

ADMISSION SHEET



Registration Details :

Admission No : IP5-00175016 Admit Date : 11-Jun-2026 Admit Time : 09:26 AM UHID : BAH-00643313

Patient Details :

Patient Name	: Baby KOTTE SAAKSHIKA (B/O ANITHA B)	Age	: 2 Y 8 M 6 D
Guardian	: Mr KOTTE NAVEEN	DOB	: 05-10-2023
Gender	: Female	Religion	:
Occupation	:	Martial Status	: Single
Address (H)	: #1-145/1 GUNDLAPALLI DIST PEDDAPALLI Kanagarthi Karimnagar Telangana INDIA 505152	Phone No	: 8919891140/ 6265288480
		E-mail	: KOTTENAVEEN38@GMAIL.COM

Admission Details :

Bed Type : DAY CARE Bed No : HO DC 1 Ward Name : 1F-HEMATO-ONCOLOGY
Room No : HO DC 1 Admission Type : First Visit

Contact Details :

Name : Mr KOTTE NAVEEN Relationship : Father
Contact Address : #1-145/1 GUNDLAPALLI DIST PEDDAPALLI Phone No : 8919891140 / 6265288480
Kanagarthi Karimnagar Telangana INDIA 505152


Signature

Doctor Details :

Doctor Name : Dr. SIRISHA RANI Specialisation : HEMATO ONCOLOGY
Referral Doctor : Self Phone No :
Co-Consultant :

Payment Details :

Payment Mode : Cash Deposit Amount : 1899.87
Payor Name : CIGNATTK HEALTH INSURANCE CO LTD

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ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____ IP _____ ant: _____ Dept : _____

Date of Admission: _____

BAH-00643313 IP5-00175016
Baby KOTTE SAAKSHIKA (B/O
05-10-2023 2 Y 8 M 6 D (F)
Dr. SIRISHA RANI

Discharge : 11/6/26 Time: 19:20 PM

Room / Bed No : 06 Ward : oncology Requested Billable bed type : _____

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
11/6/26	10:35 AM	AER	onc.	Revised

Cross Consultation Visit

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

BAH-00643313 IPS-00175016
Baby KOTTE SAAKSHIKA (B/O) (F)
05-10-2023 2 Y 8 M 6 D
Dr. SIRISHA RANI



ADMISSION CRITERIA – ONCOLOGY

Admission / Transfer from:

Emergency Outpatient (OPD) Ward Operation Theater Others:

Tick (✓) any of the following criteria requiring admission / transfer to ONCOLOGY

- For Chemotherapy-Day Care or IP Admission as per the Type of Chemotherapy
- Febrile Neutropenias (ANC <500 cells / mm³)
- Netropenic Enterocolitis
- Mucositis Induced Significant Diarrohea or Pain
- Neurological Complications (like Seizures, Bleeding, Thrombosis) that can arise while on Chemotherapy Treatment or at the Time of Presentation and also for other Systemic Problems like Pancreatitis during Chemotherapy
- Management of Oncological Emergencies
- Bleeding Problems (where it is indicated)
- Evaluation and Management of Severe Anemias
- Day Care Admissions for PRBC Transfusions
- Evaluation and Management of Sick Children who come with Hematological Problems like Severe Anemia like Autoimmune Hemolytic Anemia/ Bleeding/ Others
- Primary Immunodeficiency Disorders with Infections that Warrants Hospitalisation
- Management and Evaluation of Hemophagocytic LymphoHisticytosis
- Any Systemic Disorders with Significant Hematological issues like JRA / SLE with Secondary HLH

Signature of the Doctor: *[Signature]*

Name of the Doctor: *Sirishani*

Date & Time: *11/6/26 @ 10:50 AM*

BAH-00643313 IP5-00175016
Baby KOTTE SAAKSHIKA (B/O
05-10-2023 2 Y 8 M 6 D (F)
Dr. SIRISHA RANI



DISCHARGE CRITERIA – ONCOLOGY

Discharge to:

- HDU / Step down ICU Ward Outside Facility Others:

Tick (✓) any of the following criteria requiring discharge / transfer from ONCOLOGY

- Completion of chemotherapy, with no debilitating side effects.
 Resolution of febrile episode, with no fever > 24hrs and Absolute Neutrophil count (ANC) > 500cells/mm3.
 Admitted patients - Once the admitting problem gets resolved or made a plan to manage further on out-patient basis.

