ACTIVITY RECORD FOR BILLING

VIH-00206225 IP-00060470
Master DHANUSH
07-10-2014 11 Y 8 M 18 D (M)
Dr. GEETHA CHANDA

Name:

UHID No: Consultant : Dept :

Date of Admission : 25/6/26 Time : Date of Discharge : Time:

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
25/6/26	2 AM.	ER	PICU	[signature]
25/6/26	1:05pm	PICU	131	[signature]

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, S/E, Creatinine, Urea, Calcium, magnesium, LFT	26021438	[illegible]
25/6	VBG, RBS - 161 mg/dL	26021439	[illegible]
25/6	VBG, RBS - 109 mg/dl	26021452	[illegible]
	Cross checked done by sr. Jagarani		
25/6	EEG	26010108	[illegible]

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
25/6/26	monitor	25/6/26 12pm	25/6/26 @12pm		
	infastion pump	2Am		309420	[signature]
	cross check done by sr. Jagarani				

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
25/6/26	Iv placement	1	3094208	[signature]
	cross check done by sr. Jagarani			

ANY OTHER INFORMATION

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
	[signature] 25/06 @ 3:50 M.		

DEFICIENCY CHECK LIST OF MEDICAL CASE SHEET

Patient Name : VIH-00206225 Master DHANUSH IP-00060470 07-10-2014 11 Y 8 M 18 D (M) Dr. GEETHA CHANDA

IP.No:

Ward:

DOA:

Sl.No	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission Sheet	01	–	–	
2	Discharge Summary	02	–	–	
3	Nursing Initial assessment form	03	–	–	
4	Patient Trasfer Forms	02		–	
5	In-patient Medical Record	03	–	–	
6	Doctors Progress Sheets	02	–	–	
7	Nurses Progress notes	05	–	–	
8	Consultation Sheets				
9	General Consent for Treatment	01	–	–	
10	Conset for Surgery				
11	Consent for Blood Transfusion				
12	Consent forChemotherapy				
13	Consent for High Risk				
14	Consent for Restraint				
15	DAMA Consent				
16	Consent for Special Procedure	01	–	–	
17	Consent for Radiological Investigations				
18	Consent for HIV Test	01	–	–	
19	Anaesthesia consent form				
20	Anaesthesia notes(Pre Anaesthesia & Post)				
21	Pre Operative checklist				
22	Surgical safety Checklist				
23	Operation Theatre notes				
24	Nurses Clinical Presentation				
25	TPR & BP chart	01	–	–	
26	Intake and Output chart (fluid Chart)	01	–	–	
27	Drug Chart (Regular prescription)	03	–		
28	Daily Investigation sheet				
29	Investigation Values (Result Sheet)	01	–	–	
30	Nebulization Chart				
31	Diabetic chart				
32	Nutritional Review chart	01	–	–	
33	MLC form (in case of MLC)				
34	Patient Education Form				
	Others	16	–	–	
		44			
	Total No. of Pages				

Noted by Anitha 25/6 @3.20pm

Signature and Date :

ERROR LOG

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

ICD CODE :-

OBSERVATION: -

DATE :

MRD EXECUTIVE

Rainbow Children's Hospital
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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.
TEL NO :040-42462200, Ext 2000,2001,2002
WEB : https://rainbowhospitals.in

ADMISSION SHEET

Registration Details :

Admission No : IP-00060470 **Admit Date** : 25-Jun-2026 **Admit Time** : 01:08 AM **UHID** : VIH-00206225

Patient Details :

Patient Name : Master DHANUSH
Guardian : Mr NARESH
Gender : Male
Occupation :
Address (H) : 40 QUATEUS BALAMRAI PARADISE CIRCLE Begumpet Police Lines Hyderabad Telangana INDIA 500003
Age : 11 Y 8 M 18 D
DOB : 07-10-2014
Religion :
Martial Status :
Phone No : 9100295995
E-mail : nareshkumar295995@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 NARESH
Contact Address : 40 QUATEUS BALAMRAI PARADISE CIRCLE Begumpet Police Lines Hyderabad Telangana INDIA 500003
Relationship : Father
Phone No : 9100295995 / 7660064715

Signature

Doctor Details :

Doctor Name : Dr. GEETHA CHANDA
Referral Doctor : SELF
Co-Consultant : Dr. RAMESH KONANKI/ Dr. PAPPULA SINDHURA
Specialisation : PEDIATRIC NEUROLOGY
Phone No :

Payment Details :

Payment Mode : Cash
Deposit Amount : 0.00
Payor Name : SELFPAY

Patient Name : Mast. DHANUSH UHID : VIH-00206225 IPD : IP-00060470 Gender : Male Age : 11 Y 8 M 18 D

VIH-00206225 IP-00060470
Master DHANUSH
07-10-2014 11 Y 8 M 18 D (M)
Dr. GEETHA CHANDA

NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 25/6/26 Time of arrival : 12Am

Chief Complaints: Vomitings (1episode), Seizures RBS: 161mg/dL

Height : — Weight : 35kg 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

	Yes	No
History of Falling: within past 3 months	☐	☑
Ambulatory Aids:		
• Wheelchair	☐	☐
• Uses furniture for support	☐	☐
Gait/Transferring:		
• Bedrest / immobile	☐	☐
• Weak	☐	☐
• Impaired	☐	☐
Mental Status: Forgets limitations	☐	☐

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 : 12:03Am

Patient Name : Mast. DHANUSH UHID : VIH-00206225 IPD : IP-00060470 Gender : Male Age : 11 Y 8 M 18 D

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

Time	Nursing Notes
11:46PM	* Pt Came to ER
11:47PM	* vitals checked & Recorded
11:48PM	* ER Doctor & PICU Doctor seen the pt & advised admission
1:10AM	* Admission Done
12:10AM	* Iv placement Done
1:20AM	* samples Collected & sent to lab
	* pt shifted to PICU

Samples collected by: Sr. Shanti Time: 12:10AM

Samples sent by : Sr. Shanti Time: 1:15AM

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1
12:10 AM	Inj. levipil	Iv	700mg	[signature]	[signature]
12:05 Am	medaz Nasal spray	P/N	1-1 puff	[signature]	[signature]
1:35AM	Inj. Rabivax	Im	1ml	[signature]	[signature]
1:35AM	Rabishield	local Infiltration	100 I.U		[signature]

Condition of patient at time of shift - out :	Details of Shift - out
HR: 108b/m BP: 120/69 (78) mmHg CFT: <3sec	Shift - out from ER to: PICU
RR: 24b/m SPO2 : 100%	Time of Shift - out: 25/6/26 @
GCS: Drowsy Temperature : 97°F	Handover given to: Sr. (Nurse's Name)
Pain Score: 0	
Repeat RBS (if applicable):	

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any): Iv placement

Name of the Nurse : Sr. Nikitha Signature of the Nurse : [signature]

Date & Time : 25/6/26 @

Patient Name : Mast. DHANUSH UHID : VIH-00206225 IPD : IP-00060470 Gender : Male Age : 11 Y 8 M 18 D

