



Rainbow Children's Hospital - Banjara Hills

8-2-120/103/1,2,3,4 and 5,Road No: 2, Banjara Hills, Telangana, Hyderabad, INDIA Banjara Hills ,Hyderabad
,Telangana, India ,500034.
TEL NO :+91-40-4466 5555
WEB : <https://rainbowhospitals.in>

ADMISSION SHEET

Registration Details :



Admission No : IP5-00174341 Admit Date : 26-May-2026 Admit Time : 02:03 PM UHID : BAH-00657323

Patient Details :

Patient Name : Baby Of MAHESHWARI KAWLE Age : 0 D
Guardian : MR RAHUL KAWLE DOB : 26-05-2026 12:31 PM
Gender : Male Religion :
Occupation : Martial Status : Single
Address (H) : HNO-8-4-544/21/77,B SHANKAR LAL NAGAR,
Erragadda Hyderabad Telangana INDIA 500018 Phone No : 9000033200/ 9849416594
E-mail : rahulkawle.in@gmail.com

Admission Details :

Bed Type : BASINET Bed No : CRDL-SW-415-1 Ward Name : 4F-BIRTHING CENTRE
Room No : CRDL-SW-415-1 Admission Type : First Visit

Contact Details :

Name : MR RAHUL KAWLE Relationship : Father
Contact Address : HNO-8-4-544/21/77,B SHANKAR LAL NAGAR, Erragadda Hyderabad Telangana INDIA 500018 Phone No : / 9000033200

Signature

Doctor Details :

Doctor Name : Dr. VIJAYANAND JAMALPURI Specialisation : NEONATOLOGY
Referral Doctor : Self Phone No :
Co-Consultant :

Payment Details :

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



Mother - Hep - B Positive

NEONATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

Mother's Name : Mrs. Maheshwari Age : 33y 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 : Bio Maheshwari Kawle Mother's Blood Group : O+ve
 Gender : M F Blood Group :
 Birth Weight (gms) : 2867gms Length (cms) : 50cm
 Date of Birth : 26/5/26 Time of Birth : 12:31pm OFC (cms) : 32cm
 Place of Birth : RCH - BH Estimated Gesth Age : 36+2 weeks
 Current Obstetric History : (Booked / Unbooked Case)
 Maternal Age : 33yr^{9m} Ht : 155cm Wt : 86.2kg BMI : Married Life : LMP : 14/9/25 EDD : 21/6/26
 Conception : Spontaneous or with Rx : Spont
 Booked at what GA : 17+6 wks AN Steroids Drugs / Doses :
 Last Scans Details : 22/4/26 : 31+3wks / Cephalic / 2127gms EFW / AFI = 19.9cm /
 Placenta - A/H / Doppler - (N) TT Immunization and Iron / Folic Acid :

MATERNAL RISK FACTORS

Age : <input type="checkbox"/> <18 yrs <input type="checkbox"/> > 35yrs HBsAg +ve Consanguinity : <input type="checkbox"/> Yes <input type="checkbox"/> No Hep B positive If yes, degree of consanguinity : <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 H/o PIH (after 20 weeks) / PE Obstetric cholestasis How many Drugs / Doses / Since how long : 34+2wks H/o value of recent BP recording, proteinuria, edema, oliguria, any investigations (LFT, platelet count) : IUGR - when detected : Doppler (Increased Resistance / ADEF / REDF / Redistribtion in MCA) / Ductus Venosus : AFI :	H/o GDM/ pre GDM/ on diet or insulin Controlled or not, recent values, HbA1 values : Compliance with Rx : Scans : LGA, TIFFA , Fetal Echo : H/o Hypothyroidism : when diagnosed ? Medication? Any other Chronic Medical Problems, when detected drugs ? (Anemia, SLE, Jaundice, CHD, Heart Disease) Infection : H/O, Fever (<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 : Uterine Tenderness Foul Smelling Liquor HVS (if taken) - Results :
 Medication during Pregnancy : Duration :



PAST OBSTETRIC HISTORY

3 P: 1 A: 1 L: 1

Sl. No.	Age	GA wks	B.W	Gender	Significant	Details
1.	2021	Em LSCs	39+3	Male	2.947kg.	
2.	2025	Missed miscarriage			@ Swiss / MGRPC.	
3.	Sp. Present pregnancy.					

