


ACTIVITY RECORD FOR BILLING

VIH-00205813 IP-00060357

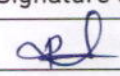
Baby B/O S VASUDHA
11-06-2026 0 Y 0 M 4 D (F)
Dr. SURENDER RAO DUSA

Name: _____ UHI:  Consultant: _____ Dept: _____

Date of Admission: 15/06/26 Time: 8:40 PM Date of Discharge: _____ Time: _____

Room / Bed No: 205 Ward: 205 Suggested Billable bed type: _____


WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
15/06/26	8:40 PM	E-R	205	

Cross Consultation Visit

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

PROCEEDURE


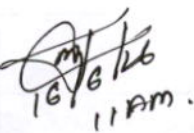
Date	Proceedure	Quantity	Order No.	Signature
16/6/26	PEOAE	1	3090808	

ANY OTHER INFORMATION

Date: 16/6/26

Time: 11 AM

Prepared By: 

Staff Nurse 	Shift / Ward  16/6/26 11 AM.	Billing Assistant	Billing Supervisor
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Name	Baby B/O S VASUDHA	UHID	VIH-00205813
Father/Guardian	Mr SAI RAGHAVENDRA SHARMA	Age/Gender	0 Y 0 M 5 D/Female
Address	FLAT NO 404, SMR MAJESTIC, JUPITER COLONY, ROAD NO 2, BOENPALLY, Bowenpally, Hyderabad, Telangana, INDIA, 500011		
IP No	IP-00060357	Admission Date	15-06-2026
Ref Doctor	DR.BHAVANA K	Discharge Date	16-06-2026

DISCHARGE SUMMARY

Consultant: Dr. SURENDER RAO DUSA

MD (Pediatrics), Fellowship in Neonatology
SENIOR CONSULTANT PEDIATRICS

Diagnosis: Neonatal hyperbilirubinemia

History: Baby of S. VASUDHA is a 5 days old term, baby girl delivered by by Emergency Lower Segment Cesarean Section (Indication : Non progression of labour) on 11.06.2026 at 02:08 pm with birth weight of 3.09 kgs. Baby cried immediately after birth. On day-4 of life, baby was found to have yellowish discolouration of skin and eyes. For the above complaints, she was investigated on OPD basis. In view of jaundice, she was admitted to Rainbow Children's Hospital for further management.

OPD basis investigations: Serum bilirubin was 17.2 mg/dl with direct fraction of 0.2 mg/dl and indirect fraction of 17.0 mg/dl.

Examination: She was euthermic, euvolemic & maintaining saturations at room air. HR- 134/min, RR- 30/min. Icterus was present. Chest was clear with normal heart sounds. Abdomen was soft without organomegaly. Cry, tone, activity and newborn reflexes were normal. There were no obvious external congenital anomalies.

Name

Baby B/O S VASUDHA UHID

VIH-00205813

Weight on Admission : 2.97 kgs.
Weight on Discharge : 2.89 kgs.
Mother blood group : "B" Positive
Baby blood group : "B" Positive

Investigations: Enclosed.

Management: She was admitted in ward. She was started on double surface phototherapy. Baby was continued on demand breast feed. Hearing screening (OAE) was normal.

Her serum bilirubin gradually decreased and her repeat bilirubin at the time of discharge is 10.7 mg/dl with indirect fraction of 10.5 mg/dl, hence phototherapy stopped. She remained hemodynamically stable and is being discharged with the following advice.

At the time of discharge : Baby was active, afebrile, hemodynamically stable, maintaining temperature, accepting & tolerating feeds well.

Advice:

1. Warmth care.
2. Exclusive breast feeding.
3. Burping after each feed.
4. Immunization to be given as per schedule.
5. Vitamin D3 drops (1ml=800 IU), 0.5 ml once daily till 1 year of age.
6. Kindly consult Dr. Surender Rao Dusa, Senior Consultant Pediatrics, after 10 days in OPD with prior appointment (This consultation will be charged).

To take appointment for OPD consultation at Rainbow Children's Hospital, just dial one number 1800-2122 (between 8 a.m. to 8 p.m.) (or) log on to www.rainbowhospitals.in

Name

Baby B/O S VASUDHA UHID

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

In Case of Emergency Contact 040-42462200 Extn: 2010 (or) 7337357870 for lethargy, respiratory distress, refusal of feeds, decreased activity, seizures, jaundice, feeding difficulty.

