

**ADMISSION SHEET**



**Registration Details :**

Admission No : IP26-00006660      Admit Date : 26-Jun-2026      Admit Time : 10:38 PM      UHID : LBH-00094266

**Patient Details :**

Patient Name	: Master PURVIK	Age	: 13 Y 7 M 16 D
Guardian	: Mrs A PADMIKA	DOB	: 10-11-2012
Gender	: Male	Religion	:
Occupation	:	Marital Status	:
Address (H)	: HOUSE NO 1-7-196 TO 198 BAKARAM Musheerabad Ndso Hyderabad Telangana INDIA 500020	Phone No	: 9032340464/ 9849921997
		E-mail	: a.padmika@gmail.com

**Admission Details :**

Bed Type : DAY CARE      Bed No : ER01      Ward Name : GF -EMERGENCY  
Room No : ER01      Admission Type : First Visit

**Contact Details :**

Name : Mrs A PADMIKA      Relationship : MOTHER  
Contact Address : HOUSE NO 1-7-196 TO 198 BAKARAM      Phone No : 9032340464  
Musheerabad Ndso Hyderabad Telangana INDIA  
500020

  
Signature

**Doctor Details :**

Doctor Name : Dr. SINDHURA MUNUKUNTLA      Specialisation : GENERAL PEDIATRICS  
Referral Doctor : SELF      Phone No :  
Co-Consultant :

**Payment Details :**

Payment Mode : DC/CC Card      Deposit Amount : 10000.00  
Payor Name : ADITYA BIRLA HEALTH INSURANCE  
CO. LTD

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**ACTIVITY RECORD FOR RII LING**

LBM-00094266 IP26-00006660

Master PURVIK

Name: 10-11-2012 13 Y 7 M 16 D (M) -----  
Dr. SINDHURA MUNUKUNTLA

UHID N 

----- Consultant : ----- Dept : *pediatrics*

Date of Admission : *26/6/20* Time : ----- Date of Discharge : ----- Time: -----

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

**WARD TRANSFERS**

Date	Time	From	To	Signature of Nurse
<i>26/6/20</i>	<i>10:35 PM</i>	<i>BR</i>	<i>214</i>	<i>K. Vijaya Lakshmi</i>

**Cross Consultation Visit**

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







Ref.No. F/IN/PR/10



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

**PEDIATRIC IN-PATIENT  
MEDICAL RECORD**

LBH-00094256      IP26-00006660  
Master PURVIK  
10-11-2012      13 Y 7 M 16 D      (M)  
Dr. SINDHURA MUNUKUNTLA



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

Patient ID# : \_\_\_\_\_

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

Final Diagnosis : \_\_\_\_\_

Name : Purvi

Informant \_\_\_\_\_

Age/Sex \_\_\_\_\_

Reliability \_\_\_\_\_



Chief Presenting Complaints & Duration (Chronologically):

clo - Fervid :: 6 days

clo Sore Body pain :: 4 days

clo Poor Oral Intake :: 3 days

clo Vomiting :: 2 days

History of present illness :

child brought with

clo Fervid :: 6 days

High grade fever - 102-103°F ass & chills  
occur 4-6<sup>th</sup> hourly  
ass & headache & body pains

clo Eye pain & retro orbital pain :: 3-4 days  
occ photophobia

clo Poor Oral intake }  
Dull activity } :: 3 days

clo Vomiting :: 2 days  
Multiple episode, non bilious vomiting  
No loose stool, occ Abdominal pain

Used Oral Paracetamol :: 3 days & Azithromycin

outside investigation → CRP - 62

CBP - HB - 12.6 / WBC - 7200  
N-77 / PH - 2.66  
L-18

Pediatric Multiorgan History & Physical Examination

LBH-00094266 IP26-00006660  
Master PURVIK  
10-11-2012 13 Y 7 M 16 D (M)  
Dr. SINDHURA MUNUKUNTLA



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

Blank lined area for Past History.

Birth & Neonatal History :

No significant birth history



Birth & Socio Economic History :

About Father :

About Mother :

Any additional Information :

Developmental History :

Normal

Immunization History :

vpta date

Pediatric Multiorgan History & Physical Exam

LBH-00094266 IP26-00006660  
Master PURVIK  
10-11-2012 13 Y 7 M 16 D (M)  
Dr. SINDHURA MUNUKUNTLA



Anthropometry

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

Weight (kgs) 56.7 Kg (Centile \_\_\_\_\_)

**On Examination :**

Temperature : 102° F Pulse Rate: 82/min Description \_\_\_\_\_

B.P. 129/73 SPO2 100 % at \_\_\_\_\_

Resp. rate and type of breathing : 18/min

Rash \_\_\_\_\_  
Sign of Dehydration (D) - sunken eye, dry lip & oral mucosa, dry skin

Lymphadenopathy \_\_\_\_\_

Oedema : B/L ankle (R > L)

**Respiratory system :**

Inspection (any s/o distress) : \_\_\_\_\_

Air entry & breath sounds : B/L A&B (D)

Any addes sounds : \_\_\_\_\_

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

Throat - Cobble stone Pharynx  
Nose - B/L Irregular Turbinate H.T  
Ears - (D)  
B/L Upper Cervical LN (<1.5cm)

**Cardiovasclular System :**

Inspection of procordium : \_\_\_\_\_

Heart Sounds : S2 (D)

Any murmur : \_\_\_\_\_

Relevant date from outside (Chest X-Ray, ECG, ECHO, Etc.,) \_\_\_\_\_

**Per Abdomen :**

Inspection \_\_\_\_\_

Palpation : Soft - Splenomegaly (D)

Auscultation : \_\_\_\_\_

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

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



**Central Nervous System :**

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

Cranial Nerves : \_\_\_\_\_

**Motor System :**

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

Tone : \_\_\_\_\_ Power \_\_\_\_\_

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

Posture : \_\_\_\_\_

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

**Reflexes :**

**DTR**

**Superficials :**

Plantars \_\_\_\_\_

**Sensory System :**

Bladder / Bowel : \_\_\_\_\_

**Clinical Summary & Diagnostic :**

*AFI - D6 - Dehydrated  
To R/O ? Enteric / ? Dengue*

Pediatric Multiorgan History & Physical Examination

LBH-00094266 IP26-00006660  
Master PURVIK  
10-11-2012 13 Y 7 M 16 D (M)  
Dr. SINDHURA MUNUKUNTLA



Preventive aspects of the treatment :

Shock

Desired goals of the treatment :

H.D stability

**Planned Labs :**

- VBG ✓
- CBP, CRP ✓
- Blood Cls + ✓
- Dengue NS, + IgM ✓
- CVE ✓
- CXR ✓
- 5 Vira Respiratory Panel ✓
- VIT D (25-OH) ✓

**Planned Management :**

- IVF - DNS
- Ij Ceftriaxone
- Ij Escamprazole
- Tab Montelukast
- Nutrition Adalt
- Ij Ondem

