Rainbow Children's Hospital

BirthRight by Rainbow

Rainbow Childrens Hospital-Himayatnagar

Rainbow Children's Hospital, Door no. 3-6-267, opp. Cafe niloufer, Old MLA quarters road AP State Housing Board Himayatnagar ,Hyderabad ,Telangana, INDIA ,500029.
TEL NO :040-48873000
WEB : https://rainbowhospitals.in

ADMISSION SHEET

Registration Details :

Admission No : IP26-00006646 **Admit Date** : 25-Jun-2026 **Admit Time** : 05:40 PM **UHID** : HNH-00016167

Patient Details :

Patient Name	: Baby GANDLA AARADHYA	**Age**	: 8 Y 1 M 23 D
Guardian	: Mr G PAVAN KUMAR	**DOB**	: 02-05-2018
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: 1731.1/V/52, SAIDABAD Saidabad Hyderabad Telangana INDIA 500059	**Phone No**	: 6301920982/ 8019811813
		E-mail	: 8019811813@GMAIL.COM

Admission Details :

Bed Type : DAY CARE **Bed No** : ER01 **Ward Name** : GF -EMERGENCY

Room No : ER01 **Admission Type** : First Visit

Contact Details :

Name : Mr G PAVAN KUMAR **Relationship** : Father

Contact Address : 1731.1/V/52, SAIDABAD Saidabad Hyderabad Telangana INDIA 500059 **Phone No** : 6301920982

Signature

Doctor Details :

Doctor Name : Dr. SINDHURA MUNUKUNTLA **Specialisation** : GENERAL PEDIATRICS

Referral Doctor : Self. **Phone No** :

Co-Consultant :

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash **Payor Name** : CARE HEALTH INSURANCE LIMITED

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ACTIVITY RECORD FOR BILLING

HNH-00016167 IP26-00006646
Baby GANDLA AARADHYA
02-05-2018 8 Y 1 M 23 D (F)
Dr. SINDHURA MUNUKUNTLA

Name: ------- ----------

UHID No : --- ------- Consultant : ---------- Dept : ----------

Date of Admission : ---------- Time : ---------- Date of Discharge : ---------- Time: ----------

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
25/6/26	5:50pm	ER	ward	

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Sign
25/6/26	CBP, CRP, Blood C/S Res Panel	10338	
25/06/26	Dengue NS1 & IgM	10349	
	Cross checked by Manipal 24M, 25/6/26		
26/6/26	X-ray nasopharynx	~~7455~~ 7574	

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
25/6/26	Infusion pump	6:20pm		8207	[illegible]

Cross checked by Monisha @ 2AM 25/6/26

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
25/6/26	IV Placement	(1)	208196	
26/6/26 (7pm)	NH A	(1)	8206	
	Opds checked by Hospital @ 2 AM. 25/6/26			

ANY OTHER INFORMATION

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

Ref.No. F/IN/PR/10

Rainbow®
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Hospital

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name : Aaradhya

Patient ID# : HNH-00016167 IP26-00006646

Baby GANDLA AARADHYA
02-05-2018 8 Y 1 M 23 D (F)
Dr. SINDHURA MUNUKUNTLA

Consultant :

Final Diagnosis :

Pediatric Multiorgan History & Physical Examination

Name : Aaradhya Age/Sex 8y/F

Informant Reliability

Chief Presenting Complaints & Duration (Chronologically):

c/o Fever :: 4-5 day
c/o Headache & generalized body pain :: 3 day
c/o Vomiting :: 2 day
c/o Abdominal pain :: 2 day
c/o ~~Fever~~ Noisy breathing :: 2 day

History of present illness :

child brought with
c/o Fever :: 5 day
Insidious onset, high grade ~103°F
Recurring 4-5 hour, ass c chills.
ass c headache & body pain
c/o ~~Fever~~ Vomiting :: 2 day
Multiple episodes, non bilious

c/o Abdominal pain :: 2 day
Diffuse, generalized, more periumbilical pain
Difficulty on passing stool

c/o Noisy breathing / Mouth breathing :: 2 day

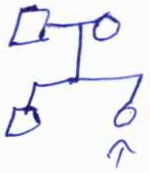
~~Outside~~ Lab (25/6)
CBP - Hb - 14.4 / WBC - 5200 < N-73 L-20 / PLT - 2.18
CRP - 38.5
CUE - ⊘ / MP - Negative
Na^+ - 133 / K^+ - 3.8 / Cl^- - 104 / Urea - 18
Creat - 0.8 mg/dl

Pediatric Multiorgan History & Physical Examination

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

Birth & Neonatal History :

FT / AGA / CIAB



Birth & Socio Economic History :

About Father :

About Mother :

Any additional Information :

Developmental History :

Immunization History :

Upto 5 yrs

Pediatric Multiorgan History & Physical Examination

Anthropometry

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

Weight (kgs) 22.8kg (Centile _____)

On Examination :

