

ACTIVITY

VIH-00205635 IP-00060231
Baby V.M.PRARTHANA
16-06-2022 3 Y 11 M 19 D (F)
Dr. PREETHAM KUMAR

IG

Name: ---



UHID No :

Consultant :

Dept :

pediatrician

Date of Admission :

4/6/26

Time :

Date of Discharge :

Time :

Room / Bed No :

111

Ward :

1st floor

Suggested Billable bed type :

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
4/6/26	12:25 AM	ER	111	

Cross Consultation Visit

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

ADMISSION SHEET

Registration Details :



Admission No : IP-00060231

Admit Date : 04-Jun-2026

Admit Time : 11:18 PM UHID : VIH-00205635

Patient Details :

Patient Name : Baby V.M.PRARTHANA

Age : 3 Y 11 M 19 D

Guardian : Mr N.VISHNU

DOB : 16-06-2022

Gender : Female

Religion :

Occupation :

Martial Status :

Address (H) : FLAT NO 302 MEGHANA SHYAM NILAYAM
STREET NO 8 GOWTHAM NAGAR Malkajgiri
Hyderabad Telangana INDIA 500047

Phone No : 8885445544/ 8886445544

E-mail : NA@GMAIL.COM

Admission Details :

Bed Type : SHARED WARD

Bed No : ER 101

Ward Name : N 0 GF-EMERGENCY

Room No : ER 101

Admission Type : First Visit

Contact Details :

Name : Mr N.VISHNU

Relationship : Father

Contact Address : FLAT NO 302 MEGHANA SHYAM NILAYAM
STREET NO 8 GOWTHAM NAGAR Malkajgiri
Hyderabad Telangana INDIA 500047

Phone No : 8885445544


Signature

Doctor Details :

Doctor Name : Dr. PREETHAM KUMAR

Specialisation : GENERAL PEDIATRICS

Referral Doctor : DR.CH.VARAPRASAD.

Phone No :

Co-Consultant :

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : STAR HEALTH AND ALLIED
INSURANCE CO LTD

VIH-00205635 IP-00060231
 Baby V.M.PRARTHANA
 16-06-2022 3 Y 11 M 19 D (F)
 Dr. PREETHAM KUMAR



EMERGENCY ROOM TRIAGE FORM

wt: - 11.6 kg

Patient's Name : Baby. prarthana Age : 4 year Gender: Male Female

Date : 4/6/26 Time of Arrival : 10:40 PM

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

Source of Information : Parents Others (Specify):

Mode of Arrival : Ambulatory Wheelchair Ambulance

Initial Vital Signs: Temp: 97.1°f PR: 102b/m BP: 99/69/79 RR: 36b/m SpO₂: 100%

Chief Complaints: VOMIT, Loose stool on 2 off, fever X 3 days

INITIAL PHYSIOLOGICAL CATEGORIZATION		INITIAL PHYSIOLOGICAL STATUS
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	<input checked="" type="checkbox"/> Stable <input type="checkbox"/> Unstable : - <input type="checkbox"/> Not - Life - Threatening - <input type="checkbox"/> Life - Threatening
	Work of Breathing <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Increased <input type="checkbox"/> Decreased <input type="checkbox"/> Gasping / Apnea	

Triage Classification	CTAS
<input type="checkbox"/> Level 1 : Resuscitation	<input type="checkbox"/> Immediate
<input type="checkbox"/> Level 2 : EMERGENT : Life or limb threatening	<input type="checkbox"/> < 15 min
<input type="checkbox"/> Level 3 : URGENT : Significant illness / injury with potential to become life or limb threatening	<input type="checkbox"/> 30 min
<input checked="" 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.

V.M. Kulkarni
 Signature of Parent / Guardian

Triage Completion Time : 10:44 PM

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 : Dr. Tharun

Date & Time : 4/6/26 @ 10:44 PM

Tharun
 Signature of Triage Nurse :

Patient Name : Baby. V.M.PRARTHANA UHID : VIH-00205635 IPD : IP-00060231 Gender : Female Age : 3 Y
11 M 19 D

VIH-00205635 IP-00060231
Baby V.M.PRARTHANA
16-06-2022 3 Y 11 M 19 D (F)
Dr. PREETHAM KUMAR



NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 4/6/26 Time of arrival : 10:45 PM
Chief Complaints : Vomit, Loose stool on 2 off, fever x 3 days RBS : -
Height : - Weight : 11.6 Kg BMI : - Head Circumference (<2 years) : -
Allergies: Yes No Medications Blood Transfusion Food Other: -
If yes, identify -
Pain Screening: Yes No If Yes, Pain Score: 0 Pain Tool Used: N Pass FLACC Wong Baker
 Character - Location - Frequency - Duration -

RISK FOR FALL:

If patient is < 6 years
tick below fall risk intervention directly
 If Patient is > 6 years
Assess the below parameters
History of Falling: within past 3 months Yes No
Ambulatory Aids:
• Wheelchair Yes No
• Uses furniture for support Yes No
Gait/Transferring:
• Bedrest / immobile Yes No
• Weak Yes No
• Impaired Yes No
Mental Status: Forgets limitations Yes No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening: No Abnormalities Detected

Mobility Problem
 Walking Problem
 Developmental Delay
 Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

Nutritional Screening: No Abnormalities Detected

Underweight
 Overweight
 Feeding Problem
 Special diet
 Special feeding method

Inform consultant for positive criteria

Psychological Screening: No Significant Findings

Unusual concerns about patient's Psychological Status: Yes No

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

Social History: Lives With Family

Siblings in household Yes No (if yes How Many?) 1 brother

Time of Initial assessment completed by ER Nurse : 10:50 PM

Patient Name : Baby. V.M.PRARTHANA UHID : VIH-00205635 IPD : IP-00060231 Gender : Female Age : 3 Y
11 M 19 D

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

Time	Nursing Notes
10:40PM	patient came to ER
10:44PM	vitals checked & recorded
10:48PM	doctor seen the patient advised Admission
10:52PM	Admission process done
11:40PM	IV placement done.
11:41PM	Blood samples collected & sent to Lab
11:42PM	Covid Rat : negative patient shifted to ward

Samples collected by: Sr. Shanthi

Time: @ 11:40pm

Samples sent by: Sr. Shanthi

Time: @ 11:45pm

Medication given in ER:

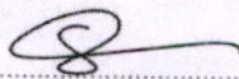
Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1
	—	Nil	—		

Condition of patient at time of shift - out :	Details of Shift - out
HR: 112 b/m BP: 98/58/69 CFT: <3sec RR: 31 b/m SPO ₂ : 100% GCS: 15/15 Temperature: 98.6 F Pain Score: 0 Repeat RBS (if applicable): —	Shift - out from ER to: 111 Time of Shift - out: 4/6/26 @ 11:55 PM Handover given to: Sr. Sreekanth (Nurse's Name) Sr. Sabin

Tick as applicable: MLC LAMA BROUGHT DEAD

Procedures done with details (if any): —

Name of the Nurse : Sabin

Signature of the Nurse : 

Date & Time : 4/6/26 @ 11:55 PM



Nursing General Admission Assessment Form For Pediatrics

Diagnosis: AGE 2 Some dehydration
Arrival Time: 12:55 AM **Mode of Arrival:** by mother lifting **Admitting From:** ER OPD Direct
Allergy / Adverse Reaction: **Body Weight:** 11.6 Kg
 ALL **Height:** cm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
NIL	NIL	NIL

Family History:
 NIL

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

If yes please list,

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

Term baby / 2.7kg / docs / CIAB, NO NICU Admission

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

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

Observations: Weight: 11.6 kg Length: Head Circumference (< 2 years):

Temp: 98.0° F HR: 126 b/min RR: 28 b/min BP: 92/68 (72)

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

Fall Risk Assessment: Yes No **Score:** 10 (Document in the Humpty Dumpty Sheet)

Risk of Pressure Sore (Braden Q Score): 24 (Document in the Braden Q Assessment Sheet)

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

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

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

Inform consultant for positive criteria

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

Inform consultant for positive criteria

Psychological Screening: No Significant Findings

Unusual concerns about patient's Psychological Status: Yes No

If Yes Consultant Notified: (Date/Time):

Social History: Lives With Parents

Siblings in household Yes No (if yes How Many?) one elder Brother

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, Father

Nurse's Name: Soikanth Date: 5/6/26 Time: 12:35 AM  Signature

PATIENT TRANSFER FORM

VIH-00205635 IP-00060231 Baby V.M. PRARTHANA 16-06-2022 3 Y 11 M 19 D (F) Dr. PREETHAM KUMAR 		Date & Time of Admission 4/6/26 @ 11:18 AM	Date & Time of Transfer Order 4/6/26 @ 12:30 AM
		Transfer Ordered by Dr. Prashanthi	Reason for Transfer for Admission
From Unit ER	To Unit III	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File 21	Number of Imaging Films VB 4 - 1	Personal belongings including clinical documents. If any handed over to attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	NS 500ml + Intralax	1	
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring Swathi		Name of Person Ordered Transfer Dr. Prashanthi	
Patient & Clinical Records Received by : Sheekanth			
Date & Time of Patient Received : 5/6/2026 @ 12:30 AM			

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

26-9-09
5 weeks
8 feet
22
104

x 1000000 + 1000000



Rainbow[®] Children's Hospital

It takes a lot to treat the little.

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: _____

VIH-00205635 IP-00060231
Baby V.M.PRARTHANA
18-06-2022 3 Y 11 M 19 D (F)
Dr. PREETHAM KUMAR

UHID ID: _____



Department: _____

Consultant: _____

Pediatric Multiorgan History & Physical Examination

Name : Prarthana. Age/Sex 4Y / F.
Information given by: mother Relationship Grand.

