

Name	Master J RUDRANSH	UHID	VIH-00197179
Father/Guardian	Mr J. DAMODAR	Age/Gender	1 Y 5 M 5 D/Male
Address	HNO 1-222- KUNTOOR ABDULLA PUR MANDAL RANGA REDDY, Pasmamla, Ranga Reddy, Telangana, INDIA, 501505		
IP No	IP-00060505	Admission Date	28-06-2026
Ref Doctor	Self	Discharge Date	29-06-2026

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: Febrile status epilepticus

History: Master J. RUDRANSH, 1 Y 5 M 5 D, boy presented with history of moderate to high grade fever not relieved on taking medications for 1 day, today at 4:00 AM in morning she had paroxysmal event in the form of staring look with behavioural arrest along with jerky respiration without any tonic-clonic movements with impaired consciousness lasted for around 40 minutes followed by post event drowsiness. For above complaints, he was taken to nearby hospital and primary management was given and the shifted at Rainbow childrens hospital for further management.

Name	Master J RUDRANSH	UHID	VIH-00197179
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Birth History: Born to non consanguineous couple, 3rd in birth order, FT/NVD/Birth weight - 3 Kgs/Cried immediately after birth / No perinatal complications.

Developmental History: Appropriate for age (Till premorbid state).

Examination: He was afebrile, maintaining saturations at room air. HR-120/min, BP- 100/60 mmHg and RR - 24/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 drowsy. Pupils were bilaterally equal and reacting to light. DTR elicitable. Tone normal. Power moving all limbs against gravity on painful stimulation. 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 : 8 kgs.
Head circumference : 45 cms.

Investigations: Enclosed.

Management: He was admitted in the ward and was started on IV fluids and IV antibiotics. In view of seizures, he was loaded with Injection Levetiracetam and continued on maintenance dose.

EEG was done which showed disturbed background with bilateral (left> right) high amplitude spike and slow wave discharges.

Name	Master J RUDRANSH	UHID
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He was regularly monitored for hemodynamic status, vital parameters & neurological status. His symptoms gradually settled & had no seizure episodes during hospital stay. 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 and taking orally well

pupils - equal reacting

EOM full.

No facial/bulbar weakness

Tone normal.

Moving all limbs against gravity

DTR-+2

Plantar - flexor

No signs of meningeal irritation.

Advice:

1. Diet as advised.
2. Kindly consult Dr. Geetha Chanda, Consultant Pediatric Neurologist, after 14 days in OPD with prior appointment (This consultation will be charged).

Syp LEVIPIL (1ml=100mg)	1.5ml 12 th hourly till further advice
Syp CEFIXIME (5ml=100mg)	3ml 12 th hourly for 5 days
Syp PARACETAMOL (5ml=240mg)	2.5ml (if required) if Temp >100 ^o F

Name	Master J RUDRANSH	UHID	VIH-00197179
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** Midacip nasal spray (Midazolam = 1.25mg/puff), 1 puff intranasal (into one nostril in sitting position) if seizure for more than 3 minutes.

Backup plan: If further seizures occur :

1. Inj. Levetiracetam, 20 mg/kg - in 20ml of NS over 20 mins loading.

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).

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 :

Name	Master J RUDRANSH	UHID
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Summary prepared by :Dr. Nikesh
DEO :MD Younus Pasha

NCU

Registrar/Resident/C.M.O

Consultants:

<p>Dr. GEETHA CHANDA MBBS, MD, Pediatrics PDF Pediatric Neurology Consultant Pediatric Neurologist APMC/FMR/87648</p>	
<p>Dr.Sindhura Pappula MBBS, MD, DrNB (Pediatric Neurology), FIPN, FIAMG Consultant Pediatric Neurologist</p>	<p>Dr. RAMESH KONANKI, MD Pediatrics (AIIMS), DM Pediatric Neurology (AIIMS), CONSULTANT PEDIATRIC NEUROLOGIST, APMC-49226</p>

PatientName : Master J RUDRANSH Inpatient No. : IP-00060505
 Age/Gender : 1 Y 5 M 4 D/ Male Admit Date : 28-06-2026
 Ward/Bed : N 0 GF-EMERGENCY/ ER 101 Discharge Date :

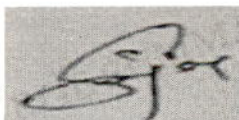
Investigation	Result	Unit	Biological Reference Interval
TEST RESULT STATUS : REPORT AUTHORISED			
Order Date :28-06-2026 11:59			
CALCIUM (Specimen : SERUM)			
CALCIUM (Arsenazo dye)	9.5	mg/dl	8.7 - 10.8



Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
TEST RESULT STATUS : REPORT AUTHORISED			
Order Date :28-06-2026 11:59			
COMPLETE BLOOD PICTURE (Specimen : BLOOD)			
HEMOGLOBIN (Colorimetry)	13.6	g/dL	H 10.5 - 13.5
RBC COUNT (DC detection method)	4.78	10 ¹² /L	3.7 - 5.6
PCV/HCT (Calculated)	37.0	VOL%	33 - 49
MCV (Calculated)	77.4	fL	70 - 86
MCH (Calculated)	28.3	pg/cells	23 - 31
MCHC (Calculated)	36.6	g/dL	H 30 - 36
RDW-CV (Calculated)	13.1	%	11.5 - 16
PLATELET COUNT (DC Detection Method)	257	10 ⁹ /L	150 - 450
MPV (Calculated)	8.2	fL	6.5 - 10
WBC COUNT (DC Detection Method)	7.88	10 ⁹ /L	6 - 17
Differential Count			
NEUTROPHILS (Microscopy, Leishman stain)	75	%	H 15 - 35
LYMPHOCYTES (Microscopy, Leishman stain)	19	%	L 45 - 76
MONOCYTES (Microscopy, Leishman stain)	05	%	4 - 12
EOSINOPHILS (Microscopy, Leishman stain)	01	%	1 - 7
PERIPHERAL SMEAR (Microscopy, Leishman stain)	RBC - NORMOCYTIC / NORMOCHROMIC WBC - MORPHOLOGY NORMAL PLATELETS - ADEQUATE		



Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
TEST RESULT STATUS : REPORT AUTHORISED			
Order Date :28-06-2026 11:59			
C REACTIVE PROTEIN (Specimen : SERUM)			
CRP (Immunoturbidimetry)	11	mg/L	H <10

PatientName	: Master J RUDRANSH	Inpatient No.	: IP-00060505
Age/Gender	: 1 Y 5 M 4 D/ Male	Admit Date	: 28-06-2026
Ward/Bed	: N 0 GF-EMERGENCY/ ER 101	Discharge Date	:

Investigation	Result	Unit	Biological Reference Interval
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Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
ELECTROLYTES (Specimen : SERUM)		TEST RESULT STATUS : REPORT AUTHORISED	
		Order Date :28-06-2026 11:59	
SODIUM (Direct ISE)	142	mmol/L	134 - 143
POTASSIUM (Direct ISE)	5.2	mmol/L	H 3.7 - 5
CHLORIDE (Direct ISE)	107	mmol/L	98 - 108



Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
MAGNESIUM (Specimen : SERUM)		TEST RESULT STATUS : REPORT AUTHORISED	
		Order Date :28-06-2026 11:59	
MAGNESIUM (Formazon dye)	2.2	mg/dl	1.6 - 2.6



Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
COMPLETE URINE EXAMINATION (Specimen : URINE)		TEST RESULT STATUS : REPORT AUTHORISED	
		Order Date :28-06-2026 19:43	
PHYSICAL			
COLOUR (Visual Examination)	PALE YELLOW		
APPEARANCE (Gross Examination)	CLEAR		
pH (Double pH indicator)	6.0		5 - 8.5
SPECIFIC GRAVITY (PKA Reaction)	1.015		1.005 - 1.030
SEDIMENT (Gross Examination)	NIL		NIL
CHEMICAL			
PROTEIN (Protein error of pH indicator)	NIL		NIL
GLUCOSE (GOD POD method)	NIL		NIL
KETONE BODIES (Acetoacetic acid reaction)	NEGATIVE		NEGATIVE
BILE SALTS (Hay's Sulfur Test)	ABSENT		ABSENT
BILE PIGMENTS (Diazo reaction)	ABSENT		ABSENT
NITRITE (Reflectance Photometry)	NEGATIVE		NEGATIVE

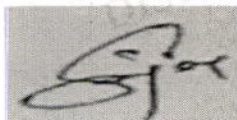
Rainbow Children's Hospital - Secunderabad

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



PatientName : Master J RUDRANSH **Inpatient No.** : IP-00060505
Age/Gender : 1 Y 5 M 4 D/ Male **Admit Date** : 28-06-2026
Ward/Bed : N 0 GF-EMERGENCY/ ER 101 **Discharge Date** :

Investigation	Result	Unit	Biological Reference Interval
BLOOD (Peroxidase reaction)	ABSENT		ABSENT
LEUCOCYTES (Esterase reaction)	NEGATIVE		NEGATIVE
MICROSCOPY			
PUS CELLS	3 - 5	HPF	L 0 - 5
EPITHELIAL CELLS	2 - 3	HPF	L 0 - 5
RBCS.	NIL	HPF	0 - 2



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

ACTIVITY RECORD FOR BILLING

VIH-00187179 IP-00060505

Master J RUDRANSH

Name: 24-01-2025 1 Y 5 M 4 D (M) -----
Dr. GEETHA CHANDA

UHID 

Consultant : ----- Dept : pediatric

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

Room / Bed No : 131 Ward : 1st floor Suggested Billable bed type : -----

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
<u>28/6/26</u>	<u>2:55 PM</u>	<u>ER</u>	<u>131</u>	<u>Nsgm</u>

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Sign
28/6/26	CBP, CRP, blood CTS	26021284	slm.
	S/E, calcium, magnesium		
28/6/26	EUF	26021802	Ggr
	EEG	26 010304	Ggr
	CNS checked by Ggr 29/6/26 @ 9.30pm		

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
28/6/26	Iv placement	①	3095480	Shay

ANY OTHER INFORMATION

Date :


Time :

Prepared By :

Staff Nurse	Shift / Ward Gayath 29/6/26	Billing Assistant	Billing Supervisor
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DEFICIENCY CHECK LIST OF MEDICAL CASE SHEET



Patient Name : **Master J RUDRANSH**
 24-01-2025 1 Y 5 M 5 D (M)
 Dr. **GEETHA CHANDA**
 Ward: 

IP.No:

DOA:

Sl.No	List of Records	o. of Pages	Legibility	Completeness	Remarks
1	Admission Sheet	1	✓	✓	
2	Discharge Summary	2	✓	✓	
3	Nursing Initial assessment form	1	✓	✓	
4	Patient Trasfer Forms	1	✓	✓	
5	In-patient Medical Record	3	✓	✓	
6	Doctors Progress Sheets	1	✓	✓	
7	Nurses Progress notes	3	✓		
8	Consultation Sheets				
9	General Consent for Treatment	1	✓	✓	
10	Conset for Surgery				
11	Consent for Blood Transfusion				
12	Consent for Chemotherapy				
13	Consent for High Risk				
14	Consent for Restraint				
15	DAMA Consent				
16	Consent for Special Procedure				
17	Consent for Radiological Investigations				
18	Consent for HIV Test				
19	Anaesthesia consent form				
20	Anaesthesia notes(Pre Anaesthesia & Post)				
21	Pre Operative checklist				
22	Surgical safety Checklist				
23	Operation Theatre notes				
24	Nurses Clinical Presentation				
25	TPR & BP chart	2	✓	✓	Noted by Anitha 29/6/26 @ 10AM
26	Intake and Output chart (fluid Chart)	2	✓	✓	
27	Drug Chart (Regular prescription)	2	✓	✓	
28	Daily Investigation sheet				
29	Investigation Values (Result Sheet)	1	✓	✓	
30	Nebulization Chart				
31	Diabetic chart				
32	Nutritional Review chart				
33	MLC form (in case of MLC)				
34	Patient Education Form				
	pain Assessment	2	✓	✓	
	Humpty Dumpty	2	✓	✓	
	Thrombophlebitis	2	✓	✓	
	others	6	✓	✓	
	Triage Form	2	✓	✓	
	Total No. of Pages	36 pages			
					Anitha 29/6/26 @ 10AM Signature and Date :

ERROR LOG

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

ICD CODE :-

OBSERVATION: -

DATE :

MRD EXECUTIVE

ADMISSION SHEET

Registration Details :



Admission No : IP-00060505

Admit Date : 28-Jun-2026

Admit Time : 11:38 AM UHID : VIH-00197179

Patient Details :

Patient Name : Master J RUDRANSH

Age : 1 Y 5 M 4 D

Guardian : Mr J. DAMODAR

DOB : 24-01-2025 06:30 AM

Gender : Male

Religion :

Occupation :

Martial Status : Single

Address (H) : HNO 1-222- KUNTOOR ABDULLA PUR
MANDAL RANGA REDDY Pasmamla Ranga
Reddy Telangana INDIA 501505

Phone No : 7989187875/

E-mail : NA@GMAIL.COM

Admission Details :

Bed Type : SHARED WARD

Bed No : ER 101

Ward Name : N 0 GF-EMERGENCY

Room No : ER 101

Admission Type : First Visit

Contact Details :

Name : Mr J. DAMODAR

Relationship : Father

Contact Address : HNO 1-222- KUNTOOR ABDULLA PUR
MANDAL RANGA REDDY Pasmamla Ranga
Reddy Telangana INDIA 501505

Phone No : 7989187875



Signature

Doctor Details :

Doctor Name : Dr. GEETHA CHANDA

Specialisation : PEDIATRIC NEUROLOGY

Referral Doctor : Self

Phone No :

Co-Consultant :

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : CARE HEALTH INSURANCE LIMITED

VIH-00197179 IP-00060505
 Master J RUDRANSH
 24-01-2025 1 Y 5 M 4 D (M)
 Dr. GEETHA CHANDA

Wt - 7.70kg



EMERGENCY ROOM TRIAGE FORM

Patient's Name : mst. Rudransh J Age : 1y5 Gender: Male Female
 Date : 22/1/25 Time of Arrival : 11 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: 99°F PR: 116b/m BP: 92/64 RR: 24b/m SpO₂: 97%
 Chief Complaints: Fever since 2 days. seizure 1 episode today

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		Work of Breathing <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Increased <input type="checkbox"/> Decreased <input type="checkbox"/> Gasping / Apnea		INITIAL PHYSIOLOGICAL STATUS <input checked="" type="checkbox"/> Stable <input type="checkbox"/> Unstable : <input type="checkbox"/> Not - Life - Threatening <input type="checkbox"/> Life -Threatening
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Triage Classification	CTAS
<input type="checkbox"/> Level 1 : Resuscitation	<input type="checkbox"/> Immediate
<input type="checkbox"/> Level 2 : EMERGENT : Life or limb threatening	<input type="checkbox"/> < 15 min
<input type="checkbox"/> Level 3 : URGENT : Significant illness / injury with potential to become life or limb threatening	<input type="checkbox"/> 30 min
<input type="checkbox"/> Level 4 : LESS URGENT : Significant illness but not life threatening	<input 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

J Bhargava
 Signature of Parent / Guardian
 Triage Completion Time : 11:05 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 : Bro. Sanjay Signature of Triage Nurse : Sanjay
 Date & Time : 22/1/25 @ 11:05 AM
 Docu. No. : RCH / FRM / CLINICAL / 085

VIH-00197179 IP-00060505
 Master J RUDRANSH
 24-01-2025 1 Y 5 M 4 D (M)
 Dr. GEETHA CHANDA




NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 28/1/25 Time of arrival : C 11-06
 Chief Complaints : fever since 3 days, 1 episode of seizure ^{month} RBS : -
 Height : - Weight : 7.70kg BMI : - Head Circumference (<2 years) : 40.5cm
 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 -

<p>RISK FOR FALL:</p> <p><input checked="" type="checkbox"/> If patient is < 6 years tick below fall risk intervention directly</p> <p><input type="checkbox"/> If Patient is > 6 years Assess the below parameters</p> <p>History of Falling: within past 3 months <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Ambulatory Aids:</p> <ul style="list-style-type: none"> Wheelchair <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Uses furniture for support <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <p>Gait/Transferring:</p> <ul style="list-style-type: none"> Bedrest / immobile <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Weak <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Impaired <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <p>Mental Status: Forgets limitations <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>IF YES FOR ANY CATEGORY = RISK FOR FALLING</p> <p>Fall Risk Intervention:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Escort while ambulating <input type="checkbox"/> Assist Patient <input checked="" type="checkbox"/> Educate patient and family on fall precautions/prevention 	<p>Functional Screening: <input checked="" type="checkbox"/> No Abnormalities Detected</p> <ul style="list-style-type: none"> <input type="checkbox"/> Mobility Problem <input type="checkbox"/> Walking Problem <input type="checkbox"/> Developmental Delay <input type="checkbox"/> Musculoskeletal Congenital Abnormality <p>Inform consultant for positive criteria</p> <p>.....</p> <p>.....</p> <p>Nutritional Screening: <input checked="" type="checkbox"/> No Abnormalities Detected</p> <ul style="list-style-type: none"> <input type="checkbox"/> Underweight <input type="checkbox"/> Overweight <input type="checkbox"/> Feeding Problem <input type="checkbox"/> Special diet <input type="checkbox"/> Special feeding method <p>Inform consultant for positive criteria</p>
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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?) 2
 Time of Initial assessment completed by ER Nurse : Dr. Nagmani @ 11:09 AM

