

VIH-00200531 IP-00060225  
Baby B/O DANJEE DANIEL  
29-12-2025 0 Y 5 M 6 D (M)  
Dr. SURENDER RAO DUSA



**ACTIVITY RECORD FOR BILLING**

Name: -----

UHID No : ----- IP No : ----- Consultant : ----- Dept : 62

Date of Admission : 4/6/26 Time : ----- Date of Discharge : ----- Time: -----

Room / Bed No : 107 Ward : 1st floor Suggested Billable bed type : -----

**WARD TRANSFERS**

Date	Time	From	To	Signature of Nurse
<u>4/6/26</u>	<u>4:15 PM</u>	<u>CR</u>	<u>107</u>	<u>(Signature)</u>

**Cross Consultation Visit**

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







## ADMISSION SHEET

### Registration Details :



Admission No : IP-00060225

Admit Date : 04-Jun-2026

Admit Time : 02:48 PM UHID : VIH-00200531

### Patient Details :

Patient Name : Baby B/O DANJEE DANIEL

Age : 0 Y 5 M 6 D

Guardian : Mr GODBIN K SAM

DOB : 29-12-2025 09:49 PM

Gender : Male

Religion :

Occupation :

Martial Status :

Address (H) : emerald plaza,flat no-304, 3rd floor behind  
vishal mega mart kapra road Kapra  
Hyderabad Telangana INDIA 500062

Phone No : 9676334520/ 7207807429

E-mail : na@gmail.com

### Admission Details :

Bed Type : SHARED WARD

Bed No : ER 101

Ward Name : N 0 GF-EMERGENCY

Room No : ER 101

Admission Type : First Visit

### Contact Details :

Name : Mr GODBIN K SAM

Relationship : Father

Contact Address : emerald plaza,flat no-304, 3rd floor behind  
vishal mega mart kapra road Kapra Hyderabad  
Telangana INDIA 500062

Phone No : 9676334520 / 7207807429

Signature

### Doctor Details :

Doctor Name : Dr. SURENDER RAO DUSA

Specialisation : GENERAL PEDIATRICS

Referral Doctor : Self

Phone No :

Co-Consultant :

### Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : ICICI LOMBARD GENERAL  
INSURANCE CO LTD

Patient Name : B/O. DANJEE DANIEL UHID : VIH-00200531 IPD : IP-00060225 Gender : Male Age : 0 Y 5 M 6 D

VIH-00200531 IP-00060225  
 Baby B/O DANJEE DANIEL  
 29-12-2025 0 Y 5 M 6 D (M)  
 Dr. SURENDER RAO DUSA



Wt: 6.7 kg

### EMERGENCY ROOM TRIAGE FORM

Patient's Name : Mast. Daniel Age : 5M Gender:  Male  Female

Date : 4/6/26 Time of Arrival : 2:25 PM

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

Source of Information:  Parents  Others (Specify) -

Mode of Arrival:  Ambulatory  Wheelchair  Ambulance

Initial Vital Signs: Temp: 97.5°F PR: 128b/m BP: crying RR: 28b/m SpO<sub>2</sub>: 97%

Chief Complaints: 60 Fever, cold, cough x 2 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"/> Increased	<input type="checkbox"/> Unstable:
<input type="checkbox"/> Sick Looking	<input type="checkbox"/> Decreased <input type="checkbox"/> Gasping / Apnea	<input type="checkbox"/> Not - Life - Threatening
<input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Bleeding		<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 type="checkbox"/> Level 4 : LESS URGENT : Significant illness but not life threatening	<input 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 : 2:38 PM

### Communicable Disease Triage Screening

**PART A. The following questions should be asked to all patients at the initial screening:**

1. Have you had fever (elevated temperature) in the past 2 weeks  Yes  No
2. Have you had cough or a rash in the past 2 weeks  Yes  No
3. 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

1. 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: Aschritte
2. 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 : Aschritte

Signature of Triage Nurse : AS

Date & Time : 4/6/26 @ 2:38 pm

Docu. No. : RCH / FRM / CLINICAL / 085

Patient Name : B/O. DANJEE DANIEL UHID : VIH-00200531 IPD : IP-00060225 Gender : Male Age : 0 Y 5 M 6 D