VIH-00206225 IP-00060470
Master DHANUSH
07-10-2014 11 Y 8 M 18 D (M)
Dr. GEETHA CHANDA

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wt - 35 kg
RBS - 161 mg/dL

EMERGENCY ROOM TRIAGE FORM

Patient's Name : Dhanush Age : 11 yrs Gender: ☑ Male ☐ Female

Date : 24/6/26 Time of Arrival : 11:46 pm

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

Source of Information : ☑ Parents ☐ Others (Specify)

Mode of Arrival : ☑ Ambulatory ☐ Wheelchair ☐ Ambulance

Initial Vital Signs: Temp: 97°F PR: 106 b/m BP: 121/64 (7 mnths) RR: 26 b/m SpO$_2$: 99%

Chief Complaints: Seizures, 1 episode vomiting

INITIAL PHYSIOLOGICAL CATEGORIZATION	INITIAL PHYSIOLOGICAL STATUS
Appearance: ☐ Normal ☑ Sick Looking Circulation / Colour: ☑ Normal ☐ Abnormal ☐ Bleeding Work of Breathing: ☑ Normal ☐ Decreased ☐ Increased ☐ Gasping / Apnea	☐ 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: [signature]

Triage Completion Time : 11:49 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 : Sr. Hema

Signature of Triage Nurse: [signature]

Date & Time : 24/6/26 @ 11:49 pm

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

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

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Your Right to a Safe Delivery

PATIENT TRANSFER FORM

Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
VIH-00206225 IP-00060470 Master DHANUSH 07-10-2014 11 Y 8 M 18 D (M) Dr. GEETHA CHANDA	25/6/26@	25/6/26@ 2pm
	Transfer Ordered by	**Reason for Transfer**
	Dr. Vishwaja	Admission
From Unit	**To Unit**	**Information to Attendant**
ER	PICU	Yes ☑ No ☐
Number of Sheets in Clinical File	**Number of Imaging Films**	**Personal belongings including clinical documents. If any handed over to attendant**
25		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
Sr. hema	Dr. Vishwaja

Patient & Clinical Records Received by : Dr Dinakar

Date & Time of Patient Received : 25 Am at 2 Am

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

Docu. No. : RCH /FRM / CLINICAL / 102

PATIENT TRANSFER FORM

Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
VIH-00206225 IP-00060470 Master DHANUSH (M) 07-10-2014 11 Y 8 M 18 D Dr. GEETHA CHANDA	25/6/26 @ 1.8Am	25/6/26 @ 1pm
	Transfer Ordered by	**Reason for Transfer**
	Dr Geetha chanda	Stable
	To Unit	**Information to Attendant**
	Y	Yes ☑ No ☐
From Unit		**Personal belongings including clinical documents. If any handed over to attendant**
PICU		Yes ☐ No ☑ If yes, what ?
Number of Sheets in Clinical File	**Number of Imaging Films**	
55	YBLZ	

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	10CC - 5	
2.	1CC - 5	
3.	Levipil - 2	
4.	pantoprazol - 1	
5.	mcdaz spray - 1	

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Sr. Sumanjali	Dr. Jayasree

Patient & Clinical Records Received by : [signature]

Date & Time of Patient Received : 25/6/26 01:57

If the transfer order time & Completion time is more than 30 minutes tick the reason mentioned below :

☐ Unavailable Bed ☐ *Nurse not Available* ☐ *Available Bed not ready*

Docu. No. : RCH /FRM / CLINICAL / 102

VIH-00206225 IP-00060470
Master DHANUSH
07-10-2014 11 Y 8 M 18 D (M)
Dr. GEETHA CHANDA

PRISM SCORE FORM

Variable	Age Restriction	Score Appointed	Score
Systolic Blood Pressure (mmHg)	**Neonate** **Infant** **Child** **Adolescent** 40-55 44-65 55-75 65-85 <40 <45 <55 <65	3 7	
Temperature	All ages <33°C OR > 40 °C	3	
Mental Status	All ages stupor or coma (GCS<8)	5	
Heart Rate	**Neonate** **Infant** **Child** **Adolescent** 215-225 215-225 185-205 145-155 <225 <225 <205 <155	3 4	0
Pupillary reflexes	All ages = One Pupil fixed, pupil > 3mm All ages = Both fixed, pupil > 3mm	7 11	
Acidosis (pH) or total CO_2(mmol/L)	All ages = pH 7.0 - 7.28 or total $CO_2$5 - 16.9 All ages = pH < 7.0 or total CO_2< 5	2 6	
pH	All ages = 7.48 - 7.55 All ages > 7.55	2 3	
PCO_2(mmHg)	All ages = 50.0 - 0 All ages > 75.0	1 3	
Total CO_2 (mmol/L)	All ages > 34.0	4	0
Artenal Pao_2(mmHg)	All ages = 42.0 - 49.9 All ages = 42.0	3 6	
Glucose	All ages > 200mg/dl	2	
Potassium	All ages > 6.9mmol/L	3	
Creatinine (mg/dl)	**Neonate** **Infant** **Child** **Adolescent** >0.84mg/dl >0.9mg/dl >0.9mg/dl >1.3mg/dl	3	
Urea (mg/dl)	**Neonate** **All other ages** 725.9 32.5	3	
White blood cells	All ages < 3000 cella/mm³	4	
Prothrombin time (PT) Or Partial thromboplastin time (PTT)	**Neonate** **All other ages** PT > 22.0 sec or PTT > 85.0 sec / PT > 22.0 sec or PTT > 57.0 sec	3	0
Platelets (cells/mm³)	All ages = 100,000 to 200,000 All ages = 50,000 to 99,999 <50,000	2 4 5	
	Total PRISM III - 24 hours.		

Name of the Doctor: CH. GANESH

Signature of the Doctor: [signature]

Date & Time: 25/6/2026 @ 11:05pm

Docu. No. : RCH /FRM / CLINICAL / 135

VIH-00206225 IP-00060470
Master DHANUSH
07-10-2014 11 Y 8 M 18 D (M)
Dr. GEETHA CHANDA

NURSING INITIAL ASSESSMENT FOR PICU

Date of Admission: 25/6/26

Source of Admission: ☐ OPD ☐ Ward ☑ Other: ....

Reason for Admission: dog bite

Admission Diagnosis: Seizures

Accompanied By: ☑ Parent ☐ Guardian ☐ Other Name: ....

Primary Language: ☑ Telugu ☐ English ☐ Hindi ☐ Other Specify ....

Do you require an interpreter? ☑ Yes ☐ No

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

If yes, identify ....

Source of Information : ☐ Family ☐ Patient ☐ Others, Specify			
SIGNIFICANT HISTORY	Past Medical History	Past Surgical History	Last Hospital Admission
	seizures.	Nil	Nil
	Family History:		
	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 MEDICATIONS	Taking Medications? ☐ Yes ☑ No If yes, Fill the reconciliation form Medicine brought to the hospital? ☐ Yes ☑ No		

Observations: Weight: 35 kgs Length: .... Head Circumference (< 2 years): ....

