

Mst - Mohammed Amran
Case - 3019





DISCHARGE TRACKING SHEET

UHID :

FLOOR:

CONSULTANT NAME: DR.

ACTIVITY	IN TIME	OUT TIME	REMARKS	<To be filled by Admin>
Activity Sheet updated by Nursing		15/6/22 12pm	 017981	
Activity Sheet updated by Pharmacy	12:11	12:19	 017933	

ACTIVITY RECORD FOR BILLING



GUC-00003019 IP28-00004569
 Master MOHAMMED IMRAN
 17-10-2018 7 Y 7 M 27 D (M)
 Dr. SHOBANA RAJENDRAN



IP No: Consultant: Dept:

Date of Admission: Time: Date of Discharge: Time:

Room / Bed No: Ward: Suggested Billable bed type:



WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
12/6/2026	12:50 PM	ER	MO5	[Signature] / 021335

CROSS CONSULTATION VISIT

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

INVESTIGATIONS

Date	Investigations	Order No.	Signature
12/6/08	CBC, CRP, Dengue NSI,	7843	 221375
	SGH, Urine R/E	7850	
	Typhidot SGH.		
14/6/08	Respiratory panel Biotin	7905	 21098

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
12/6/2026	SU line placement	6	150113	<i>[Signature]</i>
14/6/26	IV placement	①	50290	<i>[Signature]</i>

ANY OTHER INFORMATION:

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Date: 15/6/24 Time: 12PM Prepared By: Suyashini

Staff Nurse <i>[Signature]</i> 017781	Shift / Ward <i>[Signature]</i> 017781	Billing Assistant	Billing Supervisor
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9

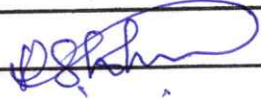
PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
13/1/2021 2.45 AM	cks/B Dr. Hamsa VS	
	C/o Abdominal pain - Epigastric regi.	
	no c/o for spike last spike at 10:15	
	C/o Bmj nichu @-	
	C/o - mnd	
	C/o - after admin 2 pound	
	O/e Abn	
	afen	Vital Rn.
	Hydr-act	
	T+T+T	
	Chia	
	S/e P/A soft, tendu @ in Epigastric regi.	no HSM B/E.
	C/S	
	R / M	
	C/S	
	Adm	
	V-G-U	Taj. Pan 20mg 1r OD
	Dr. Hamsa VS	RHT
	960h	Rest until the lab.



2

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
13/6/26 9:15 AM	S/B Dr. Aneshu Fever for Evaluation.	
	<ul style="list-style-type: none"> - fever spike (+) 102°F @ 8:00 AM. - No cough (+) - No vomiting, abd pain 	
	O/G - improving Pain well.	child comfortably sleeping pulses well felt < 3 sec CRT
	S/E - P/A - soft CNS - NAD RS - B/LAE (+) C/S - GS (+)	3-63-TLC. (leucopenia) Typhoid IgM Neg.
	<ul style="list-style-type: none"> • Fever for evaluation • ? Bronchopneumonia 	<p>Aneshu 163765</p>
	Continue IVF 1/2 maintenance 30ml/hr	
	Continue others	
	change fluvo dose	
		



3

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
13/6/26 APM	S/B Dr. Aneshu	
	<u>BRONCHOPNEUMONIA</u>	
	7AM last fever spike.	
	Cough on & off (+)	
	No fresh complaints	
	child alert	
	O/I - improving	
	O/O - Adequate	
	Dengue Neg	
	Vitals stable	
	S/E - NAD.	
		Aneshu
		163765

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4



GRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
14/10/2018	S/B m. daya sei	
10am		
	child received	
	Afebrile	
	Last fever spike - 9pm - 100.8°	
	c/o wet type of cough	
	c/o throat pain & ear pain	
	Activity	
	Appetite - Improving	
	Not passed stool - 2 days	
	O/E Whole body	
	Throat - erythema @	
	B/L Impacted wax @	
	RS JAD	
	C/S ↓	P1
	P/A - soft	1) IUF DNC @ 30ml/h.
	CNS - Active	(U2 maintenance)
		2) continue →
		INS - CEFTRIAXONE - D2
		SYP AZEE - D2
	to send	SYP FLUID - D2
	for panel	3) Monitor whole
	Severe New IUW	4)
		 14/10/18