VIH-00200531 IP-00060225  
 Baby B/O DANJEE DANIEL  
 29-12-2025 0 Y 5 M 6 D (M)  
 Dr. SURENDER RAO DUSA



## NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 4/6/26 Time of arrival : 2:41 PM

Chief Complaints: cl0 Fever, cold, cough x 2 days RBS: —

Height : — Weight : 6.7kg 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 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 : 2:44 PM

Patient Name : B/O. DANJEE DANIEL UHID : VIH-00200531 IPD : IP-00060225 Gender : Male Age : 0 Y 5 M 6 D

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

Time	Nursing Notes
2:35pm*	patient came to ER
2:38pm*	vitals checked and Recorded
	* Dr. vishwaja seen the patient & advised admission
	* Admission process done
3:25pm*	collected the Samples & send to lab
	* COVID RAT => Negative
	* patient shifted to ward

Samples collected by: }  
 Samples sent by: } Sr. Kiran

Time: }  
 Time: } 3:25pm

**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: 124/1m RR: 24/1m GCS: 15/15 Pain Score: 0 Repeat RBS (if applicable): -	BP: crying CFT: 43sec SPO <sub>2</sub> : 99% Temperature: 97°F Shift - out from ER to: 107 Time of Shift - out: 4/6/26 @ 4:15pm Handover given to: Sr. Shubham (Nurse's Name) by Architha

Tick as applicable:  MLC  LAMA  BROUGHT DEAD

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

Name of the Nurse: Architha Signature of the Nurse:

Date & Time: 4/6/26 @ 4:15pm



## Nursing General Admission Assessment Form For Pediatrics

**Diagnosis:** ARI  
**Arrival Time:** 11.15 PM **Mode of Arrival:** lifted by mother **Admitting From:**  ER  OPD  Direct

**Allergy / Adverse Reaction** ..... **Body Weight:** 6.7 Kg  
 ..... NO allergy ..... **Height:** ..... cm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
<u>NIL</u>	<u>NIL</u>	<u>NIL</u>

**Family History:** .....  
 ..... NIL .....

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

If yes please list, .....

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

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

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

**Observations:** Weight: 6.7 kg Length: ..... Head Circumference (< 2 years): .....  
 Temp.: 98.6 F HR: 130 b/min RR: 35 b/min BP: 90/40 (ss)

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

**Fall Risk Assessment:**  Yes  No Score: 13 (Document in the Humpty Dumpty Sheet)

**Risk of Pressure Sore (Braden Q Score** 26.....) (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): .....

**Social History:** Lives With Family .....

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

All Information Obtained From  Patient  Mother  Father  Other Family Member


**Orientation has been given regarding the following aspects:**

Call Bell in Reach :  Yes  No      Waste Disposal Explained:  Yes  No

Infusion Pump :  Yes  No      Hand hygiene Explained:  Yes  No       Others

Patient Rights & Responsibilities:  Yes  No

Information given to Mother .....

Nurse's Name: Subham      Date: 4/6/26      Time: 4:45pm      Signature: 



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

It takes a lot to treat the little.

## PEDIATRIC IN-PATIENT MEDICAL RECORD

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

UHID ID: \_\_\_\_\_

Department: \_\_\_\_\_

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

VIH-00200531

IP-00060225

Baby B/O DANJEE DANIEL

29-12-2025

0 Y 5 M 6 D

(M)

Dr. SURENDER RAO DUSA



**Pediatric Multiorgan History & Physical Examination**

Name : Daniel Age/Sex 5m/ma  
Information given by: Mother Relationship \_\_\_\_\_

**Chief Presenting Complaints & Duration (Chronologically)**

Ch Fever since 4 days.  
sneezing  
mild cough

**History of present illness :**

Child presented with Ch  
Fever since 4 days.  
spice - every 4<sup>th</sup> hourly  
moderate to high grade.  
Relieved on medications  
Ch mild cough - intermittent  
sneezing - occasionally  
↓  
Initially managed on OPD basis  
↓  
Ch persistent symptoms  
admitted @ Rest





### Pediatric Multiorgan History & Physical Examination

#### Anthropometry :

Head Circum (cms) \_\_\_\_\_ (Centile \_\_\_\_\_) Height (cms): \_\_\_\_\_ (Centile) \_\_\_\_\_  
Weight (kgs) ) 6.7 kg (Centile \_\_\_\_\_)

#### On Examination :

Temperature : 97.5 F Pulse Rate : 128/min B.P. \_\_\_\_\_ SPO2 97%  
Resp. rate and type of breathing : 28/min.

