

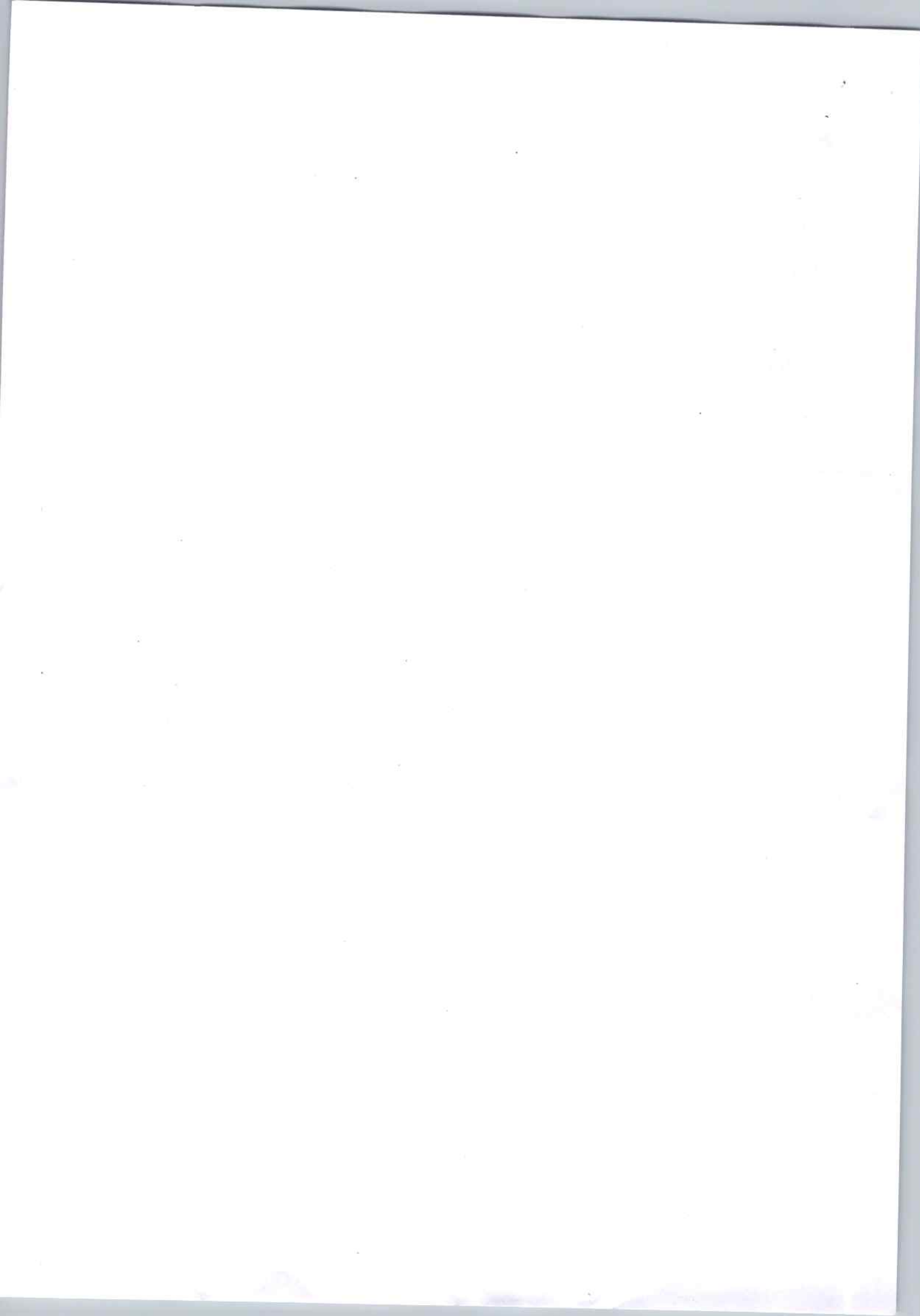


GUC-00093020  
Master HATIM.B  
28-03-2020  
Dr. NATARAJ PALANIAPPAN  
IP18-00036162  
6 Y 3 M 0 D  
(M)  
Birth Children's Hospital

### DISCHARGE TRACKING SHEET

UHID-                      FLOOR-                      NAME OF CONSULTANT-

ACTIVITY	INTIME	OUT TIME	NAME & SIGNATURE	REMARKS	<To be filled by Admin >		
Activity Sheet update by Nursing		8:30 AM	me 02/4/2020				
Activity Sheet update by Pharmacy		9:30 AM	me				



# ACTIVITY RECORD FOR BILLING



Name: .....  
 UHID No: ..... | GUC-00093020 IP18-00036162  
 Master HATIM.B  
 26-03-2020 6 Y 2 M 29 D (M)  
 Date of Admission: ..... Dr. NATARAJ PALANIAPPAN  
 Room / Bed No: .....  
 Discharge: ..... Time: .....  
 Billable bed type: .....



## WARD TRANSFERS

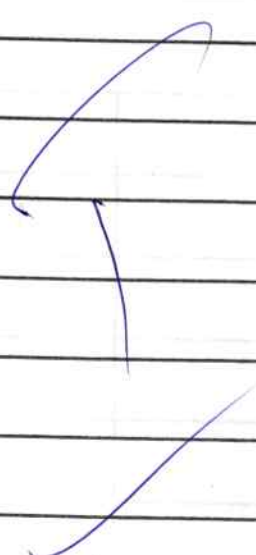
Date	Time	From	To	Signature of Nurse
24/6/20	12:15pm	ER	401	[Signature]

## CROSS CONSULTATION VISIT

	Doctor Name	Date	Order No.	Signature
1.	Dr. Nithya (ENT)	24/6/20	16743 ✓	[Signature]
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

# INVESTIGATIONS

Date	Investigations	Order No.	Signature
24/6/26	CBC, CRP, RPS, SGOT	26019998	Dr 1894
	SGPT, Dengue NS, Igm		
	Blood c/c		
24/6/26	Urine R/E	26020004	Dr 1894
24/6/26	RBS	26019999	Dr 1894
24/6/26	X-ray lateral neck	8416	Dr 1894
26/6/26	CBC	26020230	Dr 01520







GUC-00093020 IP18-00036162  
Master HATIM.B  
28-03-2020 6 Y 2 M 30 D (M)  
Dr. NATARAJ PALANIAPPAN

**DISCHARGE TRACKING SHEET**

UHID-

FLOOR-

NAME OF CONSULTANT:



ACTIVITY	TIME		NAME & SIGNATURE	REMARKS	<To be filled by Admin>
	INTIME	OUT TIME			
Discharge Announcement					
Arrangement of File by Nursing	26/3/20	11:30AM	me	OK	
Preparation of Discharge Summary					
Finalization of discharge summary					
Transfer of file from Ward to Billing Dept					
Bill Processing					
Audit Clearance					
Billing Clearance					
Physical Clearance					



ADMISSION SHEET

Registration Details :



Admission No : IP18-00036162      Admit Date : 24-Jun-2026      Admit Time : 11:10 AM      UHID : GUC-00093020

Patient Details :

Patient Name : Master HATIM.B      Age : 6 Y 2 M 29 D  
Guardian : Mr BALA KRISHNAN      DOB : 26-03-2020  
Gender : Male      Religion :  
Occupation :      Martial Status :  
Address (H) : 4/21, CHETTIYA GOUNDAN PALAYAM,  
KOVUATHAM PALAYAM, TIRUPUR Kunnathur  
Erode Madurai Tamil Nadu INDIA 638103      Phone No : 8012175560/  
E-mail : balkeemb8@gmail.com

Admission Details :

Bed Type : DAY CARE      Bed No : ER 101      Ward Name : 0F-EMERGENCY  
Room No : ER 101      Admission Type : First Visit

Contact Details :

Name : Mr BALA KRISHNAN      Relationship : Father  
Contact Address : 4/21, CHETTIYA GOUNDAN PALAYAM,  
KOVUATHAM PALAYAM, TIRUPUR Kunnathur  
Erode Madurai Tamil Nadu INDIA 638103      Phone No : / 8012175560

  
Signature

Referral Details :

Doctor Name : Dr. NATARAJ PALANIAPPAN      Specialisation : PEDIATRIC INTENSIVE CARE  
Referral Doctor : SELF      Phone No :  
Co-Consultant :

Payment Details :

Payment Mode : Cash      Deposit Amount : 0.00  
Payor Name : SELFPAY



**GENERAL CONSENT FOR TREATMENT**

Patient Name: Master HATIM.B Age : 6 Y 2 M 29 D  
IP No: IP18-00036162 Sex: Male  
Consultant: Dr. NATARAJ PALANIAPPAN Ward/Bed No: 0F-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 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:.....) *A. P. Sankar*

