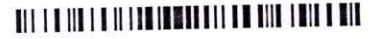


ADMISSION SHEET



Registration Details :

Admission No : IP25-00020493 Admit Date : 18-May-2026 Admit Time : 10:53 AM UHID : FDH-00045970

Patient Details :

Patient Name : Baby B/O B MAYURI Age : 0 D
Guardian : Mr B MAHESH REDDY DOB : 18-05-2026 09:09 AM
Gender : Male Religion :
Occupation : Martial Status :
Address (H) : Chevella Ranga Reddy Telangana INDIA Phone No : 8790424028/
501503 E-mail :

Admission Details :

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

Contact Details :

Name : Mr B MAHESH REDDY Relationship : Father
Contact Address : Chevella Ranga Reddy Telangana INDIA Phone No : / 9949135636
501503

B. Mahesh Reddy
Signature

Doctor Details :

Doctor Name : Dr. KONDAM PRADEEP REDDY Specialisation : NEONATOLOGY
Referral Doctor : Phone No :
Co-Consultant :

Payment Details :

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

FDH-00045970 IP25-00020493
 Baby B/O B MAYURI
 18-05-2026 0 Y 0 M 0 D 4 H (M)
 Dr. KONDAM PRADEEP REDDY



NEWBORN MONITORING FORM

Date of Birth : 18/5/26
 Time of Birth : 9:9 AM
 Mode of Delivery : Em-Lecs
 Birth Weight : 2.847
 Head Circumference : 35 cms
 Length : 45 cms
 Red Reflex :
 New Born Screening :
 TFT :
 OAE :
 Mother's Blood Group : D+ve
 Baby's Blood Group : B+ve
 Anomaly Scan :
 Vaccination : OPV, BCG, HepB given on 19/5/26

Date	Weight	Type of Feed	Quantity	Temperature	Signature
18/5/26	2.847	DBF	10 min	36.5°C	Priyanka
19/5/26	2.676 kgs	DBF	15 min	98.3°F	Debarshi
19/5/26	2.619 kgs	@ 5 PM	20 min	98.2°F	Priya
20/5/26	2.630 kgs	DBF	20 min	37°F	Neha

FDH-00045970 IP25-00020493

Baby B/O B MAYURI
18-05-2026 0 Y 0 M 0 D 4 H (M)
Dr. KONDAM PRADEEP REDDY



NURSING DEPARTMENT NEWBORN - NURSING ASSESSMENT FORM

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

Baby's Name: B/O Mayuri Mother's Name:

Date of Birth: 18/5/26 Time of Birth: 9:9 Am Gender: Male Female

Birth Weight: 2.847 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: O+ve Baby:

Feeding: Breast Feeding Formula Both First Feed Time:

AFFIX MOTHER'S IDENTIFICATION LABEL

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

Indication: Fetal distress

Physical Assessment of New Born:

Temp: 36.5 °C HR: 145 /Min RR: 48 /Min BP: SpO₂:

Pain Score: (Follow N Pass)

Fall Risk Assessment: Yes No Score: (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

