

MLC

VIH-00128871 IP-00060283
Master R.SREEVEDH CHARY
09-11-2015 10 Y 7 M 0 D (M)
Dr. GEETHA CHANDA



ACTIVITY RECORD FOR BILLING

Name: -----
UHID No : ----- IP No : ----- Consultant : ----- Dept : Pediatrics
Date of Admission : 9/6/26 Time : 6:46 AM Date of Discharge : ----- Time: -----
Room / Bed No : 218 Ward : 2nd Floor Suggested Billable bed type : -----

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
9/6/26	10:15 AM	ER	218	[Signature]
9/6/26	10:15 PM	215	PICU	[Signature]
10/6/26	12 PM	PICU	108	Reulka

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1.	DR. Sai Krishna	09/06/2026	3088449 ✓	[Signature]
2.	Dr. reba Jain	9/6/26	3088516 ✓	[Signature]
3.	<u>cross checked by Saha</u>			
4.	Dr. Arjun Kumar			
5.	Dr. Seetha Krishna	11/6/26	3089070 ✓	[Signature]
6.	Dr. Sandhya Kaddi	11/6/26	3089247 ✓	[Signature]
7.				
8.				
9.				
10.				

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
9/6/26	IV placement	1	3088403	Br Shantha Kamari
09/06/26	AABR	1	3088447	sep
<i>cross checked by [red line]</i>				
09/6/26	1/2 placement	①	3088562	Ⓜ
<i>cross checked by [red line] neha 10/6/26 2:30</i>				
11/6/26	Pure Tone Audiometry	301	3089074	f
	Tympanometry	1	3089081	g
	Wplacement	1	3089343	v
<i>cross checked by [red line] leizah v</i>				

ANY OTHER INFORMATION

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.....

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.....

.....

Date : _____ Time : _____ Prepared By : _____

Staff Nurse	Shift / Ward <i>leizah v</i>	Billing Assistant	Billing Supervisor
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Name	Master R.SREEVEDH CHARY	UHID	VIH-00128871
Father/Guardian	Mr R.VENKATA CHARY	Age/Gender	10 Y 7 M 0 D/Male
Address	HNO 2-45 SHIVALAYAM STREET VILLAGE ALIYABAD MANDAL SHAMIRPET ,, Shamirpet, Hyderabad, Telangana, INDIA, 500078		
IP No	IP-00060283	Admission Date	09-06-2026
Ref Doctor	Self	Discharge Date	13-06-2026

DISCHARGE SUMMARY

Consultants:

Dr. GEETHA CHANDA

MBBS, MD, Pediatrics
PDF Pediatric Neurology
Consultant Pediatric Neurologist
APMC/FMR/87648

Dr. Sindhura Pappula

MBBS, MD, DrNB (Pediatric Neurology),
FIPN, FIAMG
Consultant Pediatric Neurologist

Dr. RAMESH KONANKI,

MD Pediatrics (AIIMS),
DM Pediatric Neurology (AIIMS),
CONSULTANT PEDIATRIC
NEUROLOGIST, APMC-49226

Diagnosis: Traumatic Brain Injury with Cerebral Venous Sinus Thrombosis (Left internal jugular vein thrombosis and left sigmoid thrombosis) with left mild conductive hearing loss

History: Master R. SREEVEDH CHARY, 10 Y 7 M, boy presented with alleged history of fall from bed (approx 5 feet height) at 03:30 am on 09.06.2025 at Navodaya Hostel followed by 2 episodes of non bilious non projectile vomitings within 15-30 minutes after fall. History of decreased hearing on left side, pain in left temporal area and giddiness, swaying while walking. For the above complaints, he was admitted at Rainbow Children's Hospital for further management.

Name

Master R.SREEVEDH
CHARY

UHID

VIH-00128871

Birth History: Born to non consanguineous couple, 1st in birth order, FT/LSCS/Birth weight - 2.5 Kgs/Cried immediately after birth / No perinatal complications.

Developmental History: Appropriate for age.

Examination: He was afebrile, maintaining saturations at room air. HR- 94/min, BP- 118/73 mmHg and RR - 26/min. On auscultation of chest, air entry was bilaterally equal with normal heart sounds and there was no murmur. Abdomen was soft without organomegaly. Bowel sounds were heard.

Neurological examination: Child was conscious and alert. Pupils were bilaterally equal and reacting to light. EOM Full. Left beating nystagmus present. DTR +2. Tone normal. Power - 5/5. Plantars flexors. There were no focal neurological or cranial nerve deficits. There were no signs of raised intracranial pressure. No meningeal signs.

Weight on admission : 33.1 kgs.

Investigations: Enclosed.

Management: He was admitted in the ward started on IV fluids and antacids.

His complete blood picture showed Hb 11.7 gm%, WBC count of 14,470 cells/cumm, platelet count of 2.44 lakhs/cumm. Serum electrolytes showed Na - 107 mmol/L, K - 141 mmol/L, Cl - 105 mmol/L. Serum creatinine 0.5 mg/dl.

CT scan brain was done which showed left Internal jugular vein and transverse sinus thrombosis, for which MR venography was suggested.

Name

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Hospital**
It takes a lot to treat the little.


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In view of decreased hearing on left side, Hearing test (AABR) was done which was suggestive of Left ear- Hearing screening results indicates no valid response (REFFER), Right ear- Normal and advised BERA test for detailed diagnostic evaluation and to review with Pediatric Neurologist.

In view of hearing loss and giddiness, child was seen by Dr. Neha Jain, ENT Surgeon, who advised HRCT - Temporal bone (Concentrating on ossicular chain status cochlea and vestibule apparatus) and to review with report and advised Tablet Stemetil.

MRI brain with MR venography was done which showed T2 hyperintensity within distal transverse, sigmoid sinus and IJV on left side - likely thrombosis. Mildly enhancing subgaleal soft tissue is noted along left parietal lobe with small fracture line underlying it in the left parietal bone and with mild underlying dural enhancement. Homocysteine level was 16.7 umol/L. Vitamin B12 level was 260.

Injection Enoxaparin started.

Child was seen by Dr Sandhya, consultant hematoncologist was advised to do prothrombophilia workup after 2 weeks to assess or rule out the thrombotic risk, although looks like post trauma which was advised by neurophysicians and ENT surgeon.

HRCT temporal bone was done which showed left vestibular aqueduct - high riding jugular bulb dehiscence.

Child was seen by Dr Ajay, consultant ENT surgeon, who examined and made diagnosis of left conductive hearing loss with ET dysfunction and advised to start inj ceftriaxone , tab vertin, inj paracetamol and inj ondansetron.

Gradually, vomiting episodes got subsided and vertigo gradually resolved partially.

He was regularly monitored for fever spikes, hemodynamic status, vital parameters & neurological status, oxygen saturations and any signs of respiratory distress. His symptoms gradually settled. He remained hemodynamically stable during the hospital stay and is being discharged with the following advice.

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

Neurological condition at the time of discharge:

He is conscious, awake.

EOM full.

Pupils are bilaterally equal and reacting to light.

Tone normal.

No focal neurological deficits.

DTR-+2

planter- flexor

Advice:

1. Diet as advised.
2. Physiotherapy as advised.
3. Do Prothrombotic work up - after consultation with Dr. Sandhya Vaddadi.
4. To start Tablet RIVAROXABAN (10mg) once daily after 23/6/2026.
5. Kindly consult Dr. Geetha Chanda, Consultant Pediatric Neurologist, on 24.06.2026 (Wednesday) in OPD with prior appointment (This consultation will be charged).
6. Kindly consult Dr. Ajay Kumar, Consultant ENT Surgeon, on 15.06.2026 (Monday) in OPD with prior appointment (This consultation will be charged).
7. Kindly consult Dr. Tanuja Khurana, Dentist, on 15.06.2026 (Monday) in OPD with prior appointment (This consultation will be charged).

Name

Master R.SREEVEDH
CHARY

UHID



8. Kindly consult Dr. Sandhya Vaddadi, Consultant Pediatric Hemato-oncologist & Pediatrician, on 18.06.2026 (Thursday) in OPD with prior appointment (This consultation will be charged).

Tablet VERTIN (16mg)	1 tablet, 12 th hourly till further advice
NASIVION-P NASAL DROPS	2 drops in each nostril, 12 th hourly for 3 days
NASOCLEAR NASAL DROPS	3 drops in each nostril, 6 th hourly for 3 days
Injection ENOXAPARIN	30 mg Subcutaneous 12 th hourly till 23/6/2026
Tab CEFIXIME(100mg)	1 tablet 12 th hourly for 3 days and STOP
Tab ONDEM (4mg)	1 tab SOS for vomiting

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

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).

Name

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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. Nikesh
DEO :MD Younus Pasha

Registrar/Resident/C.M.O

Consultants:

Dr. GEETHA CHANDA

MBBS, MD, Pediatrics
PDF Pediatric Neurology
Consultant Pediatric Neurologist
APMC/FMR/87648

Dr. Sindhura Pappula

MBBS, MD, DrNB (Pediatric Neurology),
FIPN, FIAMG
Consultant Pediatric Neurologist

Dr. RAMESH KONANKI,

MD Pediatrics (AIIMS),
DM Pediatric Neurology
(AIIMS), Consultant Pediatric
Neurologist, APMC-49226

ADMISSION SHEET



Registration Details :

Admission No : IP-00060283 Admit Date : 09-Jun-2026 Admit Time : 06:06 AM UHID : VIH-00128871

Patient Details :

Patient Name	: Master R.SREEVEDH CHARY	Age	: 10 Y 7 M 0 D
Guardian	: Mr R.VENKATA CHARY	DOB	: 09-11-2015
Gender	: Male	Religion	:
Occupation	:	Martial Status	: Single
Address (H)	: HNO 2-45 SHIVALAYAM STREET VILLAGE ALIYABAD MANDAL SHAMIRPET , Shamirpet Hyderabad Telangana INDIA 500078	Phone No	: 9949089730
		E-mail	: CHARY.RV8@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 R.VENKATA CHARY Relationship : S/O
Contact Address : HNO 2-45 SHIVALAYAM STREET VILLAGE Phone No : 9949089730
ALIYABAD MANDAL SHAMIRPET , Shamirpet
Hyderabad Telangana INDIA 500078

[Handwritten Signature]
Signature

Doctor Details :

Doctor Name : Dr. GEETHA CHANDA Specialisation : PEDIATRIC NEUROLOGY
Referral Doctor : Self Phone No :
Co-Consultant :

Payment Details :

Payment Mode : Cash Deposit Amount : 0.00
Payor Name : CARE HEALTH INSURANCE LIMITED

Patient Name : Mast. R.SREEVEDH CHARY UHID : VIH-00128871 IPD : IP-00060283 Gender : Male Age : 10

VIH-00128871 IP-00060283
Master R.SREEVEDH CHARY
09-11-2015 10 Y 7 M 0 D (M)
Dr. GEETHA CHANDA



MLC



NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date: 9/6/26 Time of arrival: 5:52 AM
Chief Complaints: fo. Fall from Bed @ 3 Vomiting RBS: 10.7 mg/dl
Height: 145 cm Weight: 33.18 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 Parents

Siblings in household Yes No (if yes How Many?) 1 - (sister)

Time of Initial assessment completed by ER Nurse: 5:56 AM

Patient Name : Mast. R.SREEVEDH CHARY UHID : VIH-00128871 IPD : IP-00060283 Gender : Male Age : 10 Y 7 M 0 D

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

Time	Nursing Notes
5:45 AM	Patient Came to ER
5:48 AM	Vitals checked & Recorded
5:50 AM	ER doctor seen the patient & Doctor advised Admission
6:00 AM	Admission done
6:20 AM	IV Placement done, Sample collected Sent to lab
10:10 AM	Shifted to Room [218]

Samples collected by: Snagathika

Time: 6:25 AM

Samples sent by: Shanthi

Time: 6:35 AM

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1
9/6/25 6:30 AM	3% NS	IV	150ml	Dr. Vishnuja	Varshani

Condition of patient at time of shift - out :	Details of Shift - out
HR: 94b/m BP: 118/73(8) CFT: 42sec RR: 26b/m SPO ₂ : 99% GCS: 15/15 Temperature: 96.1°F Pain Score: 0 Repeat RBS (if applicable): —	Shift - out from ER to: Room [218] Time of Shift - out: @ 10:15 AM Handover given to: Sr. Nagarani (Nurse's Name)

Tick as applicable: MLC LAMA BROUGHT DEAD

Procedures done with details (if any):

IV placement done

Name of the Nurse: Suvarra

Signature of the Nurse: 

Date & Time: 9/6/26 @ 10:15 AM

Patient Name : Mast. R.SREEVEDH CHARY UHID : VIH-00128871 IPD : IP-00060283 Gender : Male Age : 10

VIH-00128871 IP-00060283
 Master R.SREEVEDH CHARY
 09-11-2015 10 Y 7 M 0 D (M)
 Dr. GEETHA CHANDA



MLC

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BirthRight
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EMERGENCY ROOM TRIAGE FORM

wt - 33.18kg

Patient's Name: Mast. R. Sreevedh Age: 11 years Gender: Male Female

Date: 9/6/26 Time of Arrival: 5:45 AM

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

Source of Information: Parents Others (Specify) _____

Mode of Arrival: Ambulatory Wheelchair Ambulance

Initial Vital Signs: Temp: 96.1°F PR: 94b/m BP: 118/130 RR: 26b/m SpO₂: 99%

Chief Complaints: 40. Fall from Bed & 3 Vomiting

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

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

NOTE: All immunocompromised children and preterm babies to be considered Level 2.
 All Children less than 2 years age with high fever to be considered Level 3.