Temp.: 98.6°F HR: 82 b/m RR: 25 b/m BP: 113/50 (68)

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

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

Risk of Pressure Sore (Braden Q Score 0) (Document in the Braden Q Assessment Sheet)

VIH-00206225 IP-00060470
Master DHANUSH
07-10-2014 11 Y 8 M 18 D (M)
Dr. GEETHA CHANDA

Behavioural Status on Admission :

- [x] Sleeping
- [ ] Crying
- [ ] Calm
- [ ] Distressed/Consolate
- [ ] Drowsy

FUNCTIONAL SCREENING: If a patient needs assistance with any of the following inform consultant

- [ ] Mobility problem
- [ ] Walking Problem
- [x] No Abnormality Detected
- [ ] Developmental Delay
- [ ] Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING:

- [ ] Underweight
- [ ] Overweight
- [ ] Special Feeding Method
- [ ] Feeding Problem
- [ ] Special diet
- [x] 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: by Geetha Chanda (Date/Time): 25/6/26 / 2 pm

Social History: Lives With ....

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

Orientation has been given regarding the following aspects:

- [x] ID Band in situ
- [x] Bedside safety explained
- [x] PICU Routine: Doctor's rounds/Medication time
- [x] Visiting policy explained

Orientation given to: ☑ Family ☐ Others specify ....

Name of Person Orientation was given to: ....

Orientation not given Reason: ....

Nurse Name: Renuka Nurse Signature : [signature]

Date & Time: 25/6/26

DISCHARGE PLAN

Source of Information: ☑ Family ☐ Friend

Will patient require transportation arrangements to go home: ☐ Yes ☑ No

Will Physiotherapy require at home: ☐ Yes ☑ No

Is home medical equipment anticipated: ☐ Yes ☑ No

Is home oxygen therapy anticipated: ☐ Yes ☑ No

Are dressing needs at home anticipated: ☐ Yes ☑ No

Any other needs anticipated: ☐ Yes ☑ No If Yes Specify ....

Discharge Medications: ☐ Yes ☑ No

Details: ....

Final Diagnosis: Seizures

Nurse Name: Renuka Nurse Signature : [signature]

Date & Time: 25/6/26 / 2 Am

PEDIATRIC IN-PATIENT MEDICAL RECORD

VIH-00206225
Master DHANUSH
07-10-2014
Dr. GEETHA CHANDA
IP-00060470
11 Y 8 M 18 D
(M)

Patient Name: ____________________

UHID ID: ____________________

Department: ____________________

Consultant: ____________________

VIH-00206225 IP-00060470
Master DHANUSH
07-10-2014 11 Y 8 M 18 D (M)
Dr. GEETHA CHANDA

Pediatric Multiorgan History & Physical Examination

Name : ______________________ Age/Sex ______

Information given by: ______________________ Relationship ______

Chief Presenting Complaints & Duration (Chronologically)

c/o. Seizure activity
lasting for 20-30sec @ 11:30pm
today

History of present illness :

Child brought by parents c̄ c/o
1 episode of seizure activity - with UROEB
Stiffening of limbs
Jerking movements of UL, LL
at residence
↓↓
child asleep during episode, onset
lasted for 20-30sec
postseizure drowsiness lasted 20-30min
↓↓
Brought to ER - RCH
similar episode of seizure activity - Midaz Spray 1puff each nostril given
f/by Inj levipsil - loading done

H/O Dog Bite - category 3 - 1hour before seizure episode - ↓ vaccination not done

H/O ? ADHD - child on medication for 3years
Stopped 1½ year back

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07-10-2014 11 Y 8 M 18 D (M)
Dr. GEETHA CHANDA

Pediatric Multiorgan History & Physical Examination

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

H/o febrile seizures @ 5 months of age. → admission.

H/o - family History of seizures — Sibling (elder)
↓ Since 3 years on medication [→ levipil 250 - 500 mg]
mother - not on medications
Maternal Grandmother - using medications.

Birth & Neonatal History:

Term / 3.5 kg / NVD / No NICU admission

(14 yr)

Birth & Socio Economic History:

About Father :
About Mother : } class III
Any additional Information :

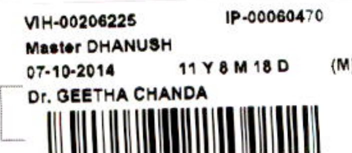
Developmental History :

Appropriate for age.

Immunization History :

Received upto date.

(P.T.O.)



Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs))________(Centile ________)

On Examination :

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

Resp.rate and type of breathing : ________

Rash ⊖

Lymphadenopathy ⊖.

Oedema : ⊖

Allergies (if any): ⊖

Respiratory System :

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

Air entry & breath sounds : BAE (+)

Any addes sounds : NO

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

Cardiovascular System :

Inspection of procordium : (N)

Heart Sounds : S_1S_2 (+)

Any murmur : No.

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

Per Abdomen :

Inspection (N)

Palpation : soft

Ausculation : BS (+)

Spine : (N) External Genitelia : ________

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

VIH-00206225 IP-00060470
Master DHANUSH
07-10-2014 11 Y 8 M 18 D (M)
Dr. GEETHA CHANDA

Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : Awake

Cranial Nerves : Intact

Motor System:

Nutriton : (N)

Tone: (N) Power 5/5 all limbs

Co-ordinator : (N)

Posture : (N)

Involuntary Movements : (-)

Reflexes :

DTR

Superficials:

Plantars flexor.

Sensory System : ↑

Bladder / Bowel : No incontinence

Clinical Summary & Diagnostic:

? Generalized GTCS.

(P.T.O.)

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: To prevent complications

Desired goals of the treatment : To treat current symptoms.

Planned Labs:

UBG, RBS
CBP
CRP
S/E
S.Ca++
S.Mg++
EEG
S.Urea, S.creat
LFT

Noted by Nikhitha.

Planned Management

1) IV fluids
2) Inj Levipil Act given
3) Watch for further Seizure episodes.
4) to continue further dose of Rabies vaccine on 3, 7, 14, 28 days. 0 dose given

Noted by Sr. Renuka 05/6/26 @ 11 AM

Signature of the Doctor: [signature]
Name of the Doctor: Dr. Vishwaja
Date & Time: 25/6/26

Signature of the Consultant: [signature]
Name of the Consultant: ...
Date & Time: ...

VIH-00206225 IP-00060470
Master DHANUSH
07-10-2014 11 Y 8 M 18 D (M)
Dr. GEETHA CHANDA

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
25/6/2026 8.30AM	Δ: Unprovoked seizure ↓ evaluation -[H/o Dog bite anticedent present].	
	Airway: Maintainable at room air	
	Breathing: No sign of bradypnoea / respiratory distress	
	Circulation: CRT <3sec BP: Within normal limit	
	Disability - GCS: 14/15 GRBS: 109 mg/dl	
	Exposure: (L) leg scratch mark (+) [Dog bite] Ig & Vaccine given	
	Adv: (1) Plan to start oral (2) Plan: eeg / MRI	
		Noted by Sr. Sumanjali 25/06/26 @9AM
		[signature]

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Master DHANUSH
07-10-2014 11 Y 8 M 18 D (M)
Dr. GEETHA CHANDA

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	S/B neurology	
25/6/26 9:10AM	ASD – Epilepsy - unprovoked focal non motor in k/c/o cognitive delay	(Plan)
	S/O No further seizure episodes No fever	T/D EEG
	O/E	↑
	vitals – (N) pupil - equal reacting	Shift to ward
	gait – (N)	
	speech – (N)	
	(N) tone	T/D MRI brain in evening
	power R L	
	UL	Noted by Sr. Suranjali 25/6/26 @10AM
	LL	
	DTR	
	Plantar –	

Docu. No. : RCH /FRM / CLINICAL / 088

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

25/6/26
10:00 am

Shifting notes

- 11 year male child presented c̄ post-ictal state to ER after 20-30 seconds of GTCS (athome) of 30min this is the 2nd time in his life, At 9 months of age he had febrile seizure. In ER he got one more seizure, during that midaz spray given fb Inj. levipil loading dose.
- He also had H/O dog bite category 3 1 hour before seizure (2nd ep),

As he remained heamodynamically stable and no further seizures noted.

