to pain relieving intervention.
  - d) Within 30 - 60 minutes after pain 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 brawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, right, or Jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams or 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
<b>Crying Irritability</b>	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
<b>Behavior State</b>	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)
<b>Facial Expression</b>	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
<b>Extremities Tone</b>	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
<b>Vital Signs HR, RR, BP, SaO<sub>2</sub></b>	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 <sub>2</sub> 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO <sub>2</sub> less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

## Wong - Baker (Pediatrics) Above 7 Years





## CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			11/6 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	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 : S. Kiran Name : S. Kiran

Signature of Ward In Charge :

Signature : Elizabeth Name : Elizabeth

VIH-00119067

IP-00060307

Master SHOURYA

14-02-2019

7 Y 3 M 27 D

(M)

Dr. PREETHAM KUMAR



## BRADEN 'Q' SCALE

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

BirthRight  
BY RAINBOW HOSPITALS  
Your Right to a Safe Delivery

				Date :	11/20	11/6	11/6	
				Time :	10:39pm	2pm	2pm	
Mobility	<b>1. Completely immobile:</b> Does not make even slight changes in body or extremity position without assistance.	<b>2. Very limited:</b> Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	<b>3. Slightly limited:</b> Makes frequent through slight changes in body or extremity position independently.	<b>4. No limitations:</b> Makes major and frequent changes in position without assistance.	A	4	4	4
"Activity The degree of physical activity"	<b>1. Bedfast :</b> Confined to bed	<b>2. Chairfast :</b> Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	<b>3. Walks occasionally:</b> Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	<b>4. All patients too young to ambulate; OR walks frequently:</b> Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	A	4	4	4
Sensory Perception	<b>1. Completely limited:</b> 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.	<b>2. Very limited:</b> 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.	<b>3. Slightly limited:</b> 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.	<b>4. No impairment:</b> Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	A	4	4	4
Moisture Degree to which skin is exposed to moisture	<b>1. Constantly moist:</b> Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	<b>2. Very moist:</b> Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	<b>3. Occasionally moist:</b> Skin is occasionally moist, requiring linen change every 12 hours.	<b>4. Rarely moist:</b> Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	A	4	4	4
<b>FRICION-SHEAR</b> <b>Friction</b> Occurs when Skin moves against support surfaces <b>Shear</b> Occurs when skin and adjacent bony surface slide across one another	<b>1. Significant problem:</b> Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	<b>2. Problem:</b> 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.	<b>3. Potential problem:</b> 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.	<b>4. No apparent problem:</b> 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."	A	4	4	4
Nutritional Usual food intake pattern	<b>1. Very Poor:</b> 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.	<b>2. Inadequate:</b> 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.	<b>3. Adequate:</b> 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.	<b>4. Excellent:</b> 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.	A	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.	A	4	4	4
				<b>TOTAL SCORE</b>	28	29	27	27
				<b>Evaluator's Name</b>	Preetham	Preetham	Preetham	Preetham