Signature of the Doctor: *[Signature]*

Name of the Doctor : *Seenu*

Date & Time: *11/6/26 @ 3pm*

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 Baby KOTTE SAAKSHIKA (B/O
 05-10-2023 2 Y 8 M 6 D (F)
 Dr. SIRISHA RANI



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RESULT SHEET

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



PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : Dr. Sirisha Rani

Date : 11/06/26

Type of Admission: OPD ER Referral (if referral, Doctor's Name:

Start Time of Assessment: 9:40 am Weight: 11.2 kg

Allergic History:

Chief Complaints: K/C/O B-cell ALL / High Count CRCA (w/ CNS -ve / 5th CRP on induction week -3
NO w came for chemotherapy
NO H/O fever, cold, cough, vomiting, loose stools

Pediatric Assessment Triangle

A Appearance - TICLS

B Breathing

C Circulation

Normal
 Abnormal

↑ WOB
 ↓ WOB
 Normal
 - Gasping / Apnea

Pallor
 Cyanosis
 Mottling
 Bleeding

Initial Physiological Status: Stable Unstable
 Life Threatening
 Non Life Threatening

Any urgent interventions needed: Yes No
 If Yes

Significant Past History:

Medication History:

Relevant Investigations:

Primary Assessment

Airway Open
 Maintainable
 Not Maintainable

Breathing
 Rate: 24/min SpO₂ on FiO₂ 96.1 on RA
 Rhythm: Regular
 Retractions: Suprasternal ICR SCR
 Sternal Supraclavicular Nasal Flaring
 Respiratory Noises: Stridor Wheezing Grunting
 Air Entry: BILAE
 Palpation Findings (if necessary).....

Any urgent interventions needed: Yes No
 If Yes

Circulation

HR: 120/min CFT Central Peripheral

BP: 97/60 mmHg

Pulse Volume: Central No

Peripheral

Murmurs: Yes No

If in Shock: Compensated Liver Span:

Hypotensive

ECG:

Muffled Heart Sound: Yes No

Engorged Neck Veins: Yes No

Any Signs of Heart Failure: Yes No

Any urgent interventions needed: Yes No

If Yes

Disability

GCS: 15/15 AVPU:

Pupils: Responsive Non-Responsive

Size: Right Left

Active Seizures: Yes No Sugars:

Signs of Neurological compromise

Any urgent interventions needed: Yes No

If Yes

Exposure

Temp.: 98.5F

Any Rash: Yes No

If yes describe the rash

Active bleed

Lacerations Abrasions bruises

Describe:

Any urgent interventions needed: Yes No

If Yes

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

Secondary Assessment: Head to toe examination with positive findings:

Labs Planned: No labs

Treatment Planned: Chemotherapy today

No lab work

11/6/26

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

Final Diagnosis with possible Differential Diagnosis (If necessary): B-cell ALL came for chemotherapy

Assessment done by
 Name of the Doctor: Dr. Rany Singh
 Signature: [Signature]
 Date & Time: 11/6/26, 9:50 am

Sr. Doctor on Duty (If necessary)
 Name of the Sr. Doctor:
 Signature:
 Date & Time:



REGULAR PRESCRIPTIONS

Weight. 11.2 kg.. Ward.

DRUG : <u>Zij ONDANSETRON</u>				Date Time	<u>11/6</u>
Dose	Route	Frequency	Start Date		
<u>2.2mg</u>	<u>IV</u>	<u>TID</u>	<u>11/6/26</u>	<u>Car X</u>	
Name & Signature of the Doctor Starting the Drugs: <u>D. Ramya</u>					
Additional Instructions: <u>2m clear nausea</u>					
Daily Doctor's Endorsement by a Sign <u>(Signature)</u>					

DRUG : <u>Syp. DOMPERIDONE</u>				Date Time	<u>11/6</u>
Dose	Route	Frequency	Start Date		
<u>2.5ml</u>	<u>PO</u>	<u>BD</u>	<u>11/6/26</u>	<u>Dr. Ramya</u>	
Name & Signature of the Doctor Starting the Drugs: <u>D. Ramya</u>					
Additional Instructions: <u>(Signature)</u>					
Daily Doctor's Endorsement by a Sign					

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

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



MEDICATION RECONCILIATION FORM

Drug Allergies:

Not known any Drug Allergies

Medication Reconciliation will be done at the time of admission and also whenever there is change in the treating team or shifting from one unit to another unit.

