

DISCHARGE SUMMARY

| | | | |
|------------------------|--|-----------------------|------------------------|
| Name | B/O SHRUTI JAISWAL | UHID | FDH-00046288 |
| Father/Guardian | Mr MUDIT GARG | Age/Gender | 0 Y 0 M 0 D 41 H/ Male |
| Address | kokapet poulomi avantee, Gandhipet Road, Hyderabad, Telangana, INDIA, 500075 | | |
| IP No | IP25-00020619 | Admission Date | 25-05-2026 |
| 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

TERM / AGA / EMERGENCY LSCS / BABY BOY / CIAB/ FILAR CYST

History: B/O SHRUTI JAISWAL, is a term (38 weeks + 4 days) baby boy, delivered to a PRIMI mother by Emergency LSCS (Ind : In view of Non - progression of labour) on 25.05.2026 at 04:29 pm with birth weight of 2.824 kgs in Rainbow Children's Hospital, Financial District, Hyderabad. Baby cried immediately after birth. APGAR scores were 8/10 at 1 min, 9/10 at 5 min. Inj. Vitamin K 1mg IM was given after delivery. Delayed cord clamping done. Fetal presentation was Vertex.

| | | | |
|-------|--------------------|----------------|--------------|
| Name | B/O SHRUTI JAISWAL | UHID | FDH-00046288 |
| IP No | IP25-00020619 | Admission Date | 25-05-2026 |

Maternal History: Mrs. SHRUTI JAISWAL, is a 33 years old PRIMI mother.

G1 - Present pregnancy, spontaneous conception, had regular Antenatal checkup's, received 2 doses of Injection. Tetanus Toxoid. Antenatal scans were normal. No history of Pregnancy Induced hypertension/ Urinary Tract Infection/ Antepartum Hemorrhage/ Hypothyroidism/ Gestational Diabetes Mellitus/ Oligohydramnios/ Polyhydramnios/ Prolonged Rupture Of Membranes/ Fever. Mother's Blood group is "B" positive. Baby's blood group is "B" positive.

Examination: Baby was euthermic. Maintaining saturations at 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. On examination pre sacral dimple with tuft of hair was seen over sacral region and left accessory nipple present. No other obvious external congenital anomalies were noted clinically. All external orifices were patent and open. All neonatal reflexes were normal.

Anthropometry:

Weight at birth : 2.824 kgs.
Weight at discharge : 2.594 kgs.
Head Circumference : 32 cms.
Length : 45 cms.

Investigations: Enclosed reports.

Management:

Course during hospital:

Feeding: Breast feeding was initiated (First feed was given within 30 minutes). Baby tolerated the feeds well.



| | | | |
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Serum bilirubin at 40 hours of life was 7.8 mg/dl with indirect fraction of 7.7 mg/dl.

Vaccination: Baby was given following vaccination:

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

TEOAE (Transient Evoked Otoacoustic Emissions): Hearing test: Done on 26.05.2026 showed Bilateral normal outer hair cells functioning.

Newborn screening advanced : Sent on 27.05.2026, report awaited.

USG Spine was done in view of presacral dimple and tuft of hair on 27.05.2026- showed elongated anechoic cyst like structure measuring 12*2 mm caudal to conus medullaris within the midline filum terminale. Suggestive of **Filar cyst**.

SPO2 : 98% at room air

Red Reflex: Present & Symmetrical

Hip Examination was normal.

Baby tolerating feeds well, hemodynamically stable, passed urine and meconium, hence being discharged with the following advice.

Condition at discharge: Baby is pink, warm, active and on direct breast feeds.



| | | | |
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Advice:

Keep the baby clean & warm
Regular breast feeding every 2nd hourly followed by burping along with measured feeds as advised
Monitor urine output
Immunization as per schedule
Vitamin D3 Drops (1ml/800IU) 0.5ml once daily till further advice (after 5 days of life).
Nasoclear Nasal drops 2 drops in each nostril SOS for nose block.

Plan:

- 1. Newborn screening advanced test to be done on follow up.**
- 2. Serum Bilirubin to be decided on follow up (Last Serum bilirubin at 40 hours of life was 7.8 mg/dl with indirect fraction of 7.7 mg/dl, as per risk stratification chart it is falling in low risk zone).**

Review consultation with Dr. KALYAN CHAKRAVARTHY KONDA, on Friday (29.05.2026) at Financial District with prior appointment **(Review consultation will be charged).**

Review back to Hospital: If baby is not feeding continuously for > 6 hours, If breathing fast, Fever or poor activity or lethargy, Bluish discolouration of lips, Increase in jaundice, Abnormal movements occurs.

The content of the patient discharge summary, medication, food & drug interaction, care to be provided at home, nutrition, immunization and safe parenting, when and how to obtain emergency care etc also have been explained by doctor in a language that I can understand and I acknowledge.



| | | | |
|-------|--------------------|----------------|--------------|
| Name | B/O SHRUTI JAISWAL | UHID | FDH-00046288 |
| IP No | IP25-00020619 | Admission Date | 25-05-2026 |

Parent/Attender

In case of emergency contact 8121039503 emergency pediatrician on duty.