Shift to room was planned by neuroteam.

Plan

- To do EEG
- MRI Brain.
  Plain (SOS) contrast in afternoon ask Dr. Nikesh.
- vitals 6th hrly
- Continue Inj. levipil & pantoprazole

Noted by Sr. Sumaiya 25/6/26

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Master DHANUSH
07-10-2014 11 Y 8 M 18 D (M)
Dr. GEETHA CHANDA

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

VIH-00206225 IP-00060470
Master DHANUSH
07-10-2014 11 Y 8 M 18 D (M)
Dr. GEETHA CHANDA

NURSE HAND OFF COMMUNICATION - ICU

SITUATION & BACKGROUND	DOA: 25/6/26	Diagnosis:		Surgery / Procedures:
	Allergies: Nill			Post OP Day:
	Date: 25/6/26			
	Area / Shift Time	PICU Night	PICU Morning	
	Diet:	NPO	NPO	
	Ventilation (RA, NP, NIV, VENTI)	R/A	R/A	
INVASIVE LINES	1.	IV-cannula	IV-cannula	
	2.	-	—	
	3.	-	—	
	4.	-	—	
ASSESSMENT	Infusions / Transfusions	DNS 50ml/hr.	DNS 50ml	
	PU Prophylaxis	-		
	DVT Prophylaxis	-		
	Vitals BP	113/50 (68) mmHg		
	PR	80 b/m		
	RR	20 b/m		
	SpO_2	99%		
	Temp	98.6°F		
	Pain Score	0		
	LOC (Alert, Conscious, Confusion, Unconscious)	confusion		
	Skin Integrity (Intact / Bedsore / Any other condition	Intact		
	Restraints If any Physical	Nill		
	Chemical			
	Fall Risk (Vulnerable Y/N) if yes score	14		
	(Ambulation, walking, moving with assistance, bed ridden)	Moving c̄ Assistance		
	ADL (Dependent / Non-Dependent)	Dependent		
	Critical Lab Test / Values (If any)	-		

Note: RA (Room Air, NP Nasal Prongs, NIV Non-Invasive Ventilation, VENTI Ventilator)

RECOMMENDATIONS		Date:			
	Investigations Procedures	Area / Shift Time	PKU Night		
		Ordered / Planned	Nil		
		Due	Nil		
		Reports Pending	Nil		
		Referrals (If any)	Nil		
	Remarks (Special Interventions like, Drainage tube flushing etc.)		Nil		
Handed Over By Name :			Renuka		
Signature :			[signature]		
Date:			25/6/26		
Time:			@8Am		
Taken Over By Name :			Sumanjali		
Signature :			[signature]		
Date:			25/6/26		
Time:			@8AM		

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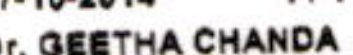
Dr. GEETHA CHANDA

NURSE HAND OFF COMMUNICATION - ICU

Section	Item			
SITUATION & BACKGROUND	DOA: 25/6/26	Diagnosis: seizures	Surgery / Procedures: –	
	Allergies: –		Post OP Day: –	
	Date:	25/6/26		
	Area / Shift Time			~~PICU~~ ER / N.
	Diet:			NPO
	Ventilation (RA, NP, NIV, VENTI)			RA
INVASIVE LINES	1.			IV cannula
	2.			
	3.			
	4.			
ASSESSMENT	Infusions / Transfusions			
	PU Prophylaxis			–
	DVT Prophylaxis			–
	Vitals — BP			103/68 (83)
	Vitals — PR			106 b/m
	Vitals — RR			26 b/m
	Vitals — SpO_2			99%
	Vitals — Temp			98.6 F
	Pain Score			0
	LOC (Alert, Conscious, Confusion, Unconscious)			conscious
	Skin Integrity (Intact / Bedsore / Any other condition			Intact
	Restraints If any — Physical			–
	Restraints If any — Chemical			–
	Fall Risk (Vulnerable Y/N) if yes score			
	(Ambulation, walking, moving with assistance, bed ridden)			bed ridden
	ADL (Dependent / Non-Dependent)			Dependent
	Critical Lab Test / Values (If any)			–

Note: RA (Room Air, NP Nasal Prongs, NIV Non-Invasive Ventilation, VENTI Ventilator)

RECOMMENDATIONS					
		Date:			
	Investigations Procedures	Area / Shift Time			ER N
		Ordered / Planned			CBP, CRP SE, ca,mg creatine, urea LFT
		Due			
		Reports Pending			CBP, CRP, SE, ca,mg, creatine, urea LFT
		Referrals (If any)			Nil
	Remarks (Special Interventions like, Drainage tube flushing etc.)				Nil
Handed Over By Name :					Nikhitha
Signature :					[signature]
Date:					25/6/26
Time:					@ 1:20AM.
Taken Over By Name :					Renuka
Signature :					[signature]
Date:					25/6/26
Time:					@2Am



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Master DHANUSH
07-10-2014 11 Y 8 M 18 D (M)
Dr. GEETHA CHANDA

NURSE HAND OFF COMMUNICATION - ICU

SITUATION & BACKGROUND	DOA: 25/6/26	Diagnosis: GTCS	Surgery / Procedures: Nil	
	Allergies: Nil		Post OP Day: –	
	Date: 25/6/26			
	Area / Shift Time	PICU 8Am-2pm		
	Diet:	NPO		
	Ventilation (RA, NP, NIV, VENTI)	R/A		
INVASIVE LINES	1.	IV Cannula		
	2.			
	3.			
	4.			
ASSESSMENT	Infusions / Transfusions	DNS 2/3 maintenance 50ml/hr		
	PU Prophylaxis	Nil		
	DVT Prophylaxis	Nil		
	Vitals BP	100/60 mmHg		
	PR	78 b/m		
	RR	28 b/m		
	SpO_2	100%		
	Temp	98.6 °F		
	Pain Score	0		
	LOC (Alert, Conscious, Confusion, Unconscious)	Alert		
	Skin Integrity (Intact / Bedsore / Any other condition	Intact		
	Restraints If any Physical	–		
	Chemical	–		
	Fall Risk (Vulnerable Y/N) if yes score	–		
	(Ambulation, walking, moving with assistance, bed ridden)	Walking		
	ADL (Dependent / Non-Dependent)	Dependent		
	Critical Lab Test / Values (If any)	–		

Note: RA (Room Air, NP Nasal Prongs, NIV Non-Invasive Ventilation, VENTI Ventilator)