(Example: at the time of admission shifting from ICU to Ward, or Ward to ICUs)

Shifting From: ICU

Shifted to: oncology

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	Syp. Septan	2.5ml	PO	BD		<input type="checkbox"/> C <input type="checkbox"/> DC
2	Syp. Moxtel	2.5ml	PO	OD		<input type="checkbox"/> C <input type="checkbox"/> DC
3	Syp. Calcimen plus	2.5ml	PO	OD		<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. Ranya

Date & Time : 11/6/26 ; 10:50am

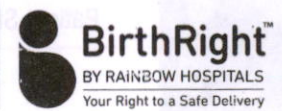
Nurse Name & Signature: Jayanya

Date & Time : 11/6/26 @ 10AM

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 Baby KOTTE SAAKSHIKA (B/O
 05-10-2023 2 Y 8 M 6 D (F)
 Dr. SIRISHA RANI



INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD



Part - I.
 Patient's / Learner Language: *Telugu* Patient / Learner Literacy: Read Write Speak Willingness to Learn: Yes No Healthcare Literacy: Yes No

- Identified Education Needs:**
- | | | | |
|----------------------------|--|--|---|
| 1. Diagnosis | 5. Medication / Therapy (safety, effects/ side effect, interactions) | 9. Nutrition / Diet | 13. Risk / Safety |
| 2. Treatment and Care Plan | 6. Discharge Medication | 10. Fall Risk Education | 14. Activity / Exercise |
| 3. Pain Management | 7. Infection Control Measures | 11. Safe use of Medical Equipment / Implantable Devices Safety | 15. Social & Rehabilitation Needs |
| 4. Informed Consent | 8. Diagnostic Test / Procedures | 12. Patient's / Family Rights | 16. Special Discharge / Follow-up Education / Coping Skills |
| | | | 17. Others |

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
11/6	9:50 AM	5	Medication / Therapy	F	1	0	1	1		<i>[Signature]</i>

Part - III: CODES

Who was taught: PT: Patient F: Father M: Mother S: Spouse Sn: Son D: Daughter C: Caregiver O: Other (Specify)

Learning Barriers:

1. No Learning Barriers	4. Language Barrier	7. Impaired Thought Process/Cognitive limitations	10. Financial Difficulties	13. Cultural/Religion Practice
2. Physical Impairment	5. Educational Level	8. Responsibilities at Home	11. Beliefs and Values	14. Others (Specify)
3. Emotional Barriers	6. Desire / Motivate to Learn	9. Cultural Differences	12. Impaired Vision/ or Hearing	

Teaching Tools Used: A: Audio D: Demonstration V: Video O: Oral P: Printed

Mechanism/s to overcome barrier/s:

1. None	3. Reassurance & Support	5. Respect values & beliefs	7. Other, Specify
2. Obtain translator	4. Teach Family / Others	6. Respect Cultural / Religion Preference	

Understanding: 1. Verbalizes Understanding 2. Demonstrates Understanding 3. Needs Review

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 Baby KOTTE SAAKSHIKA (B/O)
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 Dr. SIRISHA RANI



MULTI-DISCIPLINARY PLAN OF CARE FORM



Diagnosis:

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
11/6/26 10:30	<input checked="" type="checkbox"/> Medical <input type="checkbox"/> Nursing <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Modified <input type="checkbox"/> Per-Op <input type="checkbox"/> Post Op	B-cell ALL	Hemodynamic stability	Chemotherapy	[Signature]	<input type="checkbox"/> Nursing <input checked="" type="checkbox"/> Others:
11/6 10:50	<input type="checkbox"/> Medical <input checked="" type="checkbox"/> Nursing <input type="checkbox"/> Others:	<input type="checkbox"/> Initial <input checked="" type="checkbox"/> Modified <input checked="" type="checkbox"/> Per-Op <input type="checkbox"/> Post Op	Ensure Safety	provide side rail	provided side rail	[Signature]	<input type="checkbox"/> Medical <input checked="" type="checkbox"/> Others:
	<input type="checkbox"/> Medical <input type="checkbox"/> Nursing <input type="checkbox"/> Others:	<input type="checkbox"/> Initial <input type="checkbox"/> Modified <input type="checkbox"/> Per-Op <input type="checkbox"/> Post Op					<input type="checkbox"/> Medical <input type="checkbox"/> Nursing <input type="checkbox"/> Others:
	<input type="checkbox"/> Medical <input type="checkbox"/> Nursing <input type="checkbox"/> Others:	<input type="checkbox"/> Initial <input type="checkbox"/> Modified <input type="checkbox"/> Per-Op <input type="checkbox"/> Post Op					<input type="checkbox"/> Medical <input type="checkbox"/> Nursing <input type="checkbox"/> Others:
	<input type="checkbox"/> Medical <input type="checkbox"/> Nursing <input type="checkbox"/> Others:	<input type="checkbox"/> Initial <input type="checkbox"/> Modified <input type="checkbox"/> Per-Op <input type="checkbox"/> Post Op					<input type="checkbox"/> Medical <input type="checkbox"/> Nursing <input type="checkbox"/> Others:

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

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FLUID CHART

Sheet No. : 1

- 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 Thrombo- phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G							
11/6/20	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm		Two	100ml	50ml					100ml		
Total Intake :					Total Output : 100ml							
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :					Total Output :							
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :					Total Output :							
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :					Total Output :							

Total 24 hrs. Intake

Total 24 hrs. Output

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.
3. 24 hrs. total to be entered in the kardex in RED.

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											
	01:00 am											
Total Intake :						Total Output :						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						Total Output :						

Total 24 hrs. Intake

Total 24 hrs. Output

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Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 10:50am Mode of Arrival: By mother Admitting From: ER OPD Direct

Allergy / Adverse Reaction: No allergy reaction Body Weight: 11.20 Kg
 Height: cm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
NA	NA	NA

Family History: Healthy family

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

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

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

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

Observations: Weight: 11.20kg Length: Head Circumference (< 2 years):
 Temp.: 98.6f HR: 106b/min RR: 26b/min BP: 100/60(71)mmHg

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

Fall Risk Assessment: Yes No Score: 0 (Document in the Humpty Dumpty Sheet)

Risk of Pressure Sore (Braden Q Score 23) (Document in the Braden Q Assessment Sheet)

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

Character of Pain Location Frequency Duration

FUNCTIONAL SCREENING:

No Abnormalities Detected

Mobility Problem

Walking Problem

Developmental Delay

Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING:

No Abnormalities Detected

Underweight

Overweight

Special Feeding Method

Feeding Problem

Special diet

No Abnormality Detected

Inform consultant for positive criteria

Psychological Screening:

No Significant Findings

Unusual concerns about patient's Psychological Status: Yes No

If Yes Consultant Notified: (Date/Time):

Cultural & Spiritual Needs: Yes No if Yes specify Inform consultant for positive criteria.

Social History: Lives With parents

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

Nurse Signature: [Signature]

Nurse Name: Veera

Date: 10/6/20 @ 11 AM

Time: 11 AM

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 Baby KOTTE SAAKSHIKA (B/O
 05-10-2023 2 Y 8 M 6 D (F)
 Dr. SIRISHA RANI



NURSING CARE RECORD

Shift: Morning Afternoon Night

Date: 11/6/26

Assessment: Patient came for chemotherapy

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
10:50 am	Assess general condition of patient	11:10 am	Assessed general condition of patient	Improving activity tolerance.
11:30 am	Improve activity tolerance	12 pm	Improving activity tolerance	
12:30 pm	Maintain good nutritional status	1 pm	Maintaining nutritional status	
3 pm	Maintain personal hygiene	3:30 pm	Maintaining personal hygiene	
4 pm	Prevent infection.	4:30 pm	Preventing infections.	

Re-Assessment: NA

Special Notes: NA

Nurse Signature: Veera

Nurse Name: Veera

Date & Time: 11/6/26 @ 5 pm

Patient Sticker

NURSING CARE RECORD



Shift: Morning Afternoon Night

Date:

Assessment:

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
	<i>[Faint handwritten notes]</i>		<i>[Faint handwritten notes]</i>	<i>[Faint handwritten notes]</i>

Re-Assessment:

Special Notes:

Nurse Signature:

Nurse Name:

Date & Time:



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Sirisha Department: Onco Date of Admission: 11/6/26