Temperature : 101.5°F Pulse Rate: 132/min Description _____

B.P. _____ SPO2 98% at _____

Resp. rate and type of breathing : 24/min

Rash Sign of Dehydration ⊕ → Sunken eyes, dry lips & mucosa. Delayed skin turgor

Lymphadenopathy Cervical LN ⊕ (L > R)

Oedema : _____

Respiratory system :

ENS - ⊖ , Throat - B/L enlarged & congested tonsil (R > L) Grade 2-3

Inspection (any s/o distress) : _____

Air entry & breath sounds : B/L AE ⊕

Any addes sounds : B/L conducted sound

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

Cardiovasclular System :

Inspection of procordium : _____

Heart Sounds : $S_1 S_2$ ⊕

Any murmur : _____

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

Per Abdomen :

Inspection _____

Palpation : Soft

Ausculation : _____

Spine: _____ External Genitelia : _____

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

Pediatric Multiorgan History & Physical Examination

Central Nervous System :

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

Cranial Nerves : WNL

Motor System :

Nutrition :

Tone : Power

Co-ordinator : 6

Posture :

Involuntary Movements :

Reflexes :

DTR **Superficials :**

Plantars

Sensory System :

Bladder / Bowel : 6

Clinical Summary & Diagnostic :

Acute Febrile Illness c Dehydration - DS

Preventive aspects of the treatment :

Desired goals of the treatment :

Planned Labs :

CBP, CRP
Blood C/S
+2 Plain extra

5 Views Respiratory Panel

(X-ray after rounds)

Noted By Prabir

Planned Management :

IV Fluids
IV Ceftriaxone
Nasiva - P
~~Xyrad~~
Inj Ondem / Inj Esomeprazole
Syp Crocin / Duogesic - SOS

Noted By Prabir

Please fill up the following details

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

Doctor's Signature Name Date 26/6/18 Time 8:45 pm.

HNH-00016167 IP26-00005646
Baby GANDLA AARADHYA
02-05-2016 8 Y 1 M 23 D (F)
Dr. SINDHURA MUNUKUNTLA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
25/6/18 8:40pm	S/B Dr. Sindhura	
	∆ AFI ē dehydration	
		P/a
	Signs of	
	dehydration ⊕	– c/f CEFTRIAXONE
	CVS – S₁S₂ ⊕	– c/f ONDANSETRON
	RS – BL-AE ⊕	ESMOPRAZOLE
	P/A soft	– c/f IV fluids
	Conscious	
		– Add MUOUT powder
	B/L upper cervical	
	Lymphadenopathy	– Trace reports
		– Send Dengue NS1 & IgM
		Serum sample
		[signature]

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
26/6/26 7:15 AM	S/B Dr. Sreeshan	
	∆ AFI ē dehydration	Plan
	Fever spikes ⊕	— ✓ CEFTRIAXONE
	CVS - S1, S2 ⊕	— ✓ ONDANSETRON
	RS - BL - AE ⊕	ESMOPRAZOLE
	P/A Soft	— ✓ IV fluids
	Conscious.	
		— Trace Resp. panel
		Dengue NS1
		Igm
		NB Monitor
		@ 8 AM
	(signature)	
26/6/26 10 AM.	c/s/by Dr Sindhura	
	AFI ē dehydration	
	fever Spike ⊕	
	Noisy breathing.	— Ⓣ Adeno, culture. Dengue.
	vital stable	— ct CEFTRIAXONE
	S/E NAD	ESMO.
		— ct iv fluids.
		— Monitor vital.

HNH-00016167 IP26-00006646
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02-05-2018 8 Y 1 M 23 D (F)
Dr. SINDHURA MUNUKUNTLA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
		→ As per diet.
		→ ↓ IV fluids
		→ X Ray NP.
		AMRUTHA. D
	N.B Amrutha @ 10Am.	

HNH-00016157 IP26-00006646
Baby GANDLA AARADHYA
02-05-2018 8 Y 1 M 23 D (F)
Dr. SINDHURA MUNUKUNTLA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

HNH-00016167 IP26-00006646
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DRUG CHART

Date of Admission: ..... Drug Allergies: ..... ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

GENERAL - Ensure that all patient details are entered above. ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.

DOCTOR
- Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
- Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
- Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
- Discontinue a drug by drawing a line *I* through it and a similar line through subsequent recording panels.
- The date and time of stopping the drug along with the doctors name and sign must be mentioned.
- Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.

NURSES
- Nurses must follow strictly the FIVE RIGHTS before administration of medication.
  1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time
- AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

22.5 kg

SOS / PRN (As Required Medication)

DRUG : Syp CROCIN-DS	Dose	Route	Frequency	Start Date	Date / Time
	7.5ml	Po	SOS 6th hrly	25/6	26/6/22 11:30 Pharm
Doctor's Signature: Pharm	Valid Period:		Pharm.		
Additional Instructions: If T >100°F	5ml = 240mg				

DRUG : Syp IBUGESIC	Dose	Route	Frequency	Start Date	Date / Time
	7.5ml	Po	SOS	25/6	
Doctor's Signature: Pharm	Valid Period:		Pharm.		
Additional Instructions: If T >102°F					

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

VERIFIED BY Name Signature

HNH-00016167 IP26-00006646
Baby GANDLA AARADHYA
02-05-2018 8 Y 1 M 23 D (F)
Dr. SINDHURA MUNUKUNTLA

REGULAR PRESCRIPTIONS

Weight. 22.8kg Ward. .....