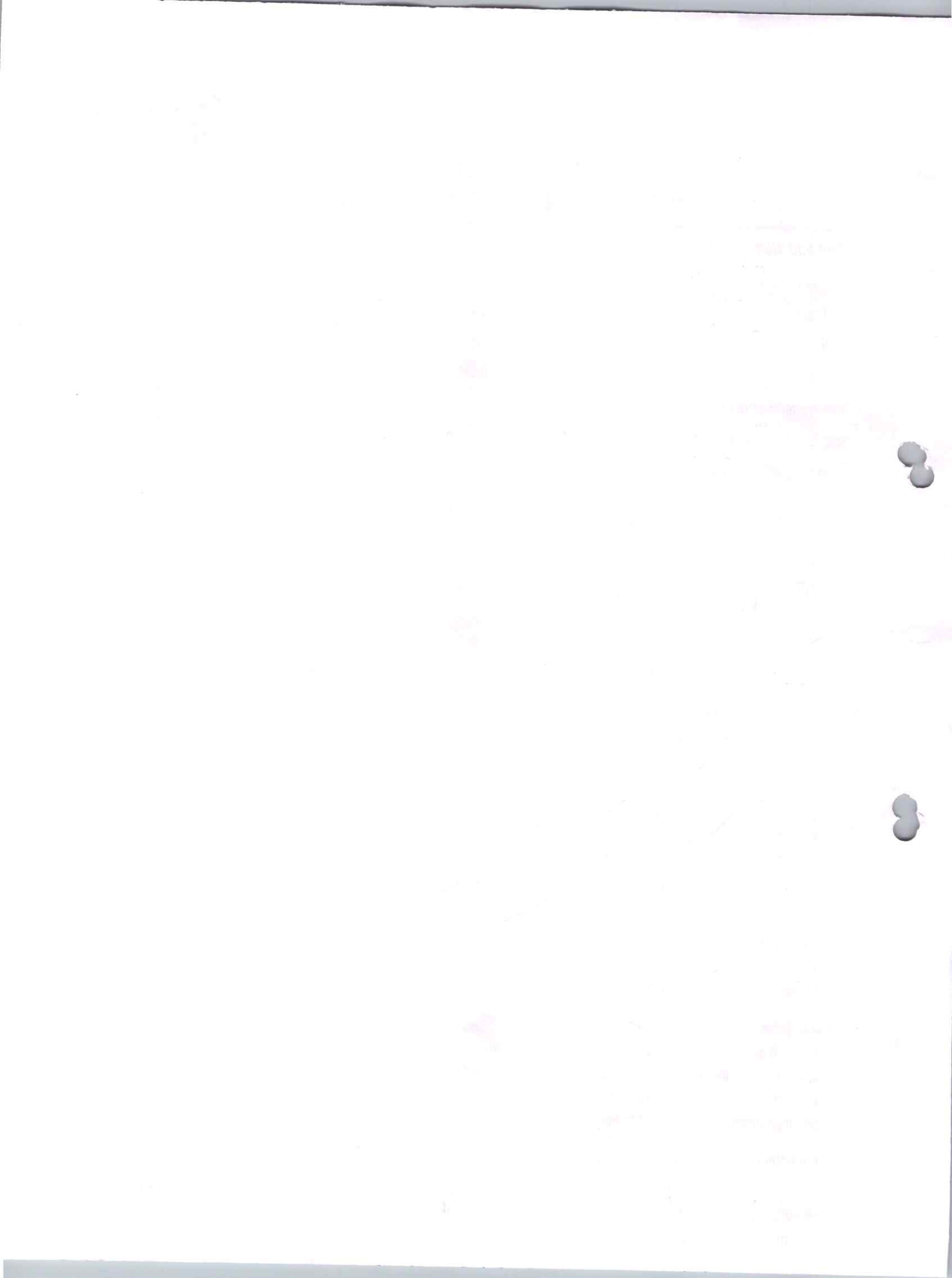
All information obtained from Mother Father Other Family Member

Newborn Screening Discussed: Yes / No

Nurse Name: Priyanka

Signature: [Signature]