To take appointment for OPD consultation at Rainbow **Financial District / Banjara Hills / Rainbow Clinic Madhapur / Kukatpally / Vikramপুরi / LB Nagar** dial just one toll free number **18002122**.

You can also take appointments at any time by going **online** to our website **www.rainbowhospitals.in**

Dr. Sreen

Registrar/Resident/C.M.O

Consultant:

Dr. Kalyan Chakravarthy Konda,
MBBS, MD, DNB (Pediatrics), DM (Neonatology)
Consultant Pediatrician & Neonatologist
APMC/FMR/76059



ADMISSION SHEET



Registration Details :

Admission No : IP25-00020619 Admit Date : 25-May-2026 Admit Time : 06:20 PM UHID : FDH-00046288

Patient Details :

Patient Name : Baby B/O SHRUTI JAISWAL Age : 0 D
Guardian : Mr MUDIT GARG DOB : 25-05-2026 04:29 PM
Gender : Male Religion :
Occupation : Martial Status :
Address (H) : kokapet poulomi avantee Gandhipet Road Phone No : 9108568034/
Hyderabad Telangana INDIA 500075 E-mail : 9108568034@GMAIL.COM

Admission Details :

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

Contact Details :

Name : Mr MUDIT GARG Relationship : Father
Contact Address : kokapet poulomi avantee Gandhipet Road Phone No : / 7028039818
Hyderabad Telangana INDIA 500075

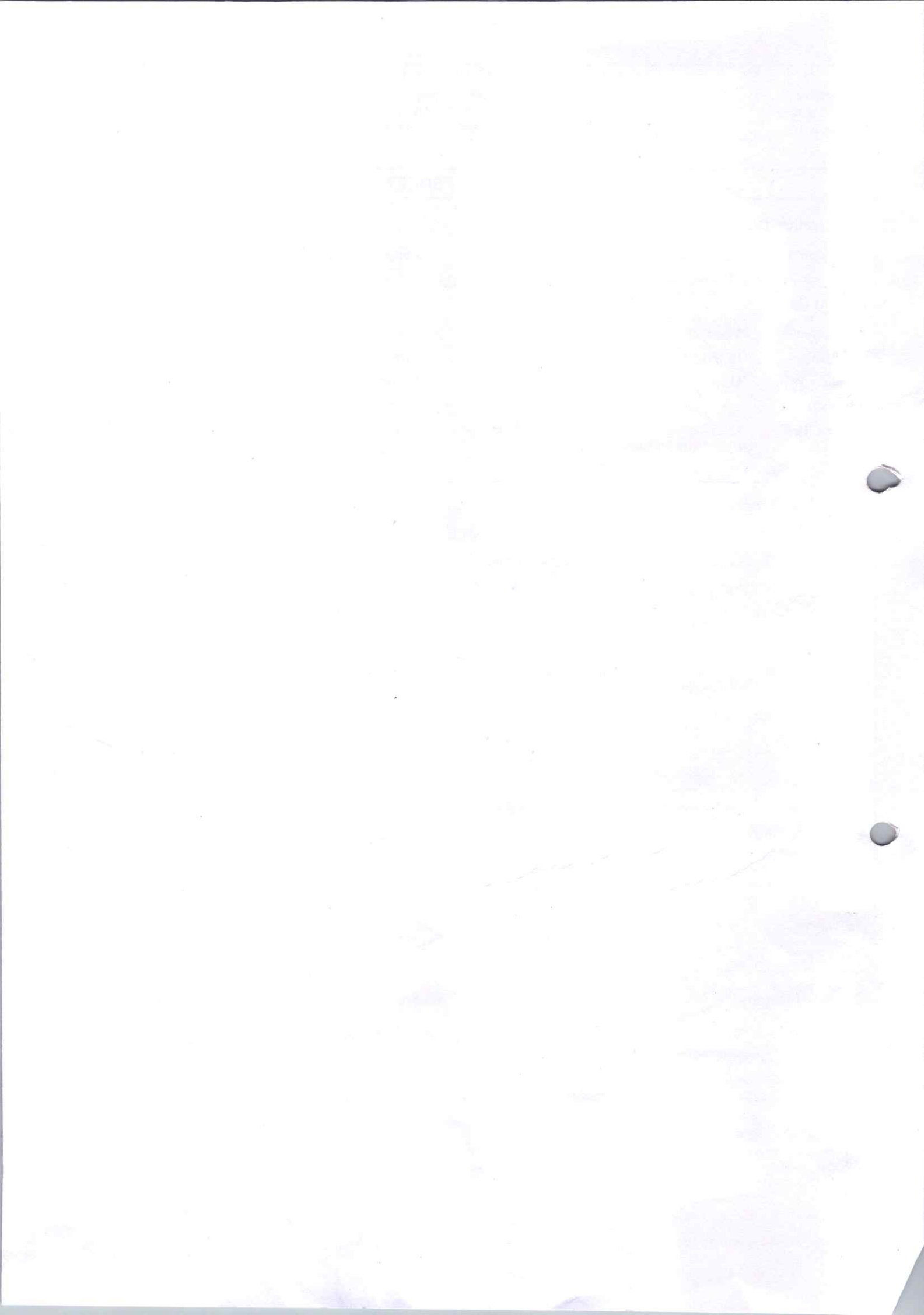

Signature

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





NURSING SHIFT HAND OVER FORM

| | | | | | | | | |
|--|--|--|---|---|---|--|--|--|
| SITUATION | Diagnosis: <i>new born care</i> | Any Infection: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify: | | | | | | |
| | Surgery / Procedure: | Post OP Day: | | | | | | |
| BACKGROUND | Date | <i>25/5/26</i> | <i>25/5</i> | <i>26/5/26</i> | <i>26/05/26</i> | | | |
| | Shift | <i>E</i> | <i>N</i> | <i>MTE</i> | <i>N</i> | | | |
| | Medical Condition (Any special condition to be noted): | <i>NBC</i> | <i>NBC</i> | | <i>-</i> | | | |
| | Diet: | <i>DBF</i> | <i>DBF</i> | <i>DBF</i> | <i>DBM</i> | | | |
| ASSESSMENT | 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 type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | Ventilation (RA, NP, NIV, VENTI): | <i>RA</i> | <i>RA</i> | <i>RA</i> | <i>RA</i> | | | |
| | Tubes/Drains/Catheter: | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | Vital Signs: | Temp: | <i>36°C</i> | <i>36.8°C</i> | <i>38°C</i> | <i>98.4°F</i> | | |
| | | Res: | <i>20</i> | <i>48</i> | <i>11</i> | <i>42</i> | | |
| | | SpO ₂ : | <i>99</i> | <i>98</i> | <i>100</i> | <i>100%</i> | | |
| | | Pulse: | <i>150</i> | <i>148</i> | <i>139</i> | <i>142</i> | | |
| | | BP: | <i>-</i> | <i>-</i> | <i>-</i> | <i>-</i> | | |
| | | LOC: | <i>conscious</i> | <i>C</i> | <i>C</i> | <i>C</i> | | |
| | | Fall Risk Score: | <i>0/10</i> | <i>0/10</i> | <i>0/10</i> | <i>0/10</i> | | |
| | Pain Score: | <i>0/10</i> | <i>0/10</i> | <i>0/10</i> | <i>0/10</i> | | | |
| | Skin Integrity | <i>Good</i> | <i>Good</i> | <i>good</i> | <i>Good</i> | | | |
| 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 type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | Physiotherapy: | | | | <i>-</i> | | | |
| | Others Specify: | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | Special Diet: | <i>DBF</i> | <i>DBF</i> | <i>DBF</i> | <i>DBM</i> | | | |
| | Critical Lab Test / Values: | | | | <i>-</i> | | | |
| | Other Special Orders / Medications: | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | PU Prophylaxis: | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input 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 type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | DVT Prophylaxis: | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input 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 type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| ADL (Dependent / Non Dependent): | <i>dependent</i> | <i>dependent</i> | <i>dependent</i> | <i>dependent</i> | | | | |
| Post Operative Procedure Special Orders: | | | <i>laugh</i> | | <i>-</i> | | | |
| Handed Over By Name : | | <i>Sadhika</i> | <i>Sushma</i> | <i>Srus</i> | <i>Pdhi</i> | | | |
| Signature / ID : | | <i>Sadhika</i> | <i>Sushma</i> | <i>Srus</i> | <i>017189</i> | | | |
| Date: | | <i>25/5/26</i> | <i>25/5/26</i> | <i>26/5/26</i> | <i>27/05/26</i> | | | |
| Time: | | <i>@ 8PM</i> | <i>@ 8PM</i> | <i>@ 8PM</i> | <i>@ 8AM</i> | | | |
| Taken Over By Name : | | <i>Sushma</i> | <i>Srus</i> | <i>Pdhi</i> | | | | |
| Signature / ID : | | <i>Sushma</i> | <i>Srus</i> | <i>017189</i> | | | | |
| Date: | | <i>25/5/26</i> | <i>25/5/26</i> | <i>26/05/26</i> | | | | |
| Time: | | <i>@ 8PM</i> | <i>@ 8AM</i> | <i>@ 8PM</i> | | | | |

Patient Sticker



NURSING SHIFT HAND OVER FORM

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

ACTIVITY RECORD FOR BII

Name: -----
 UHID No : -----
 Date of Admissic ----- Time : ----- Date of Discharge : ----- Time: -----
 Room / Bed No : ----- Ward : ----- Suggested Billable bed type : -----

FDH-00046288 IP25-00020619
 Baby BIO SHRUTI JAISWAL 0 Y 0 M 0 D 2 H (M)
 25-05-2026
 Dr. KALYAN CHAKRAVARTHY KONDA



WARD TRANSFERS

| Date | Time | From | To | Signature of Nurse |
|---------|---------|------|-------|--------------------|
| 25/5/26 | 5:10pm | DT | MICU | Sreeja |
| 25/5/26 | 10:20pm | Micu | ward | Jushna |
| 26/5/26 | 12:50pm | ward | Billu | Sumer |
| | | | | |
| | | | | |

Cross Consultation Visit

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

FDH-00046288 IP25-00020619
Baby B/O SHRUTI JAISWAL
25-05-2026 0Y0M0D2H (M)
Dr. KALYAN CHAKRAVARTHY KONDA



NURSING DEPARTMENT NEWBORN - NURSING ASSESSMENT FORM

(Select and 'tick mark' [✓] the boxes as applicable)

Baby's Name: B/O. Shruti Mother's Name: _____
Date of Birth: 25/5/26 Time of Birth: 4:29 PM Gender: Male Female
Birth Weight: 2.824 Kgs HC: _____ cm Length: _____ cm
Meconium in Liquor: Yes No Cried at Birth: Yes No
Term / Pre-term / Post-term: _____
Resuscitated: Yes No Blood Group: Mother: B+ve Baby: _____
Feeding: Breast Feeding Formula Both First Feed Time: 5:30 PM

AFFIX MOTHER'S IDENTIFICATION LABEL

Mode of Delivery: Normal LSCS - Emergency/ Elective Instrumental AVD
Indication: _____

Physical Assessment of New Born:

Temp: 36°C HR: 150 /Min RR: 40 /Min BP: _____ SpO₂: 99%
Pain Score: 0 (Follow N Pass)

Fall Risk Assessment: Yes No Score: 0 (Fill the Humpty Dumpty Sheet)

Risk in Pressure Sore: Yes No (Braden Q Score) (Fill the Braden Q Sheet)

Behaviour Status on admission: Sleeping Crying Calm Drowsy

Findings:

General Appearance: Posture: Well-Flexed Asymmetry

Skin: Pink Meconium Stain Others, Specify: _____

Nursing Management: (Please strike through if not applicable e.g. Yes / ~~No~~)

Vitamin K 1 mg I.M Administered: Yes / No

Routine Care Provided: Yes / No

Capillary Blood Glucose Monitoring Done: Yes / No

Neonatal Screening Done: Yes / No

1. Nutritional Screening: Feeding Problem Yes / No

2. Functional Screening: Musculoskeletal Congenital Abnormality Yes / No

3. Socio History: Siblings Yes / No

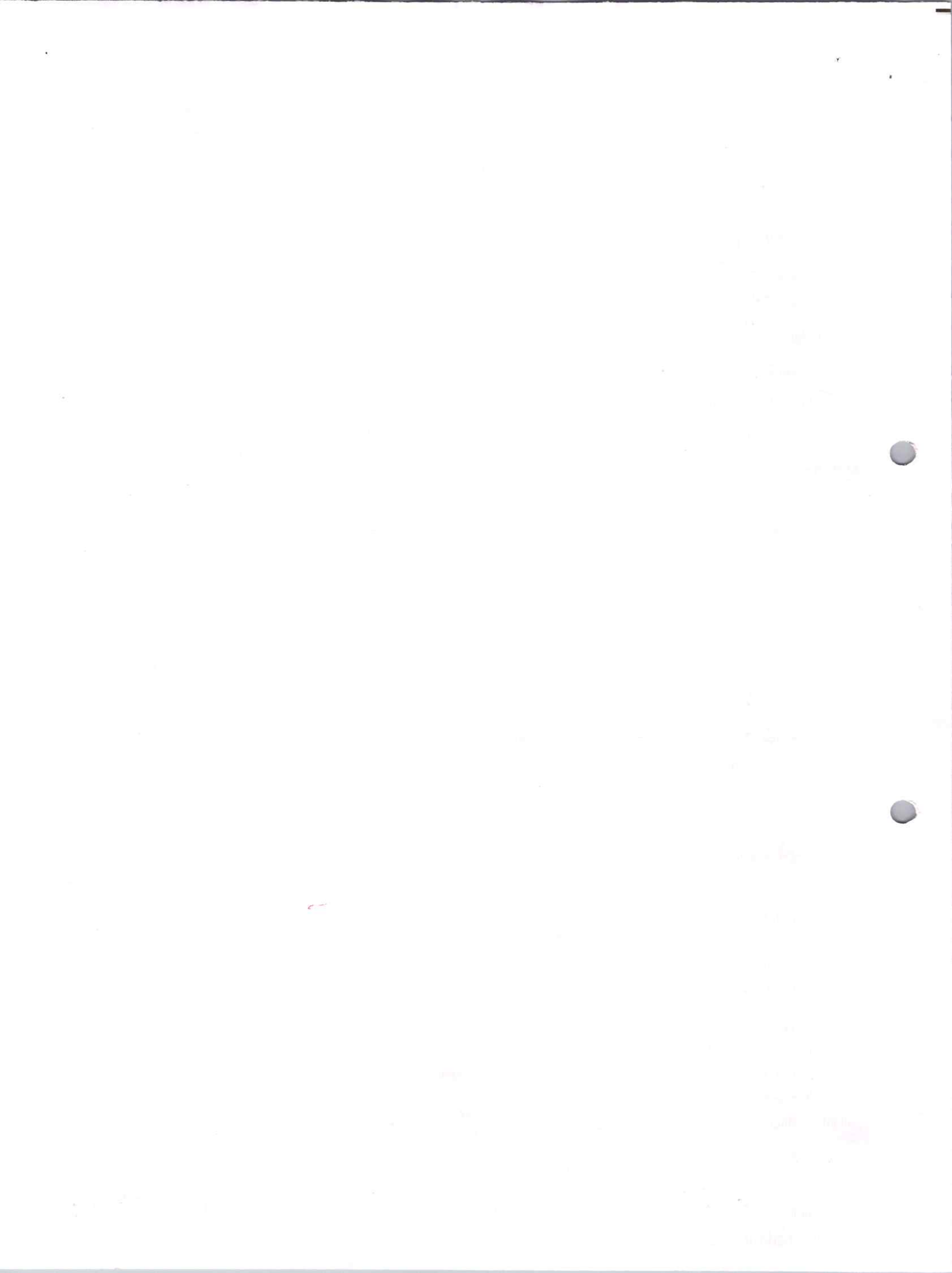
All information obtained from Mother Father Other Family Member