DRUG : Inj CEFTRIAXONE

Dose	Route	Frequency	Start Date
2 gm	IV	once Daily	25/6

Name & Signature of the Doctor Starting the Drugs: Pranav

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date/Time: 25/6 6:30PM

DRUG : ~~Inj ONDANSETRON~~

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date/Time:

DRUG : NASIVION-P NASAL Drop

Dose	Route	Frequency	Start Date
2°	P/N	~~TID~~	25/6

Name & Signature of the Doctor Starting the Drugs: Pranav

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date/Time: 25/6 GAM 26/6 6PM 10PM

DRUG : Inj ONDANSETRON

Dose	Route	Frequency	Start Date
4mg	IV	TID	25/6

Name & Signature of the Doctor Starting the Drugs: Pranav

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date/Time: 25/6 6AM 26/6 6:30PM 10PM

HNH-00016167 IP26-00006646
Baby GANDLA AARADHYA
02-05-2018 8 Y 1 M 23 D (F)
Dr. SINDHURA MUNUKUNTLA

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REGULAR PRESCRIPTIONS

Sheet No: .... Weight .... Ward ....

				Date ▸ Time ▾		
DRUG : Inj ESOMEPRAZOLE					25/6	26/6
Dose	Route	Frequency	Start Dt.			
25mg	IV	once Daily	25/6			
Name & Signature of the Doctor Starting the Drugs: Pranay				6AM	[signature]	[signature]
Additional Instructions:						
Daily Doctor's Endorsement by a Sign						
DRUG : Syp. RELENT +					25/6	26/6
Dose	Route	Frequency	Start Dt.			
5ml	oral	Q12H	25/6			
Name & Signature of the Doctor Starting the Drugs: [signature]				10AM	X	[signature]
Additional Instructions:				10PM	[signature]	
Daily Doctor's Endorsement by a Sign						
DRUG : MUOUT powder					25/6	
Dose	Route	Frequency	Start Dt.			
25 (cap)	oral	bedtime	25/6			
Name & Signature of the Doctor Starting the Drugs: B-Sneyl				10PM	[signature]	
Additional Instructions: dilute in 120 ml water						
Daily Doctor's Endorsement by a Sign						
DRUG :						
Dose	Route	Frequency	Start Dt.			
Name & Signature of the Doctor Starting the Drugs:						
Additional Instructions:						
Daily Doctor's Endorsement by a Sign						

Signature .... VERIFIED BY : Name

HNH-00016157 IP25-00006646
Baby GANDLA AARADHYA
02-05-2018 5 Y 1 M 23 D (F)
Dr. SINDHURA MUNUKUNTLA

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Sheet No: ....

REGULAR PRESCRIPTIONS

Weight .... Ward ....

VERIFIED BY : Name . ... Signature ....

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

HNH-00016167 IP26-00006646
Baby GANDLA AARADHYA
02-05-2018 8 Y 1 M 23 D (F)
Dr. SINDHURA MUNUKUNTLA

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

	Date➤ Time		Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.
DRUG :		Dose		Dose		Dose		Dose	
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Route / Start Date		Dose		Dose		Dose		Dose	
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Name & Signature of the Doctor		Dose		Dose		Dose		Dose	
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Additional Instructions:		Dose		Dose		Dose		Dose	
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	

VARIABLE DOSE	Date➤ Time		Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.
DRUG :		Dose		Dose		Dose		Dose	
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Route / Start Date		Dose		Dose		Dose		Dose	
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Name & Signature of the Doctor		Dose		Dose		Dose		Dose	
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Additional Instructions:		Dose		Dose		Dose		Dose	
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	

Signature :

Name :

VERIFIED

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses

HNH-00016167 IP26-00006646
Baby GANDLA AARADHYA
02-05-2018 8 Y 1 M 23 D (F)
Dr. SINDHURA MUNUKUNTLA

I.V. FLUIDS CHART

Weight. ...22.4 kg. Ward. .....

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
25/6	5pm	IVF - DNS (2/3rd M)	IV	40					
26/6		(1/2M)	IV	30 ml/hr					

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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: ER ..... Shifted to: Ward ....

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						☐ C ☐ DC
2						☐ C ☐ DC
3						☐ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

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

Date & Time : 25/6/26 @ 5 PM .....

Nurse Name & Signature: Prabir .....

Date & Time : 25/6/26 @ 5 PM .....