**Please fill up the following details**

1. Name of the Referring Doctor : \_\_\_\_\_
2. Name of the Referring Hospital : \_\_\_\_\_  
(Including the name of City)
3. Contact number of the Referring Doctor : \_\_\_\_\_  
(Preferring Mobile #)
4. Name of the doctor in Rainbow Team \_\_\_\_\_ on  
whose name the patient is being referred *Dr. Sindhura*

Doctor's Signature Name *[Signature]* Date *26/6* Time *11 pm*



## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
26/6 11 pm	<p><u>CP/B D. Sindhura</u></p> <p><u>AFI - D6 E Dehydration</u></p>	
	<p>Fever ⊕</p> <p>Body pain ⊕</p> <p>Nausea &amp; Vomiting ⊕</p> <p>Red eye ⊕</p>	<p><u>Plan</u></p> <p>1) IVF - DNS - 2/3<sup>rd</sup> (M)</p>
	<p>Child appear Dehydrated</p> <p>Dry skin</p> <p>Dry Oral mucosa &amp; lips</p>	<p>2) CBP, CRP</p> <p>3) Blood C/S</p> <p>4) Dengue NS, + IgM</p> <p>5) 5 Virus Respiratory Panel</p> <p>6) CUE</p>
	<p>Child Dull</p> <p>Vital stable</p> <p>Throat - Cobbleston Pharyngitis</p> <p>Nose - B/L Infected Turbinate H.T</p> <p>Ears - B/L T.M - (N)</p>	<p>7) Ixig Ceftriaxone</p> <p>8) Monitor Vital</p> <p>Inj. sos</p> <p>(Late decide on V/D)</p>
	<p>B/L Uppr Cervical LN ⊕ (&lt;1.5cm)</p> <p>C/S - S, S<sub>2</sub> ⊕</p> <p>R-S - B/L AE ⊕, conductal Swabs</p> <p>PLA - Splen Tip palpable</p> <p>No neck stiffness</p> <p>No sign of meningeal irritation</p>	<p><del>Munukunta</del></p> <p><del>Munukunta</del></p>



Patient Sticker

### PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
27/6/26 10 AM	epi/ly 2s - <del>Stindhu</del> AFI $\bar{c}$ dehydration fwe spik (+)	
	- flc - 2ay Integ	(+) Adeno. B/c/p.
	vital stable	ce 1/2 M IV fluids.
	<u>s/e</u>	Extravascular $\Rightarrow$ Send Mycoplasma IGM
	(Rls) B/c AC (+) NWBS (+)	To send CUE
	(P/A) soft non tender.	ce oth Mx x Ray NP $\rightarrow$ If Advoid Monitor vital Noted by 1 METATOP.
		<del>of Simolano M...M</del>













## MEDICATION RECONCILIATION FORM

Drug Allergies: ..... all .....  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: ..... CR ..... Shifted to: ..... 21A .....

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1						<input type="checkbox"/> C <input type="checkbox"/> DC
2						<input type="checkbox"/> C <input type="checkbox"/> DC
3						<input type="checkbox"/> C <input type="checkbox"/> DC
4						<input type="checkbox"/> C <input type="checkbox"/> DC
5						<input type="checkbox"/> C <input type="checkbox"/> DC
6						<input type="checkbox"/> C <input type="checkbox"/> DC
7						<input type="checkbox"/> C <input type="checkbox"/> DC
8						<input type="checkbox"/> C <input type="checkbox"/> DC
9						<input type="checkbox"/> C <input type="checkbox"/> DC
10						<input type="checkbox"/> C <input type="checkbox"/> DC

\* C- Continue, DC - Discontinue

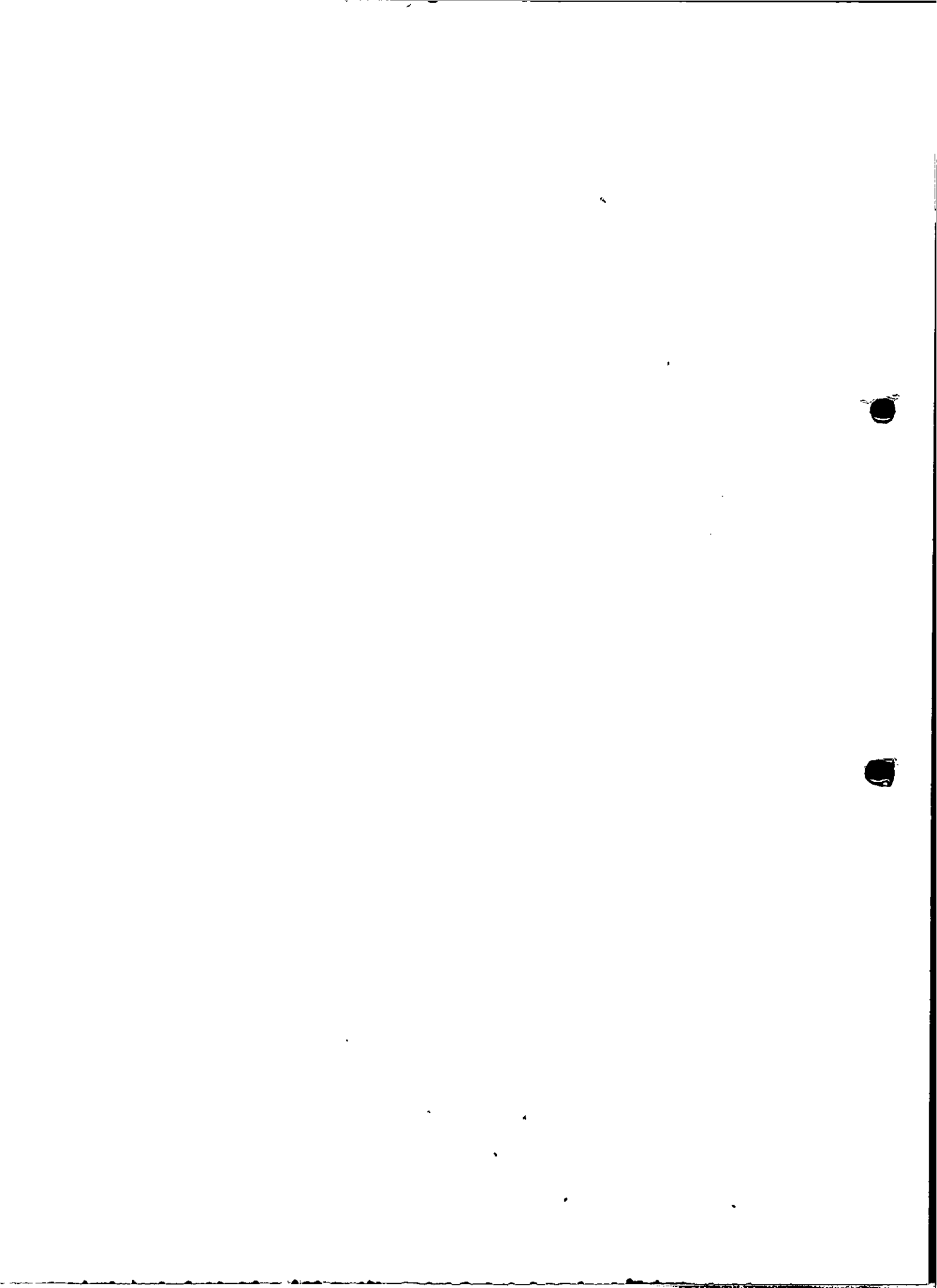
### MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Pranav .....