The discharge advice and details on how to obtain emergency care has been explained to me in the language that I understand.

Name : P. Sai Raghavendra Sharma

Signature : P. S. R. Sharma

Relationship with patient : Father

This summary has been explained by :

Summary prepared by: Dr. Sameera
Typist : Kalyan/Younus

Registrar/Resident/C.M.O

Dr. Suresh
Dr. SURENDER RAO DUSA
SENIOR CONSULTANT PEDIATRICS
MD (Pediatrics), Fellowship in Neonatology
47776

DEFICIENCY CHECK LIST OF MEDICAL CASE SHEET

Rainbow
Children's
Hospital
It takes a lot to beat the BBK.

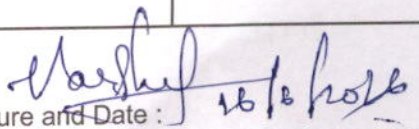
BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

VIH-00205813 IP-00060357
Baby B/O S VASUDHA
Patient No: 11-06-2026 0Y0M5D (F)
Dr. SURENDER RAO DUSA
Ward: 

IP.No:

DOA: 16/6/20

Sl.No	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission Sheet	1	-	-	
2	Discharge Summary				
3	Nursing Initial assessment form	1	-	-	
4	Patient Trasfer Forms	1	-	-	
5	In-patient Medical Record	3	-	-	
6	Doctors Progress Sheets	2	-	-	
7	Nurses Progress notes	2	-	-	
8	Consultation Sheets				
9	General Consent for Treatment	1	-	-	
10	Conset for Surgery				
	Consent for Blood Transfusion				
12	Consent forChemotherapy				
13	Consent for High Risk				
14	Consent for Restraint				
15	DAMA Consent				
16	Consent for Special Procedure				
17	Consent for Radiological Investigations				
18	Consent for HIV Test				
19	Anaesthesia consent form				
20	Anaesthesia notes(Pre Anaesthesia & Post)				
21	Pre Operative checklist				
22	Surgical safety Checklist				
23	Operation Theatre notes				
24	Nurses Clinical Presentation				
25	TPR & BP chart	2	-	-	
26	Intake and Output chart (fluid Chart)	2	-	-	
	Drug Chart (Regular prescription)	3	-	-	
28	Daily Investigation sheet				
29	Investigation Values (Result Sheet)	1	-	-	
30	Nebulization Chart				
31	Diabetic chart				
32	Nutritional Review chart				
33	MLC form (in case of MLC)				
34	Patient Education Form				
	Emergency triage form	1	-	-	
	The empty chart	1	-	-	
	Pain assessment	1	-	-	
	checklist for thromboprophylaxis	1	-	-	
	Braden scale	1	-	-	
	Others	7	-	-	
	Total No. of Pages	31			

Signature and Date:  16/6/20

ERROR LOG

LOCATION: - NICU / PICU / HDU / OT / GENERAL WARD

ICD CODE :-

OBSERVATION: -

DATE :

MRD EXECUTIVE

ADMISSION SHEET

Registration Details :



Admission No : IP-00060357

Admit Date : 15-Jun-2026

Admit Time : 07:47 PM UHID : VIH-00205813

Patient Details :

Patient Name : Baby B/O S VASUDHA

Age : 0 Y 0 M 4 D

Guardian : Mr SAI RAGHAVENDRA SHARMA

DOB : 11-06-2026 02:08 PM

Gender : Female

Religion :

Occupation :

Martial Status :

Address (H) : FLAT NO 404, SMR MAJESTIC, JUPITER
COLONY, ROAD NO 2, BOENPALLY
Bowenpally Hyderabad Telangana INDIA
500011

Phone No : 8008203330/ 8523094921

E-mail : NA@GMAIL.COM

Admission Details :

Bed Type : SHARED WARD

Bed No : ER 102

Ward Name : N 0 GF-EMERGENCY

Room No : ER 102

Admission Type : First Visit

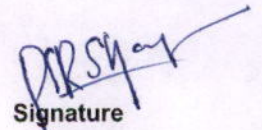
Contact Details :