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
15/6/26 8:30 AM	S/B Dr. Aneesh	/ Dr Shobana
	BRONCHOPNEUMONIA - - Afebrile ~ 24 hrs. - Cough +ing - No fresh complaints	ADENOVIRUS INFLUENZA A1
	Child alert pulses well felt CRT < 3sec	HR - 94/m RR - 24/m.
	S/E - R2 - B/LAE (+) CNS - SIS (+) CNS - N/A/D P/A - Soft	D ₃ of Ab.
	To continue the same.	
	→ D/c → 5yp FLOVIR. x 2 days → 5yp Zincovit 5ml a day → Duloxax suppository 1 stat.	Aneesh 163765
	Dr. Shobana 72405	

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 Master MOHAMMED IMRAN
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 Dr. SHOBANA RAJENDRAN



RESULT SHEET

Date						
Time						
Hb	10.7					
PCV	31					
RBC	4.03					
WBC	3.63					
N/L	63/30					
Platelets	394					
CRP	5					
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

Date	12/6/2020				
Time					
CUE - Alb	m				
CUE - Sugar	m				
CUE - Ketones	nc				
CUE - PUS Cells	2-4				
CUE - RBC Cells	2-3				
CUE					
Blood	Trace				
leucocytes	mg				
nitrite	mg				
Stool Pus Cell					
OVA / Cyst					
Occult Blood					
Typhoid IgM	Neg				

Culture and Sensitivities :

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Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI :

 Others (ECG, Contrast Studies etc.) :

GUC-00003019 IP28-00004569
 Master MOHAMMED IMRAN
 17-10-2018 7 Y 7 M 26 D (M)
 Dr. SHOBA NA RAJENDRAN

REGULAR PRESCRIPTIONS

Weight 22.8 kg Ward MAT

DRUG : <u>INJ. CETRIAXONE</u>				Date Time	13/6	14/6	15/6
Dose	Route	Frequency	Start Date	12 AM	12 AM	12 AM	12 AM
1.14gm	IV	BD	12/6/26	015	015	015	015
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Hamsa VS 96066</u>				12 AM	12 AM	12 AM	12 AM
Additional Instructions:							
Daily Doctor's Endorsement by a Sign							
DRUG : <u>INJ. EMESET</u>				Date Time	13/6	14/6	
Dose	Route	Frequency	Start Date	12 AM	12 AM	12 AM	12 AM
2mg	IV	BD	12/6/26	015	015	015	015
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Hamsa VS 96066</u>				12 AM	12 AM	12 AM	12 AM
Additional Instructions:							
Daily Doctor's Endorsement by a Sign							
DRUG : <u>SYROP FLUR</u>				Date Time	13/6	14/6	
Dose	Route	Frequency	Start Date	1 AM	1 AM	1 AM	1 AM
6ml	P/O	BD	12/6/26	015	015	015	015
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Hamsa VS 96066</u>				1 AM	1 AM	1 AM	1 AM
Additional Instructions:							
Daily Doctor's Endorsement by a Sign							
DRUG : <u>SYROP AZEE (5ml/200mg)</u>				Date Time	13/6	14/6	15/6
Dose	Route	Frequency	Start Date	12 AM	12 AM	12 AM	12 AM
10ml	P/O	OD	12/6/26	015	015	015	015
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Hamsa VS</u>				12 AM	12 AM	12 AM	12 AM
Additional Instructions: <u>(5ML/200MG)</u>							
Daily Doctor's Endorsement by a Sign							

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Sheet No: ②

REGULAR PRESCRIPTIONS

Weight 22.8 Ward m05

DRUG : <u>Syp FLUVIR</u>				Date-Time	13/6	14/6/26	15/6/26													
Dose	Route	Frequency	Start Dt.	1	9	9	9													
4ml	P/O	Q12H	13/6	pro	6.0 AM	AM	AM													
Name & Signature of the Doctor Starting the Drugs: <u>Aneesh 163765</u>																				
Additional Instructions:				9 PM																
Daily Doctor's Endorsement by a Sign																				

DRUG : <u>SYP P500</u>				Date-Time	14/6	15/6/26														
Dose	Route	Frequency	Start Dt.	12	6	6														
3-5ml	PO	Q8H	14/6/26	PM	AM	AM														
Name & Signature of the Doctor Starting the Drugs: <u>164159</u>				8 PM																
Additional Instructions: (5ml/100mg)				10 PM																
Daily Doctor's Endorsement by a Sign																				

