

ACTIVITY RE

VIH-00104167 IP-00060333
Baby KUNDHANIKAA CHANDRA
23-07-2025 0 Y 10 M 21 D (F)
Dr. PREETHAM KUMAR



Name: -----

--- Consultant : ----- Dept : Paed

UHID No : -----

Date of Admission : 13/6/26 Time : ----- Date of Discharge : ----- Time : -----

Room / Bed No : 102 Ward : 1st floor Suggested Billable bed type : -----

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
13/6/26	12:05pm	ER	102	JK

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1.	Dr. Sindura	13/6/26	3089883	JK
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Name	Baby KUNDHANIKAA CHANDRA	UHID	VIH-00194167
Father/Guardian	Mr MANIKANTAN	Age/Gender	0 Y 10 M 24 D/Female
Address	H NO 177, SAINIKPURI SEC-BAD, Sainikpuri, Hyderabad, Telangana, INDIA, 500094		
IP No	IP-00060333	Admission Date	13-06-2026
Ref Doctor	SELF	Discharge Date	16-06-2026

DISCHARGE SUMMARY

Consultant: Dr. PREETHAM KUMAR

MBBS,DNB(PEDS),DCH,FELLOW NEONATOLOGY
SENIOR CONSULTANT PEDIATRICS

Diagnosis: Acute febrile illness with first episode of febrile seizure

History: Baby KUNDHANIKAA CHANDRA is a 10 M 24 D girl presented with the history of moderate to high grade fever since 4 days, multiple episodes (2 episodes / day) of non bilious non projectile vomitings, 1 episode of seizure in the form of jerky movements of limbs, deviation of mouth and drooling of saliva lasted for about 5 minutes followed by postictal drowsiness for 10 minutes. For the above complaints, she was admitted at Rainbow Children's Hospital for further management.

Outside Investigations: Complete urine examination done on 12.06.2026 showed 3-5 pus cells, 3- epithelial cells, protein present.

Examination: She was febrile (103.6°F), maintaining saturations at room air. HR- 170/min, BP- 100/60 mmHg and RR 30/min. On auscultation of chest, air entry was bilaterally equal. Heart sounds were normal and there was no murmur. Abdomen was soft without organomegaly. Bowel sounds were heard. Neurologically, she was conscious and alert. No meningeal signs. Examination of other systems including spine was normal.

Name

Baby KUNDHANIKAA
CHANDRA

UHID

VIH-00194167

Weight on admission : 9.1 kgs.

Investigations: Enclosed.

Management: She was admitted in the ward and started on intravenous fluids and intravenous antibiotics. In view of seizures child was loaded with Injection Levitercetam followed by maintenance later changed to oral levipil. She was started on Syrup. Oseltamivir.

Her complete blood picture showed hemoglobin 12.5 gm%, white blood cells count of 18,360 cells/cumm, platelet count of 3.22 lakhs/cumm and C-reactive protein was 6.0 mg/l. Serum electrolytes showed serum sodium - 140 mmol/L, serum potassium - 5.2 mmol/L, chloride - 103 mmol/L. Serum creatinine 0.3 mg/dl. Serum calcium 11.1 mg/dl. Serum magnesium 2.2 mg/dl. Blood culture was sterile after 24 hours of incubation.

In view of seizure, child was seen by Dr. Sindhura P, Consultant Pediatric Neurologist, who advised to do EEG which was done - report awaited. Parents were counselled that if fever persists further plan to do MRI brain. Parents were counselled regarding the nature of febrile seizures and measures to reduce fever during future febrile episodes. They were also educated regarding use of intranasal Midazolam spray for termination of future seizure episodes, if any.

Her vitals were regularly monitored. Repeat hemogram done on 15.06.2026 showed hemoglobin 12.0 gm%, white blood cells count of 10,350 cells/cumm, platelet count of 2.44 lakhs/cumm and C-reactive protein was 7 mg/l. Her fever spikes and other symptoms gradually settled and was afebrile for last 24 hours. She remained hemodynamically stable during the hospital stay and is being discharged with the following advice.

Name

Baby KUNDHANIKAA
CHANDRA

UHID



At the time of discharge : She is active, afebrile and hemodynamically stable.

Advice:

1. Diet as advised.
2. Syrup Cefixime (5ml=100mg), 2.5ml 12th hourly for 2 days (Refrigerate after reconstitution).
3. Syrup Oseltamivir (1ml=12mg), 2ml 12th hourly till 19.06.2026 evening dose (To be refrigerated).
4. Syrup Levipil (1ml=100mg), 1ml 12th hourly till further advice.
5. Oral Enterogermina bottle, 1 mini bottle 12th hourly for 2 days.
6. Proctoguard ointment for local application 12th hourly for 3 days.
7. Kindly consult Dr. Preetham Kumar, Senior Consultant Pediatrics, after 3 days in OPD with prior appointment (This consultation will be charged).
8. Kindly consult Dr. P. Sindhura, Consultant Pediatric Neurologist, after 2 weeks in OPD with prior appointment (This consultation will be charged).

Febrile Seizure Prophylaxis

1. Paracetamol drops (1ml=100mg), 1 ml for fever >99.6°F (maximum 4-6 hourly).
2. Syrup. Ibugesic (5ml=100mg), 4.5ml for fever >101°F (maximum 8 hourly).
3. Tepid sponging SOS if fever >102°F.
4. Midazolam nasal spray (1.25mg/puff), 1 puff intranasal (into each nostril in sitting position) for future seizures more than 3 minutes.

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 KUNDHANIKAA
CHANDRA

UHID

VIH-00194167

Now booking appointments is much easy, download Rainbow Application for Free from Google play store.

In Case of Emergency Contact 040-42462200 Extn: 2010 (or) 7337357870, for increasing breathing difficulty, dullness or high fever.

If any IV antibiotics - will be given in Emergency Room between 6am - 7am for morning dose, between 2pm - 3pm for afternoon dose and between 10pm - 11pm for evening dose (Outside IV medication shall not be allowed with in the hospital as per the hospital protocol).

The content of the patient discharge summary, medication, food & drug interaction, care to be provided at home, nutrition, immunization and safe parenting, when and how to obtain emergency care etc also have been explained by doctorin the language that I understand and I have understood the same.

Name :

Signature :

Relationship with patient :

This summary has been explained by :

Summary prepared by: Dr. Sameera
DEO : MD Younus Pasha

Registrar/Resident/C.M.O

for Sameera
Dr. PREETHAM KUMAR
MBBS, DNB(PEDS), DCH, FELLOW NEONATOLOGY
SENIOR CONSULTANT PEDIATRICS
39859

Rainbow Children's Hospital - Secunderabad

H.No.3-7-222/223,Sy.No.51 to 54,Opp.Karkhana P S,Karkhana Main Road,Kakaguda, Karkhana ,Hyderabad ,Telangana, INDIA ,500009. 040-42462200, Ext 2000,2001,2002,



PatientName : Baby KUNDHANIKAA CHANDRA **Inpatient No.** : IP-00080333
Age/Gender : 0 Y 10 M 21 D/ Female **Admit Date** : 13-06-2026
Ward/Bed : N 0 GF-EMERGENCY/ ER 101 **Discharge Date** :

Investigation	Result	Unit	Biological Reference Interval
CALCIUM (Specimen : SERUM)			TEST RESULT STATUS : REPORT AUTHORISED
			Order Date :13-06-2026 10:59
CALCIUM (Arsenazo dye)	11.1	mg/dl	8 - 11.1

Dr. SRUJANA SHYAMALA, MD, DNB
 Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
COMPLETE BLOOD PICTURE (Specimen : BLOOD)			TEST RESULT STATUS : REPORT AUTHORISED
			Order Date :13-06-2026 10:59
HEMOGLOBIN (Colorimetry)	12.5	g/dL	10.5 - 13.5
RBC COUNT (DC detection method)	4.43	10 ¹² /L	3.7 - 5.6
PCV/HCT (Calculated)	34.2	VOL%	33 - 49
MCV (Calculated)	77.2	fL	70 - 86
MCH (Calculated)	28.1	pg/cells	23 - 31
MCHC (Calculated)	36.4	g/dL	H 30 - 36
RDW-CV (Calculated)	11.4	%	L 11.5 - 16
PLATELET COUNT (DC Detection Method)	322	10 ⁹ /L	150 - 450
MPV (Calculated)	7.0	fL	6.5 - 10
WBC COUNT (DC Detection Method)	18.36	10 ⁹ /L	H 6 - 17
Differential Count			
NEUTROPHILS (Microscopy, Leishman stain)	52	%	H 15 - 35
LYMPHOCYTES (Microscopy, Leishman stain)	41	%	L 45 - 76
MONOCYTES (Microscopy, Leishman stain)	06	%	4 - 12
EOSINOPHILS (Microscopy, Leishman stain)	01	%	1 - 7
PERIPHERAL SMEAR (Microscopy, Leishman stain)	RBC - NORMOCYTIC / NORMOCHROMIC WBC - LEUCOCYTOSIS PLATELETS - ADEQUATE		

Dr. SRUJANA SHYAMALA, MD, DNB
 Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
C REACTIVE PROTEIN (Specimen : SERUM)			TEST RESULT STATUS : REPORT AUTHORISED
			Order Date :13-06-2026 10:59

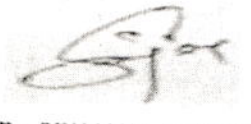
PatientName : Baby KUNDHANIKAA CHANDRA Inpatient No. : IP-00060333
 Age/Gender : 0 Y 10 M 21 D/ Female Admit Date : 13-06-2026
 Ward/Bed : N 0 GF-EMERGENCY/ ER 101 Discharge Date :

Investigation	Result	Unit	Biological Reference Interval
CRP (Immunoturbidimetry)	6.0	mg/L	<10