PERINATAL HISTORY

Treating Obstetrician : Hospital : Inborn Outborn

<p>Duration of Labour</p> <p>First stage (> 18 hours sig) <i>Previous LSCs</i></p> <p>Second stage (> 2 hours after dilation) <i>± Hep B +ve</i></p> <p>LSCS : <input checked="" type="checkbox"/> Elective <input type="checkbox"/> Emergency Indication : <i>cholestasis</i> <i>obstetric</i></p> <p>Specify the reason :</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>Resuscitation : <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
1	1	
2	2	
2	2	
2	2	
2	2	
9/10	9/10	

TOTAL

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

Snapee II Score

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)		
Birth Weight	> 3rd percentile (0)	< 3rd (12)			
SGA				Total	

POSTNATAL / HISTORY OF PRESENT ILLNESS

Chief Complaints :

G3 P1 L1 At E Previous LSCs E 36+2 wks for Elect LSCs
 E Hepatitis B +ve / Obstetric cholestasis.

Histo



Equipment check done



Baby delivered by LSCS



Baby CIAB

Baby dried, secretions cleared

Delayed cord clamping & cut done (2A + 1 vein noted)



Inj vit K 1mg IM given



Baby was given Hep B Immunoglobulin (100IU) } @ birth.
Hep B vaccine



Baby stable

Shifted to mother side

Investigation details in previous Hospital :

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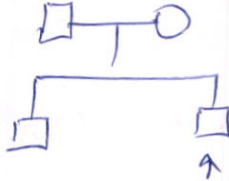
Feeding History :

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[Faint handwritten notes]

Family History :



Socio Economic History :

Upper middle class

GENERAL EXAMINATION ON ADMISSION

General Disposition :

VITALS : Temperature : *97.2°F* HR : *152/min* RR : *52/min* NIBP : CFT :
Color of the extremities : *Acrocyanosis → Pink*
Jaundice : Pallor : SpO2 :

ANTHROPOMETRY: Birth Weight : *2867gms* Length : HC : Present Weight :
Ponderal Index : AGA : SGA : LGA :



HEAD TO TOE EXAMINATION

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

FACIES :
(Any Facial Dysmorphism) } no facial dysmorphism.

NECK and CLAVICLES :
Range of Motion :
Asymmetry : } (N)
Masses :

EYES :
Symmetry :
Red Reflex : → Not checked.
Discharge :

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

THORAX and BREASTS :
Shape of Thorax :
Position of Nipples and Number : } (N)

ABDOMEN and UMBILICUS :
Shape :
Organomegaly : } (N)
Bowel Sounds :
Umbilical Stump : → 2A + 1 vein noted
Discharge :

GENITILIA :
Labia / Hymen : } Male Ext genitalia noted
Testicles/penis :
Anus : Patent

HERNIAL ORIFICES Free

TRUNK and SPINE : (N)

SKIN LESIONS : (N)

EXTREMITIES :
Fingers / Toes :
Deformities : } (N)
Hip Joint Examination :
Arms / Legs : } (N)
Mobility :



SYSTEMIC EXAMINATION

RESPIRATORY SYSTEM:

Breathing Pattern : Regular Periodic Shallow Gasping

Mention if baby has Respiratory distress: RR: 48/min 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 : 98% on RA Auscultation : S/S 2+ Breath Sounds : B/L AET Added Sounds :

CARDIOVASCULAR SYSTEM :

HR : 152/min BP :

Precordial Activity : N

Femoral Pulses : N

Murmurs : Nil

Other Peripheral Pulses : N

Signs of Cardiac Failure : Nil

ABDOMEN:

Shape : N

Hernia orifice : Free

Palpation : N

Anal Patency : Patent

Palpable masses :

Umbilical Cord : 2A + 1 vein

Abdominal girth :

First urine passed : not yet

Meconium passed :

NERVOUS SYSTEM:

Higher intellectual functions (Sensorium) : N

State of wakefulness : N

Prechtle Score :

Nerves :

MOTOR SYSTEM:

Passive Tone : N

Active Tone : N

Neonatal Reflexes :

Grasp : Palmar Plantar Sucking Rooting Crossed adductor :

Moro's : N DTR : N

ATNR :

Skull and Spine : N



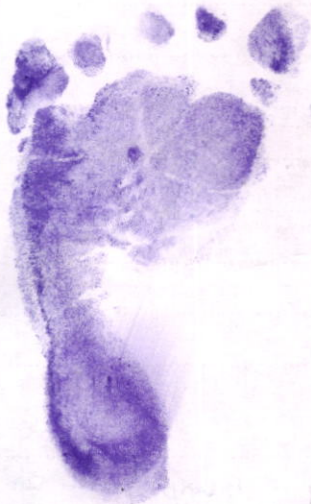
A

Diagnosis : Late PT / 36+2 / MCH / 2.867kg / LSCU / CIAB / AGA

Mother - Ref/o Hep B +ve / Obstetric cholestasis

FOOT PRINTS

Left Side :



Right Side :



Resident Doctor :

Signature : *Ramya*

Name : Dr. RAMYA

Date & Time : 26/5/26 ; 1 pm

Consultant :

Signature : *Vijayanand J.*

Name : VIJAYANAND J.