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

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

VERIFIED BY : Name Signature

Patient Sticker



Sheet No: **REGULAR PRESCRIPTIONS** Weight Ward

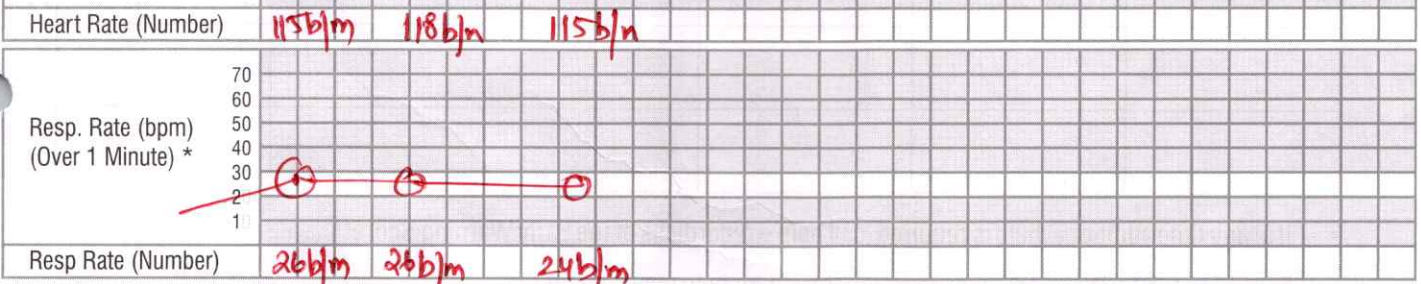
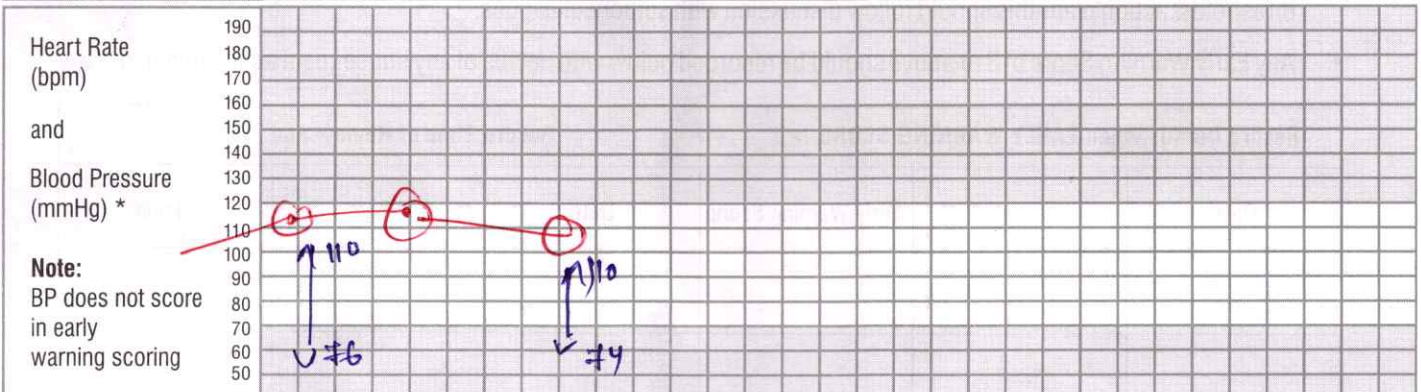
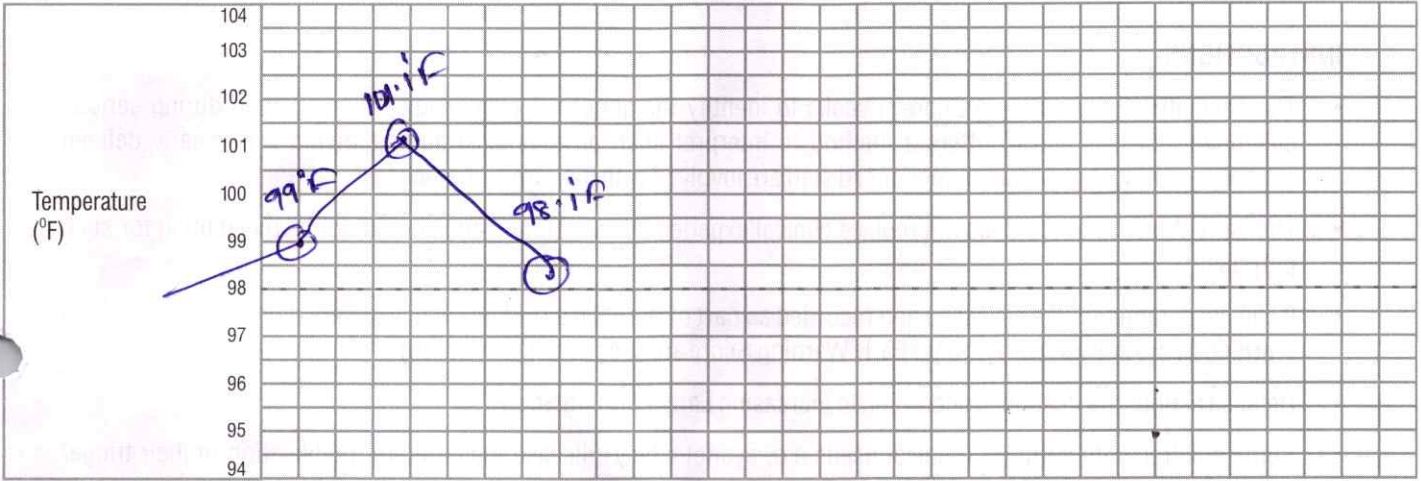
DRUG :				Date- Time																				
Dose	Route	Frequency	Start Dt.																					
Name & Signature of the Doctor Starting the Drugs:																								
Additional Instructions:																								
Daily Doctor's Endorsement by a Sign																								
DRUG :				Date- Time		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