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

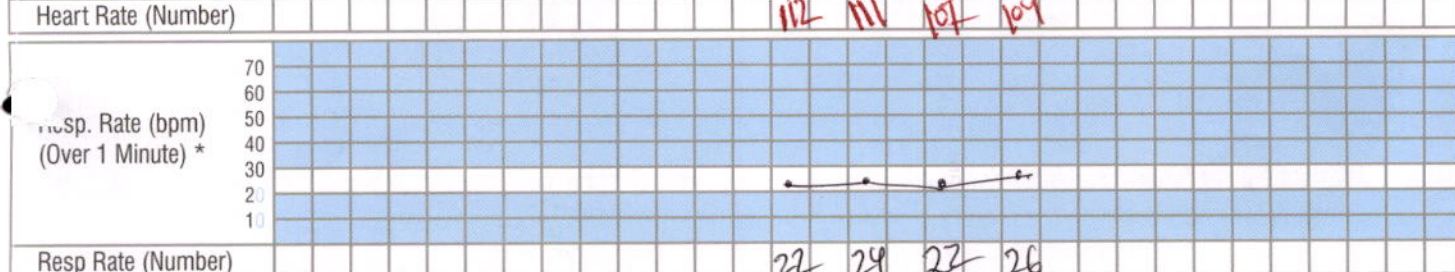
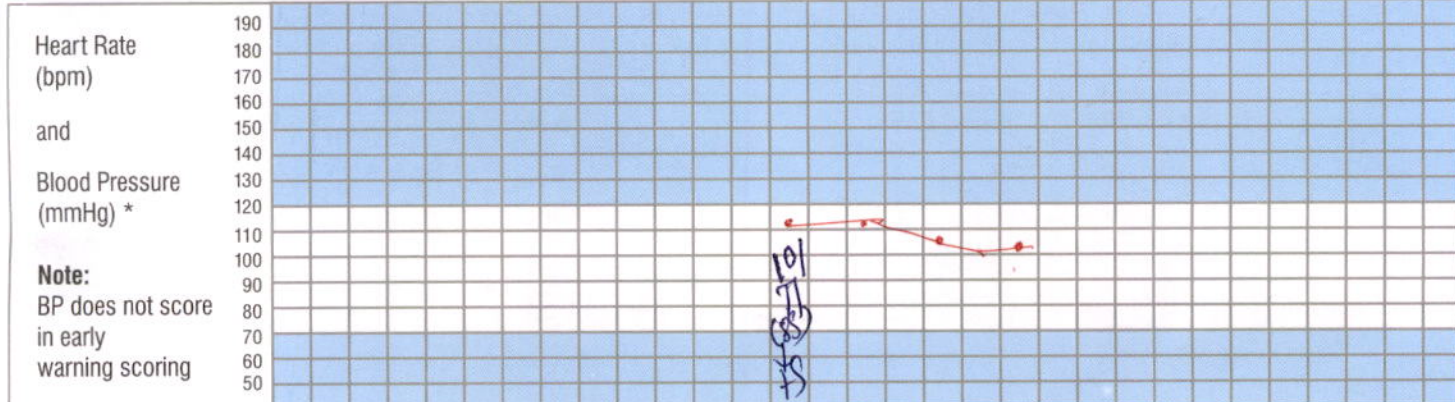
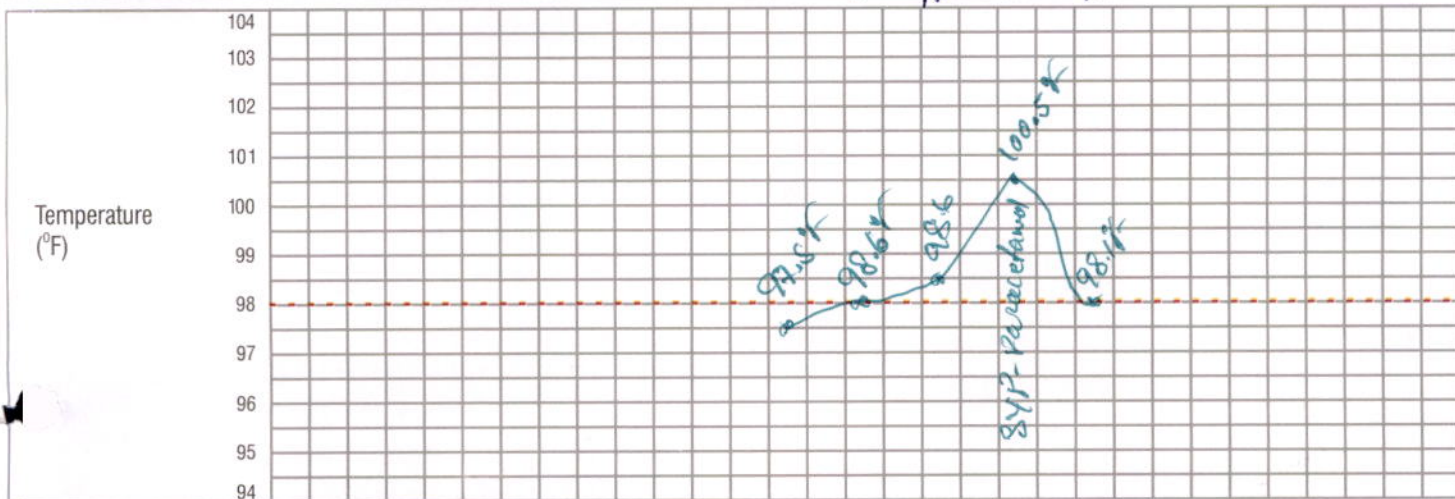
Docu. No. : RCH /FRM / CLINICAL / 119