- 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: *A. P. Sankar*

Name: *Master. Hatim*

Relationship: *Father*

Date: *24/06/2026*

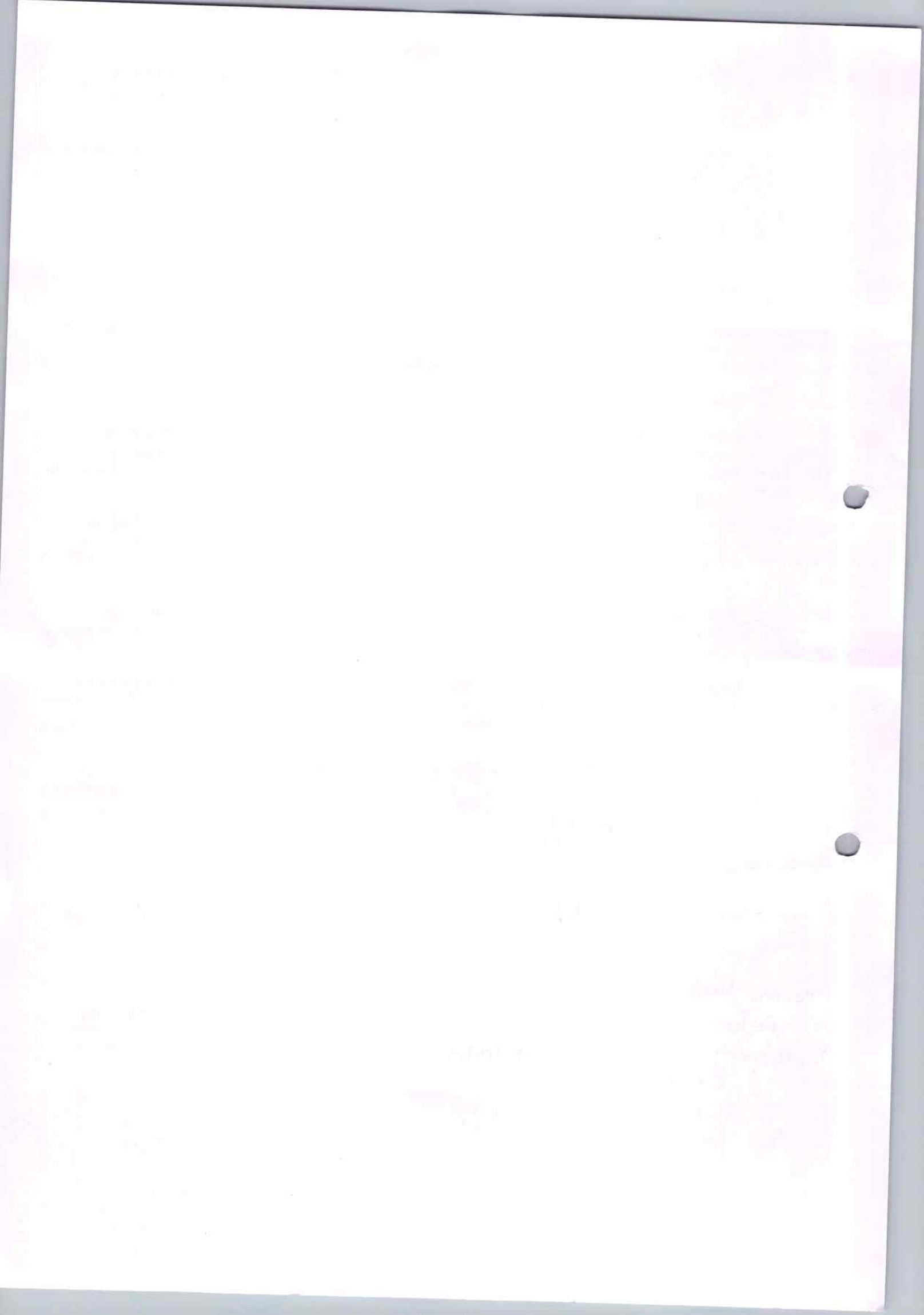
Wittness Name: *A. Sivasankari*

Wittness Signature: *A. Sankar*

Patient Address:

4/21, CHETTIYA GOUNDAN PALAYAM,  
KOVUATHAM PALAYAM, TIRUPUR  
Kunnathur Erode Madurai Tamil Nadu  
INDIA 638103

Time: *11:10 AM*



## BILLING POLICY

- ▶ **Billing Cycle:** - Bed charges will be calculated based on 12PM to 12PM checkout. Settlement post 12PM, room rent will be charged for half day extra & post 6PM, it will be charged for full day. Less than 24 hours stay will be considered as one day.
- ▶ Room Rent inclusive of Bed, Nursing, Consultation Charges and all other charges, like Diet, Investigations, IP or OP Procedures, Equipment, Cross Consultations, Blood/ Blood Products, Implants, Ward Consumables, Infection Preventive Measure Charges, Pharmacy and Consumables will be charged extra.
- ▶ 5% GST Charges applicable on more than INR 5,000/- Bed Charges which was effective from 18.07.2022 as per the GST Council.
- ▶ As per the G.O.I. guidelines, we can collect Rs 1,99,999/- only in cash mode, balance patient can pay through Credit Card/ Debit Card/ NEFT / RTGS / Demand Draft and Online Payment.
- ▶ In the event of TPA / Cashless denial or approval not received due to any reason then hospital tariff will be applicable and any discount or special rates given to TPA's / Corporate won't be applicable.
- ▶ If the Surgery/ Procedures performed in emergency hours (8PM-6AM), Public Holiday and on Sunday will be charged 30% extra.
- ▶ Asst. Surgeon and Anesthetist Charges will be charged 30% on the Surgeon Charges.
- ▶ Admission will be done according to the ward category chosen by the patient; charges will be applicable as per the ward category. All charges vary as per Room category, except Pharmacy and consumables.
- ▶ Patient / Guardian Self Attested Government ID proof is mandatory to submit at the admission.
- ▶ TPA/Insurance Processing Fee applicable for all Insurance Cases.
- ▶ In our hospital there is "No Discounts Policy". Kindly co-operate.
- ▶ No Duplicate/ Second copy of OP or IP bill will be issued.
- ▶ In case the patient is shifted from lower category to higher category, all the charges like consultant visits, investigations, operations and procedures etc. from the date of admission will be charged according to the higher category.
- ▶ If the patient is shifted to the ICU, the attendant should vacate the room. If the attender occupies the room, it will be charged as per dual occupancy.
- ▶ Room eligibility is purely subject to TPA approval. Proportionate difference of the bill amount is applicable in case the patient opts for higher category higher than the TPA approved, which has to be paid by the patient and may not be reimbursed by the TPA / Insurance Company at later stage.
- ▶ For Non - Medicals, Disposables, Consumables, Infusion Pump, Taxes, Implants, HIV/ HbsAg, Medical Records, Insurance Processing Fee, Double Occupancy and Registration Charges, Etc., credit cannot be extended. These items are not payable to us as per insurance company norms (Depends on the TPA/Insurance Co. T&C).
- ▶ It takes time for cash discharge is a minimum 3-4hrs. and in the case of insurance, it will take a minimum 6-7hrs.
- ▶ Difference, if any between the final bill amount and amount permitted / approved by the TPA or total bill amount in case of denial from TPA, has to be paid by the patient.
- ▶ Two attendants are permitted with patients in Deluxe, Private Rooms and only one is permitted in the rest of the categories of rooms. No attendant is permitted in ICU's.
- ▶ All the refunds more than Rs.5,000/- will be refunded through NEFT within 7 Bank working days.
- ▶ Patient attendant can collect for Interim/provisional bill of the patient from the billing section on daily basis. Interim Bill shall be based on the acknowledged services in HIS. Final Bill of the patient may vary from the Interim bill based on actual update taken on the day of discharge. It is requested that patients/attendants enquire daily about the bill amount from billing section and pay the outstanding as on that day. You are requested to clear your outstanding amount on daily basis before 12 PM. **Patient bill outstanding should not be increase more than 10,000/-**

### DECLARATION

I have attended the Financial Counselling desk & understood the expected costs & other conditions applicable. In this case, the TPA/Insurance Company rejects the claim for whatsoever reasons at any point of time after discharge. I promise to settle the claim with the hospital as per Hospital Cash Tariff.

Patient Name : <u>Master. Hatim</u>	UHID Number : <u>AWC-00093020</u>
Self/Attendant Name : <u>Balakrishnan</u>	Relation : <u>Father</u>
Self/ Attendant Signature : <u>[Signature]</u>	Name & Signature of Financial Counselor
Phone Number : <u>98765</u>	<u>[Signature]</u>









सत्यमेव जयते  
भारत सरकार



आधार

இந்திய அரசாங்கம்  
Government of India

இந்திய தனித்துவ அடையாள ஆணையம்  
Unique Identification Authority of India

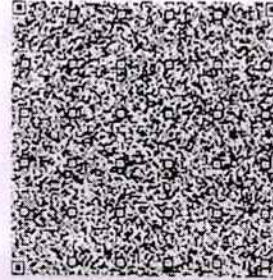
பதிவேட்டு எண் / Enrollment No.: 0000/00778/07031

To  
பாலகிருஷ்ணன்  
Balakrishnan  
35/1,  
8th Street,  
Kalapatti Road,  
Nehru Nagar,  
VTC: Coimbatore South, PO: Coimbatore Aerodrome,  
District: Coimbatore,  
State: Tamil Nadu,  
PIN Code: 641014,  
Mobile: 8012175560

00755082



KE007550824FL



உங்கள் ஆதார் எண் / Your Aadhaar No. :

**4674 2110 9684**

எனது ஆதார், எனது அடையாளம்



Aadhaar no. issued: 19/01/2014



இந்திய அரசாங்கம்

Government of India



ஆதார்

பாலகிருஷ்ணன்

Balakrishnan

பிறந்த நாள் / DOB: 30/10/1993

ஆண் / Male

ஆதார் என்பது அடையாளத்திற்கான சான்றாகும். குடியரிமை, அல்லது பிறந்த தேதிகளை சான்றல்ல. இது சரிபாற்படும் மட்டுமே பயன்படுத்தப்பட வேண்டும் (ஆன்லைன் அங்கீகாரம் அல்லது QR குறியீட்டை எங்கே செய்தல்கூட இல்லை XML)

Aadhaar is proof of identity, not of citizenship or date of birth. It should be used with verification (online authentication, or scanning of QR code / offline XML).