RECOMMENDATIONS					
		Date:	25/6/26		
	Investigations Procedures	Area / Shift Time	8Am-2pm		
		Ordered / Planned	=> MRI = EEG		
		Due	=> Nil		
		Reports Pending	- Nil		
		Referrals (If any)	- Nil		
	Remarks (Special Interventions like, Drainage tube flushing etc.)		- Nil		
Handed Over By Name :			Sumanjali		
Signature :			[signature]		
Date:			25/6/26		
Time:			@ 2pm		
Taken Over By Name :			manisha		
Signature :			N290501145		
Date:			25/6/26		
Time:			@2pm		

VIH-00206225 IP-00060470
Master DHANUSH
07-10-2014 11 Y 8 M 18 D (M)
Dr. GEETHA CHANDA

NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: Seizers			Any Infection: ☐ Yes ☑ No ☐ Not Known			
				If Yes Specify: Nil			
	Surgery / Procedure: Nil			Post OP Day: Nil			
BACKGROUND	Date / Shift	25/6/26 E					
	Medical Condition (Any special condition to be noted):	S. dNil					
	Diet:	S. diet					
ASSESSMENT	Allergy:	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Ventilation (RA, NP, NIV, VENTI):	RA					
	Tubes/Drains/Catheter:	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:	98.4 F					
	Res:	24 b/m					
	SpO_2:	98 %					
	Pulse:	108 b/m					
	BP:	98/62(73)					
	LOC:	Conscious					
	Fall Risk Score:	11					
	Pain Score:	0					
	Skin Integrity	Intact					
Recommendations	Safety Needs:	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Physiotherapy:	Nil					
	Others Specify:	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Special Diet:	S. diet					
	Critical Lab Test / Values:	Nil					
	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):	Dependent					
Post Operative Procedure Special Orders:		Nil					
Handed Over By Name :							
Signature / ID :							
Date:							
Time:							
Taken Over By Name :							
Signature / ID :							
Date:							
Time:							

Noted by Smitha 25/6 @ 3.30pm

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

Patient Sticker

NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:	Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify: ....
	Surgery / Procedure:	Post OP Day:

Section	Item						
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:						

VIH-00206225 IP-00060470
Master DHANUSH
07-10-2014 11 Y 8 M 18 D (M)
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THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE 25/6/26	DATE 25/6	DATE 26	DATE 25/6	DATE
Age	Less than 3 years old	4					
	3 to less than 7 years old	3					
	7 to less than 13 years old	2	2	2	2	2	
	13 years old and above	1					
Gender	Male	2	2	2	2	2	
	Female	1					
Diagnosis	Neurological Diagnosis	4	4	4	4	4	
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1					
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own ability	1	1	1	1	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	
	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	
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	
	Total		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	✗		✗	✗	✗	
Wheels Locked	✓		✓	✓	✓	
Room free of clutter	✓		✓	✓	✓	
Adequate lighting	✓		✓	✓	✓	
Wheel chair su[illegible]	✓		✓	✓	✓	
Other Intervention(s) Specify	✓		✓	✓	✓	
Nurse's Name:	Hema		[illegible]	[illegible]	[illegible]	
Signature:	[illegible]		[illegible]	[illegible]	[illegible]	
Date:	25/6/26		25/6	26	25/6	
Time:	1AM		8PM	1[illegible]	8PM	

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Master DHANUSH
07-10-2014 11 Y 8 M 18 D (M)
Dr. GEETHA CHANDA

BRADEN 'Q' SCALE

				Date : / Time :	25/6 1AM	25/6 8pm	[illegible]	
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.	4	4	4	
"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	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	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	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	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	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	4	
				TOTAL SCORE	28	28	28	
				Evaluator's Name	[signature]	[signature]	[signature]	

Severe Risk : less than 9 | High Risk : 10-12 | Moderate Risk : 13-14 | Mild Risk : 15-18 | Not at Risk: 19-23

Docu. No. : RCH /FRM / CLINICAL / 119

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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Dr. GEETHA CHANDA

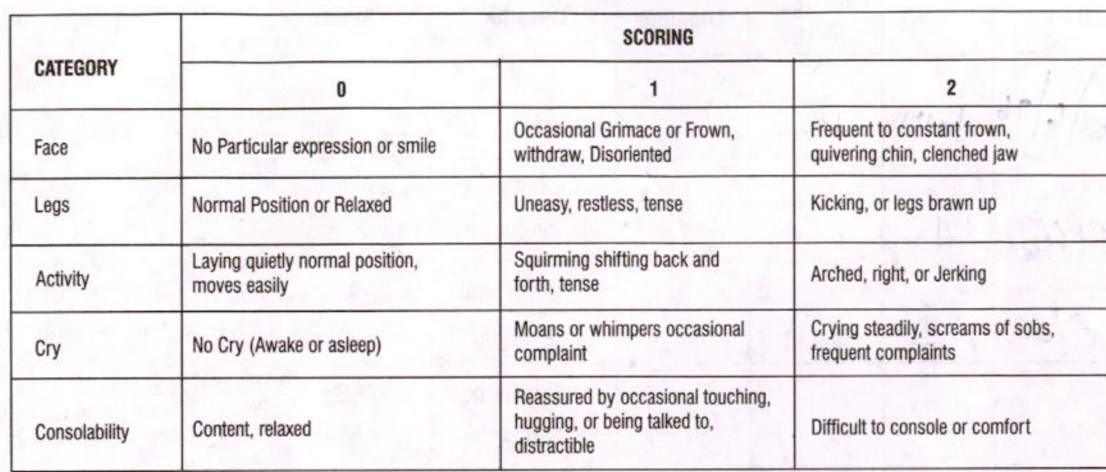
PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
25/6/26	1AM	0	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	— —	
25/6/26	3Am	0	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	— —	
26/6	8Am	0	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	— —	
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

1. Every eight hours for all hospitalized patients.
2. For post-surgical patients, patients with chronic pain, patient with severe pain:
   - a) At least every 2 hours for the first 24 hours
   - b) Then every 4 hours.
   - c) Prior to pain pain-relieving intervention.
   - d) Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS



FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
	0	1	2
Face	No Particular expression or smile	Occasional Grimace or Frown, withdraw, Disoriented	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs brawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, right, or Jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams of sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

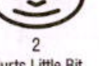
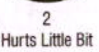
Numerical Pain Scale (Obstetric and Gynecology)

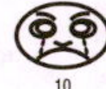
0 No Pain — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10 Worst Possible Pain

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

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR RR, BP, SaO_2	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO_2 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO_2 less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

Wong - Baker (Pediatrics) Above 7 Years



0 No Hurt — 2 Hurts Little Bit — 4 Hurts Little More — 6 Even More — 8 Hurts Whole Lot — 10 Hurts Worst

VIH-00206225 IP-00060470
Master DHANUSH
07-10-2014 11 Y 8 M 18 D (M)
Dr. GEETHA CHANDA

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			0	0	0					
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			—	—	—					
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2			—	—	—					
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			—	—	—					
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			—	—	—					
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				[signature]	[signature]	[signature]					

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 : [signature] Name : Shanti

Signature of Ward In Charge :
Signature : [signature] Name : Sr. Sujatha

Doc. No. : RCHBH/ FRM / CLINICAL /137

VIH-00206225 IP-00060470
Master DHANUSH
07-10-2014 11 Y 8 M 18 D (M)
Dr. GEETHA CHANDA

NURSING CARE RECORD

Date: ....