Rash (-)

Lymphadenopathy \_\_\_\_\_

Oedema : (-)

Allergies (if any): (-)

#### Respiratory System :

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

Air entry & breath sounds : B/LAE (+)

Any addes sounds : NO

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

#### Cardiovascular System :

Inspection of procordium : (N)

Heart Sounds : S1S2 (+)

Any murmur : NO

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

#### Per Abdomen :

Inspection (N)

Palpation : soft

Auscultation : B/L (+)

Spine : (N) External Genitelia : \_\_\_\_\_

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



### Pediatric Multiorgan History & Physical Examination

**Central Nervous System :**

Level of Consciousness : AVPU/GCS score : Awake & R

Cranial Nerves : Intact

**Motor System:**

Nutriton : \_\_\_\_\_

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

Power : 4/5 all limbs

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

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

Involuntary Movements : NO

**Reflexes :** +

**DTR** +2

**Superficials:** +

Plantars : flexor

**Sensory System :** +

**Bladder / Bowel :** NO incontinence

**Clinical Summary & Diagnostic:**

AFI (Du) ↓ evaluation



### Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: To prevent complications

Desired goals of the treatment: To treat current condition

#### Planned Labs:

Bp/s ✓  
U/e, u/c/s ✓  
cre ✓  
USG abdomen ✓

CRP } done on  
CRP } ORD basis

#### Planned Management

- 1) IV fluids
- 2) Oral Augmentin IV BID
- 3) Oral Amoxicillin IV BID
- 4) Oral Erythromycin OD

Admitted by Architha  
on 4/6/26 @ 3:45 PM

Signature of the Doctor: G.V

Name of the Doctor: Dr. Vishwas

Date & Time: 4/6/26 3pm

Signature of the Consultant: [Signature]

Name of the Consultant: [Signature]

Date & Time: [Signature]



1

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/6/26 8:45	<p><u>CS/B Resident</u>  <u>Acute febrile illness</u></p>	
	<p>one fever spike                  since Admission                  CRP - 69                  TLC - 21.41</p>	<p><u>Adm</u></p>
	<p>O/B - euthermic                  CVS - S1S2 ⊙                  RS - B/LA/B ⊙                  PA - S/S/L                  U/Bay Stable</p>	<p>- D2 7j Amoxycelan                  7j esomeprazole                  7j Amikacin</p> <p>- Continue same</p>
<p>⊙                  Aspirin</p>	<p>- CBP, CRP - 7/m.</p>	<p>⊙                  Dr. Surender Rao                  5/6/26                  10:50 AM</p>
<p>noted by Dr. S                  2:20pm                  5/6/26</p>		

**PROGRESS NOTES AND DOCTOR'S ORDER**

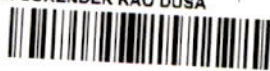
Date & Time	Progress Notes	Doctor's Order
5/6/26 3pm	<p><u>CS/B Residat</u>            Acute fibril Illus</p>	
O/R	<p>NO fever spike            Cerebr            Abnorm            as            ps / nro            ps</p>	<p><u>Adv</u>            - Control some            - with mostly</p>
		<p>of            D. Shriv</p>
		<p>noted by            Sulchan            05/6/26            @ 7pm</p>