Chief Presenting Complaints & Duration (Chronologically)

clb Vomiting on & off :: 3 days
clb fever :: 3 days
clb loose stools :: 2 days

History of present illness : ↓ oral Intake & dull activity :: 2 days.

child was apparently asymptomatic 4 days back,

then developed clb vomiting :: 3 days.

on & off :: 3 days

NB / MP / Non blood stained.

clb fever :: 3 days

(low-moderate grade)

Intermittent period - Active.

Improving on Antipyretic.

clb loose stools :: 2 days.

3-4 episodes / day.

Irregular Hiberny (+nt)

Non blood stained.

clb ↓ oral Intake & dull activity

Outside food

Consumption (+nt)

Orally Nil.

High grade dehydration (+nt)

child was treated on
opn basis

Dull activity

Ofloxacin tab^l

↓ oral Intake.



Pediatric Multiorgan History & Physical Examination

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

Not significant.

04/06/22

Ue

pus cells 1-2 Leucocytes negative.

spic cells 1-2

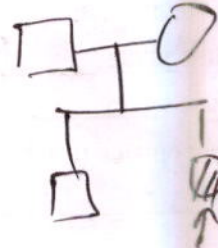
RBC -> Absent

Ketones +++

Birth & Neonatal History:

Term baby / 3.7kg / Ue

CTAB + NO NICU Admission.



Birth & Socio Economic History:

About Father :

About Mother :

Any additional Information :

Y class III

Developmental History :

Development achieved as per Age in all 4 domains.

Immunization History :

Immunized as per Age.



Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs)) 11.6 kgs (Centile _____)

On Examination :

Temperature : 99.1 f Pulse Rate : 102 b/m B.P. 99/67 SPO2 100%

Resp. rate and type of breathing : 36 B/m

Rash _____

Lymphadenopathy } (N)

Oedema : _____

Allergies (if any): _____

Respiratory System :

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

Air entry & breath sounds : Clear (N)

Any addes sounds : (N)

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

Cardiovascular System :

Inspection of precordium : (N)

Heart Sounds : S1 S2 (N)

Any murmur : (N)

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

Per Abdomen :

Inspection (N)

Palpation : PA soft

Ausculation : (N)

Spine : (N) External Genitalia : (N)

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



Pediatric Multiorgan History & Physical Examination

Central Nervous System :

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

Cranial Nerves : (N)

Motor System:

Nutriton : _____
Tone: (N) Power (R) (L)
5/5 5/5

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR +2/In all 4 limbs. Superficials: +nt
Plantars flexor.

Sensory System :

(N)

Bladder / Bowel : (N)

Clinical Summary & Diagnostic:

ACE ± some dehydration.



Genitourinary history & Physical Examination

Preventive aspects of the treatment: _____
_____ *To prevent further complications*

Desired goals of the treatment: _____
_____ *To treat the symptoms.*

Planned Labs:

_____ *CBP, CRP, ~~ESR~~, S/E*
_____ *S. creat, VBU,*
_____ *B/c/c.*
_____ *CUE → done on opp basis.*

Planned Management

_____ *- IVF*
_____ *- Inj. cefixime.*
_____ *- Inj. esomeprazole.*
_____ *- Enteroquinone suspension*
_____ *- Symp. zincaria.*
_____ *- 4/0 manureg.*

Noted by Shantika

4/6/26 @ 11:23pm

Signature of the Doctor: _____ *B*
Name of the Doctor: _____ *Dr. B. Prachanthi*
Date & Time: _____ *4/6/26*

Signature of the Consultant: _____ *[Signature]*
Name of the Consultant: _____ *[Signature]*
Date & Time: _____ *4/6/26*



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/6/22 8-300am.	<p><u>C/S/B Resident</u></p> <p>Ans: Acute Dehydration.</p>	
	<p>2 spins of looser stools :- Admision.</p> <p>No vomiting.</p>	
	<p>Not taking water.</p>	
	<p>4/0 Admision.</p> <p>o/s</p> <p>Child Alert & Active.</p> <p>Vital stable</p>	
	<p>CU: sig ⊕</p> <p>M: DUA ⊕</p>	
	<p>P/A: G/T</p> <p>CVI: NAB ⊕</p>	<p><u>Plane</u></p>
<p>Dr. Prathana</p>		<ul style="list-style-type: none"> - Race B/c/s. - Ij. Cefixime - 20 - Ij. Etoproprate - entagome suples. - Syp. Zinkonia.
<p>5/6/22 8-300am</p>	<p><i>[Handwritten signature]</i></p>	<p><i>[Handwritten signature]</i></p> <p>Noted by Anthea 5/6 @ 2pm</p>