Docu. No. : RCH / FRM / GENERAL / 090

PATIENT TRANSFER FORM

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HNH-00016167 IP26-00006646
Baby GANDLA AARADHYA
02-05-2018 8 Y 1 M 23 D (F)
Dr. SINDHURA MUNUKUNTLA

	Date & Time of Admission	Date & Time of Transfer Order
Treating Consultant Name	25/6/26 @ 5:50pm	25/6/26 @ 6PM
	Transfer Ordered by: Dr. Pranav	Reason for Transfer: Admission
From Unit: ER	To Unit: Ward 6	Information to Attendant: Yes ☑ No ☐
Number of Sheets in Clinical File: 20	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant: Yes ☐ No ☑ If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.		
2.		
3.		
4.		
5.		

Shifting Summary / Notes Written by Doctor : Yes ☐ No ☐

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Prabin	Dr. Pranav

Patient & Clinical Records Received by : Swetha

Date & Time of Patient Received : 25/6/26 @ 6pm

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

219

Patient Sticker 8Y1M

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NUTRITIONAL HEALTH ASSESSMENT - GIRLS

Date: 25/6/26 Time: 6:50pm

Weight: 22.8kg Centile: >10th

Height: — Centile: —

Inference: underweight child

RDA: — Calories: 1550 kcal/d Protein: 27 gms/d

Diet Recommendations: Normal Diet

Re-Assesment: Avoid spicy, chilled & outside foods

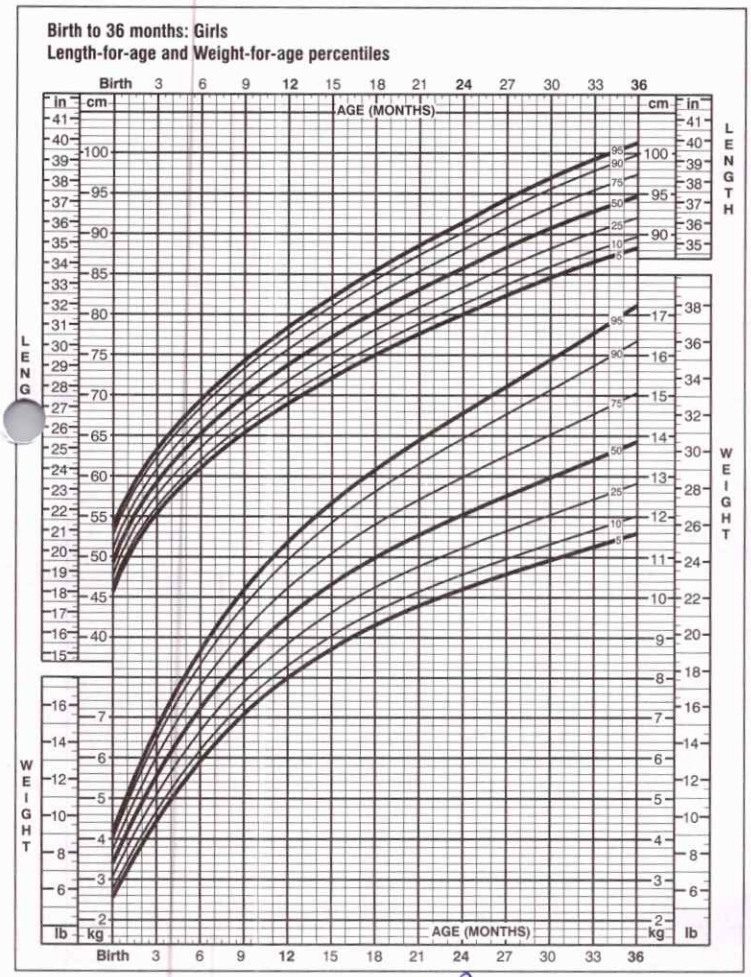
Food Allergies: NO Veg/Non-veg NON-Veg

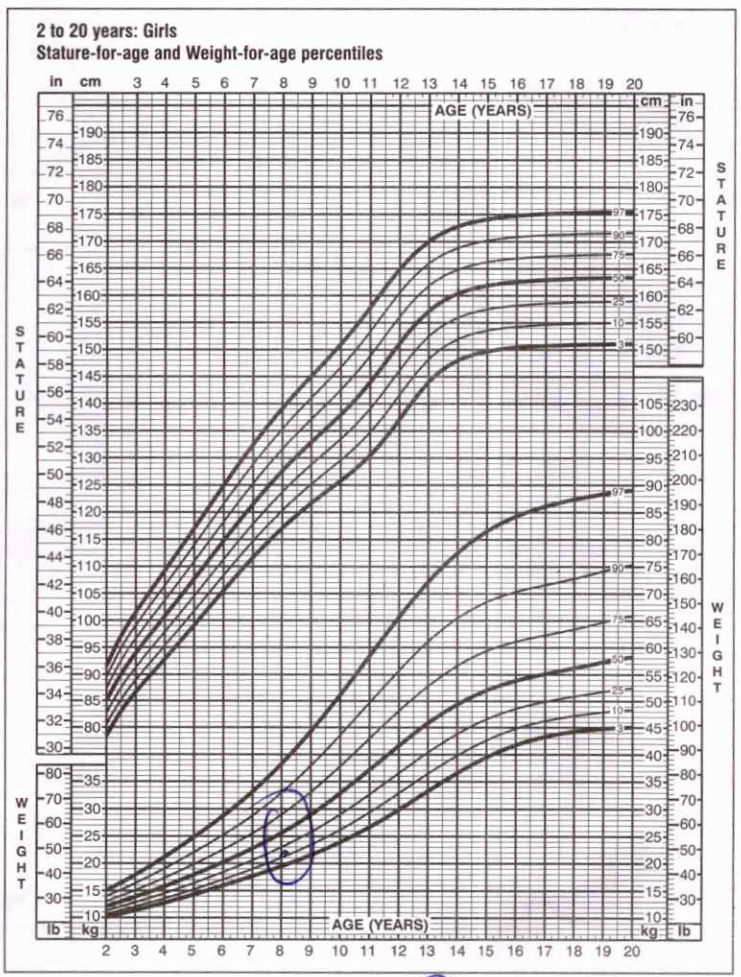
Diagnosis: AFI

Nutritional Intervention - ☑ Oral ☐ Enteral ☐ Parenteral

Patient's Signature:

GROWTH CHART (GIRLS)





Dietician's Name Sathwika.G

Dietician's Signature

Daily Notes:

HNH-00016167 IP26-00006646
Baby GANDLA AARADHYA
02-05-2018 8 Y 1 M 23 D (F)
Dr. SINDHURA MUNUKUNTLA

Wt - 22.8 kg

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EMERGENCY ROOM TRIAGE FORM

Patient's Name : G Aaradhya Age : 8 years **Gender:** ☐ Male ☑ Female

Date : 25/6/26 Time of Arrival : 4'35 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: 101.4°F PR: 131 b/m BP: ..... RR: ..... SpO_2: 100%

Chief Complaints: c/o Fever, Headache since 3 days

INITIAL PHYSIOLOGICAL CATEGORIZATION

Appearance
☑ Normal
☐ Sick Looking

Circulation / Colour
☑ Normal ☐ Abnormal ☐ Bleeding

Work of Breathing
☑ Normal ☐ Increased
☐ Decreased ☐ Gasping / Apnea

INITIAL PHYSIOLOGICAL STATUS
☑ Stable
☐ Unstable :
- ☐ Not – Life - Threatening
- ☐ Life – Threatening

Triage Classification	CTAS