Date & Time : *26/5/26*
Reg. No. 40529

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.

Patient Sticker

AT THE TIME OF TRANSFER TO THE WARD

Final Diagnosis :

Neonatal condition at the time of Transfer:

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

Any Oxygen requirement :

Systemic :

Medications :

Plan during ward follow up :

- 1-) Warm care
- 2-) Exclusive breast feeding + Burping - 2-3rd hly.
- 3-) Cord blood → Blood grouping & typing to send today.
- 4-) Hep B Immunoglobulins } Given immediately
Hep B vaccine } after birth
Inj vit k

first feed
1:10pm - 1:25pm

Feeding Plan at the time of shifting :

- 5) OPV, BCG → to be given
- 6) NBS, IRR, OAE @ 48HOL

Screenings done during NICU Stay :

- 7) Clinical assessment of jaundice @ 24HOL
- 8) WIF feeding difficulties, hypoglycemia, resp. distress
- 9) Monitor vitals.

NSG :

Hearing Screen :

ROP :

TFT :

NP2 :

Noted by RN

Doctor Signature (Handover Given): Dr. Ramya Doctor Signature (Handover Taken):

Doctor Name: Dr. RAMYA Doctor Name:

Date & Time: 26/5/26 : Date & Time:

BAH-00657323 IP5-00174341
Baby Of MAHESHWARI KAWLE
26-05-2026 0 Y 0 M 2 D (M)
Dr. VIJAYANAND JAMALPURI



CROSS CONSULTATION FORM

Doctor Name : Dr. Venkatesh Ram Raju Date : Time :

Diagnosis :

Hospital :

Type of Referral :

- Emergency
- Urgent
- Non Urgent

Referred for : Opinion Co-Management Transfer of care

Reason for Referral : If for concurrent care specify the particular need, especially in the absence of a second diagnosis:

Signature: _____

Findings and Recommendations :

Dr. Venkatesh Ram Raju
Dr. Vijayanand Jamalpuri

Dr. B. S. Anand Chetty
(all signed)

Dr. Venkatesh Ram Raju
Dr. Vijayanand Jamalpuri

Consultant :

Name : Dr. Venkatesh Ram Raju Signature : [Signature] Date & Time : 2/5/2026

BAH-00657323 IP5-00174341
Baby Of MAHESHWARI KAWLE
26-05-2026 0 Y 0 M 2 D (M)
Dr. VIJAYANAND JAMALPURI



CROSS CONSULTATION FORM

Doctor Name : Dr. Nabeel . Date : 28/5/26 Time : 9:45am

Diagnosis : USHOL | 36+2 | 2.867kg | El. LSCs. | Obc cholestasis | Maternal Hep B+

Hospital :

Type of Referral :

Emergency

Urgent

Non Urgent

Referred for : Opinion Co-Management Transfer of care

Reason for Referral : If for concurrent care specify the particular need, especially in the absence of a second diagnosis:

Signature: _____

Findings and Recommendations :

Thanks for the referral
this being noted.

USHOL | 36+2 | 2.867kg | El. LSCs |
Obstructive cholestasis | Maternal Hep B+

Adv

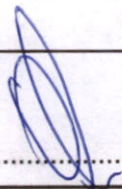
O/E - Child active
Accepting feeds.

Y/E - mild chordee +
glans tilt noted.

- No active interventions
Currently
- To review in OPD c
Dr Nabeel at 6 months
of age.

Consultant :

Name : Dr. Nabeel .