Date & Time : 26/6/26 @ 10:40pm .....

Nurse Name & Signature: K. vijaya ..... 12

Date & Time : 26/6/26 @ 10:45pm .....



## DRUG CHART

Date of Admission: 26/6/26 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)

<b>DRUG :</b> <u>Tak Dolo - 650</u>				Date Time																
Dose	Route	Frequency	Start Date	Date Time																
<u>1 tab</u>	<u>PO</u>	<u>SOS</u> <u>6* hly</u>	<u>26/6</u>																	
Doctor's Signature		Valid Period	Pharm.																	
<u>Pran</u>																				
Additional Instructions:																				

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

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

VERIFIED BY : Name ..... Signatu



Patient Sticker

Sheet No: .....

### REGULAR PRESCRIPTIONS

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

<b>DRUG :</b> <i>Inj ONDANSETRON</i>				Date Time	<i>26/6</i>																			
Dose	Route	Frequency	Start Dt.																					
<i>4mg</i>	<i>IV</i>	<i>TID</i>	<i>26/6</i>	<i>[Signature]</i>																				
Name & Signature of the Doctor Starting the Drugs:																								
Additional Instructions:																								
<b>Daily Doctor's Endorsement by a Sign</b>																								
<b>DRUG :</b>				Date Time																				
Dose	Route	Frequency	Start Dt.																					
Name & Signature of the Doctor Starting the Drugs:																								
Additional Instructions:																								
<b>Daily Doctor's Endorsement by a Sign</b>																								
<b>DRUG :</b>				Date Time																				
Dose	Route	Frequency	Start Dt.																					
Name & Signature of the Doctor Starting the Drugs:																								
Additional Instructions:																								
<b>Daily Doctor's Endorsement by a Sign</b>																								
<b>DRUG :</b>				Date Time																				
Dose	Route	Frequency	Start Dt.																					
Name & Signature of the Doctor Starting the Drugs:																								
Additional Instructions:																								
<b>Daily Doctor's Endorsement by a Sign</b>																								

Signature  
Name

Patient Sticker



Sheet No: .....

### REGULAR PRESCRIPTIONS

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


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

Signature  
Name





# PATIENT TRANSFER FORM

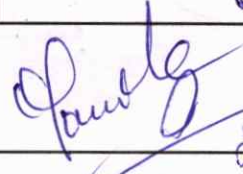
Patient Name & UHID No.  LBM-00094256      IP26-00006660 Master PURVIK 10-11-2012      13 Y 7 M 16 D (M) Dr. SINDHURA MUNUKUNTLA 	Date & Time of Admission 26/6/26 @ 10:38 PM	Date & Time of Transfer Order 26/6/26 @ 11:35 PM
	Transfer Ordered by Dr. praveen	Reason for Transfer Admission.
From Unit ER	To Unit 214	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Number of Sheets in Clinical File 14	Number of Imaging Films V136 - 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.		
2.		
3.		
4.		
5.		

Shifting Summary / Notes Written by Doctor :    Yes       No

Name & Signature of Person who is Transferring 	Name of Person Ordered Transfer Dr. praveen
---	--

Patient & Clinical Records Received by :  
 26/6/26 @ 11:39 PM

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

wt - 56.7 kg

# EMERGENCY ROOM TRIAGE FORM

Patient's Name : Purvik Age : 13 Gender:  Male  Female

Date : 26/6/26 Time of Arrival : 10:05 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: 102 PR: 81 BP: 129/73 RR: ..... SpO<sub>2</sub>: 100

Chief Complaints: Chd fever since 7 days

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

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.

\* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian

Triage Completion Time : 10:7 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 : Anupama

Signature of Triage Nurse : [Signature]

Date & Time : 26/6/26 @ 10:8 Pm



## NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date: 26/6/26 Time of arrival: 10:30pm

Chief Complaints: C/O fever since 7 days. RBS: .....

Height: ..... Weight: 56.7kg BMI: ..... Head Circumference (<2 years) .....

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

If yes, identify .....

Pain Screening:  Yes  No If Yes, Pain Score: 0/1 Pain Tool Used:  N Pass  FLACC  Wong Baker

Character .....  Location .....  Frequency .....  Duration .....

### RISK FOR FALL:

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

If Patient is > 6 years  
Assess the below parameters

History of Falling: within past 3 months  Yes  No

### Ambulatory Aids:

- Wheelchair  Yes  No
- Uses furniture for support  Yes  No

### Gait/Transferring:

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

Mental Status: Forgets limitations  Yes  No

### IF YES FOR ANY CATEGORY = RISK FOR FALLING

#### Fall Risk Intervention:

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

Functional Screening:  No Abnormalities Detected

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

#### Inform consultant for positive criteria

Nutritional Screening:  No Abnormalities Detected

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

#### Inform consultant for positive criteria

Psychological Screening:  No Significant Findings

Unusual concerns about patient's Psychological Status:  Yes  No

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

Social History: Lives With Family .....

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

Time of Initial assessment completed by ER Nurse: 10:10 P.m .....

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

Time	Nursing Notes
	Assessed The patient condition vital checked.

Samples collected by: *vitaya*  
 Samples sent by : *vitaya*

Time: *10:30 PM*

**Medication given in ER:**

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

Condition of patient at time of shift - out :	Details of Shift - out
HR: <del>130</del> 88 BP: 130/73 CFT: ..... RR: 20 SPO <sub>2</sub> : 99% GCS: 15/15 Temperature: 100 Pain Score: 1 Repeat RBS (if applicable): NO	Shift - out from ER to: 214 Time of Shift - out: 10:35 PM Handover given to: <i>A. P.</i> (Nurse's Name)