☐ Level 1 : Resuscitation	☐ Immediate
☐ Level 2 : EMERGENT : Life or limb threatening	☐ < 15 min
☐ Level 3 : URGENT : Significant illness / injury with potential to become life or limb threatening	☐ 30 min
☐ Level 4 : LESS URGENT : Significant illness but not life threatening	☐ 60 min
☐ Level 5 : NON – URGENT : May receive care when convenient	☐ 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 : 4'37 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: .....
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 : Prabin

Signature of Triage Nurse : .....

Date & Time : 25/6/26 @ 2'37 pm

HNH-00016167 IP26-00006646
Baby GANDLA AARADHYA
02-05-2018 8 Y 1 M 23 D (F)
Dr. SINDHURA MUNUKUNTLA

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 25/6/26 Time of arrival : 4:35 pm

Chief Complaints: c/o Fever, Headache since 3 days RBS: .....

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

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

If yes , identify .....

Pain Screening: ☐ Yes ☑ No If Yes, Pain Score: 10/ 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 : 4:37 PM

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

Time	Nursing Notes
	→ Assessed the pt condition
	→ Checked the pt vitals
	→ Given medicine

Samples collected by: Prabin Time:

Samples sent by : Time: 6:00pm

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1
4:40pm	Ibugesic	PO	7 ml		

Condition of patient at time of shift - out :	**Details of Shift - out**
HR: ..... BP: ..... CFT:	Shift - out from ER to: 218
RR: ..... SPO_2 :	Time of Shift - out: 5:50pm
GCS:..... Temperature :	Handover given to: .....
Pain Score:	(Nurse's Name)
Repeat RBS (if applicable):	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

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

.....

Name of the Nurse : Prabin Signature of the Nurse : .....

Date & Time : 25/6/26 @ 4:37pm

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218 219

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RESULT SHEET

Date	25/6/26					
Time						
Hb	12.4					
PCV	34.7					
RBC	4.72					
WBC	4.16					
N/L	58.6/33.6					
Platelets	234					
CRP	31					
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						

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

HNH-00016167 IP26-00006646
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H/ FRM / CLINICAL / 126