Signature
VERIFIED BY: Name



EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 13/6/20 Time: 12PM 1AM 4AM
 Doctor / Nurse / Family Concern? ✓ ✓ ✓



Resp Distress	Mod/ Severe	None / Mild	✓	✓	✓
Receiving O ₂ (l/min)					
O ₂ Saturations (%)	98	98	98		
Conscious Level	Normal	Altered	✓	✓	✓
GCS *	5/5	5/5	5/5		

TOTAL SCORE					
Number of shaded boxes	01	01	01		
Pain Score	0/10	0/10	0/10		
Observer's Initials	CS	CS	CS		

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

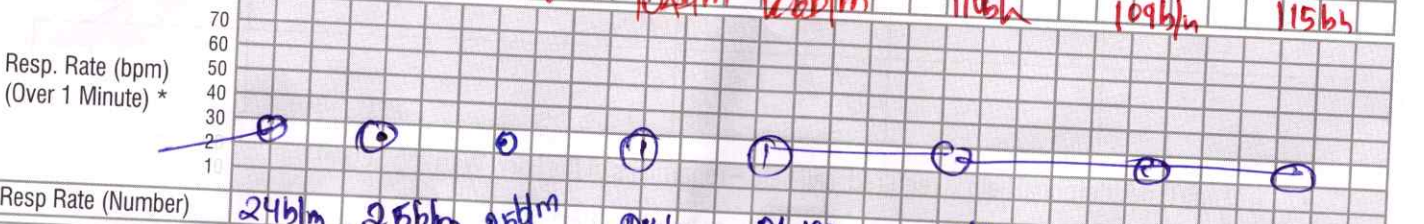
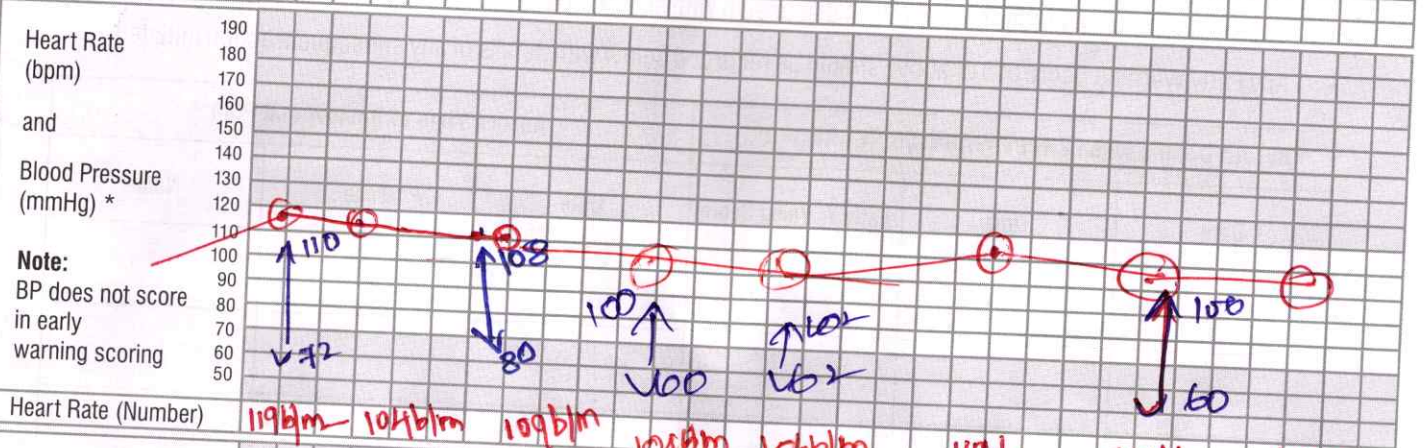
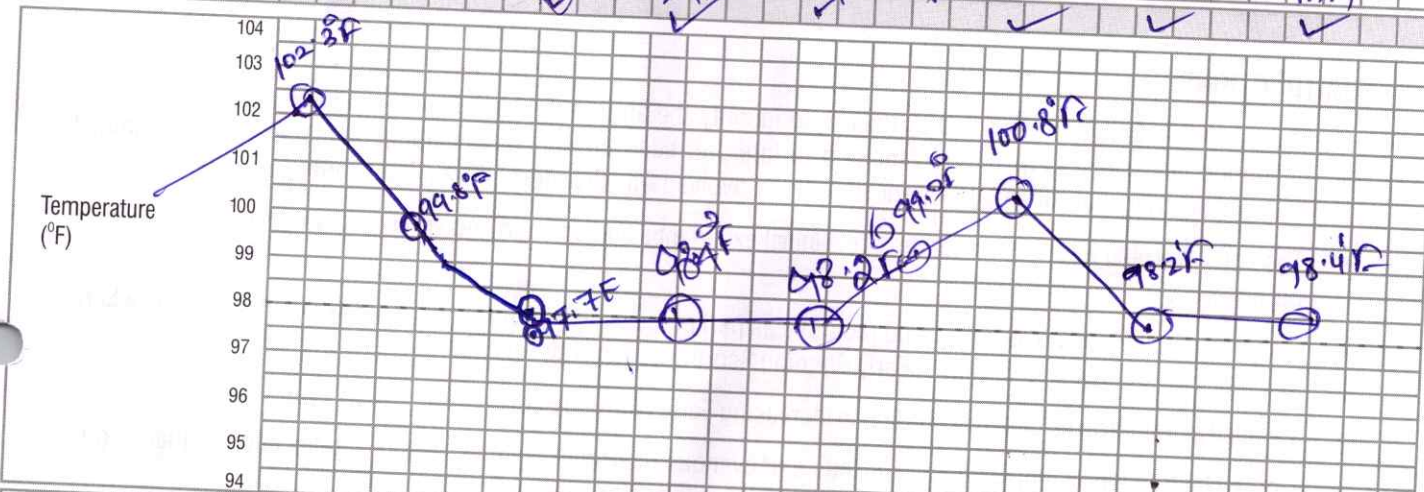
- If at any time additional help is required, call help – regardless of the Early Warning Score!
- Following a Early Warning Score assessment, senior help may be required