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



**EARLY WARNING SCORE: CHILDREN'S UNIT**

Date : 10/6/26 Time: 12 2 4 6:35 8  
 Doctor / Nurse / Family Concern? Ar Ar An An Ar



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

<b>TOTAL SCORE</b>				
Number of shaded boxes	<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>
Observer's Initials	<u>P</u>	<u>P</u>	<u>P</u>	<u>P</u>

<b>ACTIONS</b> NB: Scores 3 should be recorded overleaf	Score 1	: Continue normal observation by staff nurse
	Score 2	: Shift in charge nurse to be informed and continue hourly observations
	Score 3	: Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.
	Score 4	: Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see
	Score 5 & 6	: Shift in charge AND PICU fellow or PICU consultant to be informed.

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

## CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

### INSTRUCTIONS:

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

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

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

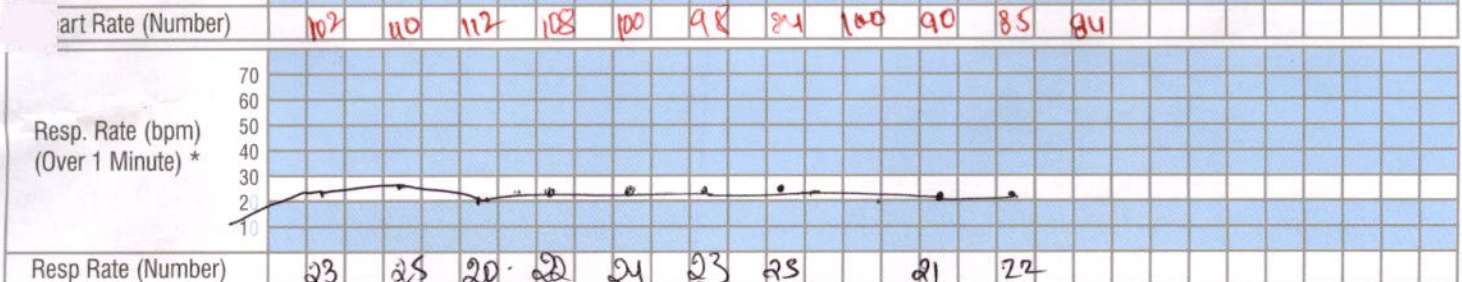
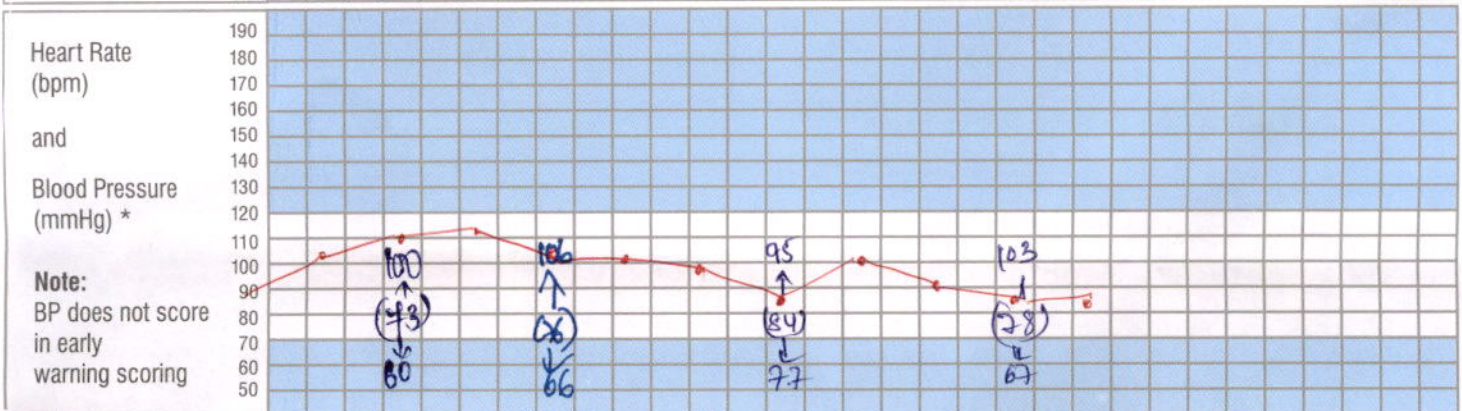
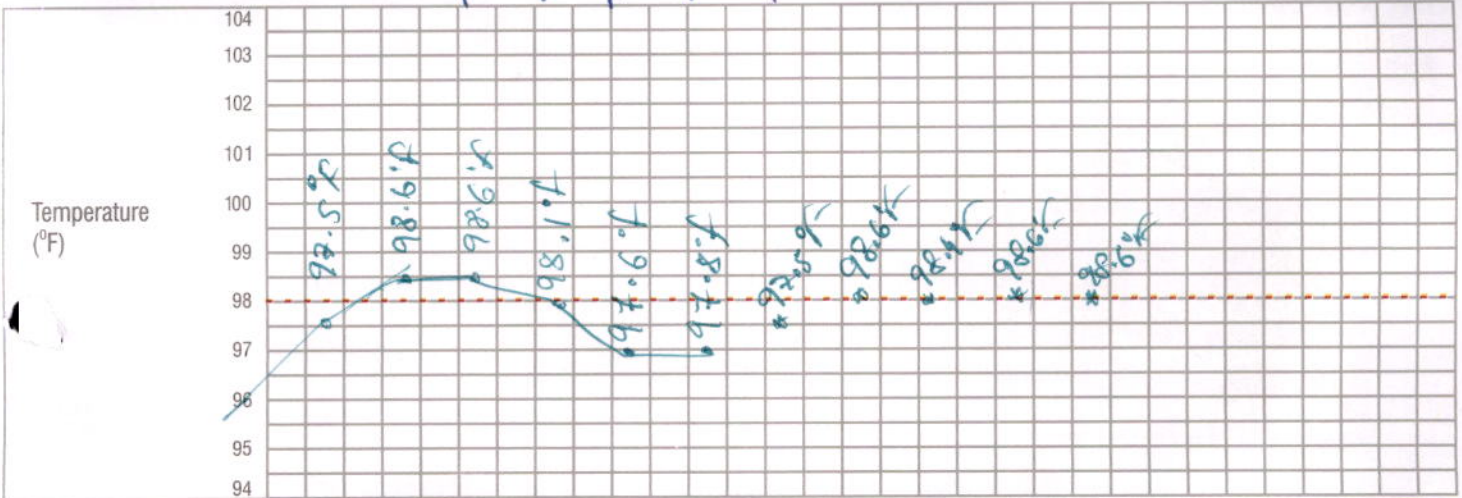
The SBAR communication tool (situation, background, assessment, recommendations) is a helpful mnemonic that can be used to describe a child's clinical condition to a colleague.