**4674 2110 9684**

எனது ஆதார், எனது அடையாளம்





Government of India



## தகவல் / INFORMATION

- ஆதார் என்பது அடையாளத்திற்கான சான்றாகும். குடியரிமை அல்லது பிறந்த தேதிக்கான சான்றல்ல. பிறந்த தேதி என்பது ஆதார் எண் வைத்திருப்பவரால் சமர்ப்பிக்கப்பட்ட விதிமுறைகளில் குறிப்பிடப்பட்டுள்ள பிறந்த தேதி ஆவணத்தின் ஆதாரம் மூலம் ஆதரிக்கப்படும் தகவலின் அடிப்படையில் அமைந்துள்ளது.
- இந்த ஆதார் கடிதத்தை UIDAI நியமித்த அங்கீகார நிறுவனத்தால் ஆன்லைன் அங்கீகாரம் அல்லது ஆப் ஸ்டோர்களில் கிடைக்கும் எம் ஆதார் அல்லது ஆதார் QR ஸ்கேனர் செயலியை பயன்படுத்தி QR குறியீடு ஸ்கேனிங் அல்லது [www.uidai.gov.in](http://www.uidai.gov.in) ல் கிடைக்கும் பாதுகாப்பான QR குறியீடு ரீடர் செயலியை பயன்படுத்தி சரிபார்க்க வேண்டும்.
- ஆதார் தனித்துவமானது மற்றும் பாதுகாப்பானது.
- ஆதார் பதிவு செய்யப்பட்ட நாளிலிருந்து ஒவ்வொரு 10 வருடங்களுக்குப் பிறகும் ஆதாரில் அடையாளம் மற்றும் முகவரிக்கான ஆவணங்கள் புதுப்பிக்கப்பட வேண்டும்.
- பல்வேறு அரசு மற்றும் அரசு சாரா பலன்கள் / சேவைகளைப் பெற ஆதார் உங்களுக்கு உதவுகிறது.
- உங்கள் மொபைல் எண் மற்றும் மின்னஞ்சல் ஐடியை ஆதாரில் புதுப்பிக்கவும்.
- ஆதார் சேவைகளைப் பெற mAadhaar செயலியை பதிவிறக்கவும்.
- ஆதார்/யோமெட்ரிக்ஸைப் பயன்படுத்தாதபோது பாதுகாப்பை உறுதிசெய்ய, ஆதார்/யோமெட்ரிக்ஸ் லாக்/அனலாக் அம்சத்தைப் பயன்படுத்தவும்.
- ஆதார் கோரும் நிறுவனங்கள் ஒப்புதலைப் பெற வேண்டிய கட்டாயம் உள்ளது.
- Aadhaar is proof of identity, not of citizenship or date of birth (DOB). DOB is based on information supported by proof of DOB document specified in regulations, submitted by Aadhaar number holder.
- This Aadhaar letter should be verified through either online authentication by UIDAI-appointed authentication agency or QR code scanning using mAadhaar or Aadhaar QR Scanner app available in app stores or using secure QR code reader app available on [www.uidai.gov.in](http://www.uidai.gov.in).
- Aadhaar is unique and secure.
- Documents to support identity and address should be updated in Aadhaar after every 10 years from date of enrolment for Aadhaar.
- Aadhaar helps you avail of various Government and Non-Government benefits/services.
- Keep your mobile number and email id updated in Aadhaar.
- Download mAadhaar app to avail of Aadhaar services.
- Use the feature of Lock/Unlock Aadhaar/biometrics to ensure security when not using Aadhaar/biometrics.
- Entities seeking Aadhaar are obligated to seek consent.



இந்திய தனித்துவ அடையாள ஆணையம்

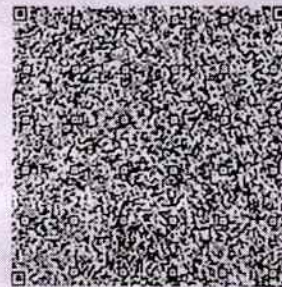
Unique Identification Authority of India



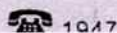
முகவரி: 35/1, 8வது வீதி,  
காளப்பட்டி ரோடு, நேருநகர்,  
கோயம்புத்தூர் தெற்கு,  
கோயம்புத்தூர், தமிழ்நாடு, 641014

Details as on 23/09/2025

Address: 35/1, 8th Street, Kalapatti Road,  
Nehru Nagar, Coimbatore South,  
PO:Coimbatore Aerodrome, DIST:Coimbatore,  
Tamil Nadu, 641014



4674 2110 9684



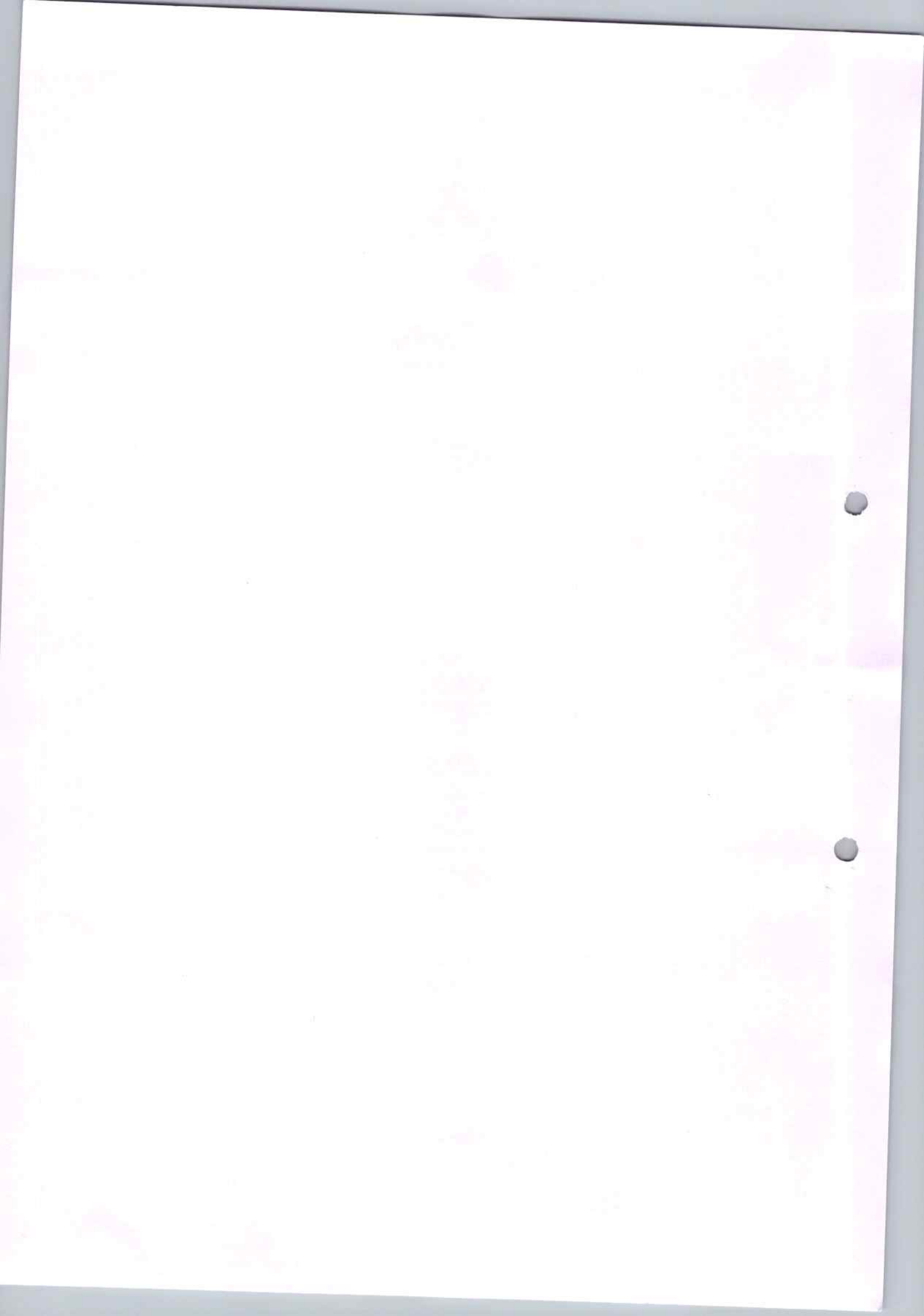
1047



help@uidai.gov.in



[www.uidai.gov.in](http://www.uidai.gov.in)





**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: \_\_\_\_\_

GUC-00093020

Master HATIM.B

26-03-2020

Dr. NATARAJ PALANIAPPAN

IP18-00036162

6 Y 2 M 29 D (M)





## Pediatric Multiorgan History & Physical Examination

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

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

### Chief Presenting Complaints & Duration (Chronologically)

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---

### History of present illness :

90 fever - D5                      90 rash on D2 of fever  
high grade, ass. c. chills & rigors, & anorexia

90 abdominal pain x 5 days

90 vomiting - 2 episodes

90 lethargy +

90 ↓ oral intake +

90 ↓ urine output +

H/o mouth breathing +

H/o ↑ daytime sleepiness +

X ray adenoid was taken 2 years back &  
nasal spray was given for 6 weeks.