* CTAS - Canadian Triage and Acuity Scale

P. Saritha
 Signature of Parent / Guardian
 Triage Completion Time: 5:48 AM

Communicable Disease Triage Screening

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

- Have you had fever (elevated temperature) in the past 2 weeks Yes No
- Have you had cough or a rash in the past 2 weeks Yes No
- Have you had shortness of breath or difficulty breathing in the past 2 weeks Yes No

PART B. For patients reporting fever and respiratory/rash symptoms: Not applicable

- Have you travelled outside the INDIA? or had close contact with someone who has recently travelled outside the INDIA, in the past two weeks? Yes No
 If yes, State Location: _____
- Are your parents / close contacts at home is/a healthcare worker? {please encircle the choices} (e.g., nurse, physician, ancillary services personnel, allied health services personnel, hospital volunteer, or laboratory worker, others) who has had a recent exposure to an individual with a highly communicable disease or unexplained, severe febrile respiratory or rash disease? Yes No

PART C. A positive communicable disease triage screening is considered for any patient who meets one of the two following criteria:

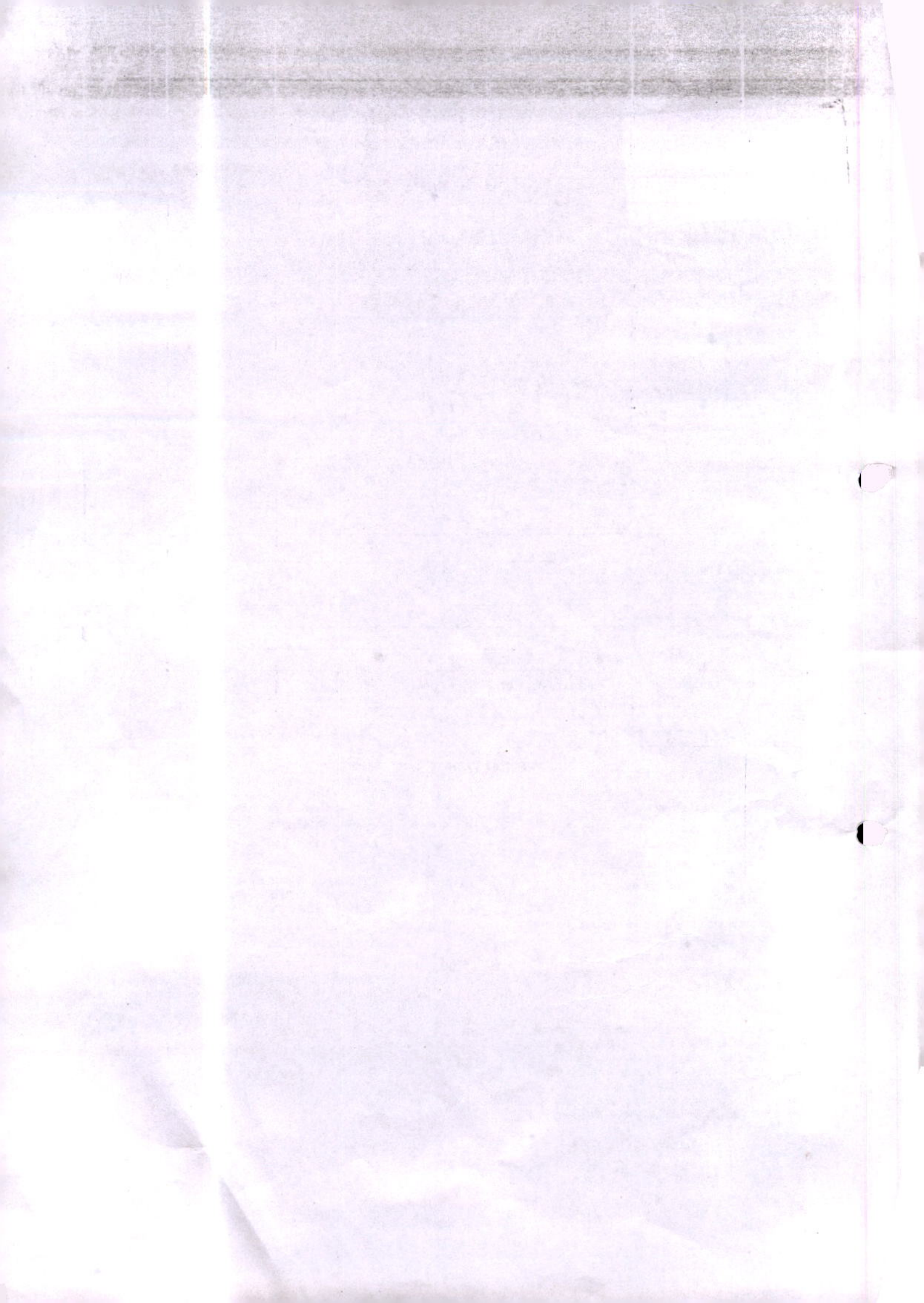
- Any patient with Fever / Rash / Vesicles / Discharge from Eyes and Cough
- Any patient with fever and respiratory symptoms who answered "YES" to any of the questions on epidemiologic risk factors in "PART B" of the triage screening above.

PART D. ACTION / INTERVENTION: (for positive suspected communicable disease triage screening)


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

Name of Triage Nurse: Vaishnavi
 Date & Time: 9/6/26 @ 5:48 AM

Vaishnavi
 Signature of Triage Nurse: _____



PATIENT TRANSFER FORM

VIH-00128871 IP-00060283 Master R. SREEVEDH CHARY 09-11-2015 10 Y 7 M 0 D (M) Dr. GEETHA CHANDA 		Date & Time of Admission	Date & Time of Transfer Order
Treating Consultant Name 2nd Floor		9/6/26 6:06AM	9/6/26 @ 10:15PM
Transfer Ordered by Dr. Nitesh		Reason for Transfer observation	
From Unit 2nd Floor	To Unit PICU	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File 35 page	Number of Imaging Films CT - 1 MRI - 1 HRCT - 1	Personal belongings including clinical documents. If any handed over to attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> If yes, what?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	Tl-stemetel	sterile water: ⑤	
2.	2-cc	6	
3.	10-cc.	1	
4.	5-cc	⑤	
5.	Ondansetron injection	①	
Shifting Summary / Notes Written by Doctor : Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring Raja		Name of Person Ordered Transfer Dr. Nitesh	
Patient & Clinical Records Received by : Su. maheswari			
Date & Time of Patient Received : 9/6/26 @ 10:15PM			

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



Nursing General Admission Assessment Form For Pediatrics

Diagnosis: Traumatic Brain Injury
 Arrival Time: 10:10 AM Mode of Arrival: Street Admitting From: ER OPD Direct

Allergy / Adverse Reaction: Nil Body Weight: 33.1 Kg
 Height: 115 cm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
<u>Dengue</u>	<u>Nil</u>	<u>Yes</u>

Family History: Nil

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

If yes please list,

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

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

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

Observations: Weight: 33.1kg Length: 115 Head Circumference (< 2 years): 48
 Temp.: 98.2 F HR: 106 b/m RR: 24 b/m BP: 100/59 mmHg

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

Fall Risk Assessment: Yes No Score: 14 (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 If Yes, Pain Score: 0 Pain Tool Used: N Pass FLACC Wong Baker

Character of Pain: Nil Location: Nil Frequency: Nil Duration: Nil

FUNCTIONAL SCREENING: No Abnormalities Detected
 Mobility Problem Walking Problem
 Developmental Delay Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING: No Abnormalities Detected
 Underweight Overweight Special Feeding Method
 Feeding Problem Special diet No Abnormality Detected

Inform consultant for positive criteria

Psychological Screening: No Significant Findings

Unusual concerns about patient's Psychological Status: Yes No

If Yes Consultant Notified: (Date/Time):

Social History: Lives With Parents

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 Parents

Nurse's Name: Ir. Nagman Date: 9/6/26 Time: 10:40 AM Signature: [Signature]



NURSING INITIAL ASSESSMENT FOR PICU

Date of Admission: 09/06/26
 Source of Admission: OPD Ward Other: 2nd Floor
 Reason for Admission: C/O fall from Bed and vomiting
 Admission Diagnosis: TBI
 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 : <input checked="" type="checkbox"/> Family <input type="checkbox"/> Patient <input type="checkbox"/> Others, Specify _____			
SIGNIFICANT HISTORY	Past Medical History	Past Surgical History	Last Hospital Admission
	null	null	null
	Family History: <u>null</u>		
	Has the child or close family member had recent contact with a communicable disease? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes please list, _____ Was the child's birth normal? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If No, please describe problems: _____ Are the child's immunization up to date? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
CURRENT MEDICATIONS	Taking Medications? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, Fill the reconciliation form Medicine brought to the hospital? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Observations: Weight: <u>33.18kg</u> Length: _____ Head Circumference (< 2 years): _____ Temp.: <u>98.6 F</u> HR: <u>116b/m</u> RR: <u>26 b/m</u> BP: <u>118/73 (88)</u> Pain Score: <u>0</u> Specify Site: _____ (Follow Pain Assessment Sheet & Document) Fall Risk Assessment: <input type="checkbox"/> Yes <input type="checkbox"/> No Score: <u>8</u> (Document in the Humpty Dumpty Sheet) Risk of Pressure Sore (Braden Q Score <u>22</u>) (Document in the Braden Q Assessment Sheet)			



Behavioural Status on Admission :

- Sleeping Crying Calm Distressed/Console Drowsy

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

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

Inform consultant for positive criteria

NUTRITIONAL SCREENING:

- Underweight Overweight Special Feeding Method
 Feeding Problem Special diet No Abnormality Detected

Inform consultant for positive criteria

Psychological Screening: No Significant Findings

Unusual concerns about patient's Psychological Status: Yes No

If Yes Consultant Notified: (Date/Time):

Social History: Lives With Parent

Siblings in household Yes No (if yes How Many?) 1 Sister

Orientation has been given regarding the following aspects:

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

Orientation given to: Family Others specify

Name of Person Orientation was given to: mother

Orientation not given Reason:

Nurse Name: Maheswari

Nurse Signature: Maheswari

Date & Time: 9/16/26 @ 10:20 PM

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: TBI


Final Diagnosis: TBI

Nurse Name: Maheswari

Nurse Signature: Maheswari

Date & Time: 9/16/26 @ 10:25 PM

PATIENT TRANSFER FORM

Patient Name & UHID No. VIH-00128871 IP-00060283 Master R.SREEVEDH CHARY 09-11-2015 10 Y 7 M 1 D (M) Dr. GEETHA CHANDA 		Date & Time of Admission 9/6/26 6:00 AM	Date & Time of Transfer Order 10/6/26/1:50 PM
		Transfer Ordered by Dr. Geetha	Reason for Transfer child is stable
From Unit D1W	To Unit 1st floor (108)	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File 6	Number of Imaging Films Cot. Brain films MRI films	Personal belongings including clinical documents. If any handed over to attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	2 cc - (2)		
2.	5 cc - (5)		
3.	Mouth wash - (1)		
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring Renuky 10/6/26/1:50 PM		Name of Person Ordered Transfer Dr. Geetha	
Patient & Clinical Records Received by : manisha			
Date & Time of Patient Received : 10/6/26 @ 1:50 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

Attender Sign :- Wibrow

16/6/26 / 1:30pm

The Patient Attending.

This all Reports given to

Medical Summary

Lab Reports

C.T. Temporal Bone (3)

M.R.I. films Brain Contrast - (6)

C.T. Films - (2)

→ Brain


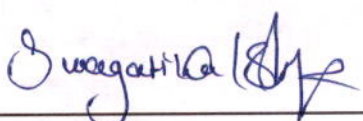


PATIENT TRANSFER FORM

MLC

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

BirthRight[™]
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

VIH-00128871 IP-00060283 Master R. SREEVEDH CHARY 09-11-2015 10 Y 7 M 0 D (M) Dr. GEETHA CHANDA  Regularly Consultant Name		Date & Time of Admission 9/6/26 @ 6:06 AM.	Date & Time of Transfer Order 9/6/26 @ 10:15 AM
		Transfer Ordered by Dr. Vishwaja.	Reason for Transfer Admission
From Unit ER	To Unit 218	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File 25	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 ?	
Medications / Consumables / Surgicals / Hand over OP			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring 		Name of Person Ordered Transfer Dr. Vishwaja.	
Patient & Clinical Records Received by : Sr. Nagmani			
Date & Time of Patient Received : 9/6/26 @ 10:20 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



MLC

Rainbow[®] Children's Hospital

It takes a lot to treat the little.

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: _____

VIH-00128871 IP-00060283
Master R.SREEVEDH CHARY
09-11-2015 10 Y 7 M 0 D (M)
Dr. GEETHA CHANDA

UHID ID: _____



Department: _____

Consultant: _____



Pediatric Multiorgan History & Physical Examination

Name : Sneekth Age/Sex _____
Information given by : mother, father Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

1st Fall from Bed (5 feet height) @ 2:30 AM
on 9/6/26 @ Narodaya Hostel.
flby 2 episodes of Vomiting.

History of present illness :

Child was brought by parents with
flby fall from bed (3-4 feet height) @ 2:30 AM on
9/6/26 @ Narodaya Hostel

flby 2 episodes of vomiting in 15-30 min post fall
a/w ↓ hearing on left side. → NB/VP / Non blood
pain in left temporal area. stem

Giddiness ⊕
swaying while walking
Contant - food.
NO H/O
seizures / LOC

O/E : Child mild drowsy, Giddiness ⊕.
pupils O/E reactive
RR - 10 / min
difficulty in walking
Gr. post fall

H/O Fever last week - managed on orobaxis



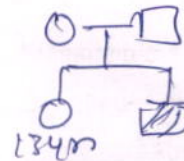
Pediatric Multiorgan History & Physical Examination

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

H/O admission for dengue @ 7yr age
(100)

Birth & Neonatal History:

Term/ ease (water / 3.5kg / no complications)



Birth & Socio Economic History:

About Father : _____

About Mother : _____

Any additional Information : _____

} class III

Developmental History :

appropriate for age in all domains

Immunization History :

Received upto date



Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs)) 33.1kg (Centile _____)

On Examination :

Temperature : 96.8 Pulse Rate : 94/min B.P. 118/73 SPO2 99%

Resp.rate and type of breathing : 22/min

Rash (-)

Lymphadenopathy (-)

Oedema : (-)

Allergies (if any): (-)

Respiratory System :

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

Air entry & breath sounds : B/LC/T (+)

Any addes sounds : W/D

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

Cardiovascular System :

Inspection of procordium : (N)

Heart Sounds : S1S2 (+)

Any murmur : NO

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

Per Abdomen :

Inspection (N)

Palpation : SOFT

Ausculation : R/L (+)

Spine : (N) External Genitalia : _____

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

Pediatric Multiorgan History & Physical Examination

Central Nervous System : _____

Level of Consciousness : AVPU/GCS score : Awake 15/5

Cranial Nerves : Intact

Motor System:

Nutriton : _____

Tone : _____ Power 4/5 all limbs

Co-ordinator : _____

Posture : _____

Involuntary Movements : NO

Reflexes :

DTR

Superficials:

Plantars flexor

Sensory System : _____

Bladder / Bowel : No incontinence.

Clinical Summary & Diagnostic:

? TBI



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: To prevent complications.