<b>I</b>	<b>IDENTITY:</b> I am (name), a nurse on ward (X). I am calling about (child X)
<b>S</b>	<b>SITUATION :</b> 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>B</b>	<b>BACK GROUND :</b> 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)
<b>A</b>	<b>ASSESSMENT :</b> 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.
<b>R</b>	<b>RECOMMENDATION :</b> 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: 11/6/26 Time: 9 11 1 3 5 7 10 1 3 5 7  
 Doctor / Nurse / Family Concern? am am pm pm pm pm pm am am am am



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

<b>TOTAL SCORE</b>	
Number of shaded boxes	0 0 0 0 0 0 0 0 0 0 0
Pain Score	0 0 0 0 0 0 0 0 0 0 0
Observer's Initials	B B B MB MB MB 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: 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

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Date	Time	Early Warning Score	Date	Time	Name

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

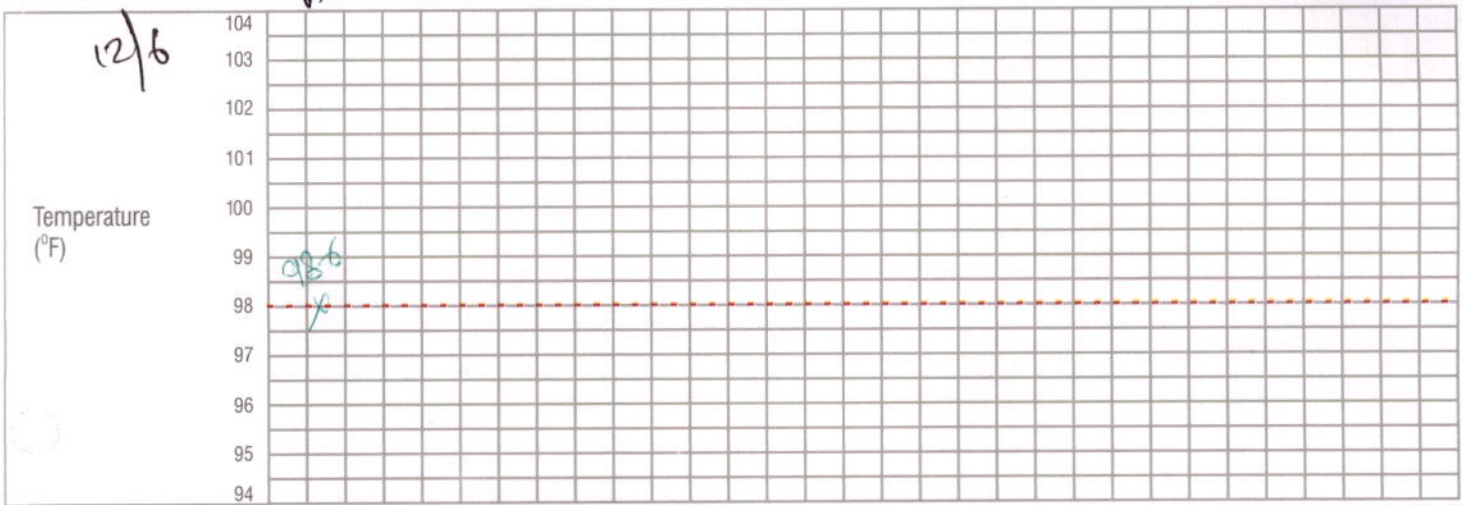
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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : ..... Time: 9

Doctor / Nurse / Family Concern? Am



Heart Rate (bpm) and Blood Pressure (mmHg) \*

Note: BP does not score in early warning scoring

Heart Rate (Number) 112

sp. Rate (bpm) (Over 1 Minute) \*

Resp Rate (Number) 22

Resp Distress Mod/ Severe None / Mild

Receiving O<sub>2</sub> (l/min) O<sub>2</sub> Saturations (%) 99

Conscious Level Normal Altered 2

GCS \* 15

TOTAL SCORE Number of shaded boxes 0

Pain Score 0

Observer's Initials PK

ACTIONS

NB: Scores 3 should be recorded overleaf

- Score 1 : Continue normal observation by staff nurse
- Score 2 : Shift in charge nurse to be informed and continue hourly observations
- Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.
- Score 4 : Shift in charge AND treating consultant (till 8 PM) or On call night duty consultant to see
- Score 5 & 6 : Shift in charge AND PICU fellow or PICU consultant to be informed.