VIH-00200531 IP-00060225  
 Baby B/O DANJEE DANIEL  
 29-12-2025 0 Y 5 M 6 D (M)  
 Dr. SURENDER RAO DUSA

Patient S



AL / 124

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

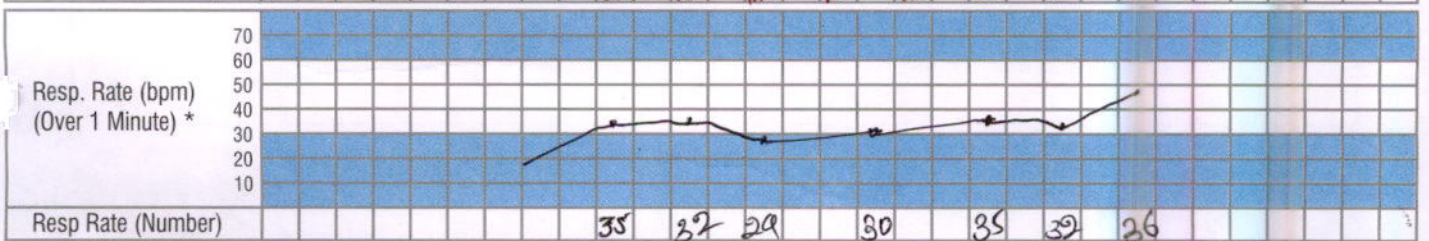
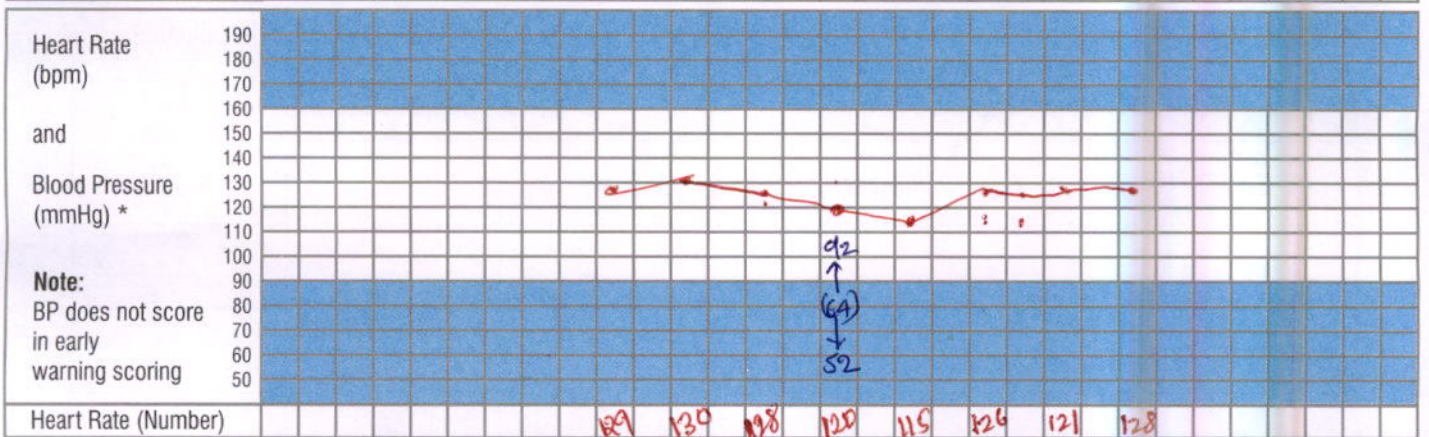
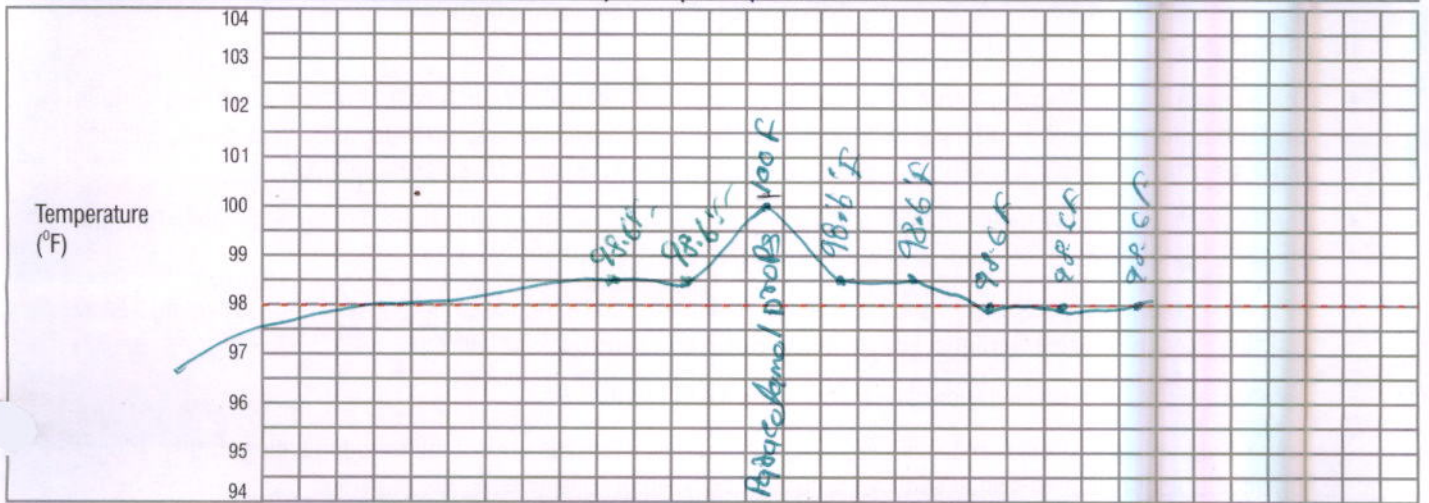
Rainbow®  
 Children's  
 Hospital  
 It takes a lot to treat the little.