VIH-00205635 IP-00060231
 Baby V.M.PRARTHANA
 16-06-2022 3 Y 11 M 20 D (F)
 Dr. PREETHAM KUMAR

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/6/26	C/S/B Residual	
3 PM	A/G/E E Dehydration	
	OP Casin	Ad
	Hydro	
		Conti same
	C/S E/S (R)	
	R - B/L/A/S (R)	
	PR - 1/2	
	V/S 8m	
	↓	
	CBP	
	CRP	T/m
	VBS	
	For: dynamic	
	5/6/26	
	6pm	

(Signature)

Dhruva

Noted by
 Manisha
 5/6/26
 @ 8pm



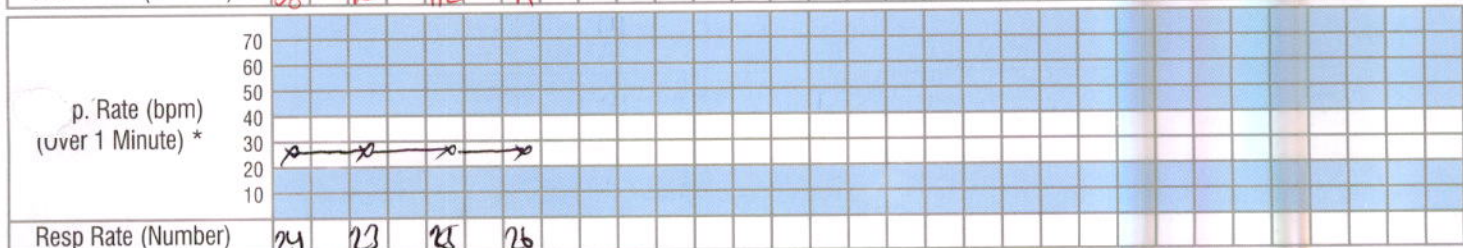
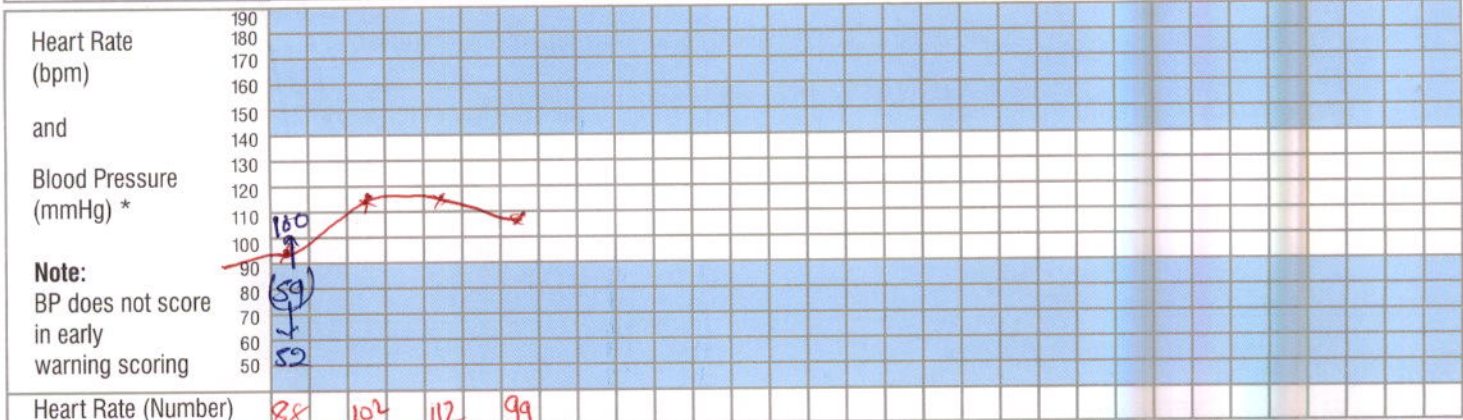
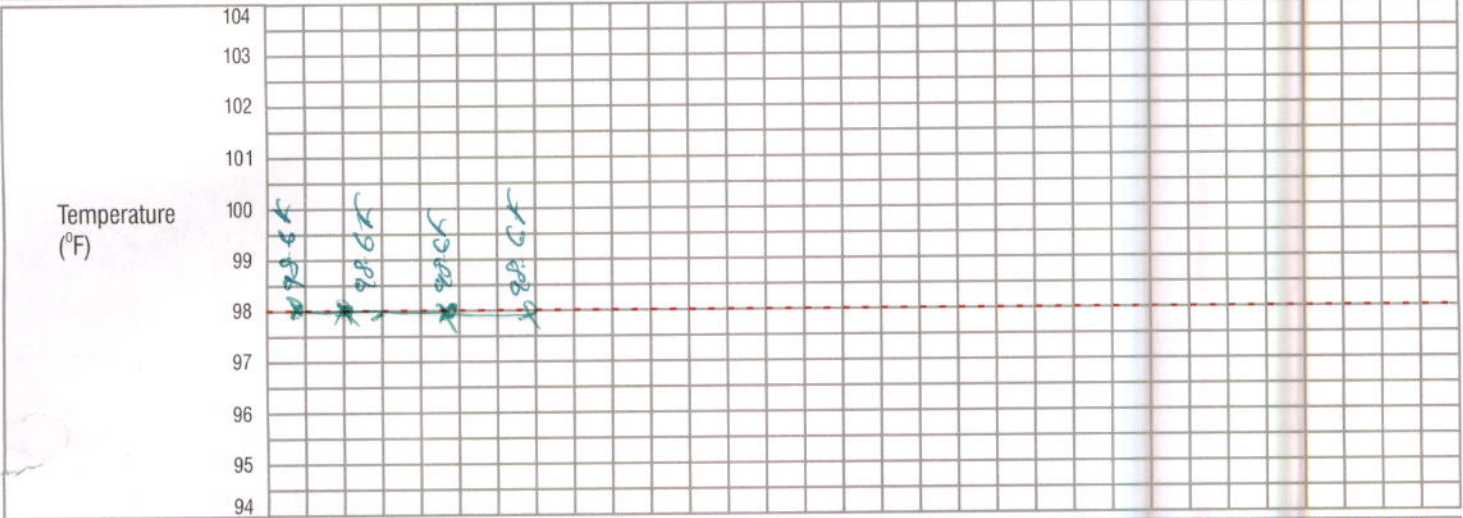
PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/6/26 8 AM	<p>S/B Resident.</p> <p>Ass: Age & i dehydration.</p> <p>NO fever spikes</p> <p>NO look stools, vomitings</p> <p>Urine ⊕</p> <p>Oral intake better.</p> <p>O/C</p> <p>Child alert</p> <p>Eutermic</p> <p>Vitals stable</p> <p>CVS-RIS ⊕</p> <p>Rf. -BAE ⊕</p> <p>pH - 7.4</p>	
	<p>serp-10 ↓</p>	<p>Plan</p> <ol style="list-style-type: none"> 1) Inj ceftazoxime D2 2) Syp. ZincORL 3) Eutermogene 4) monitor vitals inform
<p>6/6/26 SA Dr. Preetham</p>		<p>Dr. Vishwaja - O/C today.</p> <p>Oral Ab</p> <p>needed 18th</p> <p>meds</p>