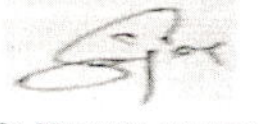
Dr. SRUJANA SHYAMALA, MD, DNB
 Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
CREATININE (Specimen : SERUM)			
TEST RESULT STATUS : REPORT AUTHORISED			
Order Date :13-06-2026 10:59			
CREATININE (Enzymatic)	0.3	mg/dl	0.03 - 0.5



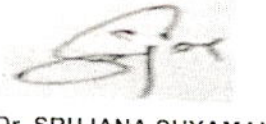
Dr. SRUJANA SHYAMALA, MD, DNB
 Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
ELECTROLYTES (Specimen : SERUM)			
TEST RESULT STATUS : REPORT AUTHORISED			
Order Date :13-06-2026 10:59			
SODIUM (Direct ISE)	140	mmol/L	134 - 144
POTASSIUM (Direct ISE)	5.2	mmol/L	3.5 - 6.1
CHLORIDE (Direct ISE)	103	mmol/L	98 - 108



Dr. SRUJANA SHYAMALA, MD, DNB
 Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
MAGNESIUM (Specimen : SERUM)			
TEST RESULT STATUS : REPORT AUTHORISED			
Order Date :13-06-2026 10:59			
MAGNESIUM (Formazon dye)	2.2	mg/dl	1.6 - 2.6



Dr. SRUJANA SHYAMALA, MD, DNB
 Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
COVID ANTIGEN RAPID TEST (Specimen : SWAB)			
TEST RESULT STATUS : REPORT ENTERED			
Order Date :13-06-2026 11:10			
COVID ANTIGEN RAPID TEST	negative		

PatientName : Baby KUNDHANIKAA CHANDRA

Inpatient No. : IP-00060333

Age/Gender : 0 Y 10 M 21 D/ Female

Admit Date : 13-06-2026

Ward/Bed : N 0 GF-EMERGENCY/ ER 101

Discharge Date :

Investigation	Result	Unit	Biological Reference Interval
---------------	--------	------	-------------------------------

Investigation	Result	Unit	Biological Reference Interval
---------------	--------	------	-------------------------------

COMPLETE BLOOD PICTURE (Specimen : BLOOD)

TEST RESULT STATUS : REPORT AUTHORISED

Order Date :15-06-2026 06:13

HEMOGLOBIN (Colorimetry)	12.0	g/dL	10.5 - 13.5
RBC COUNT (DC detection method)	4.36	10 ¹² /L	3.7 - 5.6
PCV/HCT (Calculated)	34.0	VOL%	33 - 49
MCV (Calculated)	77.9	fL	70 - 86
MCH (Calculated)	27.6	pg/cells	23 - 31
MCHC (Calculated)	35.4	g/dL	30 - 36
RDW-CV (Calculated)	11.6	%	11.5 - 16
PLATELET COUNT (DC Detection Method)	244	10 ⁹ /L	150 - 450
MPV (Calculated)	7.0	fL	6.5 - 10
WBC COUNT (DC Detection Method)	10.35	10 ⁹ /L	6 - 17

Differential Count

NEUTROPHILS (Microscopy, Leishman stain)	22	%	15 - 35
LYMPHOCYTES (Microscopy, Leishman stain)	62	%	45 - 76
MONOCYTES (Microscopy, Leishman stain)	10	%	4 - 12
EOSINOPHILS (Microscopy, Leishman stain)	06	%	1 - 7

PERIPHERAL SMEAR (Microscopy, Leishman stain) RBC - NORMOCYTIC / NORMOCHROMIC
WBC - MORPHOLOGY NORMAL
PLATELETS - ADEQUATE

Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
---------------	--------	------	-------------------------------

C REACTIVE PROTEIN (Specimen : SERUM)

TEST RESULT STATUS : REPORT AUTHORISED

Order Date :15-06-2026 06:13

CRP (Immunoturbidimetry)	7.0	mg/L	<10
--------------------------	-----	------	-----

Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Laboratory Report

Baby KUNDHANIKAA CHANDRA

7780246314

0 Y 10 M 23 D

VI26020262

Female

13-06-2026 11:01 AM

IP-00060333

13-06-2026 11:14 AM

VIH-00194167

Dr. PREETHAM KUMAR

N 0 GF-EMERGENCY / ER 101

BLOOD CULTURE AND SENSITIVITY (Specimen :BLOOD)

RESULT

TEST RESULT STATUS : REPORT ENTERED

Culture : -

Second Report - No growth after 48 hrs of incubation

..... End of the Report

ADMISSION SHEET

Registration Details :



Admission No : IP-00060333

Admit Date : 13-Jun-2026

Admit Time : 10:38 AM UHID : VIH-00194167

Patient Details :

Patient Name : Baby KUNDHANIKAA CHANDRA

Age : 0 Y 10 M 21 D

Guardian : Mr MANIKANTAN

DOB : 23-07-2025 07:26 PM

Gender : Female

Religion :

Occupation :

Martial Status :

Address (H) : H NO 177, SAINIKPURI SEC-BAD Sainikpuri
Hyderabad Telangana INDIA 500094

Phone No : 7780246314

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 MANIKANTAN

Relationship : Father

Contact Address : H NO 177, SAINIKPURI SEC-BAD Sainikpuri
Hyderabad Telangana INDIA 500094

Phone No : 7780246314 / 9908069828

Signature

Doctor Details :

Doctor Name : Dr. PREETHAM KUMAR

Specialisation : GENERAL PEDIATRICS

Referral Doctor : SELF

Phone No :

Co-Consultant :

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : MEDI ASSIST INSURANCE TPA PVT
LTD

Patient Name : Baby. KUNDHANIKAA CHANDRA UHID : VIH-00194167 IPD : IP-00060333 Gender : Female
 Age : 0 Y 10 M 21 D

VIH-00194167 IP-00060333
 Baby KUNDHANIKAA CHANDRA
 23-07-2025 0 Y 10 M 21 D (F)
 Dr. PREETHAM KUMAR



EMERGENCY ROOM TRIAGE FORM

Gender: Male Female

Patient's Name : Kundhanikaa Age : 10M
 Date : 13/6/26 Time of Arrival : 8:20AM

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

Source of Information: Parents Others (Specify): Wheelchair Ambulance

Mode of Arrival: Ambulatory Wheelchair Ambulance
 Initial Vital Signs: Temp: 103.6 F PR: 170b/m BP: crn/mg RR: 30b/m SpO₂: 97%
 Chief Complaints: Fever x 3 days, seizure 1 episode x today

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

- Level 1 : Resuscitation
- Level 2 : EMERGENT : Life or limb threatening
- Level 3 : URGENT : Significant illness / injury with potential to become life or limb threatening
- Level 4 : LESS URGENT : Significant illness but not life threatening
- Level 5 : NON - URGENT : May receive care when convenient

CTAS

- Immediate
- < 15 min
- 30 min
- 60 min
- 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 : 8:23AM

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)

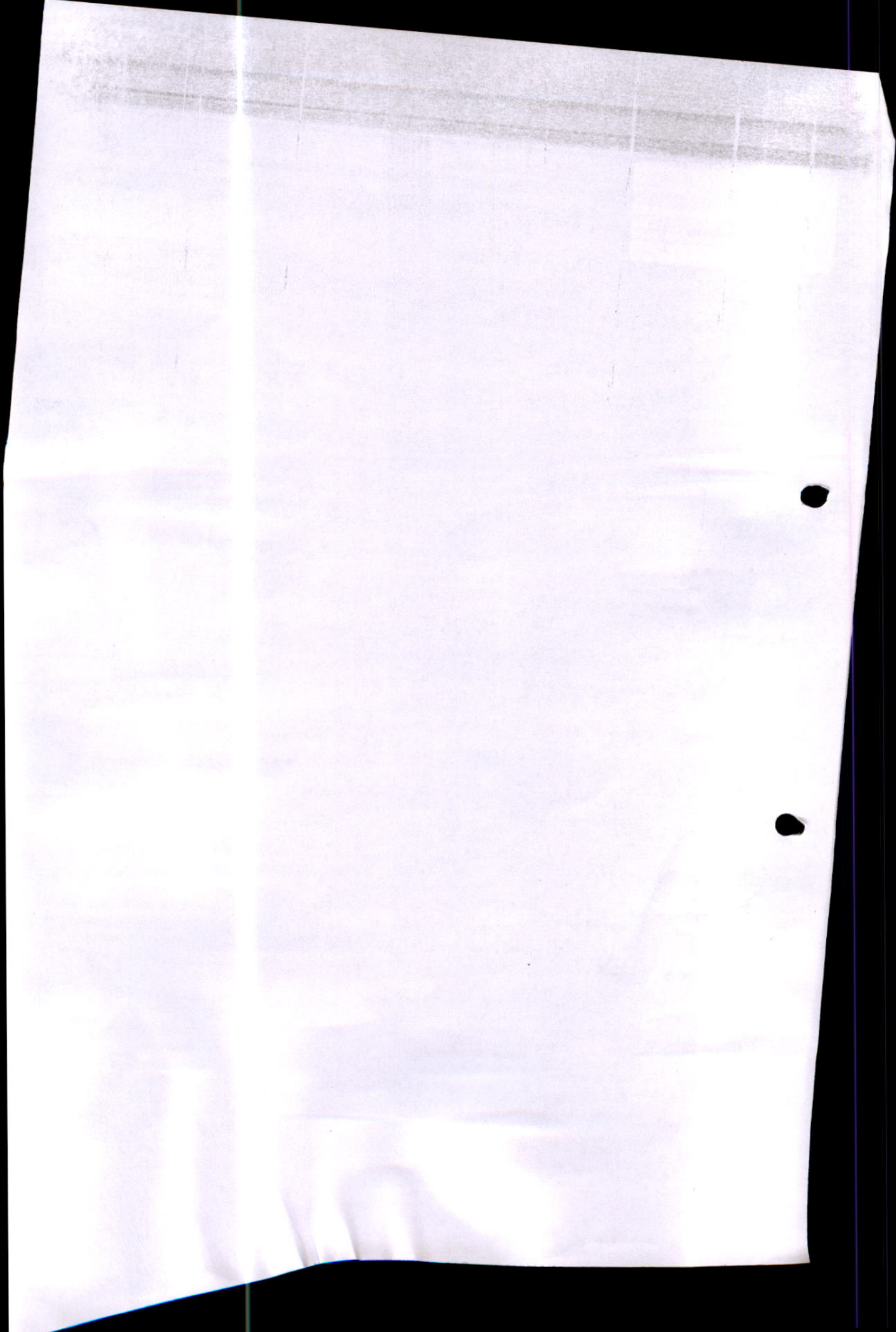
- Patients should be immediately isolated in a negative pressure room or a single room (as appropriate) for pending evaluation.
- The patient should be given a surgical mask immediately, if not already wearing one.
- Both patient and triage staff should perform hand hygiene.
- The staff should use PPE (as appropriate).