noted by  
 Selva  
 12/6 @  
 10 AM

\* 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:

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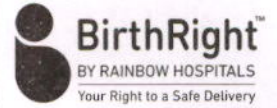
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<b>R</b>	<b>RECOMMENDATION :</b> I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

VIH-00119067 IP-00060307  
 Master SHOURYA  
 14-02-2019 7 Y 3 M 27 D (M)  
 Dr. PREETHAM KUMAR



①



# FLUID CHART

Sheet No. : ..... ①

10/6/26

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

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												
<b>Total Intake :</b>						<b>Total Output :</b>							
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
<b>Total Intake :</b>						<b>Total Output :</b>							
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am	Fully water		55ml									
	01:00 am			55ml									
<b>Total Intake :</b>						<b>Total Output :</b>							
	02:00 am			55ml									
	03:00 am			55ml									
	04:00 am			55ml									
	05:00 am			55ml									
	06:00 am			55ml									
	07:00 am			55ml									
<b>Total Intake :</b>						<b>Total Output :</b>							
<b>Total 24 hrs. Intake</b>			495 ml			<b>Total 24 hrs. Output</b>			4 times				



# FLUID CHART

Sheet No. : ..... 2 .....

11/6/26

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				
11/6			Mouth	Oral	N.G								
	08:00 am			55ml									
	09:00 am	Edly water		55ml									
	10:00 am			55ml					✓				
	11:00 am												
	12:00 pm												
	01:00 pm								✓				
<b>Total Intake :</b>			165 ml			<b>Total Output :</b>							
11/6	02:00 pm												
	03:00 pm	Edly water		55ml									
	04:00 pm			55ml									
	05:00 pm			55ml					✓				
	06:00 pm												
	07:00 pm												
<b>Total Intake :</b>			165ml			<b>Total Output :</b>							
11/6	08:00 pm												
	09:00 pm	Edly water		30ml									
	10:00 pm			30ml									
	11:00 pm			30ml									
	12:00 am			30ml					✓				
	01:00 am			30ml									
<b>Total Intake :</b>			120ml			<b>Total Output :</b>							
12/6	02:00 am			30ml									
	03:00 am			30ml					✓				
	04:00 am			30ml									
	05:00 am												
	06:00 am								✓				
	07:00 am												
<b>Total Intake :</b>			90ml			<b>Total Output :</b>							

**Total 24 hrs. Intake**      540 ml

**Total 24 hrs. Output**      6 times



# FLUID CHART

Sheet No. : ..... 3 .....

12/6/20

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
12/6	08:00 am												
	09:00 am		Sidley										
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
<b>Total Intake :</b>						<b>Total Output :</b>							
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
<b>Total Intake :</b>						<b>Total Output :</b>							
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
<b>Total Intake :</b>						<b>Total Output :</b>							
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
<b>Total Intake :</b>						<b>Total Output :</b>							

**Total 24 hrs. Intake**

**Total 24 hrs. Output**

## MEDICATION RECONCILIATION FORM

Drug Allergies: ..... 1017 .....  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: ..... 102 .....

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. Prashanthi /

Date & Time: 10/6/26 @ 10:39 PM

Nurse Name & Signature: Sr. Revathy / Revathy

Date & Time: 10/6/26 @ 10:39 PM



# DRUG CHART

Date of Admission: 10/6/26 Drug Allergies: NOT  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>Syp. PARACETAMOL</u>				Date Time
Dose	Route	Frequency	Start Date	
<u>6ml</u>	<u>P/O</u>	<u>4-6 hourly</u>	<u>10/6/26</u>	<u>6:25 AM</u>
Doctor's Signature		Valid Period	Pharm.	
<u>R</u>			<u>10/6/26</u>	
Additional Instructions:				
<u>5ml/200mg 10-15ml/4don</u>				
DRUG: <u>Syp. IBUPROFEN</u>				Date Time
Dose	Route	Frequency	Start Date	
<u>9ml</u>	<u>P/O</u>	<u>6-8 hourly</u>	<u>10/3/26</u>	
Doctor's Signature		Valid Period	Pharm.	
<u>R</u>			<u>10/6/26</u>	
Additional Instructions:				
<u>5ml/100mg 10ml/4don</u>				
DRUG: <u>Inj. ONDANATRAN</u>				Date Time
Dose	Route	Frequency	Start Date	
<u>3.5mg</u>	<u>IV</u>	<u>8 hourly</u>	<u>10/3/26</u>	
Doctor's Signature		Valid Period	Pharm.	
<u>R</u>			<u>10/6/26</u>	
Additional Instructions:				
<u>0.2 ml/4don</u>				

Signature  
 10/6/26  
 Signature  
 10/6/26  
 Signature  
 10/6/26



REGULAR PRESCRIPTIONS

Weight. 18.5 kg Ward. ....

Dr. Prabhakar  
 Rajyalakshmi  
 10/06/20

<b>DRUG:</b> Inj. CEFTRIAXONE				Date Time	11/06/20 12/6
Dose	Route	Frequency	Start Date	6	AM
900mg	IV	12 hourly	10/6/20		
Name & Signature of the Doctor Starting the Drugs:					
Dr. prabhakar					
Additional Instructions:				6 Gamp Pm all	
Daily Doctor's Endorsement by a Sign					

Dr. Prabhakar  
 Rajyalakshmi  
 10/06/20

<b>DRUG:</b> Symp. RELANT Plus.				Date Time	11/06/20 12/6
Dose	Route	Frequency	Start Date	6	AM
5ml	PO	12 hourly	10/6/20		
Name & Signature of the Doctor Starting the Drugs:					
Dr. prabhakar					
Additional Instructions:				6 Gamp Pm all	
Daily Doctor's Endorsement by a Sign					

Dr. Prabhakar  
 Rajyalakshmi  
 10/06/20

<b>DRUG:</b> REFRIN EYE DROPS				Date Time	11/06/20 12/6
Dose	Route	Frequency	Start Date	6	AM
2 DROPS	LA	8 hourly	10/6/20		
Name & Signature of the Doctor Starting the Drugs:					
Dr. prabhakar				2 Gamp Pm all	
Additional Instructions:				10 P Pm all	
2 DROPS IN EACH EYE.					
Daily Doctor's Endorsement by a Sign					

Dr. Prabhakar

<b>DRUG:</b> NARAZOLIN - P-NAL DROPS				Date Time	11/6 12/6
Dose	Route	Frequency	Start Date	6	am
2 DROPS	PO	8 hourly	10/6/20		
Name & Signature of the Doctor Starting the Drugs:					
Dr. prabhakar				2 Gamp Pm all	
Additional Instructions:				10 P Pm all	
2 DROPS IN EACH EYE.					
Daily Doctor's Endorsement by a Sign					

VIH-00119067 IP-00060307  
 Master SHOURYA  
 14-02-2019 7 Y 3 M 28 D (M)  
 Dr. PREETHAM KUMAR



Sheet No: ..... ① .....

**REGULAR PRESCRIPTIONS**

Weight 18.5 Ward .....

<b>DRUG :</b> META SPRAY <sup>SPRAY</sup> NASAL				Date Time																		
Dose	Route	Frequency	Start Dt.																			
2 puffs	P/N	12 <sup>th</sup> hly	11/6	11/6	11/6																	
Name & Signature of the Doctor Starting the Drugs:																						
Dr. Sameer																						
Additional Instructions:				7 days proceed																		
<b>Daily Doctor's Endorsement by a Sign</b>																						
<b>DRUG :</b>				Date Time																		
Dose	Route	Frequency	Start Dt.																			
Name & Signature of the Doctor Starting the Drugs:																						
Additional Instructions:																						
<b>Daily Doctor's Endorsement by a Sign</b>																						
<b>DRUG :</b>				Date Time																		
Dose	Route	Frequency	Start Dt.																			
Name & Signature of the Doctor Starting the Drugs:																						
Additional Instructions:																						
<b>Daily Doctor's Endorsement by a Sign</b>																						
<b>DRUG :</b>				Date Time																		
Dose	Route	Frequency	Start Dt.																			
Name & Signature of the Doctor Starting the Drugs:																						
Additional Instructions:																						
<b>Daily Doctor's Endorsement by a Sign</b>																						

*Dr. Dabala*

Signature  
Name

Patient Sticker

Sheet No: .....

### REGULAR PRESCRIPTIONS

Weight ..... Ward .....

VERIFIED BY : Name ..... Signature .....

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



Weight. .... Ward. ....

		Date Time	Nurse Sig.	Nurse Sig.	Nurse Sig.	Nurse Sig.
<b>DRUG :</b>		Dose		Dose		Dose
		Dr. Sign.		Dr. Sign.		Dr. Sign.
Route	Start Date	Dose		Dose		Dose
		Dr. Sign.		Dr. Sign.		Dr. Sign.
Name & Signature of the Doctor		Dose		Dose		Dose
		Dr. Sign.		Dr. Sign.		Dr. Sign.
Additional Instructions:		Dose		Dose		Dose
		Dr. Sign.		Dr. Sign.		Dr. Sign.

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

**STAT / ONCE ONLY DRUGS**

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
10/6/22	11:00pm	Inj. ONDANSETRON	3.5mg	IV		Lizom Austhyat 10/6/22

VERIFIED BY : Name: Signature



I.V. FLUIDS CHART

Weight: 18.5 kg Ward: .....

Date	Time	Composition of I.V. Fluid (If infusion, mention ml/hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
<u>10/6/20</u>	<u>11:45 PM</u>	<u>IV-F-DNS full (M)</u>	<u>IV</u>	<u>50ml/hr</u>	<u>R</u>	<u>Subhr</u> <u>R</u>	<u>11/6</u>	<u>D</u>	<u>[Signature]</u> <u>[Signature]</u>

Signature .....  
VERIFIED BY : Name .....



## RESULT SHEET

Date	10/6/26	12/6/26			
Time	10:45 PM	5 AM			
Hb	12.3	11.6			
PCV	33.1	31.5			
RBC	5.00	4.75			
WBC	10,95 <sup>+</sup>	6,58			
N/L	83.8/12.9	27.5/58.5			
Platelets	2.66	2.42			
CRP	20	15			
ESR					
PCT					
RBS					
Na	130				
K	4.0				
Cl	96				
Ca/Mg					
Phosphate					
Urea					
Creatinine	0.7				
ALP					
SGPT					
SGOT					
T.Bill/Conj					
T.Protein					
S.Albumin					
S.Globulin					
A/G Ratio					
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein / Sugar					
Cells					
N/L					

Date	11/6/26				
Time	8 AM.				
CUE - Alb	Nll				
CUE - Sugar	Nll				
CUE - Ketones	Neg				
CUE - PUS Cells	4-6				
CUE - RBC Cells	Nll				
CUE - Epith.	2-4				
New	Neg				
Blood	Absent				
Stool Pus Cell					
OVA / Cyst					
Occult Blood					

Culture and Sensitivities : ..... Blood c/s - .....

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Radiology :    USG : .....

                  X-Ray : .....

                  ECHO : .....

                  CT : .....

                  MRI : .....

                  Others (ECG, Contrast Studies etc.) : .....