WING SCORE: CHILDREN'S UNIT

Date 5/6/26..... Time: 2 3 5 7

Doctor / Nurse / Family Concern? Am Am Am Am



Resp Distress	Mod/ Severe None / Mild	N	N	N	N
Receiving O ₂ (l/min)	O ₂ Saturations (%)	099	98	100	98
Conscious Level	Normal / Altered	N	N	N	N
GCS *		15	15	15	15

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

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

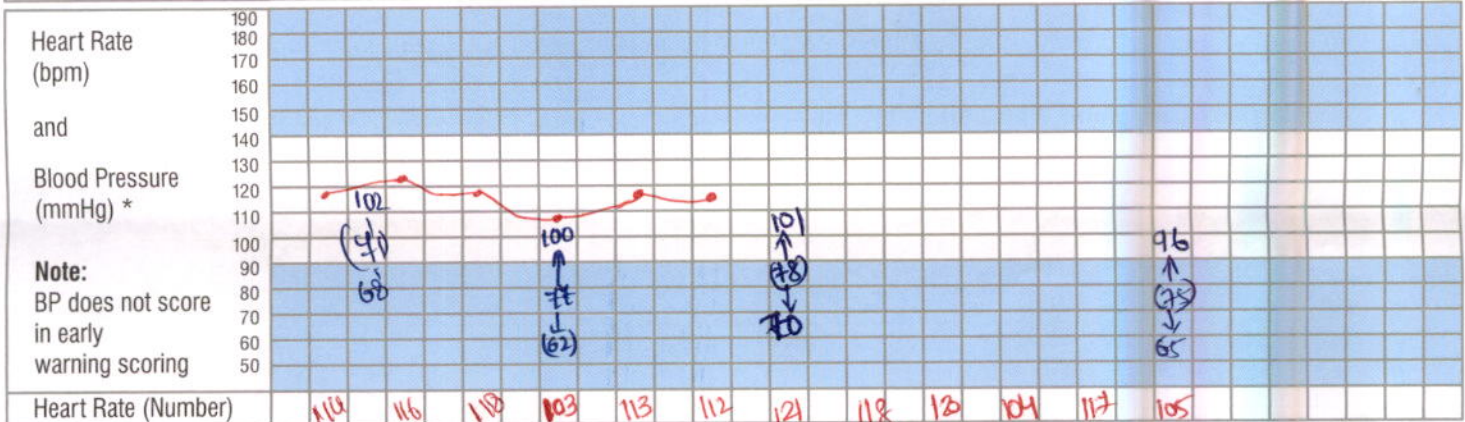
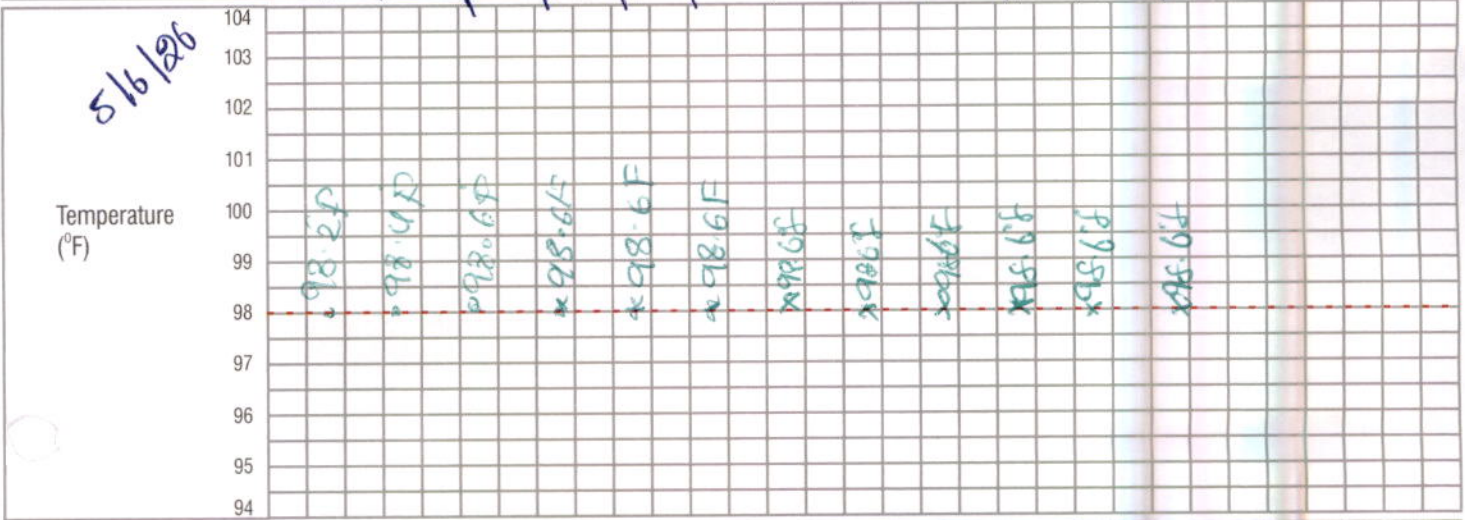
- If at any time additional help is required, call help – regardless of the Early Warning Score!
- Following a Early Warning Score assessment, senior help may be required

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 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 :	9	11	1	3	5	7	9	11	1	3	5	7
Time:	AM	AM	PM	PM	PM	PM	PM	PM	AM	AM	AM	AM
Doctor / Nurse / Family Concern?												



Resp Distress	Mod/ Severe None / Mild	N	N	N	N	N	N	N	N	N	N	N	
Receiving O ₂ (l/min)	O ₂ Saturations (%)	0	0	0	0	0	0	0	0	0	0	0	
O ₂ Saturations (%)		98	99	99	99	98	99	98	100	99	98	99	100
Conscious Level	Normal / Altered	N	N	N	N	N	N	N	N	N	N	N	
GCS *		15	15	15	15	15	15	15	15	15	15	15	

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

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.