Newborn Screening Discussed: Yes / No

Nurse Name: Sadhika

Signature: Sadhika

Date & Time: 25/5/26





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 Shruti Jaiswal Mother's Blood Group : B+ve

Gender : M F Blood Group : Birth Weight (gms) : 2.824kg Length (cms) :

Date of Birth : 25/5/26 Time of Birth : 4:29 AM OFC (cms) :

Place of Birth : REHFP Estimated Gesth Age : 38+4

Current Obstetric History : (Booked / Unbooked Case)

Maternal Age : 33yr Ht : Wt : BMI : Married Life : LMP : 30/8/25 EDD : 4/6/26

Conception : Spontaneous or with Rx :

Booked at what GA : 26 wks AN Steroids Drugs / Doses :

Last Scans Details : SUF @ 36+2, placenta - A/H, AFI - 11.6cm, cephalic
doppler, efw - 2933g (36) TT Immunization and Iron / Folic Acid :

MATERNAL RISK FACTORS

Age : <18 yrs > 35yrs

Consanguinity : Yes No

If yes, degree of consanguinity : 1 2 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

Controlled or not, recent values, HbA1 values :

Compliance with Rx :

Scans : LGA, TIFFA , Fetal Echo :

H/o Hypothyroidism : when diagnosed ? Medication?

Any other Chronic Medical Problems, when detected drugs ?

(Anemia, SLE, Jaundice, CHD, Heart Disease)

Infection : H/O, Fever

(Malaria UTI TORCH TB HIV HBV)

UTI : when : Any culture :

PPROM : Duration : Uterine Tenderness Foul Smelling Liquor HVS (if taken) - Results :

Medication during Pregnancy : Duration :

Primi

PAST OBSTETRIC HISTORY

G: P: A: L:

| Sl. No. | Age | GA wks | B. W | Gender | Significant | Details |
|---------|-----|--------|------|--------|-------------|---------|
| | | | | | | |
| | | | | | | |
| | | | | | | |

PERINATAL HISTORY

Treating Obstetrician : *Dr. Himabindu* Hospital : *ALH, ED* Inborn Outborn

Duration of Labour

First stage (> 18 hours sig)

Second stage (> 2 hours after dilation)

LSCS : Elective Emergency Indication : *NPCL*

Specify the reason :

Augmentation of Labour : Induced Assisted Vaginal

CTG : Normal Suspicious Pathological

MSL :

Resuscitation : Yes No

Cord ABG :

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

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 | <i>8/10</i> | <i>9/10</i> | |

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

Snapee II Score

| | > 30 (0) | 20-29 (9) | < 20 (19) | |
|--------------------------|----------------------|----------------|---------------|------------|
| Mean BP (mmHg) | > 96 (0) | 96-95 (8) | < 95 (15) | |
| Lowest Temp (oF) | > 2.49 (0) | 1-2.49 (5) | 0.3-0.99 (15) | < 0.3 (28) |
| Pao2 / Fio2 (mmHg%) | > = 7.2 (0) | 7.1-7.19 (7) | < 7.1 (16) | |
| Lowest Serum PH | No (0) | Yes (19) | | |
| Multiple Seizures | > = 1 (0) | 0. 1-0.9 (5) | <0.1 (18) | |
| U. Output (ml / kg / hr) | > = 7 (0) | < 7 (18) | | |
| Apgar Score | > = 1kg (0) | 750 - 999 (10) | < 750 (17) | |
| Brith Weight | > 3rd percentile (0) | < 3rd (12) | | |
| SGA | | | | |

POSTNATAL / HISTORY OF PRESENT ILLNESS

Chief Complaints :

History of Present Illness:

Baby delivered in Am. LSC

↓

CAB

↓

card clamped bent

↑

Inj. vit. K given

↓

clth - good

↓

shift to mother side

Investigation details in previous Hospital :

Feeding History :

Past History :

Family History :

Socio Economic History :

GENERAL EXAMINATION ON ADMISSION

General Disposition :

VITALS : Temperature : 36.5°C HR : 158 RR : 44 NIBP : CFT :

Color of the extremities : Acrocyanosis

Jaundice : Pallor : SpO2 : 96%

Anthropometry : Birth Weight : 2.824kg Length : HC : Present Weight :

Ponderal Index : AGA : ✓ SGA : LGA :

HEAD TO TOE EXAMINATION

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

⓪

Facies :
(Any Facial
Dysmorphism)

⓪

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

⓪

EYES :
Symmetry :
Red Reflex :
Discharge :

→ to be tested

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

⓪

THORAX and BREASTS :

Shape of Thorax :
Position of Nipples and Number :

1 @ 1 Acromion is pole below @ areole area

ABDOMEN and UMBILICUS :

Shape :
Organomegaly :
Bowel Sounds :
Umbilical Stump :
Discharge :

1 @

GENITILIA :

Labia / Hymen :
Testicles/penis :
Anus :

1 @ testis descended

HERNIAL ORIFICES

TRUNK and SPINE :

1 @ see small dimple to right of hair @

SKIN LESIONS :

1 @

EXTREMITIES :

Fingers / Toes :
Deformities :
Hip Joint Examination :

1 @

Arms / Legs :
Mobility :

1 @

SYSTEMIC EXAMINATION

Respiratory System :

Breathing Pattern : Regular Periodic Shallow Gasping

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

Scoring of respiratory distress if present (Silverman or Downe's) *1 @*

Mention if baby is on : Hood box CPAP Ventilator *1 @*

Settings :

Auscultation : Breath Sounds : Added Sounds :

Circulatory System :

BP : *50/20 @*

Precordial Activity :

Pulses :

Murmurs : *No*

Signs of Cardiac Failure :

Hernia orifice :

Anal Patency : *appears patent*

Umbilical Cord : *2A, 1V*

First urine passed : *-*

Meconium 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 :

DTR :

ATNR :

Skull and Spine :

Any Congenital Anomalies :

Diagnosis :

Term / ASA / Mch / em. / US / CIAB

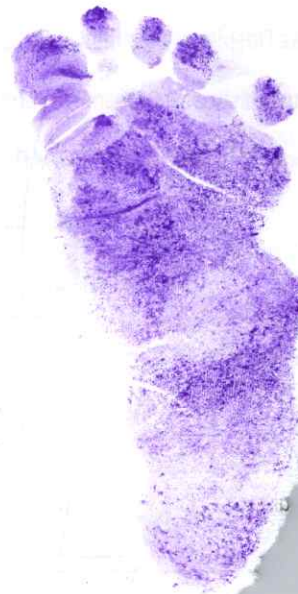
CP/A - good

FOOT PRINTS

Left Side :



Right Side :



Resident Doctor :

Signature :

Name :

Date & Time :

Dr. Prasad
28/5/26

Consultant :

Signature :

Name :

Date & Time :

[Signature]

DISCHARGE PLAN

Information given by: Family Friend

Will patient require transportation arrangements to go home: Yes No NA

Will Physiotherapy require at home: Yes No NA

Is home medical equipment anticipated: Yes No NA

Is home oxygen therapy anticipated: Yes No NA

Breastfeeding Yes No NA

Formula Feed Yes No NA

Are dressing needs at home anticipated: Yes No NA

Any other needs anticipated: Yes No If Yes Specify

Feeding Plan at the time of shifting :

.....

.....

.....

.....

.....

.....

.....

.....

Screenings done during NICU Stay :

NSG :

Hearing Screen :

ROP :

TFT :

NP2 :

Discharge Details:

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

Discharge Medications: Yes No

Details:

Final Diagnosis:

- Haemolytic disease
- DBF 2nd level + hb huping
- OAC, vaccination @ 24 hcl
- SBR, NBS @ 48 hcl
- use spin byu dls

Doctor Signature:

Doctor Name:

Date & Time:

FDH-00046288 IP25-00020619
 Baby B/O SHRUTI JAISWAL
 25-05-2026 0 Y 0 M 0 D 2 H (M)
 Dr. KALYAN CHAKRAVARTHY KONDA



①

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 |
|-------------|---|--|
| 25/5 9pm | <p>CU 43 on kalyan / a Mohd</p> <hr/> <p>- on D3C</p> <p>C / good</p> <p>4 / stable</p> | <p>Plan</p> |
| | <p>Tuft of Hair (P)</p> <p>Sacral dimple (P)</p> | <p>① DRF + wrench</p> <p>② Vaccinate BCG, OPV, Hep B</p> <p>③ SBR, NBS, OAE @ 48 Hrs</p> <p>④ USG - Spine before DS.</p> |
| | | |

FDH-00046288 IP25-00020619
Baby B/O SHRUTI JAISWAL
25-05-2026 0 Y 0 M 0 D 2 H (M)
Dr. KALYAN CHAKRAVARTHY KONDA



PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time | Progress Notes | Doctor's Order |
|-------------|--|-----------------------------|
| | <u>ds13 D Meleu</u> | |
| 26/5 9am | D: 17hm / Term / Girl / 2 Boy / cas wt. ut loss | |
| | M OBF | |
| | CIA good | |
| | PIA soft | <u>pl</u> |
| | | OBF OBF |
| | | supp |
| | | (2) Vaccination baby OAE |
| | | (3) NBS - then beam SBR |
| | | (4) USS spine - then |



PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time | Progress Notes | Doctor's Order |
|-----------------|---------------------------------|-----------------------------------|
| 22/5/26 8 AM | Dr. Kalyan C/S/B - Dr. Sneha | |
| | 4 HR term / AYA / mek / UAB | |
| | GC: stable | |
| | CRT < 3 sec | BWT / 2.824 |
| | SBR: 7-8 mg/dl | TW / 2.594 |
| | | (↓ 8.1%) |
| | | Plan |
| | | - DBF 2 hourly + measured feeds. |
| | | - USG spine today. |
| | | - Pulse oximetry screening today. |
| | | - Discharge today. |
| | | - P/U on Friday. |
| | | Sneha |

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..... *RISK of infection related to*
Nursing Diagnosis..... *hospitalization.*
Plan of Care
** give warm care.*
** Administer Vit - K.*
Planned Investigations Procedures
Implementation
** warm care given*
** Vit - K administered.*

Handed Over by : *Reepa sreeja*
Name & Signature

Radika
Received by : Name & Signature

Night Shift

Clinical Diagnosis..... *Risk of infection due to hospitalization.*
Nursing Diagnosis.....
Plan of Care
1) provide warm care
2) Monitor vitals
3) provide feeding every 2nd hour.
Planned Investigations Procedures
Implementation
1) provided warm care
2) Monitored vitals and recorded
3) provided feeding every 2nd hourly

Handed Over by : *Sushma*
Name & Signature

Received by : Name & Signature

Morning Shift *+ Evening*

Clinical Diagnosis..... *new born*

Nursing Diagnosis..... *Risk for infection related to hospitalization*

Plan of Care..... *Monitor the baby condition*

..... *maintain the fluid*

..... *and hourly feeding done*

Planned Investigations Procedures

Implementation..... *Monitor the baby condition*

..... *maintain the fluid*

..... *and hourly feeding done*

Handed Over by : Name & Signature

Received by : Name & Signature

Luna 2/10/16

Pam 2/10/16 @ 8PM

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..... *New born*

Nursing Diagnosis..... *Risk for infection related to hospitalization*

Plan of Care * *Monitor the baby condition.*

..... ** DM feed 2nd, 3rd hly.*

Planned Investigations Procedures

Implementation * *Monitor the baby condition.*

..... ** DM feed 2nd, 3rd hly.*

Handed Over by : Name & Signature


Received by : Name & Signature

Pam 2/10/16 @ 8AM

PATIENT TRANSFER FORM

OT



| | | | |
|---|--|--|---|
| Patient Name & I/HID No. FDH-00046288 IP25-00020619 Baby B/O SHRUTI JAISWAL 25-05-2026 0 Y 0 M 0 D 2 H (M) Dr. KALYAN CHAKRAVARTHY KONDA  | | Date & Time of Admission 25/5/2026 | Date & Time of Transfer Order 25/5/2026 5:10 PM |
| From Unit OT | | Transfer Ordered by Dr. prasuna | Reason for Transfer newborn case |
| To Unit MICU | | Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| Number of Sheets in Clinical File 4 | | Number of Imaging Films - | |
| | | Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| | | If yes, what ? | |

Medications / Consumables / Surgicals / Hand over

| Sl.No. | Item Name | Quantity |
|--------|-----------------|----------|
| 1. | exam case given | |
| 2. | vitals checked. | 30 mins. |
| 3. | Vit - K given | done. |
| 4. | cord clamp done | 0.5 ml |
| 5. | | 1 |

Shifting Summary / Notes Written by Doctor : Yes No

| | |
|---|--|
| Name & Signature of Person who is Transferring Sreeja [Signature] @ 5:10 PM | Name of Person Ordered Transfer Dr. prasuna |
|---|--|