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

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 13/6/20 Time: 3 AM 9 AM 12 PM 3 PM 8 PM 9 PM 12 AM 1 AM
 Doctor / Nurse / Family Concern? ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓



Resp Distress	Mod/ Severe None / Mild	Receiving O ₂ (l/min)	O ₂ Saturations (%)	Conscious Level	Normal / Altered	GCS *
✓	✓	✓	97%	✓	✓	5/5
✓	✓	✓	99%	✓	✓	5/5
✓	✓	✓	99%	✓	✓	5/5
✓	✓	✓	98%	✓	✓	5/5
✓	✓	✓	99%	✓	✓	5/5
✓	✓	✓	99%	✓	✓	5/5
✓	✓	✓	98%	✓	✓	4/5
✓	✓	✓	99%	✓	✓	4/5

TOTAL SCORE	Number of shaded boxes	Pain Score	Observer's Initials
0/1	0/1	0/10	DR
0/1	0/1	0/10	DR
0/1	0/1	0/10	DR
0/1	0/1	0/10	DR
0/1	0/1	0/10	DR
0/1	0/1	0/10	DR
0/1	0/1	0/10	DR
0/1	0/1	0/10	DR

ACTIONS
 NB: Scores 3 should be recorded overleaf

- Score 1 : Continue normal observation by staff nurse
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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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- 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.
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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.