Signature : 

Date & Time : 28/5/26

10:10am

BAH-00657323 IP5-00174341
 Baby Of MAHESHWARI KAWLE
 26-05-2026 0 Y 0 M 0 D 2 H (M)
 Dr. VIJAYANAND JAMALPURI

B/o maheshwari



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
26/5/26 3:30 pm	3 HOURS OF LIFE / Lactose intolerance / LSCs	seen by Dr. vijayanand
1st	Hep-B vaxing Hep B 1g given to b/m	1. Regular feeding
	mild tachypnoea	2. monitor vitals
	Vitals: SpO ₂ - 98% R/A	3. check SpO ₂ 1 HR.
	HR - 146/min	4. BCG, OPV . Now.
	GRAB - 77 mg/dl at 3:30 pm	done on 26/5/26. Bani
		5. GRAB monitoring proceed 3, 6, 12, 24, 36, 48 hourly up to 16 & 50 mg/dl.
		shift to NICU for observation ↓ H tachypnoea settled (P. Pruthi) ↓ shift to mother side (N. Pruthi)
26/5/26 4:45 pm	Receiving notes	Dr. VIJAYANAND JAMALPURI Reg. No: 40526
	Gt HOL / Late Preterm / 36+2 / MCH / 2.86 kg / LSCs / CIAB / AUA	
	Molting → positive → Hep B positive / Obstetric cholestasis :: 34+2 wks	
	C/O: Tachypnoea (+)	Plan:
	Nasal flaring (+)	• SOS low flow O ₂ support if
	? Grunting (+)	distress 4cs.
	OIE HR = 126/min	
	RR = 72/min	
	SPO ₂ = 99% on RA	

BAH-00657323 IP5-00174341
 Baby Of MAHESHWARI KAWLE
 26-05-2026 0 Y 0 M 0 D 12 H (M)
 Dr. VIJAYANAND JAMALPURI

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	Birth	• Regular feeding
	Vaccinations } given	
	Hep Immunoglobulin given (100 IU)	• GRBS monitoring
	RS: B/LAE ⊕	• Monitor vitals
	Substernal retractions ⊕	
		Dr. Ramp
26/5/26		Secu by Dr. Vinoba
7pm		
	Baby Euthemic On RA.	
	No distress settled.	→ shift to mother side
	No retractions	→ warmth cap
	RR = 46/min.	- DBP 2nd hly
	CRT 2 sec	Flb bump
	Vitals - RR - 130/min	
	RR - 46/min	→ To monitor vitals
	SpO ₂ - 98% RA	→ w/f ↑ WOR, dull activity
	→ Accepted feeds well	poor feeding, infans
	→ No vomited	SOS
	GRBS - 7mg/dl.	→ GRBS monitoring as planned.
		Dr. Vinoba

BAH-00857323 IPS-00174341
 Baby Of MAHESHWARI KAWLE
 26-05-2026 0 Y 0 M 0 D 12 H (M)
 Dr. VIJAYANAND JAMALPURI



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
27/5/26	Seen by Dr. Bharath (Resident)	
7:10 AM	19 HOZ 36 + 2 / late preterm 2.867 Kg CIA B EL-LSCS	
	obstetric cholestasis	
	Mat. Hep B +ve	
	Hep-B Immunoglobulins given.	
	Bt wt - 2.867 Kg	Plan -
	Today wt - 2.703 Kg	- Continue DBF f/b burping
M/O + B/B	↓ 164 gm (↓ 5.7%)	Q 2-3hrly
	Urine - 3 times	- Warmth care
	motion - 3 times	- Clinical assessment of
	GRBS - 68 - 6 HOZ	Jaundice @ 24 HOZ
	59 - 12 HOZ	- SBR ?
	O/E	NBS } @ 48 HOZ (T/m)
	- Hips are stable	- w/f r work of breathing,
	- Hood at prepuce	feeding difficulties, full activity
		- GRBS monitoring as advised
		24, 36, 48 HOZ
		- Monitor vitals and Inform
		SOS.
		- Positional Talipes
		- USG Hips @ 6 weeks
		Bharath
		B
		Signature
		DR. VIJAYANAND JAMALPURI
		Reg. No: 40526



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
27/5/26	Seen by Resident (Dr. Bharath)	
1:20pm		
	TCBR @ 24 Hrs - 9.3	Plan -
	5.7% wt. loss	- Start SSPT in eyes and genitalia covered.
	GRBS @ 24 Hrs - 51	- Continue Direct breast feeding + SOS Formula feed in spoon every 2-3 hourly.
		- Monitor and Inform SOS.
		- Give formula feed in spoon [20ml].
	Positional Talipes	<u>Bharath</u>
	Hood at prepex	- USG Hips @ 6 weeks
		- Adv Ortho opinion, Pediatric surgeon opinion.
	Seen by Dr. Vijayanand	
27/5/26		Plan
3PM		- Continue SSPT
		- Regular feeding by mother
		<i>Noted by [Signature]</i>
		<u>Bharath</u>
		<i>[Signature]</i>