Desired goals of the treatment: To treat current condition

Planned Labs:

Plasm - ① } CBP ✓
EDTA - ① } SPE ✓

Dr. Geetha Chanda
Planned Management

RIS - 107mg/dl

- 1) IV fluids. - if required.
- 2) CT Brain & Bone window.
- 3) ENT opinion to

Noted by *shweta* 9/6 @ 6:36 AM
2/0/0 ↓ Hearing on - left ear

Tennet

Signature of the Doctor: *C. K.*

Signature of the Consultant: *[Signature]*

Name of the Doctor: *Dr. Vishwas*

Name of the Consultant: *[Signature]*

Date & Time: *9/6/15*

Date & Time: *[Blank]*




PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/10/20	<p>SB <u>Necessity</u></p>	
	<p><u>AFI</u> - TBI 9 temporal bone injury on left side</p>	<p><u>Plan</u> <u>ENT revision</u></p>
	<p><u>df</u> - Nausea with vomiting - No headache Not able to hear on left side</p>	<p><u>Track</u> & continue <u>MR venogram to plan</u></p>
	<p><u>df</u> EUSTACHY conscious, oriented papils - equal, reacting EOM - full <u>df</u> force - df DTR - F3 plantars - flexor</p>	<p><u>NPO after 11.30 AM</u> <u>Audiological testing (hearing testing)</u> <u>Dr. Santhosh (ABR)</u></p>

Boja Note by
 abbb



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/6/26 3pm	<u>Cl/B Residual</u>	
	<u>Traumatic Brain Injury</u>	
	O/B Conscious C/S - S/Ls (N) B - B/LA/E (N) RA - S/L V/Ly & S/Ly	<u>Plan</u> - ENT Review - continue same
	dictated by Abanika 09/06/26 @ 4pm	 Dr. Shweta



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<u>9/6/25</u>	<u>STB Neurosurgery</u>	
	<p><u>ADT</u> - TBI with left side SNHL with left ICA & sigmoid thrombosis</p>	<p><u>Plan</u></p>
<p><u>9/6</u></p>	<p>more left neck & head pain</p>	<p>Sub. Enxaparin <u>1mg/kg</u></p>
	<p><u>(+) neurosurgery</u></p>	<p>→ shift to ICU for further management</p> <p>↓</p> <p>CBP, PT with INR, LFT</p> <p>↓</p> <p>If <u>(+)</u></p> <p>↓</p> <p>start Enxaparin</p>
<p>Note by Raju 9/6/25 es:usm</p>		<p>→ watch for signs of ICP seizures weakness encephalopathy</p>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/5/26 8:35 PM	<p><u>Shifting notes</u></p> <p>→ This child is being shifted for thrombolysis with monitoring in case of ICH IJV with sigmoid sinus thrombosis</p>	
9/5/2026 10:20 PM	<p>Case received in ICU</p> <p>D^r - The ICH side SWAC</p> <p>(4) IJV & sigmoid thrombolysis</p>	
<p>on NA.</p> <p>Haemodynamic stable</p>	<p><u>Plan</u></p> <p>1) DO give Enoxaparin 30 mg SC / 12 HRly</p> <p>(CAF PR, appt. Wk (N))</p> <p>2) w/f signs of raised ICP 'pupil monitoring' w/f hypertension (BP > 120/80) Altered consciousness Cerebral activity</p> <p>3) head end elevation 30° (Anti-Rolled bed measures)</p> <p>4) WF to continue (1/2)</p> <p>5) <u>clay rigidity</u></p>	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/06/2026	Cancelling notes (pr/geetha)	
7:40 PM	Due to full there is thrombosis near (4) & Jv & d	
	Simulated Simultaneously causing tinitus and vertigo	
	and is ^{sub} Anticoagulant therapy for the same.	
	Due to thrombosis there is ongoing tinitus and giddiness.	
	As the thrombosis resolves, these symptoms will improve.	
	plan to shift to ward # by evening, if stable	
		7:40 PM



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/06/2016 7:30 AM	e/s/B Dr. Geetha D'S - TB 2 E (L) side SNHL Lt 2/3 of sigmoid Thrombosis	
	Kidney (+) Tinnitus (-) Pain oral (L) Maxilla region (+) Nystagmus (+) (L) side	
	Received (+) dose of Etoposide No signs of renal hep hemodynamically stable	Rx 1. Ondem 1/6 tramadol 2. Continue Enoxaparin. 3. To send Prothromb both work up Serum B12, Homocysteine
Medical Summary	<p>Noted by Renuka 10/6 e 1 PM</p>	<p>4. ENT review - Dr. Neha Jain 5. Shift to room (ward) 6. Pure tone audiometry</p>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/6/2026 8:45 AM		Shifting Summary (Notes)
	<p>10 y Male child Presented with H/O fall from 4 feet also vomitings, (C) Hearing loss, Swaying while walking as per Dr. Neha Jain it was normal, the MR venogram done which showed sigmoid sinus thrombosis, CBA PT, APTT & INR done which were ok then. So the child received one dose of Enoxaparin and monitored for raised ICP signs. Fortunately he was fine no raised ICP signs hence shifting to room with following advice</p>	
		<p style="text-align: center;"><u>Plan</u></p> <ul style="list-style-type: none"> - Pure tone audiometry - ENT review by Neha Jain - To send Prothrombotic work up, Serum B12, Homocysteine; - Continue Enoxaparin & Steroids - Esomeprazole - vitals CTR by - w/ raised ICP during vomitings, seizures, altered sensor

Noted By
 Manisha
 10/6/26
 10:30pm

w/ raised ICP during vomitings, seizures, altered sensor (P.T.O)

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	<u>for Necessity</u>	
<u>01/16/26</u> <u>8:15 AM</u>	<p>4 HTS - TBZ worth left hearing loss (SNHL) with left IJV & Igmod thrombosis</p>	Plan
	<p><u>4/0</u> vomiting 1 episode weakness better (~10%), no vertigo, headache</p>	<p>T/D <u>add force</u> <u>audiometry</u></p>
	<p><u>9/6</u> EAVSM, CRTAL - (NO) Conious, oriented speech - (NO) Pupils - RL equal, reacting EOM - full, left Nystagmus - RT</p>	<p>ENT REVIEW (Dr. Meha Jha) after PTA</p> <p>Hematologist to review (Dr. Sandhya)</p>
	<p><u>10/10</u> Force - 5/5</p>	<p>PTA Tympanometry</p>
	<p>DIR - +2/+3 No neck rigidity</p>	<p>noted by Navya's 11/16 07/20</p>

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/6/26	J/S Nausea/vomiting	Plan
<u>9:00</u>	No further vomiting	<u>S. Homocysteine</u>
<u>9:15</u>	conscious, oriented pupils - RH equal, reacting EOM - full vitals good	- Inj. Diazepam 4mg iv over stat noted by Manasa 11/6 2:30 PM



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<u>12/6/26</u>	<u>TB Neurology</u>	
	<p><u>ATI</u> - TBI with left conductive HL with left JSV & sigmoid thrombosis</p>	<p>(Plan)</p>
	<p><u>cep</u> No further vomiting resolve vom.</p>	<p><u>Issue J. Neurology</u></p>
	<p>(P) <u>ATI</u> (D) Concussion resolved EOM - full No nystagmus gait - Alexia + up (btkd) (N) <u>ATI</u> (L) <u>ATI</u> JFR - +2 Altered - fixate</p>	<p><u>TM PT, APTT in morning</u> <u>TM Discharge</u></p>
<p>Noted by Bewanika 12/6 @ 9pm</p>		<p><i>[Signature]</i></p>

VH-00128871 IP-00060283
 Master R. SREEVEDH CHARY
 09-11-2015 10 Y 7 M 3 D (M)
 Dr. GEETHA CHANDA



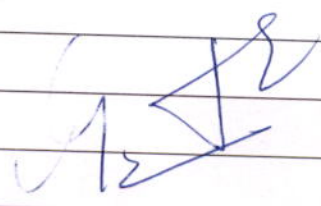
PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<u>12/6/26</u>	<u>SIB</u>	
		(Pren)
	No vomiting Dizziness better	TIM PRICPT in <u>morning</u>
(PK)	Vitals - (AD)	<u>TIM Discharge</u>
	1 LPP Seating instructions	TIM Vitamin B12 levels
		Noted by Bevanika 12/6 @ 8pm

1-00128871 IP-00060283
 Dr. R. SREEVEDH CHARY
 10 Y 7 M 3 D
 Dr. GEETHA CHANDA

(M) Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
13/6/26	<p> <u>IB</u> <u>Neurology</u> </p>	
	<p> <u>IB</u> → TBI with mild left conductive hearing loss with left IJV & sigmoid thrombosis </p>	<p> <u>IB</u> TBI c CSVT (left) </p>
<p> $\frac{1}{2}$ </p>	<p> No further complaints great better </p>	<p> <u>IB</u> PT, APTT → $\frac{1}{2}$ </p>
<p> $\frac{1}{2}$ </p>	<p> vitals - $\frac{1}{2}$ ECG - full mild ketosis free </p>	<p> <u>IB</u> vit B12 levels <u>IB</u> TTD discharge </p>
	<p> $\frac{1}{2}$ long power - 5/5 </p>	
	<p> DTR - +2 Reflexes - present </p>	



NURSE HAND OFF COMMUNICATION - ICU

SITUATION & BACKGROUND	DOA: 9/6/26	Diagnosis: TBI	Surgery / Procedures: -	
	Allergies: -		Post OP Day: -	
	Date: 9/6/26			
	Area	P	PICU	
	Shift Time		8PM-8AM	
	Diet:		NPO	
INVASIVE LINES	Ventilation (RA, NP, NIV, VENTI)		R/A	
	1.		Iv cannula	
	2.			
	3.			
	4.			
ASSESSMENT	Infusions / Transfusions		DNS @ 47 ml/hr	
	PU Prophylaxis		Nil	
	DVT Prophylaxis		Nil	
	Vitals	BP		10/60 (12)
		PR		92 bpm
		RR		18 bpm
		SpO ₂		100%
		Temp		98.2°F
	Pain Score		0	
	LOC (Alert, Conscious, Confusion, Unconscious)		Alert	
	Skin Integrity (Intact / Bedsore / Any other condition)		Intact	
	Restraints If any	Physical		Nil
		Chemical		NIV
Fall Risk (Vulnerable Y/N) if yes score		8		
(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			PKC 8pm-8pm
		Shift Time			
		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 :				<u>Mahar</u>	
Signature :				<u>Mahar</u>	
Date:				10/6/20	
Time:				8pm	
Taken Over By Name :				h.	
Signature :					
Date:					
Time:					

VH-00128871 IP-00060283
 Master R.SREEVEDH CHARY
 09-11-2015 10 Y 7 M 0 D (M)
 Dr. GEETHA CHANDA



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BirthRight
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 Your Right to a Safe Delivery

NURSE HAND OFF COMMUNICATION - ICU

SITUATION & BACKGROUND	DOA: 9/6/26	Diagnosis: TBI (Traumatic Brain Injury)	Surgery / Procedures: -	
	Allergies: Nil		Post OP Day: -	
	Date: 10/6/26			
	Area	PLUO		
	Shift Time	mmg		
	Diet: soft diet			
Ventilation (RA, NP, NIV, VENTI)	R/A			
INVASIVE LINES	1. iv cannula @			
	2. -			
	3. -			
	4. -			
ASSESSMENT	Infusions / Transfusions	Dals 47ml/hr		
	PU Prophylaxis	-		
	DVT Prophylaxis	-		
	Vitals	BP	80/52/62	
		PR	95/64	
		RR	20	
		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:	10/6/26/		
	Area	Shift Time	Plw/mmy	
	Ordered / Planned	C-S-T		
	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:		10/6		
Time:		@ 1:40pm		
Taken Over By Name :		Anisho		
Signature :		[Signature]		
Date:		10/6		
Time:		@ 10:45pm		



NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: ? TBI (Traumatic Brain Injury)	Any Infection: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify: Nil						
	Surgery / Procedure:	Post OP Day: -						
BACKGROUND	Date	9/6/26	9/6/26	9/6/26	9/6/26	10/6/26	10/6/26	
	Shift	Morning	M	E	N	E	Night	
	Medical Condition (Any special condition to be noted):	nil	nil	nil	nil	nil	nil	
ASSESSMENT	Diet:	N diet	P diet	N	NPO	N diet	N diet	
	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	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Ventilation (RA, NP, NIV, VENTI):	RA	RA	RA	RA	RA	RA	
	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	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Vital Signs:	Temp:	96.9°F	98.2°F	98.2°F	98.6°F	98.6°F	96.9°F
		Res:	22blm	22blm	23blm	26blm	24blm	28blm
		SpO ₂ :	99%	98%	98%	99%	99%	100%
		Pulse:	94blm	102blm	112blm	117blm	105blm	89blm
		BP:	118/73(88)	98/54(74)	-	105/69(80)	104/70(92)	99/55(68)
		LOC:	conscious	conscious	conscious	conscious	conscious	conscious
Fall Risk Score:		8	12	8	8	8	10	
Pain Score:	-	0	0	0	0	0		
Skin Integrity	Intact	Intact	Intact	Intact	Intact	Intact		
Recommendations	Safety Needs:	<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	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Physiotherapy:	nil	nil	nil	nil	nil	nil	
	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	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Special Diet:	N diet	P diet	N	NPO	N diet	N diet	
	Critical Lab Test / Values:	nil	nil	nil	nil	nil	nil	
	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	<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	<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	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
ADL (Dependent / Non Dependent):	Non dependent	Dependent	Dependent	Dependent	Dependent	Dependent		
Post Operative Procedure Special Orders:	nil	nil	CT done, MRI done, HRET done	CT done, MRI done, HRET done	CT done, MRI done, HRET done	nil		
Handed Over By Name :	Syvarna Nagman	Aalankar	Poju	Manisha	Subham			
Signature / ID :	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]			
Date:	9/6/26	9/6/26	9/6/26	9/6/26	10/6/26	11/6/26		
Time:	@10:15pm	@2pm	@8pm	@10:15pm	@8pm	@8pm		
Taken Over By Name :	Nagman	Aalankar	Poju	Manisha	Subham	Manisha		
Signature / ID :	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]		
Date:	9/6/26	9/6/26	9/6/26	9/6/26	10/6/26	11/6/26		
Time:	@11:20am	@2pm	@8pm	@10:30pm	@8pm	@8pm		



NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: TBI L left hearing loss	Any Infection: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify:						
	Surgery / Procedure:	Post OP Day:						
BACKGROUND	Date	11/6/26	11/6	11/6	12/6/26	12/6	12/6	
	Shift	M	E	N	M	E	N	
	Medical Condition (Any special condition to be noted):	Nil	Nil	Nil	Nil	Nil	Nil	
ASSESSMENT	Diet:	soft diet	S. diet	S. diet	S. diet	S. diet	S. diet	
	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	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Ventilation (RA, NP, NIV, VENTI):	RA	RA	RA	RA	RA	RA	
	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	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Vital Signs:	Temp:	98.5°F	98.6°F	98.2°F	98.6°F	98.6°F	98.6°F
		Res:	30 blm	28 blm	26 blm	26 blm	25 blm	26 blm
		SpO ₂ :	99.1	98.1	99.0	98.1	99.1	97.0
		Pulse:	90 blm	92 blm	94 blm	98 blm	100 blm	96 blm
		BP:	103/70(87)	106/66(72)	102/65(74)	108/60(62)	105/62	100/60(60)
		LOC:	conscious	conscious	conscious	conscious	conscious	conscious
Fall Risk Score:	10	10	10	10	10	10		
Pain Score:	0	0	0	0	0	0		
Skin Integrity	intact	intact	intact	intact	intact	intact		
Recommendations	Safety Needs:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<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	
	Physiotherapy:	Nil	Nil	Nil	Nil	Nil	Nil	
	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	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Special Diet:	soft diet	S. diet	S. diet	S. diet	S. diet	S. diet	
	Critical Lab Test / Values:	Nil	Nil	Nil	Nil	Nil	Nil	
	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	<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	<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	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
ADL (Dependent / Non Dependent):	Dependent	dependent	dependent	depend	dependent	dependent		
Post Operative Procedure Special Orders:	Nil	Nil	Nil	Nil	Nil	Nil		
Handed Over By Name :	Manasa	Manasa	Sulham	Indu	Beeonika	Manasa		
Signature / ID :	(Signature)	(Signature)	(Signature)	(Signature)	(Signature)	(Signature)		
Date:	11/6	11/6	11/6	12/6/26	12/6	13/6		
Time:	@ 8 AM	@ 8 PM	@ 8 AM	@ 8 PM	@ 3 PM	@ 8 AM		
Taken Over By Name :	Manasa	Sulham	Indu	Beeonika	Manasa	Beeonika		
Signature / ID :	(Signature)	(Signature)	(Signature)	(Signature)	(Signature)	(Signature)		
Date:	11/6	11/6/26	12/6/26	12/6/26	12/6	13/6/26		
Time:	@ 8 PM	@ 8 PM	@ 8 AM	@ 2 PM	@ 8 PM	@ 8 AM		