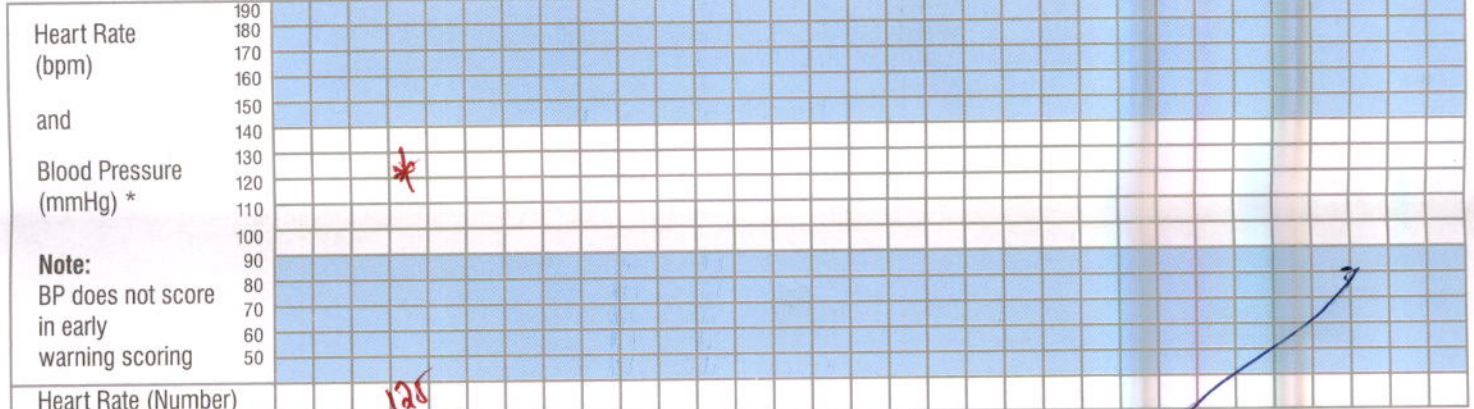
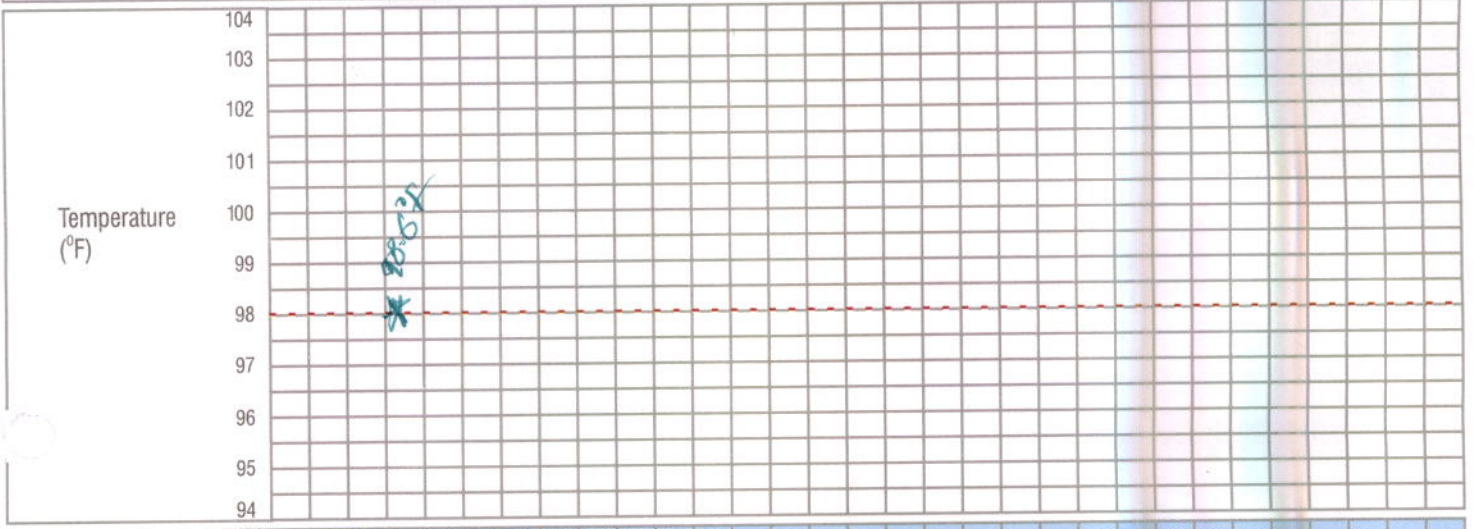
I	IDENTITY: I am (name), a nurse on ward (X). I am calling about (child X)
S	SITUATION : I am calling because I am concerned that ... (e.g. BP is low/high, pulse is XXX, Temperature is XX, Early Warning Score is XX)
B	BACK GROUND : Child (X) was admitted on (XX date) with (e.g. respiratory infection). 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 : Time: **9 AM**

Doctor / Nurse / Family Concern? **AM**



Resp Distress Mod/ Severe None / Mild **N**

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

Conscious Level Normal Altered **N**

GCS * **-**

TOTAL SCORE

Number of shaded boxes **0**

Pain Score **0**

Observer's Initials **AM**

- 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.

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VIH-00205635 IP-00060231
 Pati Baby V.M.PRARTHANA
 18-06-2022 3 Y 11 M 19 D (F)
 Dr. PREETHAM KUMAR



FLUID CHART

Sheet No. : 1

5/6/2016

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
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			45ml									
	01:00 am			45ml									
Total Intake : 90ml						Total Output : 1 time							
	02:00 am			45ml									
	03:00 am			45ml									
	04:00 am			45ml									
	05:00 am			45ml									