Tick as applicable:  MLC  LAMA  BROUGHT DEAD

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

Name of the Nurse : *Ampun*

Signature of the Nurse : *A.P.*

Date & Time : *26/6/20*

*Perwik*  
Patient Sticker  
*134*

*254*

### NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: *27/6/26* Time: *9:45am*

Weight: *56.7 kg* Centile: *75<sup>th</sup>*

Height: \_\_\_\_\_ Centile: \_\_\_\_\_

Inference: *well nourished child*

RDA: \_\_\_\_\_ Calories: *1800 kcal/day* Protein: *32 gms/day*

Diet Recommendations: *Balanced diet with liquid*

Re-Assessment: *No Junk, oily, spicy food*

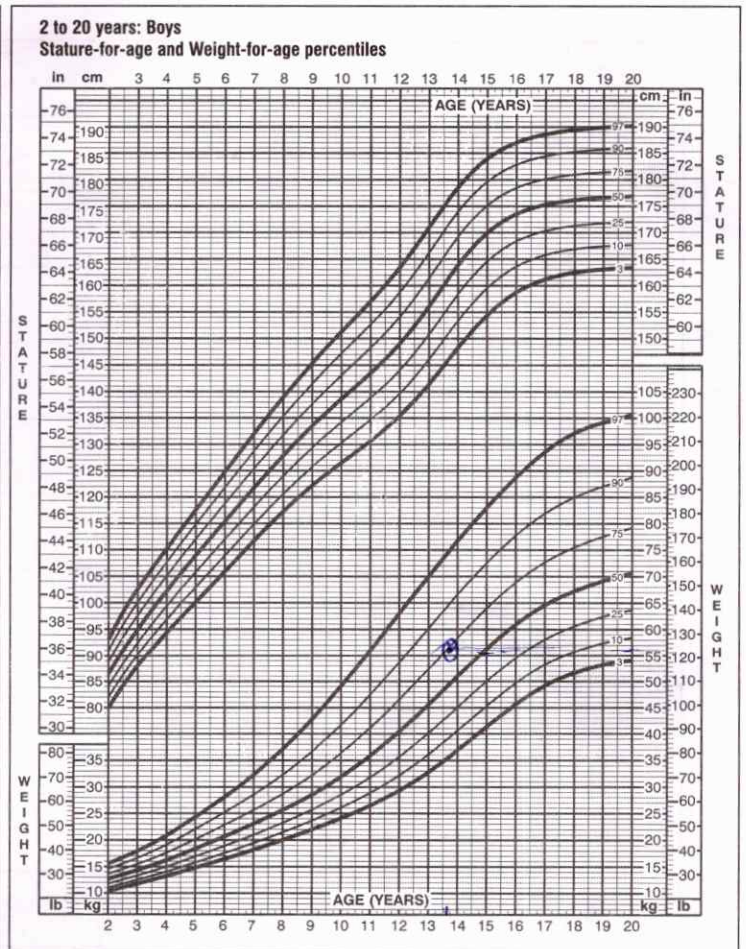
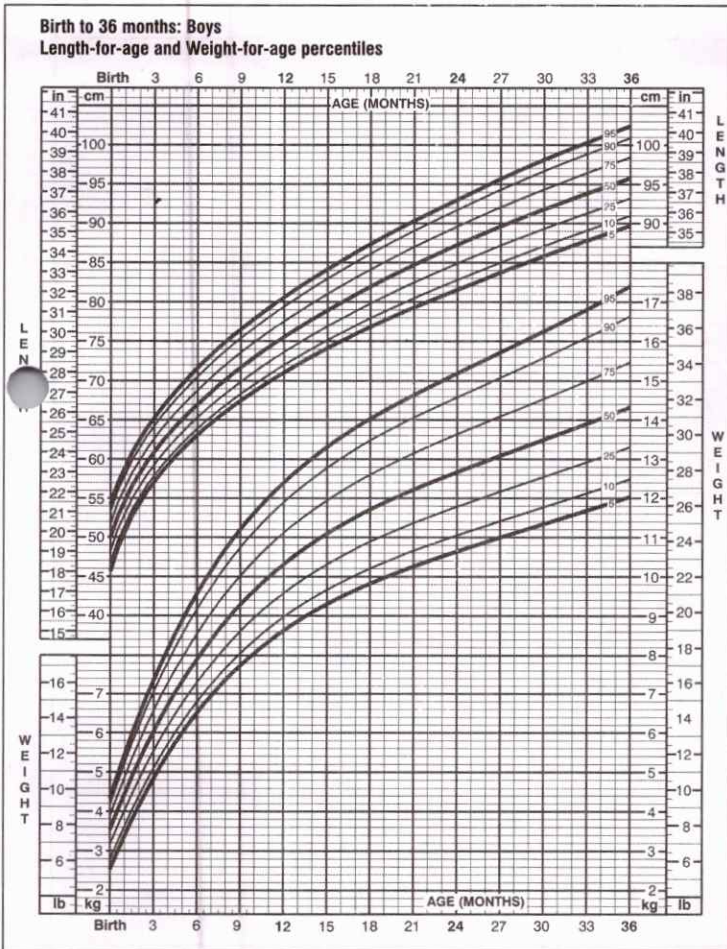
Food Allergies: *No* Veg/Non-veg: *Non Veg*

Diagnosis: *AFIC dehydration*

Nutritional Intervention -  Oral  Enteral  Parenteral

Patient's Signature: *[Signature]*

#### GROWTH CHART (BOYS)



Dietician's Name: *Syed Sobiya Zaher*

Dietician's Signature: *[Signature]*



LBH-00094266 IP26-00006660  
 Master PURVIK  
 10-11-2012 13 Y 7 M 16 D (M)  
 Dr. SINDHURA MUNUKUNTLA

214



### RESULT SHEET

Date	25/6/26	26/6/26			
Time	Outside				
Hb	12.6	11.6			
PCV	41.3	32.8			
RBC	5.7	4.77			
WBC	7200	3.03			
N/L	77/18	418/41.0			
Platelets	2.6	204			
CRP	62	374			
ESR	26				
PCT					
RBS					
Na					
K					
Cl					
Ca/Mg					
Phosphate					
Urea					
Creatinine					
ALP	195				
SGPT	26				
SGOT	35				
T.Bill/Conj	0.7/0.1				
T.Protein	7.1				
S.Albumin	4.0				
S.Globulin	3.1				
A/G Ratio	1.29				
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein / Sugar					
Cells					
N/L					

Date	25/6					
Time	09:30					
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						
WIDAL	Negative					
Malaria (F & V)	Negative					
VITAMIN D	-					
Dengue NS						
Dengue IgM						
Respiratory (S) virus						

Culture and Sensitivities : Blood cultures

.....

.....

.....

Radiology :      USG : .....

                      X-Ray : .....

                      ECHO : .....

                      CT : .....

                      MRI : .....

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

LBH-00094266 IP26-00006660  
 Master PURVIK  
 10-11-2012 13 Y 7 M 16 D (M)  
 Dr. SINDHURA MUNUKUNTLA



## RESULT SHEET

Date					
Time					
Hb					
PCV					
RBC					
WBC					
N/L					
Platelets					
CRP					
ESR					
PGT					
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					



**TEENAGE (12 + years)**  
**Children's Observation &**  
**Early Warning Scoring Chart**

Patient Name : .....  
 Date of Birth : .....