Name of Triage Nurse : Samuel

Date & Time : 13/6/26 @ 8:23AM

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

Signature of Triage Nurse : [Signature]



Patient Name : Baby. KUNDHANIKAA CHANDRA UHID : VIH-00194167 IPD : IP-00060333 Gender : Female
Age : 0 Y 10 M 21 D

VIH-00194167 IP-00060333
Baby KUNDHANIKAA CHANDRA
23-07-2025 0 Y 10 M 21 D (F)
Dr. PREETHAM KUMAR



NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 13/6/26 Time of arrival : 8:24 AM
Chief Complaints : Fever x 3 days, seizure x today (episode) RBS: —
Height : — Weight : 9.1 kg 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 : 8:26 AM

Patient Name : Baby. KUNDHANIKAA CHANDRA UHID : VIH-00194167 IPD : IP-00060333 Gender : Female
 Age : 0 Y 10 M 21 D

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

Time	Nursing Notes
8:20AM	* Pt Came to ER
8:21AM	* vitals checked and Recorded
8:25AM	* ER Doctor seen the pt & advised admission
10:38AM	* Admission Done
10:58AM	* Iv Placement Done
11:05AM	* Samples Collected & sent to lab
	* Pt shifted to ward

Samples collected by: Dr. Samuel
 Samples sent by: Dr. Jyothi

Time: 10:58AM
 Time: 11:05AM

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1
8:40 AM	Neomol Suppository	P/R	140mg	<u>[Signature]</u>	<u>[Signature]</u>

Condition of patient at time of shift - out :	Details of Shift - out
HR: <u>126/12</u> BP: <u>Cying</u> CFT: <u>23sec</u> RR: <u>28/12</u> SPO ₂ : <u>99%</u> GCS: <u>4.5.6</u> Temperature: <u>99°F</u> Pain Score: <u>0</u> Repeat RBS (if applicable):	Shift - out from ER to: <u>102</u> Time of Shift - out: <u>13/6/26 @ 12:05pm</u> Handover given to: <u>Dr. Veronica</u> (Nurse's Name)

Tick as applicable: MLC LAMA BROUGHT DEAD

Procedures done with details (if any): Iv Placement

Name of the Nurse: Sri. Vaishnavi

Signature of the Nurse: [Signature]

Date & Time: 13/6/26 @ 12:05pm



Nursing General Admission Assessment Form For Pediatrics

Diagnosis: *Simple febrile seizures*
Arrival Time: *12:05pm* **Mode of Arrival:** *By Mother* **Admitting From:** ER OPD Direct

Allergy / Adverse Reaction: *nil* **Body Weight:** *9.1* Kg
Height: cm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
<i>nil</i>	<i>nil</i>	<i>nil</i>

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: *9.1* Length: Head Circumference (< 2 years):

Temp.: *98.6 f* HR: *110 bpm* RR: *30* BP: *90/49 (ST)*

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) *20* (Document in the Braden Q Assessment Sheet)

Pain Screening: Yes No **Pain Score:** *0* **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: Nil (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, father

Nurse's Name: Bevonika Date: 13/6/26 Time: 12:30pm Signature *Bevonika*

PATIENT TRANSFER FORM

Patient Name & UHID No. VIH-00194167 IP-00060333 Baby KUNDHANIKAA CHANDRA 23-07-2025 0 Y 10 M 21 D (F) Dr. PREETHAM KUMAR 		Date & Time of Admission 13/6/26 @ 10:38AM	Date & Time of Transfer Order 13/6/26 @ 12:05pm
		Transfer Ordered by Dr. Vishwaja	Reason for Transfer Admission
From Unit ER	To Unit 102	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File 28	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? Optilegi vent to attendant E.A.	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
Name & Signature of Person who is Transferring Vaishnavi Vaishnavi		Name of Person Ordered Transfer Dr. Vishwaja	
Patient & Clinical Records Received by : Dr. Bevanika			
Date & Time of Patient Received : 13/6/26 @ 12 pm			

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-00194167 IP-00060333

Baby KUNDHANKAA CHANDRA

23-07-2025 0 Y 10 M 21 D (F)

Dr. PREETHAM KUMAR

UHID ID: _____



Department: _____

Consultant: _____



Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs)) 9.11kg (Centile _____)

On Examination :

Temperature : 103.6°F Pulse Rate : 170/min B.P. crystng SPO2 97%

Resp. rate and type of breathing : 80/min

Rash ⊖

Lymphadenopathy ⊖

Oedema : ⊖

Allergies (if any): ⊖

Respiratory System :

Inspection (any s/o distress) : R/E symmetrical chest movement

Air entry & breath sounds : BLAB ⊕

Any addes sounds : NO

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

Cardiovascular System :

Inspection of procordium : ⊖

Heart Sounds : S1S2 ⊕

Any murmur : NO

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

Per Abdomen :

Inspection ⊖

Palpation : soft

Ausculation : RS ⊕

Spine : ⊖ External Genitalia : _____

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



Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score :

Awake 15/15

Cranial Nerves :

Intact

Motor System:

Nutriton :

Tone :

Co-ordinator :

Posture :

Involuntary Movements :

(N)

Power

4/5 in all limbs

NO

Reflexes : +

DTR +2

Superficials: +

Plantars

flexor

Sensory System : +

Bladder / Bowel :

NO incontinence

Clinical Summary & Diagnostic:

Simple febrile seizure (1st episode)



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: to prevent further complications.

Desired goals of the treatment: to treat current condition

Planned Labs:

CBp ✓
CRP ✓ B/E ✓
S/E, S.creat ✓
S.co⁺² ✓
S.ng⁺² ✓

cut-down on oed haem
(12/6/25)

Planned Management

1) Proglucide
2) Piv ceftazone
3) Inj enoximazole
4) Neuroprotection
5) Monitor vitals
Enform rx

made by sound
13/6/26 @ 11:30AM

Signature of the Doctor: [Signature]

Name of the Doctor: Dr. Uthwaja

Date & Time: 13/6/26

Signature of the Consultant: [Signature]

Name of the Consultant: [Signature]

Date & Time: 13/6/26 4pm



**Rainbow[®]
Children's
Hospital**

It takes a lot to treat the little.

**PEDIATRIC IN-PATIENT
MEDICAL RECORD**

Patient Name: _____

VIH-00194167 IP-00060333
Baby KUNDHANIKA CHANDRA
23-07-2025 0 Y 10 M 21 D (F)
Dr. PREETHAM KUMAR

UHID ID: _____



Department: _____

Consultant: _____



Pediatric Multiorgan History & Physical Examination

Name : Kundhanika Age/Sex 10M

Information given by: Mother Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

no fever since 4 days.
no vomitings (+), no cold (+).
1 episode of seizure activity today

History of present illness :

child was apparently healthy 1 week back
then developed cold - Runny nose.

now settled

urine (+)

stool (+)

no fever since 4 days

moderate to high grade

insidious onset

gradually progressive.

Relieving on medications.

no vomitings - 2 episodes/day

NP/NB/NO Blood stained

content - milk/water.

→ on syp
24 hrs for
1 day

1 episode of seizure activity - today @ 8 AM

Tonic movements of limbs

deviation of mouth.

drooling of saliva.

lasted for 5 min

followed by drowsiness for 10 min



Pediatric Multiorgan History & Physical Examination

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

Non significant

CVE (12/6/20)

protein +

pus cells 3-5/HPF

eps cells 3-4/HPF

Birth & Neonatal History:

Term / CSCE-water / 2.9kg / NO NICU stay
broke



Birth & Socio Economic History:

About Father : _____

About Mother : _____

Any additional Information : _____

} class III

Developmental History :

Appropriate for age in all domains

Immunization History :

Received vaccination upto date



Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs)) 9.1kg (Centile _____)

On Examination :

Temperature : 103.6°F Pulse Rate : 170/min B.P. crystg SPO2 97%

Resp.rate and type of breathing : 80/min

Rash ⊖

Lymphadenopathy ⊖

Oedema : ⊖

Allergies (if any): ⊖

Respiratory System :

Inspection (any s/o distress) : R/E symmetrical chest movement

Air entry & breath sounds : BLAB ⊕

Any addes sounds : NO

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

Cardiovascular System :

Inspection of procordium : ⊖

Heart Sounds : S1S2 ⊕

Any murmur : NO

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

Per Abdomen :

Inspection ⊖

Palpation : soft

Ausculation : RS ⊕

Spine : ⊖ External Genitalia : _____

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



Pediatric Multiorgan History & Physical Examination

Central Nervous System :

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

Cranial Nerves : Intact

Motor System:

Nutriton : _____

Tone : _____ Power 4/5 in all limbs

Co-ordinator : _____

Posture : _____

Involuntary Movements : NO

Reflexes : +

DTR +2

Superficials: +

Plantars flexor

Sensory System : +

Bladder / Bowel : NO Incontinence

Clinical Summary & Diagnostic:

Simple febrile seizure (1st episode)



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: to prevent further complications,

Desired goals of the treatment: to treat current condition

Planned Labs:

- CBP ✓
- CRP ✓ 12/6/26
- St/E, S.creat ✓
- S.co⁺ ✓
- S.mg⁺ ✓

cut-down on oral harm
(12/6/26)

Planned Management

- 1) Profenids
- 2) Pnj ceftazone
- 3) Pnj enoxapone
- 4) Neuro pnone
- 5) Monitor vital

enform no

marked by Dr. [Signature]
13/6/26 @ 11:30 AM

Signature of the Doctor: [Signature]
Name of the Doctor: Dr. Uchwaga
Date & Time: 13/6/26

Signature of the Consultant: [Signature]
Name of the Consultant: [Signature]
Date & Time: 13/6/26 4 PM



①

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	<u>C/S/B Resident</u>	
<p>13/6/26 3:30pm</p>	<p>Δfis: General <u>White rashes</u>. ? <u>local rashes</u> No fevers/piles.</p>	
	<u>O/E</u>	
	<p>Child Alert & Active. Vital Stable CU: S12 ⊕ M: B/LAEE ⊕ P/A: Holt CU: NAP.</p>	
		<u>Plan</u>
		<p>- Inj. Levofloxacin-D1</p>
		<p>- Inj. Chlorpromazine.</p>
		<p>- Trace EEG Report ↓ discuss Dr. Nikesh.</p>
		<p>- Inj. Levocetastam (12th day) Lungs: (Pulmonary)</p>
		<p>- <u>End care.</u></p>

13/6/26
 4pm
 Dr. Preetham

Noted by
 Beenuka
 13/6/26
 @ 8pm



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
14/6/25 8:20AM	<p><u>S/B Resident</u></p> <p>Adm - febrile seizures? focal seizures.</p>	
	<p>3 fever spikes - yesterday</p> <p>Oral intake - fluids.</p> <p>U/O - adequate.</p> <p>off</p>	
	<p>cloud acetone</p>	
	<p>Euthymic</p>	
	<p>Vitals stable</p>	
	<p>CVS - S1S2 (+)</p>	
	<p>R/L - RAE (+)</p>	
	<p>I/A - soft</p>	
		<p>Plan</p>
		<p>1) Pnj ceftriaxone</p>
		<p>2) Pnj Levetiracetam</p>
		<p>3) Monitor vitals inform us</p>
		<p>4) Trace r/c/s.</p>
		<p>5) Add probiotics</p>

6
 Dr. Preetham
 14/6/25
 3:30pm
 Dr. Anshu

Noted by
 Bezonika
 14/6
 @ 2pm



...GRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	<u>S/S Resident</u>	
<u>14/6/26</u> 5 PM	febrile seizures ? o/e claudicat Autismic Vitals - stable CVR-SIS2 (+) R/E - RAE (+) PLA - nft	focal seizures. 2 fever spikes - 100F accepting milk well u/o - (a) stool (N).
		<u>Plan</u>
		1) Report critical T/m Extre plan - (a).
		2) Trace B/c/s
		3) monitor vitals infirmos
		<u>Dr. Vishwanath</u>
	Noted by Subham 14/6/26 @ 7:30P	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	<u>1/13 Resident</u>	
14/6/25 8 AM	<p>Febrie seizures? focal seizures, 3 fever spikes - in last 24 hours - 100°F</p> <p><u>OT</u> child alert Antlermer vitals stable CXR - S/S (+) EKG - RAE (+) PLA - soft @</p>	<p>afebrite > 10hr. oral intake - better urine (N) Stool: 7-8 episodes - <u>semisolid</u> diaper rash (0)</p>
		<p style="text-align: center;"><u>plan</u></p> <ol style="list-style-type: none"> 1) Trace reports - R/E/S. 2) Pxy ceftriaxone 3) Pxy lesteracetem → 4) Antlermerene <p style="text-align: right;">changed to syr. leupet.</p>
<p style="text-align: center;">15/6/25 Dr. Preetham</p>	<p>Dr. Preetham</p>	<p style="text-align: center;">- New consultation - Today</p>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16/6/25 9:00 AM	<p style="text-align: center;"><u>C/S/B Resident</u></p> <p>Dis: Admissions & local issues.</p>	
	<p style="text-align: center;">No foreigner > 2 hrs.</p>	
<p>2) IBHU</p>	<p style="text-align: center;"><u>O/S</u></p>	
<p>4) O Admit.</p>	<p>Check Alert & Active vital signs.</p>	
<p>B) dx + NO growth apex.</p>	<p>CM: 112 @ RA: BLA @ PA: 100 CU: 0 AD.</p>	<p style="text-align: center;"><u>Plan</u></p>
<p><i>Practitioner</i></p>		<p>- Tig-ciprofloxacin → D4</p>
		<p>- Symp. Oxetamir → D2</p>
<p><i>15/6/25</i> <i>Practitioner</i></p>		<p>- Continue Levofloxacin 1ml-10-10mg for 2 weeks</p> <p>- Hu i Drexidone after 2 weeks →</p> <p><u>PC today.</u></p> <p>- <u>Oral Ab</u></p>

noted by Dr. P. K. P. K.
10/10/25



NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: <i>Simple febrile seizures (1st episode)</i>	Any Infection: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify: <i>Nil</i>					
	Surgery / Procedure: <i>-</i>	Post OP Day: <i>-</i>					
BACKGROUND	Date	<i>13/6/26</i>	<i>13/6</i>	<i>13/6</i>	<i>13/6</i>	<i>14/6/26</i>	
	Shift	<i>M</i>	<i>M</i>	<i>E</i>	<i>N</i>	<i>M</i>	
	Medical Condition (Any special condition to be noted):	<i>-</i>	<i>Nil</i>	<i>Nil</i>	<i>Nil</i>	<i>Nil</i>	
	Diet:	<i>DBM</i>	<i>DBM+FF</i>	<i>FF</i>	<i>FF</i>	<i>FF</i>	
ASSESSMENT	Allergy:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Ventilation (RA, NP, NIV, VENTI):	<i>RA</i>	<i>RA</i>	<i>RA</i>	<i>RA</i>	<i>RA</i>	
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Vital Signs:	Temp:	<i>99°F</i>	<i>98.6°F</i>	<i>98.6°F</i>	<i>98.1°F</i>	<i>98.8°F</i>
		Res:	<i>28b/m</i>	<i>20b/m</i>	<i>20b/m</i>	<i>27b/m</i>	<i>25b/m</i>
	SpO ₂ :	<i>99%</i>	<i>99%</i>	<i>98%</i>	<i>97%</i>	<i>98%</i>	
	Pulse:	<i>126b/m</i>	<i>110b/m</i>	<i>122b/m</i>	<i>105b/m</i>	<i>114b/m</i>	
	BP:	<i>Ceeping</i>		<i>92/48(58)</i>	<i>95(60)</i>		
	LOC:	<i>conscious</i>	<i>conscious</i>	<i>conscious</i>	<i>conscious</i>	<i>conscious</i>	
	Fall Risk Score:	<i>11</i>	<i>11</i>	<i>11</i>	<i>11</i>	<i>11</i>	
Pain Score:	<i>0</i>	<i>0</i>	<i>0</i>	<i>0</i>	<i>0</i>		
Skin Integrity	<i>Intact</i>	<i>Intact</i>	<i>Intact</i>	<i>Intact</i>	<i>Intact</i>		
Recommendations	Safety Needs:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	Physiotherapy:	<i>-</i>	<i>Nil</i>	<i>Nil</i>	<i>Nil</i>	<i>Nil</i>	
	Others Specify:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Special Diet:	<i>DBM</i>	<i>DBM+FF</i>	<i>DBM</i>	<i>FF</i>	<i>FF</i>	
	Critical Lab Test / Values:	<i>-</i>	<i>Nil</i>	<i>Nil</i>	<i>Nil</i>	<i>Nil</i>	
	Other Special Orders / Medications:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	ADL (Dependent / Non Dependent):	<i>dependent</i>	<i>dependent</i>	<i>dependent</i>	<i>dependent</i>	<i>dependent</i>	
Post Operative Procedure Special Orders:	<i>-</i>	<i>Nil</i>	<i>Nil</i>	<i>Nil</i>	<i>Nil</i>		
Handed Over By Name :	<i>Vaishnavi Beemonika</i>	<i>Beemonika</i>	<i>Manasa</i>	<i>Beemonika</i>	<i>Subham</i>		
Signature / ID :	<i>(Signature) 201827</i>	<i>(Signature) 201827</i>	<i>(Signature) 201827</i>	<i>(Signature) 201827</i>	<i>(Signature) 201827</i>		
Date:	<i>13/6/26</i>	<i>13/6/26</i>	<i>13/6/26</i>	<i>14/6/26</i>	<i>14/6/26</i>		
Time:	<i>@ 12:05pm</i>	<i>@ 2pm</i>	<i>@ 8pm</i>	<i>@ 8am</i>	<i>@ 2pm</i>		
Taken Over By Name :	<i>Beemonika</i>	<i>Beemonika</i>	<i>Manasa</i>	<i>Beemonika</i>	<i>Subham</i>		
Signature / ID :	<i>(Signature) 13/6/26</i>	<i>(Signature) 201827</i>	<i>(Signature) 201827</i>	<i>(Signature) 201827</i>	<i>(Signature) 201827</i>		
Date:	<i>@ 201827</i>	<i>13/6/26</i>	<i>13/6/26</i>	<i>14/6/26</i>	<i>14/6/26</i>		
Time:	<i>@ 12:05pm</i>	<i>@ 2pm</i>	<i>@ 8pm</i>	<i>@ 8am</i>	<i>@ 2pm</i>		



NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: <i>febrile seizure</i>	Any Infection: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify: <i>Nil</i>					
	Surgery / Procedure: <i>nil</i>	Post OP Day: <i>Nil</i>					
BACKGROUND	Date	<i>14/6</i>	<i>15/6</i>	<i>15/6</i>	<i>15/06</i>	<i>16/6</i>	
	Shift	<i>N</i>	<i>M</i>	<i>E</i>	<i>N</i>	<i>M</i>	
	Medical Condition (Any special condition to be noted):	<i>Nil</i>	<i>nil</i>	<i>nil</i>	<i>Nil</i>	<i>nil</i>	
	Diet:	<i>FF</i>	<i>FF+DBF</i>	<i>FF+DBF</i>	<i>FF+DBF</i>	<i>FF+DBF</i>	
ASSESSMENT	Allergy:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Ventilation (RA, NP, NIV, VENTI):	<i>RA</i>	<i>RA</i>	<i>RR</i>	<i>R.A</i>	<i>RR</i>	
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Vital Signs:	Temp:	<i>98.1°F</i>	<i>98.6°</i>	<i>99.4°F</i>	<i>98.6°F</i>	<i>98.6°</i>
		Res:	<i>26 blm</i>	<i>22 blm</i>	<i>30 blm</i>	<i>28 blm</i>	<i>22 blm</i>
	SpO ₂ :	<i>98%</i>	<i>98%</i>	<i>100%</i>	<i>98%</i>	<i>98%</i>	
	Pulse:	<i>107 blm</i>	<i>118 blm</i>	<i>122 blm</i>	<i>132 blm</i>	<i>128 blm</i>	
	BP:	<i>100/60/70</i>	<i>98/60/40</i>	<i>92/55/64</i>	<i>90/64/99</i>	<i>90/60/40</i>	
	LOC:	<i>conscious</i>	<i>conscious</i>	<i>conscious</i>	<i>conscious</i>	<i>conscious</i>	
	Fall Risk Score:	<i>14</i>	<i>14</i>	<i>14</i>	<i>12</i>	<i>12</i>	
Pain Score:	<i>0</i>	<i>0</i>	<i>0</i>	<i>0</i>	<i>0</i>		
Skin Integrity	<i>intact</i>	<i>Intact</i>	<i>Intact</i>	<i>Intact</i>	<i>Intact</i>		
Recommendations	Safety Needs:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Physiotherapy:	<i>nil</i>	<i>nil</i>	<i>nil</i>	<i>nil</i>	<i>nil</i>	
	Others Specify:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Special Diet:	<i>ff</i>	<i>ff+DBF</i>	<i>ff+DBF</i>	<i>FF+DBF</i>	<i>ff+DBF</i>	
	Critical Lab Test / Values:	<i>nil</i>	<i>nil</i>	<i>nil</i>	<i>nil</i>	<i>nil</i>	
	Other Special Orders / Medications:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	PU Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	DVT Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
ADL (Dependent / Non Dependent):	<i>Dependent</i>	<i>depend</i>	<i>depend</i>	<i>Dependent</i>	<i>depend</i>		
Post Operative Procedure Special Orders:	<i>nil</i>	<i>nil</i>	<i>nil</i>	<i>nil</i>	<i>nil</i>		
Handed Over By Name :	<i>Manasa</i>	<i>Prade</i>	<i>Subham</i>	<i>Sahya</i>	<i>Prade</i>		
Signature / ID :	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>		
Date:	<i>15/6/26</i>	<i>15/6/26</i>	<i>15/6/26</i>	<i>16/06</i>	<i>16/6/26</i>		
Time:	<i>08am</i>	<i>02pm</i>	<i>08pm</i>	<i>8am</i>	<i>08am</i>		
Taken Over By Name :	<i>Prade</i>	<i>Subham</i>	<i>Sahya</i>	<i>Prade</i>	<i>Prade</i>		
Signature / ID :	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>		
Date:	<i>15/6/26</i>	<i>15/6/26</i>	<i>15/06</i>	<i>16/6/26</i>	<i>16/6/26</i>		
Time:	<i>08am</i>	<i>02pm</i>	<i>8pm</i>	<i>08am</i>	<i>08am</i>		

Noted by Prade
16/6/26



NURSING CARE RECORD



Date: 13/6/25

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	1pm	→ maintain good nutritional status		→ To oral Intake is good	→ provided Dsm + FF every 2-3 hrs	Patient is stable	Beonika 1316 @ 2pm
Afternoon	4pm	→ maintain fluid balance		→ Administered IV fluid Dns 25ml/hr	maintain Hydration	Patient is stable	Beonika 1316 @ 8pm
	6pm	→ Ensure safety		→ side rails kept up	→ prevent from fall risk	1 fever spike	
Night	9 pm	→ IV fluids on flow	9:30 pm	→ Dns 25ml/hr is maintained	→ to maintain hydration	→ patient is stable	Manasa



NURSING CARE RECORD

Date: 12/6/25

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	11 Am	→ Maintain Fluid Balance		→ Administered IV fluid DMS 24 ml/hr	Maintain Hydration	Patient is stable	Beonika 14/6 @ 2pm
	1pm	→ Ensure Safety		→ Side rails kept up	→ Prevent falls fall risk		
Afternoon	3pm	→ maintain good nutritional status		→ Provided by soft diet	→ oral intake is good	→ Patient is stable	Subhr 14/6 @ 8pm
Night	10 pm	→ Ensure Safety	10:30 pm	→ Side rails kept up	→ prevent from fall risk	→ patient is stable	Q Nurse



NURSING CARE RECORD

Date: 15/6/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	9:00	maintain aseptic technique	9:30	maintained aseptic technique	- prevent from Infection	- patient is stable	Indee @ 2pm 15/6/26
	1:00	- ensure safety	1:30	Side rails kept up	- prevent from falls risk	- no fresh complaints	
Afternoon	3:00	provide comfortable position	3:30	provided comfortable position	- to reduce discomfort	- patient is stable	Subham @ 8pm 15/6/26
	7:00	Maintain fluid Balance	7:30	maintained fluid Balance	- Maintain Hydration	- no fresh Complaints	
Night	9pm	- ensure safety	9:30 pm	- Provided side rails & safety device	- prevent from fall risk	- no fresh complaints	Sudhija @ 8AM 16/6/26
	10	- maintain fluid balance	10:30 pm	- Cont. IV fluids DRB @ 24 ml/hr.	- maintain hydration	- Pt is stable.	

VIH-00194167 IP-00060333
 Baby KUNDHANIKAA CHANDRA
 23-07-2025 0 Y 10 M 23 D (F)
 Dr. PREETHAM KUMAR



NURSING CARE RECORD



Date: 16/6/25

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning		Discharge notes & advice for discharge.		no come for rounds	patient is stable.		
Afternoon							
Night							

Noted by Roh

010A
16/6/25



THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
			13/6	13/6	13/6	13/6	14/6
Age	Less than 3 years old	4	4	4	4	4	4
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2					
	Female	1	1	1	1	1	1
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1	1	1	1
Cognitive Impairments	Not aware of Limitations	3		3	3	3	3
	Forget Limitations	2					
	Oriented to own ability	1					
	History of Falls or Infant-Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2	2	2	2	2
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours/ None	1	1	1	1	1	1
Medication Usage	Sedatives (Excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
Other Medications / None	1	1	1	1	1	1	
Total			10	13	13	13	13

Intervention:

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position	✓	✓	✓	✓	✓
Call device within reach	X	✓	✓	✓	✓
Wheels Locked	✓	✓	✓	✓	✓
Room free of clutter	✓	✓	✓	✓	✓
Adequate lighting	✓	✓	✓	✓	✓
Wheel chair supplied	✓	X	X	X	X
Other Intervention(s) Specify		✓	✓	✓	✓
Nurse's Name:	Cyona	Bevika	Brij	Manoj	Bevika
Signature:	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date:	13/6	13/6	13/6	13/6	14/6
Time:	11am	2pm	8pm	11pm	2pm



THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
			14/6	15/6	15/6	15/6	15/6
Age	Less than 3 years old	4	4	4	4	4	4
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2					
	Female	1	1	1	1	1	1
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1	1	1	1
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2	2	2	2	2	2
	Oriented to own ability	1					
	History of Falls or Infant-Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2	2	2	2	2
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours/ None	1	1	1	1	1	1
Medication Usage	Sedatives (Excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
Other Medications / None	1	1	1	1	1	1	
Total			12	12	12	12	12

Intervention:

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		✓	✓	✓	✓	✓
Call device within reach		x	✓	✓	✓	✓
Wheels Locked		✓	✓	✓	✓	✓
Room free of clutter		✓	✓	✓	✓	✓
Adequate lighting		✓	✓	✓	✓	✓
Wheel chair up		x	x	✓	x	✓
Other Intervention(s) Specify		✓	✓	✓	✓	✓
Nurse's Name:		Subh	Manish	Prade	Prade	Prade
Signature:		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date:		14/6	15/6	15/6	15/6	15/6
Time:		7pm	11am	9am	4pm	10pm

VIH-00194167 IP-00060333
 Baby KUNDHANKAA CHANDRA (F)
 23-07-2025 0 Y 10 M 23 D
 Dr. PREETHAM KUMAR

THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	16/6				
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2					
	Female	1	1				
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1				
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2	2				
	Oriented to own ability	1					
	History of Falls or Infant-Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2				
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	1				
Medication Usage	Sedatives (Excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
Other Medications / None	1	1					
Total			12				

Intervention:

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		5				
Call device within reach		5				
Wheels Locked		5				
Room free of clutter		5				
Adequate lighting		5				
Wheel chair up		4				
Other Intervention(s) Specify						
Nurse's Name:		Indu				
Signature:						
Date:		16/6				
Time:		9AM				

Noted by
 Indu
 16/6/26
 10:30 AM

GENERAL CONSENT FOR TREATMENT

Patient Name: Baby KUNDHANIKAA CHANDRA Age : 0 Y 10 M 21 D
IP No: IP-00060333 Sex: Female
Consultant: Dr. PREETHAM KUMAR Ward/Bed No: N 0 GF-EMERGENCY/ER 101

The undersigned patient and I or responsible relative or person hereby consent to and authorize Rainbow Hospitals doctors and medical personnel to perform medical examinations, conduct routine investigations and administer medical treatments, outpatient procedures, minor dressings, vaccinations and immunizations during the course of the patient's care, as in patient.