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							
Afternoon							
Night	2:30 Am	- Assessment - vitals - medications	8Am	- Assessed the general condition - monitored vitals & Recorded.	- vitals are normal	hemodynamically stabled.	Renuka 25/6/26 @8Am

VIH-00206225 IP-00060470
Master DHANUSH
07-10-2014 11 Y 8 M 18 D (M)
Dr. GEETHA CHANDA

NURSING CARE RECORD

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	=) =) =) =)	Assess the Baby condi MRI monitored vitals maintain Input and output Chart	=) =) =) =)	Assessed Baby condition monitored vitals maintained Input and output Chart child Now NPO continued flui,	-) No fresh complaints =) vitals stable	=) Hemodynamically stable	Sumanjali [signature]
Afternoon	3.20pm	→ Discharge		Note :- Doctor Come for rounds & advice Discharge		Noted by manisha 25/6 @ 3.30pm	
Night							

VIH-00206225 IP-00060470
Master DHANUSH
07-10-2014 11 Y 8 M 18 D (M)
Dr. GEETHA CHANDA

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: ......PICU......

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. Vishwaja......

Date & Time : ......25/6/26 @ 1AM......

Nurse Name & Signature: ......Sr. Hema Latha......

Date & Time : ......25/6/26 @ 1AM......

WELL'S CRITERIA FOR ASSESSING DVT

NOTE: Assign a **score of 1** if **'YES'** in **parameter 1 to 9** and **Assign a score** of **-2** if **'YES'** in **parameter No 10**

S.No	Assessment Criteria	Score	Date: 25/6 Time: 11 AM	Date: Time:	Date: Time:	Date: Time:	Date: Time:	Date: Time:
1	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)	1	0					
2	Bedridden recently >3 days or major surgery within four weeks	1	0					
3	Calf swelling >3cm compared with asymptomatic side, measured at 10 cm below tibial tubercle (Assess for both legs)	1	0					
4	Collateral (non varicose) superficial veins present (Assess for both legs)	1	0					
5	Entire leg swollen (Assess for both legs)	1	0					
6	Localized tenderness along the deep venous system (Assess for both legs)	1	0					
7	Pitting edema, greater in the symptomatic leg (Assess for both legs)	1	0					
8	Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs)	1	0					
9	Previously documented DVT (Assess for both legs)	1	0					
10	Alternative diagnosis to DVT as likely or more likely (Assess for both legs)/ Co-morbidity like ESLD /Renal disease, Renal failure, CCF Cellulitis (commonly mistaken as DVT), Dependent (stasis) oedema, Lymphatic obstruction.	-2	0					
	Total Score		0					
	Signature of the Nurse		[signature]					

Intervention: Nil

High Risk = >2 Score

Moderate Risk = 1-2 Score

Low Risk = <1 Score

Note : Daily assessment shall be carried out once every 24 hours and documented

Docu. No. : RCH /FRM / CLINICAL / 128

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.
TEL NO :040-42462200, Ext 2000,2001,2002
WEB : https://rainbowhospitals.in

GENERAL CONSENT FOR TREATMENT

Patient Name:	**Master DHANUSH**	**Age :**	**11 Y 8 M 18 D**
IP No:	**IP-00060470**	**Sex:**	**Male**
Consultant:	**Dr. GEETHA CHANDA**	**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 ɔ consent to the use of health related information/ audiovisuals of the patient for research & training purpose or for ...urance 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 ...arance. In case of failing the submission, I will pay 200/- Rs.
(Receivers Signature:.. Naresh

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: father

Name: NARESH
Relationship: FATHER
Date: 25/6/2026
Wittness Name: [signature]
Wittness Signature: [signature]

Time: 01-08 Pm

Patient Address:
40 QUATEUS BALAMRAI PARADISE CIRCLE Begumpet Police Lines Hyderabad Telangana INDIA 500003

CONSENT FOR ADMISSION IN PEDIATRIC INTENSIVE CARE UNIT

Name: Mast. Dhanush Age: 11yrs Gender: Male ☒ Female ☐

UHID.No : 206225 Date: 25/6/26

I NARESH S/o, D/o, W/o, LAXMAIAH hereby declare that our patient Master/Baby Mast. Dhanush who is related to me as Son is getting admitted in the Pediatric Intensive Care Unit of Rainbow Children's Hospital on 25/6/26

The doctors have explained to me in a language understood by me that my child has following health related issues :

....

....

....

The doctors have clearly explained to me that my patient Master / Baby Dhanush during his / her stay in the Pediatric Intensive Care Unit may undergo various medical and surgical procedures like airway management, mechanical ventilation, Central Line Insertion, Peripherally Inserted Central Catheter Line and arterial line placements, chest drain, or peritoneal drain insertion etc.

I have been told by the doctors that while performing such procedures I will be informed and a separate consent for this procedure shall be taken. However, in case of any life threatening emergency if the time is not available for taking informed consent it is implied that I give consent for various invasive procedure to save the life of my child.

I understand that a sick child in Pediatric Intensive Care Unit has life threatening medical conditions.

I understand that when a child is sick in the Pediatric Intensive Care Unit with multiple medical and surgical procedures performed upon him/her, there are inherent risks due to these high risk procedures, and high risk medications, in the form of infections, bleeding, air leaks, skin and other tissue damage etc.

I give my consent to the team of doctors to go ahead and admit the child Master / Baby : Dhanush .... in the Pediatric Intensive Care Unit fully understanding the associated risk, benefits and alternatives involved from various procedures, high risk medications and infections in the Pediatric Intensive Care Unit and treat him/her with all necessary means.

The doctors have explained to me in the language best understood to me.

Patient Attendant :

Signature: [signature]

Name: NARESH

Relationship with Patient: FATHER

Date & Time: ....

Witness :

Signature: ....

Name: ....

Date & Time: ....

Doctor (who is taking the consent) :

Signature: [signature]

Name: Dr. Vishwaja

Date & Time: 25/6/26 1:18pm.

Docu. No. : RCH /FRM / CLINICAL / 013

పిల్లల ఇంటెన్సివ్ కేర్ యూనిట్ లో అడ్మిషన్ కొరకు సమ్మతి

రోగి పేరు .... వయస్సు .... లింగం ☐ పు ☐స్త్రీ

యు.హె.ఐ.డి ....

నేను .... s/o. d/o. w/o . ...

.... అనే బాలుడు / బాలిక యొక్క చికిత్స మేరకు రెయిన్బో పిల్లల అనుపత్రి లోని పిల్లల ఇంటెన్సివ్ కేర్ యూనిట్ తేదీ .... నాడు పూర్తి సమ్మతితో చేర్చితిని.

మా బాలుడి / బాలిక లో ఈ కింద తెలిపిన ఆరోగ్య సమస్యల గురించి విద్య నిపుణుడు నాకు అర్థమగు భాషలో వివరించితిరి.

....

....

....

