

DISCHARGE SUMMARY

Name	B/O SYED AAMINA FARHEEN TWIN 2	UHID	FDH-00045624
Father/Guardian	Mr malki shaik mohammed kamil	Age/Gender	0 Y 0 M 8 D/ Female
Address	BANDLAGUDA JAGIR, Hyderabad, Telangana, INDIA, 500086		
IP No	IP25-00020339	Admission Date	08-05-2026
Ref Doctor			
Discharge Date	27-05-2026		

Consultant:

Dr. Kalyan Chakravarthy Konda,

MBBS, MD, DNB (Pediatrics), DM (Neonatology)

Consultant Pediatrician & Neonatologist

APMC/FMR/76059

DIAGNOSIS

MODERATE PRETERM (32 weeks) / EMERGENCY LSCS /LBW :1.560 kgs / DCDA TWIN- II / BREECH / BABY GIRL / CIAB

RESPIRATORY DISTRESS / PPRM

PROBABLE SEPSIS (CULTURE NEGATIVE SEPSIS)

HYPONATREMIA

FEED INTOLERANCE

History: B/O SYED AAMINA FARHEEN TWIN 2, is a moderate preterm (32 weeks) baby girl, delivered to a G2A1 mother by Emergency LSCS (Ind : In view of DCDA twins absent doppler for twin I) on 08.05.2026 at 01:34 pm



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with birth weight of 1.560 kgs in Rainbow Children's Hospital, Financial District Hyderabad. Baby cried immediately after birth. APGAR scores were 7/10 at 1 min, 9/10 at 5 min. Inj. Vitamin K 1mg IM was given after delivery. Delayed cord clamping done. Fetal presentation was Breech. Baby had Respiratory Distress soon after birth, was put on Ram's cannula, and was shifted to NICU in view of Respiratory Distress and prematurity.

Maternal History: Mrs. SYED AAMINA FARHEEN TWIN 2, is a 31 years old G2A1 mother.

G2 - Present pregnancy, IVF conception, had regular Antenatal checkup's, received 2 doses of Injection. Tetanus Toxoid. Antenatal scans were normal. History of NT at 12+1 weeks - Normal. History of TIFFA at 20+2 weeks - Normal. Fetal echo - Normal. No history of Pregnancy Induced hypertension/ Urinary Tract Infection/ Antepartum Hemorrhage/ Hypothyroidism/ Gestational Diabetes Mellitus/ Oligohydramnios/ Polyhydramnios/ Fever. History of Prolonged Rupture Of Membranes since 28 weeks of gestation. Mother's Blood group is "B" positive. Baby's blood group is O positive.

Examination: Baby was euthermic. Baby had respiratory distress with subcostal and intercostal retractions, was not maintaining target saturation on room air. On auscultation of chest, air entry was bilaterally equal with normal heart sounds. Bilateral femoral pulses well felt. Abdomen was soft with no organomegaly. Cry and activity were good. Anterior fontanelle was at level. No obvious external congenital anomalies were noted clinically. All external orifices were patent and open. All neonatal reflexes were normal.

Anthropometry:

Weight at birth : 1.560 kgs.
Weight at discharge : 1.638 kgs.
Head Circumference : 31 cms.
Length : 46 cms.



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Investigations: Enclosed reports.

Management:

RDS/ HMD - Non Invasive Ventilation: Soon after birth baby had respiratory distress, was put on Ram's cannula and was shifted to NICU. In NICU, baby was put on bubble CPAP support. Baby was nursed in thermoneutral environment and continued on non invasive ventilation support. Initial chest X - ray showed reticulogranular pattern, suggestive of HMD and blood gas analysis showed respiratory acidosis. Baby was loaded with Inj. Caffeine and continued on maintenance dose. Chest X-rays and blood gas analysis were serially monitored. Baby required non invasive ventilation support for 2 days and was weaned to HFNC support which was continued till day 5 of life. Now baby is maintaining saturation at room air without any respiratory distress. In view of circulatory insufficiency, baby was put on inotrope support (Infusion Dobutamine) on day 1 of life which was tapered and stopped within 24 hours.

Culture Negative Sepsis: Baby was nursed in thermoneutral environment. Baby was screened for sepsis and started on IV fluids and IV antibiotics after sending blood culture. Baby's blood sugars were frequently monitored which remained stable. Baby initial hemogram and CRP were normal. Serum electrolytes and renal function tests were within normal limits. Serum calcium was 7.2mg/dl for which Inj.Calcium gluconate correction was given and continued on maintenance dose. Repeat serum calcium showed improvement. Serial blood counts showed improvement. Last hemogram done on 22.05.2026 was normal. Blood culture sent at the time of admission was sterile and IV antibiotics were stopped after 5 days.

Unconjugated Hyperbilirubinemia: Baby developed jaundice on day 2 of life. Baby was started on phototherapy. Baby's serum bilirubin was 7.44 mg/dl with indirect fraction of 7.3 mg/dl. Baby's serum bilirubin levels were serially monitored which showed decreasing trend. Last serum bilirubin was done on

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26.05.2026 was 9.6 mg/dl with indirect fraction of 9.5 mg/dl. It does not comes in phototherapy range.

Hyponatremia: On day 14 of life, investigations revealed hyponatremia (serum sodium - 131 mmol/L) in view of which baby was started on oral hypertonic saline. Repeat serum sodium done on 26.05.2026 was normal (135mmol/L).

NP1: NP1 done on 09.05.2026 showed Hb was 14.2 g/dl, WBC- 13.71 cells/cumm and platelets - 3.65 lakhs/cumm. S. electrolytes showed Na - 138 mmol/L, K- 4.99 mmol/L and Cl - 111 mmol/L. Serum creatinine was 0.80 mg/dl. Blood urea was 28 mg/dl. Serum calcium was 7.2 mg/dl. CRP was 7.08 mg/L. Serum bilirubin was 7.44 mg/dl with indirect fraction of 7.34 mg/dl.

On 09.05.2026 : VBG showed pH of 7.39, pCO₂ of 34.2 mmHg, pO₂ of 56 mmHg, HCO₃ of 20.9 mmol/L and BE of -4.7mmol/L.

On 10.05.2026 : VBG showed pH of 7.34, pCO₂ of 33.0 mmHg, pO₂ of 48 mmHg, HCO₃ of 18.2 mmol/L and BE of -8.4 mmol/L.

On 11.05.2026 : CRP was 1.65 mg/L.

Neurosonogram was done on 11.05.2026 which showed :

- **Grade - I GMH on left side.**

AABR - done on 26.05.2025 : Bilateral pass

2D-Echo was done on 15.05.2026 which showed :

- Aneurysmal atrial septum with 2 mm small OSASD with b/d shunt.
- Poor echo windows due to prematurity & rectus deformity.
- Normal biventricular size & function.
- RCA not well seen. To be seen in subsequent studies.



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- Normal left aortic no coarctation.
- No PPHN.

Vaccination:

Vaccine Name	Status	Date
BCG	Given	26.05.2026
OPV	Given	26.05.2026
HEPATITIS B	Given	26.05.2026

Feeding: Once baby was hemodynamically stable, she was started on NG feeds, followed by paladay feeds, which she accepted and tolerated well. At present baby is on demand paladay feeds, which she is tolerating well.

Injection Nirsevimab 50mg intramuscular given on 27.05.2026

Advice:

- Keep baby clean and warm.
- Continue kangaroo mother care.
- Continue demand paladay feeding as advised.
- Immunization as per schedule.
- Drop Vitamin D3 0.5ML per oral once daily to continue till further advice
- Syrup Ossopan D 2ML per oral twice daily after feeds to continue till further advice
- HMF 1/2 sachet in each 25ml EBM, every alternate feed till 2kg.

Plan:

BERA to be done after 3 months.



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ROP screening to be done next week in NICU at 8.30am sharp.
NP2 and Neurosonogram to be done at 40 weeks of PMA

Review consultation with Dr. KALYAN CHAKRAVARTHY KONDA, on Saturday (30.05.2026) at Financial District with prior appointment (**Review consultation will be charged**).

Follow up immediately in Emergency Room in case of any emergency like high grade fever, vomiting, breathlessness, refusal to feed, increased icterus and any abnormal movements.

In case of emergency, **8121039503**, emergency pediatrician on duty.

To take appointment for OPD consultation at Rainbow Banjara Hills OR Rainbow, Vikrampuri or Clinic at Madhapur, just dial one toll free number **18002122**.

I was explained about feeding techniques, handling, positioning and other aspects of care of premature baby along with the risks related to prematurity like aspiration, hypothermia and infection. All the discharge advice and medications have been explained to me by Dr..... in a language that I can understand and I acknowledge.

Parents/ Attendant Name:.....

Parents/ Attendant signature:.....

Dr. S. S. S.
Registrar/Resident/C.M.O



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Consultant:

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MBBS, MD, DNB (Pediatrics), DM (Neonatology)

Consultant Pediatrician & Neonatologist

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Patient name : <i>Baby Blo Syed Ammin Farheen</i>	Age : <i>11/05/2026</i>	Rainbow Children's Hospital	BirthRight™ BY RAINBOW HOSPITALS Your Right to a Safe Delivery
Ref Dr. <i>Kalyan Chakravorty</i>	UHD: <i>F0H-00045624</i>		Date: <i>11/05/2026</i>

NEUROSONOGRAM

FINDINGS:

Both the lateral and third ventricles are normal. No hydrocephalus.

Fourth ventricle is normal. *There is an echogenic focus measuring 8x4mm in the left caudothalamic groove*

Posterior fossa structures are grossly normal.

No e/o intraventricular echoes.

Visualized cerebral parenchyma is normal.

Both thalami are normal.

No evidence of lenticulostriate artery calcification.

IMPRESSION: *grade I GNH on left side*

➤ ~~No significant sonographic abnormality.~~

Suggested clinical correlation.

[Signature]
Dr. V. Anuradha
MD (Radiodiagnosis)
Consultant Radiologist

15/5/26.

Patient Name:	FDH-00045624 IP25-00020339 Baby B/O SYED AAMINA FARHEEN	UHID NO:
Age:	08-05-2026 0 Y 0 M 6 D (F)	Date:
Dr.:	Dr. KALYAN CHAKRAVARTHY KONDA	Done by:



PEDIATRIC ECHOCARDIOGRAM REPORT

Situs & Cardiac Looping	Ⓝ
Systemic Veins	Ⓝ
Pulmonary Veins	Ⓝ
Atrio ventricular connection	Ⓝ
Ventricular arterial connection	Ⓝ
Great artery relationship	Ⓝ
Right atrium	Ⓝ
Left atrium	Ⓝ
Inter atrial septum	Aneurysmal, w/ small 2mm DS ASD bld & ven
Mitral Valve	Ⓝ
Tricuspid Valve	Ⓝ
Right ventricle	Ⓝ
Left ventricle	Ⓝ
Inter ventricular septum	Ⓝ
Aorta and aortic arch	Ⓝ
Pulmonary artery and branch PA	Ⓝ
Aortic Valve	Ⓝ
Pulmonary valve	Ⓝ
Coronaries	RCA not well seen. LCA Ⓝ
PDA	Ⓝ
Pericardium	Ⓝ
Others	

DOPPLER / TISSUE Variables		Gradients		Regurgitation
Mitral flow				
Tricuspid flow				
Aortic flow				
Pulmonary flow				
Mitral	E'	A'		S'
Medial LV	E'	A'		S'
Tricuspid	E'	A'		S'
Time intervals	IVRT	IVCT		DT
Others				

MEASUREMENTS:

PARAMETER	ABSOLUTE (cm)	Z score	PARAMETER	ABSOLUTE (cm)	Z score
AO			Tricuspid Annulus		
LA			Mitral Annulus		
IVSd			Aortic Annulus		
LVIDd			PA Annulus		
LVPWd			RPA		
IVSs			LPA		
IVIDS			MPA		
LVPWs			AO Isthmus		
EF	65 %		LV Mass		
FS	38 %		Others		

IMPRESSION:

- ① Aneurosmal atrial septum w/ 2mm small OSASD w/ bld shunt
- ② Poor echo windows due to prematurity & pectus deformity
- ③ (N) b/v size & fs
- ④ RCA not well seen. To be seen in subsequent studies
- ⑤ (S) (N) (L) Ao & CoA
- ⑥ No pphn.

CONSULTANT: Performed By:

MANISHA

ADMISSION SHEET

Registration Details :



Admission No : IP25-00020339 Admit Date : 08-May-2026 Admit Time : 03:33 PM UHID : FDH-00045624

Patient Details :

Patient Name : Baby B/O SYED AAMINA FARHEEN TWIN 2 Age : 0 D
Guardian : Mr malki shaik mohammed kamil DOB : 08-05-2026 01:34 PM
Gender : Female Religion :
Occupation : Martial Status :
Address (H) : BANDLAGUDA JAGIR Hyderabad Telangana Phone No : 6300012065
INDIA 500086 E-mail : na@gmail.com

Admission Details :

Bed Type : BASINET Bed No : CRDL MICU 2-1 Ward Name : 4F -MICU
Room No : CRDL MICU 2-1 Admission Type : First Visit

Contact Details :

Name : Mr malki shaik mohammed kamil Relationship : Father
Contact Address : BANDLAGUDA JAGIR Hyderabad Telangana Phone No : / 6300012065
INDIA 500086


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



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 Baby B/O SYED AAMINA FARHEEN
 08-05-2026 0 Y 0 M 0 D 3 H (F)
 Dr. KALYAN CHAKRAVARTHY KONDA

Twin II



NEONATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

Mother's Name : Age : Father's Name : Age :
 Date of Birth : Date of Admission : 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 Syed Aamina Farheen Mother's Blood Group : B+ve
 Gender : M F Blood Group : O+ve Birth Weight (gms) : 1.560 kg Length (cms) :
 Date of Birth : 8/5/26 Time of Birth : 1:34 PM OFC (cms) :
 Place of Birth : RCH FD Estimated Gesth Age : 32 weeks

Current Obstetric History : (Booked / Unbooked Case)

Maternal Age : 31y Ht : Wt : 77.8 BMI : Married Life : LMP : 16/10/25 EDD : 4/9/26
 Conception : Spontaneous or with Rx : IVF conception
 Booked at what GA : 12+4 wks AN Steroids/Drugs / Doses :

Last Scans Details : (8/5/26) :- DCDA twin - 31+6w, T2 breech, placenta P/H, AFI : 4.9cm (CSOP)
Doppler : (N) [T1: Anhydramnios, cephalic TT, placenta P/H, Doppler HR] Immunization and Iron / Folic Acid : given

MATERNAL RISK FACTORS

Age : <input type="checkbox"/> <18 yrs <input type="checkbox"/> > 35yrs <u>KIT at 12+4w (N)</u> Consanguinity : <input type="checkbox"/> Yes <input type="checkbox"/> No <u>TIFFA at 20+2w (N)</u> If yes, degree of consanguinity : <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <u>Fetal Echo: (N)</u> H/o PIH (after 20 weeks) / PE How many Drugs / Doses / Since how long : H/o value of recent BP recording, proteinuria, edema, oliguria, any investigations (LFT, platelet count) : IUGR - when detected : Doppler (Increased Resistance / ADEF / REDF / <u>Mosmp</u> / Redistribution in MCA) / Ductus Venosus : <u>for twin 2</u> 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 (<input type="checkbox"/> Malaria <input type="checkbox"/> UTI <input type="checkbox"/> TORCH <input type="checkbox"/> TB <input type="checkbox"/> HIV <input type="checkbox"/> HBV) UTI : when : Any culture :
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PPROM : Duration : 28 weeks Uterine Tenderness Foul Smelling Liquor HVS (if taken) - Results :
 Medication during Pregnancy : Duration :

PAST OBSTETRIC HISTORY

G : 2 P : A : 1 L :

Sl. No.	Age	GA wks	B. W	Gender	Significant	Details
1.)	22Y				Abortion.	Biochem pregnancy.
2.)					Current pregnancy.	

PERINATAL HISTORY

Treating Obstetrician : Dr. Himabindu. Hospital : Rainbow, AD. 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 checked="" type="checkbox"/> Emergency Indication :</p> <p>Specify the reason :</p> <p>Augmentation of Labour : <input type="checkbox"/> Induced <input type="checkbox"/> Assisted Vaginal</p>	<p>CTG : <input checked="" 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>
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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 was delivered via Em. LSCS
↓
CLAB
↓
Had respiratory distress
(SAs: 5/10).
↓
Put on Rom's cannula
↓
Respiratory distress persisted
↓
Baby was shifted to NIV
1/10 respiratory distress and
prematurity.

Investigation details in previous Hospital :

Feeding History :

Past History :

Family History :

Socio Economic History :

GENERAL EXAMINATION ON ADMISSION

General Disposition :

- GC: avg
- Respiratory distress present.

VITALS : Temperature : 36.5°C HR : 160/min RR : 55/min NIBP : 53/29(37) CFT : 23 sec.

Color of the extremities : PINK.

Jaundice : (-) Pallor : (-) SpO2 : 92% E-Fio2 30%

Anthropometry : Birth Weight : 1.560 Kg Length : HC : Present Weight :

Ponderal Index : AGA : SGA : LGA :

HEAD TO TOE EXAMINATION

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

Facies :
 (Any Facial Dysmorphism)

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

EYES : Symmetry :
 Red Reflex :
 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 :
 Discharge :

GENITALIA : Labia / Hymen :
 Testicles/penis :
 Anus :

HERNIAL ORIFICES

TRUNK and SPINE :

SKIN LESIONS :

EXTREMITIES : Fingers / Toes :
 Arms / Legs :
 Deformities :
 Mobility :
 Hip Joint Examination :

SYSTEMIC EXAMINATION

Respiratory System :

Respiratory distress (+)

Breathing Pattern : Regular Periodic Shallow Gasping

Mention If baby has Respiratory distress : RR : 5/min SCR / ICR / See - Saw breathing : SCR (+) ICR (+)

Scoring of respiratory distress if present (Silverman or Downe's) : GAS : 5/10

Mention if baby is on : Hood box CPAP Ventilator

Settings : FiO2 : 30% , PEEP : 6

Spo2 : 92% on 20% O2 Auscultation : B/L ACP Breath Sounds : RVS (+) Added Sounds : (+)

Cardiovascular System :

HR : 160/min BP : 53/29 (37) mmHg Precordial Activity : (+) (+)

Femoral Pulses : (+) Murmurs : (+)

Other Peripheral Pulses : (+) Signs of Cardiac Failure : (+)

Abdomen :

Shape :] Anal Patency :] (+)

Palpation : (+) Umbilical Cord :] (+)

Palpable masses : (+) First urine passed :] not passed

Abdominal girth :] Meconium passed :] not passed

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 : B/L symmetrical DTR : (+)

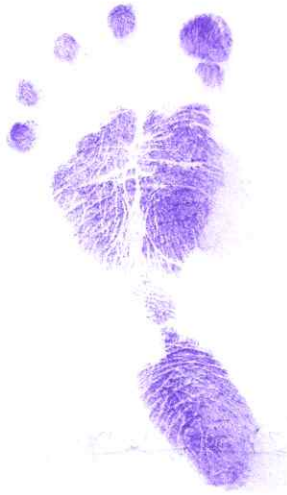
ATNR : (+) Skull and Spine : (+)

Any Congenital Anomalies :

Diagnosis : Moderate Preterm | 32w | Em LSCS | DCDA-twin II | CLAB | Fch | RD | PPROM | breech | 32w

FOOT PRINTS

Left Side :



Right Side :



Resident Doctor :

Signature : [Signature]

Name : D. Snehakar

Date & Time : 8/5/26

Consultant :

Signature : [Signature]

Name : D. Kalyan

Date & Time : 8/5/26

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 : *11 month old / 2000 lbs / 30 weeks gestation / 2000 lbs / 30 weeks gestation*

Present Issues :

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

Any Oxygen requirement :

Systemic :

Medications : ① CPAP *30%*

② TV-60 cc/kg/day *10% D* ~~Feed 2ml @ 2hr~~

Plan during ward follow up : ③ IV line - CBP, Blood CS, VBG
GRBS-86H

④ Inj. Pantoy 150mg *1/2 BD.*

⑤ *SOS* CXR
Surfactant (*FiO2 req > 30*)

Feeding Plan at the time of shifting :

⑥ *SOS* Caffeine 3mg/kg loading *→ followed by 2mg/kg qd.*

Screenings done during NICU Stay :

NSG :

Hearing Screen :

ROP :

TFT :

NP2 :

NURSING INITIAL ASSESSMENT FOR NICU

Date of Admission: 8/5/20
 Source of Admission: OPD Ward Labor Ward Other:
 Reason for Admission: RDS
 Admission Diagnosis: PT/RDS/USW
 Accompanied By: Parent Guardian Other Name:
 Primary Language: Telugu English Hindi Other Specify
 Do you require an interpreter? Yes No
 Allergies: Yes No Medications Blood Transfusion Food Other:
 If yes, identify
 Source of Information: Family Others, Specify

Past Medical History	Past Surgical History	Last Hospital Admission
/	/	/

Significant History
 Family History:

Has the child or close family member had recent contact with a communicable disease? Yes No
 If yes please list,
 Was the child's birth normal? Yes No If No, please describe problems:
 Are the child's immunization up to date? Yes No

Current Medications
 Taking Medications? Yes No
 If yes, Fill the reconciliation form
 Medicine brought to the hospital? Yes No

Observations:
 Birth Weight: 1.560 kgs Head Circumference: 32 cm Length: 40 cm
 Term Pre-Term Post-Term
Blood Group: Mother: Baby:
Feeding: Breast Feeding Formula Both
Maternal Details: Age: years **PARA:** **Gestation:** 32 Weeks, Days
Risk Factors: PROM Fetal Distress Diabetes Mellitus / Gestational Diabetes
 PH / Pre Eclampsia Others, Specify:
Mode of Delivery: Normal LSCS - Emergency / Elective Instrumental AVD
Indication: Pre-eclampsia

Newborn Assessment:Temp: 36.5 HR: 149.5/Min RR: 49.5/Min BP: 71/47 SpO₂: 96%Pain Score 0 (Follow N Pass and Document)Fall Risk Intervention Done: YesRisk of Pressure Sore: Yes No (Fill Braden Q Sheet)**General Appearance:** Posture Well-Fixed Asymmetry**Behavioural Status on Admission:** Sleeping Crying Calm Drowsy**Skin:** Pink Meconium Stain Others, Specify.....**Functional Screening:** If a patient needs assistance with any of the following inform consultant Developmental Delay Musculoskeletal Congenital Abnormality No Abnormalities Detected

Inform Consultant for Positive Criteria

Nutritional Screening: Underweight Overweight Special Feeding Method
 Feeding Problem Special Diet No Abnormalities Detected

Inform Consultant for Positive Criteria

Social History: Lives WithSiblings 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:

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

Orientation given to: Family OthersName of Person Orientation was given to: Hussain

Orientation not given Reason:

DISCHARGE PLANSource of Information: Family FriendWill patient require transportation arrangements to go home: Yes NoWill Physiotherapy require at home: Yes NoIs home medical equipment anticipated: Yes NoIs home oxygen therapy anticipated: Yes NoBreastfeeding Yes NoFormula Feed Yes NoAre dressing needs at home anticipated: Yes NoAny other needs anticipated: Yes No If Yes Specify



Discharge Medications: Yes No

Details:

Final Diagnosis:
.....
.....

Nurse Signature: *Hussain*
Nurse Name: *Hussain*
Date & Time: *8/5/26 @ upu*

Discharge Details: (To be completed by discharging Nurse)

Neonatal Condition at Discharge:

.....
.....

Feeding: Breastfeeding Exclusively Breastfeeding and Formula Feeding Formula Feeding

Vitamin K given: Yes No

Vaccinations given BCG Hepatitis B Others:

Neonatal Screen Taken: Yes No, parents advised to have Neonatal Screen at National screening program center on:/...../.....

Hearing Test: Yes No

Jaundice: NIL Slight Moderate

Passed Urine: Yes No

Passed Meconium: Yes No

Weight at discharge:

Appointment was given for follow-up at OPD: Yes No

Date of Discharge:/...../.....

Discharge to Home Other:

Against Medical Advice: Yes No

Referred to another hospital: Yes No

Nurse Signature:

Nurse Name:


Date & Time:



2

ACTIVITY RECORD FOR BILLING

Name: ----- **FDH-00045624 IP25-00020339**
Baby B/O SYED AAMINA FARHEEN
08-05-2026 0 Y 0 M 7 D (F)
Dr. KALYAN CHAKRAVARTHY KONDA

UHID No :  Consultant : ----- Dept : -----

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse

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
15/5/26	2 DECTO ①	15820 ✓	JH
16/5/26	RBS (6am - 112 mg/dl)	7385 ✓	JH
	Cross checked by Sr. Huseem on 15/5/26 @ 9pm		
18/5/26	RBS (6am - 95 mg/dl)	7484 ✓	Dub
18/5/26	RBS (6am - 87 mg/dl)	7540 ✓	ad
19/5/26	RBS (6am - 117 mg/dl)	7650 ✓	ad
20/5/26	4 RBS (96 mg/dl) 6 AM	17773 ✓	Yuli/
21/5/26	CRBS (89 mg/dl) 6 AM	7905 ✓	Am
22/5/26	CRBS (94 mg/dl) 6 AM	18009 ✓	Ⓟ
22/5/26	NBS, TBH, Free T ₄ , NP ₂	18003 ✓	Ⓟ
23/5/26	RBS (116 mg/dl) 6 AM	18133 ✓	Ⓟ
24/5/26	RBS (99 mg/dl) 6 AM	18260 ✓	Ⓟ
25/5/26	RBS (104 mg/dl) 6 AM	8324 ✓	Ⓟ
26/5/26	SBR, Sodium. } GRBS - 100 mg/dl }	82132 8431	Latheer
		Cross checked by Nima @ 24/5/26 @ 11pm	
26/5/26	AABR ✓	0111	Jumr
27/5/26	CRBS - 80 mg/dl (6 AM) ✓	8564	Pam

PROCEEDURE

Date	ProceEDURE	Quantity	Order No.	Signature

ANY OTHER INFORMATION

Date :

Time :


Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
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ACTIVITY RECORD FOR BILLING

Name : FDH-00045624 IP25-00020339
Baby B/O SYED AAMINA FARHEEN
08-05-2026 0Y0M0D2H (F)
Dr. KALYAN CHAKRAVARTHY KONDA



UHID No. :  Consultant: _____ Dept : _____

Date of Admission: _____ Time : _____ Date of Discharge : _____ Time: _____

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
8/5/20	2pm	OT	NICU	Bhargava
25/5/20	4pm	NICU	331	Chandra
27/5/20	11:30am	ward	Billing	Ji

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Signature
8/5/26	Blood Grouping & USP, Blood culture	16480 ✓	HSN
8/5/26	ABG [ⓐ]	16481 ✓	HAN
8/5/26	VBG [ⓑ]	16482 ✓	HSW
8/5/26	RBS - 71 mg/dl @ 3pm	16484 ✓	HAN
8/5/26	GRBS 174 mg/dl 10pm	16522 ✓	mayari
8/5/26	x-ray ①	15027 ✓	mayari
9/5/26	GRBS (140) VBG [ⓑ]	6553 ✓	mayari
9/5	NPT	16587 ✓	alisha
9/5	RBS (63 mg/dl) (12pm)	6588 ✓	alisha
9/5	VBC [ⓐ] (10pm)	16687 ✓	Cyflie
10/5	GRBS (75 mg/dl) 6am	6710 ✓	Cyflie
10/5	CXR (abd) ②	15210 ✓	2
10/5	GRBS @ 6pm 69 mg/dl	6770 ✓	D
10/5	VBG [ⓑ] @ 6pm		
11/5	GRBS (82 mg/dl) 6am	16820 ✓	Cyflie
11/5/26	CRP	16829 ✓	Cyflie
11/5/26	ABG - ①	5270 ✓	HAN
11/5/26	GRBS (94 mg/dL) 6pm	6932 ✓	Am
12/5	GRBS 113 mg/dl 6AM	16956 ✓	Astami
13/5	RBS 77 mg/dl	7059 ✓	fb
14/5	RBS 105 mg/dl	7176 ✓	fb
15/5	RBS - 121 mg/dl (6am)	7280 ✓	fb

Done

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
8/5/26	W placement	①	2415 ✓	HASN
	Cross checked	by	Sr. Florence	on 8/5/26 2:29 PM

ANY OTHER INFORMATION

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Date : 8/5/26 Time : 3pm Prepared By : Hurnair

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
		Nsk - ① VBG - ③ Nsk - ① CR - ②	



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NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: PT/LBW/RDS		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	24/5/26	25-5	25/5/26	25/05/26	26/5/26	
	Shift	N	M	E	N	M+E	
	Medical Condition (Any special condition to be noted):	PT/LBW	PT/LBW	PT/LBW	PT/LBW/RDS	PT/LBW/RDS	PT/LBW/RDS
ASSESSMENT	Diet:	EBM	EBM	EBM	EBM	EBM	
	Allergy:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Ventilation (RA, NP, NIV, VENTI):	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	
	Vital Signs:	Temp:	36.5°C	36.8°F	36.5°C	36.3°C	37°C
		Res:	40b/m	47b/min	45b/m	46b/m	44b/m
		SpO ₂ :	100%	99%	99%	98%	99%
		Pulse:	141b/m	150b/m	145b/m	142b/m	156b/m
		BP:	61/26(38)	62/27(39)	-	-	-
		LOC:	C	Alert	C	C	conscious
Fall Risk Score:	0	0	0	0	0/10		
Pain Score:	0	0	0	0	0/10		
Skin Integrity	normal	Normal	normal	Normal	Normal		
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	
	Physiotherapy:	-	-	-	-	-	
	Others Specify:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Special Diet:	EBM	EBM	EBM	EBM	EBM	
	Critical Lab Test / Values:	-	-	-	-	-	
	Other Special Orders / Medications:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	PU Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	DVT Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
ADL (Dependent / Non Dependent):	dependent	Dependent	dependent	dependent	dependent		
Post Operative Procedure Special Orders:	-	-	Pain	-	-		
Handed Over By Name :	Mahima	Mahima	Mahima	Laxmi	Suma	Pam	
Signature / ID :	<i>[Signature]</i>	019539	<i>[Signature]</i>	26/05/26	26/05/26	017189	
Date:	24/5/26	25-5-26	25/5/26	26/05/26	26/05/26	27/05/26	
Time:	@ 8am	2pm	@ 2pm	@ 8AM	@ 8pm	@ 8AM	
Taken Over By Name :	Mahima	Mahima	Laxmi	Suma	Pam		
Signature / ID :	019539	<i>[Signature]</i>	<i>[Signature]</i>	26/05/26	017189		
Date:	25-5-26	25/5/26	25/05/26	26/5/26	26/05/26		
Time:	8am	@ 2pm	@ 8pm	@ 8pm	@ 8pm		

DH-00045624 IP25-00020339
 by B/O SYED AAMINA FARHEEN
 3-05-2026 0 Y 0 M 15 D (F)
 R. KALYAN CHAKRAVARTHY KONDA



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	
	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	
ADL (Dependent / Non Dependent):								
Post Operative Procedure Special Orders:								
Handed Over By Name :								
Signature / ID :								
Date:								
Time:								
Taken Over By Name :								
Signature / ID :								
Date:								
Time:								



①

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/5/2026		
3pm	cf/B Dr. Kalyan	
	- on Bubble CPAP	FiO2: 30% PEEP: 6
	- SpO2: 85-92% on above settings.	
	- Respiratory distress ⊕ (decreased)	SAs: 3/10
	- on IVF, antibiotics.	
	(Maternal PROM ⊕)	
	<u>Plan</u>	<u>Plan</u>
	Vitals	→ continue antibiotics (PipTaz)
	HR: 160/min	→ continue IVF 10-10D.
	SpO2: 92% - 30% FiO2	→ continue Caffeine
	BP: 53/22 (37) mmHg	→ GRES = slowly
	Temp: 36.5°C	→ If persistent RDT
	RR: 50/min	FiO2 req. > 30% @
		plan: chest xray
		Surfactant
		→ trace reports.
		→ w/f desaturation (Apnea RDT)
		@ 2 hours of life
	Noted by Humaira	Sube



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/5 7am	cls/3 <u>Dr. Kalyan</u>	
	32 wks Mod. Preterm / 32 wks / UBW / DCDA T II / 17hm	
	PDS / Breech / rpnom	
	on CPAP - PEEP 6 Flow 2l. - NO Distress	
	→ vomiting ⊕ night SO NPO. last :- Bilan 6ml clear aspirates	
	PR 15h SpO ₂ 98%	
	BN - 68/28 (43)	ph
	PLA soft CRTA good	① cur - 60cc / 15 / day S.I.D
	peripher - ^{cytosis} improved	② NPO
	wt - 1.506 kg (454 gm)	③ cont PIPAC
	C.MBI -	④ CPAP - PEEP 6 - Flow - 2l.
	U/O -	⑤ GMBT - 0.8H
		⑥ W/P RD
		⑦ SOS - Dobutamine 2 if Acral cyanosis ⊕ result

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	<u>C/S/B Dr. Owais</u>	
<u>9/5/26</u>	on CPAP - FiO ₂ - 21% Peep - 5	
<u>5 PM</u>	No desaturations	<u>P-kan</u>
	1. 5ml clear aspirate ↓ at 2 PM	- continue CPAP
	1 feed skipped ↓ Next feed given at 3 PM	- continue Dobutamine infusion
	No further aspirates.	- TV = 60 ml / 15 / day S/D
	1/1/0 ↑ peripheral cyanosis Inj Dobutamine started. @ 0.2ml/kg - 0.4mcg/kg/min	+ 2ml OGTT @ 2 hourly (EBM > Donor)
	stool - not passed	- GRBS BD
	o/e - euthermic HR - 123/v	- Trace NPS
	SpO ₂ - 98%	- CT Paptaz / caffeine
	BP - 73/47 (57) mmHg	- NSG on Monday
	P/A - mgt.	- w/ cyanosis / feed withhold / RD
		- Injns 50 S
		<i>gaur</i>

FDH-00045624 IP25-00020339
 Baby B/O SYED AAMINA FARHEEN
 08-05-2026 0 Y 0 M 0 D 8 H (F)
 Dr. KALYAN CHAKRAVARTHY KONDA



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/5/2026 12 AM	<p>CPs/B Dr. Sneha CP/W Dr. Kalyan</p>	
	<p>Issue :- 2 feeds of 3ml given. After 2nd feed (~11:30pm) ↓ ⇒ episode of vomiting (~3ml) <u>milky</u></p>	
		<p>Plan</p> <ul style="list-style-type: none"> - NPO till further orders. - IVF to continue (S.I.D) - Rest continue as per medication charting
		<p><u>Sneha</u></p>

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/5/26 3:30 PM	<u>cls hr Dr. Prame</u>	
	35ml greenish aspirates @ 3 PM	
	abd. mild distention @	
	but soft	
	To do ECG X-ray abdomen.	
	& keep NPO till 8 PM.	
	- To reassess at 8 PM and to decide on feeds.	
	- Blood gas at 6 PM.	
	<u>cls hr Dr. Prame</u>	
	8 PM => No aspirates	
	=> turning soft	
	=> To restart feeds	2ml orhels
	=> Domstal drops	w/ distention @
		after @ 3 feeds



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/5/26	cls by Dr. Prashant	
9 AM	Del-3 / 32wks + 32+3 / CPA - Twin II LBW / Breech /	A Prem.
	Issues - RDS / Feed intolerance	
	on HFNC \uparrow 5L	
	21%.	wt = 1.402 kg (655g)!
	Maintaining SpO ₂	Uo - 3.1 cc/kg/hr.
	No desaturations.	GRBS - 82 mg/dl.
	- on 2ml of feeds	
	- No aspirates.	
	- No Abd. distension.	
	- tolerating feeds well.	
	ole: 1 hr - 140 bpm	<u>Advice</u>
	RA - 300pm	
	SpO ₂ - 99%	- on HFNC \uparrow 5L
	NIBP - 78/48 (TA)	- 21%.
		- TV 80 cc/kg/day
		- 2ml of feeds + 5.1 D.
	CITA - good.	- plan to change to 150%
	QA - soft.	- to 100 cc/kg/day.
		- GRBS - 80.
		- continue PIPAC, CAPREINE.
		- w/ RA, feed intolerance.
		- NSA today.
		- continue REMSTAL drip.



(4)

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/5/2026		
4pm	cf s/B Dr. Sreha	
	<ul style="list-style-type: none"> GC: improving CRTR 3sec 	
<p>NSG: → GIGMP left side</p>	<p>→ on HFNC @ 4Ltr, 21% Fio₂. ↓ Maintaining SpO₂, No respiratory distress.</p>	
	<p>- tolerated 3ml x 4 feeds No vomiting / aspirate / soft abdomen. Passed stool once.</p>	
	<p>P/A: Soft, non distended.</p>	
	<p>vitals</p>	
	<p>HR: 140/min</p>	<p>Plan</p>
	<p>RR: 44/min</p>	<p>1) HFNC 4Ltr 21%</p>
	<p>SpO₂: 98% @ 4Ltr/21% Fio₂</p>	<p>2) TR: 100cc/kg/day</p>
	<p>BP: 66/34 (45) mmHg</p>	<p>IVF: 10% 150P</p>
	<p>Temp: 36.5°C</p>	<p>3) Feed: OGT: 4ml/2hourly + 1ml/BP</p>
		<p>4) Continue Domstal, Parolac.</p>
		<p>5) CCP trace Blood of s</p>
		<p><i>[Signature]</i></p>



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
12/5 7am	<p>CS3 @ Melan</p> <p>Δ: D4 32 → 32+4 PCDA-Twin II / LBW / Breech</p> <p>Respiratory - RDS, feed intolerance</p>	
	<p>on HFNC - 3L - no outflow</p> <p>21% FiO2</p>	
	<p>5ml O2 feed - tolerating well</p>	
	<p>PR - 150h</p> <p>SPU 977.</p> <p>PR - 64 (34 C/W)</p>	
	<p>PLA soft</p> <p>CTA good</p>	<p>① HFNC - 3L 21% FiO2</p>
	<p>Twt - 1.348 (1.548)</p> <p>GMDI - 112 → 112</p> <p>Uo - 3.3 cc/kg/h</p>	<p>② TV - 120cc / 1 day 10% FiO2 750 P + 5ml O2 feed @ 1h 7ml feed @ 8h</p>
		<p>③ Cont Domstal Desolac</p>
		<p>④ W/F Feed intolerance NO</p>



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
12/5/20	45/13 Da - Sneha	
	- GC: improving	
	- on HFNC @ 2Ltr	
	↓	21-1 FiO2
	- maintaining saturation	
	- No respiratory distress.	
	- Tolerating feeds @ 6ml/2hours.	
	<u>Vitals</u>	<u>Plan</u>
	HR: 130/min	1) continue same
	RR: 44/min	2) TR: 120cc/kg/d
	Temp: 36.5°C	3) 1ml feed & honey
	BP: 57/28/38 mmHg	(EBM > Donor)
		4) Ref 10-11-150P.
		5) GRBS OD
		6) last day of Piptaz today

Noted by
 Dolan
 020939

[Signature]



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
23/5/26	cls by Dr. Prashant	
8 AM	PCL-5 (32 → 32+9) / PCL-5 - II / Lbw / breech /	
	assess - RR, Sat, pulse	
on HANC	12L	
	12L	
Auscultation	No RR, P	
on oral feeds	tolerates feeds well.	wt - 1.394 (kg) UIC - 3 ucc/kg/hr CRBS - 7.7 mg/dl
vitals	RR - 38	
RR - 38	SpO2 - 98%	
SpO2 - 98%	BP - 56/35 (mm)	
BP - 56/35 (mm)	CMTA - good	Advice
CMTA - good	P/A - good	- HANC 12L
P/A - good		- 12L
- 12L		- TV - 12cc/kg/day
- TV - 12cc/kg/day		- Cal - 550-p of oral feeds
- Cal - 550-p of oral feeds		- CA (incl feed slub)
- CA (incl feed slub)		- Plan to go to 140cc/kg/day
- Plan to go to 140cc/kg/day		- Continue Dom STAL, DAREAC
- Continue Dom STAL, DAREAC		- WLF feed midway RD
- WLF feed midway RD		- Plan to stop HANC today
- Plan to stop HANC today		

Noted by Ann



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	<u>c/s/B Dr. Owais</u>	
<u>14/5/26</u> <u>2:30 AM</u>	DOL-① / 32w → 32+6w / DCDA-twin ② / LBW / breech / RPS / feed intolerance (resolved)	
	on room air maintain satnata	<u>Plan</u>
	on OGT feeds (12ml) tolerating well	TV = 140 ml / 16 / day 12ml OGT feeds q2hrly (↑ 1ml q6hrly) + 10% Dso P.
	o/e - euthemic HR-138 / m SpO ₂ -98% BP-69/28(43) mmHg	- GRBS OD - CT supplement
	CT/A - good P/A - not	- w/o RD / feed intolerance.
	T.Wt = 1.350 g (↑ 6g)	<u>TV = 150 ccal/d</u> ⇒ ↑ 1ml q6hrly
	GRBS - 105 ml/d	↓ Dso P
	V/O = 2-7 ml / kg / m	gen /
	Noted by Cheli Kalyan @ 2pm	- Add vit D (7m) <u>same</u>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
14/5	<u>CLIB in Mohith</u>	
4PM	- on Room air, No RD	
	- Tolerating OGI feed well	
	on 14 ml @ 2H	
	- No other issues	
	<u>O/E</u>	
	HR - 137/min	Plan
	SpO ₂ - 97%	① TV - 150 cc/kg/day
	BP - 68/29(43)	14 ml @ 2H
		↑ 1 ml @ 6H
		rest 10% in P
	RA soft	② GABS-OD
	C/T/good	③ Start KMC
		Vit D ₃ 8mg
		④ WIF feed intolerance
		⑤ GABS-OD
	Noted by malina 14/5/26	
	4PM	Moh



(12)

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
15/5/26 8:30 AM	CLINICAL	Dr. Sajid
Del-7/1	32 w → 32 ¹⁰ 33 wks	DOPA 2mg 2/
		Wb/ breath / RD, (GCS) / feed intake
		on RA
		maintain sub well
		on oh feeds
		tolerates feeds well
clb - HR	152/70	
	SpO ₂ - 98%	
	BP - 65/51 (50)	
	L/A - good	
	RA soft	ph TU - 150cc/kg / 2x 8
wt - 1.365	kg	17m 17m 12 hrs
U.O - 2.9	ml/kg/hr	1ml - 6hrs
RBS - 121	mg/dL	+ 10 x T Sep
		- CRBS - CD
		- cont line
		- start vit D ₃
		- also - feed wks

examined today

18 weeks

1 day Dur

Noted by
 CHD
 15/5/26
 @ 2 PM



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/5 4pm	<p>CL/B <u>Archee</u></p>	
	<p>on room air</p>	
	<p>on full feeds</p>	
	<p>PR-155h</p>	
	<p>SPO₂ - 100%</p>	
	<p>RA-58738(45)</p>	
	<p>PA sdp</p>	<p>ph</p>
		<p>① on feed 18ml Q4</p>
		<p>② emit OD</p>
		<p>③ Cont RMC</p>
		<p>④ 2D ECHO today</p>
		<p>⑤ w/F Feed intolerance</p>
	<p>Noted by Nurse</p>	<p><i>[Signature]</i></p>



(13)

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16/5/24	C/S/B DR. Owalis	
6 AM	DOL - (8) / 32w → 33+ 1w / DCDA twin (2) / breach / resolved RDS / feed intolerance.	
	on RA maintain saturations	T.Wt - 1.385 (↑ 20g)
	on OG feeds tolerates well	GRBS - 12 mg/dl U/O - 2-7 cc/kg/day
	o/e - euthermic HR - 128 / min SpO ₂ - 100% BP - 66/32 (43) mmHg	plan ↑ 120 cc/kg/day - TV = 150 cc/kg/day 18ml OG feed q 2 hrs
	C/T/A - good PIA - soft	- GRBS OD - CT KMC & supplements
		- w/f feed intolerance
		- Ruman 2ml



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<u>16/5/26</u> <u>1 PM</u>	<u>cls by Dr. Kalyan</u>	
	- Baby had 7 feeds to 22 ml in the morn	
	↓	
	but baby had 1 episode	
	of vomiting	
	& 1.5 ml of milk	
	aspirate	
	↓	
	But today is held,	
	No distension.	
	↓	
	↓	
	↓	
	↓	
	↓	
	↓	
	↓	
	↓	
	↓	
	↓	
	↓	
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	↓	
	↓	
	↓	
	↓	
	↓	
	↓	
	↓	
	↓	
	↓	
	↓	
	↓	
	↓	

↓ Feeds to 10 ml and baby
to continue

- Monitor for abdominal
distension, vomiting.

Noted by
CM/Dr
16/5/26
@ 2 PM



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16/5/26 4 PM	<p>cl by Dr. Prasanna</p> <p>on room air</p> <p>maintaining sat & temp well</p> <p>on OG feeds 18ml 2nd only</p> <p>Had 2 episodes of vomiting.</p>	
	<p>o/c!</p> <p>Enteral</p> <p>HR-138</p> <p>RR-36</p> <p>SpO2-98+</p> <p>pH-7.38</p> <p>CHLA-good.</p>	<p>resist at 4 PM.</p> <p> </p>
		<p>skip 1 feed i.e at 5 PM.</p>
		<p>& interim while giving next feed.</p>
		<p><u>Advice</u></p>
		<p>- continue to - 15cc/kg/day @ 18ml OG feeds, 2nd only</p>
		<p>- GRPS 00</p>
		<p>- continue to meet supplements.</p>
		<p>- with feed intolerance abdominal distension.</p>

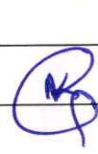


PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
12/15/26	CLINICAL	
8:30 AM	Del-91 32w → 37 1/2w DCDA twin ② /	
	breast (breast) on feed influence	
	on RA	
	monitoring feeds on	
	on RA feed	
	Tolerate feed on	
Oct - 11-158hr	SPH 90 =	
	BP - 56/32 (uo)	Man
	CITP - feed	- IV - 150cc by 1 day or
	PIA set	18 ml / 2 hrs
	ent - 1-380 15 gm	- GFR - on
	V/O - 3-0cc/kg/hr	- cut tone & supports
	RAS - 96 g/hr	- w/f - feed abts
		abd distends
		ST
		rechecked by [signature] 12/15

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
18/5/2026 8 AM	Y of B Dr. Sneeze.	
	DOL : 10 32 ^W → 33 ^W DCD A twin 2 Breech resolved PDS feed intolerance	
	<ul style="list-style-type: none"> GC: stable Maintaining saturation on room air On full feeds, not crying well. 	
	<u>Vitals</u> HR: 136/min RR: 40/min Temp: 36.5°C SpO ₂ : 96% RA BP: 69/35/48 mmHg.	T-Wt: 1.429 (949g) V/O: 3 cups/hour GRBS: 87mg/dl.
	<u>ME</u> CPPT: Good Wt: 51.52 @ P.M. Eps: B/L NURS @ PA: soft - MD <i>noted by uHuss 18/4/26 11am</i>	<u>Plan</u> 1) TV: 150cc/kg/day 2) OGTF: 19ml/honey 3) continue kmc, supplements 4) GRBS ON 5) w/f feed intolerance 



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
18/5/22 10 AM	<u>Clshy Dr. Prame</u>	
	ON Room air	
	maintaining saturation well.	
	on full ch feeds.	
	Tolerating feeds well.	
	OK?	
	enthusiastic	
	RR - 125	
	RR - 38	
	SpO2 - 99%	
	p/a - soft	
	c/t h - good.	

Advice

TV 150 ccl/kg/day
 out feeds 19 ml
 2nd feeds
 - continue kmc, supplements
 - CRBS on
 - w/ feed intolerance
 - plan to ↑ feeds to 200
 archly from

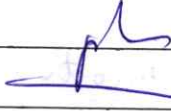


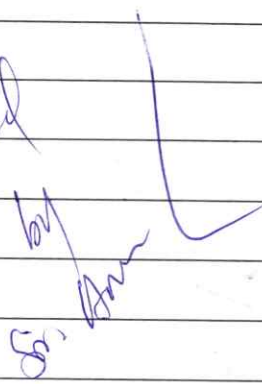
PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/5/26		
4pm	9:1 B Dg. Sneh	
	GC: improving ON room air, maintaining SpO ₂ tolerating - 20ml/2 hourly feed HMF.	
	Vitals	Plan
HR: 140/min		continue 20ml/2 hourly
RR: 42/min		feeds
SpO ₂ : 98% RA		C IV: (60cc/kg)
BP: 64/29 (43) mmHg.		HMF 1/2 sachet
Temp: 36.5°C.		hourly
		-
		continue KMC
		supplements
		w/ feed intolerance
		[Signature]



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2015	clbs <u>breast</u>	
upm	on room aa	
	on full oc feeds	
	↓ 141C	
	PR-137L	
	SPW 997.	
	pla. soft	
	clbs good	 ① TM- 160cc/hr 1hr 20ml oc feed 6hr 1/2 141C = 264
		② AMBS-on
		③ low supplement amc
		④ w/F Feed intolerance

Noted by

 Dr. Anur



①

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
0	<u>Infusion order</u>	
	<u>Dobutamin (50 mg/ml)</u>	
	Single conc ⁿ → 30mg/kg → dilute in 50ml 5% D	
	Double conc ⁿ → 60mg/kg → dilute in 50ml 5% D	
	wt = 1.560 kg	
	Double conc ⁿ → 93.6 mg	
	↓ (1.8 ml in 48ml 5% Dextrose)	
	↓ 2ml/hr → 2mcg/kg/min	
	0.2ml/hr → 0.4mcg/kg/min	



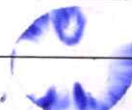
18

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
28/5/26 7:30am	<p>CHIR Dr. Sejid</p> <p>wt - 13 / 32 → 33 + w / DCDA twin 2 stretch / Reached ROS / feed milk</p>	
	<p>on RA maintaining sat sat well on OA feeds receiving feeds well</p>	
	<p>CHIR - HR - 140/140 SpO₂ - 94% BP - 62/32 mmHg C/T/A - Good P/A - SFC</p>	<p>Ph IV - 160 cc/kg/d 20ml/2hrs ch feed + 1/2 AMF @ 6hrs</p>
	<p>wt - 1.41g/kg 96 hr w/o - 2.6 / kg/hr ROS - 89mg/dl</p>	<p>- GPPS - OP - cont supportive care - WF - feed milk</p>
	<p>Noted by Aghani 21/5/26</p>	<p>- spoon feeds for PM</p> <p>- NBS, TSH, ferritin, NPL + TM</p>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/1/24	<p>CL 13 2/24</p>	
up	<p>on room air</p>	
	<p>on full feeds to catch up</p>	
	<p>PR - 140h</p>	
	<p>PR 997,</p>	
	<p>PR 1000 </p>	<p>PR</p>
		<p>① PR - 1600h</p>
		<p>20ml on feed out</p>
		<p>with 100% O2</p>
		<p>4ml feed</p>
		<p>② plan spoon feeds from 7pm</p>
		<p>③ curd 100</p>
		<p>④ MSS</p>
		<p>TSH Free T4 } T/M 6am MPQ</p>
		<p>⑤ curd supplies icmc</p>



19

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	<p><u>c/s/B DS, Oways.</u></p>	
<p>22/5/26</p>		
<p>8 AM</p>		
	<p>DOL-14/32 → 34 w /</p>	
	<p>DCPA twin (G) / breech /</p>	<p>T.Wt - 1.493 kg (774g)</p>
	<p>Resolved RDS / feed</p>	<p>GRBS - 94 ml/dl</p>
	<p>tolerance</p>	<p>U/O - 3cc/kg/hr</p>
	<p>on RA</p>	
	<p>maintaining saturation</p>	<p>Plan</p>
	<p>on O2 feeds</p>	<p>TV = 160 cc/kg/day</p>
	<p>tolerating well</p>	<p>20ml O2 feed @ 2mg</p>
		<p>+ 1/2 HMF / alt feed.</p>
	<p>SpO₂ - 99%</p>	<p>(TTM replace BM with APTAMIC TTT)</p>
	<p>BP - 55/31 (39) mmHg</p>	<p>GRBS 0.0</p>
		<p>CT ICMC / supplements</p>
	<p>CT/A good</p>	<p>(+) labs + urine sed.</p>
	<p>PIA rpt.</p>	<p>Plan to start spoon</p>
		<p>feeds after band</p>
		<p> 2 spoon feeds today</p>
	<p>Noted by Aslame 22/5/26 10:30 AM</p>	<p>su</p>
		<p>As 31.04.26</p>

DH-00045624 IP25-00020339

Baby B/O SYED AAMINA FARHEEN

8-05-2026 0 Y 0 M 13 D (F)

Dr. KALYAN CHAKRAVARTHY KONDA



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	cls/2 male	
22/5	in room an	
22/5	on full feeds - 3 spoon feeds given tolerated	
	PR - 136 L	
	SPN - 100 L	
	HA - 62/35 (L/S)	
	PR - soft	
		pl
		① 20ml feed OR 3 Spoon remaining OR feed
		+ 1ml 3l. Nacc OR
		Start Artemispept 1m
		② CINDS - 00
		③ cont all supplements
		④ w/f - Feed - 100ml

Noted by
Dulau.
 020939
 22/05/26
 SPN



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
23/5/26	clear Dx. Seg 1	
8 AM	Dx - 15/32 → 34+1w / DCPA turn - 2 / breach (Residual RPI) had milk	
	on GRA	
	milk sub with	
	on ch feed	
	recheck hds w	
	QIS - HR - 135/min	
	SpO ₂ - 98%	
	BP - 60/28 (38)	
	C/F W - good	
	PLA - 1st	6 Spoons feed
	wt - 1.50g @ 1 year	
	wa - 3.2 cc/kg/hr	ph - 70-160cc/kg lb or 2ml/kg/kg ch hrs
	RBS - 116 mg/dL	+ 1ml 3% neel @ 2 hrs
	noted by	+ 1/2 HMF @ all hrs
	Gandhi	- plan to start HMF @ Perth - tabs
	23/5/26	- CRBS - CD
	@ 2 pm	- cut home Supplies
	- GWF - Fed at home	



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
24/5/2026 7am	C/O B DS. Prehe	
	N: Dig 32 → 34+2w / DCD A twin-2 / breech / Resolved RDS / Feed intolerance.	
	<ul style="list-style-type: none"> gc: stable on RA, maintaining SpO₂ on full feeds, tolerating well. 	
Vitals	RR: 14/min PR: 44/min Temp: 36.5°C SpO ₂ : 98% RA	TW: 1.536 (132g) U/O: 3.1cc/kg/hr GRES: 99mg/dl
Plan	RR: 57/33 (41) mmHg GLE	1) TV: 160cc/kg/day 2) 20ml/2 hourly
CR/ART: Good U/S: SIS 2 P, no P/S: B/L + VRS P P/A: SFT, MID.	(6 feeds) VCS spoon (6 feeds) SFT	+ 1ml 3% NS in each feed + 1/2 HMF in alternate feed
		2) Plan to start GBS M / Aptamil Peps
		3) GRES OD.
		4) w/f Feed intolerance
		5) To send Na, SMy on TUE 6am
Noted by Dalan 020939 24/05/26 @ 9pm	full sugar fast	57 ml case Tm 6am

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	cls/b 2 weeks	
28/5 ram	Wt 32 → 34+3me / 2004 T2 / Breeds, not-responded / feeder & croaker on room air on full pediatric feeds tolerating well	
	PR-150L SPW-99%	
	PLA soft CTLA good	PL
	Wt 1.571 (35 gm) CMM- 104 mg/dl UO- 2.5cc/h	① keep baby warm ② 20ml spoonfeed. OR + 1ml 3% NaCl OR + 1/2 HMF alt feed
	91 Red wbc	③ 65ml aptenol repr.
	81 Red rpr	④ CMM- OD
	71 AAR body	⑤ To send Nat SAR 4 tim ben
		⑥ 6) vacu body



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<u>25/5/2026</u>		
<u>7:30pm</u>		
	C/S/B Dr. Gueha.	
	GC: stable	
	on room air, maintaining saturation.	
	on spoon feeds (20ml/2 hourly)	
	tolerating well.	
	<u>Vitals</u>	
	HR: 165/min	<u>Plan</u>
	RR: 50/min	continue same
	SpO ₂ : 97.7 RA	as per charting
	Temp: 36.5°C	
	<u>C/C</u>	vitals monitoring
	CNS: CR/A/T: Good	
	ECS: S/S ⊕, M ₀	Nasal clear N/D
	R/C: B/L NUBS ⊕	2/insts B/F 4 hourly
	P/A: Soft, ND.	
		- Tm: Nat SBR 6Am.
		- GRBS OD

0045624 IP25-00020339
 B/O SYED AAMINA FARHEEN (F)
 05-2026 0 Y 0 M 15 D
 KALYAN CHAKRAVARTHY KONDA

(23)

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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
26/5 9am	C/Os <u>Askelgen</u>	
	1.8/32 → 3rd line / DCPA 2 bin	Breech
	on meand feeds	
	C/Os good	
	N/A S/P	PL
		① 20ml Spoon feeds @ 2hr + 1ml 3:1:1 @ 2hr - Stop + 1/2 HR if feed
		② Vaccination AASB } today Red Reflex }
		③ amprol
		④ W/F Feed intolerance
		⑤ not next week
		Council for new prophylaxis

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
26/5	CLS 13 Antelone	
4/4	on Spoon feeds	
	UTW good	
	PA soft	
		pl
		Omeand feeds
		20ml
		→ 1ml 3-6. Nall out
		- Stop tm
		→ 1/2 hour all feed
	①	vaccination
		AASH Godey
	②	Linoson
	③	rop next week
	④	cancelled for NSU prophylax
		red refer ②



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/5/26 11 am	9/13 Dr. Kalyan Dr. Indhe	
	D: D19/32-3 cpts Sw BLDa twin 2 Rseedd Em US	
	<ul style="list-style-type: none"> • GC: stable • CRT < 3 sec • on spoon feeds, tolerating well 	
AABR Red reflex } (M)		<p>star</p> <ul style="list-style-type: none"> - Discharge today Flu on Saturday
		<ul style="list-style-type: none"> - ROP next week - stop 3-1. NS. - measured feeds: 20ml/2hrly - continue Vit D3, MMF
		<p>1st NIRSIVIMAB 50mg 1/m today</p>

FDH-00045624 IP25-00020339
 Baby B/O SYED AAMINA FARHEEN
 08-05-2026 0 Y 0 M 0 D 2 H (F)
 Dr. KALYAN CHAKRAVARTHY KONDA

BBCG - otve



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

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RESULT SHEET

Date	8/5/26	9/6/26	11/5/26	22/5/26	26/5/26
Time	3PM	3:10pm	8AM.	6AM	
Hb	16.5	14.2		14.4	
PCV	48.5	42.2			
RBC	4.46	3.84			
WBC	11.89	13.71			
N/L					
Platelets	402	365			
CRP		7.08	1.65		
ESR					
PCT					
RBS					
Na		138		131	135
K		4.99		5.0	
Cl		111		104	
Ca/Mg		7.2		9.9	
Phosphate				6.8	
Urea		2.8			
Creatinine		0.80			
ALP				440	
SGPT					
SGOT					
T.Bill/Conj		7.44 < 0.10 7.34			9.6 < 0.1 9.5
T.Protein					
S.Albumin					
S.Globulin					
A/G Ratio					
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein / Sugar					
Cells					
N/L					



DRUG CHART

Date of Admission: Drug Allergies: Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

- GENERAL** - Ensure that all patient details are entered above. ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.
- DOCTOR** - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
- Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
 - Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
 - Discontinue a drug by drawing a line **I** through it and a similar line through subsequent recording panels.
 - The date and time of stopping the drug along with the doctors name and sign must be mentioned.
 - Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.
- NURSES** - Nurses must follow strictly the FIVE RIGHTS before administration of medication.
- 1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time
- AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

SOS / PRN (As Required Medication)

DRUG :				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:																					

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

Signature
VERIFIED BY : Name

REGULAR PRESCRIPTIONS

Weight: 1.5kg Ward: NICU...



VERIFIED

VERIFIED

VERIFIED

DRUG : <u>MS PIRAZ</u>				Date	Time												
Dose	Route	Frequency	Start Date	8/5	9/5	10/5	11/5	12/5									
150mg	IV	POD	8/5/26	6 AM	X												
Name & Signature of the Doctor Starting the Drugs:				[Signatures]													
Additional Instructions:				6 4PM PM 11/5 AM AM AM (STOP)													
Daily Doctor's Endorsement by a Sign				[Signatures]													
DRUG : <u>105 Caffeine</u>				Date	Time												
Dose	Route	Frequency	Start Date	9/5	10/5	11/5	12/5	13/5	14/5	15/5	16/5						
8mg	IV	QD	8/5	6 AM													
Name & Signature of the Doctor Starting the Drugs:				[Signatures]													
Additional Instructions:				[Signatures]													
Daily Doctor's Endorsement by a Sign				[Signatures]													
DRUG : <u>GLUCOSE</u>				Date	Time												
Dose	Route	Frequency	Start Date	10/5	11/5	12/5	13/5	14/5	15/5	16/5							
0.2ml	IV	QD	10/5	10 AM													
Name & Signature of the Doctor Starting the Drugs:				[Signatures]													
Additional Instructions:				0.2ml + 0.2ml (STOP)													
Daily Doctor's Endorsement by a Sign				[Signatures]													
DRUG : <u>SYP DOMITAL</u>				Date	Time												
Dose	Route	Frequency	Start Date	10/5	11/5	12/5	13/5	14/5	15/5	16/5	17/5	18/5	19/5	20/5	21/5	22/5	23/5
0.3ml	PO	TID	10/5	6 AM													
Name & Signature of the Doctor Starting the Drugs:				[Signatures]													
Additional Instructions:				[Signatures]													
Daily Doctor's Endorsement by a Sign				[Signatures]													

Patient	I.P. No.	Sheet No.	Wards	Weight (kg)
		79	MICO	

REGULAR PRESCRIPTIONS

DRUG :	Dose	Route	Frequency	Start Dt.	Date Time														
TRUSS DABOLAI	1/4	PO	BD	11/5	11/5	12/5	13/5	14/5	15/5	16/5	17/5	18/5	19/5	20/5	21/5	22/5	23/5	24/5	25/5
Name & Signature of the Doctor starting the Drugs:	Dr. LW																		
Additional Instructions:																			
Daily Doctor's Endorsement by a Sign.	e n - f u n d a 1																		

DRUG :	Dose	Route	Frequency	Start Dt.	Date Time														
VITAMIN D3	0.5ml	oral	OD	15/5	15/5	16/5	17/5	18/5	19/5	20/5	21/5	22/5	23/5	24/5	25/5	26/5	27/5	28/5	29/5
Name & Signature of the Doctor starting the Drugs:	Mh																		
Additional Instructions:	(M=80020)																		
Daily Doctor's Endorsement by a Sign.	n d d d n																		

DRUG :	Dose	Route	Frequency	Start Dt.	Date Time													
SUP 001AN-D	2ml	PO	BD	18/5	18/5	19/5	20/5	21/5	22/5	23/5	24/5	25/5	26/5	27/5	28/5	29/5	30/5	31/5
Name & Signature of the Doctor starting the Drugs:	Dr. LW																	
Additional Instructions:																		
Daily Doctor's Endorsement by a Sign.	n a n																	

DRUG :	Dose	Route	Frequency	Start Dt.	Date Time													
HMF 4	1/2 sachet	OG	6 hourly	19/5	19/5	20/5	21/5	22/5	23/5	24/5	25/5	26/5	27/5	28/5	29/5	30/5	31/5	
Name & Signature of the Doctor starting the Drugs:	betu																	
Additional Instructions:																		
Daily Doctor's Endorsement by a Sign.	n n e																	

VERIFIED VERIFIED VERIFIED



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

DRUG : HMF SPENCET				Date																		
				Time	21/5	22/5	23/5	24/5	25/5	26/5	27/5											
Dose	Route	Frequency	Start Dt.	1 AM	X	✓	✓	✓	✓	✓	✓											
1/2	Oral	All day	21/5	5 AM	✓	✓	✓	✓	✓	✓	✓											
Name & Signature of the Doctor starting the Drugs:				9 AM	✓	✓	✓	✓	✓	✓	✓											
Additional Instructions:				12 PM	✓	✓	✓	✓	✓	✓	✓											
				5 PM	✓	✓	✓	✓	✓	✓	✓											
				9 PM	✓	✓	✓	✓	✓	✓	✓											
Daily Doctor's Endorsement by a Sign.																						

DRUG : 3% NAL				Date																			
				Time	22/5	23/5	24/5	25/5	26/5	27/5													
Dose	Route	Frequency	Start Dt.	1 AM	✓	✓	✓	✓	✓	✓													
1ml	PO	Q2H	22/5	3 AM	✓	✓	✓	✓	✓	✓													
Name & Signature of the Doctor starting the Drugs:				5 AM	✓	✓	✓	✓	✓	✓													
Additional Instructions:				9 AM	✓	✓	✓	✓	✓	✓													
				12 PM	✓	✓	✓	✓	✓	✓													
				5 PM	✓	✓	✓	✓	✓	✓													
				9 PM	✓	✓	✓	✓	✓	✓													
Daily Doctor's Endorsement by a Sign.																							

DRUG : GPR DOMSTAL				Date																			
				Time	24/5	25/5																	
Dose	Route	Frequency	Start Dt.	6 am	✓	✓																	
0.3ml	P/O	PRN	10/5																				
Name & Signature of the Doctor starting the Drugs:																							
Additional Instructions:																							
Daily Doctor's Endorsement by a Sign.																							

DRUG : NASOCLEAR MD				Date																			
				Time	25/5	26/5																	
Dose	Route	Frequency	Start Dt.	7 PM	✓	✓																	
2 drops	P/O	4 times	25/5																				
Name & Signature of the Doctor starting the Drugs:																							
Additional Instructions:																							
Daily Doctor's Endorsement by a Sign.																							

VERIFIED

VERIFIED

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

REGULAR PRESCRIPTIONS

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

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

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

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

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

REGULAR PRESCRIPTIONS

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

Patient Stock:

Weight Ward

VARIABLE DOSE		Date Time					
			Nurse Sig.	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.	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
8/5/26	3p	105 caffeine 31mg	31mg (@ 20mg/kg)	1/2	[Signature]	#82

VERIFICATION NAME: _____ SIGNATURE: _____



I.V. FLUIDS CHART

Weight. Ward.

	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
8/5	3pm	1UF 10% D		12.9 ml/hr	[Signature]	[Signature]	8/5	[Signature]	[Signature]
8/5	11pm	2UF 5% D	Du	3.2 ml/hr	[Signature]	[Signature]	11/5/26 CLEAR	[Signature]	[Signature]
11/5	10:45pm	1UF 10% 150ml	1/2	5ml/hr	[Signature]	[Signature]	9/5/26 9pm	[Signature]	[Signature]

Signature
VERIFIED BY : Name

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 25/5/26.. Time: 9am	10	12	2	4	6:30	7:30	7:30	10	12AM	3:30	6AM
Doctor/Nurse/Family Concern?	Am	Pm	Pm	Pm	Pm	Pm	Pm	Pm			
Temperature (F)	Crib care 98.5	98.5	98.5	97.9	98.5	98.5	98.5	98.6	98.6	98.6	98.6
Heart Rate (bpm) and Blood Pressure (mmHg) *	Crib care 135	Crib care 140	Crib care 160	Crib care 151	Crib care 144	Crib care 175	168-176 165	165	140	142	140
Heart Rate (Number)	135	140	160	151	144	175	168-176 165	165	140	142	140
Resp. Rate (bpm) (Over 1 Minute) *	40	48	35	38	22	40	39-50	40	40	40	40
Resp Rate (Number)	40	48	35	38	22	40	39-50	40	40	40	40
Resp Mod/ Severe Distress None / Mild	N	N	N	N	N	N	N	N	N	N	N
Receiving O ₂ (l/min) O ₂ Saturations (%)	98%	98%	100%	100%	98%	98%	99%	99%	100%	99%	98%
Conscious Level Normal / Altered	N	N	N	N	N	N	N	N	N	N	N
GCS *	C	C	C	C	C	C	C	C	C	C	C
TOTAL SCORE	0	0	0	0	0	0	0	0	0	0	0
Number of shaded boxes	0	0	0	0	0	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0	0	0	0	0	0
Observer's Initials	N	N	N	N	N	N	N	N	N	N	N
ACTIONS	Score 1 : Continue normal observation by staff nurse Score 2 : Shift in charge nurse to be informed and continue hourly observations Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue. Score 4 : Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see Score 5 & 6 : Shift incharge and PICU /NICU fellow or PICU/NICU consultant to be informed										
NB: 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

Ty = 160 cc/kg/day
 T. wt = 1.536 Kgs

Sheet No. : 11

24/5/26

- 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	NG	NG	Diarrhoea	Vomit	Drainage	Urine			
	08:00 am				NG								
	09:00 am	A:pept + 1/2 HMF + 1/2 NS	20ml				-			9ml			
	10:00 am												
	11:00 am	EBM + 3/4 NS	20ml				-			11ml			
	12:00 pm												
	01:00 pm	EBM + 1/2 HMF + 1/2 NS	20ml				-			8ml			
Total Intake :			60ml			Total Output :					6ml 26ml		
	02:00 pm												
	03:00 pm	EBM + 3/4 NS	20ml				-			6ml			
	04:00 pm												
	05:00 pm	EBM + 3/4 NS + 1/2 HMF	20ml				passed			7ml			
	06:00 pm												
	07:00 pm	EBM + 3/4 NS	20ml							10ml			
Total Intake :			60ml			Total Output :					23ml		
	08:00 pm												
	09:00 pm	EBM + 1/2 HMF + 1/2 NS	20ml				-			10ml			
	10:00 pm												
	11:00 pm	EBM + 3/4 NS	20ml				-			8ml			
	12:00 am												
	01:00 am	EBM + 3/4 NS	20ml				Passed			5ml			
Total Intake :			60ml			Total Output :					23ml		
	02:00 am												
	03:00 am	EBM + 3/4 NS	20ml				-			8ml			
	04:00 am												
	05:00 am	EBM + 3/4 NS + 1/2 HMF	20ml				-			10ml			
	06:00 am												
	07:00 am	EBM + 3/4 NS	20ml				Passed			5ml			
Total Intake :			240ml			Total Output :					95ml		

Total 24 hrs. Intake 152.7 cc/kg/day

Total 24 hrs. Output 2.5 cc/kg/hr

FLUID CHART

Sheet No. :

25/4/26

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							
	08:00 am											
	09:00 am	EBM + HMF 20ml 3% NS								10ml		AK
	10:00 am											
	11:00 am	EBM + HMF 20ml 3% NS								10ml		na
	12:00 pm											
	01:00 pm	EBM + HMF 20ml 3% NS								8ml		AK
Total Intake : 37NS					Total Output :							
	02:00 pm											
	03:00 pm	EBM + 3% NS 20ml + 1/2 HMF								12ml		G
	04:00 pm											
	05:00 pm	EBM + 3% NS 20ml + 1/2 HMF										
	06:00 pm											
	07:00 pm	EBM 20ml + 3% NS 1ml										
Total Intake : 60ml					Total Output : V=3, m=0							
	08:00 pm											
	09:00 pm	EBM 20ml + 3% NS 1ml										
	10:00 pm											
	11:00 pm	EBM 20ml + 3% NS 1ml										
	12:00 am											
	01:00 am	EBM 15ml + 3% NS 1ml										
Total Intake : 60ml					Total Output : V=2 m=0							
	02:00 am											
	03:00 am	EBM 20ml + 3% NS 1ml										
	04:00 am											
	05:00 am	EBM 20ml + 3% NS 1ml										
	06:00 am											
	07:00 am	EBM 20ml + 3% NS 1ml										
Total Intake : 60ml					Total Output :							

Total 24 hrs. Intake 240 ml

Total 24 hrs. Output V-10 m-1

DH-00045624 IP25-00020339
 Baby B/O SYED AAMINA FARHEEN
 08-05-2026 0 Y 0 M 14 D (F)
 Dr. KALYAN CHAKRAVARTHY KONDA
 It tak

light
 OSPITALS
 fe Delivery



26/5/26

VITALS CHART

Date →	26/05/26									
Time ↓	Temp	HP	RR	SPO ₂	Score	Type of Feed	Qty	Urine	Stool	Vomit
7.00 am										
8.00 am						DBF		✓		
9.00 am										
10.00 am						EBF	20ml		✓	
11.00 am	98° F	139	41	100						
12.00 pm						EBF	20ml			
1.00 pm										
2.00 pm	98° F	141	40	99		EBF	20ml	✓		
3.00 pm										
4.00 pm						EBF	20ml	✓		
5.00 pm									✓	
6.00 pm						EBF	20ml	✓		
7.00 pm	98° F	156	42	100%	0/10			✓		
8.00 pm						EBF	20ml	✓		
9.00 pm										
10.00 pm						EBF	20ml			
11.00 pm										
12.00 am						EBF	20ml	✓		
1.00 am										
2.00 am						EBF	20ml	✓		
3.00 am										
4.00 am						EBF	20ml			
5.00 am	98.2	148	40	99%	-			✓		
6.00 am						EBF	20ml			
						TOTAL	220ml	U-8	M-2	

Temperature 97.5 to 99.5 F
 HR 120 to 160 per minute
 RR 30 to 60 per minute
 SP02 93-100%

2nd hourly feeding EBM

Feeding Plan.....

DH-00045624

IP25-00020339

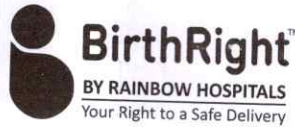
Baby B/O SYED AAMINA FARHEEN

8-05-2026

0 Y 0 M 14 D

(F)

Jr. KALYAN CHAKRAVARTHY KONDA



Morning Shift

Clinical Diagnosis..... M.

Nursing Diagnosis.....

Plan of Care

Planned Investigations Procedures

Implementation

Handed Over by : Name & Signature

Received by : Name & Signature

Evening Shift

Clinical Diagnosis..... M.P.

Nursing Diagnosis.....

Plan of Care

Planned Investigations Procedures

Implementation

Handed Over by : Name & Signature

Received by : Name & Signature

Night Shift

Clinical Diagnosis..... MPT / RD / LBW

Nursing Diagnosis..... MPT / RD / LBW

Plan of Care * Assess the Baby condition

..... * Maintain the I/O Chart

..... * Monitoring the vitals signs.

Planned Investigations Procedures ~~not start~~ due

Implementation * Assessed the Baby condition

..... * Maintained the I/O Chart,

..... * Monitored the vitals signs

..... * Drop. Nasallearz 2 Drops (B/f - 4 hourly)

..... * GRBS - OD

Handed Over by : Name & Signature

[Signature]
24/05/26
at 9 AM

Received by : Name & Signature



2

DH-00045624 IP25-00020339
 lady B/O SYED AAMINA FARHEEN
 8-05-2026 0 Y 0 M 14 D (F)
 Jr. KALYAN CHAKRAVARTHY KONDA

VITALS CHART

Date →	27/05/20									
Time ↓	Temp	HP	RR	SPO ₂	Score	Type of Feed	Qty	Urine	Stool	Vomit
7.00 am										
8.00 am										
9.00 am										
10.00 am										
11.00 am										
12.00 pm										
1.00 pm										
2.00 pm										
3.00 pm										
4.00 pm										
5.00 pm										
6.00 pm										
7.00 pm										
8.00 pm										
9.00 pm										
10.00 pm										
11.00 pm										
12.00 am										
1.00 am										
2.00 am										
3.00 am										
4.00 am										
5.00 am										
6.00 am										
						TOTAL				

Temperature 97.5 to 99.5 F
 HR 120 to 160 per minute
 RR 30 to 60 per minute
 SP02 93-100%

Feeding Plan.....



Morning Shift

Clinical Diagnosis.....

Nursing Diagnosis.....

Plan of Care

Planned Investigations Procedures

Implementation

Handed Over by : Name & Signature

Received by : Name & Signature

Evening Shift

Clinical Diagnosis.....

Nursing Diagnosis.....

Plan of Care

Planned Investigations Procedures

Implementation

Handed Over by : Name & Signature

Received by : Name & Signature

Night Shift

Clinical Diagnosis.....

Nursing Diagnosis.....

Plan of Care

Planned Investigations Procedures

Implementation

Handed Over by : Name & Signature

Received by : Name & Signature



Intensive Care Unit
Clinical Presentation Format for Nurses & Doctors

DH-00045624 IP25-00020339
Baby B/O SYED AAMINA FARHEEN
8-05-2026 0 Y 0 M 13 D (F)
Dr. KALYAN CHAKRAVARTHY KONDA

Sheet No. ②

Name :
DOB :
GEST AGE :

Maternal Blood Group : B +ve
Baby's Blood Group : O +ve
Birth Weight : 1.560 kg-

Date : 23/5/26	Date : 24/5/26.	Date : 25/05/26
DOL D15 Weight 1.504 ↑ 11gms	DOL D16 Weight 1.536 ↑ 32gms.	DOL D17 Weight 1.571 ↑ 35gms.
Problems : PT/RDS/LBW	Problems : PT/RDS/LBW	Problems : PT/RDS/LBW
Rs. 30-60bpm Exam done Vent, Setting RA ABG } Nil CXR } Nil	Rs. 30-60blm Exam done Vent, Setting RA ABG } Nil CXR } Nil	Rs. 30-60blm Exam Done Vent, Setting R/A ABG } Nil CXR } Nil
CVS Normal HR 120-160bpm BP 62/36 Map (46) Cap Refil 2sec	CVS Normal HR 120-160blm BP 63/38 Map (48) Cap Refil 2sec	CVS Normal HR 120-160blm BP 63/35 Map (45) Cap Refil 2sec
F/E/N 160cc/kg/day T.Fluids 240ml (CC/kg/day) 153.8cc/kg/day I/O/RBS : 116mg/dl U Output : (CC/Kg/hr) 120ml Exam 3.2cc/kg/hr T Bil/D Na 131 HC03 K 5.0 BUN Cl 104 Crea Hemat HB : 14.4 WCC Plants Transfusion	F/E/N 160cc/kg/day T.Fluids 240ml (CC/kg/day) 156.2cc/kg/day I/O/RBS : 99mg/dl U Output : (CC/Kg/hr) 115ml Exam 3.1cc/kg/hr T Bil/D Na 131 HC03 K 5.0 BUN Cl 104 Crea Hemat HB : 14.4 WCC Plants Transfusion	F/E/N 160cc/kg/day T.Fluids 240ml (CC/kg/day) 152.7cc/kg/day I/O/RBS : 104mg/dl U Output : (CC/Kg/hr) 95ml Exam 2.5cc/kg/hr T Bil/D Na 131 HC03 K 5.0 BUN Cl 104 Crea Hemat HB : 14.4 WCC Plants Transfusion
C/s Results } Nil CRP } Nil Antibiotics } Nil	C/s Results } Nil CRP } Nil Antibiotics } Nil	C/s Results } Nil CRP } Nil Antibiotics } Nil
Meds Symp Domstal Dorolac vit D3 Neuro : Ossopan D. 3% NaCl.	Meds Symp Domstal Dorolac vit D3 Neuro : Ossopan D. 3% NaCl.	Meds Symp Domstal vit D3 Neuro : Ossopan D. 3% NaCl.
Assessment Done.	Assessment Done.	Assessment Done.
Plan RBS OD.	Plan GRBS OD.	Plan GRBS OD

Handwritten notes at the top of the page, including a date and some illegible text.

Handwritten notes in the middle section, featuring a small table with several rows and columns.

Handwritten notes in the lower middle section, including a small diagram or flowchart.

```
graph TD
    A --> B
    B --> C
    C --> D
    D --> E
```

Handwritten notes at the bottom of the page, including a date and some illegible text.

3

Ref.No. F/NICU.WEIT/04

Patient Id #

FDH-00045624 IP25-00020339
Baby B/O SYED AAMINA FARHEEN
08-05-2026 0 Y 0 M 0 D 3 H (F)
Dr. KALYAN CHAKRAVARTHY KONDA

Name :

Date of Birth :



NEONATAL WEIGHT CHART

Birth :
Weight :

Admission Weight
Discharge Weight

NICU

Month	Date	Day	Weight (g)	Height (cm)
	8/5/26		1560gms	48cm
	9/5/26		1506gms	48cm
	10/5/26		1457gms	48cm
	11/5/26		1402gms	48cm
	12/5/26		1348gms	48cm
	13/5/26		1294gms	48cm
	14/5/26		1240gms	48cm
	15/5/26		1185gms	48cm
	16/5/26		1130gms	48cm
	17/5/26		1075gms	48cm
	18/5/26		1020gms	48cm
	19/5/26		965gms	48cm
	20/5/26		910gms	48cm
	21/5/26		855gms	48cm
	22/5/26		800gms	48cm
	23/5/26		745gms	48cm
	24/5/26		690gms	48cm
	25/5/26		635gms	48cm

DO NOT WRITE OUTSIDE THE MARGINS

Admission vitals

HR - 149 / min

SpO₂ - 95%

RR - 49 / min

Temp - 36.7°C

HR -

LC -

weight - 1.560 kg

RBS - 71 mg/dl

Date	Time	RBS	Sign.
8/5/26	3 PM	71 mg/dl	HSN
8/5/26	10 PM	174 mg/dl	Q
9/5/26	6 AM	140 mg/dl	Q
9/5/26	12 PM	63 mg/dl	HSN
10/5/26	6 AM	75 mg/dl	Cyflid
10/5/26	6 PM	69 mg/dl	Q
11/5/26	6 AM	82 mg/dl	G
11/5/26	6 PM	94 mg/dl	Q
12/5/26	6 AM	113 mg/dl	Q
13/5/26	6 AM	77 mg/dl	Q
14/5/26	6 AM	105 mg/dl	Q
15/5/26	6 AM	101 mg/dl	Q
16/5/26	6 AM	112 mg/dl	Aslan
17/5/26	6 AM	90 mg/dl	Q
18/5/26	6 AM	87 mg/dl	Q
19/5/26	6 AM	112 mg/dl	Q

20/5/26	6 AM	96 mg/dl	Cyflid
21/5/26	6 AM	89 mg/dl	Q
22/5/26	6 AM	94 mg/dl	Q
23/5/26	6 AM	116 mg/dl	Q
24/5/26	6 AM	99 mg/dl	Q
25/5/26	6 AM	101 mg	Q

51 Dextro

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

10

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 23/5/26	Time: 8	10	12	2	4	6	8	10	12	2	4	6
Doctor/Nurse/Family Concern?	an	an	pn	pn	pn	pn	pn	pn	pn	an	an	an

Temperature (F)	104												
	103												
	102												
	101												
	100												
	99	36.9	36.5	36.5	36.5	36.5	36.5	36.5	36.5	36.5	36.5	36.5	36.5
	98												
	97												
	96												
	95												
	94												

Heart Rate (bpm) and Blood Pressure (mmHg) *	190												
	180												
	170												
	160												
	150												
	140												
	130												
	120												
	110												
	100												
	90												
	80												
	70												
60													
50													
Heart Rate (Number)	139	150	152	155	148	141	145	136	146	154	140	136	

Resp. Rate (bpm) (Over 1 Minute) *	70												
	60												
	50												
	40												
	30												
	20												
	10												
	Resp Rate (Number)	46	40	36	40	43	42	41	38	46	40	38	42

Resp Distress	Mod/ Severe None / Mild												
Receiving O ₂ (l/min)		RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	
O ₂ Saturations (%)		98%	97%	99%	99%	99%	99%	99%	100%	99%	98%	100%	
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	
Pain Score		0	0	0	0	0	0	0	0	0	0	0	
Observer's Initials		W	W	W	W	W	W	W	W	W	W	W	

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date:	Time:	8	10	12	2	4	6	8	10	12	2	4	6
Doctor/Nurse/Family Concern?		am	am	pm	pm	pm	pm	pm	pm	am	am	am	am
Temperature (F)		36.50C	36.6C	36.50C	36.60C	36.5	36.5	36.5	36.5C	36.5C	36.6C	36.5C	36.5C
Heart Rate (bpm) and Blood Pressure (mmHg) *		51 (39) / 32	63 (45) / 35	61 (43) / 32	62 (46) / 32	58 (26) / 40	56 (27) / 27	57 (21) / 34	49 (34) / 24	54 (34) / 25	70 (37) / 48	54 (35) / 24	Crib care
Heart Rate (Number)		142	132	139	141	148	157	133	146	148	144	136	
Resp. Rate (bpm) (Over 1 Minute) *		30	32	38	49	48	48	48	38	40	46	42	
Resp Distress	Mod/ Severe None / Mild	RIA	RIA	RIA	RIA	RIA	RIA	RIA	RIA	RIA	RIA	RIA	RIA
Receiving O ₂ (l/min) O ₂ Saturations (%)		99% 100%	100%	100%	100%	97% 98	98	100%	106%	99% 99%	99%	100%	98%
Conscious Level	Normal Altered	N	N	N	N	N	N	N	N	N	N	N	N
GCS *		C	C	C	C	C	C	C	C	C	C	C	C
TOTAL SCORE		0	0	0	0	0	0	0	0	0	0	0	0
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		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]

ACTIONS

Score 1 : Continue normal observation by staff nurse

Score 2 : Shift in charge nurse to be informed and continue hourly observations

Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.

Score 4 : Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see

Score 5 & 6 : Shift incharge and PICU /NICU fellow or PICU/NICU consultant to be informed

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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)



FLUID CHART

TV 150cc/kg/day
 B.wt: - 1.560kg

Sheet No. : (1)

- 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	Route	NG	Diarrhoea	Vomit	Drainage	Urine			
	08:00 am			3.2	O.G								
	09:00 am	DBM		3.2ml	13ml					6ml	0		
	10:00 am			3.2									
	11:00 am	EBM		3.2	13ml		✓			9ml	0		
	12:00 pm			3.2									
	01:00 pm	EBM		3.2	13ml					12ml	0		
Total Intake :			58.2			Total Output :					27ml		
	02:00 pm			2.2									
	03:00 pm	FSM		2.2	14ml		-			8ml	0		
	04:00 pm			2.2									
	05:00 pm	DBM		2.2	14ml		-			18ml	0		
	06:00 pm			2.2									
	07:00 pm	DBM		2.2	14ml		passed			10ml	0		
Total Intake :			42.2ml 58.7ml			Total Output :					36ml		
	08:00 pm			2.2ml									
	09:00 pm	DBM		2.2ml	15ml		-			10ml	0		
	10:00 pm			2.2ml			passed						
	11:00 pm	DBM		2.2ml	15					8ml	0		
	12:00 am			2.2ml									
	01:00 am	DBM		2.2ml	15		-			7ml	0		
Total Intake :			58.7ml			Total Output :					23ml		
	02:00 am			2.2ml									
	03:00 am	DBM		1.7ml	16ml		-			11ml	0		
	04:00 am			1.7ml									
	05:00 am	DBM		1.7ml	16ml								
	06:00 am			1.7ml			passed			15ml	0		
	07:00 am	DBM		1.7ml	16ml		passed						
Total Intake :			58.7 / 234.3			Total Output :					112ml		

Total 24 hrs. Intake

150 cc/kg/day

Total 24 hrs. Output

2.9 cc/kg/day



15/5/26

FLUID CHART

Weight 1.355 gm
Birth - 1.56 gm

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 Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	Route	NG	Diarrhoea	Vomit	Drainage	Urine			
	08:00 am			2.7ml									
✓	09:00 am	DBM	↓	1.2ml	HTM	↑		✓			5ml	0	G
	10:00 am			1.2									
✓	11:00 am	DBM		stop	1.8ml			✓			9ml	0	G
	12:00 pm												
✓	01:00 pm	EBM			1.8ml						12ml	0	D
Total Intake :			57.1ml			Total Output :							
	02:00 pm												
	03:00 pm	EBM			1.8ml		passed				10ml	0	D
	04:00 pm												
	05:00 pm	EBM			1.8ml		passed				12ml	0	D
	06:00 pm												
	07:00 pm	EBM			1.8ml		passed				6ml	0	D
Total Intake :			54ml			Total Output :					28ml (2.9 cc/kg/day)		
	08:00 pm												
	09:00 pm	DBM			1.8ml		passed				11ml		D
	10:00 pm						passed						D
	11:00 pm	EBM			1.8ml								
	12:00 am												
	01:00 am	DBM			1.8ml						8ml		fb
Total Intake :			54ml			Total Output :					29ml		
	02:00 am												
	03:00 am	DBM			1.8ml		passed				8ml		D
	04:00 am												
	05:00 am	DBM			1.8ml								
	06:00 am										12ml		
	07:00 am	DBM			1.8ml								
Total Intake :			213.1ml			Total Output :					102ml		
Total 24 hrs. Intake		140 cc/kg/day											
Total 24 hrs. Output		2.7 cc/kg/day											



TV = 170 cal/kg/day

16/5/26



FLUID CHART

Pr. wt - 1.385 kg.
B. wt - 1.560 kg.

Sheet No. : (8)

- 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 Thrombo-phlebitis Score	Sign. Nurse	
		Nature of Fluid	Route		OG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	OG							
	08:00 am											
	09:00 am	DBM			18ml		✓		5ml	0		
	10:00 am									0		
	11:00 am	DBM			20ml		-			0		
	12:00 pm											
	01:00 pm	DBM			22ml	1.5ml milk	-	✓	12ml	0		
Total Intake :		60 ml			Total Output : 17 ml							
	02:00 pm											
	03:00 pm	EBM			18ml	passed	✓		9ml	0		
	04:00 pm											
	05:00 pm	Skipped				passed			12ml	0		
	06:00 pm											
	07:00 pm	EBM			18ml				10ml			
Total Intake :		36 ml			Total Output : 31 ml (3.3 ml/hr)							
	08:00 pm											
	09:00 pm	DBM			18ml	passed			11ml			
	10:00 pm											
	11:00 pm	EBM			18ml	passed			9ml			
	12:00 am											
	01:00 am	DBM			18ml		-		13ml			
Total Intake :		36 ml			Total Output : 33 ml							
	02:00 am											
	03:00 am	DBM			18ml	passed			11ml			
	04:00 am											
	05:00 am	DBM			18ml	passed			10ml			
	06:00 am											
	07:00 am	EBM			18ml				8ml			
Total Intake :		168 ml			Total Output : 110 ml							
Total 24 hrs. Intake		112 cal/kg/day			Total 24 hrs. Output		3.0 cal/kg/day					



17/5

FLUID CHART

Sheet No. : 14

TV = 150 cc/kg/day
 B.W = 1.560 kg

- 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	NG	NG	Diarrhoea	Vomit	Drainage	Urine			
	08:00 am												
	09:00 am	DBM		18ml					3ml				SV
	10:00 am												
	11:00 am	DBM		18ml			Passed		7ml				S
	12:00 pm												
	01:00 pm	DBM		↑19ml			Passed		5ml				S
Total Intake :			55ml			Total Output :					15ml		
	02:00 pm												
	03:00 pm	EBM		19ml					7ml				d
	04:00 pm												
	05:00 pm	EBM		19ml					15ml				d
	06:00 pm												
	07:00 pm	EBM		19ml			Passed		9ml				d
Total Intake :			57ml			Total Output :							
	08:00 pm												
	09:00 pm	EBM		19ml			Passed		9ml				Qs
	10:00 pm												
	11:00 pm	EBM		19ml			Passed		10ml				Qs
	12:00 am												
	01:00 am	EBM		19ml			Passed		11ml				Qs
Total Intake :			57ml			Total Output :							
	02:00 am												
	03:00 am	EBM		19ml			Passed		12ml				Qs
	04:00 am												
	05:00 am	EBM		19ml			Passed		11ml				Qs
	06:00 am												
	07:00 am	EBM		19ml			Passed		12ml				Qs
Total Intake :			226ml			Total Output :					111ml		

Total 24 hrs. Intake 150.6 cc/kg/day

Total 24 hrs. Output 3.0 cc/kg/day



18/5/26

FLUID CHART

TN = 150 cc/kg/day
 B.wt = 1.560 kgs.

Sheet No. : 3

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

		Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route		Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	NG						
	08:00 am										
→	09:00 am	EBM			19ml	0.5ml micky passed	-	-	10ml		12ml
	10:00 am										
	11:00 am	EBM			19ml	-	-	-	12ml		7ml
	12:00 pm										
	01:00 pm	DBM			19ml	-	passed		13ml		0
Total Intake : 57ml					Total Output : 35ml						
	02:00 pm										
→	03:00 pm	EBM			19ml	-					0
	04:00 pm										
→	05:00 pm	EBM			19ml				15ml		0
	06:00 pm										
→	07:00 pm	EBM			19ml	0.5ml micky passed			7ml		0
Total Intake : 57ml					Total Output : 22ml						
	08:00 pm										
	09:00 pm	EBM			19ml	passed			9ml		0
	10:00 pm										
	11:00 pm	EBM			19ml	passed			11ml		0
	12:00 am										
	01:00 am	EBM			19ml	-			12ml		0
Total Intake : 57ml					Total Output : 32ml						
	02:00 am										
	03:00 am	EBM			19ml	-			10ml		0
	04:00 am										
	05:00 am	EBM			19ml	passed			9ml		0
	06:00 am										
	07:00 am	EBM			19ml	-			12ml		0
Total Intake : 228ml					Total Output : 120ml						

3.7 cc/kg hour
 2.3 cc/kg hour
 0.6 hr

Total 24 hrs. Intake : 152 cc/kg/day

Total 24 hrs. Output : 3.3 cc/kg/day

FDH-00045624 IP25-00020339
 Baby B/O SYED AAMINA FARHEEN (F)
 08-05-2026 0 Y 0 M 9 D
 Dr. KALYAN CHAKRAVARTHY KONDA

19/05/20



FLUID CHART

TV = 1.50 cc/kg/day
 B-nt = 1.50 cc/kg/day

Sheet No. : 6

- 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	NG	Diarrhoea	Vomit	Drainage	Urine				
	08:00 am				NG								
	09:00 am	EBM		19ml		Passed	-	-	5ml	0			
	10:00 am												
	11:00 am	DBM		20ml		-	-	-	10ml	0			
	12:00 pm												
	01:00 pm	DBM		20ml		Passed	-	-	5ml	0			
Total Intake :			+ 1/2 HMF			Total Output :							
	02:00 pm												
	03:00 pm	EBM		20ml		-	-	-	-	0			
	04:00 pm												
	05:00 pm	EBM		20ml		-	-	-	14ml				
	06:00 pm												
	07:00 pm	EBM + 1/2 HMF		20ml		-	-	-	10ml				
Total Intake :						Total Output :							
	08:00 pm												
	09:00 pm	EBM		20ml		-			8ml				
	10:00 pm												
	11:00 pm	EBM		20ml		-			7ml				
	12:00 am												
	01:00 am	EBM + 1/2 HMF		20ml		✓			12ml				
Total Intake :						Total Output :							
	02:00 am												
	03:00 am	EBM		20ml		-			9ml				
	04:00 am												
	05:00 am	EBM		20ml		-			15ml				
	06:00 am												
	07:00 am	DBM		20ml		✓			10ml				
Total Intake :						Total Output :							

Total 24 hrs. Intake : 171.9 cc/kg/day **Total 24 hrs. Output** : 3.1 cc/kg/hr

20/5/26

FLUID CHART

Tr = 150 cc/kg/day
 Total = 1.413 kg

Sheet No. : 7

- 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	NG	NG	Diarrhoea	Vomit	Drainage	Urine			
	08:00 am				OG								
	09:00 am	DBM		20ml		-	-	-	7ml				De
	10:00 am												
	11:00 am	DBM		20ml		passed	-	-	12ml				De
	12:00 pm												
	01:00 pm	DBM		20ml		-	-	-	6ml				De
Total Intake :						Total Output :							
	02:00 pm												
	03:00 pm	EBM		20ml		-							De
	04:00 pm												
	05:00 pm	EBM		20ml		passed	-	-	14ml				De
	06:00 pm												
	07:00 pm	EBM		20ml		-	-	-	8ml				De
Total Intake :						Total Output :							
	08:00 pm												
	09:00 pm	EBM		20ml		-			7ml				De
	10:00 pm												
	11:00 pm	EBM		20ml		-			8ml				De
	12:00 am												
	01:00 am	EBM		20ml		-			6ml				De
Total Intake :						Total Output :							
	02:00 am												
	03:00 am	EBM		20ml		passed			10ml				De
	04:00 am												
	05:00 am	EBM		20ml		passed			8ml				De
	06:00 am												
	07:00 am	EBM		20ml		passed			12ml				De
Total Intake :						Total Output :							

Total 24 hrs. Intake : 240ml (153.8cc/kg/day)

Total 24 hrs. Output : 98ml (2.6cc/kg/day)



21/5/26

FLUID CHART

Sheet No. : (8)

- 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	NG							
	08:00 am											
	09:00 am	EBM			20ml		-			10ml		A
	10:00 am											
	11:00 am	EBM			20ml		-			13ml		d
	12:00 pm											
	01:00 pm	EBM + 1/2 HMF			20ml		-			6ml		sb
Total Intake : 60ml HMF					Total Output : 29ml							
	02:00 pm											
	03:00 pm	EBM			20ml		-			9ml		As
	04:00 pm											
	05:00 pm	EBM + 1/2 HMF			20ml		-			10ml		As
	06:00 pm											
	07:00 pm	EBM			20ml		passed			9ml		As
Total Intake :					Total Output :							
	08:00 pm											
	09:00 pm	EBM + 1/2 HMF			20ml		-			15ml		As
	10:00 pm											
	11:00 pm	EBM			20ml		passed			10ml		As
	12:00 am											
	01:00 am	EBM + 1/2 HMF			20ml		-			8ml		As
Total Intake :					Total Output :							
	02:00 am											
	03:00 am	EBM			20ml					10ml		As
	04:00 am											
	05:00 am	EBM + 1/2 HMF			20ml					6ml		As
	06:00 am											
	07:00 am	EBM			20ml					10ml		As
Total Intake :					Total Output :							

Total 24 hrs. Intake 240ml (153.8cc/kg/day)

Total 24 hrs. Output 116ml (3.0cc/kg/hr)



22/5/26

FLUID CHART

T.V :- 160 cc/kg/day
 Bwt :- 1.560 kg
 Fwt :- 1.493 kg

Sheet No. : 9

- 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 Thrombo- phlebitis Score	Sign. Nurse	
		Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
	08:00 am		Spoon Mouth	I.V	D.G							
	09:00 am	DBM			20ml		passed		12ml			A
	10:00 am											
	11:00 am	DBM	20ml				passed		9ml			A
	12:00 pm											
	01:00 pm	DBM	20ml				passed		11ml			A
Total Intake :					Total Output : 32							
	02:00 pm											
	03:00 pm	EBM	20ml				—		11ml			A
	04:00 pm											
	05:00 pm	EBM	20ml		20ml		—		9ml			A
	06:00 pm											
	07:00 pm	EBM	20ml		20ml		passed		8ml			A
Total Intake :					Total Output :							
	08:00 pm											
	09:00 pm	EBM + HMF	20ml		20ml		—		15ml			A
	10:00 pm											
	11:00 pm	EBM	20ml		20ml		—					A
	12:00 am											
	01:00 am	EBM	20ml		20ml				15ml			A
Total Intake :					Total Output :							
	02:00 am											
	03:00 am	EBM	20ml		20ml		passed		12ml			A
	04:00 am											
	05:00 am	EBM	20ml		20ml				8ml			A
	06:00 am											
	07:00 am	EBM	20ml		20ml				10ml			A
Total Intake :					Total Output :							

3.4 cc/kg
 6hr

Total 24 hrs. Intake
 240ml
 153.8 cc/kg/day

Total 24 hrs. Output
 120ml
 3.02 cc/kg/day



FLUID CHART

Sheet No. : (10)

25/5/26

TV 2/60 cc/kg/day,
 T. wt → 1.506 kgs,
 B. W. → 1.560 kgs,

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 Thrombo-phlebitis Score	Sign. Nurse	
			Route	NG	Diarrhoea	Vomit	Drainage	Urine					
			Mouth	I.V	OG								
	08:00 am												
	09:00 am	EBM		20ml		Passed	-	-	12ml				
	10:00 am												
	11:00 am	EBM	20ml			Passed	-	-	16ml				
	12:00 pm												
	01:00 pm	EBM	20ml				-	-	8ml				
Total Intake :			60ml			Total Output :					36ml		
	02:00 pm												
	03:00 pm	EBM + 3% NS	20ml				-		14ml				
	04:00 pm												
	05:00 pm	EBM + 3% NS	20ml			Stain			9ml				
	06:00 pm												
	07:00 pm	EBM + 3% NS	20ml				-		10ml				
Total Intake :			60ml			Total Output :					33ml		
	08:00 pm												
	09:00 pm	EBM + 3% NS	20ml				-		5ml				
	10:00 pm												
	11:00 pm	EBM + 3% NS		20ml			-		10ml				
	12:00 am												
	01:00 am	EBM + 3% NS		20ml			-		8ml				
Total Intake :			60ml			Total Output :					23ml		
	02:00 am												
	03:00 am	EBM + 3% NS		20ml		Passed			5ml				
	04:00 am												
	05:00 am	EBM + 3% NS		20ml		Passed			10ml				
	06:00 am												
	07:00 am	EBM + 3% NS		20ml			-		8ml				
Total Intake :			240ml			Total Output :					115ml		

Total 24 hrs. Intake 156.2 cc/kg/day

Total 24 hrs. Output 3.1 cc/kg/hr



①

Doc. No. : RCH / FRM / CLINICAL / 124

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



EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 14/5/26 Time: 8 10 12 2 4 6 8 10 12 2 4 6
 Doctor/Nurse/Family Concern? AM AM PM PM PM PM PM AM AM AM AM

Temperature (°F)	104													
	103													
	102													
	101													
	100	36.5°C												
	99		36.7°C											
	98			36.8°C										
	97				36.7°C									
	96					36.6°C								
	95						36.4°C							
	94							36.2°C						

Heart Rate (bpm) and Blood Pressure (mmHg) *	190	169	163	164	158	168	160	163	168	162	159	166	165
	180												
Note: BP does not score in early warning scoring	170	(43)	(40)	(44)	(42)	42	45	46	(51)	44	(42)	(52)	(47)
	160	28	29	34	33	27	37	37	42	25	31	44	37

Heart Rate (Number) (141) 128 135 129 135 138 147 (145) 139 (141) (149) (148)

Resp. Rate (bpm) (Over 1 Minute) *	70												
	60												
Resp Rate (Number)	50	44	41	43	45	40	35	45	(35)	(42)	(44)	(52)	(38)
	40												

Resp Distress Mod/ Severe None / Mild R/A R/A R/A R/A R/A R/A R/A R/A R/A R/A R/A R/A

Receiving O₂ (l/min) O₂ Saturations (%) 98% 97% 98% 99% 100% 100% 96% 99% 98% 99% 98%

Conscious Level Normal / Altered C C C C C C C C C C C C C

GCS * N N N N N N N N N N N N N

TOTAL SCORE Number of shaded boxes 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

Observer's Initials [Signatures]

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

1515126

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date:	Time:	8	10	12	2	4	6	8	10	12	2	4	6
Doctor/Nurse/Family Concern?		AM	AM	PM	PM	PM	PM	PM	PM	AM	AM	AM	AM
Temperature (F)		100.6	36.7°C	36.7°C	KML	36.5	36.6	36.6	36.6	36.6	36.6	36.6	36.6
Heart Rate (bpm)		55	69	59	KML	66	73	71	54	58	61	58	62
Blood Pressure (mmHg) *		(39) / 30	(38) / 47	(41) / 47	KML	51 / 43	63 / 56	41 / 32	(49) / 32	(41) / 39	(40) / 29	40 / 31	(45) / 35
Heart Rate (Number)		(156)	132	135	139	138	137	136(147)	(142)	(157)	(145)	(146)	
Resp. Rate (bpm) (Over 1 Minute) *					KML								
Resp Rate (Number)		(48)	49	49	3	48	48	48	(42)	(38)	(52)	(39)	
Resp Distress	Mod/ Severe None / Mild		RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA
Receiving O ₂ (l/min)		0.8	0.8	0.8	0.8	0.8	0.8	0.8	0.8	0.8	0.8	0.8	0.8
O ₂ Saturations (%)		98	98	98	98	98	98	98	98	98	98	98	98
Conscious Level	Normal / Altered	e	c	c	c	c	c	c	c	c	c	c	c
GCS *		m	14	14	14	14	14	14	14	14	14	14	14
TOTAL SCORE		0	0	0	0	0	0	0	0	0	0	0	0
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		A	B	B	B	B	B	B	B	B	B	B	B

ACTIONS

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

NB: 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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Date	Time	Early Warning Score	Date	Time	Name

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

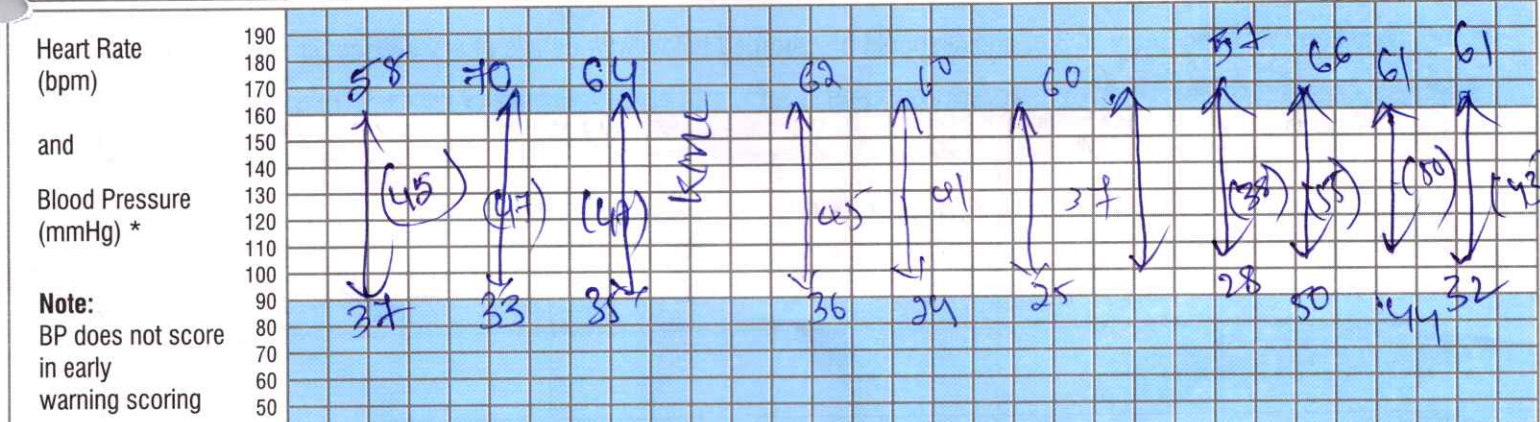
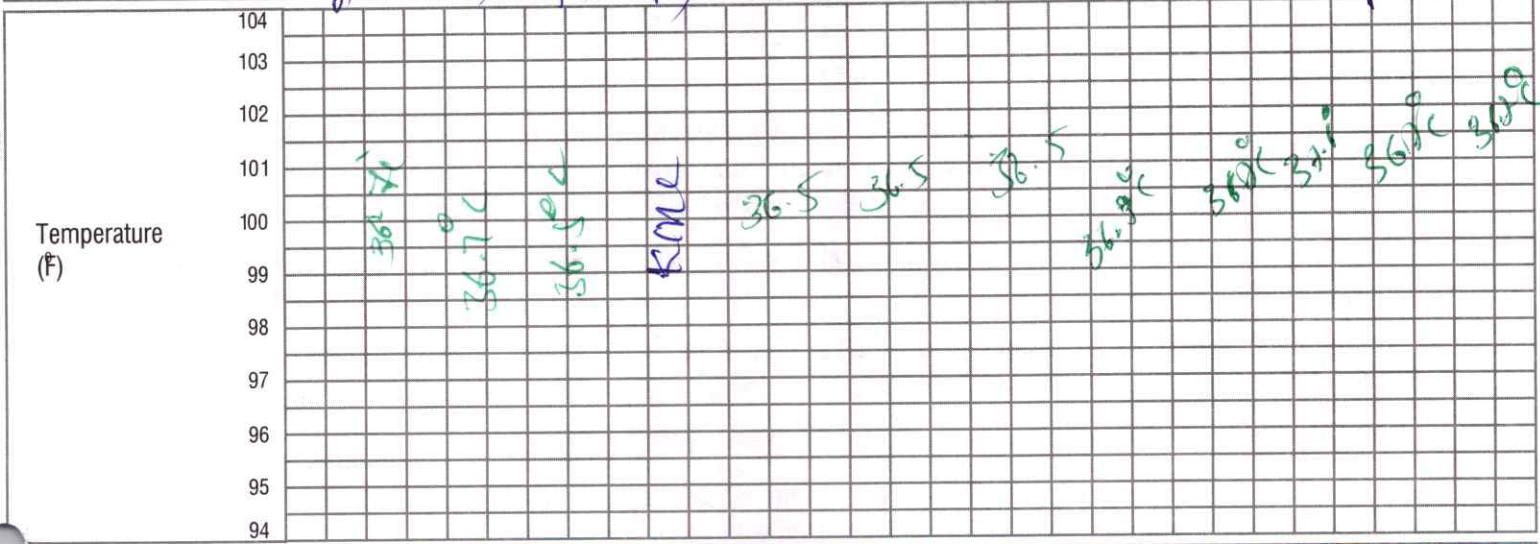


INFANT (<1 year)
Children's Observation & Early Warning Scoring Chart



EARLY WARNING SCORE: CHILDREN'S UNIT

Date:	Time:	5	10	12	2	4	6	8	10	12	2	4	6
Doctor/Nurse/Family Concern?		pm	Am	pm	pm	pm	pm	pm	pm	pm	pm	pm	pm



Heart Rate (Number)	144	129	131	135	157	161	149	140	143	134	135	132
---------------------	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----



Resp Rate (Number)	45	42	39	45	48	48	48	100	100	100	100	100
Resp Distress	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA

Receiving O ₂ (l/min)	0.5	0.5	0.5	0.5	1.0	0.7	1.0	1.0	1.0	1.0	1.0	1.0
O ₂ Saturations (%)	95	98	98	97	100	97	100	100	100	100	100	100

Conscious Level	C	C	C	C	C	C	C	C	C	C	C	C
GCS *	11	11	11	11	12	12	12	12	12	12	12	12

TOTAL SCORE	0	0	0	0	0	0	0	0	0	0	0	0
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	A	B	B	B	B	B	B	B	B	B	B	B

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.
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* 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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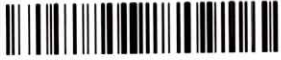
FDH-00045624 IP25-00020339
 Baby B/O SYED AAMINA FARHEEN
 08-05-2026 0 Y 0 M 9 D (F)
 Dr. KALYAN CHAKRAVARTHY KONDA

Doc. No. : RCHBH / FRM / CLINICAL / 124

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

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery



EARLY WARNING SCORE: CHILDREN'S UNIT

Date:	Time:	10	12	2	4	6	8	10	12	2	4	6
Doctor/Nurse/Family Concern?		AM	PM	PM	PM	PM	PM	PM	AM	AM	AM	AM
Temperature (F)	104	36.7	36.7	36.5	36.2	36.8	36.7	36.5	36.6	36.6	36.6	36.6
Heart Rate (bpm)	190	64	75	82	88	66	80	66	92	82	62	66
Blood Pressure (mmHg) *	140	(62)	(59)	(59)	(44)	(44)	(48)	(42)	(52)	(48)	(55)	(41)
Note: BP does not score in early warning scoring	50	32	56	31		33	41	29	53	43	53	29
Heart Rate (Number)		(144)	(145)	(136)	(136)	(144)	(148)	(132)	(140)	(142)	(143)	(120)
Resp. Rate (bpm) (Over 1 Minute) *	70											
Resp Rate (Number)		(30)	(42)	(41)	(38)	(48)	(48)	(45)	48	48	(42)	48
Resp Distress	Mod/ Severe None / Mild	R/A	R/A	R/A	R/A	R/A	R/A	R/A	R/A	R/A	R/A	R/A
Receiving O ₂ (l/min)		100%	98%	97%	98%	98%	98%	98%	99%	99%	99%	99%
O ₂ Saturations (%)		100%	98%	97%	98%	98%	98%	98%	99%	99%	99%	99%
Conscious Level	Normal / Altered	C	C	C	C	C	C	C	C	C	C	C
GCS *		N	N	N	N	N	N	N	N	N	N	N
TOTAL SCORE		0	0	0	0	0	0	0	0	0	0	0
Number of shaded boxes		0	0	0	0	0	0	0	0	0	0	0
Pain Score		0	0	0	0	0	0	0	0	0	0	0
Observer's Initials		A	A	A	A	A	A	A	A	A	A	A

ACTIONS

- Score 1 : Continue normal observation by staff nurse
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INSTRUCTIONS:

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 08/05/26	Time: 8 AM	10 AM	12 PM	2 PM	4 PM	6 PM	8 PM	10 PM	12 AM	2 AM	4 AM	6 AM
Doctor/Nurse/Family Concern?	AM	AM	PM	PM	PM	PM	PM	PM	AM	AM	AM	AM
Temperature (F)	99.6	99.5	99.5	99.5	99.8	99.8	99.7	99.5	99.5	99.5	99.5	99.5
Heart Rate (bpm)	69	61	63	61	62	65	61	66	69	62	66	66
Blood Pressure (mmHg) *	(48/25)	(46/37)	(42/31)	(45/38)	(47/40)	(54/40)	(46/37)	(42/38)	(58/52)	(48/39)	(46/35)	
Heart Rate (Number)	141	142	132	147	144	135	132	138	132	140	120	
Resp. Rate (bpm) (Over 1 Minute) *		46	42	46	(41)	(38)	(52)	(48)	(42)	(31)	(42)	
Resp Rate (Number)	30											
Resp Distress	PIA	RA	RA	RA	PIA	PIA	PIA	PIA	PIA	PIA	PIA	PIA
Receiving O ₂ (l/min)		100%	96%	96%	98%	100%	95%	100%	100%	100%	100%	100%
O ₂ Saturations (%)												
Conscious Level	C	C	C	C	C	C	C	C	C	C	C	C
GCS *	N	N	N	N	N	N	N	N	N	N	N	N
TOTAL SCORE	0	0	0	0	0	0	0	0	0	0	0	0
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	g	g	g	g	g	g	g	g	g	g	g	g
ACTIONS	Score 1 : Continue normal observation by staff nurse Score 2 : Shift in charge nurse to be informed and continue hourly observations Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue. Score 4 : Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see Score 5 & 6 : Shift incharge and PICU /NICU fellow or PICU/NICU consultant to be informed											
NB: 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)

6

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 19/05/26	Time: 8 AM	10 AM	12 PM	2 PM	4 PM	6 PM	8 PM	10 PM	12 AM	2 AM	4 AM	6 AM
Doctor/Nurse/Family Concern?	AM	AM	PM	PM	PM	PM	PM	PM	AM	AM	AM	AM

Temperature (F)	104	103	102	101	100	99	98	97	96	95	94	
	36.6°C	36.9°C	36.7°C	36.5°C	36.5°C	36.5°C	36.5°C	36.5°C	36.5°C	36.5°C	36.5°C	36.5°C

Heart Rate (bpm) and Blood Pressure (mmHg) *	190	180	170	160	150	140	130	120	110	100	90	80	70	60	50
Note: BP does not score in early warning scoring	61/40	56/41	55/41	55/41	55/41	55/41	55/41	55/41	55/41	55/41	55/41	55/41	55/41	55/41	55/41
Heart Rate (Number)	132	140	141	123	140	143	140	132	128	137	136	127			

Resp. Rate (bpm) (Over 1 Minute) *	70	60	50	40	30	20	10					
Resp Rate (Number)	33	40	42	36	42	40	36	33	39	36	31	36

Resp Distress	Mod/ Severe None / Mild	RA	RA	RA	R/A	R/A	R/A	R/A	RA	RA	RA	RA	RA
Receiving O ₂ (l/min) O ₂ Saturations (%)		100%	98%	100%	99%	99%	99%	98%	99%	99%	98%	99%	
Conscious Level	Normal Altered	R	N	N	N	N	N	N	N	N	N	N	
GCS *		15	15	15	15	15	15	15	15	15	15	15	
TOTAL SCORE		0	0	0	0	0	0	0	0	0	0	0	
Number of shaded boxes		0	0	0	0	0	0	0	0	0	0	0	
Pain Score		0	0	0	0	0	0	0	0	0	0	0	
Observer's Initials		AM	AM	AM	AM	AM	AM	AM	AM	AM	AM	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 incharge and PICU /NICU fellow or PICU/NICU consultant to be informed

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

- The paediatric Early Warning Score i) seeks to identify the abnormal physiological finding seen during serious childhood illnesses and ii) offers a method to interpret such physiological derangements with clearly defined actions, ensuring that suitably experienced staff are involved with the care of the sickest children.
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- 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

20/5/26

Date:	Time:	8	10	12	2	4	6	8	10	12	2	4	6
Doctor/Nurse/Family Concern?		Am	Am	Pm	Pm	Pm	Pm	Pm	Pm	Pm	Pm	Pm	Pm

Temperature (F)	104													
	103													
	102													
	101													
	100													
	99													
	98													
	97													
	96													
	95													
	94													

Heart Rate (bpm) and Blood Pressure (mmHg) *	190													
	180													
	170													
	160													
	150													
	140													
	130													
	120													
	110													
	100													
	90													
	80													
	70													
	60													
50														

Heart Rate (Number)	150	150	152	135	150	143	140	158	155	152	135	134
---------------------	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----

Resp. Rate (bpm) (Over 1 Minute) *	70												
	60												
	50												
	40												
	30												
	20												
	10												

Resp Rate (Number)												
--------------------	--	--	--	--	--	--	--	--	--	--	--	--

Resp Distress	Mod/ Severe	None / Mild	RA	R/A	R/A	R/A	R/A	R/A	R/A	R/A	R/A	R/A
---------------	-------------	-------------	----	-----	-----	-----	-----	-----	-----	-----	-----	-----

Receiving O ₂ (l/min)	O ₂ Saturations (%)	98%	97%	99%	99%	99%	97%	98%	97%	98%	100%	98%
----------------------------------	--------------------------------	-----	-----	-----	-----	-----	-----	-----	-----	-----	------	-----

Conscious Level	Normal	Altered	C	C	C	C	C	C	C	C	C	C
-----------------	--------	---------	---	---	---	---	---	---	---	---	---	---

GCS *			N	N	N	N	N	N	N	N	N	N
-------	--	--	---	---	---	---	---	---	---	---	---	---

TOTAL SCORE	Number of shaded boxes	0	0	0	0	0	0	0	0	0	0	0
--------------------	------------------------	---	---	---	---	---	---	---	---	---	---	---

Pain Score		0	0	0	0	0	0	0	0	0	0	0
------------	--	---	---	---	---	---	---	---	---	---	---	---

Observer's Initials		B	SP	SP	SP	SP	SP	SP	SP	SP	SP	SP
---------------------	--	---	----	----	----	----	----	----	----	----	----	----

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

- The paediatric Early Warning Score i) seeks to identify the abnormal physiological finding seen during serious childhood illnesses and ii) offers a method to interpret such physiological derangements with clearly defined actions, ensuring that suitably experienced staff are involved with the care of the sickest children.
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Record Details when EARLY WARNING SCORE > 3			Record Time of Review and Plan		
Date	Time	Early Warning Score	Date	Time	Name

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



21/5/26

(8)

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date:	Time:	8	10	12	2	4	6	8	10	12	2	4	6
Doctor/Nurse/Family Concern?		AM	AM	PM	PM	PM	PM	PM	PM	AM	AM	AM	AM

Temperature (F)	104													
	103													
	102													
	101	36.5	36.5	36.5	36.5	36.5	36.5	36.5	36.5	36.5	36.5	36.5	36.5	
	100													
	99													
	98													
	97													
	96													
	95													
	94													

Heart Rate (bpm) and Blood Pressure (mmHg) *	190												
	180												
	170												
	160												
	150												
	140												
	130												
	120												
	110												
	100												
	90												
	80												
	70												
	60												
50													

Note:
 BP does not score in early warning scoring

Heart Rate (Number)	136	(157)	(140)	(155)	(160)	(142)	(140)	144	151	126	128	130
Resp Rate (bpm) (Over 1 Minute) *												
Resp Rate (Number)	48	(52)	(38)	(39)	(40)	(22)	(39)	48	48	48	48	48

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

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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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)

DH-00045624 IP25-00020339
 Baby B/O SYED AAMINA FARHEEN
 8-05-2026 0 Y 0 M 13 D (F)
 Dr. KALYAN CHAKRAVARTHY KONDA



22/5/26

Doc. No. : RCHBH / FRM / CLINICAL / 124

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

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date:	Time:	8	10	12	2	4	6	8	10	12	2	4	6
Doctor/Nurse/Family Concern?		AM	AM	PM	PM	PM	PM	PM	PM	AM	AM	AM	AM
Temperature (F)	104												
	103												
	102												
	101	36.5											
	100		36.5										
	99			36.5									
	98				36.5								
	97												
	96												
	95												
	94												
Heart Rate (bpm)	190												
	180												
	170												
	160												
	150												
	140												
	130												
	120												
	110												
	100												
	90												
	80												
	70												
	60												
	50												
Heart Rate (Number)		128	138	148	143	142	133	142	138	152	147	154	172
and													
Blood Pressure (mmHg) *	130												
	120												
	110												
	100												
	90												
	80												
	70												
	60												
	50												
Note: BP does not score in early warning scoring													
Resp. Rate (bpm) (Over 1 Minute) *	70												
	60												
	50												
	40								46	36	38	42	46
	30												
	20												
	10												
Resp Rate (Number)		48	45	44	49	49	42	41	38	37	37	38	38
Resp Distress	Mod/ Severe	R/A	R/A	R/A	R/A	R/A	R/A	R/A	RA	RA	RA	RA	RA
	None / Mild												
Receiving O ₂ (l/min)													
O ₂ Saturations (%)		100%	98%	98%	98%	99%	100%	100%					
Conscious Level	Normal	C	C	C	C	C	C	C	C	C	C	C	C
	Altered												
GCS *		N	N	N	N	N	N	N	N	N	N	N	N
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		Q	A	A	A	A	A	A	A	A	A	A	A
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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Intensive Care Unit
Clinical Presentation Format for Nurses & Doctors

Name: Baby B/O SYED AAMINA FARHEEN
DOB: 08-05-2026
GEST AGE: 0 Y 0 M 0 D 3 H (F)
Dr. KALYAN CHAKRAVARTHY KONDA



Sheet No. ①

Maternal Blood Group : B+ve
Baby's Blood Group : O+ve
Birth Weight : 1.560 kg

Date : 8/5/26	Date : 9/5/26	Date : 10/5/26
DOL NB Weight 1.560 kg	DOL D1 Weight 1.506 kg (↓ 54gr)	DOL D2 Weight 1.457 kg ↓ 49gr
Problems : PT/RDS/LBW	Problems : PT/RDS/LBW	Problems : PT/RDS/LBW
Rs. 30-60 6/min Exam Done Vent, Setting CPAP ABG } 1 ABG CXR } 1 VRG	Rs. 30-60 b/min Exam Done Vent, Setting C-PAP ABG } nil CXR } nil	Rs. 30-60 b/min Exam Done Vent, Setting CPAP ABG } nil CXR } nil
CVS Normal HR 120-160 6/min BP 7/60 Map 63 Cap Refil 2cc	CVS Normal HR 120-160 b/min BP 7/130 Map 49 Cap Refil 2cc	CVS Normal HR 120-160 b/min BP 7/157 Map 150 Cap Refil 2cc
F/E/N 60 cc/kg/day T.Fluids (CC/kg/day) I/O/RBS : 7mg/dl U Output : (CC/Kg/hr) Exam T Bil/D Na HC03 K BUN Cl Crea Hemat HB : WCC Plants Transfusion	F/E/N 60 cc/kg/day T.Fluids 84.6ml (CC/kg/day) 54 cc/kg/day I/O/RBS : 140 U Output : (CC/Kg/hr) 80 ml (3 cc/kg/hr) Exam T Bil/D Na HC03 K BUN Cl Crea Hemat HB : WCC Plants Transfusion	F/E/N 60 cc/kg/day T.Fluids 94.1 ml (CC/kg/day) 60.3 cc/kg/day I/O/RBS : 75 mg/dl U Output : (CC/Kg/hr) 2.5 cc/kg/hr Exam T Bil/D Na HC03 K BUN Cl Crea Hemat HB : WCC Plants Transfusion
C/s Results CRP Antibiotics inj. piptaz	C/s Results CRP Antibiotics inj. piptaz	C/s Results CRP Antibiotics inj + piptaz
Meds Neuro : inj. carbice	Meds Neuro : inj. caffeine	Meds Neuro : inj + caffeine
Assessment Done	Assessment Done	Assessment Done
Plan G-RBS 6th hourly	Plan GRBS 6th hr	Plan RBS → BD.

Intensive Care Unit
Clinical Presentation Format for Nurses & Doctors

Name : **Baby B/O SYED AAMINA FARHEEN**
DOB : **08-05-2026** 0 Y 0 M 0 D 19 H (F)
GEST AGE : **Dr. KALYAN CHAKRAVARTHY KONDA**

FDH-00045624 IP25-00020339


Sheet No **2**

Maternal Blood Group : **B +ve**
Baby's Blood Group : **O +ve**
Birth Weight : **1.560 kgs**

Date : 11/5/26	Date : 12/5/26	Date : 13/5/26
DOL D3 Weight 1.402kg (+55g)	DOL D4 Weight 1.348 (+54gms)	DOL D5 Weight 1.344 (+4gms)
Problems : PT/RDS/LBW	Problems : Expt/RDS/LBW	Problems : Expt/Paps/LBW
Rs. 30-60 btlmt Exam Done Vent, Setting HFNC ABG Nil CXR Nil	Rs. 30-60 btlmt Exam Done Vent, Setting HFNC +lit ABG Nil CXR Nil	Rs. 30-60 btlmt Exam done Vent, Setting HFNC ABG Nil CXR Nil
CVS Normal HR 120-160 btlmt BP 74/40 Map (53) Cap Refil < 2-3 sec	CVS Normal HR 120-160 btlmt BP 59/44 Map (48) Cap Refil < 2-3 sec	CVS Normal HR 120-160 btlmt BP 51/39 Map (46) Cap Refil < 2-3 sec
F/E/N TV - 80 cc/kg/day T.Fluids 120.9 ml (CC/kg/day) 77.5 cc/kg/day I/O/RBS : 82 mg/dl U Output : (CC/Kg/hr) 3.1 cc/kg/hr Exam 3.1 cc/kg/hr T Bil/D Na HC03 K BUN Cl Crea Hemat HB : WCC Plants Transfusion	F/E/N TV - 100 cc/kg/day T.Fluids 171.7 ml (CC/kg/day) 110 cc/kg/day I/O/RBS : 113 mg/dl U Output : (CC/Kg/hr) 125ml Exam 3.3 cc/kg/hr T Bil/D Na HC03 K BUN Cl Crea Hemat HB : WCC Plants Transfusion	F/E/N TV - 120 cc/kg/day T.Fluids 193 ml (CC/kg/day) 123 cc/kg/day I/O/RBS : 77 mg/dl U Output : (CC/Kg/hr) 130 ml Exam 3.4 cc/kg/hr T Bil/D Na HC03 K BUN Cl Crea Hemat HB : WCC Plants Transfusion
C/s Results CRP Antibiotics Inj: piptaz	C/s Results CRP Antibiotics Inj: piptaz	C/s Results CRP Antibiotics Inj: piptaz
Meds Inj: Caffeine Neuro : Domstal drops	Meds Inj: Caffeine Neuro : Dorolac sachet Domstal syp	Meds Inj: piptaz Neuro : Inj: Caffeine Dorolac sachet Syp Domstal
Assessment Done	Assessment Done	Assessment Done
Plan GRBS - BD	Plan GRBS BD	Plan RBS - BD

Faint handwritten notes at the top of the page, possibly including a date and patient information.

Section of handwritten notes in the middle of the page, containing several lines of text.

Section of handwritten notes below the middle, featuring some red ink markings and numbers.

Section of handwritten notes in the lower middle part of the page, with some red ink used for emphasis.

Final section of handwritten notes at the bottom of the page, including a signature or date.

Intensive Care Unit
Clinical Presentation Format for Nurses & Doctors

FDH-00045624 IP25-00020339
Baby B/O SYED AAMINA FARHEEN
08-05-2026 0 Y 0 M 5 D (F)
Dr. KALYAN CHAKRAVARTHY KONDA

Sheet No. 3

Name :
DOB :
GEST AGE :



Maternal Blood Group : B+ve
Baby's Blood Group : O+ve
Birth Weight : 1.560 kg

Date : 14/5/26	Date : 15/5/26	Date : 16/5/26
DOL D6 Weight 1.350 ↑ 6gms	DOL D7 Weight 1.365 (↑15gms)	DOL D8 Weight 1.385 (↑20gms)
Problems : Expt/ARDS/LBCO	Problems : PT/LBW/ARDS	Problems : PT/LBW/ARDS
Rs. 30-60 b/min Exam done Vent, Setting R/A ABG Nil CXR Nil	Rs. 30-60 b/min Exam done Vent, Setting R/A ABG Nil CXR Nil	Rs. 30-60 b/min Exam done Vent, Setting R/A ABG Nil CXR Nil
CVS Normal HR 120-160 b/min BP 60/31 Map (42) Cap Refil 2.2 sec	CVS Normal HR 120-160 b/min BP 59/33 Map (41) Cap Refil 2.2 sec	CVS Normal HR 120-160 b/min BP 59/30 Map (40) Cap Refil 2.2 sec
F/E/N 140 CC/kg/day T.Fluids 219.3 ml (CC/kg/day) 140 CC/kg/day I/O/RBS : 105 mg/dL U Output : (CC/Kg/hr) 104 ml Exam [2.7 ml/h] T Bil/D Na HC03 K BUN Cl Crea Hemat HB : WCC Plants Transfusion	F/E/N 150 CC/kg/day T.Fluids 234.3 ml (CC/kg/day) 150 CC/kg/day I/O/RBS : 121 mg/dL U Output : (CC/Kg/hr) 112 ml Exam 2.9 cc/kg/day T Bil/D Na HC03 K BUN Cl Crea Hemat HB : WCC Plants Transfusion	F/E/N 150 CC/kg/day T.Fluids 219.1 ml (CC/kg/day) 140 CC/kg/day I/O/RBS : 112 mg/dL U Output : (CC/Kg/hr) 102 ml Exam 2.7 cc/kg/day T Bil/D Na HC03 K BUN Cl Crea Hemat HB : WCC Plants Transfusion
C/s Results	C/s Results	C/s Results
CRP Antibiotics Imi Cefazolin	CRP Antibiotics Imi-ceftio	CRP Antibiotics
Meds Domstal Neuro : Glycyline Dorabac	Meds Domstal Dorabac Neuro :	Meds Imi-ceftio Domstal Dorabac Neuro :
Assessment Done	Assessment Done	Assessment Done
Plan GRBS OD	Plan GRBS OD	Plan GRBS OD

Intensive Care Unit
Clinical Presentation Format for Nurses & Doctors

Sheet No. **4**

Name : **Baby B/O SYED AAMINA FARHEEN**
DOB : **08-05-2026** **0 Y 0 M 8 D** (F)
GEST AGE : **Dr. KALYAN CHAKRAVARTHY KONDA**

Maternal Blood Group :
Baby's Blood Group :
Birth Weight :



Date : 17/5/26	Date : 18/5/26	Date : 19/05/26
DOL Dg Weight 1.380 ↓ 5gms	DOL Dio Weight 1.429 ↑ (49gms)	DOL Du Weight 1.394 ↓ 35gms
Problems : PT/LBW/RDS	Problems : PT/LBW/RDS	Problems : PT/LBW/RDS
Rs. 30-60 blm Exam Done Vent, Setting RIA ABG] Nil CXR] Nil	Rs. 30-60 blm Exam Done Vent, Setting RIA ABG] Nil CXR] Nil	Rs. 30-60 blm Exam Done Vent, Setting RIA ABG] Nil CXR] Nil
CVS Normal HR 120-180 blm BP 88/30 Map (44) Cap Refil L2sec.	CVS Normal HR 120-160 blm. BP 68/34 Map (45) Cap Refil L2sec.	CVS Normal HR 120-160 blm BP 85 Map 46 Cap Refil L2sec
F/E/N 150 cc/kg/day T.Fluids 168 ml (CC/kg/day) 112 cc/kg/day I/O/RBS : 96 mg/dl U Output : (CC/Kg/hr) 3.0 cc/kg/hr Exam (110ml) T Bil/D Na HC03 K BUN Cl Crea Hemat HB : WCC Plants Transfusion	F/E/N 150 cc/kg/day. T.Fluids 226 ml (CC/kg/day) 150 cc/kg/day I/O/RBS : 87 mg/dl U Output : (CC/Kg/hr) (114 ml) Exam 3.0 cc/kg/day T Bil/D Na HC03 K BUN Cl Crea Hemat HB : WCC Plants Transfusion	F/E/N 150 cc/kg/day T.Fluids 228 ml (CC/kg/day) 152 cc/kg/day I/O/RBS : 112 mg/dl. U Output : (CC/Kg/hr) 3.3 cc/kg/hr. Exam (120ml) T Bil/D Na HC03 K BUN Cl Crea Hemat HB : WCC Plants Transfusion
C/s Results CRP Antibiotics	C/s Results CRP Antibiotics	C/s Results CRP Antibiotics
Meds Sup: Domstal Sup: Darolac Neuro :	Meds Sup: Domstal Sup: Darolac. Neuro :	Meds Sup: - Domstal Sup: - Darolac. Neuro :
Assessment Done	Assessment Done	Assessment Done
Plan GIRBS-OD	Plan GIRBS-OD	Plan GIRBS-OD

Page
Date

1. Introduction

The purpose of this report is to analyze the current market conditions and provide recommendations for the future.

The market has shown significant volatility in the past few months, with a general downward trend in most sectors.

Key factors influencing the market include inflationary pressures, supply chain disruptions, and changes in consumer behavior.

Based on the analysis, it is recommended that the company focus on cost reduction and diversification of its product line.

These strategies will help the company maintain its competitive edge in a challenging market environment.

The report concludes that while the market remains uncertain, proactive management and strategic planning are essential for long-term success.

Intensive Care Unit
Clinical Presentation Format for Nurses & Doctors

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Baby B/O SYED AAMINA FARHEEN
8-05-2026 0 Y 0 M 10 D (F)

Sheet No. **5**

Name : **Dr. KALYAN CHAKRAVARTHY KONDA**

Maternal Blood Group : **B + ve**

DOB : 

Baby's Blood Group : **O + ve**

GEST AGE :

Birth Weight : **1.560kg**

Date : 20/5/26	Date : 21/5/26	Date : 22/5/26
DOL D12 Weight 1.413kg ↑ 19gr	DOL D13 Weight 1.419kg ↑ 6grams	DOL D14 Weight 1.493kg ↑ 74grams
Problems : PT/RDS/LBW	Problems : PT/RDS/LBW	Problems : PT/RDS/LBW
Rs. 30-60 b/m Exam Done Vent, Setting RA ABG Nil CXR Nil	Rs. 30-60b/m Exam Done Vent, Setting RA ABG Nil CXR Nil	Rs. 30-60b/m Exam Done Vent, Setting RA ABG Nil CXR Nil
CVS normal HR 120-160b/m BP Map Cap Refil < 2 sec	CVS Normal HR 120-160b/m BP 51/39 Map (42) Cap Refil < 2 sec	CVS Normal HR 120-160b/m BP Map Cap Refil < 2 sec
F/E/N 180 ccl/kg/day T.Fluids 239ml (CC/kg/day) 171.9 ccl/kg/day I/O/RBS : 96 mg/dL U Output : (CC/Kg/hr) (105ml) Exam 3.1 ccl/kg/hr T Bil/D Na HC03 K BUN Cl Crea Hemat HB : WCC Plants Transfusion	F/E/N 160 ccl/kg/day T.Fluids 240ml (CC/kg/day) (153.8 ccl/kg/day) I/O/RBS : 89 mg/dL U Output : (CC/Kg/hr) (98ml) Exam (2.6 ccl/kg/hr) T Bil/D Na HC03 K BUN Cl Crea Hemat HB : WCC Plants Transfusion	F/E/N 160 ccl/kg/day T.Fluids 240ml (CC/kg/day) (153.8 ccl/kg/day) I/O/RBS : 94 mg/dL U Output : (CC/Kg/hr) (116ml) Exam 3.0 ccl/kg/hr T Bil/D Na HC03 K BUN Cl Crea Hemat HB : WCC Plants Transfusion
C/s Results	C/s Results	C/s Results
CRP	CRP	CRP
Antibiotics	Antibiotics	Antibiotics
Meds Syp Domstal Syp Ossopan-D Neuro : Syp Vit-D3	Meds Syp Domstal Syp Ossopan-D Neuro : Syp Vit D3	Meds Syp Domstal Syp Ossopan-D Neuro : Syp Vit D3 HMP 1/2
Assessment Done	Assessment Done	Assessment Done
Plan CRBS - OD	Plan CRBS - OD	Plan CRBS - OD