Name : Mr SAI RAGHAVENDRA SHARMA

Relationship : Father

Contact Address : FLAT NO 404, SMR MAJESTIC, JUPITER
COLONY, ROAD NO 2, BOENPALLY
Bowenpally Hyderabad Telangana INDIA 500011

Phone No : 8008203330


Signature

Doctor Details :

Doctor Name : Dr. SURENDER RAO DUSA

Specialisation : GENERAL PEDIATRICS

Referral Doctor : DR.BHAVANA K

Phone No :

Co-Consultant :

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : SELFPAY

VIH-00205813 IP-00060357
 Baby B/O S VASUDHA
 11-06-2026 0 Y 0 M 4 D (F)
 Dr. SURENDER RAO DUSA



EMERGENCY ROOM TRIAGE FORM

wt: - 2.971kg

Patient's Name: B/o. Vasudha Age: 4 Days Gender: Male Female
 Date: 15/6/26 Time of Arrival: 7:51 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: 96.7 F PR: 124b/m BP: 62/28(A) RR: 39b/m SpO₂: 98%

Chief Complaints: C/O. Yellowish discoloration of skin

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

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

NOTE : All immunocompromised children and preterm babies to be considered Level 2.
 All Children less than 2 years age with high fever to be considered Level 3.
 * CTAS - Canadian Triage and Acuity Scale
 Signature of Parent / Guardian: P.S.R. Sharma
 Triage Completion Time: 7:55pm

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: Vaishnavi
 Date & Time: 15/6/26 @ 7:55pm

Signature of Triage Nurse: Vaishnavi

Patient Name: **VIH-00205813** IP-00060357
 Baby B/D **S VASUDHA**
 11-06-2026 0 Y 0 M 4 D (F)
 Dr. SURENDER RAO DUSA

DHA UHID : VIH-00205813 IPD : IP-00060357 Gender : Female Age : 0 Y 0 M 4



NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 15/6/26 Time of arrival : T: 56pm
 Chief Complaints: clo. Yellowish discoloration of skin RBS: -
 Height : - Weight : 2.97kg BMI : - Head Circumference (<2 years) : 33 cm.
 Allergies: Yes No Medications Blood Transfusion Food Other: -
 If yes, identify -
 Pain Screening: Yes No If Yes, Pain Score: 0 Pain Tool Used: N Pass FLACC Wong Baker
 Character - Location - Frequency - Duration -

RISK FOR FALL:

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

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

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

Functional Screening: No Abnormalities Detected

Mobility Problem
 Walking Problem
 Developmental Delay
 Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

Nutritional Screening: No Abnormalities Detected

Underweight
 Overweight
 Feeding Problem
 Special diet
 Special feeding method

Inform consultant for positive criteria

Psychological Screening: No Significant Findings

Unusual concerns about patient's Psychological Status: Yes No

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

Social History: Lives With Parents

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

Time of Initial assessment completed by ER Nurse : T: 59pm

Patient Name : B/O. S VASUDHA UHID : VIH-00205813 IPD : IP-00060357 Gender : Female Age : 0 Y 0 M 4 D

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

Time	Nursing Notes
2:51 PM	- Patient Came to ER
2:55 PM	Vitals checked & Recorded
	- ER doctor seen the patient & Advised Admission
8 PM	- Admission done
	- SBR Done on OP Basis. SBR ^{19-20 mg}
8:40 PM	- shifted to Room [205]

Samples collected by: } -

Time: } -

Samples sent by: } -

Time: } -

Medication given in ER:

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

Condition of patient at time of shift - out :	Details of Shift - out
HR: ... 134 b/m BP: ... Cysty - CFT ³⁵⁴ RR: ... 33 b/m SPO ₂ : ... 100% GCS: ... 15/15 Temperature: ... 97.4 F Pain Score: ... 0 Repeat RBS (if applicable):	Shift - out from ER to: ... 205 Time of Shift - out: ... @ 8:40 PM on 15/6/20 Handover given to: ... Sr. Manisha (Nurse's Name) by or Devathy

Tick as applicable: MLC LAMA BROUGHT DEAD


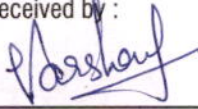
Procedures done with details (if any):