VIH-00128871 IP-00060283
 Master R.SREEVEDH CHARY
 09-11-2015 10 Y 7 M 3 D (M)
 Dr. GEETHA CHANDA



NRSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: TBI @ left hearing loss	Any Infection: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify: nil						
	Surgery / Procedure: nil	Post OP Day: nil						
BACKGROUND	Date / Shift: 13/6 / m							
	Medical Condition (Any special condition to be noted): nil							
	Diet: s diet							
ASSESSMENT	Allergy: <input type="checkbox"/> Yes <input checked="" 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	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Ventilation (RA, NP, NIV, VENTI): RA							
	Tubes/Drains/Catheter: <input type="checkbox"/> Yes <input checked="" 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	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Vital Signs:	Temp: 98.6 F						
		Res: 20 blm						
		SpO ₂ : 99.1						
		Pulse: 100 blm						
		BP: 108/62/45						
		LOC: conscious						
		Fall Risk Score: 0						
	Pain Score: 0							
	Skin Integrity: Intact							
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	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Physiotherapy: nil							
	Others Specify: <input type="checkbox"/> Yes <input checked="" 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	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Special Diet: nil							
	Critical Lab Test / Values: nil							
	Other Special Orders / Medications: <input type="checkbox"/> Yes <input checked="" 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	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	PU Prophylaxis: <input type="checkbox"/> Yes <input checked="" 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	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	DVT Prophylaxis: <input type="checkbox"/> Yes <input checked="" 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	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
ADL (Dependent / Non Dependent): dependent								
Post Operative Procedure Special Orders: nil								
Handed Over By Name: Beevanika								
Signature / ID: [Signature]								
Date: 13/6/26								
Time: @ 10am								
Taken Over By Name:								
Signature / ID: [Signature]								
Date:								
Time:								

Noted by
Beevanika
13/6
@ 10 am

Patient Sticker

NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify:					
	Surgery / Procedure:	Post OP Day:					
BACKGROUND	Date						
	Shift						
	Medical Condition (Any special condition to be noted):						
	Diet:						
ASSESSMENT	Allergy:	<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	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Ventilation (RA, NP, NIV, VENTI):						
	Tubes/Drains/Catheter:	<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	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Vital Signs:	Temp:					
		Res:					
		SpO ₂ :					
		Pulse:					
		BP:					
		LOC:					
		Fall Risk Score:					
	Pain Score:						
	Skin Integrity						
Recommendations	Safety Needs:	<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	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Physiotherapy:						
	Others Specify:	<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	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Special Diet:						
	Critical Lab Test / Values:						
	Other Special Orders / Medications:	<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	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	ADL (Dependent / Non Dependent):						
	PU Prophylaxis:	<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	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	DVT Prophylaxis:	<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	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Post Operative Procedure Special Orders:						
	Handed Over By Name :						
	Signature / ID :						
	Date:						
	Time:						
	Taken Over By Name :						
	Signature / ID :						
	Date:						
	Time:						

VIH-00128871 IP-00060283
 Master R. SREEVEDH CHARY
 09-11-2015 10 Y 7 M 0 D (M)
 Dr. GEETHA CHANDA



MIC NURSING CARE RECORD

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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Date: 9/6/26

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	10:50 AM 11:15 AM	Ensure Safety maintain fluid balance	10:50 AM 11:15 AM	Side rails kept up Administered IV fluid DNS to ml/hr.	Prevent from falls To maintain hydration	Patient is stable.	9/6/26 Nag cpn
Afternoon	3 PM	* Maintain fluid Balance. * Ensure Safety	4 PM	* Administered IV fluids DNS to ml/hr. * Provided Side Rails upside.	* Prevented Dehydration.	* Re-Assessment Done pt condition is stable.	Shankar 9/6/26 @ 8pm
Night	8:30 PM 9/6/26	+ maintain fluid balance		+ Administered IV Fluids DNS Family	+ prevented dehydration	+ re-assessment was done vital checked	8 AM 9/6/26



NURSING CARE RECORD

Date: 10/6/26

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	10/6 2pm	Assess the general condition of the child Provide IV fluids		Assessed the general condition of the child To maintain fluid balance	child is stable + active To prevent the dehydration	child is hemodynamically stable.	10/6 2pm Renu [Signature]
Afternoon	3pm 5pm	- maintain blood nutritional status ENSURE safety		- to oral intake is good - side rail kept up	- provided normal diet - prevent from fall risk	- patient is stable	manisha 10/6/26 @3pm
Night	9pm	→ maintain good nutritional status		→ provided by normal diet	→ oral intake is good	→ patient is stable	subha 11/6 @8pm



VIH-00128871 IP-00060283
 Master R.SREEVEDH CHARY
 09-11-2015 10 Y 7 M 1 D (M)
 Dr. GEETHA CHANDA

NURSING CARE RECORD



Date: 11/6/26

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	10 AM	→ Prevent Infection	10:30 AM	→ Administered medications as per drug chart	→ To prevent infection	→ patient is stable	Cl Manasa
Afternoon	4 PM	→ maintain good nutritional status	4:30 PM	→ Advise the patient to take more oral intake	→ To maintain oral intake	→ patient is stable	Cl Manasa
Night	10 PM	maintain good nutritional status	10:30 PM	Advise the patient to take more oral intake.	- To maintain oral intake	patient is stable	Sidhan 12/6 @8AM

VIH-00128871
 Master R. SREEVEDH CHARY
 09-11-2015 10 Y 7 M 1 D (M)
 Dr. GEETHA CHANDA

IP-00060283

NURSING CARE RECORD



Date: 12/6/26

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	- TO reduce infection	- patient is stable	Indu @ 2pm 12/6/26
	1:00	provide comfortable position	1:30	provided comfortable position	- TO reduce discomfort	- no fresh complaints	
Afternoon	4pm	→ maintain good nutritional status		→ To oral Intake is good	To provided soft diet	Patient is stable	Beevika 12/6 @ 8pm
	6pm	→ Ensure Safety		→ side rails kept up	→ prevent from fall risk		
Night	10 PM	→ prevent infection	10:30 pm	→ Administered medications as per drug chart	→ TO prevent infection	→ patient is stable	Dr. Vasanth



NURSING CARE RECORD



Date: 13/6/26

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				Discharge note Doctor came for rounds and advice for discharge.			
Afternoon				 Noted by Boornika 13/6 @ 10 am 			
Night							

VIH-00128871 IP-00060283
 Master R.SREEVEDH CHARY
 09-11-2015 10 Y 7 M 3 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				<i>Handwritten notes in Implementation column</i>			
Afternoon				<i>Handwritten notes in Implementation column</i>			
Night				<i>Handwritten notes in Implementation column</i>			



THE HUMPTY DUMPTY SCALE



8/11

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
			9/6/26	9/6/26	9/6	10/6	10/6
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	2
	13 years old and above	1					
Gender	Male	2	2	2	2	2	2
	Female	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					
	Oriented to own ability	1	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					
	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			1	1	1
	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			8	8	8	8	8

Intervention:

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position	X	✓	✓	✓	✓
Call device within reach	X	✓	✓	✓	✓
Wheels Locked	✓	✓	✓	✓	✓
Room free of clutter	✓	✓	✓	✓	✓
Adequate lighting	✓	✓	✓	✓	✓
Wheel chair support	X	X	X	X	✓
Other Intervention(s) Specify	X	X	X	X	✓
Nurse's Name:	Durgas	Nagmi	Shub	Mahar	Res
Signature:	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date:	9/6/26	9/6	9/6	10/6	10/6
Time:	6:55 PM	12 PM	8 PM	4 AM	2 PM



MIC



THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
			10/6	10/6	11/6	11/6	11/6
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	2
	13 years old and above	1					
Gender	Male	2	2	2	2	2	2
	Female	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					
	Oriented to own ability	1	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	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					1
	Other Medications / None	1	1	1	1	1	1
Total			8	10	10	10	10

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 support		x	x	x	x	x
Other Intervention(s) Specify		✓	✓	✓	✓	✓
Nurse's Name:		manisha	Sush	manisha	manisha	Sulham
Signature:		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date:		10/6/20	10/6	11/6	11/6	11/6
Time:		3pm	4pm	10am	4pm	11pm



THE HUMPTY DUMPTY SCALE

12/6 12/6 12/6 12/6 13/6

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	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	2
	13 years old and above	1					
Gender	Male	2	2	2	2	2	2
	Female	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					
	Oriented to own ability	1	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	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	10	10	10	10

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 support	X	X	X	X	X
Other Intervention(s) Specify					
Nurse's Name:	Andh	End	Basanta	manasa	Amity
Signature:	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date:	12/6	12/6	12/6	12/6	13/6
Time:	10am	2pm	8pm	10pm	10am

1/20/2020 1/20/2020

1/20/2020 1/20/2020

1/20/2020 1/20/2020

1/20/2020 1/20/2020

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MLC

PAIN ASSESSMENT FORM



Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
9/6/26	5:56 AM	0	-	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	-	Sujeetha
9/6/26	2 AM	0	-	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nil	Naga
9/6/26	4 PM	0	-	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	2	Abhi
10/6/26	4 AM	0	-	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	-	Mahi
10/6/26	10 AM	0	-	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	-	Remy
10/6/26	3 PM	0	-	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nil	manisha
10/6	11 PM	0	-	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nil	subha
11/6	10 AM	0	-	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nil	Q
11/6	11 PM	0	-	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nil	Q
12/6	3 AM	0	-	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nil	Rendu

Re-assessment Frequency:

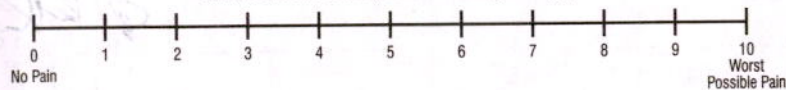
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 - 60 minutes after pain relief intervention.

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 drawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, rigid, 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)



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, SaO₂	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





MLC

PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
12/6	11pm	0	-	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	nil	Endeo
12/6	8pm	0	-	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nil	Bunif
13/6	12AM	0	-	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	nil	Q
13/6	10am	0	-	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nil	Bunif
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Re-assessment Frequency:

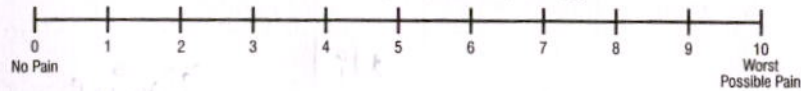
1. Every eight hours for all hospitalized patients.
2. For post-surgical patients, patients with chronic pain, patient with severe pain:
 - a) At least every 2 hours for the first 24 hours
 - b) Then every 4 hours.
 - c) Prior to pain pain-relieving intervention.
 - d) Within 30 - 60 minutes after pain 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
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Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
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Wong - Baker (Pediatrics) Above 7 Years

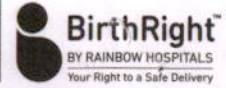


0 No Hurt 2 Hurts Little Bit 4 Hurts Little More 6 Even More 8 Hurts Whole Lot 10 Hurts Worst



MLC

BRADEN 'Q' SCALE



		Date :	9/6/2016	9/6	10/6			
		Time :	5:50 AM	2 PM	9 AM			
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	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	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	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	4
FRICITION-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	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 meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	3	3	3
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	4
		TOTAL SCORE	28	27	27	27		
		Evaluator's Name	Sreejaya	Dr. Mahi				

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

Risk Score	Category	Action	Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice)
15-18	At Risk	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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

VIH-00128871

IP-00060283

Master R.SREEVEDH CHARY

09-11-2015 10 Y 7 M 0 D (M)

Dr. GEETHA CHANDA



MLC

BRADEN 'Q' SCALE



					Date:	10/6/16	10/6/16	10/6/16	11/6/16
					Time:	12pm	3pm	11pm	10AM
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	4	
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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	4	
TOTAL SCORE					21	07	28	23	
Evaluator's Name					[Signature]	[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)
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Less than 9	Severe Risk	<ul style="list-style-type: none"> • 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



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:	Date:	Date:	Date:	Date:	Date:
			9/6/15	10/6	11/6/15	12/6		
			Time:	Time:	Time:	Time:	Time:	Time:
			11Am	11Am	11Am	11Am		
1	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)	1	0	0	0	0		
2	Bedridden recently >3 days or major surgery within four weeks	1	0	0	0	0		
3	Calf swelling >3cm compared with asymptomatic side, measured at 10 cm below tibial tubercle (Assess for both legs)	1	0	0	0	0		
4	Collateral (non varicose) superficial veins present (Assess for both legs)	1	0	0	0	0		
5	Entire leg swollen (Assess for both legs)	1	0	0	0	0		
6	Localized tenderness along the deep venous system (Assess for both legs)	1	0	0	0	0		
7	Pitting edema, greater in the symptomatic leg (Assess for both legs)	1	0	0	0	0		
8	Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs)	1	0	0	0	0		
9	Previously documented DVT (Assess for both legs)	1	0	0	0	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	0	0	0		
Total Score			0	0	0	0		
Signature of the Nurse			Nancy	Renu	manu	Indu		

Intervention: _____

- 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



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

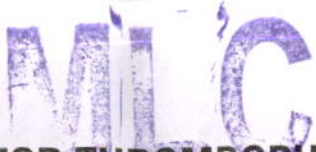
S.No	Assessment Criteria	Score	Date:	Date:	Date:	Date:	Date:	Date:
			Time:	Time:	Time:	Time:	Time:	Time:
1	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)	1						
2	Bedridden recently >3 days or major surgery within four weeks	1						
3	Calf swelling >3cm compared with asymptomatic side, measured at 10 cm below tibial tubercle (Assess for both legs)	1						
4	Collateral (non varicose) superficial veins present (Assess for both legs)	1						
5	Entire leg swollen (Assess for both legs)	1						
6	Localized tenderness along the deep venous system (Assess for both legs)	1						
7	Pitting edema, greater in the symptomatic leg (Assess for both legs)	1						
8	Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs)	1						
9	Previously documented DVT (Assess for both legs)	1						
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						
Total Score								
Signature of the Nurse								

Intervention: _____

- 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

VIH-00128871 IP-00060283
 Master R.SREEVEDH CHARY
 09-11-2015 10 Y 7 M 0 D (M)
 Dr. GEETHA CHANDA



CHECKLIST FOR THROMBOPHLEBITIS



9/6/20

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			10/6 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	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 cord pyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5			-	-	-	-	-	-		
Signature of the Nurse													

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

Signature of Shift In Charge :
 Signature : Name : Shantha Kumari

Signature of Ward In Charge :
 Signature : Name : Elizabeth



AABR/ Hearing screening report

VIH-00128871 IP-00060283
Master R.SREEVEDH CHARY
09-11-2015 10 Y 7 M 0 D (M)
Dr. GEETHA CHANDA



Hearing screening was done using AABR at 35 dB NHL

Right ear - Hearing screening results indicates clear response (PASS).