Patient Name : Mast. J RUDRANSH UHID : VIH-00197179 IPD : IP-00060505 Gender : Male Age : 1 Y 5 M 4 D

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

Time	Nursing Notes
11:05 Am	patient Came to ER
11:07 Am	Vitals checked and recorded.
11:10 Am	Dr. NPKesh seen the patient and advice for admission.
12 pm	Admission process done, Iv placement done
12:14 pm	Blood samples collected and sent to lab.
1 pm	EEG done as per doctor order.
1:30 pm	Shifted to ward.

Samples collected by: } *S. Manthi*
 Samples sent by: }

Time: } 12:15 PM
 Time: } 12:20 PM

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1
<i>Nil</i>					

Condition of patient at time of shift - out :	Details of Shift - out
HR: <i>116b/m</i> BP: <i>92/62</i> CFT: <i>23sec</i> RR: <i>25b/m</i> SPO ₂ : <i>99.1</i> GCS: <i>15</i> Temperature: <i>99.9</i> Pain Score: <i>0</i> Repeat RBS (if applicable): <i>-</i>	Shift - out from ER to: <i>151</i> Time of Shift - out: <i>28/6/26@</i> Handover given to: <i>Sr. Manisha</i> (Nurse's Name) <i>By Sabin</i>


Tick as applicable: MLC LAMA BROUGHT DEAD

Procedures done with details (if any): *Iv Placement*

Name of the Nurse : *Sr. Nagmani*
 Date & Time : *28/6/26 @ 2:50 PM*

Signature of the Nurse : *Nagmani*

PATIENT TRANSFER FORM

Patient Name & UHID No. VIH-00197179 IP-00060505 Master J RUDRANSH 24-01-2025 1 Y 5 M 4 D (M) Dr. GEETHA CHANDA 		Date & Time of Admission 28/6/26 @ 11:38 AM	Date & Time of Transfer Order 28/6/26 @ 2:55 PM
From Unit ER		Transfer Ordered by Dr. Nitesh	Reason for Transfer Admission
To Unit 131		Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File 21	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? op files given to	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.	Nil		
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 Sr. Nagmani		Name of Person Ordered Transfer Dr. Nitesh	
Patient & Clinical Records Received by :			
Date & Time of Patient Received :			

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

Patient Sticker

Nursing General Admission Assessment Form For Pediatrics

Diagnosis: febrile status epilepticus.
Arrival Time: ~~11:30~~ 11:06 **Mode of Arrival:** lifted by medics **Admitting From:** ER OPD Direct
Allergy / Adverse Reaction: nil **Body Weight:** 7.70 Kg
Height: 40.5 cm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
Yes	No	No

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: 7.70 kg Length: 40.5 cm Head Circumference (< 2 years):
 Temp.: 38.4°C HR: 100 bpm RR: 27 BP: 100/77
Pain Score: 0 **Specify Site:** Nil (Follow Pain Assessment Sheet & Document)
Fall Risk Assessment: Yes No **Score:** Nil (Document in the Humpty Dumpty Sheet)
Risk of Pressure Sore (Braden Q Score): 28 (Document in the Braden Q Assessment Sheet)

Pain Screening: Yes No If Yes, **Pain Score:** Nil **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?) 2

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

Nurse's Name: Manisha Date: 28/6/26 Time: 3:00 PM Signature: [Signature]



Rainbow[®] Children's Hospital

It takes a lot to treat the little.

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: _____

VIH-00197179 IP-00060505
Master J RUDRANSH
24-01-2025 1 Y 5 M 4 D (M)
Dr. GEETHA CHANDA



UHID ID: _____

Department: _____

Consultant: _____

febrile status epilepsy

Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

fever x 3 days
peroxymal urine x 1 day

History of present illness :

→ Fever, moderate grade
without rigors
relieved on medications x 3 days

→ Peroxymal urine
faint with jerky respiration
staring look with behavioural arrest
no tonic-clonic movements
impaired consciousness
lashed for around 40 min

→ took child to nearby hospital

→ 2ml midazolam given
in 1 amp



Pediatric Multiorgan History & Physical Examination

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

Not significant

Birth & Neonatal History:

FT/CSG/CSAB

Birth & Socio Economic History:

About Father : _____

About Mother : _____

Any additional Information : _____

Developmental History :

Appropriate for age

Immunization History :

Completed

Pediatric Multiorgan History & Physical Examination

Anthropometry :

Head Circum (cms) 45 cm (Centile _____) Height (cms): _____ (Centile _____)
Weight (kgs) _____ (Centile _____)

On Examination :

Temperature : 99.9 F Pulse Rate : 110/min B.P. 100/60 SPO2 100% on room air
Resp. rate and type of breathing : 26/min

Rash no
Lymphadenopathy no
Oedema : no
Allergies (if any): _____

Respiratory System :