Patient, be deemed advisable or necessary.

I understand that the confidentiality of all medical records shall be protected to the full extent of the Law. The undersigned also consent to the use of health related information/ audiovisuals of the patient for research & training purpose or for insurance coverage and while doing so confidentiality of the patient will be maintained at all times and this will not affect the care of the patient.


In giving my general consent to treatment, I understand that I retain the right to refuse any particular examinations, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by treating doctors. I also understand that the practice of medicine is not an exact science and that no guarantee have been made to me as the results of my evaluation and I or treatment.

I understand that I shall not bring valuables to the Hospitals and that the Hospital will not be responsible for the loss, destruction or theft of my personal belongings. I assume full responsibility for all my personal items and release the Hospital from responsibility and liability for such personal items and valuables.

"I am aware that during the patient care it is inevitable that certain re-useable equipment shall be re-used after sterilization and disinfection. I am informed that the hospital assures maximum level of precaution and care in sterilizing and disinfecting the equipment and monitors the whole process as per evidence based guidelines".

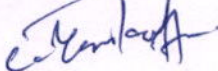
Note:

- 1 We do not allow use of medication brought from outside by the patient.
- 2 I have received attendant passes as per my room category. I understand that I have to return it back at the time of final bill clearance. In case of failing the submission, I will pay 200/- Rs.

(receivers Signature:.....) 

- 3 IP Guide book has been given to me and I have been explained about the Hospitals rules and policies.

- 4 Financial and billing counseling has been done to me.


Signature of Patient/Relative: 

Name: Manikantan

Relationship: Father

Date: 13/6/26

Witness Name:

Witness Signature: 

Patient Address:

H NO 177, SAINIKPURI SEC-BAD
Sainikpuri Hyderabad Telangana
INDIA 500094

Time: 10:38 AM

CONSULTATION FORM



VIH-00194167 IP-00060333
Baby KUNDHANIKAA CHANDRA
23-07-2025 0 Y 10 M 23 D (F)
Dr. PREETHAM KUMAR

Doctor Name :

Date :



Hospital :

Rainbow

Referred for : Opinion Co-Management

Transfer of care

Type of Referral : Emergency (within one hr.)

Urgent (within 6 hrs.) Non Urgent (within 24 hrs.)

Date : *15/6/26* Time : *11:30am* By :

Reason for Consultant : If for concurrent care specify the particular need, especially in the absence of a second diagnosis:

Signature: _____

M.D. _____

Report of Findings and Recommendations :

fever continued - mild fever

no irritability

no vomiting

no further seizures

(O/E)

vitals - (N)

conscious, active, eating well

Exam - full

(H) BNC

good all movements

DR - +2

Abuse - fever

Consultant :

Name : *Dr. P. Sindhuja*

Signature : *Sm*

Date & Time : *15/6/26 @ 11:00am*

NOTE : If more space is required use another consultation sheet as continuation

Plan

→ SOS Neuroimaging tomorrow if
Praxi spaces projects

CONSULTATION FORM



VIH-00164167 IP-00060333
Baby KUNDHANIKAA CHANDRA
23-07-2025 0 Y 10 M 21 D (F)
Dr. PREETHAM KUMAR

Doctor Name :

Date :



Hospital : Rainbow

Referred for : Opinion Co-Management
 Transfer of care

Type of Referral : Emergency (within one hr.)
 Urgent (within 6 hrs.) Non Urgent (within 24 hrs.)

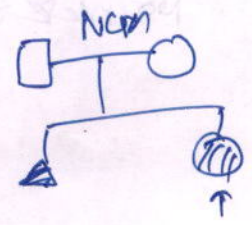
Date : 13/6/26 Time : By :

Reason for Consultant : If for concurrent care specify the particular need, especially in the absence of a second diagnosis:

Signature: _____ M.D.

Report of Findings and Recommendations :

- fever x 3 days
- T/D morning @ 7:30 AM
high fever (103F), 1 episode of vomiting
Abx unresponsive with
left UCL & LL clonus with eye strabismic
left deviation of angle of mouth
episode lasted for ~8 min
Abx post total clonus for 10-15 min



Brain for - FT / LSCS / 2.9kg / CSAB / No perinatal BSN

No family hx of epilepsy

Development - appropriate for age

Consultant :

Name : Dr. P. Sindhu Signature : P. Sm Date & Time : 13/6/26

NOTE : If more space is required use another consultation sheet as continuation



①

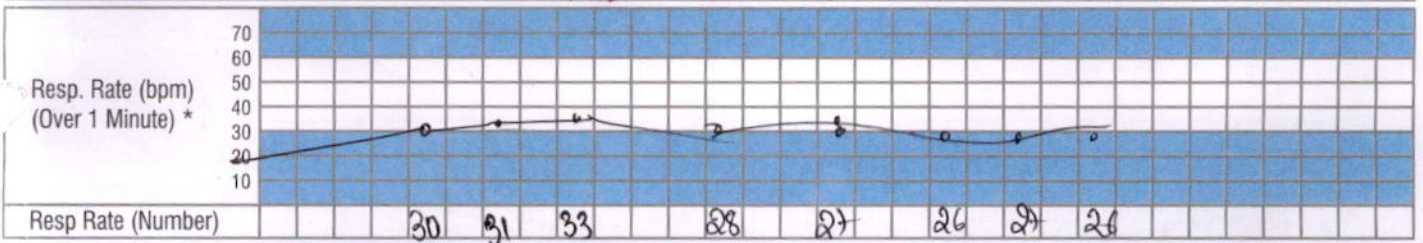
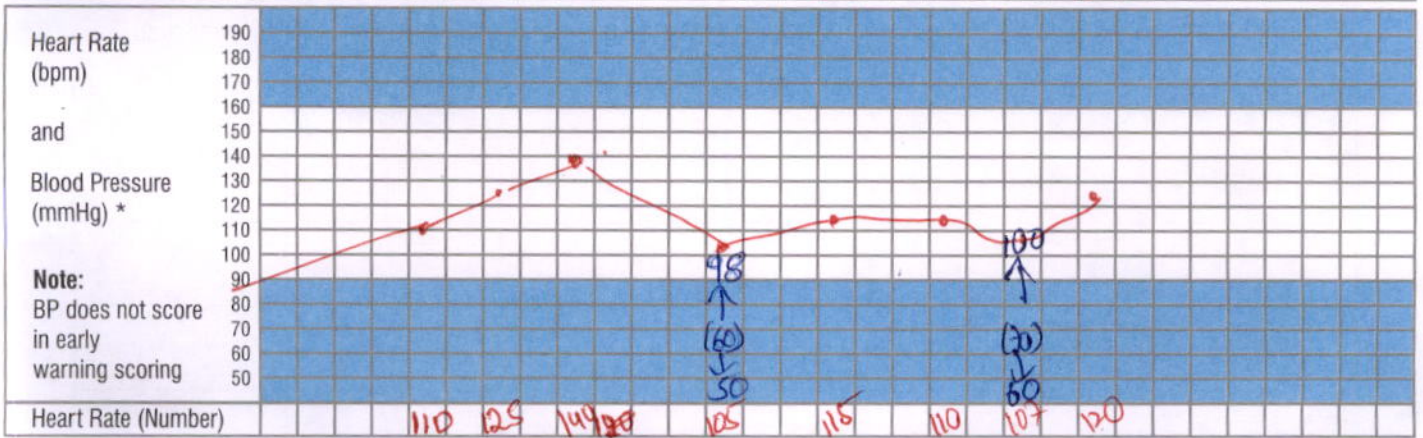
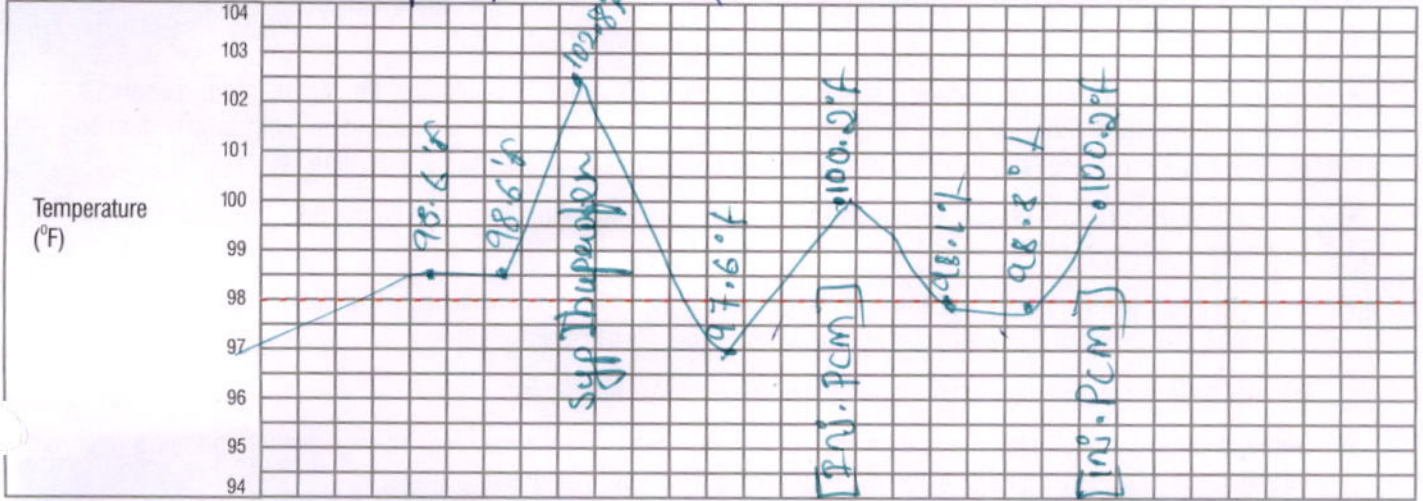
INFANT (<1 year)
Children's Observation & Early Warning Scoring Chart



EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 13/6..... Time: 1 3 5:30 9 12:45 3 5 7

Doctor/Nurse/Family Concern? pm pm pm Am Am am am Am



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

TOTAL SCORE								
Number of shaded boxes	0	0	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0	0	0
Observer's Initials	B	B	B	ma	ma	ma	ma	ma

- 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: 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

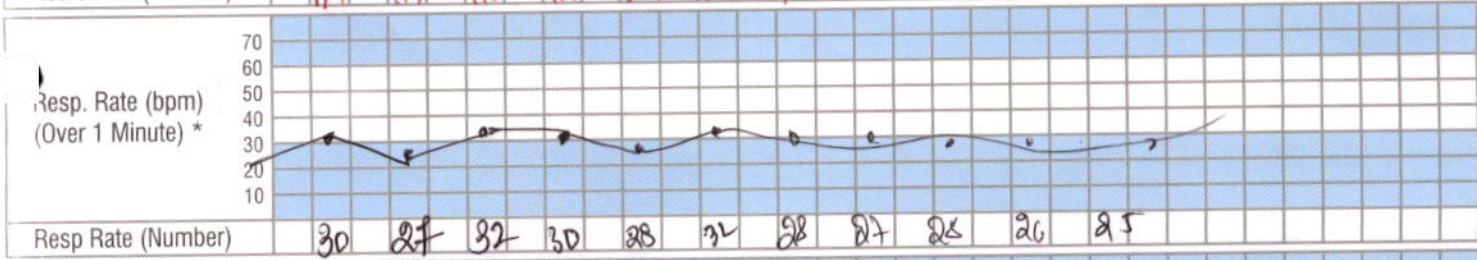
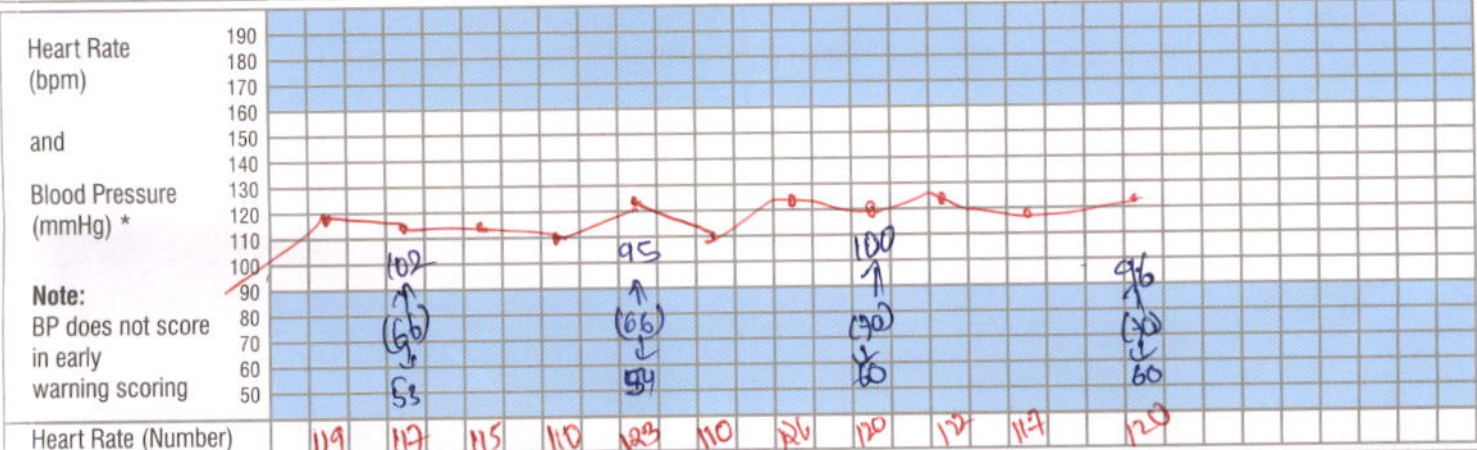
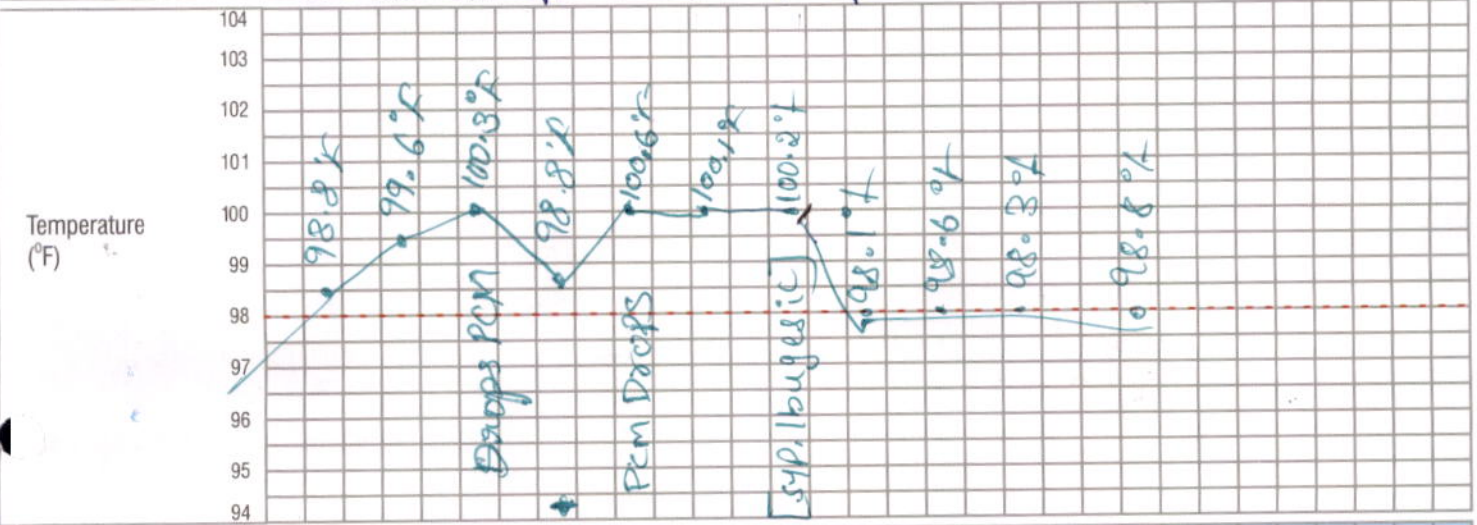
- If at any time additional help is required, call help – regardless of the Early Warning Score!
- Following a Early Warning Score assessment, senior help may be required

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.

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)

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: <u>14/6</u> Time: <u>9</u> <u>11</u> <u>12:10</u> <u>2</u> <u>5:10</u> <u>7:05</u> <u>8:20</u> <u>11</u> <u>1</u> <u>3</u> <u>3</u>
Doctor/Nurse/Family Concern? <u>am</u> <u>am</u> <u>pm</u> <u>pm</u> <u>pm</u> <u>pm</u> <u>pm</u> <u>pm</u> <u>am</u> <u>am</u> <u>am</u>



Resp Mod/ Severe Distress None / Mild	N	N	N	N	N	N	N	N	N	N	N
Receiving O ₂ (l/min)											
O ₂ Saturations (%)	99	100	100	98	96	100	97	98	99	98	98
Conscious Level Normal / Altered	N	N	N	N	N	N	N	N	N	N	N
GCS *	15	15	15	15	15	15	15	15	15	15	15
TOTAL SCORE	0	0	0	0	1	0	0	0	0	0	0
Number of shaded boxes	0	0	0	0	1	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0	0	0	0	0	0
Observer's Initials	B	B	B	B	SK	SK	Me	Me	Me	Me	Me

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: 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.

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)



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



EARLY WARNING SCORE: CHILDREN'S UNIT

Date: Time: 9

Doctor/Nurse/Family Concern? *nm*

16/6/26

Temperature (°F)

104
103
102
101
100
99
98
97
96
95
94

** 98.6°F*

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

*Noted by
 nm 16/6/26
 @ 10:30 AM*

Heart Rate (Number) *163*

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

70
60
50
40
30
20
10

Resp Rate (Number) *27*

Resp Mod/ Severe Distress None / Mild *N*

Receiving O₂ (l/min) O₂ Saturations (%) *09*

Conscious Level Normal / Altered *N*

GCS * *15*

TOTAL SCORE

Number of shaded boxes *0*

Pain Score *0*

Observer's Initials *nm*

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 incharge and PICU /NICU fellow or PICU/NICU consultant to be informed
- ... requirement is >3 l/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.