DR. VIJAYANAND JAMALPURI
 Reg. No. 40526

DR. VIJAYANAND JAMALPURI
 Reg. No. 40526

BAH-00657323 IPS-00174341
 Baby Of MAHESHWARI KAWLE (M)
 28-05-2026 0 Y 0 M 1 D
 Dr. VIJAYANAND JAMALPURI



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
28/5/26	Seen by	Dr. Bheerath (Resident)
7:17 AM	43 Hoz / 36+2 / 2-8-67 kg / CIAB / EI-LSCS	
	Obs. Cholestasis / Mat Hep. B +ve	
	Bt-wt - 2.867 kg	Planr
	Today wt - 2.640 kg	- Continue SSPT e eyes and
M/O+	↓ 227 gm (7.9%)	genitalia covered
B/B+		- Continue DBF + Formula feed
	Orine - 8 times	SOS e spoon every 2-3 hourly
	Stools - 3 times	- USG Hips @ 6 weeks
	↓ SSPT since 1:30 PM Yest.	- R/V ortho opinion
		Pediatric surgeon opinion
		- R/V SBR?
		NBS } 12:30 PM (48 Hoz)
		- Monitor vitals and Inform
		SOS
		- OAE after 48 hours of life.
		Bheerath
28/5/26	Seen by Dr. Vijayanand	
8:15 AM		- Regular feeding
		- Feeding assessment
		- Labs as planned
		- Ortho opinion
		- Surgical Adv.
		Dr. VIJAYANAND JAMALPURI
		Reg. No: 40526

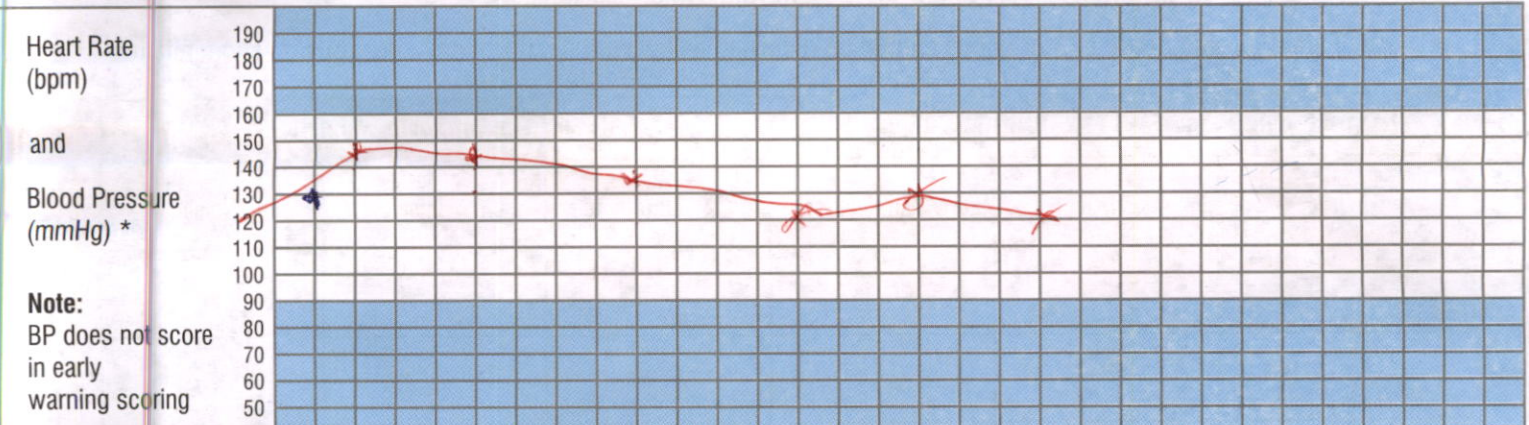
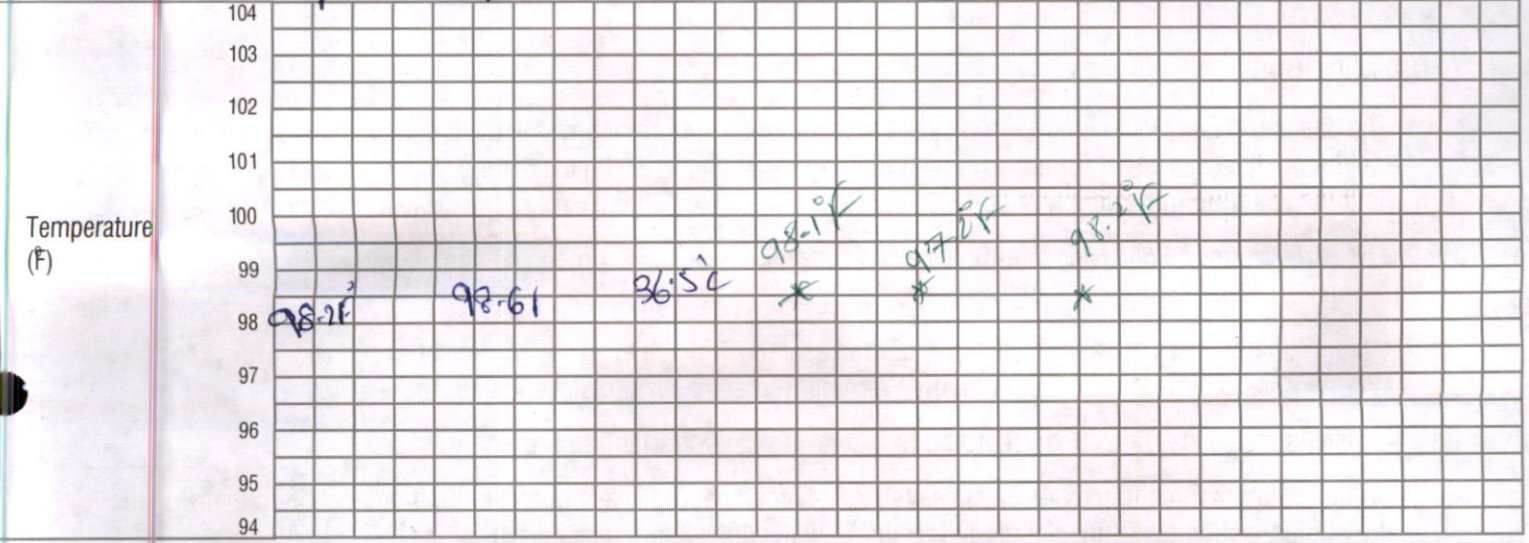


INFANT (<1 year)
Children's Observation & Early Warning Scoring Chart

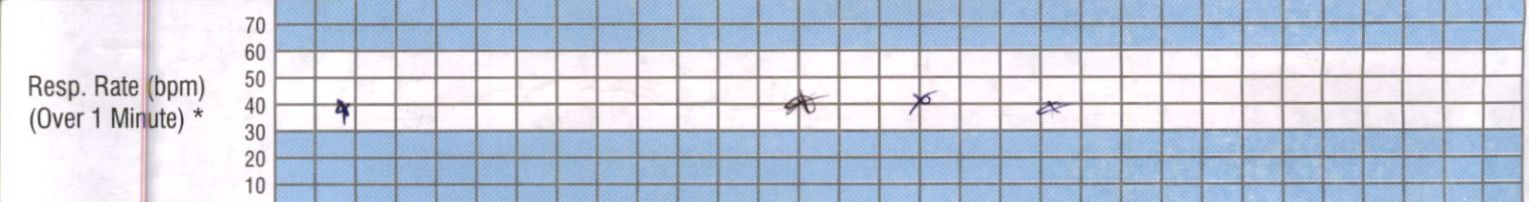
EARLY WARNING SCORE: CHILDREN'S UNIT

Date: Time:

Doctor/Nurse/Family Concern? 3pm 4pm 6pm 10pm 2AM 6AM



Heart Rate (Number) 147 142 136 128bpm 131bpm 128bpm



Resp Rate (Number) 39 42bpm 46bpm 38bpm 38bpm 33bpm

Resp Mod/ Severe Distress None / Mild

Receiving O₂(l/min) O₂Saturations (%) 98% 98% 99% 98% 98% 98%

Conscious Level Normal Altered

GCS * C (15/15) (15/15) (15/15)

TOTAL SCORE Number of shaded boxes 0 0 1 0 0 0

Pain Score 0 0 0 0 0 0

Observer's Initials R R R R R R

- 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.