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

Am 4:30Am 5Am 6Am

Temperature (°F)

Heart Rate (bpm) and Blood Pressure (mmHg)

NOTE: BP does not score in early warning scoring

Heart Rate (number)

Resp Rate (bpm)

Resp. Mod/Severe Distress None/Mild

Receiving O2 (L/min) O2 saturations (%)

Conscious Normal Level Decreased GCS \*

TOTAL SCORE Number of shaded boxes Observer's initials

**ACTIONS**

NB: Scores 3 should be recorded overleaf

- Score 1 : Continue normal observation by staff nurse
- Score 2 : Shift in charge nurse to be informed and continue hourly observations
- Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.
- Score 4 : Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see
- Score 5 & 6 : Shift 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.  
 CIN : U85110 TG1998 PTC029914

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

NOTE: BP does not score in early warning scoring

Heart Rate (number)

Resp Rate (bpm) over 1 minute

Resp Rate (number)

Distress None/Mild

Receiving O2 (L/min) O2 saturations (%)

Conscious Normal Level Decreased

TOTAL SCORE Number of shaded boxes Observer's initials

**ACTIONS**

NB: Scores 3 should be recorded overleaf

- Score 1 : Continue normal observation by staff nurse
- Score 2 : Shift in charge nurse to be informed and continue hourly observations
- Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.
- Score 4 : Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see
- Score 5 & 6 : Shift 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.  
 TG1998 PTC029914

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

It takes a lot to treat the little.



BirthRight

BY RAINBOW HOSPITAL

Your Right to a Safe Deliver

Date: 2/16..... Time: 2

Doctor / Nurse / Family Concern?

104

103





# FLUID CHART

Sheet No. : .....

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

		Intake				Output					IV Site Thrombophlebitis Score	Sign. Nurse	
Date	Time	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												
	01:00 pm												
<b>Total Intake :</b>						<b>Total Output :</b>							
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
<b>Total Intake :</b>						<b>Total Output :</b>							
	08:00 pm				coml								
	09:00 pm				coml								
	10:00 pm				coml								
	11:00 pm				coml								
	12:00 am				coml								
	01:00 am				coml								
<b>Total Intake :</b>						<b>Total Output :</b>							
	02:00 am				coml								
	03:00 am				coml								
	04:00 am				coml								
	05:00 am				coml								
	06:00 am				coml								
	07:00 am				coml								
<b>Total Intake :</b>						<b>Total Output :</b>							
<b>Total 24 hrs. Intake</b>						<b>Total 24 hrs. Output</b>							

LBH-00094268 IP26-0006660  
 Master PURVIK  
 10-11-2012 13 Y 7 M 17 D (M)  
 Dr. BINDHURA MUNUKUNTLA



# FLUID CHART

Sheet No. : .....

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

		Intake				Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
Date	Time	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												
	01:00 pm												
<b>Total Intake :</b>						<b>Total Output :</b>							
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
<b>Total Intake :</b>						<b>Total Output :</b>							
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
<b>Total Intake :</b>						<b>Total Output :</b>							
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
<b>Total Intake :</b>						<b>Total Output :</b>							

**Total 24 hrs. Intake**

**Total 24 hrs. Output**

LBH-00084266 IP26-0006660  
 Master PURVIK  
 10-11-2012 13 Y 7 M 16 D (M)  
 Dr. SINDHURA MUNUKUNTLA



# FLUID CHART

Sheet No. : .....

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

		Intake				Output					IV Site Thrombophlebitis Score	Sign. Nurse
Date	Time	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											
	01:00 pm											
<b>Total Intake :</b>						<b>Total Output :</b>						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
<b>Total Intake :</b>						<b>Total Output :</b>						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
<b>Total Intake :</b>						<b>Total Output :</b>						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
<b>Total Intake :</b>						<b>Total Output :</b>						
<b>Total 24 hrs. Intake</b>						<b>Total 24 hrs. Output</b>						

Patient Sticker



# FLUID CHART

Sheet No. : .....

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

		Intake				Output					IV Site Thrombophlebitis Score	Sign. Nurse	
Date	Time	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												
	01:00 pm												
<b>Total Intake :</b>						<b>Total Output :</b>							
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
<b>Total Intake :</b>						<b>Total Output :</b>							
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
<b>Total Intake :</b>						<b>Total Output :</b>							
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
<b>Total Intake :</b>						<b>Total Output :</b>							

<b>Total 24 hrs. Intake</b>	
-----------------------------	--

<b>Total 24 hrs. Output</b>	
-----------------------------	--

LBH-00094266  
 Master PURVIK  
 10-11-2012 13 Y 7 M 16 D (M)  
 Dr. SINDHURA MUNUKUNTLA

IP26-0006660

Patience

# NURSING CARE RECORD



Date: 26/6/26

**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							
Afternoon							
Night	8pm	Assess the general condition Check vital & recorded Administer medication as per doctor advice 8pm 1 lb chest main	8pm	Assessed the general condition checked vital & recorded administered medication as per doctor advice 8pm 1 lb chest main	All Sp Stable	checked Vital	

Patient Sticker

# NURSING CARE RECORD



Date: .....

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon							
Night							

Patient Sticker

# NURSING-CARE-RECORD



Date: .....

**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
<b>Morning</b>							
<b>Afternoon</b>							
<b>Night</b>							

Patient Sticker

# NURSING CARE RECORD



Date: .....

**Goals**

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon							
Night							



## NURSING SHIFT HAND OVER FORM

<b>SITUATION</b>	Diagnosis: <u>AFIC dehydration.</u>	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify: .....						
	Surgery / Procedure:	Post OP Day:						
<b>BACKGROUND</b>	Date	<u>22/10/12</u>						
	Shift	<u>N,</u>						
	Medical Condition (Any special condition to be noted):	<u>—</u>						
	Diet:	<u>—</u>						
<b>ASSESSMENT</b>	Allergy:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Ventilation (RA, NP, NIV, VENTI):	<u>—</u>						
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Vital Signs:	Temp:	<u>98.1°</u>					
		Res:	<u>20b/m</u>					
		SpO <sub>2</sub> :	<u>99%</u>					
		Pulse:	<u>72b/m</u>					
		BP:	<u>—</u>					
		LOC:	<u>—</u>					
		Fall Risk Score:	<u>—</u>					
Pain Score:	<u>0</u>							
Skin Integrity	<u>Good</u>							
<b>Recommendations</b>	Safety Needs:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Physiotherapy:	<u>—</u>						
	Others Specify:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Special Diet:	<u>—</u>						
	Critical Lab Test / Values:	<u>—</u>						
	Other Special Orders / Medications:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	PU Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
DVT Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
ADL (Dependent / Non Dependent):	<u>—</u>							
Post Operative Procedure Special Orders:		<u>—</u>						
Handed Over By Name :		<u>manika</u>						
Signature / ID :		<u>[Signature]</u>						
Date:		<u>22/10/12</u>						
Time:		<u>8AM</u>						
Taken Over By Name :								
Signature / ID :								
Date:								
Time:								