SITUATION	Diagnosis: <u>B cell ALL</u>	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Not Known If Yes Specify:					
BACKGROUND	Area	<u>ER</u>	<u>Onco</u>				
	Shift Time		<u>2pm</u>				
	Medical Condition (Any special condition to be noted):	<u>nil.</u>	<u>NA</u>				
ASSESSMENT	Allergy:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Vital Signs:	Temp:	<u>98°F</u>	<u>98.6f</u>			
		Res:	<u>26b/w</u>	<u>25m</u>			
		SpO ₂ :	<u>98%</u>	<u>100%</u>			
		Pulse:	<u>110b/w</u>	<u>106b/w</u>			
		BP:	<u>100/60/71</u>	<u>96/56/71</u>			
	Fall Risk Score:	<u>13</u>	<u>13</u>				
Pain Score:	<u>0/10</u>	<u>0</u>					
Recommendations	Safety Needs:	<u>yes</u>	<u>Sick call</u>				
	Physiotherapy	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<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	
	Others Specify:	<u>nil</u>	<u>NA</u>				
	Special Diet:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<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	
	Other Special Orders / Medications:	<u>nil</u>	<u>NA</u>				
	Post Operative Procedure Special Orders:	<u>nil</u>	<u>NA</u>				
	Handed Over By Name :	<u>Mr. Jayan</u>	<u>Mr. Keen</u>				
	Signature :						
	Date:	<u>11/6</u>	<u>11/6/26</u>				
	Time:	<u>10:30am</u>	<u>4pm</u>				
	Taken Over By Name :	<u>Jeery</u>					
	Signature :		<u>D/C</u>				
	Date:	<u>11/6/26</u>					
	Time:	<u>10:30pm</u>					

Patient Sticker



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

SITUATION	Diagnosis:	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify:						
BACKGROUND	Area							
	Shift Time							
	Medical Condition (Any special condition to be noted):							
ASSESSMENT	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	
	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 ₂ :						
		Pulse:						
		BP:						
	Fall Risk Score:							
Pain Score:								
Recommendations	Safety Needs:							
	Physiotherapy	<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	
	Others Specify:							
	Special Diet:	<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	
	Other Special Orders / Medications:							
	Post Operative Procedure Special Orders:							
	Handed Over By Name :							
	Signature :							
	Date:							
	Time:							
	Taken Over By Name :							
	Signature :							
	Date:							
	Time:							



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
7/10/2023	9:30 a	0/10	abd	<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	nil nil	Resid
				<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:

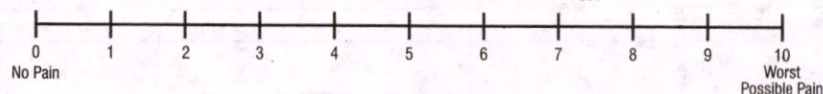
1. Every eight hours for all hospitalized patients.
2. For post-surgical patients, patients with chronic pain, patient with severe pain:
 - a) At least every 2 hours for the first 24 hours
 - b) Then every 4 hours.
 - c) Prior to pain pain-relieving intervention.
 - d) Within 30 – 60 minutes after pain 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 brawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, right, 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

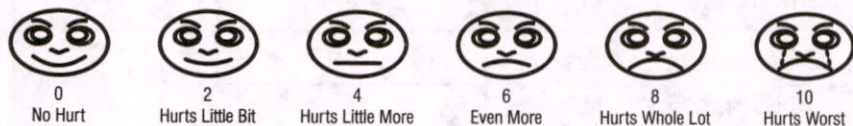
Numerical Pain Scale (Obstetric and Gynecology)



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

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	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
Behavior State	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)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	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
Vital Signs HR, RR, BP, SaO₂	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 ₂ 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

Wong - Baker (Pediatrics) Above 7 Years



CONSENT FOR CHEMOTHERAPY



Patient Name : KOTTE SAAKSHIKA Age : 2y 8mths Gender : Male Female

UHID No : RAH-00643313 Department : ONCOLOGY Date : 11/6/26

Type of Chemotherapy : intravenous

The type of reactions, nature of the major risks and complications arising from the treatment despite precautions has been explained to me. These can include Bone Marrow depression with subsequent infections, bleeding, nausea, vomiting, diarrhea, mouth ulcers, alopecia, fever, phlebitis, ulceration at the site of injection organ injuries etc.

The doctor have explained to me about the benefits and alternative for this procedure that explained

I understand that no promise of cure or freedom from risk can be given. During the course of treatment I will report any symptoms if they become bothersome.

I have read the above and have no further questions about the treatment to be given.