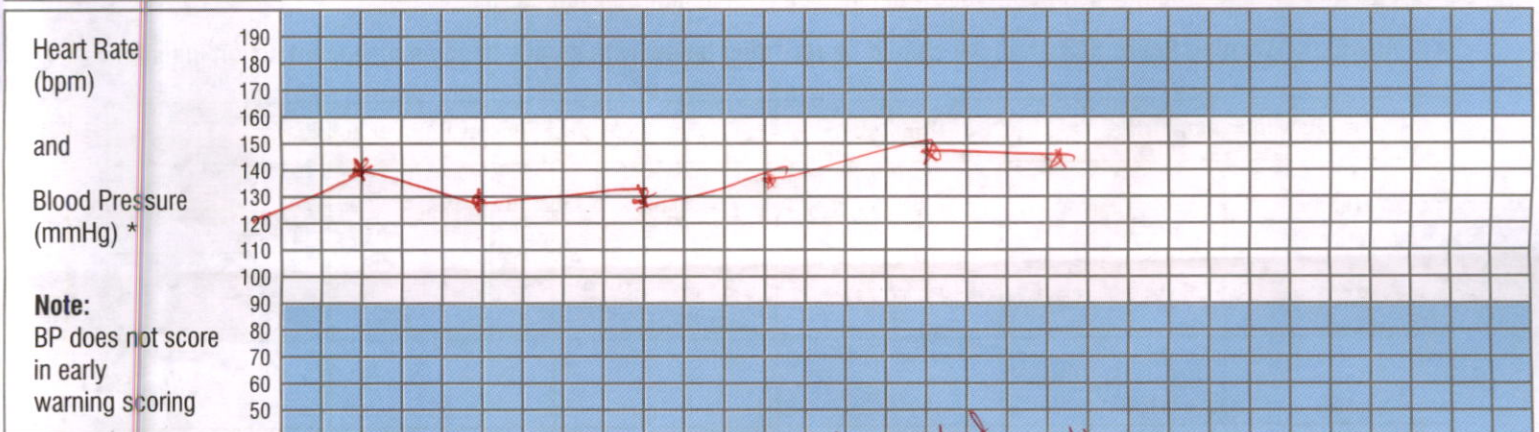
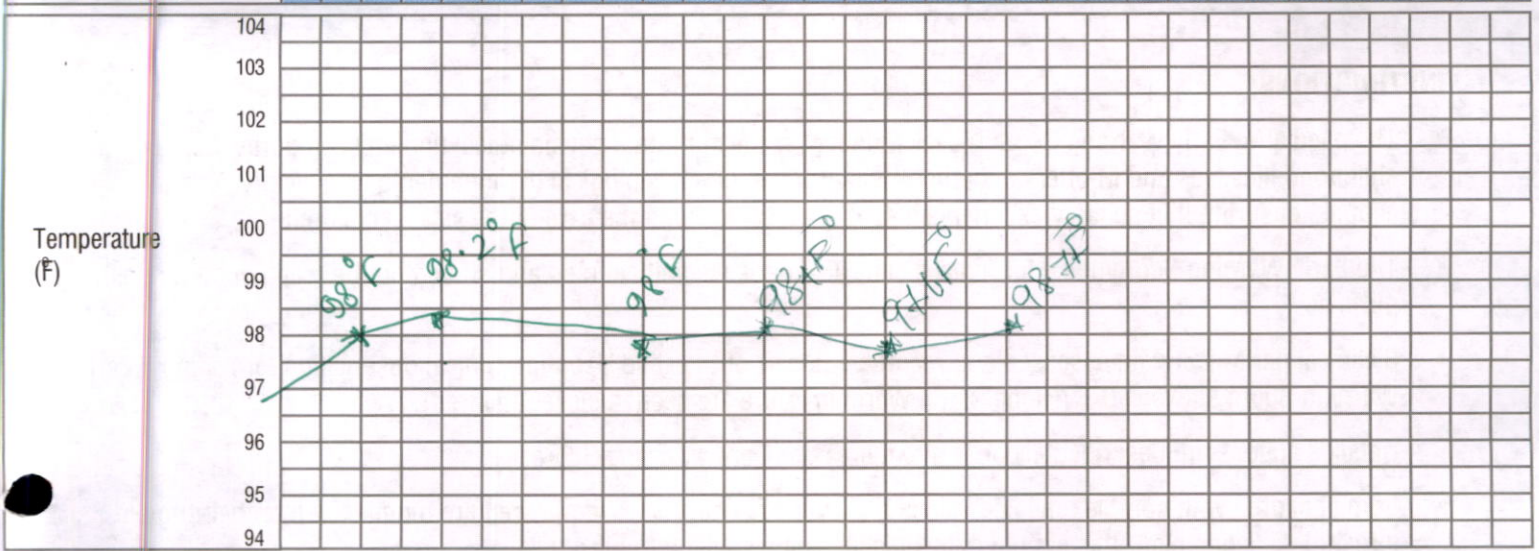
I	IDENTITY: I am (name), a nurse on ward (X). I am calling about (child X)
S	SITUATION: I am calling because I am concerned that ... (e.g. BP is low/high, pulse is XXX, Temperature is XX, Early Warning Score is XX)
B	BACK GROUND: Child (X) was admitted on (XX date) with (e.g. respiratory infection). 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)