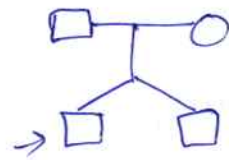
Past History (including details of any previous investigation or treatment)

+/o febrile seizures - onset @ 15m g age &  
3 episodes till 3 years, was on intermittent clobazam

Birth & Neonatal History:

Term / BW - 1.6 kg / CIAB / NO A/o  
NICU admission

Family Chart



Birth & Socio Economic History:

About Father : \_\_\_\_\_

About Mother : \_\_\_\_\_

Any additional information : \_\_\_\_\_

Developmental History :

(N)

Immunization History :

5 years vaccine pending

Anthropometry :

Head Circum (cms) \_\_\_\_\_ (Centile \_\_\_\_\_ ) Height (cms): \_\_\_\_\_ (Centile \_\_\_\_\_ )

Weight (kgs) 16.4 (Centile \_\_\_\_\_ )

On Examination :

Temperature : 100.3 °F Pulse Rate : 122 B.P. 105/75 SPO2 100%

Resp. rate and type of breathing : 22

Rash conjunctival suffusion + erythematous maculopapular rash over face, trunk & upper limb

Lymphadenopathy \_\_\_\_\_

Oedema : \_\_\_\_\_

Allergies (if any): \_\_\_\_\_

**Respiratory System :**

Inspection (any s/o distress) : N

Air entry & breath sounds : Bil AE+

Any added sounds : -

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

**Cardiovascular System :**

Inspection of precordium : N

Heart Sounds : S<sub>1</sub>, S<sub>2</sub>+

Any murmur : -

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

**Per Abdomen :**

Inspection : N

Palpation : soft, epigastric tenderness + 1cm BOM +

Auscultation : BS+

Spine : \_\_\_\_\_ External Genitalia : N

Relevant data from outside (CT, USG etc.,) \_\_\_\_\_

**Central Nervous System :**

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

Cranial Nerves : N

**Motor System :**

Nutrition : N

Tone : N Power N

Co-ordinator : \_\_\_\_\_

Posture : N

Involuntary Movements : -

Patient Sticker

GUC-00093020 IP18-00036162  
Master HATIM.B  
26-03-2020 6 Y 2 M 29 D (M)  
Dr. NATARAJ PALANIAPPAN



Reflexes :

DTR

Plantars

Sensory System :

Superficials:

Bladder / Bowel :

Clinical Summary & Diagnostic:

? Dengue with warning signs (D5 of illness)

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

Desired goals of the treatment :

Planned Labs:

CBC

CRP

RP - II

SGOT / PT

Blood Gs

Dengue NS 2, Ig M

Urine R/E

X ray - lateral neck  
for adenoids

Signature of the Doctor:

Name of the Doctor:

Date & Time:

*Keerthana D*  
125882

Keerthana D

24/6/26 11:30am

Planned Management

IVF

Dr: Pan

ENT opinion for  
adenoid hypertrophy

Signature of the Consultant:

Name of the Consultant:

Date & Time:

(P.T.O.)

Patient Sticker

# DISCHARGE PLANNING FORM

**NOTE:** \* To be completed by a Doctor within (24) hours of admission.

1. Anticipated Date of Discharge: .....

2. Destination Post Discharge:  Home  
Family Members Notified (Person Contacted)

Transfer  
Hospital Facility Notified (Person Contacted)

3. Discharge Status:  Self Care  Family Home Care  Home Professional Assistance

Needs Assistance in:

- |                                     |                              |                             |
|-------------------------------------|------------------------------|-----------------------------|
| <input type="checkbox"/> Medication | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Bathing    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Eating     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Walking    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Dressing   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Toileting  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Remarks

.....  
.....  
.....  
.....  
.....  
.....

4. Nutritional Plan:

Dietary Instruction Discussed with the:  
 Patient  Family Member

Others: .....

5. Discharge Planning Discussed with the:

Patient  Family Member

Others: .....

6. Patient/Family Educational Plan:

Educational Topic/s: .....

Patient's Educational Topic/s discussed with the:

Patient  Family Member

Others: .....

Doctor Signature: .....

Doctor Name: .....

Date and Time: .....



# DOCTOR'S SHIFT CHANGE HANDOVER FORM



Date: .....

Department: .....

Shift: .....

S.No	Patient Identification	Diagnosis / Procedure	Clinical Findings Problems	Special Concerns / Investigations / Abnormal Results	Recommendations / Follow up needed	Handing Over Doctor	Receiving Over Doctor

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28-03-2020 6 Y 2 M 29 D (M)  
Dr. NATARAJ PALANIAPPAN



# CROSS CONSULTATION FORM

Doctor Name : ..... Date : 24/6/26 ..... Time : .....

Diagnosis : .....

Hospital : .....

Referred for :  Opinion  Co-Management  Transfer of care

Type of Referral :  
 Emergency  
 Urgent  
 Non Urgent

Reason for Referral : If for concurrent care specify the particular need, especially in the absence of a second diagnosis:

Signature: \_\_\_\_\_

## Findings and Recommendations :

Throat / in the neck  
- of MF Rec'd UN- Search /  
tel, recurrent subglottic  
UN- not UN-  
grade 3b  
See (2) for wt sea 6g  
(2) 5a dell  
(PTC)

Consultant :  
Name : Nataraj ..... Signature : [Signature] ..... Date & Time : 24/6/26

Qdc

- metasy nad sy

out x 3wch

to keep of the 3wch

↓  
3  
labon-



Patient Sticker

### PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	<p><del>s/p Dr. Nalini</del></p> <p><del>Dental &amp; wound sign</del></p> <p><del>TO ↑ order</del></p> <p><del>8/8/81</del></p>	
<p>24/6/16 3pm</p> <p>24/6/16 6pm</p>	<p>s/p Dr. Chandirabage</p> <p>D - Dengue fever &amp; warning signs</p> <p>child reviewed</p> <p>Alert, dull looking</p> <p>c/o Abdominal pain (P)</p> <p>no rash, vomiting, abd distension</p> <p>UO - Adequate 960ml</p> <p>O/E</p> <p>Afebrile</p> <p>CVS - S.S (P)</p> <p>RS - B/LC/E (P)</p> <p>PIB - soft, non tender</p>	



Patient Sticker

### PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	<p><u>Adv:</u></p> <ul style="list-style-type: none"> <li>- Plan about repeat investigation</li> <li>- monitor vitals (BP, PR)</li> <li>- Glu monitoring</li> <li>- IV fluids @ 40ml/hr - Plan to stop</li> <li>- W/F Abd Pain, myalgia, fever spikes</li> </ul>	
	<p><u>ENT</u> 14/2/24</p>	
25/6/26	<p>S/D <u>D. Nohary</u></p> <p>↓ IVF - 20ml/h</p> <p>Tamoxifen 1 cbc.</p> <p>Discharge home</p>	<p><u>Gole J</u></p> <p>85887</p>
25/6/26	<p>S/D <u>D. Nohary</u></p> <p>@ Cath Same</p>	<p><u>Gole J</u></p> <p>85887</p>

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26-03-2020

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(M)

Dr. NATARAJ PALANIAPPAN



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

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

## RESULT SHEET

Date	(outside) 22/6	(outside) 24/6	24/6/20			
Time						
Hb	13.6	13.7	14.3			
PCV	40%	41.1%	41			
RBC	4.97	5.10	5.24			
WBC	6400	2200	2600			
N/L	$\frac{30}{52} / \frac{152}{17}$	$\frac{33}{52} / \frac{152}{14}$	$\frac{35}{13} / \frac{152}{13}$			
Platelets	1.77L	1.53L	1.69,000			
CRP			LS			
ESR						
PCT						
RBS						
Na			135			
K			4.5			
Cl			101			
i°Ca/Mg			1.1			
Phosphate	HCO <sub>2</sub>		19			
Urea			11			
Creatinine			0.78			
ALP						
SGPT			28			
SGOT			68 ↑			
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	24/6/26				
Time					
CUE - Alb	-				
CUE - Sugar	-				
CUE - Ketones	-				
CUE - PUS Cells	1-3				
CUE - RBC Cells	1-2				
CUE Leukocyte	negative				
nitrate	negative				
Stool Pus Cell					
OVA / Cyst					
Occult Blood					
Dengue NS <sub>1</sub> / IgM	Positive				

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI : .....

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

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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: ..... ICU ..... Shifted to: ..... ICU .....

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	SYP. P250	5ml	PO	SOS	24/6 11:15 am	<input checked="" 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 : ..... [Signature] 125882 .....

Date & Time : ..... 24/6/26 11:30 am .....

Nurse Name & Signature : ..... Praveen 3849 .....

Date & Time : ..... 24/6/26 11:30 am .....



Department of Health and Human Services  
Office of the Inspector General

Office of the Inspector General  
Department of Health and Human Services

# INDICATION CHECK

Medication Reconciliation will be done at the time of admission, transfer, or discharge. (Examples of medication reconciliation events are provided below.)

Shifting From: \_\_\_\_\_ To: \_\_\_\_\_

Sl. No.	Medication Class	Generic Name	Strength	Frequency	Route	Indication
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						

MEDICATION HISTORY REPORT

Doctor Name & Speciality: \_\_\_\_\_

Date & Time: \_\_\_\_\_

Time & Location: \_\_\_\_\_

Date & Time: \_\_\_\_\_

Doc for RCH: \_\_\_\_\_



# DRUG CHART

Date of Admission: 24/6/26 Drug Allergies: nil  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	
5ml	PO	SOS	24/6	
Doctor's Signature		Valid Period	Pharm.	
<i>[Signature]</i>				
Additional Instructions:				
<u>\$ 17100 F</u>				
DRUG :				Date/Time
Dose	Route	Frequency	Start Date	
5mg	IV	SOS	24/6	
Doctor's Signature		Valid Period	Pharm.	
<i>[Signature]</i>				
Additional Instructions:				
DRUG :				Date/Time
Dose	Route	Frequency	Start Date	
Doctor's Signature		Valid Period	Pharm.	
Additional Instructions:				

VERIFIED BY : Name Signature



REGULAR PRESCRIPTIONS

Weight 16.4 kg Ward.....