రెయిన్ బో చిల్డ్రన్స్ హాస్పిటల్ లోని పీడియాట్రిక్ ఇంటెన్సివ్ కేర్ విభాగం లో చేరింది బిడ్డకు ఆరోగ్య సంబంధిత సమస్యలు ఉన్నాయని వైద్యులు నాకు అర్థమయ్యే భాషలో వివరించారు. రోగి ______________________ పీడియాట్రిక్ ఇంటెన్సివ్ కేర్ విభాగం లో ఉన్న సమయంలో అతను వివిధ వైద్య మరియు శస్త్ర చికిత్సలకు లోనవుతారని వైద్యులు నాకు స్పష్టంగా వివరించారు. ఎయిర్ వే మేనేజ్ మెంట్, మెకానికల్ వెంటిలేషన్, బొడ్డు ధమని కాథెటర్, బొడ్డు సిర మరియు ధమనుల కాథెటర్ వంటి . పెరిఫెరల్లీ ఇన్సర్ట్ చేయబడిన సెంట్రల్ కాథెటర్ లైన్ మరియు ఆర్టరీ లైన్ ప్లేస్ మెంట్స్, ఛాతీ డ్రెయిన్ లేదా పెరిటోనియల్ డ్రెయిన్ ఇన్సర్షన్ మొదలైనవి.

అటువంటి ప్రక్రియలు చేస్తున్నప్పుడు నాకు సమాచారం ఇవ్వబడుతుందని మరియు దీనికి ప్రత్యేక సమ్మతి ఉంటుందని వైద్యులు నాకు చెప్పారు. ఏదేమైనప్పటికీ, ఏదైనా ప్రాణాంతక అత్యవసర పరిస్థితుల్లో సమాచారం తీసుకోవడానికి సమయం లేకపోతే నా బిడ్డ ప్రాణాన్ని కాపాడేందుకు ఇతర వైద్య ప్రక్రియలకకు నేను సమ్మతి ఇస్తున్నాను.

పీడియాట్రిక్ ఇంటెన్సివ్ కేర్ విభాగం లో అనారోగ్యంతో ఉన్న పిల్లవాడికి ప్రాణాంతకమైన వైద్య పరిస్థితులు ఉన్నాయని అర్థం చేసుకోవడమైనది.

ఒక బిడ్డ అనారోగ్యంతో పీడియాట్రిక్ ఇంటెన్సివ్ కేర్ విభాగం లో ఉన్నప్పుడు అతని/ఆమెపై నిర్వహించబడు అనేక వైద్య మరియు శస్త్రచికిత్సా విధానాలతో ఈ అధిక ప్రమాదకరమైన విధానాల వల్ల సంభవించు నష్టాలు మరియు అధిక ప్రమాదకరమైన మందుల రూపంలో అంటువ్యాధులు, రక్తస్రావం, శ్వాసపరమైన, చర్మం మరియు ఇతర కణజాల నష్టం మొదలైనవి కలగవచ్చు డాక్టర్లు నాకు బాగా అర్థమయ్యే భాషలో వివరించారు.

మా బాలుడు / బాలిక .... ను ఇంటెన్సివ్ కేర్ యూనిట్ (పి.ఐ.సి.యు) లో చేర్చుకొని అవసరమయ్యే వైద్యం చేయుటకు నేను వైద్య బృందానికి నా సమ్మతి ధృవపరుస్తున్నాను.

సహాయకుడు(అటెండెంట్)

సంతకము ....

పేరు ....

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము ....

పేరు ....

సాక్షి

సంతకము ....

పేరు ....

తేదీ మరియు సమయము ....

Docu. No. : RCH /FRM / CLINICAL / 013

MRI.

CONSENT FOR SPECIAL PROCEDURES

Patient Name : master . Dhanush Gender: ☑ Male ☐ Female

UHID No : 206225 Department : PICU Date : 25/6/26

I Naresh S/D/W/O Dhanush

Here by give consent for procedure of : MRI

For my patient, Named : master Dhanush

The doctors have clearly explained to me that the procedure has following possible complications:

- Anxiety

-

The doctor have explained to me about the alternatives, risks and benefits for this procedure that :

- Clue for diagnosis

I have understood the matter mentioned above in language known to me and give consent for the procedure.

Name of the Doctor performing the procedure: Radiologist & technicians

Patient Attendant :

Signature : [signature]

Name : NARESH

Relationship with Patient: FATHER

Date & Time : 25/6/26 @ 10AM

Witness :

Signature : -

Name : -

Date & Time :

Doctor (who is taking the consent) :

Signature : [signature]

Name : CH. GANESH.

Date & Time : 25/6/26 @ 10 AM

Docu. No. : RCH/FRM / CLINICAL / 019

ప్రత్యేక విధానాలకు సమ్మతి

రోగి పేరు .... లింగం ☐ పురుషుడు ☐ స్త్రీ

యు.హెచ్.ఐ.డి .... విభాగం .... తేదీ ....

నేను .... S/D/W/O ....

ప్రత్యేక విధానాలకు సమ్మతి ఇవ్వడం ద్వారా ....

నా రోగికి, పేరు : ....

ఈ ప్రక్రియ కోసం ప్రత్యామ్నాయాలు, నష్టాలు మరియు ప్రయోజనాలు గురించి డాక్టర్ నాకు తెలిసిన భాషలో వివరించా

....

....

....

నాకు తెలిసిన భాషలో పైన పేర్కొన్న విషయాన్ని నేను అర్థం చేసుకున్నాను మరియు ప్రక్రియకు సమ్మతిని తెలియజేస్తున్నాను.

ప్రక్రియ చేస్తున్న వైద్యుని పేరు : ....

సహాయకుడు(అటెండెంట్)

సంతకము ....

పేరు ....

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము ....

పేరు ....

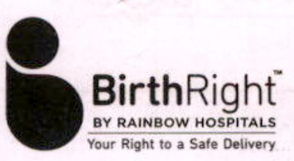
సాక్షి

సంతకము ....

పేరు ....

తేదీ మరియు సమయము ....

Ref. No. : F / HW / CON / HIV / 08



CONSENT FORM FOR HIV

Patient Name : Mast. Dhanush Age : 11yrs

Gender : M☑ F☐ - IP No : 60470 Marital Status : —

Ward / Bed No. : PICU IP/OP No. : 206225 Date : 25/6/26

I have to say that I have been counseled about the test and the reason for undergoing the test has been clearly explained to me. I have also been explained about the implications of the test result-positive, negative or indeterminate All the details pertaining to HIV, its transmission, testing procedure Its limitations and interpretation of the results have been explained to me in language that I can understand.

I, hereby give my willful consent for the HIV test to be conducted on me in order to ascertain my HIV sero status. The status of my HIV test will be confidential

Patient Attendant :

Signature : [signature]

Name : NARESH

Relationship with Patient: FATHER

Date & Time :

Parent (when patient is minor) :

Signature : —

Name : —

Relation : —

Date & Time : —

OR (Next to kin in case of unconscious patient) :

Signature : — Name : —

Relation : — Date & Time : —

I, certify that the Consent form for the HIV test has been signed in my presence and patient has been given pre-test counseling and post-test counseling is ensured by me and my team.