SCHOOL AGE (5-12 years)
Children's Observation & Early Warning Scoring Chart

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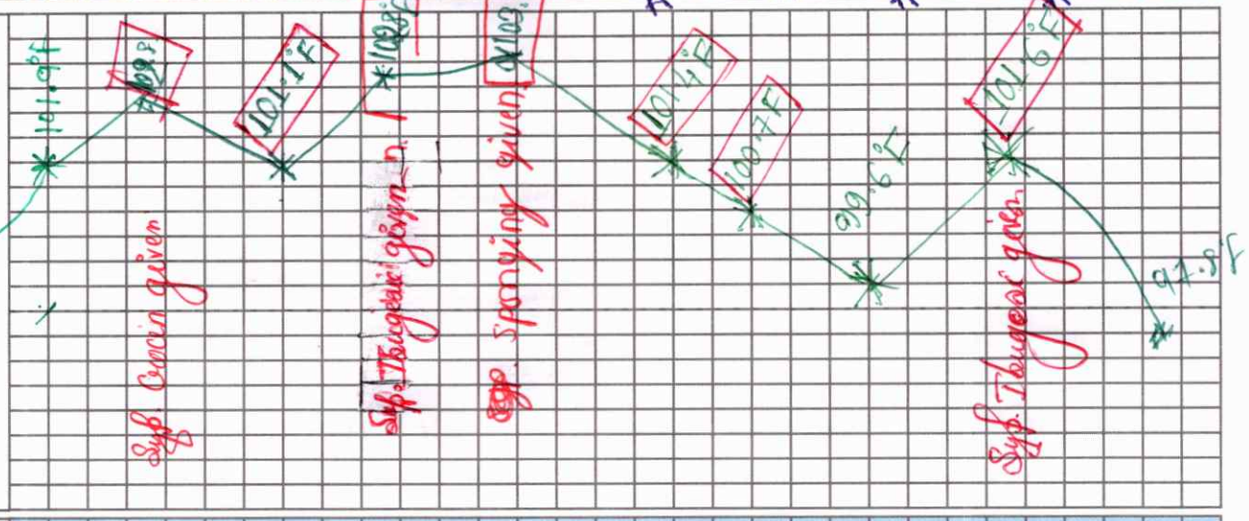
EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 25/6/26 Time: 6 | 9:40 | 11:30 PM | 1AM | 2:30AM | 3 AM | 3:30 AM | 5 AM | 7 AM | 8AM

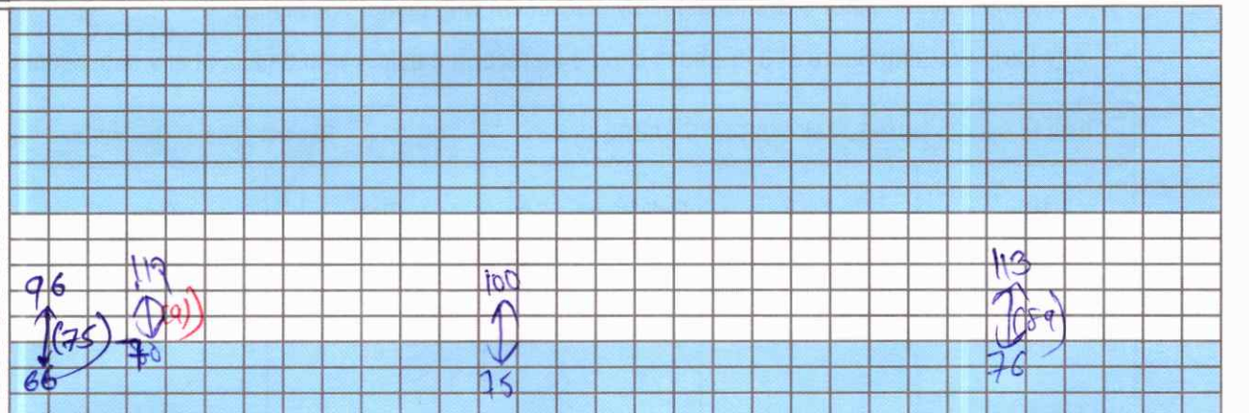
Doctor / Nurse / Family Concern? P

Temperature (F)



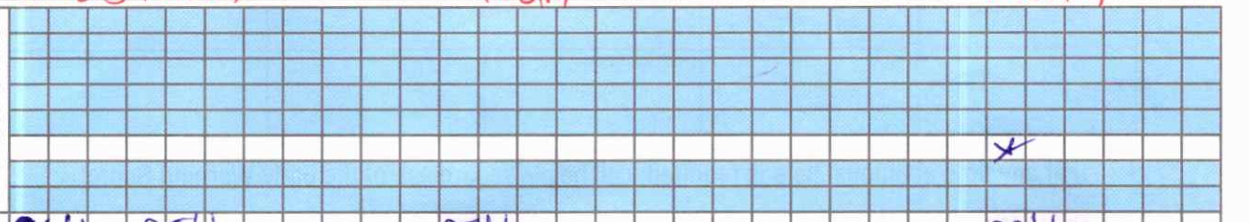
Heart Rate (bpm) and Blood Pressure (mmHg) *

Note: BP does not score in early warning scoring



Heart Rate (Number) 124bb 127b/m 120b/m 120b/m

Resp. Rate (bpm) (Over 1 Minute) *



Resp Rate (Number) 24bb 28b/m 27b/m 28b/m

Resp Distress	Mod/ Severe / None / Mild	
Receiving O_2(l/min)		
O_2Saturations (%)		100% 100% 98% 98%
Conscious Level	Normal / Altered	
GCS *		
TOTAL SCORE Number of shaded boxes		0 0 0 0
Pain Score		0 2 0 0
Observer's Initials		