**BirthRight™**  
 BY RAINBOW HOSPITALS  
 Your Right to a Safe Delivery

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

Date: 4/6/20 Time: 5 PM 7 PM 9:20 PM 11 PM 1 AM 3 AM 5 AM 7 AM

Doctor/Nurse/Family Concern? PM PM PM AM AM AM AM AM



Resp Distress	Mod/ Severe None / Mild	
Receiving O <sub>2</sub> (l/min)	O <sub>2</sub> Saturations (%)	97 99 96 98 99 97 99 96
Conscious Level	Normal / Altered	N N N N N N N N
GCS *		15 15 15 15 15 15 15 15

<b>TOTAL SCORE</b>	
Number of shaded boxes	0 0 1 0 0 0 0 0
Pain Score	0 0 0 0 0 0 0 0
Observer's Initials	SK SK S B B B B S

**ACTIONS**

Score 1 : Continue normal observation by staff nurse

Score 2 : Shift in charge nurse to be informed and continue hourly observations

Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.

Score 4 : Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see

Score 5 & 6 : Shift in charge and PICU /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.



# 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.

<b>I</b>	<b>IDENTITY:</b> I am (name), a nurse on ward (X). I am calling about (child X)
<b>S</b>	<b>SITUATION :</b> 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>B</b>	<b>BACK GROUND :</b> 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)
<b>A</b>	<b>ASSESSMENT :</b> 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.
<b>R</b>	<b>RECOMMENDATION :</b> 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)



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



## EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 5/6	Time: 9	11	1	4	7	10	1	5	8
Doctor/Nurse/Family Concern?	Am	Am	Am	Pm	Pm	Pm	Pm	Am	Am
Temperature (°F)	98.6	98.6	98.6	98.6	98.6	98.5	97.5	98.0	
Heart Rate (bpm) and Blood Pressure (mmHg) *	125	120	125	130	123	125	120	125	120
Resp. Rate (bpm) (Over 1 Minute) *	28	27	28	30		30	28	30	28
Receiving O <sub>2</sub> (l/min) O <sub>2</sub> Saturations (%)	08	08	08	97	100	99	99	99	100
Conscious Level	R	R	R	N	N	N	N	N	N
GCS *	15	15	15	15	15	15	15	15	15
TOTAL SCORE	0	0	0	0	0	0	0	0	0
Number of shaded boxes	0	0	0	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0	0	0	0
Observer's Initials	BS	P	P	SR	SR	P	P	P	P

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### 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.

<b>I</b>	<b>IDENTITY:</b> I am (name), a nurse on ward (X). I am calling about (child X)
<b>S</b>	<b>SITUATION:</b> 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>B</b>	<b>BACK GROUND:</b> 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)
<b>A</b>	<b>ASSESSMENT:</b> 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.
<b>R</b>	<b>RECOMMENDATION:</b> 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)



Patient Sticker

# FLUID CHART

Sheet No. : .....

4/6/26

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 Thrombophlebitis 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												
<b>Total Intake :</b>						<b>Total Output :</b>							
4/6	02:00 pm												
	03:00 pm												
	04:00 pm				DNS								
	05:00 pm		DBF		13ml					✓			Subher 4/6 @ 7PM
	06:00 pm				13ml					✓			
	07:00 pm					13ml							
<b>Total Intake :</b> 39 ml						<b>Total Output :</b>							
Aloke	08:00 pm												
	09:00 pm		DBF										
	10:00 pm				13 ml					✓			Reshi 5/6 @ 10AM
	11:00 pm		DBF		13 ml								
	12:00 am					13 ml							
	01:00 am		DBF		13 ml								
<b>Total Intake :</b> 52 ml						<b>Total Output :</b>							
5/6/26	02:00 am				13ml						✓		
	03:00 am		DBF		13ml								
	04:00 am				13ml								Beenuka 5/6 @ 7am
	05:00 am		DBF										
	06:00 am					13ml							
	07:00 am		DBF								✓		
<b>Total Intake :</b>						<b>Total Output :</b>							
<b>Total 24 hrs. Intake</b>			99 ml			<b>Total 24 hrs. Output</b>							



# FLUID CHART

Sheet No. : .....