Name of the Nurse : Devathy

Signature of the Nurse : *[Signature]*

Date & Time : 15/6/20 @ 8:40 PM

PATIENT TRANSFER FORM

Patient Name & UHID No. VIH-00205813 IP-00060357 Baby B/O S VASUDHA 11-06-2026 0 Y 0 M 4 D (F) Dr. SURENDER RAO DUSA 		Date & Time of Admission 15/06/26 @ 7:47pm	Date & Time of Transfer Order 15/06/26 @ 8:40pm
From Unit E-R		Transfer Ordered by Mr. prashantli	Reason for Transfer Admission
To Unit 205		Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File 21	Number of Imaging Films -	Personal belongings including clinical documents. If any handed over to attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> If yes, what? O.P file given to Naludh	
Medications / Consumables / Surgicals / Hand over Naludh			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring Mr. prashantli		Name of Person Ordered Transfer Mr. prashantli	
Patient & Clinical Records Received by : 			
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



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

**PEDIATRIC IN-PATIENT
MEDICAL RECORD**

Patient Name: _____

VIH-00205813 IP-00060357
Baby B/O S VASUDHA
11-06-2026 0 Y 0 M 4 D (F)
Dr. SURENDER RAO DUSA

UHID ID: _____



Department: _____

Consultant: _____



Pediatric Multiorgan History & Physical Examination

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

Not significant.

Birth & Neonatal History:

Birth & Socio Economic History:

About Father : _____

About Mother : 2 daughters

Any additional Information : _____

Developmental History :

(N)

Immunization History :

Immunized At 1 year - opv, HepB, BCG given.



Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

On Examination :

Temperature : _____ Pulse Rate : _____ B.P. _____ SPO2 _____

Resp.rate and type of breathing : _____

Rash _____

Lymphadenopathy Y ^(P) . Inten ^(A)

Oedema : _____ hills deep umbilicus.

Allergies (if any): _____

Respiratory System :

Inspection (any s/o distress) : 0

Air entry & breath sounds : B/C AEA ^(A)

Any addes sounds : 0 .

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

Cardiovascular System :

Inspection of procordium : N ^(N)

Heart Sounds : S1S2 ^(A)

Any murmur : 0 .

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

Per Abdomen :

Inspection N ^(N)

Palpation : 1/10

Ausculation : Y ^(P)

Spine : _____ External Genitalia : N ^(N)

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



Pediatric Multiorgan History & Physical Examination

Central Nervous System :

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

Cranial Nerves : (N)

Motor System:

Nutrition : _____

Tone : g Power (R) 3/5 (L) 3/5

Co-ordinator : _____

Posture : _____

Involuntary Movements : (-)

Reflexes :

DTR _____ Superficials: nt.
Plantars Extensors

Sensory System :

(N)

Bladder / Bowel : (N)

Clinical Summary & Diagnostic:

NNHB.



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: _____

To prevent kernicterus.

Desired goals of the treatment : _____

To treat the symptoms.

Planned Labs:

Repeat SBR T/m @ 10 Am.

Planned Management

- Start DSPT

- Warmth care

- Demand oral feeds.

- Monitor vitals

- Inj (sos).

*Noted by Dr. Prabhakar
15/6/26 @ 8:30 PM*

Signature of the Doctor: _____

Name of the Doctor: *Dr. Prabhakar*

Date & Time: *15/6/26 8:10 PM.*

Signature of the Consultant: _____

Name of the Consultant: _____

Date & Time: _____

Dr. Surender Rao Dusa
Dr. Surender Rao Dusa
Reg. No. 47719



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<p>16/6/26 3:30 AM</p>	<p>C/S/B Nilu yellow</p> <p>Go. Swellings in B/L lower limbs x 1hr.</p>	
	<p>Baby seen child in ASPT B/L lower limb - cold on touch.</p>	
	<p>Pos</p>	<p>Adv</p> <ul style="list-style-type: none"> - Cover Baby completely with cloth. - Reassess after 1hr. - Reassurance given. - Inform SOS.
		<p><i>[Signature]</i> Divishal</p>
		<p>noted by Swetha 16/6/26 at 12 PM</p>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16.6.26 9.00 AM	S/A Register	
	NNHA	
	On DSP7	
	o/e baby exam	
	cay. tone } (24)	
	activity } (24)	Plan
	CS - 5, 3, 7	-> DBM + FF
	RS - BA (C) char	-> SBR after sounds
	P/A - soft	-> Urum soap
		-> D/c
	Y. wt: 2.97 kg	
	T. wt: 2.89 kg (+81 gm)	
	Sameer (Dr. Sameer)	
		<p>Dr. Surender Rao Dusa Reg. No. 11118 16/6/26 11:24 AM</p>

