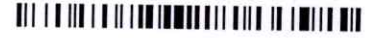


ADMISSION SHEET

Registration Details :



Admission No : IP25-00020671 Admit Date : 27-May-2026 Admit Time : 07:04 PM UHID : FDH-00046370

Patient Details :

Patient Name : Baby B/O K KANCHANA KUMARI Age : 0 D
Guardian : Mr dhana shekhar. p DOB : 27-05-2026 06:21 PM
Gender : Male Religion :
Occupation : Martial Status :
Address (H) : Signature Fortius, Isnapur Hyderabad Phone No : 9885156182/ 9885156182
Hyderabad Telangana INDIA 500001 E-mail : kanch888@gmail.com

Admission Details :

Bed Type : BASINET Bed No : CRDL MICU 4-1 Ward Name : 4F -MICU
Room No : CRDL MICU 4-1 Admission Type : First Visit

Contact Details :

Name : Mr dhana shekhar. p Relationship : Father
Contact Address : Phone No : 9886518904 / 9886518904

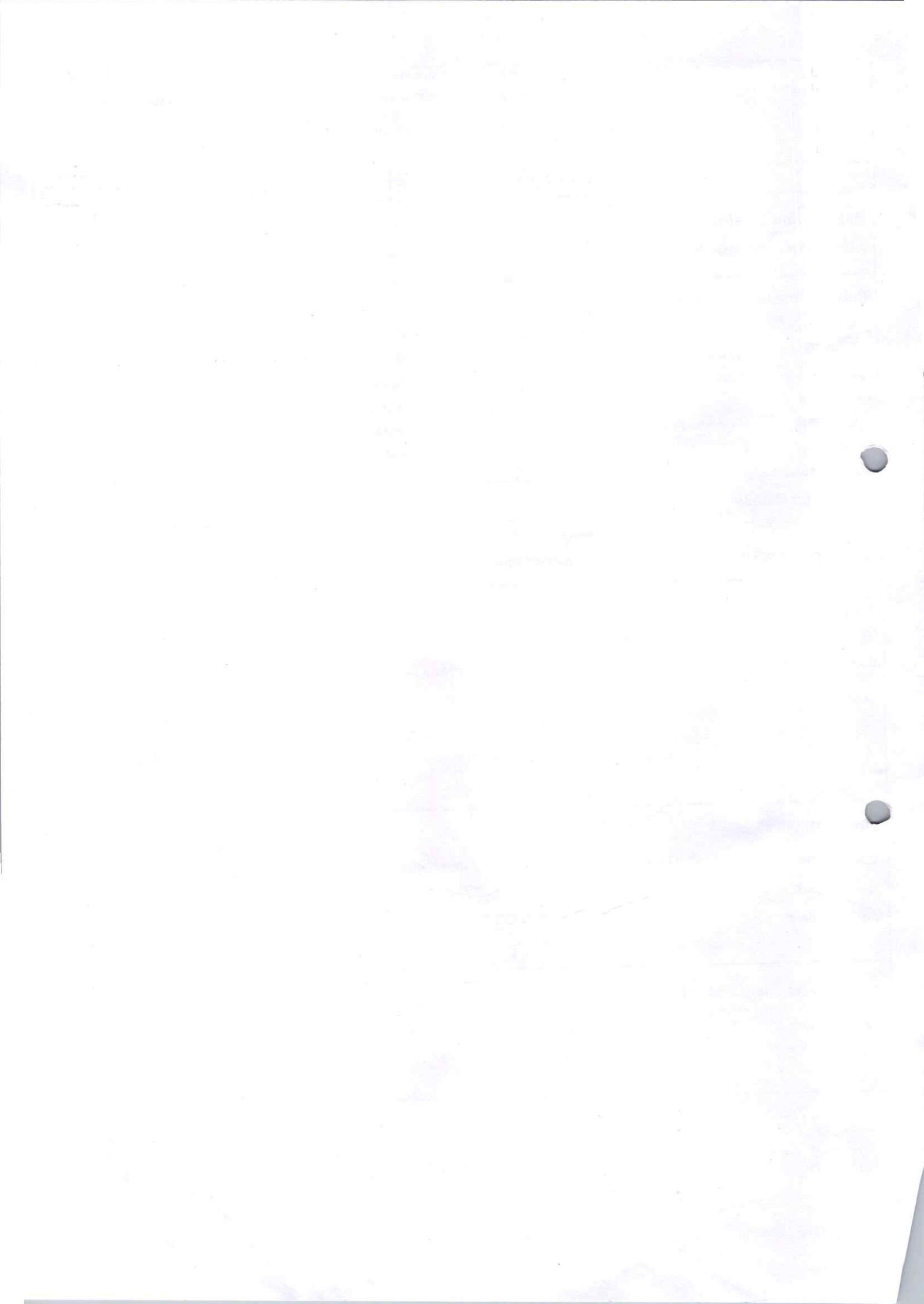

Signature

Doctor Details :

Doctor Name : Dr. KALYAN CHAKRAVARTHY KONDA Specialisation : NEONATOLOGY
Referral Doctor : Phone No :
Co-Consultant :

Payment Details :

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



RAINBOW CHILDRENS HOSPITAL
DEPARTMENT OF PAEDIATRIC AUDIOLOGY
Hearing Screening Informed Consent Form

Hi! Congratulations on the birth of your baby!!!

Dear Parent,

It is through hearing that your child will learn to talk. Approximately 3 newborns per 1000 are born with hearing loss. Although it is unlikely your baby will have a hearing loss, if there is one, it is important that you know about it as soon as possible.

The first two years of your child's life are the most important for learning speech and language. It is important to diagnose hearing problems early because a hearing loss can prevent your baby from learning speech and language.

The purpose of the screening is to check your baby's ability to hear and to help find those babies who need more hearing testing. **This screening test does not rule out severe and rarer forms of hearing loss.**

Your baby will receive the test below.

Otoacoustic Emissions test (OAE). This test will not hurt your baby. Most babies sleep through the test. A soft rubber earphone is placed in your baby's ear and makes a soft clicking sound. Healthy ears will "echo" the click sound back to a tiny microphone that is inside the earphone. Both ears will be tested.

Please ask your doctor or nurse if you have any questions about the hearing screening.

CONSENT

I authorize/request a hearing screening test for newborn, _____

Alhona

Signature of Parent/Legal Guardian

FDH-00046370 IP25-00020671
 Baby B/O K KANCHANA KUMARI
 27-05-2026 0 Y 0 M 0 D 16 H (M)
 Dr. KALYAN CHAKRAVARTHY KONDA



Date

In case if the result shows **refer** in one or both ears, this does not necessarily mean that your baby has a permanent hearing loss, but without additional testing we can't be sure. The screening results will be provided to your baby's doctor. Please be sure you make the appointment for rescreening on _____.

Signature of Parent/Legal Guardian

Date



ACTIVITY RECORD FOR BILLING

Name: ----- FDH-00046370 IP25-00020671
 UHID No: ----- IP Baby B/O K KANCHANA KUMARI
 Date of Admission: ----- 27-05-2026 OYOMODOH (M)
 Room / Bed No: ----- Dr. KALYAN CHAKRAVARTHY KONDA
 Ward: ----- Suggested Billable bed type: -----
 Itant: ----- Dept: -----
 Date of Discharge: ----- Time: -----



WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
27/5/26	10 pm	Micu	ward	Nashira

Cross Consultation Visit

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

PROCEEDURE

Date	ProceEDURE	Quantity	Order No.	Signature

ANY OTHER INFORMATION

Date : 27/5/26

Time : @ 7:30pm

Prepared By : Anika

Staff Nurse Anika	Shift / Ward MICU	Billing Assistant	Billing Supervisor
----------------------	----------------------	-------------------	--------------------



NEONATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

Mother's Name : K Kanchana Kumari Age : 37y Father's Name : Dhana Sekhar Age :
 Date of Birth : 16/5/89 Date of Admission : 27/5/22 UHID No. :
 NICU Consultant : Referring Consultant :
Transferring Unit : OT Labour Room ER Ward
Transported ? Yes No - If yes : Long (> 30 kms) Short (< 30 kms)

BIRTH INFORMATION

Name : B/o K Kanchana Kumari Mother's Blood Group : B +ve
 Gender : M F Blood Group : Birth Weight (gms) : 2940 kg Length (cms) :
 Date of Birth : 27/5/22 Time of Birth : 6:29 pm OFC (cms) :
 Place of Birth : RLH Estimated Gesth Age : 37+5 wks

Current Obstetric History : (Booked / Unbooked Case)
 Maternal Age : Ht : Wt : BMI : Married Life : LMP : 5/9/25 EDD : 12/6/26
 Conception : Spontaneous or with Rx : Spontaneously
 Booked at what GA : @ 22 wks AN Steroids Drugs / Doses :
 Last Scans Details : (21/4/22) & U/S 32+4 wks cephalic / placenta post high / APF 16.2cm
EFW 2091g (53%) AC 56cm Fetal depleat (N) TT Immunization and Iron / Folic Acid :