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GUC-00003019
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 17-10-2018 7 Y 7 M 27 D (M)
 Dr. SHOBANA RAJENDRAN



RCH/FRM/CLINICAL/126

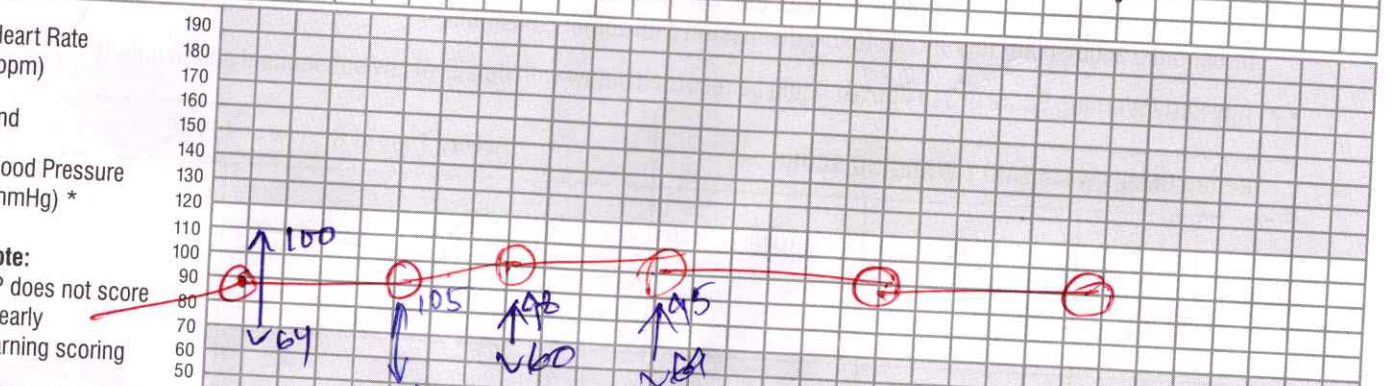
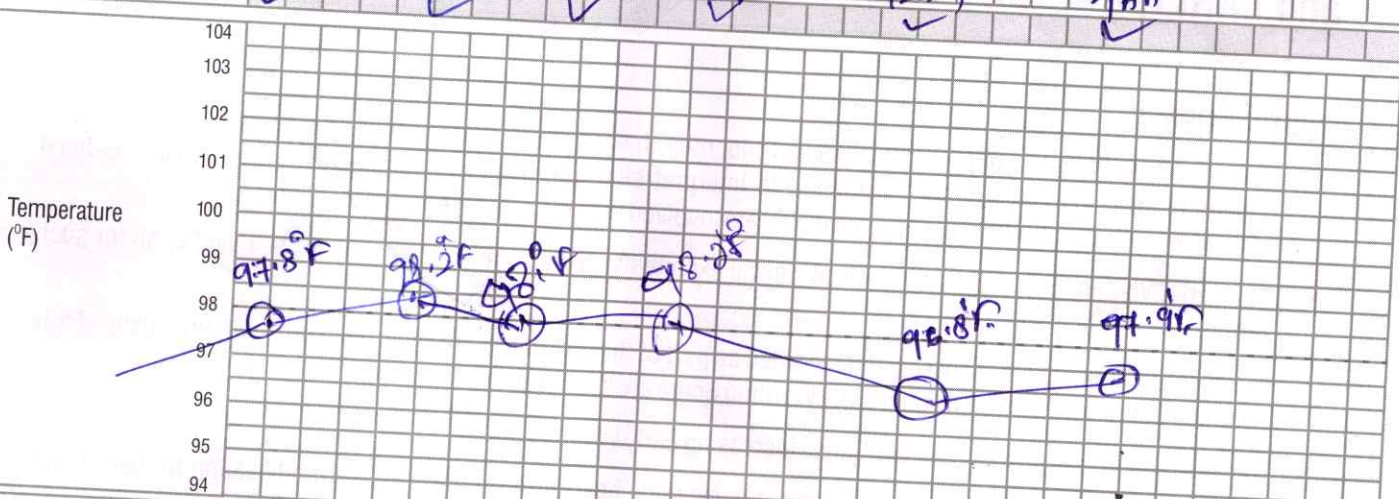
SCHOOL AGE (5-12 years)
 Children's Observation &
 Early Warning Scoring Chart

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

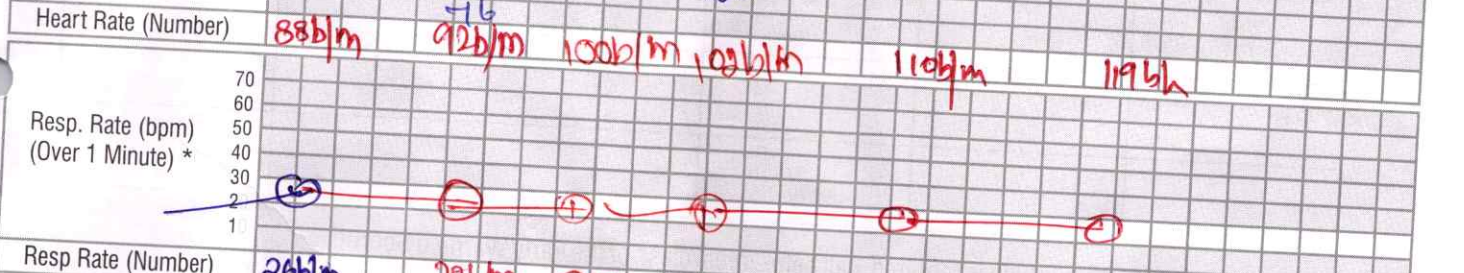
BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 14/6/20 Time: 8AM
 Doctor / Nurse / Family Concern? ✓