Left ear - Hearing screening results indicates no valid response (REFER).

Recommendation-

BERA test for detailed diagnostic evaluation

Review with Consultant Pediatric Neurologist


9/16/26
Audiologist

*AABR is a screening report only and holds good only on date of evaluation. A detailed evaluation is always recommended.



CONSULTATION FORM



Doctor Name : Dr. NEHA JAIN
 Date : 9/6/26 Hour : 4:30 PM

Hospital VIH-00128871 IP-00060283
Master R.SREEVEDH CHARY
08-11-2015 10 Y 7 M 0 D (M)
Dr. GEETHA CHANDA
 Referred ement
 Transfer of care

Type of Referral : Emergency (within one hr.)
 Urgent (within 6 hrs.) Non Urgent (within 24 hrs.)
 Date : 9/6/26 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 :

n/o (L) HEARING LOSS } SINCE TODAY
 GIDDINESS } MORNING

n/o Fall from Height @ Hostel.

n/o 3 episodes of vomitings (+)

n/o n/o LOC, ENT Blood, JLG.

n/e- EARS - B/L TM - 9/11
 NOSE - (R) DNS, TRB (+)
 O.C - (N)

(L) BEATING NYSTAGMUS (+)

RINNEI
 R/L
 +/+

WEISS
 (L)

Consultant :
 Name : Dr. NEHA JAIN Signature : _____ Date & Time : 9/6/26 4:30 PM

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

ADL

6

① HRT - TEMPORAL BONE


[CONCENTRATING ON OSSICULAR
(AIN STATUS, COCHLEA &
VESTIBULE APPARATUS)]

① T. STEMETIL - 5mg

— 0 —
[SUBLINGUAL]

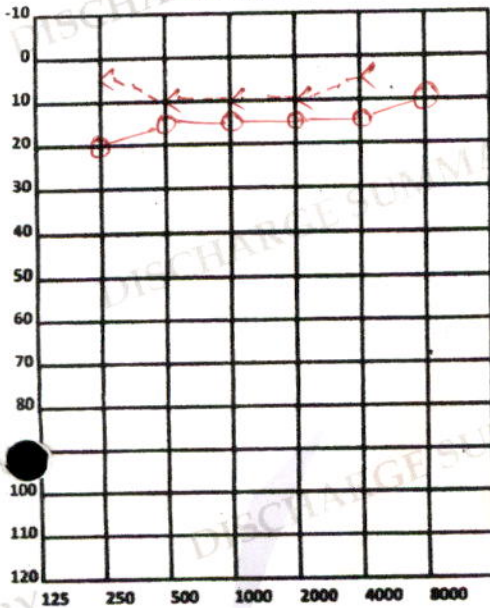
② PTA / AA

R/L - reports


[Dr. NENA JAIN]



RIGHT EAR

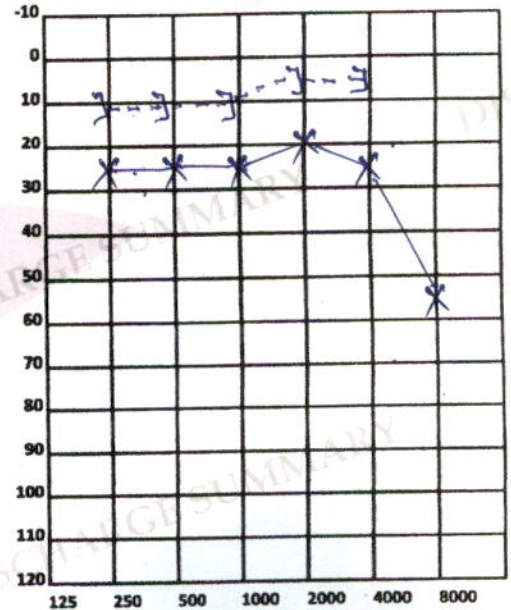


AUDIOGRAM

Audiogram Key	Right Ear	Left Ear
AC (unmasked)	○	×
AC (masked)	△	□
BC (unmasked)	<	>
BC (masked)	▭	▭
No response on any symbol	↙	↘
Sound-field (non ear specific)	S	

	RT	LT
PTA	15 dBHL	23.3 dBHL

LEFT EAR



IMPEDANCE AUDIOMETRY

Tone	Rt	Lt	HZ
226			
ECV	0.88	0.86	ml
TW	115	103	daPa
TPP	-98	-36	daPa
SA	0.37	0.43	mmho
TYPE	'A'	'A'	

SPEECH AUDIOMETRY

	RT	LT
SRT		
SDS		

TUNING FORK TEST

	Rt	Lt
Rinne		
Weber		

TINNITUS EVALUATION

Test ear	F1	F2
RT		
LT		

Provisional diagnosis

Right ear:- hearing sensitivity within normal limits.

Recommendations

Left ear:- Minimal hearing loss.

S. Jayaram

Signature

CONSULTATION FORM

108



Doctor Name : Dr. Ajay

Date : 11/6/26 Hour : 11:00pm

Hospital : RCH

Type of Referral : Emergency (within one hr.)
 Urgent (within 6 hrs.) Non Urgent (within 24 hrs.)
Date : 11/6/26 Time : 11 pm By :

Referred for : Opinion Co-Management
 Transfer of care

Reason for diagnosis : VIH-00128871 IP-00060283
Master R.SREEVEDH CHARY
09-11-2015 10 Y 7 M 1 D (M)
Dr. GEETHA CHANDA

t care specify the particular need, especially in the absence of a second



Signature: _____ M.D.

Report of Findings and Recommendations :

h/o head injury in 2 days
(fell from ~~bed~~ bunk bed)
no h/o loss of consciousness
EOT bleed / seizures
% : Both TM intact & (M)
Noen: Thick mucopus + both
nasal cavity - 3 Adenoids
& post-nasal drip
Nephro - (M)
no cervical nodes, no metastatic tenderness
Free field hearing, WNC
TFT: Ruv +ve; WNL
Imp: Mild conductive loss (ear -> EOT dysfunction) I.

Consultant :

Name : Dr. Ajay Signature : _____ Date & Time : 11/6/26 @ 11:00pm

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

① Inj ceftriaxone 1V BD

② Tab Vactin 16mg BD

③ Tab Xyloc. 250mg
(paracetamol) 1 tid

④ ~~Tab~~ Inj Zofen 4mg
1V BD
x 2d

⑤ Inj Esmerizole
2mg 1V BD

⑥ Naloxon tablet de
2mg 4 hr 4

⑦ Naloxon tablet de
2mg 2hr 4



CONSULTATION FORM



Doctor Name : Dr Smellye V
 Date : 11/6 Hour : _____

Hospital : Rainbow Children's Hospital Vikramapur

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

Referred for : Opinion Co-Management
 Transfer of care

Reason for Consultation
 diagnosis: by the particular need, especially in the absence of a second
 VIH-00128871 IP-00080283
 Master R.SREEVEDH CHARY
 09-11-2015 10 Y 7 M 2 D (M)
 Dr. GEETHA CHANDA



Signature: _____ M.D.

Report of Findings and Recommendations :

13y
 CBR
 PT/INR 18/1.2
 APTT 4)

10 fall from bed (5ft ht) @ 9/6/26
 had contusion - 2 cm x 2 cm
 pts ↓ hearing left side / giddiness &
 CT brain no # / ? haemorrhage
 MRI brain → left IJV & sigmoid sinus thrombosis
 @ mild EDH essentially stable
 Birthstroke due to low likely (Port terminate thrombosis)

no significant family history

→ Send homocysteine level.
 → ~~Start~~ A do procoagulant prophylaxis after 2 weeks
 (Proton C / Prokin S / Ants thrombin III)

Consultant : Dr Smellye
 Name : _____ Signature: _____ Date & Time : _____

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

at my examination SR for answers
2 weeks
for preparation for me
3 months
moulds in me as requested



Lab Reports Acknowledgement Receipt.

I have admitted my Son/Daughter by name Master/Baby.
 VIH-00128871 IP-00060283 inbow children's Hospitals on _____ Vide
 Master R. SREEVEDH CHARY Dr. Thamija. As we are
 09-11-2015 10 Y 7 M 1 D (M) e., on 10/6/24 11:30 pm I acknowledge that I have
 Dr. GEETHA CHANDA received my inpatient... Investigations Reports & Discharge Summary in
 (Original/Photo copy) .

	All Blood and Urine Investigation Reports .
	All Radiology Investigation Reports.
	All Films. (If any) <u>Medical Reports</u>

Signature of Patient Attendee Whay
 Name & Address:
 Contact No

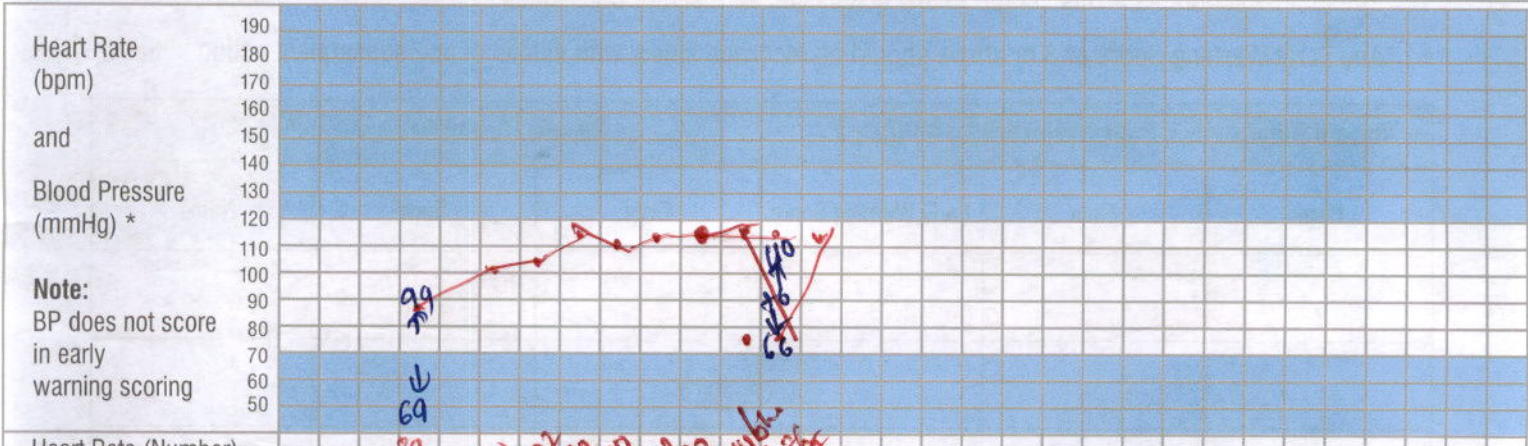
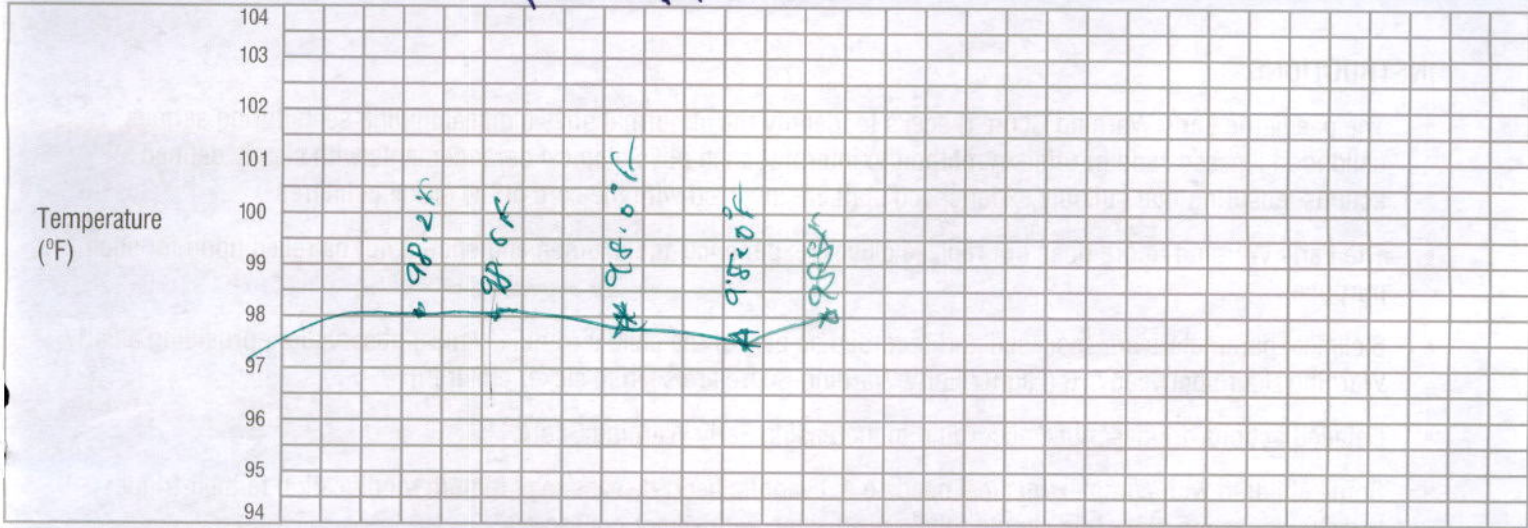
Note: For all Credit /Insurance Cases only Photocopies of Investigations will be given, X-Ray films , CT/MRI Films to be handed over in IP Billing Dept. for claiming from the respective Insurance/Credit organizations .



EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 9/6/16 Time: 11 1 2 3 4 5 6 7 8 10

Doctor / Nurse / Family Concern? Am Am Am Am Am Am Am Am Am Am



Heart Rate (Number) 89 100 102 112 110 112 113 114 110 114



Resp Rate (Number) 22 20 21 22 20 21 22 20

Resp Distress Mod/ Severe None / Mild

Receiving O₂ (l/min) O₂ Saturations (%) 08 100 100 100 100 100 100 100 100 100

Conscious Level Normal Altered N N C C C C C C C C

GCS * 15 15 15 15 15 15 15 15 15 15

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

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 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.



CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

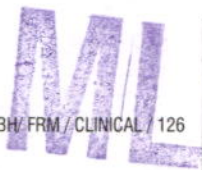
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- The Early Warning Score does not replace clinical experience and acumen and should not be relied upon for such purpose.
- 6 clinical parameters are assessed and recorded as part of the child's routine clinical observation, providing a Early Warning 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.

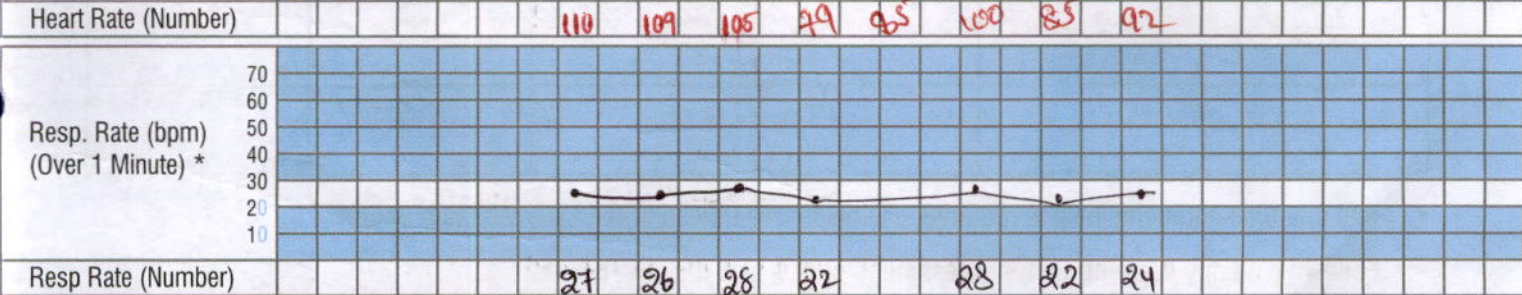
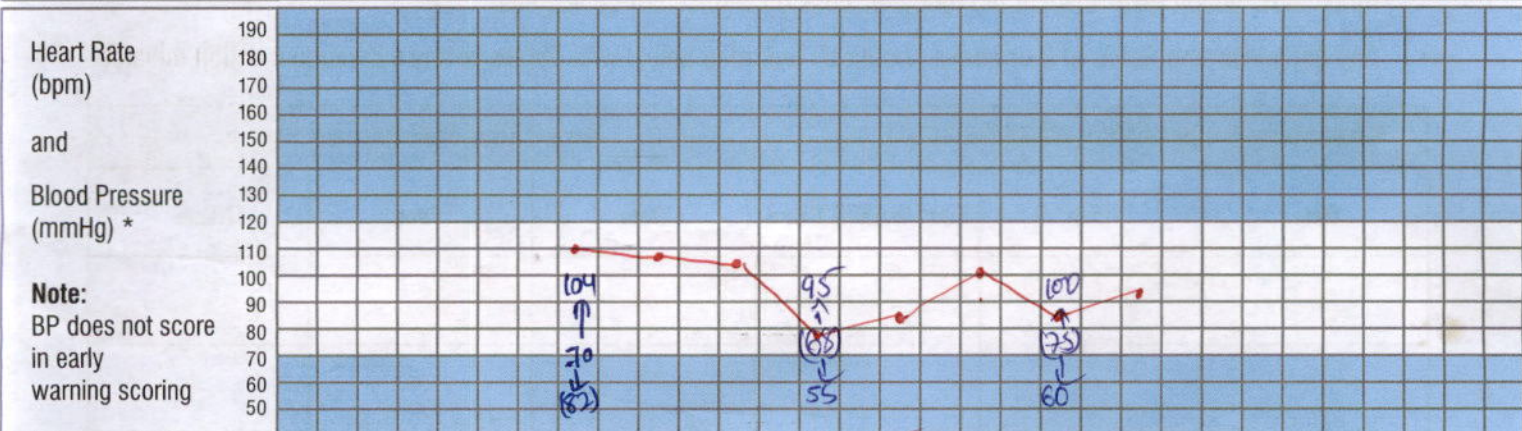
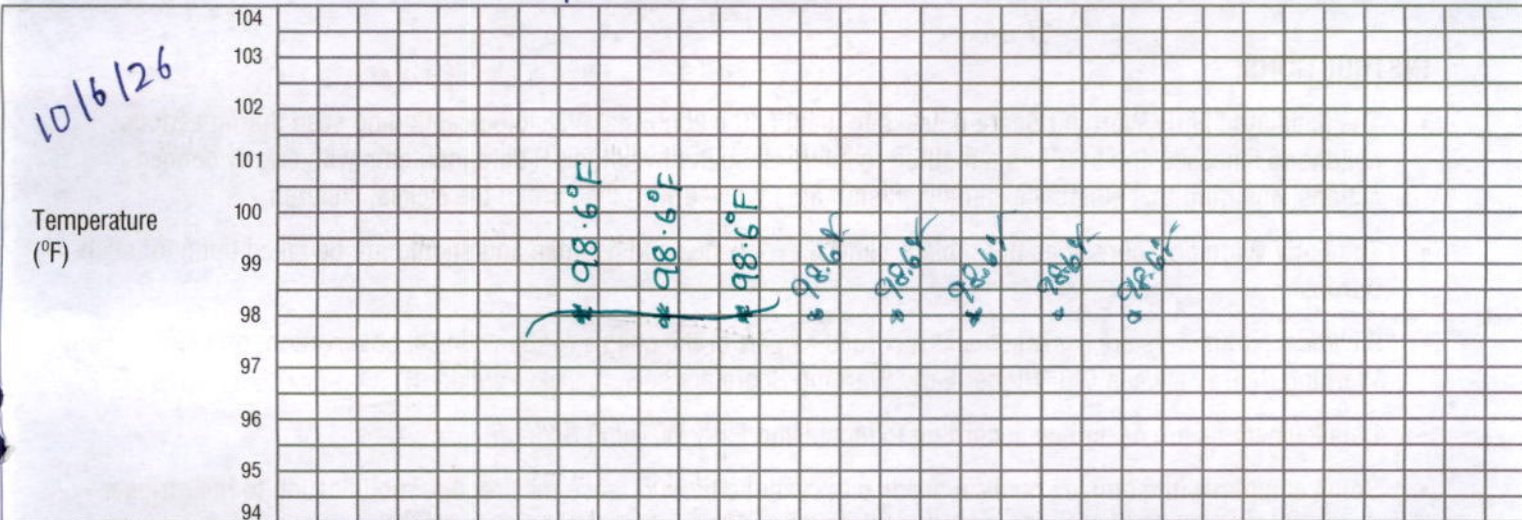
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S	SITUATION : I am calling because I am concerned that ... (e.g. BP is low/high, pulse is XXX, Temperature is XX, Early Warning Score is XX)
B	BACK GROUND : Child (X) was admitted on (XX date) with (e.g. respiratory infection). They have had (X operation/ 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 : Time: 3 5 7 10 1 3 5 7

Doctor / Nurse / Family Concern? pm pm pm pm AM AM AM AM



Resp Distress	Mod/ Severe	None / Mild						
	N	N	N	N	N	N	N	N
Receiving O ₂ (l/min)								
O ₂ Saturations (%)	98	99	99	99	100	96	97	98
Conscious Level	Normal	Altered						
	N	N	N	N	N	N	N	N
GCS *	15	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	MY	MP	ML	SK	SK	SK	SK	SK

ACTIONS

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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: Scores 3 should be recorded overleaf

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

- The paediatric Early Warning Score i) seeks to identify the abnormal physiological finding seen during serious childhood illnesses and ii) offers a method to interpret such physiological derangements with clearly defined actions, ensuring that suitably experienced staff are involved with the care of the sickest children.
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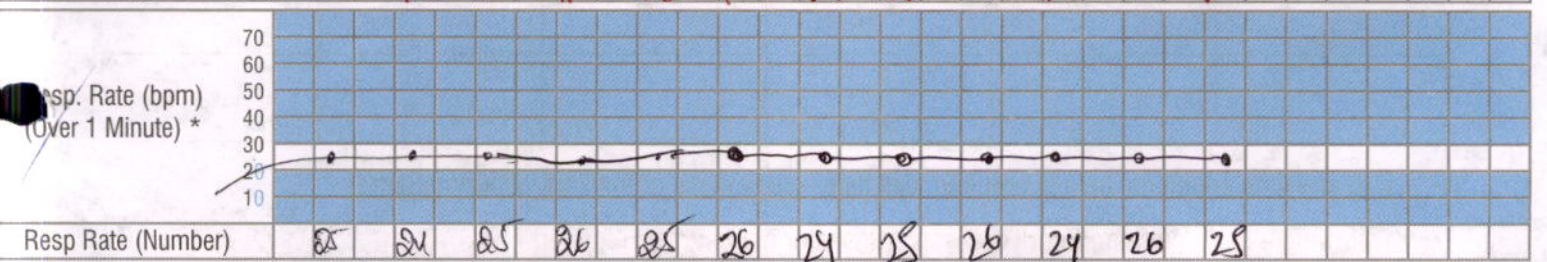
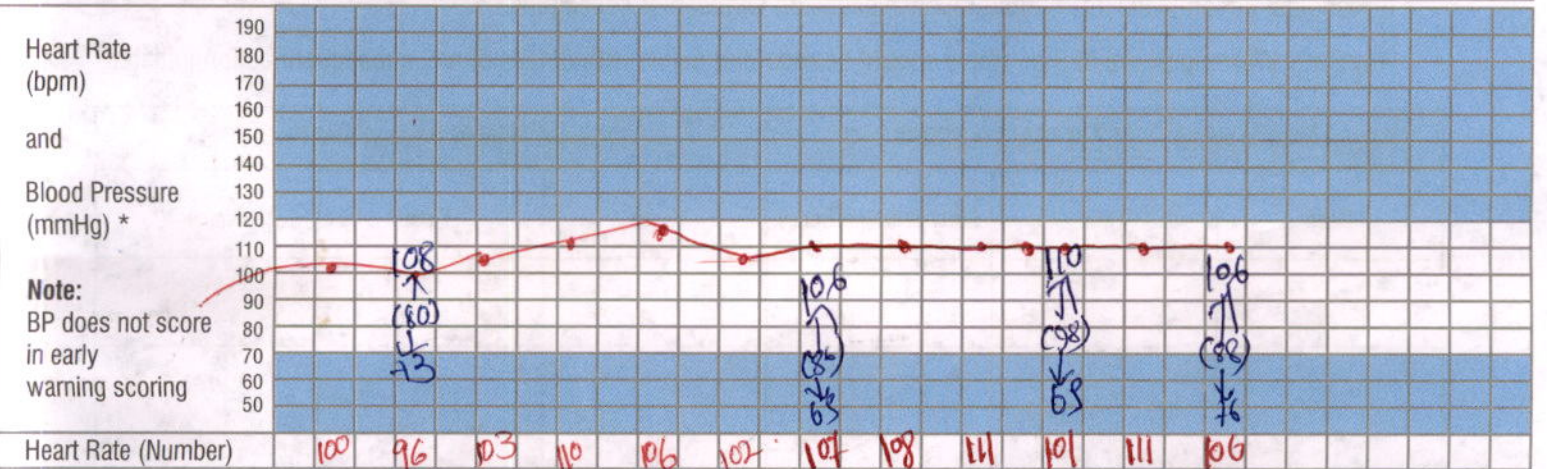
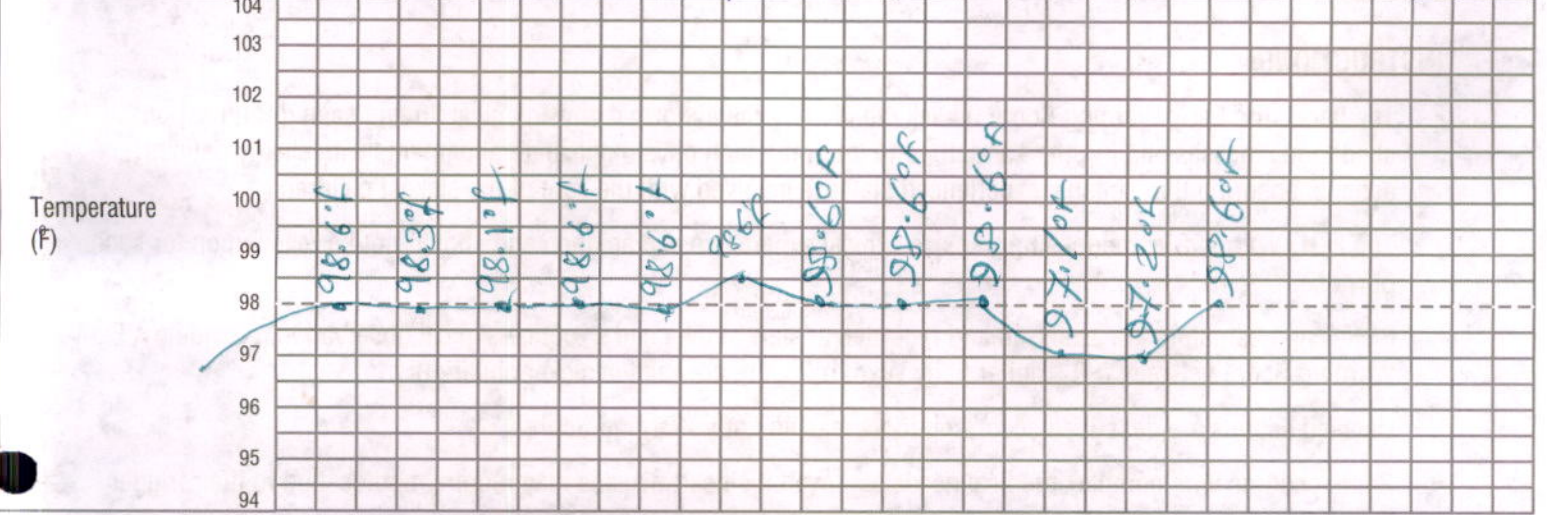
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R	RECOMMENDATION: I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 16/7/20	Time: 9	11	1	3	5	7	9	11	1	3	5	7
Doctor / Nurse / Family Concern?	AM	AM	PM	PM	PM	PM	PM	PM	AM	AM	AM	AM



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

ACTIONS	Score 1	: Continue normal observation by staff nurse
	Score 2	: Shift in charge nurse to be informed and continue hourly observations
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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