Date & Time: 18/5/26 @





NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: <i>New Born</i>	Any Infection: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify:					
	Surgery / Procedure: <i>NBC</i>	Post OP Day:					
BACKGROUND	Date	<i>18/5</i>	<i>19/5/26</i>	<i>19/5</i>	<i>19/05/26</i>	<i>19/5/26</i>	
	Shift	<i>E</i>	<i>N</i>	<i>M</i>	<i>E</i>	<i>N</i>	
	Medical Condition (Any special condition to be noted):	<i>NBC</i>	<i>NBC</i>	<i>NB</i>	<i>NB</i>	<i>New Born</i>	
ASSESSMENT	Diet:	<i>DBF</i>	<i>DBF</i>	<i>DBF</i>	<i>DBM</i>	<i>DBF+FP</i>	
	Allergy:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Ventilation (RA, NP, NIV, VENTI):	<i>RA</i>	<i>RA</i>	<i>RA</i>	<i>RA</i>	<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 checked="" type="checkbox"/> No	
	Vital Signs:	Temp:	<i>36.8°C</i>	<i>98.3°F</i>	<i>98.0°F</i>	<i>99.4°F</i>	<i>99°F</i>
		Res:	<i>24</i>	<i>14</i>	<i>12</i>	<i>12</i>	<i>10</i>
		SpO ₂ :	<i>98</i>	<i>100%</i>	<i>99%</i>	<i>99%</i>	<i>99%</i>
		Pulse:	<i>75</i>	<i>100</i>	<i>133</i>	<i>142</i>	<i>138</i>
		BP:	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>
	LOC:	<i>C</i>	<i>C</i>	<i>C</i>	<i>C</i>	<i>conscious</i>	
Fall Risk Score:	<i>0/10</i>	<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>	<i>0/10</i>		
Skin Integrity:	<i>Good</i>	<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 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:	<i>DBF</i>		<i>DBF</i>	<i>DBM</i>	<i>DBF+FP</i>	
	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	
	ADL (Dependent / Non Dependent):	<i>dependent</i>	<i>Independent</i>	<i>dependent</i>	<i>dependent</i>	<i>dependent</i>	
Post Operative Procedure Special Orders:	<i>Analgesia</i>						
Handed Over By Name :	<i>Lush</i>	<i>Rahaa</i>	<i>Suma</i>	<i>Pdhi</i>	<i>neha</i>		
Signature / ID :	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>		
Date:	<i>18/5/26</i>	<i>19/5/26</i>	<i>19/5/26</i>	<i>19/05/26</i>	<i>20/5/26</i>		
Time:	<i>@ 4h</i>	<i>@ 8 AM</i>	<i>@ 2 PM</i>	<i>@ 8 PM</i>	<i>@ 8 AM</i>		
Taken Over By Name :	<i>Rahaa</i>	<i>Suma</i>	<i>Pdhi</i>	<i>neha</i>			
Signature / ID :	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>			
Date:	<i>18/5/26</i>	<i>19/5/26</i>	<i>19/05/26</i>	<i>19/5/26</i>			
Time:	<i>@ 8 PM</i>	<i>@ 8 AM</i>	<i>@ 2 PM</i>	<i>@ 8 PM</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 BILLING

FDH-00045970 IP25-00020493

Baby B/O B MAYURI
18-05-2026 0 Y 0 M 0 D 4 H (M)

Name: --- Dr. KONDAM PRADEEP REDDY

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
18/5/26	3:40pm	Mlw	OT	<i>Sushma</i>
18/5/26	mrcu	ward	Billig	<i>Sushma</i>
20/5/26	12:06pm	ward		<i>Sushma</i>

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
18/5/26	BAT		
18/5/26	ABC	* 7602	Srija
	R. Sany	7614	Sushma
			Jaya @
19/05/26	OAE	7266	18/5/26 paul
20/5/26	SBR, NBS	7754	neha

c-c by Jaya @
 18/5/26
 paul
 neha
 c.c. by
 20/05/26
 21/5/26



NEONATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

Mother's Name : B. Mayuri Age : 26y Father's Name : Age :
 Date of Birth : 12/02/2000 Date of Admission : UHID No. :
 NICU Consultant : Dr. Pradeep 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 B. Mayuri Mother's Blood Group : O POS
 Gender : M F Blood Group : Birth Weight (gms) : 2.847 Length (cms) :
 Date of Birth : 11/01/2021 Time of Birth : 9.09 AM OFC (cms) :
 Place of Birth : RCH, CO Estimated Gesth Age : 37 weeks

Current Obstetric History : (Booked / Unbooked Case)
 Maternal Age : Ht : Wt : BMI : Married Life : LMP : 25/01/25 EDD : 7/6/2020
 Conception : Spontaneous or with Rx. : Spontaneous
 Booked at what GA : AN Steroids Drugs / Doses :
 Last Scans Details : SLEWF [36+4] cephalic placenta - Ant [high] APP - 8-7cm
(0. high) EFW - 36H + 24g fetal duph @
 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) : @ 36+4
 IUGR - when detected : @ 36+1 fetal duph @
 Doppler (Increased Resistance / ADEF / REDF / Redistribution 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 :



PAST OBSTETRIC HISTORY

P: A: L:

Sl. No.	Age	GA WKS	B. W	Gender	Significant	Details

Prim

PERINATAL HISTORY

Treating Obstetrician : Dr. Vasudha Hospital : 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 checked="" type="checkbox"/> Elective <input type="checkbox"/> Emergency Indication :</p> <p>Specify the reason : <u>1/10 fetal brady cardio</u></p> <p>Augmentation of Labour : <input type="checkbox"/> Induced <input type="checkbox"/> Assisted Vaginal</p>	<p>CTG : <input type="checkbox"/> Normal <input type="checkbox"/> Suspicious <input type="checkbox"/> Pathological</p> <p>MSL :</p> <p>Resuscitaion : <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cord ABG :</p> <p>Placenta : (weight, surface, No. of cotyledons, calcifications, malformations, clots etc :</p>
--	--

NEONATAL RESCUSTITION DETAILS

APGAR SCORE

Gestational Age : 37 Weeks :

SIGN	0	1	2
COLOUR	Blue or Pale	Acröcyanotic	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
8	9	9

TOTAL

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 :



Baby received in preheated
warms

↓
RCEAB (cord gas attached)

↓
Delayed cord clamping done

↓
C } good
T }
A }
↓

↓
Inj vit k given

Investigation details in previous Hospital :

Feeding History :

Past History :

Family History :

Socio Economic History :



GENERAL EXAMINATION ON ADMISSION

General Disposition :

(Handwritten notes in the General Disposition section, including 'normal' and other illegible scribbles)

VITALS : Temperature : 36.5C HR : 140 bpm RR : 48/min NIBP : — CFT : < 3 sec

Color of the extremities : Acrocyanosis

Jaundice : 0 Pallor : 0 SpO2 : 98%

Anthropometry : Birth Weight : 2.842 Length : HC : Present Weight :

Ponderal Index : AGA : SGA : LGA :

HEAD TO TOE EXAMINATION

HEAD : Fontanelles :
 Sutures :
 Shape / Moulding : 2 Caput 3
 Edema / Bruising :
 Size - (H.C.) :

Facies : (Any Facial Dismorphism) 2

NECK and CLAVICLES : Range of Motion :
 Asymmetry : 2
 Masses :

EYES : Symmetry :
 Red Reflex : Red reflex to be done
 Discharge :

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



horax :

(P)

BREASTS : Position of Nipples and Number :

ABDOMEN and UMBILICUS :

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

(M) WA + LW

GENITILIA :

Labia / Hymen :
 Testicles/penis :
 Anus :

(M) B/L Testis descended

HERNIAL ORIFICES

(M)

TRUNK and SPINE :

(M)

SKIN LESIONS :

(M)

EXTREMITIES :

Fingers / Toes :
 Deformities :
 Hip Joint Examination :

Arms / Legs :

Mobility :

(M)

SYSTEMIC EXAMINATION

Respiratory System :

Breathing Pattern : Regular Periodic Shallow Gasping

Mention If baby has Respiratory distress : RR : SCR / ICR / See - Saw breathing : B/CNF, der

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 : H/CNF, MC

Femoral Pulses : Murmurs :

Other Peripheral Pulses : Signs of Cardiac Failure :

Abdomen :

Shape : f sup

Palpation :

Palpable masses :

Abdominal girth :

Hernia orifice : (M)

Anal Patency : WA + LW

Umbilical Cord :

First urine passed : f not

Meconium passed : part

Central Nervous System : higher intellectual functions (Sensorium) : 1

State of wakefulness :

Prechtle Score :

Nerves : good

Motor System :

Passive Tone : normal

Active Tone :

Neonatal Reflexes :

Grasp : Palmar Plantar Sucking Rooting Crossed adductor :

Moro's : present DTR :

ATNR :

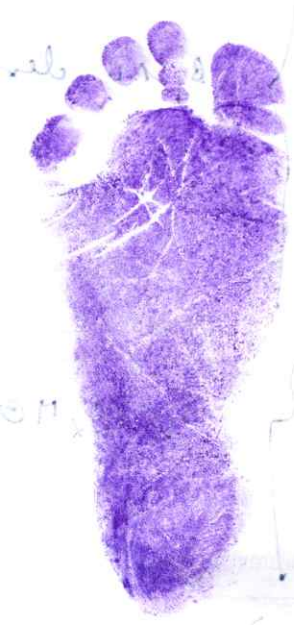
Any Congenital Anomalies :

Diagnosis : FT (37 weeks) / Em. Us 1/1/10 etc (bradycah) / scars /

AAP / nca / gingiv hypertrophy / NR

FOOT PRINTS

Left Side :



Right Side :



Resident Doctor : [Signature]

Signature :

Name : Dr. Lakshmi

Date & Time : 18/05/2026

Consultant :

Signature : [Signature]

Name :

Date & Time :

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 :

Advice

- ICBW

- ERB ffb hungry

- SBP } @ 4.30.26
 NBS

Screenings done during NICU Stay :

- @ 2.10.26 - (P) hsb spc

NSG :

Hearing Screen :

- Vaccination } of
 ORG

ROP :

TFT :

NP2 :

[Handwritten signature]

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:

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

Doctor Signature:

Doctor Name:

Date & Time:

FDH-00045870
 Baby B/O B MAYURI
 18-05-2026
 Dr. KONDAM PRADEEP REDDY

IP25-00020493

OYO MOD 4 H (M)



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
08/05/21		
4:30 AM	<p>CLIA Discharge</p>	
	<p>7 Hct</p>	
	<p>on DSP</p>	
	<p>accepting food as</p>	
	<p>CLIA level</p>	
	<p>clean & stools passed</p>	
		<p>ph</p>
		<p>- at DSP</p>
		<p>- vacuums / cm</p>
		<p>OAT</p>
		<p>- SBR NRS @</p>
		<p>48 hct</p>

FDH-00045970
 Baby B/O B MAYURI
 18-05-2026 0 Y 0 M 0 D 7 H (M)
 Dr. KONDAM PRADEEP REDDY

IP25-00020493



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/5	C/SIP by Pradeep / Dr. Mohesh	
9 AM	24 HOL / 3 Feeds / 2.8.1g / LSCS	
	-on DBF	
	<div style="display: flex; justify-content: space-around;"> <div style="text-align: center;"> $\frac{V}{M}$ </div> <div style="text-align: center;"> <u>Plan</u> </div> </div>	
	CWL ~ 7% ↓ 200 gm	(1) DBF (2) Vaccinate / today OAE
		(3) Recheck Wt in evening if (↓) Add FBM/FF top up
		(4) SBR / 6am t/m. NBS
		Moh By
19/5	S/S Dr. Vinodha (LC)(PT) Breastfeeding counselling pm	

FDH-00045970

IP25-00020493

Baby B/O B MAYURI

18-05-2028 0Y0M0D7H (M)

Dr. KONDAM PRADEEP REDDY



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
18/5/28		
3:30pm		

Child not feeding

on ~~not~~ mixed feed
accepting feed well
C/A - bud

- ph
- Cat DRF + FI
- vacutube 1pc, CAFE
- SBR @ 1hr 6ms NRJ

[Handwritten signature]

FDH-00045970 IP25-00020493
 Baby B/O B MAYURI
 18-05-2028 0 Y 0 M 2 D (M)
 Dr. KONDAM PRADEEP REDDY



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/5/20 9 AM	<p>d/c / R Dr. Pradeep / <u>As Directed</u></p>	
	<p>Direct 48 hrs</p>	
	<p>Baby well acceptly feeds well</p>	<p><u>Plan</u></p>
	<p>afe - vitally stable</p>	<p>- continue DBF Energy 82 ml/kg</p>
	<p>CRT < 3 sec</p>	<p>- plan d/s after SBR report</p>
		<p>- Fed reflex today.</p>
	<p><u>Plc Friday</u> <u>out 1-</u></p>	



VITALS CHART

Date →	18/05/26									
Time ↓	Temp	HP	RR	SPO ₂	Score	Type of Feed	Qty	Urine	Stool	Vomit
7.00 am										
8.00 am	1L									
9.00 am										
10.00 am	38.5°C	152	48	98	8/10, 9/10	DBF	10ml	-	-	-
11.00 am										
12.00 pm	36.5	152	48	98	8/10, 9/10	DBF	10ml	-	-	-
1.00 pm										
2.00 pm	36.5°C	150	48	98	8/10, 9/10	DBF	10ml	-	✓	-
3.00 pm										
4.00 pm										
5.00 pm	36.4°C	148	45	99%	0/10	DBF	15min	✓		
6.00 pm										
7.00 pm						DBF	15min	✓		
8.00 pm	36.3°C	142	48	96%	0/10	DBF	20min		✓	
9.00 pm								✓		
10.00 pm						DBF	10mls			
11.00 pm									✓	
12.00 am	38.9°F	120	40	98%		DBF	20mls			
1.00 am								✓		
2.00 am						DBF	20mls			
3.00 am									✓	
4.00 am						DBF	20mls			
5.00 am								✓		
6.00 am	38.0°F	125	42	98%		DBF	20mls	✓	✓	
						TOTAL		5	5	

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

Feeding Plan..... DBF 2nd hourly.....

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..... *New Born Case*
Nursing Diagnosis..... *Risk of infection r/t hospitalisation*

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 of infection related to hospital*

Plan of Care

Planned Investigations Procedures

Implementation

Handed Over by : Name & Signature

Received by : Name & Signature

** Assessed baby condition*
** Warm care given*
** 2nd hourly feeds*
Birth

18/5/26 28 pm

To assess baby condition, To monitor vital signs, To maintain I&O chart, To give feedings every 2nd hourly.

SBR, NBS @ 48 H.O.L.

Assessed baby condition, Monitored vital signs, Maintained I&O chart, given feedings every 2nd hourly.

19/5/26 @ 8 AM

19/5/26

VITALS CHART

Date →	Temp	HP	RR	SPO ₂	Score	Type of Feed	Qty	Urine	Stool	Vomit
7.00 am										
8.00 am	97.6 F	136	42	98%		DBF	15 ml	✓		
9.00 am								✓		
10.00 am						DBF	15 ml			
11.00 am								✓	✓	
12.00 pm	98.6 F	133	44	100%		DBF	15 ml			
1.00 pm						FF	95 ml	✓	✓	
2.00 pm						DBM + FF	15 ml	✓		
3.00 pm									✓	
4.00 pm										
5.00 pm						DBM + FF	15 ml			
6.00 pm								✓		
7.00 pm	98.2	140	42	99%		DBM	20 ml		✓	
8.00 pm										
9.00 pm						DBF	20 ml			
10.00 pm										
11.00 pm	97 F	143	40	100%	0/10	DBF + FF	30 ml	✓		
12.00 am								✓		
1.00 am						DBF + FF	30 ml		✓	
2.00 am								✓		
3.00 am	97 F	138	42	99%	0/10	DBF + FF	20 ml		✓	
4.00 am										
5.00 am						DBF + FF	20 ml			
6.00 am	96 F		40	100%	0/10					
						TOTAL		U=7	M=6	

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

Feeding Plan..... and hourly feeding done.

Morning Shift

Clinical Diagnosis..... New born
 Nursing Diagnosis..... Risk for infection related to hospitalization
 Plan of Care
 * Assess the baby condition
 Planned Investigations Procedures
 Implementation
 * Assess the baby condition
 * monitored vitals & Recorded
 * Maintained I/O chart
Every and hourly feeding done.
Suma 19/05/26 @ 2:pm
 Handed Over by : Name & Signature

Pam 19/05/26 @ 2pm
 Received by : Name & Signature

Evening Shift

Clinical Diagnosis..... New born
 Nursing Diagnosis..... Risk for infection related to hospitalization
 Plan of Care
 * Assess the baby condition
 * OBM feed 2nd 3rd hly.
 Planned Investigations Procedures
 Implementation
 * Assessed the baby condition
 * OBM feed 2nd 3rd hly.
Pam 19/05/26 @ 8pm
 Handed Over by : Name & Signature

Neha 19/05/26 @ 8pm
 Received by : Name & Signature


Night Shift

Clinical Diagnosis..... NEW BORN
 Nursing Diagnosis..... Risk for infection related to hospitalization
 Plan of Care
 * Assess the Baby condition
 * Monitors vital signs & Record
 * Maintain I/O chart
 Planned Investigations Procedures
 Implementation
 * Assessed the Baby condition
 * Monitored vital signs & Recorded
 * Maintained I/O chart
Neha 20/05/22 @ 8AM
 Handed Over by : Name & Signature