MATERNAL RISK FACTORS

Age : <18 yrs > 35yrs EFT low risk
 Consanguinity : Yes No NT scan @ 13+4 wks (N)
 If yes, degree of consanguinity : 1 2 3
H/o PIH (after 20 weeks) / PE h/o prev LSCS
 How many Drugs / Doses / Since how long :
trying for VBAC now
 H/o value of recent BP recording, proteinuria, edema, oliguria, any investigations (LFT, platelet count) :
 IUGR - when detected :
 Doppler (Increased Resistance / ADEF / REDF / Redistribtion in MCA) / Ductus Venosus :
 AFI :

H/o GDM/ pre GDM/ on diet or insulin
 Controlled or not, recent values, HbA1 values :
 Compliance with Rx :
 Scans : LGA, TIFFA , Fetal Echo :
H/o Hypothyroidism : when diagnosed ? Medication?
 Any other Chronic Medical Problems, when detected drugs ?
 (Anemia, SLE, Jaundice, CHD, Heart Disease)
 Infection : H/O, Fever
 (Malaria UTI TORCH TB HIV HBV)
 UTI : when : Any culture :

PPROM : Duration : 10 hrs Uterine Tenderness Foul Smelling Liquor HVS (if taken) - Results :
 Medication during Pregnancy : Duration :

PAST OBSTETRIC HISTORY

G: 2 P: _____ A: _____ L: _____

Sl. No.	Age	GA wks	B. W	Gender	Significant	Details
1	2019	MTP in 5 th month			in/v/o Brain Anomaly fls etc	
2	2021	FT/Mch/LSCS			failed induction / 2-8kg / A&H ? wound infection	

PERINATAL HISTORY

Treating Obstetrician : Dr Lalitha Ramani Hospital : PEH, F.D Inborn Outborn

<p>Duration of Labour</p> <p>First stage (> 18 hours sig)</p> <p>Second stage (> 2 hours after dilation)</p> <p>LSCS : <input type="checkbox"/> Elective <input type="checkbox"/> Emergency Indication : _____</p> <p>Specify the reason : <u>VBAC -> A&D</u></p> <p>Augmentation of Labour : <input type="checkbox"/> Induced <input type="checkbox"/> Assisted Vaginal</p>	<p>CTG : <input type="checkbox"/> Normal <input type="checkbox"/> Suspicious <input type="checkbox"/> Pathological</p> <p>MSL : _____</p> <p>Resuscitaion : <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cord ABG : _____</p> <p>Placenta : (weight, surface, No. of cotyledons, calcifications, malformations, clots etc : _____</p>
--	--

NEONATAL RESCUSTITION DETAILS

APGAR SCORE

Gestational Age : _____ Weeks : _____

SIGN	0	1	2
COLOUR	Blue or Pale	Acrocyanotic	Completely Pink
HEART RATE	Absent	< 100 Minutes	> Minutes
REFLEX IRRITABILITY	No Response	Grimace	Cry or Active Withdrawal
MUSCLE TONE	Limp	Some Flexion	Active Motion
RESPIRATION	Absent	Weak Cry; Hypoventilation	Good, Crying

	1 Minute	5 Minutes	10 Minutes
TOTAL	<u>7/10</u>	<u>9/10</u>	

Resuscitation			
Minutes	1	5	10
Oxygen			
PPV / NCPAP			
ETT			
Chest Compressions			
Epinephrine			

Comments :

POSTNATAL / HISTORY OF PRESENT ILLNESS

Chief Complaints :

History of Present Illness:

Baby boy born by VBAC - AVD on 27/1/26 @ 6:29 pm

↓
CBAB

16/1/29

↓
delayed cord clamping done

↓
Vitamin K given in Anterolateral thigh

↓
No S/O PO / congenital anomalies.

Investigation details in previous Hospital :

Feeding History :

Past History :

Family History :

Socio Economic History :

GENERAL EXAMINATION ON ADMISSION

General Disposition :

Euthenic
off a good

VITALS : Temperature : 98.5°F HR : 150/min RR : 50/min NIBP : CFT : Free

Color of the extremities : Pink

Jaundice : - Pallor : - SpO2 : 98% @ RA at 8 min

Anthropometry : Birth Weight : 2.90kg Length : HC : Present Weight :

Ponderal Index : AGA : SGA : LGA :

HEAD TO TOE EXAMINATION

HEAD : Fontanelles :
Sutures
Shape / Moulding : *caput (+)*
Edema / Bruising :
Size - (H.C.) :