Patient Attendant :

Signature : [Signature]

Name : [Name]

Relationship with Patient : Father

Date & Time : 11-06-2026 - 12:30pm

Witness :

Signature : [Signature]

Name : [Name]

Date & Time : 11/6/26 @ 12pm

Doctor (who is taking the consent):

Signature : [Signature]

Name : DR SANDHYA V

Date & Time : 11/6/26

కీమా థెరపీ కొరకు అంగీకారం

రోగి పేరు : వయస్సు లింగం పు స్త్రీ

యు.హెచ్.ఐ.డి. రిజిస్ట్రేషన్ నెం.: విభాగము

తేదీ

కెమోథెరపీ రకాలు:

ఈ చికిత్స చేయు సమయములో తగు జాగ్రత్తలు తీసుకున్న సంభవించు వివిధ రకములైన ప్రమాదాలు తలెత్తే సమస్యల నాకు డాక్టర్ వివరించబడింది. వీటిలో ఎముక మజ్జు మాంద్యం, తదుపరి అంటువ్యాధులు, రక్తస్రావం, వికారం, వాంతులు, విరేచనాలు, నోటి పూతల, అలోపేసియా, జ్వరం, ఫ్లేజిటిస్, అవయవ గాయాలు, ఇంజెక్షన్ ఉన్న ప్రదేశంలో పుండ్లు మొదలైనవి కలగవచ్చు ఈ విధానం యొక్క ప్రయోజనాలు మరియు ప్రత్యామ్నాయం గురించి డాక్టర్ నాకు వివరించారు.

డాక్టర్ నీకు ఈ ప్రక్రియ వల్ల కలుగు లాభాలు మరియు ప్రత్యామ్నాయాలు వివరించారు

చికిత్స వల్ల కలుగు ఫలితాలు గురించి ఏ విధమైన వాగ్దానం ఇవ్వలేరని నేను అర్థం చేసుకున్నాను. చికిత్స సమయంలో ఏవైనా లక్షణాలు ఇబ్బందికరంగా ఉంటే నేను డాక్టర్ కి తెలియపరుస్తాను.

నేను చికిత్స గురించి పూర్తిగా తెలుసుకున్నాను, చికిత్స గురించి తదుపరి ప్రశ్నలు లేవు.

సహాయకుడు (అటెండెంట్)

సంతకము

పేరు

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము

పేరు

స్థాని

సంతకము

పేరు

తేదీ మరియు సమయము

BAH-00643313 IP5-00175016
 Baby KOTTE SAAKSHIKA (B/O
 05-10-2023 2 Y 8 M 6 D (F)
 Dr. SRISHA RANI



THE HUMPTY DUMPTY SCALE

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

Intervention :

-Fall Risk : Low Humpty Dumpty Score = 7-11,

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		Yes				
Call device within reach		Yes				
Wheels Locked		Yes				
Room free of clutter		Yes				
Adequate Lighting		Yes				
Wheel Chair Support		No				
Other Intervention(s) Specify		No				
Nurse's Name :						
Signature :						
Date :			11/6/23			
Time :			9:45			

BAH-00643313 IP5-00175016
 Baby KOTTE SAAKSHIKA (B/O
 05-10-2023 2 Y 8 M 6 D (F)
 Dr. SIRISHA RANI



BRADEN 'Q' SCALE

					Date :				
					Time :	9:16			
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.		A			
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.		A			
Sensory Perception	1. Completely limited: 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.	2. Very limited: 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.	3. Slightly limited: 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.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.		A			
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.		A			
FRICION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: 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.	3. Potential problem: 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.	4. No apparent problem: 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."		A			
Nutritional Usual food intake pattern	1. Very Poor: 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.	2. Inadequate: 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.	3. Adequate: 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.	4. Excellent: 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.		A			
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.		A			
					TOTAL SCORE	28			
					Evaluator's Name	Rusmi			

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	Support Surfaces (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"> • Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • Advance to a higher level of risk if other major risk factors are present 	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	<ul style="list-style-type: none"> • Use the Same Protocol as for “At Risk” Patients • Position patient at 30 degree lateral incline using foam wedges 	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	<ul style="list-style-type: none"> • Follow the same protocol as for “Moderate Risk” Patients • In addition to regular turning schedule • Make small shifts in their position frequently 	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"> • Use same protocol as for “High Risk” Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors. 	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay