

ADMISSION SHEET

Registration Details :

Admission No : IP25-00020669 Admit Date : 27-May-2026 Admit Time : 02:46 PM UHID : FDH-00046352

Patient Details :

Patient Name : Baby B/O INDRANI P Age : 0 D
Guardian : Mr PRAVEEN KUMAR DOB : 27-05-2026 01:19 PM
Gender : Male Religion :
Occupation : Martial Status :
Address (H) : block g flat 505 mayfair apartments tellapur
Ramachandra puram Sangareddy Telangana
INDIA 502032 Phone No : 9502285551/
E-mail : 9502285551@dummy

Admission Details :

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

Contact Details :

Name : Mr PRAVEEN KUMAR Relationship : Father
Contact Address : block g flat 505 mayfair apartments tellapur
Ramachandra puram Sangareddy Telangana
INDIA 502032 Phone No : /9701114454


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

DA
(M)
5-00020669

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

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

Dear Parent,

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

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

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

Your baby will receive the test below.

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

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

CONSENT

FDH-00046352 IP25-00020669
Baby B/O INDRANI P
27-05-2026 0 Y 0 M 0 D 21 H (M)
Dr. KALYAN CHAKRAVARTHY KONDA



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

P. Lakshmi

Signature of Parent/Legal Guardian

Date

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

Signature of Parent/Legal Guardian

Date


ACTIVITY RECORD FOR BILLING

DH-00046352 IP25-00020669

Baby B/O INDRANI P

Name: --- 27-05-2026 0 Y 0 M 0 D 4 H (M) -----

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
27/5/26	7:29 pm	MICU	ward	Priyanka

Cross Consultation Visit

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

EDH-00046352
 Baby B/O INDRANI P
 27-05-2026
 Dr. KALYAN CHAKRAVARTHY KONDA
 IP25-00020669
 OYOMODAH (M)

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 Indrani Mother's Blood Group : A Positive
 Gender : M F Blood Group :
 Date of Birth : 27/5/26 Time of Birth : 1:19pm
 Place of Birth : RCMFD Birth Weight (gms) : 2.624kg Length (cms) :
 OFC (cms) : Estimated Gesth Age : 36+4
 Current Obstetric History : (Booked / Unbooked Case)
 Maternal Age : Ht : Wt : BMI : Married Life : LMP : EDD :
 Conception : Spontaneous or with Rx :
 Booked at what GA : AN Steroids Drugs / Doses :
 Last Scans Details : 23/5 - 36wks, Cephalic ? AFI - 11cm, EFW ~ 2.5kg,
Doppler - @ TT Immunization and Iron / Folic Acid :

MATERNAL RISK FACTORS

Age : <input type="checkbox"/> <18 yrs <input type="checkbox"/> > 35yrs <u>PPROM</u> Consanguinity : <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, degree of consanguinity : <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 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 / Redistrbution in MCA) / Ductus Venosus : AFI :	H/o GDM/ pre GDM/ on diet or insulin <u>on OHA</u> Controlled or not, recent values, HbA1 values : Compliance with Rx : Scans : <u>LGA, TIFFA, Fetal Echo</u> H/o Hypothyroidism : when diagnosed ? Medication? <u>Conception - 37.5kg</u> 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 : 6 hrs Uterine Tenderness Foul Smelling liquor VS (if taken) - Results :
 Medication during Pregnancy : Duration :
8 AM Today

PAST OBSTETRIC HISTORY

G: 2 P: 1 A: L: 1

Sl. No.	Age	GA wks	B. W	Gender	Significant	Details
1	3yr	term	2.25kg	F	A&M	
2	pp					

PERINATAL HISTORY

Treating Obstetrician : Hospital : Inborn Outborn

Duration of Labour

First stage (> 18 hours sig) AVD

Second stage (> 2 hours after dilation) mini

LSCS : Elective Emergency Indication : 1 hour around

Specify the reason : reck

Augmentation of Labour : Induced Assisted Vaginal

CTG : Normal Suspicious Pathological

MSL :

Resuscitaion : Yes No

Cord ABG :

Placenta : (weight, surface, No. of cotyledons, calcifications, malformations, clots etc :

NEONATAL RESCUSTITION DETAILS

APGAR SCORE

Gestational Age : 36+4 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>8/10</u>	<u>4/10</u>	

TOTAL

Comments :

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

POSTNATAL / HISTORY OF PRESENT ILLNESS

Chief Complaints :

History of Present Illness:

Baby delivered in warmer

↓

CZAB

↓

CLT 1A. good

↓

Inf Vit K in given

↓

shift to Mother side

Investigation details in previous Hospital :

Feeding History :

Past History :

Family History :

Socio Economic History :

GENERAL EXAMINATION ON ADMISSION

General Disposition :

No gross cong. anomalies

Caput (+)

VITALS : Temperature : ~~136~~ 36.5 HR : 136 RR : 38 NIBP : CFT : 23 sec

Color of the extremities : Acrocyanosis

Jaundice : Pallor : SpO2 : 97%

Anthropometry : Birth Weight : 2.62 kg Length : HC : Present Weight :
Ponderal Index : (A) SGA : LGA :

HEAD TO TOE EXAMINATION

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

caput (+)

Facies :
(Any Facial Dymorphism)

(a)

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

EYES : Symmetry :
Red Reflex : *→ To check*
Discharge :

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

(a)

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

(a)

ABDOMEN and UMBILICUS : Shape :
Organomegaly :
Bowel Sounds :
Umbilical Stump :
Discharge :

(a) 2A + IV

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

(a) 3 Lc Testi descended

HERNIAL ORIFICES

TRUNK and SPINE :

SKIN LESIONS :

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

(a)

SYSTEMIC EXAMINATION

Respiratory System :

Breathing Pattern : Regular Periodic Shallow Gasping

B/LC A/E ⊕

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

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

Mention if baby is on : Hood box CPAP Ventilator

Settings :

Spo2 : Auscultation : Breath Sounds : Added Sounds :

Cardiovascular System :

HR : BP : Precordial Activity : *S1S2 ⊕*

Femoral Pulses : Murmurs :

Other Peripheral Pulses : Signs of Cardiac Failure :

Abdomen :

Shape : Hernia prifice : *1 ⊕*

Palpation : Anal Patency : *2 A+IV*

Palpable masses : *1 ⊕* Umbilical Cord : *2 A+IV*

Abdominal girth : First urine passed : *1/20 of 1st urine*

Meconium passed : *1/20 of 1st urine*

Nervous System : Higher intellectual functions (Sensorium) :

State of wakefulness : *awake*

Prechtle Score :

Nerves :

d+LA-good

Motor System :

Passive Tone :

Active Tone :

Neonatal Reflexes :

Grasp : Palmar Plantar Sucking Rooting Crossed adductor :

Moro's : *complete* DTR :

ATNR : Skull and Spine :

Any Congenital Anomalies :

Diagnosis : Lab PT / Male / AGA / IDM
(36+4)

FOOT PRINTS

Left Side :



Right Side :



Resident Doctor :

Signature : MS
Name : Dr Mohib
Date & Time : 27/5/21

Consultant :

Signature : kp
Name : Dr Kalpana
Date & Time : 27/5/21

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 : *MAI / 10-10-10 / 06/4/10 / 79/100 / (21/10)*

Present Issues :

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

Any Oxygen requirement :

Systemic :

Medications : ① DBF

② Vaccinate - BCG, OPV, MZB

③ SBR, NBS, OPE @ 48 HOURS

Plan during ward follow up : ④ GRBS - ✓, 3, 8, 12, 24, 48 HOURS

(21/10 inform)
Prefeed

10/10

Feeding Plan at the time of shifting :

Screenings done during NICU Stay :

NSG :

Hearing Screen :


ROP :

TFT :

NP2 :

①

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
28/5/2026 9 AM	C/S/B Pg. Kalyan D. Sreeth	
	A: 20M / Pak Preterm	Mchil AGA / DM / AVD
	A/C: stable CRT < 3sec	
	GRPAT: good	MBG A+
	N Newborn examination	BBB B+
		Plan Wt 2624g (42g) Flwt 2626g
		- DBF 2h only
		- OAE
		- Vaccination
		- Red reflex
		- Pulse Oximetry screen
		- SBR, WBS @ 11m 6am
		- w/f Vomiting
		↓ Inform
		- GRBS @ 20m, 48 H.
		



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
28/5	S/s. <u>Dr. Vinodha (LC/PT)</u>	
	Breastfeeding counselling given	
28/5/2026 4pm	C/S by <u>Dr. Sneha</u>	
	<u>27HOL</u> / <u>late preterm</u> / <u>1 Day</u>	
	GL: stable CRT < 3 sec CR/AT: Good,	no further <u>workings</u>
	<u>Vitals</u>	
	HR: 136/min	<u>Plan</u>
	RR: 44/min	
	temp: 36.5°C	- DBF 2 hourly
	SpO2: 98% RA	- SBR, NBS Tm <u>6Am</u>
	OAE Red reflex Vaccination Pulse Ox screen } done.	



2

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
29/5/26 9:45 am	CP&B Dr Kalyan	
	Icteric :- late preterm / wch / AgA / BDM / AvD / NNT	
	Bwt / 2.624 kg	U / -
	TWt / 1.520 kg	H / AP
	wt base 10%	B / BT
	on DBF → feeding well.	
	glc :- eutroemic / Euglycemic	
	C/T/A good	
	Icteric.	
	S/E :- (N) acutal examination	
		Plan
		→ Lactational counselling
		C/O/O nipple crack)
		→ Start DSPT
		(C eyes / genitalia covered)
		→ DBF / warm care.
		→ Stop G/RBS monitoring

PATIENT TRANSFER FORM

DH-00046352 IP25-00020669

Baby B/O INDRANI P

27-05-2026 0 Y 0 M 0 D 4 H (M)

Dr. KALYAN CHAKRAVARTHY KONDA



Date & Time of Admission <i>27/5/26 @ 2:46 pm</i>	Date & Time of Transfer Order <i>27/5/26 @ 7:30 pm</i>	
Treating Consultant Name <i>Dr. Udita</i>	Transfer Ordered by <i>Dr.</i>	Reason for Transfer <i>post op</i>
From Unit <i>MICU</i>	To Unit <i>ward</i>	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Number of Sheets in Clinical File <i>15</i>	Number of Imaging Films <i>OP-1</i>	Personal belongings including clinical documents. If any handed over to attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.		
2.		
3.		
4.		
5.		

Shifting Summary / Notes Written by Doctor : Yes No

Name & Signature of Person who is Transferring <i>Priyanka</i>	Name of Person Ordered Transfer <i>Dr. Kalyan</i>
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Patient & Clinical Records Received by :

Laugheji

Date & Time of Patient Received :

27/5/26 7:44 pm

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

- Unavailable Bed Nurse not Available Available Bed not ready