	06:00 am			45ml									
	07:00 am			45ml									
Total Intake : 270ml						Total Output : 2 times							
Total 24 hrs. Intake			<u>360ml</u>			Total 24 hrs. Output			<u>3 times</u>				

VIH-00205635 IP-00060231
 Baby V.M.PRARTHANA
 18-06-2022 3 Y 11 M 20 D (F)
 Dr. PREETHAM KUMAR



FLUID CHART

Sheet No. : 10

- 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		
5/6/26	08:00 am											Anetha 5/6 @ 2pm
	09:00 am	7dly water	45 ml									
	10:00 am		45 ml									
	11:00 am		45 ml									
	12:00 pm		45 ml									
	01:00 pm		45 ml									
Total Intake :			225 ml			Total Output :					2 hrs	
5/6/26	02:00 pm	kichidi	45 ml								manisha 5/6/26 @ 8pm	
	03:00 pm	water	45 ml									
	04:00 pm		45 ml									
	05:00 pm	soup	45 ml									
	06:00 pm		45 ml									
	07:00 pm		45 ml									
Total Intake :			270 ml			Total Output :					3 hrs	
5/6/26	08:00 pm		45 ml								Sneha 5/6/26 @ 8 AM	
	09:00 pm		45 ml									
	10:00 pm		45 ml									
	11:00 pm		45 ml									
	12:00 am											
	01:00 am											
Total Intake :			135 ml			Total Output :					3 hrs	
6/5/26	02:00 am										Sneha 6/5/26 @ 8 AM	
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						Total Output :					1 hr	
Total 24 hrs. Intake			<u>630 ml</u>			Total 24 hrs. Output			<u>9 hrs</u>			