Patient Sticker



## NURSING SHIFT HAND OVER FORM

<b>SITUATION</b>	Diagnosis:	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify: .....					
	Surgery / Procedure:	Post OP Day:					
<b>BACKGROUND</b>	Date	/					
	Shift	/					
	Medical Condition (Any special condition to be noted):						
	Diet:						
<b>ASSESSMENT</b>	Allergy:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Ventilation (RA, NP, NIV, VENTI):						
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Vital Signs:	Temp:					
		Res:					
		SpO <sub>2</sub> :					
		Pulse:					
		BP:					
		LOC:					
		Fall Risk Score:					
	Pain Score:						
	Skin Integrity						
<b>Recommendations</b>	Safety Needs:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Physiotherapy:						
	Others Specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Special Diet:						
	Critical Lab Test / Values:						
	Other Special Orders / Medications:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	PU Prophylaxis:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	DVT Prophylaxis:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
ADL (Dependent / Non Dependent):							
Post Operative Procedure Special Orders:							
Handed Over By Name :							
Signature / ID :							
Date:							
Time:							
Taken Over By Name :							
Signature / ID :							
Date:							
Time:							

Patient Sticker



## NURSING SHIFT HAND OVER FORM

<b>SITUATION</b>	Diagnosis:	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify: .....						
	Surgery / Procedure:	Post OP Day:						
<b>BACKGROUND</b>	Date	/	/	/	/	/	/	
	Shift							
	Medical Condition (Any special condition to be noted):							
	Diet:							
<b>ASSESSMENT</b>	Allergy:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Ventilation (RA, NP, NIV, VENTI):							
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Vital Signs:	Temp:						
		Res:						
		SpO <sub>2</sub> :						
		Pulse:						
		BP:						
		LOC:						
		Fall Risk Score:						
Pain Score:								
Skin Integrity								
<b>Recommendations</b>	Safety Needs:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Physiotherapy:							
	Others Specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Special Diet:							
	Critical Lab Test / Values:							
	Other Special Orders / Medications:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	ADL (Dependent / Non-Dependent):							
	PU Prophylaxis:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	DVT Prophylaxis:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Post Operative Procedure Special Orders:							
	Handed Over By Name :							
	Signature / ID :							
	Date:							
	Time:							
	Taken Over By Name :							
	Signature / ID :							
	Date:							
	Time:							

Patient Sticker



## NURSING SHIFT HAND OVER FORM

<b>SITUATION</b>	Diagnosis:	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify: .....						
	Surgery / Procedure:	Post OP Day:						
<b>BACKGROUND</b>	Date							
	Shift							
	Medical Condition (Any special condition to be noted):							
	Diet:							
<b>ASSESSMENT</b>	Allergy:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Ventilation (RA, NP, NIV, VENTI):							
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Vital Signs:	Temp:						
		Res:						
		SpO <sub>2</sub> :						
		Pulse:						
		BP:						
		LOC:						
		Fall Risk Score:						
Pain Score:								
Skin Integrity								
<b>Recommendations</b>	Safety Needs:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Physiotherapy:							
	Others Specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Special Diet:							
	Critical Lab Test / Values:							
	Other Special Orders / Medications:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	ADL (Dependent / Non Dependent):							
	PU Prophylaxis:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	DVT Prophylaxis:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Post Operative Procedure Special Orders:							
	Handed Over By Name :							
	Signature / ID :							
	Date:							
	Time:							
	Taken Over By Name :							
	Signature / ID :							
	Date:							
	Time:							



## CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1 <i>ef</i>			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0	<i>0</i>		<i>0</i>							
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1	<i>0</i>		<i>0</i>							
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2			<i>0</i>							
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3			<i>0</i>							
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4			<i>0</i>							
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord pyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5			<i>0</i>							
Signature of the Nurse						<i>[Signature]</i>							

**NOTE :** Phlebitis greater than grade 2 should be reported to physicians and other appropriate health care personal ongoing observation of the site should continue for 48 hours post removal to detect post infusion phlebitis.

Signature of Shift In Charge :

Signature : *[Signature]* Name : *[Name]*

Signature of Ward In Charge :

Signature : *[Signature]* Name : *[Name]*

## CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0										
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1										
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2										
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3										
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Signature of Shift In Charge :

Signature of Ward In Charge :

Signature : ..... Name : .....

Signature : ..... Name : .....

Patient Sticker



## CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
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Signature of the Nurse													

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Signature of Shift In Charge :

Signature of Ward In Charge :

Signature : ..... Name : .....

Signature : ..... Name : .....

→ Patient Sticker



## CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0										
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Signature of Shift In Charge :

Signature of Ward In Charge :

Signature : ..... Name : .....

Signature : ..... Name : .....

BH-00094266  
 Master PURVIK  
 10-11-2012  
 Dr. SINDHURA MUNUKUNTLA  
 13 Y 7 M 17 D (M)  
 IP26-00006660

# PAIN ASSESSMENT FORM

Date	Time	Age (0/70)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
26/11/26	6pm		S/LW	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>[Signature]</i>	<i>[Signature]</i>
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		

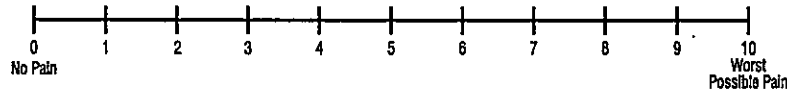
**Re-assessment Frequency:**  
 1. Every eight hours for all hospitalized patients.  
 2. For post-surgical patients, patients with chronic pain, patient with severe pain:  
 a) At least every 2 hours for the first 24 hours      b) Then every 4 hours.  
 c) Prior to pain relieving intervention.                d) Within 30 – 60 minutes after pain relief intervention.

# PAIN ASSESSMENT TOOLS

## FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
	0	1	2
Face	No Particular expression or smile	Occasional Grimace or Frown, withdraw, Disoriented	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs drawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, rigid, or Jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams of sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

## Numerical Pain Scale (Obstetric and Gynecology)



## Neonatal Pain, Agitation and Sedation Scale (upto 1 Month)

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
<b>Crying Irritability</b>	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
<b>Behavior State</b>	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
<b>Facial Expression</b>	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
<b>Extremities Tone</b>	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
<b>Vital Signs HR, RR, BP, SaO<sub>2</sub></b>	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO <sub>2</sub> 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO <sub>2</sub> less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

## Wong - Baker (Pediatrics) Above 7 Years



# PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
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				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		

**Re-assessment Frequency:**

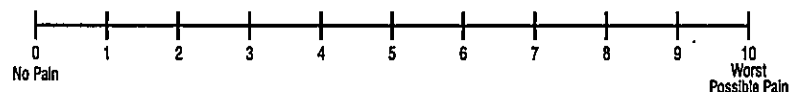
1. Every eight hours for all hospitalized patients.
2. For post-surgical patients, patients with chronic pain, patient with severe pain:
  - a) At least every 2 hours for the first 24 hours
  - b) Then every 4 hours.
  - c) Prior to pain-relieving intervention.
  - d) Within 30 – 60 minutes after pain relief intervention.