Facies :
(Any Facial Dymorphism) *No facial dymorphism.*

NECK and CLAVICLES : Range of Motion :
Asymmetry : *—*
Masses : *—*

EYES : Symmetry :
Red Reflex : *To be checked*
Discharge :

EARS, NOSE MOUTH and THROAT : Ear set / Shape :
Periauricular Pits / Tags :
Nasal shape / Patency :
Palate :
Gums :
Lips :
Tongue :

THORAX and BREASTS : Shape of Thorax :
Position of Nipples and Number :

ABDOMEN and UMBILICUS : Shape :
Organomegaly :
Bowel Sounds :
Umbilical Stump : *WA*
Discharge : *UV*

GENITILIA : Labia / Hymen :
Testicles/penis : *B/c testes palpable.*
Anus :

HERNIAL ORIFICES *—*

TRUNK and SPINE : *3 (+)*

SKIN LESIONS : *—*

EXTREMITIES : Fingers / Toes :
Arms / Legs :
Deformities : *—*
Mobility : *—*
Hip Joint Examination : *(+)*

SYSTEMIC EXAMINATION

Respiratory System :

Breathing Pattern : Regular Periodic Shallow Gasping

Mention If baby has Respiratory distress : RR : SCR / ICR / See - Saw breathing :

Scoring of respiratory distress if present (Silverman or Downe's) :

Mention if baby is on : Hood box CPAP Ventilator

Settings :

*B/c AEP
NO Added sounds
NO XCR*

Spo2 : Auscultation : Breath Sounds : Added Sounds :

Cardiovascular System :

HR : *150/min* BP : Precordial Activity :

Femoral Pulses : Murmurs : *NO murmurs heard.*

Other Peripheral Pulses : *well felt* Signs of Cardiac Failure :

Abdomen :

Shape : Hernia orifice :

Palpation : Anal Patency : *2WA*

Palpable masses : *—* Umbilical Cord : *X*

Abdominal girth : First urine passed : *X*

Meconium passed : *X*

Nervous System : Higher intellectual functions (Sensorium) :

State of wakefulness :

Prechtle Score :

Nerves :

.....
.....
.....

Motor System :

Passive Tone :

Active Tone :

Neonatal Reflexes :

Grasp : Palmar Plantar Sucking Rooting Crossed adductor :

Moro's : *Symmetrical* DTR :

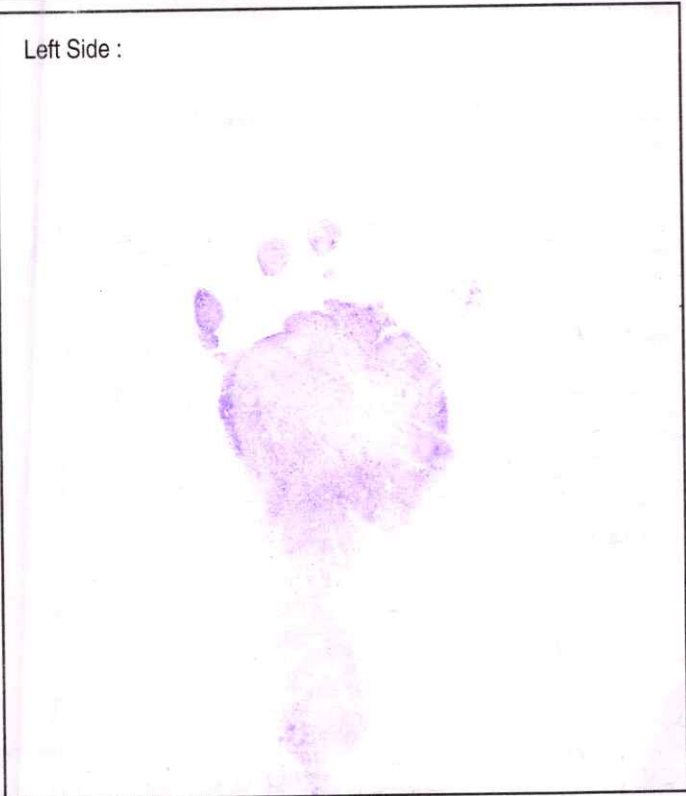
ATNR : Skull and Spine :

Any Congenital Anomalies :