**DRUG :** INS. PAN

Dose	Route	Frequency	Start Date	Date Time
<u>20mg</u>	<u>IV</u>	<u>OD</u>	<u>24/6</u>	<u>24/6/2016</u> <u>11:30 AM</u>

Name & Signature of the Doctor Starting the Drugs: [Signature]

Additional Instructions:

Daily Doctor's Endorsement by a Sign

**DRUG :** Syp. Cefixime

Dose	Route	Frequency	Start Date	Date Time
<u>3.5ml</u>	<u>PO</u>	<u>B.D</u>	<u>24/6</u>	<u>24/6/2016</u> <u>8 AM</u>

Name & Signature of the Doctor Starting the Drugs: [Signature]

Additional Instructions:

Daily Doctor's Endorsement by a Sign

**DRUG :** Syp. Sucralfate

Dose	Route	Frequency	Start Date	Date Time
<u>5ml</u>	<u>PO</u>	<u>TDS</u>	<u>24/6</u>	<u>24/6/2016</u> <u>1 PM</u>

Name & Signature of the Doctor Starting the Drugs: [Signature]

Additional Instructions:

Daily Doctor's Endorsement by a Sign

**DRUG :** MOMETASONE NASAL SPRAY

Dose	Route	Frequency	Start Date	Date Time
<u>1</u>	<u>PN</u>	<u>B24H</u>	<u>24/6/2016</u>	<u>24/6/2016</u> <u>8 PM</u>

Name & Signature of the Doctor Starting the Drugs: [Signature]

Additional Instructions: At night

Daily Doctor's Endorsement by a Sign

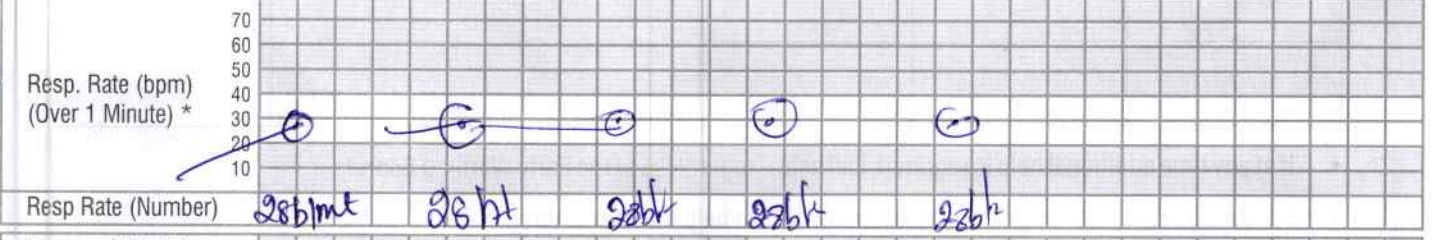
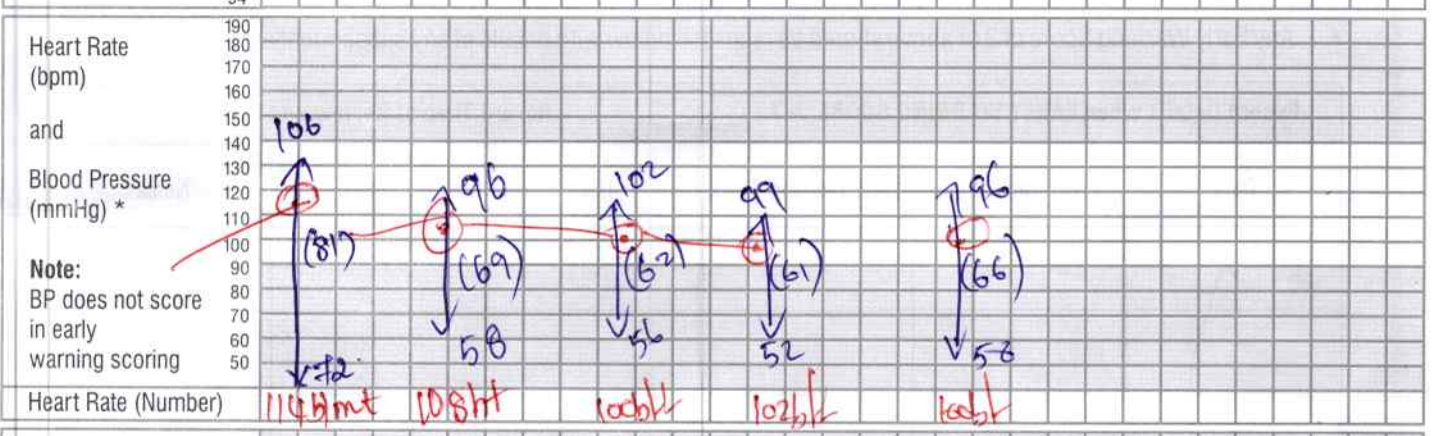
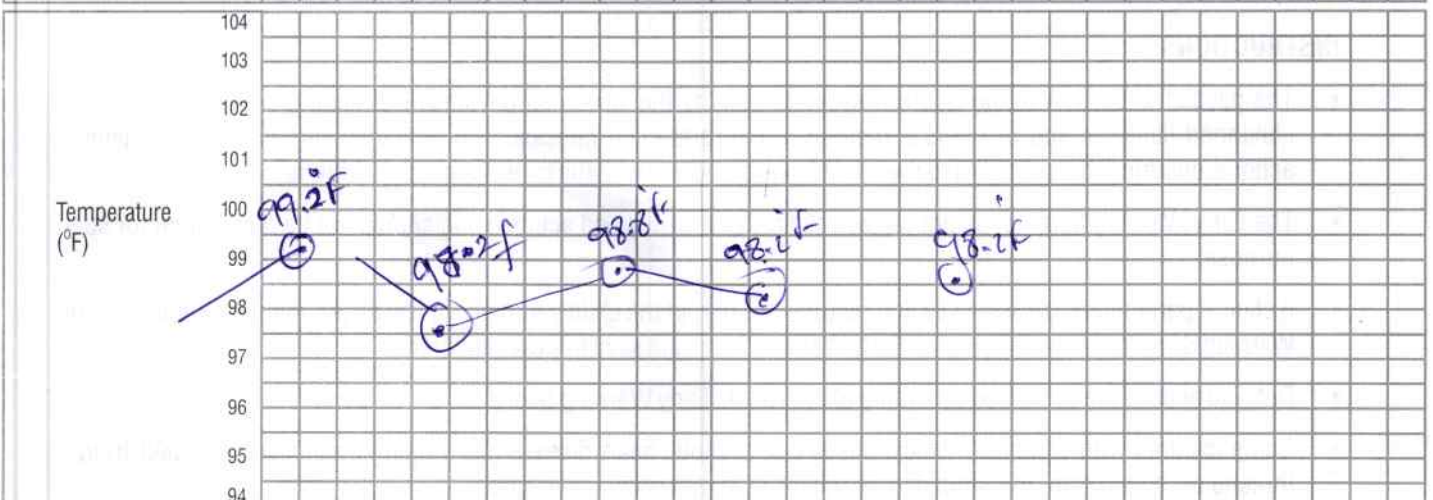






**EARLY WARNING SCORE: CHILDREN'S UNIT**

Date : 24/6 Time: 2.45pm 4pm 8pm 12AM 4AM  
 Doctor / Nurse / Family Concern?



Heart Rate (Number)	114bmt	108bt	100bt	102bt	100bt
Resp Rate (Number)	28bmt	28bt	28bt	28bt	28bt
Resp Distress	✓	✓	✓	✓	✓
Receiving O <sub>2</sub> (l/min)	✓	✓	✓	✓	✓
O <sub>2</sub> Saturations (%)	99%	98%	99%	99%	99%
Conscious Level	✓	✓	✓	✓	✓
GCS *	15/15	15/15	15/15	15/15	15/15

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

**ACTIONS**

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

NB: Scores 3 should be recorded overleaf

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

## CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

### INSTRUCTIONS:

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

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

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

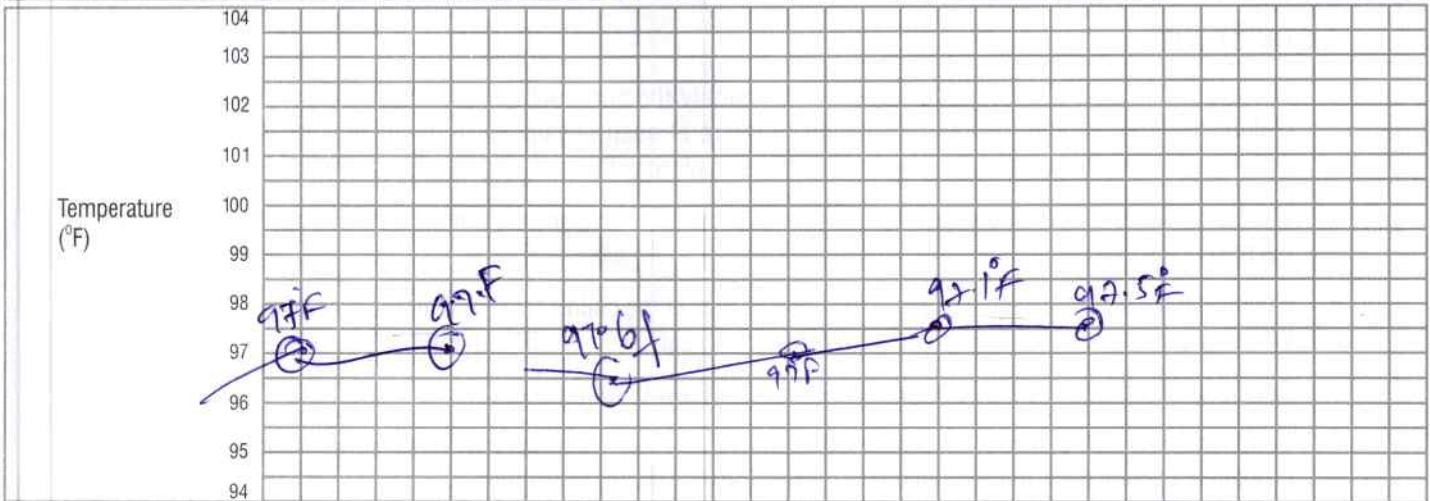
The SBAR communication tool (situation, background, assessment, recommendations) is a helpful mnemonic that can be used to describe a child's clinical condition to a colleague.