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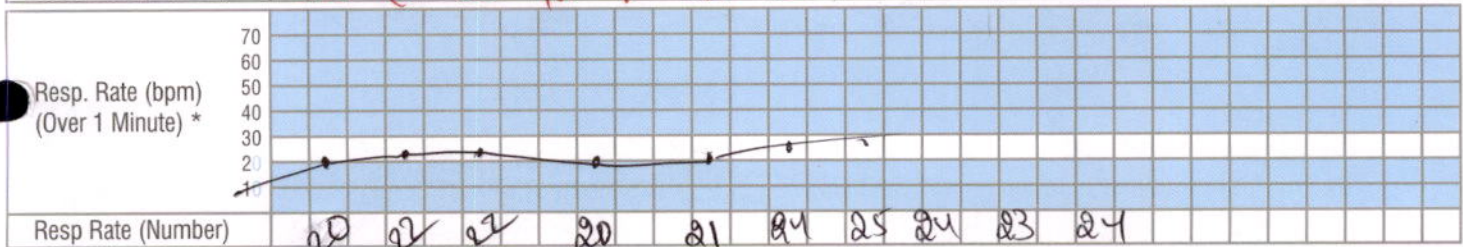
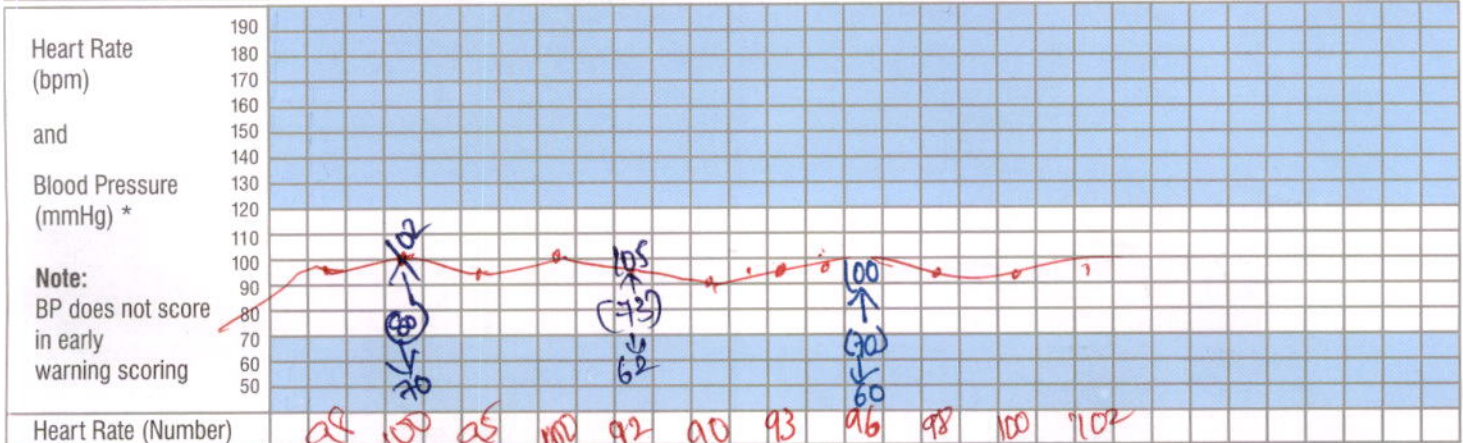
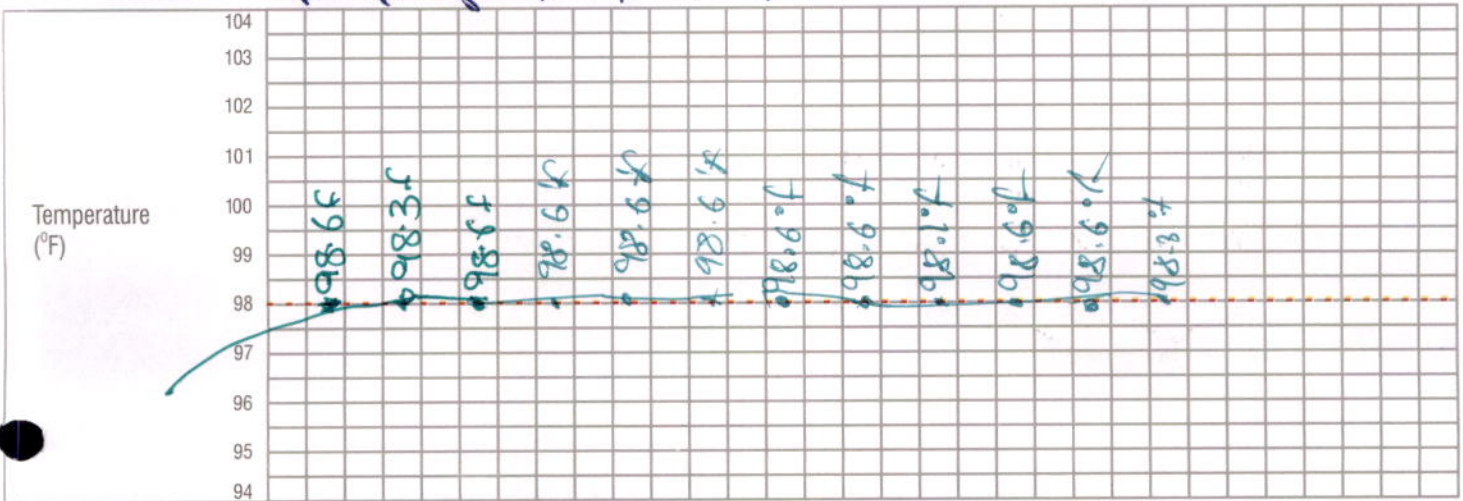
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A	ASSESSMENT: I think the problem is (XXX) and I have ... (e.g. given O2/ analgesia, stopped the infusion), OR I am not sure what the problem is but child (X) is deteriorating, OR I don't know what's wrong but I am really worried.
R	RECOMMENDATION: 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: 12/6/26	Time:	9	11	1	3	5	7	9	11	1	3	5	7
Doctor / Nurse / Family Concern?		Am	Am	Pm	Pm	Pm	Pm	Pm	Pm	Am	Am	Am	Am



Resp Distress	Mod/ Severe	
	None / Mild	
Receiving O ₂ (l/min)		
O ₂ Saturations (%)		98 97 98 98 99 100 98 97 98 95 97
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	
Number of shaded boxes	0 0 0 0 0 0 0 0 0 0 0 0
Pain Score	0 0 0 0 0 0 0 0 0 0 0 0
Observer's Initials	Am Am Am Bm Bm Bm Na Na Na Na Na

ACTIONS	Score 1 : Continue normal observation by staff nurse
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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

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- 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 Is there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

VH-00126871 IP-00060283

Master R.SREEVEDH CHARY

09-11-2015 10 Y 7 M 3 D

Dr. GEETHA CHANDA

(M)

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



SCHOOL AGE (5-12 years)

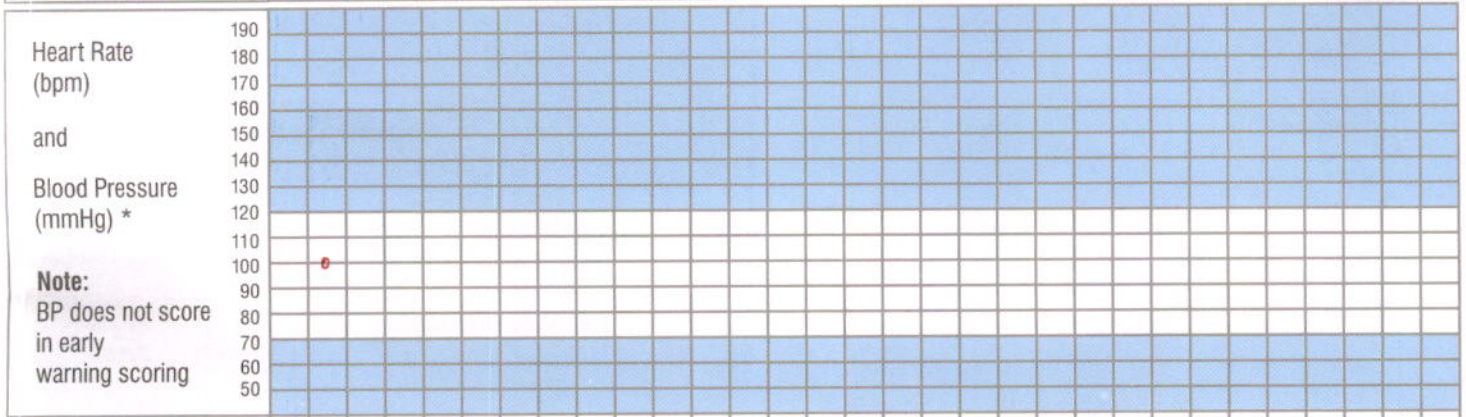
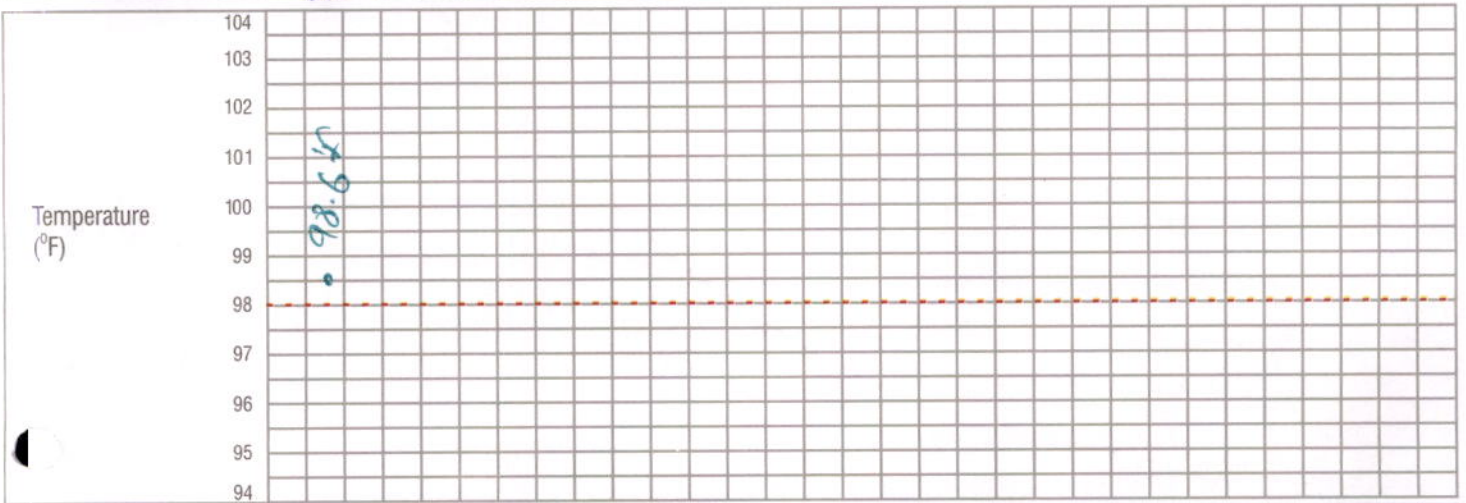
Children's Observation & Early Warning Scoring Chart



EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 13/6/26 Time: 9

Doctor / Nurse / Family Concern? am



Heart Rate (Number) 100



Resp Rate (Number) 20

Resp Distress Mod/ Severe None / Mild

Receiving O₂ (l/min) O₂ Saturations (%) 99

Conscious Level Normal / Altered H

GCS * 15

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

*Noted by
 Bewarika
 13/6
 @ 10 am*

- 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 fellow or PICU consultant to be informed.
- NB: Scores 3 should be recorded overleaf

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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)



FLUID CHART

Sheet No. : ①

9/6/26

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	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
		Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V								N.G
9/6/26	08:00 am											9/6/26 Pray Cpa
	09:00 am											
	10:00 am											
	11:30 am	Sally water					✓		✓			
	12:00 pm		Formula									
	01:30 pm		Formula				✓					
Total Intake :			140ml		Total Output :							
	02:00 pm		Formula				✓					Akash 9/6/26 @ 8pm
	03:00 pm	D	N	Formula			✓					
	04:00 pm	S	B	Formula				✓				
	05:00 pm	S	B	Formula			✓					
	06:00 pm											
	07:00 pm		Formula									
Total Intake :					Total Output :							
	08:00 pm											9/6/26
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :					Total Output :							
	02:00 am											9/6/26
	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



FLUID CHART

Sheet No. : 2

10/6/26

- 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			
	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
Total Intake :						Total Output :							
10/6/26	02:00 pm	Rice											} Manisha 10/6/26 @ 8pm
	03:00 pm	+ water								✓	1		
	04:00 pm												
	05:00 pm	Brade									0		
	06:00 pm												
	07:00 pm										✓	1	
Total Intake :						Total Output :							
10/6	08:00 pm												} Subhen 11/6 @ 7AM
	09:00 pm	Rice											
	10:00 pm	water											
	11:00 pm	Brade											
	12:00 am												
	01:00 am												
Total Intake :						Total Output :							
11/6/26	02:00 am												} Subhen 11/6 @ 7AM
	03:00 am	water											
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
Total Intake :						Total Output :							
Total 24 hrs. Intake						Total 24 hrs. Output			4 times				

VIH-00128871 IP-00060283
 Master R.SREEVEDH CHARY
 09-11-2015 10 Y 7 M 1 D (M)
 Dr. GEETHA CHANDA

FLUID CHART

Sheet No. : 3

11/6/26

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		
11/6	08:00 am									✓	1	manasa 11/6 @ 1pm
	09:00 am											
	10:00 am	Soup										
	11:00 am											
	12:00 pm									✓	1	
	01:00 pm											
	Total Intake :			Total Output :								
11/6	02:00 pm											manasa 11/6 @ 1pm
	03:00 pm											
	04:00 pm	Rice & water								✓	1	
	05:00 pm											
	06:00 pm											
	07:00 pm									✓	1	
Total Intake :			Total Output :									
11/6/26	08:00 pm											manasa 11/6/26 at 1pm
	09:00 pm											
	10:00 pm	Rice water								✓	1	
	11:00 pm											
	12:00 am									✓	1	
	01:00 am											
Total Intake :			Total Output :									
12/6/26	02:00 am											manasa 12/6/26 at 7am
	03:00 am											
	04:00 am									✓	1	
	05:00 am											
	06:00 am									✓	1	
	07:00 am											
Total Intake :			Total Output :									

Total 24 hrs. Intake

Total 24 hrs. Output 8 times

VIH-00128871 IP-00060283
 Master R.SREEVEDH CHARY
 09-11-2015 10 Y 7 M 2 D (M)
 Dr. GEETHA CHANDA



FLUID CHART

Sheet No. :

12/6/26.

- 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	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
		Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G							
12/6	08:00 am								✓		12/6/26 @ 2pm	[Signature]
	09:00 am	Jelly										
	10:00 am											
	11:00 am											
	12:00 pm	water							✓			
	01:00 pm											
Total Intake :					Total Output :							
12/6	02:00 pm										12/6/26 @ 7pm	[Signature]
	03:00 pm	Rice water										
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :					Total Output :							
12/6	08:00 pm										12/6/26 @ 7pm	[Signature]
	09:00 pm											
	10:00 pm	Rice + water							✓			
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :					Total Output :							
	02:00 am										12/6/26 @ 7am	[Signature]
	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 6 times



FLUID CHART

Sheet No. :

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			
	08:00 am												
	09:00 am	<i>Silly walk</i>											
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												

13/6

Benarika

@10am

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												

Noted by

Benarika

13/6

@10am

Total Intake :						Total Output :							
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												

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.