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)

①

FLUID CHART

Sheet No. :

13/6/26

- 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			
13/6	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm		PF										
	Total Intake :						Total Output :						
13/6	02:00 pm												
	03:00 pm												
	04:00 pm			25ml									
	05:00 pm			24ml									
	06:00 pm									✓			
	07:00 pm			24ml									
Total Intake : 72 ml						Total Output :							
13/6	08:00 pm			2uml									
	09:00 pm		similac	2uml									
	10:00 pm			2uml						✓			
	11:00 pm			2uml									
	12:00 am		ceonid	2uml						✓			
	01:00 am		similac								✓		
Total Intake : 120ml						Total Output :							
14/6	02:00 am												
	03:00 am												
	04:00 am		similac										
	05:00 am									✓			
	06:00 am		similac										
	07:00 am												
Total Intake :						Total Output :							

Benavika
13/6
@ 2pm

Benavika
13/6
@ 7pm

manasa
14/6
@ 7AM

Total 24 hrs. Intake

Total 24 hrs. Output

16/6/26 → Attendee want to remove IV Canada

on 16/6/26 @ 11:00pm

Handwritten signature

FLUID CHART

Sheet No. : 2

13/6/26

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		
14/6/26	08:00 am											Benuita 14/6 @2pm
	09:00 am	FF							✓			
	10:00 am											
	11:00 am	FF	24ml				✓					
	12:00 pm			24ml								
	01:00 pm	FF	24ml							✓		
Total Intake :						Total Output :						
14/6	02:00 pm											Subhan 14/6 @8pm
	03:00 pm	similar	180ml						✓			
	04:00 pm			24ml								
	05:00 pm			24ml								
	06:00 pm	similar	180ml	24ml			✓			✓		
	07:00 pm						✓					
Total Intake :						Total Output :						
14/6	08:00 pm											manasa 14/6 7AM
	09:00 pm	180ml										
	10:00 pm	similar										
	11:00 pm			24ml						✓		
	12:00 am			24ml								
	01:00 am	similar	24ml									
Total Intake : 82ml						Total Output :						
15/6	02:00 am			24ml								
	03:00 am			24ml								
	04:00 am			24ml						✓		
	05:00 am			24ml								
	06:00 am			24ml								
	07:00 am			24ml								
Total Intake : 96ml						Total Output :						

Total 24 hrs. Intake 178 ml

Total 24 hrs. Output 6 times



FLUID CHART

Sheet No. : 2

15/06/20

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

		Intake				Output					IV Site Thrombophlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G								
15/6	08:00 am									✓	} 3rd yr	} 22pm	
	09:00 am	DBF											
	10:00 am												
	11:00 am	+											
	12:00 pm	FF					✓			✓			
	01:00 pm												
Total Intake :						Total Output :							
15/6	02:00 pm						✓				} subam	} @ 8pm	
	03:00 pm	DBM											
	04:00 pm	Kuchai +					✓			✓			
	05:00 pm												
	06:00 pm												
	07:00 pm	DBM								✓			
Total Intake :						Total Output :							
15/6	08:00 pm										} 3rd yr	} 16/6	
	09:00 pm	DBM								✓			
	10:00 pm	FF											
	11:00 pm												
	12:00 am	DBM											
16/6	01:00 am	FF										@ 2am	
	Total Intake :						Total Output :						
16/6	02:00 am										} 3rd yr	} 16/6	
	03:00 am	FF (Similar 180ml)								✓			
	04:00 am												
	05:00 am												
	06:00 am	FF (Similar 180ml)											
	07:00 am												
Total Intake :						Total Output :							

Total 24 hrs. Intake

Total 24 hrs. Output

VIH-00194167 IP-00060333
 Baby KUNDHANIKAA CHANDRA (F)
 23-07-2025 0 Y 10 M 23 D
 Dr. PREETHAM KUMAR



FLUID CHART

Sheet No. :

16/6/26

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.

		Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G							
	08:00 am		DBM									<div style="font-size: 2em;">}</div> Indu 16/6/26 @ 10:30A
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :					Total Output :							
	02:00 pm											<div style="font-size: 2em;">←</div> Noted by Indu 16/6/26 @ 10:30AM
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :					Total Output :							
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :					Total Output :							
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :					Total Output :							

Total 24 hrs. Intake	
-----------------------------	--

Total 24 hrs. Output	
-----------------------------	--

Patient Sticker

FLUID CHART

Sheet No. :

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

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												
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							



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.

SOS / PRN (As Required Medication)

DRUG: PARACETAMOL DROPS				Date															
				Time															
Dose	Route	Frequency	Start Date																
1ml	PO	as required	13/6																
Doctor's Signature		Valid Period	Pharm																
		max 6th hourly																	
Additional Instructions: 1ml=100mg 15mg/kg/dose qf temp >100°F																			
DRUG: Symp. IRUGESIC (IRUPROFEN)				Date															
				Time															
Dose	Route	Frequency	Start Date																
4.5ml	PO	as required	13/6																
Doctor's Signature		Valid Period	Pharm																
		max 6th hourly																	
Additional Instructions: 5ml=100mg 10mg/kg/dose qf temp >102°F																			
DRUG: IVZ LEVITERACETAM				Date															
				Time															
Dose	Route	Frequency	Start Date																
100mg	IV	as required	13/6																
Doctor's Signature		Valid Period	Pharm																
		max 12th hourly																	
Additional Instructions: 10mg/kg/dose																			

Signature
 Dr. Preetham
 Dr. Preetham
 Dr. Preetham



REGULAR PRESCRIPTIONS

Weight. 9.1 kg Ward. 102

Dr. Prabhakar

DRUG : INJ. CEFTRIAXONE				Date Time	13/6	14/6	15/6	16/6												
Dose	Route	Frequency	Start Date	10	AM	11:30	12:30	1:30	2:30											
450mg	IV	12 th hourly	12/6																	
Name & Signature of the Doctor Starting the Drugs: Dr. Vishwaja																				
Additional Instructions: somy kg/dose				10 Gavage PM 10:30 AM 11:30 AM 12:30 PM 1:30 PM 2:30 PM																
Daily Doctor's Endorsement by a Sign																				

Dr. Prabhakar

DRUG : INJ. ESCOMEPRAZOLE				Date Time	13/6	14/6	15/6													
Dose	Route	Frequency	Start Date	10																
10mg	W	Once daily	13/6																	
Name & Signature of the Doctor Starting the Drugs: Dr. Vishwaja				8 AM 9 AM 10 AM 11 AM 12 PM 1 PM 2 PM 3 PM 4 PM 5 PM 6 PM 7 PM 8 PM 9 PM 10 PM 11 PM 12 AM																
Additional Instructions: 1mg/kg/dose																				
Daily Doctor's Endorsement by a Sign																				

Dr. Prabhakar

DRUG : Inj. LEVETIRACETAM				Date Time	13/6	14/6	15/6													
Dose	Route	Frequency	Start Date	6																
100mg	IV	12 hourly	13/6/24																	
Name & Signature of the Doctor Starting the Drugs: Dr. Prabhakar				6 AM 7 AM 8 AM 9 AM 10 AM 11 AM 12 PM 1 PM 2 PM 3 PM 4 PM 5 PM 6 PM 7 PM 8 PM 9 PM 10 PM 11 PM 12 AM																
Additional Instructions: 10mg/kg/dose				change to oral med																
Daily Doctor's Endorsement by a Sign																				

Dr. Prabhakar

DRUG : ENTEROGERMINA				Date Time	14/6	15/6	16/6													
Dose	Route	Frequency	Start Date	10																
1/2 capsule	PO	12 th hourly	14/6																	
Name & Signature of the Doctor Starting the Drugs: Dr. Vishwaja				10 AM 11 AM 12 PM 1 PM 2 PM 3 PM 4 PM 5 PM 6 PM 7 PM 8 PM 9 PM 10 PM 11 PM 12 AM																
Additional Instructions:				10 Gavage PM 10:30 AM 11:30 AM 12:30 PM 1:30 PM 2:30 PM																
Daily Doctor's Endorsement by a Sign																				



Sheet No:

REGULAR PRESCRIPTIONS

Weight Ward

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

VERIFIED BY : Name Signature



Date Time	Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.	
DRUG :	Dose		Dose		Dose		Dose	
	Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Route	Dose		Dose		Dose		Dose	
Start Date	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.	

Date Time	Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.	
VARIABLE DOSE	Dose		Dose		Dose		Dose	
DRUG :	Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Route	Dose		Dose		Dose		Dose	
Start Date	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.	

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
13/6	8:40AM	PARACETAMOL SUPPOSITORY	140mg	PR	[Signature]	Jam [Signature]
13/6	11:45AM	SYP. PEDICLORYL	4.5ml	PO	[Signature]	JK [Signature]
13/6	2pm	INJ. LEVITERACETAM	180mg over 1 hour	IV	[Signature]	Leelpang Geyath [Signature]
14/6	12:45 AM	INJ PARACETAMOL	130mg	iv	[Signature]	Geyath [Signature]
14/6	7AM	INJ PARACETAMOL	130mg	IV	[Signature]	Geyath [Signature]

Signature
 VERIFIED BY: Name
 JK 13/6

102

Ref. No. F/INPR/12

VIH-00194167 IP-00060333
Baby KUNDHANIKAA CHANDRA
23-07-2025 0 Y 10 M 22 D (F)
Dr. PREETHAM KUMAR

Patient Name : _

Registration No.: _



MEDICATION

NEBULISATION CHART

Date	Time	Drug	Nurse	Parents Signature
15/6/26	00.00	6am		
	1.00	Inj. Leucipil 100mg 2ml (BD)	R	Sadhya
	2.00	Inj. Esomprazole 10mg (OD)		
	3.00			
	4.00	10am		
	5.00	Inj. ceftriaxone 450mg (BD)		
	6.00	enterogemina 1/2 sup po (BD)		
	7.00			
	8.00	6pm		
	9.00	Inj. Leucipil 100mg 2ml (BD)		
	10.00			
	11.00	10pm		
	12.00	Inj. ceftriaxone 450mg (BD)		
	13.00	enterogemina 1/2 sup (BD)		
	14.00			
	15.00			
	16.00			
	17.00			
	18.00			
	19.00			
	20.00			
	21.00			
	22.00			
	23.00			