<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 : 25/6/26 Time: 8am 12pm 4pm 8pm 12am 4am  
 Doctor / Nurse / Family Concern?



Heart Rate (Number) 116b/min 92b/min 110b/min 80b/min 86b/min 92b/min



Resp Rate (Number) 28b/min 28b/min 28b/min 28b/min 28b/min 28b/min

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

<b>TOTAL SCORE</b>	
Number of shaded boxes	0
Pain Score	0
Observer's Initials	UB, RB, AR, RS, R, R

**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.

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

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28-03-2020

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(M)

Dr. NATARAJ PALANIAPPAN



# FLUID CHART

Sheet No. : ..... 1 .....

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

Date	Time	Intake			Output					IV Site Thrombo- phlebitis Score	Sign. Nurse	
		Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage			Urine
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm	Child retained received from ER to 4th Floor										
	01:00 pm									✓	0	Baleg
Total Intake :		54ml.			Total Output : 1 time urine passed							
	02:00 pm	wats 50ml		54ml							0	OK
	03:00 pm	wats 200ml		40ml					40ml		0	OK
	04:00 pm			40ml							0	OK
	05:00 pm	Tea 200ml		40ml					300ml		0	OK
	06:00 pm	wats 200ml		40ml							0	OK
	07:00 pm	wats 150ml		40ml					260ml		0	OK
Total Intake :		900ml + 254ml			Total Output : 960ml							
	08:00 pm	wats 150ml		40ml					230ml		0	OK
	09:00 pm			40ml							0	OK
	10:00 pm	wats 100ml		40ml					400ml		0	OK
	11:00 pm			40ml							0	OK
	12:00 am	wats 50ml		40ml					200ml		0	OK
	01:00 am			40ml							0	OK
Total Intake :		300ml + 240ml			Total Output : 830ml							
	02:00 am	wats 100ml		40ml							0	OK
	03:00 am			40ml							0	OK
	04:00 am			40ml							0	OK
	05:00 am			40ml							0	OK
	06:00 am	wats 100ml		40ml					400ml		0	OK
	07:00 am			40ml							0	OK
Total Intake :		200ml + 240ml			Total Output : 420ml							
Total 24 hrs. Intake		2,188ml										
Total 24 hrs. Output		1 time urine + 2,210ml										





**FLUID CHART**

Sheet No. : 2

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
	08:00 am			IV 20ml					20ml	0	Bali	
	09:00 am	water	20ml	20ml					20ml	0	Bali	
	10:00 am	water	20ml	20ml					✓	0	Bali	
	11:00 am	water	20ml	20ml						0	Bali	
	12:00 pm	saup	100ml	20ml					40ml	0	Bali	
	01:00 pm			20ml						0	Bali	
<b>Total Intake :</b>			700ml + 40ml			<b>Total Output :</b>					820ml	1 times urine pass
	02:00 pm	klaf	100ml	20ml					150ml	0	Sh	
	03:00 pm			20ml					20ml	0	Sh	
	04:00 pm			20ml						0	Sh	
	05:00 pm	klaf	150ml	20ml					260ml	0	Sh	
	06:00 pm	Milk	200ml	20ml					360ml	0	Sh	
	07:00 pm			20ml						0	Sh	
<b>Total Intake :</b>			450ml + 80ml			<b>Total Output :</b>					940ml	
	08:00 pm	Her	150ml	20ml						0	Rfu	
	09:00 pm			20ml					320ml	0	Rfu	
	10:00 pm	Azo	200ml	20ml						0	Rfu	
	11:00 pm			20ml						0	Rfu	
	12:00 am			20ml						0	Rfu	
	01:00 am			20ml						0	Rfu	
<b>Total Intake :</b>			300ml + 120ml			<b>Total Output :</b>					320ml	
	02:00 am			20ml						0	Rfu	
	03:00 am			20ml						0	Rfu	
	04:00 am			20ml						0	Rfu	
	05:00 am			20ml						0	Rfu	
	06:00 am			20ml					360ml	0	Rfu	
	07:00 am			20ml						0	Rfu	
<b>Total Intake :</b>			60ml			<b>Total Output :</b>					360ml	

Total 24 hrs. Intake 1900ml

Total 24 hrs. Output 2440ml + 1 time

over 24 hrs } - 6.1 ml/kg/hr.





### NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: ? Dengue & warning signs.	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Not Known If Yes Specify: .....						
	Surgery / Procedure: -	Post OP Day: -						
BACKGROUND	Date / Shift	24/6 M	24/6 Evening	24/6 N	25/6 M	25/6 Evening	25/6 N	
	Medical Condition (Any special condition to be noted):	Noted	Noted	Noted	Noted	Noted	Noted	
	Diet:	Ⓝ diet	Ⓝ diet	Ⓝ diet	Ⓝ diet	Ⓝ diet	Ⓝ diet	
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):	RA	RA	RA	RA	RA	RA	
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input 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:	99.2 F	98.9 F	98.8 F	97 F	98.2 F	98.2 F
		Res:	28 blwt	28 bt	28 blwt	28 blwt	28 bt	28 blwt
		SpO <sub>2</sub> :	99%	98%	99%	99%	98%	98%
		Pulse:	114 blwt	108 bt	100 blwt	116 blwt	112 bt	108 blwt
		BP:	106/72	96/58	102/56	99/62	100/59	98/56 (66)
		LOC:	15/15	15/15	15/15	15/15	15/15	15/15
	Fall Risk Score:		-	-	-	-	4	
Pain Score:	0/10	0/10	0/10	0/10	0/10	0/10		
Skin Integrity		-	-	-	-	2+		
Recommendations	Safety Needs:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	Physiotherapy:	-	-	-	-	-	-	
	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:	Ⓝ diet	Ⓝ diet	Ⓝ diet	Ⓝ diet	Ⓝ diet	-	
	Critical Lab Test / Values:	-	-	-	-	-	-	
	Other Special Orders / Medications:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	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):	Dependent	Dependent	Dependent	Dependent	Dependent	Dependent		
Post Operative Procedure Special Orders:	-	-	-	-	-	-		
Handed Over By Name :	Balraj	Angel	Basi	Balraj	Angel	Aritha		
Signature / ID :	Balraj 20685	Angel 0401895	Basi 20626	Balraj 20685	Angel 0401895	Aritha 206520		
Date:	24/6/26	24/6/26	25/6/26	25/6/26	25/6/26	26/6/26		
Time:	1:30pm	7:30pm	7:30am	1:30pm	7:30pm	7:30am		
Taken Over By Name :	Angel	Basi	Aritha	Angel	Aritha	Aritha		
Signature / ID :	Angel 0401895	Basi 20626	Aritha 206520	Angel 0401895	Aritha 206520	Aritha 206520		
Date:	24/6/26	24/6/26	25/6/26	25/6/26	25/6/26	26/6/26		
Time:	1:30pm	7:30pm	7:30am	1:30pm	7:30pm	7:30am		

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# NURSING CARE RECORD

Date: 24/6/26

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	12:30pm	Maintain fluid - Balance	1pm	I/O chart maintain Administer of IV - fluid Encourage oral - fluids	maintained fluid Balance.	Reassessment - done.	Balaji 02685
Afternoon	2pm	maintain personal hygiene.		Assess child condition maintain vital signs and I/O chart maintain hand hygiene.	Personal Hygiene was improved	Reassessment was done Vital are stable	Chy 02890
Night	7:30 pm	maintain fluid Balance	8pm	Encourage oral fluids. Administer IV fluids I/O chart maintained	maintained fluid Balance	Reassessment Done	Balaji 60726



# NURSING CARE RECORD



Date: 25/6/20

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	8am	Maintain nutritional status	10am	Assess the child's condition Monitor vitals Administered medicines Maintain Glucoact	Maintained good nutritional status	Reassessment done child was stable	Dr. Rajan
Afternoon	1:30 pm	Maintain fluid balance		Assess child condition Maintain vital signs and Glucoact Maintain hand hygiene	Improved fluid volume	Reassessment was done vital are stable	Dr. Rajan
Night	8pm	Maintain Good Nutritional status		Assess child condition Encouraged to take more oral intake	oral intake good	Reassessment done	Dr. Rajan



# NURSES NOTES

No Known Drug Allergies

Drug Allergies ..... Nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE						
		<i>Receiving Notes</i>							
24/6.	12.45pm	The child received from ER to 4th floor. Child details handing over taken from ER staff. Child is conscious. IV line present & patency. Vital signs checked & recorded. Vitals are stable.							
		<table border="1"> <tr> <td>CP</td> <td>PP</td> <td>CRP</td> </tr> <tr> <td>++</td> <td>++</td> <td>&lt;3sec</td> </tr> </table>	CP	PP	CRP	++	++	<3sec	
CP	PP	CRP							
++	++	<3sec							
	1pm.	IVF 0.9% DNS 500ml - 54ml/hr on flow. I/O chart maintained →	Balevi/020685						
	1.30pm	The child details handing over given to evening duty staff →	Balevi/020685						
		→ Evening duty on: 24/6/2020							
	1.30pm	child details hand over taken from morning duty staff. Child is conscious & oriented. Child IV cannula patent.	018950						
	2pm	IV fluid DNS 54ml per on flow. Child intake was good.							
	3.30 pm	Dr. Nataraj. Sir seen the child. Sir advise IV fluid DNS 40ml per on flow - Sup. cetirizine and Sucralfat acid. Due to medication -	dy 018950						

**NOTE : DO NOT WRITE OUTSIDE THE MARGINS**

Patient Sticker



# NURSES NOTES

- No Known Drug Allergies
- Drug Allergies ..... nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE						
24/6	4pm	<p>→ continue 24/6/26</p> <p>Given as per doctor's Order</p> <p>Vital signs checked and</p> <p>Recorded vital are stable</p> <table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td>CP</td> <td>PP</td> <td>CRT</td> </tr> <tr> <td>++</td> <td>++</td> <td>&lt;3sec</td> </tr> </table>	CP	PP	CRT	++	++	<3sec	Shy 018950
CP	PP	CRT							
++	++	<3sec							
	6pm	<p>Continue by guided DNS</p> <p>40ml per hour flow</p> <p>No any complaints</p> <p>Sto about Maintained</p>							
	7:30pm	<p>child details hand over</p> <p>given to night duty staff.</p>	Shy 018950						
24/6/26	7:30pm	<p style="text-align: center; color: red;">Night Duty</p> <p>The child details handing</p> <p>over taken from evening</p> <p>duty staff. Child is conscious</p> <p>and oriented child is</p> <p>on room air. IV line</p> <p>Present. IV line Pattern</p>	Ras 60726						
	8pm	<p>vital signs are checked</p> <p>and recorded. vital signs</p> <p>are stable.</p> <table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td>CP</td> <td>PP</td> <td>CRT</td> </tr> <tr> <td>++</td> <td>++</td> <td>&lt;3sec</td> </tr> </table>	CP	PP	CRT	++	++	<3sec	Ras 60726
CP	PP	CRT							
++	++	<3sec							
		<p>Due medications are</p> <p>given as per doctor's</p> <p>order.</p>							

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



# NURSES NOTES

No Known Drug Allergies

Drug Allergies ..... Nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE						
10pm		(Continue) →							
24/6/26	10pm	NO any other fresh complaints Patient is stable.	Basi 602262						
	12pm	vital signs are checked and recorded. vital signs are stable							
		<table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td>CP</td> <td>PP</td> <td>CRF</td> </tr> <tr> <td>++</td> <td>++</td> <td>13sec</td> </tr> </table>	CP	PP	CRF	++	++	13sec	Basi 602262
CP	PP	CRF							
++	++	13sec							
	2pm	No chart is maintained Ev fluid 0.9% GNS @ 40ml/hr on flow No any other complaints							
	4pm	vitals are checked and recorded temp is normal							
		<table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td>PP</td> <td>++</td> </tr> <tr> <td>CP</td> <td>++</td> </tr> <tr> <td>CRF</td> <td>CRS</td> </tr> </table>	PP	++	CP	++	CRF	CRS	
PP	++								
CP	++								
CRF	CRS								
	6am	Administer the medication as per doctor's orders							
	7.30am	The child details handover given to morning duty staffs.	012262						
		→ Morning Duty 25/6/26 ←							
	11.30am	Child details handover taken from Night duty S/N. Child was conscious & well. A line present & pattern chart under the covers checked sorted	B. D. S. 29/6/26						

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

# NURSES NOTES

No Known Drug Allergies

Drug Allergies ..... nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
25/10/26	8am.	<p>→ Continue notes</p> <p>Due medication given as per drug chart order.</p> <p>Vitals are checked &amp; stable.</p> <p>Vitals are stable   PP   CP   CRT     #   TT   C3E</p>	
	8.10AM	<p>Dr. Nafisaj sir came &amp; seen the child advice to reduce the IV fluids to 20ml/hr to maintain to do CBC, &amp; tomorrow plan Dis. &amp; continue further treatment.</p>	P. S. Duggal 25/10/26
	10am.	<p>child was no any fresh complaints. child clear stable.</p>	
	12pm.	<p>Vitals are checked &amp; stable.</p> <p>Vitals are stable.   PP   CP   CRT     #   TT   C3E</p> <p>NO fever.</p> <p>Maintained AFO chart.</p>	
	1.30pm	<p>Child details handed over to the evening duty staff.</p> <p>→ Evening duty Co: 25/10/26</p>	P. S. Duggal 25/10/26
	1.30pm	<p>Child details hand over taken from morning duty staff.</p> <p>Child is conscious &amp; oriented -</p>	Dr 018950.

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

GUC-00093020 IP18-00036162  
 Master HATIM.B  
 28-03-2020 6 Y 2 M 29 D (M)  
 Dr. NATARAJ PALANIAPPAN



### E HUMPTY DUMPTY SCALE

M E N M E

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
			24/6	24/6	24/6	25/6	25/6
Age	Less than 3 years old	4					
	3 to less than 7 years old	3	3	3	3	3	3
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	2	2	2	2	2
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.)	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1	1	1	1
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2	2	2	2	2	2
	Oriented to own ability	1					
	History of Falls or Infant-Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2					
	Outpatient Area	1	1	1	1	1	1
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours/ None	1	1	1	1	1	1
Medication Usage	Sedatives (Excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1	1	1	1
<b>Total</b>			11	11	11	11	11

**Intervention:** -Fall Risk: Low Humpty Dumpty Score = 7-11, High Risk Humpty Dumpty Score = 12 or above

Bed in low position	✓	✓	✓	✓	✓
Call device within reach	✓	✓	✓	✓	✓
Wheels Locked	✓	✓	✓	✓	✓
Room free of clutter	✓	✓	✓	✓	✓
Adequate lighting	✓	✓	✓	✓	✓
Wheel chair support	-	-	-	-	-
Other Intervention(s) Specify	-	-	-	-	-
Nurse's Name:	Balraj	Angel	Angel	Angel	Angel
Signature:	Balraj	Angel	Angel	Angel	Angel
Date:	24/6	24/6	24/6	25/6	25/6
Time:	1pm	2pm	3pm	8am	2pm



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35.  $\frac{1}{x^{36}} = x^{-36}$   
 $\frac{d}{dx} x^{-36} = -36x^{-37} = -\frac{36}{x^{37}}$

**STUDY OF SERIES**  
 (Chapter 11)



GUC-00093020 IP18-00036162

Master HATIM.B  
26-03-2020 6 Y 2 M 29 D (M)  
Dr. NATARAJ PALANIAPPAN



# Admission Assessment Form For Pediatrics

Diagnosis: ? Dengue E warning sign  
 Arrival Time: 12.45 pm Mode of Arrival: Walking Admitting From:  ER  OPD  Direct  
 Allergy / Adverse Reaction: Nil Body Weight: 16.4 Kg  
 Height: cm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
-	-	-

Family History: .....

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

If yes please list, .....

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

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

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

Observations: Weight: 16.4 kg Length: ..... Head Circumference (< 2 years): .....  
 Temp.: 99.2 F HR: 124 b/min RR: 28 b/min BP: 102/72 (81) mmHg

Pain Score: 0/10 Specify Site: ..... (Follow Pain Assessment Sheet & Document)

Fall Risk Assessment:  Yes  No Score: 12 (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: 0/10 Pain Tool Used:  N Pass  FLACC  Wong Baker

Character of Pain ..... Location ..... Frequency ..... Duration .....

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

Inform consultant for positive criteria

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

Inform consultant for positive criteria

Psychological Screening:  No Significant Findings

Unusual concerns about patient's Psychological Status:  Yes  No

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

Social History: Lives With .....

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: BANA 020685

Date: 24.6.26 Time: 1 p.m.

Signature: BANA 020685

11 AM. P250 5ml oral given.



# EMERGENCY ROOM TRIAGE FORM

Patient's Name: HATIM Age: 6y Gender:  Male  Female  
 Date: 24/6/2020 Time of Arrival: 10:45 AM

Allergies:  No  Yes  Food  Medications  Blood Transfusion  Other (Specify): 5  Not known

Source of Information:  Parents  Others (Specify) \_\_\_\_\_  
 Mode of Arrival:  Ambulatory  Wheelchair  Ambulance

Initial Vital Signs: Temp: 100.3°F PR: 123 BP: 105/75 RR: 22 SpO<sub>2</sub>: 100  
 Chief Complaints: cl. fever x 5 days

<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		Work of Breathing <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Increased <input type="checkbox"/> Decreased <input type="checkbox"/> Gasping / Apnea	<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
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Triage Classification	CTAS
<input type="checkbox"/> Level 1: Resuscitation	<input type="checkbox"/> Immediate
<input type="checkbox"/> Level 2: EMERGENT: Life or limb threatening	<input type="checkbox"/> < 15 min
<input type="checkbox"/> Level 3: URGENT: Significant illness / injury with potential to become life or limb threatening	<input type="checkbox"/> 30 min
<input type="checkbox"/> Level 4: LESS URGENT: Significant illness but not life threatening	<input checked="" type="checkbox"/> 60 min
<input type="checkbox"/> Level 5: NON - URGENT: May receive care when convenient	<input type="checkbox"/> 120 min

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

Signature of Parent / Guardian: [Signature]  
 Triage Completion Time: 11:00 AM

\* 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: Praveen

Signature of Triage Nurse: [Signature]