ACTIONS

NB: Scores 3 should be recorded overleaf

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

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

Patient Sticker

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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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CH/ FRM / CLINICAL / 126

SCHOOL AGE (5-12 years)
Children's Observation & Early Warning Scoring Chart

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 26/6/26 Time: 1130

Doctor / Nurse / Family Concern? Fever

Temperature (F)

104 103 102 101 100 99 98 97 96 95 94

100.8°F
Syp: Crocin given

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

Note: BP does not score in early warning scoring

190 180 170 160 150 140 130 120 110 100 90 80 70 60 50

↑100
↓60

Heart Rate (Number) 110bpm

Resp. Rate (bpm) (Over 1 Minute) *

70 60 50 40 30 20 10

Resp Rate (Number) 20b/m

Resp Distress	Mod/ Severe / None / Mild
Receiving O_2(l/min) O_2Saturations (%)	98%
Conscious Level	*Normal / Altered*
GCS *	
TOTAL SCORE *Number of shaded boxes*	0
Pain Score	0
Observer's Initials	

ACTIONS

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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)*

Patient Sticker

Doc. No. : RCH/ FRM / CLINICAL / 126

SCHOOL AGE (5-12 years)

Children's Observation & Early Warning Scoring Chart

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : ..... Time:	
Doctor / Nurse / Family Concern?	

Temperature (℉)	104, 103, 102, 101, 100, 99, 98, 97, 96, 95, 94
Heart Rate (bpm) and Blood Pressure (mmHg) * **Note:** BP does not score in early warning scoring	190, 180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60, 50
Heart Rate (Number)	
Resp. Rate (bpm) (Over 1 Minute) *	70, 60, 50, 40, 30, 20, 10
Resp Rate (Number)	
Resp Distress: Mod/ Severe / None / Mild	
Receiving O_2(l/min) O_2Saturations (%)	
Conscious Level: Normal / Altered	
GCS *	
TOTAL SCORE Number of shaded boxes	
Pain Score	
Observer's Initials	

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SCHOOL AGE (5-12 years)

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : ..... Time:																																
Doctor / Nurse / Family Concern?																																
Temperature (F)	104																															
	103																															
	102																															
	101																															
	100																															
	99																															
	98																															
	97																															
	96																															
	95																															
	94																															
Heart Rate (bpm) and Blood Pressure (mmHg) * **Note:** BP does not score in early warning scoring	190																															
	180																															
	170																															
	160																															
	150																															
	140																															
	130																															
	120																															
	110																															
	100																															
	90																															
	80																															
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	50																															
Heart Rate (Number)																																
Resp. Rate (bpm) (Over 1 Minute) *	70																															
	60																															
	50																															
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Patient Sticker

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SCHOOL AGE (5-12 years)
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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : ..... Time:																																				
Doctor / Nurse / Family Concern?																																			
Temperature (F)	104																																		
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Conscious Level: Altered																																			
GCS *																																			
TOTAL SCORE Number of shaded boxes																																			
Pain Score																																			
Observer's Initials																																			

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

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

Patient Sticker

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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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02-05-2018 8 Y 1 M 23 D (F)
Dr. SINDHURA MUNUKUNTLA

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FLUID CHART

Sheet No. : .....

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

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
	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											
25/6/26	06:00 pm	DNS		40 ml							0	
	07:00 pm	DNS		40 ml							0	
Total Intake :		Taken				**Total Output :**				U-	M-	
	08:00 pm	DNS		40ml								
	09:00 pm	DNS		40ml								
	10:00 pm	DNS		40ml						✓		
25/6/26	11:00 pm	DNS	Rice + M.D.	40ml						✓	0	
	12:00 am	DNS		40ml								
	01:00 am	DNS		40ml								
Total Intake :						**Total Output :** U-					M	
	02:00 am	DNS		40ml						✓		
	03:00 am	DNS		40ml								
	04:00 am	DNS		40ml						✓	0	
26/6/26	05:00 am	DNS		40ml								
	06:00 am	DNS		40ml								
	07:00 am	DNS		40ml						✓		
Total Intake :						**Total Output :** U-					M-	

Total 24 hrs. Intake		Total 24 hrs. Output	

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			Mouth	I.V	N.G							
26/6/26	08:00 am			40ml								
	09:00 am		Daily	40ml								
	10:00 am	DNS	1+H2O	40ml								
	11:00 am			40ml								
	12:00 pm			40ml								
	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 :**				
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	05:00 am											
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	07:00 am											
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Patient Sticker

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Total 24 hrs. Intake		**Total 24 hrs. Output**	

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	02:00 am											
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	06:00 am											
	07:00 am											
Total Intake :						**Total Output :**						