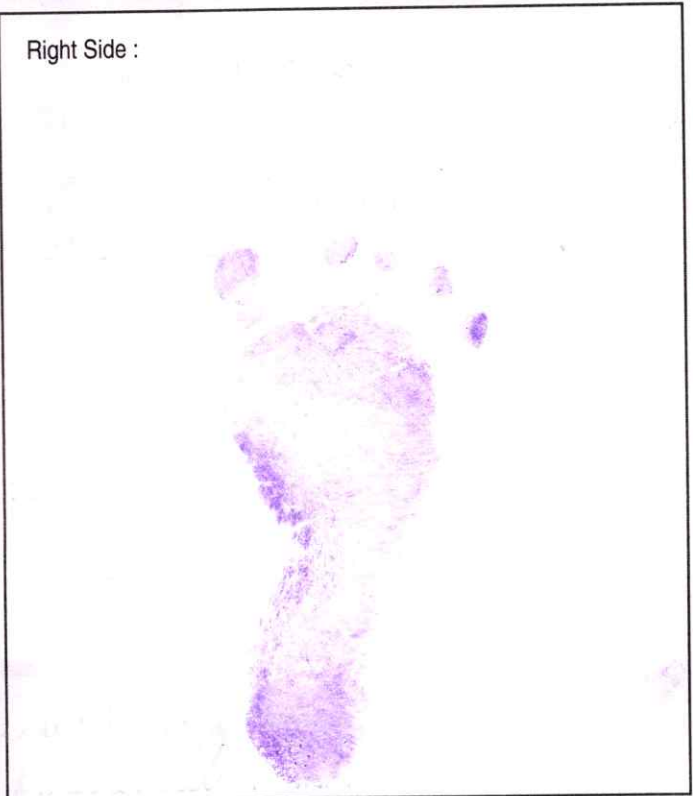
Diagnosis : Term (34 weeks) | VBAC - ANP knee | PROM (10 hrs) / mch
AGA

FOOT PRINTS

Left Side :



Right Side :



Resident Doctor :

Signature : [Signature]

Name : Dr. UNWATE AARANTA

Date & Time : 27/5/20

Consultant :

Signature : [Signature]

Name : Dr. Kalyan

Date & Time : 27/5/20

PLEASE FILL UP THE FOLLOWING DETAILS

1. Name of the referring Doctor :
2. Name of the referring Hospital :
Address :
Contact Numbers :
3. Contact Details of the referring Doctor :
Mobile No. : E-mail ID :
4. Name of the Doctor in Rainbow Team :
..... on whose name the patient is being referred.

AT THE TIME OF TRANSFER TO THE WARD

Final Diagnosis :

Present Issues :

Vital : HR : RR : BP : SPO2 : Weight :

Any Oxygen requirement :

Systemic :

Medications :

Plan during ward follow up :

DBF / warm care
OAE / vaccination / Red reflex / 4 limbs Sp. @
SBr / NBS @ 48h @ 24h test

Feeding Plan at the time of shifting :

Screenings done during NICU Stay :

NSG :

Hearing Screen :

ROP :

TFT :

NP2 :

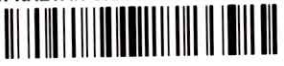
FDH-00046370 IP25-00020671
 Baby B/O K KANCHANA KUMARI
 27-05-2026 0 Y 0 M 0 D 4 H (M)
 Dr. KALYAN CHAKRAVARTHY KONDA



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
28/5/2026 9am	99/13 Dr. Kalyan Dr. Sneha	
	G: 15H term VBAG (kivi)	Prom 10h MB
	GC: stable	
	CRT < 2 SEC	
	M ✓ U ✓	BWL - 2940g
	CPA/T: Good.	TWt 2869g
	① newborn examination.	(↓ 2.4%)
		MR4 BSG } B+ve
		Plan
		- DBF 2 hourly
		- OAG
		Red reflex
		Vaccination
		Pulse Oximetry screen } today
		- SRR, OBS from @ 40H.
		from 6am.
	28/5	S/S. DR-Vinodha (LGA) Eng.
	Breastfeeding counselling per	A.

PATIENT TRANSFER FORM

Patient Name & UHID No. FDH-00046370 IP25-00020671 Baby B/O K KANCHANA KUMARI 27-05-2026 0 Y 0 M 0 D 0 H (M) Dr. KALYAN CHAKRAVARTHY KONDA 		Date & Time of Admission <i>27/5/26 @ 7:04 PM</i>	Date & Time of Transfer Order <i>27/5/26 @ 10 PM</i>
		Transfer Ordered by <i>Dr. Kalyan</i>	Reason for Transfer <i>OPS</i>
From Unit <i>Micu</i>	To Unit <i>ICU</i>	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File <i>10</i>	Number of Imaging Films <i>-</i>	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.			
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 <i>Dr. Nabhin</i>		Name of Person Ordered Transfer <i>Dr. Kalyan</i>	
Patient & Clinical Records Received by : <i>Subhara 28/5/26 @ 10 PM</i>			
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