Patient & Clinical Records Received by :
 Sadhika

Date & Time of Patient Received :
 25/5/26


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

Unavailable Bed



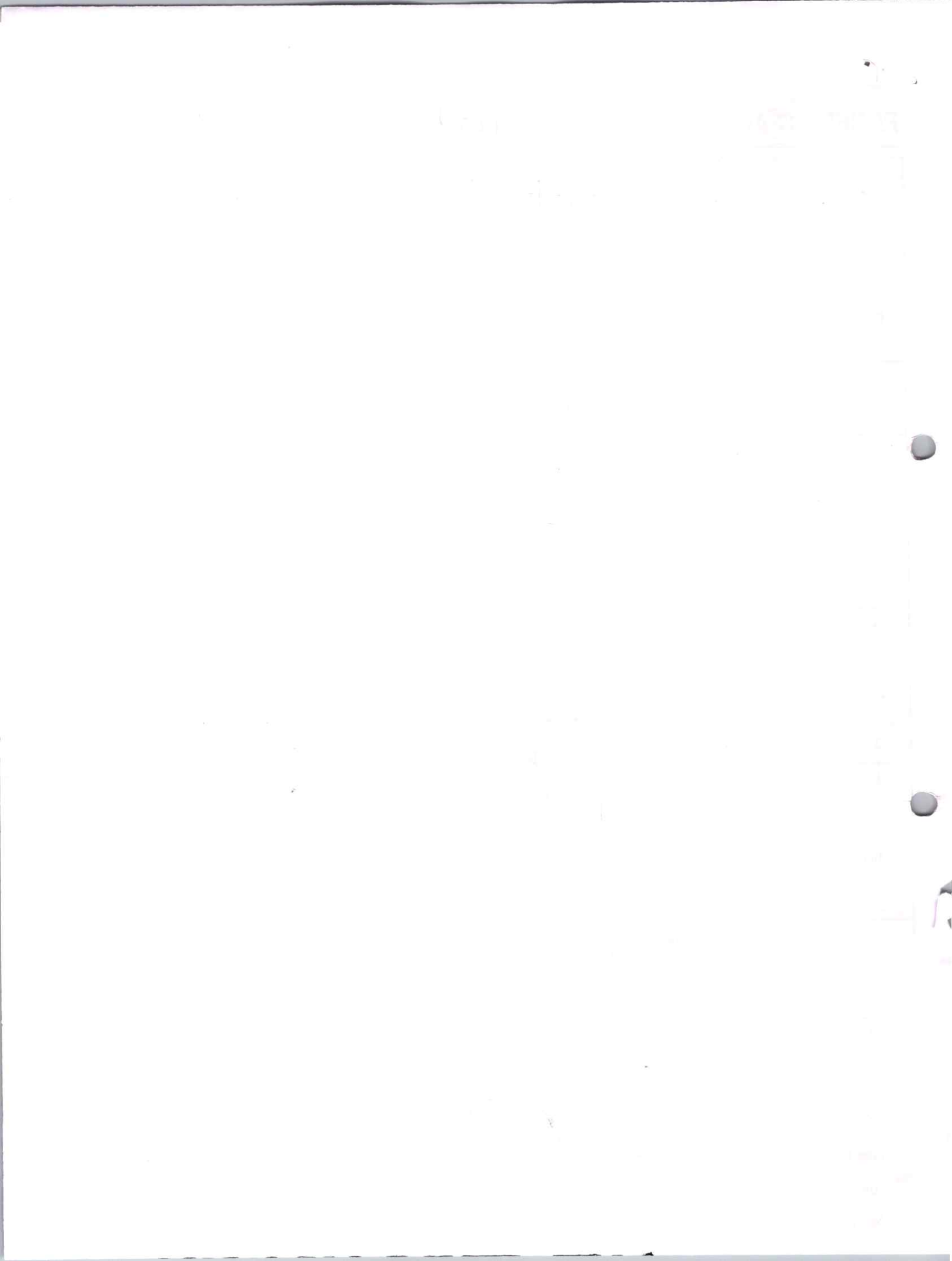
PATIENT TRANSFER FORM

OT

| Patient Name & IHID No. FDH-00046288 IP25-00020619 Baby B/O SHRUTI JAISWAL 25-05-2026 0 Y 0 M 0 D 2 H (M) Dr. KALYAN CHAKRAVARTHY KONDA  | | Date & Time of Admission 25/5/2026 | Date & Time of Transfer Order 25/5/2026 5:10 PM |
|--|------------------------------|---|---|
| Transfer Ordered by Dr. Kalyan | | Transfer Ordered by Dr. prasuna | Reason for Transfer newborn case |
| From Unit OT | To Unit MICU | Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| Number of Sheets in Clinical File 4 | Number of Imaging Films - | Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If yes, what? | |
| Medications / Consumables / Surgicals / Hand over | | | |
| Sl.No. | Item Name | Quantity | |
| 1. | exam case given | 30 mins. | |
| 2. | vitals checked. | done. | |
| 3. | Vit - K given | 0.5 ml | |
| 4. | cold clamp done | 1 | |
| 5. | | | |
| Shifting Summary / Notes Written by Doctor : Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | |
| Name & Signature of Person who is Transferring Sreeja @ 5:10 PM | | Name of Person Ordered Transfer Dr. prasuna | |
| Patient & Clinical Records Received by : Sadhika | | | |
| Date & Time of Patient Received : 25/5/26 | | | |

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

- Unavailable Bed
 Nurse not Available
 Available Bed not ready



PATIENT
 FDH-00046288 IP25-00020619
 Baby B/O SHRUTI JAISWAL
 25-05-2026 0 Y 0 M 0 D 2 H (M)
 Dr. KALYAN CHAKRAVARTHY KONDA



FORM



| | | |
|---|--|--|
| | Date & Time of Admission <i>25/5/26</i> | Date & Time of Transfer Order <i>25/5/26 @ 10:30am</i> |
| Treating Consultant Name | Transfer Ordered by <i>Dr. Kalyan</i> | Reason for Transfer <i>New Born Care</i> |
| From Unit <i>M/W</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>-</i> | Number of Imaging Films <i>-</i> | Personal belongings including clinical documents. If any handed over to attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> If yes, what ? |

Medications / Consumables / Surgicals / Hand over

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

Shifting Summary / Notes Written by Doctor : Yes No

| | |
|--|--|
| Name & Signature of Person who is Transferring <i>Sushe</i> | Name of Person Ordered Transfer <i>Dr. Kalyan</i> |
|--|--|

Patient & Clinical Records Received by :

Date & Time of Patient Received :

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

- Unavailable Bed
 Nurse not Available
 Available Bed not ready

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