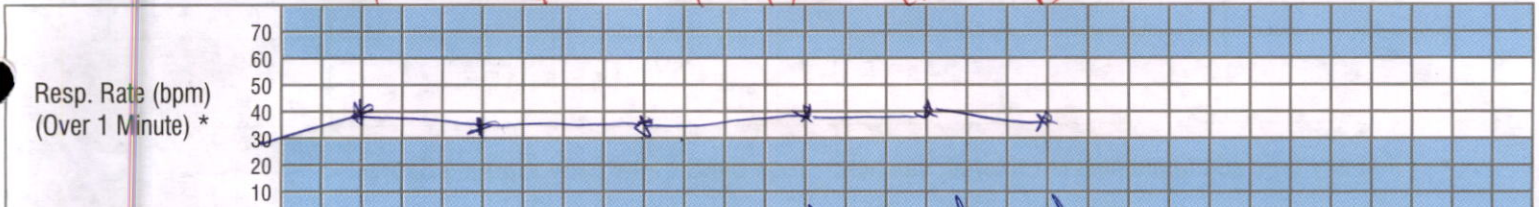
INFANT (<1 year)
Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date:	Time: 11AM	3PM	6PM	9PM	12AM	6AM
Doctor/Nurse/Family Concern?						



Heart Rate (Number)	140b/min	130b/min	130b/min	139b/min	138b/min	139b/min
---------------------	----------	----------	----------	----------	----------	----------



Resp Rate (Number)	40b/min	38b/min	38b/min	40b/min	42b/min	38b/min
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Resp Distress	Mod/ Severe	None / Mild				
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Receiving O ₂ (l/min)						
O ₂ Saturations (%)	98%	100%	99%	97%	98%	97%

Conscious Level	Normal	Altered				
GCS *						

TOTAL SCORE						
Number of shaded boxes	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0
Observer's Initials	M	M	M	R	R	R

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)

BAH-00657323 IP5-00174341
 Baby Of MAHESHWARI KAWLE
 26-05-2026 0 Y 0 M 0 D 2 H (M)
 Dr. VIJAYANAND JAMALPURI



FLUID CHART

26/5/26

Sheet No. : 10

- 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	N.G								
	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
Total Intake :		Taken			Total Output :					U- NP	M- NP		
	02:00 pm												
	03:00 pm												
	04:30 pm	DBF											
	05:00 pm												
	06:00 pm	DBF											
	07:00 pm												
Total Intake :					Total Output :					U -	M -		
	08:00 pm	DBF											
	09:00 pm												
	10:00 pm	DBF				✓							
	11:00 pm												
	12:00 am	DBF				✓							
	01:00 am												
Total Intake :					Total Output :					U - 1	M - 2		
	02:00 am	DBF											
	03:00 am												
	04:00 am	DBF				✓							
	05:00 am												
	06:00 am	DBF											
	07:00 am												
Total Intake :					Total Output :					U - 2	M - 3		
Total 24 hrs. Intake		Taken			Total 24 hrs. Output					U - 3	M - 3		



28/5/26

FLUID CHART



Sheet No. : (2)

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.
3. 24 hrs. total to be entered in the kardex in RED.

Date	Time	Nature of Fluid	Intake		Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
			Mouth	Route	NG	Diarrhoea	Vomit	Drainage	Urine			
				FF N.G								
	08:00 am											meu
	09:00 am	DBF								NO IVP		meu
	10:00 am											meu
	11:00 am					✓				Cannula		meu
	12:00 pm	DBF										meu
	01:00 pm											
Total Intake :					Total Output : U-1 m-1							
	02:00 pm	DBFT FF	25ml									
	03:00 pm											meu
	04:00 pm											
	05:00 pm	DBFT FF	25ml							NO IVP		meu
	06:00 pm	FF								Cannula		meu
	07:00 pm											
Total Intake :					Total Output : U-2 m-0							
	08:00 pm											Sueh
	09:00 pm	DBFT FF	25ml									Sueh
	10:00 pm											Sueh
	11:00 pm					✓				NO W		Sueh
	12:00 am	DBFT FF	25ml							Cannula		Sueh
	01:00 am											Sueh
Total Intake :					Total Output : M-1 U-3							
	02:00 am											Sueh
	03:00 am	DBFT FF	25ml									Sueh
	04:00 am											Sueh
	05:00 am									NO W		Sueh
	06:00 am	DBF				✓				Cannula		Sueh
	07:00 am											Sueh
Total Intake :					Total Output : M-1 U-2							

Total 24 hrs. Intake

Total 24 hrs. Output M-3 U-8