Inspection (any s/o distress) : all clear
Air entry & breath sounds : _____
Any added sounds : no
Relevant data from outside (Chest X-Ray, ABG, etc.,) _____

Cardiovascular System :

Inspection of precordium : normal
Heart Sounds : _____
Any murmur : no murmur
Relevant data from outside (Chest X-Ray, ECG, ECHO, etc.,) : _____

Per Abdomen :

Inspection soft non-tender
Palpation : _____
Auscultation : _____
Spine : _____ External Genitalia : _____
Relevant data from outside (CT, USG etc.,) _____



Pediatric Multiorgan History & Physical Examination

Central Nervous System :

conscious but lethargic

Level of Consciousness : AVPU/GCS score : _____

Cranial Nerves : _____

(II)

Motor System:

Nutriton : _____

Tone: _____

(II)

Power

good ambulatory by
moderate

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

f2

DTR

Superficials:

Plantars _____

Sensory System :

Bladder / Bowel : _____

Clinical Summary & Diagnostic:

Simple febrile ~~illness~~ status epilepticus

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: _____

Desired goals of the treatment : _____

Planned Labs:

- CBP ✓
- CRP ✓
- Blood culture ✓
- S. electrolytes ✓
- S. calcium ✓
- S. Mg⁺⁺ ✓
- FEC @ 1 PM today ✓
- CUE ✓

Planned Management

- IV fluid
- IV. Ceftriaxone
- IV. Paracetamol 505
- Tab. Levipil

noted by shanthi
28/6/26
@ 11:59 AM

Signature of the Doctor: _____

Name of the Doctor: Dr. Nishu

Date & Time: _____

Signature of the Consultant: _____

Name of the Consultant: Dr. Geetha

Date & Time: _____



NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: <i>febrile status Epilepticus</i>	Any Infection: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Not Known				
	Surgery / Procedure: <i>-</i>	Post OP Day: <i>-</i>				
BACKGROUND	Date	<i>28/6/26</i>	<i>28/6/26</i>	<i>28/6/26</i>	<i>29/6/26</i>	
	Shift	<i>M</i>	<i>E</i>	<i>N</i>	<i>M</i>	
	Medical Condition (Any special condition to be noted):	<i>Nil</i>	<i>Nil</i>	<i>Nil</i>	<i>Nil</i>	
ASSESSMENT	Diet:	<i>S-diet</i>	<i>S-diet</i>	<i>S-diet</i>	<i>S-diet</i>	
	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	
	Ventilation (RA, NP, NIV, VENTI):	<i>RA</i>	<i>RA</i>	<i>RA</i>	<i>RA</i>	
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Vital Signs:	Temp:	<i>98.6F</i>	<i>98.4F</i>	<i>98.6F</i>	<i>99.0.3F</i>
		Res:	<i>22blm</i>	<i>23blm</i>	<i>24blm</i>	<i>24blm</i>
		SpO ₂ :	<i>99.1</i>	<i>99.1</i>	<i>99.1</i>	<i>99.1</i>
		Pulse:	<i>113blm</i>	<i>110blm</i>	<i>122blm</i>	<i>127blm</i>
		BP:	<i>92/62(73)</i>	<i>100/66</i>	<i>99/77(84)</i>	<i>124/84(96)</i>
		LOC:	<i>Comious</i>	<i>conscious</i>	<i>Conscious</i>	<i>conscious</i>
Fall Risk Score:		<i>15</i>	<i>15</i>	<i>15</i>	<i>'15'</i>	
Pain Score:	<i>0</i>	<i>0</i>	<i>0</i>	<i>'0'</i>		
Skin Integrity	<i>Intact</i>	<i>Intact</i>	<i>Intact</i>	<i>Intact</i>		
Recommendations	Safety Needs:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	Physiotherapy:	<i>Nil</i>	<i>Nil</i>	<i>Nil</i>	<i>Nil</i>	
	Others Specify:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Special Diet:	<i>S-diet</i>	<i>S-diet</i>	<i>S-diet</i>	<i>S-diet</i>	
	Critical Lab Test / Values:	<i>Nil</i>	<i>Nil</i>	<i>Nil</i>	<i>Nil</i>	
	Other Special Orders / Medications:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	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	
	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	
ADL (Dependent / Non Dependent):	<i>Dependat</i>	<i>Dependat</i>	<i>dependent</i>	<i>dependent</i>		
Post Operative Procedure Special Orders:	<i>Nil</i>	<i>Nil</i>	<i>Nil</i>	<i>Nil</i>		
Handed Over By Name :	<i>Nugmani</i>	<i>Manisha</i>	<i>Kaishnai</i>	<i>Anitha</i>		
Signature / ID :	<i>@00021</i>	<i>@9050100</i>	<i>@020216</i>	<i>9050140</i>		
Date:	<i>28/6/26</i>	<i>28/6/26</i>	<i>29/6/26</i>	<i>29/6/26</i>		
Time:	<i>2:55PM</i>	<i>@8pm</i>	<i>@8 AM</i>	<i>@ 2pm</i>		
Taken Over By Name :	<i>manisha</i>	<i>Kaishnai</i>	<i>Anitha</i>			
Signature / ID :	<i>@9050100</i>	<i>@020216</i>	<i>@9050100</i>			
Date:	<i>28/6/26</i>	<i>28/6/26</i>	<i>29/6/26</i>			
Time:	<i>@2:55pm</i>	<i>@8pm</i>	<i>@8AM</i>			

*File send to Billing on
 29/6/26 @ 10AM
 Noted by Anitha
 @ 10AM*

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	<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	<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:							