10

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DRUG CHART

Date of Admission: 4/16/26 Drug Allergies: Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

- GENERAL** - Ensure that all patient details are entered above. ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.
- DOCTOR** - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
 - Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
 - Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
 - Discontinue a drug by drawing a line **I** through it and a similar line through subsequent recording panels.
 - The date and time of stopping the drug along with the doctors name and sign must be mentioned.
 - Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.
- NURSES** - Nurses must follow strictly the FIVE RIGHTS before administration of medication.
 1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time
 - AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

SOS / PRN (As Required Medication)

DRUG : <u>SUP. PARACETAMOL</u>				Date Time
Dose <u>3.5ml</u>	Route <u>PO</u>	Frequency <u>4-6 hourly</u>	Start Date <u>4/16/26</u>	
Doctor's Signature <u>[Signature]</u>		Valid Period	Pharm.	
Additional Instructions: <u>10-15ml/kg/dose</u>				
DRUG : <u>INJ. ON DANSTRON</u>				Date Time
Dose <u>2mg</u>	Route <u>IV</u>	Frequency <u>stat</u>	Start Date <u>4/16/26</u>	
Doctor's Signature <u>[Signature]</u>		Valid Period	Pharm.	
Additional Instructions: <u>0-1-0-2mg/kg/dose</u>				
DRUG :				Date Time
Dose	Route	Frequency	Start Date	
Doctor's Signature		Valid Period	Pharm.	
Additional Instructions:				

VERIFIED BY : Name S. magy kamesh s. maceey kumar
 Signature [Signature]
 Date 4/16/26



REGULAR PRESCRIPTIONS

Weight 11.6 kg Ward 111

Dr. Preetham Kumar
 16/06/2022
 Dr. Preetham Kumar
 16/06/2022
 Dr. Preetham Kumar
 16/06/2022
 Dr. Preetham Kumar
 16/06/2022

DRUG: <u>Jij. CEFTRIAXONE</u>				Date	<u>5/6</u>	<u>6/6</u>														
				Time	<u>1:20</u>															
Dose	Route	Frequency	Start Date																	
<u>500mg</u>	<u>IV</u>	<u>12th hourly</u>	<u>4/6/22</u>		<u>6 AM</u>	<u>6 PM</u>														
Name & Signature of the Doctor Starting the Drugs:																				
<u>Dr. prathanti</u>																				
Additional Instructions:				<u>ATTEN TELL DOOR</u>																
<u>& 5-500mg/ly/dose</u>																				
Daily Doctor's Endorsement by a Sign																				
DRUG: <u>Jij. Amoxicillin</u>				Date	<u>5/6</u>	<u>6/6</u>														
				Time																
Dose	Route	Frequency	Start Date																	
<u>1mg</u>	<u>IV</u>	<u>ONCE DAILY</u>	<u>4/6/22</u>		<u>6 AM</u>	<u>6 PM</u>														
Name & Signature of the Doctor Starting the Drugs:																				
<u>Dr. prathanti</u>																				
Additional Instructions:																				
<u>1mg/ly/dose</u>																				
Daily Doctor's Endorsement by a Sign																				
DRUG: <u>INTERFERON</u>				Date	<u>5/6</u>	<u>6/6</u>														
				Time																
Dose	Route	Frequency	Start Date																	
<u>1</u>	<u>P/O</u>	<u>12th hourly</u>	<u>4/6/22</u>		<u>6 AM</u>	<u>6 PM</u>														
Name & Signature of the Doctor Starting the Drugs:																				
<u>Dr. prathanti</u>																				
Additional Instructions:				<u>ATTEN TELL DOOR</u>																
<u>1 x 1 pill = 5ml</u>																				
Daily Doctor's Endorsement by a Sign																				
DRUG: <u>ZYD-ZINCINIA</u>				Date	<u>5/6</u>	<u>6/6</u>														
				Time																
Dose	Route	Frequency	Start Date																	
<u>5ml</u>	<u>P/O</u>	<u>ONCE DAILY</u>	<u>4/6/22</u>		<u>6 AM</u>	<u>6 PM</u>														
Name & Signature of the Doctor Starting the Drugs:																				
<u>Dr. prathanti</u>																				
Additional Instructions:																				
<u>5ml/20mg</u>																				
Daily Doctor's Endorsement by a Sign																				

