Rainbow® Children's Hospital
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BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery.

ACTIVITY RECORD FOR BILLING

VIH-00205862 IP-00060378
Baby B/O GAUTHAMI
13-06-2026 0 Y 0 M 4 D (M)
Dr. KODICHERLA VISHNU VARDHAN

Name: ----- ----------

UHID No : - --------- Consultant : ---------- Dept : EN.

Date of Admission : 13/6/26 Time : ---------- Date of Discharge : 18/6/26 Time: ----------

Room / Bed No : 2nd floor Ward : 211 Suggested Billable bed type : ----------

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
17/6/26	3:20PM	EN.	211	

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Sign
18/6/26	SBR	26020754	S

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
17/6	DSP1	17/6/26 03:35PM	18/6/26 C 11AM	3091308	[signature]
	Name:- Amath Kumar				
	Date:- 17-06-26				
	Time:- 03:35pm				
	Signature:- [signature]				

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature

ANY OTHER INFORMATION

Date : 18/6/26 Time : 1PM Prepared By : 18/6/26

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

DEFICIENCY CHECK LIST — CASE SHEET

IP-00060378
VIH-00205862
Baby B/O GAUTHAMI
13-06-2026 0 Y 0 M 4 D (M)
Dr. KODICHERLA VISHNU VARDHAN

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Patient Name :

IP.No: 60378.

Ward:

DOA: 13/6/26

Sl.No	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission Sheet	1	✓	✓	
2	Discharge Summary	2	✓	✓	
3	Nursing Initial assessment form				
4	Patient Trasfer Forms	1	✓	✓	
5	In-patient Medical Record	2	✓	✓	
6	Doctors Progress Sheets	2	✓	✓	
7	Nurses Progress notes	4	✓	✓	
8	Consultation Sheets				
9	General Consent for Treatment	1	✓	✓	
10	Conset for Surgery				
	Consent for Blood Transfusion				
12	Consent forChemotherapy				
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	2	✓	✓	
26	Intake and Output chart (fluid Chart)	2	✓	✓	
	Drug Chart (Regular prescription)	3	✓	✓	
28	Daily Investigation sheet				
29	Investigation Values (Result Sheet)	1	✓	✓	
30	Nebulization Chart				
31	Diabetic chart				
32	Nutritional Review chart				
33	MLC form (in case of MLC)				
34	Patient Education Form				
	Others	6	✓	✓	
	Total No. of Pages	24 pages			

Dupika 14/06/26 @10pm
Signature and Date :

ERROR LOG

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

ICD CODE :-

OBSERVATION: -

DATE :

MRD EXECUTIVE

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.
TEL NO :040-42462200, Ext 2000,2001,2002
WEB : https://rainbowhospitals.in

ADMISSION SHEET

Registration Details :

Admission No : IP-00060378 **Admit Date** : 17-Jun-2026 **Admit Time** : 02:53 PM **UHID** : VIH-00205862

Patient Details :

Patient Name	: Baby B/O GAUTHAMI	**Age**	: 0 Y 0 M 4 D
Guardian	: Mr M ANANTH KUMAR	**DOB**	: 13-06-2026 10:00 AM
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: h no-11-1-420 to 426, flat no-101, susheelas padma enclave,mylargadda Secunderabad Hyderabad Telangana INDIA 500003	**Phone No**	: 9490626351/ 9966123099
		E-mail	: na@gmail.com

Admission Details :

Bed Type : SHARED WARD **Bed No** : ER 102 **Ward Name** : N 0 GF-EMERGENCY

Room No : ER 102 **Admission Type** : First Visit

Contact Details :

Name	: Mr M ANANTH KUMAR	**Relationship**	: Father
Contact Address	: h no-11-1-420 to 426, flat no-101, susheelas padma enclave,mylargadda Secunderabad Hyderabad Telangana INDIA 500003	**Phone No**	: 9490626351 / 9966123099

Signature

Doctor Details :