# PAIN ASSESSMENT TOOLS

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## Wong - Baker (Pediatrics) Above 7 Years



BH-00094266  
 Master PURVIK  
 10-11-2012  
 Dr. SINDHURA MUNUKUNTLA  
 13 Y 7 M 17 D (M)  
 IP26-00006660

# BRADEN 'Q' SCALE



					Date :				
					Time :	14			
Mobility	<b>1. Completely immobile:</b> Does not make even slight changes in body or extremity position without assistance.	<b>2. Very limited:</b> Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	<b>3. Slightly limited:</b> Makes frequent through slight changes in body or extremity position independently.	<b>4. No limitations:</b> Makes major and frequent changes in position without assistance.	9				
"Activity The degree of physical activity"	<b>1. Bedfast :</b> Confined to bed	<b>2. Chairfast :</b> Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	<b>3. Walks occasionally:</b> Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	<b>4. All patients too young to ambulate; OR walks frequently:</b> Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	3				
Sensory Perception	<b>1. Completely limited:</b> Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	<b>2. Very limited:</b> responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	<b>3. Slightly limited:</b> Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	<b>4. No impairment:</b> Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	9				
Moisture Degree to which skin is exposed to moisture	<b>1. Constantly moist:</b> Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	<b>2. Very moist:</b> Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	<b>3. Occasionally moist:</b> Skin is occasionally moist, requiring linen change every 12 hours.	<b>4. Rarely moist:</b> Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4				
<b>FRICION-SHEAR</b> <b>Friction</b> Occurs when Skin moves against support surfaces <b>Shear</b> Occurs when skin and adjacent bony surface slide across one another	<b>1. Significant problem:</b> Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	<b>2. Problem:</b> Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	<b>3. Potential problem:</b> Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	<b>4. No apparent problem:</b> Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4				
Nutritional Usual food intake pattern	<b>1. Very Poor:</b> NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings of meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	<b>2. Inadequate:</b> Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	<b>3. Adequate:</b> Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	<b>4. Excellent:</b> Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4				
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4				
<b>TOTAL SCORE</b>					22				
<b>Evaluator's Name</b>									

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

Risk Score	Category	Action	<b>Support Surfaces</b> (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice)
15-18	At Risk	<ul style="list-style-type: none"> <li>• Regular Turning Schedule</li> <li>• Enable as much activity as possible</li> <li>• Protect the heels</li> <li>• Use pressure redistribution surfaces</li> <li>• Manage moisture, friction and shear</li> <li>• Advance to a higher level of risk if other major risk factors are present</li> </ul>	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	<ul style="list-style-type: none"> <li>• Use the Same Protocol as for “<b>At Risk</b>” Patients</li> <li>• Position patient at 30 degree lateral incline using foam wedges</li> </ul>	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	<ul style="list-style-type: none"> <li>• Follow the same protocol as for “<b>Moderate Risk</b>” Patients</li> <li>• In addition to regular turning schedule</li> <li>• Make small shifts in their position frequently</li> </ul>	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	<ul style="list-style-type: none"> <li>• Use same protocol as for “<b>High Risk</b>” Patients</li> <li>• Add a pressure redistribution surface for patients with severe pain or with additional risk factors.</li> </ul>	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

Risk Score	Category	Action	<b>Support Surfaces</b> (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice)
15-18	At Risk	<ul style="list-style-type: none"> <li>• Regular Turning Schedule</li> <li>• Enable as much activity as possible</li> <li>• Protect the heels</li> <li>• Use pressure redistribution surfaces</li> <li>• Manage moisture, friction and shear</li> <li>• Advance to a higher level of risk if other major risk factors are present</li> </ul>	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	<ul style="list-style-type: none"> <li>• Use the Same Protocol as for “At Risk” Patients</li> <li>• Position patient at 30 degree lateral incline using foam wedges</li> </ul>	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	<ul style="list-style-type: none"> <li>• Follow the same protocol as for “Moderate Risk” Patients</li> <li>• In addition to regular turning schedule</li> <li>• Make small shifts in their position frequently</li> </ul>	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	<ul style="list-style-type: none"> <li>• Use same protocol as for “High Risk” Patients</li> <li>• Add a pressure redistribution surface for patients with severe pain or with additional risk factors.</li> </ul>	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

# BRADEN 'Q' SCALE

Patient ID

					Date :				
					Time :				
Mobility	<b>1. Completely immobile:</b> Does not make even slight changes in body or extremity position without assistance.	<b>2. Very limited:</b> Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	<b>3. Slightly limited:</b> Makes frequent through slight changes in body or extremity position independently.	<b>4. No limitations:</b> Makes major and frequent changes in position without assistance.					
*Activity The degree of physical activity*	<b>1. Bedfast :</b> Confined to bed	<b>2. Chairfast :</b> Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.*	<b>3. Walks occasionally:</b> Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	<b>4. All patients too young to ambulate; OR walks frequently:</b> Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.					
Sensory Perception	<b>1. Completely limited:</b> Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	<b>2. Very limited:</b> responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	<b>3. Slightly limited:</b> Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	<b>4. No impairment:</b> Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.					
Moisture Degree to which skin is exposed to moisture	<b>1. Constantly moist:</b> Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	<b>2. Very moist:</b> Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	<b>3. Occasionally moist:</b> Skin is occasionally moist, requiring linen change every 12 hours.	<b>4. Rarely moist:</b> Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.					
<b>FRICION-SHEAR</b> Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	<b>1. Significant problem:</b> Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	<b>2. Problem:</b> Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	<b>3. Potential problem:</b> Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	<b>4. No apparent problem:</b> Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times.*					
Nutritional Usual food intake pattern	<b>1. Very Poor:</b> NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	<b>2. Inadequate:</b> Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	<b>3. Adequate:</b> Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	<b>4. Excellent:</b> Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.					
Tissue Perfusion & Oxygenation	<b>1. Extremely compromised:</b> Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	<b>2. Compromised:</b> Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	<b>3. Adequate:</b> Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	<b>4. Excellent:</b> Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.					
					<b>TOTAL SCORE</b>				
					<b>Evaluator's Name</b>				

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



## Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	Fall Risk Grading					
		Score						
History of Falling (immediately or w/in 3 months)	Yes	25	0			Risk Level	Morse Fall Score (MFS)	Action
	No	0	0					
Secondary Diagnosis (more than one diagnosis)	Yes	15	0			Low Risk	0 - 24	Standard Fall Precaution
	No	0	0					
Ambulatory Aid	Furniture	30	0			Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	Crutches, Cane(S), Walker	15	0					
	None /Bed Rest /Nurse Assist	0	0					
IV / Heparin Lock or Saline	Yes	20	20			High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	No	0	0					
GAIT / Transferring	Impaired	20	0			Total Morse Fall Scale Score:	20	
	Weak (uses touch for balance)	10	0					
	Normal /On Bed Rest /Immobile	0	0					
Mental Status	Forgets limitations	15	0			Signature		
	Oriented to own ability	0	0					

Tick (✓) whichever precaution taken.