Date & Time: 24/6/2020 At 10:45 AM





**NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM**

Date : 26/6/20 Time of arrival : 10:45 AM  
 Chief Complaints : No fever x 5 days RBS: 102 mg/dl  
 Height : - Weight : 16.4 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: 9/10 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><input checked="" type="checkbox"/> Escort while ambulating</li> <li><input checked="" type="checkbox"/> Assist Patient</li> <li><input checked="" type="checkbox"/> Educate patient and family on fall precautions/prevention</li> </ul>	<p><b>Functional Screening:</b> <input checked="" type="checkbox"/> No Abnormalities Detected</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Mobility Problem</li> <li><input type="checkbox"/> Walking Problem</li> <li><input type="checkbox"/> Developmental Delay</li> <li><input type="checkbox"/> Musculoskeletal Congenital Abnormality</li> </ul> <p><b>Inform consultant for positive criteria</b></p> <p><u>-</u></p> <p><b>Nutritional Screening:</b> <input checked="" type="checkbox"/> No Abnormalities Detected</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Underweight</li> <li><input type="checkbox"/> Overweight</li> <li><input type="checkbox"/> Feeding Problem</li> <li><input type="checkbox"/> Special diet</li> <li><input type="checkbox"/> Special feeding method</li> </ul> <p><b>Inform consultant for positive criteria</b></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 parents  
 Siblings in household  Yes  No (if yes How Many?) -  
 Time of Initial assessment completed by ER Nurse : 15 min

Time	Nursing Notes
10:45 AM	patient came to ER for no
	fever of 5 days after investigation
	Dr. Nataraj advised for admission
	vitals are checked and recorded
	2x line placement done samples
	are collected and send to lab
	patient shifted to ward.

Samples collected by: s/n Subhadip

Time: } 11:25 AM

Samples sent by: s/n praveen

**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: ..... 123 ..... BP: 105/75 ..... CFT: <3ml	Shift - out from ER to: ..... 401 .....
RR: ..... 24 ..... SPO <sub>2</sub> : ..... 98% .....	Time of Shift - out: ..... 12:15pm .....
GCS: ..... 15/15 ..... Temperature: ..... 98.3°f .....	Handover given to: ..... s/n. V. R. Subhadip .....
Pain Score: ..... 0/10 .....	(Nurse's Name)
Repeat RBS (if applicable): .....	

Tick as applicable:  MLC  LAMA  BROUGHT DEAD

Procedures done with details (if any): ..... 2x line placement done @ metacarpal 22 G. ....

Name of the Nurse : ..... praveen .....

Signature of the Nurse : ..... [Signature] .....

Date & Time : ..... 24/6/2020 .....



# PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor: Dr. Nataraj Date: 24/6/26  
 Type of Admission:  OPD  ER  Referral (if referral, Doctor's Name: .....  
 Start Time of Assessment: 10:45 am Weight: 16.4 kg  
 Allergic History: .....

Chief Complaints: .....  
90 fever - D5  
 .....  
 .....  
 .....  
 .....

Pediatric Assessment Triangle

A Appearance - TICLS .....  
 B ..... C Circulation  Normal  Abnormal  
     Pallor   
     Cyanosis   
     Mottling   
     Bleeding   
 Breathing  ↑ WOB  ↓ WOB  Normal  Gasping / Apnea

Initial Physiological Status:  Stable  Unstable  
     Life Threatening   
     Non Life Threatening   
 Any urgent interventions needed:  Yes  No  
 If Yes .....

Significant Past History: .....  
 Medication History: .....  
 Relevant Investigations: .....

**Primary Assessment**

Airway  Open  Maintainable  Not Maintainable  
 Breathing Rate: 26 SpO<sub>2</sub> on FIO<sub>2</sub> 100%  
 Rhythm: N  
 Retractions:  Suprasternal  ICR  SCR  
      Sternal  Supraclavicular  Nasal Flaring  
 Respiratory Noises:  Stridor  Wheezing  Grunting  
 Air Entry: equal  
 Palpation Findings (If necessary).....  
 Any urgent interventions needed:  Yes  No  
 If Yes .....



**Circulation**

HR: 122

CFT [ Central C3  
Peripheral C3

Any urgent interventions needed:  Yes  No

BP: 105/75 mmHg

Pulse Volume: [ Central 2+  
Peripheral 2+

Murmurs:  Yes  No

Liver Span: .....

If in Shock: [ Compensated .....  
Hypotensive .....

ECG: .....

Any Signs of Heart Failure:  Yes  No

Muffled Heart Sound:  Yes  No

Engorged Neck Veins:  Yes  No



**Disability**

GCS: 15/15 AVPU: A

Any urgent interventions needed:  Yes  No

Pupils: [ Responsive  Non-Responsive

If Yes .....

Size [ Right 2mm

Left 2mm

Active Seizures:  Yes  No Sugars: .....

Signs of Neurological compromise .....

**Exposure**



Temp.: 100.3° F

Any urgent interventions needed:  Yes  No

Any Rash:  Yes  No,

If Yes .....

If yes describe the rash .....

Active bleed .....

Lacerations  Abrasions  bruises

Describe: .....

- Final Physiological Status:**
- Respiratory Distress
  - Shock - Compensated  Hypotensive
  - Cardiopulmonary Arrest
  - Respiratory Failure
  - Hemodynamically Stable
  - Respiratory Arrest

**Secondary Assessment:** Head to toe examination with positive findings: .....

**Labs Planned:**

*Details inside*

**Treatment Planned:**

*Details inside*

Need for Oxygen:  Yes  No if yes Low Flow  High Flow  PPV

Final Diagnosis with possible Differential Diagnosis (If necessary): .....

Assessment done by Name of the Doctor: *Keerthana D*

Sr. Doctor on Duty (If necessary)

Signature: *[Signature]*

Name of the Sr. Doctor: .....

Date & Time: 29/6/26 11:15 am

Signature: .....

Date & Time: .....

# PATIENT TRANSFER FORM



GUC-00093020 IP18-00036162  
 Master HATIM.B  
 26-03-2020 6 Y 2 M 29 D (M)  
 Dr. NATARAJ PALANIAPPAN



Date & Time of Admission <i>24/6/26 11:10 AM</i>		Date & Time of Transfer Order <i>24/6/26 12:15 PM</i>
Treating Consultant Name <i>Dr. Nataraj</i>	Transfer Ordered by <i>Dr. Leethane</i>	Reason for Transfer <i>Further management</i>
From Unit <i>ER</i>	To Unit <i>201</i>	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Number of Sheets in Clinical File <i>(9)</i>	Number of Imaging Films <i>(1) X-ray neck</i>	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what ?
Medications / Consumables / Surgicals / Hand over		
Sl.No.	Item Name	Quantity
1.	<i>DNS 500ml</i>	<i>(1)</i>
2.	<i>Intropin</i>	<i>(1)</i>
3.		
4.		
5.		
Shifting Summary / Notes Written by Doctor : Yes <input type="checkbox"/> No <input type="checkbox"/> <i>? Dengue fever</i>		
Name & Signature of Person who is Transferring <i>Praveen M. 18/06/26</i>		Name of Person Ordered Transfer <i>Leethane</i>
Patient & Clinical Records Received by : <i>Balaseel 24/6/26 12:45 PM</i>		
Date & Time of Patient Received :		

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 THREAT FORM

<p>1. Name of patient</p> <p><i>John Doe</i></p>	<p>2. Address</p> <p><i>123 Main St</i></p>	<p>3. City</p> <p><i>Springfield</i></p>
<p>4. Telephone</p> <p><i>555-1234</i></p>	<p>5. Date of birth</p> <p><i>01/01/1950</i></p>	<p>6. Sex</p> <p><i>M</i></p>
<p>7. Occupation</p> <p><i>Teacher</i></p>	<p>8. Education</p> <p><i>High School</i></p>	<p>9. Religion</p> <p><i>Protestant</i></p>
<p>10. Marital status</p> <p><i>Married</i></p>	<p>11. Number of children</p> <p><i>2</i></p>	<p>12. Name of physician</p> <p><i>Dr. Smith</i></p>
<p>13. Name of hospital</p> <p><i>St. Mary's</i></p>	<p>14. Name of clinic</p> <p><i>St. Mary's</i></p>	<p>15. Name of doctor</p> <p><i>Dr. Smith</i></p>
<p>16. Name of nurse</p> <p><i>Ms. Jones</i></p>	<p>17. Name of pharmacist</p> <p><i>Mr. Brown</i></p>	<p>18. Name of dentist</p> <p><i>Dr. White</i></p>
<p>19. Name of optician</p> <p><i>Mr. Green</i></p>	<p>20. Name of podiatrist</p> <p><i>Dr. Black</i></p>	<p>21. Name of psychologist</p> <p><i>Dr. Grey</i></p>
<p>22. Name of social worker</p> <p><i>Ms. Blue</i></p>	<p>23. Name of dietitian</p> <p><i>Ms. Red</i></p>	<p>24. Name of physical therapist</p> <p><i>Mr. Yellow</i></p>
<p>25. Name of occupational therapist</p> <p><i>Ms. Purple</i></p>	<p>26. Name of speech therapist</p> <p><i>Ms. Orange</i></p>	<p>27. Name of audiologist</p> <p><i>Mr. Silver</i></p>

If the patient is under 18 years of age, the parent or guardian must sign this form. If the patient is over 18 years of age, the patient must sign this form. If the patient is unable to sign this form, the patient's physician must sign this form. If the patient is unable to sign this form, the patient's physician must sign this form. If the patient is unable to sign this form, the patient's physician must sign this form.