Total 24 hrs. Intake		**Total 24 hrs. Output**	

HNH-00016167 IP26-00006646
Baby GANDLA AARADHYA
02-05-2018 8 Y 1 M 23 D (F)
Dr. SINDHURA MUNUKUNTLA

NURSING CARE RECORD

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Date: 25/6/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning				NA			
Afternoon	2pm 8pm	- Assess the pt condition - Monitor vitals - Maintain I/O Chart - Medication Given as per drug chart	2pm 8pm	- Assessed the pt condition - Monitored vitals - Maintained I/O chart - Medication Given as per drug chart	pt is stable	Re checked vitals	Maintained
Night	8pm 8am	Assess the pt condition Monitor vital Maintain I/o chart Medication given as per drug chart	8pm 8am	Assessed the pt condition Monitor vital Maintain I/o chart Medication given as per doctor chart	pt is stable	rechecked vital	Monitored

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NURSING CARE RECORD

Date: .....

Goals

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

Patient Sticker

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

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

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Date: .....

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Morning							
Afternoon							
Night							

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Date: .....

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- ☐ Patient & Family Education
- ☐ Identify Potential Complications
- ☐ Any Others. Specify.....

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

HNH-00016167 IP26-00006646
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CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	25/6 DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0		NA	NA							
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1		NA	NA							
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2		NA	NA							
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3		NA	NA							
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4		NA	NA							
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5		NA	NA							
		Signature of the Nurse											

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

Signature of Shift In Charge :

Signature : Rani Name : Rani

Signature of Ward In Charge :

Signature : Balarani Name : Balarani

Patient Sticker

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CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0										
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6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5										
			Signature of the Nurse										

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

Signature of Shift In Charge :

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

Signature of Ward In Charge :

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

HNH-00016167 IP26-00006646
Baby GANDLA AARADHYA
02-05-2018 8 Y 1 M 23 D (F)
Dr. SINDHURA MUNUKUNTLA

BRADEN 'Q' SCALE

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				Date : 23/6/26	25/6		
				Time : 8a	N		
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.	3	3	
"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.	4	4	
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.	4	4	
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.	4	4	
FRICTION-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."	4	4	
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.	4	4	
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	
				TOTAL SCORE	23	23	
				Evaluator's Name			

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	• 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	• 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	• 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	• 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

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BRADEN 'Q' SCALE

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BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

				Date :				
				Time :				
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"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.				
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.				
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.				
FRICTION-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."				
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.				
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.				
				TOTAL SCORE				
				Evaluator's Name				

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	• 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	• 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	• 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	• 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

HNH-00016167 IP26-00006646
Baby GANDLA AARADHYA
02-05-2018 8 Y 1 M 23 D (F)
Dr. SINDHURA MUNUKUNTLA

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It takes a lot to treat the little.

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: AFI & dehydration		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:				
	Surgery / Procedure:		Post OP Day:				
BACKGROUND	Date / Shift	25/6/26 E2	25/6/26 ALL				
	Medical Condition (Any special condition to be noted):	-	-				
	Diet:	-	-				
ASSESSMENT	Allergy:	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Ventilation (RA, NP, NIV, VENTI):	-	-				
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:	98.6°F	98.2°F				
	Res:	20b/m	22b/m				
	SpO_2:	100%	100%				
	Pulse:	118b/m	120b/m				
	BP:	99/66	98/70				
	LOC:	-	-				
	Fall Risk Score:	-	-				
	Pain Score:	-	-				
	Skin Integrity	-	-				
Recommendations	Safety Needs:	☑ Yes ☐ No	☑ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Physiotherapy:	-	-				
	Others Specify:	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Special Diet:	-	-				
	Critical Lab Test / Values:	-	-				
	Other Special Orders / Medications:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	PU Prophylaxis:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	DVT Prophylaxis:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	ADL (Dependent / Non Dependent):	-	-				
Post Operative Procedure Special Orders:		-	-				
Handed Over By Name :		Swetha	Mounika				
Signature / ID :		S					
Date:		25/6/26	26/6/26				
Time:		8pm	8pm				
Taken Over By Name :		Mounika					
Signature / ID :							
Date:		25/6/26					
Time:		8pm					

Docu. No. : RCH /FRM / CLINICAL / 097

Patient Sticker

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Your Right to a Safe Delivery

NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:				Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:		
	Surgery / Procedure:				Post OP Day:		
BACKGROUND	Date / Shift						
	Medical Condition (Any special condition to be noted):						
	Diet:						
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Ventilation (RA, NP, NIV, VENTI):						
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:						
	Res:						
	SpO_2:						
	Pulse:						
	BP:						
	LOC:						
	Fall Risk Score:						
	Pain Score:						
	Skin Integrity						
Recommendations	Safety Needs:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Physiotherapy:						
	Others Specify:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Special Diet:						
	Critical Lab Test / Values:						
	Other Special Orders / Medications:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	PU Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	DVT Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	ADL (Dependent / Non-Dependent):						
Post Operative Procedure Special Orders:							
Handed Over By Name :							
Signature / ID :							
Date:							
Time:							
Taken Over By Name :							
Signature / ID :							
Date:							
Time:							