**Risk Level and Interventions**

**Low Risk (0 - 24) (Standard Falls Precautions)**

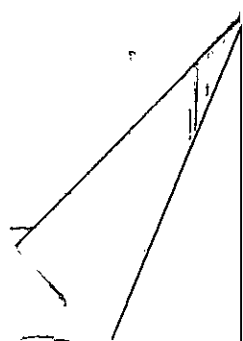
- Ensure patients use their prescribed eye glasses if any, in the hospital
- Use chairs with arm rests
- Use safety straps on stretchers and wheelchairs while transporting patients

**Moderate Risk (25-50) Apply all low risk intervention and**

- Assist and/or supervise ambulation. Reinforce to always call for assistance
- Hourly safety check
- Assess patient after visitors, leave to ensure safety measures in place

**High Risk ( ≥ 51) Apply all low and moderate risk interventions, and.**

- Initiate constant observation by healthcare provider as appropriate to patient's needs



## Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time			Fall Risk Grading		
		Score			Risk Level	Morse Fall Score (MFS)	Action
History of Falling (Immediately or w/in 3 months)	Yes	25			Low Risk	0 - 24	Standard Fall Precaution
	No	0					
Secondary Diagnosis (more than one diagnosis)	Yes	15			Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	0					
Ambulatory Aid	Furniture	30			High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Crutches, Cane(S), Walker	15					
	None /Bed Rest /Nurse Assist	0					
IV / Heparin Lock or Saline	Yes	20			Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	0					
GAIT / Transferring	Impaired	20			High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Weak (uses touch for balance)	10					
	Normal /On Bed Rest /Immobile	0					
Mental Status	Forgets limitations	15			High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Oriented to own ability	0					
Total Morse Fall Scale Score:							
		Signature					

Tick (✓) whichever precaution taken.

**Risk Level and Interventions**

**Low Risk (0 - 24) (Standard Falls Precautions)**

- Ensure patients use their prescribed eye glasses if any, in the hospital
- Use chairs with arm rests
- Use safety straps on stretchers and wheelchairs while transporting patients

**Moderate Risk (25-50) Apply all low risk intervention and**

- Assist and/or supervise ambulation. Reinforce to always call for assistance
- Hourly safety check
- Assess patient after visitors, leave to ensure safety measures in place

**High Risk (≥ 51) Apply all low and moderate risk interventions, and,**

- Initiate constant observation by healthcare provider as appropriate to patient's needs

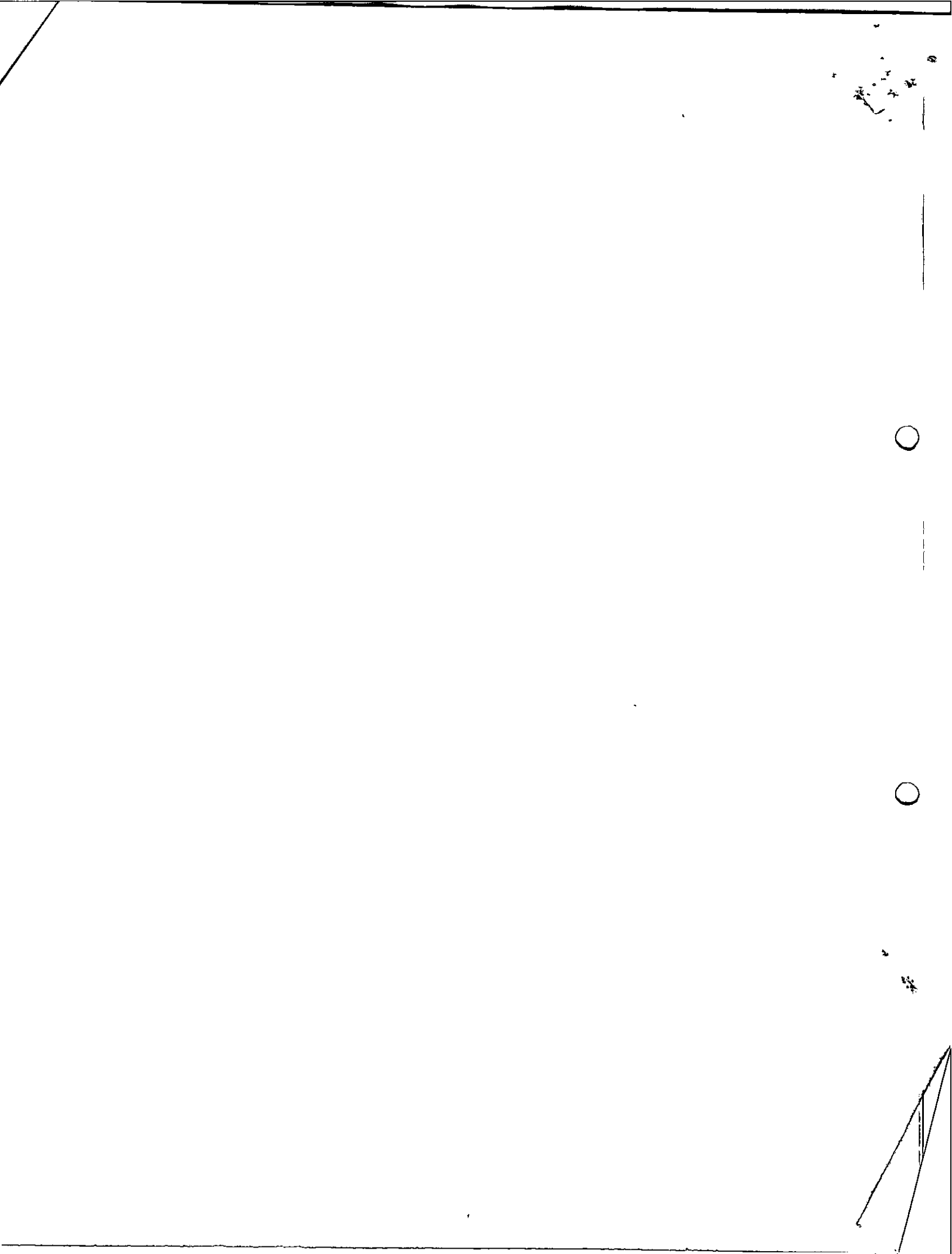






Figure 1. Lateral cephalometric radiograph showing the skeletal relationship. The image displays the maxilla, mandible, and cervical spine. The caption text is partially obscured and appears to be a mix of English and another language, possibly describing the patient's condition or the study's findings.