noted by
 Sakshi
 16/6/26
 09:12 PM



INFANT (<1 year)
Children's Observation & Early Warning Scoring Chart



EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 15/6/26	Time: 9	12	3	7
Doctor/Nurse/Family Concern?	Pro	Am	Am	Am
Temperature (°F)	98.0	98.0	98.0	98.0
Heart Rate (bpm)	135	130	142	141
Blood Pressure (mmHg) *	130	130	130	130
Resp Rate (bpm) (Over 1 Minute) *	45	42	39	44
Resp Mod/ Severe Distress None / Mild				
Receiving O ₂ (l/min)				
O ₂ Saturations (%)	98	99	100	99
Conscious Level Normal / Altered	N	N	N	N
GCS *	N	N	N	N
TOTAL SCORE				
Number of shaded boxes	0	0	0	0
Pain Score	0	0	0	0
Observer's Initials	OB	OB	OB	OB

ACTIONS

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

NB: Scores 3 should be recorded overleaf

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



ERVATION 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)

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

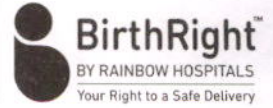
- If at any time additional help is required, call help – regardless of the Early Warning Score!
- Following a Early Warning Score assessment, senior help may be required

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)

VIH-00205813 IP-00060357

Baby B/O S VASUDHA
 11-06-2026 0 Y 0 M 4 D (F)
 Dr. SURENDER RAO DUSA



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.

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	DBMFF					✓			✓			
	10:00 pm												
	11:00 pm	DBMFF								✓			
	12:00 am												
	01:00 am												
Total Intake :						Total Output :							
	02:00 am												
	03:00 am	DBMFF					✓						
	04:00 am												
	05:00 am	DBMFF								✓			
	06:00 am												
	07:00 am	DBMFF					✓						
Total Intake :						Total Output :							
Total 24 hrs. Intake						Total 24 hrs. Output							



FLUID CHART

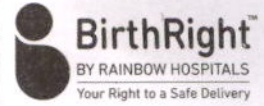
Sheet No. :

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
<i>16/6/26</i>	08:00 am											<i>scribble 16/6/26 at 1 PM</i>	
	09:00 am		<i>DBF+FF</i>										
	10:00 am						✓						
	11:00 am												
	12:00 pm		<i>DBF+FF</i>										
	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							

*noted by
Scribble
16/6/26
at 1 PM*

VIH-00205813 IP-00060357
 Baby B/D S VASUDHA (F)
 11-06-2026 0 Y 0 M 4 D
 Dr. SURENDER RAO DUSA



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: CR Shifted to: ICU 205

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. Prashanti/ [Signature]

Date & Time : 15/6/26 @ 8:30pm

Nurse Name & Signature: [Signature]

Date & Time : 15/6/26 @ 8:30pm



DRUG CHART

Date of Admission: 15/6 Drug Allergies: Nil Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

SOS / PRN (As Required Medication)

DRUG :				Date Time																
Dose	Route	Frequency	Start Date	↓																
Doctor's Signature		Valid Period	Pharm.																	
Additional Instructions:																				

DRUG :				Date Time																
Dose	Route	Frequency	Start Date	↓																
Doctor's Signature		Valid Period	Pharm.																	
Additional Instructions:																				

DRUG :				Date Time																
Dose	Route	Frequency	Start Date	↓																
Doctor's Signature		Valid Period	Pharm.																	
Additional Instructions:																				

VERIFIED BY : Name



REGULAR PRESCRIPTIONS

Weight. 2.95kg Ward. 205

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																						
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																						