Doctor Name	: Dr. KODICHERLA VISHNU VARDHAN REDDY	**Specialisation**	: GENERAL PEDIATRICS
Referral Doctor	: DR.BHAVANA K	**Phone No**	:
Co-Consultant	:		

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash **Payor Name** : SELFPAY

Patient Name : B/O. Gauthami UHID : 34445566 IPD : 3445566 Gender : Male Age : 4 D

VIH-00205862 IP-00060378
Baby B/O GAUTHAMI
13-06-2026 0 Y 0 M 4 D (M)
Dr. KODICHERLA VISHNU VARDHAN

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EMERGENCY ROOM TRIAGE FORM

Wt : 3.55 kg

Patient's Name : B/o. Gauthami Age : 4D Gender: ☑ Male ☐ Female

Date : 17/6/26 Time of Arrival : 2:10 PM

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

Source of Information : ☑ Parents ☐ Others (Specify) .....

Mode of Arrival : ☑ Ambulatory ☐ Wheelchair ☐ Ambulance

Initial Vital Signs: Temp: 98.3° F PR: 148 b/m BP: Crying RR: 26 b/m SpO_2: 99%

Chief Complaints: C/O Yellowish discolouration of eyes & skin

INITIAL PHYSIOLOGICAL CATEGORIZATION

Appearance: ☑ Normal ☐ Sick Looking

Work of Breathing: ☑ Normal ☐ Increased ☐ Decreased ☐ Gasping / Apnea

Circulation / Colour: ☑ Normal ☐ Abnormal ☐ Bleeding — Yellowish

INITIAL PHYSIOLOGICAL STATUS

☑ Stable
☐ Unstable :
- ☐ Not – Life - Threatening
- ☐ Life – Threatening

Triage Classification	CTAS
☐ Level 1 : Resuscitation	☐ Immediate
☐ Level 2 : EMERGENT : Life or limb threatening	☐ < 15 min
☐ Level 3 : URGENT : Significant illness / injury with potential to become life or limb threatening	☐ 30 min
☐ Level 4 : LESS URGENT : Significant illness but not life threatening	☑ 60 min
☐ Level 5 : NON – URGENT : May receive care when convenient	☐ 120 min

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

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian

Triage Completion Time : 2:14 PM

Communicable Disease Triage Screening

PART A. The following questions should be asked to all patients at the initial screening:

1. Have you had fever (elevated temperature) in the past 2 weeks ☐ Yes ☑ No
2. Have you had cough or a rash in the past 2 weeks ☐ Yes ☑ No
3. 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

1. 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: .....
2. 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 : Architha

Signature of Triage Nurse : AS

Date & Time : 17/6/26 @ 2:14 PM

Docu. No. : RCH /FRM / CLINICAL / 085

Patient Name : B/O. Gauthami UHID : 34445566 IPD : 3445566 Gender : Male Age : 4 D

VIH-00205862 IP-00060378
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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 17/6/26 Time of arrival : 2:16 PM

Chief Complaints: C/o Yellowish discolouration of skin & eyes RBS: —

Height : — Weight : 3.55kg BMI : — Head Circumference (<2 years) 35 cm

Allergies: ☒ Yes ☐ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other: .....

If yes , identify .....

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

☐ Character — ☐ Location — ☐ Frequency — ☐ Duration —

RISK FOR FALL:

☒ If patient is < 6 years
tick below fall risk intervention directly

☐ If Patient is > 6 years
Assess the below parameters

History of Falling: within past 3 months ☐ Yes ☒ No

Ambulatory Aids:

- Wheelchair ☐ Yes ☒ No
- Uses furniture for support ☐ Yes ☒ No

Gait/Transferring:

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

Mental Status: Forgets limitations ☐ Yes ☒ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening: ☒ No Abnormalities Detected

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

Inform consultant for positive criteria

.....

.....

Nutritional Screening: ☒ No Abnormalities Detected

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

Inform consultant for positive criteria

Psychological Screening: ☒ No Significant Findings

Unusual concerns about patient's Psychological Status: ☐ Yes ☒ No

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

Social History: Lives With Family

Siblings in household ☐ Yes ☒ No (if yes How Many?) —

Time of Initial assessment completed by ER Nurse : 2:19 PM

Patient Name : B/O Gauthami UHID : 34445566 IPD : 3445566 Gender : Male Age : 4 D

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

Time	Nursing Notes
2:10pm	* patient came to ER
2:13pm	* vitals checked and Recorded
2:16pm	* Dr. prashanthi Seen the patient & advised admission
	* Admission process Done
	* Total Bilirubin:- 17.0 mg/dl
	* patient shifted to ward

Samples collected by: — Time: —

Samples sent by : Time:

Medication given in ER:

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

Condition of patient at time of shift - out :		**Details of Shift - out**
HR: 144 b/m	BP: Crying CFT: <2sec	Shift - out from ER to: 211
RR: 28 b/m	SPO_2 : 99%	Time of Shift - out: 17/6/26 @
GCS: 15	Temperature : 98°F	Handover given to: Sr. Susila (Nurse's Name) by Sabin
Pain Score: 0		
Repeat RBS (if applicable): —		

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any): .....

.....

Name of the Nurse : Sabin Signature of the Nurse : Sn

Date & Time : 17/6/26 @ 3:20 PM

PATIENT TRANSFER FORM

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Baby B/O GAUTHAMI
13-06-2026 0 Y 0 M 4 D (M)
Dr. KODICHERLA VISHNU VARDHAN

	Date & Time of Admission	Date & Time of Transfer Order
Treating Consultant Name	17/6/26 @ 2.53PM	17/6/26 @ 3:20P
Transfer Ordered by: Dr Prashanthi		Reason for Transfer: Admission
From Unit: LER	To Unit: 211	Information to Attendant: Yes ☑ No ☐
Number of Sheets in Clinical File: 21	Number of Imaging Films: —	Personal belongings including clinical documents. If any handed over to attendant: Yes ☑ No ☐ If yes, what ? OP File

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.		
2.		
3.		
4.		
5.		

Shifting Summary / Notes Written by Doctor : Yes ☑ No ☐

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Srilaxmi	Dr Prashanthi

Patient & Clinical Records Received by : Sushila

Date & Time of Patient Received : Sushila 17/6/26 at 3:20pm

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

☐ Unavailable Bed ☐ Nurse not Available ☐ Available Bed not ready

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PEDIATRIC IN-PATIENT MEDICAL RECORD

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13-06-2026 0 Y 0 M 4 D (M)
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Patient Name: _____ _____

UHID ID: _____

Department: _____

Consultant: _____

VIH-00205862 IP-00060378
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13-06-2026 0 Y 0 M 4 D (M)
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Pediatric Multiorgan History & Physical Examination

Name : B/o Gauthami Age/Sex 4D/ Male.

Information given by: mother Relationship Good.

Chief Presenting Complaints & Duration (Chronologically)

c/o yellowish discoluration of eyes & skin.

History of present illness :

child was brought c c/o yellowish discoluration of eyes & skin ↓ till the level of umbilicus.

MBG - O+

BBG - O+

Today wt: 3.55 kgs
(3.2 kgs) at birth.

SBR → TB - 17.0 mg/dL
CB — 0.2 mg/dL
UCB - 16.8 mg/dL.

No H/o passage of dark coloured urine.

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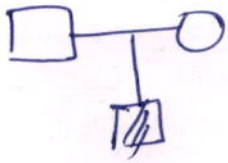
Pediatric Multiorgan History & Physical Examination

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

Not significant.

Birth & Neonatal History:

Term | Bwt: 3.67 kg | cephalic | Excess | CTAB



Birth & Socio Economic History:

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

Developmental History :

(N)

Immunization History :

BCG, OPV, Hep-B - taken.

(P.T.O.)

VIH-00205862 IP-00060378
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13-06-2026 0 Y 0 M 4 D (M)
Dr. KODICHERLA VISHNU VARDHAN

Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs)) 3.55kgs (Centile ______)

On Examination :

Temperature : 98°f Pulse Rate : 143b/m B.P. crying SPO2 99%

Resp.rate and type of breathing : 28 B/m.

Rash ______

Lymphadenopathy ______

Oedema : (-). Icterus (+)

Allergies (if any): ______

Respiratory System :

Inspection (any s/o distress) : (-)

Air entry & breath sounds : B/L AE(+)

Any addes sounds : (-)

Relevant data from outside (Chest X-Ray, ABG,etc.,) ______

Cardiovascular System :

Inspection of procordium : (N)

Heart Sounds : S1S2(+)

Any murmur : (-)

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

Per Abdomen :

Inspection (N)

Palpation : P/A: soft

Ausculation : (-)

Spine : (-) External Genitelia : (-).

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

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Pediatric Multiorgan History & Physical Examination

Central Nervous System :

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

Cranial Nerves : N

Motor System:

Nutriton : R L

Tone: N Power 3/5 3/5

Co-ordinator :

Posture :

Involuntary Movements : -

Reflexes :

DTR tnt **Superficials:** tnt

Plantars Extensor

Sensory System : N

Bladder / Bowel : N

Clinical Summary & Diagnostic:

N N+HB.

(P.T.O.)

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13-06-2026 0 Y 0 M 4 D (M)
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Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: To prevent kernicterus.

Desired goals of the treatment : To treat the symptoms.

Planned Labs:

SBR to be decided afsurounds.

Planned Management

- Start DSPT
- DBF f/b burping Every 2nd hrly
- warmth care.
- monitor vitals
- Inform (SOS)

Noted by - Sabin
17/6/26 @ 3:20 p.

Signature of the Doctor: (signed)
Name of the Doctor: Dr. prashanth.
Date & Time: 17/6/26.

Signature of the Consultant: ....
Name of the Consultant: ....
Date & Time: ....

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	NNHB (D5)	
18/6/2026		
9:20AM		B.wt - 3.67
	C/T/A Good	3.51
	CRT < 3sec	- 4.3%
	AF - (N)	
	Moro - Elicited	
	CVS - S1S2	
M/B O +ve	CNS / RS / PA — NAD	Plan
		- Repeat SBR T/D after 3:00pm
		- DSPT.
		- warmth + Cord care
		- Inform SOS
	C/S/By DR. VISHNU	
	→ Do SBR @ 12:00pm	
	→ Discharge if < 15	
	→ F/W as per chart	
	→ Cont 2hrly breast feeds	VVM

Noted by Akanksha 18/6/26 @12pm

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

VIH-00205862 IP-00060378
Baby B/O GAUTHAMI
13-06-2026 0 Y 0 M 4 D (M)
Dr. KODICHERLA VISHNU VARDHAN

M / CLINICAL / 124

INFANT (<1 year)

Children's Observation & Early Warning Scoring Chart

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 7/6/26 Time:	4	4	10	4	7
Doctor/Nurse/Family Concern?	PM	PM	PM	AM	AM
Temperature (°F)	98.6	98.6	98.2	98.9	98.8
Heart Rate (bpm) and Blood Pressure (mmHg) *					
Heart Rate (Number)	139	129			
Resp. Rate (bpm) (Over 1 Minute) *					
Resp Rate (Number)	38	40	40	43	40
Resp Distress: Mod/ Severe / None / Mild					
Receiving O_2 (l/min) O_2 Saturations (%)	99	96	99%	99%	99%
Conscious Level: Normal / Altered	N	P	N	N	N
GCS *	15	15	–	–	–
TOTAL SCORE Number of shaded boxes	0	0	0	0	0
Pain Score	0	0	0	0	0
Observer's Initials	SJ	SJ	D	D	D

Note: BP does not score in early warning scoring

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 incharge and PICU /NICU fellow or PICU/NICU 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.

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

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No. : RCH/ FRM / CLINICAL / 124

INFANT (<1 year)

Children's Observation & Early Warning Scoring Chart

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 18/6/26 Time: 10 AM 12PM

Doctor/Nurse/Family Concern?

Temperature (°F)
104 103 102 101 100 99 98 97 96 95 94
99.0°F 98.5°F

Heart Rate (bpm) and Blood Pressure (mmHg) *
190 180 170 160 150 140 130 120 110 100 90 80 70 60 50

Note: BP does not score in early warning scoring

Heart Rate (Number) 130 150

Resp. Rate (bpm) (Over 1 Minute) *
70 60 50 40 30 20 10

Resp Rate (Number) 40 50

Resp Distress	Mod/ Severe / None / Mild	
Receiving O_2 (l/min)		
O_2 Saturations (%)		99% 99%
Conscious Level	Normal / Altered	C C
GCS *		
TOTAL SCORE Number of shaded boxes		0 0
Pain Score		0 0
Observer's Initials		

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 incharge and PICU /NICU fellow or PICU/NICU 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.

Patient Sticker

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BirthRight
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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

VIH-00205862 IP-00060378
Baby B/O GAUTHAMI
13-06-2026 0 Y 0 M 4 D (M)
Dr. KODICHERLA VISHNU VARDHAN

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FLUID CHART

Sheet No. : .....

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

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						**Total Output :**						
17/6/26	02:00 pm											
	03:~~00~~ 30 pm		DBF									
	04:00 pm											
	05:00 pm											
	06:00 pm		DBF									
	07:00 pm											
Total Intake :						**Total Output :**						
17/6/26	08:00 pm											
	09:00 pm		DBF				✓			✓		
	10:00 pm											
	11:00 pm		DBF									
	12:00 am									✓		
	01:00 am		DBF									
Total Intake :						**Total Output :**						
18/6/26	02:00 am											
	03:00 am		DBF									
	04:00 am						✓			✓		
	05:00 am		DBF									
	06:00 am											
	07:00 am		DBF									
Total Intake :						**Total Output :**						

Sowmya 17/6/26 @7PM

Deepika 18/6/26 @8AM

Total 24 hrs. Intake		Total 24 hrs. Output	

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FLUID CHART

Sheet No. : 2

18/6/26.

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						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
18/6/26	08:00 am										1	
	09:00 am		EBM				✓			✓		
	10:00 am										0	
	11:00 am		DBM									
	12:00 pm											18/6/26 12pm
	01:00 pm										1	
Total Intake :						Total Output :						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						Total Output :						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						Total Output :						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						Total Output :						

Total 24 hrs. Intake		Total 24 hrs. Output	

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MEDICATION RECONCILIATION FORM

Drug Allergies: ..... Nil ..... ☐ ~~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: ..... NR. ..... Shifted to: .....

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						☐ C ☐ DC
2						☐ C ☐ DC
3						☐ C ☐ DC
4		Nil				☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr Prashanthi N.

Date & Time : 13/6/26 @ 2:20 PM

Nurse Name & Signature: Sriram N.O

Date & Time : 13/6/26 @ 2:20 PM

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DRUG CHART

Date of Admission: ..... Drug Allergies: ..... ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

GENERAL - Ensure that all patient details are entered above. ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.

DOCTOR
- Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
- Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
- Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
- Discontinue a drug by drawing a line *I* through it and a similar line through subsequent recording panels.
- The date and time of stopping the drug along with the doctors name and sign must be mentioned.
- Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.

NURSES
- Nurses must follow strictly the FIVE RIGHTS before administration of medication.
  1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time
- AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

SOS / PRN (As Required Medication)

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

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

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

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

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REGULAR PRESCRIPTIONS

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

DRUG :

Dose	Route	Frequency	Start Date

Date▸ / Time▾

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Date

Date▸ / Time▾

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Date

Date▸ / Time▾

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Date

Date▸ / Time▾

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

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

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses

Signature .....

VERIFIED BY : Name .....

Baby B/O GAUTHAMI
13-06-2026 0 Y 0 M 4 D (M)
Dr. KODICHERLA VISHNU VARDHAN

I.V. FLUIDS CHART

Weight. .... 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

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