NURSING CARE RECORD



Date: 28/6/20

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon	3pm	- Maintain Fluid Balance - Ensure safety		- Administered IV fluid 0.9% 30ml/hr - side rail kept up	- To maintain hydration - prevent from fall risk	- patient is stable	manisha 28/6/20 @ 3pm
Night	11pm	Maintain Fluid Balance - Ensure safety	11:10	- Maintained input/output chart - provided side rail	- To prevent dehydration - To prevent falls	- patient is stable	Kishnavi 28/6/20 @ 8AM

VIH-00197179 IP-00060505
 Master J RUDRANSH
 24-01-2025 1 Y 5 M 4 D (M)
 Dr. GEETHA CHANDA



NURSING CARE RECORD

Date: 29/6/26

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	8AM	Ensure Safety	2pm	To provide side rails	To provide Safety	Re-Assessment was done.	Anitha 29/6/26 @2pm
Afternoon				<u>Discharge Notes</u> Doctor came for rounds Baby is stable Doctor said patient to get discharge.			
Night				Noted by Anitha 29/6/26 @2pm			



THE HUMPTY DUMPTY SCALE *28/6/2016 28/6 29/6*

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

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	x	x	x
Wheels Locked		✓	✓	✓	✓
Room free of clutter		✓	✓	✓	✓
Adequate Lighting		✓	✓	✓	✓
Wheel Chair Support		x	x	x	x
Other Intervention(s) Specify		✓	✓	✓	✓
Nurse's Name :		Nagani	Manish	Varish	Varish
Signature :		(P)	MS	Varish	Varish
Date :		28/6	28/6	28/6	29/6
Time :		12pm	3pm	11pm	5AM

CHECKLIST FOR THROMBOPHLEBITIS

Ward
Date



S.No	SITE OBSERVATION	STAGE / ACTION	SCORE	I.P. No.						REMARKS	
				28/6	28/6						
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0	0	0	0					
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1	-	-	-					
3	Two of the following signs are evident : Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	-	-	-					
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3	-	-	-					
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4	-	-	-					
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord pyrexia	Advanced Stage of thrombophlebitis / Initiate treatment Re site Cannula	5	-	-	-					

NOTE : Phlebitis > 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 of Ward In Charge :

Signature : Name Signature : Name

CHECKLIST FOR THROMBOPHLEBITIS

29/6/26

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0	0									
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				Ary									

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 : Anitha Name : Anitha

Signature of Ward In Charge :

Signature : Name :



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
28/6/26	14pm	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	Nagmi
28/6/26	3pm	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
29/6/26	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	-	Vaishub
29/6/26	7am	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	-	Amithe
				<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:

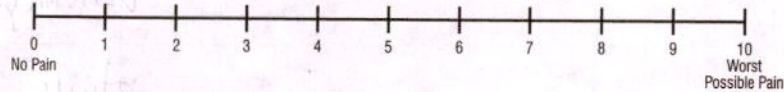
1. Every eight hours for all hospitalized patients.
2. For post-surgical patients, patients with chronic pain, patient with severe pain:
 - a) At least every 2 hours for the first 24 hours
 - b) Then every 4 hours.
 - c) Prior to pain pain-relieving intervention.
 - d) Within 30 – 60 minutes after pain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

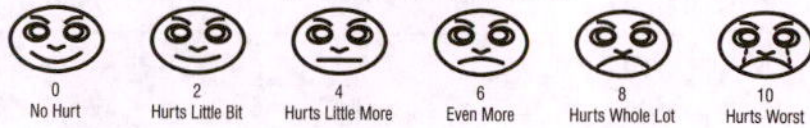
Numerical Pain Scale (Obstetric and Gynecology)



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





BRADEN 'Q' SCALE

					Date :	28/6	28/6	28/6	
					Time :	12 pm	3 pm	1 pm	
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.		3	3	3	
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.*	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.		1	1	1	
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.		2	2	2	
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.		3	3	3	
FRICION-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.*		3	3	3	
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.		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	
TOTAL SCORE						19	19	19	
Evaluator's Name						G	mg	Baich	

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

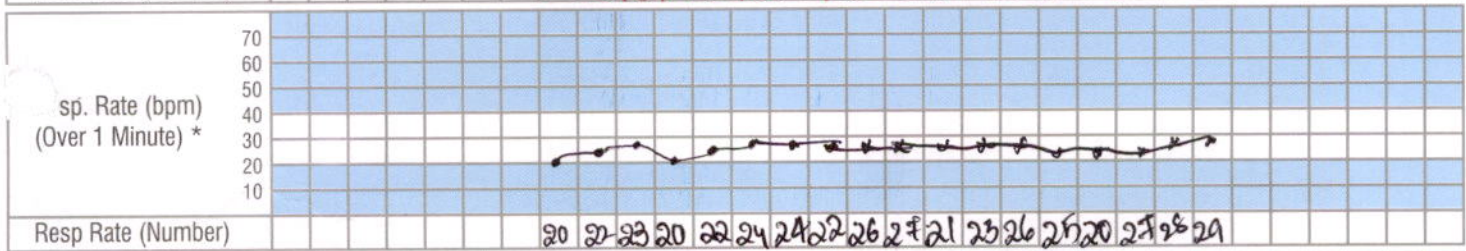
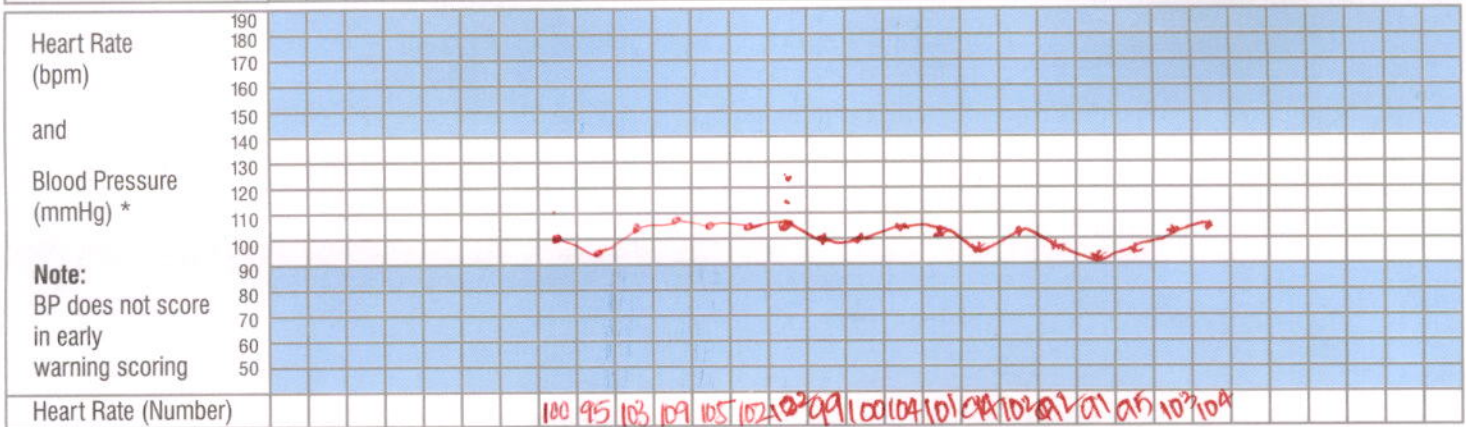
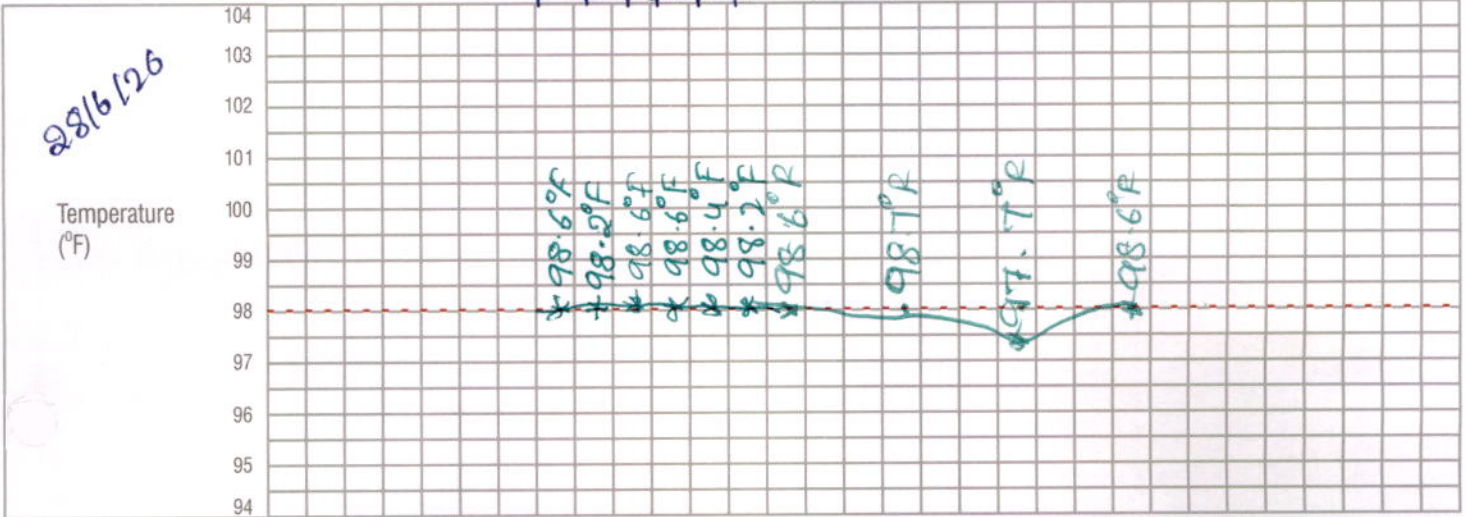
Risk Score	Category	Action	Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice)
15-18	At Risk	<ul style="list-style-type: none"> • Regular Turning Schedule • Enable as much activity as possible • Protect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



EARLY WARNING SCORE: CHILDREN'S UNIT

Date : Time: 3 4 5 6 7 8 9 10 11 12 1 2 3 4 5 6 7 8

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



Resp Distress	Mod/ Severe None / Mild	
Receiving O ₂ (l/min)		
O ₂ Saturations (%)		99 98 100 99 100 99 99 99 99 99 99 98 99 98 99 98 99 98
Conscious Level	Normal / Altered	N N N N N N N 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 15 15 15 15 15 15

TOTAL SCORE		
Number of shaded boxes		0 0 0 0 0 0 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 0 0 0 0 0 0
Observer's Initials		M M M M M M V V V V V V V V V V

ACTIONS

NB: Scores 3 should be recorded overleaf

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

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

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.