Doctor :

Signature : [signature]

Name : Dr. Vishwaja

Date & Time : 25/6/26 1:10pm

హెచ్.ఐ.వీ పరీక్ష అంగీకార పత్రం

రోగి పేరు ....,.............................. వయస్సు .... లింగం పు ☐ స్త్రీ ☐

వివాహస్థితి .... వార్డు / బెడ్ నెంబర్...

హెచ్.ఐ.వి టెస్ట్ గురించి నాకు అవగాహన కల్పించటమైనదనియు మరియు పరీక్ష చేయించుకోవలసిన కారణము నాకు స్పష్టముగా వివరించటమైనది అప నేను చెప్పుచున్నాను. ఈ టెస్ట్ ఫలితం యొక్క పర్యవసానాలకు పాజిటివ్, నెగిటివ్ లేక నిర్ధారణ విధానము, దాని పరిమితులు మరియు ఫలితాల వివరణకు నాకు అర్థమయ్యే భాషలో వివరించారు.

నా హెచ్.ఐ.వి. రోగస్థితి అంచనా వేయటానికి నాపై జరుపబడే టెస్టుకు నేను ఇష్టపూర్వకంగా తెలుపుతున్నాను. నా హెచ్.ఐ.వి. పరీక్ష ఫలితం రహస్యంగా వుంచాలి.

రోగి	సాక్షి
సంతకము:	సంతకము: ....
పేరు:	పేరు: ....
బంధము:	బంధము: ....
తేదీ మరియు సంతకము:	తేదీ మరియు సమయము: ....

(రోగి అపస్మారక స్థితిలో వున్నచో అతని దగ్గరి రక్త బంధువు)

పేరు:..	సంతకము: ....
సంబంధము :	తేదీ మరియు సంతకము: ....

హెచ్.ఐ.వి. టెస్ట్ అంగీకార పత్రంపై నా సమక్షంలో సంతకం చేయబడిన దనియు, టెస్టుకు ముందు ఇవ్వవలసిన సలహా ఇవ్వబడిన దనియు మరియు టెస్ట్ తర్వాత ఇవ్వవలసిన అవగాహన ఖచ్చితంగా ఇవ్వగలమని నేను నా బృందం ధృవీకరిస్తున్నాము.

డాక్టర్ ....

సంతకము ....

పేరు ....

తేదీ మరియు సమయము ....

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Dr. GEETHA CHANDA

Patien

LINICAL / 126

SCHOOL AGE (5-12 years)

Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : .... Time:	3 pm
Doctor / Nurse / Family Concern?	
Temperature (°F) (scale 104–94)	98.6°F
Heart Rate (bpm) and Blood Pressure (mmHg) * (scale 190–50) Note: BP does not score in early warning scoring	98 / (71) / 64
Heart Rate (Number)	110
Resp. Rate (bpm) (over 1 Minute) * (scale 70–10)	
Resp Rate (Number)	20
Resp Distress — Mod/ Severe	
Resp Distress — None / Mild	N
Receiving O_2 (l/min)	
O_2 Saturations (%)	99
Conscious Level — Normal	N
Conscious Level — Altered	
GCS *	15
TOTAL SCORE Number of shaded boxes	0
Pain Score	
Observer's Initials	[illegible]

Noted by Anitha 25/6 @3.30pm

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

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FLUID CHART

Sheet No. : ....

1. All measurements in ml.
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		Rice water									
25/6	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 :						

noted by Anitha 25/6 @ 3.30pm

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	Intake				Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
		Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			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											
	06:00 pm											
	07:00 pm											
Total Intake :						**Total Output :**						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						**Total Output :**						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						**Total Output :**						

Total 24 hrs. Intake	

Total 24 hrs. Output	

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MEDICATION RECONCILIATION FORM

Drug Allergies: Nil ☐ 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: PICU Shifted to: 131

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	INJ. LEVITIRACETAM	700mg	IV			☐C ☐DC
2	INJ. PANTAPRAZOLE	40mg	IV			☐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 : [signature], CH. GANESH

Date & Time : 25/6/2026.

Nurse Name & Signature: Sr. Sumanjali

Date & Time : 25/06/26 @ 1:5pm

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

Ref. No. : F / HW / DC / RP / INPR / 05.a

Patient Name	I.P. No.	Sheet No.	Wards	Weight (kg)

GULAR PRESCRIPTIONS

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

Ref. No. : F / HW / DC / RP / INPR / 05.a

Patient Name :	I.P. No.	Sheet No.	Wards	Weight (kg)

REGULAR PRESCRIPTIONS

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.				

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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 / 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 : INJ. LEVITERACETAM				Date ▸ / Time ▾
Dose	Route	Frequency	Start Date	
700mg	IV	as required	25/6	
Doctor's Signature		Valid Period	Pharm.	
[signature]		max 12th hrly		
Additional Instructions: 20mg/kg/dose				

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

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

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

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VIH-OP-6225

I.V. FLUIDS CHART

Weight. .... 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
25/6/26	2 AM	DNS (2/3rd)	IV	50	[signature]	Rinky / Renu	25/6	[signature]	[signature] / [signature]

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

...DHANUSH
07-10-2014 11 Y 8 M 18 D (M)
Dr. GEETHA CHANDA

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

VARIABLE ...	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.	

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
25/6	12:10AM	INJ LEVITERACETAM	700mg	IV	[illegible]	Nikith / Hema
25/6	1:35 AM	RABIVAX VACCINE	1ml	IM	[illegible]	Hema / Nikith
25/6.	1:35 AM	RABISHIELD Ig	100 IU @ site of wound	Infiltration at wound site.	[illegible]	Hema / Nikith
25/6	10:30AM	SYP. Pedicloryl	15ml	PO	[illegible]	Sumanjali / Tagarani
25/6	10:30AM	Inj. AcIT	15mg	IV	[illegible]	Sumanjali / Tagarani
25/06	10:15 AM	SYP. MELATONIN	5ml / 3mg	PO	[illegible]	Sumanjali / Tagarani

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REGULAR PRESCRIPTIONS

Weight. 35kg Ward. PICU

DRUG : INJ PANTOPRAZOLE				Date / Time	25/6
Dose	Route	Frequency	Start Date		
40mg	IV	ONCE DAILY	25/6/2026	6AM	2AM
Name & Signature of the Doctor Starting the Drugs: Dr Sweel, [illegible]					Rinky Renu
Additional Instructions: @ 1mg/kg/dose.					
Daily Doctor's Endorsement by a Sign					

S. Meenakshi 25/6/26

DRUG : INJ LEVETIRACETAM				Date / Time	25/6
Dose	Route	Frequency	Start Date		
700mg	IV	12 HOURLY	25/6/2026	12AM	X
Name & Signature of the Doctor Starting the Drugs: Dr Sweel - [illegible]					8/8
Additional Instructions: @ 20mg/kg/dose				12PM	[illegible]
Daily Doctor's Endorsement by a Sign					

S. Meenakshi 25/6/26

DRUG : T. LEVEPIL				Date / Time
Dose	Route	Frequency	Start Date	
1 tab	PO	12 hourly	25/6	
Name & Signature of the Doctor Starting the Drugs: Dr [illegible]				
Additional Instructions: 1 tab = 500mg				
Daily Doctor's Endorsement by a Sign				

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