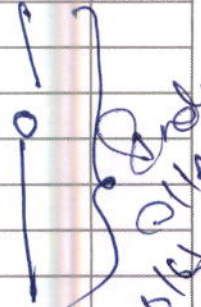
1. All measurements in ml.
2. Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
			Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
5/6/25	08:00 am			13ml						✓	} 202pm 5/6/25	
	09:00 am	DBF		13ml								
	10:00 am	DBF		13ml								
	11:00 am											
	12:00 pm	DBF		13ml						✓		
	01:00 pm			13ml								
<b>Total Intake :</b>						<b>Total Output :</b>						
5/6/26	02:00 pm			13ml							} 5/6 @ 7pm	
	03:00 pm	DBF		13ml								
	04:00 pm									✓		
	05:00 pm	DBF										
	06:00 pm											
	07:00 pm	DBF								✓		
<b>Total Intake :</b>			26ml			<b>Total Output :</b>						
6/6	08:00 pm										} 6/6/26 @ 7Am	
	09:00 pm	DBF								✓		
	10:00 pm											
	11:00 pm	DBF								✓		
	12:00 am											
	01:00 am	DBF								✓		
<b>Total Intake :</b>						<b>Total Output :</b>						
6/6	02:00 am										} 6/6/26 @ 7Am	
	03:00 am	DBF								✓		
	04:00 am											
	05:00 am	DBF								✓		
	06:00 am											
	07:00 am	DBF								✓		
<b>Total Intake :</b>						<b>Total Output :</b>						
<b>Total 24 hrs. Intake</b>						<b>Total 24 hrs. Output</b>						

# 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		
6/6	08:00 am	DEF								✓		
	09:00 am											
	10:00 am											
	11:00 am	DEF										
	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>						





PRESCRIPTIONS

Weight: 6.7kg Ward: .....

3ml 11:30 AM  
 20/12/25 6/6/26 5:30 PM  
 20/12/25 4/6/26 5:30 PM  
 20/12/25 4/6/26 5:30 PM  
 20/12/25 4/6/26 5:30 PM  
 20/12/25 4/6/26 5:30 PM

<b>DRUG: PNT. AMOXICILLIN CLAVULANATE</b>				Date Time	4/6 5/6 6/6	x 2
Dose	Route	Frequency	Start Date	6 AM	ESW	ESW
200mg	IV	6th hourly	4/6			
Name & Signature of the Doctor Starting the Drugs: Dr. Vichwaja				2 PM		
Additional Instructions: after test done 30mg/kg/dose				10 PM		
Daily Doctor's Endorsement by a Sign						
<b>DRUG: PNT. AMIKACIN</b>				Date Time	4/6 5/6 6/6	
Dose	Route	Frequency	Start Date	6 AM	ESW	ESW
50mg	IV	12th hourly	4/6			
Name & Signature of the Doctor Starting the Drugs: Dr. Vichwaja				6 PM		
Additional Instructions: 7.5mg/kg/dose						
Daily Doctor's Endorsement by a Sign						
<b>DRUG: PNT. EROMEPRAZOLE</b>				Date Time	4/6 5/6 6/6	
Dose	Route	Frequency	Start Date	6 AM	ESW	ESW
6mg	IV	once daily	4/6			
Name & Signature of the Doctor Starting the Drugs: Dr. Vichwaja				6 AM		
Additional Instructions: 1mg/kg/dose						
Daily Doctor's Endorsement by a Sign						
<b>DRUG: NABOCLANAL DROPS</b>				Date Time		
Dose	Route	Frequency	Start Date			
2 DROPS	PO	8thly	6/6/25			
Name & Signature of the Doctor Starting the Drugs: Dr. prabhanki						
Additional Instructions: 2 DROPS IN EACH NOSE						
Daily Doctor's Endorsement by a Sign						