Note:
 BP does not score
 in early
 warning scoring



Resp Distress	Mod/ Severe None / Mild	Receiving O ₂ (l/min)	O ₂ Saturations (%)	Conscious Level	Normal / Altered	GCS *
✓	✓	✓	99%	✓	✓	5/5
✓	✓	✓	100%	✓	✓	15/15
✓	✓	✓	98%	✓	✓	15/16
✓	✓	✓	97%	✓	✓	15/15
✓	✓	✓	99%	✓	✓	5/5
✓	✓	✓	98%	✓	✓	5/5

TOTAL SCORE	Number of shaded boxes	Pain Score	Observer's Initials
0/4	0/1	0/10	[Signature]
0/4	0/1	0/10	[Signature]
0/4	0/1	0/10	[Signature]
0/4	0/1	0/10	[Signature]
0/4	0/1	0/10	[Signature]
0/4	0/1	0/10	[Signature]

ACTIONS

Score 1 : Continue normal observation by staff nurse
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Date	Time	Early Warning Score	Date	Time	Name

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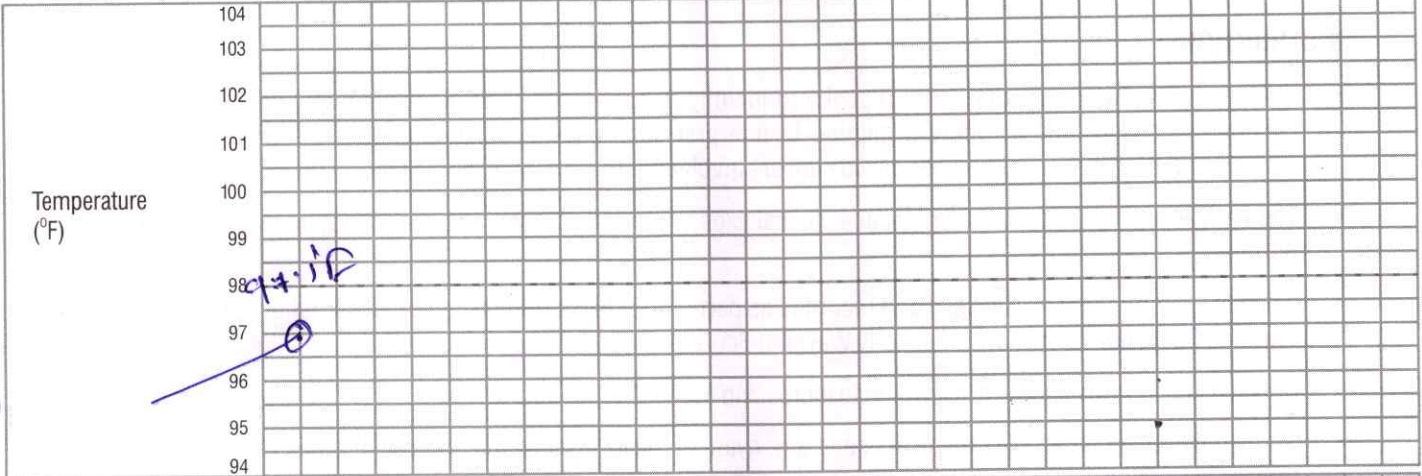
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B	BACK GROUND: Child (X) was admitted on (XX date) with (e.g. respiratory infection). They have had (X operation/ procedure/ investigation). Child (X)'s condition has changed in the last (XX mins). Their last set of observations were (XXX). The child's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



EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 15/6/26 Time: 3:30 PM

Doctor / Nurse / Family Concern?