Received by : Name & Signature

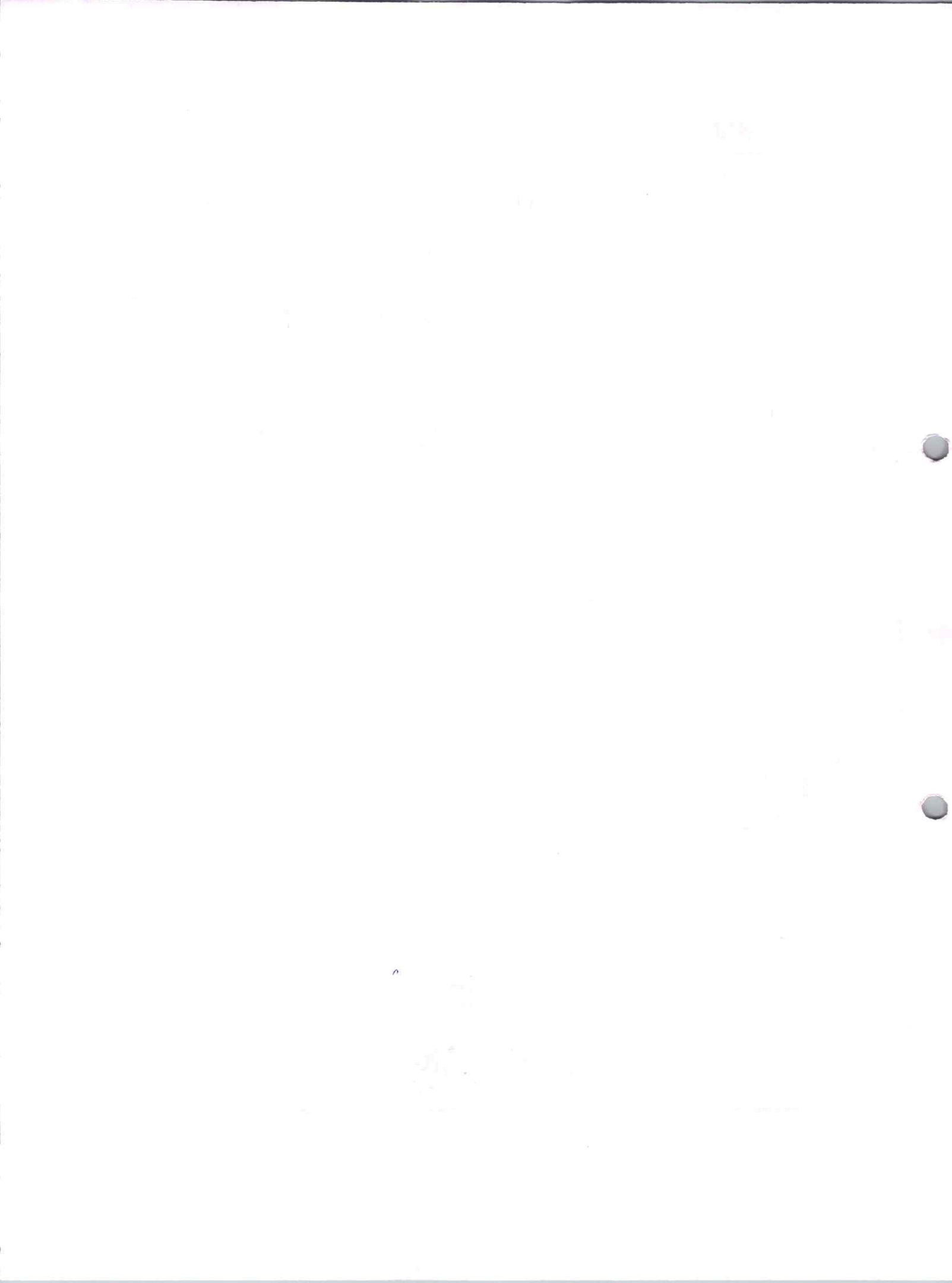
PATIENT TRANSFER FORM



Patient Name & UHID No. FDH-00045970 Baby B/O B MAYURI 18-05-2026 IP25-00020493 O Y O M O D 4 H (M) Dr. KONDAM PRADEEP REDDY 		Date & Time of Admission 18/5/16 @ 10:30	Date & Time of Transfer Order 18/5/16 @ 3:30
		Transfer Ordered by Dr. Pradeep	Reason for Transfer New Born Care
From Unit Mlw	To Unit ward	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File ✓	Number of Imaging Films ✓	Personal belongings including clinical documents. If any handed over to attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes <input type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring Sushu		Name of Person Ordered Transfer Dr. Pradeep	
Patient & Clinical Records Received by : Tranbitha 18/5/16 4:15 PM			
Date & Time of Patient Received :			


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

- Unavailable Bed
 Nurse not Available
 Available Bed not ready



PATIENT TRANSFER FORM



Patient Name & UHID No. FDH-00045870 IP25-00020493 Baby B/O B MAYURI 18-05-2026 0 Y 0 M 0 D 4 H (M) Dr. KONDAM PRADEEP REDDY 		Date & Time of Admission 18/5/20 @ 10:30am	Date & Time of Transfer Order 18/5/20 @ 3:45pm @ 10:30am
		Transfer Ordered by Dr. Pradeep	Reason for Transfer New Bed
From Unit 10th OT	To Unit Ward Men	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes <input type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring Dr. Pradeep		Name of Person Ordered Transfer Dr. Pradeep	
Patient & Clinical Records Received by : Priyanka 18/5/20 @ 10:30am			
Date & Time of Patient Received :			

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

- Unavailable Bed
 Nurse not Available
 Available Bed not ready

PATIENT TRANSFER FORM

<p>1. Patient Name</p> <p>2. Room No.</p> <p>3. Unit</p>	<p>4. Date of Transfer</p> <p>5. Time of Transfer</p>	<p>6. Reason for Transfer</p>
<p>7. Referring Physician</p> <p>8. Referring Department</p>	<p>9. Receiving Physician</p> <p>10. Receiving Department</p>	<p>11. Date & Time of Patient Received</p>
<p>12. Signature of Referring Physician</p>	<p>13. Signature of Receiving Physician</p>	<p>14. Signature of Hospital Administrator</p>
<p>15. Signature of Nurse</p>	<p>16. Signature of Transporter</p>	<p>17. Signature of Patient</p>
<p>18. Signature of Bedside Nurse</p>	<p>19. Signature of Receiving Nurse</p>	<p>20. Signature of Transporter</p>

If the transfer order has been completed, this is to be signed by the receiving department.

FOR THE HOSPITAL