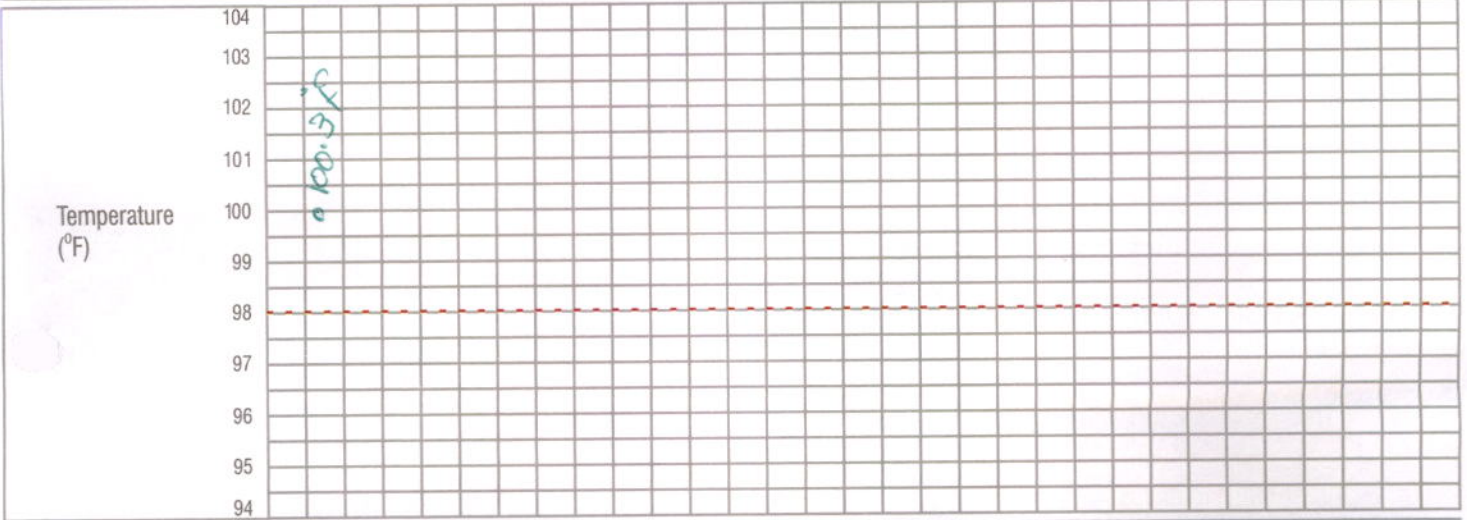
I	IDENTITY: I am (name), a nurse on ward (X). I am calling about (child X)
S	SITUATION : I am calling because I am concerned that ... (e.g. BP is low/high, pulse is XXX, Temperature is XX, Early Warning Score is XX)
B	BACK GROUND : Child (X) was admitted on (XX date) with (e.g. respiratory infection). 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 Is there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)



EARLY WARNING SCORE: CHILDREN'S UNIT

Date : Time: 9

Doctor / Nurse / Family Concern? Am



Heart Rate (bpm) and Blood Pressure (mmHg) *
77 / 60 / 55

Note: BP does not score in early warning scoring

Heart Rate (Number) 127

Resp. Rate (bpm) (Over 1 Minute) *
36

Resp Rate (Number) 36

*Noted by
 Anitha 29/1/26
 @ 10 AM*

Resp Distress | Mod/ Severe None / Mild

Receiving O₂ (l/min) | O₂ Saturations (%) 99 100

Conscious Level | Normal Altered N

GCS * 15

TOTAL SCORE
 Number of shaded boxes 0
 Pain Score 1
 Observer's Initials GA

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FLUID CHART

Sheet No. :

- 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 :							
28/6/26	02:00 pm												
	03:00 pm		30ml										
	04:00 pm		30ml										
	05:00 pm		30ml										
	06:00 pm		30ml							✓			
	07:00 pm		30ml										
Total Intake : 150ml						Total Output :							
28/6	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm									✓			
	12:00 am												
	01:00 am												
Total Intake :						Total Output :							
29/6	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							

FLUID CHART

Sheet No. : 2

- 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 Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
29/6/25	08:00 am	Pally + fho										Anitha 29/6/25 @ 2 pm
	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

VIH-00197179 IP-00060505
 Master J RUDRANSH
 24-01-2025 1 Y 5 M 4 D (M)
 Dr. GEETHA CHANDA



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: FR Shifted to: ICU

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						<input type="checkbox"/> C <input type="checkbox"/> DC
2						<input type="checkbox"/> C <input type="checkbox"/> DC
3						<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 : Dr. Nishu

Date & Time : 28/6/26 @ 12:pm

Nurse Name & Signature: Sr. Nagmani

Date & Time : 28/6/26 @ 12pm



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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
28/6	1:15 PM	Aug - AVIL	4mg	IV	[Signature]	[Signature]
28/6	1:15 PM	For. Pediclonyl	4ml	PO	[Signature]	[Signature]

VERIFIED BY : N... Signature

REGULAR PRESCRIPTIONS

Weight Ward. (31).....
 7. July



S. macey kamraj
 28/6/26

DRUG : <u>UA. CEFTRIAXONE</u>				Date	<u>28/6</u>	<u>29/6</u>														
				Time	<u>6 am</u>	<u>6 am</u>														
Dose	Route	Frequency	Start Date																	
<u>350mg</u>	<u>IV</u>	<u>12 hourly</u>	<u>28/6</u>																	
Name & Signature of the Doctor Starting the Drugs:																				
<u>[Signature]</u>																				
Additional Instructions:																				
<u>(100mg/kg/d)</u>																				
Daily Doctor's Endorsement by a Sign																				

S. macey kamraj
 28/6/26

DRUG : <u>UA. EVETIRALETAM</u>				Date	<u>28/6</u>	<u>29/6</u>														
				Time	<u>6 am</u>	<u>6 am</u>														
Dose	Route	Frequency	Start Date																	
<u>150mg</u>	<u>IV</u>	<u>Q 6hr</u>	<u>28/6</u>																	
Name & Signature of the Doctor Starting the Drugs:																				
<u>[Signature]</u>																				
Additional Instructions:																				
<u>(20mg/kg/dose)</u>																				
Daily Doctor's Endorsement by a Sign																				

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

DRUG :				Date																
				Time																
Dose	Route	Frequency	Start Date																	
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