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

Note: BP does not score in early warning scoring

Heart Rate (Number) 110b/m

Blood Pressure (mmHg) 94/61

Resp. Rate (bpm) (Over 1 Minute) *

Resp Rate (Number) 26b/m

Resp Mod/ Severe Distress None / Mild

Receiving O₂ (l/min) O₂ Saturations (%) 99%

Conscious Level Normal / Altered

GCS * 4/5

TOTAL SCORE

Number of shaded boxes 0/1

Pain Score 0/10

Observer's Initials [Signature]

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)
- 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)

GUC-00003019 IP28-00004569

Master MOHAMMED IMRAN
17-10-2018 7 Y 7 M 27 D (M)
Dr. SHOBANA RAJENDRAN



FLUID CHART

Sheet No. : ①

13/6/20

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
			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											
	01:00 pm											
Total Intake :						Total Output :						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						Total Output :						
	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	H ₂ O Soy		65ml								
	04:00 am			65ml								
	05:00 am			65ml								
	06:00 am	H ₂ O Soy		65ml								
	07:00 am			65ml								
Total Intake :			150 + 390ml			Total Output :					U-1	
Total 24 hrs. Intake			Total = 520ml Oral = 150ml			Total 24 hrs. Output					U-2 M-0	



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		Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G							
13/6/26	08:00 am	H ₂ O	50ml	PC								
	09:00 am			65ml					✓	0		
	10:00 am			65ml						0		
	11:00 am	H ₂ O	50ml	65ml					✓	0		
	12:00 pm			65ml						0		
	01:00 pm	Juice	100ml	PC					✓	0		
Total Intake :		200ml + 260ml = 460ml			m=0		Total Output : U=3 times.					
	02:00 pm			30ml						0		
	03:00 pm	H ₂ O	100ml	30ml					✓	0		
	04:00 pm			30ml						0		
	05:00 pm	Juice	100ml	30ml					✓	0		
	06:00 pm			30ml						0		
	07:00 pm			30ml					✓	0		
Total Intake :		300ml + 180ml + 220ml = 700ml					Total Output : U=3					
	08:00 pm	H ₂ O	100ml	30ml						0		
	09:00 pm			30ml						0		
	10:00 pm			30ml					✓	0		
	11:00 pm	H ₂ O	100ml	30ml						0		
	12:00 am									0		
	01:00 am	H ₂ O	100ml						✓	0		
Total Intake :		300 + 60 = 360ml					Total Output : U=2					
	02:00 am									0		
	03:00 am									0		
	04:00 am									0		
	05:00 am	H ₂ O	100ml							0		
	06:00 am									0		
	07:00 am	H ₂ O	100ml						✓	0		
Total Intake :		200ml					Total Output : U=1					
Total 24 hrs. Intake		1,200ml										
Total 24 hrs. Output		U-9 M-0										



Some notes = 10000 ft

Item	Quantity	Unit Price	Total
Excavation	10000	0.50	5000
Concrete	10000	1.00	10000
Reinforcement	10000	0.20	2000
Formwork	10000	0.10	1000
Foundation	10000	0.30	3000
Toe Drain	10000	0.15	1500
Toe Wall	10000	0.25	2500
Filter	10000	0.10	1000
Core	10000	0.40	4000
Other	10000	0.05	500
Total			30000

FLUID CHART

Sheet No. : 2

14/6/26

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	08:00 am												
	09:00 am	H ₂ O 50ml								✓	0	AS	
	10:00 am	H ₂ O 50ml									0	AS	
	11:00 am										0		
	12:00 pm	H ₂ O 50ml	20ml	→	stn - para					✓	0	AS	
	01:00 pm	H ₂ O 50ml									0	AS	
Total Intake :			200ml + 50ml → 250ml			Total Output :			U - 2 times				
	02:00 pm												
	03:00 pm												
	04:00 pm	H ₂ O 200ml								✓	0		
	05:00 pm	H ₂ O 200ml									0		
	06:00 pm									✓	0		
	07:00 pm										0		
Total Intake :			400ml			Total Output :			U - 2				
	08:00 pm												
	09:00 pm	Hu 200ml								✓	0		
	10:00 pm												
	11:00 pm	Hu 200ml								✓	0		
	12:00 am										0		
	01:00 am										0		
Total Intake :			400ml			Total Output :			U - 2				
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am									✓	0		
	06:00 am										0		
	07:00 am	Milk 200ml								✓	0		
Total Intake :			200ml			Total Output :			U - 2				
Total 24 hrs. Intake		1220ml											
Total 24 hrs. Output		U - 8 M - 0											

Handwritten notes at the top left of the page.

Handwritten word, possibly "soldier", in the upper left section.

HD

Handwritten number "3" in the upper right section.

Vertical handwritten notes on the left side of the page, including a small diagram with a circle and lines.

Large grid table with multiple columns and rows, containing handwritten entries and numerical values. The table is organized into several sections with headers like "Total" and "Total".