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse	
Date	Time	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	
-----------------------------	--

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: Shifted to:

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	T. STEMETIL	5mg tablet	PO	Once daily.		<input type="checkbox"/> C <input type="checkbox"/> DC
2	INJ. ENOXAPARIN	SC 30mg.	SC 12 th Hly.	12 th Hly		<input type="checkbox"/> C <input type="checkbox"/> DC
3	INJ - ESOMEPRAZOLE	IV	30mg.	Once daily		<input type="checkbox"/> C <input type="checkbox"/> DC
4						<input type="checkbox"/> C <input type="checkbox"/> DC
5						<input type="checkbox"/> C <input type="checkbox"/> DC
6						<input type="checkbox"/> C <input type="checkbox"/> DC
7						<input type="checkbox"/> C <input type="checkbox"/> DC
8						<input type="checkbox"/> C <input type="checkbox"/> DC
9						<input type="checkbox"/> C <input type="checkbox"/> DC
10						<input type="checkbox"/> C <input type="checkbox"/> DC

* C - Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : [Signature] / CH. GANESH S

Date & Time : 10/6/2026. 11:00 AM

Nurse Name & Signature:

Date & Time : 10/6/26 | 11:00 AM



MLC DRUG CHART

Date of Admission: 9/16/26 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 : INJ. ONDANSETRON				Date Time																
Dose	Route	Frequency	Start Date																	
4mg	W	as reqd	16																	
Doctor's Signature		Valid Period	Pharm.																	
		month																		
		hourly																		
Additional Instructions:																				
0.2mg/kg/don																				

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 Date: 9/16/26



REGULAR PRESCRIPTIONS

Weight. 38.1kg Ward.

Dr. Parola

File per doctor doly
 Filed 09/16/26 at 10P

Filed 10/16/26
 Dr. Jaganat 10am

Dr. Parola

DRUG : INJ. ENOXAPAREN				Date Time	9/6/16	10/6	11/6	12/6	13/6
Dose	Route	Frequency	Start Date						
80mg	IV	once daily	9/6						
Name & Signature of the Doctor Starting the Drugs: Dr. Vithwaje				9:00am AM Dr. Vithwaje Shantha Bindu Prasad Prasad Prasad					
Additional Instructions: mg/kg/dose									
Daily Doctor's Endorsement by a Sign									

DRUG : T. STEMETIL				Date Time	9/6/26	10/6			
Dose	Route	Frequency	Start Date						
1 tab	PO	once daily	9/6						
Name & Signature of the Doctor Starting the Drugs: Dr. Vithwaje				10 PM Dr. Vithwaje Binodh Prasad Prasad Prasad					
Additional Instructions: 1 tab = 5mg									
Daily Doctor's Endorsement by a Sign									

DRUG : INJ. ENOXAPAREN				Date Time	10/6	11/6	12/6	13/6
Dose	Route	Frequency	Start Date					
30mg	s/c	12 hourly	9/6					
Name & Signature of the Doctor Starting the Drugs: Dr. Jayhee				12 AM Dr. Jayhee Binodh Prasad Prasad Prasad				
Additional Instructions: 1mg/kg/dose								
Daily Doctor's Endorsement by a Sign								

DRUG : T. FLONARIZINE				Date Time					
Dose	Route	Frequency	Start Date						
1 tab	PO	once daily	10/6						
Name & Signature of the Doctor Starting the Drugs: Dr. Vithwaje				Dr. Vithwaje Binodh Prasad Prasad Prasad					
Additional Instructions: (1 tab = 5mg)									
Daily Doctor's Endorsement by a Sign									



Sheet No:

REGULAR PRESCRIPTIONS

Weight 33.1 kg Ward

DRUG : <u>IV. CEFTRIAZOLONE</u>				Date Time	<u>11/6/16</u>	<u>12/6/16</u>	<u>13/6/16</u>													
Dose	Route	Frequency	Start Dt.	<u>6</u>	<u>12 PM</u>	<u>6</u>	<u>6</u>													
<u>1.5gm</u>	<u>iv</u>	<u>12 hourly</u>	<u>11/6</u>	<u>am</u>	<u>6</u>	<u>6</u>	<u>6</u>													
Name & Signature of the Doctor Starting the Drugs: <u>Dr. NIKESH</u>																				
Additional Instructions: <u>(5mg/kg/dose)</u>																				
Daily Doctor's Endorsement by a Sign																				
DRUG : <u>T. VEREIN</u>				Date Time	<u>11/6/16</u>	<u>12/6/16</u>	<u>13/6/16</u>													
Dose	Route	Frequency	Start Dt.	<u>6</u>	<u>am</u>	<u>6</u>	<u>6</u>													
<u>1 tab</u>	<u>PO</u>	<u>12 hourly</u>	<u>11/6</u>	<u>am</u>	<u>6</u>	<u>6</u>	<u>6</u>													
Name & Signature of the Doctor Starting the Drugs: <u>Dr. NIKESH</u>																				
Additional Instructions: <u>1 tab + 1/6mg</u>																				
Daily Doctor's Endorsement by a Sign																				
DRUG : <u>IV. PARALSTANOL</u>				Date Time	<u>11/6/16</u>	<u>12/6/16</u>	<u>13/6/16</u>													
Dose	Route	Frequency	Start Dt.	<u>6</u>	<u>am</u>	<u>6</u>	<u>6</u>													
<u>250mg</u>	<u>iv</u>	<u>8 hourly</u>	<u>11/6</u>	<u>am</u>	<u>6</u>	<u>6</u>	<u>6</u>													
Name & Signature of the Doctor Starting the Drugs: <u>Dr. NIKESH</u>																				
Additional Instructions: <u>5mg/kg/dose</u>																				
Daily Doctor's Endorsement by a Sign																				
DRUG : <u>IV. OMDANSETRON</u>				Date Time	<u>11/6/16</u>	<u>12/6/16</u>	<u>13/6/16</u>													
Dose	Route	Frequency	Start Dt.	<u>6</u>	<u>am</u>	<u>6</u>	<u>6</u>													
<u>4mg</u>	<u>iv</u>	<u>12 hourly</u>	<u>11/6</u>	<u>am</u>	<u>6</u>	<u>6</u>	<u>6</u>													
Name & Signature of the Doctor Starting the Drugs: <u>Dr. NIKESH</u>																				
Additional Instructions: <u>2pm</u>																				
Daily Doctor's Endorsement by a Sign																				

Dr. Jyoti

Dr. Jyoti

Dr. Praveen

11/6/16

Dr. Jyoti

VIH-00128871 IP-00060283
 Master R. SREEVEDH CHARY
 09-11-2015 10 Y 7 M 2 D (M)
 Dr. GEETHA CHANDA



Sheet No:

REGULAR PRESCRIPTIONS

Weight 33.1kg Ward

Signature: Dr. Geetha

VERIFIED BY: Name

DRUG : NAJOLLEAR drops				Date Time
Dose	Route	Frequency	Start Dt.	
3 drops	nasal	4 hourly	11/6	
Name & Signature of the Doctor Starting the Drugs: <i>[Signature]</i>				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

DRUG : NALIVION nasal drops				Date Time
Dose	Route	Frequency	Start Dt.	
2 drops	nasal	12 hourly	11/6	10 am
Name & Signature of the Doctor Starting the Drugs: <i>[Signature]</i>				
Additional Instructions: 10 pm				
Daily Doctor's Endorsement by a Sign				

DRUG : IUP DEXAMETHASONE				Date Time
Dose	Route	Frequency	Start Dt.	
4mg	iv	6 hourly	11/6	
Name & Signature of the Doctor Starting the Drugs: <i>[Signature]</i>				
Additional Instructions: 0.12mg/kg doses				
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				



Weight Ward

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
8/6	@ 6:30 AM	3% NS	150ml	IV	[Signature]	Suvaraha Vaishali
		(5ml/kg)				
9/6	@ 6:30 AM	3% NS	150ml	IV	[Signature]	Suvaraha Vaishali
		(5ml/kg)				
9/6/20	9:10 AM	ENT-ONDANSETRON	4mg	SLV	[Signature]	Hema
9/6	11:45 AM	T. FLONARIZINE	1/2 tab	PO	[Signature]	Pooja
		(10mg)				
10/6	8:30 AM	T. FLONARIZINE	1/2 tab	PO	[Signature]	Reemalash Yashwanth
10/6	9:20 AM	ENT-ONDANSETRON	4mg	IV	[Signature]	Maha Binde
10/6/	10:00 AM	TAB. TRAMADOL 50mg	1 TABLET	PO	[Signature]	Reemalash Yashwanth
		(1/2 20mg/kg)				

Signature

VERIFIED BY : N

8/6
Dix. DEXAMETHASONE



I.V. FLUIDS CHART

Weight. 33.1kg 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
9/6	10:00	DNS (1/2 M)	iv	35ml/hr	[Signature]	[Signature]	9/6	[Signature]	[Signature]
		(if required)							
9/6	11:45 AM	DNS	iv	70 ml/hr	[Signature]	[Signature]	9/6/26	[Signature]	[Signature]
9/6	11 PM	DNS	iv	47	[Signature]	[Signature]	13/6	[Signature]	[Signature]

Signature

VERIFIED BY : Name

108

Ref. No. F/INPR/12

VIH-00128871 IP-00060283
Patient Name : **Master R.SREEVEDH CHARY**
09-11-2015 10 Y 7 M 3 D (M) —
Dr. GEETHA CHANDA

Registration No. _____



NEBULISATION CHART

Date	Time	Drug	Nurse	Parents Signature
11/6/26	9:30 pm	NASOCLEAR DROPS - 3 drops	}	
	9:30 pm	NASOCLEAR DROPS - 3 drops		
12/6/24	12:30 pm	NASOCLEAR DROPS - 3 drops	Pam	P. Saritha
	3.00	4:30 AM - NASOCLEAR DROPS - 3 drops		
	4.00	8:30 AM - NASOCLEAR DROPS - 3 drops		
	5.00	12:30 pm Nasoclear drops	Sadiya	P. Saritha
	6.00	6:30 pm - Nasoclear drops - 3 drops	}	
	7.00	10:30 pm - Nasoclear drops - 3 drops		
18/6/26	8.00	2:30 pm - Nasoclear drops - 3 drops		
	9.00	6:30 pm - Nasoclear drops - 3 drops		P. Saritha
	10.00			
	11.00			
	12.00			
	13.00			
	14.00			
	15.00			
	16.00			
	17.00			
	18.00			
	19.00			
	20.00			
	21.00			
	22.00			
	23.00			

MEDICO LEGAL RECORD

To
The Station House Officer,
P.S. KESARA (PS) 8712662191
Dist. / City HUD, AT-12. QPN
Ref : Our Telephone Intimation Dated 10/6/26
Received by : HIC-3864, MR. RAJU
Patient Name : R. Shreeveedh Chary
S/o. W/o. D/o MR. P. Venkatachary
Age: 11 YEAR Sex: Male / Female
Address: Shivalakshmi Street Village,
Shamirpet, Hyderabad,
Telangana
Identification Marks

Date 9/6/2026
Time 05:45 AM
1179
M.L.C. No. _____
UHID / I.P No. VGH-00128871/IP-00060283
Accompanied by P.C. / Attendant
Name : Mr./Mrs. R. Venkata chary
Relation : SON FATHER
Phone No. 9949089730
Signature : Ukay

1) Photo attached

2) _____
Signature / LTI of Patient

Brief History of the case as stated by the patient / attendant :
Fall from bed in hostel @ 3:30 AM on 9/6/2026 at Navodaya Hostel,
Keccara
Followed by vomiting, inability to walk properly &
left sided hearing loss

General Examination of the patient on arrival at Emergency Conscious Unconscious Semi-Conscious Brought Dead
Pulse : 80 /mt B.P. 97/6 /mm Hg Resp. Rate 18 /mt Temp : 97 Of
Heart : (P) Lungs : (N) Abdomen : (P) Pupils : B/L equal, reacting

DESCRIPTION OF INJURIES

S No.	Description of wounds	Dimensions

Dying Declaration Required : Yes / No

Name & Sign. of Doctor : Dr. Mitesh N. Khanna Regn No. 6-22523

MLC Received by : _____ Investigation Advised : CT scan brain Treatment Given : observatory care
Signature : _____ CBP CBP IV fluids
Name : _____ CBP Antiemetics
Designation : _____

1. Admitted in _____ Ward / ICU
2. Left Against Medical Advice _____
3. Patient Condition at the Time of Transfer stable

Name & Sign. of Doctor : Dr. Mitesh N. Khanna Regn No. 6-22523



108.

Ref. No. F/INPR/12



Patient Name : _____

VH-00128871 IP-00060283
Master R.SREEVEDH CHARY
09-11-2015 10 Y 7 M 2 D (M)
Dr. GEETHA CHANDA

Registration No.: _____



MEDICATION NEBULISATION CHART

Date	Time	Drug	Nurse	Parents Signature
12/6	00.00	12AM. Drug by - Enoxaparin - 30mg. 6AM.	Pinto	Shay
	1.00	by - Esomeprazole - 30mg.		
	2.00	by - ceftriaxone - 1.5gms.		
	3.00	tab - Vertin - 1 tab.		
	4.00	by - Paracetamol - 250mg.		
	5.00	by - Ondansetron - 4mg.		
	6.00	10AM.		
	7.00	Nasivion - P - 20/20.		
	8.00	12pm.		
	9.00	by - Enoxaparin - 30mg.	Gay	
	10.00	2pm.		
	11.00	by - Paracetamol - 250mg.		
	12.00	6pm.		
	13.00	by - Ceftriaxone - 1.5gms.		
	14.00	tab - Vertin - 1 tab.		
	15.00	by - Ondansetron - 4mg.		
	16.00	10pm.		
	17.00	by - Paracetamol - 250mg.	Pinto	P. Laxitha
	18.00	Nasivion - 20/20.		
	19.00			
	20.00			
	21.00			
	22.00			
	23.00			

108.

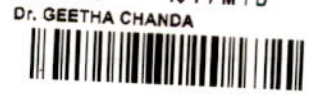
Ref. No. F/INPR/12



Patient Name :

VIH-00128871 IP-00060283
Master R.SREEVEDH CHARY
09-11-2015 10 Y 7 M 1 D (M)

Registration No



~~MEDICATION~~
NEBULISATION CHART

Date	Time	Drug	Nurse	Parents Signature
11/6	00.00			
	1.00	12AM. Inj - Enoxaparin - 30mg.	Anita	R. Sreevedh
	2.00	6AM. Inj - Esomeprazole - 30mg.		
	3.00			
	4.00	12pm.		
	5.00	Inj - Enoxaparin - 30mg.		
	6.00	10pm.		
	7.00	Tab - Stemetil - 1 tab.		
	8.00			
	9.00			
	10.00			
	11.00			
	12.00			
	13.00			
	14.00			
	15.00			
	16.00			
	17.00			
	18.00			
	19.00			
	20.00			
	21.00			
	22.00			
	23.00			